



Carbon Reduction Plan

Knights Dental Group

Environmental sustainability and carbon management

Management draft — emissions data and approval required

Document control	Details
Reporting organisation	Knights Dental Group — legal entity coverage to be confirmed in the controlled reporting register
Scope of application	NHS and private services, central operations and developments within the approved reporting boundary
Document reference	KD-CRP-01 Draft 0.3 8 th of September 2026
Accountable director	Dr Paul John Jones, Director
Publication and review	[6 th of October 2026] [6 th of October 2027]
Public website address	www.KnightsDental.co.uk

1 Commitment to achieving Net Zero

For approval by the authorised leadership of the participating entities: Knights Dental Group commits to achieving Net Zero greenhouse gas emissions by 31 December 2030 across its approved reporting boundary. This retains the ambition in our existing plan. The entities covered, precise date, quantified pathway and required investment must be approved before publication.

We will support NHS Wales and relevant commissioners’ decarbonisation initiatives, including the Welsh public sector’s 2030 ambition where we deliver NHS services. We will prioritise operational and supply-chain reductions, report progress transparently and address residual emissions through a separately disclosed, credible approach. Our wider Net Zero assessment will cover all material emissions, including relevant Scope 3 sources beyond the core categories reported in this plan.

Purpose and delivery context

This plan provides a consistent approach to carbon reduction across Knights Dental Group’s participating businesses. It covers NHS and private dental care, premises, central functions, procurement, staff travel and development activity within the approved boundary. It supports accessible, high-quality care through efficient buildings, responsible purchasing and less avoidable waste and travel. The same principles will guide refurbishment, acquisitions and new practice development.

The programme below is proposed for adoption. Reported existing measures are identified separately. No quantified emissions, carbon savings, certification or completed approval are asserted where supporting evidence is unavailable. Bracketed fields must be completed before release.

2 Baseline and current emissions

All figures must be expressed in tonnes of carbon dioxide equivalent (tCO₂e). Missing data are not zero emissions. The tables are intentionally unpopulated because no verified emissions inventory was available when this draft was prepared. The reporting boundary and calculation rules are set out in section 3.

Baseline Emissions Footprint

Baseline reporting period: [DD Month YYYY] to [DD Month YYYY].

Baseline year and reason for selection: [Complete].

The baseline will be the first complete, representative 12-month inventory for the approved reporting boundary. If there is no earlier reliable inventory, the first completed reporting year may serve as both baseline and current year. Any atypical conditions, acquisitions, incomplete coverage or estimates must be explained; no historical reduction will be claimed without comparable evidence.

Emissions	Baseline total (tCO ₂ e)	Coverage / explanation
Scope 1	[Calculate]	Direct fuel, vehicle and fugitive emissions, as applicable.
Scope 2	[Calculate]	Purchased electricity and other purchased energy; location-based.
Scope 3 — core categories	[Calculate]	Categories 4, 5, 6, 7 and 9, individually disclosed below.
Total core reported emissions	[Calculate]	Scope 1 + location-based Scope 2 + core Scope 3 subtotal.

Current Emissions Reporting

Current reporting period: [DD Month YYYY] to [DD Month YYYY].

Activity measure for intensity reporting: [Completed appointments or clinical hours; confirm coverage].

Emissions	Current total (tCO ₂ e)	Change against baseline
Scope 1	[Calculate]	[tCO ₂ e and %; explain drivers]
Scope 2 — location-based	[Calculate]	[tCO ₂ e and %; explain drivers]
Scope 3 — core categories	[Calculate]	[tCO ₂ e and %; explain drivers]
Total core reported emissions	[Calculate]	[tCO ₂ e and %; explain drivers]

Core Scope 3 breakdown

GHG Protocol category	Baseline tCO ₂ e	Current tCO ₂ e
4 Upstream transportation and distribution	[Calculate]	[Calculate]
5 Waste generated in operations	[Calculate]	[Calculate]
6 Business travel	[Calculate]	[Calculate]
7 Employee commuting	[Calculate]	[Calculate]
9 Downstream transportation and distribution	[Calculate / justified N/A]	[Calculate / justified N/A]

These five categories follow the PPN 06/21 core reporting framework. Report additional material Scope 3 categories separately, with their own subtotal, before presenting any wider organisational total. State any market-based Scope 2 figure separately; do not add it to the location-based total. For each missing item, record the reason, estimated significance, proposed remedy and date, and retain the supporting evidence with the inventory.

3 Boundary and accounting method

Organisational boundary

The proposed consolidation method is operational control, subject to verification of the participating entities' arrangements. The inventory will cover their defined UK operations, including NHS and private care, central functions, leased premises and development activity. A controlled register will identify the legal entities, company numbers, ownership/control, locations, inclusion dates and reporting responsibilities. Shared supplies and central resources will be allocated consistently without double counting.

Group-level totals will be reconciled to entity-level records; shared branding or directorship alone does not establish a reporting boundary. Each participating entity must adopt the relevant commitments through its authorised leadership. Where the plan supports procurement, the bidding entity must confirm its coverage and the applicable requirements. Proposed premises are future delivery locations, not zero-emission entries in a historical baseline.

Source	Measurement and treatment
Scope 1: direct emissions	Use metered gas and other fuel records, controlled vehicle fuel or mileage, refrigerant service and leakage records, and relevant medical-gas records. Screen nitrous oxide where sedation, storage or distribution is within operational control. Reconcile purchases, stock, returns and use; do not equate purchases automatically with releases.
Scope 2: purchased energy	Use electricity and purchased heat/cooling consumption. Obtain landlord data or transparently allocate shared supplies using a defensible method. Retain location-based reporting. A renewable tariff does not make location-based emissions zero; report a market-based figure only with suitable contractual evidence.
Scope 3: categories 4 and 9	Identify transport of purchased goods and laboratory items, payer and contractual responsibility. Assign upstream/purchased transport and downstream transport to the appropriate category without double counting. Assess category 9 explicitly; justify any non-applicability. Do not classify patient journeys automatically as downstream freight.
Scope 3: categories 5, 6 and 7	Calculate waste by mass, type and verified treatment route. Record business journeys, mode, distance and relevant accommodation. Survey commuting modes, distances and attendance with a stated response rate and extrapolation method. Explain treatment of associates and other non-employees.
Wider sources and development	Screen purchased materials, laboratory production, equipment, fit-out and other material Scope 3 sources. Keep patient travel as a separately described wider-care indicator. Assess fit-out impacts when the activity enters the reporting boundary; do not wait until a new practice opens.

Calculation, evidence and quality control

Apply the GHG Protocol and UK Government conversion factors appropriate to the activity year and source. Calculate emissions as activity × emission factor, converting kilograms CO₂e to tonnes where required. Retain quantities, units, factor version, source documents and assumptions. Distinguish calculated emissions, defensible estimates, evidenced zero and justified non-applicability. Finance will reconcile billing periods and totals; a second reviewer will check calculations and duplication. This review does not imply independent assurance.

Comparability and baseline changes

Disclose the approved materiality policy for recalculation. Review significant acquisitions, disposals, methodology changes or errors and restate the baseline and comparisons consistently where necessary. Record the rationale and effect. Organic growth, additional appointments and new surgeries must remain visible; they do not justify rebasing away an emissions increase. Track absolute emissions alongside consistent activity measures.

4 Emissions reduction targets

The existing plan contains the targets below. They are retained for continuity and must be checked against the completed baseline, forecast service growth and estate changes, technical feasibility and approved expenditure. They are commitments to be adopted, not evidence of savings already achieved.

Target retained from existing plan	Measure and implementation basis
Net Zero by 2030	Proposed deadline: 31 December 2030. Establish a costed annual pathway across the approved organisational boundary and assess all material Scope 3 emissions. Confirm feasibility and formal approval before publication.
20% less energy consumption by 2028	Track absolute annual purchased energy, in kWh, against the approved baseline. The target is not silently converted to an intensity target. Also report kWh per completed appointment or clinical hour to explain expansion. Proposed target date: 31 December 2028.
30% less waste volume by 2029	Retain the original volume target and establish a consistent, evidenced volume measure. Also collect waste mass and treatment data for carbon calculations. Any change to a mass or intensity target requires explicit approval and disclosure. Proposed target date: 31 December 2029.
100% renewable electricity procurement by 2027	Proposed deadline: 31 December 2027. Measure the share of purchased electricity supported by suitable renewable supply evidence. Map renewal dates and landlord-controlled contracts, and disclose coverage and limitations. Continue location-based emissions reporting.
Lower travel-related emissions	Establish business-travel and commuting baselines, then approve quantified annual reductions. Use proportionate remote working and meetings, practical active/public transport and clinically appropriate remote contacts. Preserve access for patients needing in-person support.

Quantified carbon trajectory

Before approval, enter the baseline total B, the current total C and annual gross-emissions ceilings for 2027–2031, in tCO₂e, showing how the 2030 goal will be maintained thereafter. For each measure, record estimated annual savings, capital and operating cost, owner, delivery date, dependencies and confidence. Use $(B - C) \div B \times 100$ for a like-for-like percentage change only where B is non-zero and the boundary is comparable. Do not derive emissions savings directly from the energy or waste percentage targets without source-specific calculations.

Prioritisation and investment

Prioritise low-cost operational controls, avoidable waste and procurement decisions first. Rank larger investments by clinical suitability, lifetime emissions, cost, delivery risk and expected benefit. The Director will approve expenditure and any target revision. A revision must explain the reason and impact openly, rather than changing the baseline to conceal underperformance.

Residual emissions and honest reporting

Report gross emissions before any credits or removals. Do not assume that renewable procurement, avoided patient travel or offsets neutralise the whole footprint. A 2030 Net Zero statement will require a clear account of actual reductions, boundary coverage and any independently evidenced residual-emissions treatment. No offset purchase or carbon-neutral certification is claimed in this plan.

5 Carbon reduction projects

Existing foundations and evidence status

Measure	Current statement and validation needed
Digital patient records	Use of Dentally has been identified for the group. Confirm coverage across the participating entities. The reduction in paper or journeys has not been quantified.
Digital radiography, LED lighting and efficient appliances	Reported in the earlier carbon plan. Confirm practice-by-practice installations, equipment inventory and dates before describing coverage. No measured savings are asserted.
Recycling and clinically appropriate reductions in single-use plastics	Reported in the earlier plan. Verify segregation arrangements, contractor records and the specific substitutions in use. Patient safety and infection prevention remain controlling requirements.

Energy and existing premises

Within 30 days of the programme commencing, practice managers will compile meter, tariff, landlord and equipment registers. Monthly monitoring will identify unexplained out-of-hours consumption, leaks and abnormal peaks. Managers will investigate material variances and retain the action and outcome. Smart metering or sub-metering will be proposed where practical and proportionate.

Introduce documented switch-off routines for non-essential equipment, sensible heating/cooling schedules, maintenance and draught controls, while protecting IT resilience, clinical storage, ventilation and validated decontamination. Review lighting and plant at replacement points. Assess insulation, heat pumps and on-site renewables through site-specific technical and financial appraisal; installation is not assumed where ownership, heritage or lease constraints prevent it.

Managing premises and future development

Area of the estate	Carbon and access considerations
Existing operations	Monitor energy, waste and activity before changes in service delivery. Use available clinical capacity efficiently and review equipment and travel arrangements while protecting patient access and quality.
Refurbishment and expansion	Assess additional surgeries and extended hours for energy demand, ventilation, lighting, decontamination capacity and equipment sizing. Separate efficiency improvements from the effects of increased activity.
Acquisitions and new developments	Assess public transport, accessible arrival, building condition, heating, metering, landlord consents, climate resilience, waste storage and fit-out impacts. Review acquired operations and obtain competent advice where buildings are listed or constrained.

Premises selection will balance carbon, safe clinical design, disability access and practical access to dental care. Refurbishment and reuse will be considered where technically suitable. Equipment and construction choices will be assessed for durability, repairability and whole-life impact. No specific site is described as secured, approved or low-carbon solely because it is modern or centrally located.

6 Purchasing, waste and clinical care

Responsible purchasing and laboratory services

Business management will include environmental questions in proportionate supplier assessments and reviews. Priority categories are dental materials, laboratories, equipment, waste services and fit-out. Seek credible emissions information, packaging options, repair/maintenance support and take-back arrangements alongside safety, quality, continuity and value. Supplier location alone will not be treated as proof of lower carbon.

Improve demand forecasting, stock rotation and inventory visibility to reduce expiry and emergency deliveries. Consolidate routine orders where storage and stock resilience allow. Review laboratory collection schedules, packaging and avoidable remakes with clinical leads; maintain turnaround standards and urgent arrangements. Record the payer and transport data so courier emissions are assigned to the correct reporting category.

Waste prevention and safe segregation

Map each practice's waste streams and obtain contractor weights or defensible estimates, collection frequencies and treatment routes. Review segregation at the point of use, bin placement and staff understanding to prevent unsuitable disposal and avoid unnecessary higher-impact treatment. Retain the relevant transfer and consignment records and investigate inconsistent weights or descriptions.

Reduce unnecessary packaging and unused stock, support suitable recycling and consider reusable alternatives only where infection prevention requirements, validated reprocessing, manufacturer instructions and whole-life assessment permit. Do not replace clinically necessary single-use items or reduce decontamination standards to meet a carbon target. Report clinical and non-clinical waste separately, together with the reliability of volume data for the retained 2029 target.

Efficient, prevention-led dental care

Support effective oral-health advice and appropriate prevention across our clinical services. Use electronic records and clinically suitable digital communication to reduce duplication and paper. Clinical teams will look for safe opportunities to coordinate care and reduce avoidable repeat visits or laboratory rework. Recall intervals, treatment choices and the need for face-to-face assessment remain matters of clinical judgement and applicable guidance.

Maintain non-digital routes for patients who need them. Remote advice or administrative contacts will be used only where appropriate and will not substitute for necessary examination or treatment. Any estimate of avoided travel will be reported separately with its assumptions, rather than deducted from the reported organisational inventory without an accepted accounting basis.

Medical gases, refrigeration and decontamination

Identify whether nitrous oxide or other relevant gases are used at any reporting site. Where applicable, competent personnel will review storage, leakage, maintenance, procurement and stock reconciliation. Clinical decisions about sedation remain governed by patient need and professional standards. Keep refrigerant service records and quantify relevant releases. Maintain and load decontamination equipment efficiently within validated processes and applicable Welsh technical requirements; do not alter validated cycles solely to save energy.

Evidence of delivery

Retain purchase and stock reports, waste records, maintenance logs, staff briefing records and corrective actions. Assess improvement through absolute quantities and appropriate activity measures, not unsupported claims that a product, supplier or procedure is "green".

7 Travel, people and resilience

Business travel and commuting

Use remote meetings for suitable management, training and administrative activity. Plan necessary inter-practice travel efficiently and encourage rail, bus, walking, cycling and shared journeys where practical, accessible and safe. Keep mileage, mode and purpose records, and avoid counting controlled vehicle emissions in both Scope 1 and business travel. Consider lower-emission vehicles at normal replacement points after assessing cost and operational needs; no fleet conversion is assumed.

An annual staff commuting survey will capture normal mode, return distance, attendance and relevant working patterns. Explain the sample, non-response treatment and seasonal limitations. Assess secure cycle storage, changing facilities, public-transport information and feasible incentives by site. Support for staff travel must reflect shift times, disability, caring responsibilities and local transport provision.

Patient access and travel

Provide clear, accessible travel information for each practice, including public transport and parking where available. Locate new provision with regard to the populations served and practical access. Coordinate clinically suitable visits and use reminders to reduce avoidable journeys associated with missed or duplicated appointments. Collect any patient-travel information proportionately and report it in aggregate. No claim is made that these steps have already reduced travel emissions.

Staff leadership and engagement

The Director will nominate a central carbon lead and a lead at each practice. Include practical energy, waste and purchasing responsibilities in induction and periodic team briefings. Seek staff suggestions, assign actions and share verified results. Changes affecting clinical processes will be reviewed by the relevant clinical lead before implementation. Carbon management will form part of normal operational review rather than relying only on an annual report.

Climate resilience and service continuity

Review material risks from overheating, flooding, utility interruption and disrupted deliveries when assessing proposed premises and existing continuity plans. Consider patient and staff safety, clinical storage, equipment, IT resilience and accessible alternative arrangements. Assess cooling and backup choices for both continuity and emissions, recognising that safe dental service delivery remains the priority. Revisit the assessment after significant incidents or estate changes.

Performance dashboard

Indicator	Frequency and interpretation
Energy: kWh, cost, source and tariff coverage	Monthly by site; absolute totals plus kWh per completed appointment or clinical hour.
Waste: mass, volume where reliable, type and treatment	Monthly/quarterly as contractor data allow; show clinical and non-clinical streams separately.
Business travel and commuting	Quarterly business-travel review; annual commuting survey and emissions calculation.
Supply-chain and project delivery	Quarterly: evidence coverage, overdue actions, completed investments and verified savings.
GHG inventory and wider footprint	Annual tCO ₂ e by scope/category; explain growth, data gaps, estimates and baseline changes.

Use a consistent denominator and explain changes in case mix, opening hours and practice coverage. An improvement in emissions intensity does not mean absolute emissions have fallen. Access, clinical outcomes, infection prevention and service quality will be reviewed alongside environmental measures.

8 Delivery programme and governance

Participating entities will adopt the programme from its approved implementation date. Development actions apply at acquisition, design, fit-out and opening stages. Complete the verified inventory and actual approval record before publishing the first version.

When	Deliverable	Accountable / delivery role
Before publication	Confirm participating entities and reporting boundary; complete baseline/current emissions and exclusions; approve the costed pathway, exact Net Zero date and declaration; publish the approved plan.	Authorised directors, finance and central carbon lead
First 30 days	Confirm named site leads and meters; establish monthly energy/waste records; check earlier claimed measures and assign evidence owners; review lease and tariff constraints.	Central carbon lead and practice managers
Within 90 days	Complete site opportunity assessments, commuting survey, priority supplier engagement and project register. Approve immediate controls and the business cases for larger investments.	Carbon lead, finance, procurement and clinical leads
Before premises selection / fit-out commitment	Complete carbon, accessibility and resilience appraisal; agree metering and landlord permissions; compare suitable whole-life options and retain the decision record.	Director and competent property/design advisers
On acquisition or opening	Confirm reporting responsibility, utility and waste records, induction, equipment controls and activity data. Include relevant fit-out and operating emissions from the appropriate control date.	Practice manager and development lead
Quarterly	Review dashboard, expenditure, data quality and action delivery. Investigate material variances, approve corrective actions and review risks to targets.	Director and governance team
Annually	Update inventory and public plan, review targets and investment, obtain director approval and share agreed information with relevant commissioners and customers.	Director and central carbon lead

Accountability and resources

Dr Paul John Jones is the proposed accountable Director for coordinating this plan. Each participating entity retains responsibility for adoption, reporting and authorised expenditure. The central carbon lead will coordinate data and actions; finance will reconcile costs and activity; practice managers will maintain records; clinical leads will review changes affecting care. Record named role-holders, delegated authority and approved resources before implementation.

Review, escalation and continuous improvement

At quarterly governance review, record progress, exceptions, clinical implications and corrective actions with owners and deadlines. Escalate material forecast overspend, data gaps or slippage affecting a target to the Director. Retain approval and closure evidence. Reassess measures that shift emissions between scopes, create waste elsewhere or compromise service delivery.

Publication and annual reporting

Publish the approved plan on the group website and retain version history. Review annually, aiming to update within six months of the agreed reporting year end. Reconcile different entity year ends. Record actual approval/publication dates and explain delays or changes. Share relevant entity-level or service-level information with commissioners and customers where agreed.

9 Declaration and sign-off

Draft declaration for adoption only after the inventory, methodology, targets and evidence have been checked. No approval, independent assurance or complete footprint is represented by the uncompleted fields in this version.

On approval, the authorised leadership of the entities listed in the reporting register confirms adoption of this plan and its stated boundary. The reporting approach draws on the PPN 06/21 framework, the GHG Protocol Corporate Standard, the Corporate Value Chain (Scope 3) Standard and relevant UK Government conversion factors. The inventory identifies Scope 1, Scope 2 and the core Scope 3 categories, explains limitations and records the assessment of other material Scope 3 sources. Any applicable Streamlined Energy and Carbon Reporting (SECR) duties will be assessed for the relevant legal entities.

Each approving director confirms the authority to adopt the plan for the entities they represent and the accuracy of the reporting periods, data, assumptions, targets and responsibilities within that scope. Participating entities commit to the reduction programme, annual review and transparent updates. The central carbon lead will retain the adoption record and supporting evidence. Reported achievements will remain distinct from proposed measures, and any limitations will be disclosed.

Approval record	Complete using actual details
Entities and approval authority	[Controlled register reference, version and adoption records for participating legal entities]
Coordinating director	Dr Paul John Jones, Director — signature pending; authority for represented entities to be confirmed
Signature	
Actual approval date	6 th of October 2026
Approved Net Zero date	[Confirm 31 December 2030 or disclose any approved revision]
Publication URL and date	[Direct public URL] [Actual date]
Next annual review	6 th of October 2027

Completion schedule — resolve before release

Required item	Record needed
Entities and scope	Controlled entity/site register; ownership/control, coverage and allocation rules; authorised adoption records.
12-month inventory	Utilities and fuel, gases/refrigerants, transport, waste and commuting evidence; completed calculation workbook and treatment of omissions.
Resources and target alignment	Baseline choice; annual tCO ₂ e trajectory; consistent activity measures; feasible, costed projects and approved dates.
Verification and publication	Existing-measure checks; second-person calculation review; authorised signatures and dates; public URL and annual review arrangements.

Complete the reporting tables with substantiated figures and explain any remaining exclusions, estimates or data gaps. Retain the remedy and responsible owner for each gap. Complete this schedule and remove the draft status only when the statements are accurate and the relevant authorised directors have approved their adoption.

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10 Reference framework

Reference framework reviewed on 6 October 2026. These sources guide organisational carbon accounting, practical reduction measures and policy alignment. They do not establish that measures have been implemented or that the plan satisfies every procurement requirement. Links below open the official sources.

Organisational basis

[1] Knights Dental Group, "Carbon Reduction Plan 2025:26": prior outline containing the 2030, 2027, 2028 and 2029 ambitions and reported existing measures. It does not contain a quantified inventory or completed approval record. Statements about site coverage and savings require verification.

Reporting and accounting

[2] Cabinet Office — [PPN 06/21 guidance and Carbon Reduction Plan template \(January 2022\)](#)

[3] Cabinet Office — [Technical standard for completing Carbon Reduction Plans](#)

[4] UK Government — [Greenhouse gas reporting conversion factors 2026](#)

Published 11 June 2026; updated 31 July 2026. Select the appropriate activity-year factors rather than applying 2026 factors automatically to every historical period.

[5] GHG Protocol — [Corporate Accounting and Reporting Standard](#)

[6] GHG Protocol — [Scope 2 Guidance](#)

[7] GHG Protocol — [Corporate Value Chain \(Scope 3\) Standard](#)

[8] GHG Protocol — [Base-year recalculation guidance](#)

Welsh policy alignment

[9] Welsh Government — [NHS Wales Decarbonisation Strategic Delivery Plan 2025–2030](#)

Published 7 November 2025. The plan's primary/community care, estate, energy, procurement, transport, clinical and waste themes inform the proposed programme. The practice estate appraisals and proportionate supplier engagement support this direction. Knights' 2030 ambition remains an organisational commitment requiring approval, rather than an assumption that every independent contractor has a statutory 2030 deadline.

Working files to retain with the final plan: controlled entity and site register; adoption records; emissions calculation workbook; supporting bills, contractor and travel records; project and investment register; approval record; publication evidence.