NHS Dorset

NHS Dorset Five Year Commissioning Plan (Strategy) - 2026/27 to 2030/31

FINAL 5 February 2026

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Foreword

It's a real privilege to introduce our new cluster, which brings together the collective strengths of NHS Bath & North East Somerset, Swindon and Wiltshire ICB, alongside NHS Dorset ICB and NHS Somerset ICB. By joining forces, we're combining the expertise, experience, and passion of three systems. Working together means we can share what we do best, learn from each other, and deliver care that is more consistent, more efficient, and more responsive to the people we serve. This is about planning for the future as one team; building a high-performing strategic commissioning organisation that can make bold, long-term decisions and achieve more for our communities as we move towards full merger in April 2027.

Many people in our communities live a significant part of their lives in poor health, and those in our most disadvantaged areas experience this earlier and more severely. This is not just a health issue; it affects families, communities, and the economic wellbeing of our region. We must act together to change this, doing this with kindness and compassion.

Our new cluster brings together our three Integrated Care Boards to work as one strategic commissioning organisation, ahead of our planned merger in April 2027. We need to plan for the long term, focusing on outcomes, and making sure every pound we spend delivers the greatest value for our population. It also means working differently, moving away from short-term fixes and towards evidence based and outcome-driven commissioning that tackles the root causes of ill health.

We know there remain significant challenges to overcome. We need to reimagine how we better support people in their communities; we will do this by building neighbourhood teams, working together with our partners across the NHS, local authorities, the voluntary and community sector and with the public. We want to improve access to GP services and NHS dentistry whilst at the same time continuing to improve access to mental health support, reducing waiting times for planned treatments and continuing the improvement we have seen over the past year in our ambulance response times.

We will make these changes supported by the latest technology and while creating a health and care system that is financially sustainable, with the workforce required to meet the care needs of our population. We also know that not everyone has the same experience, and those living in our most disadvantaged communities are least likely to receive the support they need to thrive. It is important to be clear that in the years covered by this plan, local partners will face difficult choices as a result of challenging financial positions, but we are committed to doing everything we can to deliver on the three key shifts set out in the Government's 10-Year Health Plan, moving more care from hospitals to communities, making better use of technology and preventing sickness - not just treating it.

None of our achievements, nor our aspirations for the future, would be possible without the dedication, talent and compassion of the inspirational people who work in our local health and care services – from across the statutory and the voluntary, community, and social enterprise (VCSE) sectors, and I would like to thank them for everything they do.

Our three ICB Strategic Commissioning Plans contain many shared ambitions and some locally set commissioning intentions. They set out the actions we will take to build on the solid foundations already laid and rise to the challenges we face.

At the time of finalising and publishing this, February 2026, we are in a time of unprecedented change for the NHS. We are in a period of consultation with staff across our three ICBs as part of the government-led requirement to reduce our running costs by 50% ahead of our intended merger in April 2027. We have made some good first steps to work together, with Jonathan Higman appointed as our cluster chief executive in September 2025. We also have a newly appointed cluster executive team, who are working hard to set us on the path to becoming a high-performing strategic commissioning organisation.

Alongside the changes to ICBs are the changes in NHS England and their merger with the Department of Health and Social Care. The NHS landscape is evolving, and we will continue to work with our partners, maintaining our focus on supporting our people and communities to live healthier lives.

Rob Whiteman CBE, Chair NHS Bath & North East Somerset, Swindon and Wiltshire ICB, NHS Dorset ICB and NHS Somerset ICB

1. Cluster Introduction

I'm delighted to introduce our new cluster across Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, Dorset ICB and Somerset ICB. While we are currently three systems our cluster role and purpose are clear:

Our role is to transform our local NHS through exceptional commissioning and build an innovative health system fit for the 21st century that truly meets our communities' needs.

Our purpose is to make sure we use every pound (and resource) in our system to deliver the greatest possible value for everyone we serve. We will:

- Deliver a health system that is fit for the future;
- Improve the outcomes that matter most to people to improve their health and wellbeing;
- Direct our resources to where they make the biggest difference for everyone;
- Measure our success by focussing on measuring outcomes and quality relative to the resources used, rather than the volume of services provided.

The NHS 10 Year Health Plan focuses on three shifts, and this set the direction for how we commission services in the future:

- From hospital to community we will focus on delivering more joined up support close to home, with neighbourhood teams as the default place people get help;
- From analogue to digital we will focus on simple, secure digital tools like the NHS App and shared care records that make care easier to find, book and manage. We will look for digital innovation which will support people to live healthier lives;
- From sickness to prevention we will focus on earlier help to reduce the risks around smoking, high blood pressure, excess weight and harmful alcohol use, so fewer people reach crisis.

Most importantly, we will design our future services with people and communities, not for them. We will keep listening and working with people through neighbourhood plans, VCSE partnerships, health and wellbeing boards, and ongoing public engagement so local insight shapes decisions.

What we're already doing in common – our one shared approach

Across BSW, Dorset and Somerset, our plans point in the same direction. Together we will:

- **Commission for outcomes, not just activity.** We will put outcomes frameworks into contracts and hold ourselves to reducing unwarranted variation and closing inequality gaps. This gives providers clear goals;
- **Build a Neighbourhood Health Service.** Integrated neighbourhood teams (INTs) will wrap care around people with primary care, community services, local authority and VCSE partners working as one team;
- **Improve urgent and emergency care by strengthening the community front door.** We will redesign same day and out of hours access, develop single points of access, and recommission Integrated Urgent Care (IUCS) so more needs are met safely at home;
- **Transform planned care pathways.** We will expand advice and guidance and community based diagnostics; use data and clinical standards to reduce waits; and make follow-up more personalised and efficient;
- **Focus prevention where it matters most.** Systemwide tobacco dependence support, better hypertension case finding and

treatment, integrated healthy weight support, targeted alcohol harm work and improved vaccination access are shared priorities;

- **Use data well.** We will link up and responsibly use data across partners (e.g. Dorset's Intelligence & Insight capability, Somerset's Linked Data Platform, BSW's Outcomes and Intelligence Hub) and adopt national tools like the Federated Data Platform to target support and track impact;
- **Make digital the easy option and keep nondigital routes open.** Shared care records, modern EPRs, NHS App integration, remote monitoring and inclusive digital support will be built into contracts and everyday practice;
- **Strengthen mental health and neurodiversity support.** Earlier help in the community, crisis alternatives to inpatient care, dementia pathway improvements, and fair physical health checks for people with serious mental illness, are shared commitments across the cluster;
- **Improve support for children and young people.** Speech and language, SEND reforms, family hubs, and fairer access to specialist care are shared areas of work so children get help earlier and closer to home;
- **Tackle dental access and oral health.** We will stabilise the market, widen access - especially for vulnerable groups and strengthen prevention in schools and communities;
- **Align money to value.** We will grow transformation funds, use pooled budgets (e.g., Better Care Fund) and outcome based payments to shift resources into prevention and neighbourhood care;
- **Invest wisely in estates and infrastructure.** Modern, flexible spaces including community hubs, diagnostics closer to home, greener buildings will support the left shift and make access easier, especially in rural areas.

What's next

We are clustering now and intend to merge into a single strategic commissioning organisation by April 2027. This will help us plan at scale, reduce duplication and get the best value for our communities, while keeping decisions grounded in local needs. We will do this within the new NHS national framework, building the skills, data and market shaping capability that strategic commissioning requires. Our promise is simple: we will keep people and communities at the heart of our commissioning intentions; we will measure the outcomes that matter; and we will work as one team across the six places in our cluster to deliver for our people and communities.

Chief Executive Jonathan Higman, BSW ICB, Dorset ICB, Somerset ICB

Welcome to our Cluster

Our purpose is to make sure we use every pound (and resource) in our system to deliver the greatest possible value for everyone we serve.

We will:

- deliver a health system that is fit for the future
- improve the outcomes that matter most to people to improve their health and wellbeing
- direct our resources to where they make the biggest difference for everyone
- measure our success by focussing on measuring outcomes and quality relative to the resources used, rather than the volume of services provided.

Our cluster size: 3,928.84 total square miles

* Bath and North East Somerset

** Bournemouth, Christchurch and Poole

Get to know the cluster

2.6 million people live across Bath and North East Somerset, Swindon and Wiltshire, Dorset and Somerset.

We've got:

- Dispersed rural areas
- Large coastal communities
- Big urban centres
- 10% of our population is made up of our Armed Forces community.

Our primary care services

219 GP practices

across

57 Primary Care Networks (PCNs)

with

208 Patient Participation Groups (PPGs)

373 community pharmacies,

213 optometry services

and

367 dental practices

1 ambulance trust

South Western Ambulance Service NHS Foundation Trust covers the whole cluster. It's likely we'll keep lead commissioner arrangements for the South West.

Our provider trusts

5 acute hospitals (planned and urgent care)

3 community providers

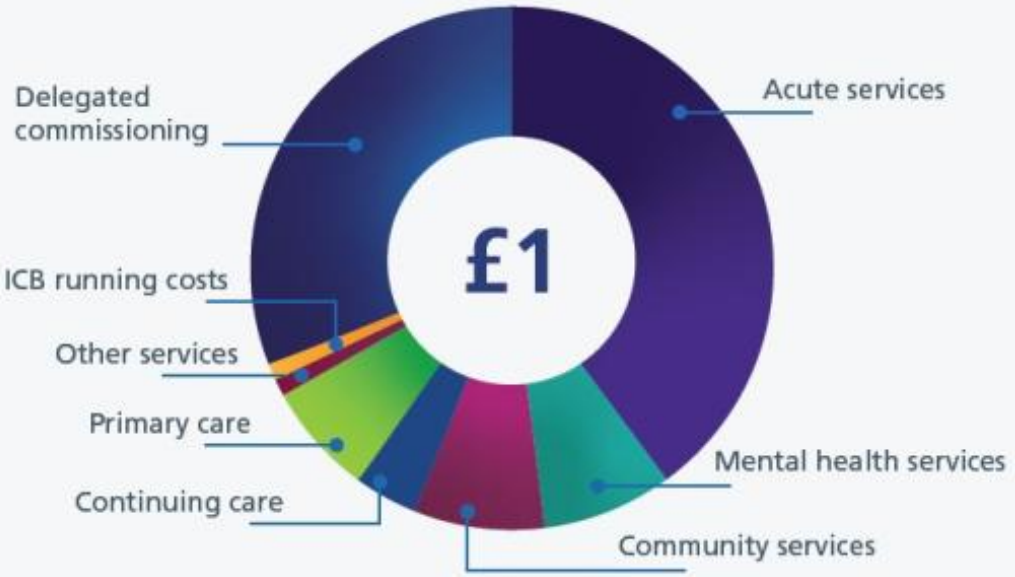
3 mental health trust

1 combined acute, community and mental health trust

Our finances

Our combined budget allocation for **2026-27 is £7.8bn** cluster (subject to change). We want to ensure the money we spend delivers the greatest value for our population. Here's how we spend every pound:

- Acute services..... **40p**
- Mental health services..... **8p**
- Community health services..... **8p**
- Continuing care services..... **4p**
- Primary care services..... **7p**
- Other commissioned services..... **0.7p**
- ICB running costs..... **0.4p**
- Delegated primary and specialised commissioning (including primary medical services, dental, pharmacy and ophthalmic services)..... **31p**



Together across NHS Bath and North East Somerset, Swindon and Wiltshire, NHS Dorset and NHS Somerset

2. Purpose and Scope

Our Commissioning Plan sets out how we will use our collective resources to improve health outcomes, tackle inequalities and deliver high-quality care for the population of Dorset as part of our wider BSW, Dorset and Somerset ICB Cluster over the coming period. It provides a clear line of sight from the needs of our communities and national NHS priorities through to the services we commission, the changes we will make and the results we expect to achieve.

This plan:

- Describes our vision and priorities – informed by population health needs, our understanding of local inequalities, and the voices of people who use services, carers and communities;
- Explains the transformation programmes we will pursue to redesign pathways, shift care closer to home, make better use of data and innovation, and deliver more integrated, person-centred care across organisational boundaries;
- Sets out our commissioning intentions for providers across the system. It describes the changes we expect in services, models of care and contracts, and forms the basis for our dialogue and agreements with NHS trusts, primary care, local authorities, the voluntary and community sector and independent providers.
- Outlines how we will use our resources – including funding, workforce, digital and estates to deliver those priorities within our financial envelope;
- Describes our governance, assurance and how we will manage our key risks and how progress will be monitored and reported, and how we will work with partners to deliver shared outcomes. In doing so, it provides a coherent framework for improving outcomes, experience and value for money for the people we serve.

3. Strategic Commissioning

What is strategic commissioning?

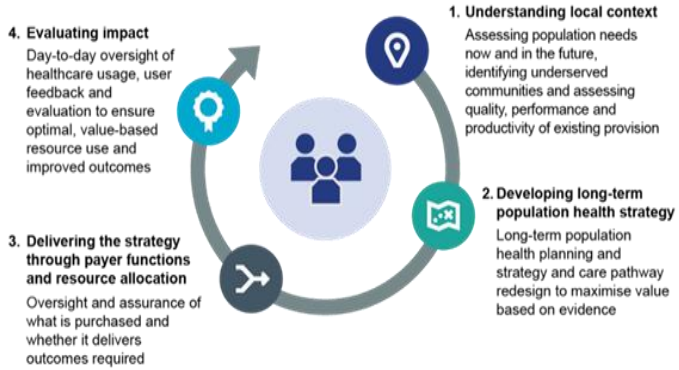
Strategic commissioning is an ongoing, evidence-based process where we plan, buy, monitor and review services over the longer term so we can improve population health, reduce health inequalities and make sure people have fair access to high-quality care.

As strategic commissioners, the ICB is responsible for getting the best value from the NHS budget by deciding how money is spent across our population, now and in the future, while making sure services uphold the rights and values set out in the NHS Constitution.

It supports delivery of the 10 Year Health Plan's three main shifts: from treating sickness to focusing on prevention, from hospital-based care to more care in the community, and from analogue to digital ways of working. In doing so, it helps ensure that money is directed to the most clinically appropriate and cost-effective services, and that providers are supported to deliver those services as efficiently as possible. Better use of technology where appropriate will be complimentary to rather than replace face to face services.

We will work closely with national and local government to tackle the wider factors that affect health, such as employment, in line with the government's health mission and the ICB's fourth purpose to support wider social and economic development.

The steps can be seen in the illustration overleaf.



4. Local Context – State of Dorset

Our Population

The following section provides an overview of the Dorset ICB context as part of the BSW, Dorset and Somerset ICB Cluster.

Our commissioning decisions are informed by Joint Strategic Needs Assessments (JSNAs) for Dorset ICS, Dorset Council, and Bournemouth, Christchurch and Poole Councils. These assessments provide a detailed picture of population health needs. In addition, this plan uses data from the Dorset Insight and Intelligence Service (DiiS) and nationally published healthcare sources to ensure a comprehensive evidence base.

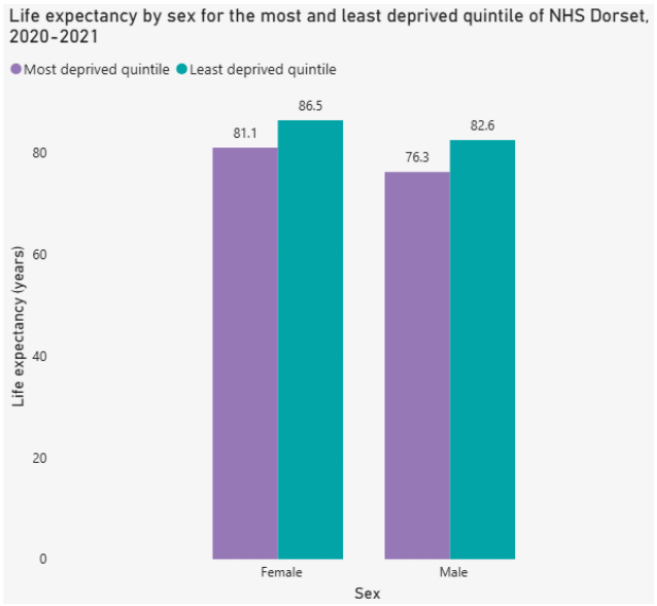
Dorset has a population of approximately 827,000 registered with a GP. Our population has grown by 4.8% in the last 10 years, this is due to people moving to area who predominantly in the older age groups. The county has more older residents than the national average, which means higher demand for health and care services, especially for long-term conditions and support for frailty.

Around 32% of households are single occupancy and 9% of residents provide unpaid care, including 20,000 giving 50+ hours a week. 19% of residents are disabled, so services need to be accessible and inclusive. Dorset is less ethnically diverse than England overall (94% White compared to 81% nationally), but 11% of residents were born outside the UK, so cultural and language needs must be considered.

We also have a large military community (serving military and their families) and over 38,000 veterans.

Overall, health outcomes in Dorset are better than the England average. However, some groups experience poorer health and shorter lives. People who face barriers to healthy living—such as limited access to resources, discrimination, or social disadvantage—are more likely to spend more of their lives in poor health and die earlier. This includes people living in deprived areas, some ethnic minority communities, 'inclusion health' groups (such as people who are homeless, vulnerable migrants, or in contact with the criminal justice system), and other priority groups such as people with learning disabilities.

In Dorset, the gap in life expectancy between the most and least deprived areas is 6.3 years for men and 5.4 years for women. National data shows this gap is even greater for homeless people, where average age at death is 45.9 years for men and 43.4 years for women, compared to 76.1 years for men and 80.9 years for women in the general population.



Analysis of children and young people's needs shows widening school-readiness gaps by deprivation, continued growth in EHCPs, higher prevalence of speech, language and communication needs, increased asthma-related emergency attendances, and persistently high rates of dental decay and tooth-extraction admissions. The neurodiversity referral trajectory and associated backlog remain significant pressures. Alongside this, emerging evidence on CYP carer

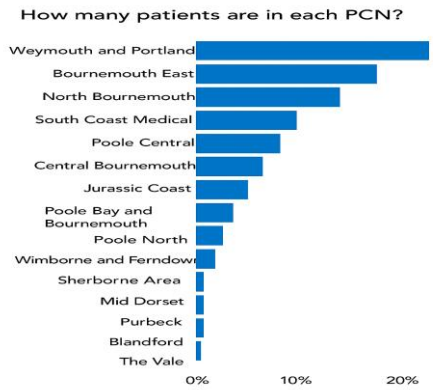
impact should inform the development of early-help, respite and wider support services.

Health related behaviour is an important determinant of the likelihood of developing long-term conditions. Obesity, smoking and physical activity are major causes of the biggest killers in Dorset and addressing these is a critical priority for our commissioning plans. Health outcomes are not the same across Dorset. Some areas have more people with poorer health than others. This means the need for healthcare and the demand for services vary between Primary Care Networks (PCNs) and neighbourhoods.

Health inequalities are not the same across the county. Around 9% of Dorset's population live in areas ranked among the 20% most deprived nationally (known as our CORE20 population). These communities are mainly located in Primary Care Networks in coastal towns, such as Weymouth, Portland, and Bournemouth.

This matters because people in these areas often have poorer health outcomes and greater need for support. Commissioning plans must focus on reducing these gaps by improving access to services, targeting prevention, and working with local partners to address wider determinants of health including housing, employment, and education.

The illustration below shows the distribution of the most deprived populations across Dorset ICB Primary Care Networks.

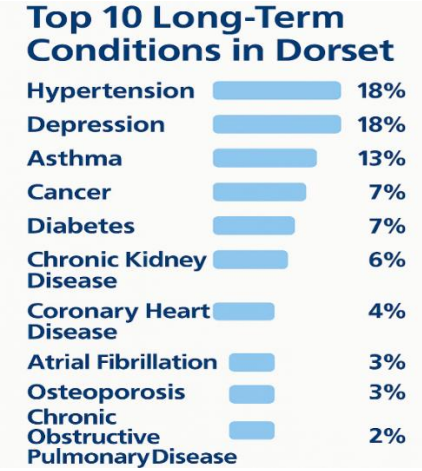


Some barriers to good health are spread across the county rather than concentrated in one area. For example, our analysis of financially vulnerable pensioners shows that while there are more in urban areas in East Dorset, there are also clusters across the whole ICB area. The numbers of financially vulnerable people are similar in both BCP Council and Dorset Council areas.

Our work on social inclusion also shows that access to good quality work is a major barrier to good health for some people of working age. This means employment support and fair access to work opportunities are important for improving health outcomes.

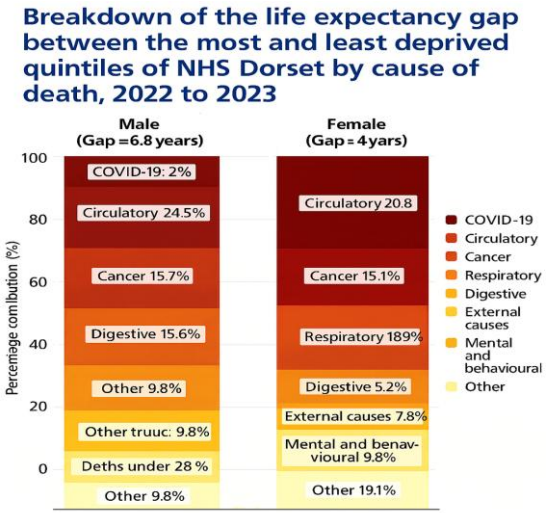
Long Term Conditions

Dorset has an older population compared to many other areas. We have a large number of people – around 459,000 – living with one or more long-term health conditions. These conditions are a major reason for healthcare need and demand. For example, more than half of people with COPD, heart disease, or diabetes have 10 or more GP appointments each year.

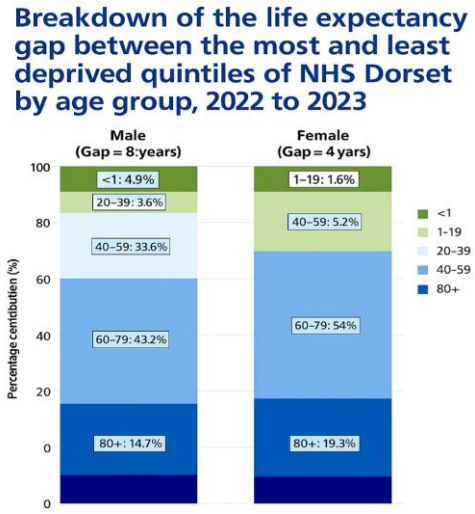


The illustration below shows the conditions that contribute most to the gap in life expectancy between Dorset's most and least deprived communities. Circulatory diseases, cancers, and respiratory

conditions have the biggest impact. Much of this gap happens during working age, making this a key point for early intervention.



Source: Office for Health Improvement and Disparities based on ONS death registration data and provisional mid-year population estimates for the relevant years, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2019.



Source: Office for Health Improvement and Disparities based on ONS death registration data and provisional mid-year population estimates for the relevan years, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation 2019.

Health Care Inequalities

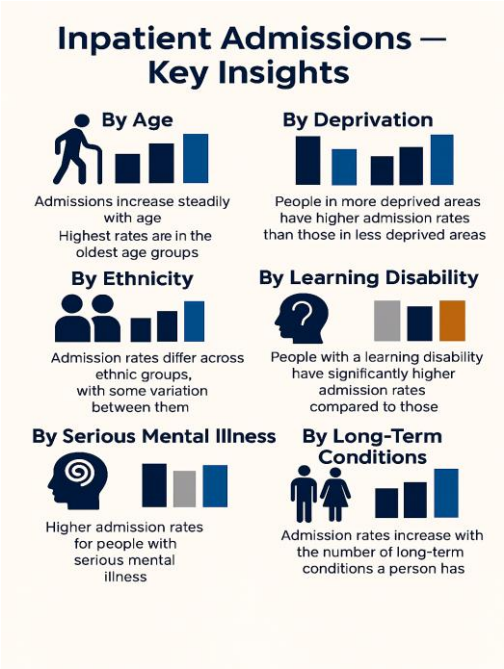
Not everyone in Dorset can access health services in the same way, and some people experience poorer outcomes when they do. Our Annual Health Inequalities Report reviews differences in access and outcomes across nine service areas and 24 indicators, including planned and urgent care, cancer, mental health, cardiovascular disease, diabetes, smoking cessation, maternity, and services for people with learning disabilities and autism. The analysis focuses on age, sex, ethnicity, and deprivation.

The findings show that age affects access: service use generally increases with age until around 80, then declines. Younger people are more likely to have cancer diagnosed early compared to older people. Sex differences are also clear: women are more likely to use outpatient services, access CAMHS, take up flu vaccination, and be diagnosed with cancer earlier, while men are more likely to be admitted with heart attacks or stroke and to have completed all eight recommended diabetes care processes.

Deprivation plays a major role: people in more deprived areas have higher emergency admissions and greater use of urgent care, while those in less deprived areas have better blood pressure management and higher vaccination uptake.

Ethnicity shows mixed patterns: white residents are more likely to receive all diabetes care processes, vaccinations, and emergency admissions when compared to other ethnic groups. It is worth noting the data for other ethnic groups is less clear due to issues such as gaps in recording, or small populations.

We will regularly review population needs and work with our providers to reduce barriers to good access, experience and outcomes from health services enabling people who face barriers to engaging with health services to understand their choices and have their voices heard. Reviewing peoples experience on an ongoing basis will underpin this.



Population health need in the future

Dorset's population is getting older, and this has major implications for future healthcare needs. Long-term conditions become more common as people age, which means demand for health and care services will rise.

Our population is expected to grow over the next seven years, with an increase of about 3.5% in the Dorset Council area and 1.7% in the BCP Council area. Much of this growth is due to older people moving into Dorset, especially into the Dorset Council area. The balance between older people and those of working age is changing. By 2040, it is estimated that around one-third of our population will be aged over 65.

Analysis by the NHS Strategy Unit shows that as people age, activity increases across all care settings. For those aged 80 and over, there are big rises in:

- Unplanned hospital admissions;
- Bed days;
- Ambulance conveyances;
- Outpatient appointments.

At the same time, elective admissions and day cases for this age group reduce. Unless we take action, an ageing population will lead to much higher demand for unplanned care.

We also recognise, that whilst older people are more likely to have health needs, they also make a huge contribution to the wellbeing of communities in Dorset. For example, national data indicates that the age group most likely to participate in formal volunteering is people aged 65-74.

Activity and Performance Context

We face many of the same challenges as a system as other parts of the NHS, and have developed an Integrated Performance Dashboard to maintain oversight of these. This shows improvement in most areas,

although like many other ICBs, we are not always meeting the national target, our Annual Report and Accounts set out our performance.

We have made significant progress; however, we still have patients waiting a long time for services such as trauma and orthopaedics, ear, nose and throat (ENT), ophthalmology and gynaecology. In addition to this we need to address the sustainability of ENT, dermatology, Oral Maxillofacial and interventional radiology services.

We have seen a growth in planned care activity (clock starts) across all of our providers of 5.2% (based on previous 12months ending September 2025) and 2.8% for A&E attendances and 2.4% non elective admissions with a 1 plus day length of stay.

The following provides an overview of key performance.

Elective Care

- Referral to Treatment (RTT) 18 Week Waits**:** Whilst we have reduced the duration of wait for elective services, we do not meet the RTT constitutional standard. We need to reduce the waiting list to 56,593 to achieve 92% of patients waiting less than 18-weeks for their first definitive treatment by March 2029 by increasing NHS and non-NHS elective activity.

Urgent & Emergency Care

- Ambulance Handovers >45 Minutes**:** We have seen improvements during 2025/26 of lost ambulance handover hours but need to go further during 2026/27 and eliminate those exceeding 45 minutes;
- A&E 4-hour Performance (All Age and Children <16 Years): A&E 4-hour performance at Type 1 A&E Departments remains lower than the operational planning ambitions set out for 26/27, 27/28 and 28/29;
- No Criteria to Reside / Patients Discharged on Discharge Ready Date: We continue to have a high number of patients in our acute hospitals and in Intermediate Care Beds who have No Criteria to Reside (are in hospital after their discharge ready date).

Primary and Community Care

Dental Activity:

- To achieve improved dental access, we need to deliver increased routine and urgent dental activity in line with our ICB ambitions which is to achieve the national target of 52,857 by 2028/29, from our current performance of 39,500.

Community Services Waiting Times:

- Neurodiversity Waits for adults and children are higher than we would like and we are not meeting the national standards. Improving waiting times remains a key priority and performance will continue to be tracked throughout the operational planning period.

Mental Health & Learning Disabilities

- During 2025/26, NHS Dorset is meeting its targets for several mental health and learning disability areas. These include the average length of stay for adults in acute mental health beds, support for adults with learning disabilities or learning disabilities and autism, support for children and young people with learning disabilities and autism, reducing inappropriate out of area placements, and delivering annual health checks for people with learning disabilities;
- However, some standards are not currently being met. These include support for adults who have autism only, recovery and improvement rates within NHS Talking Therapies, access to perinatal and maternal mental health services, access to individual placement support, and dementia diagnosis rates;
- A recovery plan has been in place to increase access to mental health services for children and young people, and we are on track to meet the revised targets. We also continue to be among the top 10 integrated care boards in England for outcomes in early intervention in psychosis and for physical health checks for people with serious mental illness;

- Our plan builds on what we achieved in 2025/26 and sets out how we will tackle the ongoing challenges. Additional SDF funding will help us to improve performance against higher targets for talking therapies, individual placement support, and mental health support teams in schools. We will also continue to work on improving data quality to make sure our performance information accurately reflects the care being provided.

Provider Market

Independent sector providers (ISPs) continue to play an important role in meeting the health needs of Dorset's population. The system is already reliant on ISP capacity across a range of pathways.

The ICB is committed to actively managing the local health and care market to ensure services are sustainable, high-quality, and responsive to population needs. We will work closely with providers to support service resilience, innovation, and collaborative approaches, while identifying opportunities to address gaps or improve outcomes.

In 2026/27, we will strengthen our understanding of provider capacity, workforce pressures, and investment requirements, engaging providers in shaping future service models. Where appropriate, commissioning levers will be used to secure high-quality, cost-effective services that deliver equitable access and improved patient outcomes.

Quality Context

The three Dorset NHS Trusts – University Hospitals Dorset, Dorset County Hospital, and Dorset HealthCare—have published their Quality Accounts for 2024/25, reflecting on achievements and setting priorities for 2025/26. These reports focus on three key domains: Patient Safety, Clinical Effectiveness, and Patient Experience.

Across the system, there has been significant progress in strengthening patient safety culture, advancing digital transformation, and enhancing community engagement. Despite these achievements, challenges remain in addressing workforce pressures and meeting national access targets. The collective commitment to collaboration, innovation, and reducing health inequalities continues to underpin all improvement efforts.

Patient safety has been a major focus, with Patient Safety Incident Response Framework (PSIRF) methodology embedded across all trusts. This has included thematic reviews on falls and pressure ulcers, medicines optimisation initiatives, and the rollout of electronic prescribing systems. Maternity safety compliance has been achieved, and improvements have been made in mental health safety. Clinical effectiveness has also advanced, with mortality indicators remaining within expected ranges—SHMI at 0.87 for University Hospitals Dorset and 1.05 for Dorset County Hospital—and improvements in the timely completion of electronic discharge summaries.

Patient experience has been enhanced through expanded engagement initiatives, the introduction of therapeutic activities such as music and arts, and the opening of Access Wellbeing hubs by Dorset HealthCare.

Our plans for 2025/26 can be seen in section 10 of this plan.

Financial Context

There is increasing pressure on financial resources across all our health and social care organisations. The funds available are not enough to maintain our current way of working. We therefore need to find ways to become more efficient and effective to deliver the care you need whilst living within our means.

In Dorset we have a budget of £2.1 billion. We need to be sure we use our resources, including our workforce, technology, and buildings, in a way that supports the three shifts and brings the greatest benefit and fair outcomes for everyone- see Dorset System Budget.

Workforce Context

Dorset faces significant workforce challenges across the health and care workforce. This includes workforce shortages, recruitment and retention issues, over-reliance on international recruitment, staff burnout and well-being challenges. Furthermore, persistent inequalities may have resulted in unfair differences in treatment,

opportunities and outcomes for staff. Local people and communities have told us that workforce pressures such as staff shortages, high turnover, and the need for temporary workers are affecting their confidence in local services. They want to see greater stability and continuity of care, supported by investment in staff development. More recently, substantial financial pressure and the productivity challenges places workforce at the centre of our operational recovery and medium to long term plans. This is driving the need for sustainable and affordable workforce planning which responds to new care models, and national and local labour market trends.

The NHS 10-year Health Plan for England places workforce reform at the heart of its strategy and the three "left shifts" outlined in the new NHS Operating Model, call for significant workforce redesign. In response to local challenges and national directives, providers in Dorset are committed to:

- Adopting a skills-based approach to workforce planning to enhance flexibility & adaptability of the workforce, support integrated care models and facilitate strategic planning;
- Improve staff experience through better working conditions, wellbeing support, and career progression pathways;
- Reduce reliance on temporary staffing, replacing it with collaborative staff banks and sustainable recruitment pipelines;
- Enhancing social value & broadening social economic through widening participation and employing people from our local communities;
- Embed digital capability across all roles to support virtual care, AI-enabled tools, and integrated health records and thereby improve workforce productivity;
- Promote a preventative agenda, engaging staff and communities in health improvement initiatives.

The Provider Collaborative Board is well placed to drive tactical and operational plans, and their key focus is temporary staffing and focused recruitment. There is also an opportunity for the GP Alliance to be the vehicle to improve workforce planning, attraction and retention of the primary care workforce. Furthermore, there is a commitment across all sectors; health, social care, education, and the voluntary sector to work collaboratively for a system wide perspective to workforce and move towards integrated thinking and planning which recognises the interdependencies between services and organisations.

Infrastructure

Health and care services are provided from more than 200 NHS sites – and from over 300 community pharmacy, and optometry sites. There are 116 GP surgery sites, three acute hospitals (Bournemouth. Poole and Dorchester). Community and mental health services provided from 85 sites. Some of the challenges we have are:

- Backlog maintenance £106m – critical infrastructure risk £60m;
- 85% of GP sites have asset rating below B and four sites have D rating;
- Challenge to meet future demand – 25% of population aged 65+ and 54k new homes planned by 2038/39;
- 88% of PCNs have insufficient space to recruit ARRS roles and/or additional GPs and nurses.

Current priorities are to deliver existing STP/CDC/NHP capital projects, totalling £722m. Significant investment is also required to upgrade the primary care estate. 214 sites identified and categorised as core, flex and tail. 52% of the estate is classified as core. 14 primary care sites are tail, but investment required to release. Future capital needs assessed at system level with 40 major projects (>£2m) prioritised with total capital requirement of £686.4m, in addition to critical backlog.

What people have told us

We know that if we want to make positive, lasting change to health and care services in Dorset, we need to listen to, and work alongside, people and communities.

By listening to local people, we have a good understanding of what they feel is most important when it comes to health and wellbeing. The views and experiences of Dorset residents help inform service planning and delivery on an ongoing basis.

To check that our ongoing response to meeting identified health needs continues to be reflective of, and respond to, what local people are telling us, we carried out a review of 38 engagement reports from the last five years. These were gathered from NHS, local council, VCS and Healthwatch colleagues.

Each document was independently reviewed to identify themes regarding local people's views. This was done rigorously with the use of the artificial intelligence (AI) tool Microsoft Copilot (2024 version). Open and non-leading questions ensured consistency and rigor, ensuring themes came from what people said, without bias.

A deliberative session, to review the identified themes, was then held with community engagement officers and members of the Dorset Public Engagement Group. They felt the themes accurately reflected what they were hearing from local people and communities.

The key areas that people feel are most important in terms of health and wellbeing are:

- Integration and joined-up working;
- Voluntary and community sector and social connection;
- Prevention and early help;
- Inequalities and inclusion;
- Digital inclusion and choice;
- Mental health and wellbeing;
- Access and barriers to services;
- Communication and information;
- Workforce and relationships;
- Wider determinants of health.

These themes are reflected in this plan, with the wider determinants of health being considered alongside local council and voluntary and community sector colleagues.

To complement the above, each of the 38 engagement reports were also independently reviewed for people's views on the following key priority areas in NHS Dorset's commissioning intentions document.

- Neighbourhood health;
- Mental health, learning disabilities, autism and neurodiversity;
- Planned care and cancer;
- Maternity, women and children and young people;
- Urgent and intermediate care services;
- Making better use of technology.

Having reviewed the emerging themes we are assured that they are reflected within this plan. To illustrate this, we have produced a series of 'You said – we are doing or planning' tables which we shared at a series of 11 engagement meetings with members of the public and community and voluntary sector representatives.

Attendees were happy that the themes and related plans made sense, and questions and suggestions regarding implementation of the plans will be shared (with the insight review) with programme leads, to underpin their future engagement and co-production work.

In addition, observations at these meetings have informed the final version of this plan, including:

- opportunities and challenges that come with cross boundary and cluster working;
- 'communications' being included throughout the plan;
- supporting people to increase their knowledge and confidence, to make better use of technology;

- technology complementing rather than replacing face to face services;
- consideration of marginalised and ethnically diverse communities;
- improving access to services being throughout the plan;
- consideration of people's experiences to inform future care; and
- plans for working alongside people, communities and the voluntary sector locally when implementing these plans.

A copy of the insight report can be read here:

https://nhsdorset.nhs.uk/wp-content/uploads/2026/01/Insight-report-Local-peoples-views-on-health-and-wellbeing-December-2025.pdf

Our ongoing approach to communications and engagement is described in Section 13.

What does this mean for our plans

Dorset faces rising healthcare demand driven by an ageing population, increasing complexity of needs, and persistent health inequalities. Key challenges include improving access for vulnerable groups, addressing cultural and physical barriers (including those experienced by marginalised and ethnically diverse communities), and supporting carers under growing pressure. Health-related behaviours such as obesity, smoking, and inactivity remain major contributors to long-term conditions, alongside high prevalence of mental health issues. Key to success will be continuation and rapid scaling of population health management approaches underpinned by principles of left-shift from acute to community, analogue to digital and treatment to prevention. To support this, our commissioning priorities focus on:

- Prevention and early intervention for major conditions and risk factors. Including investing in services that prevent or reduce exacerbations linked to the main risk factors for long-term conditions such as obesity, cardiovascular disease, respiratory disease and chronic kidney disease. This includes:
  - Making Every Contact Count as a core requirement across all commissioned services;
  - Commissioning specific prevention and support services such as the Activation Hub, weight management, smoking cessation and health coaching;
- Integrated care models to manage complexity and reduce avoidable hospital admissions. Including embedding personalised care approaches so that people are supported and confident to manage their long-term conditions once they develop them;
- Targeted action to reduce health inequalities, ensuring equitable access across rural and urban communities;
- Support for carers and mental health services, alongside physical health care;
- Collaboration with partners strengthen partnership working at Place and Neighbourhood level – collaborating to remove barriers to good outcomes, especially where we are not directly in control such as housing, employment, and education, and accelerating access to preventive support;
- Commission for outcomes – expecting providers to segment their populations, understand different levels of risk, need and ability to benefit, and take appropriate action. This includes using digital-first approaches and avoiding "one-size-fits-all" models that waste scarce resources or create barriers for our most vulnerable groups.

These priorities will guide investment and service design to improve outcomes, reduce gaps, and deliver sustainable, person-centred care across Dorset.

5. Vision and Strategic Priorities

Our Vision: Dorset Integrated Care System works together to deliver the best possible improvements in health and wellbeing, and address health inequalities.

Our vision is underpinned by four medium-term strategic priorities:

- Neighbourhood Based Care – strengthening proactive community models, supporting residents with high and ongoing needs and ensuring continuity of care across neighbourhood providers. Integrated Neighbourhood Teams (INTs) will coordinate prevention, early detection, and management of long-term conditions and provide urgent community response to avoid unnecessary hospital admissions;
- Service Sustainability – redesigning fragile services to ensure long-term viability and alignment with national standards;
- Prevention of Long-Term Conditions – improving life expectancy and reducing preventable illness through proactive, prevention-focused approaches;
- Digital Leadership – delivering integrated digital infrastructure and data-driven care to enable seamless, patient-centred services.

As set out in our through our Integrated Care Partnership Strategy and Joint Forward Plan we are committed to improving healthier lives, thriving communities, and care that is integrated, digitally enabled, and delivered close to home. Aligned with the NHS 10-Year Health Plan, we are focusing on three key shifts:

- Hospital to Community- creation of the Neighbourhood Health Service bringing care closer to or in patient's homes where possible, supporting people to feel more in control of and manage their own care. Making greater investment in out of hospital care;
- Analogue to Digital- make the NHS the most digitally accessible health system in the world - including creating and giving patients access to a single patient record, expanding the utility of the NHS App and expanding the use of digital tools. Supporting people to increase their knowledge, skill and confidence to maximise the benefits of making better use of technology;
- Sickness to Prevention- halve the gap in healthy life expectancy between the richest and poorest regions through a range of prevention activities including a focus on tobacco use, expanding free school meals and an expansion of access to weight loss medication.

Over the next five years, our ambition is to create a system that empowers people to live healthier lives and builds resilience within our communities. By doing this we will see improvements in our key outcomes which are set out in our detailed commissioning priorities over the next five years and outlined in the following sections.

6. Transformation and Core Programmes

This section of our plan sets out how we will transform services over the next five years to better meet the needs of our local people.

Right now, demand for services is higher than the funding we have. To keep services sustainable, we need to change how we plan and deliver care. This means:

- Expanding community and neighbourhood health teams so people get proactive, coordinated care;
- Strengthening primary and community services to reduce pressure on hospitals;
- Improving outcomes and experiences for everyone, while tackling health inequalities.

The plan reflects major reconfiguration to acute services arising from the Dorset Clinical Services Review with Royal Bournemouth Hospital site moving to be the Urgent and Emergency Care Hospital and a Poole site becoming the Planned Care Hospital. These changes are designed to improve quality, safety and resilience of hospital services and must be supported by strong community and neighbourhood services.

To enable this, we will need to focus investment in out-of-hospital pathways, including alternatives to admission, timely discharge, and ongoing care and support in the community. This will ensure people receive the right care, in the right place, at the right time.

This plan is developed within the context of increased collaboration across systems, including the formation of a cluster ICB bringing together BSW, Dorset and Somerset ICBs. This provides opportunities to align strategy, share learning and work at scale, remove barriers to cross-border service provision, while maintaining a strong focus on local needs and place-based delivery.

Together, these commissioning intentions set out a clear direction for transformation: shifting care into neighbourhoods, supporting major service reconfiguration, and working collaboratively to deliver sustainable, high-quality services for our population.

Neighbourhood Health and Wellbeing

We know people want strong, local services that wrap around individuals and communities. These services should keep people well, provide proactive and preventive care, and reduce the need for hospital-based treatment.

Currently, too many people attend hospital unnecessarily or stay longer than needed, which can negatively affect recovery. Strengthening community care is essential to deliver better outcomes and value for money

We want healthcare services in Dorset to become more proactive, supporting residents with high and ongoing needs and ensuring continuity of care across neighbourhood providers. Integrated Neighbourhood Teams (INTs) will coordinate prevention, early detection, and management of long-term conditions and provide urgent community response to avoid unnecessary hospital admissions.

Our Neighbourhood Health and Wellbeing development starts with a central INT Programme supported by the National Neighbourhood Health Improvement Programme (NNHIP).

Integrated Neighbourhood Health and Wellbeing Programme

The programme focuses on building strong neighbourhood health services through staff and person activation and responds to the ambitions set out in the 10 Year Plan to shift settings of care from hospital to community and aligns to the plans set out in Dorset's Clinical Services Review.

We already have in place 18 INT across Dorset and Bournemouth Christchurch and Poole Place within existing Primary Care Network footprints. Each INT supports several communities, and we have been working with them to understand what is important to them and co-designing services that meet local needs, delivered in a way that works for the community and delivers on the 10-year health plan.

Progress to date

We have already made significant progress which can be seen below:

- Secured social investment funding from Macmillan to support transformation and contractual changes for sustainable "left shift";
- Set out seven headline monitored outputs demonstrating outcomes which support the left shift linked to activity changes from acute to community, and agreed contractual and growth changes;
- Established an activation model and maturity matrix for INTs to drive accountability and innovation;
- Co-designed priorities with communities and our workforce to address prevention, equality, and population health needs;
- Implemented governance that prioritises co-production and stakeholder collaboration;
- Joined the National Neighbourhood Health Improvement Programme;
- Developed contractual and commissioning changes to engage primary care (GP, Pharmacy, Optometry, Dental) in integrated models;
- Identified 855 high intensity users over a range of conditions and a larger group of people with rising risk at System, Place and Neighbourhood level;
- Introduced monitoring and oversight so partners can track INT development and outcomes;
- Supporting social prescribing in our communities across Dorset to support health and wellbeing and self care.

Key Workstreams

To deliver our ambition for neighbourhood health we will focus on the following workstreams:

- Building the teams- Local health and care teams are now established, meeting regularly, and working together to identify improvements and deliver better care for the community;
- Integrating care around individuals- plan care around people's needs, using data to spot those who need extra help early, creating care and support plans, and finding new ways to keep people healthy at home.

Sitting alongside the core Neighbourhood programme we then have three integrated programmes which are taking the learning from the Neighbourhood programme and the associated NNHIP to develop thinking across other key areas.

Neighbourhood End of Life

A particular group within this ambition are people at the end of life, giving them more options to be cared for in their own community whenever possible, offering more comfort, choice, and family support. Working with Macmillan and using social finance, we will:

- Provide a 24-hour helpline for advice and support;
- Offer a rapid response service to avoid unnecessary hospital visits;
- Support advanced care planning so people can make informed choices.

This new service will start in Spring 2026 and will work alongside our local health and care teams.

Neighbourhood Medicines Strategy

Our plans for medicines and prescribing support our move to neighbourhood-based care. Local teams understand the health needs of their communities and can help reduce differences in how long-term conditions are treated and managed. Medicines play a key role in preventing illness, improving health, and making care more effective.

Our strategy puts people's safety and experience at the centre of everything we commission. This means making sure medicines are used in the right way, at the right time, and that people feel confident about their treatment.

The phased introduction of the Single National Formulary from 2027 will ensure quick, equitable access to a list of priority new and current medicines. Its introduction will simplify local decision-making and encourage improvements in clinical pathways for community-based care.

To get the most from new advances in medicine, we will:

- Use our medicines budget carefully and make the most of treatments we already have;
- Adopt new medicines in our care pathways as they are recommended for use in the NHS;
- Commission services that utilise medicines and technology to personalise care;
- Make it easier to get medicines and clinical advice from your local pharmacy, including support from trained independent prescribers;
- Offer structured reviews within the INT programme for anyone taking ten or more different medicines for several health issues, to make sure their medication is safe and effective;
- Ensure people have access to monitoring of the medicines closer to home;
- Through Integrated Neighbourhood Teams (INTs), link pharmacies and health teams to provide more care locally and reduce hospital visits
- Give patients access to prescriptions through the NHS App, whether their doctor is in hospital or the community
- Coordinate funding and resources with local teams, using contractual arrangements, ensuring that prescribing services and pharmacies are focused, delivering results and accountable for improving your neighbourhood's health.

Neighbourhood Oral Health Programme

Dorset is facing big challenges in dental care. Our population is growing, but there aren't enough NHS dentists. This means many adults and children struggle to get the care they need. We want to make

dental care easier to get, fairer for everyone, and focused on prevention. Through our Oral Health Programme we will:

- Recruit and retain more dentists and dental staff
- Improve access to NHS dental care, especially for vulnerable groups
- Focus on prevention through school toothbrushing schemes and oral health campaigns
- Provide extra support to communities with the greatest need
- Build a long-term, joined-up oral health system for Dorset

Neighbourhood Primary Care

Primary Care remains the first point of care for our neighbourhood response. and we are actively investing and growing our primary care services through our neighbourhood approach. To support the delivery of integrated care we are:

- Working together with our General Practice, Community Pharmacy, Community Optometry and Dental practices to respond to local population needs with a focus on access and better outcomes
- Supporting ways of working that help services build capacity for new models of care, to be more sustainable, drive-up quality and reduce variation
- Focusing on new ways of investing in core services that incentivise improvement, innovation and service integration.

What it means to the three shifts:

- From Sickness to Prevention- focus on helping people stay healthy and avoid illness. This means more support in communities, better advice, and services that make it easier for people to take care of themselves. By working together on population health, medicines, and primary care, we can reduce health inequalities and improve wellbeing for everyone.
- From Hospital to Community- building strong neighbourhood health teams so more care can happen closer to home. These teams bring together local doctors, nurses, pharmacists, and other professionals to give joined-up care. This will reduce unnecessary hospital visits and help people recover faster in their own community.
- From Analogue to Digital- using technology to make care simpler and more connected. This includes online GP appointments, smart tools like AI to help with triage, and shared care records so professionals can work together easily. Digital services will save time, improve safety, and give people more choice in how they access care

Oversight

Our INT and EoL programmes are managed by a board that includes people from across the system and is also linked to the national Neighbourhood Health Programme (NNHIP). It links to delivery oversight for both Dorset and BCP. Dorset HealthCare (DHC), the community health provider, leads the programme. The changes are part of their contract and our agreement with Macmillan.

There is a Programme Director at DHC and a Deputy Director for Commissioning at Dorset ICB. The other programmes, Oral health, Medicines management, and neighbourhood commissioning, are overseen by the Quality and Commissioning Committee. These also report to the Health and Wellbeing Boards and council scrutiny committees when needed.

We also work with the General Practice Alliance, the Primary Care Delivery Group, Healthwatch, and the coproduction team within the INT programme to support consultation and joint working.

Our commissioning intentions set out the areas we have identified as priorities for further focussed action to improve outcomes for our population over the next five years which can be seen in Appendix 1.

Transforming Mental health, learning disabilities, autism and neurodiversity services

We know that mental health and mental health disorders have a significant impact on the overall health of our population, with estimates suggesting that nearly a quarter of the total burden of disease nationally is attributable to mental disorder. Mental disorders arise early in the life course, increase the risk of developing a wider range of health conditions, and impact on the ability of people to lead healthy fulfilling lives.

Feedback from people with learning disabilities and their families has highlighted the importance of services that are accessible, inclusive, and tailored to individual needs. Annual health checks continue to be highly valued, but these appointments must allow enough time, offer easy to understand and accessible communication, and provide stronger follow-up support—particularly for those living in supported living environments.

As part of our approach to mental health commissioning we are keen to ensure there is fair access, experience and outcomes for mental health services. We will utilise population health data to assess unwarranted variation and ensure actions are in place to reduce health inequalities. The CYP MH business case and the work to improve uptake in health checks for people with serious mental illness are key programmes of work related to this agenda.

Progress to date

We want to make sure everyone gets help for their mental health as soon as possible. We have already made significant progress which can be seen below:

- We've worked with children, young people, and families to improve local mental health services using the 'THRIVE' approach. This includes expanding Mental Health Support Teams in schools and helping more young people access specialist care;
- Through our dedicated maternal mental health and specialist perinatal mental health service, we have increased access to support mental health difficulties during pregnancy or after having a baby, ensuring those in need are getting the right support to give their child the best possible start in life;
- Implemented a new Access Wellbeing Service and opened three 'Universal' Hubs with local community and voluntary groups. These hubs offer drop-in spaces across Dorset;
- People with serious mental illness often have shorter lives. We're tackling this by increasing annual health checks. Over 60% of those registered have had a check and received support to stop smoking, eat well, and be more active;
- We continue to work with local councils (including partnership Boards) to support people with learning disabilities. Over 75% now receiving annual health checks to identify issues early, stay healthy, and ensure appropriate care;
- Building on public feedback, we continue to improve our annual health check pathways to make sure that appointments are longer where needed;
- More information has been made available in 'easy-read' formats and we will continue to identity more opportunities to provide this;
- We review data to find gaps in access and outcomes, such as talking therapies and the use of restrictive practices, so we can make services fairer for everyone.

Key workstreams

- Continuation of the Community Mental Health transformation focusing on timely, open access support, preventing escalation to more severe mental health challenges;

- Children and young people mental health transformation enabling earlier access and support for children and families in partnership with local authorities, as well as considering transition from children to adult services;
- Focusing on the adult in patient bed stock we will co-develop a strategy to ensure value for money and improve quality and flow;
- Review and refresh of the mental health rehabilitation pathway leading to improved flow and repatriation of out of area patients;
- Development of Mental Health ED's at our acute hospital sites ensuring that people get the right support in the right environment;
- Development of 24/7 neighbourhood mental health centres that become a multi-agency hub providing timely mental support to local communities;
- Increasing access to both adult and children community mental health services;
- Ensure that population health measures are used to consider access, experience and outcomes from services, including understanding barriers and facilitators such as digital exclusion, and health literacy, variation by population group (such as by deprivation and ethnicity) and the impact of wider determinants such as housing insecurity.
- Enhancing support for people with learning disabilities through improved communication formats, extended appointment times where clinically appropriate, and closer integration with supported living teams to ensure consistent follow up and continuity of care;
- Integrate genomics to guide mental health prescribing, reducing trial-and-error and enhancing treatment outcomes;
- Apply pharmacogenomics in mental health care to optimise medication selection and improve patient safety.

What it means to the three shifts:

- From hospital to community**-** Both the adult and children mental health transformation programmes are focused on earlier help with a shift to empowerment and supported self-management. We will work with the integrated neighbourhood teams programme of work to ensure that mental health priorities are taken forward and aligned, particularly 24/7 neighbourhood mental health centres.
- From analogue to digital-Mental health initiatives will be implemented in accordance with the Dorset Digital Strategy with a particular focus on strengthening online access (including crisis text messaging service) and utilisation of AI solutions.
- From sickness to prevention- The adult and mental health transformation programmes are designed to evolve into a prevention-based model. We will continue to focus on delivery of prevention initiatives such as health checks, ensuring no unwarranted variation. This includes improving the accessibility of health checks for people with learning disabilities by ensuring communications are clear, inclusive, and easy to understand.

Oversight

This programme is overseen by the Mental Health, Learning Disability and Autism Delivery Group with a Senior Responsible Officer- Chief Executive from Dorset HealthCare University NHS Foundation Trust.

Our commissioning intentions set out the areas we have identified as priorities for further focussed action to improve outcomes for our population over the next five years which can be seen in Appendix 1.

Transforming Planned Care and Cancer Services

Our ambition for planned care is to deliver high quality, safe, diagnostics and treatment for our patients, with no unnecessary waits, managing demand to enable better access and a reduction in health inequalities. Led and delivered by a valued and supported workforce.

We are developing new models of care through our commissioning for sustainability workstream. These reviews aim to transform planned care services to improve patient experience and reduce unnecessary attendances at hospital, ensuring the patient is seen in the right place by the right professional at the right time. This will be achieved by commissioning along end-to-end pathways, via outcomes-based specifications. We are strategically commissioning the dermatology end-to-end pathway first, closely followed by ophthalmology and then other specialities, providing a clear ask for provides to respond to.

We are in the process of refreshing our System Planned Care Strategy following a system event and through our Clinical Services work with Vista Health. This aims to create a more ambitious strategy and delivery plan, one which empowers and digitally enables patients, and treats them in places that are tailored to episodic verses place-based care.

We will develop services responding to the NHS Plan, NHS Elective Reform Plan, Medium Term Planning Framework, NHSE Statement on Health Inequalities and the 10 year Cancer Plan. This will support us to deliver the Referral to Treatment 18 week target by March 2029 but also support our commitment to reducing variation, investing in prevention and supporting people to be cared for closer to home, through GPs, community and neighbourhood teams working together.

In Dorset we have also looked at what local people have been telling us about health services over the last 5 years – to help inform our local plans that will help to deliver the 10 Year Health Plan for England.

People told us that our communication, especially about virtual clinics and service changes, needs to be clearer, more transparent and easier to understand. We heard that when information received before and after appointments is inconsistent, it can leave people feeling anxious or unsure about what to expect, particularly when care is delivered in new ways. We will use this feedback to improve our communication across all planned care and cancer pathways.

Our plan sets out how we will improve health outcomes for local people and make access to services fair for everyone, how we use our budget and other resources and what outcomes we expect for local people, informed by our engagement activities.

We are also considering 'fragile' services in collaboration with our One Dorset Provider Collaborative, to develop single services and waiting lists across trusts. We are considering our approach to funding and contracting models, including how we transact activity between contracts to deliver the left-shift priority in the 10-year plan.

In all we do, we will, ensure that delivery models support earlier access to elective intervention and address the disproportionate impact of long waiting times on Children and Young People (CYP). We know that CYP continue to face longer waiting times for planned care and experience an impact of long waits on their development and longer-term outcomes. We will address this disproportionate impact of long waiting times on Children and Young People.

We will also review how information is shared with patients using virtual clinics, remote monitoring, or alternative pathways to ensure people receive consistent, timely communication that clearly explains what will happen next, how to prepare, and who to contact for support.

Progress to date

We have already made significant progress which can be seen below:

- Piloted the use of AI in triage and diagnosis of patients with skin lesions which could be cancer, the learning has informed the plan to develop primary/ community based services;
- Implemented clinical decision support in primary care for suspected cancer, getting the right referral to the right place first time;
- Implemented community weight management service including single point of access;
- Implemented Advice and Guidance within primary care and continued roll out within secondary care;
- Planned implementation of straight to test diagnostic pathways including breathlessness, children and young people asthma, liver, capsule sponge and Faecal Immunochemical testing;
- Developing plans for commissioning of a Women's Health Hub informed by clinical audit work;
- We have developed and reviewed comprehensive dashboards to help us to identify variation in planned care, including for planned care and cancer

Key Workstreams

To deliver our ambition for planned care and cancer services we will focus on the following workstreams:

- Recommissioning end to end pathways of care;
- Referral Management including clinical decision support and advice and guidance;
- Commission transformed outpatients;
- Diagnostics and straight to test pathways.
- Strengthened communication processes to ensure patients receive clearer instructions, reminders, and follow up information—particularly for virtual and hybrid appointment models in response to concerns raised by local people.

What it means to the three shifts:

- From hospital to community – We will work closely with INT colleagues to embed planned care and cancer services within neighbourhoods. As well as implementing further straight to test and self referral diagnostic pathways to enable primary care to make the right referral first time;
- From analogue to digital- We will make use of AI in our pathways and use clinical decision support in primary care aligned to clinical guidance and referral pathways. We will also ensure digital pathways are supported by clear, user friendly communication so patients feel confident using virtual clinics or digital tools.
- From sickness to prevention- We will use data to identify at risk groups for early intervention and to reduce unwarranted variation in outcomes. We support people to wait well working with voluntary and community sector services. People will be supported through improved communication that explains steps they can take while waiting and where to access additional help.

Oversight

This programme is over seen by the Planned Care Delivery Group with a Senior Responsible Officer- Chief Executive from University Hospitals Dorset.

Our commissioning intentions set out the areas we have identified as priorities for further focussed action to improve outcomes for our population over the next five years which can be seen in Appendix 1.

Maternity, Women and Children and Young People

We want to make sure personalised care, prevention, and the use of technology are part of everything we do to improve health at every stage of life.

Right now, services that support parents and children from pregnancy to age three are not consistent across our area. This means some children are less ready for school, especially those from disadvantaged backgrounds. Children who start school without meeting key developmental milestones often face challenges in education, health, and wellbeing throughout their lives.

Children in more deprived areas are also more likely to have poorer health overall, which increases inequalities from the very start.

To change this, we need stronger and more joined-up early years support. This includes better access to dental care and oral health advice, and timely help for emotional health and wellbeing. Acting early is vital because late diagnosis of mental health problems can affect children and families for years.

By commissioning high-quality, evidence-based early years services together, we aim to reduce inequalities, improve school readiness, and give every child the best start for lifelong health and wellbeing.

Local parents and families have told us that health visiting services and responsive communication channels such as text based advice are highly valued. They also highlighted the need for smoother communication across maternity, health visiting, and early years services, so that families feel supported and informed at every stage. A strong theme from local feedback was the desire for continuity of care, with the same midwife or health visitor wherever possible to help build trust and provide consistent support.

Progress to date

We have already made significant progress which can be seen below:

- Through the Healthy Movers programme 145 early years settings have been trained, helping 2,444 children get active and develop new skills. Many children have also improved their personal, social, and emotional development;
- We've worked with local councils to improve care for pregnant people and new parents. This includes personalised care plans, fair access to services, and better experiences. We've launched the *Maternity Matters* website, supported infant feeding initiatives, and achieved Baby Friendly accreditation to help parents;
- Implemented Healthy Start Scheme which provides healthy foods and vitamins to low-income families with children under four;
- Implemented the Big Brush Club in schools in the most deprived areas and special education settings, we've introduced supervised toothbrushing for 4–6-year-olds. Over 3,000 children have taken part and received a take-home pack;
- We've improved early years support by training Communication Champions to provide consistent help. Parents can now self-refer if they're worried about their child's speech and language development. Everyone gets an appointment within 14 days. Speech and language therapists are now based in all mainstream school;
- We've embedded training opportunities to meet the needs of staff working with children and young people;
- We've created a maternity and neonatal dashboard to track and tackle health inequalities;
- University Hospitals Dorset is piloting a service for children and young people with complications linked to excess weight. This service is for those already under specialist paediatric care and supports up to age 18;
- Dorset County Hospital and University Hospitals Dorset use the Paediatric Early Warning Score to spot early signs of deterioration

in a child's condition. This works alongside the 'Call for Concern' patient safety initiative.

Key Workstreams

- Speech, Language and Communication pathway for children and young people;
- Continue to develop the CEWS service, linking with the overall strategy for addressing obesity;
- Work with key stakeholders to implement SEND reforms and local action plans;
- Support Primary Care Networks to develop family hub-based clinics and Multi-Disciplinary Team case discussions to improve integrated care for CYP, linking with Family First Partnerships, and Integrated Neighbourhood Teams;
- Analysis of urgent care activity and develop initiatives that achieve 4-hour A&E waiting times for children;
- Improve communication pathways across maternity, health visiting, early years and CYP services, ensuring smoother handovers and clearer, more consistent information for families;
- Explore models that increase continuity of midwifery and health visiting, recognising the importance families place on seeing the same trusted professional wherever possible.

What it means to the three shifts:

- From hospital to community -For CYP, this means increased community-based, integrated care, such as family hubs and improved speech and language support in all educational settings. Early intervention and personalised planning will support the reduction of emergency admissions alongside reducing the impacts of long waits for services. This also includes strengthening continuity of care so families receive joinedup support from pregnancy onwards.
- From analogue to digital-These initiatives will be implemented in accordance with the Dorset Digital Strategy with a particular focus on strengthening online access and utilisation of AI solutions. Digital channels—such as textbased advice and personalised digital updates—will help parents access timely advice and navigate services more easily.
- From sickness to prevention - We will use data to identify at risk groups for early intervention and to reduce unwarranted variation in outcomes. We will focus on ensuring good uptake in prevention initiatives including relevant vaccination and screening programmes. Improved communication between services will help families receive earlier, clearer advice, supporting prevention at every stage of childhood.

Oversight

The maternity programme is overseen by the Local Maternity and Neonatal Service.

The CYP programme is led by a Deputy Director, Dorset ICB and as senior manager leads for individual work programmes. The governance route varies according to the programme of work utilising existing governance structures to ensure alignment and efficiency.

Our commissioning intentions set out the areas we have identified as priorities for further focussed action to improve Maternity, Women and Children and Young People outcomes for our population over the next five years, which can be seen in Appendix 1.

Urgent and Intermediate Care Services

Our plans for Urgent and Emergency Care (UEC) and Intermediate Care are closely linked. Both aim to make sure people in Dorset get the right care, in the right place, at the right time, whilst contributing to good patient flow across the system.

Our UEC services, delivered by hospitals, community teams, and ambulance services, provide fast assessment, treatment, and support for people with urgent or life-threatening health needs.

These are aligned to our intermediate care services, delivered jointly with local authorities, which provide short-term recovery support in the community to both prevent hospital admission and enable people to leave hospital sooner. Both services focus on quick access, smooth transitions, and good recovery outcome.

In line with the NHS 10-Year Plan and the 2025/26 UEC improvement framework, our strategy focuses on:

- Reducing avoidable hospital admissions through urgent community response, hospital-at-home, and same-day emergency care;
- Accelerating discharge using strong intermediate care pathways and a "Home First" approach.

By moving more care from hospitals to home and community settings, reducing long hospital stays, and embedding recovery-focused rehabilitation, we will help people in Dorset live healthier, more independent lives and meet national standards for access and outcomes.

Much of this work is part of FutureCare, a three-year programme to transform UEC and intermediate care by 2027. This partnership across health and social care aims to create a system that is:

- Integrated and straightforward for people to access and navigate;
- Responsive, dependable, and safe so people have confidence in using it;
- Focused on reducing unnecessary hospital admissions to keep people supported a supported at home;
- Accelerating discharge into effective intermediate care that promotes effective recovery and ongoing independence.

Progress to date

We have already made significant progress in key areas :

- Further development of our Single Point of Access (SPoA) model to include specialist paramedic input and direct links into social care as well as community health first response services;
- Extension of direct access pathways for SWAST into hospital at home and SDEC services;
- Increased utilisation of SDEC services and strong partnerships with community health and care service to support rapid turnaround at ED front door (FutureCare);
- Development of acute-based Transfer of Care hubs with a dedicated flow team in place to drive better decision-making and more timely discharge from hospital (Future Care);
- Reduced length of stay in community hospital beds to support better flow and utilisation of these services (Future Care);
- Work to strengthen escalation processes for people delayed in acute, community and mental health beds to support better onward flow and release capacity for those that needed.

Key Workstreams -

- UEC Front Door Transformation – Redesigning our Urgent Treatment Centres (UTCs) and Minor Injury Units (MIUs) so they can better meet people's same-day care needs. Linking closely with new neighbourhood teams;

- IUCS Transformation – Working across the ICB to redesign a future model that gives people faster access to assessment and support, both during the day and out of hours;
- Alternatives to Admission - Making better use of same-day care and urgent response services to help more people stay at home and avoid unnecessary hospital stays;
- Transfers of Care – Improving how hospitals and intermediate care services work together to reduce delays and make sure people can return home as soon as possible-prioritizing a home first approach;
- Home-Based and Bed-Based intermediate Care - Reshaping our intermediate care offer in partnership with local authorities as part of BCF planning, to ensure that our Dorset offer is recovery focused and centered on supporting people to return home at the earliest opportunity;
- Mental Health Flow Improvement – Ensuring we give equal focus to maintaining flow in mental health step-up and step-down services to ensure people can access these services when they need them and reducing the risk of out of area placement.

What it means to the three shifts:

- From hospital to community - A focus on delivering out of hospital urgent and intermediate care services that support people to remain in their own homes, keep them connected to their communities and avoid the need for hospital attendance unless clinically necessary
- From analogue to digital- Greater use of online tools, video consultations and technology-enabled care to support people to remain safe and supported at home or to return home sooner from hospital, giving their greater confidence and independence
- From sickness to prevention- Consistent focus on self-care and supported self-management alongside targeted interventions for those at highest risk of hospitalisation, such as high intensity users, using population health analytics to shape proactive and personalised responses at neighbourhood level.

Oversight

This programme is overseen by the Urgent and Emergency Care Delivery Group, with the Chief Executive of NHS Dorset as Senior Responsible Office with led by Deputy Director for UEC and Flow. The group is multi-agency and meets monthly, focusing in two key areas:

- Ensuring delivery of key performance standards and assurance of improvement plans to address areas of risk and concern;
- Setting the direction and longer-term strategy for an improved unplanned care pathway, ensuring it meets the current and future needs of Dorset residents.

It is supported by a multi-agency Weekly Improvement Group (WIG) which is responsible for tracking progress and addressing risk at place-level as part of targeted improvement plans.

Our commissioning intentions set out the areas we have identified as priorities for further focussed action to improve outcomes for people accessing urgent and emergency and intermediate care in over the next five years, these can be seen in Appendix 1.

We recognise the importance of providing easy to understand and accessible communications to help people access the care they need when they need it.

Ambulance Services

The SWASFT contract covers the existing seven Integrated Care Boards (ICBs) across the South West region.

In Dorset, SWASFT provides the 999 emergency ambulance service. This includes responding to all call categories (1 to 5). The service also carries out urgent interfacility transfers between hospitals when patients need to reach a specialist service.

As part of the wider aim to support more care in the community, SWASFT has focused on increasing "hear and treat" activity. This means giving clinical advice over the phone so that people can stay safely at home where possible. SWASFT is also working with local partners to create more alternative care pathways so patients do not always need to be taken to hospital. However, these pathways are sometimes limited by the lack of referral options, especially during evenings, nights and weekends.

Progress to date

We have already made significant progress in key areas:

- Introduction of THP 45 mins has seen an improvement in hours lost to handover delays across Dorsets three acute sites the aim is to continue to reduce the time lost to handover delays during 26/27;
- Introduction of paramedic direct referral into Hospital@Home services – live across six hubs;
- Introduction of an Enhanced SPoA continues to support admission avoidance and further work is planned with system partners to develop this service with the addition of a senior clinical lead.

Key Workstreams -

- Increase paramedic direct referral pathways into SDEC services across acute trusts;
- Using information from the 'Right Care' report to inform alternative to admission deep dives and improvement programmes;
- Working with system partners to develop a 'care home call before convey' process;
- Expand on the work commenced with Dorset Integrated Urgent Care Service regarding 'holding handovers';
- Work in partnership with acute trusts to reduce hours lost to handover delays to below 45 mins.

What it means to the three shifts:

- From hospital to community – focused on supporting people to stay safely at home wherever possible. Work with system partners aims to ensure patients who do not need urgent admission receive appropriate support at home, or are taken directly to Same Day Emergency Care when hospital attendance is required.
- From analogue to digital- increased use of online tools and video consultations and technology-enabled care support patients remote clinicians assessing if it is appropriate to care for people in their own homes.
- From sickness to prevention- reducing hours lost to handover delays, ensures ambulances can respond to Cat 2 calls in a timely way, which can often prevent deterioration and lead to a shorter hospital admission. Ensuring only patients who need conveyance are taken to hospital reduces inappropriate admissions which can lead to a longer length of stay and deconditioning or harm.

Oversight

This programme is overseen by both the regional Operational Executive Committee (OEC) and Urgent and Emergency Care Delivery group. Both groups are chaired by the Chief Operating Officer NHS Dorset as Senior Responsible Officer.

In addition, as part of the 999 Lead Commissioner oversight and governance framework monthly System Touchpoint and Contract Touchpoint Groups are held which are attended by SWASFT and ICBs.

The commissioning intentions developed for the regions are set out the areas we have identified as priorities for further focussed action to improve outcomes for people over the next five years, these can be seen in Appendix 2.

7. Strategic Commissioning Development

Becoming a strategic commissioning organisation means that we will need to enhance our capabilities and skills in new and different areas. To help with this, we will be supported by a nationally led programme of strategic commissioning capability development which we expect to commence from April 2026.

The NHSE Strategic Commissioning Framework, sets out the skills and capabilities which will be important for our future success:

- System leadership and managing complexity;
- Population health management, population segmentation and population health management;
- Data, analytics and technology;
- Citizen involvement/engagement and coproduction capabilities;
- Commissioning, finance and contracting;
- Effective and broad multidisciplinary clinical and professional leadership;
- Strategy and systems thinking;
- Transformation and change management.

8. Financial Plan

NHS organisations must live within the funding they are given each year. We have set out that the funds we have available are not enough to maintain our current way of working. This in part reflects legacy contracts, models of care focussed on hospitals, underdeveloped coordination of services in the community.

We are committed to meeting our legal financial duties with an aim to break-even position, to ensure a sustainable financial footing for the future, while continuing to meet the needs of our population. Our plans are based on the national requirements which are:

- Deliver in-year financial balance, demonstrating monthly compliance with agreed control totals and proactive management of emerging financial risks;
- Improvement in run rates to deliver within budgets;
- Deliver Recurrent Cost Improvement Plans (CIPs);
- 2% year on year productivity gains for 3 years;
- Deliver corporate cost reductions per head of population;
- Effective utilisation of cash and capital both strategic and operational;
- Implement new payment mechanisms for UEC;
- Implement new best practice tariffs, incentivising left shift;
- Deliver improvement in productivity through in line with opportunities identified though Model Hospital and GIRFT, evidencing year-on-year gains.

The ICB is submitting a balanced financial plan for each of the three years 2026/27, 2027/28 and 2028/29. An overview of the spend for the three-year balanced financial plan for 2026/27 to 2028/29 is shown in the table below:

	2026/27	2027/28	2028/29
NHS Dorset ICB	£2,134m	£2,203m	£2,267m

The medium-term planning guidance and the multi-year settlement provides the foundation on which we can move away from annual to medium-term financial and delivery planning cycles. This approach enables:

- Better alignment of incentives to enable more robust delivery;
- Move to fairer distribution of funding across the NHS;
- Longer-term planning;
- New approach to capital.

This new approach will be underpinned by far greater transparency of increasingly granular financial data – with NHS England committing to publish trust-level productivity statistics on a routine basis to provide transparency on performance.

This new approach supports our aim to increase investment in prevention and early care. Over the next five years, we plan to invest significant funding into out of hospital care and prevention, with over £11m already committed against specific programmes across the life of the three-year plan and further plans being worked up utilising current budgets in alternative way and additional pump priming investment funds set aside. To do this, we need to move to a new financial framework which will:

- Create incentives that encourage transformation and integration;
- Use contracts and payments based on outcomes and value;
- Introduce lead provider models (where suitable) to promote collaboration, including supporting voluntary and community groups;
- Allocate funding based on population health data and report on the impact of spending;
- Develop risk and gain-sharing arrangements to encourage innovation and collaboration.

We want our Neighbourhood teams, Integrated Health Organisation and providers at large to be incentivised to address health inequalities. We will work with providers to develop approaches to demonstrate how they are contributing to relevant outcomes metrics delivering national best practice, acting on patient reported outcomes and reducing inequalities.

In support of this we expect to see different payment models in place that allow Integrated Health Organisation to commission services on behalf of the strategic commissioner (e.g. VCFSE sector or GP Enhanced Services).

The ICB is committed to managing the local health and care market so services are sustainable, high-quality, and meet people's needs. We will work with providers to support resilience, innovation, and collaboration, and identify gaps or areas for improvement.

In 2026/27, we will improve our understanding of provider capacity, workforce challenges, and investment needs. Providers will help shape future service models. Where needed, we will use commissioning tools to secure high-quality, cost-effective services that give fair access and better outcomes

In addition, we will continue to work closely with colleagues where we have delegated services such as specialist commissioning and pharmacy, optometry and dental services to ensure the needs of the people are Dorset are met. As well as working with colleagues to prepare for the delegation of commissioning for vaccinations and screening from April 2027 ensuring we support the development and implementation of the regional commissioning intentions.

9. Workforce

As strategic commissioners, we play a critical role in shaping the workforce agenda across the health and care system. Our responsibility extends beyond service commissioning to ensuring that workforce planning is embedded within every transformation programme and commissioning intention. As a system, we have a strong grasp of workforce supply risks at a professional and organisational level, however, we need to develop our strategic, system-wide insight into longer term workforce planning which responds to workforce supply and demand and aligns with emerging care pathways and population health management.

Our Commissioning Plan describes the transformation programmes and commissioning intentions that supports the delivery of the 10-year health plan's three main shifts. In addition, health and care organisations in Dorset have a role in broadening social economic development by working together to ensure we employ people from our local communities. Central to successful delivery of our transformation plans and enhancing social value is a new workforce model that moves beyond the traditional "how many staff do we need?", to a "what skills do we need and where?" approach. In Dorset, we have embarked on a programme of work to design and develop an overarching strategic workforce framework for the ICS. The framework will set out the principles and assumptions that underpin strategic workforce planning and align to health and care priorities across all partners.

The programme of work consists of three phases - discovery, design and delivery. The completed discovery phase and subsequent stakeholder engagement identified an appetite across all partners for a unified approach to workforce planning and a gap in our understanding of the skills and capabilities needed to meet the future needs of our population. During the upcoming design phase, we will establish connections with key partners and professionals across priority transformation programmes, specifically the Integrated Neighbourhood Teams programme, and bring scenario-based workforce planning into evolving pathway redesign and transformation discussions.

We will continue to act as convenors, bringing together system partners to better understand what collective skills, roles and capabilities are needed to deliver emerging models of care. We will bring together providers, education partners, and voluntary organisations to design workforce strategies that tackle health inequalities, support prevention, and contribute to social and economic growth. This partnership approach will help us build a more stable, confident workforce able to deliver the continuity, understanding, and relationship-based care that our communities value. We will ensure workforce planning is responsive to our local Widening Participation Plan and Get Dorset and BCP Working Plan. We will use population health management and actionable insight to forecast demand and inform workforce priorities. This includes:

- Supporting place and neighbourhood teams to co-ordinate care and case finding across multidisciplinary teams;
- Using data-driven approaches to optimise workforce deployment and ensure equitable access to care;
- Embedding workforce expectations in contracts, including optimal deployment and skill mix;
- Driving innovation in care models and new ways of working to maximise value across the system;
- Linking workforce planning to financial and quality objectives for integrated care delivery.

By embedding workforce planning into long-term health strategies, aligning resources to population needs, and promoting collaboration, we will shape a workforce that meets the needs of the future.

10. Quality

As we progress, we recognise that delivering a quality led health and care system is a continuous process requiring sustained improvement and strong partnership working. We remain committed to collaborating with all stakeholders to ensure consistently safe, high-quality care, and to address unwarranted variation in access, experience and outcomes.

The Dorset ICS Quality Framework (2025–2027) sets out how we apply a strengths based approach to systemwide quality improvement. This reflects a shift from traditional assurance models to a collaborative system model, where responsibility and accountability for quality is shared equally across partners.

Our approach recognises that quality is shaped by the interrelationship of four dimensions:

- **Practice** – what we do;
- **Structure** – what we are required to do;
- **Values** – the spirit in which we do it;
- **Outcomes** – the difference it makes.

Success in Dorset will depend on achieving a balanced focus across these dimensions, supported by a shared vision, transparency, and a willingness to challenge, scrutinise and learn together. This includes proactively sharing best practice and learning from incidents to improve outcomes.

In Dorset, we hold a statutory responsibility to secure continuous improvement in the quality of services commissioned and delivered across our system. Our approach is aligned with the National Quality Board (NQB) expectations and the National Quality Strategy, (both of which will be updated in 2026). This is supported by Dorset's Patient Safety Strategy and the new national Primary Care Patient Safety Strategy, incorporating the Learning from Patient Safety Events (LFPSE) framework, the Patient Safety Incident Response Framework (PSIRF), and the ambitions outlined in the NHS 10-Year Health Plan for England.

The NQB defines high quality care as safe, effective and person-centred care that minimises harm and applies evidence based practice to improve health and tackle inequalities, and ultimately delivers compassionate, inclusive and personalised experiences aligned to what matters most to people.

Within Dorset, we will ensure:

- **Robust patient safety reporting:** All providers will report patient safety incidents via LFPSE in a timely and accurate manner, maintain regular review of PSIRPs, and undertake thematic reviews to identify trends and drive continuous learning and improvement.
- **Clear oversight of quality metrics:** Services must remain within acceptable quality thresholds. Where improvement is required, we will work with providers to agree comprehensive improvement plans with clear trajectories for compliance.
- **Compliance with national quality requirements:** Providers will meet NHS England thresholds for key areas, including infection prevention and control and VTE, in line with NHS contract quality standards.
- **A systemwide focus on continuous quality improvement:** Providers will demonstrate their commitment to delivering safe, effective and person-centred care through structured and sustained quality improvement activity.
- **Meaningful patient involvement:** One of the key steps to success for Quality Framework is the broad engagement in relation to staff, service recipients and community members. Patient Safety Partners and direct patient involvement will be embedded within Dorset's learning and improvement processes, ensuring the patient voice informs safety, design and decision making across the system.

- **Meaningful Stakeholder involvement:** To compliment the delivery of Dorsets shared quality framework, we will ensure an inclusive, fair approach to system improvements that systematically engages all major stakeholders, including those who would not naturally have an influential voice (including those in marginalised and ethnically diverse communities). Key steps to success for this quality approach is the broad engagement in relation to staff, service recipients and community members.
- **Strong system governance:** The System Quality Group (SQG) will act as the strategic forum for partners across health, social care, public health and the wider ICS. SQG will identify quality concerns, risks and opportunities, coordinate system responses, and provide assurance that actions have delivered demonstrable improvements and reduced inequalities.
- **Improvement metrics**: The ICS Quality Dashboard will allow for close monitoring by all partners across all the required standards and most importantly, a shared understanding of the issues when improvements and a system wide approach to making these improvements is required.
- **A collaborative approach to quality and risk:** Within the NQB guidance (2024), alignment of system risks when managing delivering and commissioning health and care, needs to ensure quality and experience is incorporated. Recognition of the close alliance has been established via the ICS System Quality Group.
- **Quantifying and Prioritising Quality Risks:** Through the SQG and ICS Quality and Commissioning Committee, the system will apply a consistent and transparent approach to identifying, quantifying and prioritising quality risks. Risks will be assessed using the NHS 5×5 risk-scoring matrix, evaluating likelihood and impact across patient safety, clinical effectiveness and patient experience, and taking into account existing controls and the systems risk appetite.
- **Robust impact assessment:** Dorset's System Quality, Equity and Equality Impact Assessment (SQEEIA) process will provide assurance that any proposed service changes are evaluated for quality and equality impact, with appropriate mitigations identified and overseen.
- **Quality risk management**: Dorset ICS risk oversight is based on three main levels of assurance within the SQG arena, as defined by NHSE: routine quality assurance and improvement, enhanced quality assurance and improvement and intensive assurance and improvement.

Our success in Dorset is underpinned by these governance structures as set out in our Quality Framework, which provide robust assurance and oversight across an evolving provider landscape as the ICS matures. Targeted understanding of services and providers placed under enhanced surveillance through the System Quality Group enables a coordinated, system-wide approach to improving quality.

Looking ahead, the Dorset System has identified three system-wide priority areas—each requiring sustained, coordinated oversight over the next 1, 3 and 5 years and some of which are currently subject to enhanced surveillance under SQG:

- **Urgent and Emergency Care (UEC) pathway** – with a focus on reducing unwarranted variation in the application of *No Criteria to Reside* and ensuring pathway flow, safety and performance over the short, medium and longer term.
- **AACC service delivery** – where significant unwarranted variation has been identified, requiring standardisation and strengthened assurance to deliver consistent quality across providers over the 1-, 3- and 5-year planning periods.
- **Independent sector provision** – enhancing oversight of a growing and increasingly diverse provider market, and supporting providers experiencing quality challenges to secure safe, reliable and sustainable services across all planning horizons.

11. Digital and Data Strategy

The Dorset Digital Strategy sets out how we will transform health and care through making better use of technology by 2030. Our vision is to create a fully connected, digitally enabled system that improves outcomes, reduces inequalities, and empowers both people and staff. This strategy supports the NHS Long Term Plan and focuses on four key objectives: integrated digital care, empowered people, a digitally skilled workforce, and modern infrastructure underpinned by robust data and analytics.

People have told us that digital transformation must be matched with clear, transparent communication about how their data is used, and that information should be easy to understand and in accessible formats. We also heard that there is a need for support and follow up when digital tools or online routes do not work, so that nobody is left feeling stuck or unheard.

To enable care across all settings, we will move from fragmented systems to a single, interoperable digital ecosystem. This includes rolling out a unified Electronic Health Record across acute, community, and mental health services, eliminating paper-based processes, and ensuring clinicians have secure access to patient information wherever they work. Integrated Neighbourhood Teams will be fully supported by shared digital tools and data, enabling proactive, preventative care closer to home.

Our workforce is central to this transformation. We will embed digital leadership at every level and launch a Dorset-wide digital skills framework to ensure all staff feel confident using technology. Professionalising the digital workforce and creating accredited career pathways will help us attract and retain talent. Alongside this, we will provide flexible, accessible training for all health and care staff, tackling digital exclusion and fostering a culture of innovation.

This will include training staff on how to communicate digital information clearly and how to support people when they encounter barriers using online services.

The people who live in Dorset will benefit from a simple, trusted digital front door to health and care services. We will expand the functionality of the NHS App to allow people to book appointments, manage prescriptions, and access their health records easily. A Digital Champion programme will support those with low confidence or connectivity, ensuring no one is left behind. By 2028, we aim for 80% of the population to use digital services as part of their care.

Modern infrastructure is the backbone of this strategy. We will standardise procurement, adopt cloud-based solutions, and improve connectivity across all care settings. Cybersecurity and disaster recovery plans will be strengthened to protect patient data and maintain service continuity. At the same time, we will implement green IT practices to reduce our environmental impact. Reliable, intuitive systems will improve staff experience and enable seamless care delivery.

Alongside this, we will share clear, accessible information about how data is stored, used, and protected, helping to build public trust and understanding.

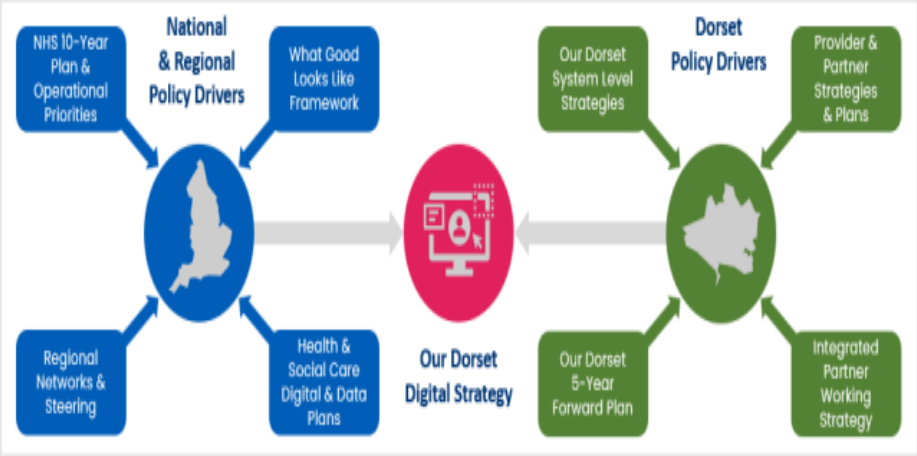
Data and analytics will drive better decision-making and proactive care. We will enhance data sharing and governance, develop a robust architecture, and expand the Dorset Intelligence & Insight Service to provide real-time insights and predictive modelling. Aligning with the national Federated Data Platform will allow benchmarking and research, while advanced analytics and AI will support population health management and early intervention.

We will support this with communication that is open, consistent, and accessible to all residents so people understand how data shapes their care.

Progress will be measured through clear KPIs, including 99.9% uptime for core digital services, 80% clinician adoption of digital tools by 2028, and 75% of people will have access to services via the NHS App by 2030. Our approach is built on shared governance, co-design with staff and

people, and alignment with national frameworks such as *What Good Looks Like*. By embedding digital into every aspect of care, we will create a system that is sustainable, inclusive, and ready for the future.

The Dorset Digital Strategy strategic alignment



12. Estates and Facilities

To realise the three shifts we want people to be able to access the support they need as easily and close to home as possible. Some of our buildings are modern, well-designed, and efficient to run – but others are not. Some older buildings cost a lot to maintain, need upgrades so staff can deliver care properly, or are no longer in the right location.

Health and care services are provided from more than 200 NHS sites – and from over 300 community pharmacy, dental & optometry sites. There are 116 GP surgery sites. Acute services are provided from 3 hospitals (Bournemouth. Poole and Dorchester). Community and mental health services provided from 85 sites. Some of the challenges we have are:

- Backlog maintenance £106m – critical infrastructure risk £60m;
- 85% of GP sites have asset rating below B and 4 sites have D rating;
- Meet future demand – 25% of population aged 65+ and 54k new homes planned by 2038/39;
- 88% of PCNs have insufficient space to recruit ARRS roles and/or additional GPs and nurses.

We've made a lot of progress bringing our buildings up to date. In line with the Clinical Services Review, we secured over £722m to reconfigure acute and mental health hospital services. Helping create specialist centres with distinct roles, saving more lives. Investment in our primary care and community estate has provided some much-needed clinical space and allows our teams to deliver more joined-up care, together.

Most of our capital is used to maintain our current estate. This doesn't leave much for new investment and transformational change. We have identified 40 major priority projects that need an investment of around £686m, and as the projects are developed, we expect this amount to rise.

Progress to date

We have already made significant progress which can be seen below:

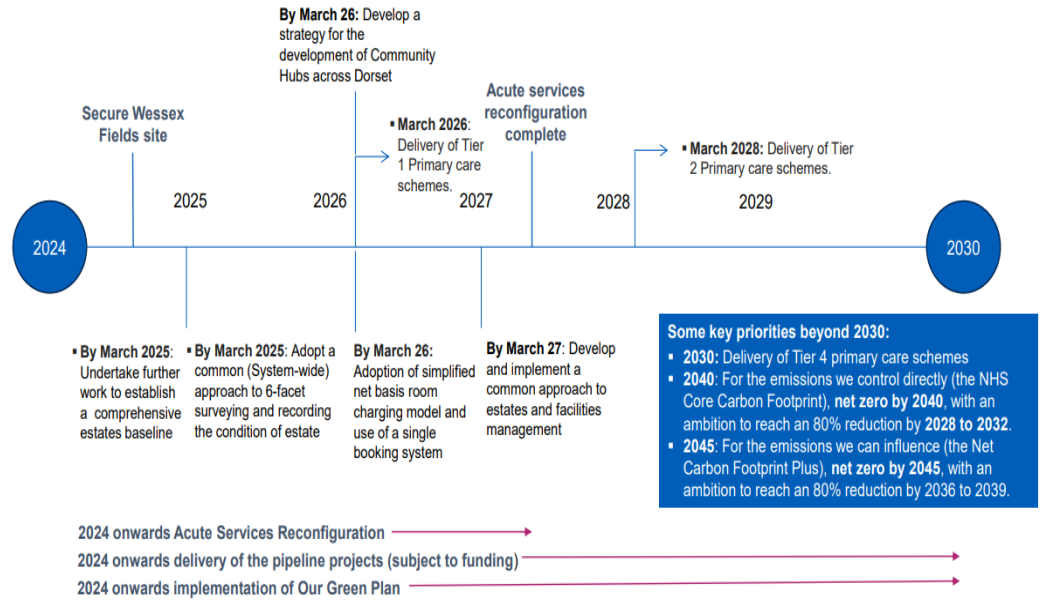
- £722m investment secured through a combination of funding sources including STP and New Hospital Programme in 2024/25 and 2025/26 to significantly enhance our community and secondary care estate;
- Rapid creation of appropriate and flexible space to manage the COVID-19 pandemic and vaccination programme;
- Development of Health Villages and Outpatient Assessment Centres at Beales, Dolphin Shopping Centre, Poole; South Walks House, Dorchester; CDC Scanner at AECC University College, Boscombe; and Lindon Unit, Weymouth;
- Delivery of two ETTF schemes and numerous general practice estate minor improvements. Completion of primary care estates strategies and identification of investment requirements for all GP surgeries through the implementation of the PCN Services and Estate Toolkit programme;
- Improved estates and FM workforce co-ordination, shared training and apprenticeships;
- Green plans produced, including decarbonisation progress and reduced energy costs (PV solar & LED);
- Robust management information so that backlog maintenance requirements are identified, and investment prioritised;
- Progressed with the development of Wellbeing Hubs with voluntary and community sector (VCS) providing housing, finance, benefits and other advice.

Workstreams

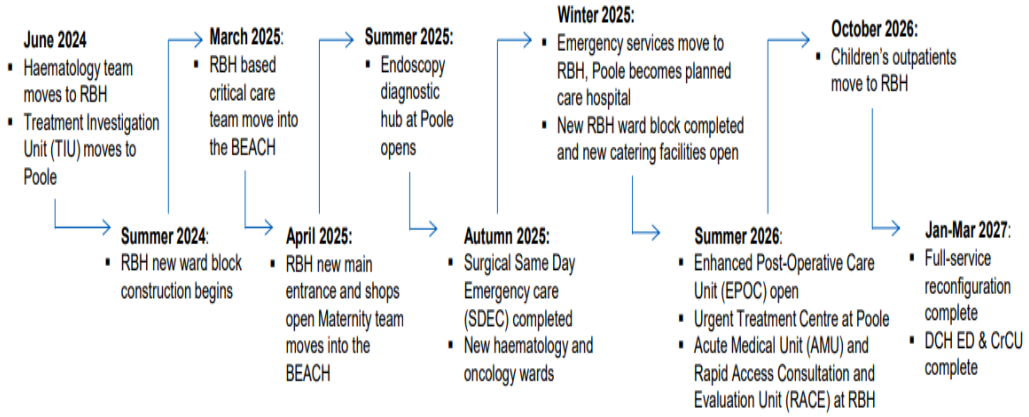
We have eight areas of focus as follows:

1. Acute Hospital Services: Deliver the planned reconfiguration of acute hospital services by 2027/28 and ensure critical infrastructure is funded;
2. Primary Care Services: Expand capacity in high-growth areas and progress estate priorities, especially in deprived communities, using ICB funds when available
3. Community Services: Develop a strategy for Community Hubs to bring care closer to home and explore co-location of primary and community services, subject to funding;
4. Funding Sources: Address the capital funding gap through system-wide prioritisation and innovative funding models, including a cross-charging policy;
5. Estates Data: Improve data on estate condition and usage through a common approach to surveying and recording;
6. Estate Utilisation: Assess simplified room charging and implement a single booking system to make under-used space available across organisations;
7. Sustainability: Deliver Green Plan actions to meet NHS Net Zero goals and share best practice to reduce carbon footprint;
8. Collaborative Working: Update the Infrastructure Strategy with system partners and councils, adopt common estates management practices, and align workforce training to 14 estates principles.

Our high level timelines can be seen overleaf.



Timeline for Acute Services Reconfiguration:



Oversight

This programme is over seen by the Local Infrastructure Group.

13. Communications and Engagement

We have a clear vision in Dorset – working together to achieve the best possible improvements in the health and wellbeing of our communities. This vision can only be achieved by collectively listening to and working alongside people and communities.

We work with our local partners and communities to help keep the public informed and to support people looking for information about local services and support. We use local data on how services are used to help inform our campaigns and messages. We have also been working to understand how people behave and make decisions, helping us reach the right people with the right messaging.

We've brought together the best local health and care advice from Dorset's NHS, councils, health and voluntary organisations at Stay Well Dorset – Stay informed, stay protected, stay well

To make positive, lasting change to health and care services in Dorset, we need to listen to the people that use them. Not just listen – really hear what they have to tell us, engage with their experiences, understanding their beliefs, cultures, behaviours and aspirations, and use what we learn to influence how services are run and developed.

Our 'Listening better in Dorset' webpage can be viewed here: www.ourdorset.org.uk/listening/

To complement this, we will shortly be launching an Insight Bank – so everyone can consider people's views and experiences captured from across the NHS, local councils and the community and voluntary sector – at the start all areas of work.

In addition, we are working with partners on a new programme of work called "Every insight counts" – helping us to use other sources of existing insight better and quicker. This will help us to better understand, and respond to, the changing needs and experiences of all communities.

The Voluntary and Community Sector (VCS) in Dorset is extensive, diverse, experienced, productive and supportive. Collectively the sector has a hugely rich knowledge and expertise, plays a crucial role in supporting health and wellbeing across the county, and is helping to improve health outcomes.

Dorset's VCS Assembly (VCSA) provide an independent and trusted portal into the voice of local communities. They ensure the voice of the voluntary sector is embedded in shaping local health and care priorities. Working with them we will continue to gain a greater understanding of geographical and demographic inequalities (including those experienced by marginalised groups and ethnically diverse communities) and the things that matter most to them. Through continued support of our VCS infrastructure partners, we will access sustained and meaningful engagement with people and expertise to inform our decision-making and targeted interventions.

Our approach and work with our VCS infrastructure partners at neighbourhood level will also continue the ongoing development of a vibrant and self-sustaining grass roots sector that embodies the aspiration of the 10-year health plan to empower community driven solutions and an asset-based approach within our neighbourhoods.

Core Neighbourhood programmes and commissioning intentions will build upon engagement as the foundation for change building in collaboration, consultation and engagement as core approaches to achieving the left shift. For all new areas of work, we will continue to routinely carry out Equality Impact Assessments to ensure our engagement is appropriate and accessible for all and this is also built into ongoing monitoring and review.

We will continue to work in accordance with our strategic approach for working alongside people and communities and evolving national statutory guidance.

14. Monitoring Delivery

In 2026/27, we will create an Outcomes Framework that everyone agrees on. This will follow the NHS England approach and align with our Cluster partners. The framework will include a clear set of measures and a way to track progress over the next five years. It will help us understand how well we are improving Healthy Life Expectancy (HLE) in Dorset.

We will start to include this outcomes framework in our contracts. As part of this shift, we will work closely with providers to show how their work supports the outcomes, delivers national best practice, responds to patient-reported outcomes, and helps reduce health inequalities.

We will use our integrated data to better understand the health needs of people in Dorset and to identify where there are unfair differences in health or access to care. This will support actions to reduce these inequalities.

We will support a “left shift” by using new and flexible commissioning approaches. To do this, we will develop more tools that help align funding with value, allow a broader range of providers and partnerships to succeed, and give people more say and control over their care. Where it makes sense, we will also make savings by working at greater scale.

We will set out the improvements needed across the system to ensure people get timely access to care, in line with national Medium-Term Planning Guidance. Providers will be expected to meet key performance standards within our outcomes framework, with incentives linked to achieving these. We will have strong assurance processes in place to maintain the quality of services.

We will strengthen joint commissioning and shared accountability between the ICB and Local Authorities. This will be supported through the Better Care Fund and other pooled budget arrangements.

We will also encourage a deeper understanding of health inequalities and take action where some groups face barriers to accessing care. We will explore new payment approaches linked to differences in access and use these to support improvements.

15. Key Risks and Mitigations

NHS Dorset manages risk in line with our NHS Dorset ICB Risk Framework. The risk assessment below identifies the key strategic risks to delivery of the Five Year Strategic Commissioning Plan and achieving the Dorset Health and Care Systems strategic purposes. These risks will be documented within the Board Assurance Framework (BAF) and will be directly monitored by the ICB Board.

Each individual programme of work will assess the impact and deliverability, undertaking a risk assessment and System Quality Equity and Equality Impact Assessment as part of the Gateway Assurance Process for approval to proceed.

This NPSA risk matrix is used to assess the level of risk identified, considering both likelihood and Severity should the event occur.

Risk Matrix	Likelihood				
Severity	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Serious	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risks are then scored:

Very low risk 0-3	Low risk 4-6	Moderate risk 8-12	High risk 15-25

Risk Description	Severity	Likelihood	Alignment to BAF risk ID	Key controls
Digital Maturity: Insufficient Digital maturity leading to failure to deliver digital shift and release planned efficiencies.			BAF Risk ID 01	Plan outcomes aligned with system digital strategy and workforce plans.
Ability to Transform: Risk Dorset lacks the capacity and capability to deliver scale of change required leading to failure to deliver intended outcomes for population.			BAF Risk ID 02	System governance and assurance of overarching plan delivery
Ability to Transform: Failure to maintain quality and safety in service deliver due to scale and breadth of system change leading to poor service delivery and reputational damage			BAF Risk ID 02	
Workforce and Culture: Inability to maintain sustainable workforce model leading to insufficient capacity and capability to be able to delivery and sustain services and deliver the transformation.			BAF Risk ID 03	ICS People Plan co design by the system Workforce expansion plans under development and implementation converging MHIS, CDC,

				ARRS, NHSE 111 First, discharge and primary care Provider workforce risk assessments for primary services and outputs
Health Inequalities: Failure to align financial resources and models of care to deliver left shift and sustain to improve population healthy life expectancy.			BAF Risk ID 04	Robust financial management processes and plans System health Inequalities framework Equality delivery system annual review System Quality, Equity, Equality Impact Assessment (EEQIA) Process
Productivity, Financial Performance and Value: Failure to maintain NHS financial sustainability, including the ability to deliver Financial Improvement Plans leading to financially destabilising organisations and the system.			BAF Risk ID 05	Robust financial management process in place to monitor delivery through Medium Term Planning Steering Group Development of provider CIP plans to undergo peer scrutiny.
Productivity, Financial Performance and Value: Five Year Commissioning Plans investment and investment shifts undermine financial sustainability of Dorset system partners.			BAF Risk ID 05	Supporting through partnership working System consultation on commissioning plans and Five Year Commissioning Plans
Productivity, Financial Performance and Value: Change in market conditions inhibiting ability to deliver financial performance and delivery of planned outcomes.			BAF Risk ID 05	Market engagement and testing
Strategic Partnerships: Lack of effective engagement across strategic partners to leading to lack of support for plans in balance cost, quality, service delivery, outcomes and patient preference and impacting ability to achieve outcomes.			BAF Risk ID 06	Engagement and involvement, testing levels of ambition of all partners at each stage.

16. Governance

The following section sets out the governance for this plan.

During 2025/26, the Dorset ICB's governance and decision-making arrangements will ensure appropriate decision-making and oversight and assurance with regards to the approval, implementation and delivery of the plan. The relevant forums in the Dorset ICB's governance arrangements are:

Dorset ICB Board – this joint committee with delegated authority from each of the three individual ICB Boards will have responsibility for approval of the plan

- Dorset ICB Finance and Planning Committee – oversight and assurance of the plan and its delivery, risk monitoring and assurance that risks are managed, and commissioning decisions where the value of the commissioned services contracts reach the relevant threshold per our Schemes of Reservation and Delegation (the ICB Board is the decision-maker for the most high-value commissioning decisions)
- Dorset ICB Senior Leadership Team – day-to-day monitoring, operational decision-making in line with the SoRDs, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes.

From 1 April 2026, BSW, Dorset and Somerset ICBs will closely collaborate as a cluster. The intention is to have in place cluster governance and decision-making arrangements. While these arrangements have not been finalized at this point in time, we anticipate the following as relevant forums for decision-making, oversight and assurance with regards to the delivery of the plan – to note that this is indicative only at this point in time and may be subject to change:

- Cluster Board – approval of any material changes to the plan, decision-making with regards to very high-value commissioning decisions, decision-making with regards to novel or contentious commissioning models
- Joint cluster committee for commissioning – oversight and assurance of the plan and its delivery, commissioning decisions, risk monitoring and assurance that risks are managed
- Joint cluster Executive Group – day-to-day monitoring, operational decision-making, operational management to ensure delivery of the plan to projected timelines, metrics and outcomes
- As we move forward Place 'boards' may play a role in the oversight and assurance of the plan and its delivery where intentions have particular local / place implications.

Oversight via Executive structures

The Cluster executive structure will have overall oversight of the commissioning intentions as set out in this plan. The Outcome Committee will hold the oversight of the Population Health Improvement as part of this plan and our priorities in relation to outcomes and inequalities.

Accountability

We will report regularly to the ICB board on progress against the priorities set out here.

Detailed Delivery Plans

Integrated Neighbourhood Commissioning Intentions

Delivery Scale: Place, Neighbourhood, ICB , Pan ICB

Intention	Outcome	Delivery Scale	Timeline				
			Year 1	Year 2	Year 3	Year 4	Year 5
Neighbourhood Development							
INT Programme monitoring Oversight - Activation, Maturity, service measures, system measures and finance measures	Reduced demand across unplanned care, elective care and prescribing, and stable community provision. There are 7 key metric including impact on ED, elective and non-elective admissions, outpatients, medicines, length of acute stay and diagnostic demand. This is translated to to direct activity and cost as the Macmillan social impact funding is linked to real time contract changes in years 2 and 3.	Neighbourhood and Place					
Developing the neighbourhood Provider market in Dorset to be able to commission with Neighbourhood Health Organisations and Engagement in the National Neighbourhood Health Implementation Programme: Dorset Place in wave 1 of programme and support to place based liaison	Developed NHOs. Being part of the NNHIP is expected to lead to direct changes in commissioned care as above.	Place, Neighbourhood					
Developing the workforce COM, systems and processes for embedding activation and prevention as a measurable component of personalised care	Increase in the effectiveness of activation and health related behaviour change interventions at scale	Place, Neighbourhood					

Neighbourhood Commissioning							
Diabetes - Outcomes based spec, alignment with CVD as part of prevention, education and early help, codesign of the new model - preparing for recommissioning. (This is part of preparation for commissioning of the Community Health contract)	Outcomes based model of community care	ICB, Place, Neighbourhood					
Wound management and secondary prevention & Dermatology, Minor Surgery (including Lower limb care) Whole pathway design, coding and financing - preparing for recommissioning. (This is part of preparation for commissioning of the Community Health contract)	Outcomes based model of community care	ICB, Place, Neighbourhood					
CVD - addressing the funding, data, specification and preparing for recommissioning. (This is part of preparation for commissioning of the Community Health contract)	Care closer to home and improved population health outcomes and reduced inequalities	ICB, Place, Neighbourhood					
End of Life - establish funding, implementing strategy and link to hospice contract renewal	Social investment funding to deliver EOL strategy. Improved outcomes and supports delivering care closer to home.	ICB, Place, Neighbourhood					
Co-designing of end-to-end pathways of care including a shift in the model of outpatients to deliver more services within the communities, including medical dermatology and minor skin surgery in line with EBI, Cardiology service, Gastroenterology service, Respiratory / breathlessness / asthma service, ENT / OMF service		ICB, Neighbourhood, Place					
Implement new technologies to support people to self-manage their conditions including Hybrid Closed Loop	Better patient led care	ICB, Neighbourhood, Place					

INT Commissioning - a full programme of work reviewing and resetting all primary care and POD contracts and funding streams to support neighbourhood health, the development of accountable organisations and outcomes-based commissioning.	A commissioned INT Programme. Clearly understood integration funding. Single financial envelope at neighbourhood. Processes fit for purpose and offering univeral standards.	Neighbourhood, Place					
INT Commissioning - recommissioning of the community health contract	A newly procured neighbourhood service that supports delivering neighbourhood health and improved population health and reduced inequalities	ICB, Place, Neighbourhood					
Oral Health Programme - oversight of the development programme - Workforce, Prevention, Access	A Community led sustainable model for future dental access	ICB, Place, Neighbourhood					
Development of specific contracting vehicles for Shared care, Phlebotomy and GP Plus, outbreak management, MGUS, Health and wellbeing coaches	Sustainable services embedded in left shift commitments						
Commissioning a Community Pharmacy Independent Prescribing Service	A newly procured neighbourhood service that expands access to condition management and reduces inequalities	ICB, Place, Neighbourhood					
Commissioning a Community Pharmacy Palliative care medication drug supply service to support availability of palliative care medications in Primary care	Contracts that support neighbourhood health	ICB, Place, Neighbourhood					
Neighbourhood Assurance							
Redesign of contracts, access and capacity outcomes through the lens of INTs, including contract oversight, assurance, renewal, payer functions,	Contracts that support neighbourhood health						

estates (including identification of ICHs) and liaison with region/national							
Pharmacy and Optometry - PIFU contract pathway, palliative drugs, overall oversight Payer functions - reframing of contractual obligations and approach, increasing capacity and delivering Pharmacy First	Contracts that support neighbourhood health	ICB, Place, Neighbourhood					
Prescribing/Pharmacy - Working with providers to codesign delegation arrangements that enable the effective use of resources to improve population health outcomes through prescribing bring closer to home	Contracts that support neighbourhood health	ICB, Place, Neighbourhood					
Prescribing/Pharmacy - Revising the prescribing quality scheme to outcomes-based assurance for access to services to reduce medicines harm in key populations at higher risk of unplanned admission	Contracts that support neighbourhood health	ICB, Place, Neighbourhood					
Prescribing/Pharmacy - Requiring providers to deliver electronic prescribing, increasing access to outpatient options visible in NHS App	Increased capacity and improved patient safety	ICB, Place					
Oral Health - Dental capacity and development, stabilisation, uplifts and contract extensions, vulnerable GP access	Increased dental capacity, community dental service spec agreed	ICB					
Lipid management - Commissioning secondary prevention services within INT/PCN providers for identification and lipid management, supporting the management of long term conditions. Embedded in primary care and incorporate digital, non digital and community outreach approaches into routine care	Contracts that support neighbourhood health	ICB					
Community cancer care - Identifying opportunities for pre and post cancer treatment care to be integrated with local neighbourhood services including prehabilitation, rehabilitation, enabling healthy choices and psychosocial support. As well as	Contracts that support neighbourhood health Reduction in inequalities in percentage of cancers	ICB					

community services for late effects of treatment to prevent future health crisis	diagnosed at stage 1 and 2						
MND - Undertaking a comprehensive review supported by the MND Association of all Motor Neurone Disease services as part of INT development		ICB					
Allergies - Review and recommission allergy services in line with National Allergy Strategy due for publication in October 2025		ICB					
Vaccinations - Increasing number of people accessing routine and seasonal vaccinations and relevant screening programmes, particularly in hard-to-reach/underserved communities	Reduction in inequalities in uptake of COVID and flu vaccines	ICB					
Focussed action on health inequalities	Reduction in inequalities in emergency admissions for stroke, Myocardial infarction Increase in the proportion of people who are treated to target for hypertension, cholesterol, atrial fibrillation	ICB					

Mental health, learning disabilities, autism and neurodiversity services Commissioning Intentions

Delivery Scale: Place, Neighbourhood, ICB , Pan ICB

Intention	Outcome	Delivery Scale	Timeline				
			Year 1	Year 2	Year 3	Year 4	Year 5
Full implementation of a system wide (0-25yr) Keyworker model in both Dorset and BCP	Faster, more joined-up support for young people with the most complex needs Fewer avoidable mental health inpatient admissions	Place					

	Shorter hospital stays and fewer readmissions Better experiences and reduced stress for families More seamless transitions up to age 25 Stronger multi-agency coordination across the system						
Review and enhance the current Dynamic Support Register, outlining all stakeholder responsibilities	Timely identification and review of children, young people, and adults at risk of mental health admission	Place					
Launch a Neurodiversity Exploration and Strengths Tool (NEST) proof-of-concept pilot	Ensure Children and Young People receive appropriate support sooner, even while waiting for formal neurodevelopmental assessment.	ICB					
Develop a need-based model of care with a single point of access for children, young people, and adults (neurodiversity)	Improve early identification, reduce escalation to crisis, streamline multi-agency planning, shorten waiting times, and enhance overall experience and outcomes for children, young people and adults who are neurodiverse	ICB					
Enhance the capacity of neurodiversity services for children and young people to monitor and manage ADHD locally, addressing the rise in private and Right to Choose assessments resulting in ADHD diagnoses	Additional short-term capacity to support Children and Young People with the longest waits, including those needing ADHD follow-up and medication.	ICB					

Co-production of a pathway to meet the needs of people with neurodiversity and waiting time expectations, utilising national tools/frameworks	Increased satisfaction reported from families and professionals. Reduced waiting times leading to earlier access to support	ICB					
Fully implement Access Wellbeing (community adult MH transformation program) including Focused and Specialist elements and Complex Trauma Pathway	More accessible, coordinated and needs-led adult mental health system that provides timely support, reduces crisis escalation, and improves recovery and wellbeing outcomes across the community.	ICB					
Deliver the Children and Young People's Mental Health Transformation programme by introducing a new model of care that is needs-led, based on the 'THRIVE model so that CYP and their families/carers can access the right emotional wellbeing and mental health support at the right time	Children, young people and their families can access the right emotional wellbeing and mental health support at the right time, improving early help, reducing escalation to specialist services, and enhancing overall mental health outcomes	ICB					
Co-develop and implement an inpatient commission plan/strategy which maximises the utilisation of adult MH inpatient beds including the new 10-bedded unit under construction, addressing current challenges around length of stay and out of area placements	Reducing length of stay, minimising out-of-area placements, and improving timely access to high-quality local inpatient care.	ICB					
Expand current talking therapies, continuing to review inequalities in access and outcomes and Individual Placement and Support service, ensuring full recruitment and training of workforce	Increase access, reduce inequalities in outcomes, and ensure more people receive timely, evidence-based psychological and	ICB					

	employment support that improves recovery and long-term wellbeing.						
Enable all patients to have timely access to assessment, treatment and support services relating to dementia through implementation of transformation programme	Improved access to dementia assessment services and support following diagnosis.	ICB					
Enhance and improve Access Mental Health Cluster of services, including Crisis Text Service	Ensure timely, responsive and easier-to-reach support during periods of distress, reducing escalation to crisis services and improving overall mental health outcomes and user experience.	ICB					
Ensure that there is an accessible and sustainable all age community eating disorders services	Timely access to specialist support, reduce the need for inpatient care, and deliver consistent, high-quality treatment that enhances recovery and long-term wellbeing for people of all ages.	ICB					
Expand the Severe Mental Illness (SMI) Physical Health Checks service to incorporate Do Not Attend liaison service and incorporate/subcontract the facilitated SMI pathway with LiveWell Dorset	Increase uptake of physical health checks, reduce missed appointments, and ensure people with SMI receive more proactive, coordinated support to improve their physical health and long-term wellbeing.	ICB					
Review and redesign of MH Community and Inpatient Rehabilitation pathway	More consistent, effective and recovery-focused model that improves flow,	ICB					

	reduces delays in discharge, and ensures people receive the right level of rehabilitative support closer to home, leading to better long-term independence and wellbeing						
Review of contractual arrangements for secure transport and potential procurement	Ensure a safe, high-quality and cost-effective service that meets demand, improves responsiveness, and supports timely and appropriate patient transfers across the system.	ICB					
Ensure compliance of Oliver MGowan training to ensure our workforce have the skills and understanding to support members of the local community when accessing health and care services	Provide workforce with the knowledge, skills and confidence to support people with learning disabilities and autistic people effectively, leading to safer, more equitable and more inclusive access to health and care services across the community	ICB					
Ensure that inequalities are identified and addressed- in particular Identifying variation in rates of restrictive interventions in inpatient services and in the use of the mental health act including use of community treatment orders (CTOs) Ensuring compliance with ethnicity recording, enabling staff to develop the skills and confidence to ask the question	Ensure accurate ethnicity recording—will enable fairer, safer and more equitable care, with a workforce confident in asking about ethnicity and responsive to the needs of all communities.	ICB					

Planned Care and Cancer Services Commissioning Intentions

Delivery Scale: Place, Neighbourhood, ICB , Pan ICB

Intention	Outcome	Delivery Scale	Timeline				
			Year 1	Year 2	Year 3	Year 4	Year 5
Pilot the use of technologies in community pharmacies in 2025/26 to inform recommissioning of the audiology pathway	Improved access to community based audiology services	ICB					
Redesign and re-commission end to end ophthalmology pathway including single point of access	Improved access to ophthalmology services ensuring right referral, right place right time	ICB					
Provide access to weight management services, aligning with expansion of clinical criteria for medicines in line with national guidance	Reduce inequalities of access to weight management support	ICB					
Commission a community-based service specification for management of headaches include new high-cost migraine drugs	Improve access to recurrent migraine services ensuring right referral, right place right time	ICB					
Implement a decision support AI in primary care	Reduce variation in how GPs and ANPs manage and refer patients for elective, non-cancer and cancer conditions to improve referral quality, reduce referral demand, and health inequalities	ICB					
Implement prior approval for Evidence Based Intervention Policies ensuring adherence to the policy	Reducing variation and improve equity for all patients in Dorset	ICB					
Commission GP direct access diagnostics including CT and MRI, and self referral pathways such as FIT, CXR, ultrasound for post menopausal bleeding and physiotherapy	Ensure right test first time improving equity and timeliness of access for all patients in Dorset	ICB					
Commission a Non Specific Symptom pathway for patients with symptoms or test results that do not	Faster diagnosis of cancer supporting improved	ICB					

meet NICE guidance for urgent suspected cancer referral, but for whom there is a suspicion of cancer	outcomes and better patient experience						
Develop digital family history risk assessment for people in Dorset to complete themselves initially for breast cancer family history with expansion to all cancers and other non-cancer conditions for pro-active risk assessment.	Earlier diagnosis of breast cancer and improved survival rates	ICB					
Personalised care for cancer to include commissioning for sustainable care closer to home for the whole population, in line with evidence presented by Portland pilot	Reduction in emergency presentations and healthcare use and improved cancer survival	ICB					
Embed Lynch syndrome testing in cancer pathway for the whole eligible population	Personalised treatment and improved survival rates	ICB					
Explore the opportunities for implementing consistent clinical pathways – potentially through central hub (s)	Reduce variation in access	ICB					
Commission a breast pain pathway to reduce inappropriate urgent suspected cancer referral demand	Improve patient experience and release suspected cancer capacity to improve faster diagnosis	Place					
Commission a women's health service outside of the acute trusts to provide assessment, diagnosis and advice to primary care on a range of conditions as per GIRFT guidance and best practice from other parts of the country; closing the gaps in care for women, including earlier diagnosis of cancer	Improve access to women's health care and increase primary and secondary prevention opportunities	Place					
As part of the transfer of screening commissioning to ICBs due in 2026/27 we will commission a lowering of the bowel screening threshold from 120ug/Hb/g/faeces to 80ug/Hb/g/faeces to improve early diagnosis of colorectal cancer	Early diagnosis of colorectal cancer and improved survival	ICB					
Enhancing AI utilisation to support personalised triage, navigation, and decision-making, reducing unnecessary clinical contact and improving efficiency, including:	Improved productivity releasing capacity to improve access	ICB					

• Commission an end to end dermatology pathway including efficiency outcomes achieved by artificial intelligence to triage patients to the right place first time; • Further utilisation of AI decision support in primary care to diagnose cancer earlier; • Utilise the Targeted Prevention Hub (TPH) for neighbourhood decision support, enabling prevention, referral prioritisation and case finding through AI algorithms							
Implement digital platform to enable remote monitoring to shift left from acute trusts to primary care starting with PSA surveillance	Increase care closer to home and improved patient experience and improved access in secondary care for people who need the services	ICB					
Focussed action on health inequalities	Reduction in any variation in waiting times, waiting list size and DNA/'was not brought' (including for core community services and people who are frail) are identified and addressed						
	Reduction in inequalities in pulmonary rehab completion rates Reduction in inequalities in access to diagnostic procedures for respiratory disease Reduction inequalities in under 75 premature						

	mortality rate from chronic lower respiratory disease						

Maternity, Women and Children and Young People Commissioning Intentions

Delivery Scale: Place, Neighbourhood, ICB , Pan ICB

Intention	Outcome	Delivery Scale	Timeline				
			Year 1	Year 2	Year 3	Year 4	Year 5
Strengthen community End of Life and palliative care pathways for babies, children and young people	Achieve timely, personalised, and co-ordinated palliative care for babies, children, and young people, including at end of life, with a strong emphasis on what matters most to them and their individual preferences.	ICB					
Supporting all children in identifying health needs earlier to self manage through delivery of the Dorset Birth to settled adulthood(B2SA) programme	Integrated approaches and working arrangements in place between DC and NHS services and partners. CYP health needs are identified and supported holistically	Place					
Consolidate the existing CYP Speech Language and Communication Needs contracts with Local Authority partners to ensure consistency, reduce duplication, and streamline service delivery across all education settings	Contracts will have a greater focus on universal and targeted provision in Early Years, mainstream education settings and across specialist education settings.	Place					
Focussed action on health inequalities	Reduction in inequalities in core indicators: gestational age at booking, completeness of ethnicity data in the Maternity, in women who have a post-partum haemorrhage, children and young people (CYP) emergency	ICB					

	department attendances, CYP asthma, including emergency department admissions and dispensing of reliever only inhalers, accessing specialist paediatric and multidisciplinary support for CYP in community settings, CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes, access to epilepsy specialist nurses in the first year of care for those with a learning disability or autism, elective admissions of hospital-based tooth extractions due to dental caries, access rates to CYP mental health services for 0–17-year-olds						

Urgent and Emergency Care and Intermediate Care Services Commissioning Intentions

Delivery Scale: Place, Neighbourhood, ICB , Pan ICB

Intention	Outcome	Delivery Scale	Timeline				
			Year 1	Year 2	Year 3	Year 4	Year 5
Consolidation of the P1 offer across healthcare providers and Local Authorities through the Better Care Fund (BCF)	More people supported at home Better recovery outcomes Reduced community beds Reduced NCTR	ICB					
In line with FutureCare (FC) Plans realign and recommissioning community (P2) beds, including new specification with wraparound support through the BCF	More people supported to return home Better recovery outcomes	ICB					

	Reduced NCTR						
Implement new commissioning arrangements for complex Discharge to Assess potential options linked to reconfiguration of P2 beds and/or new block arrangements and/or pooled budget for spot placements plus	More people supported to return home Better recovery outcomes Reduced NCTR	ICB					
Commission Transfer of Care hubs (Flow Teams) as part of revised joint intermediate care delivery model through the BCF	More people supported to return home Better recovery outcomes Reduced NCTR	ICB					
Procurement of Integrated Urgent Care Service to include GP out of hours	Improved access to urgent care Reduced ED attendances	Pan ICB					
Delivery of co-located UTCs on acute and community sites (new specification and aligned delivery model)	Improved access to urgent care Reduced ED attendances	ICB					
Review and reshape MIU services following consultation with partners and the public	Improved access to urgent care Reduced ED attendances	ICB					
Review and consider the options for the Purbeck Car scheme following consultation with partners and the public	Improved access to urgent care	Place					
Review the support to care home support service to inform future commissioning	Fewer hospital conveyances from care homes	ICB					
Integration of the three-frailty hospital at home models into one services model and specification with integrated budget, considering a lead provider model.	More people supported at home Fewer hospital conveyances	ICB					

Continue to prioritise action on health inequalities	Reduction in inequalities in mean time in emergency department Reduction in inequalities in the proportion of ambulance patients in cardiac arrest that receive a post-ROSC care bundle Reduction in inequalities in the proportion of ambulance patients with a ST-elevation myocardial infarction (STEMI) that receive the appropriate care bundle						

South West Ambulance Service Regional Commissioning Intentions

Patient Outcomes & Experience

- Category 2 response times: Improve upon 2025/26 standard to reach an average response time of 25 minutes (2026/27 target). Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes (*Medium Term Planning Framework*)

- Increase the percentage of eligible incidents managed through 'hear and treat / refer' options including into non-ED and community services where appropriate, either directly or through Single Points of Access (SPoA). This will be supported by:

    - Ensuring there are sufficient numbers of EOC clinicians, with the right skill mix and seniority, to achieve the level of clinical navigation and clinical validation required to meet demand;
    - Following clinical assessment, maximise referrals into alternative services / pathways, using the Trusted Assessor Model, supported by SPoA.
    - Maximise the delivery of Category 2 streaming to ensure maximum opportunity for clinical navigation and clinical validation to the most appropriate service / pathway before dispatch of an ambulance

- Increase the percentage of eligible incidents managed through 'see and treat / refer' options including into non-ED and community services where appropriate, either directly or through SPoA. This will be supported by:

    - Ensuring there is adequate remote senior clinical support to ambulance clinicians and Community First Responders (CFR) via the EOC or access to a SPoA.
    - Utilise 'call before convey' models to support clinical decision-making on scene.

- Recognising the need to increase levels of H&T/R and S&T/R, there is still the desire from Commissioners to work collectively with SWASFT to explore the hear and treat / refer model. As a priority we need to determine what other opportunities there are to further develop the clinical model and skill set within their CSD, with the aim of potentially progressing towards a Consult & Close approach. This begins to consider the 'Clinical Assessment Hub' model as set out within the "*AACE Response to the Fit for the Future 10 Year Health Plan September 2025*" and what that could look like across the South West.

- There is a clear need for a consistent and collaborative approach to ensure that the implementation of EOC58 / CSP levels reflects not only demand within the Trust but also wider system pressures across the ICS footprint. It is acknowledged that CSP levels are designed to increase in times of extremis and are implemented region-wide; however, this inevitably impacts the Trust's ability to optimise their AQI H&T outcome. The ability to implement appropriate EOC 58/CSP levels by ICS needs to be considered with the aim to have an agreed framework in place. This will support safe decision-making, improve regional resilience, and maximise opportunities to maintain responsiveness to AQI H&T incidents even under significant system pressure .

- Enhance and expand paramedic-led care in the community so more patients receive effective treatment at the scene or in their own homes, reducing avoidable hospital conveyance

- Work with system partners to strengthen consistent access to alternative provision including SDEC and UCR, supported by trusted assessor principles.

- Reduction in Recontact rates for all cases passed from the EOC to Care Co / SPOA / CAS - Continue to build on the analysis already undertaken during 2025/26. Establish common causes as to why recontacts occur and seek to agree viable improvement actions. Agree an acceptable recontact threshold / target for 2026/27

Integrated & Preventative care

- Engage with system partners as they look to develop community hubs and neighbourhood health teams to ensure there is full integration with the ambulance service, supporting care closer to home.

- To support the focus on embedding a public health approach within the ambulance sector to reduce health inequalities, AACE developed an interactive toolkit (Implementation Toolkit) containing a Maturity Matrix which enables ambulance services to undertake a self-assessment process measuring their organisational maturity against the following four key objectives:
    - Building Public Health Capacity and Capability
    - Data, Insight, Evidence and Evaluation
    - Strategic Leadership and Accountability
    - System Partnerships

- Given the drive and focus in the 10-year health plan to move from sickness to prevention we need SWASFT to move from an 'Emerging' baseline position (based on the above matrix) to one of 'Developing, then Maturing and then finally Thriving'. Ambulance data is rich in what it can capture, particularly those interactions in community settings and the identification of high intensity users, vulnerable individuals, and patterns of avoidable demand. In collaboration with ICBs we need to utilise this ambulance data more effectively to understand how the Trust can support partners in the South West to identify population health needs and implement preventative interventions. By doing this we can work towards funding mechanisms that reward preventative activities and population heath contributions whilst also reducing unwarranted variation across the South West.

- To support the above, SWASFT to provide an annual health inequalities report. This should utilise SWASFT data, disaggregated by age, sex, deprivation and ethnicity, to identify opportunities to implement culturally appropriate, proactive care models for high-risk populations which optimise patient care and system performance and reduce health inequalities.

Workforce & Culture

- Continue to build a resilient, skilled and supported ambulance workforce. This will be supported by:
    - Ensuring collaborative planning with ICBs to ensure workforce strategies align with system-wide goals and evolving patient needs
    - Improving retention rates through enhanced wellbeing and career support
    - Expanding access to clinical education, apprenticeships and leadership development
    - Reducing sickness absence and burnout through targeted well being / staying well initiatives
    - Increase Flu vaccination rates to pre-pandemic uptake level, increase of at least 5% (from UEC recovery plan)
- SWASFT will continue to promote national NHSE workforce surveys, including the *National Education and Training Survey (NETS),* to ensure that learners and trainees across their organisation are able to share their experiences. This feedback will enable SWASFT to identify opportunities for improvement and further develop a supportive, high-quality learning and training programme that delivers the best possible placement experience.
- Acknowledging the progress already made to strengthen workforce establishment levels across the organisation — for example, through the TUPE transfer of PAS employees — recruitment plans must now be further developed, with clear actions to address any remaining significant shortfalls and recruitment challenges. These plans will need to be regularly reported on and monitored to ensure progress is maintained.
- Continued implementation of the Ambulance Culture Review recommendations.
- Continue to embed the range of programmes and projects such as the 'Integrated County Leadership Model' and 'Quality and Culture Improvement Programme'
- Continue to implement key recommendations set out in the AACE '*Reducing Misogyny & Improving Sexual Safety in the Ambulance Service: Consensus Statement 2023*'

Digital

- Enhance the use of digital applications and use of AI to enable more seamless connectivity and improved user experience across platforms. To include:
    - Continued access and enhancement of the 'OL334' dashboard to support systems in real time decision making and awareness of demand
    - Use of AI tools such as 'Ambient Voice Technology' (AVT) – Building on the LAS trial, SWASFT to seek out further learning and look to set up a similar trial with possible implementation.
    - Use of 'single sign on' solutions for staff to reduce the need to log into every digital platform/system each time – SWASFT to progress opportunities already identified such as the digital solution to support access to Mental Health patient records across the region.
    - Continued engagement as part of the National Ambulance Data Set (ADS) implementation programme including identification of further opportunities which support the development of the Federated Data Platform (FDP).
- Commissioners to have greater awareness and understanding of the Trusts Digital Strategy / Roadmap – To include an understanding of future priorities; planned upgrades to digital infrastructure already in place and upcoming procurements such as CAD Implementation inc. roll out of Cleric portal and Mobimed/EPR.
- To ensure lessons from PaCCS are carried forward, SWASFT should work with Commissioners (via the Lead Commissioner) and relevant partners to support a smooth CAD implementation in 2026, potentially through a CAD Implementation Working Group
- Strengthen staff confidence and skills in using PaCCS within the EOC, so it is fully effective for clinical triage and referrals to alternative services. SWASFT should continue working with the Regional DOS Team, particularly to access training support that ensures the tool is used to its full potential.
- Delivery of 'Connected Records' as part of NHSEs Shared Care Records programme
- To review implementation of Prehospital Video Triage (PVT) within Somerset and across all systems where required, taking into account national guidance and learning from the pilot sites, and subject to consideration of the future funding requirements needed to support this.

Efficiency & Sustainability

- Continue to build on improvements seen in performance and productivity to ensure Medium Term Planning Framework aims are being met. This will be supported by:
    - Continuing to optimise fleet mix and ensure sufficient conveying resource to meet demand
    - Optimise productivity gains in areas such as crew unavailability, non conveyed on scene times and conveyed on scene times – to include improvements made in crew wrap up times
    - Providing clarity on productivity improvements achieved in 2025/26, outline how these will deliver the 2% annual productivity ambition and explain the expected financial and operational benefits
    - Continue to share and learn from best practice within the Southern Ambulance Services Collaboration and from high-performing ambulance trusts across the country, to support the Trust in achieving the highest levels of efficiency and to deliver the best possible care for patients
- SWASFT to work with system partners to maintain and improve the 'timely handover process,' ensuring ambulance handover improvements are sustained through 2026/27 and beyond, so that conveying resources remain available for community dispatch when needed.

Transformation

- On the back of the AACE response to the 10 Year Health Plan, we now ask for SWASFT to set out formally their response to the 10 Year Health Plan. This should include clarity on the Trusts future operating model and ensuring there is an opportunity for partners to collaboratively engage in the design of future strategies including the following: digital strategy, future/transformation strategy, people/workforce strategy.
- Building on the above point and what we know from previous regional workshops held on UEC/999Transformation, priority needs to focus on:
    - Regional 111 model and whether there is appetite across the South West to explore this.
    - Development of the 'Hear & Treat/Refer' model – building on the proposed single, multi disciplinary Clinical Assessment Hub model set out within the AACE publication.

Legislative Requirements

Legislative Requirement	How we deliver our requirements
1. Describing the health services for which the ICB proposes to make arrangements	Our Commissioning Plan explains the health services that have been put in place to help us meet the needs of the people living in Dorset and provides high level overview of population needs and how the system is performing and what actions we are taking this year. On the websites below, you can find out more information about the services we offer in Dorset: • Dorset Integrated Care Board • Dorset County Hospital NHS Foundation Trust • Dorset Healthcare University NHS Foundation Trust • South Western Ambulance Service NHS Foundation Trust • University Hospitals Dorset NHS Foundation Trust Our plan sets out how we will work to improve access to urgent care, neighbourhood and place services, which our plan focuses on, so that everyone gets the right help when they need it. Since April 2023, we have been responsible for commissioning pharmacy, optometry and dentistry services in Dorset. We are developing ways to improve access to these services and also the healthcare that people receive. As an NHS-funded organisation we must align with the principles for health emergency preparedness resilience and response outlined within the NHS EPRR Framework and meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Care Act 2022, the NHS standard contract, the NHS Core Standards for EPRR and NHS England business continuity management framework. The NHS is also responsible for responding to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease such as Covid or a major transport accident. This is referred to as emergency preparedness, resilience and response (EPRR). The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded services, to show that they can deal with such incidents while maintaining services. • The ICB is known as a Category 1 responder which means we must: • assess the risk of emergencies occurring and use this to inform contingency planning • put in place emergency plans and business continuity management arrangements • make information available to the public, including warning and informing in the event of an emergency • co-operate with and share information with other local responder.

	We coordinate the activities of all providers of NHS funded healthcare to plan for and respond to emergencies. The ICB represents the NHS at the Dorset Local Resilience Forum, which coordinates multi-agency partners to prepare for and respond to civil emergencies. The ICB has an Accountable Emergency Officer (AEO) for EPRR, who is responsible for discharging the ICBs responsibilities around EPRR and providing assurance to the board.
2. Duty to promote integration	We want to provide health services in an integrated way and that's why we made our Commissioning Plan. Our Constitution and Governance Handbook explains how we work together to make decisions. Working with local authorities, we have agreed on Better Care Fund plans. These plans are for intermediate care, short term care capacity and demand, offering support to unpaid carers, and providing help with housing adaptations. Integrated Neighbourhood Teams are a key priority for the ICB. These teams will bring primary care, secondary care, social care and voluntary and community services together to work seamlessly and respond proactively to the needs of their local communities.
3. Duty to have regard to wider effect of decisions	To deliver our goals set out in our Commissioning Plan, we will focus on and make sure that when we make decision we will consider the impact they have on health and wellbeing of people in Dorset, the quality of services and how efficiently and sustainably we use our resources. • **Health and wellbeing -** our commissioning plan out our commissioning intentions and linked outcomes for delivery which also support the Health and Wellbeing Strategies. • **Quality of services** - we have a Risk Strategy and a Quality Framework in place which describes how we monitor quality and identify any risks for health services and across the Dorset System. We do this by using data and intelligence to monitor quality of service, health inequalities. • **Efficiency and sustainability**- we have a Finance and Planning Committee and which helps us manage our money. Our plan sets out the financial challenges and sets out plans for how we will use our resources (money and workforce) in the best way to produce the best quality outcomes and make sure we live within our means. We have a performance and contract framework which sets out how we will monitor the delivery of our plans through our groups and committees. It includes early warnings measure which will show when our performance is declining, what we need to do.
4. Financial duties	The national financial framework sets out that each Integrated Care Board (ICB) and its partner trusts don't spend more money than they have been allocated. Each year we plan how we will spend our capital and revenue resources as part of the Planning Process to make sure we do not spend more money than we have whilst still maintaining quality and access to services and improving outcomes. The details are seen in our Commissioning Plan for 2026/27 to 2030/31. The financial plan sets out what this entails, including our efficiency and productivity programmes. This is reported to the Board each month to show

	the progress we are making in delivering our plans and any risks that we may have. Our plans are shared with both Dorset and Bournemouth, Christchurch and Poole Health and Wellbeing Boards. Our commissioning plan ensures that the goals and service improvements are met in a way that is sustainable. This will include our joint capital plan and future years which will be reviewed each month.
5. Duty to improve quality of services	We work with our partners to make sure that all of our services are up to standard and safe. We have processes in place to do this which also set out what we do when our quality and safety standards are not being met. Our Quality and Commissioning Committee and System Quality Group is where our partners come together to discuss intelligence and learning on all quality matters across the system where we share responsibility for this. Our Quality Framework sets out how with our partners to monitor our services, to make sure everything is working and that our services are of good quality services. We want to make sure that we all improve together, that everyone is heard and that all services are meeting the needs of everyone. We will know when we have reached our goal as: • We will always make sure that practice, structures, values & outcomes are discussed and recorded before major decisions are made • The ICS improves together • We listed to staff and service to make sure they are heard • All our partners will have a culture that reflects, appreciates, and shares learning We will deliver high quality services, that best meet the needs of the people of Dorset.
6. Duty to reduce inequalities	In Dorset, people generally have good health and live longer than the England average. However, life expectancy is different between the most wealthy and the least wealthy areas. Our Integrated Care Partnership Strategy - Working Better Together has five goals to help the people who are in greatest need. We have a Health Inequalities Group that makes sure all the organisations involved work together in a way that helps everyone across Dorset. Through programmes of work such as CORE20Plus5 for adults and children. Using our Dorset Intelligence and Insights Service we will be able to target the areas where people and communities most need help, where there are the greatest differences and improve the outcomes for the people who live there.
7. Duty to promote involvement of each patient	We want to make sure people have more choice and control over their health and care. To do that, we will continue to develop our partnerships so we have a Universal Personalised Care Model across our organisations. This work will help us towards achieving our five outcomes for Dorset ICS. We want to use population health management and tackle health inequalities so that people have sustainable and high-quality health and care in Dorset. This approach is important for us to reach our goals at a system, place and neighbourhood level. We are going to spread and make bigger the Universal Care model in Dorset. This will help us to:

	1. Change how health and care practitioners work and communicate with people 2. Help to reduce the differences in health care in Dorset 3. Make sure the right health and care services are in the right places 4. Make people healthier and get better care. We are working with our partners to: • make sure people have the skills needed to give personal care • will increase Personal Health Budgets, including temporary ones to help you after leaving hospital, stop you from going into hospital and keep you healthy • use digital technology to make it easier to get and receive non-medical support • make sure people get the care they need in Dorset and that personal care is in place • give people with long-term conditions the help and support they need to manage their own health and wellbeing, helping them cope with their condition and reducing the need for services. • make sure personal care is part of programs like Aging Well and Elective Care • help Primary Care Networks to deliver the goals from the Fuller Review for a personalised care network • use our population health tool (Dorset Information and Insights Services) to understand the difference in outcomes for people and tailor support to them and to make sure we know the impact. We will know when we have reached our goal as: • We will always make sure that practice, structures, values & outcomes are discussed and recorded before major decisions are made • The ICS improves together • We listed to staff and service to make sure they are heard • All our partners will have a culture that reflects, appreciates, and shares learning • We will deliver high quality services, that best meet the needs of the people of Dorset.
8. Duty to involve the public	Our Working with People and Communities Strategy explains how we will work with people and communities. It describes our principles, how we will work and what we will do to make sure people and communities come first. Our plan matches the 10 principles for working with people that NHS England published in the national statutory guidance.
9. Duty as to patient choice	We support our GPs to offer choice to people registered within their GP Practice, this in in line with NHS Constitution for England and the NHS Choice Framework. We make sure service users and GPs know about the different places they could go for consultant-led services, and the amount of time they would have to wait at each place. When service users need a consultant led appointment they are given a full choice list at the point of referral and we keep

	GPs up to date with the shortest waiting time. Information about services are publicised on local websites, we have more information in our access policy and Waiting Well information which is available on trust websites. We provide our services on ERS and use open procurement for any cases which don't fit this. This ensures the best care and value-for-money.
10. Duty to obtain appropriate advice	Our Clinical and Care Professional Leadership Framework sets out how we make sure that there is a strong clinical and care professional involvement in advice and decision making across the system. When we make decisions we make sure that we take advice from lots of difference experts, some examples can be seen below: • Social care practitioners • Public Heath • Voluntary and Community Sector • Housing • Educations • NHE England • Clinical Networks and Senates There are lots of ways we seek this advice, we do this through our: • Integrated Care Board where there are clinical leaders such as chief Medical Officer, Chief Nurse and representation from primary care, ambulance service and local authority • Integrated Care Partnership where there are also professionals from fire, police, community and voluntary sector • Clinical Delivery Groups who have both clinical and non-clinical professionals e.g. Urgent and Emergency Care, Elective Care, Primary and Community Care, Mental Health • Provider Collaborative and Place Based forums who include both clinical and non clinical professional.

11. Duty to promote innovation	• Under the Health and Care Act 2022, ICBs must promote Innovation as part of their core functions:
	  ○ 14Z40 Duty in respect of Innovation
	  ○ Each integrated care board must, in the exercise of its functions, facilitate or otherwise promote—Innovation on matters relevant to the health service
	• Must report on how they support research and evidence use in their joint forward plans and annual reports.
	• Duties include facilitating innovation relevant to the NHS and promoting evidence-based improvements.
	• ICBs are responsible for ensuring innovation informs commissioning decisions and population health strategies.
	• These duties underpin the importance of innovation in improving health outcomes.
	Embedding innovation within strategic commissioning means:
	• Understanding local context to surface innovation needs and opportunities

	• Creating a pro-innovation population health strategy which mobilises providers, Health Innovation Networks, and other partners to deliver a whole-system, mission-aligned innovation portfolio • Using commissioning and contractual levers to accelerate adoption • Evaluating the commissioning, implementation and impact of new innovations, and continuously improving the system's approach to innovation adoption. Central to how we achieve our innovation ambitions in Dorset are the networks of key collaborations, strategic partnerships and partners. It is recognised with the evolving geographical changes with ICB cluster formation, devolution and wider that we will pivot and establish new partnerships and collaborations as necessary. The current innovation key collaborations, strategic partnerships and partners include the below non exhaustive list **Dorset Innovation Hub.** NHS Dorset ICB host the Dorset Innovation Hub (DIH) which is a strategic system partnership that is likened to a mini Integrated Care Partnership (ICP) and is made up of 12 partner organisations: primary, community, secondary and social care, academia, innovation, research, economy and industry (see figure 1 below). The DIH draws together partner organisations to provide expertise to spread and adopt prioritised innovation across Dorset **Health Innovation Wessex** Health Innovation Wessex (HIW) are a system capability for Wessex funded through NHS England, the Office for Life Sciences and other commissioned activities. They are part of the Health Innovation Network (HIN), the innovation arm of the NHS, and transforms lives through innovation by supporting health and social care teams to find, test and implement proven evidence-based innovations locally and at scale to the NHS greatest challenges, driving economic growth.
12. Duty in respect of research	• Under the Health and Care Act 2022, ICBs must promote research as part of their core functions: ○ 14Z40 Duty in respect of research ○ Each integrated care board must, in the exercise of its functions, facilitate or otherwise promote— (a)research on matters relevant to the health service, and (b)the use in the health service of evidence obtained from research • Must report on how they support research and evidence use in their joint forward plans and annual reports. • Duties include facilitating research relevant to the NHS and promoting evidence-based improvements. • ICBs are responsible for ensuring research informs commissioning decisions and population health strategies. • These duties underpin the importance of research in driving service innovation and health outcomes. In 2021, we published a Research Strategy which set out how we will create patient-centred care that makes use of the newest technology and encourages everyone to take part in research that is relevant to them. Our research strategy sets out how we will deliver the national and local goals, by focusing on four themes which are: • **Our people** – giving everyone in Dorset the chance to take part in research near their homes • **Our workforce** – staff research opportunities and make sure they understand and use research • **Working in partnership** – partner with organisations so that different people and ideas can work together

- **Management of research** – make research easy and efficient to manage across all our organisations

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Wessex Health Partners (WHP)

- In 2022 NHS Dorset joined WHP, the region's academic health science partnership. WHP is a strategic alliance of 14 organisations across Dorset and Hampshire and the Isle of Wight including four Universities, seven NHS providers, two ICB and HIW. For the Dorset geography WHP members include NHS Dorset, UHD, DCH, Dorset HealthCare, Bournemouth University and HSU.

- The WHP partners came together around the common purpose, through partnership working, to accelerate improvements in health and social care through research, innovation, and training for the benefit of the public and patients in Wessex and globally. The agreed ambitions of partners in the WHP strategic alliance are, by working together to:
    - Improve the region's collective ability to tackle the greatest challenges facing the Wessex health and care system, and
    - Generate greater collaborative and interdisciplinary research and speed the development and adoption of innovation at scale.

    - This will improve health and care services by translating early scientific research and innovation into benefits in healthcare at local and regional level, linking with local authorities and industry.

NIHR Wessex Applied Research Collaboration.

- NHS Dorset is an active partner of the NIHR Wessex Applied Research Collaboration. The NIHR ARC Wessex is one of 15 ARCs across England, part of a £135 million investment by the NIHR to improve the health and care of patients and the public. The NIHR Applied Research Collaborations (ARCs) support applied health and care research that responds to, and meets, the needs of local populations and local health and care systems, with the mission statement 'to improve outcomes for patients and public; improve quality, delivery and efficiency of health and care services; increase the sustainability of health and care systems locally and nationally'.
- NIHR Wessex Applied Research Collaboration conduct applied health research with partners and others in the health and care sector, alongside patients and members of the public. Applied health research aims to address the immediate issues facing the health and social care system. We also help bring research evidence into practice and provide training for the local workforce.

South West Central Regional Research Delivery Network (RRDN)

	• **Vision, purposes and objectives.** The South West Central RRDN's vision is for the UK to be a global leader in the delivery of high-quality research that is inclusive, accessible, and improves health and care. The vision is supported by two primary purposes. Firstly, to support the successful delivery of high-quality research, as an active partner in the research system and secondly to increase capacity and capability of the research delivery infrastructure for the future. The purposes are designed to:
	  • Enable more people to access health and social care research where they live
	  • Support changing population needs by delivering a wider range of research and deliver research in areas of most need
	  • Provide support to the health and care system through research
	  • Encourage research to become a routine part of care
	  • Support economic growth by attracting investment to the UK economy
	
	NIHR Commercial Research Delivery Centres
	• NHS Dorset is a partner in the NIHR Commercial Research Delivery Centre (CRDC) hosted by and governance oversight Wessex Health Partners and has been awarded £4.7m in April 2025. NHS Dorset ICB supports the NIHR CRDC as a core delivery vehicle for Dorsets research functionality and delivery within the community and recognises it is one of several key strategic partnerships that are pivotal to the success of the ongoing commercial and non-commercial work building capacity and capability across the region.
	• The CRDC's are four hubs and mobile units hosted by University of Southampton. Two of the four hubs are located in Dorset, one of which is jointly hosted and lead under the federated model by Dorset HealthCare University Foundation Trust and Dorset County Hospital Foundation Trust. The other Dorset based hub is in Bournemouth. Furthermore, we are awaiting the outcome of a primary care CRDC bid.

13. Duty to promote education and training	Developing our People is one of four priorities set out in the Dorset ICS People Plan 2023-2028. We know that investing in the continued professional development, education and training of our workforce is key to ensuring our local population receive the best possible care. Individually as ICS partners, and collectively as a system, we work together to ensure a comprehensive development offer is in place, for our current and future workforce. Some key achievements in the last 18 months in line with the Dorset ICS People Plan 2023-2028 include: • Working as a system to support new routes into employment through T Levels • Undertaking optioneering across all professional workforce faculties to understand the future skills and requirements needed from the future workforce • Investing in system wide leadership development • Investing in system wide inclusive leadership, leading for inclusion and conscious inclusion development • Looking at different employment models and recruitment techniques to attract people to hard to recruit roles and/or areas of health and care which struggle to recruit.

	• Working as a system to ensure the workforce has access to the nationally endorsed Oliver McGowan mandatory training at both tier 1 and tier 2, providing a variety of inclusive ways the development is accessed • Supporting our future workforce, by working closely with education providers to make sure our staff and students have the best experience. We also inform the development of the Dorset Local Skills Improvement Plan to ensure development for the health and care workforce continues to be prioritised and invested in.
14. Duty as to climate change	We want to do all that we can to help our communities develop and grow this means that we will also make sure we do all we can to help environmental, economic and social value. As part of this we approved our Green Plan in 2022. The Green Plan sets out how we across health partners will reduce our carbon emissions and support sustainability goals including supporting the two NHS targets in its aim to be the worlds first net zero national health service as follows: • For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032; For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.
15. Addressing the particular needs of children and young people	We want the best for children and young people. That's why our joint plan puts a bigger focus on early help, primary and secondary prevention. We're working with the local authorities to create a care plan for children and young people's mental health and emotional wellbeing. This will be based on the principle of helping children to thrive. We want to make sure there's 'no wrong door' for children and young people looking for help and that physical and mental health are integrated. These are the key outcomes from this work: • children and families at the centre and design of service coproduced with CYP and families creating a model that works for families. • families to be trusted and have more control in relation to the of support they can access • Help and support available much sooner in the places CYP are, in communities, in schools. Immediate access to help when heading towards a crisis. • no wrong door, integrated, very few if any thresholds or barriers to accessing help and fully inclusive for any young person who needs support. • services properly invested in to meet the level of need and anticipated need with a single agreed funding pot, ending arguments. We want to make sure children are healthy, so they can reach their potential. One of our priorities in our plan is to prevent and reduce levels of childhood obesity. We're working with local authorities, Public Health Dorset and education to

	focus on early years and the things that affect physical and mental wellbeing in children. This includes the Better Births programme, supporting and advising on infant feeding and giving children more physical activity with things like the Healthy Movers and the Daily Mile. We are working on the CORE20PLUS5 programme for children focussing on children from the worst off areas to understand what services they use, what they need and then to come up with possible solutions. We have an ICB executive lead who looks after making sure that these solutions for children and young people are carried out. NHS Dorset is a statutory partner organisation in the Pan Dorset Safeguarding Children Partnership. The Partnership has three current priorities which are: • violence experienced by children and young people, • children's mental health and emotional well-being, and neglect.
16. Addressing the particular needs of victims of abuse	We want to make sure everyone is safe, that's why the ICB and all the services provided by our partners must follow the NHSE Safeguarding Assurance and Accountability Framework. This year, we plan to work with our partners to implement the changes to Working Together 2023, which is the revised statutory guidance for safeguarding children. We will also respond to the Victim and Prisoners Bill, should this be required.
17. Implementing any joint local health and wellbeing strategy	Dorset has two Health and Wellbeing Boards: • Dorset Health and Wellbeing Board • Bournemouth, Christchurch and Poole Health and Wellbeing Board Our plan aligns with the priorities outlined in our Health and Wellbeing Strategies. The priorities set out in the Health and Wellbeing Strategies and how we support the delivery of these are: **Empowering communities:** In our plan, we focus on working with communities to help them live independently and access the services they need. We pay special attention to communities with the greatest needs. **Promoting healthy lives**: Our plan outlines how we will improve outcomes for children, young people, and adults with mental health conditions. We also aim to ensure that children have a healthy start in life by addressing issues like overweight and obesity. Additionally, we strive to reduce disparities in health outcomes, such as high blood pressure. **Supporting and challenging:** Our plan explains how we will collaborate with partners across the healthcare system to develop integrated care solutions for communities and neighbourhoods. This includes urgent care services. We also highlight the importance of joining up health and care services through initiatives like the Better Care Fund.