OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 16 December 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 16 December 2025

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

35th Meeting 2025, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Joe FitzPatrick (Dundee City West) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Patrick Harvie (Glasgow) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rachel Coutts (Scottish Government)
Dr George Fernie (Healthcare Improvement Scotland Death Certification Review Service)
Owen Griffiths (Scottish Government)
Annemarie MacAlpine (Association of Registrars of Scotland)
Katrina McNeill (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)
Jim Murdoch (East Ayrshire Health and Social Care Partnership)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 16 December 2025

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 35th meeting in 2025 of the Health, Social Care and Sport Committee. I have received no apologies for today's meeting.

The first item on our agenda is a decision on taking business in private. Do members agree to take items 4 and 5 in private?

Members *indicated agreement.*

Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill: Stage 1

09:16

The Convener: The second item on our agenda is an oral evidence-taking session with two panels of witnesses as part of the committee's stage 1 scrutiny of the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill. The first of this morning's panels will focus on part 2 of the bill, which relates to the functions of medical reviewers and death certification and, in policy terms, is completely unrelated to part 1.

I welcome to the committee Dr George Fernie, senior medical reviewer and Caldicott guardian, Healthcare Improvement Scotland death certification review service; Annemarie MacAlpine, president of the Association of Registrars of Scotland; and Jim Murdoch, senior manager, wellbeing planning and performance, East Ayrshire Health and Social Care Partnership, who joins us online.

We will move straight to questions from Sandesh Gulhane.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising national health service general practitioner.

Good morning. As the convener has said, part 2 of the bill has nothing to do with, and is completely separate from, part 1, but the bill is the vehicle for getting this policy into legislation. Why do we need it? Can you give me an example of when it would be necessary to use it?

Dr George Fernie (Healthcare Improvement Scotland Death Certification Review Service): A very small number of cases would be involved. An interested person review allows somebody with a connection to the deceased person to have a review of the medical certificate of cause of death. Up until now, you have been ineligible—that is, you have not been allowed to have one—if a review has already taken place.

Sandesh Gulhane: Can you give me an example of how it would work?

Dr Fernie: If somebody is unhappy with the content of the MCCD—which you will be familiar with completing, Dr Gulhane—they will normally have an opportunity to ask questions about it and have my service conduct a review. Until now, if a review had already been conducted—and I should say that we are only talking about two or three such cases in 10 years—they have not been allowed to have that other review under the Certification of Death (Scotland) Act 2011.

In my annual report of 2018-19, we identified that we would welcome the possibility of people being able to have a review. As I have said, it relates to a very small number of cases, but it just seemed inherently unfair that they could not have a review because they had had a more basic one, when they had additional information that they wanted us to test for them.

Sandesh Gulhane: You are right that I have had to fill out those certificates, and I have also gone through a level 1 investigation, which is quite thorough, to check what was happening. What is the difference between a level 1 investigation and what happens when somebody asks you for a review of the death certificate?

Dr Fernie: The interested person review is a more detailed level 2 review. I should say, though, that there was some slight blurring in the system during the pandemic. For both reviews, you have a conversation with the doctor—the sort of conversation that you, Dr Gulhane, have already experienced—and you also go through in a structured manner the content of the MCCD. The difference with a level 2 review is that there will be some corroboration of what the doctor is saying by looking at the clinical record, too.

Before the pandemic, we would check that we had the right patient with the right community health index—CHI—number, and we would check that we had the correct doctor by asking for their General Medical Council reference number and making sure that that was correct. We would also look at the emergency care summary, which would include information on medication and allergies.

However, when the pandemic came, we started to be allowed to look at the electronic key information summary too. That approach strengthened the information and was more focused, and we were able to ask more detailed questions of the certifying doctor. We are also now able to access the clinical portal in virtually all the territorial health boards. Doing that forms part of the level 2 review—we use it to confirm that what is being said is accurate. So, the level 2 review is better and more detailed.

The other thing about an interested person review is that we try to ascertain from the applicant their basis for seeking the review, so that we can try to address their concerns as thoroughly as possible. We are not obliged to do that, but we think that it is more helpful to them and gives greater transparency.

Sandesh Gulhane: Jim Murdoch, we have heard from Dr Fernie that there are possibly two or three cases that have involved this kind of review. I assume that you have enough resource capacity to deal with that.

Jim Murdoch (East Ayrshire Health and Social Care Partnership): I am a resident in the health and social care partnership in East Ayrshire. We do not commonly see such cases—I would suggest that it is uncommon. Given the limited numbers, we would seek to support the process within our existing capacity.

Our role is to support the families of people who are at that stage of life. Our integration joint board has the strategic priority of dying well, which is about supporting people at that stage and their families post death. We broadly support the bill's provisions to support accuracy in the death certification process, which will give families the confidence that, if they have any concerns, they will have a wider opportunity to raise them.

Sandesh Gulhane: On that point about confidence, I would say that, in the 2000s, there was not a great deal of confidence in the process, and things has been improved robustly as time has gone on.

Is there going to be a time limit for such a review? What would count as new evidence for it?

Dr Fernie: The time limit would remain as it stands—that is, within three years of the certificate being issued. The material should be reasonably accessible within that period. We would be happy with that limit continuing as it has been, because it has not been an issue with the system.

In 10 years, there have been a total of 13 certificates that we were not able to review. Of those, 10 had already gone through the procurator fiscal system, and there is no proposal to change that. Indeed, I do not believe that it would be in the public interest for conflicting views, perhaps, to be expressed if that were the case.

There were only three cases that we identified that we would have liked to have been able to review, to help the relatives who had suffered a loss and who had made the request. As far as the service is concerned, we do not see this as a great burden. It will benefit a small number of people, but it is still incredibly important to them that the certificate be as accurate as possible.

The three primary drivers of the death certification review service remain the same: to improve the quality and accuracy of the MCCD; to derive better public health data, something that became particularly important during the pandemic; and to strengthen clinical governance. Those are the same principles that we would want to continue with.

Sandesh Gulhane: My final question is for Annemarie MacAlpine. What is the opinion of the Association of Registrars of Scotland?

Annemarie MacAlpine (Association of Registrars of Scotland): The Association of

Registrars of Scotland supports the proposals. We do not see them having a great direct impact on our own day-to-day work, but we support them if they will bring about an improvement that will help our colleagues at the DCRS and Healthcare Improvement Scotland.

Carol Mochan (South Scotland) (Lab): I have a few questions about those situations in which a reviewer rejects an application. How might that happen? What reasons might there be for such a rejection, and how might they be communicated to people who have applied?

Dr Fernie: As I have explained, the main reason for a case being rejected now is that it has already been reported to the Procurator Fiscal Service. We think that it should deal with such cases and that they should go through the process that it has in place. We would communicate that as sensitively and as quickly as possible to the applicant and give them a clear rationale for that.

A provision in the current legislation allows us to reject a case if it is "vexatious", but we have never had to invoke it. When, at the service's inception, we discussed what would be considered vexatious, our thinking was "Hopefully, we will find out." We never have—no one has made an application for some spurious reason. They might have got hold of the wrong end of things, and they might be more concerned about the care that was delivered to the deceased person prior to their death—you can understand why they would have that concern. We have always attempted to be bereaved focused with regard to such applications and to be as sensitive and as accommodating as possible.

Carol Mochan: In that case, do you feel that, if the legislation were to be changed, those cases would not increase in number and that you could manage them as you manage them at the moment?

Dr Fernie: I believe that we could manage them in a similar way. The only reason for rejecting such cases would be if there were duplicate requests, but I do not believe that that is likely. The whole purpose of change is to be more open and to try to help relatives come to an understanding of what has happened—typically to their loved one—so that they can follow what is within the MCCD.

Carol Mochan: To what extent is there consistency across Scotland, and could the bill help with that? Do we need to consider anything in that respect, or does consistency come about quite naturally?

Dr Fernie: I believe that there is consistency. In the 10 years that the service has been in existence, we have taken a more structured approach to our annual reviews with the territorial health boards. We try to focus the reviews on what has been taking place and on the educational resources that we have available to support the boards.

One thing that we would have liked to see is mandatory training, especially for younger doctors coming into the service, but there are so many competing demands on their time that that has not been possible up until now. We have worked in conjunction with NHS Education Scotland on educational materials for its support around death—or SAD—website, which is an excellent resource, especially for doctors who are in training.

Carol Mochan: That was helpful. Are there any other safeguards that you feel that we should put in place to ensure that reviewers are consistent?

Dr Fernie: No, not in this bill. We peer review medical reviewers within the service, and we also review an annual sample of 12 per cent of MCCDs relating to non-procurator-fiscal-related deaths. That appears to be having the desired effect, because the not-in-order rate, which is the metric that we use, has fallen from just over half in the first quarter following the service's launch—that rate was due to some fairly minor administrative errors and some more significant errors—to around 18 per cent at the moment. We think that there will be another step improvement with the roll-out of electronically completed MCCDs, which we anticipate happening in secondary care in 2026. I believe that we are on track to deliver what has been asked of us.

Additionally, there are no undue delays. In our neighbouring jurisdiction, there has been some criticism of delays in the medical examiner service, whereas we have been able to deliver in real time, with a very small breach rate of the aim to complete a level 1 review in one working day and a level 2 review in three working days. I am not aware of any significant delays in funeral arrangements as a consequence.

Carol Mochan: Thank you.

09:30

The Convener: Picking up from where Carol Mochan left off, can you tell us how the reasons for rejecting a review should be communicated to interested parties?

Dr Fernie: They should be communicated clearly, transparently and as soon as possible. It is unlikely that we would reject a request for a review. The only sort of situation in which I envisage that happening is one in which part of a family was unaware that an interested person review had already been completed. However, it would depend on the individual case, because other family members might have different

reasons for seeking a review. That is why we suggest that some flexibility would be appropriate, because there might be situations in which further detail has been communicated that would make a difference to the review that we had completed.

The Convener: Would you support a formal process of appeal if a request for a review were rejected? If so, how would that work?

Dr Fernie: As somebody who is qualified in both law and medicine, I would always support an appeals process. It seems unfair not to have it. I do not quite know how it would work but, in principle, I would always support having it.

Elena Whitham (Carrick, Cumnock and Doon Valley) (SNP): Good morning. A death can lead to a very troubling time for a family. Some of the responses that we received to our call for views expressed concern about the possibility that the new procedure might cause delays. Can you reassure us that the new process would cause minimal delays—or no real delays—in the system?

Dr Fernie: That depends on the stage at which an interested person review is requested. The majority of requests are post-registration, and we would have 14 days in which to undertake such a review. I do not think that that will cause a problem.

If the request is made pre-registration—there is no reason for people not to do that—the funeral arrangements obviously cannot go ahead. Managing the process within three days—gathering the information and speaking to the relevant professionals that are involved—is very tight. However, that issue is the same just now, and I do not believe that the new arrangement is more likely to cause a problem.

Elena Whitham: The advance registration procedure was introduced recently. Do you foresee that it would still be available in those circumstances, or is there anything to prevent that?

Dr Fernie: The advance registration procedure is not new. It has existed since the start of the service, mainly to accommodate minority faith groups—the Muslim and Jewish communities. We have around 60,000 in the Muslim community and about 6,500 in the Jewish community. They have very similar requirements, which involve burial as soon as possible—before sunset or within 24 hours. We really try our best to allow that to proceed.

The only situation in which we cannot grant advance registration is when, clearly, the case should have gone to the procurator fiscal. Again, that is not going to change. That is the main possible impediment. If the certificate is substantially in order—a phrase that I coined, I think—even if we know that an amendment may be required, that does not stop the advance registration from going ahead. The same would apply in the new arrangements. I do not see it as a problem.

Elena Whitham: That is very helpful.

Do witnesses agree that clear guidance and processes should be developed, to inform those who request an additional review? How could that work in practice? Obviously, it is a change, and a lot of people do not know that the arrangements exist anyway. How should we communicate that to individuals?

Dr Fernie: Annemarie MacAlpine might answer that better than me.

Annemarie MacAlpine: It is important to educate people and make them aware that the process is available when they find themselves in that circumstance. Bereaved family members need to be given guidance and to be signposted to DCRS for the more detailed assistance that they need.

Elena Whitham: Would that take place when a registrar is dealing with a bereaved family and things that are said in the meeting lead the registrar to believe that there might be an avenue for that type of review to be requested?

Annemarie MacAlpine: I have not had that experience, but I can see that registrars might find themselves in that situation.

Elena Whitham: Jim Murdoch, you spoke about East Ayrshire health and social care partnership's dying well strategy. How do you foresee those who are working within the partnership being able to communicate the new review process effectively to people and to support them in it?

Jim Murdoch: It is always helpful to have clear guidance and to communicate it well across our communities and our workforce. We must do everything that we can to raise awareness of the process, so that families who have concerns know what their options are now and what the wider options will be as a result of the bill. We can do communications work and can raise awareness in our workforce by providing information and guidance. We could probably do more to raise awareness about those rights in our communities. We do that in the course of our work and our on-going support for families at that stage of life and more broadly as part of our on-going workforce learning and development.

The Convener: Does East Ayrshire health and social care partnership currently have policy guidance about how to inform families of their right to ask for a review?

Jim Murdoch: There will be broad information, but I will have to get back to you with the detail on that. When our workforce is supporting families at that stage, information and guidance will be provided to support the relationship between our staff and the person or family.

As I said, I think that we can work more broadly to raise awareness, and there is an opportunity to do that through the bill process.

The Convener: Yes, there will be an opportunity to expand on that work, should the bill pass. However, I am trying to establish whether there are policies and procedures for informing families about the current law regarding their right to ask for a review.

Jim Murdoch: I am not sure if there is an actual policy on that—I will have to check. However, doing that would be part of the support that we give to families in the course of our work.

The Convener: So, currently, they would be given the relevant information.

Jim Murdoch: Yes.

The Convener: This would not be something new for East Ayrshire HSCP, then.

Jim Murdoch: It would not.

The Convener: Okay; grand.

David Torrance has some questions.

David Torrance (Kirkcaldy) (SNP): Can the witnesses set out the rationale behind the 2011 act exempting the MCCD from being subject to a request for an interested person's review if the death has been investigated by the procurator fiscal? How many cases would such a scenario apply to?

Dr Fernie: The rationale was that we could come to a contrary view to that of the Scottish fatalities investigation unit with regard to the MCCD, which we did not believe would be in the public interest. We believed that there would be a loss of public confidence if we had contradictory views.

The procurator fiscal carries out a different sort of investigation. We tend to look at normal deaths, as it were—deaths that are expected—whereas the procurator fiscal looks at deaths where there is a possibility of criminality or a concern about the level of care that was provided that would potentially merit a fatal accident inquiry. In the case of a small number of deaths that come to our service—about 3 per cent, at the moment—we advise that the doctor should have reported them to the procurator fiscal, in keeping with the Crown Office and Procurator Fiscal Service's guidance. I think that it is important that we keep those separate.

In answer to your question about the numbers, as I said, we did a search in our electronic case management system. There were 10 cases for which we were unable to do an interested person review because they had already gone to the Procurator Fiscal Service.

With regard to the interested person review, you have to bear in mind that it can have different outcomes. One of them is that we would recommend that there be no change to the MCCD, because we believe that it is in order. Another is that we would recommend a change to the MCCD, and there is a process for doing that through the National Records of Scotland. The third alternative is that we would advise the doctor concerned that they should report the matter to the procurator fiscal. That advice might come several weeks or months or—exceptionally—a year or two after the death. Doctors have always been willing to do that when that has been our recommendation as a consequence of an interested person review.

David Torrance: What risks could arise if certificates from procurator fiscal cases are not subject to any further scrutiny?

Dr Fernie: That question relates more to the care that was administered to a deceased person prior to their death, and the investigation that took place in that regard. Our function is primarily to ensure that the MCCD content is as accurate as possible. Our service and the Procurator Fiscal Service have different functions in that respect.

We work in conjunction with the Scottish fatalities investigation unit, and if, after it has conducted an investigation, it has concerns that the content of the MCCD might not be correct, it will direct the doctor back to us for advice about a possible change to the MCCD. We do not work in complete isolation from the Procurator Fiscal Service, but we are very much aware of our respective purposes.

David Torrance: Finally, should the Scottish Government consider revisiting the exemption in future reforms, and are witnesses sympathetic to the argument that removing the exemption would strengthen the confidence in the process of a death certification?

Dr Fernie: Sorry—I do not understand that question.

David Torrance: Should the Scottish Government consider revisiting the exemption in future reforms of the 2011 act?

Dr Fernie: Do you mean the exemption as regards the Procurator Fiscal Service?

David Torrance: Yes.

Dr Fernie: If the Scottish Government was minded to do that, it could be done. It would have

resource implications. Again, we do not have a coronial jurisdiction, as our neighbours in the other parts of the United Kingdom do, so it would be a radically different approach to that issue. We certainly could work more closely in co-operation with the Crown Office and Procurator Fiscal Service, but that would be a different arrangement to the one that we currently have. I can see advantages and disadvantages with that. I am a visiting professor at the centre for contemporary coronial law at the University of Greater Manchester, so I have an understanding of the alternative approaches.

The arrangement that we have in Scotland has served us pretty well over the years, so you would be talking about a wider policy decision.

David Torrance: I have no further questions.

Paul Sweeney (Glasgow) (Lab): One real concern with this reform is the level of public awareness. What further action is needed to make sure that the public fully understand the cremation process and feel reassured that all necessary checks have been completed, particularly when a death has been certified in another part of the UK?

Dr Fernie: It has always been an accepted principle that we should respect the arrangements in other parts of the UK, and I do not think that that has changed. That is the policy that was promoted within the statutory guidance associated with the legislation. We do not want undue delays.

Typically, a coroner's inquest is convened and is then adjourned to allow the burial or cremation arrangements to go ahead satisfactorily. It is a matter of being focused on the bereaved.

09:45

Paul Sweeney: Do you foresee any risks in relying on certification from other parts of the UK?

Dr Fernie: There are limited risks. If anything, the processes are more akin to what existed before the medical examiner system came into being there. As I think that I said earlier, half of the deaths there go to the medical examiner and half go to the coroner. I would hope that there are adequate arrangements in England, Wales and Northern Ireland for that not to be a significant problem.

Paul Sweeney: Do you think that there need to be any specific data-sharing arrangements in place? Is there anything that you would recommend?

Dr Fernie: That might be a question that local authorities could answer better than I can. The arrangements appear to have worked well thus far, and we now have 10 years' experience. You will be aware that, prior to the current service coming into existence, we had crematorium referees and two doctors as signatories. The new system, with the revised medical certificate of cause of death, seems to have worked pretty well in conjunction with the crematorium managers in different local authorities. I am unaware of there having been any issues with that.

Paul Sweeney: Would Mr Murdoch or Ms MacAlpine like to add any comments in relation to that?

Annemarie MacAlpine: I have no further comment.

Paul Sweeney: Perhaps from a local authority perspective, Mr Murdoch. Do you have any thoughts on specific guidance or data-sharing processes that you think might be helpful?

Jim Murdoch: We would be broadly supportive of the proposed measure, as it reduces additional requirements in relation to cremation. Good communication and data sharing would be important to ensure that any concerns or risks were mitigated. We would support the measure, building on cross-border authorisation wherever possible. The provision takes us to a further stage, with an additional review under the process. That will hopefully make things more straightforward and will reassure families.

Paul Sweeney: Just to be clear, there are no specific recommendations from anyone on further guidance or processes that may be required at this stage.

I see that our witnesses agree that that is the case. That is helpful.

The Convener: I thank the witnesses for their attendance this morning. You are now free to go, but the committee will continue working.

Subordinate Legislation

The National Health Service (General Dental Services) (Scotland) Amendment Regulations 2025 (SSI 2025/380)

09:48

The Convener: As we are running slightly ahead of schedule, I will now move to agenda item 3, which is to consider one Scottish statutory instrument under the negative procedure.

The purpose of the regulations is to amend the National Health Service (General Dental Services) (Scotland) Regulations 2010 to allow health boards to include the name of a dentist on their dental lists on a provisional basis where that dentist has not yet completed mandatory training where required by regulation 5A of the 2010 regulations, and to amend provisions relating to requirements to obtain the prior approval of the Scottish dental practice board before carrying out care and treatment.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 9 December and made no recommendations in relation to the instrument. No motion to annul has so far been received in relation to the instrument.

Sandesh Gulhane: I declare an interest as a practising NHS GP.

Given the policy objectives and the movement to a high-trust, low-bureaucracy approach, I would be interested to know what sampling is taking place in terms of looking at a proportion of practices to ensure compliance. We have just been discussing death certificates, and we sample about 10 per cent of death certificates to ensure accuracy.

Moving on to the mandatory training aspect, I fully support the idea of getting people into work as dentists and, on the face of it, giving people a provisional status for six months is a very good thing. My question is, does that concern the NHS only, or does it include private work? Can a dentist take the six months and perform private work? Is there any oversight of the dentist over those first six months?

Those are my only questions. In general, I support the move to ensure that dentists are working here in Scotland.

The Convener: Does the committee agree to not make any recommendations in relation to the regulations?

Members *indicated agreement.*

The Convener: I will now suspend the meeting before we return to agenda item 2.

09:51

Meeting suspended.

09:59

On resuming—

Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill: Stage 1

The Convener: Under agenda item 2, we will continue taking oral evidence on the Non-Surgical Procedures and Functions of Medical Reviewers (Scotland) Bill, and I welcome to the committee Jenni Minto, the Minister for Public Health and Women's Health, and her officials. Supporting the minister on part 1 of the bill are Rachel Coutts and Alison McLeod, who are both lawyers at the Scottish Government, and Owen Griffiths, who is the bill team leader. I invite the minister to make a brief opening statement.

10:00

The Minister for Public Health and Women's Health (Jenni Minto): I thank the committee for the opportunity to support its consideration of the Non-Surgical Procedures and Functions of Medical Reviewers (Scotland) Bill. I have some opening comments to make about part 1 of the bill concerning non-surgical procedures, and I also have some comments about part 2 of the bill. I hope that you are content for those to be made at a later stage, during the session when you consider evidence on that part of the bill.

I will start by reflecting on the issues that we seek to address through part 1 of the bill. The issue was brought home to me and a number of other members last year at a round-table meeting, organised by Miles Briggs MSP, where we heard some harrowing experiences from people who had been seriously injured after improperly carried-out procedures.

During the past few weeks, the committee, too, has heard evidence about exactly that. Although many Scottish people undergo popular procedures with little thought to potential consequences, the committee, like me, has heard that adverse consequences can include necrosis or vascular occlusion, burns or scarring and, in the worst cases, sepsis, blindness or death. I do not say that to be alarmist or to malign the many reputable providers of those procedures; I say it to remind us all that there are serious risks to the public, which the bill seeks to address.

The bill is robust but proportionate, and it seeks to ensure that those who choose to undergo non-surgical procedures can do so safely. The bill contains substantive provisions that will make the public safer. It does so by making it an offence to provide such procedures to those under the age of 18, which I hope we can all agree is a sensible and important step. It also makes it an offence to provide procedures outwith permitted premises. Permitted premises will be safe, hygienic settings that will be subject to regulatory oversight and from which healthcare professionals will provide or manage services. The involvement of healthcare professionals also supports safe and appropriate prescribing and will enable those healthcare professionals to intervene in the event of complications. If the bill becomes law, it will be an offence for procedures regulated by it to be provided, for example, in the back of a taxi, to be given to teenage children or to be delivered at a fizz and filler party in someone's home.

Having discussed the main intent of the bill, I will highlight particular issues that might be of interest. I am, of course, happy to address any of the issues in more detail during questions.

I have said a lot about what happens when things go wrong, but I also want to reflect on some of the dedicated and highly trained practitioners, not just in the already regulated medical part of the sector but those in the broader beauty and aesthetics sector. I and my officials have met some of the practitioners who gave evidence to your committee. There is no doubt that many practitioners have invested in their own training and are committed to providing a safe and professional service to their clients. Many of you will have constituents who work in the sector and will know that the businesses are often small and female led. There is room for a thriving non-surgical procedure sector and an important continuing role for non-healthcare professionals in that sector but with some changes to current practice to support safety.

Although public safety is my priority, I have always been clear that we should not put a disproportionate burden on businesses. I am comfortable that the provisions in the bill are the least restrictive means of achieving the bill's aims. Many experts and respondents to our consultation want to see a more restrictive approach than the one that is provided for in the bill.

In many countries where procedures such as Botox or dermal fillers have been regulated, those may only be carried out by doctors or, in some countries, by doctors, dentists or nurses. However, under our proposals, I consider it appropriate that non-healthcare professional practitioners can continue to provide procedures as long as they do so in permitted premises where services are provided or managed by a healthcare professional. I will come on to training and qualification standards shortly.

I have ensured that procedures are included in the bill only when it is absolutely necessary. Lower-risk procedures that do not require to be undertaken in a setting that involves a healthcare

professional will be included in a local authority licensing scheme, akin to the scheme that is in existence for tattooing and skin piercing.

I know that the committee has heard evidence about the importance of training standards for practitioners. I am happy to reconfirm the Scottish Government's commitment to establishing training standards for procedures that are in the bill. Unfortunately, legislation that sets those standards would engage part 3 of the United Kingdom Internal Market Act 2020. I am happy to discuss that in more detail but, for the time being, I assure the committee that, although the bill does not include such provisions, the Scottish Government is engaging with the UK Government with a view to implementing training standards in a way that will be effective and workable.

The final point in relation to part 1 of the bill is the fact that, last week, a draft order was laid under the Civic Government (Scotland) Act 1982 for the Parliament's consideration. If affirmed, the order will establish a licensing scheme for low-risk procedures that do not require to be carried out in a setting that involves healthcare professionals and, therefore, do not merit inclusion in the bill. The scheme that will be established by the order and the provisions of the bill are intended to work alongside each other to provide a comprehensive regulatory regime. The order sets a date after which businesses will have to comply with the licensing scheme. I have not previously provided a date on which we intend the offences in the bill to come into force, but I take this opportunity to set out my intention that the bill will come into force on the same day that the licensing scheme becomes operable, which is 6 September 2027.

I look forward to answering the committee's questions.

The Convener: We move straight to questions.

Sandesh Gulhane: I declare an interest as a practising NHS GP, as stated in my entry in the members' register of interests.

Good morning, minister. Thank you for coming to the meeting. I have quite a lot of questions for you. My first question is about the definition of regulated healthcare professionals and the list of councils that has been provided. Why have the General Osteopathic Council and the General Chiropractic Council been included in the list? Is that necessary?

Jenni Minto: When we were creating the list of professions that we felt were appropriate to include, we wanted to understand their qualifications in prescribing and whether they understood how to mitigate any negative impact of items that they could prescribe.

Sandesh Gulhane: Would an osteopath be able to prescribe Botox?

Owen Griffiths (Scottish Government): It is not our understanding that osteopaths are currently involved in any prescribing activity. You are referring to the list of professions related to the healthcare exemption in the bill. The list has been broadly drawn to ensure that no—I hesitate to use the word "legitimate"—healthcare activity that you might expect to be associated with the list of professions is inadvertently excluded by being captured by the offences in the bill.

Sandesh Gulhane: Are there any examples of procedures that osteopaths undertake that would be exempted?

Owen Griffiths: We are not currently aware of any procedures that are being undertaken by osteopaths that would be captured by any provisions in the bill; we reconsidered that after the committee took evidence on it a few weeks ago. We can provide examples for some other healthcare professionals, such as members of the chiropractic council or the Health and Care Professions Council, but we are not aware of any current activity that osteopaths undertake to prescribe or administer injections or other procedures that might fall under the bill. However, if the osteopathic council were excluded from the list, further work would need to be done with the council to ensure that nothing was inadvertently excluded.

Sandesh Gulhane: I am sure that my colleagues will come on to that, so I will move on.

The minister spoke about permitted premises being very important. When we took evidence from dentists, they mentioned the fact that not all practices are inspected by HIS and that the regime that applies depends on whether any private work is done in the practice. How will you ensure that dentists and dentists' premises are captured?

Jenni Minto: As you point out, dentists' practices that provide NHS services are covered by NHS regulations. Therefore, we would expect permitted premises to be hygienic and adequately staffed, in line with what we would expect of NHS inspected, registered and regulated premises.

Sandesh Gulhane: The word "supervise" appears in the bill. A lot of us want to know what that means. For example, if a prescribing doctor is supervising people, do they need to be in the room during the procedure? How many people would it be appropriate for someone to supervise? Could one doctor supervise 100 people, for example, or is there a limit?

Jenni Minto: Thank you for raising that question, because I know from watching the

evidence that the definition of supervision is playing on a lot of people's minds.

As I highlighted in my opening statement, we have not included specific provisions on that in the bill, because we are still in discussions with the UK Government on the United Kingdom Internal Market Act 2020. It is the view of the Scottish Government that part 3 of that act would be engaged by legislation that set training standards in this area. We want to ensure that we have the right conversations and make the right decisions about training and supervision. That is covered under section 5 of the bill, which will allow us to make secondary legislation on such matters.

Sandesh Gulhane: Do you think that you might be able to lodge an amendment in that regard at stage 2 or stage 3?

Jenni Minto: Our conversations and work with the UK Government have been progressing. Both the Department for Business and Trade and the Department of Health and Social Care are involved. I will write to the UK Government, probably later this week, to see how we can make progress. Sadly, however, one of the unintended consequences of UKIMA is that we can no longer make specific decisions on public health that we could have made when we were part of the European Union.

Sandesh Gulhane: We heard about people going underground and doing things illegally—that is the whole point of going underground. Should practitioners who do not comply with the law be billed by the NHS for mistakes, errors or complications that they cause that force people to come to the NHS for help?

Jenni Minto: That is a really interesting question about an issue that has preyed on my mind since the first round-table meeting that I attended, when it was made clear that there is no way of specifying in records how an impact has occurred. For example, there is no part of a person's NHS records that says that something was done specifically in response to a Botox injection or whatever. We did work to assess whether we could change that, but the whole reason for bringing in regulation in this area is to ensure that we have better records of the impacts, and that will be provided as part of the regulation work that Healthcare Improvement Scotland will do.

Sandesh Gulhane: I know that time is short, so I will move on to my final question. When people go to the shops to buy paracetamol, they expect the drugs that they can buy—whether we are talking about Panadol or anything else—to essentially be the same thing. They are drugs that work and are regulated. However, we know that Botox is not always Botox, and people buy it from all sorts of different places.

We also know that people's training is not the same. If you go to a doctor, pharmacist or nurse, you expect a basic level of training. I am keen for the bill to ensure that such training takes place. At one of our first evidence sessions, we heard about a practice that removes moles and skin lumps. The overriding regulator—the person who looks at those lumps and decides whether they are cancer—is not a registered nurse and certainly not a doctor. My fear is that those lumps are not being sent to a pathology lab. I did orthopaedics for many years, and I would not have been allowed just to whip out a lump on my own with no supervision or without the consultant knowing about it. I trained in surgery for a long time. You would not see somebody for a lump or mole who is not a professional and is not regulated. Is that going to fall within the provision to ensure safety and that people are not having cancers removed in that way?

10:15

Jenni Minto: The committee heard evidence from one of the practitioners that, if they were concerned that something could be cancerous, they would direct their client to their GP, which is the right thing to do. That situation absolutely falls under the public safety element of the bill. The committee took a lot of evidence about educating the public, and your question fits into that. You raise an important point, which I am happy to take away and think about. I will ensure that we have taken proper consideration of what you have said.

Joe FitzPatrick (Dundee City West) (SNP): Minister, I go back to Sandesh Gulhane's question about regulated professional bodies and the inclusion of the General Osteopathic Council and the General Chiropractic Council. My understanding is that neither osteopaths nor chiropractors in this country are medically trained—though they are in some other countries—and I am therefore not aware of their ability to prescribe pharmaceuticals, so their inclusion is unclear. When we asked which procedures they might be covered for, we were not given an answer.

I am really concerned that we have a potential loophole that could cause confusion. People might think that, because someone is regulated by the General Osteopathic Council or the General Chiropractic Council, they can perform the procedures that are outlined in the legislation. There is no reason for people to think that, so I ask you to consider whether those two bodies should be removed from the bill to ensure that it is as clear as possible.

Jenni Minto: I thank Mr FitzPatrick for pressing that issue. In drafting the bill, we have always been clear that there is a difference between healthcare need and the aesthetic wish to have certain treatments. If I go back to my past life, I used to work with the BBC Scottish Symphony Orchestra. Two of the players had specific issues that affected their ability to play, and both were prescribed Botox injections. Children living with cerebral palsy can also get Botox injections. Therefore, we must ensure that that element of healthcare is not lost. With regard to chiropractors, they can give a hyaluronic acid injection to reduce joint pain. That is another aspect. However, I am content to take the issue away, given that it has been raised by both you and Dr Gulhane.

Joe FitzPatrick: I would appreciate it if you would do that. If someone has cerebral palsy and requires those injections, they should go to a medical practitioner to receive them. I would be concerned if people were routinely receiving medical treatment from people who are not medically trained.

I am not criticising the work that those bodies do, but neither of them have medically trained individuals. If we are inadvertently indicating to the public that they are somehow medical practitioners, I would be concerned about that. I am grateful for your agreement to look at that again and consider whether the two groups should be removed from the bill.

Jenni Minto: Given that the underlying aim of the bill is to protect public health, I am content to look at that.

Emma Harper (South Scotland) (SNP): On the back of the questions from Joe FitzPatrick and Sandesh Gulhane, I note that hyaluronic acid is a dermal filler that is registered as a medical device by the Medicines and Healthcare products Regulatory Agency, whereas the antidote, hyaluronidase, must be prescribed. There could be an issue with that. Osteopaths who are not medically trained do not prescribe, but they can give a device. Does that create a problem? If so, what work is being done with the MHRA to examine how we regulate that device? I note that it is not actually a device but a medication that has to be injected.

Jenni Minto: As you will know, Ms Harper, the MHRA is a reserved body, but you have highlighted the exact issue that we are trying to cover by saying that a healthcare specialist needs to be there in case something goes wrong. That has been the premise behind permitted premises with the right qualified staff and the regulations from Healthcare Improvement Scotland. As I said in my response to Mr FitzPatrick, I am happy to provide you with further information on that.

Emma Harper: Does that mean that, if someone is going to administer a dermal filler, they will need to have the antidote on site? Time is critical if the blood supply to someone's upper lip has been injected instead of the tissue around it. That would mean that the antidote would need to be readily available at whatever site is determined to be a Healthcare Improvement Scotland-regulated clinic.

Jenni Minto: If I have understood you correctly, you are saying that the antidote, because it is a separate prescription, needs to be held on the premises to ensure a timely intervention. That is exactly why we are saying that we need healthcare clinician specialists on site when the procedures are being carried out.

Owen Griffiths is champing at the bit to say something.

Owen Griffiths: As I understand it, what you have described is standard practice in HIS-regulated settings. Where dermal fillers are being provided for cosmetic reasons, it would be usual for the provider to hold stocks of hyaluronidase and, where HIS is regulating that, it would expect somebody who is capable of making that prescription to be available on site when the procedure is being carried out. That is standard in the regulated setting, and the bill brings the procedure into that regulated setting so that it can continue to happen.

The Convener: I will just backtrack to one of Sandesh Gulhane's questions, which was on supervision. I might have missed the answer, but I am not clear on that. Sandesh Gulhane asked how many people a healthcare professional can supervise. I am keen to hear the answer to that, because several witnesses have raised the issue with the committee. What exactly does the term "supervise" mean?

Jenni Minto: As I said to Dr Gulhane, we are still in discussions with the UK Government to understand what we can do as a result of the United Kingdom Internal Market Act 2020. When HIS is regulating specific businesses, there is a provision in legislation that says that those businesses need to be staffed appropriately. Our work on supervision runs in parallel with Healthcare Improvement Scotland and with the work that we are doing on UKIMA.

At this time, I cannot say how many people would be required to be supervised. That will be worked through once we understand the level of training and qualifications and the regulations that Healthcare Improvement Scotland deems appropriate to ensure the proper, robust regulation of those businesses.

The Convener: As things currently stand—from what you and Owen Griffiths have said—if a

dermal filler or Botox procedure is carried out in a HIS-regulated setting, a prescriber will be there who can step in and prescribe an appropriate treatment if things go wrong; however, if a single practitioner is carrying out such procedures in a room in a beauty salon or a hairdressing salon, or in their own home, they will not have access to a healthcare professional to prescribe something. Do you anticipate that, if the bill is passed as drafted, a sole practitioner would not be able to become HIS regulated and carry out those procedures?

Jenni Minto: There are a few things in that question. HIS regulation will also look at the premises, to make sure that they are safe and hygienic.

The Convener: I appreciate that. I am sorry for interrupting you, minister. My question is specifically about the supervision element. I am just trying to get my head around whether there would need to be someone on site who could prescribe an antidote or a remedy to relieve a complication.

Jenni Minto: As Owen Griffiths said, that is currently the situation with HIS-regulated premises. We are currently looking at whether that would be the requirement in this instance. It is about striking a balance and ensuring that each place to which people can go for such treatments is as safe as possible.

Paul Sweeney: Last week, the committee heard that only wholly private dental practices are HIS registered, whereas oversight by NHS boards applies only to practices that provide NHS dental services. How will the bill ensure the consistent regulation of schedule 1 procedures that are delivered in dental practices and, if HIS oversight cannot be assumed, what measures can the Government take to ensure that there are no gaps in assurance?

Jenni Minto: That is a really important question, and we will be discussing it in more detail with HIS. A key element of the bill is that premises are properly regulated, hygienic and safe. That is the work that we are currently doing with HIS.

Brian Whittle (South Scotland) (Con): Good morning. My question is on training and training standards. You will be aware that a lot of stakeholders have called for minimum training standards and mandatory qualifications to be set for all practitioners—medical and non-medical alike. What is the Government's response to those calls?

Jenni Minto: I am sorry, I did not hear your question; you were speaking from behind your hand.

Brian Whittle: I apologise. There have been calls for minimum training standards and mandatory qualifications for all practitioners. What is the Government's response to those calls from stakeholders?

Jenni Minto: I agree that appropriate training standards are needed. As you will know, the bill's contents do not include standards or supervision requirements. It is really important that we get the right training for people and that they become properly regulated. I see that as important for the Government.

10:30

Brian Whittle: I agree with that. From a practical perspective, we heard a lot about the ability of a person to take a course for a day or a couple of days, after which, all of a sudden, they are qualified. Over time, could the bill eradicate that kind of inadequate training?

Jenni Minto: One area that I am clear on, which is part of our conversation with the UK Government about the United Kingdom Internal Market Act 2020, is that we need to have a proper standard for qualifications. According to the evidence that was provided to you, the University of South Wales provides a course; we have not yet engaged with it, but we are planning to do so. We also understand that a couple of universities in Scotland are looking to provide better courses—regulated courses—that would help to ensure that the people who offer such treatments have the right training and qualifications.

Brian Whittle: How would you define approved training providers and what the curriculum would be? How do you plan to provide that? Is there a role for the Scottish Qualifications Authority in setting the standards that are related to the bill?

Jenni Minto: That may well be a role for the SQA, but it may also be for specific universities.

Brian Whittle: One risk or potential unintended consequence of the bill is that practitioners with high-level aesthetic qualifications may be prevented from practising, whereas a nurse with no Office of Qualifications and Examinations Regulation-recognised training would be permitted to carry out regulated procedures. How does the Scottish Government intend to mitigate that risk?

Jenni Minto: It came very clearly through the evidence that you have taken and the meetings that I have had that practitioners are qualified up to scottish credit and qualifications framework level 7. We will therefore be looking at how to shift credits from such training and how that would fit in with the regulated training and qualifications that we have just been talking about.

Brian Whittle: Will that be included in the bill, or will you do that under secondary legislation?

Jenni Minto: Currently, the plan is to do it under secondary legislation.

Brian Whittle: You mentioned work with the UK. What sort of consultations have you had with other UK nations on the mutual recognition of training and qualifications, so that there is a level playing field?

Jenni Minto: That is part of our conversations with the UK Government. Owen Griffiths and other Scottish Government officials have been speaking directly to its officials, so that we understand the impact of ensuring that qualifications can be as consistent as possible across the four nations and reach the standards that are appropriate to ensuring public safety across the UK.

Carol Mochan: Good morning, minister. We have heard evidence on public awareness, which you have spoken about in the past. What needs to accompany the bill in order to raise public awareness about the dangers of such procedures and how to identify reputable practitioners?

Jenni Minto: When any legislation comes in, there must be appropriate public messaging and engagement. That was made very clear through the evidence that you received on communication from Douglas White.

We have not set out a specific communication plan. Clearly, we will work on that if the bill is passed, to ensure that the right people get the information. I was asked if I would front the announcement of the consultation. I did not think that somebody in their late 50s would be the right person to do that, so we have to ensure that we target any information to the public in the right way, using channels that people can access.

Carol Mochan: Similarly, how can we combat advertising and marketing that perhaps trivialises the procedures and makes it seem like they are not medical procedures? Do we have a plan for that?

Jenni Minto: I have met the Advertising Standards Authority regarding other parts of my portfolio to talk about advertising on social media around smoking, vaping and suchlike. As you will know, advertising standards are reserved, so advertising on procedures is an issue on which we would be looking to work with other Governments across the UK.

Carol Mochan: Great. That partly answers another question that I was going to ask. I know that you have committed to doing that in the past, which is really helpful.

You indicated that we know that younger people are sometimes attracted to non-surgical procedures. The bill sets an age limit of 18. Will we need campaigning to ensure that younger people are aware of the pros and cons of such procedures? It has been suggested that a register of licensed practitioners should be created. How would that work and how would we ensure that people were made aware of it?

Jenni Minto: Public awareness is one of the most important things that every one of us, as elected representatives in Scotland, can support the Scottish Government and the public with. It is important that people understand the possible negative outcomes of receiving such treatments from unregulated practitioners, which I will certainly focus on if the bill is passed.

Patrick Harvie (Glasgow) (Green): Good morning. I just want to follow up on the questions about public awareness and perhaps draw out a little more the Government's attitude to the balance between the public sector's responsibility to provide public awareness information and providers' responsibility to provide information.

When we talk about other products on sale that have some health harms, we do not simply say that there is a public health awareness campaign and we do not simply say that providers have to give information—we say both things. I am not quite clear whether the Scottish Government is saying that it wants to regulate the information on risks that providers of such procedures have to make available. I recognise that advertising is reserved, but regulating the provision of information about risks is surely a public health matter and therefore devolved.

Jenni Minto: That is a really interesting question, Mr Harvie. I envisage that any messaging that comes from a public health perspective will display the negative aspects and the risk of doing something.

I am just thinking back to our work on the UK Tobacco and Vapes Bill with regard to ensuring—this is perhaps what you are getting at—that the onus is on manufacturers to provide such information on their packets. It is a really interesting concept and a way forward that we can certainly explore.

Patrick Harvie: Tobacco is an interesting comparison, because we require information to be provided not simply in text form but through images that are sometimes deliberately shocking.

Jenni Minto: They are graphic, yes.

Patrick Harvie: Do you expect to explore that approach in relation to non-surgical procedures?

Jenni Minto: I am certainly content to do so. Seeing the impact of bad procedures has shaped my own thoughts on the matter.

David Torrance: Good morning. My questions are on the impact on businesses. How will the Scottish Government ensure that there is clear guidance for practitioners and businesses on the compliance requirements set out in the bill?

Jenni Minto: That is key to ensuring that the bill works—we must ensure that businesses are absolutely clear about the requirements. The businesses that are currently regulated by Healthcare Improvement Scotland make it clear on their websites and their premises that they have that additional regulation.

David Torrance: If the bill is passed, what is the timeline for bringing in its provisions?

Jenni Minto: As I said in my introduction, we have just laid an SSI on the licensing for group 1 of the procedures, and the date set out in that instrument is 6 September 2027. We envisage that, if the bill is enacted, the provisions will come into force then, too. Therefore, on the assumption that the bill will be passed, businesses will have more than a year to comply with the regulations and to ready themselves for them.

David Torrance: What work has the Scottish Government undertaken to assess the financial impact on, and the viability of, small businesses as a result of the bill? What practical, financial or advisory transitional support will be available for practitioners to help businesses meet the new requirements under the bill?

Jenni Minto: We have engaged a lot with small businesses, because we recognise that the regulations will have an impact on certain businesses that are carrying out certain listed procedures, and we have also been speaking to various areas within the business elements of Government to see what support could be provided. There is a bit more work that we can do in that area to consider what support businesses might need—perhaps through, say, the Federation of Small Businesses. Those conversations are on-going, but I do recognise that we have to get the balance right.

David Torrance: How will the Scottish Government ensure that implementation of the bill does not push treatments underground, with the associated risks of reducing safety and choice?

Jenni Minto: That is always a concern when bringing in regulations. I have been asked whether we are introducing the regulations too late, and my response has been that, when it came to driving safety, it was not too late to bring in rules on wearing seat belts in cars. It is important to recognise the need to regulate in this area in order to improve public health and safety, but we need to enforce it well, too, and that is why we have been working with Healthcare Improvement Scotland and environmental health officers.

The Convener: Do you have timescales for when you expect businesses to comply with the new regulations?

Jenni Minto: We have said that we will bring the act into force on 6 September 2027. I have not had any conversations with officials on whether there will be a phased introduction, but I am happy to come back to the committee on that.

The Convener: So, that is something that you might consider.

With regard to enforcement, will the Scottish Government adopt an improvement-first approach, rather than immediate punitive measures for non-compliance on the part of businesses?

10:45

Jenni Minto: I think that I am right in saying that the evidence that you received from Healthcare Improvement Scotland described the process, which would involve inspection, making recommendations and then re-inspection. That is an appropriate way to move forward, with the caveat that it would all depend on what had gone wrong and what was being investigated.

The Convener: If an improvement notice was served to a business, how would that business be supported to improve its standards?

Jenni Minto: My understanding is that Healthcare Improvement Scotland is there to give support.

The Convener: Are you confident that Healthcare Improvement Scotland has the capacity to do that?

Jenni Minto: You had evidence from Healthcare Improvement Scotland last week about the capacity that it might or might not have. One of our on-going conversations that we are having with it is on how it will provide the regulation and enforcement work that we envisage arising from the bill. When businesses register, they will pay a one-off registration fee and then a regular fee every year after that. Our aim is for Healthcare Improvement Scotland to become financially self-sustaining as a regulator. Those are, as I have said, the on-going conversations that we are having with it.

Elena Whitham: Following on from enforcement, I want to focus on the unregulated aspects that we know will be created here. We have heard concerns that the bill might not give HIS sufficient powers, systems or resources to undertake effective enforcement in unregistered settings. What additional resource and support will Healthcare Improvement Scotland receive to enforce the bill's provisions effectively, given the scale of expectations? That relates both to the

regulated setting as well as settings outside of that, where there might be underground rogue traders.

Jenni Minto: The bill gives HIS the powers to enter unregulated settings if specific complaints have been made or if evidence has been given to it. With regard to resourcing, we expect, as I said to the convener, Healthcare Improvement Scotland's regulatory services to be financially self-sustaining—that is part of our on-going conversations.

I do recognise your point—an unregulated business would not be paying for the regulatory people. Therefore, I am content to look at that and bottom it out if we get through stage 1 and move towards stage 2.

Elena Whitham: What do you foresee as the balance between the proactive and reactive approaches that Healthcare Improvement Scotland will take? How much of its work will involve going out and having regular inspections or reacting to intelligence, and how will that balance be struck?

Jenni Minto: As you know, Healthcare Improvement Scotland is independent of Government, so the intention is that it will work out the best way of ensuring that it inspects regulated premises as often as it needs to. Food Standards Scotland and environmental health officers have similar models to ensure that premises are properly regulated.

Elena Whitham: Thinking about all the players that need to be involved in counterfeit products—you mentioned environmental health officers in relation to licences—I wonder whether there is a role for Police Scotland here, too. We know that these things already happen, but what will happen with regard to the black market and unregistered premises?

Jenni Minto: I expect all health and safety agencies, including Police Scotland, to work together. Food Standards Scotland has had a number of successful forays with regard to unregulated food products on the market, and they have been carried out very much in partnership with Police Scotland.

Elena Whitham: It would be helpful to have a route map published and on the record in the lead-up to the regulations coming into force. Are you content to do that? After all, it would be good for the industry to have a staged understanding of what is expected and at what point. There might even be an element of education in the scaled-up improvement notices that are expected. Are you content to look at that?

Jenni Minto: There has to be a route map towards full implementation with any new piece of legislation that comes in. I would be content to consider including education for businesses and the general public in the process and to think about whether we need phased implementation.

Paul Sweeney: Enforcement might sit on one side of this, but incentives sit on the other, and I want to ask about them. Practitioners have raised concerns about the burden of training costs. Could an incentive scheme be created by offering supportive grants to enable small business owners to access training and accreditation if they are to meet any new mandatory requirements or standards? That could have a positive, as well as negative, effect.

Jenni Minto: Paul Sweeney makes a really good point about how we ensure that good businesses can reach the right standard and undertake the regulatory regime that we are introducing.

As I said in reply to an earlier question—which might have come from the convener—we have been actively looking at support for businesses while we have been drafting the bill. We will continue to do so and will take on board the point about incentives.

Patrick Harvie: I just want to follow up on the enforcement theme. The bill would create an offence of providing procedures outwith permitted premises, but it does not include an offence of offering those procedures in those circumstances. Are there any existing offences that would come into play in relation to offering procedures in that way and which could play a role in enforcement? The powers to inspect premises, including powers of entry, come into play where there is a reasonable belief that the offence of carrying out the procedure has been, or is being, committed. Is there another way of allowing enforcement authorities to exercise that power of entry where procedures are being offered, or where the offer to make them available can be demonstrated, but there is no evidence that a procedure has actually happened?

Jenni Minto: I will ask Rachel Coutts to answer that from a legal perspective.

Rachel Coutts (Scottish Government): The offence relates to providing the procedure. Under criminal law, it is where the offence happens that will determine what stage you are at with regard to whatever is happening, so it will all depend on the facts and circumstances of the case. We might need to go away and look a bit further at the issue of where the actual offence happens.

Patrick Harvie: If someone makes an offer on social media, perhaps even within a friendship group, to provide procedures outwith permitted premises, is there anything in the bill, or under the

current law, that will allow enforcement action to be taken?

Rachel Coutts: That would depend. I would have to go away and look at the specific detail of where the two elements of the offence would happen. At the moment, it is about the point where provision takes place.

Patrick Harvie: If anything further could be provided in writing before the bill progresses, that would be helpful.

The Convener: I will suspend the meeting briefly for a changeover of witnesses to allow for scrutiny of part 2 of the bill.

10:54

Meeting suspended.

10:58

On resuming—

The Convener: We will now continue our evidence-taking session with the Minister for Public Health and Women's Health on the Non-surgical Procedures and Functions of Medical Reviewers (Scotland) Bill. In this part of the meeting, we will be focusing on part 2, and supporting the minister are Katrina McNeill, team leader, burial and cremation team, and Lucy Orren, lawyer, Scottish Government.

Minister, I believe that you have a further statement to make.

Jenni Minto: Thank you. I am pleased that, in the bill, we are also considering two amendments to the Certification of Death (Scotland) Act 2011, to extend the right to request an interested person review and to amend the provision concerning the authorisation of cremation in Scotland when the death has occurred elsewhere.

The extension of the interested person reviews set out in the 2011 act represents an important step in strengthening public confidence in the death certification process by allowing all relatives equal standing in being able to request an interested person review. Medical reviewers already undertake randomised reviews to improve the quality and accuracy of medical certificates of cause of death, but where such a review has taken place, an interested person review cannot then be carried out. The amendment allows individuals with a legitimate connection, such as family members, healthcare professionals or funeral directors, to request a detailed review where they believe further scrutiny is warranted. It will mean that interested persons can request a review, irrespective of whether a medical certificate of cause of death has been randomly selected for review already.

11:00

With the bill enabling further targeted reviews, all bereaved families will have the same right to request a review. The system will be more transparent and responsive, ensuring that specific issues can be examined thoroughly and sensitively. Ultimately, this amendment will enhance accountability and provide an additional safeguard to reassure the public and professionals who are involved in end-of-life care.

On the other amendment set out in the bill, section 18 of the 2011 act currently applies to deaths that occur "outwith Scotland". That includes deaths that occur in other parts of the UK, thereby creating a legal requirement for medical reviewers to authorise cremation in Scotland where a person has died in England, Wales or Northern Ireland. Other UK nations have robust procedures in place for death certification and apply relevant checks, and it is appropriate for those procedures to be respected in cases in which it is intended for the deceased to be cremated in Scotland. The amendment set out in the bill will remove the need for medical reviewers to authorise cremation where a death occurs in another part of the UK, thus recognising the reciprocal checks in other parts of the UK and avoiding unnecessary duplication of work.

The extension of interested person reviews and the amendment to section 18 of the 2011 act reflect our continued commitment to clarity, transparency, and public trust in the death certification process. The changes will not only strengthen safeguards for families and professionals but ensure that our legislation recognises existing robust checks and procedures and is responsive to real-world practice.

I therefore propose that the committee recommend the extension of interested person reviews and the amendment concerning the authorisation of cremations in Scotland where the death has occurred outwith Scotland, and I look forward to answering any questions that the committee might have.

The Convener: Thank you, minister, for those further remarks. We will move straight to questions.

Paul Sweeney: What resources will the Government put at the disposal of registrars and the death certification review service to ensure that they have sufficient capacity to handle what will clearly be an additional workload?

Jenni Minto: I will pass that question to Katrina McNeill.

Katrina McNeill (Scottish Government): There is currently a low number of interested person reviews—indeed, only six in the past

year—and the death certification review service has confirmed that it does not expect any huge increase if this amendment to the 2011 act is passed, and that any increase can be absorbed into its current workload.

Paul Sweeney: That was helpful. So, you do not envisage there being any additional workload or any effect on the timeliness of burial in such cases.

Katrina McNeill: No, we do not.

Paul Sweeney: Okay. On what timeframe does the Government expect to be able to publish clear criteria and guidance for accepting or rejecting review requests, to ensure that misuse and delays are prevented?

Katrina McNeill: That is an operational question for the death certification review service. Its random reviews are normally done within one day. Interested person reviews are done quickly, too—in maybe one or two days. We would not issue guidance on how it would do those reviews; it already knows how to do them, so it will not need any further guidance.

Paul Sweeney: Has the Government considered a transparent appeals process for declined review requests?

Jenni Minto: I am not aware of any process to decline reviews.

Paul Sweeney: Okay. To reinforce confidence in certification, would the Government, as part of these reforms, reconsider the current exemption of medical certificates of cause of death from review where the death has been investigated by the procurator fiscal?

Katrina McNeill: Do you mean the current exemption from interested person reviews?

Paul Sweeney: Yes—the exemption of MCCDs from review where the death has been investigated by the procurator fiscal.

Katrina McNeill: We could do that, but we are not aware of any call for it. The Crown Office can investigate the much wider circumstances around a death than those relating just to the MCCD. However, if there were a need to do that, we could certainly consider it, and we would be happy to engage with you further if you wanted to discuss it.

Paul Sweeney: Okay. That will be helpful when the committee comes to think about that.

What practical steps are you thinking of taking with regard to national guidance on and appropriate public communication of these changes to the provisions on interested person reviews?

Katrina McNeill: There is death certification review service statutory guidance, which is published. If the amendment in the bill is passed, we could update that to ensure that it is clear in what circumstances an interested person review can be requested.

Paul Sweeney: Is there some public interface that members of the public can use in order to understand the changes?

Katrina McNeill: Yes. It is on the Health Improvement Scotland website.

Paul Sweeney: Thank you.

The Convener: On the theme of public awareness of the right to ask for a review, how do you propose to ensure that that right is more widely known?

Jenni Minto: As I said in my introductory remarks, there will be no change to the fact that people can have reviews. That has always been the case, and people should be informed of that and aware that they can do that. The change just ensures that, if a case is randomly chosen for review, it will not stop a connected person—whether it be a member of the family or a healthcare professional—asking for a further review.

The ability for people to have a review is already there. However, what I am taking away from this is that it is, perhaps, not known widely enough, so we should probably take the issue away and look at it.

The Convener: I think that you are correct, minister, that it is not widely known. The proposed change to the legislation might be small, but it would provide an opportunity for that information to be disseminated more widely, so that members of the public—and healthcare professionals and funeral directors, in particular—could become more aware of that part of the legislation. Of course, it might have the knock-on effect of there being more requests for reviews.

Jenni Minto: I agree with you on both points, convener.

The Convener: With regard to the provisions in the bill on cross-UK cremation authorisation, how confident is the Scottish Government that the bill ensures clear, consistent processes for authorising cremations for deaths that have occurred outside Scotland?

Jenni Minto: As I noted in my introductory remarks, each of the four nations has robust procedures. We are taking note of them and operating in a way that provides consistency across the four nations.

The Convener: Are you confident about that?

Jenni Minto: Yes, I am.

The Convener: What data-sharing and governance arrangements would the Scottish Government expect to be in place across the UK jurisdictions to protect privacy and ensure accuracy?

Jenni Minto: The Scottish Government has clear guidelines for funeral directors on those areas, but Katrina McNeill can add a bit more on that.

Katrina McNeill: Information sharing between the organisations, such as the death certification review service in Scotland and the Office of the Chief Coroner in England and Wales, will comply with data protection legislation. The Scottish Government, including our office, does not actually see any of that information—we do not see personal medical records.

The Convener: Do you foresee the DCRS handling exceptional cases, such as repatriations, and ensuring that equivalent checks have taken place elsewhere?

Jenni Minto: Yes.

Katrina McNeill: Yes.

The Convener: You have both made that very clear.

How will the Scottish Government monitor and evaluate implementation, quality and timeliness across jurisdictions? Do you have plans for data gathering and report publishing?

Katrina McNeill: I am a member of the DCRS management board, and we discuss all of those issues at its quarterly meetings. We also have six-monthly meetings with DCRS about its operational procedures, where we engage on all those points.

The Convener: Do you envisage those meetings continuing if the legislation is passed?

Jenni Minto: Yes.

Katrina McNeill: Yes.

The Convener: That ends our questioning this morning, minister. I thank you and both sets of your officials for attending today.

As this is the final meeting of the Health, Social Care and Sport Committee in 2025, I want to take the opportunity, on behalf of the committee, to thank everyone who has contributed to our work this year and to wish everyone a happy and restful festive period.

11:10

Meeting continued in private until 11:34.

Official Report
Room T2.20
Scottish Parliament
Edinburgh
EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

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