An exploration of the workplace experiences of the international clinical workforce in the public sector

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1. Justification of the research

Underrepresented group across the National Health Service often experience ineffective competency training and inadequate educational support across the National Health Service. This directly impacts their workplace wellbeing, career progression and ultimately quality of practice across the teams in which they work and lead.

Current workforce data shows that over 15% of the NHS's workforce is non-British and of this 22% of our doctors are nationals of non- European countries (Baker, 2021). Access to the training and development pathway for overseas doctors in the UK was estimated to cost the applicant over £7,500 in 2013 (Rothwell et al, 2013). This medical training pathway differs from that of British trained medical students. Doctors who have trained internationally are expected to work through a lengthy process of registration (The General Medical Council, 2021). Often these aspects of accessing training programmes can be costly, time consuming and challenging for overseas doctors which creates additional complexity when they arrive to work in the UK (Oikelome and Healy, 2007). This, coupled with the transitions, adjustments, restrictions, and inequality in training can present an inadequate system for training our international workforce in the UK (Rothwell et al, 2013).

2. Research question:

- How do we understand the short- and longer-term issues faced by underrepresented groups in healthcare who experience insufficient competency development support in their training?
- How far does inadequate cross-cultural leadership effect the training and work environment experiences of the international clinical workforce?

3. Research aim objectives:

To create a framework which directly supports competency development for the international clinical workforce in healthcare and improves their workplace experiences.

1. To establish the existing situation faced by underrepresented groups across the national health service with regards to cross-cultural leadership.
2. To identify key aspects of cultural safety within training and development that apply to the well-being experiences of the international workforce in the NHS.
3. To create conceptual framework that evaluates cross-cultural leadership within competency development across the NHS.
4. To investigate training and development needs to improve workforce culture within international groups across the NHS through a competency framework.

4. Literature Review

Leadership of multiple cultures is a highly debated area of leadership theory and as Northouse (2015) suggests is a key emerging area within the next generation of leadership theory and practice. Understanding of cultural values and individual beliefs in the workplace is likely to impact leadership behaviour and certainly are key to understanding the multi-cultural environments that are inhabited by the NHS workforce (Yukl and Gardner, 2020). These challenges are becoming increasingly important as workplace pressure and global leadership evolves and the literature acknowledges that although

elements of cross-cultural leadership knowledge are growing the lack of application and connection to training is a concern for leadership experts and healthcare education.

Connection to understanding cultural dimensions and cultural intelligence in the workplace and across organisations has begun to take more of a centre stage in leadership discussions since Williams and Richards (1999) proposal of promoting and understanding 'cultural safety' to empower in the workplace. However, there appears to be a long way to go until these elements are meaningfully integration into training and development and most importantly to become a high priority in leadership practice and an understanding of how this can renew and improve systems and workplace performance (Holtbrugge, 2022 and Hofstede, 2010).

5. The methodical phases and design model

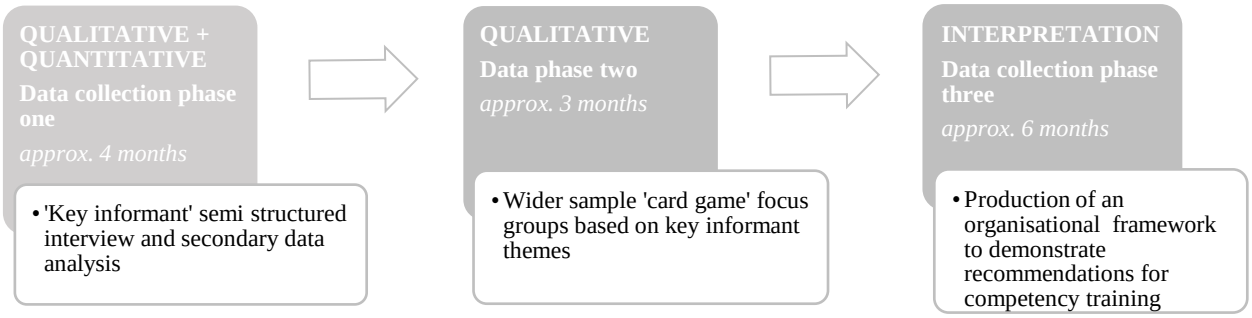

Figure 1. *Overview of data collection phases within sequential exploratory design*.

A sequential exploratory design model will be used to establish phases of the data collection process based on Creswell's (2015) recommendations for best practice in mixed methods research. The phased approach to data collection which is an intergral component of this study. The emergent processes generated from a phased data collection connects the researcher to the methdological philosphopy when 'uncovering' (Saunders et al, 2016) new themes and signifcant or central constructs.

The first stage of phase one will be a secondary archival data collection from a selection of Trust websites using publically available policy. The second part of phase one data collection would be to conduct a semi-structured interview using a 'key informant' participant. Phase two data collection will comprise of a number of focus groups that use the card game feature as discussed by Jones and Rowley (2012). Participants will be invited from some local partnership Trusts to be involved in one of a number of 30 to 40 minutes focus groups. The final third phase of the data collection is to develop a framework for recommendations that connects to the impact and professional application of the research. In order to triangulate the sequential data collection phases, a framework of key features and competency elements will be devised based on the research question and themes that emerged from the phase one and phase two data collection processes (Östlun et al, 2010).

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