Experiences of overseas nurses recruited to the NHS

Julia Nichols and Jackie Campbell discuss findings from an integrative review of the opinions of internationally recruited nurses who have worked in the UK

Summary

Overseas staff have been described as the ‘saviours of British nursing’ and it has been mooted that some healthcare organisations, particularly in the independent sector, would cease to function without them (Buchan 2003). This article discusses a review of the experiences of migrant nurses who came to the UK between 1995 and 2007, focusing on the implications of its findings for senior nurses and managers. It also makes recommendations for the future recruitment and retention of internationally recruited nurses.

Keywords

International recruitment, migrant nurses, deskilling, professional status

There is a long history of recruiting migrant nurses to the UK in times of staffing need. The Colonial Nursing Service, established in 1940 to unify the administration of British nurse appointments across the empire, effectively created an imperial market in nursing labour, and set a precedent for a greater flow of nurses to and from the UK (Solano and Rafferty 2006).

Hospitals also relied heavily on Irish workers up to the 1950s, when recruitment campaigns were redirected towards Commonwealth countries, where a common nursing curriculum along with relaxed immigration policies ensured a steady flow of trainees until the 1970s (Baxter 1988).

The numbers of overseas nurses then steadily declined until the early 1990s, when recruiters started to look overseas once more to meet the then rapidly growing demands of the UK workforce.

Between 1995 and 2007, and particularly after the NHS Plan (Department of Health (DH) 2000) set a target of 20,000 nurses to be added to the register by 2005, about 100,000 internationally recruited nurses (IRNs) from more than 50 countries became eligible to practise in the UK.

In 2001/02, for the first time, more IRNs were admitted to the register than UK nursing graduates (Buchan et al 2005). The volume of nurses recruited at this time was unprecedented and not without controversy; there were concerns, for example, that the UK was ‘poaching’ nurses from countries where they were desperately needed (Nelson 2004).

To address such concerns, the government published ethical recruitment guidelines (DH 1999) that banned NHS employers from targeting the Caribbean and South Africa.

In recent years, overseas recruitment has slowed, but reliance on valuable overseas recruits will continue as migrant nurses meet staffing requirements in the UK by working as healthcare assistants (HCAs).

In the DH (1999) code of practice of international recruitment, recruitment from a long list of developing countries is banned except where there are government-to-government agreements such as those that exist between the UK and China, India and the Philippines. Other developing countries are ‘no-go areas’ for NHS recruiters.

Integrative review

In 2009, the author undertook an integrative review of the experiences of overseas nurses who had arrived in the UK as a result of recruitment campaigns in the 1990s.

In integrative reviews, past research on specific subjects is summarised and conclusions are drawn. A good integrative review meets the same standards of clarity, rigor and replication as primary research (Beyea and Nicoll 1998).

The aim of this review was to improve the recruitment and retention of migrant nurses by gaining insights into their working lives,
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the challenges they face and how they cope with them, and their views on UK nursing.

The review process began with an extensive literature search, using a set of keywords to identify appropriate studies from electronic databases such as the Applied Social Sciences Index and Abstracts, the British Medical Journal, the British Nursing Index, the Cumulative Index to Nursing and Allied Health Literature, Cochrane Collaboration, Internurse, Medline and the Web of Science.

The inclusion criteria specified that studies had to be of the lived experiences of nurses whose primary registration was obtained overseas, and had to have been published in the UK after 1994. Three hundred and sixty five articles were retrieved, of which 30 primary qualitative and quantitative studies met the inclusion criteria. After a process of content and thematic analysis, several themes emerged, seven of which are discussed below.

Motivations for migration Many IRNs leave families, spouses or young children to work in the UK, which indicates a powerful motivation for migration. Kingma (2006) says that this motive is primarily economic, whereby the perceived cost to IRNs of moving to another country is less than the perceived cost of staying.

Most other migrants from developing countries identify this motive along with strong commitment to support their families, but also highlight the importance of professional factors such as career development opportunities unavailable in their home countries (Daniel et al 2001, Allen and Larsen 2003, Withers and Snowball 2003, Buchan et al 2005). These nurses usually intend to stay in the UK long term or move to other countries where English is the first language, such as Canada or the United States.

Many identify the excitement of the prospect of working in what they anticipate as ‘advanced’ healthcare settings (Hardhill and MacDonald 2000, Aboderin 2007), and expect to enjoy a good standard of living in the UK and the ability to send money home. Some of these nurses are surprised at the cost of living, however, and note that accommodation, transport and food are expensive, and that taxes are unexpectedly high (Allen and Larsen 2003, Buchan et al 2005, Smith et al 2006).

Other studies highlight ‘adventurer’ or ‘backpacker’ nurses, typically from Australia, Canada, New Zealand and South Africa, who cite opportunities for travel and adventure as their primary motives for migration. These nurses usually come to the UK for working holidays and rarely intend to stay for long (Buchan et al 2005, Kingma 2006).

Cultural differences In contrast to previous recruitment campaigns, the one in the 1990s encouraged nurses from more than 50 countries to travel to the UK.

These IRNs will have experienced different models of training and had been professionally socialised in various cultural, political, social, religious and economic circumstances. Perhaps as a result, perceived differences in how they understood the role, purpose and nature of nursing emerged from several studies.

Many IRNs had experienced ‘professional excitement’ at coming to work in ‘first-world’ health care and had expected that nursing in the UK would involve advanced equipment, modern and clean hospitals, high standards of care, good staff-to-patient ratios and good working conditions.

The shock experienced by many of these nurses when they encounter the reality of care environments in the UK, as well as unfamiliar nursing roles and different approaches to patient care, is recorded by Withers and Snowball (2003), among others.

The cultural behaviours of some IRNs may put them at a professional disadvantage. For example, Parry and Lipp (2006) observe that Filipino nurses who are content to display cultural behaviours such as deference of women to men, general deference to authority and avoidance of conflict may find being assertive in practice or challenging poor care difficult. This was identified as an area that has to be addressed through appropriate training and cross-cultural understanding.

Some researchers record problematic working relationships between IRNs and HCAs. Aboderin (2007), for example, describes a cultural expectation

Some internationally recruited nurses think that UK nurses demonstrate great autonomy in their roles.
Nurse identity Some studies point out that IRNs are usually technically proficient and view their technical abilities as central to their identity as nurses. Because few nurses in the UK exercise technical skills, therefore, they often find their role frustratingly restrictive (Gerrish and Griffith 2004, Smith et al 2006).

Many IRNs think that standards of nursing in the UK are low (Allen and Larsen 2003) and perceive the plethora of specialist nursing roles here as a fragmentation of the role (Daniel et al 2001). There are also differences in the expectations and understanding of personal levels of responsibility, accountability and decision making among IRNs (Taylor 2005), which have implications for registered nurse roles.

Some IRNs think that UK nurses demonstrate great autonomy in their roles, and find the generally informal relationships between them and other healthcare professionals attractive (Withers and Snowball 2003, Smith 2004, Taylor 2005). Others, however, find these relationships disconcerting and indicative of a lack of respect (Gerrish and Griffith 2004).

In the authors' experience, many IRNs, particularly those from China and the Philippines, think that nurses should follow 'doctors' orders' even if they conflict with what is in the best interests of patients and that, if actions are sanctioned by doctors, nurses are not accountable for their outcome.

Reimbursement The review revealed that many IRNs think that they are neither fairly reimbursed for the work they do nor graded appropriately for their level of responsibility. RCN labour surveys by Ball and Pike (2005, 2007) support this claim by showing that more IRNs work at band 5 or the equivalent, and are promoted more slowly, than their UK-born counterparts. This perceived inequity can lead to feelings of unfairness, dissatisfaction, anger and resentment.

Deskilling Many IRNs express frustration and resentment that their qualifications, knowledge, skills and experiences go unrecognised or unvalued by UK employers (Allen and Larsen 2003, Withers and Snowball 2003, Gerrish and Griffith 2004, Matiti and Taylor 2005, O'Brien 2007), and some of those who were recruited to take up roles more junior than those of nurses with fewer qualifications became aggrieved (Smith et al 2006).

Some IRNs describe disguising their expertise and experience from colleagues so that they do not appear arrogant, a process described by one nurse as 'learning to be humble' (Smith et al 2006).
Overseas nurses often arrive in the UK expecting to use technical skills such as venepuncture and cannulation that they had learned during their basic training programmes and that had been part of their routine daily practice.

Many see these skills as basic nursing duties and central to their nursing role and identity (O’Brien 2007, Smith et al 2006, Gerrish and Griffith 2004). Some thought that they were being prevented from using these skills and that the system to which they were recruited did not support their development, and so they were becoming deskilled.

O’Brien (2007) explored this issue with IRNs from three NHS trusts and concludes that, although IRNs are usually highly trained and proficient in technical skills, the system to which they are recruited expects them to occupy a ‘particular and subordinate position’ that is ‘incompatible with the expression of advanced clinical skills’.

O’Brien claims that lack of access to relevant training prevents overseas nurses from practising their full range of skills and notes that, because they are routinely recruited to NHS hospitals and care homes on lower nursing grades, this creates a situation where deskilling occurs.

Many IRNs are highly skilled and experienced. According to a Market and Opinion Research International (MORI) (2002) poll of 1,119 IRNs, 85 per cent of the sample had more than five years’ experience while 20 per cent had more than 20 years’. A more recent study identifies an average experience of 14 years among 140 IRNs, half of whom had held senior positions (Winklemann-Gleed and Seeley 2005).

Racial discrimination Hunt (2007) suggests that racial and cultural workforce diversity management in the UK health sector has been consistently poor, and that little has been learned from more than half a century’s experience of recruiting healthcare professionals of different racial and cultural backgrounds.

The MORI (2002) poll reported that 14 per cent of respondents cited racism or racial discrimination as the worst aspects of living and working in the UK, while other studies identify racism or discrimination as a recurring theme or suggest that it is an underlying problem for IRNs.

For example, two RCN-commissioned reports (Ball and Pike 2005, 2007) reveal discrimination against nurses and IRNs from black and minority ethnic (BME) backgrounds through inequalities in pay, grading, working conditions and opportunities. Data also show that IRNs are more likely to work longer hours and be rotated internally, have additional jobs and think that their grades are inappropriately low for their roles and responsibilities.


Smith et al (2006) identify two types of discrimination described by interviewees:

- Overt discrimination appears as blatant racism, xenophobia or strategies to exclude or harm IRNs. This can be evident in minor but consistently occurring events such as unfair job allocation or being left to work alone while others work in pairs.

- Indirect discrimination was evident in the failure to recognise the qualities and needs of IRNs, or in the expectation that IRNs conform to predominant social values and practices.

In Allen and Larsen’s (2003) study of the experiences of IRNs, many of the 67 respondents report racism and discrimination. Some thought that the things that made them different from other nurses, such as their skin colour, language, culture or behaviours, affected their relationships with UK nurses before their attributes could be judged.

In some cases, these perceived differences made them question whether other staff viewed them as human beings, and led them to feel vulnerable to racial harassment. In this context, racism was described by respondents as a general resentment of foreigners and IRNs, manifested as social exclusion and impairment of career progression.

Racial tension is not confined to relationships between IRNs and UK-born staff. Social divisions between different BME groups were found by Smith et al (2006), for example, and Winklemann-Gleed and Seeley (2005) noted racist attitudes in the interview stories of 22 migrant nurses, whereby IRNs form ‘in’ and ‘out’ groups according to their prejudices, leading to different levels of social exclusion.

Winklemann-Gleed and Seeley (2005) note, however, that the interpretation of staff interactions is complex and subjective, and other studies acknowledge that discrimination in the workplace cannot always be attributed to racism. It may be due to other differences between staff or may reflect a general malaise in the relationships between nurses.

Like all nurses, IRNs who experience racism and discrimination in their workplaces can become alienated and demoralised. As Winklemann-Gleed (2006) explains, individuals need to identify with others at their workplaces, and become socially excluded and isolated if they are prevented.
from doing so. This can be especially true of IRNs, who tend to spend most of their time at work and so become detached from their familiar social support networks.

As a result, their interactions with colleagues can assume greater significance, and affect their self-esteem and sense of wellbeing more deeply, than those between other nurses.

Implications for practice

Matching expectations The integrative review shows that the emotions commonly experienced by IRNs on arrival in the UK include surprise and sometimes disappointment, because their expectations of ‘first-world’ health care, and of the work and role of UK nurses, are not met.

Such inflated and unfulfilled expectations among IRNs are likely to lead to dissatisfaction, reduced motivation and poor performance.

Some IRNs may think that they have been deceived or misled, which can lead to high staff turnover and emigration to healthcare systems that they think will reflect their expectations more accurately.

Overselling the experience of working and living in the UK may win candidates, but empty promises ultimately result in frustration, resentment and poor commitment.

It is important, therefore, that those involved in the recruitment of IRNs, give them an accurate picture of nursing in the UK and clearly explain the nature of the roles to which they are being recruited, particularly if they are to care for older people. Recruiters and recruitment agents should also avoid appointing experienced staff to junior positions.

Many IRNs have dependent families and expect to be able to send money home, so the cost of living and working in the UK should be discussed with them. These discussions should include likely additional demands on salaries such as undertaking the Overseas Nursing Programme, which incurs fees that can vary enormously.

Addressing cultural differences Careful consideration should be given to the support offered to IRNs as they adapt to the different approaches to care in the UK, and to the role and responsibilities of UK nurses. Recruiters who take time to gain insights into the prevailing cultures of nursing in IRNs’ own countries can better anticipate and address some of the differences during recruitment processes.

Recruiters can also appoint ‘buddies’ or mentors from among experienced members of staff, who can support new IRNs through their orientation periods and beyond. This support could be provided by IRNs already in post.

There are several examples in the literature of successful orientation programmes for new overseas staff, including support groups that meet to review and discuss language, cultural and nursing issues (Witchell and Ouch 2002).

Where more tailored input is appropriate, clinical supervision sessions can be used to review specific issues, such as accountability, personal responsibility and teamwork.

In another example of this, Parry and Lipp (2006) worked with Filipino recruits to increase their assertiveness.

Although all IRNs are required to demonstrate proficiency in English through the International English Language Testing System, additional language support specific to particular areas of clinical practice may be beneficial, and local language schools or higher or further education organisations can be approached for advice.

Professional status To benefit from IRNs’ range of attributes, their knowledge and experience must be acknowledged and valued. Before they are appointed, or during their first few weeks in post, they should undertake formal procedures as part of their personal development plans (PDPs) to establish their experience and clinical skills so that they can be helped to reach the appropriate levels of responsibility.

Staff already working in organisations should be made aware of the level of experience and skill that IRNs bring to their posts. Timely professional development, and particularly the validation of existing skills, should be a priority, and mechanisms should be in place for IRNs to attend appropriate training programmes and update their technical skills as soon as possible. These programmes can be identified during PDPs.

O’Brien (2007) claims that there is an arrogant assumption in the UK nursing profession that ‘our way is the only way’ and that overseas nurses must adapt to it.

This assumption should be challenged through a culture of openness to new ideas, and an exchange of knowledge and approaches to practice.

It must be remembered that IRNs have not been socialised into the UK way of doing things and can often offer valuable insights into, and potentially challenge, established practice.

Managing racism Managers are aware of their responsibility under the amended Race Relations Act 2000 to ensure racial equality in their workplace.
They must also recognise their accountability in this area, and tackle racism wherever it appears.

Nurses do not always need to be directed to challenge racism in the workplace. For example, Taylor (2005) found that IRNs who had experienced hostility from patients were supported by UK staff.

Similar support must be offered by managers, and robust systems should be put in place to ensure that all staff and service users know that prejudice and racism, including those between different BME groups, have no place in UK healthcare services.

The suitability of local policies to address discrimination and racism should be reviewed to ensure that they provide sufficient guidance for managers, while a swift and appropriate response to incidents, and a culture of zero tolerance, can demonstrate strong managerial support.

Insidious racism, which can be demonstrated by a lack of career development opportunities being offered to IRNs and nurses from BME backgrounds, must be addressed through transparent systems for monitoring career progression.

In addition, human resource departments can undertake long-term monitoring of career progression to ensure that IRNs are represented proportionately at senior level, while similar monitoring can be undertaken to ensure that these nurses have appropriate access to the training they need to to apply successfully for senior posts.

Finally, all staff should attend diversity awareness training and be required to demonstrate their awareness of the relevant issues and commitment to good practice.

Conclusion

While measures have been put in place to address recruitment and retention issues for UK nurses, staffing certain areas of the NHS continue to raise concerns.

The nursing workforce, like the population as a whole, is ageing (Nursing and Midwifery Council 2008), which means that, as demand for health care rises, healthcare providers will continue to recruit nurses from overseas. International recruitment offers many advantages and senior nurses who are willing to invest in the wellbeing, and embrace the rich diversity, of overseas recruits can benefit greatly from their experience, insight and motivation.

Investing time and resources in the orientation and ongoing support of these nurses can offer managers the opportunity to benefit from the many qualities that migrant nurses bring to UK healthcare services.

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References


