General Dental Council

GDC consultation response

Scottish Government Consultation: Regulation and licensing of non-surgical cosmetic procedures

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Response to the Scottish Government consultation: Regulation and licensing of non-surgical cosmetic procedures

1. About the GDC

The General Dental Council (GDC) is the UK-wide statutory professional regulator of over 125,000 members of the dental team, including around 45,000 dentists and around 79,000 dental care professionals (DCPs). As of 15 January 2025, there were 12,522 registered dental professionals in Scotland.

An individual must be registered with the GDC to practise dentistry in the UK. Unlike other health professional regulators, we register the whole professional team, across the four nations of the UK: dental nurses, clinical dental technicians, dental hygienists, dental technicians, dental therapists, orthodontic therapists and dentists.

Our primary objective is to protect the public, and in doing so to:

- Protect, promote and maintain the health, safety, and well-being of the public.
- Promote and maintain public confidence in the professions regulated.
- Promote and maintain proper professional standards and conduct for members of those professions.

All patients should be confident that the treatment they receive is provided by a dental professional who is properly trained, qualified, and meets our standards. To achieve this, we register qualified dental professionals, set standards for the dental team, investigate complaints about dental professionals' fitness to practise, and work to ensure the quality of dental education.

We welcome the opportunity to respond to this consultation. We recognise that there is a growing consumer market for non-surgical cosmetic procedures (NSCP) and a growing range of procedures – associated with different types and levels of risk − accessible to the public. We also recognise that there are increasing numbers of dental professionals performing NSCP, such as botulinum toxin and dermal filler injections.

We support the intention for a clear regulatory framework around the provision of NSCP – to reduce risks to patient safety and address the current gaps in regulation which may arise when GDC registrants deliver procedures that are not technically dentistry.

However, it will be important that the resultant cosmetics framework takes into account:

- The legislative requirement in the GDC’s existing regulatory model that the practice of dentistry is restricted to GDC registrants only.
- The range of training and scope of practice across different dental professional groups.
- The need for clarity amongst professionals, regulators and the public about the specific roles of different bodies involved in cosmetics and/or HCP regulation when concerns relating to the delivery of cosmetic procedures are raised.

2. How we have responded to this consultation

In section 3, we have set out our overarching concerns around proposals, which are also referenced in subsequent parts of our response.

In section 4, we have responded to selected consultation questions which are directly related to our role as dental professional regulator. We have disregarded questions which are outside of our remit to answer, in particular those around the categorisation of specific procedures based on their associated levels of clinical risk. When answering selected questions, we have sometimes chosen not to explicitly select one of the options presented in the consultation but instead have set out any issues we perceive from our perspective as a regulator of healthcare professionals (HCPs) e.g. our answer concerning age restrictions (Questions 17 and 18).

Our response also reflects some of our thinking regarding issues that have been raised in the Department of Health and Social Care (DHSC) consultation on the regulation of non-surgical cosmetic procedures in England, although we recognise the key differences between the two sets of proposals.

We also consider that it would be helpful if further clarification could be provided on a number of issues, in particular regarding the specifics around the application of the Healthcare Improvement Scotland (HIS) regulatory regime and the criteria for appropriate supervisors for group 2 procedures.

We would be happy to provide further information to the Scottish Government as this work develops. We would also welcome further discussion with the Scottish Government and other stakeholders about the issues we describe where alignment of positions and approaches is required.

3. Overarching issues

3.1. Lack of recognition of legal restrictions around 'the practice of dentistry'

The proposed cosmetic framework does not explicitly recognise, or make allowances for, the GDC's existing regulatory framework in relation to "the practice of dentistry". This poses risks around the possibility of conflicts arising between legal frameworks, the 'double' regulation of the practice of dentistry, and inadvertently encouraging illegal practice offences, as explained below.

The practice of dentistry is defined under Section 37 of the Dentists Act 1984 ('the Act'). In broad terms, practising dentistry means:

- providing the treatment, advice or attendance that would usually be given by a dentist, or
- providing any treatment, advice or attendance to a person in connection with fitting dentures, artificial teeth or other dental appliances.

For the purpose of public protection, the practice of dentistry is restricted to GDC registrants only, unless a legal exemption applies. In accordance with Section 38 of the Act, it is a criminal offence for a person who is not a GDC registrant to practise dentistry, or to offer or

imply they are prepared to practise dentistry. Anyone who practises while unregistered is at risk of prosecution for an illegal practice offence by the GDC.

We recognise that the purpose of the proposals is not to bring procedures which constitute the practice of dentistry into the scope of the proposed cosmetics framework, and we would not consider any of the procedures currently listed in the three groups to be the practice of dentistry. However, we recognise that other procedures may need to be considered for inclusion in the proposed regulatory scheme in future as a result of this consultation, or over time, as new practices and risks emerge.

Non-GDC-registrants undertaking cosmetic procedures must not be put in a situation where they are at risk of GDC prosecution because they are practising dentistry without GDC registration.

Similarly, it is essential to avoid a situation where dental professionals are expected to fulfil additional requirements to carry out procedures which they may already lawfully perform (and are regulated to perform) as GDC registrants.

Procedures which the GDC recognises as the practice of dentistry – both now and in future – must not be in the scope of the NSCP regulatory scheme, to avoid the risk that these sorts of procedures are regulated in two different ways by two different frameworks. This should be made explicit, and the resultant framework should be future proofed.

Please see our comments on tooth whitening at 5A, which are relevant.

3.2. Differences in training and scope of practice amongst the dental professions

Under the proposals, the delivery of medium-risk group 2 procedures could only be undertaken in HIS regulated premises under supervision by ‘appropriate’ HCPs. However, the consultation is silent on which specific groups of HCPs are appropriate to supervise group 2 procedures. This must be considered in the design of the regulatory regime, as supervisory arrangements are an integral patient safety mechanism.

It is also proposed that high-risk group 3 procedures would have to be carried out by ‘appropriate’ professionals. However, it is unclear whether the intention is to restrict them to doctors and nurse prescribers with advanced training, as set out in the background paper. We also note that in the consultation questions on the matter, DCP are categorised together in one group for responders to consider their appropriateness to carry out group 3 procedures, despite critical differences between the six different types of DCP.

We would like to draw attention to the broad variation that exists in training and scope of practice amongst dental – and wider healthcare - professions and have elaborated further on the issue in our response to question 14. Professional registration in and of itself will not provide an additional layer of assurance unless it is associated with requirements which are appropriate to the provision of cosmetic procedures.

The GDC regulates seven dental professions, and there are several factors which may have implications for determining whether certain cosmetic procedures or supervision could be delivered safely by different professional groups:

a. There is significant variation across professions in the knowledge and skill requirements for registration – as reflected by GDC guidance which contains the learning outcomes that individuals must be able to demonstrate by the end of the pre-registration education or training.

b. The GDC's Scope of Practice guidance, sets out the significant variation in the skills and abilities in the scope of each of the dental professions. For example, some dental professions do not diagnose, plan treatment, or provide invasive treatment to patients, meaning they have relatively limited clinical − or even patient-facing − scope compared to others. Further, some dental professionals would not usually be involved in other activities which may apply to the provision of cosmetic procedures, such as explaining risks and benefits of different treatment, or taking informed consent.
Within each professional group, scope of practice will vary between individuals, and may change over the course of an individual's career, based on their training, experience and continuing professional development.

   We note that the Scope of Practice guidance outlines key competences within the boundaries of each professional role and is not exhaustive. If a professional expands their scope of practice, this does not extend to undertaking key competences that fall under another professional title.

c. The GDC also regulates which dental professional groups can provide treatment to patients independently, known as 'direct access'. The GDC's Direct access guidance explains when certain dental care professionals can provide care to patients without prescription by a dentist. Some DCPs, such as dental nurses, dental technicians and orthodontic therapists, perform most or all of their work under supervision by another registrant or under prescription by a dentist.

d. Under medicines legislation, dentists have broad entitlement to prescribe, administer and supply medicines. In keeping with GDC's guidance on Prescribing Medicines, the GDC expects dentists to prescribe within their competence. Other arrangements exist which allow DCPs to supply or administer (but not prescribe) some medicines in particular circumstances – sometimes independently (e.g. under a Patient Group Direction or legal exemptions), and other times under prescription.

We therefore consider that dental professionals should only perform cosmetic procedures or supervision activities which are appropriate to their training and scope, and which they are trained, competent and indemnified to perform.

This may mean that some dental professionals would:

- supervision to undertake some or all group 2 procedures
- not be able to supervise some or all group 2 procedures
- not be able to undertake some or all group 3 procedures, and
- require supervision by an 'appropriate' HCP to undertake some or all group 3 procedures.

Given that amongst the dental professions, dentists are the only group with independent prescribing rights, only a dentist could potentially serve the role of the prescribing

supervising clinician during the supervision of procedures which require prescription-only medicines − where they are trained, competent and indemnified to do so.

3.3. Professional accountability and interaction between Fitness to Practise and other enforcement approaches

To adhere to the principles of right-touch regulation and ensure that professionals are regulated fairly and proportionately in the cosmetics context, it will be important that the lines of accountability for registrants delivering or supervising cosmetic procedures, and the roles of different regulatory bodies, are clarified and understood by all stakeholders. This will enable HCP regulators and other organisations involved in cosmetics regulation to develop co-ordinated, co-operative and consistent approaches when requiring things of registrants (e.g. meeting particular standards), or dealing with concerns raised about registrants. Existing gaps in regulation should be addressed without placing inappropriate burdens on professionals, or creating new gaps or needless overlaps in the way regulatory bodies work together.

We seek further information on the scenarios below:

a. Arrangements for regulation of Group 1 procedures

Under the proposals, a Local Authority licence (for the premises and the individual) would be required to carry out group 1 procedures in non-HIS regulated premises. Were a concern to be raised about a HCP undertaking group1 procedures, our understanding is that the Local Authority would take enforcement action if the professional was practising these procedures in a non-HIS regulated setting without a licence (for the premises or the individual), or the standards required for the professional to hold a licence were breached. However, we seek clarification as to the circumstances in which a Local Authority would take action and what the nature and extent of that action would be – in order to consider how this would interact with our approaches around professional standards and Fitness to Practise.

We also seek clarification around how the equivalence of the Local Authority premises licensing regime and HIS regulation would work to ensure that patients in both types of locations would be afforded similar protection.

b. Arrangements for regulation of supervised Group 2 procedures

Under the proposals, non-HCPs could only undertake group 2 procedures in a HIS regulated setting under supervision by a named regulated HCP who will be responsible for ensuring that the practitioner’s training and competence is appropriate to the procedure. This raises questions around where liability falls when there are problems linked to a group 2 procedure.

Whilst HCP supervision may provide additional safety assurances for group 2 procedures, supervisors and their HCP regulators cannot address risks in the same way as Local Authorities operating the licensing scheme for group 1 procedures. Neither the HCP, nor the HCP’s regulator, can legally require things of a non-HCP supervisee in relation to standards and is therefore not able to enforce compliance with the regulatory regime. Whilst a supervisor could opt to stop supervising someone, that does not necessarily stop the non-HCP finding another supervisor and continuing to work. We therefore consider that group 1

procedures in a licensed setting may end up being subject to a more effective enforcement regime than group 2 procedures carried out by practitioners under supervision as the enforcement regime is more clearly defined.

It is also unclear from proposals which body would be responsible for enforcement action against non-HCPs carrying out group 2 procedures, if HIS would have this role and, if so, how they would carry out appropriate enforcement action for non-HCPs where needed. A body with specific enforcement powers for non-HCPs must be ultimately responsible for determining whether a non-HCP has met and maintains the requisite standards to practise a particular cosmetic procedure.

We consider that if a HCP has properly fulfilled their supervisory requirements and upheld professional standards, they should not be held responsible for the actions of their supervisee. We would also expect that in future there will be clear training standards and criteria to be met by practitioners to enable supervising HCP to easily check whether someone is qualified to carry out certain procedures.

Were a concern to arise in connection with a supervised group 2 procedure, we seek clarification as to the circumstances in which HIS would take action and what the nature and extent of that action would be with regard to both supervisee and supervisor – in order to consider how this would interact with our approaches around professional standards and fitness to practise.

c. Arrangements for regulation of high-risk group 3 procedures

Under proposals, group 3 procedures could only be carried out in HIS regulated premises by appropriate regulated HCPs. We seek clarification as to the circumstances in which HIS would take action were a concern to be raised about a HCPundertaking a group 3 procedure, and what the nature and extent of that action would be – in order to consider how this may interact with our approaches around professional standards and fitness to practise.

4. Consultation Questions

4.1. Grouping of procedures (Q1-4)

We agree that approaches to categorisation and system-design should be based around the risks of procedures and their complications in order to most effectively protect the public. As regulator, we are not in a position to comment on the appropriate categorisation of individual procedures. It would however make sense for categories to be aligned with similar regulatory schemes across the four nations.

As discussed in section 3.1, all categories must exclude procedures which constitute the practice of dentistry − to avoid tensions arising between cosmetics and GDC regulatory frameworks and the issues that would flow from that.

We also note that on the face of it, it may seem sensible to categorise anything which is considered to be the practice of dentistry as group 3, and then restrict it to appropriate regulated dental professionals only. However, this sort of approach must not result in GDC registrants having to fulfil additional requirements for activity which they are already regulated to provide.

4.2. Questions about the proposed licensing regime (Q5-10)

Q5: Do you support or oppose the proposal that the practitioner of a Group 1 procedure operating in a licensed premises should also require a licence?

We agree that the individual practitioner should require a licence. Whilst the premises licensing process should ensure that procedures take place in locations that are safe and hygienic, the licensing process of practitioners will provide a number of important additional safeguards relating to their training and competence.

Q6. Do you support or oppose the proposal that the practitioner of a Group 1 procedure operating in a HIS regulated setting should not require a licence?

We refer to our answer to question 7.

Q7. Please provide any comments about the answers you have given to questions 5 and 6 about the proposals for the establishment of licensing arrangements for Group 1 procedures:

Although the consultation sets out that the HIS regulatory regime will take account of the training and competence of practitioners operating at HIS regulated premises, the regime was not initially set up with the purpose of regulating individual practitioners and taking enforcement action against them. We therefore seek further clarification as to how equivalence in user protection between services provided by individuals practising in Local Authority licensed venues and HIS regulated venues will be addressed. If the HIS regime cannot afford the same protection as a Local Authority licence, then practitioners should be required to obtain a licence.

It is not entirely clear from the proposals whether registered HCPs carrying out group 1 procedures in Local Authority licensed premises will be required to obtain a licence. The training and scope of particular HCPs will be relevant in this regard. We consider that it may be appropriate to require at least some groups of HCPs to obtain an Local Authority licence for group 1 procedures in line with non-HCP practitioners, where their training and scope is not relevant to the group 1 procedure(s) in question.

Q8. To what extent do you agree or disagree that the Scottish Government should establish:

- *Standards of hygiene and health and safety for licensed premises?*
- *Standards of training and qualification for licensed practitioners?*
- *Mandatory insurance and indemnity to compensate clients who suffer harm as a result of negligence or malpractice?*

We agree that the Scottish Government should establish all of the above standards and requirements. We would be pleased to input into the future work proposed to develop the education and training standards which will underpin the licensing scheme.

We also seek clarification as to how these training standards would be enforced, including which organisations would be involved in enforcement and their specific roles.

Q9. To what extent do you agree or disagree that local authority officers should have powers of inspection and enforcement, including:

- *The removing of a licence from premises or practitioners who cannot demonstrate compliance with standards established by the Scottish Government?*
- *Barring individuals from holding a licence if they are associated with serious or repeated non-compliance with the standards established by the Scottish Government?*

We agree that there is a need for a robust inspection and enforcement regime to underpin the licensing regime. However, we seek clarification as to the circumstances in which a Local Authority would take action and what the nature and extent of that action would be – in order to consider how this would interact with our approaches around professional standards and fitness to practise.

Q10. Which of the following statements do you agree with in relation to whether a vehicle can receive a licence as a premises? (Pick one)

- *Local authorities should have discretion to decide whether a vehicle can receive a licence as a premises.*
- *Vehicles should be eligible for a licence in all local authorities.*
- *I don't know.*

We acknowledge that mobile premises can offer benefits to both service users and providers. However, anecdotally we are aware that mobile service provision has caused health and safety concerns in the past through providers being able to evade regulation by moving location. In particular, we foresee issues with vehicles being moved between different Local Authorities.

Therefore, we do not think a vehicle should be able to receive a licence as a premises unless the following issues have been considered and addressed:

- a robust inspection system that ensures that all the required conditions imposed on premises have been met
- effective enforcement procedures which can accommodate the mobile nature of the venue
- consistency in licensing and inspection across Local Authorities.

4.3. Questions about the restriction of procedures to a HIS regulated setting (Q11-16)

Q11. To what extent do you agree or disagree that the Scottish Government should establish:

- *Standards of training and qualification for non-healthcare and HCPs undertaking procedures in HIS regulated services?*
- *Mandatory insurance and indemnity to compensate clients who suffer harm as a result of negligence or malpractice?*

We agree that the Scottish Government should establish all of the above standards and requirements. We would be pleased to input into the future work proposed to develop the education and training standards which will underpin the licensing scheme.

When defining mandatory insurance and indemnity requirements, it will be important to consider where liability falls between premises providers, practitioners and supervisors and how this will impact access to compensation for patients/service users.

We also seek clarification as to how these training standards would be enforced, including which organisations would be involved in enforcement and their specific roles.

Q12. Do you agree or disagree that the HCP supervising a group 2 procedure should:

- *Conduct the / any initial consultation(s) with the client?*
- *Prescribe any medications (e.g. Botox TM, lidocaine) required during the procedure, or required for the management of any complications that arise?*

We agree with the above proposals.

- *Remain available on site for the duration of any procedure?*

We consider that there should be further exploration whether the regulatory framework could provide a degree of flexibility for supervisors when considering the level of risk involved regarding different procedures within group 2 and the needs of the professionals carrying out the procedure.

It could for example be possible that remote supervision may be an acceptable option in some circumstances where the supervisor has carried out an appropriate risk assessment and would be available at short notice, if needed.

- *Be responsible for ensuring the practitioner is suitably trained for the procedure?*

We seek further clarification regarding the process that supervising HCPs will have to follow to evidence their compliance with the above requirements. Supervisors should not be expected to carry out an in-depth assessment of the supervisee's qualifications and training. The process should be simple to follow with supervisees required to provide evidence of suitable qualifications and training which can be easily checked against a list of approved qualifications.

- *Be responsible for ensuring the procedure will be undertaken safely?*

We seek further clarification around how supervising HCPs would evidence their compliance with this requirement. We consider that it is reasonable to require them to check qualifications and take responsibility for the safety of the environment. By supervising the procedure, they also take responsibility for the initial assessment, the prescription of any Prescription Only Medicines (POMs), and around managing any complications that may arise.

However, non-HCP regulated practitioners may still engage in unsafe activities that are outside the control of the supervising HCP despite the HCP fulfilling the obligations of their role. We consider that in such cases the HCP should not be made to take responsibility, including accepting liability for patient complaints.

We also draw attention to the risks to safety which may arise as unintended consequences of the supervisor-supervisee relationship. This relationship would likely involve a contractual arrangement in a commercial setting; therefore, all practitioners should be supported to mitigate risks associated with potential conflicts of interest when entering into such arrangements.

- *Be themselves suitably trained and qualified in the procedure being undertaken?*

We agree with this proposal.

Additional comments:

We seek further clarification regarding the supervisory requirements for procedures using a POM. We understand that the POM must be prescribed by a supervising professional. However, it is unclear whether non-prescribing clinicians will be precluded from supervising certain aspects of the procedure – for example, if there was an appropriately designed joint supervision arrangement.

Q13. Thinking about the HCP undertaking a group 3 procedure, which statement below do you agree with:

- *These procedures should be undertaken by a suitably trained and qualified HCP working within their scope of practice, but not otherwise be limited.*
- *These procedures should only be undertaken by certain HCPs.*

Please see list in next question and tick all that apply.

We consider that high-risk NSCP should be restricted to qualified and regulated HCPs whose training and scope of practice are relevant to the procedure, and who are trained, competent and indemnified to undertake the procedure.

In addition, it may be necessary to consider whether some HCPs require supervision by other HCPs when carrying out high-risk procedures – for example, to support safe delivery of the procedure, to manage the prescription and administration of POMs, and to ensure access to the necessary skills if complications arise.

Please refer to our comments in section 3.2 which are relevant to this question.

Q14. If your answer to the last question was that these procedures should only be undertaken by certain HCPs, please tick all the HCPs to which they should apply:

- *Medical practitioners (Doctors).*
- *Dental practitioners.*
- *Dental care professionals.*
- *Registered nurses.*
- *Registered midwives.*
- *Registered pharmacists.*
- *Registered pharmacy technicians.*

We refer to our comments in section 3.2 in which we have set out our views regarding the safe delivery of certain cosmetic procedures as well as the delivery of supervisory activity by different professional groups.

With regard to GDC registered dental professional, we consider that only dentists (and possibly dental therapists and dental hygienists) may potentially have the required training and scope of practice to carry out selected group 3 procedures. We would be happy to work with the Scottish Government to clarify the specifics of our position, as we do not have the clinical expertise around different types of NSCP.

We also refer to our answer to question 13.

Q15. Do you agree or disagree that the following settings should be required to register with HIS if they are offering NSCPs?

- *GP practices.*
- *Dental practices.*
- *Community pharmacies.*

It is important that regulatory equivalence is established across venues that are offering the same procedures carried out by professionals with comparable qualifications to ensure public safety and protect confidence in the sector. We therefore agree that all the above settings should be required to register with HIS unless there is another way that the regulation of such premises could be ensured to be equivalent.

Additionally, the roles of the different regulators need to be clearly identified and addressed to avoid regulatory gaps or overlaps. This includes providing clarity around their respective responsibilities with regard to the enforcement of training standards

There is also a risk, that dental patients who undergo both medical and NSCP at the same venue may misunderstand the regulatory regime applicable to them. Consideration should be given how the differences and resulting complaints and compensation processes can be adequately communicated.

We also refer to our comments in section 3.3 which are relevant to this question.

Q16. Do you agree or disagree that HIS should have powers of inspection, including powers of entry and inspection of unregistered settings where there is reason to believe registration is required?

Yes, we agree that such powers should be granted to allow HIS to ensure public safety.

4.4. Questions about age restrictions (questions 17-19)

Please note that rather than answering the individual questions in this section, we have set out the issues related to age restrictions which we have observed as part of our regulatory work and relevant considerations.

Q17. Which of the following statements is closest to your view? (select only one option)

- *There should be a lower age limit under which clients should not be allowed to undertake an NSCPs (different ages are considered in Question 18)*
- *There should be no lower age limit under which clients should not be allowed to undertake an NSCPs, but all procedures for under 18s should be treated as a group 3 procedure and be required to be carried out by an appropriate HCP.*
- *I don't know.*

Q18. Regardless of your answer to question 17, if an age limit is to be put in place please indicate for each procedure group what you think is the appropriate age to be set for the procedures in that group.

Proposals in the 2023 DHSC consultation on regulating NSCPs had the effect that under 18s could undergo a NSCP if it was for therapeutic purposes or to treat a disease, disorder or injury. We continue to agree with this approach and can see no other reason to expose a child to the risks of a cosmetic procedure.

We agree that for under 18s, cosmetic procedures should always be carried out by a specified HCP who is acting within their scope and is suitably trained and qualified.

We have set out our views on the importance of ensuring alignment of licensing and regulatory requirements across the four nations in section 5 A. Alignment across the four nations is of particular importance with regard to age limits for procedures, so that under 18s are not encouraged to travel to other parts of the country to obtain treatment which is illegal in their nation of residence.

Q19. Do you agree or disagree that procedures on intimate areas should only be available to clients of 18 years of age and over?

Yes, we agree.

4.5. Questions about equalities, Fairer Scotland duty, impact on island communities and UNCRC (Questions 20-23)

We emphasise the importance of equality and health inequalities impact assessments as this work progresses. Equality, diversity and inclusion considerations will be particularly important when developing the training standards associated with the cosmetics framework, to ensure that procedural risks are mitigated, and that patient groups are not disproportionately affected by adverse outcomes. For example:

- the effects of a procedure may vary across different skin types or tones, meaning people from certain ethnic or racial groups may be at higher risk of complications, or
- certain population groups may be more likely to choose to undergo particular procedures, increasing their exposure to the risks associated with those procedures.

We are conscious of the difference in ease of access to services in urban and rural areas and how provision may be impacted by the introduction of a licensing and regulatory regime. We have considered this in our response to question 10.

5. Additional comments

5.1. Tooth whitening

Tooth whitening has not been included in proposals; however, we anticipate that other stakeholders responding to this consultation may suggest that it is brought into the scope of this work.

The GDC is clear in its position that tooth whitening is the practice of dentistry. This has also been established in case law, namely the case of GDC v Jamous [2013] EQHC 1428.

As such, tooth whitening treatment can only be offered or provided by registered dental professionals in line with GDC's Scope of Practice guidance. This is regardless of the type or concentration of tooth whitening product being used.

As explained in section 3.1, the legal definition of the practice of dentistry includes giving 'treatment, advice or attendance' that would usually be given by a dentist. Therefore, various activities associated with tooth whitening treatment may constitute the practice of dentistry – for example, delivering the actual treatment to a person, handing a tooth whitening tray to a person, or advising a person on application.

Noting that under the Health and Care Act 2022 definition a cosmetic procedure could include the application of light – for the avoidance of doubt, a person applying light to another person for tooth whitening purposes would still be carrying out the practice of dentistry.

To practise dentistry (in this case, providing tooth whitening treatment) without GDC registration is an illegal practice offence which carries the risk of GDC prosecution.

Therefore, we consider that tooth whitening should remain out of scope of proposals, as the practice of dentistry is regulated by the GDC.

Under the GDC's Scope of Practice guidance, only certain dental professionals can carry out tooth whitening treatments:

- dentists can carry out tooth whitening independently
- dental therapists, dental hygienists and clinical dental technicians can carry out tooth whitening under the prescription of a dentist.

Please see our comments at section 3.1 which are also relevant to this question.

5.2. Training standards

We would be pleased to input into the future work proposed to develop the education and training standards which will underpin the regulatory scheme. We seek clarification as to how these training standards would be enforced, including which organisations would be involved in enforcement and their specific roles.

5.3. Regulatory approaches across the four UK nations

Approaches to the regulation of NSCP should be as aligned as possible across the four nations of the UK. Members of the public may cross borders to access cosmetic treatment in different nations, and professionals may provide cosmetic services in different nations over their careers. Similar approaches would promote consistent safety standards and reduce confusion amongst the public and professionals arising from differences in the various requirements for the provision of cosmetic procedures.

14 February 2025