OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 20 January 2026

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 20 January 2026

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
3rd Meeting 2026, 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)
*Gillian Mackay (Central Scotland) (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:

Gerald Byrne (Scottish Government)
Jackie Dunbar (Aberdeen Donside) (SNP) (Committee Substitute)
Neil Gray (Cabinet Secretary for Health and Social Care)
Liam McArthur (Orkney Islands) (LD)
Jane Miller (Health and Social Care Alliance Scotland)
Dr Joanna Teuton (Public Health Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 20 January 2026

[The Convener opened the meeting at 08:45]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the third meeting of the Health, Social Care and Sport Committee in 2026. I have received apologies from Elena Whitham and Paul Sweeney. Jackie Dunbar will be joining us as a substitute member of the committee.

Agenda item 1 is for the committee to decide whether to take items 5 and 7 in private. Do members agree to take those items in private?

Members *indicated agreement*.

Draft Climate Change Plan

08:46

The Convener: Item 2 is to take oral evidence from a second panel of witnesses on the draft climate change plan and its implications for public health in Scotland. I welcome Jane Miller, programme manager at the Health and Social Care Alliance Scotland, and Dr Joanna Teuton, health improvement manager for population health and climate change at Public Health Scotland.

We will move straight to questions.

Emma Harper (South Scotland) (SNP): I have loads of questions, but I will kick off with these. Are you aware of any health impact assessments that have been carried out in relation to policies covered by the climate change plan? If so, what were the findings? If not, what do you think such assessments could or would tell us?

Dr Joanna Teuton (Public Health Scotland): I am happy to take that question. Thank you very much for the opportunity to contribute to this session and for the committee's scrutiny of the climate change plan. Climate change, and our response to it, is a key public health issue and we are very keen to engage with the committee's work.

There have been several impact assessments of the climate change plan. I do not have the detail of the health impact assessments, but we have been contributing to some of the work on the potential health benefits and health risks.

There is quite a range of health benefits across the climate change plan for all the sectors and for buildings, transport, green space and food. However, there are also potential risks, as you point out, and potential inequalities that need to be considered.

From a public health perspective, we are keen to work with colleagues to undertake health impact assessments. We think that they are important in the design and delivery of plans. We welcome the work that has been done so far by the Scottish Government on that and support on-going work on that.

Jane Miller (Health and Social Care Alliance Scotland): I would also like to add that climate change has a disproportionate impact on particular groups, including disabled people, people living with long-term health conditions and unpaid carers. We would therefore definitely welcome an equalities angle for health impact assessments, so that we note that there is a disproportionate impact that will not be felt equally and think about applying a wider lens to health inequalities and taking a structural approach.

Emma Harper: How does climate change disproportionately affect people with disabilities and carers?

Jane Miller: It disproportionately impacts those people directly and indirectly because of health consequences. Flooding and heating will have a disproportionate impact on older people. For example, the risk of death to older people due to a lack of heating is quite significant.

There are also costs associated with climate action. Disabled people might need to have more access to energy and heat for their conditions, as will those with long-term health conditions. That will have an impact on cost for them. The cost of living crisis can have a disproportionate impact on disabled people and people living with long-term health conditions. There are multifaceted ways in which climate change can disproportionately impact those groups.

Dr Teuton: Some of the same principles apply to our policy responses, which can disproportionately impact different population groups; I am thinking of disability, socioeconomic status and gender—indeed, all the protected characteristics. As we design and deliver the policy responses, such as retrofit in housing or active travel routes, we need to do so with health and equity in mind, working with communities and with the evidence base to ensure that we anticipate any disproportionate impacts or any potential associated health risks, and maximise the health benefits.

For example, we carried out a health impact assessment, and made recommendations, on the draft plan for just transition for transport in Scotland. We were able to identify some of the potential risks for population groups, as well as the determinants of health, and to make recommendations to support the delivery of policies and plans in a way that not only mitigated those risks but helped maximise the benefits accruing from those policies.

Emma Harper: I find it quite interesting that you are talking about housing and transport, because people might not think that the issues that we are talking about relate specifically to the national health service or to health. It just shows that climate change affects all policies in all areas. Does that mean that we should be considering health in all portfolio areas? I know that other committees are scrutinising the draft climate change plan—we are doing it in the Rural Affairs and Islands Committee at the moment—but to what extent could, or should, a health-in-all-policies approach support climate change plan policies?

Dr Teuton: As this committee will probably be aware, most of the factors that affect, and create, good health lie outside the health service; in fact, around 80 per cent of the factors that influence our health are in the places where we live, work and play. Things such as transport, housing, food and income—that is, good-quality jobs—are what we refer to as the building blocks of health; the climate change plan cuts across all those areas and, as a result, we need to be thinking about those as determinants of health. If we can create policies that reduce emissions while maximising health benefits, and if we can consider potential risks to health and equity in the design and the delivery of those policies, they will produce good outcomes with regard to emissions reductions and meet some of those very significant health challenges that we have in Scotland such as the very low levels of life expectancy, and health inequality.

Therefore, we would, from a Public Health Scotland perspective, very much welcome a health-in-all-policies approach and explicit recognition that the climate change plan presents a massive opportunity to contribute to improved health and reducing health inequalities in Scotland.

Jane Miller: I agree. We need to view climate action as a way of preventing ill health and addressing health inequalities.

We would also want to recognise the role of social care in that wider picture. Social care is often quite neglected in the climate discourse; the sector does contribute emissions, but it also addresses those impacts by serving people in their communities. Therefore, we would want the role that the sector plays in that wider picture to be recognised when we consider climate impacts.

It brings me back to the point about health inequalities. A preventative approach will reduce emissions, which will give us a healthier society and put people's rights at the forefront of things, too.

Emma Harper: Thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS general practitioner. Thank you very much for joining us. How much money would it cost to decarbonise the NHS estate?

Dr Teuton: I do not come from a perspective of NHS facilities. My focus is on the public health perspective on the climate change plan, so I would not be able to answer that question.

Sandesh Gulhane: Many of our hospitals and NHS buildings are crumbling. We have a £1.5 billion maintenance backlog, and that is not an abstract concept—it means unsafe hospital buildings with reinforced autoclaved aerated concrete or water ingress, an ageing electrical supply that might not meet modern electrical

standards and standards of equipment, failing heating systems and outdated mental health facilities. As we have seen at the Queen Elizabeth university hospital, contaminated water costs lives. We are talking about the basic needs of patients, so, surely, we need to fix the basics before spending a lot of money on the decarbonisation of the infrastructure.

Dr Teuton: As I have said, I do not come from a health facilities perspective, so I am not able to respond in relation to the decarbonisation of the health service. Public Health Scotland's focus is broadly on the determinants of health and the role that decarbonisation of housing, heat in buildings, transport, food and the economy will have in improving health and addressing health inequalities. I suggest that NHS Scotland Assure—NHS National Services Scotland—which takes a lead on the decarbonisation of the health service, would probably be able to provide a more helpful response to that question than I am able to give.

Sandesh Gulhane: Given that the theme that we are on is all about NHS emissions and given the answers that we have received, I think that it is worth moving on.

The Convener: The committee could perhaps write to NSS with some of the specific questions that you want an answer for, Sandesh.

Carol Mochan (South Scotland) (Lab): I am particularly interested in active travel but also in other things to do with the decarbonisation of transport. In your public health role, are you familiar with how much energy the NHS is putting into facilitating active travel for people to get to appointments and for staff and so on?

Dr Teuton: To clarify, is your question about how much energy the NHS is putting into supporting active travel in relation to the NHS?

Carol Mochan: Yes, and about how hard you think it is working to those aims.

Dr Teuton: Again, I am not involved in working with the NHS estate; my focus is broader and relates to the population health work. However, I can say that the NHS has the NHS climate and emergency strategy, which sets out how it will deliver decarbonisation. A part of that strategy is about travel and emissions not only from the fleet but in relation to patients, staff and visitors.

I am aware that a programme of work is in place that looks at that aspect and takes a public health perspective. It is working to link up health boards with local regional transport groups in order to develop ways of enabling sustainable travel from communities into healthcare facilities. There are good relationships between health boards and local and regional transport services.

We would like to see a greater focus on the reduction of transport poverty in that context, as we know that inequalities exist in relation to access to sustainable transport generally but also in relation to accessing NHS services.

09:00

That is being taken forward. Lots of hospitals have active travel plans and are working on that. There are good relationships between NHS Scotland Assure, which leads the facilities work, and the territorial boards.

There is also a partnership group involving colleagues working in the transport sector, local authorities, health boards and public health that allows us to support, and share any learning about, the delivery of sustainable transport options that will help to address inequalities and transport poverty and to maximise health benefits.

Carol Mochan: You are absolutely right that that is important. I hear particularly about rural poverty and the lack of transport, so we do need to do some stuff on that. I was recently contacted by staff living in rural areas who told me that they just cannot get to a shift that starts at 7 in the morning unless they drive and who asked me to raise that. That is important if we want to make changes.

Does anyone else want to come in? It is hard to see that when I am online.

Jane Miller: Transport policies must be designed in a way that does not disadvantage certain groups. Some disabled people might have to use a car, as might some social care workers because of their roles. That is also particularly important in the rural context. When transport policies are being designed, we must ensure that we engage with people who might be impacted by those policies and that any financial implications are also resolved for any individuals who might be impacted.

In 2022, we did some work with Disability Equality Scotland and the Mobility and Access Committee for Scotland. We highlighted that disabled people and those delivering and receiving care can be impacted by sustainable travel plans and that it is important to ensure that a diverse range of groups are involved in any planning. It is also important to think about how people with visual impairments might be impacted by active travel infrastructure. We need to take a rights-based approach to the design and delivery of climate action policies.

Carol Mochan: My questions deal directly with transport. Can anyone on the panel tell us about the amount of mileage undertaken by staff and whether there is any plan or programme to look at how we can reduce that mileage in health and

social care? Is anyone familiar with any of that work?

Dr Teuton: I am not familiar with that. My organisation, Public Health Scotland, undertakes travel surveys, as I imagine all health boards would, to understand staff travel patterns. We will be working to develop plans, based on our surveys, to support the use of sustainable transport, with a shift to supporting active travel and the use of public transport. Some car use is obviously necessary, particularly in rural areas, but we will encourage a shift towards reducing car kilometres and increasing the uptake of sustainable transport modes.

Carol Mochan: Thank you. I appreciate those answers.

Sandesh Gulhane: Yesterday, along with First Bus, I launched Glasgow's first 24-hour bus route, the 77 from the Queen Elizabeth university hospital down into Glasgow city centre, through the west end and out to the airport. That means that any staff who live along that extensive bus route and are working late can use public transport. It also means that patients, who do not always get sick between 9 and 5, can come into hospital on the bus.

Do we need to realign our work timetables, especially late at night, to fit public transport routes? Given that public transport is so important to decarbonisation, do we need more focus on getting routes to major sites, such as the Queen Elizabeth hospital and the royal infirmaries in Edinburgh and Aberdeen? Major carbon dioxide use also occurs up there. Would that make a huge difference?

Dr Teuton: Access to health and social care facilities through sustainable transport is vital for many reasons, and not just from a carbon perspective. Public Health Scotland has recently done quite a lot of work on transport poverty, which is about people not having access to reliable, accessible, safe and available transport. We know that transport poverty can limit people's access to services, as you have outlined, and that there is a need to develop transport systems that meet those criteria so that people can access services.

It is not just about the transport system. Obviously, with public transport, it is important that we have a frequent service that goes to the right places and is safe and accessible. However, that is also linked to spatial planning and to the design and delivery of our services. We need to ensure that they are joined up so that systems take into account the fact that people work shifts or, as you say, that patients do not get sick only between 9 and 5.

Working together across health, local and national transport, spatial planning and service provision, we can develop a system of sustainable transport that supports the net zero agenda as well as access to health and social care facilities. That will also be good for the population's health, because it encourages a reduction in car use and greater active travel—given the first and last miles that are often associated with public transport—and there are the benefits of reducing air pollution. There are extensive potential implications and impacts from something like a bus route.

Jane Miller: I echo the point about interconnections and the need to ensure that, with any transport or bus routes, people can access the services that they need. We know that women are more likely to use buses and public transport, particularly for multiple short journeys, to aid caring responsibilities. Health and social care will be included in that.

There is also the wider point about making sure that people can access buses and transport. We know that, for disabled people and people with long-term health conditions, being able to get to transport can be challenging because of the infrastructure in local communities. For example, there might not be dropped kerbs or appropriate pavement infrastructure. The challenges of being able to get to transport in order to access health services also need to be taken into account.

We emphasise that interconnection and wider planning picture in terms of transport.

Sandesh Gulhane: Thank you.

Emma Harper: I have a supplementary question about car pooling and sharing. When I worked in California as a nurse, I was a member of the car pool team. You got points, and they led to prizes, which incentivised people to share a car in Los Angeles, which was a very choked-up city with lots of vehicles. A number of NHS boards have some type of car pooling or sharing schemes, including for sharing electric vehicles. Should we encourage that more? I am not necessarily talking about points and prizes; it is about encouraging people to car share more.

I have noticed that NHS Dumfries and Galloway's appointment letters advise people to show up 15 minutes early so that they can get a parking space. Maybe instead, the reverse of the appointment letter could say that people can take the number 9 bus or use a cycle route for their appointment. Should we encourage more incentivisation of things such as car pooling and use of other modes of transport to get to hospital appointments?

Dr Teuton: Yes—absolutely. Encouraging people, giving them information and providing

alternatives to car use are great ideas. I like your suggestion that, at the bottom of the appointment letter, rather than saying that people should come early to park, it should say what the options are.

Jane Miller: From a social care perspective, with the switch to electric vehicles, given that a lot of social care professionals use their own vehicles, there is a bigger point about supporting staff with being able to have more low-carbon options.

Emma Harper: Eddie Fraser of East Ayrshire Council told us in evidence that the council uses electric cars for care workers, which I think is welcomed by the staff. Thank you.

Gillian Mackay (Central Scotland) (Green): Good morning. The Scottish Care response to the Scottish Government consultation on the draft circular economy strategy in January 2026 stated:

"Without targeted support to achieve this vision, care providers will struggle to implement circular practices effectively, risking further service reductions and loss of choice for individuals who rely on care."

What further support is needed for social care to ensure that it can meet targets for waste reduction and embedding circular practices?

Jane Miller: In 2022, we worked with Scottish Care to run a series of round-table discussions on climate action in the context of social care. From that, we made recommendations, one of which was on the need for a climate emergency innovation fund for independent and third sector organisations. We proposed that the fund would enable providers to take meaningful steps on climate action, such as improving energy efficiency, adopting sustainable procurement practices and investing in greener technologies.

From our and Scottish Care's perspective, that was about making sure that there was appropriate funding for social care and recognising that, in discourse on climate action, the sector is often neglected. We wanted to highlight the role that the social care workforce can play in creating green and sustainable jobs and ensure that they are part of the just transition.

The Just Transition Commission recognised the role that sectors such as health and social care can play in supporting the economy and providing jobs, and in relation to the greener piece. We advocate that the sector should be valued for its contribution to climate action, and that the workforce should be supported through pay and conditions.

Gillian Mackay: A number of health professional leadership bodies, led by the Royal College of General Practitioners and the Royal Pharmaceutical Society, have written "A Manifesto for Health and Climate", which calls on us to

"Urgently accelerate the electronic prescribing programme, by allocating appropriate resource."

Do the witnesses have any thoughts on what impact that could have on NHS sustainability? I will go to Joanna Teuton first.

Dr Teuton: As I said to another member earlier, my focus is not on health services, so I am not as well briefed on that agenda. Unfortunately, I again point you to other parts of the health service that might be able to answer that better than I can.

Gillian Mackay: That is great—thank you.

Brian Whittle (South Scotland) (Con): I will stick to the theme of waste and focus on food waste. There is significant food wastage in hospitals—I think that the figure is more than 50 per cent in some hospitals—and the procurement policy for some major hospitals allows food to be procured south of the border, packaged and driven up the M6 every day. Have you looked at that issue, given that food waste has a huge impact on climate change?

09:15

Dr Teuton: Again, I cannot talk to the health service, but I can make some general points about that. I agree that food waste is a big contributor, both from the NHS and more broadly from the population. Reducing food waste will not only reduce emissions but have implications for disposable income and the cost of living.

The NHS is a significant anchor institution in local communities, so it is important from not just a waste perspective but a procurement perspective. A lot of work has been done in the NHS as an anchor institution to use its procurement power to source food locally, to use local suppliers and to invest in the local community through buying food. That has benefits beyond net zero; it has benefits in terms of community wealth building and investment back into communities. Therefore, as a general point, the role of the NHS as an anchor in relation to food is an important one.

Brian Whittle: I accept that the NHS should be an anchor, but I am saying that, in a lot of cases, it currently is not an anchor when it comes to food procurement. More concerning is the impact that that has on patient health, given that the quality of food is not as high as it should be and that more than 50 per cent of it is thrown away. If the NHS is supposed to be an anchor institution, why is it not, and who has the power to make sure that it is?

Dr Teuton: Again, I note that I do not work directly with the territorial boards. However, Public Health Scotland has a programme of work supporting a progression framework on anchor institutions, which is working with the health

boards on how they move forward. I imagine that boards are at different stages in fulfilling their anchor institution duties.

Work is on-going; I do not know whether that is the case in relation to the food sector in particular, but it is more generally, and I imagine that that is part of the procurement process. Again, I cannot really comment on what is currently happening in the NHS.

Emma Harper: I have a supplementary question. As a former theatre nurse, I am interested in all the changes that have been made in relation to medical gases, green theatres and so on. It is important to get people on the right inhaler, and I have been involved in learning about changes to the propellant gases that are used in multidose inhalers. There are concerns that the propellants currently used for multidose inhalers contribute to climate emissions, so is that change happening fast enough?

Dr Teuton: Again, as I am not in the NHS, I am not involved in sustainable healthcare, but I am aware that those changes have been made. I think that, in evidence last week, one of your witnesses said that Scotland was doing really well in relation to that. However, I do not have the details about that side of the NHS; my focus is more on the population health side of the work. An organisation such as NHS Scotland Assure would be in a stronger position than me to comment on something like that.

Joe FitzPatrick (Dundee City West) (SNP): I want to explore engagement and communication, both in the health and social care sector and in communities. Has there been good engagement with the health and social care sector in developing the plan?

Jane Miller: I am speaking from the social care perspective, and I would say that there needs to be a stronger emphasis on engaging with the sector around the implications of the climate change plan. Issues around buildings, transport and waste all have an impact on sectors such as health and social care, and there is a lack of awareness in that regard.

There needs to be accessible communication around climate action and what that means for people on a day-to-day level, within their roles and jobs. There also needs to be an emphasis on the impact on individuals and on ensuring that any low-carbon options are person centred. It is important to ensure that when people are receiving and delivering care, their rights, needs and preferences are at the heart of the conversations. There should be a recognition of the importance of individual choice. A small example of the importance of that point is the ban on plastic straws, which was brought in on sustainability grounds but had a significant impact on disabled people.

In relation to low-carbon options for individuals as well as the bigger initiatives, we need to make sure that people who are impacted, including staff, are engaged in the decision-making process. We would advocate for any engagement to use the six principles of inclusive communication, in order to ensure that everyone is able to participate in the conversations around climate action and sustainability.

Joe FitzPatrick: Thank you. I will come back to you on that point, but Dr Teuton wants to add something first.

Dr Teuton: As I mentioned, the NHS has a climate and sustainability strategy, with good engagement across the climate healthcare agenda in terms of how it will deliver on the climate change plan in relation to heating, car use, procurement and so on. There is a clear governance structure around that in terms of oversight of that process and engagement and working with relevant sectors in order to support delivery. At that level, there is good communication.

I support what Jane Miller said about the need for communication to be accessible and the importance of ensuring that the low-carbon options are understood and that the benefits beyond greenhouse gas emission reductions are clear. We know from the evidence that the health and cost of living benefits of a lot of climate actions have a lot of salience with the general public, so there is a strong move around stressing the benefits of many of the actions that we are taking, both in and outwith the health service, to reduce emissions.

Joe FitzPatrick: That is the area that I was keen to go into next. There are pros and cons to the initiatives, but we often just hear the challenges of making the effort: “It is too hard to cycle” and “The LEZs are too restrictive—I cannae get to my shop.” How do we make sure that people can understand the benefits to them? We heard last week that the health benefits from the LEZs are looking good, but I still get constituents complaining that they are too restrictive and that they stop them running their business. I say to them that it looks like the LEZs are saving people’s lives and ensuring that children will not suffer lifetime breathing conditions, so we need to do more in that regard. How do we ensure that people understand the benefits to them of all the initiatives that have health and climate benefits?

Jane Miller: There is a need to engage with people and involve them in the decision-making process, because that will make them more invested in the decisions that are made. It is also

important to stress the wider connection between taking climate action and reducing health inequalities and the role that those play in relation to people's human rights.

You mentioned the LEZs. We need to ensure that disabled people are involved and are aware of any potential implications. Mitigation measures need to be in place.

Engagement is key, but it needs to be done in an accessible way. That is why I mentioned the six principles of inclusive communication. We need to ensure that everyone is being engaged and able to participate, that they are aware of and understand the potential benefits, and that they are involved in the design process.

Dr Teuton: I completely agree with that. We need to think about how we frame some of this. There is an increasing recognition that the health and cost of living benefits of many of these things are important. We have done some thinking about how to frame public messages in other areas. For example, in public health, we talk about the building blocks of health as a way of explaining how we can be healthy. Work has also been done on how we frame and think about the benefits of climate action for communities. I completely agree that there is a need to engage with communities to understand issues and create solutions together.

In health and the climate world, there is a strong emphasis on place-based approaches. Often, there is a lot of synergy. For example, we want to create transport systems with health benefits that are also low carbon and equitable. We can bring those things together if we work with communities and use the tools that we have, such as the place standard tool with a climate lens, which allow us to look at those things when we conduct health impact assessments. We are able to understand and anticipate potential disbenefits and inequalities.

We also need to recognise that information alone will not change people's behaviours. Not everyone always has the capacity or the ability to act on information. Often, there are inequalities with people's ability to do that. There are structural things that we need to do to work with communities to create solutions that make low carbon, healthy options more accessible and available, and the easier choice. Sector teams working together on the areas that affect health and the climate will be really important in order to promote behaviour change.

Joe FitzPatrick: I was going to ask you about place-based planning, but I think that you have covered it.

The Convener: I am keen to hear what more the Government should do to align health and social care budgets, as well as their carbon budgets, to help them to reduce their emissions and meet emissions targets.

Dr Teuton: I can talk about that from a preventative perspective. I am sure that the committee is aware that the new population health framework has a renewed focus on the prevention agenda. I am aware that work is being done with the Scottish Government on tracking preventative spend and thinking about how that goes forward. Early engagement between health and the climate agenda will be important from a governance point of view for the Scottish Government, alongside thinking about how we can understand the cost savings for health from climate action.

We know that not doing anything will have a massive cost implication, and that climate change is having an impact on the health of our population, which will get worse. Therefore, taking action to reduce emissions is part of our prevention agenda from a health perspective and will have a cost saving.

We have talked about the health co-benefits from climate action. There will also be cost savings for the health service. Alignment between the population health framework, health service reform and the climate agenda is important in order to maximise those benefits.

09:30

Jane Miller: From our perspective, a clean and safe climate is a human right, so we would advocate for human rights budgeting in relation to raising, allocating and spending resources to meet the emissions targets. We would also advocate for looking at the wider piece around gender budgeting, particularly in relation to social care, and the wellbeing economy. We should take that broader, holistic view when we are thinking about budgeting and spending.

Brian Whittle: On the budgeting, one of the issues in the NHS is the huge use of plastics and the like. Is any work being done about how we tackle that particular issue? It is one of the biggest problems that we have in relation to climate change and the NHS.

Dr Teuton: I am sure that it is. I am not linked to NHS Scotland Assure, which is doing that work, so I do not have that information to hand—I am sorry.

Emma Harper: I have a quick question. We have been talking about population health. This evidence session is about emissions reduction and the things that we can do. Professor Sir Gregor Smith gave evidence to the committee about the climate change impacts of pandemic planning for the NHS. We know that people with disabilities and health inequalities may suffer more

disproportionately from climate impacts. I am also thinking about disease management, such as for mosquito-borne or avian influenza—I am not saying that avian influenza is mosquito-borne—and other such diseases. Climate change is causing issues with zoonotic diseases and there may be an impact on humans, too. Are those part of the planning for the future impact of climate and disease management?

Dr Teuton: That planning is on two levels. The UK Health Security Agency does work on the impact of climate change, including in terms of vector-borne diseases and zoonosis. It published its most recent report on the state of the evidence around that a couple of years ago: "Health Effects of Climate Change in the UK: State of the Evidence 2023". We have a sense of where that is that currently. In addition, the Climate Change Committee does a risk assessment technical report, which sets out the position in relation to those impacts—not only the climate impacts but the implications for health. We have that evidence base. The latest technical report is due to come out next year—that work is being done and I am aware that health is a significant part of that.

In Public Health Scotland, we are beginning to look at some of the data from Scotland on the impacts of climate change on health outcomes. Work is beginning on heat and temperature-related mortality. We are in a position to consider that in relation to the wider surveillance of diseases. We have a Lyme disease surveillance programme in Scotland and we are considering supplementing it with other programmes.

Those things need to be thought about and how we do that will be determined by the extent to which we reduce emissions, because that will have an impact on the climate effects, which, subsequently, have an impact on health.

The Convener: I thank the witnesses for the evidence. The committee will write to relevant stakeholders about the information that the witnesses were not able to speak to today.

The meeting will briefly go into private session.

09:34

Meeting continued in private.

10:01

Meeting continued in public.

Subordinate Legislation

Scotland Act 1998 (Modification of Schedule 5) Order 2026 [Draft]

The Convener: Our third agenda item is consideration of one affirmative instrument: the draft Scotland Act 1998 (Modification of Schedule 5) Order 2026. This draft statutory instrument requires approval by resolution of the Parliament before it can become law. In this case, the instrument also requires approval by both houses of the United Kingdom Parliament before it can become law.

The purpose of the order is to provide for a limited exception to the list of reserved matters in schedule 5 to the Scotland Act 1998, in respect of the identification and regulation of substances and devices for use in assisted dying. The order has been laid in the context of the Assisted Dying for Terminally Ill Adults (Scotland) Bill. I welcome Liam McArthur, the member in charge of the bill, to our meeting.

The order will enable the Scottish Parliament, subject to certain limitations, to confer a power on the Scottish ministers by way of subordinate legislation made with the agreement of the secretary of state to identify substances and devices for use in assisting a terminally ill adult to voluntarily end their own life, and to confer a power on the secretary of state to regulate such substances and devices by way of subordinate legislation.

The Delegated Powers and Law Reform Committee considered the order at its meeting of 13 January 2026 and made no recommendations. However, it agreed to write to this committee and to the Scottish Government with further questions about the order.

We will now have an evidence session on the order with the Cabinet Secretary for Health and Social Care and supporting officials. Once we have had any questions answered, we will proceed to a formal debate on the motion.

I welcome to the committee Neil Gray, the Cabinet Secretary for Health and Social Care, and, from the Scottish Government, Gerald Byrne, head of constitutional policy; Nicki Crossan, assisted dying shadow bill team leader; and Ailsa Garland, principal legal officer. I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Social Care (Neil Gray): Good morning. Thank you for inviting me to speak about the draft Scotland Act

1998 (Modification of Schedule 5) Order 2026, and for considering the order in such a timely manner.

As the committee will know, after Liam McArthur's Assisted Dying for Terminally Ill Adults (Scotland) Bill passed the stage 1 vote last May, the Scottish Government committed to engaging with the UK Government to try to resolve the legislative competence issues identified with the bill. Work has taken place at pace to fulfil that obligation and to lay the order ahead of the Scottish Parliament's stage 3 proceedings, so that members are free to make decisions based on their own convictions, and those of their constituents, rather than on whether the bill is outwith competence.

This section 30 order is the result of that work, although it must be noted that it goes only some way towards resolving those issues, and a section 104 order or other measures will still be needed to resolve the remaining issues with the bill. The details of that order are still being worked through, bearing in mind that a section 104 order can be laid in the UK Parliament only after a bill receives royal assent.

It was with that in mind that we opted to focus our attention on the section 30 order in the first instance, given that it also needs to be laid in the Scottish Parliament and is, therefore, time bound by the dissolution of Parliament ahead of the Scottish election later this year.

The section 30 order will modify schedule 5 to the Scotland Act 1998, which defines reserved matters for the purposes of that act. It will give the Scottish Parliament limited competence to legislate in relation to the identification and regulation of substances and devices for use in assisting terminally ill adults to voluntarily end their own lives.

The conferral of competence is time limited, in that it extends only to provision contained in an act of the Scottish Parliament that results from a bill passed before 7 May 2026. That means that it can apply only to Mr McArthur's Assisted Dying for Terminally Ill Adults (Scotland) Bill. That was felt by both the Scottish Government and the UK Government to be appropriate, given that both Governments are neutral on the issue of assisted dying and do not, therefore, feel that it would be right to pre-empt any future legislation brought to the Scottish Parliament on the issue, should the bill not pass the stage 3 vote.

Although the order will enable the Scottish Parliament to confer a power on the Scottish ministers to identify substances or devices by way of subordinate legislation, the committee will note that that must be with the agreement of the secretary of state. Similarly, the order will enable the Scottish Parliament to confer a power on the secretary of state to regulate such substances or devices by way of subordinate legislation.

I recognise that these are slightly unusual provisions. However, the UK Government was extremely keen that UK ministers retain a role in the overarching regulation of medicines and devices, which is a reserved matter, as they felt that that would be the best way of ensuring continued regulatory consistency across the UK.

It should be noted that, although the section 30 order will make the necessary provision for the Scottish Parliament to legislate on the identification and regulation of substances and devices, at this time, the bill includes provision only for the identification of substances in section 15(8). It would need to be amended to include provision for the identification of devices, an aspect that was introduced into the bill at stage 2, and for the regulation of both substances and devices.

The inclusion of provisions on the regulation of substances and devices is to allow the Medicines and Healthcare products Regulatory Agency—MHRA—to have a role, and the committee will note that Kim Leadbeater MP's Terminally Ill Adults (End of Life) Bill also includes such provisions. However, I must be clear that exactly what that role would look like has not been determined.

I turn back briefly to the section 104 order, although I recognise that that is not the focus of today's session. As members may have noted from my letter of 16 December, proceeding by way of a section 104 order would require the Assisted Dying for Terminally Ill Adults (Scotland) Bill to be amended to remove provisions, which would then be dealt with through the 104 order after royal assent, should the bill pass. That removal of provisions would be necessary to bring the bill within competence before the stage 3 vote, as, were the bill to be passed outside competence, there is a strong likelihood of its being referred to the Supreme Court. With that in mind, MSPs should be similarly mindful of the need to ensure that no new provisions are added to the bill at stage 3 that would take it further outside legislative competence.

I recognise the challenges that this poses for MSPs, particularly given the importance of the areas being discussed for removal—namely, provisions relating to the regulation of health professions and to employment rights and protections—but this Parliament has a duty to ensure that any bill passed is within competence.

I hope that the committee has found that information helpful, and I welcome any questions.

The Convener: Thank you very much, cabinet secretary. I will bring in Sandesh Gulhane.

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

Thank you very much for your statement, cabinet secretary. I understand that the Scottish Government is neutral on the bill. It is really important that we recognise that what is before us today is not about whether you are for or against assisted dying; it is about enabling the will of the Scottish Parliament to be enacted, should the bill pass. With that in mind, I have a few questions.

With regard to the section 104 order, if we pass the bill at stage 3, do you have an assurance and a guarantee from the secretary of state that it will be laid in the UK Parliament, regardless of what happens to Kim Leadbeater MP's bill? That action would allow Mr McArthur's bill to progress.

Neil Gray: I thank Dr Gulhane for his questions, and for the preamble. He is absolutely right that proceeding with the committee's consideration of the section 30 order does not change the Government's position of neutrality. It is about enabling the Parliament to make its decision based on the merits of the issue and the conscience of individual MSPs. Earlier in the process, we committed to engaging to ensure that that would happen in the best way that we could possibly manage.

The discussions are clearly based on an element of negotiation between Governments. We are talking about areas of reserved policy that are, at the end of the day, the responsibility of the UK Government, and it is for the UK Government to decide which elements are contained in a section 30 order and which are contained in a section 104 order.

Dr Gulhane is also correct that my understanding—officials may correct me if I am wrong—is that a section 104 order would require to proceed regardless of whether similar legislation was going through the House of Commons or the House of Lords and, indeed, whether that particular legislation passed. This is a separate process that is based on the Scottish Parliament's processes.

Sandesh Gulhane: Has the UK Government indicated that it will do that if we pass the bill?

Neil Gray: Discussions on the terms and what they will look like are still on-going. However, the fact that elements will go into a section 104 process means that assurances will be given about the UK Government's role thereafter. The discussions on those elements have not concluded, however, so it would be unfair of me to state categorically the position right now.

Sandesh Gulhane: Given the position that we are in currently with the section 30 order and potential section 104 orders, are you and your officials content that the process will provide everything that we need, should the bill pass at stage 3 and become law?

Neil Gray: Yes, although, as I say, the section 104 order elements are slightly more complicated because some form of amendment will require to be made to the bill for it to meet the legislative competence requirements. I am, however, certainly content that the section 30 order elements will give the Parliament the ability to legislate in the areas that the order covers. The section 104 process has to run its course and, regardless of the conclusion of those discussions, there will still be a requirement for amendment to the bill in order for it to be passed as competent.

Sandesh Gulhane: My final question is about unintended consequences. Medications and devices will change with time as medical expertise improves. Do such orders give us the flexibility to change medications and devices as required? Are we also content that the orders will apply only to medication and devices in connection with assisted dying and nothing else?

Neil Gray: The answer to your second question is yes.

On your first point, the role of the MHRA will be important. It regulates and approves medications and devices for use within the health service, so its role in being able to determine new approaches will be important to the flexibility that you mentioned.

Gillian Mackay: The Scottish Parliament cannot scrutinise any potential section 104 order in the same way as it can the section 30 order. What does the Scottish Government propose to do to keep the Parliament as involved and informed as possible, should any section 104 order be laid?

Neil Gray: As I said in my response to Dr Gulhane, the decision on whether elements of the bill come under section 30 or section 104 is for UK ministers. However, for our part, I commit to continuing to keep the committee, the Parliament and Mr McArthur as up to date as we can about progress with the discussions and what the outcome of them means for the progress of the bill. That is probably as much as I can say at this stage.

10:15

Brian Whittle: Good morning, cabinet secretary. I have a point of clarification, I suppose. Are the discussions on section 30 and section 104 orders about trying to limit any potential divergence, should both bills—the one in Scotland and the one in England and Wales—be passed? Is it your intention to try to reduce any potential divergence in policy and any inherent issues that might arise?

Neil Gray: First of all, Mr Whittle will understand that I am neutral on Mr McArthur's bill. I have met Kim Leadbeater, but that interaction was not, for me, about policy coherence. It is for Mr McArthur to lead on that. That said, I know that the discussions with UK ministers on the routes that have been applied with regard to the decisions on the section 30 order and the role of the secretary of state have been about providing for some form of policy coherence.

There are various scenarios at play here: Ms Leadbeater's bill could fall, Mr McArthur's bill could fall or they could both proceed. We do not know the outcome in that respect; each Parliament has an independent process to go through, and interaction between the two processes is very limited.

Again, it is for Mr McArthur and Ms Leadbeater to answer the majority of the question on policy coherence, but as far as discussions on legislative competence are concerned—and it is an issue that the Scottish and UK Governments have been discussing—I set out in my opening statement that the secretary of state has been involved in order to provide coherence with regard to the regulation of medicines and devices.

Emma Harper: Good morning, cabinet secretary. I think that you have already answered my question, because you have said that discussions, or dialogue, are on-going with the UK Government, and that they will continue until votes are taken and decisions are made about the bill going through the UK Parliament and the bill in the Scottish Parliament. I am just interested to hear a wee bit more about the discussions that have taken place and how things will proceed until decisions are made here in Scotland and then again at Westminster.

Neil Gray: I thank Ms Harper for her question, because it gives me the opportunity to set out, again, that these discussions are being had at pace. Colleagues who have some familiarity with section 30 orders that have been laid in the past, and, indeed, the predictions about the time that these things can take, will be aware that the process has moved at pace. It has been very constructive, and I am very grateful to UK ministers and officials, as well as my officials, for the work that has been done to progress these matters at pace. I expect a similarly constructive approach to be taken to the section 104 process, and that I will be able to provide an update as soon as possible to the committee, and to all members, on the conclusion of the section 104 discussions.

Emma Harper: Thanks.

Liam McArthur (Orkney Islands) (LD): I echo the comments that the cabinet secretary has just made. I said as much at last week's First Minister's question time, but I am genuinely grateful to the cabinet secretary, his counterparts in the UK Government and officials for expediting this process at pace. As the cabinet secretary has said, there were many predictions about how long the process would inevitably take, and it is to the credit of the UK and Scottish Governments that they have managed to reach this agreement.

The points that Gillian Mackay has raised with regard to the transparency of the section 104 process are probably those of most concern to many colleagues, and it would be helpful if the cabinet secretary could confirm that my understanding of section 104 orders, which is that they are a fairly routine mechanism for dealing with such issues, is his understanding, too. Will he also reiterate the importance of ensuring that, as we progress to stage 3, MSPs are kept fully informed, on a timely basis, of the progress of those discussions with the UK Government?

Neil Gray: I thank Mr McArthur for those questions. I will bring in Mr Byrne in a second to talk about the constitutional elements and how familiar or routine the section 104 process is, but I absolutely give the commitment that Mr McArthur seeks. When it comes to transparency, we have attempted to furnish the committee, Mr McArthur and MSPs with as much information as we can. Indeed, we did so all through the stage 2 process, when we gave a critique of amendments and of elements of the bill as it stood, and we will endeavour to do what we can and provide as much information as we can in relation to Mr McArthur's question about the section 104 process.

Perhaps Mr Byrne can provide further illumination of the precedent here.

Gerald Byrne (Scottish Government): Perhaps "routine" is not the right word, but section 104 orders are certainly not an unusual part of the legislative process. If an act of the Scottish Parliament will affect reserved matters and there needs to be some consequential provision as a result, or if a bill can be brought fully into effect only by changing reserved matters—which is the category that we are talking about here—it is normal for the Governments to discuss the need for a section 104 order as that bill progresses through Holyrood.

That is what has happened in this case, although it has happened alongside a section 30 order. As has already been observed, both Governments have worked closely to address the legislative competence issues that both have identified in the bill as it stands. That process is now well under way.

Liam McArthur: Thank you—that was very helpful.

I just want take this opportunity to reiterate the question that I posed to the First Minister. I absolutely respect and understand the rationale for the Government's position of neutrality, but as we saw through the stage 2 process, there is a growing expectation among colleagues, irrespective of the position that was taken on the bill at stage 1, that the Government will engage more actively in the amending process, even if it is only around technical amendments to ensure the workability of any legislation that the Parliament passes.

I know that there have been on-going discussions in Government on that. Again, it would be helpful—certainly for the member in charge, but also for the committee and other MSP colleagues—to have clarity on the level of engagement that the Government is going to be committed to at stage 3.

Neil Gray: Mr McArthur is correct. Discussions are on-going, and it would be my expectation to advise colleagues as soon as I am able to on the Government's intention with regard to our approach to stage 3.

Liam McArthur: Thank you.

The Convener: I thank the cabinet secretary for his evidence.

We now move to agenda item 4, which is the formal debate on the instrument on which we have just taken evidence. I remind the committee that officials may not speak in the debate.

Cabinet secretary, I ask you to move and speak to motion S6M-20226.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Scotland Act 1998 (Modification of Schedule 5) Order 2026 be approved.—[*Neil Gray*]

Neil Gray: I have nothing further to add, convener.

The Convener: I have no indication from committee members that they wish to contribute to the debate. Mr McArthur, do you wish to put anything further on record?

Liam McArthur: No, thank you, convener.

Motion agreed to.

The Convener: That concludes consideration of the instrument.

At our next meeting, we will take evidence from the Cabinet Secretary for Health and Social Care on the Scottish budget for 2026-27. That concludes the public part of today's meeting.

10:23

Meeting continued in private until 10:52.

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