

Developing Compassionate Leadership in the UK in Healthcare Contexts: A Narrative Review of Leadership Programmes and Outcomes

Jonathan Minh Phuong ¹, James Higgerson ¹, Emma LT Pearce ¹, Sarah C Willis ²,
Ellen Ingrid Schafheutle ¹

¹Centre for Pharmacy Workforce Studies, School of Health Sciences, Faculty of Biology Medicine and Health, The University of Manchester, Manchester, M13 9PT, UK; ²Alliance Manchester Business School, The University of Manchester, Manchester, M13 9PT, UK

Correspondence: Jonathan Minh Phuong, Centre for Pharmacy Workforce Studies, School of Health Sciences, Faculty of Biology Medicine and Health, The University of Manchester, Manchester, M13 9PT, UK, Email johnny.phuong@manchester.ac.uk

Purpose: Leadership within UK healthcare has been criticised for focusing on performance and financial indicators. Compassionate leadership has emerged as a promising approach to shift organisational culture by focusing on empowering healthcare staff and improving patient outcomes. While compassionate leadership is a stated priority within NHS policy, the extent to which UK-based leadership programmes explicitly incorporate and develop this is unclear. By using West's compassionate leadership framework, this narrative review aimed to identify leadership programmes for staff working in UK healthcare which contain a compassionate leadership element. It also reported the aims, components, outcomes, and impacts of such training on programme participants, their teams, organisations, and patients.

Methods: A narrative review was conducted following guidelines from the Preferred Reporting Items for Systematic Reviews and Meta Analyses and JBI. Five databases were searched for records published between January 2013 and June 2025. Data were extracted and thematically analysed using West's four elements of compassionate leadership: attending, understanding, empathising, and helping.

Results: Of 550 records screened, seven papers met eligibility, reporting on five distinct leadership programmes. None of the programmes explicitly aimed to develop compassionate leadership. Positive outcomes were consistently reported across all four of West's elements of compassionate leadership, particularly for programme participants. An additional theme emerged of enhanced compassion and relationships within workplace culture. Evidence of organisational or long-term impact was limited, and reporting of programme characteristics lacked depth.

Conclusion: This review found limited evidence for leadership programmes that explicitly focus on compassionate care leadership practices in UK healthcare. Despite this, existing programmes do report positive outcomes that map to West's four elements of compassionate leadership. Further programmes that focus more explicitly on compassionate leadership skills, and study of those outcomes, are needed.

Keywords: compassionate leadership, development, healthcare leadership, review

Introduction

People are the most important resource in any healthcare system, and leadership is a key factor to supporting staff to deliver safe and high-quality care.¹⁻³ However, a number of key reviews have reported issues in NHS leadership.^{4,5} The 2013 Francis review exposed a culture where leadership was found to prioritise financial and key performance indicators rather than the care of staff and patients.⁴ This resulted in poorer staff performance and poorer patient care.⁴ More recently, the 2024 Darzi report noted that chief executive remuneration was primarily linked to revenue rather than patient-centred metrics such as timeliness of access to care or quality of care.⁵ These reports highlight how healthcare

Table 1 Elements of Compassionate Leadership

Available from: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-compassionate-leadership Creative Commons Non-Commercial 4.0 license)	
Element	Definition
Attending	This means being present with and focusing on others – “listening with fascination”. Listening is probably the most important leadership skill and compassionate leaders take time to listen to the challenges, obstacles, frustrations and harms colleagues experience as well as listening to accounts of their successes and joys.
Understanding	This involves taking time to properly explore and understand the situations people are struggling with. It implies valuing and exploring conflicting perspectives rather than leaders simply imposing their own understanding.
Empathising	This involves mirroring and feeling colleagues' distress, frustration, joy, etc, without being overwhelmed by the emotion and becoming unable to help.
Helping	This involves taking thoughtful and intelligent action to support individuals and teams. Removing obstacles that get in the way of people doing their work (eg. chronic excessive workloads, conflicts between departments) and providing the resources people and services need (eg. staff, equipment, training) are the most important tasks for leaders.

system leadership has been incentivised to focus on efficiencies and budgets, rather than to improve operational performance or what matters most to their workers and patients.^{4,5}

Accordingly, national bodies have called for leadership approaches that place greater emphasis on employee and patient care.^{6–8} One approach was to develop compassionate leadership. As conceptualised by West, compassionate leadership involves a focus on relationships through four elements: attending (careful listening to), understanding, empathising with and helping other people.⁹ These elements are defined in Table 1. Compassionate leadership focuses on enabling those being led to feel valued, respected, and cared for, so they can reach their potential and do their best work.⁹

Within healthcare settings, compassionate leadership has been linked with wide-ranging benefits for staff, patients, and organisations including reduced levels of stress, errors, staff injuries, and absenteeism.^{9,10} However, critiques of compassionate leadership argue that the definitions of compassionate leadership itself are fragmented, and there is a lack of evidence for standard measures of compassionate leadership.¹¹

Several reviews have been published around outcomes of compassion,¹² compassionate leadership,^{3,11,13} and leadership training more broadly.^{14–17} However, no review has yet examined how compassionate leadership is being developed through leadership programmes in UK healthcare, nor the outcomes of developing compassionate leadership. Given the NHS ambition for compassionate leadership as a key strategy for improving culture and staff experience, addressing this evidence gap is timely and necessary.¹⁸

The aim of this review was to identify leadership programmes for staff, both clinical and non-clinical, working in UK healthcare which contain a compassionate leadership element, and to report the aims, components, outcomes, and impacts of such training programmes on participants, their teams, organisations, and patients.

Methods

This narrative review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) and JBI methodological guidelines.^{19,20}

The inclusion and exclusion criteria were formulated using the Population, Concept, Context (PCC) framework and consisted of: (P) staff (clinical and non-clinical) working; (C) training programmes that explicitly or implicitly aimed to develop compassionate leadership; (C) in the UK healthcare system.^{19,20}

The lack of conceptual clarity about compassionate leadership in the literature necessitated an inclusive approach to studies that were not necessarily labelled as a “compassionate leadership programme.” The inclusion criteria relating to the concept of “compassionate leadership programmes” was therefore based on the four elements of compassionate leadership described by West (Table 1). West’s compassionate leadership model was chosen as it is highly cited within UK healthcare contexts and provides a clear, practical framework which addresses challenges faced by leadership in the NHS.⁹ Studies were potentially

eligible for inclusion if an implicit or explicit goal of the programme was about developing compassionate leadership. Inclusion through implicit goals was determined through study team discussion after familiarisation with West's conceptualisation of compassionate leadership.^{9,10} Studies were included even if compassionate leadership development was one of multiple programme goals.

Only peer-reviewed studies published in English between January 2013, and the present (June 2025) were included. The search was limited to this timeframe given the publication of the 2013 Francis Review which heavily influenced the landscape on leadership development in the NHS.⁴ Exclusions included continuing professional development articles, conference abstracts, studies that included students only, and studies which reported outcomes only relating to compassionate care.

The full PCC and search criteria are included as [Table 2](#) and [Table 3](#). No quality assessment or risk of bias was conducted as they are not applicable for narrative reviews.^{19,20}

Search Strategy

Using the PCC, a search strategy was developed by the research team, and an example of the search strategy is included as [Appendix 1](#). The searches were conducted in June 2025. The following databases were searched: Medline, Embase, CINAHL, Web of Science, and PsycINFO. The search strategy was adapted for each database.

Study Selection

Search results were exported into an EndNote library and deduplicated. The remaining papers were exported into Rayyan, and the titles and abstracts were screened against the inclusion and exclusion criteria.²¹ Full text screening was then conducted of the remaining studies using the same criteria.

Table 2 Inclusion and Exclusion Criteria Using the Population, Concept, Context Framework

	Inclusion	Exclusion
Population	Studies involving staff (both clinical and non-clinical) working in health in the UK	Studies with only student participants
Concept	Studies reporting a leadership training programme for staff working in UK healthcare that explicitly or implicitly have a programme learning outcome or aim of the paper related to the development of compassionate leadership	Training programmes with a sole focus on increasing compassionate care to patients and their families
Context	The leadership training was delivered in the UK (face to face and/or virtual)	

Table 3 Search Terms

Healthcare Professional Terms	Leader Terms	Training Terms	UK Terms	Compassion
Health professional* OR Nurs* OR Doctor* OR Physician* OR Pharmacist* OR Allied Health Health* ADJ2 leader* Health* ADJ2 manag* MeSH – health personnel	Leader* MeSH - leadership	Train* Program* Develop* Educat* Learn* MeSH – Education, Professional	NHS National Health Service United Kingdom UK Great Britain England Scotland Wales Northern Ireland	Compassion*

Note: * Denotes a truncation in the database search term.

Data Extraction

Data from included studies were extracted using NVivo14 software.²² The following data were extracted: citation, study setting and location, study aims, programme aims, study design, number of participants, participant characteristics, programme description and content, and outcomes.

Data Analysis

The paper aims, programme aims, programme description, content, and outcomes were initially inductively coded. Outcomes were then coded deductively using West's four elements of compassionate leadership (attending, understanding, empathising, helping). Although the original studies did not use this framework, it was applied here to categorise and compare reported outcomes across programmes. Additional emergent themes that did not fit within West's framework were also identified and are reported separately. Verbatim quotes from the included studies have been used in reporting findings to illustrate and support the framework and emergent themes. For outcomes, some data related to more than one element or theme and were assigned to multiple codes. Where applicable, the outcomes were categorised at the following levels: individual, team/organisation, and patient.

Results

In total, 550 records were identified from databases. After duplicates removal, 326 records were screened based on title and abstract. In total 50 full-text records were assessed for eligibility. Using the inclusion and exclusion criteria, seven papers were included in the review. Details about the identification and screening process are shown in [Figure 1](#).

The seven included papers investigated five distinct leadership programmes. These programmes were:

- Creating Learning Environments for Compassionate Care (CLECC), one programme reported in three papers.^{23–25} One paper investigated the extent to which CLECC was implemented into existing work practices,²³ another paper compared changes in self-reported empathy, patient reported care, and observations of interactions with patients,²⁴ and the last paper reported the feasibility and impact on patient care.²⁵
- Resilience and Well-being Training Programme²⁶
- Heart of Leadership²⁷
- Leadership Programme²⁸
- Cultivating compassion²⁹

A summary table of programme characteristics including programme content and teaching methods is included as [Table 4](#).

All programmes had multiple aims which included leadership development, compassionate leadership elements, and compassionate care. Notably, none explicitly stated the programme aim was to develop “compassionate leadership”, rather compassionate leadership elements were alluded to in the broader programme objectives. For example, one programme aimed to encourage leaders to engage in appreciating caring conversations and questioning to appreciate others' perspectives and to guide development and action, aligning with West's elements of attending, understanding, and helping.²⁸

Programme participants were recruited from a small range of healthcare settings in the UK. Four programmes (six papers) involved hospital staff only,^{23–28} one programme reported participants from both hospital and community settings.²⁹

Programme duration varied, from 9 days to 12 months with one paper not specifying.²⁹ The number of hours spent within the programme was not specified in any of the included papers.

Teaching methods varied between programmes with a number of approaches used across multiple programmes such as action learning sets,^{23–25,28} group activities,^{23–25,29} discussion groups,^{23–26} and evidence-based leadership information.^{26,29} Other methods used are reported in [Table 4](#).

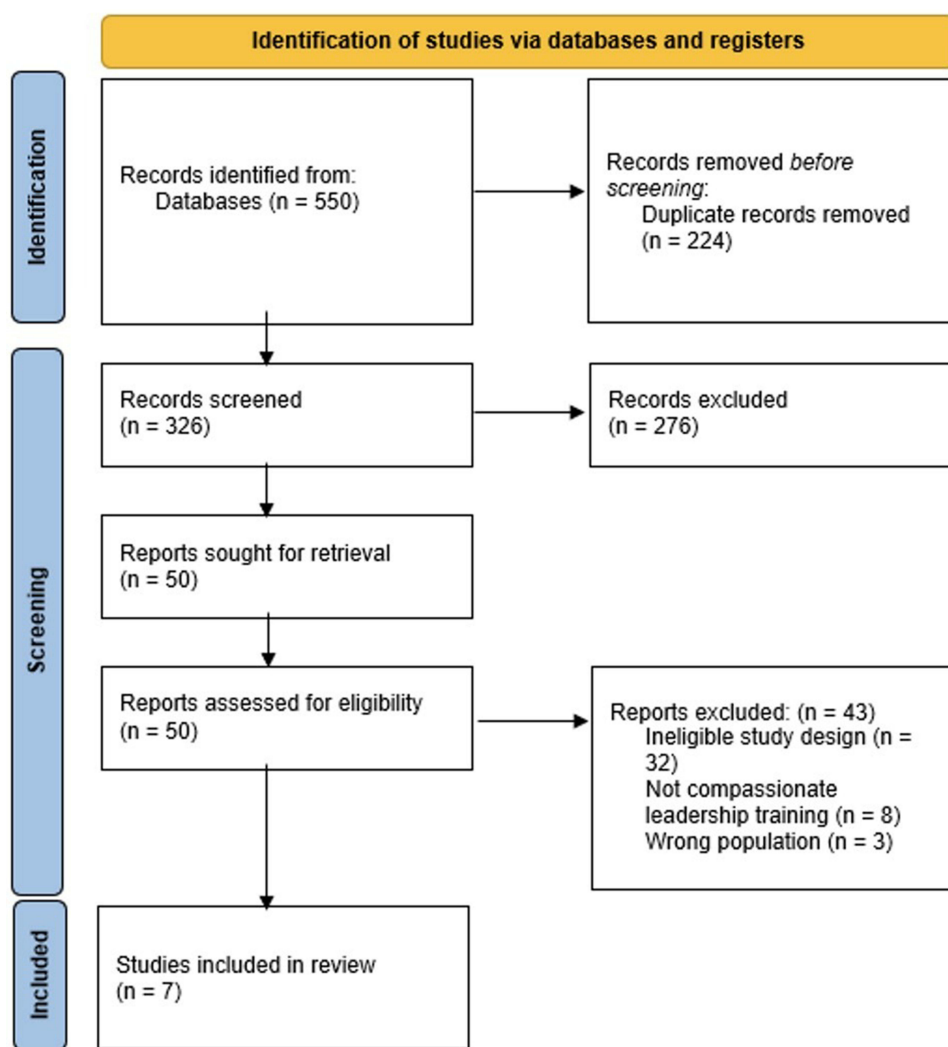


Figure 1 PRISMA Flowchart.

Content taught within each programme also varied. Commonly taught were team building and relationships,^{23–25,27} relational knowledge,^{23–25,28} compassion to self,^{27,28} compassion to others,^{27,28} identifying compassion,^{28,29} and resilience.^{26,27} Other content taught is reported in Table 4.

Follow-up and data collection periods varied and were inconsistently reported, from during the programme to up to 12 months after the end of the programme. Three papers did not clearly specify at what time point data collection occurred.^{26,27,29}

Four papers reported outcomes from the perspective of programme participants through interviews and focus groups.^{26–29} The other papers all reported the CLECC programme which reported outcomes from the perspective of the programme participants (interviews),^{23,25} ward staff,²⁴ patients,²⁴ research team observers,²³ and peer observers.^{23–25}

Thematic Analysis

The next section of the results presents findings from the included programmes using West's four elements of compassionate leadership (defined in Table 1). West's framework, while not used in the original papers, was used here to map the reported outcomes of the programmes. The elements are reported at the individual, team/organisation, and patient level where applicable, and are followed by emergent themes that did not fit in West's model. This analysis is supported with quotes from the included papers.

Table 4 Programme Characteristics

Programme Name	Source (First Author, Year)	Setting	Intervention Length, Number of Participants, and Their Characteristics	Teaching Methods	Follow Up Period and Data Capture Methods	“Theory/Model” of Development <ul style="list-style-type: none"> Educational Content
Creating Learning Environments for Compassionate Care (CLECC)	Bridges, 2017 ²³	Six wards in two hospitals in England.	4 months Total participants = 25 4 ward managers, 2 deputy ward managers, 8 staff nurses, 7 healthcare assistants, 2 senior hospital nurses, 2 PDNs	<ul style="list-style-type: none"> Action learning sets Team learning activities Peer observations of practice Feedback to team Team study days Team building Cluster discussions Reflective discussions 	Interviews with intervention participants at 0, 3–6, and 7–12 months. Observations by trained researchers at month 3 and 4.	Theory not specified <ul style="list-style-type: none"> Influencing senior managers Relational knowledge and capacity Setting team values Team building
	Gould, 2018 ²⁴	Six wards in two hospitals in England	4 months Total participants = 805 627 patients, 178 staff		Questionnaires with patients and ward staff 2 months prior to intervention and 4 months after completion. Observations by researchers at month 3 and 4.	
	Bridges, 2018 ²⁵	Six wards in two hospitals in England	4 months Total participants = 52 33 interviews of nursing staff and managers, 12 ward leader questionnaires, 7 sets of observations		Interviews with intervention participants at 0, 3–6, and 7–12 months. Observations by trained peer volunteers at month 3 and 4. Questionnaires 2 months prior to intervention and 4 months after completion.	
Cultivating compassion	Curtis, 2016 ²⁹	Two hospitals, one mental health service, one community primary care service provider in England	Duration not specified Total participants not specified Doctors, nurses, receptionists, chaplains, and others working in close contact with service users	<ul style="list-style-type: none"> Online toolkit of compassion resources Digital stories Group activities Mindfulness exercises Electronic links to published literature. 	Not clearly specified (data collection points were during the training days and at monthly follow-up meetings). Focus groups and interviews with intervention participants.	“Appreciative inquiry” <ul style="list-style-type: none"> Appreciative stance Avoiding blame culture Identifying compassion
Leadership Programme	Dewar & Cook, 2014 ²⁸	One hospital in Scotland	12 months Total participants = 86 nursing staff	<ul style="list-style-type: none"> Action learning sets Communities of practice 	Interviews with intervention participants at end of the programme.	“Appreciative caring conversations” <ul style="list-style-type: none"> Compassion to others Compassion to self Identifying compassion Relational knowledge
Heart of Leadership (Companions in Leadership + Soul of Leadership)	Hall, 2015 ²⁷	Six trusts in England	9 days (Companions in Compassion 5 days + Soul of Leadership 4 days) Total participants = 63 63 nurses	Teaching methods not specified	Follow up period not specified. Interviews with intervention participants.	Theory not specified <ul style="list-style-type: none"> Compassion to others Compassion to self Concepts and challenges in delivering compassionate care National compassion agenda – 6C’s Resilience Team relationships
Resilience and Well-being Training Programme	Ooms, 2022 ²⁶	One hospital in England	8 weeks Total participants = 72 Health professionals bands 2-8	<ul style="list-style-type: none"> Research evidence Lectures Structured exercises Facilitated discussion Work Discussion Groups Plenaries Coaching 	Follow up duration not specified. Questionnaires of intervention participants. Focus groups and interviews with intervention participants.	“Tavistock systems psychodynamic model” <ul style="list-style-type: none"> Change Emotion in nursing Group dynamics Mindfulness Resilience Understanding organisations

Themes – West’s Elements

Attending

West defined “attending” as “being present with and focusing on others – ‘listening with fascination’”.¹⁰ Four papers (three programmes) provided evidence of “attending”.^{23,25,26,28}

At an individual level, several programmes reported participants demonstrating attentiveness where they had used compassionate approaches to seek and listen to what others wanted to say and how they felt. Participants reported being more thorough in finding out what was actually going on and less likely to make assumptions about others or engage in fault finding.

I am much less judgemental now — I don’t rush in with my judgement of how I see things I try to ask people questions to hear what they have to say.²⁸

At a team level, programmes introduced new initiatives and methods for communication between staff. One example of this was cluster meetings. These provided an opportunity for teams to discuss current challenges and issues.

...the fact that we’re all sitting down and going – is there anything we can do to help you? And if they are going – well actually I’ve got a really poorly patient, so I’ve been struggling with the others – right – well then – we’ll come and help you.²⁵

At the patient level, programme attendees reported changing the way they communicated with patients, involving them more in discussions, being more respectful, and again seeking their actual perspectives.

Before I might have said to patients everything ok now I try to ask them how they are actually feeling.²⁸

Understanding

West described “understanding” as taking time to properly explore and understand the situations people are struggling with. It implies valuing and exploring conflicting perspectives rather than leaders simply imposing their own understanding.¹⁰ Six papers (five programmes) reported improvements in “understanding”.^{23,25–29}

At an individual level, programme participants reported better understanding of the feelings, perspectives, abilities, and personal situations of others.

We have had the chance to talk with each other outside work on a more personal level...so we tend to understand. ‘oh I am a mother of two’, so now I know that she needs to go home early. But before that... I am just thinking ‘where are you going? The job is not yet done’.²⁶

Leaders also had a better understanding of themselves and their role as leaders and how their actions, mood, and behaviour could influence the team.

Many participants were more aware of their leadership strengths and individual contribution to the team. They recognised their own situation more and that of others... “I am more aware of my actions and how they are perceived.”²⁸

At the team level, leaders were able to communicate both shared goals and visions with their teams, creating a more unified or better understanding of goals, objectives, and tasks.

Staff saw the study day as a way of ensuring that they were working together and an opportunity to engage with the ward vision, which was not previously explicit.²³

Understanding also improved relationships across different levels of the staff hierarchy, with senior and junior staff understanding the other’s objectives, motivations, and constraints better.

I also understand that [senior staff] are not doing it to bother me... they are actually doing this because it’s something they also have responsibility to do.²⁶

Empathising

West described “empathising” as “mirroring and feeling colleagues’ distress, frustration, joy, etc., without being overwhelmed by the emotion and becoming unable to help”.¹⁰ Six papers (four programmes) provided some evidence of improvements/changes in “empathising”.^{24,26–28}

Senior staff in one programme described having a new, empathetic way of thinking towards junior staff, acknowledging their own expectations and experiences may not reflect the present.

Although I have come up through those ranks and I have been in their shoes, it was quite a long time ago, and things are very different now.²⁶

Also at a team level, participants empathising with colleagues, resulting in greater understanding and better communication to resolve workplace conflicts.

Data suggested that participants were using the caring conversations framework to resolve difficulties in relationships in the workplace.²⁸

One paper measured empathy quantitatively using the Jefferson Scale of Empathy (JSE), a validated instrument that measures health professionals’ empathy in a clinical setting.³⁰ Nurses completed a self-reported questionnaire where, however, the JSE score between baseline and follow-up was not significantly different.²⁴

Helping

West described “helping” as taking thoughtful and intelligent action to support individuals and teams. This involves removing obstacles that get in the way of people doing their work (e.g. chronic excessive workloads and conflicts between departments) and providing the resources people and services need (e.g. staff, equipment, and training).¹⁰ Five papers (three programmes) reported increasing “helping”.^{23–26,28}

At an individual level, leaders reported shifting from shouldering all the responsibility themselves to becoming more collaborative and delegatory.

I know I need to be more collaborative instead of feeling I have to do it all by myself.²⁸

At a team and patient level, helping was through sharing the workload. In one instance, this improved teamwork freed up time for activities that promoted patient dignity and comfort.

The improved team working has reduced the work burden for some staff and has provided opportunities for staff to undertake activities that previously would have been rare occurrences. “And then that means we’ve got more time to do things that we might not be able to normally do, like – wash someone’s hair, give them a nice – you know – do their nails”²⁵

One paper quantitatively investigated changes in positive and negative interactions between staff and patients between intervention and control wards.²⁴ It was found that although there was an increase in positive interactions between staff and patients and initial chi-square testing was significant, significance was not reached when multilevel logistic regression was applied. This was also the case for reductions in negative interactions.²⁴

Themes – Emergent

As well as the four elements of compassionate leadership within the West model, other impacts and outcomes were reported, which are presented next.

Enhanced Compassion and Relationships Within the Workplace Culture

One emergent theme was changes in workplace culture and relationships and this was reported in six papers (five programmes) where participants described forming professional networks, strengthening team relationships, and creating a positive, collaborative, and compassionate environment.^{23,25–29}

Individuals reported that developing professional networks with others outside the team was a highlight of several programmes and allowed for shared problem solving and learning.^{23,25,28}

One of the biggest things for me on this programme has been the realisation that I have a whole network of people I can go to outside of my ward area.²⁸

Individuals also reported being more reflective and compassionate to themselves and others, recognising their own compassionate leadership strengths and capability.^{23,28,29}

Despite a belief that they already understood compassion and ‘it’s that word again’, exposure to a toolkit of materials raised awareness.²⁹

At a team level, workplace relationships were developed and strengthened and became more trusting. Participants reported developing friendships and being more receptive to providing and receiving constructive feedback.^{23,25,26,28}

We became more than colleagues; we became friends as well.²⁶

The way we have worked together on this programme, learning how to ask better questions has meant that I feel more confident to both question things that I am not sure about but also to hear feedback that is a bit negative. You know that someone is doing this to help you rather than to get at you. It’s difficult because those that have not been on the programme have not learnt how to do this and its hard work trying to influence others but I suppose that is what leadership is about.²⁸

Participants also described a culture shift from being task orientated to having a compassionate care and patient orientation.^{25,27,28}

CLECC, for me, is about giving the staff the empowerment to feel like they can sit and do things with patients that are compassionate rather than task orientated²⁵

Some programmes encouraged staff to take initiative and implement their ideas.^{23,28,29}

Staff felt more empowered than before to respond to ideas and to implement change²³

Participants reported a more positive workplace culture overall, with a focus on possibilities rather than problems.^{23,28}

I have changed my management style. I never used to comment about the things people did well just on what they were not doing well. This has changed — it has not been easy but I am trying, and it is making a difference to the atmosphere on the ward —people are more supportive of each other.²⁸

Discussion

This narrative review aimed to identify leadership programmes for staff, both clinical and non-clinical, working in UK healthcare, which contain a compassionate leadership element, and to report the aims, components, outcomes, and impacts of such training on programme participants, their teams, organisations, and patients. Seven papers were included, reporting studies involving five different leadership programmes. Although compassionate leadership is emphasised in NHS policy and reports, this review has found that the evidence base for how it is developed through formal programmes is limited.

No included papers described programmes that explicitly aimed to develop compassionate leadership. However, our analysis did find that leadership programmes were successful in developing behaviours aligned with at least some of West’s four elements of compassionate leadership. Outcomes relating to “understanding” were evidenced in all programmes, while “attending” and “helping” were only observed in three and “empathising” in four of the five programmes. An additional emerging outcome was enhanced compassion and relationships within the workplace. All reported outcomes were positive or neutral, suggesting that leadership programmes can develop compassionate leadership and impact on individuals, teams, patients, and organisations. However, outcomes were most commonly assessed at the individual level, with comparatively fewer evaluations at team, organisational or patient levels. Outcomes were predominantly reported qualitatively, most commonly by interviewing programme participants. Only one paper sought to investigate impact quantitatively, and whilst a positive effect could be seen in chi-square tests, this was not maintained in

regression analysis.²⁴ While some benefits on programme participants themselves was reported, impact on others and particularly patients is lacking and warrants further investigation.

Some programmes in this review reported a culture shift, where leaders directed their teams from a task-orientation to care-focused and compassionate orientation and hence addressed the central criticism of the Francis review.⁴

In this review, leadership programmes were found to enhance leadership capability, for example, leaders reporting a greater ability to support staff through compassionate leadership behaviours. These improvements align with the Messenger Review's call to institutionally improve leadership capability and are consistent with other evidence demonstrating the positive impact of leadership development programmes.^{8,14,16}

Whilst this review identified some evidence of the impact of training on compassionate leadership behaviours, robust evidence remains limited, a challenge that was noted both in the 2015 King's Fund report of the state of healthcare in the UK and in a more recent 2025 umbrella review of leadership training in healthcare.^{7,31} A 2022 scoping review of health care leadership development programmes discussed the challenge of attributing the influence of healthcare leadership development programmes to outcomes, given the complexity of the health system.¹⁷ That scoping review argued that leaders facilitate the process in which the change occurs and are not the direct source.¹⁷ This issue of attribution is particularly relevant for the included studies in this review, where in all studies, leadership training was included as a part of a suite of actions intended to improve compassion and compassionate leadership approaches. As such, determining the specific impact of the leadership development component within complex interventions remains challenging.⁷

Our review's strengths include the robust approach to the narrative review, following systematic guidelines. Using West's framework for the analysis is also novel.

This review only included a small number of eligible papers, reducing generalisability, particularly given the heterogeneity of the included papers. Although quality assessment was beyond the scope of this review, broad indicators of quality were considered. Most papers relied on qualitative and self-reported outcomes, risking bias and limiting the strength of the conclusions. Many aspects of the programme design itself such as their content, cost, duration, or timeframe of reporting were not clearly reported. As such, the study designs and programmes may not be sufficiently detailed for the studies to be repeated based on what's reported in the papers. It is also unclear of which components offer better value for money or are more likely to produce desired outcomes. Future research, leadership frameworks, and organisations within the NHS (such as the upcoming College of Executive and Clinical Leadership) should consider such factors in evaluations to allow comparisons and inform decision-making in order to understand not only whether capability is developed and sustained, but also how efficiently it is achieved.³²

Future research may choose to investigate the West elements directly, with longer follow-up periods recognising that outcomes may take time to emerge after the completion of training. Additionally, focusing data collection from individuals other than the leader themselves who may have self-report bias and inflate their leadership ability, impact, or skills gained. Other workplace metrics might also be useful to capture the non-West-element outcomes of the programme such as organisational turnover, profits, and absenteeism. Other non-tangible aspects of compassionate leadership such as trust, relational quality, and psychological safety might also be worth exploring. Additionally, reviewing grey literature, particularly evaluations of NHS Leadership Academy (NHSLA) programmes may provide further insights.³³ While such programmes exist, evaluations are not all publicly available, so future work could engage directly with the NHSLA to provide a more complete review.³³

Conclusion

This review found limited evidence for leadership programmes that explicitly focus on compassionate care leadership practices in UK healthcare. Despite this, existing programmes do report positive outcomes that map to West's four elements of compassionate leadership. Further programmes that focus more explicitly on compassionate leadership skills, and study of those outcomes, are needed.

Disclosure

The authors declare that they have no competing interests for this work.

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