

ALLIED HEALTH LEADERSHIP TRAINING IMPACT ON EMPLOYEE EXPERIENCE: A NEAR-EMPTY SCOPING REVIEW

Katherine Morris^{*1}, Patrick Summerell², Kara Batch², Hannah Myer², Karen Wilkie-Smith², Caroline Guille², Martin Checklin^{1,2}

1. Discipline of Speech Pathology, School of Allied Health, Human Services and Sport, La Trobe University, Melbourne, Victoria, Australia

2. Department of Allied Health, Epworth Healthcare, Richmond, Victoria, Australia

*Correspondence: k.morris@latrobe.edu.au

ABSTRACT

BACKGROUND

Allied Health practitioners (AHPs) are crucial in improving patient outcomes, reducing mortality and morbidity, and supporting timely discharge in a hospital setting. Despite their importance in the hospital workforce, recruitment and ongoing retention of AHPs remain significant challenges. More recently, leadership development has been a key strategy in enhancing employee capability and wellbeing. While leadership programs show benefits from the leader's perspective, little is known about the impact on employee experience.

AIM

A scoping review was undertaken to determine the impact of allied health leadership programs on employee experience in hospital settings.

METHOD

The Arksey and O'Malley's [1] framework was employed to guide the search. A systematic search across Medline, CINAHL, Embase, and PsycINFO was conducted in May 2025, capturing four concepts: Allied Health, Hospitals, Leadership Training, and Employee Experience. Articles included empirical, peer-reviewed studies, and were individually assessed against the inclusion criteria, ensuring that at least one of the outcomes was the employee experience of those who were being led. Data extracted included study demographics, details of training, and measurement of employee experience.

RESULTS

A total of 3,644 articles were identified, with initial screening reducing this to 72 articles for in-depth review. After further screening the final yield was just one article, resulting in a near-empty scoping review.

CONCLUSION

This review highlights the employee experience and demonstrates the substantial gap in the literature on how allied health leadership programs influence employee experience in hospital settings. Employee experience is a novel and under-researched outcome, yet crucial for a functioning hospital system and allied health retention therefore further research is required in this area.

KEYWORDS

allied health, healthcare, employee experience, leadership, training

INTRODUCTION

Allied Health Professionals (AHPs) encompass a variety of disciplines, including but not limited to physiotherapy, psychology, occupational therapy, social work, dietetics and speech pathology [2]. In Australia, approximately 300,000 AHPs are registered, with hospitals representing the predominant setting of employment [3]. AHPs play a vital role in the safe and efficient operating of healthcare services through improving functional outcomes for patients, reducing or preventing hospital related complications, supporting timely discharge, facilitating goal achievement, and supporting transition back into the community [4-6]. Despite the critical role of AHPs, retention and attrition remain significant challenges [4, 7-9]. AH (Allied Health) shortages have been reported due to a variety of attrition triggers including post-COVID-19 burnout, compassion fatigue, inability to be involved with decision making, system and process issues, and dissatisfaction with performance review processes [4, 10, 11].

These workforce retention challenges have prompted healthcare organisations to begin to address high attrition rates and strengthen the AH workforce through implementing a range of strategic initiatives. Career progression has been supported through guiding documents such as the 'Allied Health Career Blueprint' [12], which provides structured pathways for advancement and helps AHPs navigate their careers with clarity and purpose. Professional development frameworks have also been introduced to deliver efficient and effective training aligned with service demands and patient care outcomes [13]. These frameworks aim to build workforce capability, enhance clinical performance, and improve retention, with leadership and management training being a key part of AH practice. Nevertheless, initiatives alone may be insufficient, and a broader cultural focus on leadership and employee experience is increasingly necessary. Effective leadership within the healthcare sector is crucial to foster staff development and has been tied to improved patient and organisational outcomes [14]. Effective leaders can impact clinical safety, quality decision making and ability to sustain organisational change, optimising patient care [15]. They must not only advance the technical aspects of care but also demonstrate active listening, agility, creativity, and balance to maximise patient outcomes, meet organisational requirements, and support staff wellbeing [16]. Within the AH healthcare context, leadership programs have been shown to enhance transformational leadership skills and capabilities [17]. Strong AH leaders are required to facilitate interaction between professions through explicit collaboration opportunities, provide advocacy for all AH professions allowing equitable representation and adapt to the changing healthcare landscape, leading to improved AH workforce retention and improved patient outcomes [18]. However, most evaluations of leadership programs have focused on the leader's perspective, leaving limited understanding of their impact from the viewpoint of those being led [19, 20].

One aspect of leadership that has been gaining increased attention is that of employee experience [21]. Employee experience is an important part of work and can be defined as "the sum of interactions that are influenced by employees' perceptions of the individual and the organizational factors within the workplace" [22 p93]. Employee experience and wellbeing are integral to a well-performing and stable healthcare system [23]. Key factors influencing employee experience and satisfaction include opportunities for professional development and career progression [24] and enhanced clinical teamwork with improved clinical outcomes, particularly when healthcare teams are developed with a person-centred focus [15]. For AHPs, employee experience directly influences decisions to remain in or leave the healthcare system, thereby shaping retention and attrition rates [10]. Effective leadership enables employees to flourish by encouraging autonomy, empowerment, and a sense of achievement, which in turn strengthens confidence and positively impacts workplace culture [10, 25].

Given the vulnerability of AHPs in the healthcare labour force and the evolution of leadership philosophy to include employee experience, it is timely to investigate the role of leadership training at influencing employee experience within the AHP workforce. It is essential to understand how leadership programs shape the employment experiences of those being led, ultimately affecting retention, satisfaction, and other workforce outcomes. As a result, this scoping review was conducted to explore what has already been investigated in AH leadership training and employee experience. A scoping review was chosen to summarise what is already known and identify potential research gaps to guide future projects in this emerging area.

AIM

The aim of this scoping review is to examine how AH leadership programs influence employee experience from the perspective of staff being led within healthcare settings.

METHOD

This scoping review was conducted according to the scoping review procedures described by Arksey and O'Malley [1], with guidance and modifications from more recent scoping review methodology [26, 27]. It was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA ScR) guidelines [27]. The protocol for this scoping review was published on Open Science Framework on 5th May 2025, with nil amendments made (doi.org/10.17605/OSF.IO/EAQBX).

SEARCH STRATEGY

A systematic search across four databases was conducted (Medline, CINAHL, Embase, PsycINFO) in June 2025. Additional searching was conducted in Google Scholar (first 200 entries), Trip Database, Clinicaltrials.gov, Scopus, australianclinicaltrials.gov.au, and CDC Wonder. Citation and reference checking were conducted on the final yield. The search terms captured four concepts; Allied Health, Hospitals, Leadership Training, and Employee Experience (See supplementary material for details and example of search). The Allied Health Professionals included in the search (Table 1) typically report under Allied Health directorship [28]. Employee experience terms (Table 2) drew on a broad range of components [10, 15, 21-25, 29]. The concepts and search terms were generated by five authors and were refined through consultations with one academic, one medical librarian, an Allied Health Manager who was not one of the authors, and cross checking with key literature [22, 29, 30]. The research team comprised AH leaders from six disciplines with private and public healthcare experience, across Australia and internationally.

TABLE 1

Allied Health Professionals
Allied Health
Allied Health Assistant
Art therapy
Clinical psychology
Dietetics
Exercise physiology
Music therapy
Neuropsychology
Nutrition
Occupational therapy
Prosthetics and Orthotics
Physiotherapy
Physical therapy
Podiatry
Social work
Speech pathology

TABLE 2

Employee experience terms
Absenteeism
Attitude of health personnel
Employee experience
Employee engagement

Employee health
Employee wellbeing
Flexibility
Inclusion
Innovation
Job autonomy
Job satisfaction
Lifelong learning
Meaningful work
Motivation
Occupational stress
Organisational commitment
Organisational innovation
Personnel turnover
Presenteeism
Professional burnout
Retention
Safety
Staff engagement
Staff wellbeing
Trust
Work engagement

Studies sourced from the searches were exported into Covidence (Veritas Health Innovation, Melbourne, Australia) for review. Duplicates were removed using the automatic feature in Covidence. All authors were involved in screening titles and abstracts, and then full articles against the selection criteria, with each step involving two authors per article. Disagreements were resolved through a third reviewer. All reviewers had a guide outlining the selection criteria in detail, with instructions on how to proceed with the screening tasks, to ensure adherence to the screening process. Group training and calibration activities were conducted.

SELECTION CRITERIA

Table 3 outlines the inclusion/exclusion criteria. No historical timeframe was set. Articles published in English (no funding available for translation), in peer reviewed journals were included. Conference abstracts, theses and opinion pieces were excluded. As we were interested in AH results, papers which included mixed professionals were excluded if they did not separate results for AH from non-AH professionals. Any formalised leadership training programs, either bespoke or commercially available, were included. As we were primarily interested in the outcome of employee experience, one of the outcomes measured had to include any type of measurement about the impact on employee experience from those who the trainees led, as opposed to how the trainees felt about the training.

TABLE 3. INCLUSION/EXCLUSION CRITERIA

Inclusion	Exclusion
Studies which have measured a concept connected with employee experience	Studies that only report the leaders' experience of the training and do not measure any employee experience concept
Studies that report employee experiences of those who leaders lead	Non-English
All countries	Multidisciplinary participants that do not report AH results separately
Hospital/Healthcare network based	

Single or multidisciplinary leadership but must include AH disciplines	Conference presentations, opinion pieces, review articles, theses
Any formalised leadership program/s that has run at least once	

RESULTS

An initial total of 3,644 articles were identified through database and other source searching. Following title and abstract screening, 72 studies progressed to full-text review, with only one meeting the inclusion criteria (Figure 1). This one study by Bradd et al., 2018 [28], conducted in 2014–2015 across a multisite Australian public healthcare network, examined the development of AH leaders from nine disciplines over a 10-month period. Participants were divided into a control group (n = 16) and an intervention group (n = 14), with three withdrawals overall. The locally developed program was delivered face-to-face, without a formal assessment component, and reported no substantial expenses beyond personnel time. Costs related to course development, staff time (paid or unpaid), and materials were not specified. Training comprised eight sessions covering leadership theory, facilitation skills, leadership styles, critical inquiry, improvement science, and project management, with additional individual coaching provided to the intervention group. Feedback from managers, peers, and subordinates was collected using the Multifactor Leadership Questionnaire (MLQ) [31, 32], though data were not separated to isolate supervisee responses. While the MLQ is not an employee-experience-specific measure, the study was included as it addressed related domains such as workplace culture, engagement, and leadership capability.

FIGURE 1. PREFERRED REPORTING ITEMS FOR SYSTEMATIC REVIEWS AND META-ANALYSES EXTENSION FOR SCOPING REVIEWS
FLOW DIAGRAM

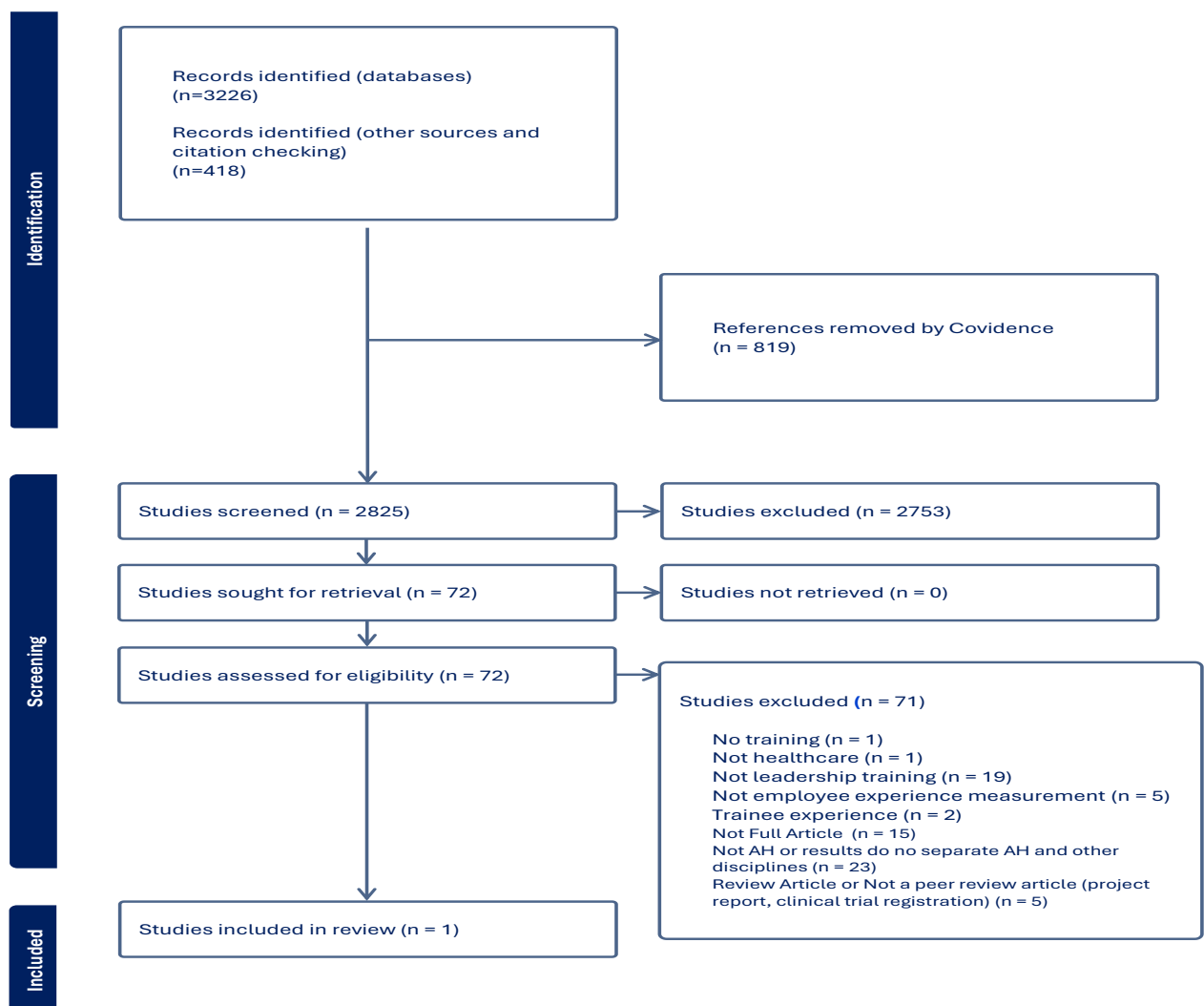


TABLE 4 DATA EXTRACTION

Author, Year published	Country	Course dates/year(s)	Training duration	AH details (# of disciplines)	Attrition rate (number of participants/ number withdrew)	Facilitator background (discipline, in-house vs external)	Setting	Type of training (name of program if stated vs bespoke)
Bradd et al., 2018	Australia	May 2014-March 2015	10 months	9	n=30 Withdrawals – 3 (2/16 intervention and 1/17 control) Attrition rate 3/33=9%	Existing in-house personnel	Public healthcare network (7 sites covering acute, sub-acute and community)	Bespoke program
	Hours of total training (direct and indirect)	Mode of training (face to face/online/independent study)		Course content	Cost	Employee experience area	How employee experience was measured (questionnaires/surveys)	Is there an assessment component?
Bradd et al., 2018	3 days, and four 3-hour action learning sets. Final 3-hr session 4 x 60min individual coaching sessions for intervention group B	Face-to-face		Leadership theory and practice development, facilitation skills, leadership styles, critical inquiry, improvement science and project management	NR	Workplace culture, engagement, & leadership	Other raters including 'subordinates', MLQ	NR

Key. AH = Allied Health; MLQ = Multifactor Leadership Questionnaire; NR = Not Reported.

DISCUSSION

With the aim of understanding the impact of AH leadership programs on employee experience, a robust scoping review was conducted, resulting in one study found that met the eligibility criteria. The paucity of studies indicates the need for more attention in this area to guide both future research and leadership course content. Employee experience remains a novel area as an outcome measure, and we invite future researchers and employers to consider data collection in this area. The single study that met our selection criteria contrasts with the findings of a related scoping review [33]. McKeever & Brown [33] conducted a scoping review to identify the client, organisational and employee-related outcomes of high-quality leadership in the AH workforce. Whilst their scoping review demonstrated the value of AH leadership more broadly, it did not assess the effectiveness of specific leadership programs from the employee perspective. In addition, their scope included the full continuum of care, including community services, whereas this review focuses specifically on hospital (acute and sub-acute) settings. This distinction highlights the unique contribution of the present review: it highlights a critical evidence gap by examining how AH leadership programs affect employee experience in hospital environments.

Low-yield reviews, defined as those identifying no eligible studies (empty) or only a few (near-empty), are often overlooked in academic publishing [34-36] yet 8.7% of Cochrane reviews are empty [36]. Despite limited findings, low-yield reviews remain critical for advancing knowledge and guiding future research. By systematically searching and screening the literature, low-yield reviews reveal areas where research is absent or underdeveloped [34, 37]. This is particularly salient in health sciences, where clinical and policy decisions rely on robust evidence; absence of studies warrants explicit reporting

rather than disregard. Highlighting gaps in AH skills development and employee experience enables future researchers to address these topics and pursue novel yet important concepts.

Failure to report low-yield reviews creates self-imposed publication bias and undermines the transparency and comprehensive reporting that underpin evidence-based practice. To mitigate this bias, low-yield reviews should still be published when pre-registered and conducted with robust methods [34], as in this review. Currently, no specific reporting guidelines exist on low yield reviews (34), hence the reporting of this review still incorporating PRISMA-ScR as per our pre-registration.

The one identified study by Bradd et al. [28] evaluated a bespoke AH leadership program in Australia across seven hospital sites over a 10-month period. Thirty participants from nine disciplines took part, with three withdrawals (an attrition rate of 9%). The program was facilitated internally, delivered 39–43 hours of face-to-face training. Topics covered included leadership theory, facilitation skills, improvement science, and project management. Outcomes focused on workplace culture, engagement, and leadership capability, measured using the MLQ. It is important, however, to note that although the study met our selection criteria, its primary outcome was not captured using a specific employee experience measurement tool. The MLQ includes domains that represent multiple leadership domains. In Bradd et al. [28], trainees themselves rated these, as well as another group comprising managers, peers and subordinates. Additionally, their program did not show significant improvements in how this mixed group rated the leadership skills of the intervention group. This finding, along with the combining of subordinate ratings with others and use of a broad rating tool, mean that it is difficult to further elucidate our research question from this study alone. The study was conducted over ten years ago, so it is understandable that more recent concepts and influences in employee experience were not available at that time to shape the study design.

Salas et al. [38] identified seven evidence-based success factors for conducting training in healthcare. While all are important, two specifically align with this current study's data extraction: determining resources and measuring effectiveness. Bradd et al. [28] reported personnel time and direct training hours but no other resources were identified. To be able to fully consider whether a healthcare organisation can financially implement a full training program, full detailed costings in research studies need to be reported. These include direct personnel time, time and salary for work done in paid hours, unpaid work, materials and licensing, trainer salaries etc. Without such comprehensive reporting, the economic viability of implementing training interventions remain unclear. It is important that future research outlines the financial and non-financial commitments required so organisations can make an economic value assessment.

Although difficult to formulate robust clinical recommendations from the low yield, this study does have important clinical implications. This review has emphasized employee experience as a valuable outcome even though there is little in the literature to guide in terms of AH. Clinicians and researchers are invited to consider employee experience when implementing locally based training initiatives, and to reflect on how such outcomes may be systematically captured. The present study deliberately focused on employee experience as an outcome, as the authors, who are AH leaders, aimed to inform the redevelopment and re-evaluation of their own bespoke, locally implemented AH training program designed for individuals transitioning into AH leadership roles. In the absence of empirical guidance, it is further recommended that AH training, either bespoke or packaged, begins to investigate the impact of such programs on the employee experience of those who AHPs lead. Leadership training programs currently in place may begin to extend their review processes to explore the impact of such training on supervisees. This would then add insight on whether AH leadership training could in fact be an influential factor and strategy for AH workforce capability, clinical performance, satisfaction and retention. However, how to capture such data requires further elucidation.

One of the challenges of measuring employee experience is that it is a multidimensional construct shaped by more than one metric [30]. Therefore, there remains considerable work required on how best to capture employee experience for AH. Despite this, there is potential for future research to bridge this gap. Firstly, further review articles could focus on summarising what standardised outcome measures are appropriate to be used to capture AH employee experience in healthcare settings and further understand the contexts within such measures can be used (e.g., assessing leadership

training outcomes). Such a review will enable researchers and healthcare leaders to be able to select measurements that are relevant to their objectives. Secondly, and related to the first point, is to ensure that employee experience outcome measures are valid for the AH workforce. Pangallo et al. [30] developed an employee experience model from other industries and applied it to two healthcare groups: nurses and physicians. They found that while these two groups had similarities, they also had differences. This illustrates that findings may not be transferable to AH, so therefore AH deserves its own attention. Finally, there is opportunity to engage in qualitative methods to advance our knowledge in aspects of employee experience, which although are not well-represented in AH literature, but have been demonstrated to be insightful tools elsewhere [39, 40]. Qualitative methods have also been used to examine leadership development programs previously, albeit not exploring the impact on employee experience [41].

Despite a broad search strategy and following the PRISMA-ScR protocol, the yield was small. This is not a limit of the review, as a low yield suggests that there requires further work to be done on this topic, but it does limit the breadth of conclusions made. If other studies exist in languages other than English, then they were not represented in this study due to searching in English only with no funding for translation services. Another potential limitation of this paper is that any papers that combined data with other healthcare professionals were excluded, therefore limiting potential multidisciplinary contributions. The PRISMA-ScR reporting suggests 23 studies were excluded for this reason. It is likely, however, that even within this yield, the final yield would be low, as many of these studies also did not report employee experience measures or leadership training programs. Finally, medical radiation sciences, radiography or nuclear medicine were not included, as these disciplines do not report to AH directorships and have different pathways [28], and the exclusion of these professionals may have limited sources being identified.

CONCLUSION

In summary, the present scoping review identified a critical and underexplored gap in the evidence base regarding the impact of AH leadership programs on employee experience within hospital settings. The low yield of only one eligible study underscores that employee experience remains a novel outcome in AH leadership research, despite its clear importance in workforce capability, satisfaction, and retention. While the included study demonstrated the feasibility of evaluating leadership programs, limitations in outcome measurement, conflating of group outcomes, and insufficient reporting of resources limit the conclusions that can be drawn. Importantly, the low yield of this review is itself a meaningful finding, warranting transparent reporting and reinforcing the need for AH and employee experience-targeted research. Future studies should prioritise the development and validation of AH-specific employee experience measures, utilise qualitative data, and report comprehensive resource/cost data to support decisions around implementation. Collectively, these steps are necessary to advance our true understanding of how AH leadership programs influence the employee experience of those they lead.

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CONFLICTS OF INTEREST

The Authors declare that there is no conflict of interest

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SUPPLEMENTARY MATERIAL 1. SEARCH TERMS

Population: Allied Health	Place: Hospitals	Intervention: Leadership Training Programs	Outcomes: Employee Experience
Allied Health	Inpatients (MeSH)	"Leadership development"	"Employee experience"
Allied Health Occupations	Inpatient*.mp	"Leadership train*"	"Staff engagement"
Allied Health Personnel	Hospitals (MeSH)	"Leadership capacity" "Leadership competenc*" "Leadership program*" "Leadership course*" "Leadership education*" "Leadership strengthening"	"Employee engagement"
Allied Health Professions	Hospital*.mp		Work engagement (MeSH)
Art therap*	Subacute care (MeSH)	"Management development"	Job Satisfaction (MeSH)
Clinical Psycholog*	Subacute care.mp	"Management train*" "Management capacity"	"Staff wellbeing"
Dietetics	Rehabilitation (MeSH)	"Management competenc*"	"Employee wellbeing"
Dietitian*	Rehab*.mp	"Management program*" "Management course*"	"Employee health"
Dietician*	Rehabilitation Centers (MeSH)	"Management education*" "Management strengthening"	Occupational stress (MeSH)
Nutritionist*	Acute Care.mp (Not a MeSH on Medline)		Stress, Occupational (MeSH)
Exercise Physiolog*	Hospital Units (MeSH)		"Professional burnout" (MeSH)
Music Therap*	Health care		Innovation
Occupational Therap*			Organizational innovation (MeSH)
Orthoti*			Safety (MeSH)
Prostheti*			Personnel Turnover (MeSH)
Physiotherap*			"intent to stay"
Physical Therap*			Retention
Podiatr*			Absenteeism (MeSH)
Psycholog*			Presenteeism (MeSH)
Neuropsycholog*			Lifelong learning (MeSH)
Social Work*			Attitude of Health Personnel (MeSH)
Speech Patholog*			"Meaningful work"
Speech Language Patholog*			Inclusion
Speech Therap*			Flexibility
"Allied health assistant"			Trust (MeSH)
			"Job Autonomy"
			"Organizational commitment"
			"Organisational commitment"
			Motivation
Notes: Growth and development – Removed, as Medline topic is gene/biology. Career development and agility – Removed, as yield of two irrelevant articles. Recognition and reward – Removed, as yield of 15 irrelevant articles. Individual purpose – Removed, as yield of 9 irrelevant articles. Nutritionist* is a MeSH term for "dietician, dieticians, dietitian, dietitians, nutritionist, nutritionists"			

SUPPLEMENTARY MATERIAL 2. SEARCH EXAMPLE.

Database:

Embase <1974 to 2025 May 07>

#	Query	Results from 9 May 2025
1	Allied Health.mp.	18,587
2	Allied Health Occupation*.mp.	114
3	Allied Health Personnel.mp. or paramedical personnel/	17,494
4	Allied Health Professions.mp. or paramedical profession/	2,923
5	art therapy/ or Art therap*.mp.	6,334
6	clinical psychology/ or Clinical Psycholog*.mp.	11,883
7	Dietetics.mp. or dietetics/	10,058
8	dietitian/ or Dietitian*.mp.	26,095
9	Nutritionist*.mp.	7,365
10	Dietician*.mp.	6,355
11	exercise physiology/ or Exercise Physiolog*.mp.	4,380
12	music therapy/ or Music Therap*.mp.	11,030
13	occupational therapy/ or occupational therapist/ or Occupational Therap*.mp.	43,118
14	orthotics/ or Orthoti*.mp.	9,172
15	Prostheti*.mp.	89,404
16	physiotherapist/ or physiotherapy/ or Physiotherap*.mp.	161,585
17	Physical Therap*.mp.	53,387
18	podiatrist/ or podiatry/ or Podiatr*.mp.	6,058
19	psychology/ or Psycholog*.mp.	1,373,041
20	Neuropsycholog*.mp.	150,265
21	social worker/ or social work/ or Social Work*.mp.	56,004
22	Speech Patholog*.mp.	2,687
23	speech language pathologist/ or Speech Language Patholog*.mp.	9,383
24	speech therapy/ or Speech Therap*.mp.	20,137
25	"Allied health assistant".mp.	42
26	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25	1,900,073
27	Inpatient*.mp.	272,292
28	Hospital*.mp. or geriatric hospital/ or private hospital/ or teaching hospital/ or general hospital/ or public hospital/ or mental hospital/ or community hospital/	3,688,269
29	Subacute care.mp. or subacute care/	2,834

30	rehabilitation/	103,630
31	Rehab*.mp.	497,500
32	Rehabilitation Centers.mp.	1
33	Acute Care.mp.	44,813
34	Hospital Units.mp.	2,347
35	Health care.mp. or health care/	2,123,503
36	27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35	5,649,456
37	"Leadership development".mp.	2,390
38	"Leadership train*".mp.	1,388
39	"Leadership capacity".mp.	294
40	"Leadership competenc*".mp.	665
41	"Leadership program*".mp.	809
42	"Leadership course*".mp.	201
43	"Leadership education*".mp.	539
44	"Leadership strengthening".mp.	10
45	"Management development".mp.	611
46	"Management train*".mp.	3,724
47	"Management capacity".mp.	623
48	"Management competenc*".mp.	500
49	"Management program*".mp.	25,377
50	"Management course*".mp.	1,016
51	"Management education*".mp.	4,937
52	"Management strengthening".mp.	69
53	37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52	40,951
54	"Employee experience".mp.	49
55	"Staff engagement".mp. or work engagement/	3,851
56	"Employee engagement".mp.	584
57	Job Satisfaction.mp. or job satisfaction/	41,761
58	"Staff wellbeing".mp.	514
59	"Employee wellbeing".mp.	155
60	"Employee health".mp.	2,074
61	Occupational stress.mp. or job stress/	17,908
62	"Professional burnout".mp. or professional burnout/	6,261
63	Innovation.mp.	84,688
64	Safety.mp. or safety/	1,662,545

65	Personnel Turnover.mp.	203
66	"intent to stay".mp.	252
67	Retention.mp.	356,626
68	Absenteeism.mp. or absenteeism/	24,723
69	Presenteeism.mp. or presenteeism/	4,303
70	Lifelong learning.mp. or lifelong learning/	3,499
71	Attitude of Health Personnel.mp. or health personnel attitude/	93,297
72	"Meaningful work".mp.	371
73	Inclusion.mp.	595,957
74	Flexibility.mp.	129,392
75	trust/ or Trust.mp.	98,145
76	"Job Autonomy".mp.	314
77	"Organizational commitment".mp.	1,460
78	"Organisational commitment".mp.	229
79	Motivation.mp. or motivation/	190,640
80	54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79	3,134,814
81	26 and 36 and 53 and 80	1,030