Draft New London Plan – NHSPS, NHSE, NHSI & CHP Representations

indigo.

Draft New London Plan – NHSPS, NHSE, NHSI & CHP Representations

March 2018

Indigo

Aldermary House
10-15 Queen Street
London EC4N 1TX

T 020 3848 2500
E info@indigoplanning.com
W indigoplanning.com

Draft New London Plan – NHSPS, NHSE, NHSI & CHP Representations

Contents Page

1. Introduction

1.1. We have been instructed by NHS Property Services (NHSPS) to respond to the Draft New London Plan on its behalf, as well as on behalf of NHS England (NHSE), NHS Improvement (NHSI) and Community Health Partnerships (CHP).

1.2. Fundamentally the Draft New London Plan seeks to promote 'Good Growth', which is defined as 'growth that is socially and economically inclusive and environmentally sustainable'. This aspiration is broadly supported by the NHS, in that it generally aligns with the NHS' aim for a healthier London. The NHS also supports the Draft New London Plan in seeking to provide a consistent approach across the London boroughs in relation to important planning issues, such as the approach to the reconfiguration of health and social care facilities.

1.3. However, these representations set out clear recommendations for how the proposed policies can be improved to better align with the needs of a modern NHS, which increasingly relies on the efficient management of its property estate to generate much needed funds for re-investment in new and improved healthcare services and facilities.

1.4. Where appropriate we have clearly set out suggested changes.

2. Summary

2.1. These representations set out the comments of organisations representing London's NHS commissioners and providers, as well as those responsible for its leadership and funding, and the management of its property portfolio in London.

2.2. The NHS Estate Code clearly recognises the importance of the planning system for the NHS, both in terms of the need to engage with the planning system to ensure that local health needs are delivered, and the role that it can play in enabling the efficient management of the NHS estate through development, acquisitions and disposals.

2.3. The London Health and Social Care Devolution Memorandum of Understanding, of which the Mayor is a signatory, devolves decision making for the NHS in London to the local level and sets up the London Estates Board. It recognises the need for investment in London's healthcare services and facilities, and the role that the sale of surplus property can play in raising the necessary funding for the NHS and providing land to help deliver the ambitious housing targets set for London.

2.4. The size of the NHS estate in London and the existence of NHS development and disposal programmes means that there are significant opportunities to improve the quality and quantity of healthcare facilities, and deliver much needed housing for London.

2.5. Policies that generally promote healthy communities are supported.

2.6. Policies that would require boroughs to work with NHS organisations in ensuring that adequate provision is made for healthcare and recognise that large sites can play a role in delivering healthcare infrastructure through planning obligations are supported, subject to some recommended amendments.

2.7. Policies that seek to make the best use of public sector land, social infrastructure and health and social care facilities are supported, as these will assist with the optimisation of the NHS estate through its development and disposal programmes. Policies that make specific provision for the loss of healthcare facilities, under the same circumstances in which the NHS would seek to dispose of them, are especially welcome, and clarifications are recommended to strengthen them.

2.8. Policies that seek the delivery of affordable housing are generally supported. However, there are concerns that the separate, higher 50% requirement for affordable housing on public sector land could have unintended consequences. This requirement should be changed and NHS property should be dealt with on at least the same basis as equivalent property in private ownership.

2.9. Whilst the London Plan generally seeks to minimise viability testing, it should be made clear, through a clarification, that it will be appropriate to review viability on a site-specific basis and particularly where development is required to enable new or improved healthcare facilities.

2.10. There is a concern that the proposed policy on vacant building credit applies an overly strict test to demonstrate that a building has not been made vacant for the sole purpose of redevelopment. The policy could also be interpreted as preventing the credit from being applied to surplus healthcare properties, and a clarification is suggested to prevent its misapplication at a borough level.

3. Overview of the NHS organisations

3.1. The four organisations on behalf of whom these representations are made play clearly defined roles within the wider NHS. They represent the interests of NHS commissioners and providers, as well as those responsible for its leadership and funding, and the management of its property portfolio.

NHS England (NHSE)

3.2. NHSE is an independent body, at arm's length to the Department of Health and Social Care (DHSC). It leads the NHS in England, setting its priorities and direction.

3.3. A key part of NHSE's role is the commissioning of healthcare services. It pays for GPs, pharmacists, and dentists. It also oversees and supports CCGs, which plan and pay for other healthcare services, such as hospitals and ambulances, in their local areas.

3.4. Commissioners do not own or manage property. However, NHSE, and the 32 London CCGs that it supports, have a keen interest in the role that the London Plan can play in helping to improve the health of Londoners, through reducing health inequalities, the promotion of healthy lifestyles, and the efficient management of the NHS estate.

NHS Improvement (NHSI)

3.5. NHSI is another independent body, also at arm's length to the DHSC. It is responsible for overseeing and supporting the various organisations that provide NHS funded healthcare. This includes foundation trusts and NHS trusts, as well as any independent providers.

3.6. Foundation trusts, NHS trusts and independent providers often own and manage the facilities from which they deliver healthcare services. Given that these providers include large groups of hospitals, such as University College London Hospitals Foundation Trust and Barts Health NHS Trust, some have major estates within London.

3.7. Like commissioners, providers have an interest in the use of the London Plan to support the health of Londoners. They also have an interest in how the London Plan can be used to support the development and management of their property assets, to ensure that they are able to fund and deliver healthcare services. This can involve the acquisition and development of new facilities, the redevelopment of existing facilities and the disposal of facilities that are no longer needed.

NHS Property Services (NHSPS)

3.8. NHSPS is a limited company owned by the DHSC. It was established in 2013 to bring property expertise to the NHS estate, with the aims of creating a more fit for purpose estate, reducing property related costs and generating funds to be reinvested in healthcare services and facilities.

3.9. NHSPS has a portfolio of around 3,500 buildings across England, which represents around ten percent of the entire NHS estate. Most of these buildings are used for primary healthcare and are either health centres or hospitals. However, NHSPS' properties are diverse in terms of their function and include many other types of premises, such as care homes and offices. Within London, NHSPS has around 400 buildings.

3.10. A key part of NHSPS' role relates to the provision of new healthcare facilities with the goal of ensuring that the healthcare needs of communities can be met. NHSPS works with commissioners to identify and respond to local property needs. As such, it is involved in the

acquisition and development of new facilities, and the redevelopment of existing facilities. Another important aspect of NHSPS' role is to dispose of facilities that have been identified as surplus to NHS requirements by commissioners.

Community Health Partnerships (CHP)

3.11. CHP is also owned by the DHSC. Its main role is to enable public-private partnerships to deliver new healthcare facilities through the Local Improvement Finance Trust (LIFT) programme. There are 49 LIFT companies, including several in London, such as Barking Dagenham Havering Community Ventures Limited and Camden & Islington Community Solutions Limited.

3.12. CHP has responsibility for over 300 healthcare facilities across England. It has an interest in the London Plan's influence over its ability to manage and improve these facilities in London and develop new facilities.

4. NHS estate code

4.1. DHSC's Health Building Note 00-08 (HBN 00-08) sets out guidance for NHS organisations on achieving efficiency savings and reducing costs in the NHS estate. It includes specific guidance on achieving the best property solutions, including in relation to development, acquisitions and disposals.

4.2. Additional funds created through efficiency savings and reducing costs in the NHS estate. These are passed back to the NHS to reinvest in the provision of healthcare services. As such, the management of NHS property should be focused on achieving savings to enhance the NHS' ability to deliver healthcare services in line with its core principles.

4.3. HBN 00-08 Part B contains detailed guidance on disposals, which can only take place once commissioners have declared a property surplus to the NHS' requirements, following a rigorous process, which also gives other public-sector organisations first refusal prior to any sale on the open market. Paragraph 4.116 states that NHS organisations should *"ensure that surplus land and property is sold at the best price reasonably obtainable in the open market."* Paragraph 4.123 makes clear that *"land and property with potential for development should normally be sold with the benefit of planning permission for alternative use."*

4.4. There is also guidance (in Addendum 2) for NHS organisations on how to engage with the planning system more generally. This is focused on encouraging active engagement in the planning system to ensure that local health needs and priorities are addressed through planning policies and decision making in relation to planning applications.

5. London Health and Social Care Devolution Memorandum of Understanding

5.1. The London Health and Social Care Devolution Memorandum of Understanding (MoU) was agreed by the Mayor of London, the Secretary of State for Health and Social Care, NHSE, NHSI and other bodies, including London Councils, in November 2017. The MoU principally aims to bring about improvements to healthcare through devolving decision making, so that service can be more joined-up.

5.2. There is also a commitment to set up the London Estates Board (LEB), which will provide a single forum for estate discussions in London and work to overcome challenges related to securing the approvals needed for the efficient management of NHS property. The LEB will help to ensure that investments and disposals are coordinated to help achieve both national and London needs and priorities.

5.3. There is a recognition that significant capital investment is needed for healthcare in London and that the sale of surplus property should provide capital receipts that can help to provide funding, as well as deliver significant amounts of housing.

6. The opportunity

6.1. The scale of the NHS estate in London is significant. There are more than 2,000 NHS properties in London with a total net internal area (NIA) of 4,700,000sqm.

6.2. In line with NHS Estate Code, NHS organisations in London are seeking to optimise their estates through development and disposal programmes.

6.3. NHS development programmes are seeking to provide new and improved healthcare facilities to meet local needs. In many cases, enabling development, such as housing, is delivered alongside healthcare facilities on existing or newly acquired sites to provide essential funding.

6.4. NHS surplus land disposal programmes are being utilised to sell property that is no longer needed for healthcare purposes. The main aim of these disposal programmes is to unburden the NHS of properties that it no longer needs, meaning that it can reduce revenue costs associated with holding void space and gain a capital receipt. Whilst surplus properties would be sold for best price and could be purchased for any use in future, a main aim of the programme is to redevelop surplus public land into housing where appropriate, contributing to the cross government Public Land for Housing Programme. It is therefore likely that in the current market a significant proportion of properties in London would be sold for eventual redevelopment for residential purposes.

6.5. The NHS estate in London therefore presents an opportunity to improve the quality and quantity of healthcare services and facilities, as well as deliver additional much needed homes, in support of the Draft New London Plans ambitious housing targets. The NHS has a multi-billion pound pipeline of capital healthcare facility projects in London and its 46 development sites, totalling 73 hectares, which may come forward for development between 2015 and 2020, have the potential to deliver in excess of 4,000 homes. Between 2015 and 2018, approximately 3,000 homes were delivered across 55 NHS development sites in London.

6.6. The Naylor Review (NHS Property and Estates: Why the estate matters for patients) (March 2017) estimates that the wider NHS estate could release at least £2 billion of assets and deliver 26,000 homes; and that an extra £3 billion of assets could be released through effective management of the NHS estate in London alone. This would raise funds to reinvest, so that the NHS estate remains fit-for-purpose, as well as provide new homes. The government's January 2018 response to the Naylor Review supports the efficient and productive use of NHS land and property to facilitate the provision of high-quality healthcare.

6.7. It should be noted that NHSPS previously made a confidential submission to the GLA's call for sites for the 2016 London SHLAA, which set out a number of disposal, potential disposal and potential development sites with capacity for housing. This information remains relevant.

7. Healthy communities

7.1. Policies that promote healthy communities are generally supported, as these correspond closely with the NHS' desire to promote the health and wellbeing of Londoners through spatial planning as well as other means.

Relevant Policies

7.2. Such policies run through the Draft New London Plan, given its emphasis on 'Good Growth'. These include specific policies such as:

- Policy GG3 (Creating a healthy city), which seeks to generally improve Londoners' health and reduce health inequalities;
- Policy SD6 (Town centres), which recognises that town centres are key for building healthy communities;
- Policy D5 (Accessible housing), which sets out requirements for developments to meet a range of accessibility needs;
- Policy D13 (Noise), which seeks to prevent noise from having adverse impacts on health;
- H14 (Supported and specialised accomodation), which seeks the provision of accomodation for those with specialist health requirements;
- Policy S6 (Public toilets), which requires the provision of public toilets for a range of users to improve the usability and accessibility of the capital's public realm;
- Policy E8 (Sector growth opportunities and clusters), which seeks to support MedCity;
- Policy E9 (Retail, markets and hot food takeaways), which includes measures to combat childhood obesity through the prevention of hot food takeaway development near schools;
- Policy G1 (Green infrastructure), which requires boroughs to prepare green infrastructure strategies to promote health and wellbeing;
- Policy T2 (Healthy streets), which requires the implementation of the Healthy Streets Approach; and
- Policy T5 (Cycling), which promotes cycling as a healthy form of transport and seeks to remove barriers to its uptake.

Commentary

7.3. The NHS broadly encourages measures that promote healthy communities. Such policies will help to deliver a healthier capital and the focus on preventing ill health will help to reduce the burden that is placed on NHS services.

7.4. Such measures are also in line with NHS initiatives, such as NHSE's Heathy New Towns programme, which includes Barking Riverside as a demonstrator site. The objective of this programme is to develop best practice, case studies and guidance to help ensure all new housing developments embed certain principles, promoting health and wellbeing and securing high quality health and care services. The NHS would like to see principles that are established influence development across London, and England.

8. Healthcare facilities provision

8.1. We support the Draft New London Plan's proposed requirement that boroughs work with NHS organisations to ensure that adequate provision is made for healthcare. We also support the recognition that large sites can play a role in delivering healthcare infrastructure through planning obligations.

Policy S2

8.2. Policy S2 (Health and social care facilities) sets out a requirement for boroughs to work with NHS organisations to identify and address health and social care needs within development plans, including through the identification of sites for future provision. There are also requirements to make regular assessments of health and social care needs, understand the impacts of changes in the ways that health and social care is provided, and support proposals for new health and social care facilities.

Policy DF1

8.3. Policy DF1 (Delivery of the plan and planning obligations) deals with situations where boroughs are setting policies seeking planning obligations or it has been demonstrated that a development proposal cannot viably support all the planning obligations that are sought by a borough. It requires that boroughs "recognise the role large sites can play in delivering necessary health and education infrastructure", as a matter of priority.

Commentary

8.4. It is vital that boroughs work with NHS organisations to plan for healthcare facilities to meet the needs of London's future population, especially in the light of the Draft New London Plan's ambitious proposed housing targets. The explicit requirement for boroughs to work with the NHS in the preparation of their local plans is welcomed, as this will help to enable the NHS to provide a comprehensive healthcare service to London's growing population.

8.5. It is also important the boroughs maximise opportunities to use planning obligations to secure healthcare infrastructure. Large residential developments often have very significant impacts in terms of the need for additional healthcare provision for future residents, meaning that a planning obligation requiring that the development delivers a new healthcare facility is necessary. The requirement that boroughs recognise the role large sites can play in delivering necessary health facilities is welcomed.

8.6. However, the significant cumulative impacts of smaller residential developments should also be recognised and health facilities should be put on a level footing with affordable housing and public transport improvements, given their strategic importance. A change is suggested to Policy DF1 along these lines. It is recognised that the policy text could also be changed to remove the prioritisation of any specific type of infrastructure; if this is the case the supporting text should be amended to highlight the importance of new development mitigating impacts on healthcare provision.

Revisions to Policy DF1

8.7. We suggest the following revised wording for Policy DF1:

A. Applicants should take account of Development Plan policies when developing proposals and acquiring land. It is expected that viability testing should normally only be undertaken on a site-specific basis where there are clear circumstances creating barriers to delivery.

B. If an applicant wishes to make the case that viability should be considered on a site-specific basis, they should provide clear evidence of the specific issues that would prevent delivery, in line with relevant Development Plan policy, prior to submission of an application.

C. Where it is accepted that viability of a specific site should be considered as part of an application, the borough should determine the weight to be given to a viability assessment alongside other material considerations. Viability assessments should be *tested rigorously and undertaken in line with the Mayor's Affordable H*ousing and Viability SPG.

D. When setting policies seeking planning obligations in local Development Plan Documents and in situations where it has been demonstrated that planning obligations cannot viably be supported by a specific development, applicants and decision-makers should firstly apply priority to affordable housing and necessary public transport improvements and health infrastructure, and following this:

   1. Recognise the role large sites can play in delivering necessary ~~health and~~ education infrastructure; and

   2. Recognise the importance of affordable workspace and culture and leisure facilities in delivering good growth.

E. Boroughs are also encouraged to take account of part D in developing their Community Infrastructure Levy Charging Schedule and Regulation 123 list.

9. Optimising the NHS estate

9.1. There is broad support for policies in the Draft New London Plan that seek to make the best use of public sector land, social infrastructure, and health and social care facilities. These policies support the NHS's drive to optimise its estate through development and disposals.

Policies GG2, SD8, H1, S1 and S2

9.2. There are a number of policies that would support the efficient use of the NHS estate. These include:

- Policy GG2 (Making the best use of land), which requires the prioritisation of surplus public sector land, alongside some other categories of land, in the creation of high-density, mixed-use places;
- Policy SD8 (Town centre: development principles and development plan documents), which lists locations above existing social infrastructure as a type of site that boroughs should identify as suitable for higher density mixed-use residential intensification;
- Policy H1 (Increasing housing supply), which requires that boroughs optimise the potential for housing delivery through the redevelopment of surplus public sector owned sites; and
- Policy S1 (Developing London's Social Infrastructure), which encourages the best use of land including the public sector estate, including through the rationalisation of facilities.

9.3. Policy S1 (Developing London's social infrastructure) also includes a mechanism that allows for the loss of social infrastructure in areas of defined need in some cases where there are either "realistic proposals for re-provision that continue to serve the needs of the neighbourhood" or "the loss is part of a wider public service transformation plan which requires investment in modern, fit for purpose infrastructure and facilities in order to meet future population needs or to sustain and improve services". The supporting text for this policy, in Paragraph 5.1.6 specifically acknowledges that that later includes "cases where social infrastructure providers are undertaking an agreed programme of social infrastructure re-provision or service reconfiguration, such as has been seen within healthcare".

9.4. Policy S2 (Health and social care facilities) builds on these other policies stating that boroughs should work with the NHS *"identify opportunities to make better use of existing and proposed new infrastructure through integration, co-location or reconfiguration of services, and facilitate the release of surplus buildings and land for other uses"*. The supporting text for this policy, at Paragraph 5.2.9, makes specific reference to the role of the LEB in identifying and releasing surplus and underused NHS properties.

Commentary

9.5. The NHS is committed to making best use of its property assets to help improve the provision of healthcare services and facilities. Policies that encourage and enable the development of the NHS estate, either for more intensive healthcare facilities, a mix of uses including healthcare facilities, or alternative uses, such as residential, are welcome. Such policies will help the NHS to provide new and improved healthcare facilities and contribute towards London's equitable and sustainable growth, including through the delivery of new homes.

9.6. Polices that allow for the loss of healthcare facilities, where this forms part of a wider NHS strategy, are also welcome. Historically the NHS has faced opposition from boroughs to the

reconfiguration of healthcare facilities, and this has resulted in the NHS either being unable to dispose of surplus properties or facing costly delays during this process. The NHS needs to be able to dispose of surplus properties to meet healthcare needs, which often involves strategic reorganisation and alternative provision across administrative boundaries.

9.7. The Draft New London Plan proposes to make specific provision within the main text of its policies for the loss of healthcare facilities under the same circumstances in which the NHS would seek to dispose of them. The supporting text makes specific reference to the LEB, which will help to co-ordinate this disposal process in consultation with the and boroughs.

9.8. This proposed new approach goes further than the existing London Plan and the Social Infrastructure Supplementary Planning Guidance (2015), which is welcomed. However, as small change is suggested to the text of Proposed Policy S1 to ensure that boroughs do not request long marketing periods before planning permission is granted for the change of use of social infrastructure where the criteria for their loss is met, as has frequently been the case in relation to surplus healthcare facilities in the past.

9.9. A minor clarification is suggested to ensure that Policy S1 is not misinterpreted to mean that the proposed flexibilities in relation to the loss of social infrastructure should be overridden by the separate proposed requirement for redundant social infrastructure to be considered for full or partial use as other forms of social infrastructure before alternative developments are considered.

9.10. Minor additions are also suggested to Policies S1 and S2 to ensure their strategic aims are met via specific recognition of the need for boroughs to support cross boundary re-provision through the planning process.

9.11. A further clarification should be added to ensure that the redevelopment of NHS properties is not prevented by inappropriately approved Asset of Community Value (ACV) designations.

Revisions to Policy S1

A. Boroughs, in their Development Plans, should undertake a needs assessment of social *infrastructure to meet the needs of London's diverse communities.*

B. In areas of major new development and regeneration, social infrastructure needs should be addressed via area-based planning such as Opportunity Area Planning Frameworks, Area Action Plans, Development Infrastructure Funding Studies, Neighbourhood Plans or master plans.

C. Development proposals that provide high quality, inclusive social infrastructure that addresses a local or strategic need and supports service delivery strategies should be supported.

D. Development proposals that seek to make best use of land, including the public-sector estate, should be encouraged and supported. This includes the co-location of different forms of social infrastructure and the rationalisation or sharing of facilities.

E. New facilities should be easily accessible by public transport, cycling and walking.

F. Development proposals that would result in a loss of social infrastructure in an area of defined need should be refused unless:

   1. there are realistic proposals for re-provision that continue to serve the needs of the neighbourhood and wider social geographies, or;

   2. the loss is part of a wider public service transformation plan which requires investment in modern, fit for purpose infrastructure and facilities in order to meet future population needs or to sustain and improve services across London.

G. In cases where the proposed loss of social infrastructure in an area of defined need meets the criteria in part F no marketing evidence should be required to demonstrate that it is no longer needed.

H. Redundant social infrastructure should be considered for full or partial use as other forms of social infrastructure before alternative developments are considered.

Revisions to Policy S2

A. Boroughs should work with Clinical Commissioning Groups (CCGs) and other NHS and community organisations to:

1. identify and address local health and social care needs within Development Plans taking account of NHS Forward Planning documents and related commissioning and estate strategies, Joint Strategic Needs Assessments and Health and Wellbeing Strategies

2. understand the impact and implications of service transformation plans and new models of care on current and future health infrastructure provision in order to maximise health and care outcomes

3. regularly assess the need for health and social care facilities locally and sub-regionally, addressing borough and CCG cross-boundary issues and offer full support for infrastructure re-provision across-boundaries through the planning process

4. identify sites in Development Plans for future provision, particularly in areas with significant growth and/or under provision

5. identify opportunities to make better use of existing and proposed new infrastructure through integration, co-location or reconfiguration of services, and facilitate the release of surplus buildings and land for other uses.

B. Development proposals that support the provision of high-quality new and enhanced facilities to meet identified need and new models of care should be supported.

C. New facilities should be easily accessible by public transport, cycling and walking.

Revisions to Paragraph 5.1.4

9.12. We suggest the following revised wording for Paragraph 5.1.4:

The loss of social infrastructure can have a detrimental effect on a community. Where possible, boroughs should protect such facilities and uses, and where a development proposal leads to the loss of a facility, require a replacement that continues to meet the needs of the neighbourhood it serves. To further protect against the loss of social infrastructure that is valued by a local community or group, boroughs should consider approving the designation of a facility as an Asset of Community Value (ACV) if put forward by the local community. However, boroughs should not approve such an application where it relates to a type of social infrastructure that would not meet the relevant legal criteria for designation or where the site forms part of a public sector land development programme which would facilitate wider community benefit.

Revisions to Paragraph 5.1.6

9.13. We suggest the following revised wording for Paragraph 5.1.6:

It is recognised that there will be cases where social infrastructure providers are undertaking an agreed programme of social infrastructure re-provision or

service reconfiguration, such as has been seen within healthcare. Where social infrastructure premises are deemed redundant as part of this process, such losses may be acceptable in line with parts D and F of Policy S1 Developing *London's social infrastructure and Policy S2 Health and social care facilities and* any related information or guidance in order to achieve the overall aims of the programme and to continue to meet the needs of Londoners. In such cases, *part H of Policy S1 Developing London's social should not be applied.*

10. Affordable housing

10.1. The Draft New London Plan sets out ambitious targets for affordable housing. There is support for policies that aim to deliver housing that is affordable for Londoners, especially given that access to appropriate housing has clear health benefits. It is also recognised that there are opportunities to delivery affordable homes for NHS workers. However, there are concerns about the potential impact of the specific, higher affordable housing requirement for public sector land.

Policies H5 and H6

10.2. Policy H5 (Delivering affordable housing) sets out a requirement for 'public sector land delivering at least 50 per cent affordable housing across its portfolio' to help deliver the strategic affordable housing target.

10.3. Policy H6 (Threshold approach to applications) relates to the application of the Draft New London Plan's proposed threshold approach. The threshold approach requires different viability information in support of planning applications depending on the level of affordable housing proposed. Where a minimum level is met or exceeded, subject to some other requirements, no viability information would be required. Where this minimum level is not met without public subsidy, detailed viability information would be required. The minimum level is set at 35 percent in most cases, however the minimum level is set at 50 per cent for public sector land. The exception to this is where there is an agreement with the Mayor to deliver at least 50 per cent affordable housing across a public sector land portfolio, in which case the 35 per cent threshold will apply.

10.4. In effect, this sets an initial 50 per cent housing affordable housing target for public sector land. The portfolio approach may reduce the burden on some individual public sector land sites within a wider portfolio, but in doing so it would place greater pressure on the viability of other sites.

London Plan Viability Study

10.5. The evidence base for the Draft New London Plan includes the London Plan Viability Study (December 2017), which sets out the justification for the proposed affordable housing policies. This Study concludes that the proposed policies in the Draft New London Plan, including the specific, higher affordable housing requirement for public sector land, would not harm development viability.

10.6. The Study assessed the viability of the proposed Draft New London Plan policies, through testing a range of case studies that reflect the typologies of sites likely to come forward over the life of the plan. The testing of residential typologies made assumptions about the inputs used to calculate residual value, such as tenure, mix, development costs, including planning policy requirements, and sale values. Sales values were categorised into five bands, from A (high) to E (low), which were intended to reflect residential price differences across London.

10.7. Residual values were compared against benchmark land values, which reflect the price that would have to be paid to provide a competitive return to a land owner. The benchmark land values used in the testing were split into five bands, corresponding with those for residential sale values, and within each band low, mid and high points were given, to reflect the land values associated with different existing uses. Where it was found that the residual land value was higher than the benchmark land value it was concluded that development would be viable.

10.8. The testing of residential case studies concludes that the specific, higher affordable housing requirement for public sector land, would be viable. Paragraph 9.5.5 of the Study states that:

> *"*Overall, in value bands A and B schemes are able to provide higher levels of affordable housing depending on the benchmark land value and 35% affordable housing where 50% is not viable. However, in lower value areas, the viability headroom is generally smaller and there are more instances where the case studies are viable against the lower benchmarks but not the medium or higher benchmarks. In relation to the viability against the lower land values, this indicates that a threshold of 50% is appropriate on public se*ctor land and industrial sites."*

10.9. A key assumption in reaching this conclusion is that public sector land will have a low to mid benchmark land value. Paragraph 8.2.3 of the Study states that low to mid benchmark land values are attributed to *"*sites in industrial/ warehouse *use and community/ public use"*, whereas mid to high benchmark land values are attributed to *"*sites with retail, office and *residential use"*.

10.10. The argument set out in the Study could be summarised as follows: public land will have a low to mid benchmark land value; sites with low to mid benchmark land values can viably support a higher requirement for 50 percent affordable housing; therefore, public land will always be able to support a higher requirement for 50 percent affordable housing.

10.11. However, this assumption appears to conflate land use with land ownership. It is true that some of the land owned by the public sector will be in a use with a low benchmark land value, but this is not the case with all such land. Taking NHSPS as an example, whilst it owns a large amount of land in community / public use, such as health centres or hospitals, it also has a significant amount of land in other uses, such as office use, within its portfolio.

10.12. This means that some public sector land could have higher benchmark land values. There are concerns, therefore, that the higher affordable housing requirement for public sector land could harm development viability.

10.13. Moreover, it seems incongruous that a healthcare facility in private ownership that is redeveloped for housing would be subject to a lower initial affordable housing requirement under the proposed threshold approach than one in public ownership, despite both sites having the same use and similar benchmark land values.

Commentary

10.14. As explained above, we have concerns about the evidence base supporting the imposition of a separate, higher affordable housing requirement for public land. It appears to assume that land owned by the public sector will always be in a use that has a lower benchmark land value. However, large amounts of land in public ownership are in uses that have higher benchmark land values. This means that the proposed initial affordable housing requirement for public sector land through the threshold approach could be unviable.

10.15. As already stated, the portfolio approach to public sector land would do little to help. Whilst it could reduce the initial requirement to provide greater levels of affordable housing on individual public sector sites, it would mean that other sites may have to support even greater levels of affordable housing, which does not appear to have been tested and may not be viable.

10.16. NHS organisations may wish to seek planning permission for residential development for one of two main reasons. The first is to secure the redevelopment of an existing healthcare facility, with residential development enabling new or improved healthcare facilities by generating funding. The second is to obtain a residential planning permission for surplus property prior to its disposal on the open market, in line with NHS Estate Code.

10.17. The proposed imposition of a separate, higher initial affordable housing requirement for public land could result in the development of NHS property for residential or a mix of uses including residential and healthcare from not coming forward due to viability issues, or result in substantial delays through the planning process due to the time and cost involved in producing viability evidence and engaging in lengthy negotiations.

10.18. In cases where there is an aspiration to redevelop an existing healthcare facility, with enabling residential development funding new or improved healthcare facilities, the NHS requires that sufficient value is generated to pay for the new or improved healthcare facilities. The proposed imposition of a separate, higher initial affordable housing requirement, over and above the standard initial requirement, could result in some such developments not coming forward because the NHS would not be able to deliver a new or improved healthcare facility due to the impact that the level of affordable housing required would have on development costs. In such cases, this would prevent the delivery of a new or improved healthcare facility and new housing. In other cases, it may delay the delivery of vital healthcare facilities.

10.19. In cases where there is an aspiration to obtain a residential planning permission for surplus property prior to its disposal on the open market, the NHS would require that there is a sufficient incentive for it to release the land for residential development, the same as with any other land owner. If the imposition of a separate, higher initial affordable housing requirement, over and above the standard initial requirement results in the residual land value being below the benchmark land value, as may be the case, the NHS is less likely to be incentivised to sell the property, without first needing to go through the process of producing viability evidence. This would have a potentially negative impact on housing land supply. It would also have a potentially negative impact on the NHS' ability to raise funds for new and improved healthcare service and facilities through capital receipts from property disposals.

10.20. The fact that the proposed separate, higher affordable housing requirement for public sector land appears to be unviable may also mean that the Draft New London Plan does not accord with the National Planning Policy Framework (NPPF). Paragraph 173 of the NPPF states that:

> *"*Plans should be deliverable. Therefore, the sites and the scale of development identified in the plan should not be subject to such a scale of obligations and policy burdens that their ability to be developed viably is threatened. To ensure viability, the costs of any requirements likely to be applied to development, such as requirements for affordable housing, standards, infrastructure contributions or other requirements should, when taking account of the normal cost of development and mitigation, provide competitive returns to a willing land owner and willing developer to enable the development to be deliverable.*"*

10.21. Paragraph 174 of the NPPF continues, stating that local planning authorities should "assess the likely cumulative impacts on development in their area of all existing and proposed local standards, supplementary planning documents and policies that support the development plan, when added to nationally required standards*"* and that *"*the cumulative impact of these standards and policies should not put implementation of the plan at serious risk, and should facilitate development throughout the economic cycle*"*.

10.22. The proposed imposition of a separate, higher affordable housing requirement for public land has been assessed alongside other standards. However, as set out, the assessment fails to demonstrate that this requirement could not prevent the development of public land from coming forward on account of proposals failing to provide a competitive return for public sector land owners, in some instances.

10.23. It is therefore suggested that revisions are made to proposed Policies H5 and H6 to remove the separate, higher affordable housing requirement for public land. This would place public

land on the same footing as the majority of other sites and is a position that could be supported by the Draft New London Plan's own evidence base. This is very important in light of the NHS reliance on funds generated through efficient management of its estate to fund improved healthcare services and facilities.

10.24. It should be noted that NHSPS made representations to the consultation on the Affordable Housing and Viability Supplementary Planning Guidance (SPG) in February 2017 along these same lines.

Revisions to Policy H5

10.25. We suggest the following revised wording for Policy H5:

A. The strategic target is for 50 per cent of all new homes delivered across London to be affordable. Specific measures to achieve this aim include:

1. requiring residential and mixed-use developments to provide affordable housing through the threshold approach (Policy H6 Threshold approach to applications)

2. using grant to increase affordable housing delivery beyond the level that would otherwise be provided

3. affordable housing providers with agreements with the Mayor delivering at least 50 per cent affordable housing across their portfolio

~~4. public sector land delivering at least 50 per cent affordable housing across its portfolio~~

4. strategic partners with agreements with the Mayor aiming to deliver at least 60 per cent affordable housing across their portfolio.

B. Affordable housing should be provided on site in order to deliver communities which are inclusive and mixed by tenure and household income, providing choice to a range of Londoners. Affordable housing must only be provided off-site or as a cash in lieu contribution in exceptional circumstances.

Revisions to Policy H6

10.26. We suggest the following revised wording for Policy H6:

A. The threshold approach applies to development proposals which are capable of delivering more than ten units or which have a combined floor space greater than 1,000 sqm (see paragraph 4.6.14 for exclusions to the threshold approach and 4.6.15 for scheme types with bespoke approaches).

B. The threshold level of affordable housing is initially set at:

1. a minimum of 35 per cent

~~2. 50 per cent for public sector land~~

2. 50 per cent for Strategic Industrial Locations, Locally Significant Industrial Sites and other industrial sites deemed appropriate to release for other uses (see Policy E7 Intensification, co-location and substitution of land for industry, logistics and services *to support London's economic function).*

The 35 per cent threshold will be reviewed in 2021 and if appropriate increased through Supplementary Planning Guidance.

C. To follow the Fast Track Route of the threshold approach, applications must meet all the following criteria:

   1. meet or exceed the relevant threshold level of affordable housing on site without public subsidy

   2. be consistent with the relevant tenure split (Policy H7 Affordable housing tenure)

   3. meet other relevant policy requirements and obligations to the satisfaction of the borough and the Mayor where relevant

   4. demonstrate that they have taken account of the strategic 50 per cent target in Policy H5 Delivering affordable housing and have sought grant where required to increase the level of affordable housing beyond 35 per cent.

D. Fast tracked applications are not required to provide a viability assessment at application stage. To ensure an applicant fully intends to build out the permission, the requirement for an Early Stage Viability Review will be triggered if an agreed level of progress on implementation is not made within two years of the permission being granted (or a period agreed by the borough).

E. Where an application does not meet the requirements set out in part C it must follow the Viability Tested Route. This requires detailed supporting viability evidence to be submitted in a standardised and accessible format as part of the application:

   1. the borough, and where relevant the Mayor, should scrutinise the viability information to ascertain the maximum level of affordable housing using the methodology and assumptions set out in this Plan and the Affordable Housing and Viability SPG.

   2. viability tested schemes will be subject to:

      a. an Early Stage Viability Review if an agreed level of progress on implementation is not made within two years of the permission being granted (or a period agreed by the borough)

      b. a Late Stage Viability Review which is triggered when 75 per cent of the units in a scheme are sold or let (or a period agreed by the borough)

      c. Mid Term Reviews prior to implementation of phases for larger phased schemes.

F. Where a viability assessment is required to ascertain the maximum level of affordable housing deliverable on a scheme, the assessment should be treated transparently and *undertaken in line with the Mayor's Affordable Housing and Viability SPG.*

Scheme amendments – Section 73 applications and deeds of variations

G. For schemes that were approved under the Fast Track Route, any subsequent applications to vary the consent will not be required to submit viability information, providing the resultant development continues to meet the relevant threshold and the criteria in part C.

H. For schemes where the original permission did not meet the threshold or required tenure split, viability information will be required where an application is submitted to vary the consent and this would alter the economic circumstances of the scheme. Such cases will be assessed under the Viability Tested Route.

I. Any proposed amendments that result in a reduction in affordable housing, affordability or other obligations or requirements of the original permission should be rigorously assessed under the Viability Tested Route. In such instances, a full viability review should

be undertaken that reconsiders the value, costs, profit requirements and land value of the scheme.

J. The Mayor should be consulted on any proposed amendments on referable schemes that change the level of affordable housing from that which was secured through the original planning permission.

Strategic affordable housing target

10.27. We have concerns with the strategic target for 50 percent of all new homes to be affordable, which has been set out in Policies GG4 and H5. It appears that this strategic target may be based partly on the assumption that 50 percent of housing on public land will be affordable. Based our arguments above, we believe that the strategic target may be undeliverable.

11. Viability testing

11.1. The proposed approach to planning obligations seeks to minimise viability testing. Whilst we recognise that this would have some benefits, such as a reduction in uncertainty, we are concerned that, without clarification, it could impact on the NHS's ability to undertake development that is needed to help fund new or improved healthcare infrastructure.

Policy DF1

11.2. Policy DF1 (Delivery of the plan and planning obligations) states that viability testing should only be undertaken in relation to specific development proposals where there are "clear circumstances creating barriers to delivery". It is expected that development plan policies should be taken into account when land is acquired and proposals worked-up, to ensure that the prices paid for land reflect policy requirements, like those relating to affordable housing provision, and prevent such policy requirements from later rendering development proposals unviable.

Commentary

The NHS has a development programme aimed at delivering the healthcare facilities that London needs. In many cases the NHS needs to raise funding to deliver new and improved healthcare facilities through the redevelopment of existing property to provide other uses, such as residential, as well as healthcare facilities. In such cases, the other uses would create value and be used to fund costly healthcare facilities. In most cases, healthcare facilities require very significant capital investment and add significant costs to development, eating away at the ability for the development proposal to remain viable whilst also providing other mitigation, such as affordable housing.

Whilst we believe that the need for a development to fund the delivery of new or improved healthcare infrastructure would constitute a clear circumstance creating a barrier to delivery, we believe that wording should be added to the supporting text for Policy DF1, which sets out examples of such circumstances, making this clear.

Failure to provide such a clarification would result in Policy DF1 being subject to misinterpretation. This could result in the NHS facing barriers to the delivery of enabling development that is needed to facilitate the provision of new and improved healthcare facilities. It could also create barriers to the delivery of housing, if viability reasons were to prevent the enabling development associated within new and improved healthcare facilities from coming forward.

Revisions to Paragraph 11.1.4

11.3. We suggest the following revised wording for Paragraph 11.1.4:

In setting Local Plan policies and associated guidance, boroughs should consider whether there are circumstances in which it may be acceptable to review the viability of a development on a site-specific basis. These may include circumstances where an applicant is required to provide significant infrastructure improvements to facilitate delivery of a development (beyond the level that would typically be required for the scale of development), where the development would enable new or improved infrastructure (such as healthcare facilities) or where the value generated by a development would be exceptionally low.

12. Vacant building credit

12.1. There are concerns about the Draft London Plans proposed policy on vacant building credit, as it applies an overly strict test to demonstrate that a building has not been made vacant for the sole purpose of redevelopment, and could also be interpreted as preventing the credit from being applied to surplus healthcare properties.

Policy H9

12.2. Policy H9 (Vacant building credit) generally seeks to discourage the use of vacant building credit in London. However, its sets out circumstances where the use of the credit would be acceptable. One of these is in cases where "the site is not protected for an alternative use". Another is where "the building has not been made vacant for the sole purpose of redevelopment".

12.3. It sets out a test that must be met to demonstrate that the building has not been made vacant for the sole purpose of redevelopment, which is that it must be demonstrated "that it has been vacant for a continuous period of at least five years before the application was submitted" and that there must also be evidence that "the site has been actively marketed for at least two of those five years at realistic prices".

Commentary

12.4. The NHS supports the legitimate use of vacant building credit, in line with the government's intentions. The NHS has benefited from the application of the credit where it is seeking to obtain a residential planning permission for a surplus property, in line with NHS Estate Code, prior to its disposal on the open market. In such cases, the credit has meant that the NHS can advance policy-compliant schemes with lower affordable housing provision. This has improved the viability position of complex vacant sites and assisted in the delivery on additional homes. It has also helped the NHS to reduce the revenue costs associated with holding vacant property and generate capital receipts through disposals, both of which increase the amount of money that is available to spend on the delivery of new and improved healthcare services and facilities.

12.5. There is a concern that the test that must be met to demonstrate that a building has not been made vacant for the sole purpose of redevelopment is too strict. The very high bar set by this policy, in terms of the overall period of vacancy required, would cause delays to the disposal of vacant property, which would hold-up the delivery of much needed new residential development and result in increased holding costs for land owners.

12.6. It also appears to be at odds with Planning Practice Guidance (PPG), which states that vacant building credit "is intended to incentivise brownfield development, including the reuse or redevelopment of empty and redundant buildings" (Paragraph: 023 Reference ID: 23b-023-20160519). The test that must be met to demonstrate that the building has not been made vacant for the sole purpose of redevelopment would act to materially reduce this incentive and is therefore not consistent with national policy.

12.7. The test should be changed to reflect the occupancy test for the Community Infrastructure Levy (CIL), which requires buildings to have been occupied for six months in the three years immediately preceding the date on which planning permission first permits the development. This would cause less delay and provide an incentive for development. It would also be in line with national policy and generally accepted approaches to such tests.

12.8. In relation to the restriction of vacant building credit being applied to sites that are protected for an alternative use other than residential, it is suggested that additional wording is added

to the policy supporting text to make it clear and prevent misinterpretation. The supporting text should state that this restriction would not apply where the loss of an otherwise protected use would be acceptable under other proposed policies in the Draft New London Plan.

12.9. There is currently a risk that the wording of the policy could be interpreted to mean that vacant building credit should not be applied in cases where social infrastructure or health and social care facilities would be lost, even though such a loss could be in accordance with proposed Policies S1 and S2.

Revisions to Policy H9

12.10. We suggest the following revised wording for Policy H9:

A. The Vacant Building Credit is unlikely to bring forward additional development in London, therefore in most circumstances, its application will not be appropriate in London. However, there may be some limited circumstances where the credit would, in line with the intention of the credit, provide an incentive for development on sites containing vacant buildings that would not otherwise come forward for development. As part of assessing whether this is the case, decision-makers are advised to take account of the criteria below as well as locally-specific factors influencing the site.

B. In the limited circumstance where a borough feels the credit should be applied, boroughs are advised to consider applying the credit only where all of the following criteria are met:

1. the building is not in use at the time the application is submitted

2. the building is not covered by an extant or recently expired permission

3. the site is not protected for alternative land use

4. the building has not been made vacant for the sole purpose of redevelopment.

C. To demonstrate that a building has not been made vacant for the sole purpose of redevelopment, an applicant will be required to demonstrate that it has been in lawful use for a continuous period of fewer than six months within the period of three years ~~vacant for a continuous period of at least five years~~ before the application was submitted and will also be required to provide evidence that the site has been actively marketed for at least two of those three ~~five~~ years at realistic prices.

New Paragraph 4.9.3

12.11. We suggest that the following text is added to form a new Paragraph 4.9.3 between proposed Paragraphs 4.9.2 and 4.9.3:

For the avoidance of doubt, the application of vacant building credit should be considered in cases where the loss of social infrastructure or health and social care facilities would accord with Policies S1 and S2, as in such cases sites should not be regarded as protected for alternative land use.

13. Conclusion

13.1. The NHS organisations on whose behalf these representations are made are generally supportive of the Draft New London Plan, in so far as it aligns with the NHS' aspirations for a healthier London.

13.2. There are some concerns in relation to the imposition of a separate, higher affordable housing target for public land and the application of the vacant building credit. These proposals are likely to have unintended consequences, impeding the delivery of much needed healthcare services and facilities, as well as housing. Where this is the case clear suggestions have been set out for changes. Some clarifications are also suggested where there is the risk of misinterpretation.

13.3. We trust that these representations will be taken into consideration.