Developing clinical leadership for quality and safety

A half-day workshop for emerging clinical leaders

Tuesday 18 September 2018

12.00pm – 5.00pm
Lunch provided

Charthouse, 72 Keith Allen Drive, Tauranga

This half-day workshop is jointly hosted by the Health Quality & Safety Commission and Bay of Plenty District Health Board.

It focuses on the skills clinical leaders need to improve quality and safety in their organisation. The aim of the workshop is to give clinicians the tools and motivation to prioritise and champion a continually improving quality and safety culture.

Clinical leaders at all levels, and from all disciplines across the health and disability sector, are welcome.

This is a free event, however numbers are limited.

To register: suzanne.board@bopdhb.govt.nz

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Part one: What makes a great clinical leader?

A clinician's leadership skills, abilities and knowledge play a key role in improving health care quality and safety. We take a look at the characteristics of effective leadership and focus on the different leadership skills and behaviours that are appropriate in different settings and contexts.

At the end of part one, participants will:

- understand clinical leadership strengths
- be able to identify the characteristics that make an effective clinical leader, depending on the context they are in (e.g. leadership approaches needed in a new situation versus those needed when the environment is more certain)
- carry out self-assessment of their quality and safety capability.

Part two: Where is harm occuring and, as leaders, what can we do about it?

To be able to lead improvements in quality and safety in your organisation, you need to know which areas need the most attention, and how to measure improvement.

We look at data sources containing national and DHB-specific information on areas of patient harm, so participants can identify areas they may wish to focus on.

At the end of part two, participants will:

- understand the level of harm caused to patients in New Zealand within the health care system
- understand various quality improvement approaches and tools
- understand basic measurement principles and tools
- understand how to involve patients and their families/whanau in quality improvement
- be able to answer these five questions:
    1. How do we measure?
    2. How safe are we?
    3. Are we improving?
    4. How do we compare with the best?
    5. Do patients/consumers have input into everything we do?

Part three: Leading change within a complex system

Health care is a complex system, delivered by teams, and to lead within it requires an understanding of how to make sense of this complexity. Most medical errors are not caused by individual mistakes, but by poor systems and processes – which are under the control of leaders.

We look at how leaders can work within systems to make change and improve quality of care and patient safety. We also consider the key aspects of effective change management and we will look at clinical governance in organisations and discuss the Commission's framework.

At the end of this part of the module, participants will:

- be introduced to systems thinking that can help understand the complexity of health care systems
- be able to identify ways leaders can change systems so care is safer
- understand the need to work as part of a team
- understand the basics of change management and 'bringing people on the journey'
- understand how the culture of organisations impacts on patient safety
- be part of the network of clinical leaders, developed as part of this module
- understand their role in clinical governance.