International Mobility and Learning in the UK National Health Service

Abstract This chapter sets the study of international placements for healthcare professionals in the wider context of knowledge mobilisation characterising mobile health workers as knowledge brokers. It then discusses the concept of 'volunteer' and how appropriate this term is to the study of placement learning. The term 'professional volunteer' is proposed as a compromise. Two key contextual dimensions are then outlined: first, global health and the needs of low-resource settings. Secondly, the challenges facing a resource constrained UK National Health Service.

Keywords International mobility · Training · UK National Health Service

Internationalisation has become a feature of many, if not most, careers. It can be achieved through a variety of mechanisms, including, perhaps most obviously, the recruitment of staff from other countries. Certainly, international mobility has come to play an important role both in terms of attracting the 'brightest and best' across global labour markets (Iredale 2001; Mahroum 2000; Smetherham et al. 2010) and in terms of fostering mechanisms to provide international exposure to locally recruited staff. Mobilities of various forms involving shorter or longer stays at different stages in careers and to diverse locations are widely acknowledged to play an important role in the generation and exploitation of knowledge and

innovation. Whilst the 'mobility imperative' (Ackers 2010; Cox 2008) has received greatest attention in those careers specifically associated with knowledge generation (such as research), there is increasing recognition that all professionals are inherently engaged in knowledge creation and mobilisation (Baruch and Hall 2004; Baruch and Reis 2015; DeFillippi and Arthur 1994).

Healthcare professionals are not simply the consumers or users of knowledge but through their daily lives actively engage in its co-creation. The concept of 'lifelong learning' bridges archaic boundaries by distinguishing early career phases of intense knowledge acquisition (through formal 'learning') with subsequent knowledge utilisation (through professional practice or 'doing'). Set within this wider context, the growth in professional mobilities involving healthcare professionals will come as no surprise. In some cases, these mobilities may themselves represent 'migrations' as healthcare professionals identify opportunities for longer term relocation abroad (Buchan 2001). Recent years have seen a growing interest amongst British healthcare professionals in Australia and New Zealand contributing to what is often referred to, somewhat simplistically, as the 'brain drain' (Lumley 2011). In many other cases, mobilities take the form of shorter stays to gain exposure, respite or adventure in foreign climes (Hudson and Inkson 2006).

This book and the studies on which it is based focuses on one component of these complex mobility flows, namely temporary stays undertaken by National Health Service (NHS) employees in low- and middle-income countries (LMICs). The individuals and groups involved in these forms of movement are by no means homogenous, either in terms of personal characteristics or motivations (Bussell and Forbes 2002; Lewis 2006; Strachan 2009). The nature of their deployment, their roles in the receiving country and the objectives and quality of the placement organisation all vary enormously. Collectively, these forms of mobility are historically associated with voluntarism largely because the periods of time spent in the low-resource setting are not remunerated by the hosting organisation. (So, objectively, they are volunteers in the receiving country and organisation.) This does not mean that the individuals involved receive no financial support. The (quite contentious) concept of 'compensation' has been utilised to distinguish contributions to maintenance and travel and so on, from remuneration (as pay). In many respects, this tells us little about the motivations or roles of those involved and more about attempts to negotiate legal parameters on the part of deploying organisations.[1]

Whilst most 'volunteers' will not be remunerated as employees of the deploying or host organisation and therefore are technically unpaid (so 'volunteering'), the concept of 'volunteer' has various connotations and infers motivations associated with altruism. Many of the organisations involved in the deployment of NHS professionals and creating opportunities for these forms of mobility do have charitable objectives. The British Red Cross, for example, has been actively recruiting volunteers since the beginning of the Voluntary Aid Detachment Scheme, which deployed volunteers to treat wounded soldiers during the First World War. Fifty years later in 1958, Voluntary Services Overseas (VSO) began linking international volunteers to projects. There are now many smaller charities offering international volunteering placements, including the much-publicised response of volunteers to the Ebola crisis in West Africa. Altruism of one form or another, often linked to forms of religiosity, may stimulate interest in placements in low-resource settings but this is by no means the sole factor.

In reality it is extremely difficult to characterise any form of human mobility in terms of one or two key motivations. Migration (or mobility) decision-making almost always involves a complex range of interacting factors combining lifestyle with career and sometimes adventure or escape. And motivational factors may combine genuine free choice with increasing elements of what we have called the 'expectation of mobility' (Ackers and Gill 2008; Cox 2008), as early career mobility becomes a rite of passage shaping entry into highly prized careers such as medicine. In the context of gap year mobilities, Heath (2007) points to a rise in numbers and argues that the socio-demographic profile of those involved is changing because of the increasing cost of university education. The act of being mobile (irrespective of learning) and displaying that on CVs becomes an important means of 'gaining the edge' in the competition for entry to elite institutions and subsequent career progression. This form of CV-enhancement has become an increasing expectation amongst junior doctors and perhaps lies behind the remarkable growth in the percentage of doctors 'choosing' to work and travel after foundation year, which almost doubled from 2011 to 2013 (UKFPO 2013).

The emergence of the 'global health' concept and the connections it has forged between International Development and Health policies in the UK has added new dynamics and actors. The Tropical Health and Education Trust (THET) itself funded through UK Aid has actively sought to recruit 'volunteers' to support its Health Partnership Scheme

(HPS). Two of the authors of this book (Ackers and Ackers-Johnson) have managed the THET-funded Sustainable Volunteering Project (SVP)[2] which sought to harness volunteers in knowledge mobilisation projects in support of maternal and new-born health in Uganda. The SVP developed the concept of 'professional volunteer' in an attempt to capture the fact that the NHS staff deployed were first and foremost highly skilled professionals, and it was their knowledge and professionalism that were fostered and mobilised as much as any altruistic motivation. This conceptualisation of the people involved in international placements in low-resource settings as 'knowledge brokers' captures their roles perfectly but fails to engage with popular terminology. In our recent work in Uganda, we have tried to substitute the very loaded concept of 'volunteer' with the more familiar concept of 'international faculty' but this tends to work better for those individuals and organisations engaging with university actors. In this book, we have decided to stick with the concept of 'professional volunteer' (PV).

Recruiting PVs to knowledge mobilisation interventions involves a range of considerations. In reality recruiting and deploying organisations will be balancing the expressed needs (wants) of host organisations with the needs (and supply) of potential professional volunteers and a degree of 'tension' often exists between those demanding (seeking) professional volunteers and those supplying them. Hosting organisations will often articulate a need for very highly qualified and experienced faculty even privileging the more prestigious professions (such as surgery or obstetrics) over nursing, midwifery and allied health professions – and they will express a strong preference for long stays. Put simply, they are looking for knowledge rich 'teachers'. On the other hand, the supply of potential faculty available to deploying organisations is skewed in the direction of early career individuals often seeking shorter stays that fit within training programmes and life course decisions (Ackers 2015). These forms of shorter stay mobility of more junior cadres of staff may be what offer the greatest return to the NHS. From the perspective of the NHS then, they may be looking at exporting knowledge-hungry 'learners'. What is clear from our work is that this simple binary characterising teachers at one end of a continuum and 'learners' at the other fails entirely to capture the complexity of knowledge mobilisation and lifelong learning.

Notwithstanding the motivations behind the professional volunteering or the cadres involved, there is a general consensus in the literature that relevant and valuable learning happens as a result of this activity (Crisp

2014; Jones et al. 2013; Kiernan et al. 2014; Lumb and Murdoch-Eaton 2014). And, that learning is often described as 'transformational' or life-changing (Fee and Gray 2013). Banatvala and Macklow-Smith (1997) suggest that the experience doctors gain overseas contributes significantly towards their professional development and that their clinical, organisational and managerial skills are improved when they return to the UK. In practice, much of the existing research on professional voluntarism focuses on impacts on host settings (Ackers and Ackers-Johnson 2016) and undergraduate electives (Ahmed et al. 2016). To the extent that studies address the returns to professionals and their employing organisations, these often take the form of opinion pieces or small-scale case studies, with a significant emphasis on medical electives. Just as we know relatively little about the more specific learning outcomes associated with professional volunteering in general, we also need more detailed understanding of the contextual and organisational variables that facilitate or inhibit these different forms of learning.

Healthcare professionals on international placements will undertake a diverse range of activities reflecting the objectives and structure of the deploying agencies and projects. Some, especially if they are taking time out of their careers or towards the end of their careers, may actively select placements outside of formal health systems, in orphanages, religious or environmental projects (Bhatta et al. 2009). Whilst most early career professionals will seek out placements in healthcare settings, these will involve quite different organisational and professional settings to those they are accustomed to in the NHS. Disciplinary boundaries are often dissolved, and a doctor may find herself doing the work of a nurse and vice versa (Button and Green 2005; Longstaff 2012). They will often work at the boundaries of their specialities, undertaking activities they would not engage in in the UK, or working with different populations (Kiernan et al. 2014; Lumb and Murdoch-Eaton 2014). The objectives of the deploying organisations will also impact learning; placements focused on service delivery in humanitarian emergency relief work may play a bigger role in supporting explicit clinical skills than capacity-building projects such as the SVP with its focus on systems change and capacity-building. The level of supervision is also likely to shape learning in interesting and perhaps surprising ways. The emphasis on 'co-presence' in the SVP project (Ackers and Ackers-Johnson 2014) and resistance to lone working and gap-filling may enhance some forms of learning whilst potentially detracting from others.

SUPPORTING CAREER MOBILITY IN RESOURCE CONSTRAINED ENVIRONMENTS: THE UK NHS

The Global Financial Crisis and ensuing financial (austerity) constraints have adversely affected healthcare systems in most developed nations. In turn, this has put pressure on public healthcare systems to increase efficiency and reduce waste by adopting approaches used in private enterprise to promote 'lean healthcare'. There is growing concern that importing organisational systems from private companies may fail to achieve the goals of large public sector not-for-profit organisations. Gover et al. point to some of the potential barriers and political resistance to the imposition of 'lean' business models in public service environments and introduce a parallel concept of 'frugal innovation'. They define frugal innovation as the search for 'efficient, low costs solutions to everyday problems' capable of containing or reducing public healthcare spending, whilst simultaneously assuring levels of service and extending provision to marginalised groups. Frugal innovation, they suggest, demands a 'reconfiguration of capabilities, resources and competencies' (p. 3). Of central importance to this book, the concept of frugal or 'reverse' innovation (Zedtwitz et al. 2015) implies that low-resource settings characterised by stark resource constraints may stimulate relevant learning or knowledge mobilisation (Petrick and Juntiwasarakij 2011). Crisp captures this concept in his book *Turning the World Upside Down: The search for global health in the 21st century*. Put simply, he argues that his book, 'explores what richer countries can learn from poorer ones' through processes of co-development. Whilst frugal innovation is often described by reference to physical devices such as low cost, 'no-frills' equipment or prosthetics, the concept also extends in interesting ways to aspects of human resource management such as 'task-shifting'[3] (Schneeberger and Mathai 2015).

The UK National Health Service, as a universal service providing free healthcare at the point of use, and in the context of increasing dependency and medical advances, inevitably faces ongoing funding challenges. It is in this specific context that the case for expanding resource on professional mobility needs to be fully justified to NHS managers, employees and patients. Increasing numbers of NHS providers are in financial difficulties. In 2011–12 only 24% of NHS Trusts[4] reported overspending (The Kings Fund 2015). The projected figures for the end of 2016 suggest it is likely to be in the region of 67%, with 89% of acute hospitals projecting a deficit

(Appleby et al. 2016). For the first time since the Kings Trust Quarterly Monthly Report began in 2011, more than half of the trust directors believe that the quality of care in their local area has worsened in the past year (Appleby et al. 2016).

The NHS financial crisis is progressively worsening despite government initiatives to reduce spending (Appleby et al. 2016), and it would seem that human resource deficits lie at the heart of the current funding crisis. Addicott et al. (2015), for example, argue that 70% of costs incurred by NHS trusts are workforce related. This human resource crisis has left NHS managers increasingly reliant on a very expensive locum or agency staff. Figures suggest that 80% of hospital trusts spend more than £1,000 per shift on medical cover for doctors. This equates to more than £2 billion in two years, which could have paid the wages of 48,000 nurses or 33,000 junior doctors over the same period (Donnelly and Mulhern 2012). Migration trends lie at the heart of the problem, and the potential solution. In order to fill the vacancies, 69% of trusts are actively recruiting doctors and nurses from overseas (Hughes and Clarke 2016); 11% of NHS staff and 26% of doctors are non-British (Sidduique 2014). Professional migration is not unidirectional; the number of doctors seeking to emigrate from the UK has increased by 20% in the past five years (Boffey 2014).

The pressure on human resource budgets is also manifest in demands for workforce efficiency and productivity; the NHS requires more from current staff than ever before, resulting in an emphasis on resourcefulness, cost efficiency, flexibility and inter-professional working (Health Education England 2016a; 2016b).

These demands for improved productivity imply further investment in staff through continuing professional development (CPD). Health Education England (HEE) has organisational responsibility for the commissioning of training and the professional development of NHS professionals. It aims 'to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place' (Health Education England 2016C).

Health Education England's 15-year Strategic Plan focuses on the skills and competencies needed for the future workforce (HEE 2014). The emergence of new infections and antimicrobial resistances underlines an emphasis on cross-professional training to support generic competencies. The plan is based on core characteristics of the future workforce and

includes the need for adaptable skills that are responsive to evidence and innovation. It also proposes that finite resources need to be invested more wisely and healthcare facilities should focus on coordinated care delivered by multidisciplinary teams. The NHS *5 year Forward View* is a similar, more short-term, focused document outlining what the NHS plans to achieve in the next five years (NHS England 2014). It also places an emphasis on training to equip staff with skills and flexibilities to deliver new models of care with a focus on innovation and an investment in improving leadership.

In this environment, it is hardly surprising that many NHS employers are reluctant to agree to requests for leave to undertake international placements even when they involve a high level of self-funding. 'Back-fill' (funding staff to cover the work of those who are not on duty) represents a major and very expensive challenge to line managers on the ground (Longstaff 2012). And, in the current environment back-fill will often have to be provided by agency or locum staff who are in turn significantly more expensive (Donnelly and Mulhern 2012). Smith et al. (2012) suggest that this situation leads to reluctance to release staff for international placements.

In addition to political and economic pressures on NHS budgets, government spending on International Development has also been called into question. In reality, the UK Aid budget has been successfully ring-fenced and insulated from public sector cuts. However, this has come with increasing pressure for public accountability reflected in an explicit policy emphasis on the UK 'national interest' (UK Aid 2015). In future, all spending on aid will have to demonstrate that it either responds to a direct threat to British interests (such as terrorism or climate change) or has spill-over components that present a simultaneous challenge to the UK; global health features in this group with specific reference to epidemics and anti-microbial resistance. Whilst there is no specific reference in this chapter to professional volunteering amongst NHS employees, the case remains to be made that this form of UK investment falls squarely in the 'national interest'. Crisp (2010) suggests that in the brave new world of global health we are all increasingly connected and interdependent. It is not only health systems in low-resource settings that are challenged by issues of sustainability and funding, but high-resource settings now face the same problems, and so the growing mobility of the international labour force plays a key role in the mutual cross-fertilisation of knowledge and ideas.

To summarise, the UK NHS faces a serious human resource crisis; this is manifest in two ways of direct relevance to our research. In the first instance, we are dealing with an immediate shortage of staff. In this context, international placements represent an additional and immediate burden on the already pressed systems. Secondly, the pressure for efficiency and productivity increasingly places an emphasis on improved continuing professional development, and in this context, international placements present potentially fruitful and highly efficient opportunities for lesson learning and 'frugal innovation'.

Whilst there is strong evidence to support the view that international placements present valuable and enjoyable opportunities for healthcare professionals, there is insufficient evidence at the present to justify and lend public credibility to NHS expenditure in this area of activity. The quality of the learning and potential for effective knowledge mobilisation and innovation requires a higher level of specification aligning, wherever possible, to identified staff development priorities and costing accordingly. Every international placement is distinct in terms of its context, the activities that the professional volunteer engages in, and the learning opportunities that they present. We need to understand more about the conditions under which mutual learning is optimised and opportunities for translational impact (for the NHS) generated. What exactly this learning entails and how it is facilitated within an international context or how it maps onto CPD needs in the NHS is less well known (Jones et al. 2013).

What interests us in this book and the *Measuring the Outcomes of Volunteering for Education* (MOVE) study[5] is the collective impact of these disparate processes on the National Health Service as an employer with responsibility for the delivery of universal public healthcare in the UK.

The MOVE study was a collaborative project conducted by the research teams based at the School of Nursing, Midwifery, Social Work & Social Sciences, University of Salford and Manchester University Medical School. It ran for two years from 2014 until 2016 and was commissioned and funded by Health Education England (Department of Health). The key objectives were as follows:

Objectives

1. What forms of mobility are present within the current NHS workforce?
2. What forms of knowledge are effectively mobilised during these mobility episodes?

3. How does knowledge gain map onto strategic training objectives in the NHS? (How relevant is the knowledge?)
4. What organisational and contextual variables facilitate the optimal acquisition of these forms of knowledge?
5. What barriers exist to international placements and to the mobilisation of the knowledge gained from them on return to the NHS (is the NHS receptive to new knowledge?)
6. Can the evidence base derived from this research support the development of a psychometric tool capable of measuring quantitatively the outcomes associated with professional volunteering in LMICs?

The MOVE Study: Methods

The MOVE study built on extensive previous action-research on professional voluntarism within the frame of the THET-funded Sustainable Volunteering Project (SVP). Further details of this are contained in Appendix 2 and reported on in Ackers et al. (2016) and Ackers and Ackers-Johnson (2016). Building on many years' experience of research on highly skilled mobilities and knowledge transfer processes, the evaluation strategy included a range of methods complementing and balancing each other through a process of triangulation. The study adopted a multi-method approach designed to capture as accurately as possible the complexity of learning that takes place during international placements. We utilised the following data sources:

- A review of available research and literature on professional volunteering.[6]
- A face-to-face electronic survey of staff in a selection of NHS facilities in the North West of England.
- Semi-structured interviews with key informants and returned professional volunteers (both within the frame of the SVP ($n = 150$[7]) and drawing on the survey population ($n = 51$))
- Analysis of documentary evidence collated as part of the SVP including volunteers' monthly reports
- Ethnographic observation and fieldwork with professional volunteers deployed via the SVP to Uganda.

In addition to this, members of the MOVE team (headed by Dr. Byrne-Davis) have utilised a Delphi approach for assessing the possibility of developing a psychometric tool to measure the core outcomes associated with professional volunteering. The tool is not reported in this book.

NOTES

1. For details see https://www.gov.uk/volunteering/pay-and-expenses
2. A summary of the SVP is contained in Appendix 2.
3. Defined as the 'systematic delegation of tasks to less-specialised cadres' or 'optimising health worker roles'.
4. A National Health Service trust is an organisation within the English NHS generally serving either a geographical area or a specialised function (such as an ambulance service). In any particular location, there may be several trusts involved in the different aspects of healthcare for a resident.
5. Companion volumes focus on the impact on the host (LMIC) settings (Ackers et al. 2016) and undergraduate mobilities (Ackers et al. 2016).
6. This included a systematic review undertaken by Tyler and explained in detail in her doctoral thesis (unpublished).
7. The numbers cited here are constantly increasing as we continue to deploy volunteers and assess impacts.