

Decarbonising and the Future of the NHS Estate

Patient safety, capital constraint in a live clinical environment

Bevan Brittan

Contents

Executive Summary	3
Introduction	5
About this research	5
Prioritising patient safety in decarbonisation	6
Capital, competing priorities and the funding relationship	8
Supply chain, procurement and holding partners to account	10
Partnership models and the capability gap	13
A historical estate in a changing climate	17
Conclusion – Delivering change without interruption	19



Executive Summary

The NHS decarbonisation challenge at a glance:

£15.9bn
NHS maintenance backlog

90%
of hospital estates susceptible to overheating

68%
reduction in direct NHS emissions since 1990

Decarbonisation programmes delivered in live clinical environments



The NHS was the world's first national health system to commit to net zero[1], and the first to embed that commitment in legislation through the Health and Care Act 2022. Direct emissions are down by 68% from the 1990 baseline and 14% since 2020[2].

The next phase will be considerably harder.

Like other mission-critical public services such as emergency services, defence, prisons and parts of the justice system, NHS infrastructure must remain operational while transformation is delivered. However, the complexity of live clinical environments, and the direct relationship between operational continuity and patient outcomes, create a distinctive set of considerations for decarbonisation projects.

1 NHS becomes the world's first national health system to commit to become 'carbon net zero', backed by clear deliverables and milestones
2 Greener NHS

This shapes a large part of the decarbonisation agenda: what can be installed, when it can be installed, how risk is allocated, and which suppliers are capable of delivering.

Our research identifies five themes shaping the sector's next phase:

01

Patient safety governs every technical decision

Decarbonisation programmes in healthcare require failsafes planning, business continuity provision, workaround design and rigorous testing at a level unfamiliar in other sectors. Where interdependencies touch critical care, the tolerance for delivery risk approaches zero.

02

Capital is scarce and contested

With an estimated £15.9 billion backlog maintenance liability across the NHS estate in England and total estate running costs of £14.0 billion a year[3], decarbonisation competes directly with statutory compliance and critical infrastructure risk for the same constrained capital.

03

Suppliers need healthcare-specific capability

Not all suppliers have experience of operating within live healthcare environments, and the NHS often places particular value on partners with direct NHS delivery experience.

04

Specialist expertise is growing across the sector but remains unevenly distributed

While pockets of excellent practice have emerged, formal sustainability expertise and dedicated resource remain limited in many organisations, creating challenges for the delivery of increasingly complex programmes.

The result is either outsourcing at cost or accepting commitments that are not subsequently verified.

05

The estate was not designed for the current climate

Much of the NHS estate predates modern thermal design requirements. The 2026 heatwaves exposed this directly, with the UK Health Alliance on Climate Change estimating that almost 90% of England's hospital estates are susceptible to overheating[4]. The government recently announced a £1.5 billion emergency capital funding injection to help upgrade and heatproof NHS estates against increasingly frequent summer crises[5].

The NHS is striving to deliver structural change while maintaining essential frontline services and continuous patient care.

3 Estates Returns Information Collection 2024/25
4 Building a climate resilient health system in the UK
5 Over £1.5 billion to help NHS withstand year-round pressure

Introduction

Intensive care, neonatal units, theatres, diagnostics, pharmacy cold chain and clinical IT run continuously, and the consequences of interruption are measured in patient outcomes. This has a direct bearing on decarbonisation. Replacing a heating system, upgrading electrical infrastructure, installing a building management system or connecting to a heat network are all interventions that touch the operational continuity of a clinical environment.

At the same time, the sector is operating under significant structural and financial pressure. The estimated backlog maintenance liability across the NHS estate in England stands at £15.9 billion, against total estate running costs of £14.0 billion for the year, and the proportion of that backlog classified as high or significant risk has been rising[6]. The Government has committed at least £64 billion over the next decade to maintain the health estate under the 10-Year Infrastructure Strategy, including a £6.75 billion Estates Safety Fund targeted at critical infrastructure risk and statutory compliance. From 2026/27, operational capital allocations flow directly to individual providers rather than through systems to increase accountability and transparency[7].

This is happening alongside the most significant restructuring of the NHS's national architecture in over a decade, with NHS England's functions being consolidated into the Department of Health and Social Care[8].

Almost every challenge discussed in this report stems from a single reality: like other operators of critical national and public service infrastructure, the NHS must modernise its estate while remaining fully operational. The consequences of interruption within a clinical environment, however, create a particularly complex risk landscape for decarbonisation programmes.

This report examines how the decarbonisation commitments stated by the NHS are delivered in practice, and what the sector's operating conditions mean for how projects should be structured, contracted and risk-managed.



About this research

This research draws on detailed interviews with sustainability, estates and capital development leaders at NHS Trusts, alongside a review of published Green Plans, capital guidance and estates data across the wider NHS provider landscape. The report references statistics from publications by the Greener NHS programme, the NHS Confederation, the Nuffield Trust and the UK Health Alliance on Climate Change. The analysis and recommendations are grounded in Bevan Brittan's legal advisory expertise across the health sector.

6 Estates Returns Information Collection 2024/25
7 Capital guidance 2026/27 to 2029/30
8 Health Bill: role and functions of the restructured DHSC

Prioritising patient safety in decarbonisation

In healthcare, decarbonisation is fundamentally a clinical risk management exercise. While selecting a technical solution is a necessary first step, the more substantial challenge lies in executing the project without compromising clinical continuity. Decarbonisation works often require physical access to facilities, which in turn demands system downtime that clinical demand rarely permits.

Consequently, healthcare projects require a level of contingency design and rigorous testing unfamiliar to many commercial suppliers. This operational reality materially impacts both programme costs and delivery durations.

From a delivery perspective, contractors and legal teams must account for the financial and operational friction of working within a live hospital environment. Replacing legacy infrastructure while maintaining daily patient care slows project progress and increases the risk profile.

It's around interdependencies. For example, we've got ICUs and neonatal, that link to other systems. The failsafes and business continuity planning are very strict. If we have any issues, what would be the speed of response? Then we need to really robustly test those because the downside, if anything goes wrong, could be catastrophic.

It's difficult with huge demand across the services. It's not always easy to schedule that downtime to install. That always has an impact. Things might be delayed by a month. These are the practicalities we face.

NHS Trust

Replacing existing infrastructure is very costly and very time-consuming. We've got to run and maintain a hospital at the same time. It becomes a much slower piece of work.

University Teaching Hospital Trust



Direction of travel – Bevan Brittan view

Patient safety obligations should determine how the contract is written.

In our experience, the most common source of dispute in healthcare infrastructure projects is not the technical specification but the allocation of risk where clinical continuity is affected. Where a system fails, is taken offline unexpectedly, or cannot be commissioned within an agreed access window, the question of who bears the consequence is frequently unresolved.

Trusts should be addressing this at contract stage rather than at the point of failure. That means clearly defined access and possession regimes reflecting clinical priority; contractual obligations on business continuity provision, failsafe design and testing before handover; performance regimes that reflect availability rather than installation completion; and exit and step-in rights that allow the trust to act quickly where a supplier's performance creates operational risk.

Where a project touches critical clinical infrastructure, these provisions are not administrative detail. They are the mechanism by which patient safety risk is managed.

In healthcare, decarbonisation is first and foremost a **patient safety issue**

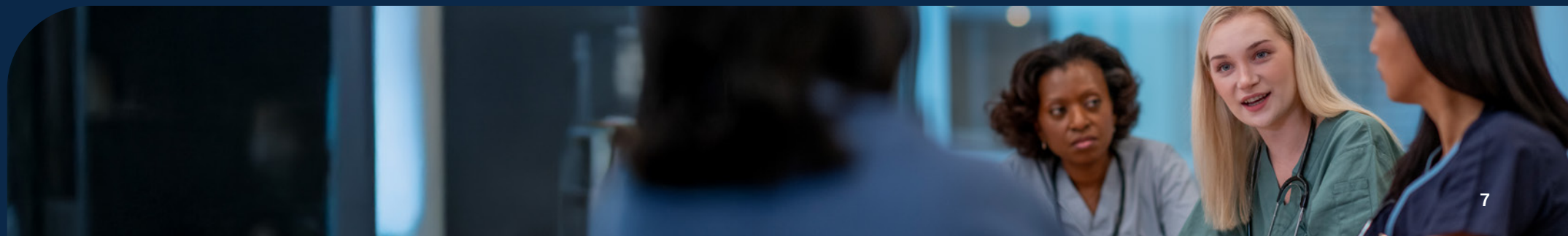
Key Takeaways

Clinical service continuity, not technical feasibility, determines what can be delivered and when.

Interdependencies with critical care require failsafe design, business continuity planning and testing before commissioning.

Access and downtime constraints typically delay programmes.

Contractual risk allocation should reflect clinical consequence, not standard construction practice.



Capital, competing priorities and the funding relationship

The estimated backlog maintenance liability across the NHS estate in England is £15.9 billion, against total estate running costs of £14.0 billion for the year[9]. That backlog now exceeds the annual cost of operating the estate. The Government has allocated £750 million per year for estates safety from 2026/27 to 2029/30, with planning certainty for a further five years, totalling £6.75 billion, dedicated to tackling critical infrastructure risk, improving statutory compliance and reducing incidents that impact the operation of clinical services[10].

Against this, decarbonisation is one proposed business case among several on a constrained capital envelope.

A lot of these decarbonisation initiatives require high input. You need a lot of upfront capital. There are lots of competing priorities, what do you prioritise?

It is really dependent on national allocation of capital money. I think we're all pragmatic enough to realise that there's a lot of pressure, and not all of the strategy is going to be delivered.

University Teaching Hospital Trust

Capital allocation alone does not resolve the delivery problem. While capital covers the physical assets, the personnel required to plan, procure, manage, and maintain these programmes must be funded through separate operational revenue budgets. Allocating capital without corresponding revenue funding risks creating "stranded assets" – infrastructure that cannot be optimised due to a lack of organisational capacity, causing projects to stall.

There are lots of conflicting priorities within an NHS organisation because your primary function is to serve the patient, and the NHS is under a lot of stress and financial strain. At the same time, you've got this sustainability function you need to push through as well, which it didn't have before, so it's an added task you need to perform. It's a team effort, but it requires resource, time, effort, and money.

University Teaching Hospital Trust

Funding conditions and the accountability loop

When funding is successfully secured, NHS Trusts face rigorous and resource-intensive reporting obligations.

There's a feedback loop. You have to demonstrate how well that money's been spent, what was done, and how the project has progressed.

University Teaching Hospital Trust

Furthermore, friction frequently arises when central funding bodies impose rigid timelines that fail to account for the unique operational realities of a live clinical environment. External macroeconomic shocks, such as inflation and energy supply volatility, exacerbate these delivery challenges.

We might have agreed plans, and if we lapse, sometimes that patience wears thin. A lot of times it's because there isn't enough understanding or knowledge of the sector. Another challenge is putting aggressive timelines in place and meeting deadlines. Time overruns are not always best received, but sometimes these things are out of our hands.

Costs overrun and we need flexibility of funding as well. There are things like inflation and energy supply shocks, so sometimes it's also the cost overrun and it's out of our control.

NHS Trust

9 Estates Returns Information Collection 2024/25
10 Capital guidance 2026/27 to 2029/30

Direction of travel – Bevan Brittan view

The competition between decarbonisation and backlog maintenance is often presented as a choice. In many cases it should not be.

A substantial proportion of the backlog concerns ageing mechanical and electrical plant, heating systems, ventilation and building fabric. These are precisely the assets whose replacement determines the trust's energy consumption and carbon position for the next twenty to thirty years. Where a boiler, chiller or air handling unit is being replaced on condition grounds, the specification decision taken at that point is a decarbonisation decision, whether or not it is described as one.

Trusts that align their capital planning, backlog remediation and Green Plan delivery into a single prioritisation process are better placed to justify investment, access multiple funding routes for the same intervention and avoid returning to the same asset twice. This requires estates, sustainability and finance functions to work from a shared asset dataset and a shared programme.

It also requires care at contract stage. Where works are funded from more than one source, each with its own conditions, reporting obligations and clawback provisions, those conditions should be reconciled before commitment and reflected in the supply chain contract rather than retained by the trust by default.

The NHS maintenance backlog now **exceeds annual estate operating costs**

Key Takeaways

Backlog maintenance and decarbonisation compete for the same capital and, increasingly, impact the same assets.

Capital funding without recurrent revenue does not resolve delivery capacity.

Expectations from stakeholders frequently do not reflect the delivery realities of a clinical environment.



Supply chain, procurement and holding partners to account

Supply chain emissions make up the largest share of the NHS's environmental impact, and the NHS supplier roadmap is tightening accordingly.

Since **April 2022**, all NHS procurements have included a minimum 10% net zero and social value weighting[11].

From **April 2026**, suppliers must complete the Evergreen Sustainable Supplier Assessment and reach at least Level 1[12].

From **April 2027**, larger suppliers with new contracts and frameworks worth £5 million or more per year must report global emissions across all Scope 3 categories[13].

From **April 2028**, product-level carbon footprint requirements are planned. From 2030, suppliers will only be able to qualify for NHS contracts if they can demonstrate progress through published reports and continued emissions reporting[14].

The strategic direction is clear. The practical difficulty is that while many suppliers have developed deep expertise working with the sector, NHS trusts noted that organisations entering the sector for the first time can sometimes underestimate the operational complexity of live clinical environments.

> *We're one of the largest clients in the area for some of our vendors. A lot of the time, they don't always have huge expertise in healthcare. When it comes to negotiations, it's important to have the right conversations with the right level of education and knowledge about the system.*
>
> *Some of the challenges we face there is understanding our healthcare-specific needs that a lot of these vendors are not used to.*
>
> **NHS Trust**



11 Greener NHS: Suppliers
12 Evergreen Sustainable Supplier Assessment: What Suppliers Need to Know for April 2026
13 NHS England Net Zero Supplier Roadmap – April 2027 milestone requirements
14 Greener NHS: Suppliers

Holding suppliers to their commitments

Trusts described varying experiences with suppliers. While many partnerships are highly effective and built on a strong understanding of NHS requirements, some organisations highlighted challenges around verifying sustainability commitments and ensuring that intended outcomes are monitored throughout the life of a contract.

This matters increasingly as procurement weighting rises. The mandatory weighting is currently 10% for net zero and social value. However, a gap remains between compliance at the tender stage and measurable delivery during the operational phase. Sustainability criteria are heavily weighted during evaluation but often left unmonitored throughout the contract lifecycle.

> *As we install new technologies, it's great to put them in, and they might have great headline benefits. But how do we take the responsibility of tracking and measuring, rather than just leaving it to the vendor? Internally, how can we make sure those benefits are realised?*
>
> *We're training our staff to utilise software with building management systems to understand areas where heat is being lost and then also making active tweaks.*
>
> **NHS Trust**

While this is the correct instinct, it also has direct contractual implications, since a trust that intends to verify performance requires the data rights, access and measurement provisions to do so.



Direction of travel – Bevan Brittan view

The gap between what is promised at tender and what is delivered in performance has, in our experience, the potential to be an under-managed commercial risk in NHS sustainability procurement.

It is addressable, and the mechanisms are well established in other sectors. Sustainability commitments made in a tender response should be incorporated as contractual obligations rather than remaining as evaluated statements. Where a supplier commits to a carbon reduction, a performance level or a social value outcome, the contract should specify how it will be measured, how frequently it will be reported, what evidence is required, and what the consequence of non-delivery is.

For technology and plant installations, we would encourage Trusts to consider output-based provisions: an obligation to deliver a defined performance in use, with a verification methodology and a remedy, rather than an obligation to install specified equipment and an expectation that the benefit follows. This shifts performance risk to the party best placed to manage it, and it gives the trust something enforceable when benefits are not realised.

Given healthcare-specific operational requirements, we would also encourage explicit contractual treatment of uptime and availability, failsafe provision and testing, and the trust's rights on exit where supplier performance creates clinical risk.



Key Takeaways

Supply chain emissions represent the largest share of the NHS footprint, and supplier requirements tighten materially from April 2026.

Successful delivery is often supported by suppliers with healthcare-specific operational understanding and experience of working in live clinical environments. Wider sustainability commitments are being evaluated and represent a benefit to Trust but there is a risk that they are not managed through the contract term.

Trusts intending to verify benefits require the data, access and measurement rights to do so.

Partnership models and the capability gap

The sector is increasingly exploring long-term delivery and partnership models to support decarbonisation. However, unlike some other infrastructure sectors, there is currently no widely adopted commercial model for the delivery of NHS decarbonisation programmes, creating uncertainty around risk allocation, governance, funding structures and long-term performance obligations.

A recurring theme from participants was the absence of a standardised commercial framework that organisations can readily adopt and adapt. As a result, Trusts are often developing bespoke arrangements, which can increase transaction costs, extend procurement timetables and create uncertainty for both public and private sector partners.

> *It's a different focus to attract investment and more longer-term partnerships with vendors who share our vision. They will also have their own long-term vision of working with new technologies for example, innovative treatments, robotics, and gene therapies. New technologies create synergy within the Private-Public Partnership, which can be a true driver for revenue and for the whole NHS ecosystem.*
>
> **NHS Trust**

By partnering with the private sector to co-build and co-operate facilities, NHS Trusts/NHS Foundation Trusts can share risk, reduce upfront capital expenditure, and accelerate the modernisation of legacy estates. Strategic, multi-year partnerships can leverage the research, development, and operational scale of third-party networks to meet strict net-zero and efficiency mandates significantly faster than traditional procurement routes would allow.

To do so, it must actively study, adapt, and legalise successful commercial models developed in the private sector. This requires contractual frameworks that protect public interests while incentivising commercial delivery.

> *The NHS has to look at privately funded models and learn from them. A lot of them have been hugely successful in healthcare. We don't need to reinvent the wheel. We just need to find the right partner.*
>
> **University Teaching Hospital Trust**

> *Vendors can provide a lot of help. For example, MedTech companies and IT companies have a lot of good initiatives. They have their own targets as well, so it's about leaning into those partnerships to not just focus on products and systems, but working together help achieve the targets faster.*
>
> **NHS Trust**



What effective partnership requires

Successful partnerships depend on clear expectations, strong governance and open communication. Trusts and their partners need a shared understanding of objectives, risk allocation and long-term outcomes from the outset.

Effective delivery also requires robust contractual frameworks. Expectations around capital investment, ongoing operational costs and long-term responsibilities should be clearly defined, ensuring public resources are protected and all parties remain accountable for delivering agreed outcomes.

We need clear expectations on both sides. How much is the funding split between capital and consumables? What are the ongoing commitments? All parties need to be clear on expectations.

NHS Trust

The partnership itself demands sustained institutional investment. Mitigating risk requires dedicated time to cultivate deep cross-organisational relationships. Establishing consistent communication channels ensures that disparate corporate and clinical priorities are continuously aligned.

No NHS organisation is the same, and the NHS is very different compared to other organisations. It's spending the time to cultivate those relationships and having consistent communication, so all parties understand the important factors and priorities across each system.

NHS Trust

Capability and capacity challenges

While many Trusts have developed strong estates, sustainability and commercial capabilities, expertise remains unevenly distributed across the sector. The delivery of complex decarbonisation programmes can therefore be constrained by shortages of specialist commercial, financial and environmental resource, particularly where organisations are managing multiple competing priorities.

Formal sustainability qualifications remain rare among internal trust personnel. This expertise deficit is compounded by competing organisational priorities. Decarbonisation initiatives require significant workforce education and dedicated headcount, yet they must compete directly for capital and administrative bandwidth against the core operational mandate of delivering patient care. For legal and corporate advisors, this friction highlights that sustainability strategies cannot be treated in isolation; they must be structured to co-exist with clinical risk management.

The challenges are conflicting priorities. It's a big change. I think people don't really understand what decarbonisation entails. It's a lot of training, education, and investment. It requires additional staff, and at the same time, you have to focus on delivering effective patient care. We have a very limited number of people working on it, because it's in its infancy. Something has to give along the way. We need more embedded expertise and formal qualifications in sustainability.

University Teaching Hospital Trust



What NHS Trusts/NHS Foundation Trusts want from external advisers

When seeking external advisory support, Trusts require specific, technical expertise that may not be found internally. In highly technical, unprecedented projects, such as installing hospital software or partnering with new market entrants, the risk profile escalates dramatically. Legal counsel must be integrated early to draft robust protections against catastrophic failures, define liability for system downtime, and engineer enforceable exit strategies within long-term contract structures.

External counsel adds distinct value in three core areas:

Cross-Sector Knowledge Transfer:

Importing established infrastructure and commercial templates from more advanced industries to avoid reinventing the wheel.

Benefits Realisation Frameworks:

Structuring mechanisms to verify that capital investments deliver guaranteed efficiencies and operational returns.

Innovative Commercial Contracting:

Drafting sophisticated, multi-year contracts that maximise commercial upside while protecting public sector assets.



How do you work smarter? If we're putting new systems in place, what's the best way to realise the benefits, or where is it worth spending additionally more money?

These are new contracts that we've never worked with before. Are we missing a trick here in terms of commercial contracting?

If we see something that is really concerning, how do we protect ourselves? How do we exit a contract with longer lead times?

NHS Trust



Direction of travel – Bevan Brittan view

Trusts are increasingly exploring partnership models that engage multiple legal and regulatory frameworks simultaneously. In many cases, the challenge is not identifying opportunities but establishing organisational positions on ownership, risk allocation and exit arrangements before opportunities arise.

Key implications:

Establish governance principles before transactions are developed.

Assess procurement, subsidy control and tax implications early.

Make healthcare-specific operational requirements explicit within contracts.

Key Takeaways

Trusts are actively exploring joint ownership, strategic vendor partnerships and privately funded models.

Effective partnership depends on shared baseline data, acknowledged cost volatility and explicit expectations on both sides.

Formal sustainability expertise within Trusts remains scarce, and procurement functions generally lack specialist evaluation capability.

Partnership structures engage multiple legal regimes and are best resolved in principle before a live transaction.



A historical estate in a changing climate

Much of the NHS estate was designed for a climate that no longer exists.



The 2026 heatwaves brought this into sharp focus. There were an estimated 2,877 deaths in England during the May and June 2026 heatwaves, almost twice the number recorded in 2025[15]. A Doctors' Association UK survey of 1,111 healthcare workers found that 95.6% said their workplace was at least uncomfortably warm, while 83.3% described it as very or dangerously hot; 68.3% said heat had affected patient safety[16]. The UK Health Alliance on Climate Change estimates that almost 90% of England's hospital estates are susceptible to overheating[17].

The heatwave has caused lots of issues, particularly within the hospital, because they're not geared up for the excess heat. Everybody knows what the solution is, but it's getting the capital money to implement those solutions.

University Teaching Hospital Trust

The UK Health Alliance on Climate Change estimates that almost 90% of England's hospital estates are **susceptible to overheating**

Overheating in hospitals has exacerbated the issue of patient safety and operational resilience. This is a tension within decarbonisation. Measures that improve winter thermal performance can worsen summer overheating unless ventilation, shading and glazing are addressed at the same time. In a clinical setting, where equipment generates heat, ventilation requirements are governed by infection control, and patients are disproportionately vulnerable to thermal stress, the design is materially harder than in other building types.

The NHS Green Plan guidance is explicit that resilience and adaptation should be built into business continuity and longer-term planning to avoid climate-related service disruptions, and that partnership working between sustainability leads, public health, emergency response teams and estates leads at trust and system level is crucial.

The scale of historical estates means that even successful interventions address only part of the problem. However, the path forward does not demand architectural or operational innovation. Instead, long-term asset value and clinical efficacy are best secured by identifying, legalising, and replicating proven decarbonisation models.

The problem with NHS infrastructure is that a lot of it is historical. If you address one element of it, the bigger chunk still takes time.

It's not about doing something new. It's trying to sense what people have done before, what has been successful, and then implementing that into the hospital and lab environments.

University Teaching Hospital Trust

15 Interim heat mortality monitoring report, England: May and June 2026
16 Extreme Heat in the NHS - DAUK heatwave survey
17 Building a climate resilient health system in the UK

Direction of travel – Bevan Brittan view

Climate adaptation is becoming a legal and regulatory question for Trusts, not solely an estates one.

Overheating in a clinical setting engages duties that extend well beyond environmental strategy: obligations to patients, employer duties to staff under health and safety legislation, emergency preparedness and business continuity requirements under the NHS Standard Contract, and CQC assessment of environmental sustainability alongside safety and quality of care. A trust that has assessed overheating risk across its estate and is working to a documented, prioritised programme is in a materially stronger position than one that has not.

Practically, we would encourage three things. First, that overheating and flood exposure are assessed at estate level and recorded formally, since the absence of assessment is itself an exposure. Second, that adaptation criteria are written into new build and major refurbishment specifications now, because buildings being designed today will operate through a considerably warmer century. Third, that where decarbonisation works are undertaken on the fabric or services of a building, the overheating consequence is assessed at design stage rather than discovered in the following summer.



Key Takeaways

Overheating in healthcare settings is a patient safety and operational continuity issue be considered.

Winter efficiency and summer resilience must be designed together, particularly in clinical environments.

Adaptation exposure engages duties to patients, staff and regulators, and should be documented accordingly.

Conclusion: Delivering change without interruption

Every decarbonisation intervention takes place inside a live clinical environment, where the estate cannot be taken out of service, interdependencies run into critical care, and the consequence of failure is catastrophic.

This produces a set of recommendations that are specific to healthcare.

Patient safety should shape the contract.

Access regimes, failsafe obligations, testing before handover, availability-based performance and exit rights where clinical risk arises are the mechanisms through which safety risk is managed in a delivered project.

Adaptation has moved from strategy to obligation.

With the majority of the hospital estate susceptible to overheating and the clinical consequences now documented, Trusts that have assessed and prioritised their exposure are in a substantially stronger position than those that have not.

Supplier commitments require contractual expression and active management.

As net zero weighting rises through the procurement roadmap, the difference between evaluated commitments and delivered outcomes will become the principal determinant of whether supply chain emissions fall.

Partnership ambition needs commercial and legal groundwork ahead of opportunity.

Developing clearer and more replicable commercial models for decarbonisation projects could help accelerate delivery and reduce transaction complexity across the sector.

Decarbonisation is largely a matter of identifying what has worked elsewhere and implementing it within a hospital environment. The difficulty is that the hospital environment permits very little margin for error, and the capital, capacity and specialist expertise available to manage that margin is all in short supply.

Addressing that is, in significant part, a commercial and contractual task. The next phase of NHS decarbonisation will not be determined by technology alone. It will be determined by whether Trusts can successfully align patient safety, capital planning, operational resilience and commercial delivery within a healthcare environment that cannot pause.

Bevan Brittan advises NHS Trusts, Integrated Care Boards and their partners on estate decarbonisation, energy infrastructure and heat networks, procurement and commercial contracting, technology and system implementation, joint ventures and strategic partnerships, and the regulatory framework governing sustainability in healthcare settings.

Our team



Nadeem Arshad

Partner and Head of Energy & Resource Management

0370 194 8932 | 07795 495643

nadeem.arshad@bevanbrittan.com



Rupert Lugg

Partner

0370 194 8535 | 07917 272296

rupert.lugg@bevanbrittan.com



Nathan Bradberry

Partner

0370 194 1666 | 07810 882309

nathan.bradberry@bevanbrittan.com



Rosemary Jago

Partner

0370 194 3032 | 07780 998185

rosemary.jago@bevanbrittan.com



Julie Charlton

Partner

0370 194 7916 | 07958 779141

julie.charlton@bevanbrittan.com



Ian Caplan

Partner

0370 194 7738 | 07950 629684

ian.caplan@bevanbrittan.com



Bevan Brittan

bevanbrittan.com
Birmingham | Bristol | Leeds | London

Bevan Brittan is a limited liability partnership registered in England & Wales: Number OC309219. Registered office: Kings Orchard, 1 Queen Street, Bristol BS2 0HQ.
A list of members is available from our offices in London, Leeds, Birmingham and Bristol and on our website (which has other regulatory information).
Authorised and regulated by the Solicitors Regulation Authority: number 406315. Any reference to a partner in relation to Bevan Brittan LLP means a member, consultant or employee of the firm who is a lawyer.