Global Engagement and Cultural Competence in the NHS Workforce:

An Evidence Review

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Final Report 8th August 2024

Table of Contents

Report Structure

The report opens with an Introduction (Section 1). Section 1 describes the Study Objectives and Methods and outlines the context within which the Review was commissioned. This captures the workforce challenges currently in the National Health Service (NHS) that the Review is responding to.

It identifies the relevance of a discussion about cultural competence to workforce transformation and the ways the term 'culture' has permeated two rather different aspects of this debate. In the first instance 'culture-as-ethnicity' frequently emerges in discussions around the relevance of the NHS and its sensitivities to fast-changing population dynamics and associated health care needs.

In the second, a broader concern with 'culture-as-organisation' emerges as a barrier to (and enabler of) change and workforce retention. Exposing the rather different (but inter-linked) dynamics in these 2 different approaches sets the scene for a discussion about the role of global health engagement in workforce transformation.

Sections 2 and 3 review the evidence around 'culture-as-ethnicity' and 'culture-as-organisation' respectively.

Section 4 examines the concept and mechanisms of 'global engagement' and the value of these in stimulating NHS-relevant learning in the area of 'cultural-competency'.

Section 5 summarises and integrates the previous discussion and presents recommendations.

Section 1. The NHS Workforce Challenge and the Global Health Opportunity

Study Objectives

This study was commissioned by the Global Health Unit at NHS England. The authors were tasked to provide an evidence review of existing research addressing the following questions:

1. What is cultural competence in the context of global volunteering?
2. What key issues must be considered in the development of cultural competence in global volunteering?
3. How do we best measure cultural competence as a learning and development outcome?
4. How can global volunteering programmes be designed to effectively facilitate the development of cultural competence?

The review was supported by on-going discussions with an Advisory Group.[a]

The National Health Service in Context

The publication of the 2023 NHS Long-Term Workforce Plan[1] marks the 75th Anniversary of the NHS and identifies the impact of demographic change on demand for health services:

[a] The Study Methodology is outlined in Annex 1.

The lack of a sufficient workforce, in number and skills, is already impacting patient experience, service capacity and productivity, and constrains our ability to transform the way we look after patients (p.4).

It describes the Plan as a *'once-in-a-generation opportunity to put staffing on a sustainable footing and improve patient care'.*

Two of the 3 priority areas refer to the role of 'culture' in this opportunity. Firstly, in the context of staff retention it refers to the need to improve culture and *leadership* across NHS organisations. Secondly, it identifies culture in the context of improved productivity and the need for more flexible approaches to the provision of *patient care*. Implicit in this is the issue of increasing population diversity.

In the same year NHS England's Global Health Unit[b] published its Global Health Learning Outcomes Framework arguing that, to meet the challenges described above, '*the NHS will need to work differently. Engagement in global activity can support this transition.*'[2]

The NHS Workforce Plan clarifies the urgent need for change and the emphasis on strategic workforce planning.

But where does Global Health and Global Volunteering fit in this context?

The Outcomes Framework outlines some of the key capabilities associated with global health engagement that have the potential to support workforce transformation. Two rather different concepts of 'culture' are peppered throughout. When 'culture' emerges in the context of patient care or personal and professional capabilities it has an implicit or explicit reference to individual diversity shaped by 'cultural heritage' (Domain A):

Domain A: Professional Practice
*Understand how **cultural differences** within groups, communities, and organisations exist, and how these might impact on health and the delivery of healthcare services.*

For clarity we are going to refer to this as *'culture as ethnicity'*[c] emphasising relationships between the NHS and wider society.

Where culture is discussed in the context of the NHS as an organisation the emphasis is on a much broader concept of organisational or occupational culture (Domains B and C):

Domain B: People Development
*Be better placed to advocate for and contribute to a **culture of organisational learning** to inspire future and existing staff.*

Domain C: Leadership, Management and Organisation
*Establish effective relationships within organisations, in order to understand the **cultural context** and learn 'how things are done', within the new environment.*

To distinguish this from the above we refer to this as *'culture-as-organisation'* emphasising relationships within the NHS including internal workforce relationships and their relationships with patients. These two concepts of culture are inextricably linked. Occupational segregation along lines

[b] Based in the Workforce, Training and Education Directorate at NHS England.
[c] Defined as, 'a group of people who have the same national, racial, or cultural origins, or the state of belonging to such a group' ETHNICITY | English meaning - Cambridge Dictionary)

of ethnicity, gender and other characteristics of personhood inevitably intersects with professional hierarchies to impact, for example, multi-disciplinary team working.

Clarity in defining the concept/s of culture and cultural competence and the role that these play in NHS workforce enhancement are necessary prerequisites to capturing the potential of global health engagement in competency enhancement and NHS reform.

Section 2: Culture-as-Ethnicity

The term 'culture' is widely contested[3] and contextual. 'Culture' is often conflated with aspects of diversity linked to race, ethnicity, and religion, with an emphasis on individual or group differences.

There is huge scope for ambiguity. Within NHS England literature and other research, ethnic, national and racial identities are often foregrounded in resources about cultural competence.[4,5] Other aspects of personhood such as gender and sexual identities, age and social class are also acknowledged.[6]

This approach risks an essentialising attitude to culture within healthcare, implying that individuals can be characterised according to static categorisations and obscuring the complex interplay of multiple identities, personalities and relationships that shape us and our relationships with others.

This approach also has the (implicit) tendency to see culture as belonging to the 'other person' in an encounter (whether patient or colleague) rather than being of the self and the dynamically relational encounter between the self and others.[7]

When discussed in the context of the NHS this 'othering' can over-emphasise the exotic dimensions of 'foreign' cultures and may create the misleading impression that the indigenous community and the organisations they comprise are culturally homogenous.

When the term 'culture' is prefixed to 'competency' it is typically deployed in the NHS context to refer to a set of skills, knowledge, and attributes that are considered necessary to the delivery of respectful patient care in the context of diversity.

The NHS England Cultural Competency and Cultural Safety E-Learning package illustrates this approach. NHS staff should 'respect and appreciate the cultural contexts of patients' lives', 'understand the way we deliver health care' and 'respond to the needs of our diverse population'.[6] Here, cultural competence is closely linked to aspects of Equality, Diversity and Inclusion.[8,9] The end goal is explicitly expressed as 'reducing disparities in health care outcomes' and counteracting racism and discrimination.[6]

The term 'cultural competence' emerged in the United States in the 1970s and has evolved over the past 50 years.[10] Multiple definitions and frameworks abound. Terms are used interchangeably but rarely specified. The competency element is often linked to a variety of attributes (or 'behaviours') including cultural *awareness*; cultural *sensitivity*; cultural *humility*; cultural *safety*; cultural *respect*; cultural *adaptation*; and transcultural competence.[11,12,13]

The more generic concept of 'cultural literacy' was first coined by Hirsch (1987) to refer to, 'the ability to understand and participate fluently in a given culture'.[14] Hodgson and Harris (2022) argue that this approach, combined with Bourdieu's concept of cultural capital (1986) has shaped the Department of Education's Inspection Framework (Ofsted) which assesses the extent to which curricula are 'designed to give all learners the knowledge and cultural capital they need to succeed in life'.[15]

This definition has the potential to combine the two approaches to culture outlined above in a more relevant and integrated concept.

Competence as a Fixed Outcome

Linking the term 'culture' with 'competence' also implies an end-goal of mastery, a measurable and monitorable outcome stripped of its inherent complexity. It also assumes a consensus definition of 'culture' in which it is possible to achieve competence once and for all.[6,16]

When culture is used to refer to individual attributes, the concept of cultural *humility* rather than *competence* has become a more widely used concept in the past decade.

NHS Scotland's e-learning resources, for example, reflect more a fluid 'work in progress' approach focused on '…the (continuous) practice of self-reflection to consider how our backgrounds and the backgrounds of others can impact our relationships': *[A] journey of developing a cultural humility mindset through being open to what we haven't learned yet, embracing continuous learning, and promoting equity and inclusion across health and social care"* [17]

Section 3: Organisational Culture in the NHS

An over-emphasis on the 'diversity' or 'culture-as-ethnicity' lens runs the risk of obscuring other dimensions of culture and their impact on operational efficacy in the NHS; cultural norms that determine 'how things are done'[2] or shape attitudes to organisational learning.

Spicer defines organisational culture as, *'the signs and symbols, shared practices and underlying assumptions of organisations'*.[18] Hofstede et al use the language of 'layers of culture' to describe how, '*As almost everyone belongs to a number of different groups and categories at the same time, we unavoidably carry several layers of mental programming within ourselves, corresponding to different levels of culture'.*

This includes nationality, ethnicity, religion, linguistic affiliations, gender, generation, social class (and occupation) but also, *'organisational, departmental and/or corporate levels according to the way employees have been socialised by their work organisation'*.[19]

The need for a transformation of organisational culture in the NHS is explicit in many documents (as noted in Section 1). NHS England's 'Culture and Leadership' programme, for example, responds to the identified critical need for *deep-seated organisational culture change*:

It is the overall culture – 'the way we do things in the NHS' – which will define what the NHS means and does…A positive culture does not just emerge through the good intentions of those working in the system. It needs to be defined, accepted by those who are to be part of it, and continually reinforced by leadership, training, personal engagement, and commitment.[20]

Our review compared literature with the keywords 'NHS cultural competence' and simply 'NHS culture'. Linking culture to competence meant the loss of discussion around organisational culture. It also became clear that debates around 'cultural competence' and 'organisational culture' in relation to the NHS have evolved in parallel silos.

The NHS Long Term Workforce Plan directly links retention issues in the NHS with the need to 'embed the right culture'.[1] It recognises that the NHS has a powerful institutional culture that shapes (and constrains or empowers) those who train and work within in it. It is characterised by, for example, excessive bureaucracy and data-gathering, task-orientation, over-specialisation of roles, unequal gender dynamics and an assumption of superiority of knowledge and skills in relation to other countries' health systems.[21,22]

Discussion of culture in terms of the characteristics of individual personhood obscures the powerful and interacting impacts of organisational, occupational, and professional cultures that form barriers to or enablers of change impacting, amongst other things, workforce retention.

Of immediate relevance to this Review, we would argue that, in so doing, it also *obscures some of the most critical returns to the NHS from global engagement*.

Section 4: What is Global Health Engagement?

For the purposes of this review, global health engagement can be understood, at its simplest, as any active exposure to another health system at some point in a person's career journey from student through to retirement.

Traditionally this may have been interpreted narrowly as physical co-presence, often in a Low or Middle Income Country and involving geographical mobility (a relocation) often through a student or 'volunteer' placement.[d] The need for physical co-presence for extended periods has gradually eroded over time with an acceleration of interest in 'virtual' mobilities during the COVID-19 pandemic.[23] Historically these forms of global engagement were largely restricted to medical students or junior doctors in 'rite-of-passage' mobilities and, in the main, involved health professionals based in high income countries spending time in LMICs. Medical electives have been a formal part of the medicine curricula since the 1970s.[24] The 'Mobility Imperative' influencing progression in medical careers has a much longer history.[25]

In discussions of cultural competence and global health volunteering, much of the literature continues to convey an implicit assumption that the volunteer is white (often a doctor). The culture they are encountering within the LMIC is othered as 'non-white'.[23,26,27] The assumptions continue: the volunteer is portrayed as having had limited exposure to different cultures or diversity in the UK. 'Culture shock' is portrayed as fundamentally relating to encountering organisations where both staff and patient populations are predominantly from another ethnicity in the LMIC. The exception to this is when more recent literature specifically refers to 'the diaspora' (see below). These binary distinctions do not reflect the empirical evidence. NHS volunteers and students undertaking global health placements are not an homogenous group, and reflect the diversity of the NHS workforce. A survey undertaken as part of the then Health Education England MOVE study exposed a far greater diversity in global exposure amongst NHS staff but still heavily skewed towards higher clinical staff grades.[26,27]

Global Health Engagement Roles

Our review has taken a life-course perspective embracing early career student 'placement' activity through to advanced career engagements. The term 'professional volunteer' is used here to characterise the kinds of highly skilled mobile professionals that undertake global volunteering placements.

[d] There is growing recognition of the potential for similar learning to be gained in High Income Settings. This may include both high income countries and well-resourced private institutions in any global location.

Within NHS England, the term 'Global Health Fellows' is commonly used. 'Volunteer' is more widely used in the literature, or sometimes 'international mentor'. We acknowledge 'volunteer' is an imperfect and value-laden term, particularly in relation to global health work. In this report we conceptualise NHS volunteers as professionals who are engaging with fellow professionals during global placements. We situate their work within the frame of both international knowledge mobilisation and human resource management. 'Professional volunteer' also reflects the complex motivational dynamics at play which often combine aspects of career progression, travel and tourism, and altruism.[28]

The demographic and migration context within which these forms of global engagement take place has changed significantly as the NHS increasingly draws on the wider UK population as well as actively recruiting from overseas. Indeed, the NHS is probably one of the most diverse employers in the world.

The NHS employs over 1.3 million people. Out of staff whose ethnicity was known, 74.3% were white and 25.7% were from ethnic minority groups (not including white minority groups). Ethnic minority staff made up 49.9% of hospital and community health services doctors.[e]

The population of students studying in UK Universities is also changing rapidly with increasing diversity seen across the country but with specific regional characteristics.[f] In the 2021/22 academic year 54.4% (UK domiciled) medical students and 66.7% students in 'subjects allied to medicine' self-reported as white. This excludes foreign students who are not required to report their ethnicity but add significantly to diversity.[g]

The wider patient demographic is also very dynamic. The 2021 Census reported a reduction in the population that identified their ethnic group as 'English, Welsh, Scottish, Northern Irish or British' to 74.4% (44.4 million) of the total population.

It is particularly interesting to see the growth in households consisting of members identifying with two or more different ethnic groups, to 10.1% (2.5 million). Nevertheless, it is important to remember that this diversity is not evenly distributed amongst either patients or NHS staff recruitment and shows marked regional variations.[h]

It is within this fast-changing demographic that global engagement is still considered to be a key mechanism for acquiring cultural competence and accelerated 'cultural learning'.[29]

Leather *et al*. express the popular view that, 'international health links' are of 'particularly timely' benefit to the NHS given the UK's increasingly diverse patient population and, *'should be seized upon as an excellent and economical means of increasing the cross-cultural experience and awareness of staff'* (2010:167).[30]

There is rarely any reflection, in this expression, of the relationship between population diversity and diversity within the NHS workforce itself. One could make the case that this increasingly diverse context reduces the need to gain exposure overseas in what are often far less culturally heterogenous environments.

The discussion now turns to consider the evidence that global engagement 'adds-value' to cultural humility in the contemporary context.

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[e] NHS workforce - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

[f] First year entrants onto undergraduate and postgraduate degrees - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

[g] International students in UK higher education - House of Commons Library (parliament.uk)

[h] Regional ethnic diversity - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

The Added-Value of Global Health Engagement

Culture-as-ethnicity and Patient Care

Sadly, population diversity (and greater patient and staff 'exposure') does not translate in any simple way to greater understanding, sensitivity, or cultural humility.[i] Health disparities within the UK have been rigorously documented,[31] and the causal dynamics explored. Improved awareness of NHS staff of issues around culture and health are a necessary if not sufficient means of reducing health disparities through an improved ability of health professionals to care for a diverse patient cohort.[32]

Evidence suggests that global health engagement supports heightened awareness (although this is largely based on self-reported measurement tools).[33,34,35] However, there is no significant research to show that this has resulted in any tangible impact on health disparities or patient outcomes. There is also likely to be a significant self-selection bias and confounding Hawthorne effect amongst those who have actively sought global health activity.[j]

Many studies have reported on the contribution that global health exposures have made to culture-as-ethnicity learning experiences. The MOVE project, for example, used a variety of research methods to measure the outcomes of international volunteering placements. This included a psychometric questionnaire developed with support from Health Education England. This demonstrated the development of 'cultural competencies' through self-evaluation of professional volunteers following international learning experiences.[36] Participants reported increases in the following responses:

- *I demonstrated a good awareness about how culture influences health*
- *I frequently demonstrated cultural sensitivity*
- *I was constantly conscious of culture when working with patients*

These questions, answered using Likert scales, illustrate some of the difficulties in capturing anything other than the most superficial kind of measurement, particularly in using self-reported methods. Other aspects of the MOVE research used qualitative methodologies to expose the more complex dynamics of cultural learning.[37]

Respondents' narratives suggest a far deeper process than one simply of observing and learning about different cultures. Indeed, what many volunteers learn, particularly if they spend some time in one location and build relationships effectively with their peers, is that cultural humility is more than about observing difference; it is fundamentally about trying (as a privileged outsider) to understand behaviour and engage with the contextual underpinnings of that. Greatrex-White argues that the experience of being a 'foreigner' is underrated, and that this 'disturbance' impacts cultural knowledge and perspectives.[38]

One of the volunteers quoted in Ackers *et al.* (2017)[37] suggests that, whilst her own experience as a first-generation migrant from Thailand inevitably helped her to 'integrate' in a culturally diverse NHS, the experience of a global placement *may help others* with communication skills:

I am from Thailand so for me I am used to it and can integrate but I think it's a very useful skill for people. It's really important, in any job communication is so important and in the UK there are so many different cultures, it does help for communication.

Conversely, a British Muslim doctor felt that his exposure heightened his own awareness of culture:

[i] Similar assumptions need to be made about overseas encounters.

[j] Hawthorne Effect In Psychology: Experimental Studies (simplypsychology.org)

I am more in tune with how cultural differences affect you professionally; you can't go in there and start shouting and screaming, you need to build relationships. I always knew they were important but maybe didn't appreciate how important. I will be a lot more in tune about how I'm making people feel because I've been in situations where all of a sudden, I'm the foreigner.

It is interesting to see how this doctor specifically refers to his status as a 'foreigner'. This experience is echoed in many other cases emphasising not so much awareness of the culture of others but the experience of being an 'outsider':

The placement was an eye opener. In the UK you're kind of aware of all the cultural differences and you 'do' equal opportunities but until you're actually in a place where you're the outsider, you don't realise how much it impacts, so I've gained non clinical skills such as communication and cultural awareness.

This qualitative data supports the view that cultural literacy derived from an 'outsider experience' can improve the sensitivities required in a culturally and socially diverse workforce supporting NHS objectives in terms of recruitment, retention and team working.[39]

In an ideal form, international placements provide a unique mechanism for developing cultural literacy for both students and professional volunteers. The process of becoming 'the other' through corporeal immersion in another country and health system plunges a person into a state of vulnerability, only replicable through this embodied dislocation.[40]

Helga, a professional nurse volunteer, reflects on her own discomfort and embodied learning:

It makes me uncomfortable 'cause I've been travelling but never like this, I never experienced that before. Like being the white one and the rest are black. Back home I have so many friends that are black and we talk about it, and I couldn't really understand it until I experienced it.[41]

Helga equates her cultural learning with ethnicity and race (she describes herself as 'white' and the people she interacts with in Uganda as 'black'). She had a conception of herself as someone with high levels of cultural competency before her placement. Only once physically in Uganda is she able to fully experience the discover being 'the other'. Her perspective is transformed, and she has gained humility. Only through uncomfortable experience could she begin to 'understand'.

As we have noted, the NHS has one of the most culturally diverse populations and health systems in the world. So, why do we need to encourage (and facilitate) students and NHS staff to go to other countries to experience diversity?

Other mechanisms exist. For example, undertaking placements in different settings within the UK, such as remote rural areas or areas with higher or lower levels of diversity (in all its forms). However, global health volunteering speaks to a kind of corporeal transnationalism of discomfort that accelerates learning through the kinds of powerfully transformative experiences that are experienced when immersed in another country and health system.

The essence of acute learning from a global health perspective may be this experience of being 'the outsider'. It leads to the exposure and examination of one's own culture, prejudice, and unconscious bias. As much as learning about others and becoming masters of understanding of 'another' culture global learners heighten their understanding of themselves as individuals and actors within their home organisational and systemic cultures.[42]

This is why transnational exposure is an effective mechanism for cultural learning. It is also why in-person (or co-present) placements remain vital to optimise exposure. Virtual engagement in global health, though in some areas an effective compromise that addresses some issues of cost, carbon

emissions and widening participation, is unable to replicate the conditions required for internal transformation and development of cultural humility. Internal transformation at an individual level is really required to begin to change organisational cultures.

Evidence also suggests that global engagement contributes to greater problem-solving through team working. Global placements often trigger the development of mixed professional groups in problem solving missions. They usually live together as well as working together and share experiences of discomfort and vulnerability eroding professional hierarchies. On their return, they are better able to demonstrate the effective multidisciplinary working that optimises communication and patient safety.

Cultural Literacy and the Ethics of Global Volunteering

If there is serious concern about cultural competency in the NHS workforce one might question the ethics of exporting this to LMIC settings with much higher levels of vulnerability and fewer safeguards around cultural safety. The emphasis in the global citizenship literature is firmly on what individuals and the NHS or high-income country health systems gain from global volunteering.[43,44,45]

The NHS rarely considers these questions. Intermediary organisations responsible for volunteer and student deployment may have their own systems which either attempt to identify and 'weed-out' individuals who present a threat to LMIC settings. As such they self-select individuals with greatest pre-existing humility in order to optimise local impacts. The process of widening participation to maximise returns to the NHS would require greater support for placements.

Various studies report the risk that placements especially when poorly supported, may reinforce stereotypes and 'cultural mislearning'.[37,46] This is a particular problem when aspects of organisational culture (such as absenteeism, for example) become falsely interpreted as national, racial, or ethnic culture.[3] They may also reinforce discriminatory stereotypes and forms of 'white saviourism'.[37,47] Speaking before her international placement, a student nurse from the UK discusses her preconceptions about bereavement care:

I think they think over there when a child has died at birth that not seeing the child and not making memories with that child is better than seeing it. But we know in this country that that doesn't work.[37]

This quote illustrates a wealth of preconceptions and lack of humility awarded credibility by reference to the NHS tenet of 'evidence-based practice'. Subsequently, LMIC partner staff reported that students caused immense distress to bereaved mothers by insisting that they hold their stillborn baby.

This rather extreme example illustrates the normative assumptions held by some international learners and the harm that can result from a lack of cultural safety. This links not to the national identity of either student nurse or Ugandan patients, but rather to the powerful occupational culture of nursing, as described in this discussion of cultural voyeurism in international nursing placements:

The nurse stands outside, secure in the culture of nursing, and surveys the patient from the viewpoint of their interesting exoticism. The interesting exoticism is usually in deficit compared with the culture of nursing and allows the nurse to be patronising and powerful. [47]

Inherent assumptions of power are exposed here, as volunteers (and students) often immediately identify as 'expert' change agents; a role many of them (especially nurses and Allied Health Professionals) may not have identified with prior to their placement.

Once they become an outsider in the LMIC system they start to conceptualise their role and even their mandate as being to 'make a change' – yet without the necessary understanding of the systemic factors that are shaping what they see.

Another recurring characterisation by volunteers and students of nursing colleagues in the partner country as lacking in compassion,[37,47] for example, obscures the impact of occupational and institutional culture within public health systems in both HICs and LMICs. The same member of staff may act quite differently at work within the private health sector, for example. Indeed, pay constraints within government health work often mean that health workers do have dual employment within public and private sectors.[48]

Diaspora Engagement in Global Health

We previously noted the fast-growing diversity of the NHS Workforce reflecting wider population heterogeneity and a growing reliance on international recruitment.[49] In June 2023, almost 1 in 5 NHS staff in England (19%) reported a nationality other than British. For doctors this figure rises to 35%, and for nurses it is 27%.[k] Recognition of the 'global' experience that derives from international migration including first generation migrants, subsequent generations and the fast-growing population of 'mixed' heritage British people (which is predicted to form the majority of the UK population in the next century[50]) has led to an interest in the role of the 'Diaspora'.[51]

The lack of clarity around this concept undermines the ability to understand and foster this opportunity for learning and knowledge mobilisation. 'Diaspora' is itself a contested term and risks othering and essentialising complex individual identities and mobilities to simplistic geographical, racial, or ethnic definitions. Health workers of white ethnic backgrounds who have migrated to work elsewhere are rarely referred to as 'diaspora', for example. In practical terms the term 'diaspora' may tell us little about individual exposure to culture or foreign health systems. The recent report by the Tropical Health and Education Trust, *'Experts in Our Midst: Recognising the contribution NHS diaspora staff make to global health'* acknowledges the lack of definitional clarity and chooses a definition combining residence with more subjective notions:

Modern diasporas are ethnic minority groups of migrant origins residing and acting in host countries but maintaining strong sentimental and material links with their countries of origin.[51]

This report is one of few references to the role of the diaspora in the development of cultural competence in the NHS[l]. With an emphasis on a culture-as ethnicity approach, the report argues that:

Diaspora NHS staff have particular competencies to offer and that fully harnessing their power will be vital if we are to build a future NHS that values all of its staff and serves all of its patients equally. [51]

The presumed experience of another country (if not the health system) is seen as the key learning rather than perhaps their experience of being 'othered' – of not quite 'fitting in' wherever they are. Further examination is warranted of the impact these assumptions could have in restricting the contribution this disparate group can make both to global engagement and NHS learning.

There is also a risk that 'diaspora' individuals are presumed to have greater resilience to the 'culture shock' associated with global engagement. This is a reductionist linking culture shock narrowly culture-as-ethnicity. In reality, the shock (and acute learning) that students and volunteers describe is almost

[l] Greater emphasis is given in other reports to the role of the diaspora in harnessing international recruitment, in supporting critical remittance payments to LMIC economies and, in the context of Health Partnership working to the efficacy of volunteering from the host country perspective. The presumed greater cultural awareness of the diaspora supports an argument in favour of their international deployment. From a very pragmatic perspective and with the NHS interests in mind we could argue that the NHS will get less added value when supporting the international placement of people with pre-existing exposure (including the diaspora).

always linked to health systems and organisational cultures and is felt just or more acutely by diaspora participants.

Global Engagement and Organisational Culture

We described Hofsted's 'layers of culture' approach in Section 1 combining those more individual attributes such as ethnicity, gender or age, for example with concepts of organisational or occupational culture.[19] The NHS as a public health system is quite unique globally, dwarfing the role that private and/or private-not-for-profit providers play in most mixed economies.

Whilst the concept of diversity and heterogeneity characterises the UK population and NHS workforce, the overwhelming majority of health workers in the UK are trained and work within the NHS.

In marked contrast to most LMIC settings the majority of health workers and their families rely on the NHS for their own healthcare reducing still further their exposure to private (or private-not-for-profit) organisations. This is very different in many LMICs where health workers rarely access the public services they are employed in for their own and their family's care.

Of course, different organisational cultures do exist within the wider UK health system, particularly in areas such as social care and dentistry, and many health workers will have some exposure to these. This is especially true of those people who have migrated into the UK to work in healthcare. And it may be that their exposures to diverse organisational cultures in the mixed economies of their home countries (as care givers or recipients) is as valuable as their 'culture-as-ethnicity' experience.

As such NHS staff share a common exposure to one corporate culture.[m] This culture is dissected by occupational or professional sub-cultures which frame the NHS approach to multi-disciplinary team working. Being a part of such an overwhelming organisation can impede awareness of its distinctive culture and an individual's role within that. The monolithic nature of the NHS assumes a normative power that makes it very difficult for individuals to see themselves as being shaped by its organisational culture.

Stepping outside the NHS into a 'foreign' system facilitates this ability to recognise the NHS for the system that it is and the complex organisational and occupational cultures that define it. One of the key areas of global learning derives from this profound experience of leaving a niche and typically 'boxed-in' position and beginning to reflect on the NHS from the outside as a system.

Evidence suggest that much of the transformational learning stimulated by international engagement does result from shock and discomfort, but this is not necessarily linked to 'culture-as-ethnicity'. Volunteers and students, themselves from diverse backgrounds, are expecting to encounter people who may speak a different language, eat different food, identify with different religions, and have a different ethnicity.

Their shock and discomfort often result from encountering a radically different health system which was beyond their prior imagining. This professional midwife volunteer was asked about what she found the most difficult part of adjusting to life, shortly before returning to the UK:

I'm leaving with a completely different outlook. It's the lack of resources. I thought lack of resource would be like not having blood products on time, but it's literally like as basic as we've run out of gauze and gloves today.[41]

[m] Of course, the culture of individual units or facilities will be mediated by the influence of diverse leadership styles and structures.

Some of the initial shock becomes about their own safety as health workers.[52] The pervasive safety culture within the NHS renders it unimaginable that gloves would not be provided within a health facility. This brings volunteers up sharply against the realities of health systems (dys)function and they are forced to develop an understanding outside their clinical role: about supply chains, human resource management, and other system factors. In this respect, the exoticism of 'culture-as ethnicity' may be a distractor. The transformative learning, of greatest benefit to the NHS, may come from the mundane exposure to lack of basic physical and human resource and audit mechanisms.

Empirical research on the experience of volunteers on the verge of returning to their NHS roles exposed a common reluctance and anxiety to return. Volunteers frequently cited excessive bureaucracy, punishing working patterns and bullying among many other aspects as defining their NHS experience. They describe a pervasive organisational culture that they are more able to identify once they have stepped away from it:

I find more of a culture shock when I come home than when I go away. And when I come back into the NHS setting, I find it quite frustrating.[22]

Many global learners will return to the NHS as systems thinkers and problem solvers who have identified the need for and participated in active multi-professional team working, challenging organisational norms and hierarchies often through active leadership roles. This may be the most difficult aspect of 'culture' for new (and returning) entrants, including internationally recruited staff, to navigate.

The literature about learning on international placements suggests that the most significant and transformational learning arising from LMIC placements falls into the category of 'soft' skills or 'tacit knowledge', particularly around systems thinking.[23,28,37,53] This systems learning is most effectively acquired by stepping out of the system.

Section 5: Summary and Recommendations

Cultural Literacy and NHS Transformation

The term 'culture' appears in most policy documents related to the NHS and particularly those focused on workforce development. The word is used in two rather distinct contexts:

On the one hand as a patient and health worker 'attribute' linked primarily to culture-as-ethnicity and linked to wider societal dynamics. In this context there is a strong tendency to essentialise ethnicity and fail to capture its dynamic relationship with other personal attributes (gender, nationality, religion, social class etc.).

Secondly, culture is also commonly linked to organisational or occupational dynamics operating specifically within the NHS often in the context of discussions about barriers to or enablers of organisational change. More specifically, organisational culture is identified as a driver of retention and multi-professional team working.

It is in the former context (culture-as-ethnicity) that most of the existing research/literature around global placements discusses cultural competence linking it primarily to soft skills including empathy and communication and the importance of this to patient care.

The world has changed since global placements became established as a 'rite of passage' in medical training. Widespread demographic change and international migration has transformed patient

populations and the health workforce. The NHS is now possibly one of the most diverse employers in the world.

Many (but not all) students and health workers will gain significant and complex exposure to cultural diversity within their UK-based institutions. What global health exposures offer to these people, whatever their own exposures to 'other' cultures, is the profound and discomforting experience of being an 'outsider' in another country; of being personally 'othered'. And this learning, when supported, is profoundly beneficial.

The overwhelming dominance of the National Health Service in the UK's health economy, on the other hand, restricts exposure of the domestic health workforce to other health systems and organisational cultures. Students and health workers are predominantly socialised within the culture of the NHS.

The concept of cultural literacy has the potential to combine the two approaches to culture outlined above in a more relevant and integrated concept. This then supports the framing of critical questions about the role of global engagement in the promotion of the kinds of cultural literacy capable of stimulating and optimising NHS transformation.

Our review of the evidence suggests that the most acute cultural learning is associated with exposure to foreign systems and associated organisational cultures. Here 'culture shock' is associated with human resource *systems* but also wider physical resource and management/accountability *systems*. Being and experiencing being an outsider in a foreign system creates profound and valuable opportunities for frugal innovation learning.

Cultural Literacy and Outcomes

We have noted the tendency to equate 'competence' with a given endpoint rather than a dynamic process of lifelong learning. This has implications for measurement/evaluation processes.

Several measurement and assessment tools for assessing cultural learning in relation to global health volunteering have been developed.[54,55] However, from a policy impact perspective it is simplified, quantifiable measurements that gain most attention despite a growing recognition of multi-methods in Complex Intervention contexts.[56]

The review team acknowledges the political and economic importance of specifying learning and its relevance and translational potential, in this instance the frugal innovation returns on 'cultural learning'.

Attempting to quantify these more fluid forms of tacit knowledge (in a before-and-after quantitative assessment) will fail to capture the complexity of transformational change which often emerges some time post-return and even later over people's lives and careers.[28]

It is also important to move away from reliance on self-reported evaluation to capture a richer range of perspectives from service users and colleagues, as well as empirical study on the relationship between global engagement and tangible impacts on health disparities and organisational change within the NHS.

Structuring Global Health Engagement to Optimise Learning and Minimise Risk

The kinds of transformative learning identified above illustrate the potential for global health engagements to support NHS change.

Achieving optimal cultural literacy does not happen passively. It must be actively fostered and developed. Integrating opportunities for these exposures into existing training and career systems

rather than positioning them as extra-curricular or 'personal development' opportunities would support this. This also creates the potential to widen participation and access to all cadres.

The contexts and deployment approaches must be carefully considered to optimise both the learning and the ability to translate and apply this on return. Effective learning and lifelong training of NHS professionals within the UK health system is acknowledged to develop through combinations of preparation, teaching, mentorship, guidance, reflection, 'hands-on' practice and debrief.

Structures and systems are also needed to guard against potential externality effects including the risks of cultural 'mislearning'. Being 'thrown in at the deep end' with little active support as was common practice in many early medical placements or engagement in 'observation-only' voyeuristic activities may support an essentialising appreciation of 'culture'. Skopec *et al.* refer to the risk that 'cultural learning as the path of least resistance' on volunteering placements may contribute to a simplistic awareness of different racial/ethnic/national traits.[57] At its most harmful this becomes cultural mislearning that entrenches harmful stereotypes and discriminatory attitudes within the health worker. This may be detrimental both to the host context and to opportunities for knowledge sharing and frugal innovation on return.

In order to make sense of what they are encountering and develop systems thinking, participants in global learning need carefully tailored support, robust management and accountability. This is a challenge for placement organisations as volunteers are often explicitly seeking to escape NHS management structures.

The discomfort and vulnerability experienced by the individual during their placement leads to radical learning. The quality and transferability of this learning is mediated by the level of support they receive.

Induction and Debriefing Processes

As noted, the optimal mechanism for cultural literacy may be through the immersive and embodied 'self-othering' of migration or mobility, but preparatory induction through face to face and/or virtual means enhances learning. Much has been done in recent years to professionalise global health placements, but there is still work to be done.[58] Some form of pre-departure induction that introduces aspects of reflexivity and cultural learning is essential. Effective placement preparation and debriefing is associated with cost, both financially and in terms of people's time, and requires sufficient investment at an organisational level.[59]

Key to this approach would be a 'reframing of the participant's thinking ahead of the partnership to be able to see not the differences in the country contexts, but to focus instead on the similarities' to try to overcome the exoticisation of international placements.[57]

Resource constraints and the likelihood that NHS staff will quickly be reabsorbed into their old roles (or students return to their studies) in practice often mean that post-return debriefs fall by the wayside. Post-return debriefs are an essential mechanism to challenge lingering cultural mislearning and enable participants to reflexively recognise and utilise their enhanced cultural literacy within their NHS roles.

Building a Community of Practice for global health participants would support this process and overcome isolation.

Mentoring and Cultural Brokerage

Extensive work on theories of learning has emphasised the importance of a 'More Knowledgeable Other', sometimes called a 'cultural broker' to mediate learning and the transfer of knowledge.[46] We

refer to knowledge in its broadest sense here rather than technical or explicit forms (of medical knowledge, for example). People with diverse experience are optimally placed to support people to make sense of what they see and hear in order to develop a systems understanding.

Recent work at the University of Plymouth has provided evidence for the benefits of connecting staff to others who have undertaken global engagement.[22,60] Their group workshops supported volunteers to recognise and understand their new skills and learning and utilise them in their NHS roles, contributing to change at an organisational level.

This is not the same as simply having a 'mentor' for the placement. Placements should ideally be embedded within long term partnerships with a multi-disciplinary team of people. These would include other volunteers but also experienced placement managers and other national staff team members who are used to supporting and working with volunteers. A form of cultural brokerage is then facilitated, through informal discussion but also through regular formal reflexive episodes for which protected time is provided.

Integrating Student and Professional Learning

For student placements, NHS volunteers have the potential to play this cultural brokerage role, facilitating the dismantling of prejudices and bridging the gap between the student's home health system and the partner health system. Placing NHS volunteers in this role both helps the volunteer to develop their own understanding and reflexivity around notions of cultural humility and prevents an undue burden on national teams for supporting student groups. It is recommended that international student placements are integrated with NHS (or other accredited partnerships) professional volunteering sites.

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Annex 1: Study Methodology

An integrative review methodology was used. This form of review is associated with evidence reviews related to clinical disciplines. It differs from systematic reviews in that it intentionally seeks to capture a diverse range of literature, including both published and grey literature, and methodologies across a spectrum of qualitative and qualitative methodologies. The aim is to enable evidence-based recommendations for policy and practice that reflect the complexity and nuance of theoretical concepts: in this case, 'cultural competence'.

A pilot scoping search was conducted using the following databases: PubMed; ProQuest; Medline; Google Scholar and CINAHL. Subsequently, an iterative search strategy was refined, and strengthened through reference-chaining, key term cross-referencing and consultation with experts in the field of global health volunteering and reciprocal knowledge mobilisation. Empirical evidence from a current NHSE doctoral research study was used for some illustrative quotes, for which ethical approval was obtained from the University of Salford, ref. 4763.

Inclusion criteria:

Literature from the period of 1st January 2014 to 14th March 2024 was initially included. Following reference chaining, some additional research published prior to 2014 was included as being of key relevance to the discussion.

Literature relating to post-registration (qualified) health workforce of all cadres were included. By health workforce we refer to professionals working within the health sector. These may not be professionally qualified clinical staff groups. Indeed, only about half of the NHS workforce, for example, belongs to clinical groups such as doctors, nurses, midwives, and allied health professionals. Nonetheless, it is of note that the literature reviewed predominantly referred to clinical cadres.

Literature relating to international placements of pre-registration (student) health workforce was also included. This reflects our holistic life-long learning approach to this discussion of the health workforce. We recognise that within the UK, healthcare students are on the whole being trained within NHS environments and being prepared for a career within that institution. A high proportion of the evidence relating to cultural learning through international placements does refer specifically to student placements, and there are many closely shared themes and cross-cutting issues between student and professional volunteer placements. Indeed, the distinction is not binary, as many healthcare students also work or have worked in healthcare settings as paid employees. For example, the role of healthcare assistant is often regarded as a 'pathway to nursing' and a first step on the ladder to a professional health care registration.[a]

'Global health volunteering' included any international context (high or low-and middle-income countries) and included stays of any duration. However, the literature referring to 'global health' generally related to individuals from high income countries undertaking transnational experience in low-and middle-income countries. This implied assumption is itself worthy of examination, though outwith the scope of this report.

Exclusion criteria:

Literature relating to non-healthcare-related international placements and/or volunteering was excluded (for example, teaching or 'voluntourism').

Search results were limited to include only literature written in English (the language spoken by all reviewers).

Analytical approach:

A total of 1,527 publications in total were generated through the iterative review process. Three interlinked thematic domains were used: a) cultural competence, b) global health volunteering and c) the NHS. De-duplication, title and abstract screening resulted in 157 papers for full-text review. After full-text review, 72 pieces of literature were agreed as suitable for final inclusion. An inductive thematic analysis approach was used to generate key themes from the literature and respond to the research questions. Full search terms are listed in Table 1:

Table 1: Search Terms

Domain 1: Cultural competence	**Domain 2: Global health volunteering**	**Domain 3: NHS**
Crosscultural/Cross-cultural	Global volunteer/s/ing	NHS Culture
Cultural adaptation	Elective/s	Interprofessional
Cultural attitude/s	Global fellow/s/ships	MDT
Cultural awareness	Global health	Multidisciplinary
Cultural change	Global health volunteer/s/ing	NHS
Cultural competence	International elective/s	NHS staff
Cultural diversity	International experience/s	NHS workforce
Cultural humility	International placement/s	Occupational culture
Cultural inequity	International student placement/s	Organisational culture
Cultural knowledge	International volunteer/s/ing	Organizational culture
Cultural learning	Medical elective/s	Professional culture
Cultural practice	Professional volunteer/s/ing	Workplace culture
Cultural respect	Student placement/s	
Cultural safety	Student placement/s	
Cultural sensitivit/ies	Volunteer/s/ing	
Cultural skill/s	Voluntour/ist/ism	
Cultural voyeur/ism		
Culture		
Diversity		
Equity		
Health disparit/ies		
Inclusion		
Inequality		
Intercultural/Inter-cultural		
Transcultural		
Transcultural competence		