Operational Plan 2017 – 2019

Forward view 2018/19

July 2018

NHS

Harrogate and Rural District
Clinical Commissioning Group

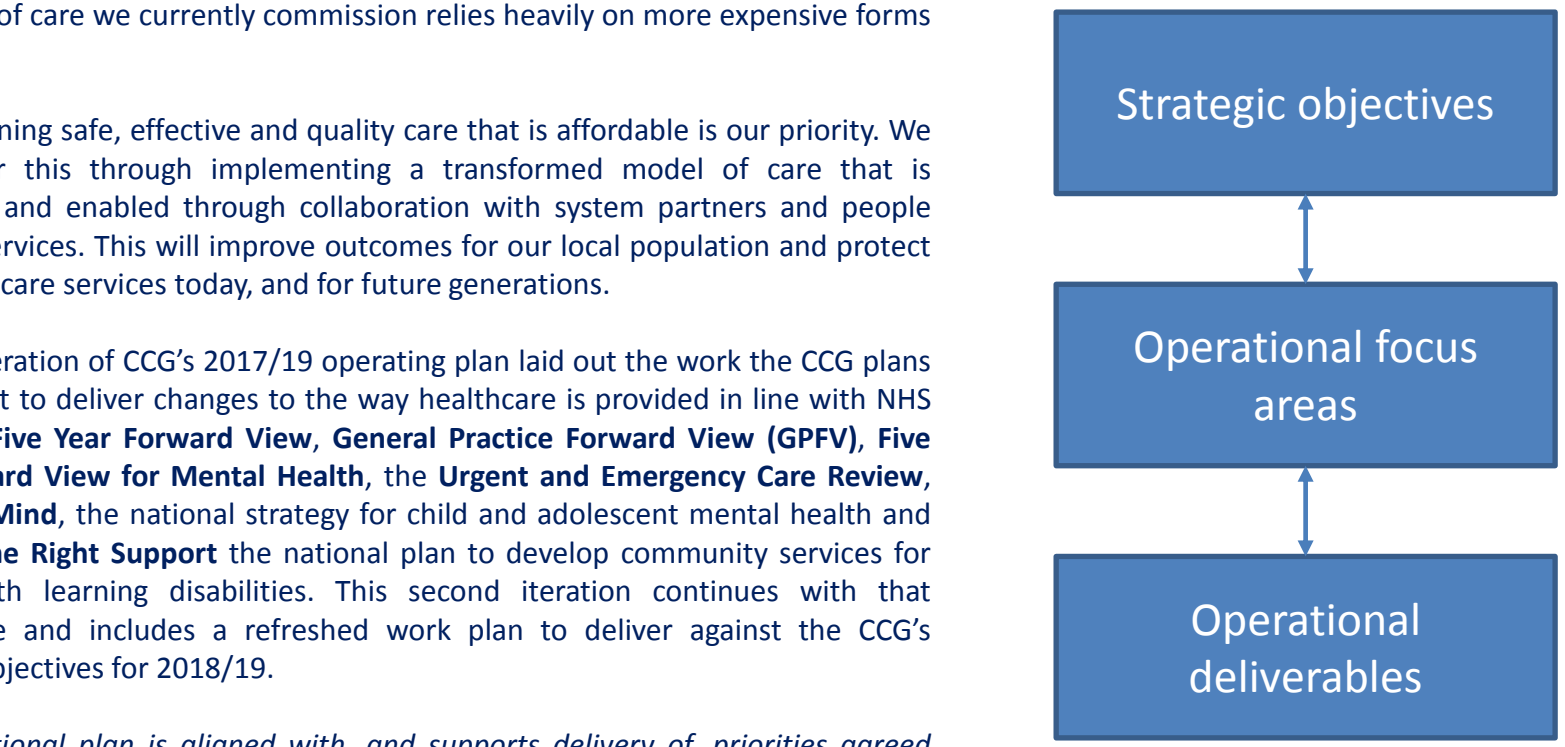
Introduction

As a local health and social care system we have a significant financial challenge. The gap between funding available and system costs is driven by rapidly increasing demand for services, operational inefficiencies, variation in practice and that the the model of care we currently commission relies heavily on more expensive forms of care.

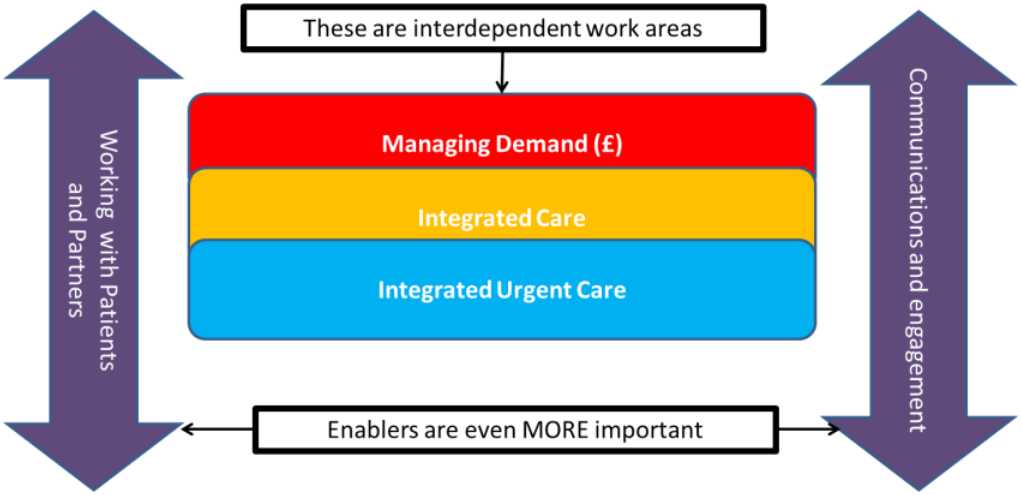
Commissioning safe, effective and quality care that is affordable is our priority. We will deliver this through implementing a transformed model of care that is developed and enabled through collaboration with system partners and people who use services. This will improve outcomes for our local population and protect health and care services today, and for future generations.

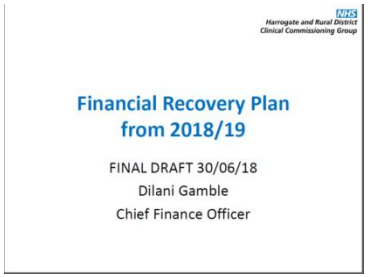
The first iteration of CCG's 2017/19 operating plan laid out the work the CCG plans to carry out to deliver changes to the way healthcare is provided in line with NHS England's **Five Year Forward View**, **General Practice Forward View (GPFV)**, **Five Year Forward View for Mental Health**, the **Urgent and Emergency Care Review**, **Future in Mind**, the national strategy for child and adolescent mental health and **Building the Right Support** the national plan to develop community services for people with learning disabilities. This second iteration continues with that programme and includes a refreshed work plan to deliver against the CCG's strategic objectives for 2018/19.

Our operational plan is aligned with, and supports delivery of, priorities agreed through The West Yorkshire Health and Care Partnership and The North Yorkshire Health and Wellbeing Board.



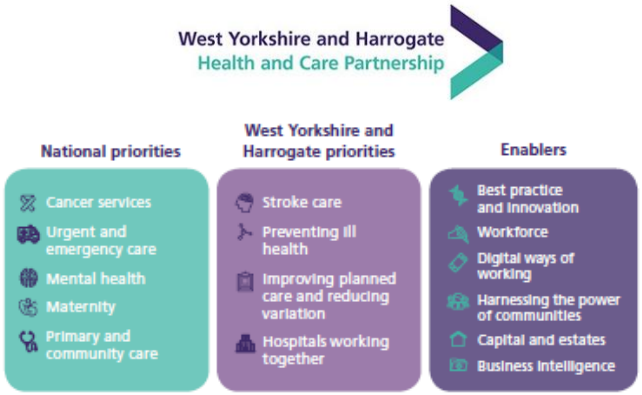
Objectives

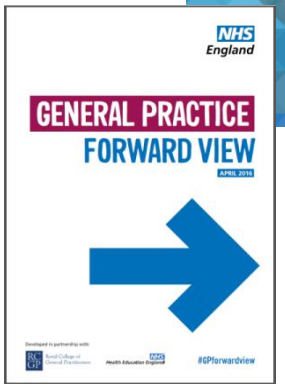




9 Must Do's

13 Questions





NHS

Harrogate and Rural District Clinical Commissioning Group

Operational focus areas

Quality assurance

Quality and Safety

The CCG has a number of key quality requirements and these are :

- To ensure we discharge our statutory functions in relation to quality and patient safety
- To commission services that are safe, effective and provide a good patient experience
- To ensure systems and processes are in place to provide assurance that quality standards are being monitored, maintained and where necessary improved
- To actively seek patient feedback and engage with all sections of the population with the intention of commissioning services the best possible services and positive outcomes for patients, within the financial resources available to it.

*Fundamental to providing safe care is the protection of our most vulnerable people, usually those who are older, frail, who potentially lack capacity and children. Our **Safeguarding** systems aim to **protect people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect .***

Quality assurance

Quality assurance is integral to the commissioning process and is a systematic process of determining in a transparent way whether a product or service being commissioned or developed is meeting its specified requirements.

Measuring quality and gaining assurance is complex and incorporates monitoring of many aspects of data, information or feedback from a wide variety of sources.

How we commission and measure quality or prevention of harm

- Each provider is required, contractually, to submit information on agreed indicators of safety, quality and effectiveness of services.
- Performance, Quality and Safety forums are established to enable mutual dialogue regarding all aspects of quality.
- CQC well led framework , surveys, national audits , patient feedback, compliments and complaints – all provide quality intelligence
- NHS Outcomes Framework provides focus of national priorities
- Commissioning for quality and innovation (CQUIN) are utilised where increased focus is required.
- Review of all serious incidents to ensure robust investigation, assurance regarding lessons learnt and progress regarding action plans
- Joint approach with NYCC and safeguarding teams for quality assurance of our local care homes
- Equality and Quality Impact Assessments for any new or changes to services to ensure any impact is fully understood and mitigated.
- Well developed approach to integration of the Public and our 'Patient Partners' to ensure the patient voice is always heard
- Participation with regional quality groups to understand and share any system wide 'early warning signs' that may impact upon quality

Patient involvement

The CCG strongly believes that the population within Harrogate and Rural District should be an integral part of shaping local health services and that it's role as leader of the health economy is to ensure that local people have the opportunity to get involved. To achieve this, the CCG will continue to communicate and engage with the population in an open, transparent and proactive way with a real understanding of what matters to our patients, local communities and member practices.

Our aim is to:

- Ensure patient experience and insight help shape our commissioning intentions and effective feedback mechanisms are in place to demonstrate that we are a listening, learning organisation.
- Develop and maintain effective communication channels to ensure that the people of Harrogate and Rural District locality have the information they need to enable them to access the right care at the right time, realise their own potential to self-care and improve their overall health and wellbeing.
- Continue to build meaningful engagement with our public, patients, carers and partners to influence the shaping of future services in the Harrogate and Rural District locality.
- Increase confidence, with patients, public, provider and partner organisations in our CCG as an effective and responsive commissioning organisation.
- Develop a culture within our CCG that promotes open engagement and communication within and outside the organisation.
- Ensure our behaviours and activities meet the standards expected of an NHS organisation and that it fulfils it's commitments, as set out in national legislation and through locally published intentions.

We are committed to listening to our communities and acting on the information they give us. This past year we have supported GP practices to strengthen their Patient Participation Groups with visits to all groups over summer 2017 and training provided January 2018. These groups provide invaluable feedback on the patient experience directly to GP practices.

We are also strengthening our engagement with patient partners and now have 30 trained partners in place. These partners will provide structured input into proposed projects and service developments. Their input will be a key element in ensuring that the user perspective is taken into account when we make decisions.

Operational focus areas

plan on a page

Harrogate and Rural District
Clinical Commissioning Group

Finance and financial recovery

Objectives

- Deliver control total 2018/19
- Focus on reducing waste and variation, improving efficiency and have a pragmatic approach to managing demand.
- Target areas of limited clinical value supported by a quality impact assessment.
- Focus on financing 'essential' services.
- Address radical options and consider 'hard choices'.
- Ensure value for money for the public purse. This may involve delivering longer term improvements in health by making difficult decisions and choices in the short term.
- Ensure robust risk assessment to ensure there is sufficient capacity and capability to deliver the intended outcomes.
- Ensure congruence with the CCG's overall commissioning strategy and the West Yorkshire and Harrogate Health and Sustainability and Transformation Plan and effectively work with partners to avoid duplication of effort.

KPIs and Metrics

- Deliver control total of £234m (including £10m Commissioner Sustainability Funding).
- £5.6m QIPP savings.
- £10m in year deficit.
- 2.8% budget growth to meet Mental Health Investment Standard.

Deliverables	Timescale
• Complete review of 'Difficult Decisions'	August 2018
• Jointly deliver projects that manage costs across the system enabling secondary care services at HDFT to be delivered within the agreed contract value of £94m.	March 2019
• Deliver Medicines Management QIPP programme.	March 2019
• Deliver CHC QIPP programme.	March 2019
• Deliver Mental Health Investment Standard.	March 2019
• Deliver the - £3 per head Primary Care Investment.	March 2019

Cancer

Objectives

- Preventing cancer by addressing cancer risk factors.
- Diagnosing more cancers early.
- Improve cancer treatment and care.
- Maintain 62 day pathway delivery.
- Increase rates of uptake of breast, bowel and cervical screening programmes, particularly targeting rural and older populations and people with learning disabilities.

KPIs and Metrics

- Ensure that 85% of patients continue to meet the 62 day standard, identify any 2017/18 diagnostic capacity gaps, increasing GP direct access to diagnostics (blood tests, chest x-ray, non-obstetric ultrasound, MRI, CT, endoscopy) and planning for a 7% per year level of headline growth in diagnostics up to 2020/21 within available resources, recognising that the Cancer Alliance Delivery Plan will include a 5 year diagnostic capacity building plan and service model.
- Increase 1 year survival from 72.6% in 2015/16 to 75% in 2020/21.
- Increase stage 1 and 2 diagnoses from 52.4% in 2015/16 to 62% in 2020/21.
- Reducing the proportion of cancers diagnosed following an emergency admission.

Deliverables 2018/19	Timescale
• Full implementation of revised NICE two week wait (2 ww) referral forms using ESR.	Ongoing 2018/19
• Completion of initial round of GP masterclasses.	Ongoing 2018/19
• Increase uptake in national screening programme particularly for rural, elderly and vulnerable people.	Ongoing 2018/19
• Recommendation for 'a vague symptoms' pathway.	Ongoing 2018/19
• Agreed safe pathway for brain and CNS pathways to Leeds.	Ongoing 2018/19
• Commence roll out of FIT for symptomatic bowel patients.	March 2019
• Maintain high quality cancer patient experience - as evidenced by national survey.	Ongoing 2018/19
• Patients engaged in service development.	Continuous
• Commence integration of cancer support into community services.	Ongoing 2018/19
• Optimise patient access to clinical research/ trials.	Continuous
• Plan for new model of diagnostics.	Ongoing 2018/19
• Plan for sustainable access to oncology services including link with WYH Cancer Workforce planning.	Ongoing 2018/19
• Completion of RPIW for implementation of timed pathways and commence delivery of the pathways.	March 2019
• Complete roll out of e HNA and treatment summaries for all patients.	March 2019
• Roll out of risk stratified pathway for prostate cancer.	March 2019

Mental health and learning disabilities

Objectives

- Delivering the Mental Health Investment Standard.
- Develop a combined provider/commissioner partnership (ACP).
- Reviewing and improving perinatal mental health care provision.
- Develop local solutions with partners for crisis service.
- Improve access to healthcare and improve and expand the services we provide in the community for people with learning disabilities.
- Making sure the North Yorkshire & York Transforming Care Partnership (NY&Y TCP) has the right staff with the right skills to provide a new type of service 24/7.

KPIs and Metrics

- 19% of people with anxiety and depression access IAPT, with the increase from the baseline of 15%. At least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019.
- 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline.
- 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Work in partnership to reduce inpatient LD bed capacity across NY&Y TCP by March 2019 to 9 CCG-commissioned beds, and 15 NHS England-commissioned beds.
- Ensure at least 75% of people with a LD on a GP register are receiving an annual health check by March 2020.

Deliverables	Timescale
• Commission a Secure Outreach Transitions team (SOTT) and a Community Crisis Intervention service for LD patients.	October 2018
• Adapt WY&H A&E liaison service model for local implementation.	December 2018
• Develop an estates strategy with our MH provider to reconfigure our commissioned in patient beds to align with NY&Y TCP target.	December 2018
• Develop, in partnership with our MH provider, homes for people that are suitable for discharged patients from long stay hospital placements for both TCP and MH.	December 2018
• Improving Access to Psychological Therapies: Access level at 19% or better.	March 2019
• Deliver improves diagnosis rate for people with dementia.	Ongoing
• Improving Access to Psychological Therapies recovery rate of 50%.	Ongoing
• People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral - 50%.	Ongoing
• 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases.	Ongoing
• Support and assist GP practices to deliver annual health checks for patients with LD.	Ongoing

NHS

Harrogate and Rural District
Clinical Commissioning Group

Planned care

Objectives

- Maintain good quality of care.
- Ensure that member practices refer the right patients for a specialist opinion and/or treatment in an outpatients setting, based on clinical effectiveness protocols.
- Ensure that patients receive the right care in the right place at the right time, taking in to account all components of the pathway to understand the impact of service changes on providers.
- Managing the costs of planned care with providers to ensure the CCG can deliver the 2018/19 financial plan and meet the expectations of the Financial Recovery Plan – includes Leeds Teaching Hospital, York Foundation Trust, South Tees Trust, BMI Duchy and Harrogate and District Foundation Trust (HDFT).
- Use the outputs and learning from WY&H Health & Care Partnership (HCP) Standardising Commissioning Policies Programme to inform demand management and elective redesign within HaRD CCG. The CCG is involved with the following work streams: orthopaedics and MSK; clinical thresholds; ophthalmology.

KPIs and Metrics

- 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).
- Two week wait targets.
- Number of reported serious incidents.
- Achievement of quality metrics
- Outpatient in admitted activity data. Plan v Actual.
- Work with providers and referrers to manage growth in demand for services within 1%.
- Primary care referral data by practice

Deliverables	Timescale
• Delivery of Demand Management projects to maintain referrals within planned activity trajectories.	Ongoing through 2018/19
• Introduce Demand Management strategic framework to enhance patient experience and manage growth in service demand.	August 2018
• AIC Programme: Extend clinically led triage service for gastro using strategic framework.	October 2018
• AIC Programme: Establish MSK and orthopaedics demand management approach using strategic framework.	November 2018
• AIC Programme: Establish dermatology demand management approach using strategic framework.	November 2018
• AIC Programme: Establish ophthalmology demand management approach using strategic framework.	November 2018
• Use demand management strategic framework to implement improvements with non-HDFT providers.	Ongoing
• Work with GP Practices to understand causes of variation and identify changes to maximise consistency	Ongoing
• Implement clinical threshold standards from WY HCP programme where appropriate for HaRD.	Ongoing

Unplanned, urgent and emergency care

Objectives

- Develop a system wide Urgent Care Strategy that takes account of the Integrated Urgent Care specification and ensures a simple to navigate urgent care system to reduce duplication and ensure financial sustainability.
- Develop a proposal for future provision of GP Extended Access and GP Out of Hours services.
- Maintain 999 ambulance conveyances to A&E at 2017/18 level
- Maintain Accident and Emergency Type 1 attendances at 2017/18 level.
- Maintain non-elective hospital admissions at 2017/18 level.
- Deliver a reduction in out of area Mental Health placements.
- Monitor network performance and access to services through an Urgent and Emergency Network of commissioners and providers.
- Improve the standards for ambulance response times through the Ambulance Response Programme pilot.
- Deliver the 95% 4 hour waiting time target.
- Reduce the number of Delayed Transfers of Care (DTOC) to 3.5% of occupied bed days.

KPIs and Metrics

- A reduction in 999 ambulance conveyances to A&E.
- Number of A&E attendances.
- A&E waiting times target.
- Number of out of area Mental Health placements.
- Increase in the number of callers to 111 who speak to a clinician to achieve the 50% target by April 2019.
- DTOC performance at 3.5% of occupied bed days.
- Number of non-elective admissions.
- Patient length of stay in an acute hospital.

Deliverables	Timescale
• Development of a supported discharge scheme.	August 2018
• Develop a three year Urgent Care Strategy in collaboration with patients, partners and other stakeholders.	October 2018
• Deliver a Discharge Project 'Why not home? Why not today?' to ensure patients are discharged to their own home or most appropriate care setting as soon as possible.	October 2018
• Introduce system for managing and monitoring capacity to support re-ablement and packages of care.	January 2019
• Complete implementation of standardised hyper acute stroke service pathway following agreement across the West Yorkshire & Harrogate Health & Care Partnership.	March 2019
• Working with STP partners to procure a new 111 service in line with the national specification.	April 2019
• Service model agreed for extended access, out of hours, primary care streaming.	April 2019

Winter resilience

Objectives

- To deliver safe patient care during periods of increased activity and increased number of hospital admissions.
- Maintain the 4 hour waiting times target.
- Implement a system wide Winter Resilience Plan for 2018/19 including system wide responses to increased activity.
- Deliver a Flu vaccination programme in collaboration with providers to reduce the impact of flu infections on staff and patients.
- Maintain average ambulance handover tines of 15 minutes.

KPIs and Metrics

- Meet the 4 hour waiting times targets – 95%.
- Daily reporting of Operational Escalation Level (OPEL) levels for providers and HaRD A&E Delivery Board.
- Flu vaccination uptake performance.
- Zero 12 hr A&E breaches.
- Ambulance handover waiting times of no more than 15 minutes.
- No system wide OPEL 4 escalations.

Deliverables	Timescale
• Multi agency discharge events (MADE) to prepare and support staff.	September 2018 December 2018
• Agreed HaRD A&E Delivery Board Winter Resilience Plan 2018/19.	October 2018
• Establish integrated discharge hub.	November 2018
• Provide support to “Every Hour Matters” week at HDFT.	December 2018 January 2019
• Flu vaccination programme uptake.	March 2019

Integrated care

Objectives

A service that is integrated from the viewpoint of the people who access it, built around people in their community, with an emphasis on prevention. The vision includes developing **Primary Care Home hubs** in primary care and around which integrated teams will be built.

There are 3 overarching objectives:

1) The population has improved health and wellbeing:
- Better health
- Good quality of life
- Reduced inequalities

2) The quality of care is high with:
- Effective care
- Good patient experiences
- Safe care

3) The health system is affordable and sustainable by:
- Reducing independence on health and care services
- Managing demand within resources

KPIs and Metrics

Detailed KPI/ metrics will be developed, based on the following:
- Proportion of people feeling supported to manage their condition.
- Proportion of patients maintained at home or an intermediate care facility.
- Patient experience of GP services.
- Proportion of people dying in preferred place of death.
- Health related quality of life for carers.
- Reductions in emergency admissions for over 65s.
- Reductions in delayed transfers of care.
- Improving people's experience of integrated care.

Deliverables	Timescale
• Commissioning strategy developed, Your community, your care: developing Harrogate and Rural District together.	December 2017
• Collaborative established with governance structure.	April 2018
• **CCG Assurance Checkpoint 1**: Alliance agreement, communications plan, vision and values, data gathering , draft implementation plan (incl. hub options) and OBC.	August 2018
• Staff development/ engagement sessions.	September 2018 October 2018
• Patient and public engagement events.	October 2018 onwards
• **CCG Assurance Checkpoint 2**: Integrated hub model proposals.	November 2018
• **CCG Assurance Checkpoint 3:** Mobilisation plan for new integrated service completed	January 2019
• **Primary Care Home/ Networks** phased implementation of integrated primary care, physical health, social care and mental health services.	April 2019

Primary care

Objectives

Support the resilience and transformation of primary care by:

- Improve access to general practice in and out of hours.
- Improve utilisation of technology.
- Better manage workload to release time in the GP Practice – primary care working at scale
- Improve management of medicines prescribing and reduce waste.
- Grow the primary care workforce.
- Improving primary care premises.

KPIs and Metrics

- Increase in percentage of patients able to access care at another GP practice.
- Increased uptake of Extended Access appointments across all practices.
- Increase in percentage rates of patients with access to GP online services.

Deliverables	Timescale
• Online Consultation software implemented within 'Early Adopter' practices.	August 2018
• Primary Care workforce group implemented and operational.	September 2018
• Productive General Practice programme delivered • Learning from Productive General Practice shared across practices.	October 2018 November 2018
• The 'Care Navigator' role established in all practices to ensure patients see the most appropriate clinician.	November 2018
• Increased uptake of GP Online across all practices.	April 2019
• Primary Care Estates improvements through capital grants.	April 2019
• GP Federation - Yorkshire Health Network – firmly established as a viable provider of services and partner in healthcare.	April 2019
• **Primary Care Home/ Networks** – structure of hubs agreed and implementation commenced with a phased plan.	April 2019 – April 2020
• Extended Access model delivery plan developed • Extended Access model finalised for 2019/20 contract award.	August 2018 June 2019

Continuing healthcare (CHC)

Objectives

- Support the delivery of the Financial Recovery Plan.
- Ensure and provide assurance of adherence to the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care.
- National Policy Revisions to implement from 1st October 2018.
- Improve patient experience with developments in personalised care, choice and control through the increased offer of Personal Health Budgets.
- By April 2019, NHS England expects that unless there are exceptional circumstances, everyone living in their own home who is in receipt of NHS Continuing Healthcare funding will be offered a personal health budget.

KPIs and Metrics

- Quality Premium – Less than 15% full NHS Assessments undertaken in Acute hospital setting.
- Quality Premium – Ensure at least 80% referrals for full NHS Assessment are completed within 28 days.
- Delivery of QIPP savings.

Deliverables	Timescale
• All Fast track patients are reviewed within 6 weeks and 12 weeks thereafter to determine Fast Track remains appropriate.	January 2018
• Ensure that all new referrals for FNC have the required assessment to determine eligibility before awarding funding.	March 2018
• Establish a brokerage service with North Yorkshire County Council to deliver more cost effective commissioning and procurement of Care Home placements and home care packages.	July 2018
• Establish a brokerage service with North Yorkshire County Council to deliver more cost effective commissioning and procurement of Personal Health Budgets.	September 2018
• Establish a brokerage service with North Yorkshire County Council to deliver more cost effective commissioning and procurement for people requiring a Fast Track service.	September 2018
• Undertake a program of joint reviews with the Local Authority to determine funding remains appropriate and reflects health needs.	Commenced to be completed March 2019
• Offer PHB as default for all new CHC Home Care packages.	March 2019

Children and young people

Objectives

- To ensure providers deliver the Children and Young People (CYP) autism assessment and diagnostic pathway in line with the NICE guidance.
- Deliver against the 49 recommendations in the National Framework 'Future in Mind' with partners by 2020/21.
- Ensure continued compliance with Children & Families Act 2014 Code of Practice.
- To reduce inappropriate inpatient admission for CYP cohort.
- To provide emotional and mental health services into schools.
- Improve access, information and signposting cross-agency for CYP services for those with additional needs.

KPIs and Metrics

- Target of 90% of second CAMHs contacts seen within 9 weeks.
- Percentage of transitions plans in place for YP receiving CAMHs services.
- Report against 6 week target for completion of health reports for EHCP (target 90%).
- Monthly collection of Continuing Care numbers caseload, out of area placements, referrals and discharges.
- Improved waiting times for CYP autism diagnostic services.

Deliverables	Timescale
• Delivering waiting time standards for CYP eating disorder services 95% receive first treatment within 4 weeks routine and one week urgent cases.	2020/21
• Additional 4900 CYP receive treatment from NHS commissioned service (32% above 2014/15 baseline) nationally.	2020/21
• Ensure all commissioned activity is recorded and reported through the Mental Health Services Dataset.	2020/21
• Refresh of the Future in Mind Local Transformation Plan.	October 2018
• Dynamic risk register in place for CYP TCP cohort.	October 2018
• Mechanism for tracking and reporting care, education and treatment reviews (CETR) for CYP TCP.	October 2018
• Development of a Continuing Care Policy.	March 2019

Medicines management

Objectives

- Cost effective medicine choices: Review existing prescribing in both primary and secondary care to make sure most cost effective treatments are prescribed first time.
- Reduce Medicines waste: Increase public awareness to the cost of medicines waste and promote self ordering of repeat medication.
- Self-care and over the counter medicines: Encourage patients to think of other channels to access advice and/or medication for minor ailments, such as going to community pharmacy. Reduces the unnecessary use of GP appointments and A&E attendance.
- Increase clinical pharmacist support to GP practices with a specific focus on carrying our in-depth medication reviews in care homes.
- Antimicrobial stewardship: Reduce inappropriate use of antibiotics.
- Biosimilar medicines: Continue to work with secondary care to make sure that biosimilar medicines are introduced in a quick, efficient and safe way.

KPIs and Metrics

- Delivery of prescribing savings against the 18/19 medicines management prescribing plan.
- Delivery of primary care prescribing spend within the set primary care prescribing budget for 18/19.
- Achieve national QP antibiotic targets.
- Proportionate use of biosimilars within key therapeutic areas optimised throughout 18/19.
- Reduction in spend on prescribing self care medicines.
- Increase number of care home residents whose medicines have been optimised.

Deliverables	Timescale
• Launch local pilots with pharmacists working from GP practices with a specific focus on increasing input to care homes and carrying out in-depth medication reviews for frail elderly patients.	June 2018
• Launch local pilot with pharmacy technician focusing on waste reduction and reviewing repeat prescription ordering.	July 2018
• Aim to switch appropriate patients from Humira to biosimilar adalimumab when it becomes available in Quarter3.	December 2018
• Deliver a comprehensive programme of prescribing initiatives which will reduce waste and optimise use of most cost effective drugs.	March 2019
• Implement national guidance on conditions for which over the counter items should not routinely be prescribed in primary care.	March 2019
• Continue to promote appropriate prescribing of antibiotics by maintaining the local primary care antibiotic formulary and specific focus around appropriate management of Utis.	Ongoing

West Yorkshire and Harrogate

Health and Care Partnership

NHS

Harrogate and Rural District
Clinical Commissioning Group

Health and Care Partnership vision

A vision for health and care in West Yorkshire and Harrogate….

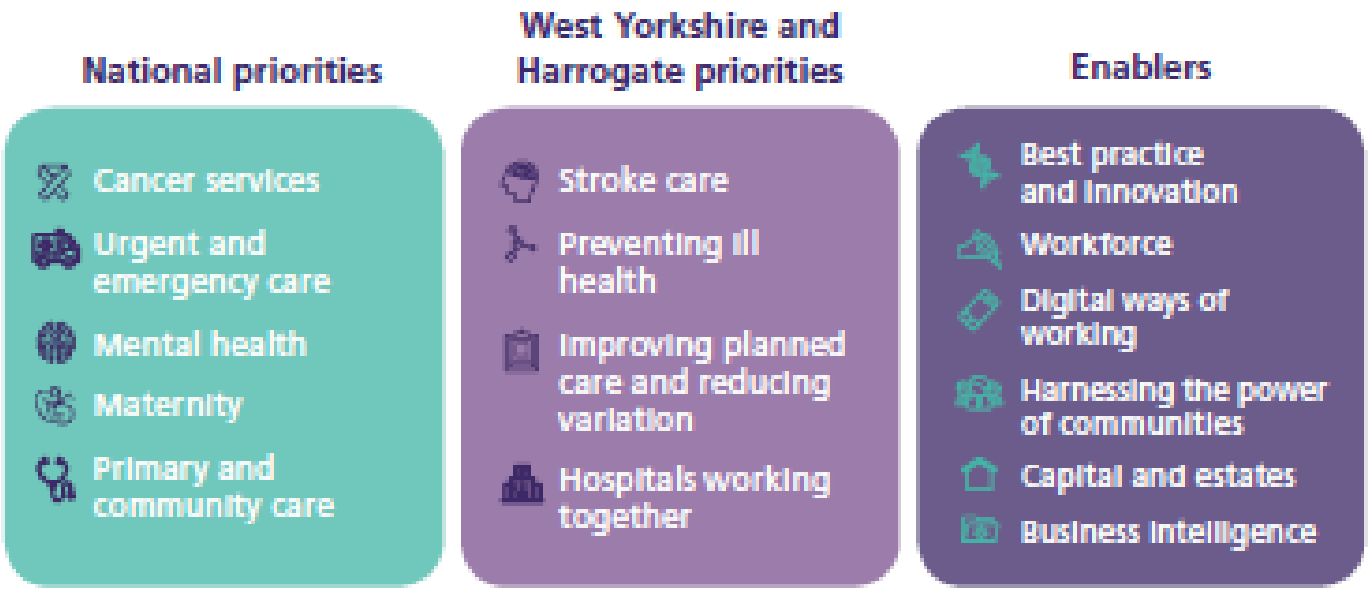
We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All our proposals, both local and at STP level support the delivery of this vision.

The guiding principles that shape everything we do as we build trust and delivery

- We will be **ambitious** for the populations we serve and the staff we employ.
- The West Yorkshire and Harrogate STP belongs to Commissioners, providers, local government and NHS.
- We will **do the work once**–duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.
- We will undertake **shared analysis** of problems and issues as the basis of taking action.
- We will apply **subsidiarity** principles in all that we do –with work taking place at the appropriate level and as near to local as possible.

These are critical common points of agreement that bind us together.

Health and Care Partnership priority work



Our operational plan is aligned with, and supports delivery of, priorities agreed through The West Yorkshire Health and Care Partnership.