

Here to stay?

International nurses in the UK

Summary

The Royal College of Nursing commissioned this report into the employment policy and practice implications of the rapid growth in the number of internationally recruited nurses (IRNs) working in the UK.

In the early to mid 1990s about one in ten of the annual new entrants to the UK nursing register was from non-UK sources. By 2000/2001 this had risen to almost four in ten of total initial registrations, and in then 2001/2002 for the first time ever there were more overseas additions to the register than there were UK registrants. The Philippines, Australia and South Africa are the three main source countries.

Analysis of postcode data on IRNs working in the UK has revealed that there are at least 42,000 international nurses in the UK. This is more than double the number of IRNs working in the UK three years ago. This means that one in 12 nurses in England has come from abroad, with the figure for London rising to one in four (28%). International nurses also have a younger age profile than UK trained nurses, and a higher proportion is male.

Five NHS and five private sector case studies were conducted. These found that IRNs made up between 4% to 65% of the total qualified nursing workforce in the ten organisations. All actively recruited IRNs in the case study organisations worked full time, and the highest employment levels of international nurses were in the independent sector.

The processes of international recruitment in these organisations had become more systematic in the last year. There has been a shift from regarding international recruitment as a reactive, one-off last resort. It is now planned and linked more directly to other aspects of recruitment and retention.

Managers in all the case studies reported that the main challenges they faced when employing IRNs were language, differences in clinical and technical skills, racism in the workplace, and the reaction of patients.

The managers rated international recruitment as a relatively “easy” method of meeting current nurse staffing requirements, compared to home-based initiatives. They reported that it is regarded as no less cost effective as other recruitment and retention policies.

The managers were also asked to assess likely requirements for registered staffing within the organisation, over the next five years. The likely relative contribution of international recruitment over the next five years was estimated as providing between 10% and 60% of total nurse staffing needs in the ten organisations.

For most UK health care employers meeting staffing targets is the imperative that drives their recruitment and retention policies, and as a result the UK, particularly England, has taken a lead on establishing policy guidance on international recruitment but relative to most other developed countries, England is also currently highly dependent on internationally recruited nurses.

Here to stay? is divided into the following seven sections:

1. introduction
2. employment trends

3. profile of international nurses in the UK today
4. international nurses at work : the case studies
5. international recruitment in context
6. policy implications
7. annex 1.

Acknowledgements

Professor James Buchan from Queen Margaret University College, Edinburgh was commissioned by the RCN to conduct research into IRN employment policy and practice, as part of a broader programme of research on international recruitment of nurses

Thanks go to the Nursing and Midwifery Council staff who the provided data for the study, and the managers in the ten case study organisations who agreed to participate in the study.

1. Introduction

Here to stay? examines the employment policy and practice implications of the rapid growth in the number of IRNs working in the UK.

The report profiles international nurses currently working in the UK. The research explores employment issues based on case studies in ten health care organisations that have actively recruited IRNs.

The objectives of the report are to:

- provide a demographic profile of IRNs in the UK
- examine the geographic distribution of IRNs in the UK
- examine the importance of IRN recruitment compared to policies aimed at UK-based nurses
- look at examples of local IRN recruitment practice
- assess the overall policy implications of employing IRNs.

Here to stay? builds on a previous study into the flows of international nurses coming to the UK¹. It will be complimented by a parallel RCN study into the experiences and attitudes of overseas nurses.

2. Employment trends

This section maps recent trends in the inflow of nurses to the UK from other countries. The aim is to assess the overall contribution of international recruitment and to identify the main source countries from which the UK is recruiting.

Nurse staffing levels is one of the critical issues that the government has to get right if it is to deliver the *NHS plan*. The Department of Health (DH) in England initial target for increasing nurse staffing levels was an additional 20,000 nurses by the year 2004, a target that has already been met. Subsequently a further long-term target of 35,000 more nurses by 2008² was set.

The DH is achieving growth in staffing levels by concentrating on the following four areas³:

1. attracting and funding more entrants to nurse education
2. encouraging returners to nursing employment
3. improving retention through improved career structures and flexible working practices
4. recruiting nurses from abroad.

International recruitment is attractive to employers because it offers a relatively quick fix. It has scope for rapid increases in staff without the need to wait the three years for increased numbers of home grown student nurses to enter the workforce. The scale of the contribution of international recruitment is illustrated by the growth in the number of overseas nurses registering to practice in the UK.

Any nurse who wishes to practice in the UK must be registered with the UK's professional regulatory authority the Nursing and Midwifery Council (NMC). The NMC was created in April 2002 as the successor body to the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC)⁴. There are two main types of overseas applications:

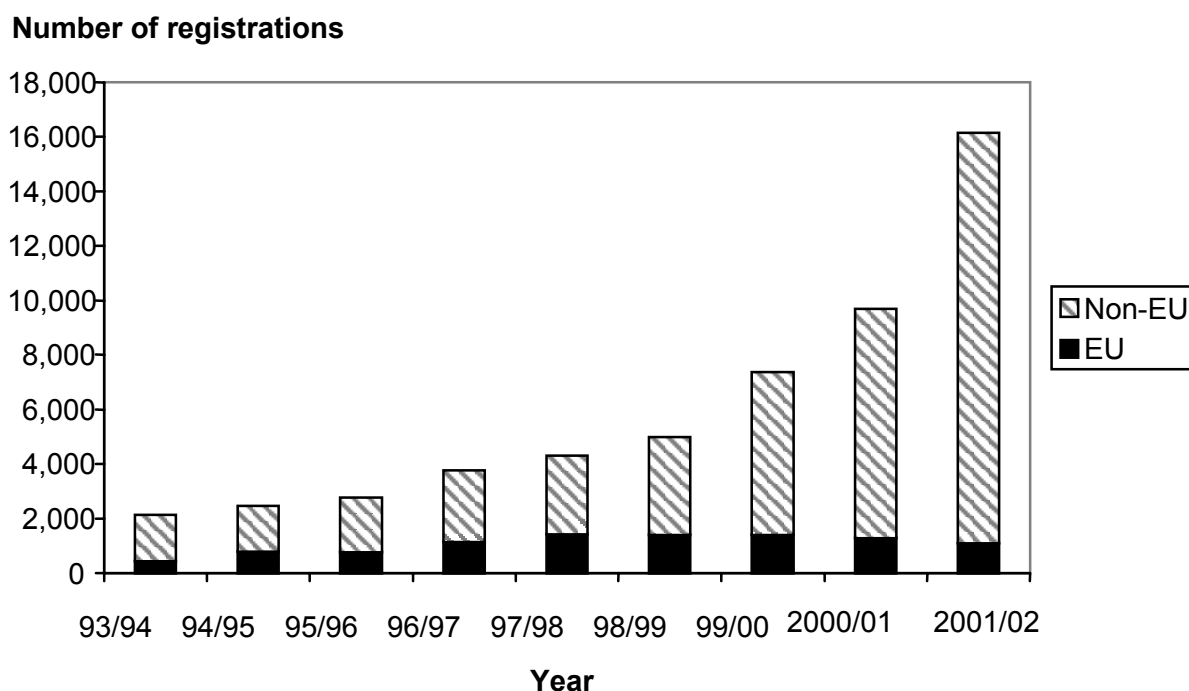
1. applicants from the countries of the European Union and the European Economic Area (EU/EEA)
2. non-EU applicants.

Applicants with general nursing qualifications from the EU/EEA have the right to practice in the UK because of mutual recognition of qualifications. They can register with the NMC using the European Community Directives. Nurses from countries outside the EU have to apply to the NMC for verification of their qualifications in order to be admitted to the register. Most nurses from outside the EU will also have to apply for a work permit to take up paid employment in the UK. This means that their employment in the UK is time-limited.

Registration data records only the fact that a nurse has been registered. The data does not show when a nurse actually enters the UK neither does it indicate what the nurse is doing. Even so, it is a strong indicator of trends in entry to practice in the UK.

Figure 1 highlights the strong upward growth in the numbers of new overseas nurse registrants. In the last three years more than 30,000 new registrants from overseas have been admitted to the UK register. In 2001/2002 a total of 15,064 new non-EU entrants were recorded, and 1,091 from the EU/EEA. This gives total overseas admissions for the year of over 16,000.

Figure 1: admissions to the UKCC register from EU directive/non-EU sources 1993/1994 to 2001/2002 (initial registrations)



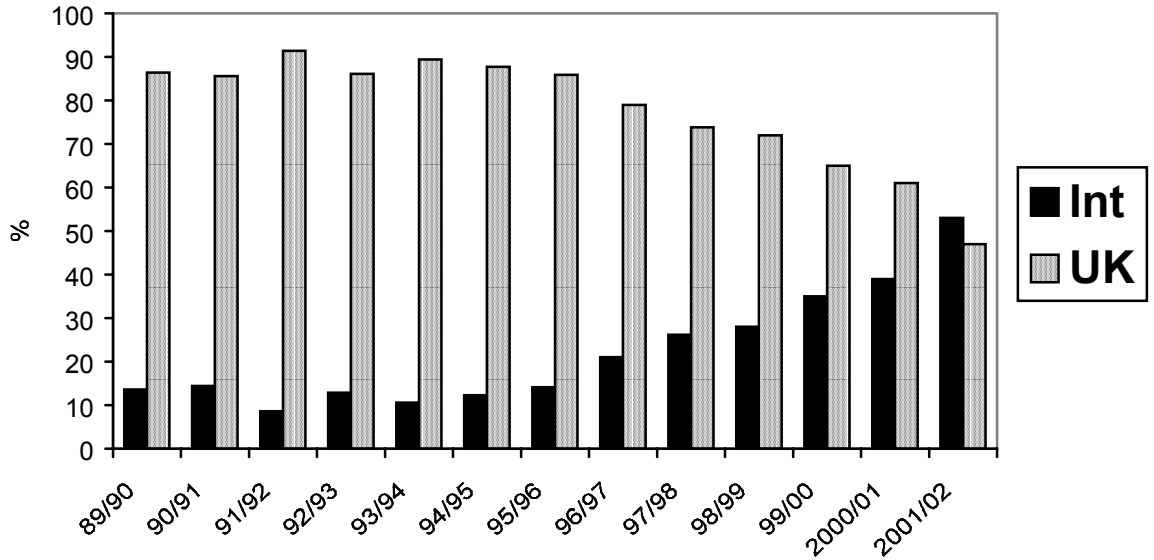
Source: UKCC/NMC

The main non-EU countries in 2001/02 were the Philippines (7,235), South Africa (2,114) and Australia (1,342). Other countries such as India and Zimbabwe have also increased significantly over the last three years. In the previous year (2000/2001) a total of 9,694 entrants were recorded from the same three main source countries.

Figure 2 shows the comparative importance of non-UK source countries in relation to the annual total number of all new nurses to the UK register, including those from UK sources. In the early to mid 1990s about one in ten new entrants was from non-UK sources, and by 2000/2001 this figure had risen to almost four in ten of the total initial registrations. But in 2001/2002 for the first time ever there were more overseas additions to the register than from the UK.

The significant flow of IRNs to the UK over the last few years is graphically presented in figures 1 and 2. The UK is now as reliant on external sources for new nurses as it is on nurses from UK-based sources.

Figure 2: International and UK sources as a % of total new admissions to the UK Register, 1989/90 - 2001/2002 (Initial Registrations)



Source: UKCC/NMC data

It is possible to track trends in the flow of IRNs in to and out of the UK using NMC published data. This shows a tremendous growth in the numbers of international nurses coming to the UK. It should also be noted that thousands more international nurses are in the process of applying to nurse in the UK, or are already in the UK working a period of adaption so that they can be registered for practice.

However, relatively little is actually known about the IRNs who are in the UK. The report uses new and unpublished data to provide information on the demographic profile, geographic location and actual contribution of IRNs to health care.

3. The profile of international nurses in the UK

This section of the report draws from unpublished data provided by the NMC to present a profile of international nurses in the UK. The October 2002 data provides a snapshot of the demographic and geographic profile of IRNs registered at that time with the NMC with a UK postal address.

To analyse the profile of international nurses in comparison to UK-trained nurses, the registrants on the NMC register are divided into three groups.

1. “UK registrants” (UK): nurses trained and educated in the UK.
2. “EU registrants” (EU): nurses and midwives from EU and EEA countries, who have registered in the UK.
3. “Overseas registrants” (OS): nurses from all other (non-EU/EEA) countries, who have registered in the UK.

Table 1 shows data from October 2002. The table shows the number of registrants in each of the three groups, who reported a UK address, a non-UK address, or for whom full postcode and address details were not known.

Table 1: UK, EU and OS nurses on the UK register, October 2002

Source	Total number of registrants	UK resident	Non-UK resident	Incomplete data
UK	58,2866	52,0322	17,897	44,647
EU	7,076	4,053	2,595	428
OS	50,081	38,096	8,832	3,153

Source: NMC

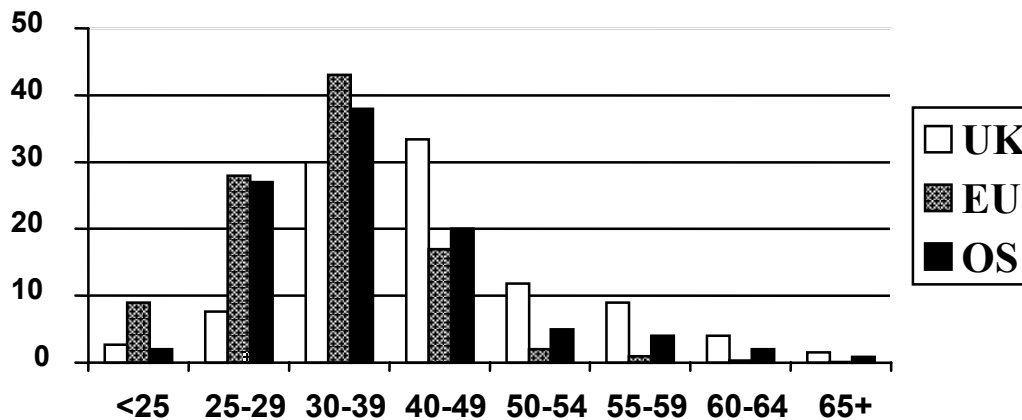
In October 2002 there were 4,053 EU nurses with a UK address and 38,096 OS nurses with a UK address, giving a total of 42,149 IRNs with an address in the UK. This represents approximately 7.5% of all UK-based nurses that there were complete address details for.

This NMC data is not routinely published, so it is not possible to judge trends in the numbers of EU and OS nurses actually in the UK. However, an assessment made in February 1999⁵ estimated that there were 17,674 overseas registrants with a UK postcode. This would have represented approximately 3% of the total on the register at that time for which full postcode data was available.

The two snapshot pictures from February 1999 and October 2002 suggest that the number of EU and OS nurses in the UK has more than doubled in three and a half years. There has been a net increase of approximately 25,000 EU/OS nurses in the UK since February 1999, taking the level to 42,000 in October 2002.

The October 2002 age profile of OS and EU nurses compared to UK trained nurses is shown in Figure 3. OS and EU nurses have a younger age profile. One in three of OS and EU nurses is aged under 30, compared to only one in ten of UK nurses.

Figure 3: age profile of UK, EU and OS nurses with UK address, October 2002



This data highlights the extent to which international nurses are, on average significantly younger than those from UK sources- this is likely to be a reflection of the fact that younger individuals tend to be geographically mobile. If international nurses follow similar work patterns to UK educated nurses it also means that they are more likely to work full time (the case studies in the next section of this report reinforce this possibility). OS nurses have a significantly higher proportion of male registrants – 15%, as compared to 10% for the UK average

The geographic distribution of EU and OS nurses, in comparison to UK trained nurses, is shown in Table 2 below. England has a much higher proportion of nurses who are from overseas (OS). The figures show that 7.8% of total registrants with an English address are OS, compared to only 1.8% in Scotland, 3.1% in Wales and 2.7% in Northern Ireland. EU nurses are proportionally more evenly distributed across the four countries (the higher % of EU trained nurses in Northern Ireland than in Scotland or Wales is likely to be explained by numbers of nurses trained in Eire).

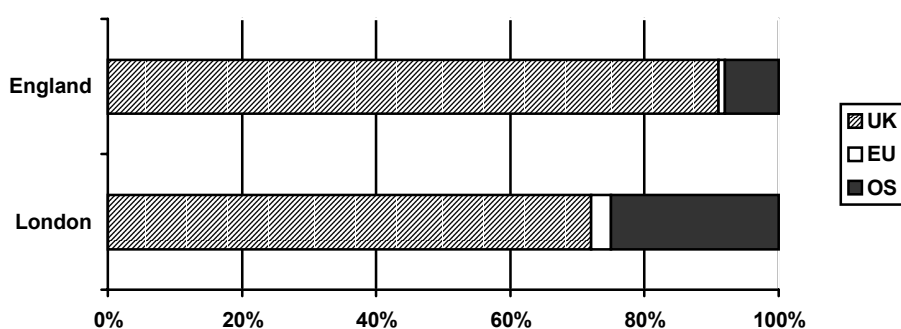
Table 2: % distribution of UK, EU and OS nurses in each of the four UK countries in October 2002 (UK-based registrants with available postcode data)

	%			N =
	UK	EU	OS	
England	91.4	0.7	7.8	45,838
Scotland	97.7	0.5	1.8	53,867
Wales	96.7	0.3	3.1	29,940
Northern Ireland	96.7	0.7	2.7	20,782

Source: NMC

Further analysis of postcode data for some of the English urban areas highlights much higher proportions of OS/EU nurses in London. In October 2002 one in four (28%) of all registered nurses in Greater London was from overseas or the EU (see figure 4). (Note: some recently arrived nurses may report a recruitment agency as “their” address/postcode - this may overstate certain postcodes, including some in London).

Figure 4: % distribution of UK, EU and OS nurses, England, and London, October 2002



This snapshot of the profile of OS and EU nurses highlights that they have a younger age profile than UK-trained nurses, and are more likely to be based in England, particularly in London, than UK educated nurses. The data supports the analysis highlighted in the previous section, which showed significant growth in the number of internationally recruited nurses coming to the UK.

The evidence of the data in this section is clear and compelling – there has been huge growth in the number of UK-based IRNs, and much of this growth has been in London and the South East.

4. International nurses at work in the UK: the case studies

This section examines the issue of IRNs from the perspective of health care employers in England. It is based on ten case studies that were conducted in August to October 2002.

Five of the organisations were NHS acute sector trusts. The other five were independent sector health care employers, one of which was a multisite mental health/rehab care provider. Geographic distribution of the organisations is shown in table 3. Aside from achieving a geographical mix, each sample was drawn randomly from lists of employers known to have been involved in recent international nurse recruitment.

There has been media coverage of poor employment practice by some employers recruiting IRNs. There have been examples of misleading information being given about pay and working conditions, or substandard accommodation being offered⁶. However, the primary purpose of the case studies was to focus on current practice and to examine the approaches of the employers to international recruitment. No attempt was made to select employers that had either a bad or good reputation.

The very fact that the employers agreed to participate may be an indication that they believed that their own practices were at an acceptable level. It should also be noted that while the organisations had actively participated in international recruitment, many also employed IRNs who had been recruited in other ways.

Table 3: the case studies

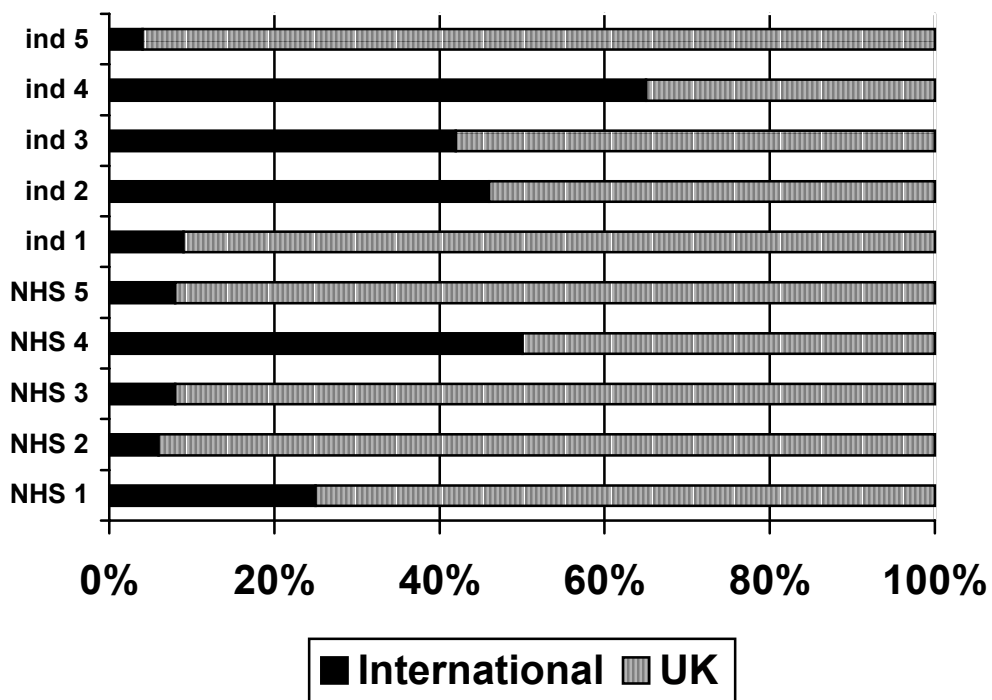
	NHS	Non-NHS
London	2	2
South East England	1	1 [1 multisite]
Midlands/North England	2	1

Figure 5 gives an indication of the extent of organisational reliance on international nurses. It shows the current reported profile of IRNs in the five NHS organisations (NHS) and the five independent health care organisations (IND). The current representation of international nurses varied from 4% to 65% of the total qualified nursing workforce in the ten organisations. The highest levels of IRN employment were in the independent sector, which tended to be smaller organisations that employed fewer nurses.

While some employers could give a precise figure for the number of international nurses in their employment, others could provide only an estimate. In part this relates to differences in definitions of international. For example, some, but not all, IRNs require a work permit and some international nurses are foreign nationals who have trained as nurses in UK.

Note: data for NHS 1 relates to only one part of a multisite trust; data for NHS 4 refers to the nationality of nurses, who in some cases may be UK-trained.

Figure 5: UK nurse : international nurses as a % of total qualified nursing workforce in 10 UK health care organisations



The data in Figure 5 only provides estimates for ten organisations in the UK, and cannot be generalised. However, with an overall estimate for England of more than 8% of IRNs on the register, with 28% in London, these figures do not appear to be unrepresentative.

The key message from Figure 5 is that some employers are now reliant on international nurses as the core of their organisation. For many others the IRNs represent a significant proportion of the total nursing workforce. It is no exaggeration to state that some health care organisations, particularly in the independent sector, would cease to function without international nurses. Many NHS trusts too could not function effectively without IRNs. One London-based manager commented that “they [internationally recruited nurses] have been the saviours of the organisation”.

Most of the organisations reported employing nurses from more than one country. In terms of active recruitment by employers in recent years, the Philippines was the most common source country. However, some of the non-NHS employers had also recently recruited in the Caribbean and in Africa and Asia. Some NHS managers reported that they were planning to recruit in India.

As well as active recruitment, there are three types of passive recruitment that contribute to increasing the number of IRNs in the NHS in the UK:

1. a direct application by an individual nurse for a post from other countries
2. a nurse who is resident in the UK but not yet in employment, such as a refugee. One London-based NHS organisation reported actively tapping into its local labour market and recruiting IRNs through a modified return to practice scheme
3. moving job in the UK. Three of the independent sector employers reported that many of the IRNs had, or were planning to move into NHS employment.

In relation to the third method above, one of the independent sector employers reported deliberately targeting overseas nurses from the Indian and African sub continents. They were charged a fee, and offered an adaption course so that they could become UK registered and move on to NHS employment. This was proving very popular as a means of entry into the UK nursing labour market for some international nurses (the employer stated that “we have over 1000 [applicants] on our books”).

Another independent acute sector employer reported that they had recruited some IRNs from a UK nursing home employer. The nursing home had recruited these nurses from abroad and employed them as care assistants while they were on an adaption programme. The acute sector employer reported that “we would not take them again from a nursing home adaption programme- they were not well adapted for the acute care environment”.

This is secondary market, where IRNs spend a relatively short period of time with one UK employer in order to pass adaption and obtain a visa before moving onto other UK employment. It has implications for the Department of Health in England Code of conduct on international recruitment, which states that NHS employers should not “actively recruit nurses from developing countries”. NHS employers may recruit relatively recently arrived nurses from Africa without breaking the Code (the Code is discussed in more detail later in this report).

The combination of active international recruitment, employment of nurses who apply on their own initiative, and tapping into local labour markets for IRNs already in the country can lead to a nursing workforce with a very broad global profile. One of the London-based NHS trusts reported employing nurses from 68 countries (see table 4 below).

Table 4: nationalities of nurses and midwives employed in one London NHS trust, 2002

Algeria	Angola	Australia
Austria	Barbados	Belgium
Benin (Dahomey)	Brazil	Cameroon
Canada	Central African Republic (empire)	China (Peoples Republic)
Congo	Denmark	Dominica
Finland	France	Gambia
Germany	Ghana	Greece
Grenada	Guyana(British Guyana)	Hong Kong
Hungary	India	Ireland
Isle of man	Italy	Ivory Coast
Jamaica & Cayman Islands	Japan	Kenya
Korea (South)	Malawi	Malaysia
Malta	Mauritius & Reunion	Mauritania
Moldavia	Nepal	Netherlands
Netherlands Antilles	New Zealand	Niger
Nigeria	Norway	Philippines
Poland	Romania	Russia (USSR)
Sierra Leone	Singapore	South Africa
Spain (inc Canary Islands)	Sri Lanka (Ceylon)	St Lucia
St Vincent (Grenadines)	Swaziland	Sweden
Tanzania (Tanganyika/Zanzibar)	Trinidad & Tobago	Turkey
Uganda	United kingdom	United States of America
West Indies	Zambia	Zimbabwe
(plus unknown)		

It is not possible to disaggregate the relative contribution of each of these three sources, but it is clear from reports in the case studies that active recruitment has rapidly grown in the last three years.

Nursing shortages

In order to place international recruitment in context, managers in the case study organisations were asked to report on the extent of current difficulties with recruitment and retention of staff.

All of the case study organisations reported some level of difficulty in recruiting and retaining qualified nursing staff. This tended to be more pronounced in London and the South East, where the cost of housing was highlighted as a contributory factor. NHS organisations (not just in London) reported problems in high-tech specialities, such as theatre, intensive care and neonatal care. They also reported that recruitment was most difficult for “experienced” staff (nurses at grade E and above). The pattern of responses reflects the geographic and speciality spread of nursing shortages, as indicated by variations in the level of nursing vacancies reported by NHS trusts in England.

One issue that was explored in the case studies was the extent to which active international recruitment was part of an overall organisational strategy of recruitment and retention. All ten organisations reported a range of other interventions to improve recruitment and retention of nursing staff. This was most commonly focused on the provision of flexible hours, and improvements in accommodation provision. While these initiatives were reported to have had some impact in most cases, they had not been sufficient to meet staffing requirements.

The use of international recruitment was therefore a response to the need to find an alternative and additional source of new recruits, rather than a reaction to failure of other policies to improve recruitment and retention. As one NHS manager noted “we’ve tried them all [the various interventions] and international recruitment has had the biggest impact”.

Several of the organisations had been involved with international recruitment for a number of years. There was a clear sense in most of the organisations that the processes of recruitment had become more systematic, planned and strategic in the last year. This was partly a result of the recognition that international recruitment was no longer a one-off exercise. It was also partly an attempt to improve the efficiency of the approach, and a reaction to external policy change, particularly in the NHS.

The situation in the NHS had become more formalised. This is because of controlled recruitment directed through the regional offices of NHS Professionals (now renamed WYMAS), and because of the introduction of Department of Health guidelines.

The change can be characterised as a shift from regarding international recruitment as a reactive, one-off last resort, to one that is planned and linked more directly to other aspects of recruitment and retention.

The process of international recruitment

In the source country

Essentially there are three options open to an organisation that decides to recruit internationally. It can recruit directly; it can work with a recruitment agency; or it can combine its recruitment effort with other employers, either directly or via an intermediary.

All three models were reported by the case study organisations. However, there was a trend towards the combined model from NHS organisations, and a shift away from direct recruitment unsupported by recruitment agencies. The argument for the combined approach was that it secured economies of scale and reduced unnecessary competition. The argument against the latter was that most individual UK employers did not have the knowledge and skills to be effective in isolated recruitment in international nursing labour markets.

The most common model reported was to work either as an individual organisation or in combination with a recruitment agency. In the case of the NHS organisations, some had co-ordinated their efforts via NHS Professionals/WYMAS, while others had worked with a private sector UK-based international recruitment agency.

The usual process was to draw up a shopping list of numbers of nurses and skills required in the recruitment, and to work with the agency to determine which country to target. At the time of the research, the Philippines was the preferred source in nearly all cases. This is partly because it was regarded as a plentiful source of well-trained English speaking nurses. Also for NHS employers it had been flagged by the Department of Health as an ethical country to target.

The effect of the Department of Health code on international recruitment⁷ is difficult to assess on the basis of a small number of NHS case studies. One dedicated international recruitment co-ordinator in a NHS trust raised concerns that there was no explicit list of countries that were acceptable recruitment targets: "It is difficult to get information on a list of countries from the department. A new one [list] is apparently going to be issued." (This list was published by the Department of Health in January 2003).

The earlier guidelines issued by the DH in 1999 specifically stated that NHS employers should not recruit in South Africa or the Caribbean. At the time of the case studies, the current code was less explicit, stating that: "NHS employers should not target developing countries for recruitment of health care personnel unless the government of the country formally agrees via the Department of Health. In these circumstances individuals may be appointed to a structured programme aimed at enhancing clinical practice in order for them to return home after an agreed period." In 2002, only India and the Philippines were "positively" listed on the Department of Health website. In January 2003 the Department posted a list of developing countries from which active recruitment should not take place.

Advertisements, supplemented by word of mouth information, were used to stimulate in-country enquiries from nurses. Pre-screening was conducted and then an intensive period of in-country interviews used to select recruits. The ratio of applicants to interviewees was usually 3 or 4 to 1. For example, one manager reported that 180 were interviewed, and 50 recruited; another that 120 were interviewed, and 30 recruited. Nurse managers from the employing organisation, supported by recruitment agency staff normally conducted interviews. The organisations reported recruiting nurses in batches of ten to 50 per

recruitment trip. Managers said that very few nurses who were interviewed and offered a job in the UK declined the offer.

Having selected appropriate nurses they were then supported in obtaining registration from the NMC and, where necessary, in obtaining a UK work permit. Generally it was the recruitment agency that took the lead in the initial phases of application and paperwork, assisting individual nurses to complete applications.

The employing organisations tended to take a greater role in the latter stages, liaising with the NMC and Work Permits UK to ensure that the bureaucratic processes were completed. However, in one case a private sector organisation had an agreement with the agency whereby the agency handled all aspects of liaison with NMC: “They [the nurses] came with their PIN [NMC identification number].....this made them a very attractive proposition.”

Many of the recruited nurses were required to undertake a period of adaption or supervised practice in the UK. In the case of NMC registration all the case study organisations expressed concern about the time taken to obtain registration. One organisation said it was “like pulling teeth”, and another said it was “a very frustrating experience”. While one a further example quoted that it was “a nightmare.....they lost the transcripts”.

In contrast none of the respondents reported that obtaining work permits for nurses had presented any problems or delays in their recruitment effort. They reported that the process was “excellent”, and “improved tremendously”.

Direct costs of active international recruitment were related to three main activities:

1. cost of time and travel for recruiters from the employing organisation
2. fees paid to an agency, which usually amounted to at least £1,000 per nurse (see table 5 below)
3. cost of providing travel for the nurses to come to the UK (all the organisations reported that they met this cost).

Table 5: Examples of fees charged by recruitment agencies (and source country)

- 8% of salary per nurse (Dubai)
- £1,200 per nurse recruited (Philippines)
- £1,000 per nurse recruited (Philippines)
- £1,000 per nurse recruited (Caribbean).

Several of the organisations had made some attempt at estimating all of these total direct costs per nurse. This was to assess cost-effectiveness, or to justify cost outlay to a finance department. These figures tended to be between £2,500 to £4,000. The main variable was the time and travel of recruiters, with the agency fee and nurse travel being more predictable.

Recruiting a large batch in one recruitment visit could best reduce average cost per nurse recruited.

Arriving in the UK

The processes of receiving and inducting IRNs can be divided into two main areas of work:

1. clinical issues
2. non-work issues, such as housing and settling in.

In relation to the latter, most of the managers reported that they had learned from previous mistakes, or had taken advice from other organisations. They used this advice to develop a planned programme of “meet and greet” and induction for newly recruited international nurses. In most cases this covered briefings on the organisation, UK culture, local geography, and the use of public transport and amenities – including bank accounts, postal services and telephones⁸.

Most also provided on-site or local subsidised accommodation. In London and the South East this was flagged up as an important factor. One NHS organisation was working with a local housing association to provide inexpensive accommodation; two of the independent sector organisations were housing the majority of their international nurses on site in hospital accommodation. Four of the organisations also provided nurses with a starter pack of food and phone cards and so on. Three mentioned the need to ensure that the nurses were put in contact with relevant local religious institutions such as Filipino nurses with the local Catholic church.

Most nurses recruited actively by UK employers have arrived recently from source countries that required them to have a work permit to live and work in the UK. Nursing is currently flagged as a shortage occupation in the UK, and permits are issued on a fast track basis. Initial permits are usually issued for two years, although some employers reported recently longer time periods of five years. None of the managers reported any difficulties in obtaining permits.

As noted earlier, all nurses working in the UK must be registered with the Nursing and Midwifery Council. The NMC deals with each individual application, and in many instances there will be a requirement for applicants to work a period of adaption in the UK prior to being registered to work as a practitioner. In most cases this will be a period of up to six months.

The likelihood of acceptance and requirement for a period of adaption by NMC varies significantly depending on the source country of the applicant. Most Filipino nurses have been required to work a period of adaption of three to six months. The managers reported variations in local practice about how they had structured the period of adaption including individual supervision and mentoring of recently recruited nurses. Some employers have established their own adaption processes using NMC guidelines, while others were working with local education providers.

One important variation was reported in local practice. This was the level of payment made to nurses who were working during their adaption period (see table 6 below).

Table 6: reported pay rates for international nurses during adaption period (reported as clinical grade)

NHS	top B
	C
	mid B
	D
Non-NHS	mid B
	initially D
	D
	as health care assistant (HCA)
	HCA B
	B

In some cases, both in the NHS and independent sector, nurses were being paid as a health care assistant during adaption, which is NHS grade B or equivalent. In other examples they were reported to have been paid as staff nurses.

On completion of adaption the nurses are signed off and their registration is processed by the NMC. Total elapsed time between initial application and registration was reported to be up to one year in some cases. The NMC has acknowledged that a backlog of applications developed in 2002 that amounted to more than 7,000⁹. This is partly as a result of the actual increase in applications, and partly because of problems created by implementing new information systems in March/April of the year¹⁰.

Compliance both with NMC and work permit requirements is one aspect of work-related induction. Another is the actual integration of international nurses into the workplace and clinical team. All of the organisations reported some level of formal induction tailored to the anticipated needs of international nurses. All the NHS organisations and most of the independent sector organisations had designated nurses to supervise the nurses during the first few months, who are usually experienced clinicians or ward managers. Two had also set up a more informal buddy system where IRNs were paired with a local nurse. In another case this buddy system was used to pair up a recently recruited international nurses with one who had arrived earlier.

The main challenges reported by the managers during this period were linked to four issues:

1. language
2. differences in clinical and technical skills
3. racism in the workplace

4. reaction of patients.

Seven of the ten managers reported some problems with the English language capabilities of recruits. This was the case even when the nurses were technically very proficient in speaking English, but had difficulty in writing or comprehending English, or could not understand local accents or colloquialisms. One manager said: “English language is a problem...they can speak it but don’t comprehend.” Another reported: “Language is the main issue.”

There have been media reports of difficulties with English language skills of some nurses, particularly those recruited from Spain¹¹. In May 2002 the NMC issued strengthened guidelines on the need for non-EU nurses to have demonstrated competency in English language¹². One NHS case study trust reported that it was now working with an education provider to run a short training course in English proficiency for recently arrived nurses. This has also been reported as being provided by other employers¹³. One NHS trust reported that the recently recruited nurses were themselves suggesting changes to the language-based induction.

The second issue related to differences in clinical and technical skills. Nurses from different countries begin with a different range of skills at different levels, and have training in different approaches to specific clinical practice. For example, one manager noted that nurses they had recruited from Africa had different training in caring for patients in long-term psychiatric institutions. The manager said: “They have a very different approach to de-escalation and patient restraint.” Another noted that nurses recruited from a developing country had a different attitude to pain relief than UK trained nurses had. This reflected the relative lack of pain relief drugs available in their home country.

Some of the managers emphasised that sensitivity was required to re-focus the skills of these international nurses to ensure that they complied with current UK practice. Initially this had been trial and error for some employers, but most now reported a more pro-active approach that attempted to take into account differences in care philosophy as well as technical skills.

There was also an overlap in broader cultural differences. One manager employing Filipino nurses noted that they tended to be much more confident in the use of the Internet than UK nurses. The manager reported: “They are technically better than UK nurses, and they are also more computer literate.” However, another manager noted that nurses from the same country were “used to a hierarchy ...we need to help them to be more assertive”. Integration therefore bridged clinical and cultural issues. Other comments included “the biggest challenge is integrating the nurses, we have to avoid reinventing imperialism”, and “for cultural issues we are working to cross the cultural divide”.

The third problem that was highlighted by managers was workplace racism. Two of the managers, one in the NHS and the other in the independent sector from outside the South East, reported that there had been incidents of overt racism from other health professionals when the IRNs had first been employed. One manager reported: “There has been some racism in the workplace – staff-to-staff is the problem - but we have zero tolerance of this.”. Others reported that they had anticipated such problems but they had not happened. One said: “We had expectations of prejudice from some English nurses - but now they [the international nurses] are so popular and very hard working.”

Finally, there was also a reported issue of patient reaction to being cared for by an international nurse. This may reflect a more covert form of racism from individual patients. Two managers reported that this had initially created some difficulties: “Some patients have

complained.” Another reported: “One of our ladies woke up the other day and asked which country am I in?”

Racism from staff, managers or patients is likely to be a continuing issue. Two of the NHS managers reported that they were actively working to reduce and end racism through a policy of zero tolerance. Others highlighted that they were addressing racism as an element of a broader attempt to improve the work environment, and as a part of the *Improving working lives*¹⁴ initiative being promoted by the Department of Health.

Once registered with the NMC international nurses are able to practice in the UK. All ten organisations reported that all actively recruited IRNs were employed on full-time contracts. This was usually on grade D initially but in some individual cases nurses had been promoted to grade E or above. None reported significant variations from the terms and conditions offered to UK-trained nurses. However, some of the managers did express some concern that they thought that some nurses were “undervalued” when they were first employed, and that their experience and skills should have warranted immediate appointment to grade E or equivalent.

One key issue, both for individual organisations and at a national policy level is how long these nurses are likely to stay in the UK. As most are employed in the UK on work permits, they do not have an automatic right of residence. Feedback from the managers suggests that their organisations would like to continue their employment and that the managers believe most nurses would stay on. “Most will stay...a lot have their families over with them.” Another manager commented: “They are getting mortgages...they are planning to stay.” One reported: “Many have settled and bought houses - they don’t anticipate leaving.”

One qualification to this view was reported by a London-based manager, who noted that Filipino nurses may move on to the USA if jobs became available. Another independent sector manager reported that “we will retain about 50% of them, the others are making a strategic decision to move to the NHS to broaden their experience”.

This latter point highlights another policy issue that will become more apparent over the next two years. There is no reason why international nurses should behave any differently from UK-trained nurses in striving to meet their career aspirations and to identify career development strategies and opportunities in the UK health care.

One constraint on mobility for some IRNs will be the need to have employer sponsorship to move with a work permit. However, it is anticipated that international nurses will begin to move around the UK nursing labour market in order to maximise their career opportunities and job satisfaction. As long as nursing shortages are a feature of this market IRNs too will be in a sellers market for their skills.

Current rates of staying on appear high. Managers reported that very few actively recruited international nurses were leaving before their agreed contract period. However, in some instances the nurses are subject to financial penalties, having to repay travel and accommodation costs if they leave the job before the end of the two-year contract.

5. International recruitment in context

This section assesses the continuing relevance of international recruitment of nurses to the case study organisations set in the broader context of other recruitment and retention initiatives.

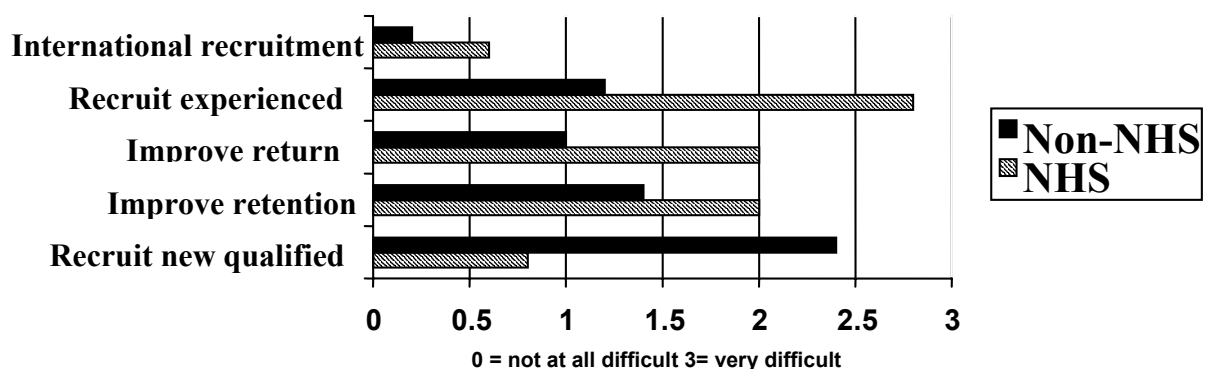
International recruitment is examined as one of five options for achieving staffing targets:

- recruitment of newly qualified UK nurses
- retention improvements
- increases in the number of returners (nurses returning to practice)
- recruitment of experienced UK nurses
- international recruitment.

Managers in the ten case study organisations were asked to rate each of the five possible initiatives in terms of their level of difficulty and perceived cost-effectiveness. The five methods are not mutually exclusive. They represent the options available to managers in meeting their requirements for nurse staffing numbers. The objective was to assess the extent to which managers regard international recruitment as relatively easy or cost-effective.

The managers were first asked how easy or difficult it was to use each of the five interventions to meet nurse staffing requirements. The responses are shown in Figure 6. The main point to note is the fact that international recruitment was rated as the easiest of the five interventions by both NHS and non-NHS managers.

Figure 6: relative difficulty of five recruitment and retention options: NHS and non-NHS employers



Other points to note are the different responses from NHS and non-NHS managers about recruitment of newly qualified and experienced nurses. Most of the NHS managers reported that recruitment of newly qualified staff was relatively easy. They pointed to the expansion in

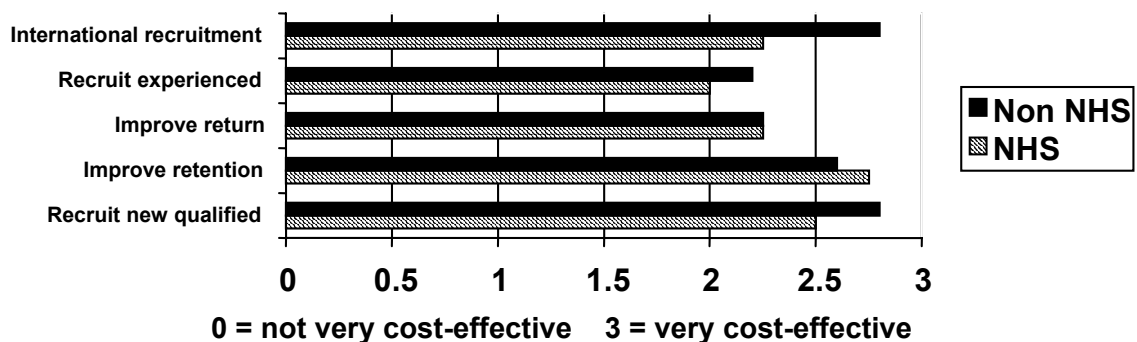
student nurse numbers in recent years, and the well-established connections with local education providers.

In contrast non-NHS employers reported significant levels of difficulty recruiting newly qualified staff, highlighting that most newly qualified nurses were looking for a career in the NHS.

Responses were reversed when managers were asked about recruiting experienced UK nurses. NHS employers reported a very competitive labour market where nurses were in sellers' market for their skills. They said they had significant difficulty in recruiting at grade E and above. Non-NHS employers tended to recruit fewer nurses from a narrower range of specialities. They reported that the provision of part-time and flexible hours enabled them to tap into local labour markets to meet staffing requirements.

The case study organisations were also asked to rate the cost-effectiveness of each recruitment method. The objective was to check if international recruitment was regarded as significantly more or less cost-effective than UK-based initiatives. Figure 7 shows that there is no indication from the managers that international recruitment was regarded as less cost-effective.

Figure 7: reported cost-effectiveness of five recruitment and retention options in NHS and non-NHS employers

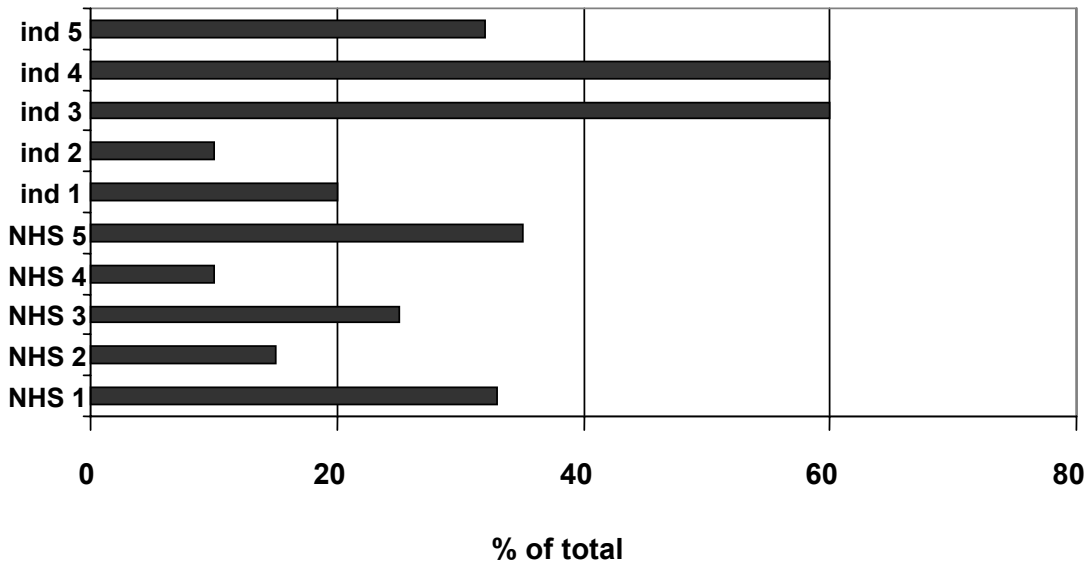


Several managers from both sectors highlighted that international recruitment was an effective approach when the costs of advertising for UK recruits were taken into account.

The overall response from the managers suggests that they view international recruitment as a relatively easy method of meeting current staffing requirements. They regard it as no less cost-effective than other recruitment and retention initiatives.

The managers were also asked to assess their likely staffing needs over the next five years by assessing the relative contribution of each of the five recruitment methods. Figure 8 shows their responses.

Figure 8: % contribution of international recruitment to total nurse staffing requirements over next five years



The overall pattern of responses varies to reflect individual assessments of needs and extended labour market dynamics. However, all ten managers reported that they anticipate international recruitment would continue to be a significant source of recruits.

The managers assessed that the likely relative contribution of IRNs over the next five years would meet between 10% and 60% of total staffing needs. Non-NHS organisations in London and the South East reported the highest level of likely reliance on international recruitment. NHS managers assessed that they were likely to meet up to 35% of total staffing need through international recruitment

This reinforces the notion that international recruitment has become a more significant and long-term element in the staffing plans of the case study organisations. The move towards a more systematic approach to international recruitment is a response to the need to be more effective in recruitment, but it also contributes to making the approach more sustainable.

The reasons given by the managers for the likelihood of a continuing dependence on international recruitment related to three main factors:

- planned staffing expansion (particularly in some of the NHS organisations)
- increasing nurse retirement levels
- fewer returners in some labour markets.

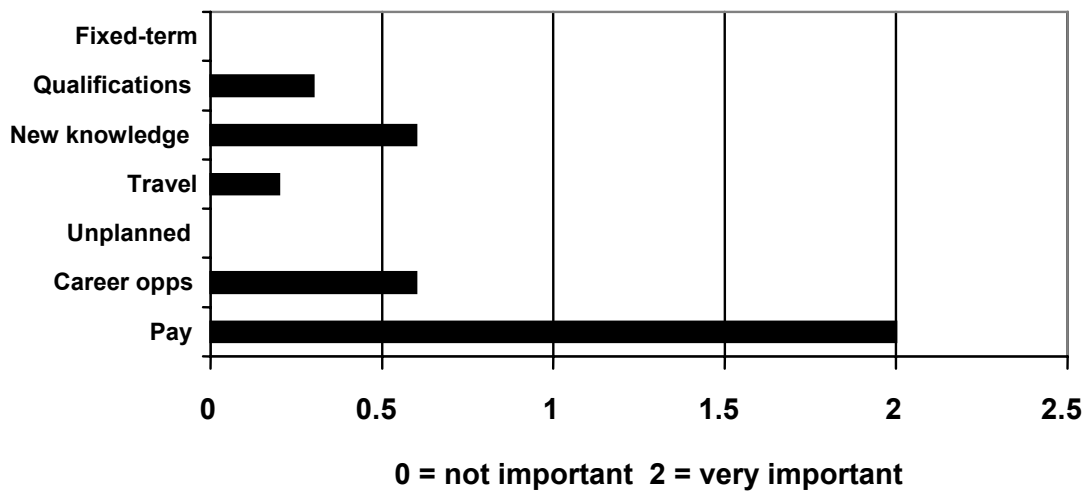
One London-based manager noted about returners: “There is not a great deal of interest.” In combination the impact of these factors led the managers to believe that there would continue to be a staffing gap, which they would have to fill by international recruitment.

The management perception of why IRNs had come to the UK to work is the final issue looked at in this section. The responses should be regarded as a summary, but they are

important because they will shape management policy and practice. (For more detail on the motivations of nurses that come to the UK see Buchan (2002)¹⁵ and the forthcoming study to be published by the RCN).

Managers were asked to rate seven factors that may play a part in stimulating nurses to come to the UK (see figure 9). The pattern of response is clear. They regarded pay and/or a better standard of living as the main driver, and this was the case irrespective of the organisation or the source country of the nurses.

Figure 9: managers' opinions of reasons why international nurses were attracted to work in the UK



The managers identified other reasons that were more country or nurse-specific. For example, organisations employing Australian nurses tended to report the working holiday model as a factor for some of the nurses. Employers of Filipino and South African nurses highlighted career development opportunities as an important secondary pull factor.

The overall assessment from managers about the reasons why IRNs are in the UK is primarily about better pay, and career development prospects. Managers considered that most of the IRNs would stay permanently in the UK. Although there were some notable exceptions, there was little sign of nurses making a temporary move to improve their skills for use “back home”.

6. Policy implications

There has been huge growth in active international recruitment of nurses to the UK in recent years driven by nursing shortages. This report has already highlighted the doubling of the number of IRNs in the UK since 1999. In England today one in 12 nurses on the register is from a non-UK source, and in London the figure is one in four. Some individual health care organisations are now reliant on IRNs to provide half or more of their nurse staffing.

When significant growth in active international recruitment became apparent in 1999/2000 it was regarded as a short-term quick fix. It is now apparent that the continuing need to maintain or increase nurse staffing levels has created a situation where international recruitment is routine to many health care employers' recruitment and retention strategies.

There are two key policy challenges related to the growth in international nurse recruitment:

- ethical – is the UK creating a brain drain of nurses in other countries (ethical recruitment), and are IRNs being treated equitably in the UK (ethical employment)?
- efficiency – if international recruitment is a necessary part of recruitment and retention strategies, how can it be made more efficient?

The issue of ethical recruitment is widely debated. There is increasing recognition that an over-simplistic view of “brain drain” takes insufficient account of the complexities and dynamics of the motivations and rights of individual nurses and of push factors, such as lack of career prospects or the threat of violence. Even so, it has to be recognised that active recruitment by UK employers is a pull factor, and has been the dominant dynamic. Without it the number of nurses coming to the UK from developing countries would have been much smaller. It is “pull” rather than “push” which has determined the size of inflow.

So it is UK employers and the Department of Health (DH) in England that hold primary responsibility for the increase in international nurses, and any associated ethical considerations. The DH has taken a lead on introducing guidelines in international recruitment that were first published in 1999¹⁶, and revamped in 2001¹⁷. The 1999 guidelines required NHS employers not to recruit in the West Indies and South Africa. This appeared to have a short term impact in reducing the numbers of nurses coming from these specified countries, but recruitment from other developing countries grew more rapidly – perhaps because it had been ‘displaced’ from the West Indies and South Africa¹⁸.

The revised 2001 guidelines were extended to cover recruitment agencies working on behalf of NHS employers. However, there has been recent criticism by one MP that this aspect of the Code is a “sham” with only 30 out of 92 agencies reportedly complying with the Code, with no formal mechanism in place for the Department to check on compliance¹⁹ and that the Code did not have a complete list of source countries that are either “banned” or “approved”. (This list was published in January 2003). The policy emphasis has been on the few countries (for example, Spain, India and the Philippines) where the Department has reportedly secured “government to government” agreements, but many other countries are currently sources of nurses for the UK.

It was evident in one of the NHS case studies conducted for this report that the manager responsible for international recruitment wanted more guidance on which countries were or were not approved “ethical” sources of nurses.. The recent announcement in the Chief Nursing Officer’s (CNO) bulletin for England said that NHS employers should “reconsider”

if they had planned to recruit via an agent in Ghana. This apparently followed representations from that country's health minister²⁰. This reinforces the uncertainty. If NHS employers were complying with the DH code they would not have considered Ghana in the first place. The publication of the list in January 2003 may assist in ending the confusion that was evident in 2002, at the time of the case studies.

The CNO bulletin also suggested that UK recruitment activity in Ghana might have been on behalf of private health care employers. The Independent Health Care Association that represents the non-NHS sector has also published guidance for member organisations²¹. This focuses on good practice aspects of the induction and employment of international nurses.

The ethical recruitment issue is further complicated because many IRNs recruited by independent sector employers move on to NHS employment shortly after NMC registration. But because the NHS has not actively recruited them, NHS employers can argue that they have complied with the code.

This issue of this secondary market is likely to become more apparent over the next few years as IRNs already in the UK begin to move jobs and employers. Anecdotally the main trend is a move from non-NHS to NHS employment.

The ethical employment issue is blurred, overlapping as it does into efficiency issues. There is little doubt that the "efficiency" of active international recruitment has improved in recent years, as employers have become more adept at the practice, working together to secure economies of scale, and improving recruitment and induction. The case studies in *Here to stay?* flag up examples of induction good practice, but also problems with racism and the need to support cultural diversity at the workplace. Until recently the NHS has had a stronger framework to support improvements in this aspect of ethical employment, through Improving Working Lives, and the good practice outlined in the Code (supported by the RCN recommendations on international recruitment²²), than it did on the ethical recruitment issue. The January 2003 listing of developing countries may strengthen the ethical dimension.

The final policy point to note that the UK is also a potential source of nurses for other English-speaking countries. There are already some signs of an increase in outflow of nurses from the UK to the USA, Australia and New Zealand²³. In some cases these may be recently recruited IRNs who are moving on to a new country.

In a situation where many developed countries are facing an increasing challenge to solve nursing shortages²⁴, a continuing growth in the level of international mobility of nurses is likely. This is both in terms of developing-to-developed country, and developed-to-developed country. Some international agencies, such as the Commonwealth and the International Council of Nurses²⁵, are attempting to underpin this process with multinational guidance. But it is evident that the global dynamic will continue. The UK may decide to continue with current international recruitment, but it will also have to be aware that the flow of nurses out of the UK may become a more significant factor.

There will be some tension between ethics and efficiency, particularly when there is a high degree of reliance on recruiting from developing countries. At the moment, for most health care employers in UK, the "ethics" of international recruitment is subsidiary to the efficiency of the process. Relative to most other developed countries, the UK, particularly England, has taken a lead on establishing policy guidance – but relative to most other developed countries England is also currently highly dependent on internationally recruited nurses.

Annex 1: London postcodes used

E1 – E18

EC1 – EC4

N1 – N22

NW1 – NW11

SE1 – SE28

SW1 – SW20

W1 – W14

WC1 – WC2

Source: www.brainstorm.co.uk/public/utis/PostLondon.html

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- ¹⁴ Improving working lives is a Department of Health England model of good HR practice against which NHS Employers and their staff can measure the organisation's HR management and against which NHS employers will be kite-marked. NHS organisations will be required to achieve accreditation against the Standard by April 2003, demonstrating they are improving the working lives of staff. For further information visit website www.doh.gov.uk/iwl
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- ¹⁶ *Guidance on international recruitment* (1999). London: DH
- ¹⁷ As endnote 7
- ¹⁸ See Buchan J (2002) *International Recruitment of Nurses: UK Case Study*. Royal College of Nursing/ World Health Organisation/ International Council of Nurses. RCN, London., for more details.
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