Douglas Hamandishe:

I'm super happy to see you again Richard, as always, it is a pleasure we have in these fantastic conversations that just keep them growing. It's the conversation that keeps on giving think big act now, and today we have Sally Bannister who is the deputy director of service delivery at Dorset CCG. Yeah. Wow.

Richard Wyatt-Haines:

Looking forward to her. She's um, she's a bundle of energy, which is just great. You'll see that. I think as soon as we start talking to her, but she's a practical woman as well, that job service delivery she'll tell us, I know what yet well actually means, but she's so practical and yet also challenging what's possible. What's feasible. And I think it's a really, I'm really looking forward to this one.

Douglas Hamandishe:

Absolutely, absolutely. Let's go. Excellent. So, um, in terms of, um, how we want to frame the discussion, right? There's lots of exciting stuff that we wanted to touch base a few, but essentially we want to get across the think big at now. And I think one of the core elements you've mentioned just prior was resilience as one of the components that we need to have to stack a cloak of armor around us as we think big and act now, because sometimes people will throw stones at you. If you stick your head above the parapet high enough. Yeah. Gotcha. Can you tell us what the call was like?

Sally Bannister:

Well, it was about, um, our program that's called ThinkBIG coincidentally. So that's confused a lot of people looking at my diary, but, um, so our local program called ThinkBIG, which is a little bit more, um, radical and has a bit more risk appetite than things traditionally do in the NHS. Um, and it's been at the Mo probably to date. It's been a relatively closed group of enthusiastic people that want to try something different and it's not foundation lists. It does have a basis. So we know, you know, places like one of our work streams is around ophthalmology. We know more fields has done it like this before, or, um, one of our work streams is around breastfeeding and we know somewhere else has done it like this before. But as soon as you start opening it up, you, you meet the people who, who are more traditional in their approach and start to tell you all the reasons why you can't do it. And, and that's fine. And those things, those are hurdles that have to be overcome. Like it is really important that there's no asbestos and we have radiological protection for the people that are using the breastfeeding unit. And none of us would have thought differently, but let's start from a position of where we might be able do it, not from a position where we work from there. So, um, I, I mean, I can just talk, you know, you can just set me go in and I'll just talk, so, okay.

Sally Bannister:

Um, well I've been really amazed by how resilient people have been. So if I think about people in my team last, um, let's think March when people got sent home, if I had predicted who was going to manage well and wasn't going to manage well and, um, how much people would get done. I, I wouldn't have been as optimistic as, as I should have been because people have been amazing people who were thought had limited sort of resilience have absolutely turned their hands to something they've never

done before. Picked it up with Gusto and applied brains and creativity and ingenuity to things that I, and I just didn't think they would.

Richard Wyatt-Haines:

Why do you think they have done that, Sally? Well, how have they done that? Why have they done it? I don't know.

Sally Bannister:

I think the, um, the common enemy of fighting the pandemic has brought people together where they were in sort of slightly opposing teams or competitive teams before. That's one aspect of it, but I think it's the, um, right. I'll just roll up my sleeves and I trust that the organization's organization around me, isn't going to condemn me if I get it wrong. But the thing that we've got to do is so big, let's just crack on and have a go. And I think that that has prevailed and that's taken over from, I must write a paper and get it through three committees before we can even slightly tweak something. People have been a bit more fluid and they felt permitted to be more fluid. And that's the bit I want to keep.

Douglas Hamandishe:

Excellent in your role then if you just give us a brief description of what you do in your role, and also how would you measure success in your role when you're working with such a dynamic environment?

Sally Bannister:

So, so my title is deputy director of integrated care development, which could mean almost anything, um, which I like. Um, and I'm responsible for elective commissioning maternity have a dotted blind for all the cancer commissioning. So I, I look after all the staff, but they work, uh, to, uh, an integrated, uh, mini ICS. But I look after the team I'm responsible for the CCGs contract monitoring and relationship management function and system-wide performance reporting. So among, amongst all of that, I can get myself involved in almost anything that isn't primary care or community services or mental health, um, in terms of success, I think so, so there'd be some things, you know, I'm sure the CCG would want me to say like, um, uh, well-managed contracting process and no surprises for the governing body and those kinds of things. But actually what I want is to run the team.

Sally Bannister:

Everybody wants to work in cause it's really good, fun, and exciting, and we're able to offer good value to the trusts more and more. I think what we do really should be sitting in a trust it's tactical commissioning, it's not strategic commissioning. So if the chief operating officer thinks my team are delivering a good service to him in terms of supporting some transformation or some qui, then I think I've done a good job, but there's, there's a sort of more formal response, which would be, you know, if we times returned to their pre pandemic or better levels, those kinds of things, but actually those are, those are sort of transactional outcomes. What I want is to be managing a set of people that are helping create better outcomes for the health of people, endorser in an actually tangible, what have we changed for the better that's what I'm after.

Richard Wyatt-Haines:

And over the last year, then how does that sort of, how has that manifested itself what's do you seen that that team have brought about what sort of things have happened that really cheered you?

Sally Bannister:

So a couple of things around networks where it had felt like we were pushing against her wet shut door for getting networks up and running networks of clinicians to share scarce resource across a geo geographically wide area, that's got, you know, a big rural area and a town area. Um, so getting those networks up and running and actually moving staff or patients between places in order to even out access. So you you're getting, it's not completely equal, but a more equal level of access, irrespective of whether you live in the place where they happened to have five consultant neurologists versus an area where there's only one. So that evening out of resources, which is part of, um, what we call one acute network. So that was one of our STP programs, one acute network. So that's, that's one bit that it's really, I think, come on a long way in the pandemic in areas where they hadn't wanted, particularly to work together previously.

Sally Bannister:

And the other is digital solutions. So, so pre pandemic on my teams was looking after outpatient transformation and it really felt like we were, um, not getting into the trust. So you had a couple of key people that come to the meetings and say good things, but nobody was that in doing the developments. Um, whereas now, um, or pretty much from as soon as the pandemic hit people's interest in those digital solutions, um, short write up and so did the use. So we, um, uh, the beginning of, um, the pandemic, we had, um, very small use of virtual consultations. Um, and we now regularly have 600 virtual consultations a week, uh, which is about 250 hours worth of consultations a week. Um, and that's been because clinicians found it necessary during the height of the pandemic, but the benefit of it they've seen carry on even when the pandemic's receded slightly. So they're still interested and still doing those consultations, um, online, even though that's that doesn't save them really much time. The, some argue that it might save them a little bit, but it doesn't really save them that much time on, but it's hugely more convenient for patients if it's clinically suitable. And as somebody that recently had to park in pools, multi-story car park, it saves you parking fees and straps and congestion and carbon footprint and all of those things. So that's, that's really good. Sorry go on Richard.

Richard Wyatt-Haines:

I was going to say, so one of the things that strikes me in this conversation is that you, you, you almost make things very tangible and grounded. You know, you've, you've dressed in a way some of the NHS speak, but equally you go the other way and you just go, no, this is what we've got to deliver. These are the numbers, this is the practical thing. It's not parking. I don't want people parking pool, car park, and you make it very grounded and real, if I may say, is that, is that part of this?

Sally Bannister:

Yeah, I suppose so. But we're all patients, we're all patients. So I have had online consultations and, you know, I live 27 miles from my nearest hospitals. Is it pretty much an hour by the time you park? It's so much better for me. And I, I know what it's like, I'm a carer for my 86 year old mother-in-law I know what

it's like trying to get her into a disabled access taxi. If we could do something in her flat, if we could do something in our local community hospital, that's so much better for her and it's better for me. And if it doesn't have an ad clinical impact, well, why, why not? So let's do it. Um, yeah, I do. I do really care about these things. Um, but I think I would, I would slightly, um, I wouldn't want it to give the impression that I'm saying to the system, this is what we need to do. That's not, I don't really feel that's my job. My job is to sort of hear and give options to them and then help the system develop what the system thinks it needs to do rather than act as a traditional commissioner and say, and they just think that says, there is this policy you must implement. I don't know who's going to be listening to this, but I don't really much care.

Sally Bannister:

Well, I care about is what's better for the Dorset patient or the Dorset clinician.

Douglas Hamandishe:

I don't know. I think more importantly to support, which is point of view. There is you are providing you create an environment that enables people to create, um, and introduce better solutions for the health service. And, um, there is this argument whereby you have the protocols, procedures, and all of those things in statute that you have to abide by. But the human side of this first and foremost, you have to create a safe place where people are happy to come to work, are able to give the all we've had this compelling event that has changed the whole dynamic COVID. Now, if you remove that competitive event, there's a risk that people will go back to old ways and put up barriers and all of these protocols, which we do not want. So your approach, um, is, is one that is refreshing and should be adopted. What are you doing to ensure that, um, all the great innovation has come through such as visual consultations that increased continue post pandemic.

Sally Bannister:

I think, um, I would say that Dorsett was quite collaborative and progressive even before the pandemic and, and even probably going back 3, 4, 5, 6 years. It has been a place that almost through stealth has been gradually bringing, bringing, I don't know, minimizing the gap between the provider and the commissioner and gradually bringing in people teams together. So I don't think it's just a pandemic and it's definitely not just me. It is, it is a whole kind of sea of people who, um, whose attitude, it's something you said a minute ago. I think it's about setting the conditions to allow people to be innovative. So balsa did away with the purchase of provider split quite a long time before you would really give them permission to do that. Um, it was already operating combined committee structures between providers and commissioner before really we were given the nudge in the direction of being an ICS before ICS was afraid.

Sally Bannister:

So we've been doing that kind of thing for a long time. I think the way in which we sustain it is that, um, there's probably loads of different things that we have to do, but one of them is to, um, really share, um, share out with good practice, but also share out who leads. So, so it's not the commissioner defining, um, what's, it's a shared responsibility across all of us and we share leading those things. So within elective care, we've got a number of programs underneath our elective care board. Um, and there are, some of them are led by providers. Some of them are led by commissioners. Some of them led by GPS.

They've all got everyone in them, but the responsibility and the sort of distributed leadership, uh, help knit everybody in, I think for the long-term I, um, I mostly think the things that we are involved in sit best in a provider space.

Sally Bannister:

Um, so whilst my team are helping that they're helping, they can't drive it on their own. It's got to be out in the provider world. Um, and, and the commissioner's role is probably going to shrink to be more about TJ commissioning. I think having people in place who are prepared to take a bit of a risk rather than, um, more traditional commissioners or even more traditional NHS managers, probably being a little, having a bit more of a risk appetite, um, will support keeping the things that we've gained. So the other digital things we had, we did our digital library, um, using HCI, which when we started pre pandemic, we were looking at, let's do two or three, um, let's start small and grow it and get some kind of, um, momentum behind it. And actually, um, with Richard's felt, we, we went really big and we went for 300 very, very quickly. And we're now I think 400 and some, um, and I think people's appetite for being able to help their patients, knowing that they couldn't help them face to face as much as they wanted to do, help them get on board with the idea of something else that they might have bulked out otherwise.

Richard Wyatt-Haines:

Just looking ahead, your, your think big, could you just because getting down to the tangible I'm conscious of time running away from us, but Peter, describe what you're doing in your think big and let us know. Cause I, I think lists what, what you've seen and makes it a future looking program.

Sally Bannister:

What we're trying to do is look at, um, massive backlog of patients and that not, that's not just patients waiting for a first appointment. Sometimes it's the follow-up was screening. What can we do with, how can we narrow that down through digital validation? How can we in a really personal way, ask people questions and then take the information from those questions and work out what is the best route for those patients. And then when we narrowed that down to the people that we must say, then how many of them, and how can we see them virtually? And then when we've narrowed that down and we've got the ones that need to be seen face to face, how can we ramp up by an order of magnitude, our ability to see patients face-to-face and the way we think we're going to do that is by running outpatients, like the massive vaccination centers in a big open plan space. So potentially a shopping center,

Sally Bannister:

Using a kind of lane structure and we might swap one specialty in one day and swap another one in another day, use volunteers having connected to, um, lifestyle strokes type choices. So if we're having an orthopedic lane, um, we might see people who've been on the waiting list for an orthopedic, um, surgical intervention. And actually what we might find is a more conservative approach or a lifestyle approach might help them now. I mean, they don't need the operation or help them in the meantime, whilst they wait. So looking at things like, um, healthy Dorset, um, active Dorsa those kinds of, um, third sector organizations that we might be able to have on the premises. And then at the very back end for the people who absolutely do need a surgical intervention, making really good use of the independent sector, um, at a scale that perhaps we haven't done before, because we haven't needed to before.

Sally Bannister:

So, um, there's a lot of learning from the vaccine sites. We've got somebody in my team that was involved in our local mass back center, but also was the military person in charge of the first Nightingale, the build. So he is advising us on the build within this large open plan, uh, department store in a shopping center. And there are lots of benefits to that. So it's right next to the bus station, the train station, um, the shopping center love it because they'll have footfall and they are absolutely decimated. So there are loads of things. There are lots of barriers to overcome, like, is there asbestos in the roof? What's the radiant screening going to be for the breast screening equipment, but these things are, they are doable. I think the pandemic has shown us that lots of things are actually doable if we have some urgency in, um, pace behind it.

Richard Wyatt-Haines:

But also, uh, leadership. That's brave if I may say, um, because actually you are, I don't, I don't know how you write a business case for that or whether you just go, no, we believe-

Sally Bannister:

So that is what I'm struggling with right this week, because I need to put something in this that gives the trust that is predominantly leading this. And I would say this is being led by one of the coups, um, not by me, but, um, he needs the confidence to write the checks. So the system needs to give him the confidence to write the checks. And it is a little bit on faith. Um, and, and actually my boss has said, don't write a business case, just keep taking people with you on the story. And I'm, um, whilst some people, they think I'm a bit flaky and a bit wacky to other people. I like the forces of conservatism because I'm saying, no, I think we must have a business case. So somewhere in between, you know, you have to have reasonable governance, it's public money. On the other hand, we don't want to be tied up so much in red tape that we don't get anywhere because there's no good governance or privacy or dignity and being sat untreated on a waiting list. And our responsibility is to treat those people, not to do the same thing all the time. That's easy, which is sort of nothing.

Douglas Hamandishe:

Sally you're a very inspirational leader and leadership is what Richard was, um, um, speak about earlier. And I just wanted to paraphrase. What I'm getting from, from this is radical. You have to be radical as an organization and the people within it. I have to think in a very radical ways, you take your learnings from a pandemic and reframing them to introduce new capabilities into the health system. Um, we spend a lot of time talking about our hospital's needs to provide care outside the physical boundaries of the hospital. That's exactly what you're doing. And th this is the challenge you have and you articulated it well in terms of the benefits, as you see it with innovation, we always know there's going to be new unquantifiable benefits to anything you innovate, because you don't know until you brought in the new capabilities that you have. Do, you were talking about this.

Sally Bannister:

We are talking about it often as an experiment, because we don't know what, what challenges we'll come up against. And we also don't know what things were learned from it, but we know there'll be things that we'll want to build into how we do outpatients in the long run from this. Um, rather than it just being a 12 to 18 months, standalone backlog, Clarence, they are the parts of it that like that, but there'll be other parts of it that we want to keep as a kind of legacy for, for how we deliver outpatients the next 20 years.

Richard Wyatt-Haines:

Sally, we're out of time, I could talk to you forever. I've got to say it. If there was one thing you'd say to people going away from this call, uh, this, this discussion, what would you say they should get on and do? Or how should they think or what, what's the one thing that would stick with you that you'd like others to think through?

Sally Bannister:

I think it is about being brave enough to step outside of what's safe and traditional. Um, and not all of those things will work and, but some of them will, and then we'll learn from it because none of us learned from doing the same thing as we did last time, you know, it's safe and it might achieve X, but it's only, you know, achieved. That's where we want to achieve X, Y, and Zed. We need to try something else. So being, being brave enough to try.

Douglas Hamandishe:

Excellent. And I'll take another message in terms of the story, taking people on that journey with your story. Um, this is now the second, um, show we've done. Think big act now, and the theme emerging here, widget, and is about resilience as come up and being brave. Yeah. You know, something about bravery is coming up there. So no, thank you for that. There's a synergy there. And, um, we inspired think big act. Now your name should be a verb because you're doing person to sell it.

Sally Bannister:

It's not just it. Isn't just it. Isn't definitely not just me.

Douglas Hamandishe:

Yeah, no, no, thank you very much for your time. It's much appreciated.

Richard Wyatt-Haines:

You're a star. Thank you so much, everybody. Everybody will benefit from this. Thank you and see you soon. Thanks again. Bye-bye.