CHAIR STATEMENT

Sharon Bennett, BACN Chair, speaks freely about her thoughts on the launch of the JCCP/CPSA.

Sharon Bennett

Dear members,

Last weekend, I attended a conference with my colleagues whilst also looking at some of the questions surrounding the BACN regarding the Joint Council of Cosmetic Practitioners (JCCP) and the Cosmetic Practice Standards Authority (CPSA). The whole BACN board is aware of the host of conflicting opinions and the reading into certain drafts which have been made available by the JCCP and CPSA.

The JCCP launch on Thursday 22nd February at the House of Lords presented the outline of the council and the CPSA. Various publications, press, medical, nursing and educational representatives attended, and the wider industry was represented. Aesthetic Journal summed the evening up in a 'On the Scene' piece, which can be found at https://aestheticsjournal.com/news/on-the-scene-jccp-launch-house-of-lords.

The JCCP is such an emotive subject, but may I firstly say, it is voluntary and no one has to join. However, before one decides either way, it is important to look at the whole cosmetic arena picture and think more open in regards to it, rather than fixated on some of the white noise that has blown up, creating confusion.

What I have gathered from listening to others, and what I have been informed, there seems to be a blur or a misunderstanding between the BACN as an organisation and the organisation and work undertaken by the JCCP and CPSA.

The BACN have representation within the JCCP just like all the other associations such as PIAPA, BCAM, BAPRAS, BAD, not to mention many expert individuals. As an association, we do not have a greater or lesser voice than any other expert or organisation. The BACN wanted to input in setting cosmetic clinical standards and clarity in educational levels as a continuation of the Health Education England (HEE) framework, which was handed by Department of Health (DoH) to the JCCP. HEE framework was loose in many areas, and is still being mapped against, ad hoc, by multiple training organisations and unfortunately regarded as the holy grail. I have asked Andrew Rankin, Vice Chair of the BACN, to give a precis of HEE and its journey.

The BACN vehemently oppose beauty therapists undertaking higher level aesthetic procedures at Level 6 and Level 7. We would not bely the excellent therapists out there who are working within their competencies at the lower levels.

Patients have to be afforded a delivery of safe, managed, well delivered, appropriate treatments mapped against a set of robust approved, evidenced clinical standards. Training must be delivered to reflect these ideals and both training and practitioners should be subject to scrutiny and appraisal. This is something I do not think anyone would disagree with. Many BACN members may say it is unsafe having beauty therapists injecting and I completely agree. However, to try and control the havoc of no regulation with which we have been dealt with (frustratingly) by the DoH and Department of Trade and Industry (DTI), perhaps making it difficult for beauty therapists by placing barriers and limitations is better than helplessly and furiously observing them carry on as they are; able to set up poor training courses delivered by lay people or unscrupulous medical practitioners and managing to acquire insurance for their low qualified delegates.

I do think both the JCCP, which owns the HEE Framework, and the CPSA are still developing and have a way to go, much like any new business would be. HEE was mandated by government to be inclusive of the beauty therapists and the final report offloaded any responsibility rather than putting a law in place.

The BACN believe cosmetic practice should be delivered by healthcare professionals. It does not seem enough that we are medical. Evidence is required to make our case and the collection of data has not been formal, with small groups (including the BACN) collecting, what is often, anecdotal reports from members. What currently exists is not enough to present to Government or change policy. This is something that has been tried before and also through HEE, and the government informed us as such.

I understand the CPSA have set up (or are in the process of setting up) a national collection base of evidence and for this I am glad, as it is too big a task for us or any small organisation and it needs properly centralising. I think we would agree also that we must look at our own regulated practitioners as the recent statistics from Safety In Beauty shows both medical and non-medical practitioners reported to them relating to poor practice, and I believe this is mirrored within the other groups who have collected some data. A code of practice is clearly not enough. Professor David Sines (JCCP Chair) has said in a number of public forums, and at the launch of the JCCP and CPSA, that he will continue to press the Government to regulate in this arena and that he agrees with the recommendations made by Keogh to limit the higher level treatments to medical practitioners only.

A robust set of evidenced clinical standards to work against are very much required and should not frighten us. It is as it should be as there are none, and very needed in our haphazard cosmetic arena where there is poor training, questionable qualifications, questionable experts, lone working and rarely a professional oversight of competence. Grandfathering clauses would ensure those who can demonstrate their experience and/or qualifications, can carry on as normal. From looking at what has been worked on to date, the non-healthcare practitioners would struggle to reach the standards. Those committees creating the standards of education and clinical practice are mainly nurses and other medical practitioners from a variety of areas of practice and expertise. Regardless of this, the CPSA have one end point in mind when creating the standards which is patient safety and not ease of practice. Any clinical standards produced need to be achievable without compromising patient safety. Additionally, what I understand at the moment, there seems to be concern over the Draft Supervision matrix which was circulated in various forums and which is still subject to final changes before its publication. I have read the Draft Supervision matrix to see where supervision is required for us for every first patient (as previously reported on social media) and I still cannot identify this. The Draft Supervision matrix which I have a copy of outlines on the front page to consider the matrix as if a Day 1 practitioner. These are for new practitioners or those who have just done a course in something new, rather than a new technique in something you are experienced in. Someone pointed out that we are supervised as student nurses, then when qualified we are also supervised (more lightly) when we work on a new ward or move into a new area of practice. An example of the outline of supervision can be considered when looking at Toxins.

The supervision matrix outlines that a non-prescribing nurse requires direct supervision for the first patient after training. Then non direct supervision for first 4 months of practice. The supervisor will deem if further supervision is necessary. (In 4 months the nurse may have performed only a few treatments or alternatively multiple, and so competency requires assessment). For prescribers, it currently outlines that it is direct supervision for first patient after training and non-direct for 2 months and more if supervisor seems necessary. For non-healthcare practitioners I have been informed that if they managed to achieve Level 7, there is no scenario where they can work independently. Supervision ranges (according to the assessment of the supervisor) from 'direct' i.e. looking over their shoulder, to being able to respond in an emergency. This latter is the named prescriber's responsibility which they will sign up to, but I am told is likely to be defined as something like 'in the same building'. Responding to an emergency might be closer supervision for fillers than for toxin for instance, but either way, close supervision is demanded.

All practitioners are being encouraged to move away from lone practice and develop networks in their geographical area either through the JCCP portal or themselves. The CPSA recognise this is an evolutionary process and will take time to establish. As an association, the BACN regions are ideal for preventing isolation and as we have already established the shadowing programme this may be something we should be doing anyway to defend our competence as experienced practitioners in emerging treatments and for new practitioners. There is scope here for the BACN to support this area of practice. I have just completed a Level 7 University mentorship course in cosmetic practice and know the NMC are currently in consultation over mentoring, supervision and assessment and the likelihood is they will move from the 2 person relationship of mentor and mentee to 3 people with an additional assessor who is expert in the field of practice.

Many beauty therapists and other Non-Healthcare practitioners will not sign up to the JCCP because they do not need to, or more likely, they will find it exceptionally challenging to attain the standards coupled with the requirement for supervision, which will be difficult for them. If they do not, or are unable then what happens to them? I do believe that they will find it more difficult to work as they now do now over time. The tightening up of filler regulation, data protection is changing considerably and insurers, pharmacies, suppliers are all at the table to put limitations in place. A solution which would help is to penalise those who prescribe or support these practitioners and we continue to work on this, it is not forgotten.

With or without non healthcare practitioners included, cross disciplinary evidenced standards of practice are required. As we well know there are many poor medical practitioners as well as non-medical. Our regulators are there to protect the patient and we have a Code but specific guidance in the cosmetic arena is lacking. My understanding is that the JCCP will be publishing in the next few weeks a detailed memorandum agreed with the General Medical Council (GMC) over joint working and recognition of the CPSA standards and the Joint JCCP/CPSA Code of Practice. Negotiations are currently taking place with all the Professional Statutory Regulatory Bodies to follow the GMC model.

I love the BACN, I love cosmetic practice and I do not support the fact that a beauty therapist can pick up a syringe. But I am not having panic attacks about it now as I used to, as I feel that at least there is something starting which can potentially develop some form of control where there is absolutely none, and change will come about. I try and see a bigger picture, which is far stronger, by having closer ties with all the multi-disciplinary medical associations and those in high positions to force the change we want. It has to be highly strategic and measured, as policy change is never based on an instinct or emotion. It is based on expert knowledge, in depth research backed evidence coupled with the legal considerations. Coming together to agree a common goal is stronger than many individual voices travelling in different directions and speeds to achieve the same. Various organisations have different roles of expertise, assets and resources which can complement each other and speed up the process to influence. Policy change takes sustained collaboration and communication with all stakeholders PLUS evidence of the need to change.

Whether anyone joins the JCCP or any other register makes no difference to the work of the BACN. The BACN supports anything or anyone that looks to clean up our industry, forces practitioners to raise the bar and scrutinise their practice. The BACN is mindful that we need to inform our members more frequently with news items and info as it emerges, however that info can be outdated within a very short space of time and suppositions made, hence we tend to await until our information can be guaranteed. (For reference, the BACN Board will communicate through the BACN Social Media sites only and all information, statements, and press releases will be on the BACN website).

In the meantime there has to be a focus on BACN issues. For instance, our own education, our successful and updated regional meetings, the Autumn Aesthetic Conference, new opportunities for facial anatomy courses which will be released, GDPR issues and guidance, VAT, business and social media courses and succeeding in our own clinics across the UK.

From all this it is fundamental to establish, what is your USP?
Being a BACN nurse I hope.

Sharon Bennett
BACN Chair