Oxford-Cambridge Arc Consultation Response

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Contents

Purpose of this document

This document is a response to consultations on two publications by HM Government.

- Creating a vision for the Oxford-Cambridge Arc
- Oxford-Cambridge Arc spatial framework - sustainability appraisal scoping report (subsequently 'SASR' or 'the scoping report').

This latter document, as the name suggests, focuses on the sustainability aspects of the Vison for the Oxford-Cambridge Arc (subsequently 'the Arc') with the goal of ensuring that sustainability is embedded into the development of the spatial framework. The SASR sets out the dimensions of sustainability and discusses these in the context of the Arc. **This submission focuses exclusively on one of these dimensions: healthcare infrastructure, which falls under the broader heading of social infrastructure.**

The key argument made in this submission is that there is a profound disconnect between spatial planning and healthcare planning at all levels and across the Arc. Unless this disconnect can be remedied, investment in healthcare infrastructure will continue to lag housing development and population growth. This is unsustainable. The current situation cannot be improved upon sufficiently without fundamental change. The Health and Care Bill now before parliament may present the opportunity for such change, but only if there is a wider recognition of the issue and a bold, innovative response.

About the author

I am a retired healthcare manager, with a professional background in finance and planning. I am also a historian of health and health science. I have lived and worked in Cambridge since 1986. I am responding to the consultation as a private citizen and am one of 'those people who normally do not engage in planning consultations and decisions'.[1] I am motivated by my concern at the way in which healthcare infrastructure has already lagged behind growth in Cambridgeshire and will continue to do so in the absence of fundamental change. I have no reason to think that this situation will be very different elsewhere in the Arc.

As Executive Director with responsibility for strategy and planning at Addenbrooke's Hospital (1998 to 2004), I was responsible for 'Addenbrooke's: the 2020 Vision'. I authored all three versions of this strategy, published between 1999 and 2004, and led the process of engagement with local authorities, landowners, and other stakeholders. This experience left me with an understanding of the importance of close engagement by the NHS in regional and local spatial planning processes. I also led the process that led to the approval of the most significant NHS development on the site in the past two decades, the Addenbrooke's Treatment Centre, and have a keen appreciation of just how difficult gaining any capital investment in the NHS Estate can be, even in relatively well-funded periods.

My other relevant credentials are that I was Chief Operating Officer of Cambridge University Health Partners (2009 to 2012) and Chief Executive of Addenbrooke's Charitable Trust (2011 to 2018). I have also been programme director for an NHS R&D commissioning programme, working for the Department of Health (2005 to 2008). I have higher degrees in health policy and history of public health, both from the London School of Hygiene and Tropical Medicine and am a former Harkness Fellow in health care policy. I have published over twenty articles in international peer reviewed journals on history and health policy. I thus have a mix of national, local, and international perspectives, practical experience, and knowledge relevant to this topic.

Healthcare infrastructure in the SASR.

The population of the Oxford Cambridge Arc (subsequently 'the Arc') has increased from 2.8 million in 1991 to 3.7 million today and is expected to grow further to nearly 4 million by 2043. The proportion of older people in this population will increase. More people, and more older people, will lead to increased demand for health care. Despite this inescapable consequence of predicted demographic change, planning for healthcare infrastructure is barely discussed in the SASR. The topic is mentioned in passing as an example of 'social facilities', as is the aim of 'improved health and wellbeing' (p.24). In contrast to this thin treatment, there is extensive discussion of other sustainability issues, such as housing, transport, utilities, and digital infrastructure. The report also states that a health impact assessment will be undertaken, presumably of the spatial framework itself, although this is

[1] HM Government, Creating a Vision for the Oxford-Cambridge Arc, 2021, p. 4.

not made clear (p.35). Healthcare infrastructure as a dimension of sustainable development is not otherwise discussed.

Over the past 18 months, the economy of the UK was put into extended periods of lockdown to 'save lives' and 'protect the NHS'. High levels of public compliance into these intrusive interventions demonstrate how highly the public values its health and the NHS. How, then, might the near absence of any examination of the status of health care infrastructure in the SASR be explained? We can dismiss the possibility that nobody thinks this matter important. A more convincing explanation is that it is widely assumed that the those responsible for the NHS have the plans, structures, processes, and funding needed to address this issue. This is not the case. Instead, there are significant, structural shortcomings in planning for health care infrastructure at all levels. These include:

- The national planning policy framework says little about planning for healthcare infrastructure.
- NHS structures are disengaged from spatial planning at regional and sub-regional levels.
- NHS bodies with sub-regional responsibilities have failed to deliver credible plans for healthcare infrastructure.
- At the local level, there is a widespread failure to capture and spend s.106 contributions for health care.

The national policy planning framework says little about planning for healthcare infrastructure.

The national policy planning framework (subsequently NPPF) includes few references to health care infrastructure. Paragraph 20c says that 'strategic policies…should make sufficient provision for community facilities (such as health, education and cultural facilities)'. [2] This formulation is echoed in the SASR, where health care infrastructure appears as one item on a list, in parenthesis, of 'community facilities.' On a more positive note, paragraph 34 recognises the expectation that developers should be required to make contributions towards a range of 'other infrastructure'. 'Health' is mentioned alongside social housing, education, transport, flood and water management, green and digital infrastructure. However, NPPF adds that 'such [developer contribution] policies should not undermine the deliverability of the plan', suggesting that these various aspects of infrastructure are secondary to the primary objectives of housing and jobs growth. This is not a formulation that prioritises sustainability.

In a chapter on 'promoting a health and safe environment', NPPF says nothing more about planning for healthcare infrastructure. Instead, the chapter's sole focus is on shaping the built environment in a way that promotes healthy lifestyles, social inclusion, community

2 National Policy Planning Framework, Ministry of Housing, Communities and Local Government, 2021. https://www.gov.uk/government/publications/national-planning-policy-framework--2

facilities, and public safety. These are important goals and, if realised, would reduce demand for health care in the longer term. However, they are not, on their own, sufficient for sustainable development. As well as being able to keep physically and mentally healthy by, for example, going to the park, cycling to work, participating in sport, and joining community groups, people must also be able to access their GP and local hospital when sickness, infirmity and injury befall them.

In summary, NPPF majors on issues that have a long lead time and for which responsibility is diffused among multiple actors. The more challenging issue of how adequate healthcare infrastructure is to be funded in a country where 82% of health care expenditure is government funded and which is an outlier in terms of low levels of inputs per capita (hospital beds, intensive care beds, workforce), is side-stepped.[3]

NHS structures are disengaged from sub-regional spatial planning

The 2012 Health and Social Care Act (subsequently 'the 2012 Act') abolished Strategic Health Authorities and, in so doing, removed the regional layer of NHS governance. This left a vacuum of systems-level leadership, with various negative consequences.[4] Among these, no organisation was left with a mandate to lead on engagement with spatial planning at a regional or sub-regional level. In truth, the ability of the NHS to engage in this had already been weakened by serial re-organisations between 1996 and 2012. The most recent review of NHS estates, undertaken by Sir Robert Naylor in 2017 ('the Naylor report), found that 'there is currently no overarching estates strategy for the NHS; it is not clear where leadership for NHS estates strategy lies.' Furthermore, 'many local areas have established structures for place-based estates strategy and partnership working, but the health sector has often been absent.' [5]

The government accepted Naylor's recommendation that a national NHS property board should be established to provide strategic leadership. However, the terms of reference for this Board are focused more on the realisation of value from the NHS estate, primarily through the disposal of surplus land, than on strategic planning. Sir Robert Naylor has since gone on the record to say that the property board lacks influence and is unable to make important decisions.[6] At the sub-national level, the Government response to the Naylor report placed the onus on sustainability and transformation partnerships (STPs), non-statutory collaborations between NHS organisations and local authorities, to develop 'robust estates strategies.' The public was assured that 'the NHS is working hard to develop

3 OECD Healthcare Statistics 2021 https://stats.oecd.org/; The Kings Fund, NHS bed numbers: past, present, future (March 2020) https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

4 The Kings Fund, The NHS under coalition government, part 1: NHS Reform (2015) https://www.kingsfund.org.uk/publications/nhs-under-coalition-government

5 Independent report by Sir Robert Naylor for the Secretary of State, NHS property and estates: why the estate matters for patients (March 2017). https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review.

6 'NHS Property Board 'unable' to make important decisions, says outgoing government adviser', *Health Service Journal,* 21 April 2021.

credible capital and estates plans, fully aligned with clinical service strategies and supported by strong and credible business cases, as integral elements of their wider transformation plans to modernise services'.[7]

There are no meaningful plans at the sub-regional level for healthcare infrastructure investment

STPs were launched by NHS England in 2016 as a response to the fragmentation and loss of systems leadership created by the 2012 Act.[8] Most STPs are now re-badging themselves as 'integrated care systems' (subsequently 'ICS'), new organisations which for which a statutory basis is proposed in the Health and Care Bill 2021 (subsequently 'the Bill'). The Bill, which is currently at committee stage, proposes that ICSs will be placed on a statutory basis from 1 April 2022. The lack of any statutory basis for STP/ICSs hitherto will undoubtedly have made the task of partnership working more difficult. Nevertheless, the STPs/ICSs covering the Arc could already have taken a lead on engagement with spatial planning in their geographies. Indeed, as STPs they were mandated to do so by the Government in its 2018 response to the Naylor report.

A review of published plans indicates that they have failed to take on and develop this role in any meaningful way.

- The **Cambridgeshire and Peterborough** STP published its most recent strategy in 2016.[9] This acknowledges that the health system faces an unusually challenging combination of rapid population growth, an aging population, persistent health inequalities and financial challenges. The strategy places great faith in 'partnership working' and moving towards becoming an 'accountable care organisation' as organisational remedies for these profound structural challenges. Its focus is on reducing use of healthcare facilities, and thereby saving money, rather than planning for the entirely predictable increased demand upon such facilities from demographic change. The strategy says nothing about engagement with spatial planning, other than 'where possible…influencing the design of new housing developments.'

- In **Bedfordshire, Luton, and Milton Keynes** the process of evolution from STP to ICS appears further ahead and 'BLMK ICS' has published a 'long term strategy for the period 2019 to 2024.[10] Whilst also acknowledging the pressures of a growing and aging population, this strategy is silent about how the required health care infrastructure will be provided. Instead, it presents the 'anticipation' that greater

7 Department of Health and Social Care, 'The government response to the Naylor Review', January 2018, p. 18. https://www.gov.uk/government/publications/naylor-review-government-response

8 Lewis Pickett, House of Commons Library Briefing Paper Number CBP8093, 29 September 2017, 'Sustainability and transformation plans and partnerships'

9 https://www.fitforfuture.org.uk/wp-content/uploads/2016/11/Cambridgeshire-and-Peterborough-Sustainability-and-Transformation-Plan-October-2016.pdf

10 https://www.blmkpartnership.co.uk/wp-content/uploads/2020/10/10137-BLMK-LTP-SUMMARY-Living-longer-in-good-health-05.03.2020-1.pdf

investment in community care, combined with better information, will reduce demand on existing facilities. No evidence is provided to support this aspiration. No reference at all is made to engagement with spatial planning.

- The **Buckinghamshire, Oxfordshire, and Berkshire West** ICS, which has evolved from an STP for the same geography, published a five-year plan in September 2019.[11] This acknowledges the same challenges: demography, health inequalities, funding shortfalls, and hospitals 'struggling to meet demand'. It also talks about 'designing in' healthy living to new communities (although only in West Berkshire, for some reason that is not explained). It too places great hope organisational changes, partnership working and technology. It too is silent on the wider questions of engagement with spatial planning.

These documents suggest that the exhortations in the government's response to the Naylor report have not been acted upon. NHS management is practiced at distinguishing between government statements that have a serious intent behind them, and those that do not, and have presumably placed the response to Naylor in the latter category. Consequently, we now see a significant gulf between the rhetoric and the reality of NHS disengagement from sub-regional spatial planning.

Recent place-based partnerships 'design guidance' for ICSs are more encouraging, in that it offers some basis for improving on this situation. This has been developed jointly by NHS England and the Local Government Association. The guidance makes no specific reference to engagement with spatial planning, being more preoccupied with the continuation of joint commissioning arrangements and the integration of health and social care provision. However, it does identify the need for joint mechanisms and governance for place-based planning. [12] It is not prescriptive about the form this should take, saying that there is no single approach to this and that effective partnerships are 'built by doing'. This guidance represents a possible starting point for greater proactivity by ICSs in becoming engaged with spatial planning.

There is a widespread failure to capture and spend s.106 contributions for health care.

No NHS bodies are itemised by government guidance as statutory consultees for planning applications, other than for nationally significant infrastructure projects. One of the consequences of this is that local planning authorities have not consistently sought s.106 contributions towards the healthcare infrastructure necessary for sustainable development. Even where such contributions are being sought by local authorities, clinical commissioning groups may be choosing to divert these into their revenue budgets. Nearly half of s.106 contributions for health that have been obtained remained unspent in 2018, largely because the NHS has never made the case for such allocations and local planning officers are unable

11 https://www.bobstp.org.uk/media/1749/bob-report-2019-final.pdf

12 Thriving places: Guidance on the development of place-based partnerships NHS England/LGA https://www.england.nhs.uk/publication/integrated-care-systems-guidance/

to identify anyone in local NHS organisations to talk to.[13] This is a shameful systems failure, with adverse consequences for the public.

Other key aspects of context

Before considering whether there is any way of repairing the disconnect between spatial planning and healthcare planning, which has been shown to exist at all levels, two other key aspects of the current context for healthcare infrastructure investment are examined, with reference to the specific circumstances of the Arc.

- The Health Infrastructure Plan
- The UK Life Sciences Vision

Health Infrastructure Plan

The Health Infrastructure Plan (HIP) is the government's response to the Conservative Party's 2019 manifesto pledge to build 40 new hospitals over 10 years. This number has recently been increased to 48 and the sum pledged increased to £3.8 billion. The government has billed this as 'the biggest new hospital building programme in a generation'.[14] HIP involves a phased programme of new hospital schemes, as set out in the table below.

Phase	Delivery period	Number of schemes nationally	Schemes located in Arc
In build	2020-2025	5	None
Pending final approval	2020-2025	4	None
HIP 1	2020-2025	6	None
HIP 2	2025-2030	25	• New women's and children's facility at Milton Keynes Hospital • Rebuild of Kettering General Hospital • New Addenbrooke's cancer hospital, Cambridge
Competition	Not specified	8	Unknown
Total		48	

13 Claudia Martinez and Lily Brown, 'Planning for patients: the role of s106 planning contributions' Reform Research Trust, January 2019.

14 https://www.gov.uk/government/news/pm-confirms-37-billion-for-40-hospitals-in-biggest-hospital-building-programme-in-a-generation

It is evident from this analysis that, although HIP will be very important to a small number of hospitals, the impact of the programme on the Arc overall will be limited. No schemes located in the Arc have yet advanced beyond HIP 1 stage, which is defined by the Department of Health and Social Care as 'sufficiently developed in order to get the full go ahead now, subject to business case approvals.' HIP 2 has been pushed back to receiving some form of approval and support after 2025 and these schemes have received 'seed funding' of undisclosed amounts.[15]

The prospects for HIP delivering a full programme of 48 new hospitals appear remote. The global sum involved works out at between £79 or £95 million per scheme (depending on whether 40 or 48 is used as the denominator). This is sufficient to build a new wing or block, but it is not enough to build a new hospital, which might cost between £0.5 and £1 billion plus, depending on size[16]. It has been reported that the DHSC's response to this obvious difficulty has been to redefine the meaning of a 'new hospital' to include any major capital project, whether new build or refurbishment, backing this with an instruction to hospital managers to support this misrepresentation in public.[17]

A further issue, and one that bodes ill for the realisation of HIP, is the scale of the backlog maintenance bill facing NHS hospitals. This had risen to above £9 billion at March 2020, of which more than half is 'high risk' or 'significant risk'.[18] Hospitals across the Arc are, in total, facing £532 million of backlog maintenance, of which £147 million is high or significant risk. The hospitals with the biggest backlog maintenance issues are the John Radcliffe, Oxford (£117 million), Addenbrooke's, Cambridge (£104 million), Hinchingbrooke, Huntingdon (£50 million) and Kettering (£39 million). There is no obvious alignment between the backlog maintenance list and the prioritisation of schemes in HIP.

The backlog maintenance crisis has arisen through the longstanding insufficiency of capital allocations to the NHS. This has been exacerbated over recent years by the practice of transferring funds from already inadequate capital budgets to balance the NHS revenue

15 'The Health Infrastructure Plan', Department of Health and Social Care, 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835657/health-infrastructure-plan.pdf. How is the Plan for 48 New Hospitals Going? BBC Reality Check Team https://www.bbc.co.uk/news/54481865

16 As an example, the Queen Elizabeth Hospital Kings Lynn, which has its collapsing roof held up by 210 props, has estimated the cost of a complete hospital rebuild as £650 million. This is a typical, mid-size District General Hospital and one of the 1960's batch of 'best buy' hospitals in the Eastern region. The same issue is faced by best buy hospitals in Huntingdon, Bury St Edmunds, and Great Yarmouth. Eastern Daily Press, 16 August 2021 https://www.edp24.co.uk/news/health/more-props-needed-at-crumbling-qeh-kings-lynn-8240550

17 DHSC 'playbook' orders trusts to describe big building projects as 'new hospitals' Health Service Journal, 26 August 2021.

18 Estates Return Information Collection (ERIC) 2019/20, NHS Digital.

account. Over the five years to 2018/19, £4.3 billion was diverted by DHSC in this way.[19] There is thus every prospect that the £3.8 billion pledged to HIP will be eroded over time by the triple pressures of growing high risk backlog maintenance; the return of significant price inflation (already evident in the construction industry); and the ongoing temptation to divert capital funds to balance revenue budgets. The extra £5.4 billion for the NHS announced in September 2021 was given to clear the unprecedented waiting lists that are a legacy of the pandemic. However, the underlying level of recurrent funding growth allocated for the NHS over the period 2018/19 to 2023/4 will average 3.4%, which will be insufficient to modernise the NHS. Recent funding increases announced for the NHS may thus go some way towards mitigating the risk of capital budgets being eaten into by recurrent spending, but they have not eliminated it.[20]

In summary, HIP will have, in the best-case scenario, only a limited impact on the Arc. It can be seen primarily as an outcome of the government's need to be seen to be responding to manifesto pledges, rather than as a serious exercise in comprehensive health infrastructure planning.

UK Life Sciences Vision

The Arc contains two of the leading biomedical sciences clusters in the world and is significantly defined by this attribute. The government has recently published a UK life sciences vision.[21] The articulation of national life sciences strategy, spatial planning, and health infrastructure planning must, therefore, be considered when assessing the Arc vision, and the sustainability of that vision.

The life sciences vision recognises that the UK can support clinical innovation and research at scale, as most recently evidenced by large scale Covid-19 trials and studies. This is because the UK has a highly integrated national health system that has been supported in developing its research capacity by the National Institute for Health Research (NIHR). The strength of biomedical research in university, research council and industry partners has supported this research and innovation capacity in the NHS, and close collaboration with the NHS has been of reciprocal benefit to these partners, all to the benefit of the UK. In centres of excellence, this has been recognised through formal designation of and support for such clinical academic partnerships. In the Arc, there are the two NIHR Biomedical Research Centres and Academic Health Sciences Centres in Oxford and Cambridge. Elsewhere in the Arc, there is significant higher education and NHS engagement in research through Academic Health Sciences Networks.

19 'Capital expenditure in the NHS', Report by the Comptroller and Auditor General, HC 43 Session 2019-20, 5 February 2020

20 The Health Foundation, Is the recent funding announcement enough for NHS England? June 2018 https://www.health.org.uk/chart/chart-is-the-recent-funding-announcement-enough-for-nhs-england

21 HM Government, Life sciences vision, (July 2021) https://www.gov.uk/government/publications/life-sciences-vision

To sustain successful biomedical research partnerships, development of healthcare and other biomedical sciences infrastructure must proceed in lockstep and with balanced investment in all sectors of biomedical clusters. This is recognised to some extent in the life sciences vision, which identifies the need to 'embed clinical research across the NHS, bolstering capacity and creating a research positive culture in which all staff are supported and expected to participate'. One aspect of capacity is the space and staffing to accommodate clinical trials and studies alongside routine patient care without the latter squeezing out the former. Unfortunately, the delivery strategy for UK Clinical Research (a supporting strategy for the life sciences vision) does not acknowledge this basic requirement for adequate healthcare infrastructure amongst its 5 'key themes'.[22] Under the theme of 'clinical research delivery embedded in the NHS' it omits any mention of the need for adequate clinical infrastructure to support research, preferring to focus instead on culture change. Its 7 'specific commitments' similarly omits any mention of the need for investment in research intensive hospitals. This is even though, as we have seen, hospitals in Oxford and Cambridge face major issues of backlog maintenance and capacity constraints. This is a significant weakness in this supporting delivery strategy.

Failure to address the requirement for adequate clinical capacity will have adverse consequences for both the public and for clinical research itself. The current situation in Cambridge illustrates this at the local level. Here a partnership of organisations sharing the Cambridge Biomedical Campus (CBC): NHS organisations, the University of Cambridge, Medical Research Council, and industrial partners have signed up to a strategy called 'Vision 2050'.[23] This strategy has been aligned with a developer led submission to the 'call for sites' stage of the Greater Cambridge Shared Planning (GCSP) local plan process, which proposed extensive mixed-use development on two large sites, one contiguous with the existing CBC campus and one detached from it. Part of the contiguous site to the south has subsequently been identified as a 'preferred site' in the first draft of the local plan. Vision 2050 rehearses familiar arguments about the importance of Cambridge as a centre for biomedical science. However, it pays no attention to the need to balance clinical and non-clinical infrastructure, barely discussing the development of clinical infrastructure other than to make claims that 'soon building will commence on new cancer hospital and children's hospital on site'. The new cancer hospital is placed in HIP1 (to be considered for approval after 2025), so this is an elastic use of 'soon'. A much-needed new children's hospital is also promised, but the funding status of this project is unclear as is not included in HIP and has yet to receive outline business case approval from DHSC.

Development of the CBC on the scale proposed to GCSP would further increase the local population making demands on an already overstretched and crumbling hospital. Such a situation would lead to a further reduction in capacity for research and innovation, as this is squeezed out further by service pressures. The lack of attention paid to the need to balance

22 https://www.gov.uk/government/publications/the-future-of-uk-clinical-research-delivery/saving-and-improving-lives-the-future-of-uk-clinical-research-delivery#our-strategy-and-plans-for-delivery

23 Cambridge Biomedical Campus Vision 2050. https://www.cbc-vision.co.uk/

clinical and research infrastructure in Vision 2050 is concerning, given the already evident mismatch between the aged state of Addenbrooke's Hospital and the gleaming new research facilities that now surround it.

Proposals towards a remedy

This submission has set out, in some detail, the systematic disconnect between spatial and health planning. This gives rise to significant risk that spatial planning envisages population growth that runs ahead of healthcare infrastructure investment, with negative consequences for access to care. HIP may, at best, provide some marginal improvement in healthcare infrastructure in some of the Arc, but this will be limited in scope and as much directed towards removing backlog maintenance as improving capacity. The life sciences vision, and supporting clinical research strategy risk, worsening the situation, especially in Oxford and Cambridge, because of their disregard for clinical infrastructure requirements. This situation is, within the definitions and parameters of sustainability as rehearsed in SASR, unsustainable.

As a contribution to debate, this submission proposes five changes that might begin to shift the discourse.

1) A joint forum, representing all the local authorities in the Arc, should be established with the remit, resources, and powers to critically examine Arc ICS health care infrastructure plans and their sustainability. The forum should commission independent health impact assessments of such plans.
2) The joint forum should devise a levy scheme for additional developer contributions, to be hypothecated specifically for health care infrastructure. The mechanism for controlling and allocating such developer contributions would need to be safeguarded, so that funds could not be diverted into NHS or local authority revenue budgets.
3) As part of this work, the joint forum should critically examine the use of s.106 contributions and the impediments to the use of these for healthcare infrastructure.
4) The joint forum should work with NHS England and the LGA to further develop ICS design guidance to include a requirement for systematic engagement in sub-regional spatial planning.
5) All parties should be more candid about the problem and recognises the disconnects that are baked into the current system.

The Oxford Cambridge Arc presents exceptional challenges and presents exceptional opportunities. It needs bold and novel remedies to achieve sustainable development, at least when when it comes to health care infrastructure. It must, surely, be within be within the imagination, will and capability of stakeholders within the Arc to create such remedies.

Abbreviations used in this document

CBC	Cambridge Biomedical Campus
DHSC	Department of Health and Social Care
GCSP	Greater Cambridge Shared Planning
HIP	Health Infrastructure Plan
ICS	Integrated Care System
LGA	Local Government Association
NHS	National Health Service
NIHR	National Institute for Health Research
NPPF	National Policy Planning Framework
SASR	Sustainability Appraisal Scoping Report
STP	Sustainability and Transformation Partnership