REPRESENTATIONS ON CHANGES TO THE CURRENT PLANNING SYSTEM CONSULTATION

Prepared on behalf of

NHS Property Services Ltd, NHS England and NHS Improvement, and Community Health Partnerships

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1.0 Introduction and Background

PURPOSE AND STRUCTURE OF THIS DOCUMENT

1.1 In response to the Ministry of Housing, Communities and Local Government's (MHCLG) consultation on 'Changes to the current planning system' (published 6th October 2020), we are pleased to share the enclosed representations jointly prepared by NHS Property Services Ltd (NHSPS), NHS England and NHS Improvement (NHSE&I) and Community Health Partnerships (CHP).

1.2 These representations build on previous detailed Joint NHS responses to the National Planning Policy Framework (May 2018), and the Draft new London Plan (March 2018 & January 2019).

1.3 A Joint NHS Response is also being prepared for the 'Consultation on proposals for reform of the planning system in England' following the publication of the Planning for the Future White Paper (Deadline 31st October 2020).

1.4 This section sets out the roles and responsibilities of the four NHS bodies on whose behalf these representations are made.

1.5 Sections 2, 3, 4 and 5 provide detailed responses to each of the 4 main proposal (where relevant to the NHS), namely:

Section 2 - changes to the standard method for assessing local housing need

Section 3 - securing of First Homes through developer contributions in the short term until the transition to a new system

Section 4 - supporting small and medium-sized builders by temporarily lifting the small sites threshold below which developers do not need to contribute to affordable housing

Section 5 - extending the current Permission in Principle to major development

1.6 The following section provides a brief, non-exhaustive overview of the roles and responsibilities of the NHS organisations on whose behalf these joint representations are made.

NHS PROPERTY SERVICES (NHSPS)

1.7 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.

1.8 NHSPS has a portfolio of around 3,500 buildings across England, representing approximately 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.

1.9 NHSPS manages, maintains and improves NHS properties and facilities, working in partnership with NHS organisations to create safe, efficient, sustainable and modern

healthcare and working environments. NHSPS has a clear mandate to provide a quality service to its tenants and minimise the cost of the NHS estate to those organisations using it. Any savings made are passed back to the NHS.

1.10 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 and care providers 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. Furthermore, another important aspect of NHSPS' role is to dispose of land and property assets or facilities that have been identified as surplus to NHS requirements by Commissioners. This has resulted the sale of 203 surplus properties, generated c.£131.1million of sales receipts for the public purse, delivered almost £10m savings in operating costs from 2013-2016, and contributed to land sales supporting in excess of 2,600 housing units.

NHS ENGLAND AND NHS IMPROVEMENT (NHSE&I)

1.11 NHS E&I 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.

1.12 A key part of NHS England's role is the commissioning of healthcare services. It pays for GPs, pharmacists, and dentists. It also oversees and supports Clinical Commissioning Groups (CCG's), which plan and pay for other healthcare services, such as hospitals and ambulances, in their local areas. In addition it provides oversight and guidance to NHS trusts and Foundation Trusts, ensuring that the providers maintain financial viability and they are able to provide health services to their communities within appropriate environments.

1.13 NHS E&I has identified the significant role that National Planning Policy and Guidance can play in helping to improve health, through reducing health inequalities, the promotion of healthy lifestyles, and to support the flexible and effective use of the NHS estate and assets to deliver improved services. NHS England has previously delivered a programme working with 10 demonstrator sites across England to explore how the development of new places could create healthier and connected communities with integrated and high-quality services. The output of this work, "Putting Health into Place" is available here.

1.14 NHS foundation trusts and NHS trusts provide acute, community and mental health services across England and their estates are highly varied, subject to the role that they play in supporting the health of the nation. Services are provided within community settings, as well as major core sites; the NHS is the 5th biggest employer in the world and the majority of these are employed by the NHS provider sector.

1.15 These organisations often own and manage the facilities from which they deliver healthcare services. Given that these providers include large groups of hospitals providing world leading specialist care, some have major estates and assets around England and, taken as a collective, would be one of the largest land owners in England. In the 2018/2019 financial year, NHS providers disposed of approximately £460m of land and building assets contributing to the housing targets although the cost of re-providing these assets in new facilities was far greater.

1.16 Like Commissioners, providers have an interest in the use of the National Planning Policy and Guidance to optimise their estate and support the health of the nation. They have an

interest in how National Planning Policy and Guidance 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 through access to s106 and CIL funds. This can involve the construction of new facilities, the redevelopment of existing facilities, making them more optimal from a planning perspective, and the disposal of facilities that are no longer needed for healthcare use.

1.17 NHS providers also face massive challenges around the recruitment and retention of a wide range of staff and clinicians. Whilst some of the challenges may not be resolved by property solutions, there is a need in some locations to support staff through key worker accommodation.

COMMUNITY HEALTH PARTNERSHIPS (CHP)

1.18 CHP is also owned by the DHSC. CHP's main role is to enable public-private partnerships (PPP) to deliver new healthcare facilities through the Local Improvement Finance Trust (LIFT) programme. The aim of CHP is to deliver savings, increase service integration and drive efficient use of the primary and community health estate.

1.19 As head tenant for the £2.5bn LIFT estate, CHP is also responsible for the overall management of 305 primary and community healthcare buildings across England. CHP has a key interest in National Planning Policy and Guidance due to the impact this can have upon CHP's ability to manage and improve existing facilities, and to develop new facilities.

2.0 Changes to the standard method for assessing housing need

2.1 This section sets out our joint response on the proposed changes to the standard method for assessing local housing need (pages 8-18 – Q1-7).

2.0 Changes to the standard method for assessing housing need

General Comments

2.2 An area of historic challenge for the NHS has been the increasingly complex calculations for housing growth within Local Plan documents, with approaches varying substantially between different local planning authority areas, including neighbouring authorities.

2.3 This has made it challenging to obtain accurate and consistent population forecasts, making it difficult for health commissioners to accurately link future health requirements with the growth proposals within Local Plans. This caused further challenges when trying to evidence requests for developer contributions and providing accurate information into infrastructure delivery plans.

2.4 We therefore support the principle of a standardised method for assessing local housing need, provided this will provide the NHS with a consistent evidence base (particularly population forecasts) against which to assess future healthcare requirements to respond to the growth proposals within Local Plans.

2.5 This should allow health commissioners to review health infrastructure requirements at a local, regional, and national level based on a more consistent population forecast assumption, to better plan to meet the demands of growth ambitions within Local Plans.

2.6 We would also support any guidance/policies which make clear the support for making the best use of NHS land, and ensuring that any land surplus to the operational healthcare requirements of the NHS is free from restriction against providing alternative uses, principally, but not always, housing.

2.7 Further detail on this matter will be provided in our joint response to the Planning for the Future White Paper.

3.0 Delivering First Homes

3.1 This section sets out our joint response on the proposals for delivering First Homes (pages 19-24 – Q8-16).

3.0 Delivering First Homes

Q8 (iii) - Do you agree that planning practice guidance should be amended to specify that the appropriate baseline for the standard method is whichever is the higher of the level of 0.5% of housing stock in each local authority area OR the latest household projections averaged over a 10-year period? - (other comments) General Comments

3.2 As identified in our joint response to the National Planning Policy Framework (May 2018), NHS providers face massive challenges around the recruitment and retention of a wide range of staff and clinicians. Whilst some of the challenges may not be resolved by property solutions, there is a need in some locations to support staff through key worker accommodation.

3.3 We are therefore supportive of the inclusion of 'Key Worker' accommodation within the provisions for First Homes as specified below (emphasis added):

- *securing of First Homes, sold at a discount to market price for first time buyers, **including key workers**, through developer contributions in the short term until the transition to a new system*

3.4 We note that the proposals for First Homes for Key Workers, would count as contributing towards a development's overall affordable housing offer, without the need to provide additional 'general needs' affordable accommodation, i.e. no double counting. This approach is supported and follows the recommendations of our previous responses.

3.5 We would request that the government gives consideration to a mechanism which ensures that key workers, including NHS staff, are prioritised for the allocation of 'First Homes', particularly in high cost areas where recruitment/retention may be an issue.

3.6 This should be identified as a part of a wider package for increasing the availability of homes for NHS staff in priority areas. Further detail on the delivery of NHS Key Worker housing will be provided in our joint response to the Planning for the Future White Paper.

3.7 We are also supportive of the approach for introducing an exemption from the Community Infrastructure Levy for First Homes for Key Workers. This is an approach we would like to see replicated on all forms of Homes for NHS Staff, particularly when being implemented on NHS owned land.

4.0 Supporting small and medium-sized developers

4.1 This section sets out our joint response on the proposals for supporting small and medium-sized developers (pages 25-28 – Q17-23).

4.0 Supporting small and medium sized developers

Q17 - Do you agree with the proposed approach to raise the small sites threshold for a time-limited period?

4.2 We would emphasise that access to high quality and affordable housing is an important driver of people's health and wellbeing. Further detailed comments on affordable housing, including homes for NHS staff, will be provided in our substantive response to the White Paper.

4.3 In specific response to Q17, we note the government's aim to stimulate the economic response to the Coronavirus Pandemic, by temporarily extending the small sites policy. We support the principle of this temporary measure and would request that clarification is provided to ensure that this extension would apply to all NHS organisations.

4.4 This is particularly important for NHS Development sites, where NHS organisations are exploring innovative redevelopment opportunities of underutilised and inefficient sites to provide modern, fit for purpose healthcare facilities, alongside the provision of new housing and alternative uses. The release of land for housing from these sites is often an important component in funding the new/improved health facilities.

4.5 Many of these schemes, prior to the Coronavirus Pandemic, were subject to marginal viability, and any mechanism that can help support the progression of these schemes under these challenging conditions is welcomed.

4.6 Any increased threshold should apply to all NHS organisations, particularly where planning permission is secured before the sale of the site to a developer to build out the scheme. This will ensure that the NHS retains the ability to optimise the value of the site so that funds gained can be reinvested back into the NHS.

4.7 Similarly, we would request that sites delivered within this revised threshold continue to deliver on other obligations in line with Local Plan requirements, particularly delivering 'healthy' places, and ensuring that local health infrastructure is supported. The implementation of this revised threshold should be effectively monitored through planning application statistics at a local and national level.

5.0 Extension of the Permission in Principle consent regime

5.1 This section sets out our joint response on proposals for the Extension of the Permission in Principle consent regime (pages 29-36 – Q24-34).

5.0 Extension of the Permission in Principle consent regime

Q:24 Do you agree that the new Permission in Principle should remove the restriction on major development?

5.1 We are generally supportive of the principal of extending the scope of the Permission in Principle Consent scheme.

5.2 NHS Property Services have regularly used this new consent route for smaller sites declared as surplus to the operational healthcare requirements of the NHS. This route has proved effective in securing the principle of residential led development, whilst minimising the associated time/cost delay of more traditional application types.

5.3 We would add however, that if the Permission in Principle route is to be extended, we would need to ensure PiP for major developments require the local planning authority to consult more widely with the public health and health/care consultees during identification in the Brownfield Land Register, and when individual PiP applications are received. We need to ensure that the health impacts of proposed new development are fully considered, and that this engagement is effectively built into any revised PiP procedure, particularly when looking at larger more complex development proposals.

5.4 If this route is to be extended, we would like to ensure that consideration is given to the process for effectively securing both financial and 'in kind' contributions towards the necessary health infrastructure.

Q25: Should the new Permission in Principle for major development set any limit on the amount of commercial development (providing housing still occupies the majority of the floorspace of the overall scheme)? Please provide any comments in support of your views.

5.5 We seek clarification that new health facilities are included within the definition of 'commercial development' and would therefore be eligible to be considered under the extended Permission in Principle route if part of a housing led scheme.

5.6 This will be important when considering larger schemes where new health space/buildings are to be included as a developer contribution. Similarly, this could be an important application route for the NHS when looking at intensifying existing under-utilised NHS sites, reducing the cost/time involved in securing the principle of a housing-led redevelopment scheme which includes new/improved health floorspace.

Q31: Do you agree that any brownfield site that is granted Permission in Principle through the application process should be included in Part 2 of the Brownfield Land Register? If you disagree, please state why.

5.7 We are supportive of the proposal to introduce a national brownfield map (paragraph 114). This would be a useful tool for health commissioners to better understand the distribution of new housing sites across commissioning areas, that often span multiple local planning authority boundaries.

5.8 Unlike larger site allocations, smaller brownfield sites are rarely identified spatially within Local Plan documents, making it challenging for the NHS to assess the distribution of smaller housing schemes, and their cumulative impact on health infrastructure. We would request that NHS commissioning boundaries (CCG/STP) are included as a search feature on this mapping tool.

5.9 Multiple NHS organisations including NHS Property Services have been proactive in submitting sites for inclusion on local planning authority Brownfield Land Registers since its introduction. We have however been surprised at the lack of uptake from local planning authorities across England in progressing sites onto Part 2 of the register.

5.10 We are supportive of any mechanism that can help to de-risk the principle of housing on surplus or under-utilised NHS sites, whilst reducing the time/cost associated with more traditional application routes.