



How can the NHS recruit and retain migrant nurses after Brexit?

Dr Georgia Spiliopoulos, School of International Studies, UNNC

Prof Stephen Timmons, Nottingham University Business School, UNUK

Introduction

The UK Referendum decision to leave the European Union in June 2016 exacerbated some of the long-standing challenges the National Health Service (NHS) has been facing in recruiting and retaining nursing staff. In 2018, it was estimated that one in eight posts was vacant, which translates into 36,000 nursing vacancies (King's Fund, 2018). Arguably, these challenges have been present since the founding of the NHS in 1948. Pre-established initiatives recruiting overseas nurses to deal with acute staffing shortages during the war effort, mainly from the Commonwealth, were also adopted by the NHS. Hence, the Nurses' Act of 1949 relaxed the criteria for the registration of overseas nurses set up by the General Nursing Council (Solano and Rafferty, 2007). Therefore, we can trace historical developments in recruiting non-UK nurses, which reflect changing state regulations over time, connected to particular political and financial factors, xenophobic rhetoric and also problems in retaining British nursing staff (Bach, 2007; Ball, 2004; Cangiano *et al*, 2009; Simpkin and Mossialos, 2017; Solano and Rafferty, 2007). In the 1950s, for example, significant numbers of overseas nurses entered the UK as trainees, while an even higher number of British nurses emigrated abroad, fuelling concerns over training of overseas nurses but also bringing to the forefront anxieties over race (Solano and Rafferty, 2007). An illustrative example of political will influencing recruitment of overseas nurses was seen in New Labour's push for a 'modernization agenda' in the late 1990s and subsequently, a push for international recruitment (Deeming, 2004). However, aggressive recruitment initiatives targeting nursing staff from developing countries such as Zimbabwe, Kenya and Zambia, led to the introduction of the NHS 'Code of Practice' on ethical recruitment in 2001 (Deeming, 2004), with calls for overseas recruitment to focus mainly on pre-existing agreements with countries such as the Philippines and India (Buchan, 2006).

In the early 2000s, the highest numbers of overseas nurses were from the Philippines and India (Solano and Rafferty, 2007). However, changes to recruiting from outside the UK can be seen from the mid-2000s, following the 2004 EU enlargement and freedom of movement for Eastern European health professionals, with Polish nurses being the most prominent example of newly non-UK registered nurses (Deeming, 2004; Jayaweera, 2015). Previous efforts in the late 1990s and early 2000s to actively recruit from the EU countries had very little yield (Deeming, 2004). This phenomenon of increasing numbers of EU nurses, predominately from former Eastern European bloc and registering with the Nursing Midwifery Council (NMC), coincided with the 2005/06 tighter NHS fiscal policy, which translated into cuts to international nurse recruitment (Buchan, 2009). Moreover, in the aftermath of the 2008/09 global financial crisis, the number of EU nurses employed by the NHS increased significantly, from 7,895 nurses and health visitors in September 2010 to 21,237 in September 2017 (NHS Digital, n.d.). The numbers of Southern European nurses, for example from Greece, Italy and Spain, increased ten-fold in this period (NHS Digital, n.d.). The picture changes, once more, following the EU Referendum, with a sharp decline



UoN Asia Research Institute Policy Brief Background Report

observed in numbers of new NMC registrants from EU countries. More specifically, in June 2017 there was a decrease of 96% of EU applicants in comparison to the previous year, equating to only 46 applicants (Lintern, 2017; Orr, 2017). A decline in the numbers of EU nurses registering with the NMC was also a result of the NMC's introduction of language requirements for EU nurses in 2017, already in place for non-EU nurses (Lintern, 2017). Furthermore, between July 2017 and 2018, a significant number of EU nurses left the UK, with just under 1,600 EU nurses and health visitors quitting their NHS employment positions more than those joining the NHS (King's Fund, 2018).

Government initiatives were put in place in the late 1990s to encourage training of 'home-grown' nurses through increasing available funding for pre-registration nurse education. This was one of several policy options put in place in order to increase numbers of NHS nurses, with international recruitment only intended as a 'quick fix' (Buchan, 2009). However, bursaries in place to encourage entrance into nurse education were cut in 2017 and replaced by loans. The move was introduced in order to create additional nursing roles and also to lift the cap on student numbers (Johnston, 2016). The result was a 23% drop in applicants taking up a nursing degree in 2017 (Ford, 2017), with nursing students accruing debt and the government losing an important driver for encouraging nurse education (Rafferty, 2018).

The NHS has also placed significant importance on the retention of British and migrant nursing staff. Under New Labour's 'modernization agenda', for example, focus was placed on increasing numbers of nursing staff to match the levels of staffing in other EU countries and thus efforts were made to increase pay and attract returnee nurses (Deeming, 2004). These efforts included increases in pay annually and opportunities for flexible employment and career advancement. The results were overall positive, however, the measuring of how successful retention and recruitment were, was through counting numbers of employees and not taking into consideration part-time contracts (*ibid*). Buchan (2009) also comments on the retention of staff and the difficulties of measuring success. The offering of 'accreditation programmes', 'flexible hours' and 'access to education' is hard to correlate with increasing numbers in staff, while data collected by the Office of Manpower Economics was not conclusive because of varying responses over the years (Buchan, 2009:5). High turnover of staff and lack of career satisfaction are linked to burnout and work-related stress (Aiken *et al*, 2014; McKenna, 2017), and also lack of equal opportunities for career development (Alexis and Vydellingum, 2009) and institutional racism, experienced by nurses from BME communities and migrant nurses (Iganski and Mason, 2002; Solano and Rafferty, 2007). NHS England has recognised the importance of encouraging race equality and putting into place initiatives to tackle race, gender, ethnicity, and other forms of inequality by introducing standards such as the Workforce Race Equality Standard (WRES), part of its 'NHS Long Term Plan' (Naqvi and Coghill, 2019). The WRES is identifying good practices and areas of improvement in terms of enhancing opportunities to take on leadership positions in NHS Trusts for BME and overseas staff and also tackling discrimination. Arguably, such issues of discrimination are long-standing within the NHS (Adhikari and Melia, 2015; Solano and Rafferty, 2007; Yeates, 2009) and 'Brexit' has only encouraged xenophobic and racist sentiments (Johnson, 2016).

Finally, another 'quick fix' solution for meeting understaffing pressures is the hiring of agency nurses (Deeming, 2004; Street, 2015). Agency staff are often called in to cover for staff who have taken leave because of health problems related to work-related stress (King's Fund,



UoN Asia Research Institute Policy Brief Background Report

2018) and for other reasons, such as efforts made by financial directors in reducing costs connected to permanent staff and long-term financial commitments (Buchan, 2013). Nevertheless, criticisms connected to the high costs of the hiring of agency staff, medical and nursing staff, charged by recruitment agencies, triggered a reaction by the government in April 2016 and specifically an introduction of caps to hourly payment (Street, 2015). Such responses, however, do not deal with underlying problems which lead NHS staff to take on agency work, such as higher payment and more flexible work patterns as agency workers.

In this section, we have sketched out some of the most controversial, ongoing issues that the NHS has been facing in terms of retention and recruitment of British and overseas nurses. In the following section, we discuss the methods of data collection and analysis of our project on EU and non-EU NHS nurses, before presenting some of our key findings in connection to retention and recruitment of migrant nursing staff in the context of 'Brexit'.

Methodology

The participants of this study were nurses working for two NHS Trusts, in the Midlands and in Southwest England. Recruitment for this project was made possible with the assistance of three gatekeepers, a community leader and a former research participant based in the Philippines who provided contact details for the Filipino nurses; and a Greek NHS nurse, in the case of the EU nurses. Snowballing technique was employed which led to the interviewing of eleven nurses in total. The NHS nurses came from EU and non-EU countries, namely the Philippines, Greece, Italy and Spain, and worked for an average of just over two and a half years – from being newly employed (two months) to being employed for five years. The gender ratio was nine female and two male nurses. Recruitment for the NHS was through two main routes: private employment agencies, whose agents travelled to nursing schools in Europe or, as in the case of the Philippines, had partner agencies in the UK; and through advertisements for job vacancies (NHS jobs website, social media and adverts on university websites). In terms of positions held in the NHS, these were: staff nurse (band 5); clinical educator (band 6); pre-NMC registration nurse (band 3); and bank nurse (see Table 1 below).

Table 1: Participant demographics (information accurate at the time of data collection)

Name*	Gender	Age	Nationality	Area	Recruitment	No. of years / months	Current position	Future plans
Alfred	M	31	Philippines	Midlands	Private agency in	2 ys	Band 5	Apply for Band 6



UoN Asia Research Institute Policy Brief Background Report

					Philippines (flyer)			position; British citizenship; find new employer; migrate to the USA
Maria	F	28	Philippines	Midlands	Social media	6m	Band 5	British citizenship; migrate to the USA
Martin	M	29	Philippines	Midlands	Private agency in Philippines	2 ys	Band 6	Moving to another NHS Trust
Theodora	F	27	Greece	Southwest England	Private agency travelled to Greece	3.5 ys	Band 5	Migrate again after 2 years
Michaela	F	27	Greece	Southwest England	Private agency travelled to Greece	3.5 ys	Band 5	Stay for 2-3 years and return to home country
Alexandra	F	29	Greece	Southwest England	Private agency travelled to Greece	3.5 ys	Bank nurse	Career change
Anna-Maria	F	28	Spain	Southwest England	Agency travelled to Spain	5 ys	Band 5	Advance career but depends on 'Brexit' outcome
Sofia	F	26	Italy	Southwest England	Agency approached in Italy	3.5 ys	Band 5	Wants to stay in the UK but depends on 'Brexit'
Joseita	F	25	Philippines	Midlands	Private agency in the Philippines	2m	Band 3	Finish 2-year contract in geriatric ward and transfer to ICU (local hospital)
Christina	F	28	Philippines	Midlands	Private agency in the Philippines	2m	Band 3	Finish 2-year contract in geriatric ward and move to another ward/geographical area



UoN Asia Research Institute Policy Brief Background Report

Theresa	F	31	Spain	Southwest England	NHS jobs website	4.5 ys	Bank nurse	Nursing exam in home country; looking for work in emergency ward; career change
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* all names used here are pseudonyms

The findings of this research project, presented here, derive from using qualitative methods of data collection and analysis, namely semi-structured interviews (Galetta and Cross, 2013) and thematic analysis (Boyatzis, 1998; Braun and Clarke, 2006). Face-to-face interviews took place in cafés, with one interview taking place over the telephone. Average time of interviewing was over forty minutes. Follow-ups through telephone or through email were also used. The questions posed to the participants focused on the following broad areas: recruitment/pathway to the NHS; training; job satisfaction and opportunities for career development; their experiences of ‘Brexit’; and finally, their future, long-term plans. Below we present our key findings connected to these issues which illustrate propensity, or lack of, for long-term commitment to the NHS.

Findings

In this section we present some of our key findings which provide evidence for the policy recommendations connected to retention and recruitment of migrant staff post-Brexit. We focus on the following: understaffing following from the 2016 Referendum and pressures on nursing staff; discrimination experienced in and outside the workplace; delays and frustration experienced by EU and non-EU migrant nurses in gaining professional recognition; limited opportunities for social mobility and career development; and increased possibilities of moving to other NHS Trusts or migrating elsewhere.

i. Challenges connected to the departure of EU nurses

The participants in this study, EU and other overseas nurses, identified understaffing, due to EU nurses leaving the NHS, as a major challenge. As Martin mentions here, with EU nurses leaving the NHS, there is a heavier load to undertake;

*‘EU nurses are leaving England, we will always be short-staffed. How the Trust will support the ward, it is all British and Filipinos here, all the Italians have left’
(Martin)*

Similarly, for Alfred, understaffing was experienced as taking on additional responsibilities, without recognition or additional pay:

‘Basically, we are really short, we are really short of nurses. Sometimes, when you are the nurse in charge, you are not meant to handle patients. So, when you



UoN Asia Research Institute Policy Brief Background Report

are the nurse in charge and handle patients at the same time, you're the team leader, so it's like doing two jobs at the same time' (Alfred)

Taking on a heavy workload can have a detrimental affect on patient care and mortality (Aiken *et al*, 2014) and can lead to poor nurse retention (Aiken *et al*, 2018).

The two NHS Trusts whose staff we interviewed were dealing with understaffing problems by hiring staff from outside the EU, namely from the Philippines. However, this was not a panacea; as stated by the participants, limited hospital budgets meant limited numbers of new staff being hired; *'they have stopped recruiting now, maybe because of the budget. Where will we get those nurses? Maybe in April' (Joseita)*.

For the EU nurses participating in this study, they experienced the same issues as the Filipino staff in terms of understaffing and overwork, however, they also felt less emotional support, with many of their co-ethnics having returned to their home countries since 2016;

'The first two years, I had my Spanish friends here, 12 people here. We are still in touch, but they have all gone back to Spain. Progressively, since 2016' (Anna-Maria)

Co-ethnic communities and networks can provide significant emotional and practical support by easing the entrance of new migrants and also assisting in the adaptation to a new social and employment culture (Al-Hamdan *et al*, 2015; Iosifides *et al*, 2007). Without such emotional anchoring, Spanish nurses like Theresa feel that they do not belong to the local community and, in Theresa's case, are contemplating migrating again;

'...if I am not happy with the job or no supportive circle here and no friends, I don't have reasons to stay here. I was thinking of applying to work in France before coming to England, but level not as good as English. At this point I am also thinking of migrating to other countries' (Theresa)

Finally, the introduction of the International English Language Testing System (IELTS) examinations for EU nurses in 2017 as a requirement for registering through the NMC, this also discouraged EU nurses from seeking employment in the UK. As Sofia, an Italian nurse working in Southwest England, mentioned:

'When they introduced the IELTS, there wasn't anyone to come over anymore. People not motivated anymore, not sure about passing. I think they set the bar too high, even British nurses said it is too high' (Sofia)

Such criticisms about the English language standard required for migrant nurses to register for recognition of their professional skills and to practice as nurses in the UK have been put forward not only for the EU but also the non-EU nurses (for example, Cuban, 2013).

ii. Experiencing discrimination in and outside the workplace

One of the most frequently disclosed challenges for the participants was the experience of being discriminated against, in the workplace and in the community. For the Filipino nurses who had been working for the NHS for over two years, they experienced bullying and



UoN Asia Research Institute Policy Brief Background Report

discrimination, overtly and covertly. For the EU nurses they experienced discrimination increasingly in their workplaces and in public spaces since the 2016 Referendum decision to leave the EU. Theodora's experience of working and living in Southwest England as a Greek nurse has been tainted because of 'Brexit' uncertainty and rising xenophobia. She states that, after three and a half years of living in this area, she has experienced more discrimination from the public and does not feel as settled;

'After three and a half years I don't feel quite settled. All those (EU) nurses have now left, they have gone back to their countries... They were all European nurses, some of them came for the experience and they had a job back home. Or they were not satisfied because they didn't like the life here or the hospital. Some of them had difficulties in the hospital, the matrons were not very supportive, or there were issues of discrimination. I had racist attitudes from patient's family members and when I was giving his wife medication, he was telling me to go back to the country I came from; I told him I can't go because I have to take care of patients in the NHS and he then calmed down – we had a few issues. Recently the executive from the hospital wrote an official report, that they appreciate EU nurses because they make such a difference and they will do what they can to protect their rights. And if anything happens, e.g. racism, this is unacceptable, and we have to report it straight away. We feel protected in theory but there is still an attitude, you can feel there is something wrong in the air, that there is something wrong. I felt it more after the Referendum. After the Referendum the situation has changed' (Theodora)

For EU nurses especially and for non-EU nurses, they do feel supported through implementation of protocols and by hospital senior staff but there are inconsistencies in practice between NHS Trusts and hospital wards. For Alfred, when there are British and international staff on the ward, he has felt more accepted and supported, in comparison to other wards in the same hospital where there are only British staff. Moreover, migrant staff have also experienced bullying by their colleagues on the same ward. In such incidents, senior staff and Human Resources departments have played an important role in supporting migrant nurses. As mentioned, NHS England initiatives such as the WRES are important in highlight issues of discrimination and bias against BME and migrant nurses (Naqvi and Coghill, 2019), for an otherwise long-standing problem of institutional discrimination within the NHS (Iganski and Mason, 2002; Solano and Rafferty, 2007).

iii. Delays in recognising nursing qualifications and experience

The participants of this study who had been working for the NHS for a number of years experienced, when they first arrived, difficulties and delays in receiving recognition of their nursing skills and qualifications.

The paths for nurses trained in the EU/EEA in registering through the NMC are as follows: assessment and recognition of qualifications; English language controls; and application for entry to the register (NMC, 2019a). If there are any shortfalls in the training received, EU/EEA nurses can take an adaptation programme or an aptitude test, consisting of two multiple choice question papers, a short answer question paper and a practical examination,



UoN Asia Research Institute Policy Brief Background Report

the Observed Structured Clinical Examination (OSCE) (NMC, n.d.a). For nurses trained outside the EU/EEA are: English language competence and nursing competence. The latter is assessed through the registration process, consisting of the following steps: self-eligibility/online self-assessment, part one of the competence test, a computer-based test (CBT), and part two of the competence test, the Observed Structured Clinical Examination (OSCE). On completion of the final part of the process, the applicants must also provide additional information for an ID check and upon successful completion of all these processes, receive their registration number (Pin) (NMC, 2019b). Previous practice requirement of 12 months practice post-nursing training for overseas nurses has now been removed (NMC, n.d.b).

For migrant nurses, the adaptation to a new work environment, such as the NHS, can hold emotional (Al-Hamdan *et al*, 2015) and practical challenges. For the nurses interviewed here, the process of accreditation and registration was expensive, lengthy and stressful. In some cases, staff were not given sufficient time to prepare for the OSCE examination, as was the case for two Filipino nurses. For others, the frustration was due to a lack of sufficient number of staff responsible for observing nursing competencies. For Sofia, an Italian nurse, her experience of being first employed at the NHS hospital in Southwest England was perceived as positive because of the support received from staff. However, the process of nursing skills observed and certified by hospital trainers was overly lengthy, due to a small number of staff trained to carry out such as task;

'You are not allowed to give medication, so they would come to work with you, then assess you, to give drugs or do other procedures. It wasn't easy, we had to step back because we had to wait. It took about six months, there were loads of us and the facilitators were very busy, six, seven facilitators for the whole hospital. I completely understand but if there were more of them, they would had more competent nurses straightaway' (Sofia)

Not only do nurses have to wait for their competencies to be recognized but some the participants felt as if their nursing qualifications and especially their former experience was not recognized. Other complications came from the lack of experience by hospital management and senior staff in helping overseas staff to adapt and prepare for their Objective Structured Clinical Examination (OSCE). As stated by one of the participants, Martin, he felt as if they were 'guinea pigs' due to the lack of time offered to the new hires to prepare for the examinations and also underprepared staff in the wards who were assisting with the adaptation process and training. Such delays because of reasons such as low numbers of trained staff lead to frustration by migrant staff and to overall mismanagement of nursing staff and resources.

iv. Limited opportunities for career development and social mobility

As mentioned by the participants, the most important motivating factors for choosing to work for the NHS in the UK were financial factors and also aspirations for further training, with the potential for social mobility. Such factors have been discussed in the surrounding literature on motivation for migrant nurses to seek employment in the UK and elsewhere (for example, Buchan, 2009). The responses from the participants were mixed. Some of the NHS nurses, such as in the examples of Alfred, Martin and Anna-Maria, actively sought accreditation



UoN Asia Research Institute Policy Brief Background Report

programmes and additional training which would lead to career development. For other participants, the opportunities for career development and social mobility were sought after following their hire but were overall limited due to a lack of information or even bias from senior staff and management. Such challenges are felt by the wider nursing population (for example, McGabe and Garavan, 2008), but more acutely by migrant nurses for reasons such as discrimination.

An illustrative example of difficulties posed to migrant nursing staff, in this case narrated by Theodora, she was not given enough time to prepare for the interview for a band 6 position;

'Few months ago, I applied for the position of nurse in charge, I knew I would have the interview and I asked the matron to tell me when the interview was because I was struggling with the night shifts. She was on annual leave and she sent me an email to tell me 20 hours before the interview. I tried to prepare between night shifts. I wasn't ready enough and I wasn't successful. I found it quite challenging and they didn't let me know in advance... I feel ready to try again' (Theodora)

Theresa, a Spanish nurse, also highlighted the issue of bias from hospital senior management towards migrant nurses, an attitude that migrant nurses are not worth investing in because of the possibility of migrating again. Moreover, the lack of ethnic and racial diversity in leadership roles is also perceived as a factor disenfranchising migrant nurses;

'Even if I have been here for 4 years, they don't trust you. If there is an important job, unless they are desperate, they will not give it to you. I know in terms of develop my career, it's not going to happen here. To develop your career, you need to focus in one field. In endoscopy we had a lot of issues and all the management was English, and every time someone who was not English wanted to apply for the job, the most often comment you got, you are not getting it. People who working there, they knew the pattern. It came from everyone – it was like a non-written rule, you are not going to get the job, you know who is going to get it. Our colleagues (English and foreigners), they knew the patterns – the top management was still the same' (Theresa)

However, such attitudes are costly and can lead to lack of retention. Theresa and Alexandra, a Greek nurse, when interviewed were both working as bank staff after having worked as band 5 nursing staff. Stress-related issues and other issues connected to the management and allocation of staff to particular wards led both of them to work as bank staff, having in this way more flexibility in choosing shifts. In Theresa's case, for example, when first hired she was placed in the acute stroke unit but two weeks later moved to the geriatric unit, which was less favourable, especially as such opportunities were already available to her in Spain. More worryingly, both nurses are now considering a career change and looking into moving to another geographical area or country, because of their negative experiences of working for the particular NHS Trust and feeling of disenfranchisement. Such lack of propensity of committing to long-term employment within the NHS is also evidenced in Table 1.

In the cases of Sofia and Anna-Maria, who are band 5 nurses in the Southwest of England, having opportunities for training and social mobility seemed to counteract other issues such as limited support system of co-ethnics in the community. In Anna-Maria's case, senior staff's



UoN Asia Research Institute Policy Brief Background Report

support in advancing her nursing skills was a strong motivating factor for continuing to work for the NHS Trust in Southwest England.

v. Inconsistencies between NHS Trusts

Finally, another area of concern for the participants of this study were the inconsistencies between NHS Trusts in benefits offered to EU and non-EU nursing staff. As Michael mentioned in his interview, an issue of contention was that at the end of his two-year contract, the Trust's human resources office would not renew his contract for three years, as in other Trusts. He viewed having a renewed contract for two years and going through this process every two years disadvantageous and was considering finding employment in another Trust. Similarly, for Christina, a Filipino nurse, she made comparisons between the benefits offered to staff in other Trusts and was subsequently disadvantaged in her current position;

'Exams supposed to be shouldered by the agency, IELTS, CBT – already two months and we haven't received reimbursement. The others, on the day they arrived, for us we have to wait for 2 months. We are paying for OSCE, others don't pay in other Trusts – they pay here. Almost £1000, and we can pay the agency within 4 months' (Christina)

Such differences can lead to staff 'shopping around' and finding positions in other Trusts, which was the case for Martin, who eventually found employment in another Trust in the South of England. Other suggestions to counteract disadvantages for staff in their current place of employment, put forward by the participants, was increased collaboration between NHS Trusts in supporting newly hired migrant staff.

Policy recommendations and concluding remarks

Based on findings of this research project, the policy recommendations focus on the following areas: providing opportunities for migrant nurses to develop their careers through training schemes and to take on more senior positions; protecting against discrimination from patients and colleagues and also from bias by senior management; increasing collaboration between NHS Trusts on providing benefits and offering training; recognising professional qualifications and competencies through more efficient mechanisms, also valuing previous experience and skills; and having good communication between NHS Trusts and employment agencies in offering accurate information on available positions and taking personal preferences into consideration.

The participants disclosed examples of good practices of supporting EU and non-EU nursing staff, for example, Anna-Maria and Sofia, Spanish and Italian nurses respectively, appreciated the hospital's human resources office assistance with gaining settlement status. Such good practices should be acknowledged and replicated where appropriate.

From the presentation of the main areas of concern for the EU and non-EU nurses interviewed for this study, we can surmise that ongoing concerns for recruitment and retention of non-UK nursing staff are complex and connected to financial and management of resources, also to issues of discrimination and bias. Such issues can be dealt with



UoN Asia Research Institute Policy Brief Background Report

appropriately within NHS Trusts and through collaboration between Trusts in sharing good practices. Other issues such as the uncertainties connected to 'Brexit' are not in the scope of responsibility of NHS Trusts, however support in the form of recognition of experience, skills, diversity, opportunities for training and other practical support in the form of benefits for EU and non-EU nurses, are all factors which can enhance retention and career satisfaction.

Limitations

The findings from this study derive from data collection which took place in two geographical areas (Midlands and Southwest England) in January and February 2019. The limitations of such a small-scale study are specific time/place restrictions and challenges connected to the methods of data collection and analysis. For further research into the positioning and experiences of EU and non-EU migrant nurses, data collection from other NHS Trusts around the UK could offer other insights, for example, in terms of policies in place for training of nursing staff and benefits, also protection from discrimination. The timing of the research study was reflective of the uncertainties surrounding the 'Brexit' negotiations and it would be of interest to replicate such a study at a later stage of the Brexit negotiations. Additionally, the use of qualitative methods of collection and analysis, such as in this study (for example, Boyatzis, 1998; Denzin and Lincoln, 2000), is advantageous when seeking to examine the participants' experiences and future aspirations in some detail. However, other methods of data collection such as surveys, would allow for a more expansive sample of participants (for example, Aiken *et al*, 2018).

Acknowledgments

We would like to sincerely thank the participants of this study for their time and disclosure of their experiences as NHS nurses and of their future plans and aspirations – without their help, this project would not be possible. We also need to thank our two research assistants, Leilei Zhang and Xinran Ji, doctoral and undergraduate students respectively, from the School of International Studies, University of Nottingham Ningbo China for their contributions to this report. Finally, we would like to express gratitude to the Asia Research Institute for all their support in presenting the current findings as part of their collection of policy briefs and background reports on the societal impact of 'Brexit'.

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UoN Asia Research Institute Policy Brief Background Report

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UoN Asia Research Institute Policy Brief Background Report

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Funding: Awarded through the Research Priority Area Development Fund, University of Nottingham in November 2018 (Global Research Theme: Cultures and Communications; Research Area: Rights and Justice - <https://www.nottingham.ac.uk/research/research-areas/index.aspx>)