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Stakeholder Perspectives of an Approach to Healthcare Leadership Development through Use of a Multidimensional Leadership Development Conceptual Model

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Abstract

Leadership is often the driver used to transform healthcare services. Healthcare leadership development is often situated around conceptual frameworks or leadership development models. The aim of the study reported here was to evaluate multistakeholder perspectives on leadership development when applying a Multidimensional Leadership Development Conceptual Model to post-graduate healthcare leadership programmes at a university in England. This exploratory qualitative study of healthcare leadership development comprised face-to-face interviews. Six interviews were undertaken with academics from a post-graduate leadership programme team, a family carer and service-user of health care services, and current United Kingdom students and former United Kingdom and international students who had undertaken the leadership development programme. Transcripts were thematically analysed. Three themes emerged: Expectations of the contemporary healthcare leader; Experiences of the Multidimensional Leadership Development Conceptual Model on leadership development; and Improvements to the model. We conclude that framing post-graduate leadership programmes around a conceptual model can aid identification of the key components required for effective leadership development. Evidence-informed recommendations are provided which seek to optimise healthcare leadership development using a leadership development conceptual model which (1) represents the values and beliefs of all stakeholders involved; (2) is reviewed annually to critically explore the internal and external evidence base for leadership development; gain stakeholder consensus of expectations of the healthcare leader; and provide the reality check to ensure a 'fit for purpose' programme; and (3) is constructively aligned to leadership programme curricula with sufficient flexibility to tailor an effective teaching and learning platform for preparing the individual leader, noting unique circumstances and contexts.

Keywords: conceptual model; effectiveness; leadership strategy; multidimensional leadership model; practice learning

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Introduction and background

The complexities and challenges facing healthcare leaders have never been greater. These include system change ([Mahon et al. 2009](#)) that is reliant on leaders working together and in partnership to 'dissolve' the traditional divide between healthcare services ([West et al. 2015](#)). The UK has experienced unprecedented change within its National Health Service. Application of political policy ([NHS England 2014](#)) has resulted in changes to workforce development and the merger and integration of traditionally stable health and social care organisations. The health and social care leader is required to contain costs but deliver on quality. Healthcare professionals are increasingly required to work in partnership with a range of other workers, often leading service design and delivery to effect excellent patient care. The concept of shared and distributed leadership is prominent, whereby service improvement is reliant on personnel working together; this promotes improved patient outcomes through service improvement ([Leigh et al. 2015](#), [Storey and Holti 2013](#), [West et al. 2015](#)).

There is prevalence of healthcare leadership development activity that is situated within some kind of conceptual framework or leadership development model ([Fealy et al. 2011](#), [MacPhee et al. 2014](#), [Pepin et al. 2011](#), [Steinert, Goebel, and Rieger 2006](#), [VanVactor 2012](#)). These models can be locally or nationally driven and have the potential for operationalising leadership development around a clear set of assumptions that are agreed by the programme team and key stakeholders. The often descriptive reporting of the impact of the model on leadership development is noticeable along with the absence of a robust evaluation framework. Despite the inception of such models, the Kings Fund in 2015 concluded that evidence for the effectiveness of specific leadership development programmes within the NHS is extremely variable and little robust evidence has been acquired, despite the vast sums spent ([West et al. 2015](#)).

This research is timely, providing multistakeholder perspectives on the impact on leadership development when applying a Multidimensional Leadership Development Conceptual Model to post-graduate healthcare leadership programmes at a university in the North West of England.

Healthcare leadership development

Leadership is often defined as a process whereby an individual influences a group of individuals to achieve a common goal ([Northouse 2016](#)). The purpose of leadership development is to expand the capacity of individuals to perform in leadership roles within organisations. [Hartley and Hinksman \(2003\)](#), in their systematic review of leadership development, report on Day's (2000) approach that distinguishes between developing the person (leader development) and organisational leadership development (leadership within the organisation). The latter approach best fits the contemporary UK healthcare agenda whereby all frontline healthcare staff members are defined as healthcare leaders who are required to deliver healthcare outcomes that are the best in the world ([Leigh et al. 2015](#), [NHS England 2014](#)).

The healthcare literature provides evidence of diverse approaches to leadership development. Authors who report on this literature often situate their approach within a leadership model or conceptual framework that aims to bring together those components essential for effective leadership development ([Leigh et al. 2015](#), [Redmond and Dolan 2016](#)). For example, [Pepin et al. \(2011\)](#) report on their Cognitive Learning Model as applied to nurses. Their premise is that clinical nursing leadership is competency-based. To apply their model to real-world leadership development, a leadership development programme should provide developmental competency-based opportunities for the leader to work within. A Collaborative Communications Leadership model ([VanVactor 2012](#)) focuses on the concept of a synergistic work environment. A leadership programme applying this model therefore requires opportunities for multiple parties to work together towards the enhancement of effective practices and processes. Other models apply concepts of situational leadership whereby opportunities for co-working across key areas of the organisation are provided ([Steinert, Goebel, and Rieger 2006](#)). Further examples relate to

developing interdisciplinary relations ([Fealy et al. 2011](#)), and introducing a scaffolding approach to leadership development ([MacPhee et al. 2014](#)).

There is a wide variety of leadership development models available, often responding to local workforce development and organisational needs. Despite a lack of robust evidence, authors of those models present them as effective, and it should be noted that there are common characteristics amongst the models. These suggest that there are core requirements for a healthcare leadership development model to be effective. For example, there is a noticeable global paradigm shift with movement away from the theoretical programme curricula to one that includes work- (practice-) based leadership learning ([Cunningham, Dawes, and Bennett 2016](#) [Leigh et al. 2015](#)).

Key success factors include the need for effective leadership teaching and learning strategies which include exposing developing leaders to established leaders both within and outside their organisation ([Leigh 2016](#)) as well as activities and strategies that promote effective teamwork ([Crofts 2006](#), [MacPhee et al. 2014](#)). Examples include activities that promote teamwork when working on a specific component of professional practice such as development of a policy or engagement within a clinical case ([Crofts 2006](#)). Teamwork activities are also commonly utilised to uncover the learner's decision-making skills which are then used to promote the paradigm shift from leaders acting in disciplinary silos to engaging collaboratively in the important work of the organisation ([MacPhee et al. 2014](#), [Steinert, Goebel, and Rieger 2006](#)). Other contemporary leadership teaching and learning strategies include: planned leadership experiences; workshops; action-learning sets; mentoring and coaching ([Leigh et al. 2015](#)). Recognising instruction and feedback as a legitimate practice-based leadership teaching and learning strategy is an interesting concept that has been effectively used to combine leadership competency development for new managers supporting newly qualified staff through their period of preceptorship ([Hsu et al. 2011](#)).

A further key success factor is to situate the leadership learning within a learning organisation ([Supamanee et al. 2011](#)). A learning organisation is one which facilitates the learning of its members and continuously transforms itself ([Senge 2006](#)). Teaching and learning strategies that commonly promote opportunities to effectively communicate within the learning organisation are those that assist healthcare leaders to build relationships with the right people and to demonstrate exemplary leadership ([Kouzes and Posner 2012](#)). The notion of structural empowerment ([Leigh 2014](#), [Patrick et al. 2011](#), [Steinert, Goebel, and Rieger 2006](#)) may be achieved through the leader demonstrating effective sharing of information through all tiers of their organisation. A notion often connected to this is the need to develop a shared purpose ([Manley, Parlour, and Yalden 2013](#)) which is a key activity of practice development work.

Promoting leadership development within a learning organisation has advantages. For example [Crofts \(2006\)](#), [Patrick et al. \(2011\)](#) and [MacPhee et al. \(2014\)](#) all report on the positive effect that the organisation has when taking an interest in its staff and in the leadership programme itself and valuing staff education and development. Indeed those behaviours exhibited by managers from within empowered clinical contexts positively influence staff perceptions of clinical leadership ([Patrick et al. 2011](#)).

A further key factor is the provision of opportunities for the developing leader to demonstrate leadership behaviours from within their individual context ([Cook and Leathard 2004](#), [Fealy et al. 2011](#), [MacPhee et al. 2014](#), [Stanley 2006](#), [VanVactor 2012](#)). An example is the implementation of a leadership competency culture applied by healthcare organisations, to define and then measure the knowledge, skills and behaviours of the healthcare leader ([Leigh et al. 2013](#), [Leigh et al. 2015](#), [Patrick et al. 2011](#), [Storey and Holti 2013](#), [Supamanee et al. 2011](#)).

Background to the Multidimensional Leadership Development Conceptual Model

The lead author of this article has a role as course leader for a suite of post-graduate healthcare leadership and educational leadership programmes. Their team developed a conceptual model of healthcare leadership development. This model made clear their philosophy and assumptions around leadership and leadership development.

The approach taken to developing the model was participative and included the programme team challenging their assumptions about existing leadership development models. Exploring hunches, channelling curiosity into learning about new, innovative models provided the platform for discussion of stories and reflections about the often challenging realities of providing leadership development. At the start of these discussions all programme staff were clear that the leadership knowledge, skills and attitudes attained must not only be theoretical but also applicable in practice. Importantly, innovative teaching and learning strategies would be viewed as a requisite to integrate leadership theory into practice and to help the students achieve the programmes' aims and intended learning outcomes.

The emergent model was underpinned by the available evidence base for effective leadership development and leadership development models, thus requiring a shift from the traditional theoretical programme curricula to one that would include work- (practice-) based leadership learning. The intention was to apply the final model to two healthcare leadership and management post-graduate programmes - *Healthcare Leadership and Management* and *Healthcare Educational Leadership and Management*.

The model is unusual as it incorporates the Leadership Qualities Framework (LQF) Five E's approach to learning (NHS Institute for Innovation and Improvement 2006) with Biggs' (2003) Constructive Alignment Curricular framework, which are explained next.

Understanding the Multidimensional Leadership Development Conceptual Model

The team envisaged a leadership development philosophy whereby teaching is viewed as a catalyst for learning, with the developing leader constructing meaning from the range of relevant teaching, learning and assessment activities made available to them by the programme team. The team recognised how the Leadership Qualities Framework (LQF) (NHS Institute for Innovation and Improvement 2006) Five E's approach to learning: Examine, education, experience, exposure and evaluation, could provide some of the key elements they believed were required for effective leadership teaching and learning.

The team established how the Five E's could represent their shared philosophy for leadership development:

Leadership development will place the individual at the centre of their educational leadership learning journey enabling them to: *Examine* themselves as a leader; contextualise their learning against the contemporary healthcare agenda and within their healthcare organisation; and to make judgements about (*Evaluate*) their personal and professional leadership.

The use of combined theoretical and practice based leadership development educational activities (*Education, Experience, Exposure*) will challenge the leader's values and assumptions, and this in turn will provide them with the opportunity to problem solve and lead through influence.

The team agreed that the Five E's framework should not be operated in isolation from the programme curricula, and therefore explored approaches to curricula design that, if integrated with the Five E's, could provide the link between effective approaches to academic and practice learning as well as learning and meeting the intended learning outcomes of a leadership development programme.

Biggs' (2003) Constructive Alignment Curricular framework provided a conceptual basis which requires leadership developers to carefully consider four key aspects:

- (1) Defining the programmes' intended learning outcomes;
- (2) Choosing teaching/learning activities likely to lead to achievement of the learning outcomes;
- (3) Assessing students' actual learning outcomes to see how well they match what is intended;
- (4) Arriving at a final grade.

This unique integration of Biggs' constructive alignment curriculum framework with the Five E's manifested into the Multidimensional Leadership Development Conceptual Model (Figure 1).

Figure 1: The Multidimensional Leadership Conceptual Development Model



In 2010, this model, which encompassed both leader and leadership development, was subsequently applied to two of the programme team's post-graduate healthcare leadership programmes and used to operationalise their curricula.

Table 1 provides examples of how the programme team applied the Five E's through creating both timely leadership teaching, and learning and assessment opportunities for students to engage with, that reflected the programmes' aims and intended learning outcomes.

Table 1: Teaching and Learning Strategies relating to the Leadership Qualities Framework (LQF) (NHS Institute for Innovation and Improvement 2006) Five E's

Examine	Self-assess prior to commencement of programme: 360-degree self-assessment, influencing style questionnaires, emotional intelligence testing
Education	Learning through formal approaches: masterclasses, workshop, action learning
Experience	Opportunity to try things out; participate in dynamic assessment processes (Patchwork Text Assessment with the embedded critical commentary)
Exposure	Exposure, for example shadowing in own or other organisation, mentoring, coaching, active learning
Evaluation	Reviewing the effectiveness of learning, reflection, Patchwork Text Assessment with the embedded critical commentary

Having developed the model, the next step was to test it out. To deepen understanding of leadership development through use of the model, an evaluation was undertaken. This brought together different stakeholders' perceptions and experiences of post-graduate healthcare leadership programmes that had been framed around the model. The evaluation sought evidence of the impact of the model's application and insights which could be used to inform recommendations for providers of leadership development programmes.

Study aim and objectives

Aim

The aim of the study was to evaluate multi-stakeholder views of leadership development when applying the model to two post-graduate healthcare leadership programmes.

Sample

Application of purposive sampling techniques ([Silverman 2016](#)) resulted in the following stakeholder groups participating in the study:

- 2 current students (UK)
- 3 former students (UK and International)
- 3 post-graduate programme team members (Academics)
- 1 healthcare service-user
- 1 carer of a healthcare service-user

Participants consisted of international and UK male and female students that spanned a range of healthcare disciplines and roles including nursing, physiotherapy, quality lead, multi-professional/continuing professional development lead, specialist practitioner, service-user and family carer, and programme team academics. All participants had experience of working in a leadership role, and this experience varied from 3 years to over 5 years.

Methods

The semi-structured interview was used as the data-collection tool ([Silverman 2016](#)) and either applied to a one-to-one interview situation with participants or as a focus group interview. The

face-to-face individual interviews were used with the service-user and family carer and with students who could not attend a focus group. Focus groups were used when interviewing groups of students and programme team members and are a form of group interview used to obtain multiple perspectives on the same topic area at the same time and to generate debate (Green and Thorogood 2014). Green and Thorogood (2014) suggest how the focus group interview provides access to those interactions between participants and propounds how social knowledge is constructed. The semi-structured interview schedule consisted of nine questions informed by the evidence of conceptual models as applied to healthcare leadership development (Fealy *et al.* 2011, Leigh *et al.* 2015, MacPhee *et al.* 2014, Pepin *et al.* 2011, Steinert, Goebel, and Rieger 2006, VanVactor 2012). The questions for current and past students and post-graduate programme team participants sought to elicit their experiences of leadership and of the Multidimensional Leadership Development Model. Questions for the service-user and family carer focused on their perceptions of the future potential of the model. All participants were provided with the opportunity to propose refinements to the model.

Three focus group interviews took place, two with students and one with the programme team. Three individual interviews took place with the service-user, family carer and a former student.

Data collection

Potential participants were invited by a letter from the lead author, with interviews taking place in a venue that suited the participants (home or university). The University Lone Researcher Policy was followed. Informed consent was obtained and data were collected between February 2015 and January 2016.

Ethical considerations

The University Research Ethics Committee provided ethical approval. Participation in the study was voluntary with participants able to withdraw at any time without prejudice. Existing students were reassured that their views would not affect their treatment on their programme of study.

Data analysis and findings

All of the interviews were audio-recorded and transcribed verbatim by the lead author and coding schemes generated from the line-by-line analysis of the interview schedules (Graneheim and Lundman 2004). Inductive content analysis (Moretti *et al.* 2011) allowed for an initial exploration of the associations between attitudes, behaviours and impact about leadership development and expectations of the healthcare leader. This was followed by exploration of views and experiences of undertaking a post-graduate programme structured around the model. The interviews were undertaken by the lead author who was known to some of the student population as she was also a member of the post-graduate programme team. It was essential therefore that students were reassured that their views would not affect their treatment on the programme. Data were organised into codes and then into broader categories. The first and second authors met to discuss the emergent categories and to verify these across all the data.

This approach to data analysis led to the identification of three themes:

- (1) Expectations of the contemporary healthcare leader;
- (2) Experiences of the Multidimensional Leadership Development Conceptual Model on leadership development;
- (3) Improvements to the model.

Theme 1: Expectations of the contemporary healthcare leader

The programme team participants explored their expectations of the contemporary healthcare leader and how this information is important to them when planning and operationalising leadership development programmes within the philosophy of the model they had developed.

They believed these expectations should be translated into the leadership programme curriculum content and embedded teaching, learning and assessment strategies:

The programme is about opening people's minds to see the bigger picture and develop skills and then at the end of the programme student demonstrate these skills and reflect. (Programme Team Member 1)

There is a need for effective micro leaders, looking at the traits they have, this constant desire of never giving up. (Programme Team Member 2)

Other participants articulated their expectations of the healthcare leader and these were varied, encompassing leadership behaviours, clinical competence, team-building, role-modelling, and inter- and intrapersonal skills:

People that are open to challenge, even from a junior member of staff, challenging your ideas and not the person, way to draw on strengths and weaknesses of the team, getting people on board as opposed to alienating people. (Former Student 3)

They [leaders] invest in people, inspirational, interactive with relationships, can see potential and nurture potential. (Programme Team Member 2)

Setting the culture and atmosphere giving people opportunities and demonstrating an interest and engaging intellectually with a topic area. (Current Student 1)

Leadership is visionary, leading from the front and having [a] picture of where the team need to go... and wanting the team to follow them. (Service User)

The family carer provided their experiences of when leadership does not meet their expectations. The following comment was in relation to them attending an outpatient appointment with their teenage son:

I was feeling that the left hand did not know what the right hand was doing... lack of vision or direction of the overall picture... the consultant used language that we did not understand. (Family Carer)

Perceptions of leadership are influenced by those behaviours exhibited by the leader's managers and these include acting as a role model for effective leadership, with emotional intelligence exhibited by the leader seen as imperative:

I look up to them as role models, demonstrating good relationships, decisive decision making... emotional intelligence is the key... (Former Student 3)

Theme 2: Experiences of the Multidimensional Leadership Conceptual Model on

The programme team reported on their experiences of developing and subsequently applying the model to their post-graduate programme curriculum:

Developing our own conceptual model provided the space for us to explore our own assumptions about what was important to us as a team and for our students. Take stock of teaching and learning strategies and the ordering of theory and practice-based learning opportunities... total rethink of our underpinning philosophy. (Programme Team Member 2)

Students could read about SWOT (strengths, weaknesses, opportunities and threats) and stakeholder analysis but they have done it as part of engaging with the Patchwork Text Assessment, sharing with each other and living it... and it's this combination with teaching and learning approaches such as facilitation, reflection

through action learning, and feedback on the practice-based learning that makes this programme a success. (Programme Team Member 1)

An organisation's structure was viewed as having an impact on synergetic working relationships and team working. The programme team clearly identified the need to create teaching and learning opportunities for students to help them to build the optimal relationships with the most appropriate stakeholders and to recognise and then develop a suitable culture for leadership to flourish:

Break down boundaries and hierarchies with the leader's ability to create the right culture and skills set and to get to know their staff and people. (Programme Team Member 3)

Current and former students provided their experiences of the model which they encountered through studying on the post-graduate leadership programmes. They recognised the impact that the adopted curricula teaching and learning strategies had on their leadership development and how the concept of self as a professional could be explored within the context of real life leadership conundrums:

The programme is more than just about the books. I benefited from working together and sharing my real life leadership practice-based experiences with others... demonstrating my behaviours within groups. (Former Student 2)

You have to reflect on your leadership journey [self-assessment and critical commentary as part of the Patchwork Text Assessment] and demonstrate the leadership that is inside you. (Former Student 3)

Emotional intelligence, the one [I was] least interested in but I enjoyed it the most because I could put myself in key situations, and make the connections with past managers so I could see where they were coming from. (Former Student 1)

Student participants were asked what they perceived as the biggest personal impact of the structure and design of the model as it applied to their leadership programme:

Education gave me knowledge, power and understanding and gave confidence to do things on a bigger scale. (Former Student 2)

Networking and working with others in action-learning sets. Discussing others' problems and comparing them with leadership issues in my own organisation and country... work out the best direction and solution. (Former Student 3).

Furthermore, leaders demonstrate how exploring the world that they live (work) in and the structures and systems within and around it can help them to clarify emerging contentious leadership issues:

How to manage self and manage time, learning and being more responsible, this was a great experience, 90% good leaders need to be highly emotionally intelligent. Transformational point in my life [was] the leadership model. (Former Student 2)

Theme 3: Improvements to the model

The Multi-dimensional Leadership Development Conceptual Model advocates self-assessment as a leadership teaching and learning strategy. The service-user and family carer both identified the need to embed self-assessments and multi-source feedback assessments such as the 360-degree performance appraisal approach throughout the programme. The consequences of this embedded assessment approach supports the scaffolding of leadership learning and can be

used to provide leaders with opportunities to understand how they (through self-assessments) and others view their leadership behaviours from within the practice setting:

Self-assessment at beginning of programme and then at the end of programme or at end of each module. See differences and how they have developed. (Family Carer)

The insight of somebody else [the 360-degree assessment] provides that lightbulb moment. You don't always know what you need to know or see yourself through somebody else's eyes. (Service User)

Exposure to effective leadership from non-healthcare organisations was identified as a possible improvement to the model's embedded practice-based teaching and learning strategies by the service-user and family carer:

Explore organisations outside the NHS and see if there are any lessons to be learned. (Service User)

Meet with senior leaders and unpick leadership abilities of somebody who has a reputation as a good leader. (Family Carer)

Similarly, the international students felt that whilst the model was sound, they suggested an alternative range of pedagogical approaches to support their leadership development. These included better application of simulation and exposure to leadership from within a UK healthcare system so that they could compare and contrast global approaches and work on real-life leadership dilemmas:

The model is right but are we applying it to the international student as the work-based opportunities are missing? Too NHS orientated, structure of the programme. (Former Student 2)

Using simulation, case studies-scenario simulation such as coaching simulate conversation and critically explore in terms of building relationships. (Former Student 1)

The family carer also identified the value of alternative pedagogical approaches in support of effective leadership teaching and learning:

Use a combination of UK and international student ideas to explore and solve a conundrum from NHS healthcare organisations... Would need to agree who owns the solution. (Family Carer)

Discussion

Situating post-graduate leadership programmes around a conceptual model offers a promising approach for optimising healthcare leadership development. This is because the aim of the conceptual model presented here is to identify those key components required for effective leadership development (Leigh *et al.* 2015, Redmond and Dolan 2016). Not all post-graduate teams or leadership developers will develop their own model and there are multiple healthcare leadership development models in existence (Fealy *et al.* 2011, MacPhee *et al.* 2014, NHS Leadership Academy 2014, Pepin *et al.* 2011, Steinert, Goebel, and Rieger 2006, VanVactor 2012).

The unusual integration of the Leadership Qualities Framework (LQF) Five E's approach to learning (NHS Institute for Innovation and Improvement 2006) with Biggs' (2003) Constructive Alignment Curricular framework extends the reach of the Multidimensional Leadership Development Conceptual Model to multiple leadership development programme contexts that

extend beyond the healthcare environment or country of origin. Leadership developers are required to examine and subsequently apply those innovative teaching, learning and assessment strategies that support both leader and leadership development, and to map these to their programmes aims and intended learning outcomes with due regard to cultural differences. The model we have presented supports this.

Similarly, the embedding of the Five E's approach ([NHS Institute for Innovation and Improvement 2006](#)) to leadership learning within the context of a dynamic and flexible leadership curriculum promotes a powerful combination for effective leadership development. Leadership teaching and learning approaches should be varied and should include participation in action-learning sets and participation in the use of simulated leadership case studies and participation in real-life practice-based healthcare leadership challenges. Multi-professional action-learning sets assist leaders to solve their own 'real world' leadership challenges, leading to the realisation that they are all facing similar issues. Action learning provides the opportunity to challenge each other within a safe learning environment ([Leigh et al. 2012](#), [Young et al. 2010](#)).

An additional element, the acquisition of meta-competence, was identified as essential in this model, unlike most other models. This is a process which enables the leaders to learn and apply competencies effectively in many different aspects of their work, in this case throughout the leadership development experience. This is the essence of the model whereby there is recognition of the challenges facing the contemporary healthcare leader and these include dealing with unpredictable and often unique situations.

The evaluation of the application of the model provided opportunity to examine successfully the model from multiple stakeholder perspectives (programme team, students, a user of healthcare services, and a family carer) to: critically explore the internal and external evidence base for leadership development; gain stakeholder consensus of expectations of the healthcare leader; and provide the reality check for delivering a programme that offers both a contemporary approach to leadership development and applies innovative approaches to teaching, learning and assessment. This approach manages risk through capturing changes in the external evidence base for leadership development and internally through exploration of the vision and mission of the organisation implementing the model. Furthermore, it provides opportunity for the leader to contextualise and position their role within their practice workplace.

The advantages of the Multidimensional Leadership Development Conceptual Model have been demonstrated, including providing post-graduate leadership programme teams with an opportunity to challenge their assumptions about expectations of the contemporary healthcare leader and of what constitutes leadership development. The emergent model combined elements that the team believed would promote effective leadership development, with the final model subsequently applied to its post-graduate programme curriculum.

These findings report on the students' journeys of self-discovery whilst undertaking the leadership programme. Comparisons can be made with the scaffolding approach to leadership development ([MacPhee et al. 2014](#)) that encompasses individual development and collaborative team development, finally connecting teams in networks across the organisation. [Leigh et al. \(2015\)](#) suggest that leadership development does not follow a linear model, rather that the critical point is embedding the unique circumstance and context of the leader, throughout their programme of study. The strength of any model lies in its component parts whereby equal attention is afforded to both leader and leadership development ([Day 2000](#)). The role of the leadership programme developer is to provide the tools to set the students on their journey of becoming the courageous leader who demonstrates exemplary leadership skills ([Kouzes and Posner 2012](#)) and who can influence others; this is not solely conditional upon them being in a position of power.

One important finding from this study is the imperative for a curriculum that promotes the emotionally intelligent healthcare leader ([Goleman 1995](#), [Guillen and Florent-Treacy 2011](#),

[Leigh et al. 2013](#), [Leigh et al. 2015](#)). Students applied emotional intelligence theory to reflect and to gain a personal self-awareness about the impact of their behaviours on others and on meeting their organisation's aims and objectives, working in a team. Moreover, reflection through action learning and learning about oneself through exposure to real-life leadership situations and engagement in practice-based learning support lifelong leadership learning, a prerequisite of professional practice ([Leigh et al. 2015](#)).

For leadership developers who are considering applying an existing conceptual model to their leadership development programme, it is recommended that they first confirm with key stakeholders that the key concepts contained in the model fit with their assumptions of the expectations of the healthcare leader and leadership development. This should achieve from the outset the 'buy-in' from all involved. It is also recommended that there is agreement on how to align the model to the programme aims and intended learning outcomes.

Key messages have been formulated as a result of the study, not least that the attainment of leadership development knowledge, skills and attitudes should be applied in practice as well as theory ([Fealy et al. 2011](#), [Leigh et al. 2012](#), [Leigh et al. 2013](#), [Leigh et al. 2015](#)). [Jackson and Watson \(2009\)](#) and [Pepin et al. \(2011\)](#) concur that leadership development is context-specific, requiring attention to both the situation and circumstance of the leader. Importantly, any skills development must be transferrable to the 'real world' of healthcare leadership ([Leigh et al. 2012](#), [Leigh et al. 2013](#), [Leigh et al. 2015](#), [Skipton Leonard and Lang 2010](#)).

Within the context of the Lifelong Learning agenda ([Leigh 2016](#), [Nursing and Midwifery Council 2015](#)), enabling leaders to become empowered and autonomous lifelong learners is important, with [Chapman and Howkins \(2003\)](#) suggesting that work-based learning is a learning process rather than a teaching process. This is achieved through encouraging learners to take responsibility for their own lifelong (leadership) learning by developing attitudes and skills appropriate to the practice setting. [Coffield \(2004\)](#) comments that this is especially relevant in contemporary healthcare, because work-based learning is not just about the realisation of individual learning needs within the work setting, but also helps to achieve ongoing organisational goals. Higher education institutions have realised that individuals can learn in practice by using a reflective and theoretical framework that applies to their world of work and as such provides the symbiosis between personal and professional development ([Burton and Jackson 2003](#)).

Providing leaders with opportunities to demonstrate their leadership competence and behaviours is paramount. Strategies to achieve this include exposure to and working alongside leadership role models from within and outside of their own organisation ([Crofts 2006](#), [Leigh et al. 2013](#), [Leigh et al. 2015](#), [MacPhee et al. 2014](#), [Patrick et al 2011](#)),. Learning from within an empowered learning organisation ([Senge 2006](#)) whereby the leader learns from others who share similar values and behaviours around leadership, thus witnessing somebody else being rewarded for a particular act, is a useful approach. Simulation can be applied and is especially useful for those situations where the work-based experience is unavailable.

Curriculum planning for leadership development requires the implementation of suitable opportunities for 'learning to lead', an approach used by [Cook and Leathard \(2004\)](#) and [Pepin et al. \(2011\)](#) in relation to effective role transition. The critical success factor lies in the ordering of all practice-based learning planned activities. It is recommended that participants are provided with the theory of leadership that is contextualised through the leaders' participation in the range of relevant practice-based leadership and reflective learning activities made available to them by the programme team ([Leigh et al. 2013](#), [Leigh et al. 2015](#)). The use of combined theoretical and practice-based leadership development activities promotes 'double loop' learning whereby the leader's values and assumptions are challenged with the leader looking deeply at their leadership conundrum, using feedback to review past actions and to problem-solve ([Argyris and Schön 1996](#)).

For international students, exposure to UK healthcare organisations is a key expectation. Practice-based instruction and feedback is a legitimate leadership-teaching and learning strategy ([Hsu et al. 2011](#)) and is achieved through providing incentives, timely feedback, embracing skills for networking and deep reflection, and utilising coaching conversations from within the healthcare and academic organisation.

Dynamic and flexible leadership programmes should provide opportunities for leaders to work towards personal, professional and organisational goals. The leadership theory and taught sessions should target and complement any competency-based frameworks that the participant is working with. Examples include the Healthcare Leadership Model and Kouzes and Posner's exemplary leadership challenge ([Kouzes and Posner 2012](#), [Leigh 2016](#), [NHS Leadership Academy 2014](#)), whereby the qualities and behaviours of the healthcare leader are explicit. The competency-based framework should in turn complement the leader's healthcare organisation and its mission and vision ([Hernez-Broome and Hughes, 2004](#)). Importantly, the implementation of the competency-based framework is more important than the framework itself ([Bolden and Gosling 2006](#)). Interestingly, students do not report on the impact of aligning their leadership programme to the healthcare leadership model.

A key study finding leads to the conclusion that leadership self-assessment and 360-degree assessments should be embedded within a leadership programme of study and not be as [Chappelow \(2004\)](#) suggests, an activity that takes place at the beginning and end of a programme. Leadership students should be given opportunities for self-assessment and 360-degree feedback throughout a programme and this approach can support their leadership journey, clearly demonstrating the added value to themselves and their organisation of attending a theoretical and practice-based programme of study. Self-assessments promote the concept of personal development planning and lifelong learning with a willingness to promote patient safety ([Nursing and Midwifery Council 2015](#)) and this in turn can enhance the skilled global healthcare workforce. Application of the Patchwork Text Assessment with its embedded critical commentary also promotes a framework for students to reflect on their leadership journey and to explore the impact that the module content has on them both now and in the future ([Leigh et al. 2012, 2013](#)).

Changes to the Multidimensional Leadership Development Conceptual Model

The unique circumstance and practice context for leadership learning is a key finding of this study, recognising that the best outputs from leadership development are achieved in learning organisations ([Crofts 2006](#), [MacPhee et al. 2014](#), [Patrick et al. 2011](#), [Pepin et al. 2011](#), [Senge 2006](#)). For this reason the Multidimensional Leadership Development Conceptual Model has been refined to incorporate a sixth 'E' pertaining to Environment, recognising the need to promote leadership development from within an empowered academic and healthcare learning organisation ([Figure 2](#)). [Leigh \(2016\)](#) reports how the empowered leadership learning environment can also accelerate leadership development.

Figure 2: Refined Multidimensional Leadership Development Model



Finally, evidence-informed recommendations are provided for situating leadership development within the Multidimensional Leadership Development Conceptual Model.

Situating post-graduate leadership programmes around this conceptual model offers a promising approach for successful healthcare leadership development. This is because the aim of the conceptual model is to identify those the key components required for effective leadership development:

- Ensure that the Multidimensional Leadership Development Conceptual Model:
 - Represents the values and beliefs of all stakeholders involved;
 - Is reviewed annually by stakeholders to:
 - critically explore the internal and external evidence base for leadership development; gain stakeholder consensus of expectations of the healthcare leader; and provide the reality check for delivering a programme that offers both a contemporary approach to leadership development and that applies innovative approaches to teaching, learning and assessment;

- Constructively align the leadership programme curricula with sufficient flexibility to provide an effective teaching and learning platform for preparing the individual leader, taking into consideration their unique circumstance and practice-based leadership context;
- Optimise practice-based approaches for leadership development that are dynamic and extend beyond theoretical approaches, to include instruction, feedback, action learning, simulation, assessment, coaching, facilitation, and working through real-life healthcare leadership conundrums;
- Operationalise the leadership curriculum that takes place in both the empowered healthcare (workplace) and academic setting;
- Expose leaders to the range of self-assessments and other assessments (the 360-degree assessment) throughout the programme and use the outputs to demonstrate the added value that their practice learning has had on their unique circumstance and workplace context;
- Embed concepts of emotional intelligence within the curriculum design; these should be used to promote the self-aware leader who is resilient and leads from within the practice setting with integrity.

Limitations

Although this study has met its intended aims and objectives, the sample size is not large. The sample was sufficient to gain rich data from a range of stakeholders including UK and international students, programme team staff, and a service-user and family carer. The proposed Multidimensional Leadership Development Model is transferrable across healthcare organisations and other sectors and this is a significant strength of the model. Whilst the lead author in her role as programme team member had taught some of the student participants, all findings were discussed with an independent researcher and all students were assured that their participation in the study would not affect their participation on the post-graduate programme.

Future study opportunities include stakeholder perspectives on how to measure or evaluate the impact of leadership development on the individual leader, their team and their healthcare organisation including patients and carers.

Conclusion

The aims and outcomes of the study have been met through critically exploring the perceived potential and actual experience of the application of the Multidimensional Leadership Development Conceptual Model with its embedded practice-learning opportunities from the perspective of key stakeholders. Findings demonstrate how adopting a multidimensional model that is constructively aligned to a leadership programme curriculum provides the teaching and learning platform for preparing the individual leader, taking into consideration their unique circumstance and leadership context. A useful output from the study is the identification of evidence-informed recommendations for best practice pedagogical principles for practice-based leadership development.

Future possibilities for the model include a developmental context-bound approach that has an in-built evaluation framework to provide the evidence for the individual leader, their organisation and programme team on how specific practice-based interventions of healthcare leadership development are impacting on service improvement and patient outcomes. The context for collective leadership ([West et al. 2015](#)) could be strengthened through team activities and by more communications between the programme team and senior leaders from within the healthcare organisations. Applying the model with a stakeholder group approach to leadership development offers a promising structure that supplies multiple viewpoints, perspectives, and expertise and can change the balance of power at the top ([Girard 2009](#)).

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