



Environmental Audit Committee

Oral evidence: Sustainability in the NHS, HC 1040

Wednesday 11 March 2015

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Members present: Joan Walley(Chair), Katy Clark, Mark Lazarowicz, Caroline Lucas, Dr Matthew Offord, Dr Alan Whitehead

Questions 1–43

Witnesses: **Dr Gina Radford**, Deputy Chief Medical Officer, Department of Health, **John Holden**, Director of Policy Partnerships and Innovation, NHS England, and **Sonia Roschnik**, Head, Sustainable Development Unit gave evidence.

Q1 Chair: I would like to start by thanking each of you for coming along this afternoon for this one-off inquiry, Sustainability in the NHS, which was specifically requested by one of our members. We were very keen to fit it in before the end of the Session, but I am sure you will understand that at this time in the parliamentary proceedings there is an enormous amount of business going on. Members are having to be in two places at the same time and we may have some difficulty with a quorum because members have been called away or are not able to be here. We shall do our very best, but please do not think that it is any lack of commitment to this issue if we are not able to complete the full amount of time because of other meetings in the House.

We do feel that looking at the NHS and sustainability issues is important. Some would say, and not everybody would agree, that there is a strategic approach towards what is happening in the NHS, but in terms of sustainability is there a buy-in from all levels of the NHS on this? We would be interested in hearing your response to that. The fact that we might not be able to do the whole session does not mean that the comments that we already have are not going to be taken into account, and I am sure that your preparations for this afternoon have flagged up the importance of sustainable development as far as the NHS is concerned. Mr Holden, I think you were going to come in first of all to my question about how much buy-in there is. The acoustics are very bad and we all have very bad colds—another reason for the poor turnout—so please shout out.

John Holden: No one has ever accused me of being too quiet. Is there buy-in? I think that is a really good place to start because it is a good news story. We have had a lot of change in the NHS recently and, if you will forgive the pun, we have tried to sustain what was already there and what was good and adapt it to make sure that it continues to be fit for purpose and as effective as possible. An example of that would be the Sustainable

Development Unit itself, which existed before as part of the NHS arrangements in the east of England but, as a result of the changes that have happened, it is now jointly funded and governed by Public Health England and NHS England on behalf of the NHS, public health and social care. So, immediately we have tried to build in an extra pillar there and make sure that we have strengthened the arrangements.

That is the Sustainable Development Unit. Around that we now have a national steering group. Previously there was an advisory group supporting the work of the SDU.

Q2 Chair: Who is on that national steering group?

John Holden: It is a long list. We very deliberately got a chair from a different sector. Martin Reeves, who is the Chief Executive of Coventry City Council, is the chair of the national steering group. Then you have senior officials from different organisations, like myself from NHS England, a colleague from the Department of Health, Monitor, the Care Quality Commission. We have a range of national bodies all around the table in support of this agenda. Do we have buy-in nationally? I think I can honestly say to the Committee, yes, we have because very explicitly we have a wide range of members from different organisations. What is really key to this is not just about having the breadth of coverage nationally but also making sure that is replicated at a more local level. We can do that in different ways: building on what is there and putting new things in place. I can say more if you wish.

Q3 Chair: How do you go about getting that? I will give you an example from my constituency, which you may be aware of. We have a council that is closing down community centres, a health clinic right next door to one that is in the process of being closed down, but we also have another health centre where there is a large car park that a sports facility opposite wishes to use when the sports facility is in use. The local GPs are absolutely refusing to have any kind of a dialogue about how, in terms of the leases and the insurance arrangements, that car park could be used for car parking in such a way that it would help people participate in sport and stay healthy. There is no preparedness at all to engage on that. I am not quite sure how what you are saying about sustainability issues at a national level is trickling down into perceptions as to how the estate management part of the NHS or the contractual arrangements with various bits of the NHS are looking at and buying into the overall bit about sustainability.

John Holden: I understand the point you make and it is quite hard for me, hearing that for the first time, to extrapolate from one local example and say there is a particular problem or a particular solution. There will not be a one size fits all and it sounds like—

Q4 Chair: No, but the point that I am making is that where is the buy-in from everybody at every level so that when an issue like that is identified there are people who can do a “I can sort this out” if there is such resistance, for example, from the GP in question?

John Holden: I don’t really want to comment on the individual situation but across the country—

Chair: But what do you hope would be the approach, not the specific issue but the approach towards resolving this?

John Holden: I understand. It goes without saying I think the answer is dialogue and partners who have a mutual interest in serving the local population. An example would be health and wellbeing boards that deliberately bring together the commissioners of healthcare and social care, planning, emergency services, education and others, and that would include primary care. Local commissioners of healthcare are clinical commissioning groups and they are specifically led by local family doctors, so there is a real opportunity to get all the different participants in a room to talk about what are the identified needs locally, come up with a plan for how you are going to address those needs, and then bring together the different pots of money for commissioning to do something about that. It is one of the ways in which the system as it exists locally is designed to try to address some of these issues, where there might be competing interests, both legitimate, and you have to try to resolve the tension. It is not a magic answer in every situation, but a health and wellbeing board would be one example. There are other ways of dealing with sustainability issues but that is the one I would suggest for this example.

Q5 Chair: Do you think there are lessons for other departments from what has been done inside the Department of Health?

John Holden: You mean specifically inside the Department of Health? I am NHS England and I have a Department of Health colleague beside me, so I am not just sure precisely what you mean. You said what lessons are there for other departments from what has been done inside the Department of Health.

Q6 Chair: Not just within the NHS but elsewhere in terms of the strategy that you have and how you have gone about getting this buy-in from senior management.

Sonia Roschnik: We have taken an approach that is very much bottom-up and top-down and about working together at every level, the way we have approached the carbon footprint, the way that we have approached planning so that it includes sustainable development management plans that are approved at board level, be it at an organisational level but also we are suggesting that is an approach for health and wellbeing boards. I would suggest that other sectors could be adopting a similar approach. One of the things we are all quite proud of is that across the health sector we tried to make sure we had a system-wide approach and tried to do that at every level. It does mean that we have variation across different pieces and some areas where people are stronger on food or travel or different elements, but very much we are trying to share the good practice and build that up and do it in a system-wide way. With sustainability you recognise that the best progress can be made through the synergies. Travel is very difficult to do as a single issue; it needs to be done much more jointly.

Q7 Chair: How do you co-ordinate action among so many different groups, different organisations within the NHS? How do you get the whole systems approach to getting them to interpret what sustainability means for the way they go about their operational work?

Sonia Roschnik: We have quite a simple approach and it has been that, like John has described, at the national level we try to bring in everybody together on it. They all sit around the table and we are holding a mirror to each other to see whether we can make better progress and how we want to take it forward. The approach has very much been that we develop sustainable development management plans and that that should be something

that happens at board level. That brings in mitigation, adaptation and lots of different areas of sustainability, so it is trying to bring them into a joined-up discussion. Then we propose—

Q8 Chair: Is the sustainable development management plan at board level the equivalent of some kind of guidance?

Sonia Roschnik: It is something that each organisation will develop for themselves. As a unit, we have developed some guidance to support people as to what they might include in it and we would suggest it would include looking at what your estates and facilities are like, looking at your travel plan, looking at adaptation to climate change. That would all come together in one plan that a board approves and takes forward.

Q9 Dr Whitehead: I want to address this specifically to Dr Radford. You are the sustainability champion for the Department of Health.

Dr Radford: Yes.

Dr Whitehead: Is that a champion on the board or is it a role that has separate objectives in its own right and resources to draw on in pursuit of those objectives?

Dr Radford: In terms of resources I have colleagues who have the policy for sustainable development and we work very much as a team, and a couple of them are sitting behind me. There are resources that the department has put in around sustainable development. My role is at a senior level to champion that advocacy, that presence, that voice at a very senior level, whether it be going to the departmental board or talking to permanent secretaries or whatever. I am seen as having that champion role that is not necessarily linked with purely the policy. I can champion across the piece and make the links across other policy areas on behalf of colleagues as well. It is very much an advocacy championing role but with dedicated resources within the department who lead on this.

Q10 Dr Whitehead: In the sustainable development strategy, the emphasis is on encouraging and supporting organisations to adopt good practice as opposed to any new mandatory requirements, although there are some pre-existing. I imagine your particular role as champion is all about encouraging and supporting organisations. How successful do you think that particular approach has been in embedding sustainability across the picture? Are you encouraging and supporting organisations that are otherwise recalcitrant or do you have a more general role in that?

Dr Radford: My role is more general and I think my colleagues can speak in more detail about the success of our overall approach, whether it be the Department of Health or NHS England's approach to encourage and support. We are really clear that this is about significant cultural organisational change. It is about hearts and minds, having sustainability at mainstream and at the heart of what we do rather than see it as an added extra. It has always been our push that we need to get it embedded across policy areas within the departmental business plan and within the mainstream organisational business of the NHS organisations, the elements within the NHS. My colleagues can better demonstrate and explain some of the success as real examples.

Q11 Dr Whitehead: Is your role in part going beyond the paper function, spotting elements in the NHS organisations, areas of the NHS that really have not focused on the issue of sustainability and geeing them up or moving them further forward?

Dr Radford: No, my role is much more within the Department of Health. Clearly we work with NHS England but colleagues within NHS England are responsible for supporting the individual organisations there. The Department of Health is the overall steward, so to speak, and we have that overall and overarching responsibility to support, give direction, encourage, but NHS England and the SDU are better placed for working with individual organisations and spotting the issues within elements of the NHS.

Chair: I am very conscious of time. I want to turn to Caroline Lucas because I know she has another meeting to go to. She specially wanted to come in about carbon.

Q12 Caroline Lucas: I wanted to ask about the 2020 targets for reducing the NHS carbon footprint. As I understand it, the total carbon footprint of the NHS is about 3% of the national total, which is quite significant. Could you tell us what you think the implications are for the UK carbon budgets if the NHS fails to meet its own commitments?

Sonia Roschnik: If you would allow me, I would like to give a little bit of background about how we have set our level of ambition for the carbon target. The Government targets are based primarily around energy and the carbon reduction commitment and energy efficiency scheme is primarily around bigger organisations. The level of ambition, because it is really linked into the Government target, is much broader than that and it is trying to cover the whole of the sector, but also we are trying to cover all the elements that can be related to carbon: energy, travel, waste, water, procurement, food; all of those different elements. We have adopted the same targets, so 34% by 2020. It is really difficult to say where we will be by 2020 and the aim of the sustainable development strategy was to make sure that we could at least do our best to achieve it. I am pleased to say that we think we are going to be achieving the in-between level of ambition that we had set ourselves, which was 10% by the end of 2015 from a 2007 target. We are making good progress and of course the progress is not just through the work we do ourselves. It is also because the rest of UK plc is reducing carbon and so the carbon intensities are coming down across the piece. Broadly, we think we are going in the right direction.

We are not complacent. The sustainable development strategy is very ambitious in what it is trying to achieve and we believe that the only way we can do it is by working more closely together and making sure we are making the most of the cross-organisational working. We are on the right road—I don't know if that is the right language—and we have a long way to go still. We really hope we will achieve it and we will do our best to do so. There are areas of the carbon footprint that have higher greenhouse gas emissions; for instance, anaesthetics represent quite a large component of acute hospitals. It is about 5% of that and if we were able to look at those in more detail we could do more around that. Quite a lot is in the pharmaceutical industry. We have taken an approach where we try to target the biggest areas first, what we are calling the hotspots, because we could not tackle everything and that was a way of trying to make sure that we were attacking the bigger areas first. Does that help?

Q13 Caroline Lucas: It does, thank you, particularly the stress on working together, because my next question was: how feasible is it to leave it almost entirely to individual

organisations to come up with their own actions in response to the sustainable development strategy? Is there a danger of recreating the wheel because each bit of the whole is doing something slightly different and perhaps not in sufficient co-ordination?

Sonia Roschnik: The NHS is a multiplicity of organisations that have to decide at board level how they are going to take these things forward. We hope that by having local networks—we have the NHS sustainability day this month on 26 March—people can spread good practice and learn from each other.

Q14 Caroline Lucas: Between the different elements of the NHS?

Sonia Roschnik: Yes, between the different elements of the NHS but also within localities, with health and wellbeing boards, the local acute trusts, mental health trusts, ambulance trusts. They can get together and work on what that might look like. To be fair, each area is championing different things. Some areas are doing fantastic work on travel and others are doing great work on procurement, and ideally we would like that practice to spread everywhere.

Q15 Caroline Lucas: How do you share that?

Sonia Roschnik: We share that through case studies, awards that are set on a yearly basis, networks that bring people together across different geographical areas to share the learning, and we have lots of guidance to support people for what would a good sustainable development management plan look like. We also produce some maps to highlight where we think we are at in terms of carbon in relation to energy or waste or water or how many organisations are good at reporting publicly on sustainable development. That brings an edge of willingness to be transparent about the journey and sharing where we are at and how we can do more and take it further forward.

John Holden: Could I amplify that point? It is sometimes tempting to think that the only sustainable development things that happen are those that have sustainable development on the front cover, but if we get this right it is woven into the fabric of pretty much everything the NHS does. I was talking to a colleague this morning about how local clinical commissioning groups—and there are over 200 of them—achieve a kind of synergy from working together. There are six commissioning support units that help local commissioning groups work.

There is an example in the south-west of the commissioning support unit helping the individual clinical commissioning groups by triangulating different sets of data from different places and identifying people with dementia who were living alone and were therefore potentially more vulnerable, heavier users of services, needing admission to hospital, transport, greater intervention and so on. It gave them the opportunity to do some interventions upstream and avoiding the admission and all of the associated implications of that. It does not have sustainable development written on the lid of the tin but it is a very good local example of how joining up the support units, the CCG, the local authority social care provision can work together to support patients and service users closer to home. I think we need to keep in mind those sorts of examples as well as the very explicit heat, power, light and things like that.

Q16 Caroline Lucas: Can I ask one last question that is coming from a slightly different angle? There was a report published last month by Medact and other leading health and environment NGOs arguing that the UK health community needed to phase out its investments in the fossil fuel industry, with air pollution from fossil fuels being responsible for around 5% of all UK deaths. I know that representatives from the BMA have also spoken out about ending investments in the fossil fuel industry. Is there any connection between the work that you are talking about, which is pretty much the practical on the ground work, and these bigger strategic issues like the investment of the NHS in fossil fuels?

Sonia Roschnik: There is obviously a connection because they are all part of the same carbon footprint of the UK.

Caroline Lucas: But is it a part of your strategy?

Sonia Roschnik: I don't think influencing the way organisations are making their investment decisions is specifically part of our strategy. We are saying that every organisation needs to make their own decisions about how they are going to take it forward for themselves.

Q17 Caroline Lucas: Could it be on there? You now have everybody from the Governor of the Bank of England through to the UN to everyone saying that, just like the health profession really did lead the way when it came to divestment from tobacco, in a sense there is a real scope here for also leading the way on divestment from fossil fuels.

Sonia Roschnik: I think there is a scope. We would not say that this is a must do, like we are not saying that anything is a must do. We are trying to provide a framework for each organisation to make its own decisions.

Q18 Caroline Lucas: But could you add it in? From your response—what I am reading between the lines and maybe this is not fair—it feels like this is not something that is on the agenda that you are pursuing at the moment. There are plenty of other things that are not, and I am not complaining, but I am just asking if it could be, if you could add it into the menu of things that you are asking?

Sonia Roschnik: That people could consider. I am sure we could.

John Holden: Yes, and there are different ways to skin a cat. For example, in the contract that all NHS commissioners have with providers of NHS-funded care, taxpayer-funded care, there are explicit provisions about providers minimising the impact on the environment of the care they provide. That goes for every provider. We require the largest providers to maintain sustainable development plans and to be able to account for the impact of their activities and also to think about social value and other things like that. There are lots of different levers and lots of different ways in which we can have that conversation. The reality is that the system we have in the NHS, the system we are working on, is not one of top-down, centralised control where we issue an edict and it just happens. Coming back to Dr Radford's point, it is about winning hearts and minds and it is possible to do that because there is an economic case here. Very often it is possible to achieve better results in different ways. There is a better outcomes for patients' case and there is an environmental sustainability case, and it is the evidence and it is the encouragement.

Q19 Caroline Lucas: I appreciate that, but one way of adding the NHS's incredibly powerful and large voice to a growing movement around divestment would be, for all of the reasons you have just outlined, if this could be a more overt, explicit suggestion, recommendation for attention? That is what I am asking.

Sonia Roschnik: I am sure it can be considered. I don't know what the answer would be.

John Holden: I am sure it can be and we need to take that away.

Caroline Lucas: All just say yes.

Q20 Mark Lazarowicz: I was interested in the report from the Sustainable Development Unit regarding the extent to which procurement was a very big contributor to the NHS carbon footprint. It was 61%, which I found quite surprising. I understand that now a Coalition for Sustainable Pharmaceuticals and Medical Devices has been set up. Can you tell us what that coalition has achieved to date and, more generally, how constructively has the pharmaceutical industry engaged on the issue of addressing emissions through procurement as far as the NHS is concerned?

Sonia Roschnik: That has been a really interesting journey. When we did our first carbon footprint we decided to take this broader approach that highlighted that a very significant part of the footprint is within procurement and that about 22% is within pharmaceutical products, so that is a big chunk. We decided very early on, about five years ago, that we would start talking to the industry to say, "We share this big thing here. What are we going to do about it?" That was the beginning of bringing together the pharmaceutical industry alongside NICE, the Department of Health, the Unit and the different components of the health service. We decided that we need to develop more methodology to look at how you properly carbon footprint pharmaceutical products, because there was not any real guidance about how to do it. So we did that as a global activity with a global consultation with the greenhouse gas protocol people to make sure that we had a common standard for it. That has enabled us to have a language that we can use.

One such company has looked at its carbon footprint across the UK, at the fact that a lot of that is in inhalers, because the gas at the bottom of inhalers is quite potent, and started to do recycling schemes for those inhalers but also to look at whether they could start substituting some of those inhalers to a more pulverised form so that there is a shift in the way that we use and prescribe some of the medicines. Now we are looking at whether we can develop some more guidance on the patient pathways so it is not just in relation to products but it is how the products might enable a reduction in length of stay or other ways of looking at it.

It has been a very strong coalition that has been highlighted around the world, that the United Nations think is exemplary, and we are hoping that we can try to develop a lot more understanding and take that forward. We are still at the beginning of that journey though.

Q21 Mark Lazarowicz: Is this coalition an international effort not just a UK one? I see people nodding behind you.

Sonia Roschnik: It is UK based but it has international membership. All the companies have global representation and also the United Nations and the WHO are part of that coalition.

Q22 Mark Lazarowicz: That is interesting. Obviously we are looking at the NHS in the UK, so I would be tempted to follow that international dimension but I won't. In terms of the UK, you mentioned one example about the start of a journey. Can you indicate what are the next stages of that journey? You have mentioned one example. How far are we going to see a wider take-up by pharmaceutical companies in this area?

Sonia Roschnik: All the pharmaceutical companies that are part of the coalition are very committed to this. We started looking at what are the top carbon-intense drugs that the NHS utilises so that we can understand those better and see how much they contribute to the footprint. Just like we were talking about this sort of hotspot, picking up the big areas, it is trying to look at what those are. We are going to do the same for medical devices and try to see how we can start bringing those down. Every time the coalition meets, we share examples of good practice where people have done their carbon footprinting and highlight how it has shifted practice within their own companies. We are not at the stage where we can compare paracetamol A versus paracetamol B and their carbon footprints. We are far from that, but we are in the space where we can say, "These are the big areas. Inhalers are very big; they are 5% of the pharmaceutical products for the UK. What are we going to do around that?"

Q23 Mark Lazarowicz: Are all the big pharmaceutical companies more or less signed up to this effort or are there any who you need to prod more to do something?

Sonia Roschnik: We have got quite a lot. We have eight that are part of it now and it has been a voluntary membership. I mean they are not forced to join. They are invited to join and they pay to be part of that coalition.

Q24 Mark Lazarowicz: Presumably at some stage you could adapt procurement to ensure that those companies that responded positively were the ones who were procured from and those that did not were in some ways not given the same priority?

Sonia Roschnik: What we would first like is our procurement practice to suggest that when we are procuring things people could use the guidance to make sure that within their companies they are reducing their carbon footprint and taking it more broadly. I think generally the companies are finding that they are saving a lot of money themselves by reducing the carbon footprint within their own areas. We are not quite at the stage of wanting to say that we would give them preferential treatment, because I think that would probably not be appropriate.

Q25 Mark Lazarowicz: It was not about preferential treatment. It was basically including as one of the indicators for choosing contractors that if you reduce emissions that is a factor that is taken into account. Isn't that quite a reasonable thing to do?

Sonia Roschnik: I think we would want to do that across all of procurement. We have a procuring for carbon reduction framework that is about how we engage with suppliers and start the discussion about them reducing their carbon footprint and start entering it into contracts. What we have found is that it is not sufficient to just put it into the contracts.

We need to understand the work behind what they are doing and how it is influencing the overall. There is a lot about educating ourselves in the process as well.

Q26 Mark Lazarowicz: That takes me on to the final point I was going to ask you about anyway. My question was about procurement in terms of pharmaceutical products and services. Obviously you are spending £20 billion every year in England alone on goods and services. I understand that organisations can carry out their own procurement exercise or go through an existing framework agreement with suppliers. To what extent do these framework agreements include sustainability clauses at present?

Sonia Roschnik: Within the procurement standard there is a sustainability standard that people are expected to work with and I think it is about how much they are stressing it. We are just at the stages where we are beginning to include it into contracts, discussions, ways of doing things, but not yet at the stage of measuring the difference and apportioning it within contracts. I think that would be a next step, possibly.

Q27 Mark Lazarowicz: How actively do you monitor the sustainability clauses actually being implemented or observed? It is a very big organisation and there will be some who may be not as effective. How do you try to do that?

Sonia Roschnik: It is a very good question. In a way, it is a little bit like the discussion we have had that so much of this is down to local level and local procurement teams and how they take it forward. We are trying to support them with that process, with training about how to have conversations about carbon and also how to start including it in the clauses and start influencing some of the contracts. You are right, if we could get that right there is a huge area of influence there and we are still at the early stages of developing that.

Q28 Mark Lazarowicz: I get the impression that it is very much a matter of encouragement, best practice sharing, more than any kind of requirement as such. That may be the right thing to do, I don't know, but is it fair to say that the approach now is voluntary encouragement rather than some requirement?

John Holden: Yes, and the point I alluded to earlier that in contracts between NHS commissioners and NHS providers there is a service condition that requires them to think about their environmental impact. That is the basis for a conversation in terms of the contract management about, "How are you fulfilling that obligation? What ways are you doing it?" But you are correct in your probing that we don't sit down and point the finger and say, "Why didn't you buy this from X and why not from Y?" The way the NHS is is that local organisations do have a significant degree of autonomy to do the right things for their patients.

Q29 Mark Lazarowicz: I am just a bit concerned that particularly with more devolution of purchasing power to commissioning groups or parallel systems elsewhere that with such a big organisation—I suppose any organisation—some of this will be an exercise where there is a statement in the report but no one checks it is actually happening. It is a question of how far can you monitor that?

John Holden: I think you are right about that risk. There is also an opportunity that local organisations will surprise us with the way in which they go further than we imagined and find solutions that we in Whitehall would not have dreamt up, and that is an important part

of why the NHS is structured how it is. You are right, there is a balance between trying to keep an eye on everything locally and recognising that sometimes you get the best results by letting go a bit, giving people information, evidence, peer support and letting them get on with it. That is the balance we try to strike.

Q30 Mark Lazarowicz: On all this question of monitoring the clauses, what is the mechanism in the central position as to how you carry out some checking? You must do some checking, presumably?

John Holden: I think there are two things here. One of them is the line of accountability for the spending of taxpayers' money. NHS England distributes funding to clinical commissioning groups. They in turn let contracts to commission care for the communities they serve. Increasingly they do it working with local providers of care, local authorities and others. There is that kind of line of accountability. You could conceptually imagine a situation where there is this clause in the contract and the national organisation, NHS England, is asking the clinical commissioning groups who we support and hold to account, "What have you done about this?" and they in turn are talking to the providers and saying, "What have you done about this?" That is possible and I can imagine it happening but, to be honest with you, I don't think that is the most prevalent conversation they would be having about the service that was being delivered and how it was being delivered. I think there are other things they would be more worried about.

More generally, monitoring of sustainability in the NHS is about providing information and evidence and supporting, holding a mirror up. Very often organisations will make the smart choices for themselves because they can see the benefit. Sonia, I don't know if there is more to add but I don't want to conflate it with the commissioning accountability route.

Sonia Roschnik: I think it is similar for procurement that in a way it is down to local teams and how they take it forward. We have been trying to support them with training and guidance and best practice exemplars, but there is not a, "This is the way to do it". With teams where I have taken it forward, there is an example in Essex where they have systematically gone through all their procurement within the hospital and tried to make sure they were putting up a greener alternative. They have made the decision within their organisation that that is what they wanted to do because they saw that procurement was such a big part of the carbon footprint. That has worked really well and has saved them money. London has analysed, across London, all of their procurement and where the big hotspots were, realised that there was an awful lot of bottled water, for instance, and how they were going to approach that.

The approach we have been taking is to encourage each organisation to look at where the bulk of their big carbon purchases are and how they can influence that. Some of that might be about their own practice, about making sure that they are wasting less upfront and not so much about the supply chain. We have been quite keen to highlight this as a shared issue across the supply chain and ourselves and not just a supply chain issue.

Q31 Chair: Arising out of that question of how organisations are able to monitor sustainability clauses in contracts is again a constituency experience of a particular contract that is in the process of being let where patients would have had to travel quite considerable distances compared to what they currently do for treatment from scanners as a result of a new contract that has been brought in for the PET scanner. This relates to the north Staffordshire

area. How much say is there in looking at the specification for contracts so that we don't end up with much wider distances and a much greater carbon footprint as a result of that? I am relating that further to Mr Lazarowicz's question.

John Holden: The starting point for any service that is commissioned, either by local clinical commissioners or by NHS England—because we do commission some services nationally on behalf of patients—is the understanding of what is best for patients. There is no better way to determine that than by talking to patients themselves. The very beginning of answering that question is about saying what do patients need, what do they want, how do we balance that with all of the other considerations. Sustainability is one of them; financial, environmental, social. I would imagine any contract being let would ask those questions as part of the criteria for looking at the tenders, including access for patients, travel time, the quality and resilience of the service; all of those factors would be taken into account.

Sonia Roschnik: I think this touches on one of the most exciting parts of sustainability and the healthcare sector, which is that we need to look at how it gets integrated and embedded in the models of care. It is not just about transport; it is also about dependency on pharmaceuticals and medical devices. It might be about whether there is care closer to home, different ways of delivering improved prevention and things like that. That is a real area of opportunity for us to be taking forward where we can integrate it in everything that we do, and we have some way to go on that.

I guess the point was around how we contract services and take into account all the patient needs. In a way, what we would like to advocate and what we tried to suggest with the sustainable development strategy is that the quality of care includes sustainability, just like it should include best value and fairness. That should be part and parcel of the way we look at the models of care and work to deliver them in the round. That is quite a lot more complex than looking at travel or procurement and some of these other elements. It takes it to another whole new level. I think we have all come to the conclusion as a system that if we are going to do this well we need to go way beyond buildings and facilities and integrate it into our core business and how we do things. At the end of the day, this is about health because we know all of what we do impacts on health, so we have a real reason to want to take this very seriously and take it forward in a much broader way.

Q32 Katy Clark: I want to ask about foundation trusts in other parts of the health service. NHS England requires all clinical commissioning groups and the Department of Health requires all NHS trusts to report on sustainability as part of their annual reporting process but foundation trusts don't, although there are Treasury guidelines that encourage them to monitor. Why do foundation trusts not have any requirements on sustainability reporting?

John Holden: I suppose the short answer is the statutory basis of foundation trusts is different from other NHS organisations and there was a conscious decision made at the time to give them greater autonomy, greater freedom in the interests of patients. Sometimes it is the case that giving an organisation greater freedom to best serve their patients in the way they see fit allows them to do things they would not otherwise be able to do.

Q33 Katy Clark: What are the implications of that? Has that been a good thing or a bad thing? Is there any sign that standards of sustainability have increased as a result of that or would you say that it is quite obvious that foundation trusts are perhaps failing in some of the ways that we would want them to deliver?

Sonia Roschnik: I would say that foundation trusts are often still reporting on it because they see it as being important. They have a different view of the way they utilise their autonomy and their governance. Some of the best reporting has been from foundation trusts. They are not compelled to have to do it but a lot of them do it because they think it makes good business sense and it also is the right way to approach their community involvement. It is about that transparency. I think a lot of them recognise that this is a very good way of involving their community and their patients.

Q34 Katy Clark: Are you saying it does not really make any difference whether you have this requirement or not?

John Holden: I think it is worth recognising that foundation trusts have different governance arrangements. I made the point earlier—it is hackneyed—about different ways to skin a cat. A foundation trust has governors and members and part of the accountability is exercised through those governors and members. An NHS trust might not have that and there might be different ways in which we work with NHS trusts.

Q35 Katy Clark: You think that some of the best examples are from foundation trusts. Are there very bad examples from foundation trusts as well? Would you say that the fact that there is no requirement mean that there are some examples that are very bad, that the minimum standard is different or—

Sonia Roschnik: I don't think we have undertaken an exercise to compare non-foundation trusts and foundation trusts. We have looked at NHS trusts overall and we think that 49% have good sustainability reporting. That means that they include quite a lot of the data from the Treasury guidance and some words about their plan in their guidance. That is compared to hardly any five years ago, so we think we are on the right trend. I would say there are some great examples in NHS trusts, CCGs and foundation trusts and there are bad examples in all of those as well. I don't know if the governance mechanism is the thing that makes the difference to that.

Q36 Katy Clark: What about primary care and community service organisations? What requirements are on them to report on sustainability?

Sonia Roschnik: There are the commissioning groups that report and certainly GPs and primary care, the smaller organisations, are not required to report but a lot of them will recognise that they need to be taking this seriously because they are seen as very influential members of the public and the professional world. If GP practices are taking this forward, it sets an example for the rest of the world. It is patchy; we have some very good examples and some where there is less happening.

Q37 Katy Clark: If requirements to report don't necessarily have a massive impact on performance, what do you think the drivers are that would ensure that there is better reporting but, more importantly, better delivery on these issues?

John Holden: I would suggest, picking up on Dr Radford's point from earlier on, that it is culture, hearts and minds and good evidence. Primary care professionals are very interested in data, benchmarking and understanding how what they do with their population compares with comparable organisations and communities elsewhere. There are lots of data available where you can identify a cluster of organisations similar to your own and make those comparisons. I would suggest it is about making good information available that is relevant and timely so that professionals can look at the impact they are having in the way they are working and do something with it. Sometimes there is false comfort in reporting, having a report that is well written and presents the most positive picture. It is a good thing to have and it is a start, but it is really about winning the hearts and minds of people to make the changes, giving them the evidence.

Sonia Roschnik: I would say that at the moment still a lot of sustainable development initiatives save organisations money and that has been quite a driver. At the beginning people thought that maybe it would cost more, but there is a lot of evidence now that it is saving organisations money and that is a driver in today's world. I think the other one is about public opinion and what patients are suggesting. Public opinion does suggest that they would expect the NHS to be more sustainable and to use taxpayers' money in a good way.

Dr Radford: The other element is there is one thing to provide information, there is one thing to try to get some cultural buy-in, but also it is about helping people understand what they can do, because that is one of the biggest challenges, "You may believe all this stuff, but what can I do sitting here?" The Department of Health, the Sustainable Development Unit and the NHS spend a lot of time preparing guidance, learning tools, opportunities for people to share good practice. It is by sharing those practical examples of what you can do in your situation for some of your issues that helps people hugely, otherwise if we are not careful it becomes an issue, "But what does it mean for us?" It is about translating this into, "Therefore, what can I do sitting in whatever part of the NHS I'm sitting in?"

Q38 Dr Whitehead: Can I go briefly to adaptation? The sustainable development strategy incorporates or acknowledges the plans that have been produced, such as the national heatwave plan and the cold weather plan. I believe there is a report on how the healthcare system is adapting to climate change, due for publication in May, which I would like to come to in a moment, Do you consider that the sustainable development strategy does overall take account of those risks of climate change, extreme weather, floods, hotter summers, air pollution and so on? Do you think it covers the whole area successfully or do you think there is further work to be done?

Sonia Roschnik: I think it does. It will be supplemented by this report that is currently going through approval processes within NHS England, Public Health England and the Department of Health. One of the difficulties with sustainable development and climate change is bringing alongside each other the carbon reduction and the adaptation to climate change and not getting lost in the responses but also getting into the strategic planning. Trying to bring all those dimensions together is not always an easy solution. So the strategy is trying to do that and it is trying to do it not just through a risk-based approach of saying, "We need to reduce our impact, we need to reduce inequalities and reduce the risks" but also trying to look at where there are opportunities. What the strategy is trying to highlight is that there is a lot of opportunity within community resilience and the way

we can work together to build that for better health, better wellbeing and better communities. If we do that well, we will be preparing ourselves for adapting to climate change as well as looking at how we deal with heatwaves, flooding and those kind of events.

It is quite a multi-faceted thing that we are trying to bring together as a whole. I think the biggest danger would be to end up having energy efficiency here and adaptation here and having them all as separate things that might counteract each other. For me, one of the scariest scenarios would be to have a hot ward with lots of portable air conditioning units, when we could have approached it in a more strategic way by thinking about how we were going to deal with that ahead of time.

Q39 Dr Whitehead: As you mentioned, this report is coming out in May 2015. I imagine you are not in a position to say exactly what is in the report, but we are among friends here. Would it be possible to sketch some of the headlines that that report is likely to address without compromising the integrity of the report in any way?

Sonia Roschnik: The report is trying to address some of the things we have been talking about just now. One is the risks to the population but also the risks to the infrastructure and the risks to service patterns and how we might bring that together and work locally to address it so that we are not just dealing with separate issues. It is a good way of pulling together a lot of what we have been talking about today. There is everything that we can do locally and how we can support that happening, but there is an element of understanding and we are going through this at a national level: what are the sorts of things that we need to understand nationally to better support that happening at a local level? As an example, we will be in the position of being able to look much more closely at the flooding areas and where buildings are located in those different areas and what we might want to do in the longer term about that, as well as supporting local developments and how they might adapt to it.

Q40 Dr Whitehead: You mentioned the question of how you might deal with, say, extended heatwaves, high temperature episodes. What sort of direction are you likely to be pointing at in the report?

Sonia Roschnik: We have very good heatwave plans and we think that we are very good at responding to them. The challenge is also how do we prepare for this in five years' time, 10 years' time and going forward. What we have recognised in the system is that we have lots of information that is available at local level. In the estates and facilities departments of every hospital they have a premises assurance model that is utilised where they are trying to look at some of these issues more specifically and make sure that they have considered the issues for their locality. We are looking at whether we could bring some of that together to get a better understanding nationally about what it means and how we might need to take that forward.

John Holden: Could I make a point about process on this as well, just to give you some reassurance? Adaptation reporting is not an exact science. There is not a simple template to fill in and there has had to be some decisions here about the scale and scope of it. This is ground-breaking because it is sector-wide; it is looking across the sector of health and

public health and it is not just one organisation and one segment of the sector. It is right across health and public health and that is ground-breaking because it is the first time. One of the Committee members was asking earlier about what lessons there are for others to learn. We would stop short of trying to preach, but I do think it is a really important development in the context of health and public health that we have an adaptation report that looks right across the piece for the whole sector. We will learn from that and possibly others will too. It is very good.

Sonia Roschnik: It has not been a mean feat.

Q41 Dr Whitehead: I am sure it hasn't. On that particular point, you have emphasised that this is across the sector and brings in a whole range of actors within the sector. I imagine that also applies to the extent to which the health service would be co-operating and assisting other affected bodies outside the health service in terms of what the overall public health consequences of adaptation turn out to be. Our Committee has a climate change adaptation report coming out now that, among other things, calls on Government to consider making adaptation reporting mandatory for all organisations managing critical infrastructure and services. How helpful do you think it would be for the NHS if that were to be the case? Are there particular organisations and sectors that you might identify that would be of assistance in hooking on to your report so that you can push that out right across boundaries as well as possible?

Sonia Roschnik: I think DEFRA's approach has been a voluntary one this round and we have very much welcomed the invitation to respond and to be able to do it sector-wide. If we asked every health sector organisation to report, that would be a lot of different organisations. There are—

John Holden: Many.

Sonia Roschnik: —many hundreds of different organisations that would need to be doing it. The approach that we have been taking is if they have a sustainable development management plan that is approved at board level that should include adaptation just as much as it should include all the other things that we have been discussing. We hope that that would help drive it forward. I recognise that there is some critical infrastructure that does need to be looked at and I think that the Civil Contingencies Act picks that up as well. There are some interlinkages between the Climate Change Act and the Civil Contingencies Act that we do need to consider. I know that has been part of the discussion that we have had with the adaptation report. Going through the process of doing the report has flushed out a lot of discussions and has enabled us to look at it with fresh eyes, and I think that has been a very useful process.

John Holden: I don't think we have a concern, having worked through this, that there is a part of the system that we would have liked to co-operate or support and they have been unwilling and it needs more push. The scale has been quite challenging already and making sense of it, interpreting what is an awful lot of information has been the challenge rather than cajoling people to support it.

Sonia Roschnik: We haven't included social care, just because this was already huge, but in an ideal world we would and we would develop that partnership further. That has been a pragmatic exercise really.

Q42 Chair: I am very conscious of time. I have two very quick questions. If we don't have a chance for a full response perhaps you could reply in writing. The Sustainable Development Unit commissioned the modelling exercise looking at reductions over time but there does not appear to be an action plan to put into practice that modelling plan for CO₂ reduction up until 2020. Is there going to be an implementation action plan?

Sonia Roschnik: There is a sustainable development strategy implementation plan that is being discussed at the moment at the cross-system group level. It is being held within our system walls, as it were.

Q43 Chair: Is it the case that there is a separate water and waste target within that?

Sonia Roschnik: Waste and water are integrated within the carbon approach and we monitor that on a yearly basis. We do know that, for instance, we have reduced water by 6% since 2007-08 and we have reduced the non-recycled waste by 33% since then as well and energy by 3.5%. It is worth saying that these are all absolutes, so this has been alongside an increase in inpatient admissions of 13%. I think it is quite laudable that we have been bringing things down while activity is going up, and we are still trying to report in an absolute sense rather than per patient or per pound or per cubic metre.

Chair: I would like to explore some of that further but I am afraid we have run out of time. Can I thank the three of you for coming along? I very much hope that this is not just a case of coming before a Select Committee; that the work that is ongoing will be going on with intense pressure behind the scenes. Thank you all very much for coming along and thank you to my colleagues as well.