## Introduction

These Representations have been prepared on behalf of the **Tavistock and Portman NHS Foundation Trust** (henceforth 'the Trust').

### About The Trust

For almost 100 years, the Tavistock and Portman clinics have embodied a distinctive way of thinking about and understanding mental distress, mental health and emotional wellbeing. Working with children and families and adults, their approach brings together psychoanalytic, psychodynamic and systemic theory and practice and other approaches and seeks to understand the unconscious as well as conscious aspects of a person's experience.

The Trust's highly skilled and specialist staff continue to build on these approaches, welcoming new ideas and developing innovative interventions, services and models of care which respond to contemporary challenges.

The Trust's goal is that more people should have the opportunity to benefit from its approach. It seeks to spread its thinking and practice through devising and delivering high quality clinical services, the provision of training and education, research, organisational consulting and influencing public debate.

The Trust's aims are to:

- continue to deliver and develop high quality and high impact patient services;
- offer training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care and other sectors;
- develop its presence as a centre of excellence in research;
- lead the development and evaluation of new models of care and innovative approaches to addressing systemic issues in the delivery of care and other services; and
- use its insights and expertise to contribute to the development of national debate and public policy.

### The Trust's Estate

The Trust occupies three main sites:

- The Tavistock Centre at 120 Belsize Lane, NW3 – built in the late 1960s, this is the main location for treatment, study and education, and where the Trust's administrative staff are generally located;

- The Portman Clinic at 8 Fitzjohn's Avenue, NW3 – occupying a large turn-of-the century former dwelling house, The Portman Clinic offers specialist long-term psychoanalytically informed psychotherapeutic help to people who suffer from problems arising from: delinquent behaviour; criminal behaviour; violent behaviour; and paraphilias (i.e. disturbing and damaging sexual behaviours or experiences); and

- Gloucester House at 33 Daleham Gardens, NW3 – part of the Child and Adolescent Mental Health Service of the Tavistock and Portman NHS Foundation Trust, Gloucester House is a leading independent special school with a fully integrated specialist clinical team. This service also occupies a large turn-of-the century former dwelling house.

The Tavistock Centre is now approaching the end of its useful life. The Trust's other buildings are also reaching the end of their operational life and provide a sub-optimal environment for the services that occupy them. There is an increasingly urgent need for, and it is the Trust's aspiration to achieve, a better-adapted estate. Options that are being considered are redevelopment *in situ*, and relocation within London with the disposal of existing sites paying for new facilities.

## Representations

### Draft Policy S1 – Developing London's Social Infrastructure

The Trust supports the general aims of **Part D** of this draft policy which says that:

> *"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."*

The Trust also supports **Part F2** of the draft policy which says that:

> *"Development proposals that would result in a loss of social infrastructure in an area of defined need should be refused unless…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."*

Part F is followed by Part G which reads as follows:

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

Paragraphs 5.1.6 and 5.1.7 of the supporting text read as follows:

> *"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.*
>
> *"5.1.7 In all cases, where housing is considered to be an appropriate alternative use, opportunities for **affordable housing provision** should be maximised."*

### Our Comments

Organisations such as the Trust are well-regulated outside of the planning regime and there is significant oversight by parties such as Clinical Commissioning Groups ('CCGs'), NHS England and NHS Improvement who take a 'forward view' in regard to changes in population and the socio-economic and epidemiological needs of the population. Trusts also undertake significant amounts of consultation including statutory consultation with stakeholders in relation to any service changes that they propose. Such regulation, oversight and consultation ensures that, in relation to healthcare premises, service reconfiguration is undertaken on a sound basis that does not prejudice service delivery for the foreseeable future.

The flexibility that Part F2 would afford providers such as the Trust is welcomed and strongly supported; the ability to optimise the use of buildings and land is often an essential pre-requisite to enhance service provision and delivery with the provision of new facilities, for example through the generation of a receipt and / or the more efficient use of land.

Similar provisions already exist in the current London Plan at paragraph 3.87A. It is our experience, however, that some local planning authorities are very reluctant to proceed on the basis of such provisions. We have encountered the following issues when trying to negotiate schemes with local planning authorities:

- they want to rely solely on much more restrictive local plan policies which generally require a marketing exercise to be undertaken to demonstrate that there is no need for any type of social infrastructure before they will entertain an alternative (i.e. a non-social infrastructure) land use;

- in circumstances where such marketing yields responses, the authority will take a position that the use(s) for which marketing has demonstrated a demand should be preferred over the sale of the site for investment in an agreed programme of service reconfiguration – in effect creating a barrier to the replacement of unsatisfactory facilities with new fit-for-purpose buildings;

- they sometimes struggle to understand or to accept that new ways of working and different models of care can mean that there is often a requirement for much smaller amounts of purpose-built floorspace when compared with existing (often Victorian or early twentieth century) buildings. Instead, they seek to maintain the *status quo* or to achieve net gains. In this context, the use of the term 're-provision' in a policy can be misleading and unhelpful;

- they may make the provision of a certain amount of affordable housing a pre-requisite for the 'loss' of social infrastructure, an added cost that can render unviable an agreed programme of social infrastructure re-provision or service reconfiguration;

- they will place little reliance on the decisions of their health scrutiny committees' endorsements of service reconfiguration and even attach little weight to business plans and other similar documents even when they are approved by healthcare regulators and / or HM Treasury; and

- where new facilities of a strategic nature are proposed (for example providing a service that covers more than one borough) and the borough that hosts all or part of an existing facility is not the local planning authority where the new facility is proposed, the resistance to the 'loss' of the existing facility can be even greater.

We have encountered all of these situations in a number of London boroughs and the common consequence is that necessary investment in facilities of benefit to Londoners is delayed. In some cases, other funding streams that are needed to pay for new facilities (in addition to the receipt from the land) can be lost because of the passage of time or simply because deals can fall through as a result of delay.

Our concerns with this proposed policy – all of which can very easily be addressed – are that:

- in relation to **Part D**, and unless it is specifically said so, local planning authorities are likely to require social infrastructure on land that is freed up by rationalisation or sharing of facilities. This will prove to be a disincentive to making the best use of the public estate and could have the unintended consequence of dissuading public organisations from considering rationalisation / sharing which then enables the release of land to be used for other priorities such as housing;

- in the absence of conjunctive words between the limbs of this policy, local planning authorities may apply **Part G** in addition to **Part F**. It should be made clear that **Part F2** operates on its own even where there might be a need for community facilities, albeit provided that the absolute 'loss'

of a community facility or land in community use is justified on the basis of an agreed programme of investment;

- reconfiguration should not be characterised as 're-provision', at least not in the same form; there should not be an expectation that reconfiguration and modernisation will result in the same amount or type of floorspace;

- whilst the expectation that opportunities for affordable housing are maximised is a very important consideration generally, this should not be at the expense of investment in facilities that are necessary for the health and wellbeing of everyone in the community. Rather it should be clear that ensuring that London is properly catered for with sustainable healthcare facilities is also a very high priority and that this may need to be balanced against the general affordable housing targets. Almost needless to say, without essential healthcare facilities, London cannot sustainably accommodate the significant quantum of additional housing that Mayor is seeking; and

- based on our experience, local planning authorities can be reluctant to accept evidence that originates from outside of the planning regime, even if the planning regime in not the competent authority. The Mayor should prepare brief but clear guidance, in conjunction with stakeholders, as to the nature of information that will be needed to enable reconfiguration proposals to be assessed as according with draft **Policy S1**.

## Draft Policy S2 – Health and Social Care Facilities

The Trust supports this policy and in particular its recognition that 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.

The Trust also supports paragraph 5.2.9 of the supporting text which states that:

> *"Development and regeneration proposals for an area provide an opportunity to **re-think how land and buildings are used** and whether there is a more optimal configuration or use of that land. Hospital reconfigurations are an example where more intensive and better use of a site can lead to a combination of improved facilities and the creation and release of surplus land for other priorities. The London Estates Board aims to improve the way surplus and underused NHS assets are identified and released, and provide a single forum for estate discussions in London, ensuring early involvement of London Government partners. Membership includes NHS partners, local Government, the GLA and national partners (central Government, NHS England, One Public Estate and the national NHS property companies)."*

However, the Trust wishes to highlight that it is often the case that 'surplus' or 'underused' land must be used to support necessary healthcare estate renewal programmes. As such, it is often the case that other policy demands such as affordable housing need to be balanced with the necessity of ensuring that essential services for Londoners have a sustainable future.

## Draft Policy H5 – Delivering Affordable Housing

The Trust supports the Mayor's aims to boost the supply of housing and to deliver more affordable homes for Londoners. This draft policy notes that 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.

As with our comments on other draft policies, we consider it important to highlight that affordable housing should not be sought at the cost of investment in important services, including healthcare, that are necessary to the successful functioning of London.

Where affordable housing is provided on surplus NHS land it should be aimed at, in the first instance (e.g. by way of a nominations agreement), healthcare staff and other NHS workers in line with the aims of the 2017 Naylor Review.

## Policy T6 – Car Parking

Part I of this draft policy says that:

> *"Where sites are redeveloped, existing parking provision should be reduced to reflect the current approach and not be re-provided at previous levels where this exceeds the standards set out in this policy."*

It can be the case that parking related to healthcare facilities can be reconfigured to release land for development consistent with part D of draft **Policy S1** (*Developing London's Infrastructure*) which says that:

> *"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."*

Vehicle parking can be an essential facility for healthcare facilities, not only for patients and their carers but also for clinicians and other staff who may have to work anti-social hours or who may need to be able to travel efficiently between multiple sites as part of their duties. This is especially the case in London where many of the larger Trusts operate from multiple sites, sometimes in different boroughs.

Part I of the policy as proposed could operate as a disincentive to the optimisation of public land if Trusts will lose what they consider to be an essential part of their operational estate.

We strongly encourage the Mayor to incorporate some flexibility so that applicants may demonstrate the need for parking on case-by-case basis.

## Policy T6.5 – Parking for People with Disabilities

The Trust supports the provision of adequate car parking for people with disabilities regardless of whether general use car parking is provided or not. The draft policy expresses a requirement for parking for people with disabilities to be provided and says that the quantum should be calculated as a percentage of the total general use car parking provision. We do not see how such a policy could be reasonably operated in circumstances (as encouraged by other draft London Plan policy) whereby a proposed development is otherwise car free.

The new London Plan should clarify the approach to the provision of car parking for people with disabilities in the event that no general use car parking is to be provided.

## Policy T9 – Funding Transport Infrastructure Through Planning

Part C of this draft policy says that:

> *"Planning obligations (Section 106 agreements), including financial contributions, will be sought to mitigate impacts from development, which may be cumulative. Such obligations and contributions may include the provision of new and improved public transport services, capacity and infrastructure, the expansion of the London-wide cycle networks and supporting infrastructure, and making streets pleasant environments for walking and socialising, in line with the Healthy Streets Approach."*

We make the following observations:

- some if not all of these matters should be addressed by CIL, the aim of which is to mitigate the impacts of development on infrastructure. Where CIL is in operation, seeking contributions in relation to the above is likely to amount to 'double dipping';

- whilst it is acknowledged that effects can be cumulative, it should be made clear that individual developments will only be required to make contributions that are proportionate to each individual development's impacts (or each development's share of a cumulative impact) and the Mayor should have a policy on pooled contributions to deal with cumulative impact mitigation; and

- individual developments should not be liable to provide section 106 contributions for schemes that are not needed solely to mitigate the impacts of an individual development, eg London-wide cycle networks, Crossrail line 2 and so on. These should be funded through CIL / Crossrail Levy or other similar means.

## Policy HC1 – Heritage Assets

Part C of draft **Policy HC1** (*Heritage conservation and growth*; page 268) says that:

> *"Development proposals affecting heritage assets, and their settings, should conserve their significance, by being sympathetic to the assets' significance and appreciation within their surroundings. The cumulative impacts of incremental change from development on heritage assets and their settings, should also be actively managed. Development proposals should seek to avoid harm and identify enhancement opportunities by integrating heritage considerations early on in the design process."*

There are a number of issues with this proposed policy. First of all it is a 'one size fits all' test and does not distinguish between designated heritage assets (such as statutorily-listed buildings and conservation areas) and non-designated heritage assets (such as locally-listed buildings or buildings of townscape merit) despite there being separate and distinct tests in the 2012 NPPF for these two categories of assets.

Second, it requires the avoidance of harm whereas national policy recognises that harm can be acceptable in the wider balance; this is unduly restrictive and not consistent with national policy.

Third, it gives no indication of how different degrees of harm should be weighed in the overall balance, nor does it recognise the need for special regard to be paid to the effect of development on listed buildings in accordance with the Planning (Listed Buildings and Conservation Areas) Act 1990.

This policy should be drafted so that it reflects, and can be operated in accordance with, national policy and the aforementioned statutory instrument.