

A Paradigmatic Replication of NHS Improvement (2019): Evaluating Health Governance and the Roles of Clinical Leadership Competency Model

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ABSTRACT The growing demand for effective healthcare practice and efficient service delivery within managed care signifies the importance of healthcare professional practice, which places an enormous burden on healthcare practice in Nigeria and the world. The clinical leadership competency model (CLCM) explains why and how governance factors influence patient practice and attempts to identify factors outside of the patient involved in improving health outcomes. This study focuses on improving health governance among hospital managers using the CLCM. A cross-sectional study on health included two phases of pre-intervention and post-intervention among health managers in private and public health institutions in the Federal Capital Territory, Nigeria. Participants who scored low on the healthcare governance measure were divided into three groups: treatment group, first, and second control group. Data were collected using a self-reported questionnaire from health managers. The mean scores of health governance efficacy were significantly higher in the treatment group than those in the control group 1 and control group 2 ($p < 0.05$). The results further revealed that health managers exposed to CLCM (treatment group) measured the highest efficiency of healthcare governance compared to those not exposed to it (control group 2). CLCM significantly improves health governance efficiency among healthcare managers in Nigeria. There is a need for research on the effectiveness of interventions to improve clinical leadership practices, improved research methods, uniform metrics to assess the impact of various health governance interventions, and the evaluation of the transferability of successful interventions to broader populations of health employees.

KEYWORDS: Clinical Leadership, Healthcare managers, Health Governance, NHS Improvement.

I. INTRODUCTION

The growing demand for effective healthcare practice and efficient service delivery within managed care signifies the importance of healthcare professional practice, which places an enormous burden on healthcare practice in Nigeria and the world. Healthcare leadership has been identified as a factor in the efficacy of health governance among health managers. Leadership is a mechanism or process of influencing and mobilizing human and material resources toward achieving a common goal [1]. Governance within health practice is changing as healthcare leadership focuses more on the participation of diverse healthcare professionals [2, 3]. Placing clinicians as organizational leaders is an enormous, complicated, and expensive undertaking [4, 5]. However, more change is still required despite advancements in health. Leadership is needed, and governance must largely emanate from the activities and control of those engaged in the healthcare practice, irrespective of their designated management responsibilities [6]. The need for health providers to make decisive health planning and administration that affect the standard and efficacy of medical and therapeutic care that impacts patients outcome, is a function of comprehensive technical knowledge and the ability to develop and implement strategic policies that have a sustained effect on longer-term patterns of health service delivery [7, 8, 4, 6] with the complication of how health systems work, it is often difficult to measure healthcare performance due to the presence of co-occurring tasks that characterizes healthcare practice. However, studies have shown that healthcare institutions that have embraced clinical leadership models in their management system that have witnessed significant improvement in care, treatments and overall patient outcome and professional healthcare practice [4, 9]. Clinical leadership has recently been identified as a concept within health management practice [10, 11, 12].

The goal of this paper was to determine whether efficacy of health governance would improve when managers are exposed to the Clinical Leadership Competency Model C.L.C.M, such that health governance is significantly enhanced. In other to achieve the objectives of the study, the following hypotheses were formulated; H1: Health

managers in public and private healthcare institutions exposed to C.L.C.M will have the best score on health governance efficacy compared to their colleagues who were not exposed to C.L.C.M. H2: Health governance efficacy score of the first control group, the second control group and the treatment group will significantly differ from one another. Against this background, a clear definition is fundamentally required to understand what constitutes clinical leadership. [13] refer to clinical leadership as a form of leadership that incorporates health professionals as leaders in health management. Clinical leadership competence is a clinicians' capacity to convey motivating and inspiring decisions and action that drive healthcare excellence by demonstrating clinical expertise, guiding and supporting colleagues and leading by exemplary decisions and actions [14]. Similarly, clinical leadership competence is a learned skill that puts clinicians at the forefront of designing and delivering patient-centered care, making exceptional outcomes a core part of their daily work, not just a one-time goal or activity [7,4]. Also, [15] maintained that clinical leadership offers clinicians who are at the forefront of healthcare management to implement innovative ways to solve healthcare-related problems by enhancing healthcare delivery outcomes, thus leading to sustainable managed care strategies, better patient outcomes and improve wellbeing for both clinician and patients. Several researchers have emphasized the link of clinical leadership in health management as a critical factor in developing and maintaining the potential impact on clinical practice in a clinical care environment and in fostering safe and quality patient care, job satisfaction, and retention of front-line health managers [16, 17,18, 19, 20]. Given the importance of clinical leadership in health management, this study focuses on improving health governance among hospital managers using the C.L.C.M.

II. RELATED WORKS

CLCM is based on the fundamental principle of collective governance in which leadership is not limited to people who are in the position of authority or influence, rather leadership is perceived a shared responsibility where inputs from healthcare professionals aimed at effectively employing competencies that improve patient outcomes [21, 22, 23]. It suggests that clinical leadership can emanate from any person in the organization, making it suitable at any point in time. It focuses on the group's achievement rather than an individual [4, 6, 23]. C.L.C.M., engages planning, and transformation in the provision of healthcare services and deliverables [23]. C.L.C.M., is incorporated into health services to provide high-quality patient care by demonstrating the following. Clinicians can use the five C.L.C.M. domains throughout their careers. The C.L.C.M. is embedded within the leadership framework, and the first five domains begin by creating the vision and delivering the strategy. The C.L.C.M is designed to support those in leadership roles by broadening healthcare frontiers that build confidence and help to harness qualitative clinical practice [23]. Healthcare institutions face a myriad of challenges that can be traced to a lack of effective leadership and governance (stewardship) especially in developing economies nations, and this has led to systemic failure in healthcare governance [24]. Particularly, in Nigeria's health sector the apparent issues plaguing this sector has been linked to poor healthcare administration and management [25]. Health management challenges include a lack of competent leadership in fully functioning healthcare systems, poor health infrastructure, and a scarcity of well-trained health providers [26]. If clinical leadership practice is not established in clinical practice, this can lead to underutilization of human resources within health providers, reducing competitiveness, innovation, performance, and quality of service delivery [27]. In a leadership and governance training workshop to address this situation, it was identified that most) policy reform recommendations have not been successful because those saddled with this responsibility do not have requisite training and experience in leadership roles [25]. In other to improve healthcare governance and could be achieved with adequate attention to the factors responsible for clinical leadership, as shown in Figure 1. This model explicitly focuses on how C.L.C.M improved health governance among health institution managers.

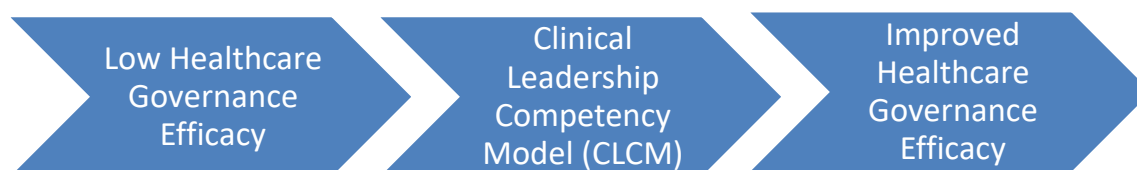


Figure 1: Conceptual Model Showing the Intervention Effect of the Clinical Leadership Competency Model on the Projected Improvement in Health Governance Efficacy

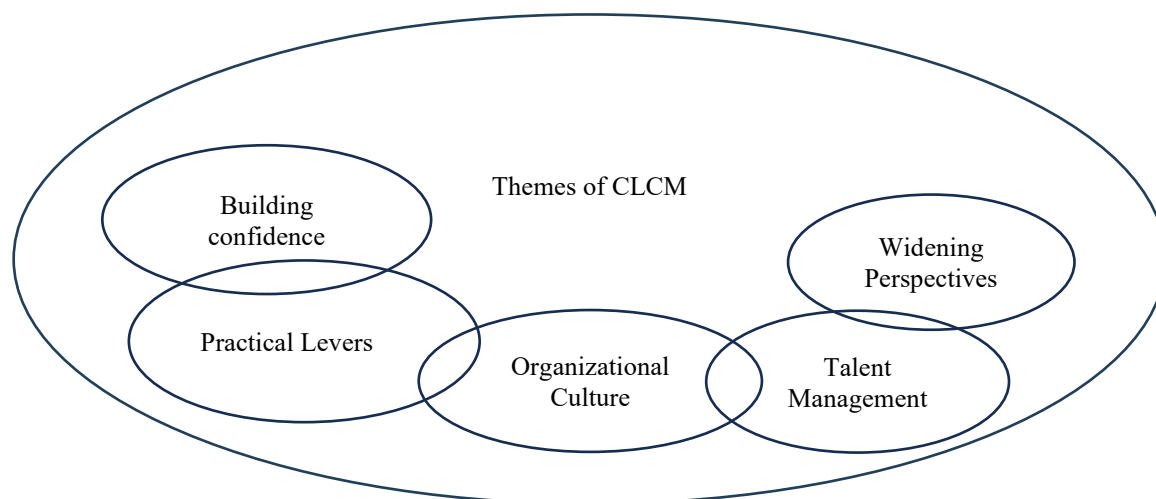


Figure 2: Showing the Themes of C.L.C.M. (Source: NHS., 2019).

Figure 2 shows the expected result of C.L.C.M that leads to improved health governance effectiveness among health institution managers. When applying the C.L.C.M., themes to healthcare managers, as shown in Figure 2, though, themes may not be generalized to all disciplines, it should be noted that this model is not designed for any particular set of groups. The themes are generated because the model seeks to stimulate Innovative thinking and course of action in line with professional healthcare practices that boost patient care as shared collective to effectively reduce barriers to healthcare governance so as to create a platform for clinicians to engage in healthcare governance within healthcare teams [23].

III. MATERIALS AND METHODS

This study was designed as a cross-sectional study and it comprised two phases of pre-intervention and post-intervention among health managers in private and public health institutions in the Federal Capital Territory (F.C.T.) of Abuja, Nigeria. It has a total population (2011 census) of 2,238,800 [28]. F.C.T. is a cosmopolitan city strategically located in the center of Nigeria. The F.C.T comprises 6 districts; Abaji, Abuja Municipal, Bwari, Gwagwalada, Kuje, and Kwali [29]. For this study, a 3-group pre-test-post-test design was considered. Participants who scored low on the healthcare governance measure were separated into three clusters: Experimental/Treatment group, first, and second control group. Health governance assessment was conducted in the pre-intervention stage for the treatment and first control groups, and the second control group was not tested in the pre-intervention stage. Table 1 briefly summarizes how participants were exposed to the C.L.C.M.

Table 1: Summary of the Research Design for the Pre-Intervention, Intervention, and Post-Intervention Phases

Characteristics	Pre-Intervention Phase	Intervention and post-intervention phase	
<i>Groups (N=360)</i>	<i>Pre-test</i>	<i>Treatment</i>	<i>Post-test</i>
Group1 (treatment group) <i>n</i> = 120	Yes <i>n</i> = 120	Yes, <i>n</i> = 120	Yes, <i>n</i> = 120
Group 2 (first control group) <i>n</i> = 120	Yes <i>n</i> = 120	Not Applicable	Yes, <i>n</i> = 120
Group 3 (second control group) <i>n</i> = 120	No	Not Applicable	Yes, <i>n</i> = 120

Note: n = number of participants in each group; N = total number of participants.

As shown in Table 1, the treatment and first control groups were exposed to C.L.C.M., (pre-test). The second control group was not exposed to the model. Only the treatment group underwent the intervention condition (C.L.C.M.). In the post-test stage, all participants in the three groups were exposed to C.L.C.M.

A. POPULATION

The source population was all health managers working in the Federal Capital, Nigeria's health institutions. In contrast, those health managers in selected public and private health institutions were the study population. Inclusion criteria: Clinicians with a working experience of not less than six months in health institutions. Exclusion criteria: Clinicians who are not active service or superannuated and those who do not work in Abuja (retired) as at the time of this study were excluded.

B. REPRESENTATIVE SIZE AND SAMPLING PROCESS

Purposive sampling technique determined the minimum number of participants for each study phase. Convenient sampling was then used to select each participant who met the selection criteria for each of the three groups. Therefore, the representative sample for this study was 360. Health institutions were classified according to public/private criteria as hospitals, psychological clinics, rehabilitation centers, and health centers. These participants selected include Directors/Heads of Departments and health parastatals. A multistage stratified-sampling technique was used to select participants that took part in this study. A simple random balloting method was then used to select eight public and eight private hospitals, 25 health centers, and nine health offices in South-West, Nigeria and the Federal Capital Territory. Participants were assigned to each designated public and private health institution centered on the number of managers present in each health institution. A simple random sampling technique (balloting) was employed to determine the study participants.

C. CHARACTERISTICS OF THE PARTICIPANTS

The participants' sociodemographic characteristics revealed that *N* = 360 managers participated in the study and 120 managers for each of the three groups. More than half, 216 (66%) of the participants were men, and more than 40%, 144 (40%) were women. The age range of the managers was 31 to 45 years. The average age of the participants was 37.5. Most health managers (70.5%) had a master's degree and a bachelor's degree (29.5%). Work experience showed that most health managers had worked for more than ten years (70.5%), depending on the type of institution; health managers in public institutions were 241 (120%) and those in private institutions 119 (33%).

D. TOOLS FOR DATA COLLECTION AND PROCEDURES

Data was obtained using self-reported questionnaire from health managers in public and private healthcare institutions, health centers, and healthcare centers. The questionnaire comprised of sections that focused on sociodemographic information (gender, age, rank/category of managers, type of organization, qualification). Healthcare was first administered to management (pre-test). The C.L.C.M was conducted, and managers were engaged in a re-test to determine the level of improvement in health governance. The health governance of managers was measured using 16-item semi-structured statements on good governance practices [30, 31]. Sample items include "Are there available avenues for reporting, investigating, and adjudicating misuse of available resources", "Are there opportunities for employees to engage with senior management to discuss issues about the efficacy of healthcare services", and "Are there opportunities for patients who seek health service to influence they type od services they are offered". Responses were classified between 1 and 4 (4 = agree, 3 = somewhat agree,

3 = somewhat agree, 2 = somewhat disagree, 1 = disagree). The questionnaire was adapted from [32]. Authors in [32] reported an α of 0.78. The present study recorded an α of 0.81.

E. VARIABLES AND MEASUREMENTS

The dependent variable for this study was the effectiveness of health governance, while sociodemographic factors considered were; age of participants, participant's gender, and professional experience, level of education, type of healthcare institution they worked in, were independent variables. The C.L.C.M. was used as the intervention variable for this study. The C.L.C.M., was used to provide psychoeducation to health managers, which was beneficial in identifying significant barriers and solutions in clinical leadership. C.L.C.M., used incorporated five dimensions which served as a yardstick to determine specific domains of inquiry [23]. The C.L.C.M., took approximately 45 minutes to complete. [23] outlines five themes for C.L.C.M:

(a). Building Confidence: This theme covers perceived and actual competencies based on leadership roles. Questions such as "What measures are been used to boost clinician confidence in their effort to lead healthcare teams"?

(b). Widening perspectives: This theme exposes health managers to tact in meeting obligations, such as ambiguity of clinician roles, because some clinicians perceive transitioning into leadership positions as different from their clinical roles and duties. Answers are derived from questions such as: "*Are there ways in which is clinicians leadership abilities are harnessed*"?

(c). Talent management: This encapsulates inclusive talent agency for clinicians, that potentially increase probability of taking on management or leadership roles as a veritable tool to increase opportunities for talent management. The resources to help harness talent management and relevant leadership development is a crucial element in the development of clinical leadership. Creating talent agency for developing crucial skills needed for clinical leadership competence that offer training opportunities on clinical leadership skills. Questions such as "*What parameters are in place to help clinicians gain direct leadership experience*"?

(d). Practical levers: The practical levers theme involves the creative use of emolument schemes that optimize compensations by creating organizational culture that encourage leadership roles and responsibility. Questions such as: "*What processes are in place to help clinicians prepare for clinical leadership roles*"?

(e). Organizational culture: This theme involves promoting the agenda for professional diversity, requires multifaceted approaches that guarantee beneficial organizational climax. Healthcare managers are taught how to change the climate of the organization and promote it as priority. Questions such as: "*In what ways are you assisting clinicians to develop as clinical leadership skills as they carry out their responsibilities*"?

F. STRUCTURE OF THE SESSIONS OF THE CLINICAL LEADERSHIP COMPETENCY MODEL

By the C.L.C.M., recommendations, the structure of the five themes was stratified (they followed sequential order, for example, step one, step two, and then step three, respectively). However, in situations where more than one problem theme cluster was found in managers, the organizational culture was first developed, followed by building confidence in talent management and practical levers. The session was 45 minutes, and there was one session per day for each group of health managers. In each group, public and private health institution managers were mixed.

G. DATA MANAGEMENT AND ANALYSIS

Two-step hierarchical multiple regression analyses and a combination of two sets of t-tests for dependent samples were employed so as to match pre-assessment and post-assessment scores of the treatment and control group to test formulated hypotheses. Furthermore, a One-way Analysis of Variance (A.N.O.V.A.) was employed to analyze data to find out if C.L.C.M., significantly varied from healthcare governance. Again, Bonferroni's post hoc test was used to determine how much the three participant groups differed.

IV. RESULTS AND DISCUSSION

A. TESTING FOR HYPOTHESIS 1: T-TEST FOR DEPENDENT ANALYSIS ON HYPOTHESIS 1

Two sets of t-tests for dependent samples were performed on the data to determine how much the mean scores of the pre-test and post-test of the treatment and first control groups differed. The statistical outcomes are presented in Table 2.

Table 2: Summary of *t*-Dependent Test on Pre-Test Scores of the Treatment and First Control Groups on Efficacy of Health Governance.

Groups	Test Condition	<i>N</i>	\bar{x}	<i>SD</i>	<i>df</i>	<i>T</i>	<i>p</i>
Treatment Group	Pre-test	120	1.32	0.56	119	32.42	< 0.01
	Posttest	120	4.78	0.67			
	Pretest	120	1.25	0.54	119	2.45	> 0.05
Control Group 1	Posttest	120	1.86	0.81			

N = Number of participants; M = Mean.

The results in Table 2 indicated that the variance between the pre-test and post-test scores of health managers in the treatment group was significant [$t(119) = 32.42, p < 0.01$]. It showed that the participants performed better in the efficiency of health governance ($\bar{x} = 4.78$; $SD = 0.67$) than in the pre-test ($\bar{x} = 1.32$; $SD = 0.56$). The outcome of this comparison implied that CLCM affected those in the treatment group. The post-test mean results of the 3 groups were compared, as shown in Table 4, to show how effective C.L.C.M., is in improving the efficacy of health governance among health managers.

B. TEST OF HYPOTHESIS 2

A one-way Analysis of Variance (ANOVA) was performed on post-test data to ascertain if observed differences in the mean scores of the 3 groups were statistically significant. The results are presented in Table 3.

Table 3: Summary of a One-Way ANOVA on the Efficiency of Healthcare Governance among Healthcare Managers in the Public and Private Sectors.

Sources	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P</i>
Between Groups	275.23	3	144.24	244.32	< 0.01
Within Groups	156.44	357	1.78		
Total	431.67	360			

Table 3 shows that the variations in the health governance efficacy score of the first control group, the second control group and the treatment group were found to be significant [$F(3, 360) = 244.32, p < 0.01$]. The results of the *F* test did not indicate which group, in particular, had the best level of health governance efficacy to support Hypothesis 2. As a result, the Bonferroni post hoc test was used to compare the mean scores of the three groups.

C. POST HOC ANALYSIS OF HYPOTHESIS 2

Result of post hoc analysis is shown in Table 4.

Table 4: Summary of the Post hoc Test on Health Governance Efficacy of Health Managers

Groups	<i>N</i>	\bar{x}	<i>SD</i>	1	2	3
Control Group 1	120	1.45	1.18			
Second control group	120	0.52	0.43	0.46*		
Treatment group	120	4.77	0.78	2.60*	2.72*	

Note: * $p < 0.05$.

Post hoc findings as shown in Table 4 shows the highest and most significant mean difference (Bonferroni = 4.77, $p < 0.05$) was observed between the treatment group (participants who were subjected to C.L.C.M.,) and the control group two (who were neither pre-tested nor experienced any form of intervention). Furthermore, the mean difference between the treatment group and the control group 1 (Bonferroni = 2.60, $p < 0.05$) and the mean variance between control group 1 and control group 2 (Bonferroni = 0.46, $p < 0.05$) were found to be significant. However, these mean differences were less than the considerable variance between the treatment group and control group 2, validating effect of C.L.C.M., intervention in determining the efficacy of health governance among health managers. The mean scores indicated that the health managers in the treatment group measured the highest efficiency of health governance compared to those of control group 1 and control group 2. Therefore, Hypotheses 2 was accepted.

The study examined the roles of demographic information and C.L.C.M., effectiveness in managers in public and private healthcare institutions in Federal Capital Territory, F.C.T, Nigeria. The study findings revealed that health managers' rank and qualification level showed significant predictions about the efficacy of health governance. This outcome suggests that the qualifications or positions of health managers increase the chances of developing effective health governance. A plausible reason for this outcome can be linked to leadership effectiveness by drawing from a wealth of experience that accumulates as a result of qualification and having the proper requirements that serve as a prerequisite for achieving organizational objectives and personal goals. Studies have recorded similar findings and suggested that highly qualified managers ensure skillset, professionalism, credibility, and experience, which allows managers to govern the affairs of both the organization and their team members toward the overall success of the organization [33, 34]. Healthcare managers are tasked with ensuring optimal operations within the organization. Therefore, healthcare managers should have appropriate professional qualifications to gain patient trust and expectations while influencing employees toward better patient treatment and the prospect of career advancement. Such additional training would allow them to develop skills and assume responsibilities aligned with the required qualifications [35]. Within professional health practice, regular training and development help identify the manager's repository of knowledge and abilities regarding what has been acquired and also provide a platform for managers to influence patients and employees to trust their judgment. Given the importance of qualification and classification, they cannot guarantee the efficacy of healthcare governance in healthcare practice. One plausible reason why qualification and rank predict health governance is the principal application of qualification and rank in the practice of healthcare professionals. For example, within public and private health practice, the roles and identities of health managers constantly change because qualification and rank are integrated into the professional culture and practices acquired through learning (knowledge and skills), incorporating the roles of formal education and the learning process (Sethi *et al.* 2018).

This study showed that health managers exposed to C.L.C.M., (treatment group) measured the highest efficacy of health governance compared to those not exposed to C.L.C.M., (control group 1 and control group 2). C.L.C.M., integrates shared leadership principles in clinical leadership, administration, health data management, and clinical leadership abilities [38]. It is the opinion of this researcher that health managers can increase their knowledge of the core competencies of clinical leadership in order to promote and carry out health governance practices. Given this importance, C.L.C.M., equips health managers with the skills to carry out professional healthcare practice to mitigate health delivery problems. Since C.L.C.M., offers a scientific explanation of why and how governance factors influence patient practice and attempts to identify factors outside of the patient involved in improving health outcomes, this study has shown that exposing health managers to C.L.C.M., would improve health governance. It is a typical mistaken belief that employing health administrators with competency in patient care without engaging them in constant training is enough. This study sheds more light on this by suggesting that providing appropriate competence models and intervention programme to health workers improves professional health practice. Given this training, health management must ensure that all health managers and clinicians are extensively exposed to C.L.C.M.

V. Conclusion

The findings of this study demonstrate that public and private health institutions' health managers, their qualifications, and rank are significant predictors of the efficacy of health governance. This study also revealed that health managers who reported low levels of health governance efficacy when exposed to C.L.C.M., showed a significant improvement in healthcare governance efficacy more than their counterparts who were not exposed to C.L.C.M., suggesting that C.L.C.M., significantly improves health governance efficacy among health managers. It is suggested that future studies can improve on the shortcomings of this study by conducting treatment designs so as to establish a causal relationship between the variables examined in the study. In this study, self-report instruments were used to collect data, and a significant characteristic of self-report questionnaires is that they are prone to response bias therefore, future studies should consider other forms of data collection techniques and conduct studies that represent the six geopolitical zones of the Nigerian Federation. Given the outcomes of this study, several suggestions were addressed to help address and provide scientific and culturally sensitive solutions to the problems of healthcare governance efficacy among health managers in Nigeria. Based on current medical and mental health practices, today's health professionals need hands-on information to provide qualitative patient care in practical clinical settings, immediate implementation of professional training, and increased funding for professional education on the efficacy of health governance. This need comes when Nigeria's health practice is on a downward spiral. Health Maintenance Organizations (H.M.O.'s), healthcare bodies, as well as subspecialty organizations should apply these research findings to professional education through continuing education models and lecture series on the efficacy of health governance.

Develop a C.L.C.M., curriculum on the efficacy of health governance for medical schools and academic institutions related to health. Lack of awareness among stakeholders in the health sectors on the effectiveness of health governance may be responsible for poor patient care and management. Changing this situation and perception will require institutionalizing this C.L.C.M., curriculum at the H.M.O., level. At the primary health levels, medical training and research institutions will need to foster the efficacy of health governance as a core competency in training and managed care. National health quality improvement strategies and policy formation should be articulated, implemented and monitored to explicitly recognize that health governance efficacy and leadership within health are critical to improving health quality and clinical outcomes in a wide range of medical specialties. In doing so, health information technology and related standards must improve the flow of complete and timely information among health managers to facilitate participation in their care and allow clinicians and health stakeholders (hospital management boards) to identify and address gaps in the efficacy of health governance.

Research is a critical area for new research efforts, and as such, efforts should be intensified to reap the rewards of research-proven solutions. As such, there is a need for research on the efficacy of health governance, including a focus on the effectiveness of interventions to improve clinical leadership practices, improved research methods, and uniform metrics to assess the impact of various health governance efficacy interventions, and the evaluation of the transferability of successful interventions to broader populations of health employees. Therefore, stakeholders must advocate for the integrated health governance research network and hospital management boards to significantly increase the proportion of their research funding to test health governance efficacy interventions such as C.L.C.M., and measure their effectiveness. Health expenditures will be reduced if the Ministry of Health intensifies its commitment. If these recommendations are implemented, an ideal system for improving the efficacy of health governance would involve health managers themselves, leverage health outcomes, and directly engage the collective-support network. This system would also allow for a secure means of knowledge-base for data regarding clinical leadership and efficacy in health governance.

REFERENCES

- [1] A. Silva., "What is leadership?" *Journal of Business Studies Quarterly*; Antioch, 8 (1), September, 2016, pp. 1-5. Retrieved from: <https://www.proquest.com/docview/1831706711?pq-origsite=gscholar&fromopenview=true&sourcetype=Scholarly%20Journals>
- [2] W. Wondimu, A. Girmaw, & M. Yassin, "The effect of leadership styles and emotional intelligence on leadership effectiveness in some selected public sectors in Kaffa zone, Ethiopia" 2017, Jimma University Open Access Institutional Repository. <http://10.140.5.162/handle/123456789/1168>
- [3] K. Teame, A. Debie, and M. Tullu, "Healthcare leadership effectiveness among managers in public health institutions of Addis Ababa, Central Ethiopia: A mixed methods study". *BMC Health Services Research*, April 22, 2022, 22:540. <https://doi.org/10.1186/s12913-022-07879-6>
- [4] U. D. Dennis, "Challenges of clinical leadership in Nigeria", *Journal of Psychiatry*, 18, 210, 2015. <https://doi.org/10.4172/2378-5756.1000210>

- [5] McKinsey Quarterly, "A healthier healthcare system for the United Kingdom" February 2008. Retrieved from: https://heeoe.hee.nhs.uk/sites/default/files/1262948659_rgg_n_healthcare_system.pdf
- [6] J. Mountford, and C. Webb, "When clinicians lead". McKinsey Quarterly, February 1, 2009. Accessed on 24/08/2024; Retrieved from: <https://www.mckinsey.com/industries/healthcare/our-insights/when-clinicians-lead>
- [7] J. O. Busari, "Management and leadership development in healthcare and the challenges facing physician managers in clinical practice". *Int. J. Clin. Leadership*, 2012; 17(4):211–216.
- [8] Z. K. Dagona, and U. D. Dennis, "Clinical leadership competence in professional healthcare management system: The role of self-esteem, extraversion, and interpersonal relationship among clinicians in Ondo and Lagos State, Nigeria". *Scholarly Journal of Psychology and Behavioural Sciences*, 4(5), 2021, 486–496.
- [9] U. D. Dennis, and F. A. Oluwatelure, "Self-esteem and extroversion as predictors of clinical leadership competence among clinicians in Nigeria". *Clinical Treatment Journal of Psychology*, 2, 122, 2016. <https://doi.org/10.4172/2471-2701.1000122>.
- [10] Edmonson, C., et al. "Emerging global health issues: A Nurse's role" *OJIN*: Online J. Issues Nurs. 2017, Jan 31;22(1):2. <https://doi.org/10.3912/OJIN.Vol22No01Man02>
- [11] M. T. Mrayyan, et al., "Attributes, skills, and actions of clinical leadership in nursing as reported by hospital nurses: A cross-sectional study", *BMJ Leader*, January 25, 2023. <https://doi.org/10.1136/leader-2022-000672>.
- [12] M. W. True et al., "Leadership training in graduate medical education: time for a requirement?" *Military Medicine*, January-February, 2022, 185(1-2), e11–e16, <https://doi.org/10.1093/milmed/usz140>
- [13] P. Dash, and P. Garside, "Clinical leadership: Wanted doctors to help redesign services". *Health Service Journal*, 2007, 7, 117(6059). <https://documentsdelivered.com/source/000/013/000013781/2007/024516426.php>
- [14] P. Lewis, and R. Murphy, "New directions in school leadership". *School Leadership and Management*, 28(2), 2 April, 2008, 127–146. Retrieved 25/08/2024 from <https://www.learntechlib.org/p/101057/>.
- [15] M. L. Joseph, and D. L. Huber, "Clinical leadership development and education for nurses: Prospects and opportunities". *Journal of Healthcare Leadership*, 15 March, 2015, 7, 55–64. <https://doi.org/10.2147/JHL.S68071>
- [16] A. Abraham, "Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people". London, February, 2011. <https://www.ombudsman.org.uk/sites/default/files/2016-10/Care%20and%20Compassion.pdf>
- [17] M. Casey et al., "Nurses' and midwives' clinical leadership development needs: A mixed methods study". *Journal of Advance Nursery*, 15 March, 2011, 67, 1502–1513. <https://doi.org/10.1111/j.1365-2648.2010.05581.x> <https://pubmed.ncbi.nlm.nih.gov/21323973/>
- [18] J. Daly, et al., "The importance of clinical leadership in the hospital setting". *Journal of Healthcare Leadership*, 2014, 6, 75–83. <https://doi.org/10.2147/JHL.S46161>
- [19] J. Edmonstone, "Evaluating clinical leadership: A case study". *Leadership Health Service*, July, 2009, 22, 210–224. https://www.researchgate.net/publication/235321390_Evaluating_clinical_leadership_A_case_study
- [20] S. Mianda, and A. Voce, "Developing and evaluating clinical leadership interventions for front-line healthcare providers: A review of the literature". *BMC Health Service Resources*, 1 October, 2018, 18, 747. <https://doi.org/10.1186/s12913-018-3561-4>
- [21] D. L. Bradford, and A. R. Cohen, "Power up: Transforming organisations through shared leadership". John Wiley & Sons, 2008, <https://archive.org/details/poweruptransform0000brad/page/n1/mode/2up>
- [22] A. Konu, and E. Viitanen, "Shared leadership in Finnish social and health care", *Leadership in Health Services*, 2008, 21(1), 28–40. <https://doi.org/10.1108/17511870810845888>
- [23] NHS Improvement, "Clinical leadership: A framework for action: A guide for senior leaders on developing professional diversity at board level". 26 June, 2019. Accessed on 15/06/2024; Retrieved from: <https://www.pslhub.org/learn/leadership-for-patient-safety/exec-teams/clinical-leadership-%E2%80%93a-framework-for-action-a-guide-for-senior-leaders-on-developing-professional-diversity-at-board-level-january-2019-r82/>
- [24] C. Uneke, et al. "Enhancing leadership and governance competencies to strengthen health systems in Nigeria: Assessment of organisational human resources development". *Healthcare policy = Politiques de sante*, February, 2012, 7(3), 73–84. <https://doi.org/10.12927/hepol.2013.22749>
- [25] FMOH, "Health Sector Reform Programme: Thrusts with a Logical Framework and Plans of Action, 2004–2007. Abuja: Federal Ministry of Health". https://books.google.com.ng/books/about/Health_Sector_Reform_Programme.html?id=JkAyQwAACAAJ&redir_esc=y
- [26] O. J. Busari, et al. "Clinical leadership as an agent for change: A health system improvement intervention in Curaçao". *Journal of Multidisciplinary Healthcare*, 2020, 13, 787–798. <https://doi.org/10.2147/JMDH.S262415>.
- [27] J. P. Kouzes and B. Posner, "The leadership challenge", 3rd Ed., 2022, Jossey Bass. https://nibmehub.com/opac-service/pdf/read/The%20Leadership%20Challenge_%20How%20to%20Make%20Extraordinary%20Things%20Happen%20in%20Organizations.pdf
- [28] Federal Capital Territory, Nigeria. "City population". 2022 National Population Commission of Nigeria (web), National Bureau of Statistics (web). Accessed on 28/06/2024; Retrieved from: <https://www.citypopulation.de/en/nigeria/admin/>
- [29] W. Odunsi, "Gwagwalada re-run poll: APC beats APGA, PDP in narrow victory". 13 January, 2018. *Daily Post Nigeria*. Accessed 28/08/2023; Retrieved from: <https://dailypost.ng/2018/01/13/gwagwalada-re-run-poll-apc-beats-apga-pdp-narrow-victory/>
- [30] D. W. Brinkerhoff, C. Fort, and S. Stratton, "Good governance and health: Assessing progress in Rwanda". 2009. Kigali: USAID. https://www.researchgate.net/publication/237464786_Good_Governance_and_Health_Assessing_Progress_in_Rwanda
- [31] D. W. Brinkerhoff, and S. Helfenbein, "What health professionals think about good governance practises. Results of an online survey". 2008, Policy Brief. Results of an Online Survey. Washington, DC: US Agency for International Development, Health Systems 20/20, Policy Brief, August.
- [32] W. Mutale, et al. "Measuring governance at health facility level: Developing and validation of simple governance tool in Zambia". *BMC International Health Human Rights*, 2013, 13, 34. <https://doi.org/10.1186/1472-698X-13-34>
- [33] K. I. Khoshhal, and S. Y. Guraya, "Leaders produce leaders, and managers produce followers: A systematic review of the desired competencies and standard settings for physician leadership". *Saudi Medical Journal*, 2016, 37(10), 1061–1067. <https://doi.org/10.15537/smj.2016.10.15620>
- [34] J. Rasa, "Developing effective health leaders: The critical elements for success". *Journal of Hospital Management & Health Policy*, 25 March, 2019, 4. <https://doi.org/10.21037/jhmhp.2019.11.02>
- [35] F. Moradi, et al., "Hospital managers' skills required and onwards challenges: A qualitative study". *Journal of Education and Health Promotion*, 2020, 9, 228. https://doi.org/10.4103/jehp.jehp_171_20
- [36] A. Sethi, "The influence of postgraduate qualifications on educational identity formation of healthcare professionals". *Advances in Health Science Education Theory and Practise*, 2018, 23(3):567–585. <https://doi.org/10.1007/s10459-018-9814-5>.
- [37] NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges. "Medical Leadership Competency Framework 2nd edition. Coventry: NHS Institute for Innovation and Improvement", 2009. <https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf>