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Recruitment of nurses from overseas

Exploring the factors affecting levels of international recruitment

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About this report

In this report, we seek to explore the factors affecting levels of recruitment from overseas to the NHS in England. These include the multitude of push and pull factors and the effect of recruitment policies and processes. The report is primarily based on a review of existing literature; interviews with diasporas; informal conversations with other key stakeholders; and analysis of available data. A more detailed methodology is provided on p51.

The dynamics of overseas recruitment are extremely complex and we did not set out to provide an exhaustive, unified theory but rather to outline key drivers and barriers and highlight where and what further work would be beneficial to gain a better understanding. This could inform more effective recruitment practices as well as national and local policies that play a direct or indirect role in determining levels of overseas recruitment.

This report sits alongside two other publications – a research report on the return-on-investment of overseas recruitment and a further shorter output which summarises those results for those in the NHS. We have presented our findings over the course of the following three chapters covering: the choice to come to England; the choice of employer and, finally, factors relating to the recruitment process.

Acknowledgements

We are grateful to NHS England & NHS Improvement for commissioning and supporting the research and, in particular, Philip Reynolds, Stephanie Wilson and Ed Cowley who provided advice and insights throughout the project. We are also grateful to the various experts we spoke to who were generous in sharing their wisdom. NHS Digital's workforce team provided us with novel summary data which was greatly appreciated. We would also like to thank Professor Joanne Garside and Linda Everet who commented on an earlier version of the report. Finally, we would like to thank the wider expert panel who commented on our emerging findings and the different Diasporas (including representatives from BINA UK, the Jamaican diaspora, PNAUK and FNA-UK) and recruitment agencies that kindly gave up their time to speak to us.

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Key findings

The contribution of overseas recruitment

1 International nurses play an invaluable role in the delivery of high-quality health care in England. The registered nurses living in England were trained in 141 different countries and nearly one in five (18.5%) nurses in NHS hospital and community services are overseas nationals. This is likely to continue to increase given, in recent years, those with overseas nationalities accounting for around a quarter of nurse joiners.

2 Compared to other high-income countries, the UK has a relatively high proportion of its current nursing workforce that trained abroad. However, the inflow in 2019 – equivalent to 1% of the current workforce – is significantly below Switzerland, New Zealand and Republic of Ireland which have levels closer to 3%.

3 Overseas recruitment will have to play a key role in meeting the Government's ambitions to increase nurse numbers. Given the global nature of the nursing market, the NHS's ambitions should not, of course, be viewed in isolation. Trends in other high-income countries show that some other nations, such as Germany, also appear to be increasing their recruitment of overseas nurses.

4 History suggests overseas recruitment has the potential to play a substantial role in increasing nurse numbers. For example, across the USA more than 46,000 overseas nurses recruited in just two years (2006 and 2007) while the recruitment to the UK in the early 2000s – some 49,000 over a four-year period – show what is possible.

The decision to move to England

5 The decision to migrate is made at a personal level determined by a complex interplay of professional, local and national drivers. Typically, the decision involves making a series of comparative judgements between the quality of life, working conditions, and opportunities nurses have in their home country with what they could achieve in the destination one.

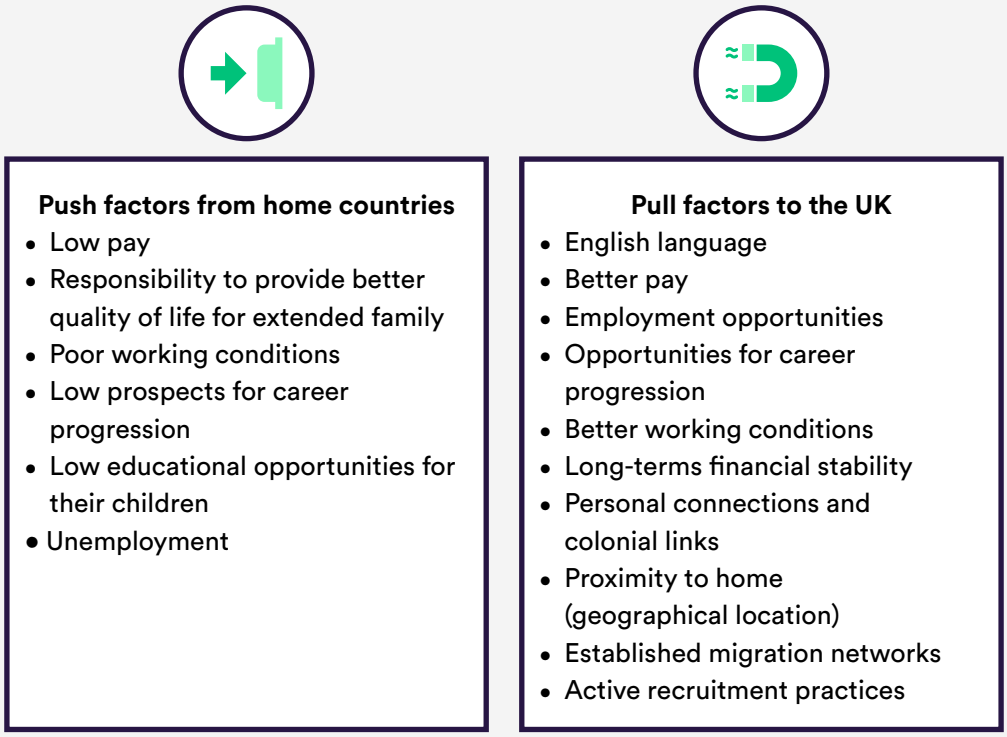
6 Better career opportunities, access to postgraduate education, funding of continuing professional development and perceptions of the quality, style and culture of learning all appear to be important factors. Professional motivations seem to typically be more commonly associated with migrants from higher income countries.

7 For many nurses – particularly those from low/middle income countries – the main factor driving their choice of destination is the possibility of achieving long-term financial stability. According to some diasporas in the study, the possibility of accessing a pension, free health care and education for their children makes England in particular more appealing.

8 Pay is an important factor. The relative pay of a country is determined not only by its pay policy structure, overall market and competition but also international exchange rates. And the level of pay may also be viewed in relation to actual or perceived cost-of-living. However, it is clear that average pay in the UK for nurses (equivalent to US$47,100) is becoming less competitive than some countries, such as Australia (US$77,900) and the United States (US$77,700).

9 Similarities or links between the home and destination country can be important factors in determining levels of overseas migration. One aspect of this is familiarity with English language. In recent years a huge number of overseas recruits to the UK have come from countries, such as India and the Philippines, where English is an official language and/or language of education. However, perceptions of proximity to home, personal connections, and colonial links are all factors too (Figure 1). Perceived levels of discrimination and of visa restrictions to reunite with family seem to be some of the main potential disincentives for nurses to choose England as a destination country.

Figure 1: Overview of some key push and pull factors



Source: Nuffield Trust

10 The global nurse market is affected by changes in competition for staff from various countries. Several other high-income countries within Europe, such as Germany and France, are also actively recruiting to increase their workforce capacity. Moreover, China and India are increasing the ratio of nurses to people – albeit from a low starting point – and, given their vast populations, this translates to huge additional demand for nurses in these nations.

11 In recent years, there has been a series of announcements and new policies (such as removing the Health Immigration Surcharge for health professionals coming to work in the NHS and the introduction of a new points-based immigration system) influencing nurse international recruitment. There has been a significant decline in new EU nurse registrations. However, Brexit appears neither the only nor the main factor affecting the inflow of European nurses to England and the other UK nations, at least not up to the end of the transition period in December 2020. Among other factors at play are the introduction of English tests for

EU nurses in 2016 and the improvement of working conditions for nurses in many European countries, such as Spain and Italy.

12 The Code of Practice for the international recruitment of health care personnel aims to avoid active recruitment from countries with pressing health workforce challenges and so not exacerbate the fragility of their health systems. The data suggest there has been, at times, significant passive (and even active recruitment to social care which was not covered in the code until 2021) from countries on the no-active-recruitment list; however, in the spirit of inclusion and that some of these nurses may be escaping difficult situations in their home countries, we believe it may be reasonable that there is some passive recruitment from such countries. It is the view of this report that in such cases, some compensation for the loss of clinical assets should be considered.

Variation between employers

13 A number of individual and organisational factors may influence nurses' selection of a trust or region within a destination country. But this is not always the case, as we heard during our interviews that for many communities of nurses, it is really about whoever offers a job first.

14 Acute trusts have seen increases in the proportion of nurses from overseas, a phenomenon not seen in other types, such as community trusts and mental health and learning disability trusts. Given different services will require different nursing roles and specialisms some variation in absolute level (if not the trend) of overseas nurses by trust type is to be expected. Only certain countries have, for instance, mental health nursing qualifications that would have been recognised by the NMC prior to 2019. However, since then, nurses seeking to join the NMC register in specialties other than adult nursing (e.g. mental health) do not require to hold a qualification specific to that specialty but instead take a test of competence relevant to that area of practice.

15 The trend in movement of overseas nurses once they have joined the NHS may demonstrate their preferences on locations in England. In particular, there is some evidence to suggest that nurses from the rest of the world are more likely than those from the UK to move within the NHS from trusts which are unavoidably small due to their remoteness. For other trusts, the converse appears to be true.

16 Despite the high level of competition between trusts, there is also large variation in the benefit packages. We heard that benefits offered usually include the flight to the UK, three months accommodation, and pastoral support services on arrival; however, practice varies. While most trusts tend to place migrant nurses at the bottom of level 5 – equivalent to a newly qualified nurse – which may put off some more experience nurses, other trusts offer a pay review after a year or recognise previous experience in certain settings.

Recruitment process

17 Appropriate language skills are critical to effective and safe nursing practices. However, we were told by different nurse diasporas that the level of difficulty of the required language tests is one of the main challenges. With many agencies and employers only taking candidates once they have passed their language tests the costs of these, especially if retakes are needed, can be off-putting.

18 The duration of the overall recruitment process is important, and for many nurse communities, speed is the main factor influencing the selection of not only the trust but also the country of destination. In 2019, the NMC launched a new and streamlined overseas registration process, aiming to facilitate and simplify the assessment and registration processes of recruitment.

19 The different challenges during the recruitment journey for the nurses make a strong argument for the importance of providing a well-supported process. For many nurses, the burden of future circumstances for themselves as well as their family, can be difficult and stressful, particularly if the decision to migrate involves moving away from family and friends.

Recommendations

In light of these findings and given the importance of developing a better understanding of overseas recruitment so the UK can recruit ethically to fill shortfalls, we make a number of recommendations for further work:

- There is scope for further work to gain a better understanding of what has made nurses leave their home and select a particular country and employer. Such information might provide relevant information to better plan for their arrival and influence subsequent experiences and decisions, such as whether to stay or leave.

- Given the importance of career progression and access to training as motivations to migrate, further analysis of administrative and survey data is required to see how overseas nurses fare. Those managing the NHS staff survey should consider adding 'country of qualification' and/or nationality to the questionnaire.

- There are many, well-established factors that are known to affect migration; however, there is limited understanding of the relative importance of these. Further analysis, potentially employing techniques such as discrete choice experiments, should be conducted to understand what appear to be of highest priority and the trade-offs nurses are willing to make. The lack of comparative studies on which features make the various English-speaking nations particularly attractive, could usefully be addressed in future work.

- Given the importance of pay, further analysis should look at the association between pay levels of migration including between high-income English-speaking countries.

- NHS Digital and NMC need to undertake further work to understand the workforce in more detail including place (and, for the register data, country) of work. By working across these two datasets, it will be possible to explore who is working as a nurse in England but outside the NHS.

- Given the importance of fairness and transparency, recruitment by referral and feedback loops, we need to better understand the expectations and experiences of nurses during recruitment and the support their needs. Employers should consider having a member of a migrant community in the recruitment team to allow for better communication and overall adaptation.

1 Introduction

The contribution of overseas recruitment

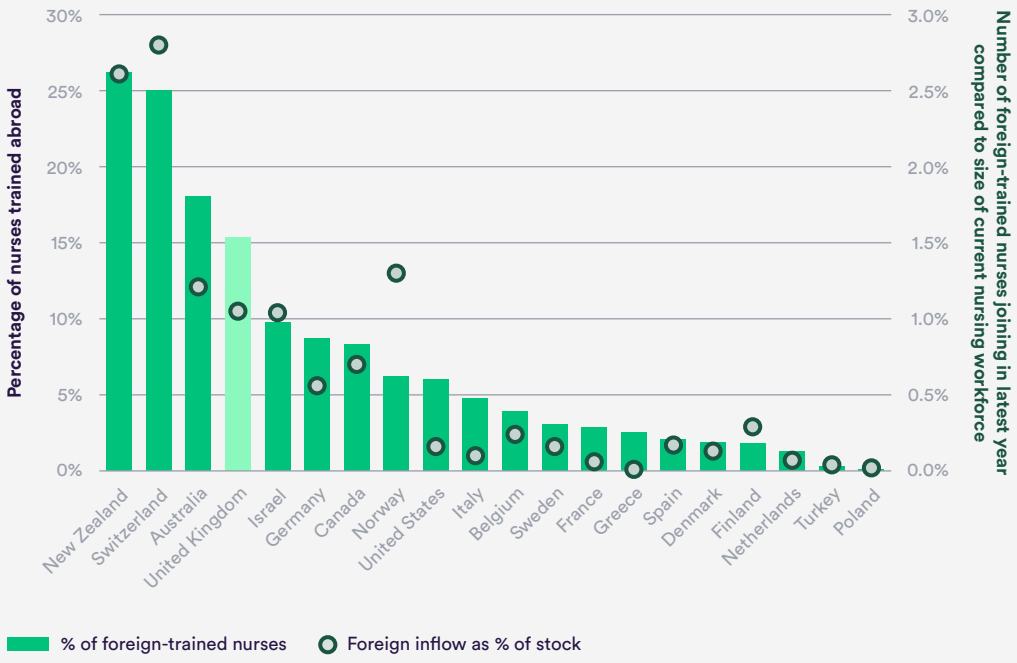
International nurses play an invaluable role in the delivery of high-quality health care in England. While the majority (around 84%) of those on the Nursing and Midwifery Council (NMC) register with an address in England as at March 2021, trained in the UK, around 1 in 8 (12%) trained outside the EU and a further 1 in 24 (4%) trained in the EU (Nursing and Midwifery Council, N.D.b).[1] Looking at NHS hospital and community services in England specifically, nearly one in five (18.5%) nurses are overseas nationals (NHS Digital, 2021a). This is likely to continue to increase with, in recent years, those with overseas nationalities accounting for around a quarter of nurse joiners.

Compared to other high-income countries, the UK has a relatively high proportion of its current nursing workforce that trained abroad (*see bars in Figure 2*). According to data published by the OECD, the recent inflow is also relatively higher; the number recruited from abroad in 2019 was equivalent to 1% of the current workforce (*denoted by the dots*).[2] That said in some countries – including Switzerland, New Zealand and Ireland (*the latter not shown*) – the level is closer to 3% annual overseas recruitment as a percentage of current workforce. These data therefore suggest the UK as a whole is far from being the most reliant.

1 The Nursing and Midwifery Council (NMC) professional register includes nurses, midwives and nursing associates although 94% are registered nurses (including those with dual midwifery and nursing registration).

2 NMC data suggests the level of overseas joiners as a percentage of number of nurses on the register was higher, at 1.9% in year to March 2020 and 1.5% in year to March 2021.

Figure 2: Levels of overseas nurse recruitment across selected high-income countries

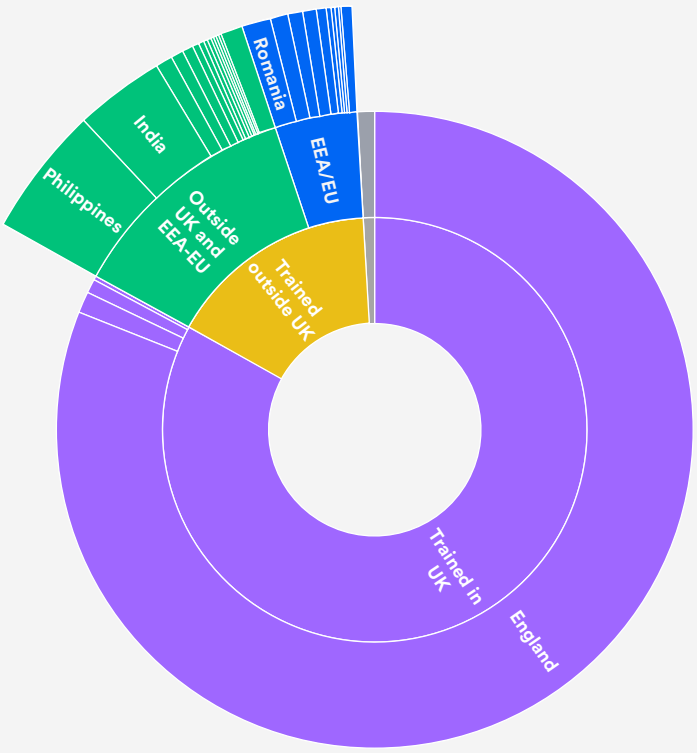


Notes: For latest year available (typically 2019 or 2018). For selected countries only and with some countries (such as Ireland) excluded as they did not have data for both measures. See footnote 2 for details about UK figure.
Source: Nuffield Trust analysis of OECD data (*OECD Statistics*, n.d.)

Sources of UK recruits

The NHS in England has benefited from recruiting nurses from a range of different countries. The registered nurses living in England were trained in 141 different countries. The register includes large numbers from EU countries – such as Romania (6,499) and Portugal (3,830) – and outside the EU, such as the Philippines (28,521) and India (19,912). It is also important not to forget the movement of nurses between the four UK nations with, for example, over 6,000 people on the NMC register with an address in England having qualified in Scotland (Figure 3).

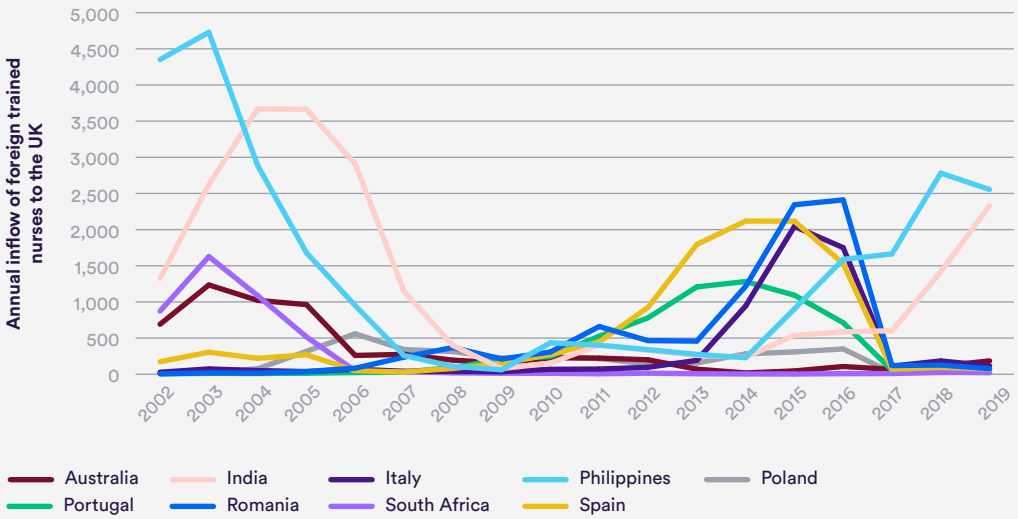
Figure 3: The proportion of people on the nursing register living in England, by country of training



Notes: The Nursing and Midwifery Council (NMC) professional register includes nurses, midwives and nursing associates although 94% are registered nurses (including those with dual midwifery and nursing registration). Data shown based on those with an address in England, as at March 2021.
Source: (Nursing and Midwifery Council, 2021a).

The overall level of overseas recruitment and the balance between different countries of origin have changed repeatedly over time. This suggests there is a complex dynamic of push and pull factors affecting the trends. For instance, there have been: large oscillations in overall levels from Indian and Philippines; a rise-and-fall of recruitment from EU nations such as Romania, Spain, Italy and Portugal, albeit at different rates; and an almost total drop-off of recruitment from South Africa and Australia (Figure 4).

Figure 4: Annual inflow of foreign trained nurses to the UK



Notes: Recent trends should be treated with caution due to discrepancies between OECD and NMC data over this period; for example, NMC data suggest joiners from India and Philippines are much higher in 2019.
Source: Nuffield Trust analysis of OECD data (*OECD Statistics*, n.d.)

The nursing workforce challenge

As at September 2020, there were more than 530,000 registered nurses living in England. These cover adult, children's, learning disability and mental health nursing fields of practice and include those specialist practitioners such as district nurses and nurse independent prescribers (Nursing and Midwifery Council, N.D.b). Some 342,300 are recorded as working in NHS hospital and community health services in England (NHS Digital, 2021d) and 23,900 working in general practice (NHS Digital, 2021b).[3]

However, there are urgent ambitions to increase the number of nurses. There were 39,000 full-time equivalent nurse vacancies by mid-2021, representing a 10% vacancy rate. The vacancy rate for doctors is 7% (NHS Digital, 2021c). The 2019 NHS Long Term Plan committed to reducing the nursing vacancy rate

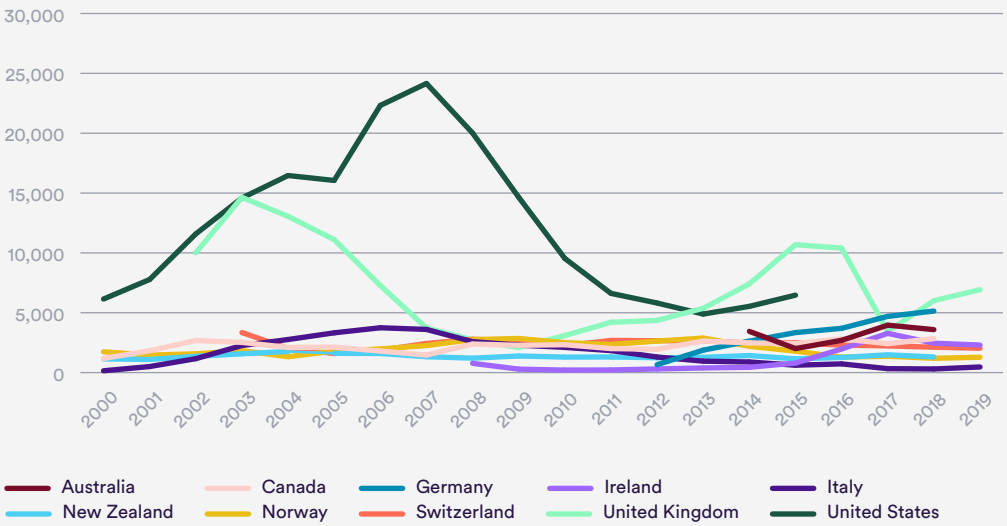
3 Excludes the small number employed by Primary Care Networks. The numbers for those working the NHS are for December 2020.

to 5% by 2028 (NHS England, 2019). Later that year, the government pledged to increase the number of NHS nurses by 50,000 by 2025 (National Audit Office, 2020).

Achieving these goals will require efforts across a range of levers including improved retention, an increase in the number of nurses being trained domestically and previous NHS nurses returning to practice. However, given the time taken to train new nurses, international staff are a key short-term lever for dealing with current widespread vacancies (Beech et al., 2019). Indeed, the People Plan for 2020/2021 acknowledged the importance of increasing our ethical international recruitment and building partnerships with new countries (NHS England, 2020).

Given the global nature of the nursing market, the NHS's ambitions should not, of course, be viewed in isolation. Trends in other high-income countries show that some other countries, such as Germany, also appear to be increasing their recruitment of overseas nurses. However, the figure below, showing recruitment patterns from 2000 onwards, highlights the scope for international recruitment. In particular, it is notable that across the USA more than 46,000 overseas nurses were recruited in just two years (2006 and 2007) while the recruitment to the UK in the early 2000s – some 49,000 over a four-year period – show what is possible (Figure 5).

Figure 5: Recruitment from overseas for selected high-income countries



Source: OECD data (*OECD Statistics*, n.d.)

Overview of responsibilities around overseas recruitment

A huge number of organisations play a role in determining levels of overseas recruitment. Individual NHS providers (and other employers) are responsible for their own overseas recruitment, although they may do so in partnership with others. Through their regional teams, both NHS England & NHS Improvement and Health Education England (HEE) provide support for overseas recruitment planning. HEE also ran a national recruitment initiative, the *Global Learners Programme* (National Audit Office, 2020).

The Department of Health and Social Care and its arm's-length bodies have developed procurement frameworks and best practice guidance to support NHS providers. National bodies also committed, in the Interim People Plan, to work with professional regulators to help improve and streamline regulation processes (NHS Improvement, 2019). The Nursing and Midwifery Council (NMC) is responsible for setting the requirements for those wanting to gain professional registration to work in the UK. However, wider immigration policy is set by the Home Office.

2 The decision to move to the UK

In the following chapter we have focused on the main push and pull factors identified through our research. These factors often overlap and interact, making it difficult to assess and quantify separately. The complexity of the decision move also means that we have not sought to provide an exhaustive list, although have highlighted gaps in current knowledge and ideas for further research.

The decision to migrate

The decision to migrate is made at a personal level. However, the how, why, where and when to migrate appears to be determined by a complex interplay of professional, local and national drivers, both in the source and destination countries (Figure 6) (Davda et al., 2018; European Commission, 2018). Typically, the decision to migrate involves making a series of comparative judgements between the quality of life, working conditions, and opportunities nurses have in their home country with what they could achieve in the destination country (European Commission, 2018). Often, the influences of these decisions are presented in terms of push and pull factors, referring to the aspects in the country of origin that motivate people to leave, and the pull factors that attract them to a particular destination country.

Figure 6: Overview of key push and pull factors

	National/local drivers	Professional drivers	Personal drivers
Push factors	• Deterioration of macro-economic situation • Corruption, poor health infrastructure • Systemic deficiencies in care provision	• Job shortages • Lack of professional ethos • Lack of medical resources • Poor working conditions • Low job satisfaction • Low remuneration • Feeling under-valued/ low esteem • Difficulties reintegrating after return	• Poor quality of life • Responsibility to provide better life for family (many cases extended) as main breadwinners • Low educational opportunities for their children
Pull factors	• Economic, political and social stability • Positive views of country's society and governance • Increasing use of social media platforms linked to more information and access to international and agency/active recruitment.	• Opportunities for career progression • Shortage of postgraduate training • Better pay • Better working conditions • Access to networks and mentors • Clear career pathway • Societal respect for profession • Working in advanced clinical settings • Perception of facilitated immigration process due to demand of staff	• Novel life and cultural experience • Personal fulfilment • Marriage and a spouse's employment • Safer environment to raise family • Better quality of life • Long-term financial stability • Familiarity with language • Personal connections in destination country • Country's proximity to home • Ease and low cost of travel

Source: Nuffield Trust analysis of various sources

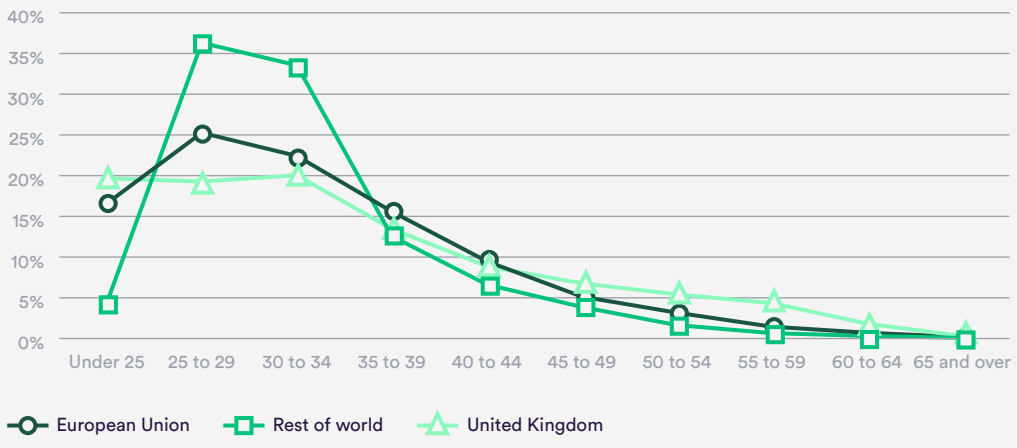
The decision to migrate marks the beginning of the nurse migration experience, and it is often when the initial expectations and goals for a future in the destination country are set, including what they would like their roles to be, their potential earning power, and the different professional opportunities and clinical experiences available to them. And yet the NHS, arm's-length bodies and regulators have not yet sought to systematically understand the detail of these decisions.

In the next sections, we draw on UK literature, interviews and informal conversations to present the main push and pull factors for nurses from different countries to come to the NHS in England.

Age of nurse

To understand the push, pull and prompting factors for migration, it is useful to look at the age of recruitment as it provides some information on what career and life stage these nurses are at. The age profile has changed over time but in recent years, those joining the NHS from the EU are of similar age to those from the UK. However, those from outside the EU are less likely to be aged under 25, but over two-thirds (70%) – far higher than UK (39%) and EU (48%) counterparts – are aged 25 to 34 (Figure 7).

Figure 7: The age breakdown of nurses and health visitors joining the NHS from October 2017 to October 2020



Notes: For NHS Hospital and Community Health Services. This analysis might pick up some re-joining over the period.
Sources: Nuffield Trust analysis of NHS Digital data (NHS Digital, 2021a)

Employment, pay and conditions

Stability and employment

The level of economic development of the home country is an important determining factor in skilled migration flows, although our work suggests that there are important nuances between different communities. Low growth, poor remuneration and a low prospect of providing a better life and education for their families and children, seem to dominate the reasons why nurses want to leave their country (Aboderin, 2007; Alexis et al., 2007; Davda et al., 2018; European Commission, 2018; Likupe, 2015).

Limited employment opportunities and poor working conditions are another key push factor for emigration of qualified workers (Davda et al., 2018; European Commission, 2018; OECD, 2010). According to the diaspora of Indian nurses, the main motivation to leave is the lack of job opportunities in the public sector, with nurses aspiring to higher paying salaries, better job security and even a pension compared to the private sector. Similar factors explained the large outflows of Spanish nurses when the economic crisis that started in 2009 impacted on working conditions and increased unemployment (Rodriguez-Arrastia et al., 2021).

As previously discussed, push and pull factors are often complementary, as nurses often look at destination countries to provide what they lack at home. For many nurses, the main factor driving their choice of destination is the possibility of achieving long-term financial stability. According to some diasporas in our study, the possibility of accessing a pension through citizenship or accessing free health care and education for their children makes working in the NHS in England in particular more appealing, especially when compared to countries with higher nursing salaries such as the US.

Opportunities for career progression

The existing migration literature and our own work both emphasise that the combination of perceived barriers to professional progression and a desire to advance their careers is also a strong driver to look for opportunities abroad (Davda et al., 2018; European Commission, 2018; Leone et al., 2020; Young et al., 2014). A study of Portuguese nurses in the England found that they

had low expectations of career progression in their country and often felt 'frustrated' or 'stagnant' professionally (Leone et al., 2020). Our interviews suggested that this is also a common motivator for Italian and Spanish nurses to leave their countries to come to the NHS in England since broader opportunities for career development remain scarce there. Other associated push factors are limited opportunities for postgraduate education (Davda et al., 2018), lack of funding of continuing professional development (Kelly & Fowler, 2019) and perceptions of poor quality, style and culture of learning (Young et al., 2014).

Some studies suggest professional motivations are more commonly associated with migrants from higher income countries, while economic aspirations are more closely associated with professionals from low/middle-income countries (O'Brien, 2007; Winkelmann-Gleed, 2006). Our analysis revealed similar conclusions, although we recognise that there might also be important nuances depending on the country's economic environment at the time. These include the economic crisis that began in 2009 and precipitated pay cuts, promotion freezes and unemployment in many higher income countries in Europe such as Spain, Italy and Portugal.

Pay

Pay is an important pull and push factor. For example, the typical case of the Filipino nurse in Box 1 illustrates how the aspiration for a better quality-of-life is directly related to the possibility to save and send back remittances to their extended family in their home country.

Box 1. A typical case of a Filipino nurse

In the Philippines, nursing as a profession represents an opportunity to migrate, and migration is a common gateway for a better life for the extended family. For many, nursing is even a second university degree, perceived to allow for a better and quicker return on investment in education.

The financial responsibility towards the extended family is very strong in the Filipino culture. It is very common for many members of the family to help finance nurse education and the costs of international recruitment with the expectation of getting back remittances.

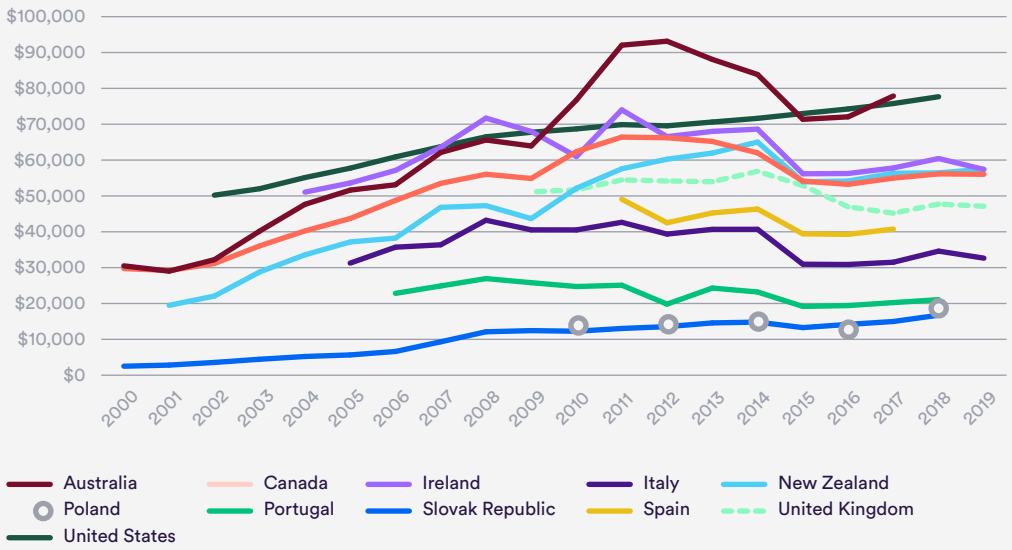
The foundation for nursing migration is based on low nursing salaries, even in big and renowned hospitals in the capital, as well as on an established and encouraging network of bilateral agreements and governmental recruitment agencies. The most common destinations are English-speaking countries such as England, the US, Canada and Australia, although Singapore, and Saudi Arabia are also typical.

The relative pay of a country is determined not only by its own pay levels but also international exchange rates. And the level of pay may also be viewed in relation to actual or perceived cost-of-living. However, it is clear that average pay in the UK for nurses (at equivalent to US$47,100) is becoming less competitive than some countries, such as Australia (US$77,900) and the United States (US$77,700).[4] However, salaries in England remain above levels in some other higher income countries, for example, Italy and Spain (Figure 8).

Pay differences are even higher when compared with most developing countries. Although there is limited robust information on average nurse pay in these countries, data from our interviews and from some more informal sources suggest that in both India and the Philippines, the average monthly salary for a nurse may be around £200.

4 Due to gaps in available data the years these salary figures relate to differ by country; 2019 for UK, 2018 for US and 2017 for Australia.

Figure 8: Salary of nurses in selected countries

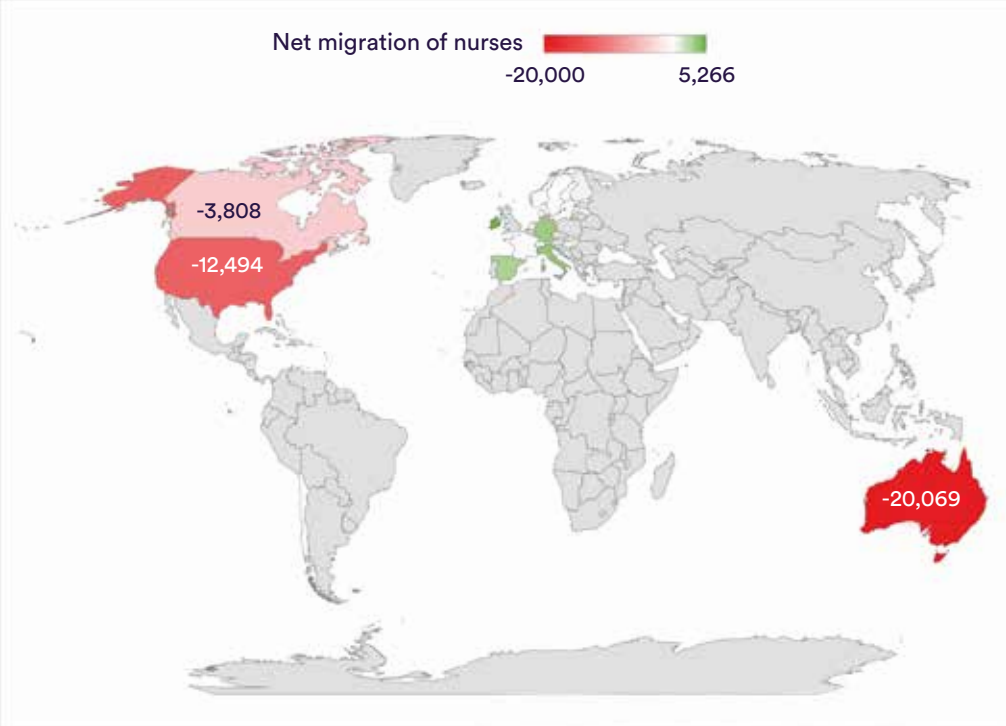


Notes: Remuneration of hospital nurses. Salaried, income, US$ exchange rate. Data not available for all countries for all years. Some values in source data are noted as estimates.
Sources: Nuffield Trust analysis of OECD data (*OECD Statistics*, n.d.)

Push factors for UK nurses

The UK as a whole is often seen as purely a beneficiary of overseas recruitment. However, substantial numbers of UK nurses also leave for typically high-income, English-speaking nations. Across 20 high-income countries for which data are available, there were over 20,000 more UK-born nurses working overseas than vice-versa as of 2015–16. In particular, at that time there were over 12,000 more UK born nurses in the USA than USA born nurses in the UK. The equivalent net-outflow to Australia is 20,000 (Figure 9). Further research on the migration between high-income, English-speaking countries may provide some valuable insights.

Figure 9: Net stock of foreign-born nurses, based on country of birth and country of destination of selected OECD countries, 2015/16



Source: Nuffield Trust analysis of OECD data (Socha-Dietrich & Dumont, 2021)

Closeness

In this section we outlined similarities or links between the home and destination country which are a factor in determining levels of overseas migration.

Language

We heard views, consistent with the literature, identifying familiarity with English language as one of the main factors influencing the choice of destination (Davda et al., 2018; European Commission, 2018; Leone et al., 2020; Young et al., 2014). These may, even stimulate movement between English-speaking countries. The lack of comparative studies on which features make the various English-speaking nations particularly attractive, could usefully be addressed in future work. In recent years a huge number

of overseas recruits to England have come from countries, such as India and the Philippines, where English is an official language and/or language of education).

While it is only a few years since the majority of migrants came from EU countries where English was neither the primary, official nor education language, the context has changed. In particular, until January 2016, EU nurse candidates were not required to provide evidence of language fluency or pass an English language test, rather it was up to the employers to decide and define the acceptable level of English for them.

Perception of proximity to home

The perception of proximity to their home country, as well as the ease and low cost of travel, plays an important role in the choice of the destination country for many communities. For EU nurses, the geographical proximity of England allows the possibility to return to their country whenever necessary, providing a sense of 'closeness to home' that favours it as a popular destination (Leone et al., 2020; Young et al., 2014). The pandemic may have had an effect, given restrictions on movement, on the apparent proximity between England and other countries.

Personal connections and colonial links

Having family and/or relatives already in the country also seems to play an important role in the selection of destination (Davda et al., 2018; Leone et al., 2020), influencing nurses from countries with long and traditional (labour and/or colonial) ties with England, such as India or the Philippines. Similarly, having a community of nurses of the same nationality in the recruiting trust is perceived as crucial for integration, and easing the transition into a new culture and environment.

Beyond the factors discussed in the push and pull model, recent literature suggests there are also a series of prompting factors that influence migration decisions. In most cases, these are related to established social, community networks of migrants in destination countries (Alonso-Garbayo & Maben, 2009), existing bilateral agreements and the involvement and presence of recruitment agencies (Davda et al., 2018; Leone et al., 2020; Pereira, 2015; Young et al., 2014).

Potential disincentives to come to or leave England

Perceived levels of discrimination

Some diasporas mentioned that the awareness and prospects of discrimination and abuse in the destination countries put off some prospective nurse. These perceptions are particularly strong if candidates are migrating with family and to regions without communities of the same nationality. On this, the 2020 workforce race equality standards report highlighted the extent of issues around discrimination in the NHS. In particular, staff from black and minority ethnic backgrounds are, compared to white staff/applicants: less likely to be shortlisted for a job, more likely to enter formal disciplinary processes; less likely to access non-mandatory training; more likely to experience bullying, harassment or abuse from patients or staff; and less likely to be in senior roles.

Family reunification

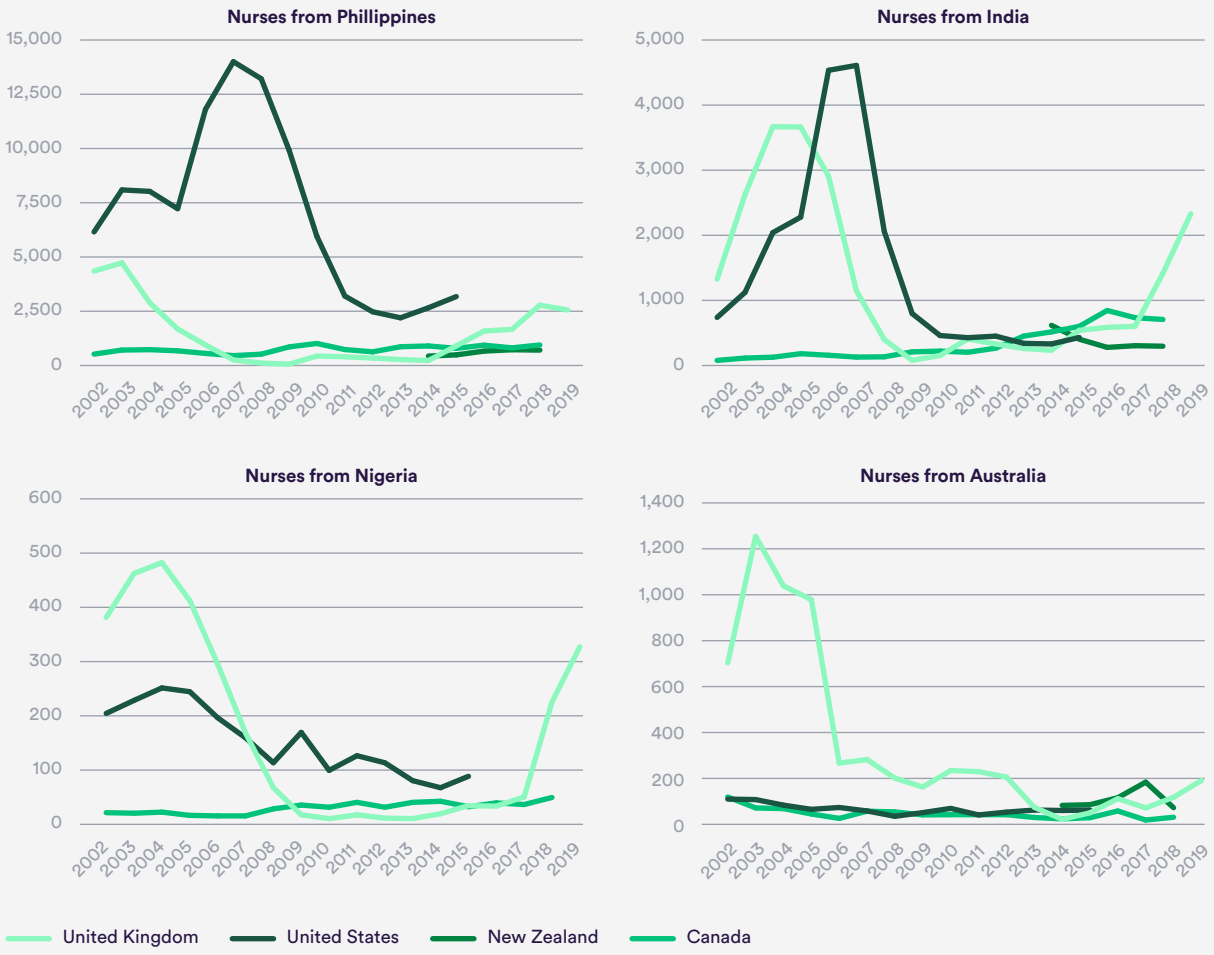
Available opportunities to reunite with their family members either on a temporary or more permanent basis are significant factors for most nurses. We heard that for some communities, the visa requirements in place for family reunification in the UK as a whole, particularly of elderly parents and relatives, may be a disincentive. In some cases, these requirements may even act as a pull factor to go to other English-speaking countries such as Australia, where reunification is facilitated through several different types of parent visas (e.g. Parent Category Visa, Aged Parent Visa). We discussed policies in greater detail below. As the following quote illustrates, the pandemic is an added barrier, affecting the possibilities of these nurses to go back home whenever necessary.

> *the other barrier is mainly leaving the family and friends back home.... Personally, the pandemic makes it really worse. [You] can't even travel back if anything happened to your parents, to look after if they are in end of life or pay last respects in worst case scenario*
>
> British Indian Nurse Association (BINAUK)

Policies

Pull factors may, of course, change over time and affect the destinations nurses choose to migrate to. Figure 10 illustrates the changeable patterns of migration from the Philippines, India and Nigeria and Australia to the UK and three other high-income English-speaking countries. It is notable that while the US recruited 14,000 nurses from the Philippines in 2007, the UK recruited fewer than 300, and that the UK is the only one of these nations to have had a considerable inflow of nurses from Australia, albeit some time ago.

Figure 10: Trend in recruitment from the Philippines, Indian, Nigeria and Australia to UK and three other high-income English-speaking countries (USA, Canada and New Zealand)



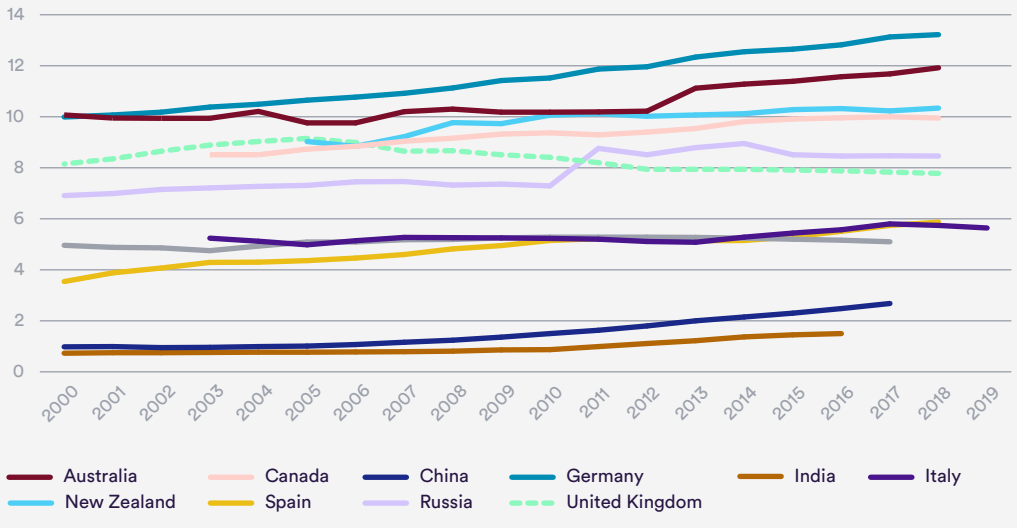
Notes: Data not available for all years for all nations.
Source: Nuffield Trust analysis of OECD data (*OECD Statistics*, n.d.)

There may also be policies in the country of origin that influence not only the nurses' decision to leave but also the ease with which they can be recruited. These include the home countries' policies to accept experience gained in the UK (under discussion for example in several EU Member States), the active training of more nurses than are needed domestically, and more recently, the constantly changing travel restrictions imposed by Covid-19.

Demand

The UK is not the only country seeking to increase nurse numbers. Several other high-income countries within Europe, such as Germany and France, are also actively recruiting to increase their workforce capacity (Figure 11). It is also important to note the trends in China and India which are increasing the ratio of nurses to people – albeit from a low starting point – and, given their vast populations, this translates to huge additional demand for nurses in these nations. These changes in nurses per head of population need to be considered in the context of changing population sizes (for instance, the number of nurses in the UK has increased but just not at the same pace as the population).

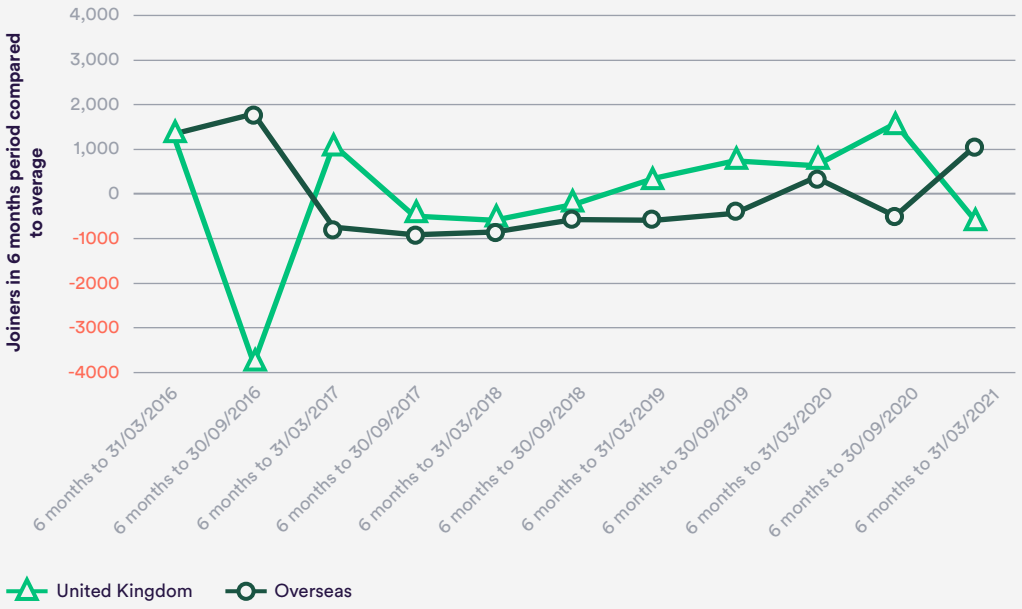
Figure 11: Practising nurses per 1,000 population for selected countries



Notes: Nurse numbers are headcount.
Source: Nuffield Trust analysis of OECD data (*OECD Statistics*, n.d.)

In the 5 years to September 2020, the average number of joiners who qualified in the UK was almost 12,000 compared to around 4,000 from overseas. Looking at how recruitment changed from this average over time suggests that, while there is no consistent, simple relationship, significant dips in recruitment of UK trained nurses – such as between March and September 2016 – appear to be associated with an increase in recruitment from overseas (Figure 12). Of course, the recent trends have been affected by, for example, the pandemic. This association also needs to be considered in the context of the number of commissioned training places three to four years prior, as this is the average time it takes to train a nurse and the annual education cycle (particularly for UK joiners). Certainly, it would make sense that when the domestic supply is short, then employers look to recruit from abroad.

Figure 12: Variation in level of joiners to UK register since September 2015 by region of qualification, by comparing to average



Notes: Based on people with an address in England. Includes midwives and nursing associates although the vast majority on the register are nurses.
Source: Nuffield Trust analysis of NMC data (Nursing and Midwifery Council, 2021b)

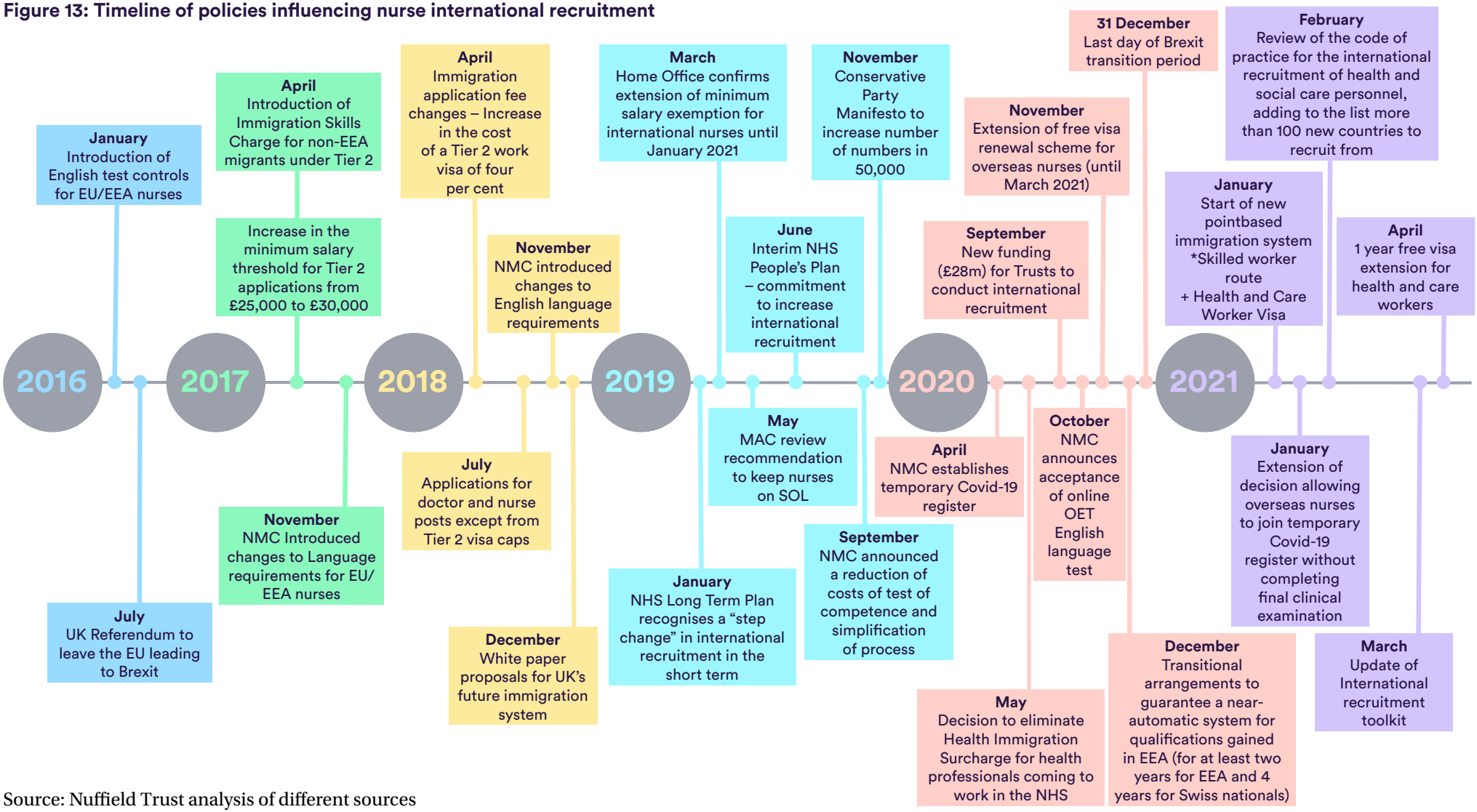
Policies influencing international recruitment

In recent years, there has been a series of announcements and new policies influencing nurse international recruitment (Figure 13). However, the aim and impact of these policies were not always aligned with the need to build the system's capacity to increase workforce supply, particularly in times of great shortage. Some examples are the introduction of immigration skills charge or the increase in the minimum salary threshold, both applying to Tier 2 visa applicants from 2017.

In the last three years, however, there has been a shift towards policies that facilitate recruitment. This is in part due to pressure from different sectors to reverse the impact of previous, more restrictive policies. The publication of the NHS Long Term Plan and the government pledge to increase the number of NHS nurses by 50,000 by 2025 have been pivotal in securing a renewed commitment to increase the number of nurses in the system, and recognition that international recruitment needs to increase in the short and middle term.

In direct response to the Covid-19 pandemic, further measures were taken to facilitate the entry and registration of overseas nurses, such as a waiver of clinical exams for overseas nurses to enable temporary coronavirus registration by the NMC and Home Office agreement to allow cost-free visa extensions for health and care workers.

Figure 13: Timeline of policies influencing nurse international recruitment



Source: Nuffield Trust analysis of different sources

The UK's decision to leave the EU

There are several reports on the effect of Brexit on European nurse recruitment to the UK as a whole (Buchan et al., 2019; Dolton et al., 2018; Marangozov et al., 2016). As shown earlier (Figure 4, p. 11) there has been a significant decline in new EU nurse registrations. However, other data suggest that Brexit is neither the main nor the only factor affecting the inflow of European nurses to the UK, at least not until the end of the transition period in December 2020.

There are several other factors also influencing these declining figures, including the:

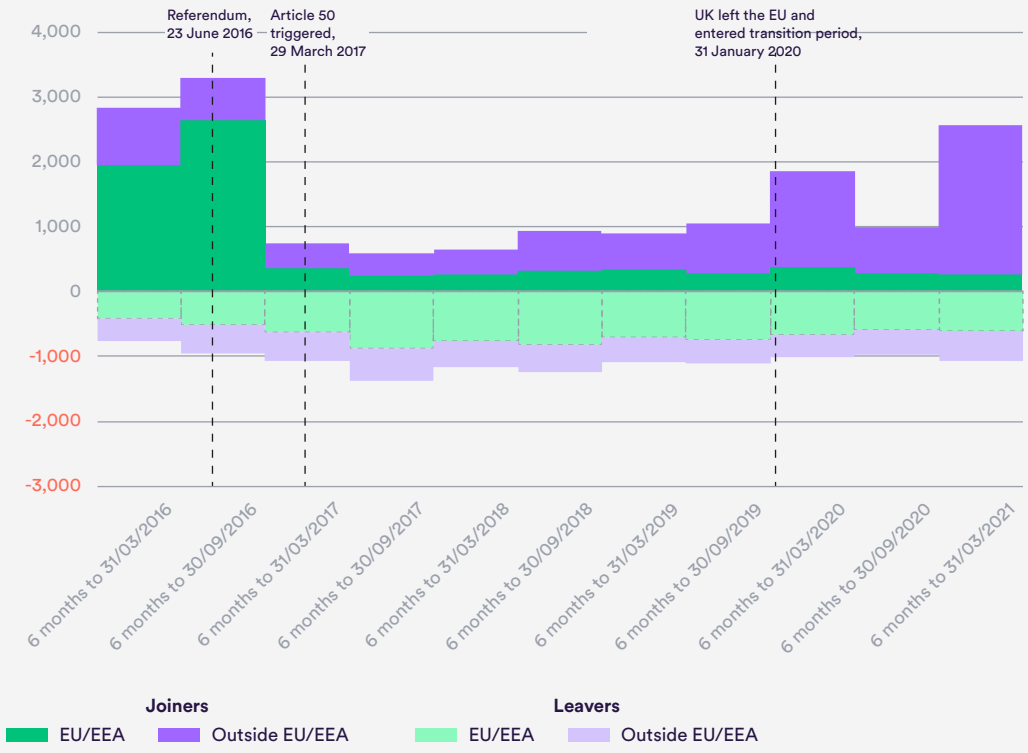
- Introduction of English tests in 2016 for European nurses (Nursing and Midwifery Council, 2015).
- Improvement of working conditions for nurses in many European countries, such as Spain and Italy (OECD, 2020).
- Relaxation of visa restrictions, allowing non-EU recruitment to increase (Beech et al., 2019).
- Competition and intensive nurse recruitment in several other high-income countries, such as Germany, France and the US (OECD, 2019).
- increasing offers of nursing posts in the public sector in many European countries as a response to the Covid-19 pandemic (Dayan et al., 2020).

According to data from our interviews, European nurses continue to come and chose the UK as their main destination for several reasons. In many respects, the UK still offers better working conditions, more opportunities to progress and more opportunities to have their specialties recognised. Additionally, until the end of the transition period, there were effectively no changes to the requirements and duration of the recruitment process that was in place in the beginning of 2016.

As discussed at the beginning of the chapter, it is very difficult to assess the effect of individual policies on the decision to migrate (Figure 14). Close monitoring of the inflows of EU nurses to the NMC register from January 2021 would allow a better understanding of the effect of Brexit on European nurse

recruitment, including the new requirement for EU nurses to have a visa to work and live in the UK. In particular, it will be interesting to see if EU nurse recruitment to Ireland – a similar English-speaking country, albeit with a higher average nurse salary (see Figure 8, p. 20) – will continue to remain high.

Figure 14: Joiners and leavers from the register in England by region of training



Notes: Based on people with an address in England. Includes midwives and nursing associates although the vast majority on the register are nurses.
Source: Nuffield Trust analysis of data from NMC register (Nursing and Midwifery Council, N.D.b).

Ethical recruitment policies

The Code of Practice for the international recruitment of health care personnel was first introduced in 2001, updated in 2004, and more recently, revised in 2021 (Department of Health and Social Care, 2021). From the outset, the code was based on the principles set out in the World Health Organisation's (WHO's) global code of practice (WHO, 2010) with the main aim of avoiding active recruitment from countries with pressing health workforce challenges, to avoid exacerbating the fragility of their health systems.

Some of the main changes of new code include:

- The countries included in the active recruitment safeguarding list went down from 152 to the 47 countries included on the WHO Health Workforce Support and Safeguards List 2020.

- The scope of the code has been extended to cover the social care sector.

- Recruitment agencies can only support candidates from countries included in the safeguarding list once the candidate has applied and secured a post directly and individually.

- Active recruitment from countries on the list can still only go ahead if there is a government-to-government agreement in place.

The main and most direct implication of these changes on recruiting trusts is the expansion of the lists of countries where it is now considered ethical to recruit from, opening many new nursing supply markets. However, as the Covid-19 pandemic continues to stretch healthcare services around the world, with especially acute pressures in low- and middle-income countries, it is critical that trusts not only abide by the pledge to protect their different national health systems, regardless of their inclusion in the safeguarding list, but also the overall wellbeing and personal (and family) circumstances of their potential and future candidates.

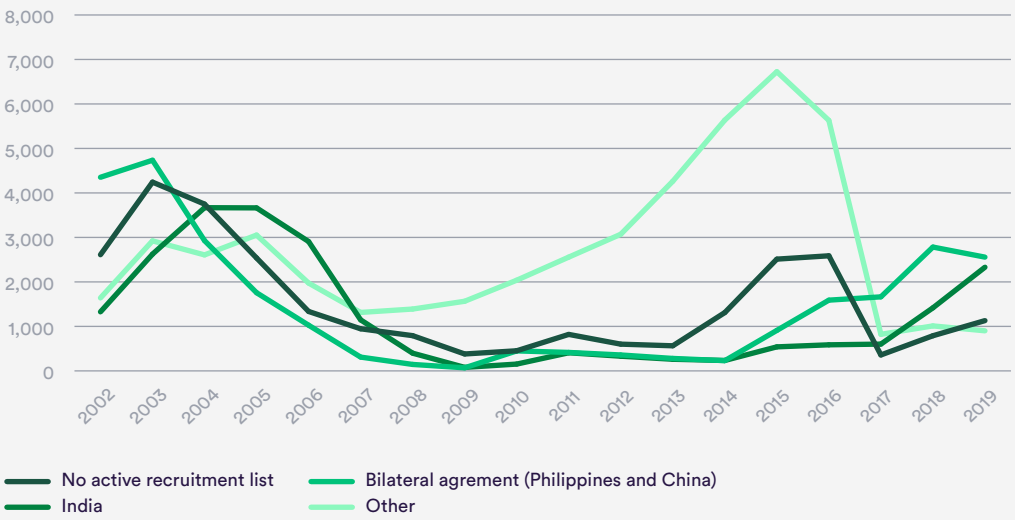
We heard that many recruiting trusts have been severely affected by Covid-19 travel restrictions in and from some of the source countries, particularly where these trusts are focusing all their recruitment efforts on countries currently (at the time of drafting) on the Government's red travel list such as India. Many are also struggling to abide by the rules on providing housing for nurses from these countries with, for example, burdensome and costly cleaning and quarantine protocols.

The NHS continues to recruit nurses from countries on the active recruitment safeguarding list. We heard that some Trusts are now aware of which recruitment platforms are likely to result in applications from nurses from countries on the list (for instance, we were told that Nigerian nurses often apply directly to the NHS job platform). Certainly, the data show there has

been, at times, significant inflow from countries on the list (Figure 15). This may be partly explained not only by passive recruitment but also, for example, the social care sector not being covered by the code of practice until 2021.

Of course, in the spirit of inclusion and that some of these nurses may be escaping difficult situations in their home countries, it is the view of this report's authors that it may be reasonable that there is some passive recruitment from countries on the list. But, if so, we believe there needs to be consideration of what compensation England, as well as the other UK nations, offer the countries of origin – to those on the list and potentially other countries with vulnerable health systems not on the list – for their lost clinical assets.

Figure 15: Joiners to the UK register by country of qualification, categorised by ethical recruitment relationships

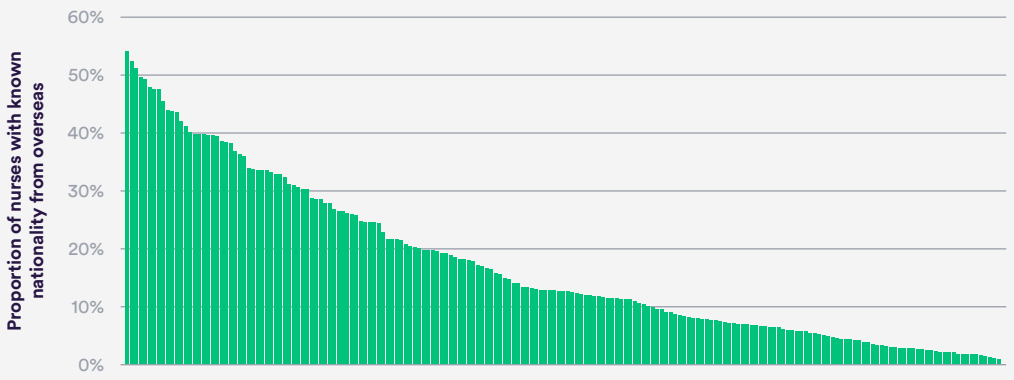


Notes: Indian treated separately as some – but not all – of their states are not targets for recruitment.
Sources: Nuffield Trust analysis of OECD data (*OECD Statistics*, n.d.)

3 Variation between employers

While a number of individual and organisational factors may influence nurses' selection of a particular trust or region within a destination country, this is not always the case. As we heard that for many communities, it is often about whoever offers a job first. For context, in the first section of this chapter we highlight the variation in levels of overseas nursing between Trusts (Figure 16). Overseas staff account for over a half of nurses in a few NHS organisations and for over a third in 32 Trusts. However, in some organisations it is close to zero. Of course, there are many reasons why this variation may occur, including due to a Trust's specialty, location, and supply of UK nurses locally.

Figure 16: Proportion of nurses as at October 2020 with known nationality from overseas



Notes: Excludes organisations with fewer than 500 nurses and health visitors.
Source: Nuffield Trust analysis of NHS Digital data (NHS Digital, 2021a)

Feedback loops

Interviewees of different diasporas confirmed that in the last couple of years nurse candidates have become more aware of the variability of the offer in the NHS as well as of the cost of living in different regions, and make their choice

of trust accordingly. Social media platforms and personal connections in the different regions and Trusts are facilitating a better understanding of the differences between employers, both in terms of the benefits package included in the offer and the overall working conditions and levels of support available.

> *They are now more savvy. I think that is because people talk on the internet... people are able to talk... and ask the question, is it OK? Is it better to actually work outside London because the quality of the living wage is less expensive compared to working in London... now, more newly recruited nurses are actually talking in the Philippines to say, where's the better place*
>
> Philippine Nurse Association UK (PNAUK)

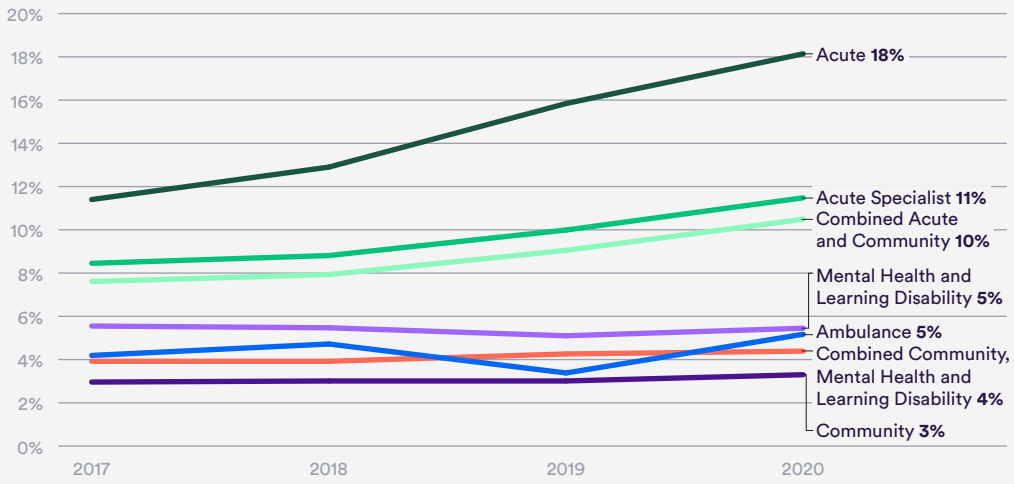
Beyond practical advice and information, we found that formal and informal networks of nurse migrants such as regional or trust-specific networks of nurses from the same community operate as one of the main sources of support and information throughout the entire migration process. These networks provide knowledge, confidence, and emotional, practical and professional resources that help the nurse make a more informed decision and smooth their recruitment journey.

Trust type

Acute Trusts have seen increases in the proportion of nurses from overseas, a phenomenon not seen in other Trust types. In the three years to October 2020, the percentage of nurses from outside the EU in acute Trusts rose from 12% to 18%. Acute specialist and combined acute & community Trusts also saw significant increases. However, the levels in other Trust types plateaued from already lower levels (Figure 17).

The nature of the roles means that variation by Trust type is to be expected. Only certain countries have, for example, mental health nursing qualifications that would have been recognised by the NMC prior to 2019. However, since then, nurses seeking to join the NMC register in specialties other than adult nursing (e.g. mental health) do not require to hold a qualification specific to that specialty but instead take a test of competence relevant to that area of practice.

Figure 17: Trend in proportion of nurses from outside the UK/EU by Trust type

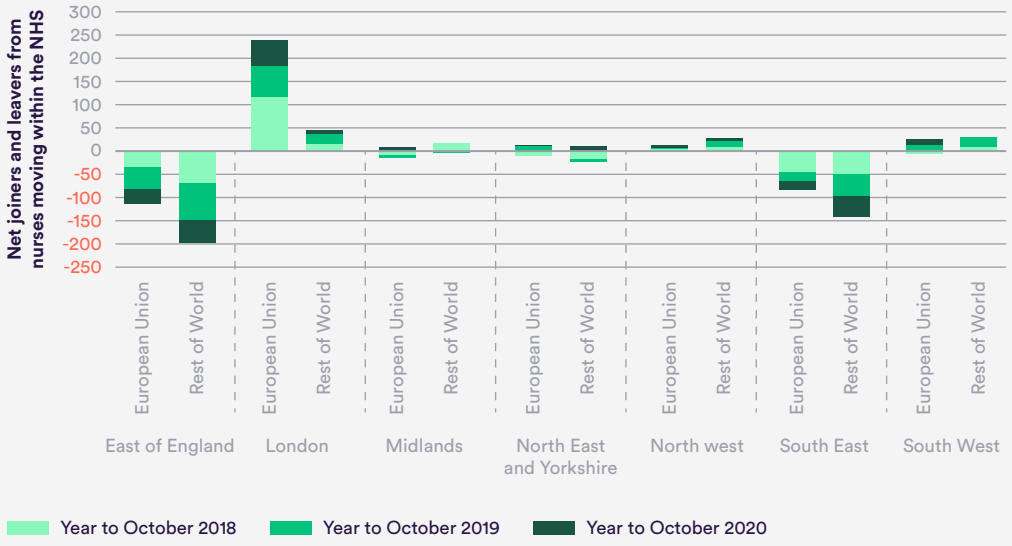


Source: Nuffield Trust analysis of NHS Digital data (NHS Digital, 2021a)

Region

The subsequent migration of nurses in the NHS suggests that there is a greater preference by overseas nurses for some areas although it is unclear as to the extent to which this affects their recruitment decisions. The proportion of all nurses staying within the NHS but moving to another region in a typical year is small, often little over 1%. Over the last few years the proportion has fallen. There are some winners and losers in this regional migration. For overseas nurses there is a drift from the East and South East primarily towards London. This pattern is not the same for UK nationals where the North West gains the most and East or England (Figure 18).

Figure 18: The proportion of nurses and health visitors moving to another region, by region and nationality



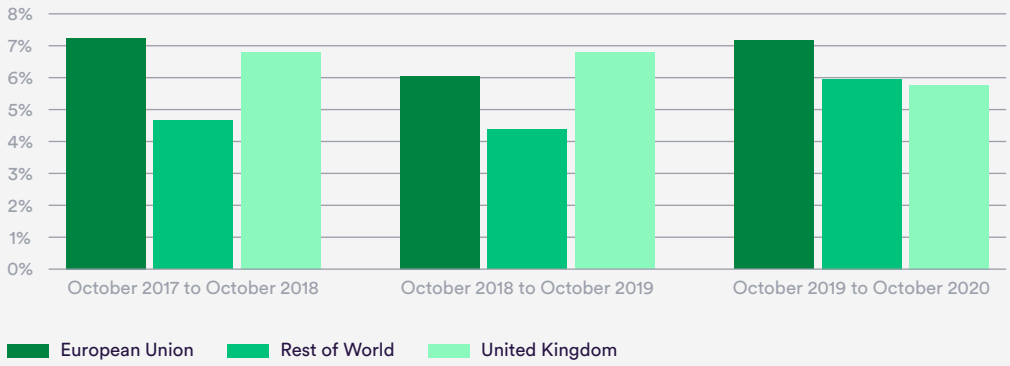
Notes: A mover is classed as a nurse or health visitors who has left the NHS England Region to move to another NHS England Region. It does not include those who joined/left the NHS altogether.
Source: Nuffield Trust analysis of NHS Digital data (NHS Digital, 2021a)

Location

In a given year, the data suggest we might expect around 1-in-16 nurses (around 6%) to move to another NHS organisation. While the rate of such internal NHS moves appear to differ between EU, UK and other nationals, the differences have not been consistent over recent years (Figure 19). These data also need to be treated with caution. The actual physical migration between services may be less than this as administrative changes in the name of the employer would count as leaving one organisation and joining another even if the nurse was to remain working at the same service.[5]

5 For instance, on inspection of the data, we found artificially high levels of leavers from at least five Trusts in 2018–19 (North Cumbria University Hospitals NHS Trust; Royal Liverpool and Broadgreen University Hospitals NHS Trust; City Hospitals Sunderland NHS Foundation Trust; South Tyneside NHS Foundation Trust; Gloucestershire Care Services NHS Trust) due to administrative changes in data. Removing these and services with small number of nurses (<500) reduced rates to 5.3% for EU, 3.3% for rest of world and 4.8% for UK nationals).

Figure 19: The proportion of nurses and health visitors leaving for another NHS hospital and community service employer



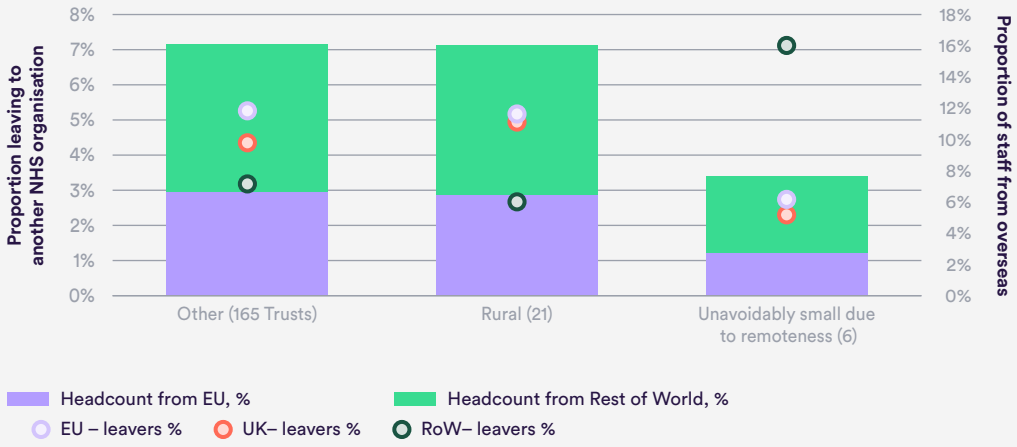
Source: Nuffield Trust analysis of NHS Digital data (NHS Digital, 2021a)

As discussed in the next section of the chapter, many trusts add a financial penalty to international nurses' contracts if they leave before completing a certain number of years of employment (often 2 years). This is mainly to secure return on investment.

> *It's not very common, very few people do move within the NHS. Even if they move that's more often for a career progression, rather than draw them just sideways. Because it's not just you are moving but you are moving your with your whole family. As we know the majority of the Nursing workforce is females . So their priority is always the family hence they don't move places unless this is for career progression*
>
> British Indian Nurse Association (BINAUK)

There is some evidence to suggest that nurses from the rest of the world are more likely to move to another NHS employer from trusts that are unavoidably small due to their remoteness. For other Trusts, the converse appears to be true (Figure 20). The data also suggest some variation between types of services. In acute trusts, the proportion of UK and EU nurses leaving for another Trust is higher although this does not appear to be consistent looking at some other Trust types. However, these differences should be treated with caution – particularly where the number of employers in a group is small – as they are susceptible to data quality issues.

Figure 20: Proportion of workforce by nationality region and rate they leave a Trust, by Trust geography, in year to October 2019



Notes: Excludes five Trusts with apparent data quality issues. Differences should be treated with caution – particularly where the number of employers in a group is small – as susceptible to data quality issues. The category 'unavoidably small due to remoteness' is used by NHS England & NHS Improvement in funding allocations. Rural trusts are categorised by proportion of patients from rural areas.
Source: Nuffield Trust analysis of NHS Digital data (NHS Digital, 2021a)

According to our interviews and informal discussions with recruitment agencies and trusts, the geographical location of the trust is more relevant to some nurse communities than others. For some, the proximity to London, is imperative, potentially explained by its appeal as a multicultural capital and with many well-known and teaching hospitals. We also heard that, for some, reasons to choose trusts in cities such as London and Manchester are related to perceptions of more welcoming environments and higher acceptance towards migrants and ethnic minorities. In contrast, for others, London hospitals are best avoided due to the higher cost of living, leading many communities to opt for either surrounding trusts or for those located in smaller cities.

There are also nurse communities for whom migration is a goal and aspiration in itself, and the question of where to move to within the country is mainly secondary. As some interviewees explained, once the decision to migrate is made, it is not uncommon for nurses to apply to more than one agency, trust or even country at the same time, aiming to go to whoever offers a job first and processes the overall application fastest.

Most of the time is the first one that give an offer. They don't care. They don't check the CQC rating, they don't check other organisational reports, they don't check the quality measures or anything about it, they you know, they know that it's NHS organisation, at the end of the day, they all pay the same throughout the Agenda for change. It doesn't matter which organisation go to so they just go as it comes along.

Diaspora interview

Costs for employers

The costs of recruiting a nurse from overseas vary but are typically in the region of around £10-12,000 per nurse. As we highlight in our accompanying report, there are various one-off costs, particularly when setting up an international recruitment route. As a result, some organisations with more money and experience in international recruitment might have found it more economical and affordable to recruit from overseas than those with less experience or available funding. However, recent funding initiatives – such as a £28m fund for Trusts – to support international recruitment may mitigate this potential barrier. We also heard examples of Trusts working collaboratively to benefit from economies of scale.

Offer of employment and benefit package

We heard that most trusts tend to place migrant nurses at the bottom level of band 5 positions, equivalent to a newly qualified nurse regardless of their experience in their home or a third country. Some diasporas told us that this tendency not only acts as a potential disincentive for more experienced nurses but may directly impact on their motivation and overall sense of value of the most experienced nurses (see quote below). Some trusts, however, offer a pay review after a year, while others recognise previous experience in acute care, placing these nurses in corresponding bands and pay scales. One trust added that due severe shortages in some specialties such as mental health nursing in the global market, recognition of previous experience might become the norm in the near future.

> *One of the major issues (is) the payment, the starting salary, because imagine if you worked in India for five or six years, and you have already worked up to the level as a senior manager, team lead or clinic lead in India. When they start their job here and are treated like a newly qualified, their salary pay point is as same as the newly qualified staff in UK. How do we justify that? … But at the same time, other European countries including Ireland consider your experience, so the salary reflect their overseas experience*
>
> British Indian Nurse Association (BINA UK)

Despite the high level of competition between trusts, there is also large variation in the benefit packages. We heard that benefits offered usually include the flight to the UK, three months accommodation, and pastoral support services on arrival. Some trusts, however, are increasingly aware of what their counterparts offer, and in order to be competitive, they also include the payment of the NMC registration fee, the OSCE exam fee and training, Computer Based Test (CBT) and English tests fees as well as a supernumerary salary while the nurses wait for their registration to be completed.

4 Recruitment process

In this section we focus on the recruitment journey, mapping the different phases as well as the potential obstacles that might arise both from the perspective of the nurse and recruiting trust. However, we recognise that migration doesn't end at the moment of arrival and the recruitment journey is only one phase of the nurse' migration experience.

Recruitment process

The typical recruitment journey starts with the nurses' decision to migrate and ends at the point they commence their nursing role in the trust (Figure 21). The whole process commonly lasts a minimum of 4 to 6 months, depending mainly on successfully passing the different tests (English and competency) as well as on the visa application (Figure 1). It is important to note that although experiences after arrival go beyond the scope of this report, we recognise that these might have important implications for subsequent experiences and retention.

Foreign nurses are recruited in two main ways, either directly by the trusts without any intermediaries (e.g. through the NHS jobs platform) or through a recruitment agency. Recruitment after referral from a peer is increasingly common, taking advantage of the large communities of nurses already in the region and/or trust. The main differences between agency recruitment and the other routes is that for a fee payed by the trust, the former identifies, selects and facilitates the recruitment process. In the other routes, both trusts and candidates go through the process by themselves.

Agencies' services vary greatly, but most commonly, they get involved in the process only when the candidate has passed the required English test and CBT, although some of them engage with the candidates from the outset, providing language training and support. Similarly, some recruitment agencies remain accessible to the candidates during the first six months to

a year after arrival, although most commonly their responsibility ends once candidates start working in the recruiting trust. Typical services include assistance with translation of important documentation and NMC registration, legal advice and liaison with the employer to organise travel and arrival. In the other recruitment routes, nurses go through this process by themselves,

The main phases of the recruitment process, regardless of the route, are passing the English tests, completing the NMC registration process, acquiring the Certificate of Sponsorship (CoS) and the visa application, all of which are under the responsibility of different organisations, have a specific order, timeline and requirements (Figure 21). A brief overview of the recruitment responsibilities is given at the end of Chapter 1.

Figure 21: A typical nurse recruitment journey

Sources: Nuffield Trust analysis of different sources and interview data

English test

All nurses trained outside of the UK must meet the English language standards set by the NMC. This can be demonstrated either by successfully completing a language test such as the International English Language Testing System (IELTS) or the Occupational English Test (OET), or through evidence that their pre-registration nursing programme was taught and examined in English,12 months of practice in the last two years in a majority English-speaking country, and that at least 50% of the programme involved clinical interaction using English. This first step is usually taken at the nurses' home country as it determines whether the nurse is eligible to start the NMC registration process.

NMC registration process

The NMC registration process has two main steps: the eligibility and qualifications application and passing the test of competence, which itself comprises in two elements: the Computer-based Test (CBT), recently updated to cover numeracy and clinical questions, and the Objective Structured Clinical Examination (OSCE). The CBT is accessible in many countries around the world, while the OSCE is a practical, observed, structured clinical examination which needs to be taken in the UK and usually requires considerable preparation (around 3 months). Due to these specificities, most commonly the CBT is taken first and in the nurses' home country.

Certificate of sponsorship

Once the Trust has made a job offer to a candidate, the recruiting organisation acts as a sponsor of candidates and applies for the Certificate of Sponsorship on their behalf. From the date of issue, the candidate has three months to apply for the visa. In June 2018, annual visa caps were removed for doctors and nurses on a temporary basis, so Trusts are currently allowed to apply for as many Certificates of Sponsorship they might need and at any point in time (Figure 12).

Health and Care visa application

A Health and Care worker visa was introduced in 2020 (Figure 12) to allow for a faster and more streamlined route to any medical professional with a Certificate of Sponsorship and a confirmed job offer with the NHS, an NHS supplier or in adult social care. Candidates applying for this visa also benefit from reduced fees and exemption from the immigration health surcharge.

The decision on the visa usually takes 3 weeks for those applying from inside the UK or 8 weeks for those applying from outside, leaving one month for the expiration of the Certificate of sponsorship. The duration of this visa is typically up to 5 years, with the possibility to apply for an extension. However, if visa holders want to change job or employer they need to apply for an update.

What has changed for EU nurse recruitment?

For candidates with EU qualifications, who started their application and paid their assessment fee by the last day of the transition period in 31 December 2020, the process is the same as under the previous regulation (Nursing and Midwifery Council, N.D.a).

Those who applied after this date and until January 2023 are covered by a transitional legislation (SI 2019/593, SI2019/585, SI2020/1394) to guarantee a near-to automatic recognition of EU qualifications although the need to acquire a right to live and work in the UK through a visa (Gov.uk, 2020). This legislation is subject to review (at the latest by 31 December 2022).

Another relevant difference is that EU nurses will no longer be able to provide temporary and occasional services, as the UK no longer has access to the Internal Market Information (IMI) system, and the European Professional Card (EPC) for registrations to the temporary register can no longer be processed by UK regulators (Gov.uk, 2020). Nurses already registered to undertake these services won't be able to renew their temporary registration once it has expired.

Another main source of uncertainty for EU recruitment is that experiences and qualifications gained in the UK will no longer be automatically accepted on EEA states, as the transitional legislation put in place in the UK is not reciprocal. Each member state will make their own decisions regarding the recognition of UK qualifications, potentially influencing the possibility of return migration or even the choice of UK as a destination in the first place. In this sense, the real impact of Brexit is not yet fully visible, and it is still too early to assess at the time of finalising this report.

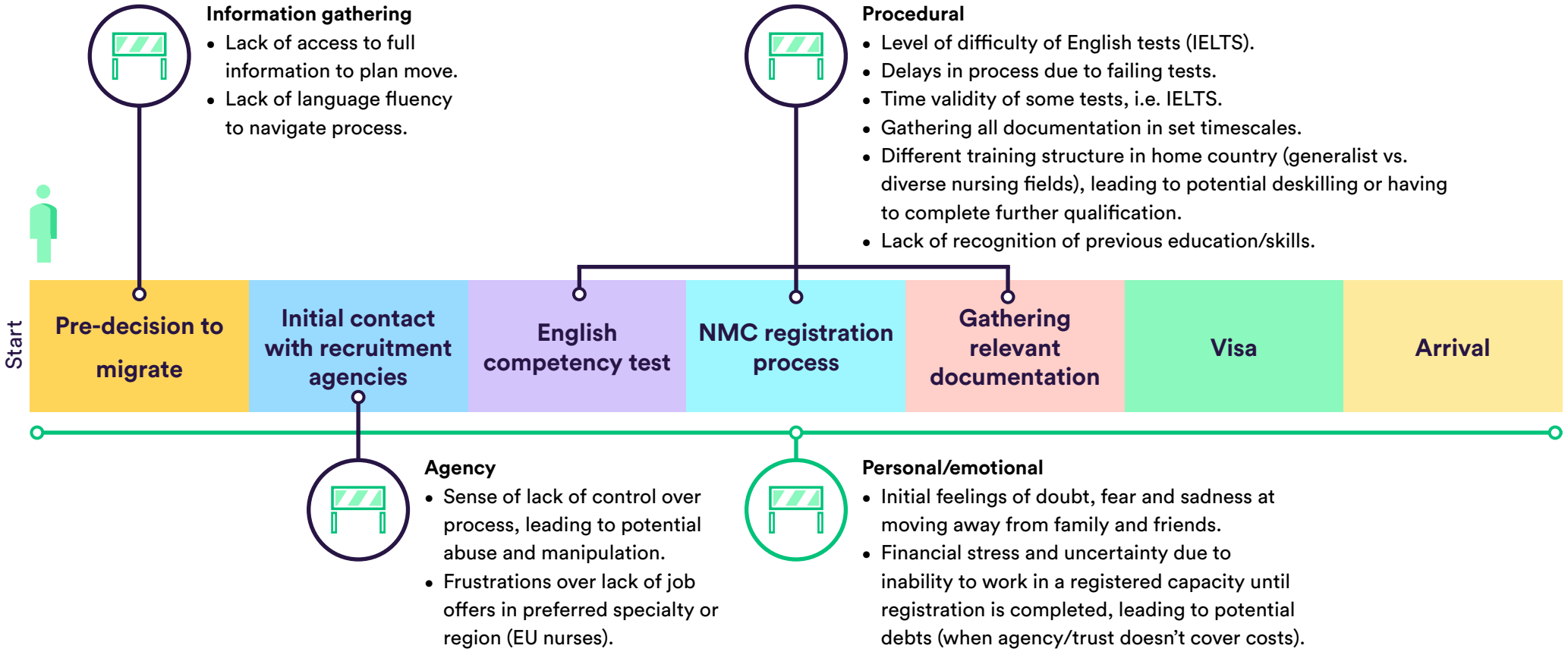
Key challenges during recruitment

In the literature, available evidence concerning nurses' experiences during the recruitment processes are limited. However, there is an overall understanding that nurses who wish to migrate face a significant range of potential emotional and practical challenges, regardless of the country of origin (Chok et al., 2018; Covell et al., 2016; Mowat & Haar, 2018). Challenges for migration are multifaceted, and often start prior to taking any tests or commencing the interaction with a recruitment agency.

Figure 22 highlights some potential obstacles to migration, although it is important to note that these are not always present. Our work suggests that part of making migration decisions is understanding the recruitment process and the different timelines, requisites and criteria they need to meet in order to travel, find a job and register in the destination country. This process depends on their access and understand all relevant documentation and information to plan adequately for their move, often in a new language.

In this section, we draw from the wider literature as well as our interviews and other informal conversations with stakeholders on nurses' experiences during recruitment.

Figure 22: Potential obstacles for migration during recruitment process



Sources: Nuffield Trust analysis of different sources

Language

Appropriate language skills are critical to effective and safe nursing practices. However, we were told the level of difficulty of the required language tests (i.e. IELTS or OET) as one of the main challenges, particularly in the case of IELTS. We also heard that, even after the changes introduced to streamline the process by the NMC in 2018, many nurses often have to take the test several times, requiring extensive preparation to do so. The implications of this are not only significant delays to their overall recruitment but also added costs (Kelly & Fowler, 2019; Mowat & Haar, 2018). The exam fees are around £300 for OET and around £180 for IELTS for one sitting.

We heard that as many recruitment agencies and employers appear to only take candidates on board once they have passed the language test, they are often unaware of the time and financial efforts for the nurses. There is recent evidence suggesting that the introduction of OET has increased the pass rate, as it is designed specifically for healthcare professionals; however, it is more expensive than the IELTS, making it less accessible for some candidates.

Registration process

In 2019, the NMC launched a new and streamlined overseas registration process, aiming to facilitate and simplify the assessment process (Figure 12). Among the main changes were: the shift towards an online system where candidates are able to track progress of their application online; and a simplification of the requirements, such as the removal of the 12 months of required practice after qualification. This last requirement may explain, in part, the previously small number of nurses aged under 25 joining from outside the UK (Figure 7, p. 17).

However, we heard in interviews that these changes may have yet to fully materialise in a shorter and easier registration and overall recruitment process for many nurses. Often, candidates go through a more “stop-go” registration, more similar to the one existing before the 2019 changes were introduced. One potential explanation is that recruiters and employers are still encouraging and following the previous process. Similarly, some organisations involved

in the process, such as regulators in the nurses' source countries, might still be adapting to the new changes and requirements, potentially causing unexpected delays (i.e. regulators need to fill and sign an online form for each nurse candidate to confirm their registration).

As noted above, the duration of the overall recruitment process is important, and for many nurse communities, speed is the main factor influencing the selection of not only the trust but also the country of destination. The previous process of recruitment had been perceived as lengthy and costly, causing temporary inability to work, and therefore a loss of income and debts (Davda et al., 2018; Kingma, 2006; Newton et al., 2012; Wojczewski et al., 2015).

> *So if for example, there's USA, Australia, UK… offering me to travel there, I will say whoever is the first one who will process my application quicker. That's where I will go.*
>
> Philippine Nurse Association UK (PNAUK)

Failing any of the required tests may delay the processes even further, introducing additional procedural and financial challenges, both for the nurse and the employer. For example, having to retake any of the required tests may cause some time-limited qualifications or certifications (i.e. CoS) to no longer be valid, incurring in longer delays and additional costs. Similarly, overseas nurses in many cases have to save money to pay for all initial recruitment costs (i.e. CBT and language tests fees), potentially requiring them to work for a period of time and so, therefore, may explain – at least in part – why they are significantly less likely to be aged under 25 years old (Figure 7, p. 17).

Support

The different challenges during the recruitment journey for the nurses make a strong argument for the importance of providing a well-supported journey. Another set of obstacles that remain present throughout the entire recruitment process are personal, and may involve initial feelings of doubt, frustration, shock and sadness (Chok et al., 2018; Mowat & Haar, 2018). According to the literature, for many nurses, bearing the burden of future circumstances for themselves as well as of their family can be difficult and stressful, particularly if the decision to migrate involves moving away from family and friends (Chok

et al., 2018; Leone et al., 2020; Mowat & Haar, 2018). It is important to note that while these challenges might not immediately influence levels of recruitment, it might have important implications for the nurse's subsequent experiences and retention. Interviewees also suggested that travel restrictions imposed by the pandemic are intensifying feelings of homesickness and distance, making it more difficult to make the final decision to leave home.

Most of these challenges intensify if the nurses are migrating without the assistance of a recruitment agency, as they have to navigate the process by themselves without any training or admin support (Hardill & MacDonald, 2000; Wismar et al., 2011; Young et al., 2014). In fact, even in cases where individuals go through direct recruitment, it is common for them to consult or ask additional guidance to recruitment agencies at some point in their journey.

However, there are several reports of abuse and lack of transparency from recruiting agencies in the literature, including high and hidden breach fees (Shaffer et al., 2020) or allocating migrants in rural and/or clinical areas without considering the nurses' own preferences for location or specialty (Chok et al., 2018; Leone et al., 2020; Shaffer et al., 2020). Hopefully, as more information and feedback loops are available to guide and advise nurses throughout the process, they are becoming increasingly aware of any sketchy recruitment practices or untrustworthy agencies.

Trusts' recruitment process

Finances and available resources might also directly affect the ability to recruit internationally, as even without considering the recent funding of £28m specifically assigned for recruitment purposes, the required time and human resources to recruit in a proper and ethical manner are still significant.

Due to data limitations, we limited our analysis in this section to addressing general and overall systemic challenges and issues related to international recruitment rather than going into organisational challenges more specifically. We also recognise that the experiences of local NHS organisations may vary greatly, and many of them might encounter other set of challenges not considered in this section.

Methodology

Expert panel

Our research was supported by an expert panel. The panel met once during the course of the project and provided invaluable expertise and insight. Several conversations with different members of the panel were also held during the course of the project to gain more insight into particular aspects of the research, as well as to validate and expand on our findings. A full list of members can be found in the Acknowledgements.

Literature review

We conducted a pragmatic review to identify papers relating the drivers and obstacles for nurse international migration to different English-speaking countries, as well as to challenges during the recruitment process. This review mainly complemented and updated previous work on the subject.

The search strategy was developed with support from the University of Birmingham's Health Services Management Centre library and information services and mainly covered the following bibliographic databases: *MEDLINE*, Healthcare Management Information Consortium (HMIC), CINAHL, British Nursing Index, PsycINFO, ABI and Web of Science, also including a search of grey literature. More details of the literature search strategy, inclusion and exclusion criteria are given below in Table 1. In total, out of the 1187 articles initially yielded in the search, we included 7, which were then added to a list of other 25 studies identified through previous work.

Table 1: Inclusion and exclusion criteria for literature review

	Inclusion criteria	Exclusion criteria
Topic/relevance	• Focused on qualified nurse drivers/motivation to migrate • Focused on nurses aiming to work in the NHS	• Focused on other health professionals • Focused on experiences during recruitment or in destination country • Focused on nursing students • Focus on nurses aiming to work in the private sector or community
Methodology	• Qualitative and quantitative empirical studies (including literature reviews)	• Commentary or discussion pieces without empirical data or not linked to research
Countries/health services	• Developed English-speaking countries as destination countries • Nurse nationality: any	• Non-English speaking countries or low-income, less developed countries as destination countries
Data	• Published in 2018 or later	• Pre-2018 publication date*
Language	• English, Spanish and Portuguese	• Other languages

*Older references used in the report relate to previous work on the subject.

Policy review

We also conducted a review and analysis of international recruitment policy and initiatives over last decade in England, including the most recent changes introduced to our commitment to ethical recruitment of health personnel. We developed a policy timeline with the most relevant policies influencing international recruitment, which was then presented to the expert panel for review and discussion to make sure we were comprehensive in our analysis.

Quantitative data analysis

We undertook descriptive analysis on trend of recruitment of overseas nurses to and from here, by country of origin and of destination, using data from NMC, OECD and NHS Digital. We focused on England as the country of destination, but UK figures were included where this was not possible.

Interviews

We conducted six semi-structured interviews with nurse Diasporas from four overseas countries and one recruitment agency based in EU.

We contacted eleven other nurse Diasporas from different countries with the aim of covering a boarder set of perspectives and from different regions, but we were unable to secure interviews.

Calls with stakeholders

We supported our data collection and overall work through scoping conversations with key stakeholders, including the Nursing and Midwifery Council, one recruitment agency, two recruiting trusts (including a regional recruiter lead), the Global Learners Programme from Health Education England, NHS Employers, and NHS Professionals. These calls broaden the perspectives collected during the study and helped to provide context for the work, including current policy considerations and implications for our current and future research.

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