Internationally Educated Nurses Experience of the First Two Years Working and Living in England: a mixed methods study

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University of Huddersfield

Contents

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Executive Summary

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Executive Summary

Introduction

The recruitment of international nurses in England is increasing to fill nursing vacancies and meet the rising demands of healthcare. Progressing recruitment to the oversight of the retention of England's nursing workforce is a transactional and brittle ineffective plan for both individual international nurses and healthcare systems alike. Migrating to live and work thousands of kilometres away from home, often imposing separation from partners and families, for an undetermined period of time is a significant decision for an international nurse to take (Bond, 2022). Despite the large numbers of international nurses migrating to live and work in England in recent years, there are no studies published that explore their lived experiences during the initial few years' post migration (Dahl et al., 2022; Palmer et al. 2021). This study therefore builds on the global knowledge of international nurses' motivations for migration and explores their experiences in the first two years post-migration in England with the intention of laying a foundation of new knowledge in this currently under-investigated phenomenon (Pressley et al., 2022; Buchan et al., 2022).

Methods

The mixed methods questionnaire following both the systematic review of the current evidence (Pressley et al., 2022) and the gaps and areas of further interest generated from previous work undertaken by the project team titled "International nurses and the initial integration into the NHS England's healthcare workforce: a population analysis. The questions sought to explore the international nurses' demographic information, professional backgrounds and previous nursing experiences alongside their current NHS role allocation and contractual arrangements. We further explored experiences of professional orientation and integration, communication and belonging within the workplace. We then sought to understand experiences of integration into communities including housing situations, community networks and their financial situation followed by their plans and aspirations for the future and concluding with the impact of migration on their health and wellbeing.

Findings

The research results are presented in the following 4 sections: i) demographics, ii Professional integration iii) Life outside work iv) mental wellbeing.

i) 773 international nurses completed the survey from across all regions in England. The respondents were originally from 33 different countries but principally from India, Nigeria, Philippines, and a smaller subset of African countries. Most international nurses are females and aged between 25 and 39 and almost all the international nurses separated from their partners and children hope to live united in the future.

ii) International nurses are highly skilled professionals with extensive transferable knowledge and experience, yet many international nurses are placed on the first pay band for a registered nurse (Band 5) and assigned to work in areas overlooking prior skills and experiences. International nurses had often migrated to England from countries where nurses were paid at least equivalent wages to nurses in England, and for many the choice to move on and to work in England was based on their family priorities. There is a mixed picture of experiences of supporting career development and variability in existing processes to realise career aspirations. Many international nurses feel confident working in England without a language barrier; however, recurrent communication challenge is reported with accents, dialects, colloquialisms and slang. Findings suggest this is a transient and temporary state of professional integration.

iii) It is often the case that international nurses have within a short period lived in two or more properties, suggesting initial housing situations are often transient and temporary. Independently finding suitable and affordable housing was often complex and challenging and resulted in situational and/or financial compromise. Many expressed dissatisfactions at the proportion of salary spent on living in England. For some, high cost of housing and living in England may compromise long term retention plans. Despite the importance of international nurses having contacts, friends, and communities for receiving support, wellbeing, and information, it is not commonplace for international nurses to know their neighbours and other local people in their area (18.1%). Adjusting in a different culture without family is one of the most difficult factors of migration. At a point in time of less than 2 years post-migration to work in England, 71.3% returned a favourable response (agree or strongly agree) when asked whether they were happy with their decision to migrate.

iv) International nurses who reported being happy with their decision to migrate to England have significantly higher mental wellbeing scores than those who were not happy with their decision. Mental wellbeing scores recorded variation between different country/region of origins. However, there were no other significant differentiating differences or common themes in the remaining S-WEMWBS scores. Being overworked due to staffing constraints and high workloads and pressures, affected stress levels, self-esteem and confidence. Professional behaviours, attitudes and support from colleagues influenced perceptions of inclusion and belonging, and nurses preferred working in friendly environments where they can share concerns and ask for help when needed. Support from professional and personal networks helps in difficult times with mental wellbeing.

Conclusion

Most international nurses described feeling happy with their decision to migrate and are having a positive experience both at work and at home. However, we need to acknowledge the wider narrative and learn from all experiences both positive and negative to support the retention of more of our international colleagues. Throughout the research, there is a mixed picture of experiences and a variability in employer offers suggesting an urgency to resolve equity across the sector. When considering international nurses' experiences, it was clear that personal integration and life outside of work is just as important, if not more so, than professional integration, and yet this is where the body of global evidence is under researched. What is clear from this study is that international nurses are not a homogenous population and have vastly different family and social circumstances, and employment and personal needs, and yet describe receiving an almost universal initial employment offer from the English healthcare system. That said, when considering internationally educated nurses experience of the first two years working and living in England nothing in the findings was seemingly definitively propositioned as a terminal challenge for more than a few individuals. The reality is that healthcare systems must have sight of these issues and situations that significantly challenge the experience of international nurses to put plans in place to resolve them if they are to secure the longer-term retention of this important population of the nursing workforce.

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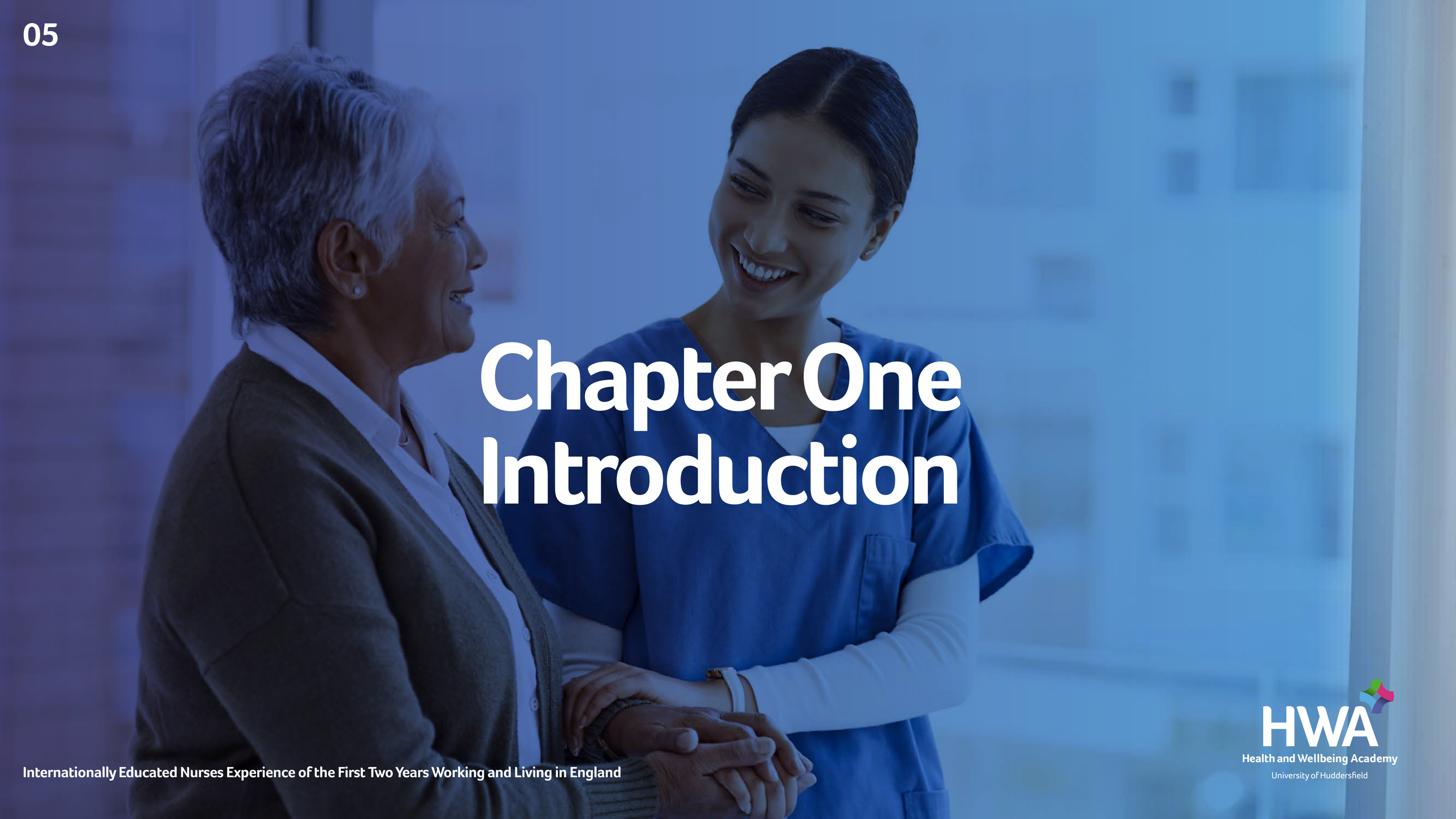

Chapter One Introduction

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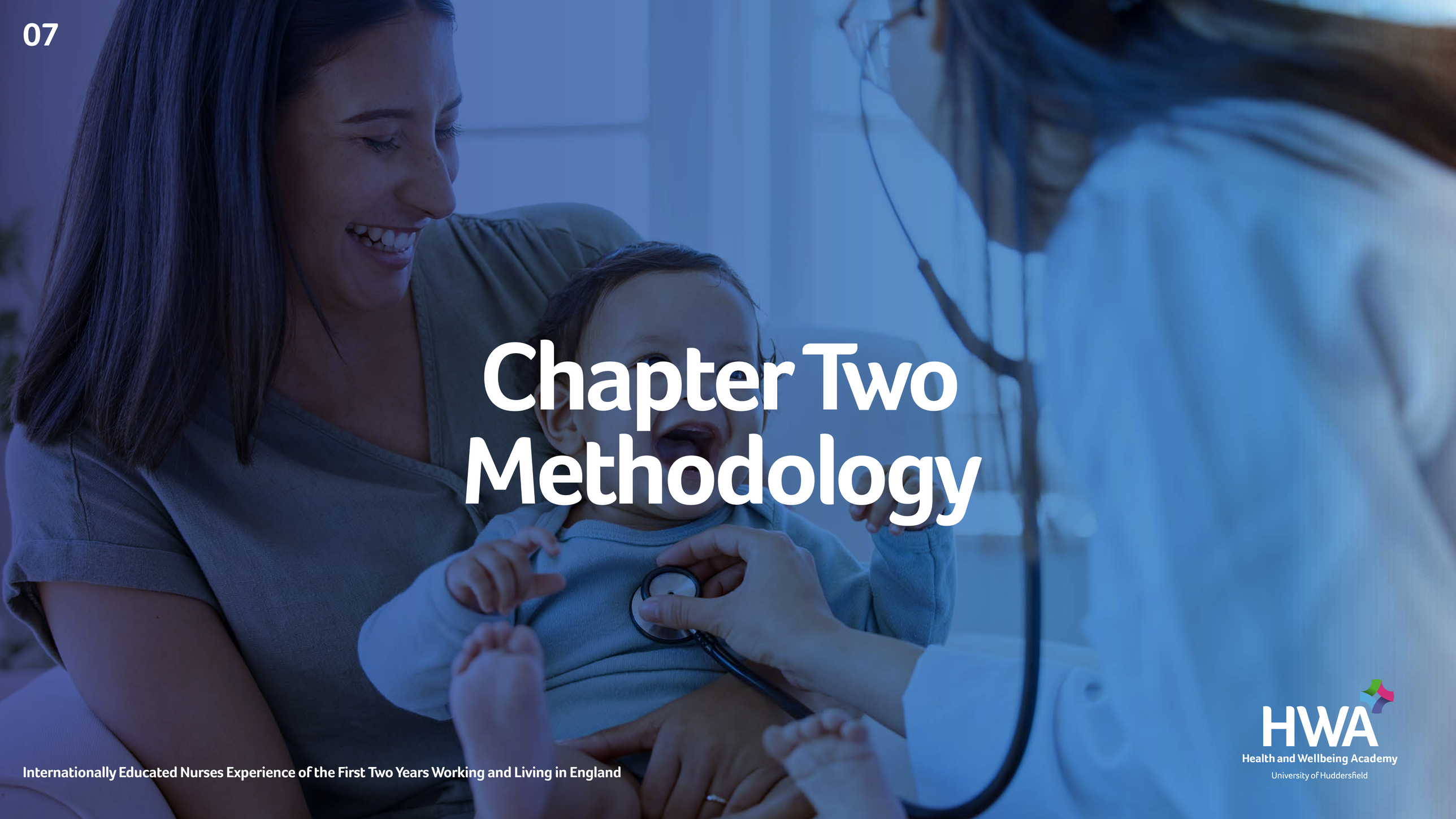
Chapter One: Introduction

Almost half of the nurses who joined the United Kingdom (UK) professional nursing register in 2022 were from outside the UK, an on-year increase of 30% from 2021, which is causing concern that the UK is becoming overdependent on the overseas recruitment for the nursing workforce (Buchan et al., 2022; Nursing and Midwifery Council [NMC], 2022). England's healthcare system decrees having an adequately resourced and sustainable workforce to govern the capacity and capability to provide safe and effective patient care (Buchan et al., 2022). That said, whilst having enough nurses in the workforce is the mandate, the problem is more complex than a high-level comprehension of having either enough nurses or not enough. Moreover, where and when determining there is not enough, simply increasing recruitment to the oversight of issues affecting the retention of England's nursing workforce is a transactional and ineffective plan for both individual international nurses and healthcare systems alike.

Migrating to live and work thousands of kilometres away from home, often imposing separation from partners and families, for an undetermined period of time is a significant decision for an international nurse to take. Likewise, the permanence of building a life and career and working in the longer term as a professional in a host country is a greater decision still; a choice found to be made easier when comprehending achieving fulfilling and sustainable lives (Buchan et al., 2022; Davda et al., 2018). Despite the large numbers of international nurses migrating to live and work in England in recent years, there are no studies published that explore their lived experiences during the initial few years' post migration (Buchan et al., 2022; Palmer et al. 2021).

Much is known about initial motivations for international nurses' migration, such as opportunities for career development and improved quality of lives (Pressley et al., 2022; Alexis & Shillingford, 2015). Young et al., (2014) suggests that individual decisions to stay or leave is a result of a complex process influenced by considerations endogenous to the health systems, and yet the actualisation of the determinants of retention presently remains somewhat unexplored in empirical knowledge in England.

This study therefore builds on the global knowledge of international nurses' motivations for migration and explores their experiences in the first two years post-migration in England with the intention of laying a foundation of new knowledge in this currently under-investigated phenomenon (Pressley et al., 2022; Buchan et al., 2022). This study will compliment improving lives and career satisfaction to augment retention of international nurse employment and stabilise nursing workforce for healthcare systems.



Chapter Two
Methodology

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Chapter Two: Methodolgy

2.0 Introduction

To enable the interweaving and combination of statistical quantitative and rich qualitative narratives, a mixed methods survey was the data collection tool of choice.

This mixed approach allowed research breadth, through collecting quantitative data from large numbers of international nurses, whilst also retrieving in-depth responses and personal experiences through the narratives (Creswell & Plano Clark, 2018). Integrating the benefits of both approaches provides the opportunity to utilise the strengths of each methodology to explore research objectives in full and to gain a complete and meaningful picture of the experiences of international nurses within their first two years of working in England (Dawadi et al., 2021).

2.1 Design

The mixed methods questionnaire content was developed following both the systematic review of the current evidence (Pressley et al., 2022) and the gaps and areas of further interest generated from previous work undertaken by the project team titled "International nurses and the initial integration into the NHS England's healthcare workforce: a population analysis".

The draft questionnaire was reviewed for content, accuracy, and quality control by an expert advisory group that included representatives from NHS England, Health Education England, diaspora groups and established international nurses. The questions sought to explore the international nurses' demographic information, professional backgrounds and previous nursing experiences alongside their current NHS role allocation and contractual arrangements. We further explored experiences of professional orientation and integration, communication and belonging within the workplace. We then sought to understand experiences of integration into communities including housing situations, community networks and their financial situation followed by their plans and aspirations for the future and concluding with the impact of migration on their health and wellbeing.

2.2 Ethics

Ethical approval was received from the University of Huddersfield's School Research Ethics and Integrity Committee prior to dissemination and analysis. The research was confirmed by Health Research Authority (HRA) decision tool as not requiring HRA/IRAS (Integrated Research Application System) approval, as it was not medical research or a clinical trial and did not involve service users. Informed consent was required prior to completion of the questionnaire which reassured respondents that confidentiality and anonymity would be maintained, and that individuals would not be identifiable in any reports or other documents resulting from the research.

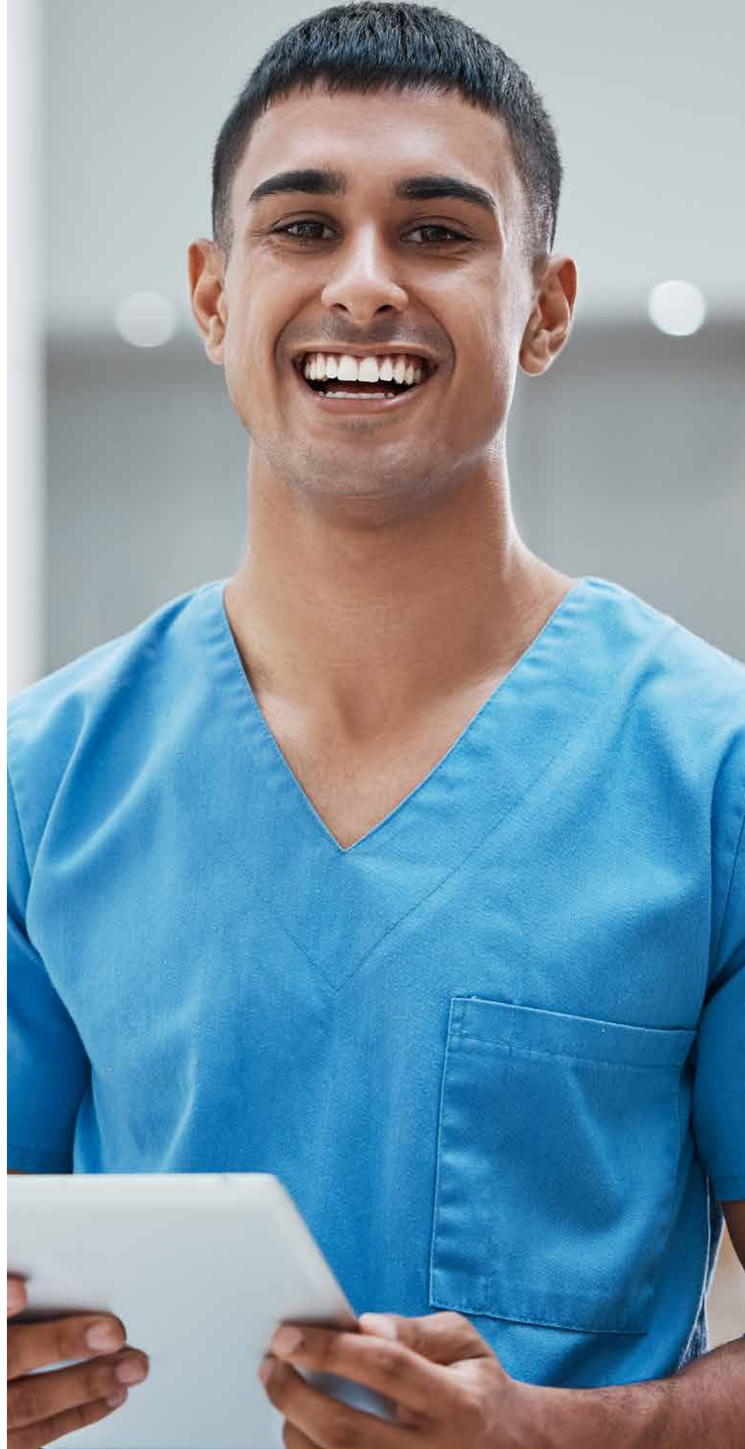
2.3 Data Collection

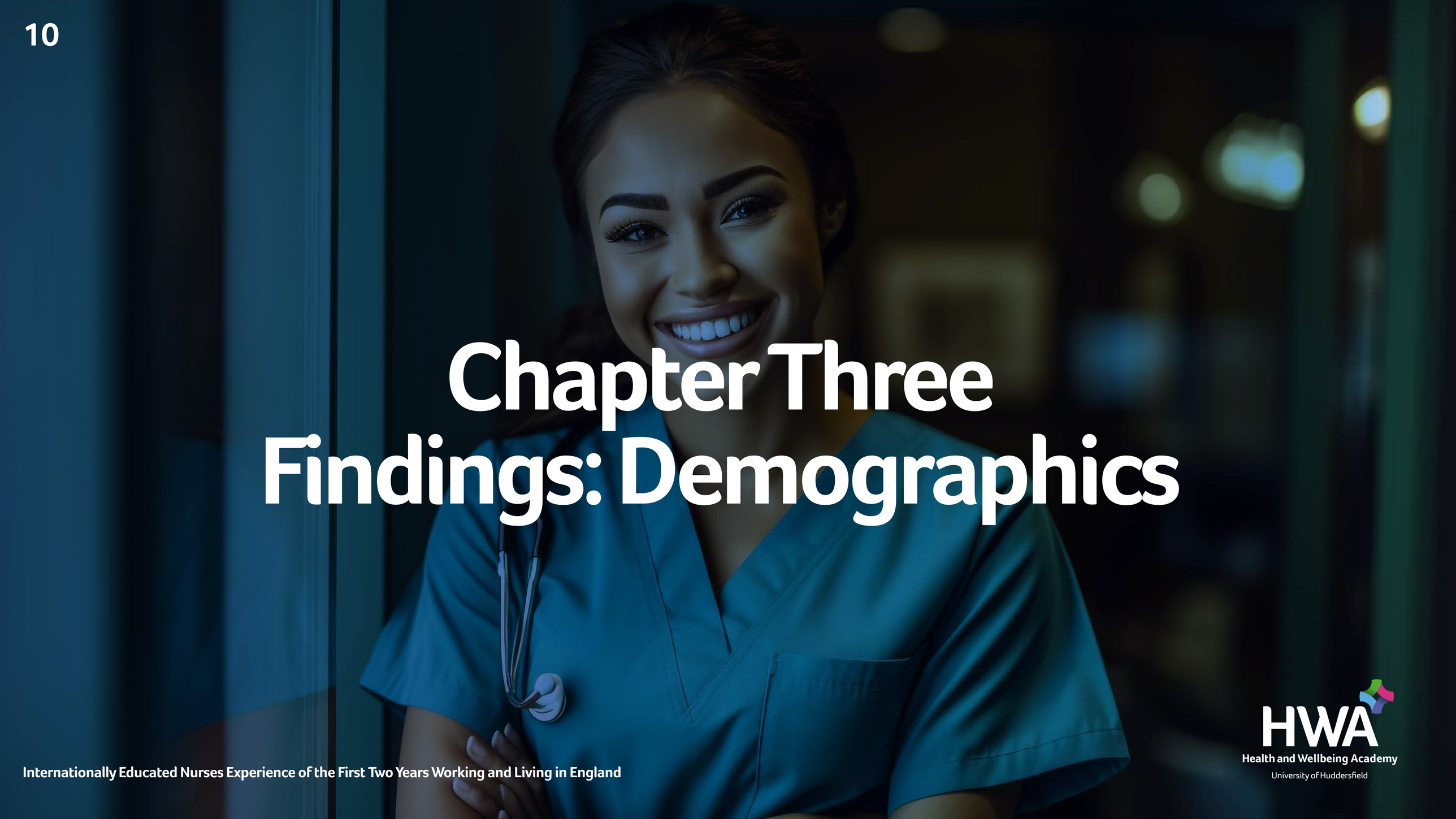
The electronic questionnaire (managed and disseminated by Qualtrics software) was distributed from August 2022 to October 2022 through gatekeepers (system leads and associated networks) across all the seven NHS regions in England (Northeast & Yorkshire, Northwest, Midlands, East of England, London, Southeast and Southwest). We were seeking an average of 100 respondents per NHS England region to ensure that key information was captured from a broad cohort of respondents and to prevent the survey becoming imbalanced, and perhaps misrepresentative.

2.4 Data Analysis

Descriptive analysis, including crosstabulation comprised the initial analysis of the quantitative data. Associations between factors of specific interest collected in the survey were analysed using inferential procedures to assess generalisability of associations to the wider population of international nurses. For the purposes of this analyses, Likert-style survey items were dichotomised into positive responses (strongly agree or agree) versus a neutral response (neither agree or disagree) and negative responses (disagree or strongly disagree). Some associations between categorical predictors and outcomes were assessed for significance using the chi-squared test for association. The direction of any effect was noted, and the magnitude of any effect was reported using the phi-statistic.

Qualitative data extraction processes were formed following Braun & Clarke (2006) six phase inductive thematic review process to identify, analyse and report patterns and themes in the research findings. An initial and open coding process was thus established using NVivo qualitative data analysis software, to classify the categories of information emerging from the research findings. As coding developed, it became clear that overlap was present, and codes were collapsed, and initial themes identified and compared against the quantitative findings.





Chapter Three Findings: Demographics

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Chapter Three: Findings: Demographics

3.0 Introduction

This chapter presents the demographic background of respondents and reports on findings of gender, country of birth, marital status and family composition, and place of residence in England. Data was obtained from 773 participating international nurses. Data and subsequent percentages are based on valid responses and therefore total numbers may vary slightly throughout the report.

Key Learning Points

Most international nurses are females and aged between 25 and 39.

Almost all the international nurses separated from partners and children want to live united in England.

Respondents are principally from India, Nigeria, Philippines, and a smaller subset of African countries

3.1 Demographics of the respondents

Gender: Of the 773 respondents in the survey, 80.9% (n=625) identified as females and 17.4% (n=135) as males; 1.7% (n=13) chose not to say.

Age: Respondents were diverse in ages with the youngest respondent at 22 years and the oldest respondent at 62 years. The median age was 33 years, with most between ages 25 years and 39 years (figure 1).

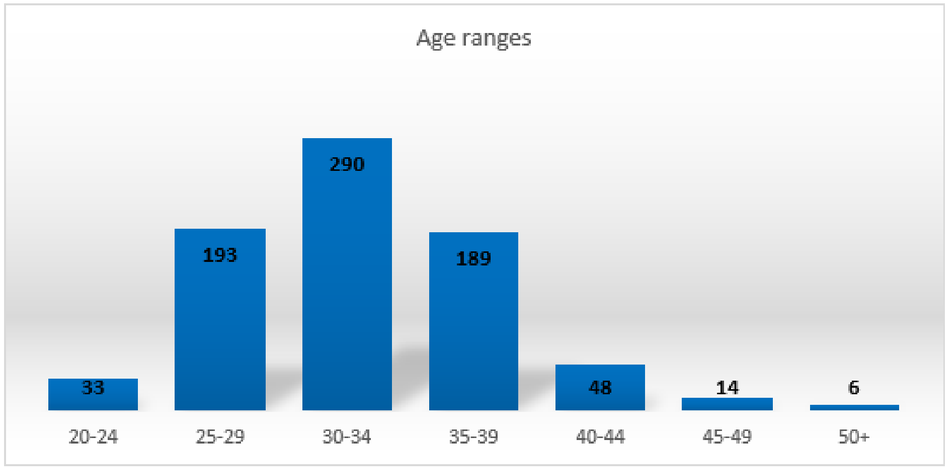


Figure 1: Age ranges of respondents

Country of birth: Respondents contributing to the survey were from 33 countries in total (figure 2). The largest number were Indian nationals at 321 (42.2%) followed by Filipino nationals at 182 (23.5%) and Nigerian nationals at 134 (17.3%). Also, 101 respondents were from a smaller subset of African countries (13.1%) and the remaining 34 were from the rest of the world (3.9%), including 1 respondent from a European Economic Area country.

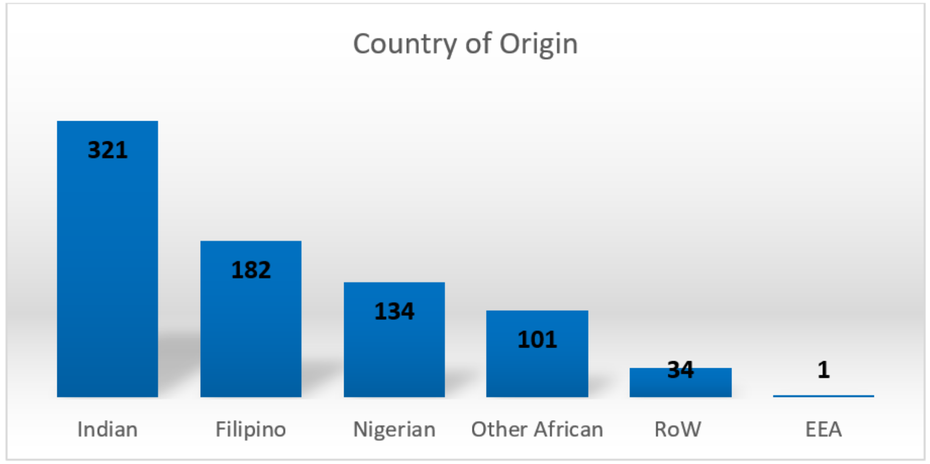


Figure 2: Respondents' country of origin

Domestic situation: Marital status and family compositions: Figure 3 represents the marital status of the survey's 773 respondents. Of this, 441 were married (61.6%) and 258 were single and never married (33.3%); remaining categories are shown below.

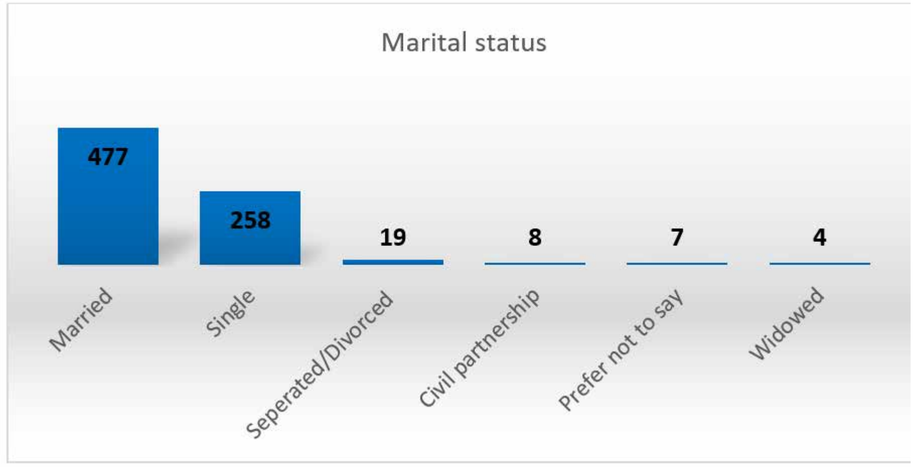


Figure 3: Respondents' legal marital or registered civil partnership status

The 485 respondents who were married or in civil partnerships (71.6% combined) were subsequently asked whether their partners lived with them in England (figure 4). Of these respondents, 322 (70.8%) said their partners did live with them in England, and 132 (29.1%) said their partners did not live with them in England (or did so only some of the time). Almost all living without partners (n=128 which is 97.1%), hoped for their partner to join them full time in the future.

Respondents were also asked whether their children, if they had any, lived with them in England (figure 5). Of this subsample, 381 respondents (49.2%) had children under the age of 18, and of this subsample, 223 respondents (58.5%) reported that all their children lived with them in England, 13 (3.4%) reported that some but not all their children lived with them in England, and 145 (38.1%) reported that their children did not live in England. For the 155 respondents without or with some of their children in England, again almost all (n=153 which is 99.3% of the subsample) said they hoped they would join them in the future. In addition, 312 (40.4%) hoped other extended family members such as parents, would also be able to join living with them in England.

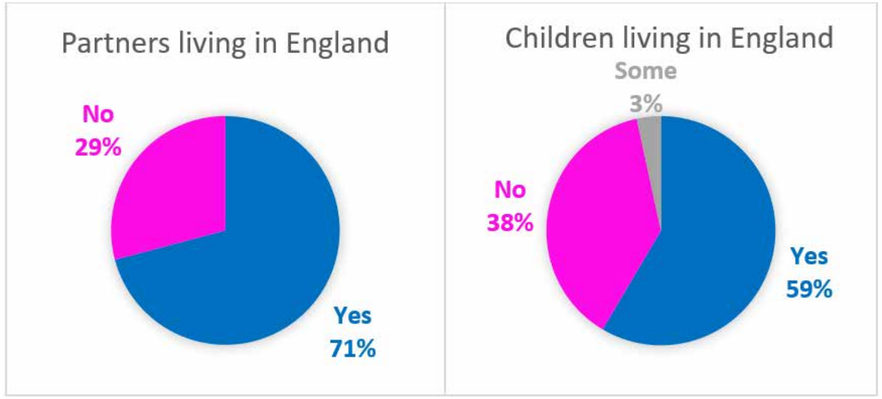


Figure 4: Partners living with respondents in England (Total 485 respondents)

Figure 3: Children living with respondents in England (Total 381 respondents)

Region in England: The survey returned detailed information of respondents working across the geographical regions in England as demonstrated in figure 6.

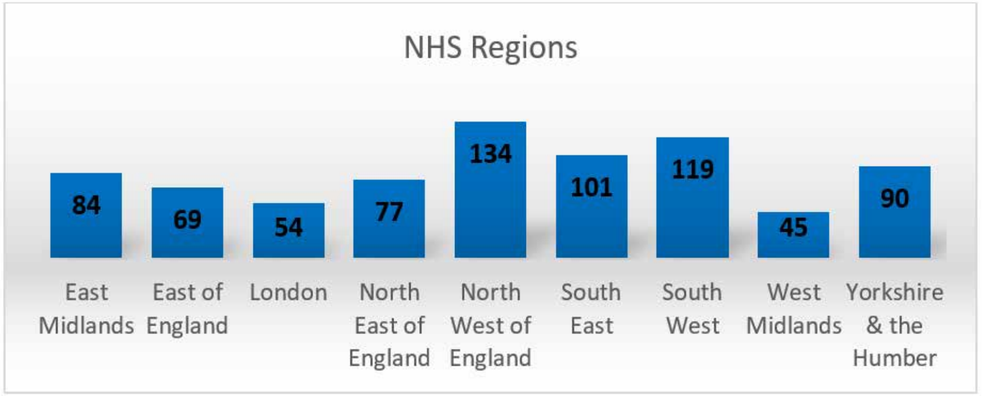
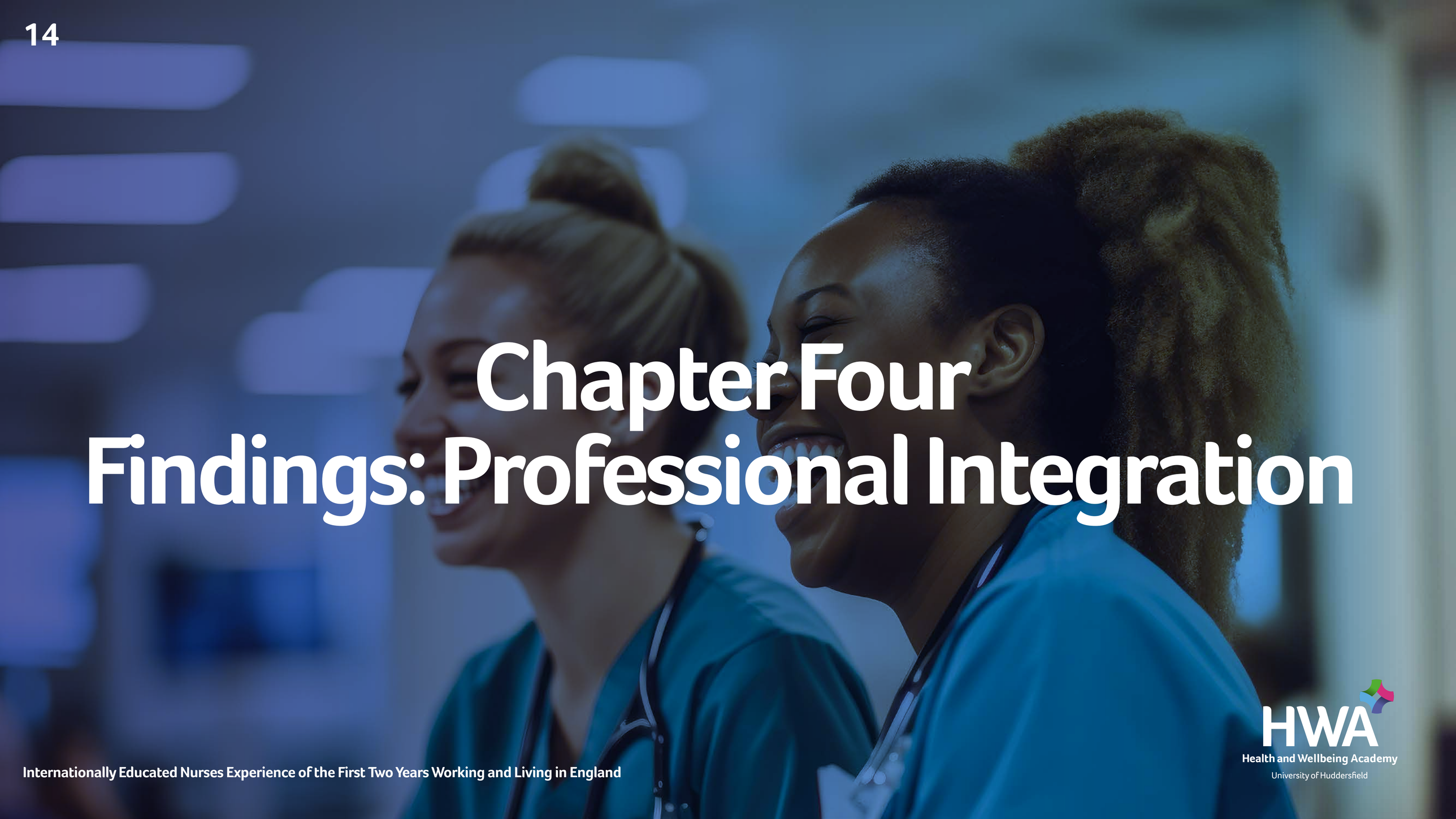


Figure 6: English NHS region where respondents worked



Chapter Four
Findings: Professional Integration

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Chapter Four: Findings: Professional Integration

4.0 Introduction

This chapter explores international nurses' experiences of working in England. The chapter presents how long this cohort of international nurses have worked in England, and how recently they registered as a nurse with the NMC UK. We then present the length of nursing careers of the respondents before coming to work in England and current employment profiles together with the narrative on whether prior skills and experiences are currently being utilised and optimised.

The perceived effectiveness of initial induction programmes and support when first starting out in practice is considered. Finally, understanding and perceptions of wider human resource processes and contractual terms and conditions working in England are put forward. The chapter ends by exploring career development and future aspirations, recommendations from international nurses about how to achieve successful professional integration working in England.

Key Learning Points

International nurses are highly skilled professionals with extensive transferable knowledge and experience. Unjustifiably, many international nurses are placed on the first pay band for a registered nurse (Band 5) and assigned to work in areas overlooking prior skills and experiences.

International nurses had often migrated to England from countries where nurses were paid at least equivalent wages to nurses in England, and for many the choice to move on and to work in England was based on their family priorities.

Professional support is key to successful integration, ensuring effective integration processes are in place eases uncertainty and anxiety.

Many international nurses feel confident working in England without a language barrier; however, recurrent communication challenge is reported with accents, dialects, colloquialisms and slang. Findings suggest this is a transient and temporary state of professional integration.

Human resource processes govern professional working arrangements and are unique to a particular country. Issues such as pay, terms and conditions and contracts are important considerations for professional integration. International nurses reported that they could be better informed of benefits and restrictions of working in England.

There is a mixed picture of experiences of supporting career development and variability in existing processes to realise career aspirations.

For some nurses, there is an urgency to resolve matters which challenge professional integration.

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4.1 Working as a nurse in England

When exploring how long the international nurses had worked in the NHS in England, 99 respondents (12.9%) had been working for the NHS between less than 1 month and 2 months, 153 (19.8%) had between 3 and 5 months, 300 (38.9%) had been working for between 6 and 12 months, and 219 (28.4%) had been working for between 1 and 2 years.

International nurses can, and frequently do join the NHS whilst they complete the examination to registration with the NMC UK. Figure 7 shows the percentages of nurses, broken down by the yearly quarter, in which they had registered with the NMC UK. Conjecturing, while most of the respondents had 12 months or less experience of working as a nurse some may have worked longer in the NHS.

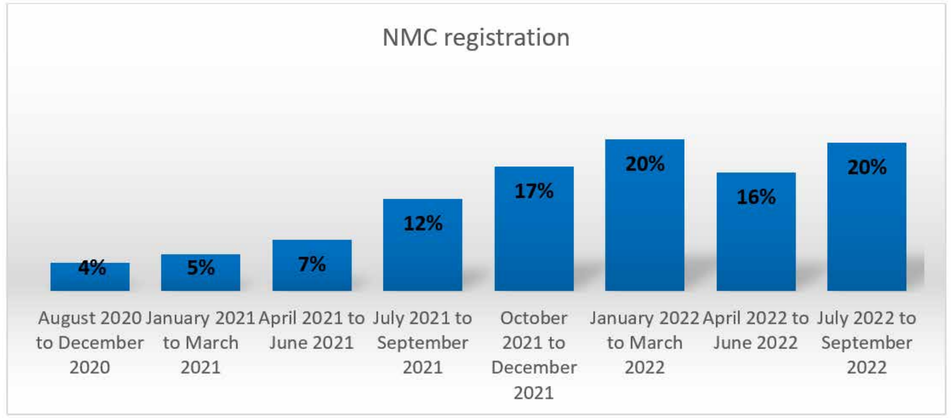


Figure 7: Date of NMC registration

Total years of nursing experience: although many of the respondents had recently registered with the NMC to work as a nurse in the (UK, most respondents had several years of qualified nursing experience working in other countries (figure 8). Thirty respondents (3.9%) had been qualified as a nurse for less than one year, 191 (24.7%) had been qualified for between 2 and 5 years, 282 (36.5%) had been qualified for between 6 and 10 years, and 270 (34.9%) had been qualified for more than 11 years. In total, 552 nurses (71.4%) had been qualified as nurses for more than six years prior to arriving in England.

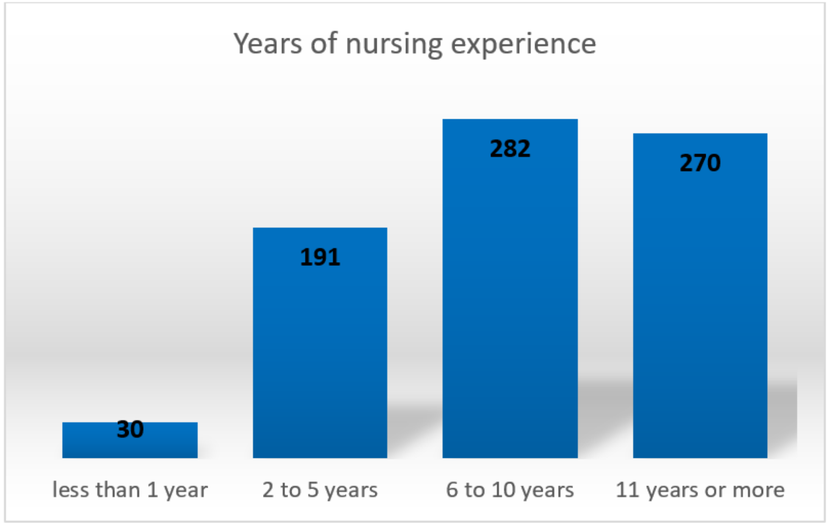


Figure 8: Respondents' years of nursing experiences prior to working in England

Employment profiles: Prior experience working as a nurse was frequently not recognised as reflected in employment profile findings. Figure 9 demonstrates the pay band of the respondents at the time of completing the survey. Of the respondents, 71 international nurses (9.2%) were working as band 3, and 85 (11%) as band 4; suggesting that these international nurses are pre-NMC registration. The majority 603 (77.9%) were band 5 positions, which is ordinarily the first pay band for a registered nurse. Also, 13 (1.7%) international nurses were working at band 6 and 1 (0.1%) was working at band 7.

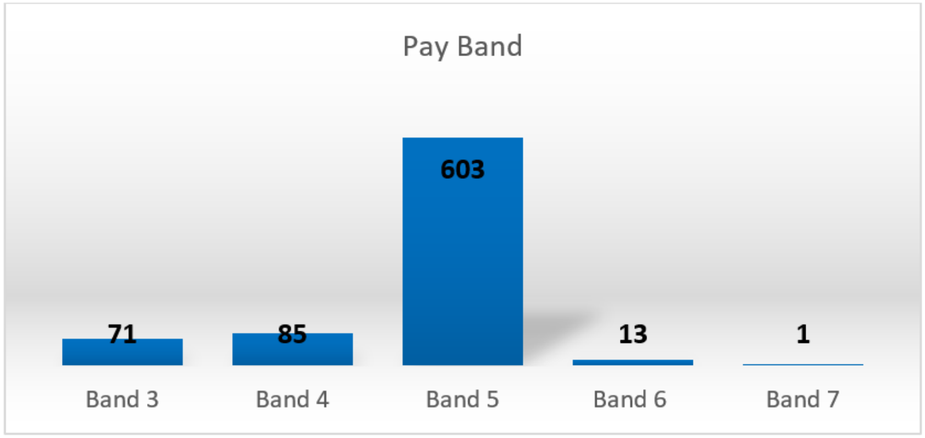


Figure 9: Respondents pay band at the time of completing the survey

A concern was that international nurses felt that their years of working were not considered particularly in the band allocation and determination of wages. In turn, around one-fifth (20%) of the participants claimed that their previous experiences were not acknowledged. For many nurses, having many years of nursing experience and being placed on the first pay band for a registered nurse (Band 5) felt unjust:

'My previous experience is not considered, and my salary band pay is starting of band 5...'

'I had the base salary annually, so it means that my previous work experience was not recognised which is disappointing and we had to start work as a band 3 staff…'

'I have realised that they did not consider my previous experience and those who have 25 years of experience and 5 years of experience falls under the same pay category which is completely wrong…'

For others, their level of experience was only acknowledged for work but there was no increment in wage. This was expressed in comments such as:

'I have 13 years of experience, but I started here as a newly graduated nurse but when in work they consider my experience but not in salary. The salary of starting band 5 is not enough to bring my family and kids in UK…'

'I am a nurse with overall 11 years of clinical experience…it is better if NHS would consider our previous experience for salary package.'

Employment profiles, human resource processes, and terms and conditions of employment will be discussed in greater details later in this chapter.

Exploring international nurses' previous employment: within other international settings, 252 (32.6%) indicated that England was a second or third country they had worked after completing training in their country of origin. Interestingly, 218 (86.9% of this subsample) had worked in one or more countries in the Gulf Cooperation Council (GCC).

In the qualitative comments, reasons for choosing to work in the GCC included the perceived opportunity to advance their careers and work with the latest healthcare technology. In addition, many commented that GCC countries provided financial stability because of low taxation and generous recruitment packages that had included free accommodation and reimbursed transport costs. However, the choice to onward migrate was, for many, based on their family priorities:

'I chose the United Kingdom because here I can settle with my family. But in Saudi Arabia, I can't. Social life is hard to maintain in Saudi Arabia as all laws are based on that particular religion …'

Recognition of specialist nursing experience: Many international nurses had previous specialist nursing experience prior to migrating to work in England. Respondents were asked which area of nursing speciality they had worked in before relocating to England, and the corresponding area that they currently worked in England. The level of agreement between nursing speciality pre- and post-relocation was assessed (figure 10). Due to a large number of low-frequency roles being identified, analysis was conducted on the 7 most reported roles (general nursing, medical-surgical, critical care, mental health, operating theatre, and emergency department). The results indicated a moderate agreement between nursing speciality pre- and post-relocation to England. There were 461 nurses (59.7%) who agreed that their previous experiences had been acknowledged by their Trusts when allocated to their specialist areas of work. Also, 158 nurses (20.5%) disagreed and 152 (19.6%) were unsure.

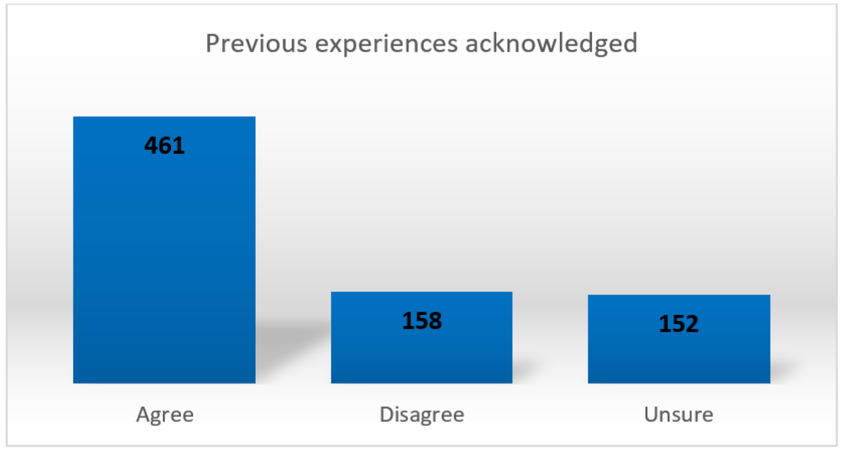


Figure 10: Respondents' acknowledgement of previous experiences

Allocating into chosen specialities to utilise previous knowledge and skills has many benefits for both employee and employer. The qualitative answers gave more insight into the importance of allocating the international nurse to areas of their chosen specialism:

'I am very blessed that I'm still in the same allocation as it helped me big time in adjusting…'

'As a general nurse I have the ability to work across units and this made it easier for my employer to put me in one of the community hospitals where my potential is being used to maximum.'

'I used to work in the rehabilitative mental health service back in my country. Working here at the rehabilitation ward made my adaptation and transition into the system faster.'

Nurses not 'matched' with their skill sets and their previous experiences rationalised the decision-making processes in that the needs of the service influenced decisions as follows:

'Initially, the employer enquired about the area of experience but allocated in a different area due to shortage of staff…'

'They just wanted to fill in the vacancies rather than looking and placing nurses according to their specialities. They struggled a lot with understaffing, and we were never getting the chance to choose an area to work in. It was already preselected for us…'

That said, the opportunity to be allocated to specialities with which the nurses were not familiar appeared to be attractive to some nurses, as it provided opportunities for professional development:

'I opted to open new horizons for my nursing career. I am now moving to ED [Emergency Department] …'

'I had requested a role entirely different from my previous experience to allow me to learn new skills as well as develop my career in the long run …'

It seemed satisfaction was realised when international nurses had choice and control over allocated areas of work. Conversely, dissatisfaction was apparent when international nurses felt that their previous experiences were not recognised and acknowledged by their UK colleagues. This led to a sense of disappointment and feeling devalued and in turn demotivated:

'At times, it is demotivating that a system may accept your qualifications as a nurse but disregards the experience thereof...'

'I attended the interview as an ED nurse. But got the posting in ward …I am disappointed…'

Indeed, allocating nurses to their choice of nursing speciality from initial appointment gave the opportunity for international nurses to feel more confident with their skills, benefitting them, the service and patients.

4.2 Optimising working experiences in England

No matter whether the international nurses were allocated to an area of previous experience or a completely new specialism, a key to the successful integration into any new setting is the support available; and indeed, support was a recurring theme for successful professional integration. International nurses require post migration sponsorship from leaders and mentors and access to guidance with the nuance of communicating when working in a different country. And frequently, assistance is required with NMC exam preparation to work as a nurse in England. It is also necessary for international nurses to receive support to understand human resource processes bespoke to working in England and the NHS. Lastly, notwithstanding, international nurses warrant assistance with professional development and realising future career aspirations.

Preparing to work as a nurse in England: There was natural anxiety and worry among international nurses about how nursing practices and routines in England differ from the countries where they had previously worked. In turn, induction programmes are a way of supporting nurses as they begin that transition to working in England. Most respondents (715 nurses; 92.5%), said that they did have an induction programme. Of these respondents, 406 (52.5%) felt their induction programme had prepared them for their role. However, overall responses were mixed, with 257 respondents (33.2%) stating their induction had provided only partial preparation and 53 respondents (6.8%) stating the induction provided no preparation for their clinical role.

Despite the high numbers participating in induction programmes, qualitative comments confirm quantitative findings that this offer was not always independently comprehensive enough to meet needs:

> *'Knowing fully well that we are not familiar with many of the equipment and procedures, as they are different from what we do back home. Yet, many colleagues expect us to do it right from the first attempt and look down on us if we do not know...'*

Additional to induction programmes, most organisations mandate the complimentary requirement that nurses receive supernumerary time to develop skills and confidence working in new clinical areas. Of the respondents, 612 nurses (79.2%) reported having been supernumerary for more than three weeks, and indeed the highest proportion at 349 (45.2%) stated being supernumerary for more than 6 weeks (figure 11).

Robust induction processes and supernumerary periods can positively support professional integration, as emphasised in these qualitative accounts:

> *'They have supported me to do my role independently with lots of additional support like supernumerary periods to build up my confidence…'*

> *'…my employer supported me and guided me by conducting classes and teaching things in the clinical areas...'*

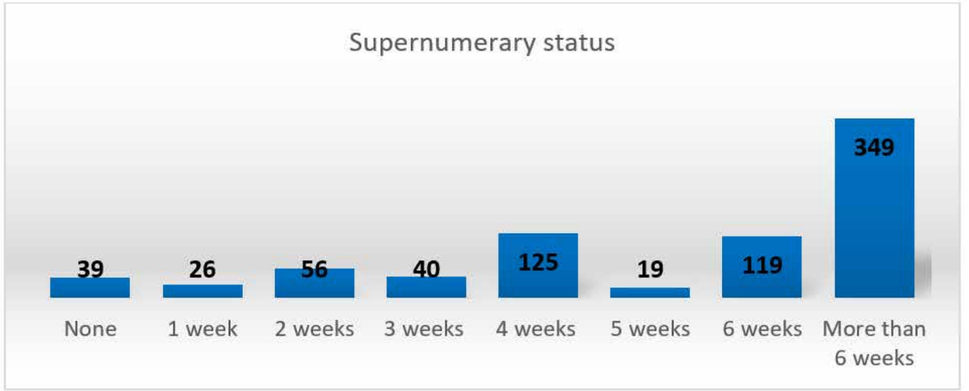


Figure 11: Length of supernumerary status

Further to the highlighted benefits of induction programmes and supernumerary time, when international nurses needed to undertake the Objective Structured Clinical Examination (OSCE) to establish registration with the NMC UK, nurses described benefiting from practical employer support with preparation for the examination:

'In terms of the OSCE examination, my employer assigned a tutor who takes us through the training. [they] also provided equipment to guide us during the practical. A laptop was given to me with a working internet for adequate preparation. This helped me ace my OSCE exam at a sitting.'

Support processes determine successful professional integration working within the NHS; however, unfortunately, there were copious qualitative comments about less-than-optimal support provided:

'At first it was as if I will never adapt to the new culture, but I find myself integrating better with each passing day, but this integration has been difficult because I had little or no support…'

And regrettably, there were indecorous accounts of microaggression from colleagues:

'the staff are generally not nice… and it affects my mental health no matter how I try to shrug it off...'

Disconsolately, there seemed to be a pragmatic acceptance of vulnerability being a part of professional integration:

'I think it's the adjusting with the work. Thinking like I don't know anything and I'm just useless and afraid to make mistakes…'

Unbeknownst to the absolute cause, there were apparent barriers preventing international nurses feeling supported, and examples of experiencing challenges and narratives of finding individual workarounds:

'The moment you verbalise you don't know something; you appear a fool…'

'…but I've had to manage and survive on my own and by learning from experiences of my fellow international nurses in my ward…'

Proactively, some respondents offered solutions to their challenges. They shared reflections such as:

'It would be highly beneficial if you put new staff under a senior staff to learn about the routine in our department. Me, I am not from an English-speaking country and no staff in my ward is from [country of origin] hence, even with 12 years of clinical experience I'm struggling a lot in the ward. There should be clinical instructors in every ward…'

Sponsorship from leaders and mentors: Synopsis of findings regarding maximising opportunities to prepare international nurses to work in England suggests that whilst induction programmes, supernumerary time and training to undertake OSCE examinations may aid professional integration, it appears roles such as line managers, clinical educators and/or mentors were often the individuals who were recognised as most effective in holistically bridging professional support offers to fulfil meeting professional integration needs.

Indeed, it was found that sponsorship from leaders and mentors is an essential component of professional integration:

'To be honest, I am privileged to work with very nice people. I am being mentored well and I am happy to work…'

'The presence of clinical nurse educators and supportive managers have played a great role in my development as a UK nurse…'

'They allocated a mentor for me, so that I can approach at any time for queries and clarification… I have no words to explain about her as such a really supportive teacher.'

Narratives detailed how supportive relationships at work often extended beyond solely meeting professional needs:

'Words of encouragement…' or a '…very supportive Manager who actually takes her time to sit and listen to me when l am faced with work or even personal issues…[including] … support when I could not understand things, emotional support when I felt homesick and good guidance about how I can improve…'

Done well, synergising processes to support professional integration eases uncertainty and anxiety:

'The NHS where I am working always make sure that we are happy and healthy".

4.3 Language and communication

Supporting international nurses with communication barriers when needed is a further way to assist professional integration. International nurses acknowledged the importance and recognised the significance of being able to effectively communicate within the professional working environment:

> *'We are dealing with lives so near misses or error should be avoided.'*

That said, communication was not raised as a concern for all international nurses:

> *'My first language is English language and I speak and write better than the Brits in my ward' and 'I trained with English in my country, so I speak English fluently.'*

Even when communication was described as *'of a good level'* there was *'surprise how people could take your word out of context'* and reflections of how international nurse *'learnt to be careful with choice of words.'*

Some international nurses, posited English as their second or third language, and described difficulties with communication:

> *'Even though we have taught English Language since childhood, it is really difficult sometimes to understand because this is not our native language.'*

Respondents were asked whether they were able to communicate with colleagues without a language barrier (figure 12). Overall, 573 respondents (74.2%) returned a positive response, 94 respondents (12.1%) were neutral and 106 (13.7%) returned negative responses. Next, when asked whether they felt able to communicate with patients without a language barrier (figure 13), 550 (71.1%) returned a positive response, 124 (16.0%) were neutral and 94 (1.2%) returned a negative response.

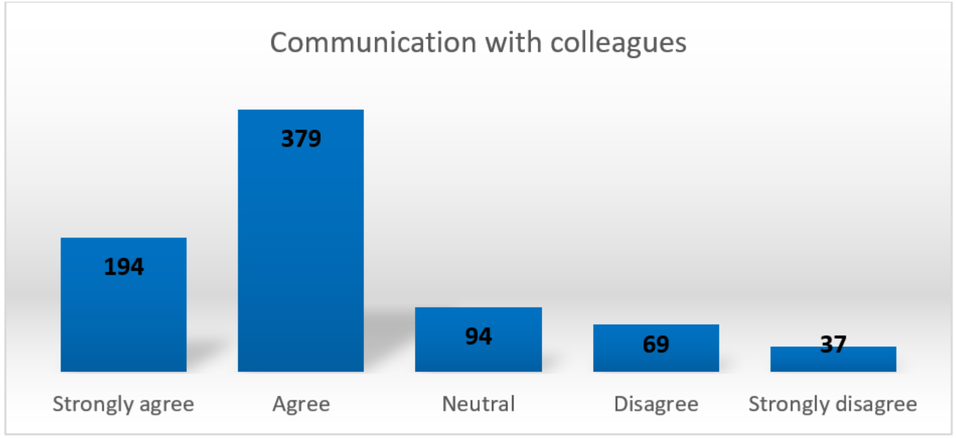


Figure 12: Respondents perceptions of their ability to fully communicate with colleagues without a language barrier

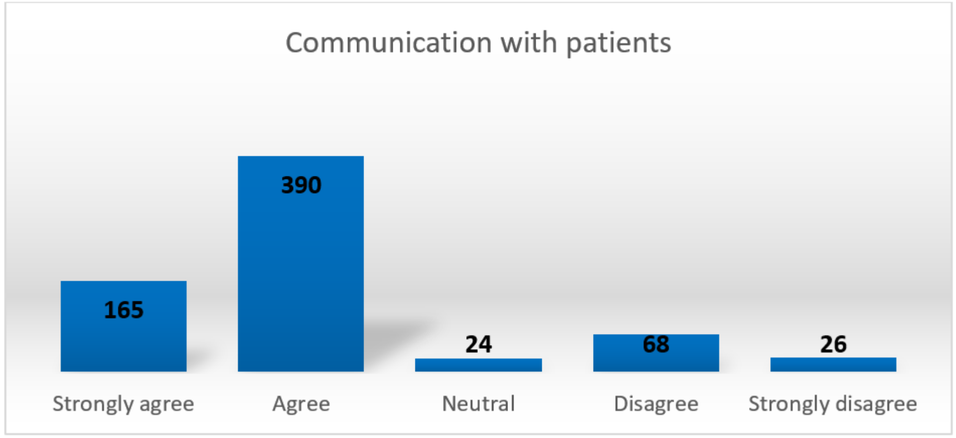


Figure 13: Respondents perceptions of their ability to fully communicate with patients without a language barrier

While often international nurses expressed being able to communicate without a language barrier, the most recurrent communication challenges reported with both patients and colleagues is accents, dialects, colloquialisms, and slang. Here are some respondents' accounts:

'I am used to hearing the queen's English, Irish and Scottish from films but I am not familiar with the [country of origin] accent: that's why I had trouble during the first month …'

'Being relatively new in England, I am still currently adjusting on how people speak, especially those with accents…'

'…And also sometimes I think there are phrases that are new to my ears, I'm not sure if what they meant is figuratively speaking…'

Exploring the everyday situations that cause additional language barriers to the international nurses within the professional context such as speed of speech, face masks and conversations over the telephone; there were accounts of the following:

'There are times I am having difficulty with understanding what people were saying especially if they speak fast…'

'At times there are challenges, and we can't understand each other because of different pronunciations and tone…'

'In addition, I cannot lip read because we are wearing mask at work…'

Many respondents reported communication issues with certain groups of patients. For example:

'I am currently working in an elderly care unit, hence, the reason for the barrier [I] experience some difficulty with patients especially those with hearing difficulties...'

Whilst others reflected on the multicultural environments which made it more challenging to understand other international colleagues and patients:

'I work in a multi-ethnic area and understanding is hard.'

International nurses that experienced challenges asked people to consider the language barrier and speak audibly, slowly and clearly especially with international colleagues during handovers in order for communication to be clearly received.

'…speak clearly and legibly without rush…'

And then, given time and learning through exposure:

'Getting into a new environment requires learning the accent. But the more I speak and interact with people, the better it becomes … I am just adapting but I guess I will get a grip of it pretty soon …'

'English accent is hard to comprehend at times, but I take it day by day.'

A further recurrent request was for tolerance:

'It's a bit difficult to understand the accent of some of them. Initially I had to ask everyone to repeat what they've just said. Now I have and I can feel the difference in that. But I could feel that at least some of them judging and getting irritated …'

Alongside accommodation, to allow new international nurses to speak up and let their colleagues know that they did not understand or hear them clearly.

'I see many colleagues ridiculed and disrespected because of their accents or language differences and I remind colleagues who only speak one language not to be so rude.'

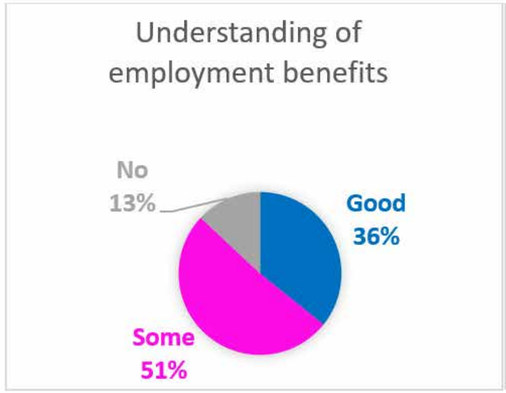
Exploring solutions to those international nurses who have language and communication challenges the following respondent presented their position well:

'I hope that my colleagues will speak to my pace while I adapt with the language. Also, I hope that the preceptor or trainer is from the same country as us so we, newcomers, really understand how we should work in the area, introduce us the differences, make us feel welcome and comfortable in asking questions because everything is new to us. I feel like we need something/someone familiar to us to slowly integrate with the system and not feel overwhelmed and culture-shock. English people are so nice and respectful but for us, it is difficult to say, "Slow down" I don't understand what you are telling or teaching but I will pretend that I understand so I don't look stupid to you. We will say yes to almost everything even though we did not get it. That's a common story for all my [country of origin] friends here…'

4.4 Human resource processes

Human resource processes govern professional working arrangements, including things such as pay, terms and conditions, and contracts. Arrangements are different in each country, and it is an important consideration for professional integration that international nurses understand and feel human resource processes are well found. Further to pay bands discussed earlier in this chapter, there are other components to the total reward package for international nurses working in the NHS in England.

Terms and conditions (T&C) of employment: There are extensive employee benefits working in the NHS. However, in terms of the nurses' understanding of organisational employment benefits, just 276 (35.8%) felt they had a good understanding of sick and annual leave human resources (HR) procedures and NHS pension schemes (figure 14). There were 396 respondents (51.2%) who reported only having some understanding, and 101 (13.0%) reported having no understanding at all. This suggests international nurses could be better informed to maximise opportunities to access benefiting from terms and conditions of employment.



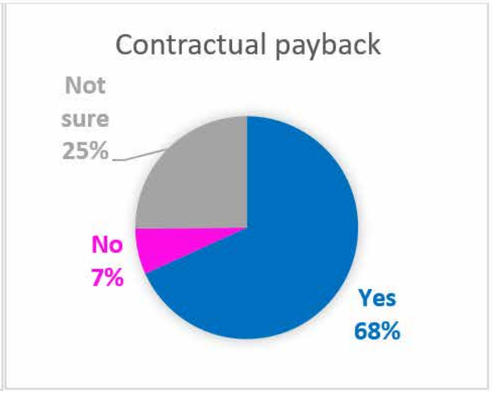


Figure 14: Respondents understanding of employment benefits
Figure 15: Respondents understanding of the T&C for contractual payback arrangements

Respondents were asked about contractual payback arrangements (figure 15). Of the respondents, 531 nurses (68.7%) said that leaving their contract required them to payback the Trusts' costs of recruitment, whilst 195 (25.3%) were not sure, and 52 (6.7%) said they would not be required. Some employers referred to employment payback policies partly to ensure the retention of international nurses. This policy stipulates that the recruited nurses will pay an amount of money as payback for the support rendered to them in their relocation to England in cases where they decide to change jobs or back out of the contract at an earlier time than agreed. Sometimes, this also incorporates the cost of accommodation for a short period of time.

The study explored the perceptions of the participants about this policy which received mixed reactions. Some were positive and understood that it was necessary to pay back the amount used to support their transitioning to the UK. They had this to say in that regard:

'I agree to it as the Trust spent a lot of money to get us hired from my country …'

'Fair enough since they paid for it for us to come here. As long as it's not more than what they paid for OSCE, visa, flight ticket. It's somewhat of a fair deal…'

'Payback is something I think is only fair for the recruiters, they can't spend money bringing in people so that they leave and go elsewhere, this way most people will see through their contracts while those who opt out pay…'

Others understood the necessity for the payback, but wanted some modifications to be undertaken to make it more acceptable to nurses and hold the employers accountable in case of a breach of contract. This was evident in responses such as:

'I actually understand the need to payback the hospital that help us to get through with the process of coming here. But hopefully things will change regarding how long international nurses need to serve the Trust (at least only 1 year) we can now decide if we want to continue working with the current Trust and can transfer without paying the cost…'

'I think it is fair because they paid all the expenses. It's an agreement of which I consented to, so I am okay with it. I think they could have reduced the amount of payback. I think anyone who works for a Trust for a year should not be made to payback anything…'

Others were very much against this policy. According to them, the policy was unfair and made them stay in a particular place even when the conditions are poor. This may have a negative impact on their mental health and productivity since they were working in a dissatisfied state. This opposition was highlighted in comments such as:

'…We should not be inhibited to leave so long as the reason is valid like if we are not being treated fairly, being intimidated in any forms, or even not being allowed to transfer in a different unit.'

Suggesting:

'If any party is falling short of upholding the conditions, say if the employer refuses to keep to the terms of the agreement I feel it's fair to leave without any 'payback' in order to allow for equal rights to be exercised.'

4.5 Career development and future aspirations

A further important aspect of professional integration is having a visible and clear professional development framework to realise advancement needs and achieve career aspirations. The survey asked respondents about the support they had received in achieving their career aspirations. When asked whether they have had a conversation with a line manager or mentor about their career plans, 329 nurses (42.6%) returned a negative response, 315 (40.6%) returned a favourable response and 130 (16.8%) were neutral.

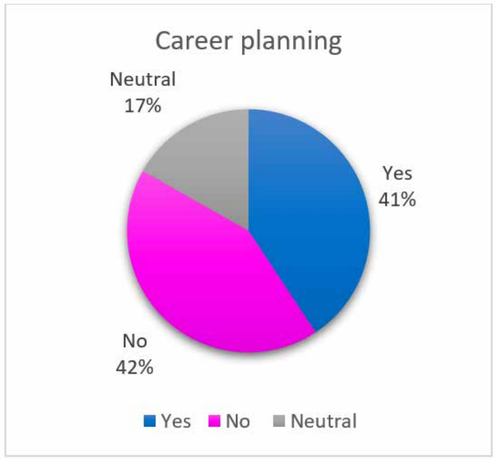


Figure 16: Career planning conversations

For individuals who are keen to meet their aspirations working in England's health and social care system which propositions itself as providing opportunity for personal and professional development, qualitative comments highlight how important having conversations with line managers or mentor are to facilitate achieving career goals:

'They are discussing with me that undergoing different training will prepare me for bigger responsibilities in the future, like being a nurse in charge or a band 6 nurse.'

'My manager encouraged me to apply for the post of Band 6 and enrolled me into university-based course.'

'I have had a conversation with my line manager about my career. It was really helpful, and I got to know various opportunities in front of me.'

Of the international nurses who had not had conversations about their development, some felt disillusioned and not valued to a point that they were considering leaving England:

'There's no opportunity to have such conversations as there is no support. My line manager doesn't even know my name, and has never called me in for a discussion or see how I am fairing…'

'No one never asked or given opportunities… I am just working without a path or career goals…'

Despite some negative experiences, 66% of international nurses were feeling optimistic about their future. These comments captured some of the proactive things that are happening:

'The NHS conducted an international nurse event, which was really effective to keep going on and solve the problem if someone struggling on work...'

'We also have a peer group discussion monthly for international nurses where we discuss our strengths, weaknesses and challenges we have on the ward. All of these put together has made work enjoyable with the support of the staff on the ward as well…'

However, as the chapter concludes, some respondents highlight how for some there is an urgency that matters thus challenging professional integration are addressed:

'I have not had that discussion with my manager, and I do not even want to, I look forward to getting another job in another role and leave my current ward…'

'I am planning of quitting NHS, cannot handle stress, despite working in a vulnerable environment, under paid, I cannot find a reason why I should hold on to this job…'

Chapter Five
Findings: Life Outside of Work

HWA
Health and Wellbeing Academy
University of Huddersfield

Chapter Five: Findings: Life Outside of Work

5.0 Introduction

This chapter considers the international nurses experiences of life outside of work. An exploration of the nursing role and UK organisational factors that influence retention of international nurses has been presented. In turn, personal and social contexts also have significant influence on the decisions of international nurses to stay, or to leave England. Alongside this the lives of international nurses outside of work have implications for longer-term retention dependent on wider social integration with England.

This chapter therefore explores the lived experiences of international nurses' lives outside of work, alongside the personal and social contexts of their living in England. It first explores housing situations and experiences, the cost of housing, the associated cost of living in England and community integration. The chapter then looks at preferences and the features valued by nurses in local communities. It discusses the social lives of international nurses outside of work, and addresses the importance of having contacts, friends, and communities for receiving support, wellbeing and information.

Key Learning Points

It is often the case that international nurses have within a short period lived in two or more properties, suggesting initial housing situations are often transient and temporary.

Independently finding suitable and affordable housing was often complex and challenging and resulted in situational and/or financial compromise.

Many expressed dissatisfactions at the proportion of salary spent on living in England. For some, high cost of housing and living in England may compromise long term retention plans.

There is a mixed population distribution of respondents living in a city or town (47.5%), suburban areas (25.1%), and semi-rural or rural areas (27.4%). The majority (71.4%) stated that they liked the area where they lived. Housing priorities are safety, proximity to amenities and transport connections to work.

Despite the importance of international nurses having contacts, friends, and communities for receiving support, wellbeing, and information, it is not commonplace for international nurses to know their neighbours and other local people in their area (18.1%). Adjusting in a different culture without family is one of the most difficult factors of migration.

At a point in time of less than 2 years post-migration to work in England, 71.3% returned a favourable response (agree or strongly agree) when asked whether they were happy with their decision to migrate.

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5.1 Housing circumstances and experiences

Respondents were asked how many properties they had lived in since moving to England. In total, 266 nurses (34.4%) had lived in one property, 363 (47.0%) had lived in two or more properties, and 141 (18.3%) had lived in 3 or more properties. The qualitative comments reflect the accommodation feedback presented:

The process of finding accommodation: often employers provided accommodation in the immediate short-term post migration. There were many qualitative examples describing satisfaction and gratitude of this offer and an overriding demand to be extended in the longer term:

'NHS accommodation is really good and safe.'

'It would be better if the hospital can provide their own accommodation.'

When international nurses had to independently find accommodation, many described challenges due to constraints of timescales, costs, and having limited insight of local areas, landlords and guarantor processes:

'I did not have enough time to get a place of my own that I really like after the one month given by my Trust elapsed. It was hard getting a new place as I do not know anywhere. I recommend that Trust should give at least 3 months accommodation to enable international nurses to relax first. I had to live in a house sharing toilet with strangers because I do not know where else to go and makes me feel bad…'

Often, international nurses described making compromises and sacrifices with housing choices:

'Because of the fact that most landlords and agents refused to rent out the accommodations I wanted to rent to me, I have ended up renting a place that is very far from my work and sometimes very inconvenient to commute. After working a long day, it takes over an hour for me to get home. I end up getting home exhausted.'

Pressures to find housing were seemingly compounded further when looking to host families:

'I live where no children are allowed, so I will need to move out when family joins.'

'I had to settle for the accommodation because my family were to join me, and the time frame was short…'

'It's enough to accommodate my family and close to the hospital though took me more than 5 months to secure the house.'

And constrictions with processes often limited and forced housing decisions:

'… they are asking so many documents…'

'Not where I would have loved to live but due to the difficulty in getting an accommodation, guarantor and all, and no Employer's support…'

'Unable to get a guarantor so have to share.'

All of which, could explain why in the short term many international nurses reported peripatetic turmoil of moving accommodation several times in the early stages of migration.

Property proprietorship: In respect of property proprietorship, 589 nurses (76.2%) lived in privately rented housing, whilst 125 (16.2%) lived in accommodation provided by their employers. Also, 16 nurses (2.1%) lived in a socially rented property, and just 6 (0.7%) owned their property outright or with a mortgage (figure 17).

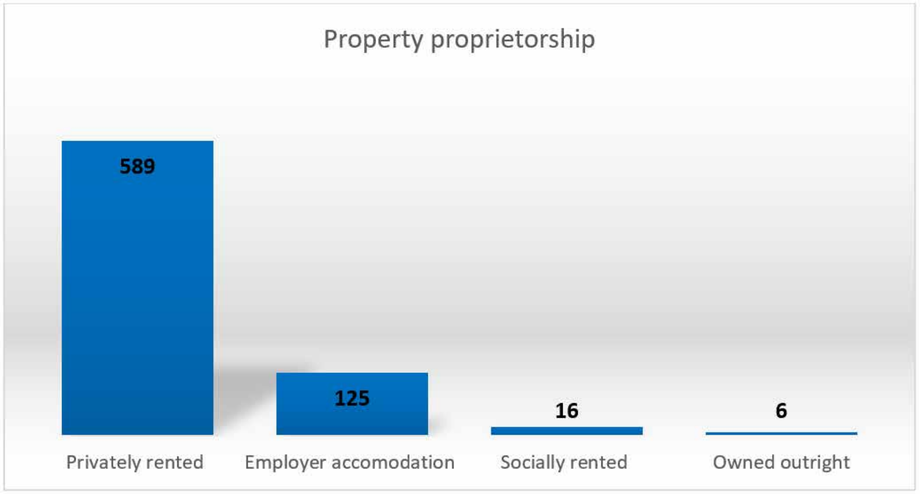


Figure 17: Respondents property proprietorship

In the main, many housing arrangements were styled as temporary, with very few respondents, irrespective of preference, owning or planning to own their accommodation outright:

'With the inflation now, rent takes almost half of my salary, it would be great if we could get support for those who wanted to buy house.'

'I would like to get my own place and be on the property ladder. I can definitely pay a mortgage; however, it is the application and requirements stopping me from getting one.'

It was hard to definitively ascertain if most respondents held a pragmatic acceptance of living in rented accommodation, in that home ownership was dismissed as untenable, or if indeed this was ever a desire. It seemed that primary ownership of properties was principally dismissed as outside of an individual's control in preference of securing well maintained, conveniently located and suitable accommodation. What distinctly came through in survey findings was that international nurses had modest requests of housing situations, such as:

'Quiet, peaceful and we have our privacy.'

'Close to work, not too expensive and comfortable.'

It was clear in many cases that despite these unpretentious requirements for living arrangements, compromises were still being made by some regarding property size, privacy and cleanliness of living conditions:

'The cost of renting is high, and I had to rent the accommodation that was available, not what I would have preferred. Moulds are growing in the property due to dampness…the search for a property to rent was very challenging.'

'It is very far from the hospital where I work. I have to spend significant amount of money to travel by bus or if not, I have to walk 45 minutes back and forth just to ride on the free shuttle. Sharing bathrooms and kitchen with a lot of tenants is also stressful especially with hours of use, taking turns and cleanliness issue.'

Household compositions: When considering household composition there was a mixed picture of living arrangements. In all, 243 nurses (31.3%) lived with friends or shared their accommodation with other people, 237 (30.5%) lived with their partners and children, and 97 (12.5%) lived with just their partner. A smaller overall proportion of 148 (19.1%) lived alone. What is not clear from these quantitative survey responses, and perhaps what matters most can be appreciated through the experiences of individual living arrangements and how satisfied respondents were with their household composition in relation to how it suits their bespoke needs.

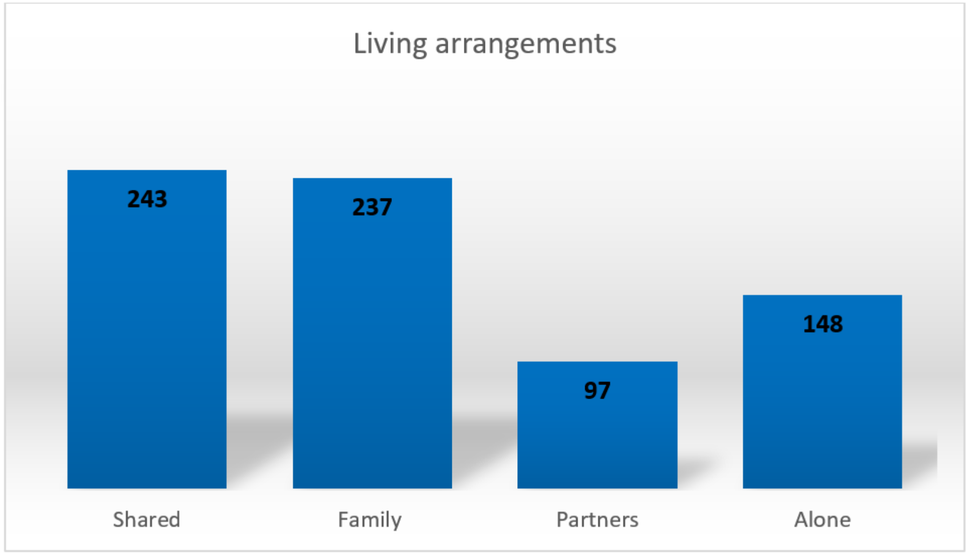


Figure 18: Respondents household composition

For some international nurses, sharing accommodation with others offered them a much-welcomed social support network:

'I have lived here for 2 years, my landlady has been absolutely wonderful, it's quite near my workplace and I have been blessed with a lovely housemate - whom I consider a family now.'

'I live with my cohort who became my close friends here in England. This is a big help to reduce homesickness.'

While for some international nurses living with spouses and children meant there was a situational compromise:

'I like my studio flat, but it is a bit small for when my daughter is able to visit for a few months at a time. Getting something larger may not be affordable.'

'The house is small for my family. I have 3 teenage children, 1 girl and 2 boys, we live in a two-bedroom apartment.'

'My concern is that if I want another kid, then I have to search for 2 bedrooms in order to accommodate new family setting, housing rules. BUT it will be a burden financially…'

Satisfaction with current housing situations: diffidently, whilst much compromise was seemingly being made in terms of housing situations and arrangements, findings reported 399 nurses (51.5%) returned a favourable response when asked if they were happy with their current housing situation, 179 nurses (23.1%) returned a neutral response, and 197 (25.4%) returned a negative response. This suggests that whilst lots felt there were improvements to be made, many were happy with living arrangements:

'We have a lovely home and neighbourhood. Most of our neighbours have kids who are my son's age, and the school is not too far. We feel truly blessed as we couldn't ask for more. It's all fallen in place incredibly well.'

'Our house is near to hospital and school where my child studies, so I am happy about it.'

5.2 The cost of housing and living in England

The cost of living in England appears mutually inclusive to decisions made regarding housing situations that impacts experience.

The cost of housing: When replying to whether their monthly basic salary covered housing costs, 434 (56.2%) returned a negative response, followed by 166 (21.5%) who were neutral. Also, 172 nurses (just 22.3%) expressed a favourable response (figure 19).

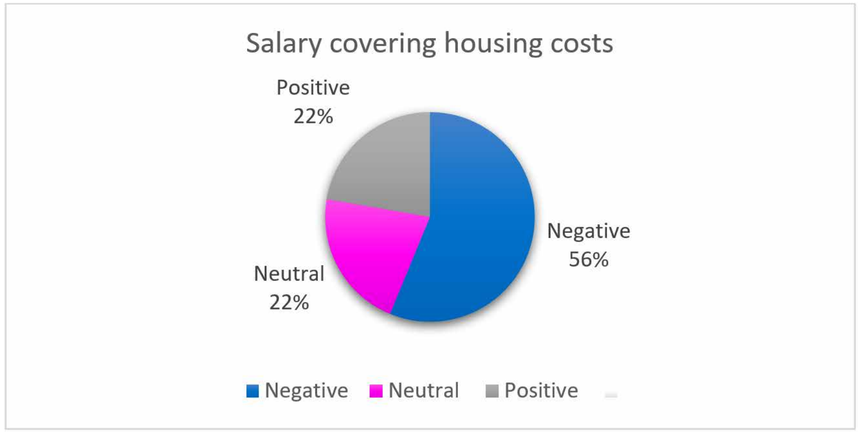


Figure 19: Respondents feeling on their salary being able to cover housing costs

For example, when asked if monthly basic salary adequately covers housing costs such as mortgage/rent payments, council tax and utility bills, many expressed dissatisfactions at the proportion of salary spent:

'Salary not enough to meet the living expenses…'

'The affordability is something that has been bothering me and that is prompting my relocation to another area.'

'The house rent is expensive, and it excludes bills. With the current NHS band 5 salary and tax system of the country, it leaves little at the end for savings and personal needs.'

The cost of living: Compounding issues of the experience of finding suitable affordable housing, nurses were asked whether their monthly basic salary covered their living costs, to which a minority of just 173 nurses (22.4%) returned a positive response (figure 20).

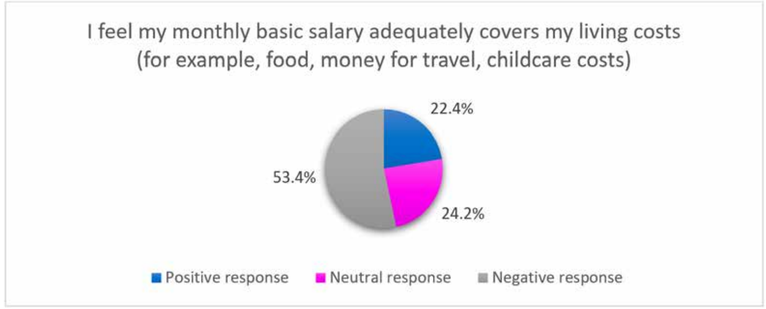


Figure 20: I feel my monthly basic salary adequately covers my living costs (for example, food, money for travel, childcare costs)

Of those satisfied with housing situations, for many, bills were described as becoming an ever-increasing concern. Several international nurses reported:

'Living paycheck to paycheck due to high cost of living.'

'Satisfied with housing, bills were huge now.'

Cost of living was a pertinent theme that was affecting many nurses. In the qualitative data, nurses describe feeling 'surprised' or 'shocked' at the cost of living in England, as it related to tax, rising inflation and the cost of fuel and food. For some, this was understood comparatively with the experiences of working elsewhere as internationally recruited nurses:

'I am working in KSA [Kingdom of Saudi Arabia] before and I was earning and saving more.'

For one nurse, this cost of living had dampened their expectations of living in England:

'I had too many expectations when I moved but I was shocked at the heavy tax and rising living costs, and now all my expectations are gone.'

5.3 The impact on individuals from cost of housing and living in England

It was clear that cost of living challenges was impacting nurses who had moved to England to achieve a good standard of life, or to send money home. When nurses were asked whether they had enough money to save, send to relatives in a different country or spend on luxury items, 591 nurses (76.4%) returned a negative response, 117 nurses (15.1%) were neutral, and just 66 nurses at 8.5% returned positive responses (figure 21).

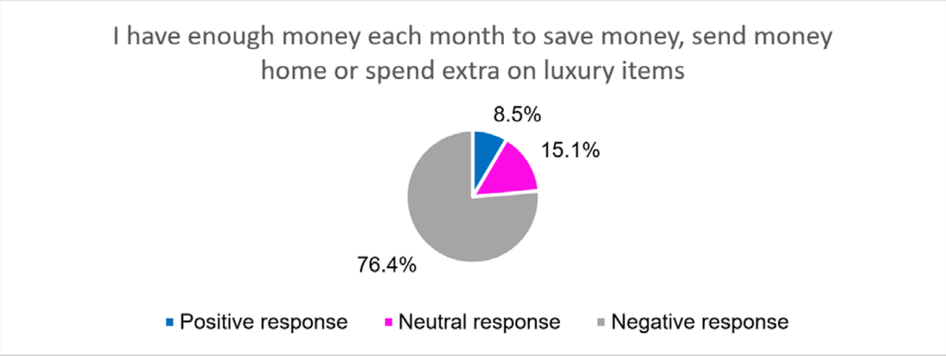


Figure 21: Respondents assessment of their financial situation

International nurses recounted only just managing financially and expressed worries about ability to fund contingencies and emergencies:

'I am spending my whole salary for rent, bills and groceries. If any emergency happens, I don't have any money to [buy] flight ticket as well.'

'Don't know what to do if any emergencies happened.'

'It covers just these basics. Not enough to afford other luxury good … like a holiday.'

International nurses described financial reliance on spouses to meet living costs:

'I can afford my rent at this time because I and my spouse work.'

And there were many accounts of international nurses frequently working extra shifts as a routine way of affording everyday living costs:

'I was shocked to know that our salary is not that high as I expected, I thought that with my salary, I can save and send money to my family back home, but as I see it, with the increasing cost of expenses here, my salary is not enough. I am working extra shifts and now even these are not enough.'

Qualitative findings describe, for some international nurses, an imbalance between sacrifice made and reward gained:

'The Trust needs to remember that we left our homes and lives… It is difficult on this salary.'

'We do so much as nurses and earn so little, I struggle monthly to ensure my income is enough for my family, if my Trust had considered my level and years of experience and placed me on the last band 5 salary rate like other Trusts do, I wouldn't have had to struggle this much.'

The outcome of high cost of living and housing: For some, high cost of housing and living may affect long term plans to remain working in England:

'The salary is adequate for single and not people with kids. Bear in mind that we have no access to public funds, childcare cost alone could gulp all my salary for the month if I don't strategize. Coupled with other amenities charges and the cost of an apartment if you've got kids. You can't have your kids in a shared apartment of all bills inclusive or in a one-bedroom flat…it is expensive to have a family as an immigrant. So, to your question, my salary has never been enough since my kids moved to England to join me but what can I do.'

'… as a band 5 is a struggle. It made me think of leaving the NHS or transfer to USA.'

By and large, cost of living was described as a make-or-break issue for continuing to live and work in England:

'If it comes to a point where my salary can no longer sustain the cost of living then I will leave.'

'I came with a plan to stay lifelong but now I decided to migrate to Australia which pay better salary.'

And, when considered in the context of other workplace issues, cost of living may be the deciding determinant of onwards migration:

'I really find it difficult to stay here lifelong because of the high expenses and less salary, it's difficult to settle with a family in such a situation so I will consider looking for work in a different country.'

'With my current salary, pressure from work and short staffing, I am now thinking of migrating to other western country with better healthcare system.'

5.4 Community integration

Alongside housing and cost of living, community integration factors influenced an international nurse's experience of life outside of work. Place of residence was an issue that had importance for many, and often positive experiences were associated with factors relating to the location of where nurses live and social connectivity with communities.

Place of residence: 367 (47.5%) of respondents lived in a city or town, whilst 194 (25.1%) lived in a suburban area, and 212 (27.4) resided in semi-rural or rural areas. There was also a mixed response to whether nurses liked the area where they lived. A total of 552 nurses (71.4%) said they liked the area where they lived, 156 (20.2%) were neutral, and 65 (8.4%) disagreed (figure 22).

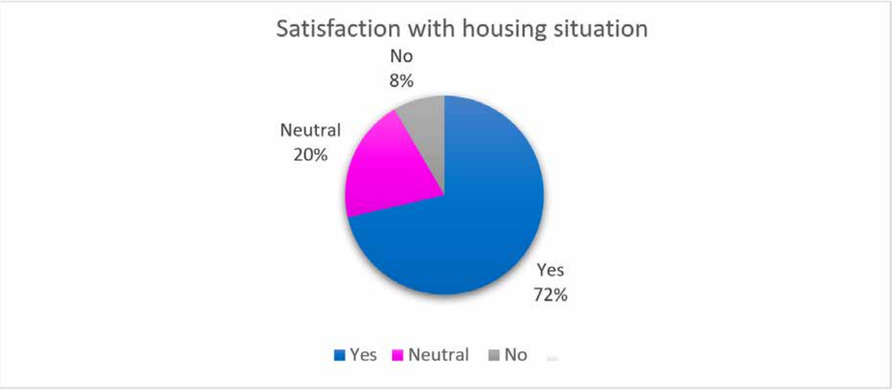


Figure 22: Respondents satisfaction with their housing situation

It was clear from the responses to the qualitative comments that nurses had a set of generic preferences and features that they valued in their place of residence. The first preference was the need to feel 'safe'. Across the comments, it was clear that feeling safe closely aligned with the physical features of place and perceptions of how 'quiet' or 'peaceful' an area was:

> *'It is really peaceful and away from pubs and the noise of the city. Makes me feel safe as well, as it's not a dodgy area.'*

But for some, compromise and being unfamiliar with areas brought about unintentional consequence when finding a place of residence:

> *'I didn't find a place to rent near the hospital I work at, so I settled in a distant one not knowing it was not the safest area to live in. Tales of crimes and not good, stuff has happened around area. Luckily, I have never encountered one. Although, I often see police cars in our street.'*

In addition to valuing safer areas to live, the nurses also prioritised those areas of residence that provided access to amenities in the local area such as local shops, supermarkets, gyms and schools. This was conveyed widely as both important in decisions about where to live and appeared to be a significant factor behind the formation of positive perceptions of local areas:

> *'The area where I live is peaceful and quiet. It is also near the town for shopping and places where I can visit which is great.'*

Conversely, those without local amenities had mixed feelings about their areas that left them feeling unsettled:

> *'Sometimes I like the town where I live since it's really quiet, but sometimes I dislike it because [it's] boring since there are limited shops or places to visit, so I'm feeling quite mixed and unsettled [about] living here.'*

Lastly, a third neighbourhood preference was having transport connections to and from work. When asked if they had no difficulties commuting to work, 517 nurses (66.9%) returned a favourable response, 107 (13.8%) were neutral, and 149 (19.3%) returned a negative response (figure 23).

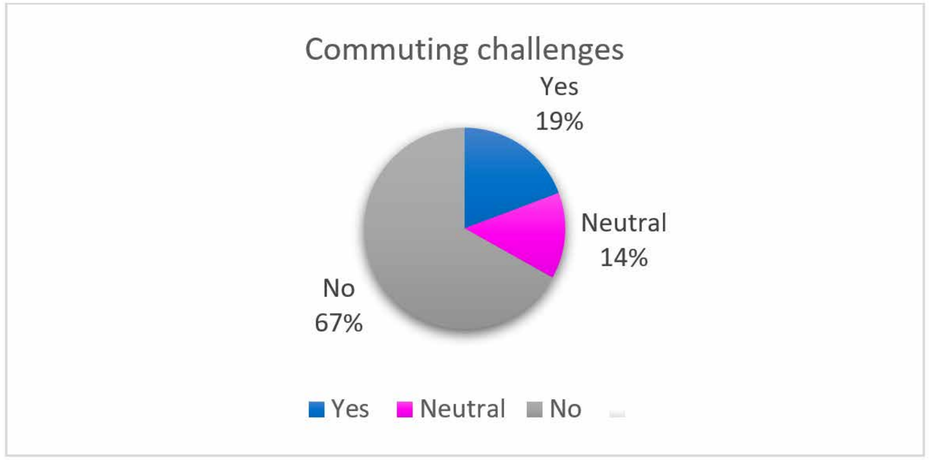


Figure 23: Respondents challenges commuting to and from work

Ideally, neighbourhoods where the nurses lived would be located close to work where walking distance was preferable. If finding accommodation close to work was difficult, the nurses described the need to be close to reliable and safe transport links:

'My neighbourhood has a good environment and is accessible to all facilities such as shops and bus stops which enable me to get to places, particularly to work.'

In summary of place of residence, international nurses prefer neighbourhoods that leave them feeling safe, contain a good range of local amenities, are close to sites of employment and/or provide good access to transport connections to workplaces.

5.5 Social support networks

The next feature of community integration explored is social support networks and those whom international nurses socialised with outside of work. This addresses the importance of international nurses having contacts, friends, and communities for receiving support, wellbeing and information.

Social contacts outside of work: Respondents were asked about their social contacts and quality of their relationships with people outside of work. Overall, 434 nurses (56.4%) returned a negative response when asked whether they knew their neighbours and other local people in their area, and 197 (25.5%) returned a neutral response. Also, 140 nurses (18.1%) returned a positive response.

Respondents who reported that they knew their neighbours reflected on interactions with neighbours as providing help and as important sources of information following their initial arrival, such as in the following example:

> *'I have a wonderful neighbour. He supported me when I was new, telling me about bin collections, how to register bills. The day I bought a car, he waited for me by his door to give me information about paying for residential parking, road tax and reliable insurance. He even gave me parking coupons for three days while I was sorting myself out which, I must say, was a great relief.'*

> *'My neighbours (to the right and left sides) are friendly, we interact like family members. They are amazing people, and they have helped me with many things since I moved here, everyday things which are often difficult to understand as someone who is new here.'*

Another nurse described the meaning of exchanging pleasantries and small-scale interactions in everyday situations such as when out shopping for groceries:

> *'Most of the people when I go outside and buy groceries or go to work, we don't speak much but they are very hospitable, very kind and polite. This why I felt accepted here.'*

International nurses also recounted the importance of socialising outside of work with people of the same nationality or backgrounds as an important way of overcoming the challenges of integrating:

> *'I have joined the Muslim community in my area as well as the Nigerian community. We hold monthly meetings and hangout which is nice.'*

The general sense was these connections provided an important source of information exchange, as well as being regenerative to wellbeing by mitigating feelings of loneliness, isolation and homesickness:

> *'It is fun to get to know other [people from country of origin] that come here first. Getting to know them and meeting them helps me to know how to live here… Being inspired to know how they do it despite being far away from home makes me feel that I can do any challenges that comes.'*

> *'I primarily mix with [people from country of origin], and we cook together and enjoy most of our traditional dishes that we miss eating back home. Doing this strengthens our friendship and support for one another, and I can learn about their experiences here and they can learn about mine too.'*

Adjusting in a different culture without family: adjusting in a different culture without family was found to be one of the most difficult factors of migration for international nurses:

> *'It's hard to get adjusted to new place where never went, with exam pressure, search of accommodation, then paper works for bringing family to England, getting adjusted and learning routines of setting you are working. It takes time to adjust and get settled.'*

> *'Being far from your loved ones (family and friends) while working in another country with different culture, etc…you cannot help but feel like sometimes, it's hard to penetrate the social barrier caused by the cultural differences.'*

5.6 Reasons for family separation

Participants were asked about issues separating them from their families. The reasons reported include, financial constraints, visa processing issues, difficulty obtaining jobs for partners, planned delays, and unwillingness of the family to relocate.

Financial constraints: Most participants cited financial problems as a factor for separation from their families. Even though they had plans of reuniting with them, the plans were mostly stalled due to inadequate finances. Whilst previously indicated 76% of the participants indicated that they did not earn enough to be able to save and even send remittances home. Some participants indicated that money required for documentation was not easy to come by. This was evident in comments such as:

'The rent and expenses are high with low salary and heavy taxes. As such, I cannot save enough for their travel documents.'

'On my current salary, I cannot afford the accommodation and childcare cost necessary to live with my son in England as a single mother with no other benefits and no family members to assist with childcare.'

Due to this constraint, most participants described wanting to become financially stable before bringing their family to England. In their quest to realise this, they had set financial targets, some of which are quoted below:

'I need to be financially prepared first before bringing my partner and kids here. My current financial situation will not permit me to take on the extra burden of bringing my family over.'

'I need adequate salary to afford appropriate accommodation and childcare…. When I meet this target, then I'll give the greenlight for my kids to come over.'

'I need extra income to be able to afford the processes, once that is done, I'll bring the family over.'

Assistance with educational support and affordable childcare costs were reported to drive reuniting families. This was evident in reports such as:

'A non-expensive facility was provided by the NHS to care for my kids while at work. That eased the pressure on me a lot.'

'I was able to get a student visa for my daughter to continue her education in England kind courtesy of my employer.'

Visa processing delays: Another reason for prolonged separation from families was delays in processing travelling documents and visas. Some of the respondents intimated in the following comments:

'He will come next month to UK. Waiting for the visa.'

'We are still waiting for the approval of the visa of my husband and two children.'

Difficulty finding jobs for partners: The decision to migrate with one's partner is mostly determined by the barriers of them finding appropriate employment. According to some participants, it was difficult for their partners to find appropriate jobs based on their skill sets, readily making migration improbable for such partners:

'Just got married and we don't know if he will be able to get a good job here.'

'Because he is in a banking position back home which pays well and will not get an equally good job here since he didn't School in England.'

Planned delays for family separation: As part of adaptation, some international nurses also preferred to wait till they had become conversant with the environment and work schedules before starting the reunion plan with their families. Others wanted to be done with their examinations before making the move to bring in the family. This was to ensure that they provide a comfortable environment for their families. This was evident in the following accounts:

> *'I can bring my partner and kids to the UK after the successful completion of my OSCE exam.'*

> *'Because I still want to settle first and make sure she and my kids will be comfortable if they come here.'*

> *'I had to come first to finish the registration with the NMC. It has been 6 months and hopefully he will be here soon.'*

As part of the plans, some of the participants wanted to get flexible work schedules before they can bring their children over. For instance, one participant opined that they need a flexible work schedule in order to bring her kids to England.

5.7 Satisfaction with decision to migrate to England

Overall, 551 nurses (71.3%) returned a favourable response when asked whether they were happy with their decision to migrate. Additionally, 167 (21.6%) were neutral and 28 (3.6%) returned a negative response (figure 24).

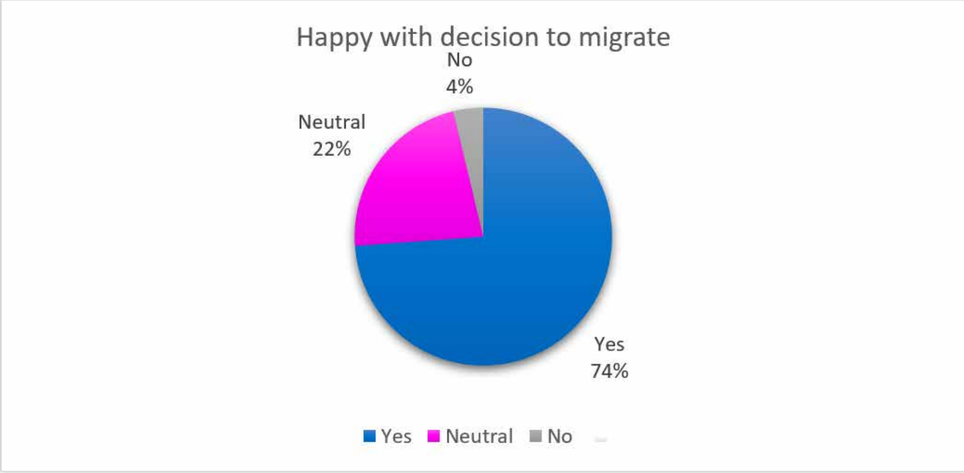


Figure 24: Respondents satisfaction with their decision to migrate

Enablers of retention: International nurses discussed factors that were viewed as enabling them to stay working and living in England in the longer term.

Whilst cost of living challenges seemed to be the major issue likely to trigger nurses to leave, reasons to stay were informed by a myriad of differing factors. These reasons could be broadly divided between role-based factors, organisational/workplace factors, and social reasons. Role-based factors included the opportunity for career progression, development and the relatively high pay compared with their countries of origins:

> *'Having more opportunity to increase my income relative to my home country is a big reason to stay, my salary is huge in the Philippine Peso once it is converted.'*

Organisational and workplace influences included the ability to practice nursing in an advanced healthcare environment, and for some, the work-life balance that was afforded by their roles:

> *'I like working in a developed country like UK which have state-of-the-art facilities in health care setting.'*

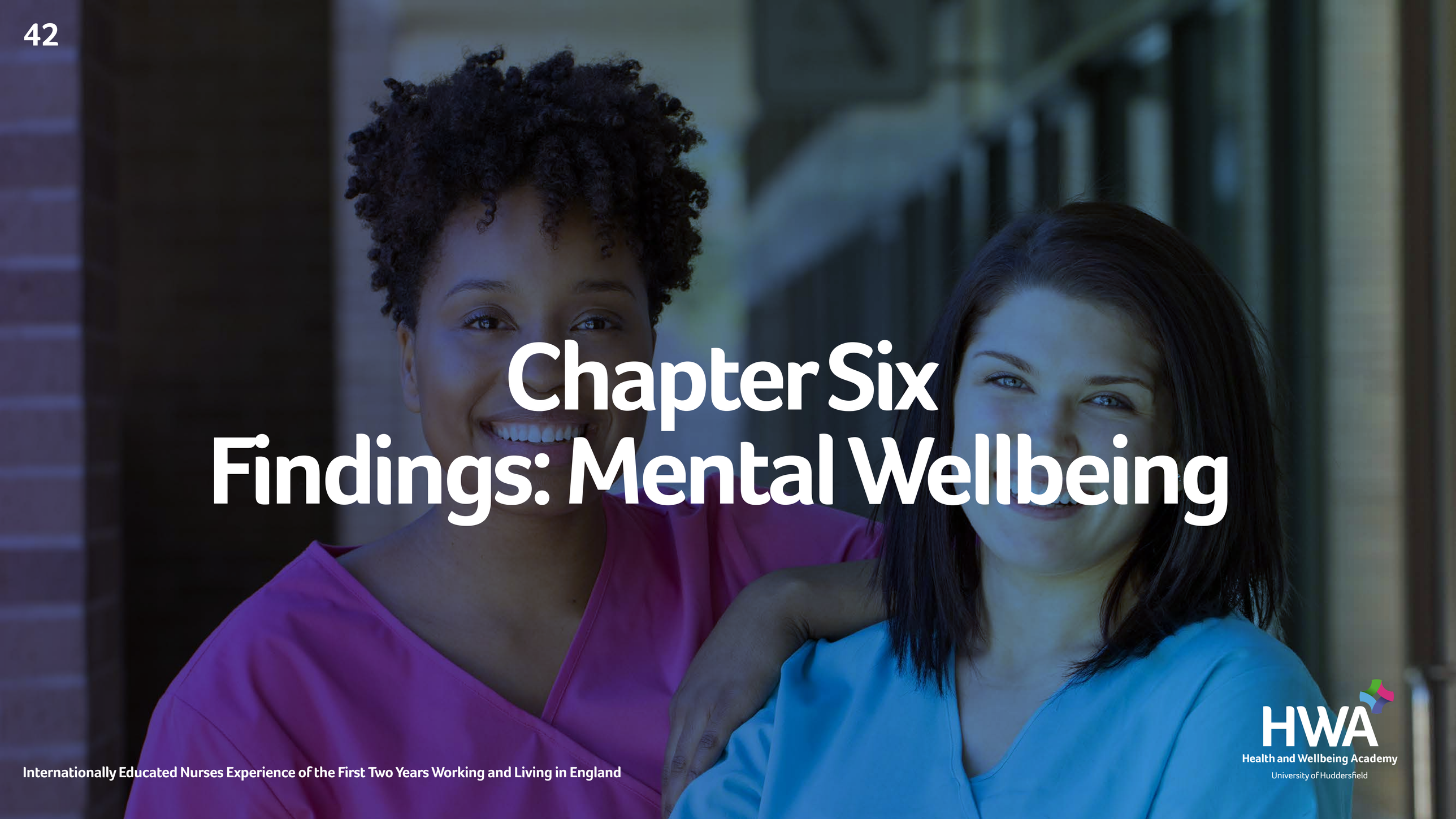
> *'Work-life balance, I appreciate that here in England we have more off days and rest days and that our mental health is being prioritised here.'*

Social reasons related to contexts outside of work that involved personal and family-related factors. That the UK is a developed country with good healthcare and education systems (for children) were viewed as a major reason to stay, as well as the perception that the UK was a safe country that valued personal and religious minorities and provided security and stability that were not available in some countries:

> *'The country, the nice people here, the freedom of being myself will make me stay.'*

> *'Personal freedom and religious freedoms are tolerated here.'*

Despite some of the discouraging individual findings of this report, on balance there were clear themes about what employers have done well to support international nurses with challenges, and a clear understanding of what can be implemented going forward to improve the future migration experiences of international nurses.



Chapter Six
Findings: Mental Wellbeing

HWA
Health and Wellbeing Academy
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Chapter Six: Findings: Mental Wellbeing

6.0 Introduction

This last section of findings presents the mental wellbeing of international nurses working in England. The chapter looks at variances in mental wellbeing and recorded associations with wider determinants considered within this study. The chapter upholds the characteristics of both higher levels of mental wellbeing and lower levels of wellbeing and confirms factors that contribute to mental wellbeing concerning professional integration and life outside of work. The chapter closes with positive accounts of coping strategies that support professional and personal enculturation.

Key Learning Points

International nurses who reported being happy with their decision to migrate to England have significantly higher mental wellbeing scores than those who were not happy with their decision.

Mental wellbeing scores recorded variation between different country/region of origins. However, there were no other significant differentiating differences or common themes in the remaining S-WEMWBS scores.

Being overworked due to staffing constraints and high workloads and pressures, affected stress levels, self-esteem and confidence.

Professional behaviours, attitudes and support from colleagues influenced perceptions of inclusion and belonging, and nurses preferred working in friendly environments where they can share concerns and ask for help when needed.

Support from professional and personal networks helps in difficult times with mental wellbeing.

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6.1 Mental wellbeing

Mental wellbeing was obtained from international nurses using the short (7-item) version of the Warwick-Edinburgh Mental Wellbeing Scale (S-WEMWBS). Each item in the S-WEMWBS tool was scored from 1 to 5 points, yielding a possible range of raw S-WEMWBS scores from 7 to 35 points, with higher scores representing higher levels of mental wellbeing. The S-WEMWBS tool has been validated in a general population (Fat et al., 2017), with national norms for mental wellbeing established for males and females using Health Survey for England data (Mindell et al., 2017). Using these studies, mean S-WEMWBS scores are 23.67 for males and 23.59 for females.

The mean score of the 773 overall respondents in this current study was 23.05 points, representing levels of mental wellbeing slightly lower, but very similar to those found in the validated general population (Fat et al., 2017; Mindell et al., 2017). That said, variation was observed between respondents from different countries/regions of origin. Nurses of African and Indian origins scored highest levels of wellbeing (mean scores: 23.5 points for African nurses; 23.3 points for Indian nurses); nurses of Filipino origin scored lower levels of mental wellbeing (mean score 22.3 points); and nurses who originated from elsewhere in the world scored lower still (mean score 21.6 points, albeit based on a low sample size). Inferential analysis revealed that mental wellbeing was significantly related to country/region of origin, as measured by the S-WEBWMS score at the 5% significance level but with an effect low in magnitude.

The association between mental wellbeing and age; and mental wellbeing and requirements to '*payback*' any costs of recruitment to employer was assessed via correlation analyses. Both revealed no evidence for significant or substantive associations. Further correlational analyses also revealed that housing satisfaction and mental wellbeing were weakly negatively correlated, indicating that mental wellbeing was not necessarily impacted by housing satisfaction. A further analysis of S-WEMWBS scores on country/region of origin, age and housing satisfaction revealed that no substantive associations existed between S-WEBWMS score and any of: country/region of origin, age, and housing satisfaction.

Subsidiary analyses were conducted on the subgroup of respondents who had children, comparing those respondents with all their children living with them in England with those with none or not all their children living with them in England. Mean wellbeing, as measured by the S-WEMWBS transformed scores, were 23.4 in respondents with all their children living with them in England and 22.9 in respondents with some or none of their children living with them in England; hence a difference of 0.56 points. This represents a small effect. A further analysis revealed no evidence for a difference in mental wellbeing of respondents with, and without, all their children living with them in England.

6.2 The characteristics of higher levels of mental wellbeing

Intentions to stay in England: The nurses were asked how long they hoped to stay in England. The majority of 338 nurses (58.0%) said they wanted to stay in England for more than 10 years, whilst 185 (24.0%) said they wanted to stay between 3 and 5 years. Also, 86 respondents (11.1%) said they wanted to stay between 6 and 10 years, and 53 respondents (6.9%) said they intended to stay less than 1 year to 2 years. A finding of substantive importance was that those who reported being happy with their decision to migrate to England have significantly higher S-WEMWBS scores than those who were not happy with their decision.

6.3 The characteristics of low levels of mental wellbeing

An analysis was conducted on respondents who scored significantly below the national norms of mental wellbeing in a general population. Overall, 29 respondents were analysed in this subsidiary analysis. Out of these, 20 were females and 7 were males, with 2 having gender unspecified. Also, 12 gave their countries/regions of origin as the Philippines (41.4%); 7 as India (24.1%); 6 as Africa (20.7%); and 4 from the rest of the world (13.8%). This equates to 2.6% of African nurses, 2.14% of Indian nurses, 6.6% of Filipino nurses, and 13.8% of nurses from the rest of the world appeared to suffer from low levels of mental well-being. Respondents in the subgroup had a mean age of 33.1 years (SD 6.32 years; range 25-49 years). Ages of subgroup respondents were not substantively different from ages of respondents from the full cohort. There were 14 subgroup respondents who had children; of which 8 had all their children living with them in England. This proportion is not substantively different from the corresponding proportion in the entire cohort.

The measure of housing dissatisfaction reported by this subgroup of nurses, defined earlier, yielded a mean score of 7.48. The constituent items yielded mean score measured on this subgroup of 3.31 for the item *I am happy with my current housing situation,* and 4.17 for the item *I think my basic monthly salary adequately covers my housing costs*. These values, which are based on responses to 5-point Likert items suggest that nurses are generally happy with their housing situation and have no obvious concerns about their ability to afford to maintain their accommodation.

Qualitative responses highlighted supplementary factors contributing to international nurse's mental wellbeing:

Work settings: within the working environment, workforce challenges make for stressful working environments. Many international nurses reported that they felt overloaded with a perceived unrealistic workload:

> *'The workload is huge. Very stressful physically and mentally.'*

> *'… at work kills my mood, I'm too exhausted to make friends or even laugh at jokes...'*

Professional attitudes and support from colleagues: workplace pressure and stress were cited as major challenges. There were descriptions of subtle acts of intolerance and disrespect from domestic nurses. Judgement was mainly linked with unequal opportunities and assignment of the daily work of nursing. This intolerance perceived by international nurses was in most cases described as covert but in some instances was obvious and caused considerable distress and confusion. Some international nurses were stressed with the lack of acceptance from their colleagues and made comments such as:

> *'Such a toxic workplace, I have just 3 months of working [experience] in the NHS and it is heart wrenching. Adjusting was difficult and not everyone was understanding…I have lost my confidence and feel like quitting… It leaves me mostly depressed…'*

International nurses described how in some cases, but not all, colleagues' attitudes were unwelcoming:

> *'… The nursing I was doing in my home country is slightly different from the way things are done here, you need someone to show you how to do things here, but no one wants to work with you. So, it is hard to incorporate yourself when you feel left out and alone. You just go home, cry about it and feel like going back home or quitting. Some colleagues are excellent. When you are together on shift, you learn a lot. Trouble is when you have the colleagues that side line you, a 12-hours shift feels like forever to complete…'*

6.4 Wellbeing coping strategies: professional and personal support

Respondents suggested a need to raise awareness facilitating international nurses to work in friendly environments where they can feel comfortable sharing concerns and asking for help when needed:

'… anyone coming from overseas should be given more support. They should be given time to see if they could adjust, also feedback should be taken and reviewed if the individual is happy or not.'

International nurses told of requirements to support mental wellbeing:

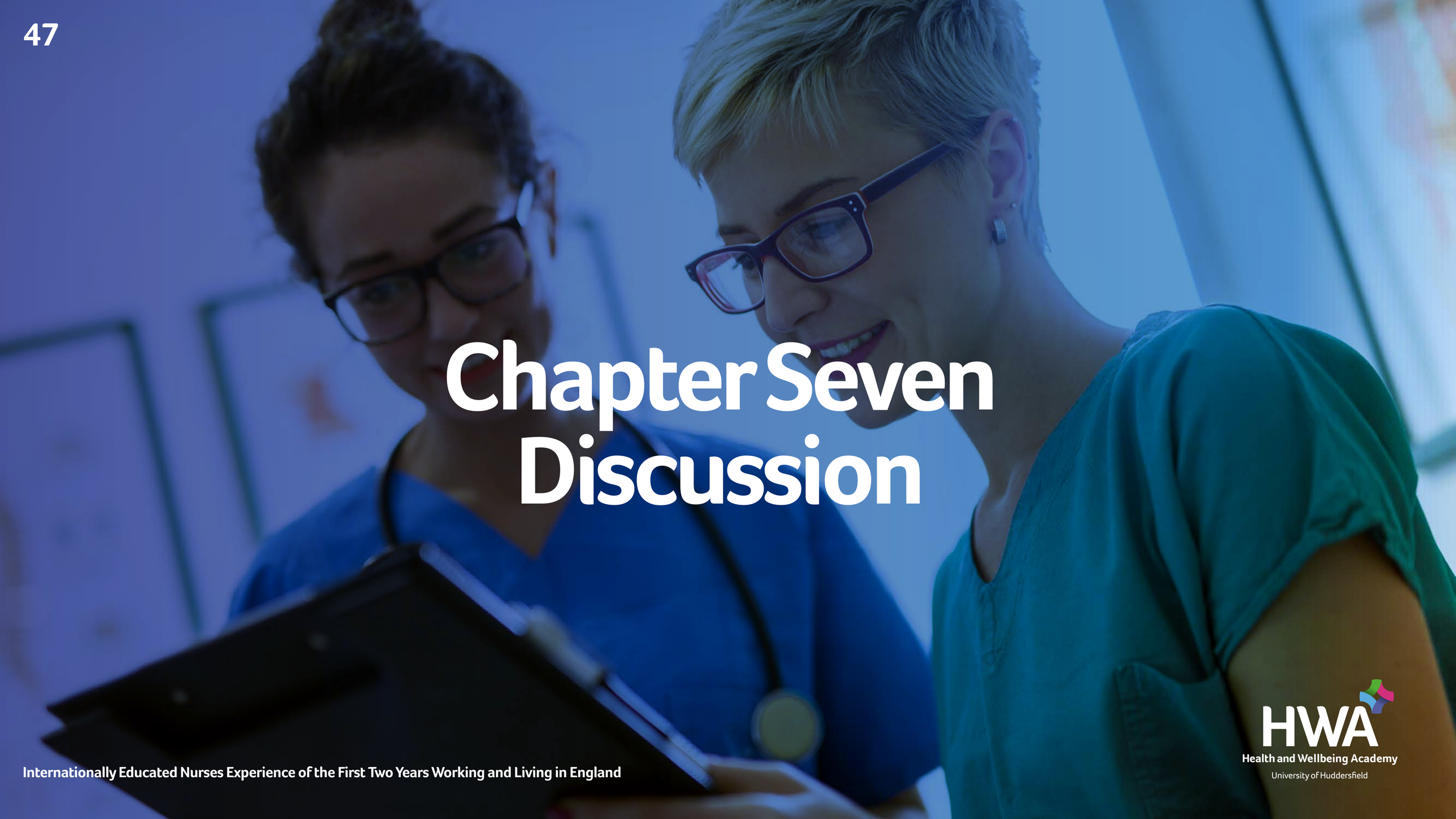
'Working in the NHS can be Physically, Mentally and Emotionally draining... I think there should be a regular session with the psychologist for us to help us cope with the stress of work.'

'Last month, I had terrible anxiety about work. I kept crying before going to work but having my partner and family on video call before going to sleep and when I wake up have helped ease my worries. I think having my support system with me here in England would be good for my mental health.'

Some respondents articulated how support from personal networks and faith has helped coping in difficult times:

'My faith has greatly helped me to cope, as well as my personal support network of family and friends.'

Support provision in relation to membership of diaspora groups was investigated. A total of 669 respondents (86.3%) said they were not members of any diaspora group. However, of these numbers there was no association between mental wellbeing and membership of diaspora groups. In other words, low mental wellbeing did not correlate to membership (or lack of) to a diaspora group.



Chapter Seven
Discussion

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Chapter Seven: Discussion

Following on from findings chapters, this chapter consolidates issues raised in the context of what is known from previous studies and considers the possible affects findings may have on the longer-term experiences and retention outcomes for the wider population of international nurses working and living in England. On the surface of this report, the key findings, most international nurses are happy with their decision to migrate. But caution advises against the principle of the majority rule when looking to interpret findings, and urges we consider the understory of the whole narrative of this study as it is the combined effect of learning from these experiences that will ultimately protect the flight risk of nurses from not only the country as is the case for international nurses, but the nursing profession for all nurses in England per se (Buchan et al., 2022).

There is a widely evidenced global narrative of healthcare systems worldwide overlooking international nurses' previous experiences and qualifications and placing them in junior positions, leaving those exposed disillusioned and frustrated (Sands et al., 2020; Adhikari and Melia, 2015). The World Health Organisation (WHO) in 2020 called for transparent and merit-based opportunities for career progression of international nurses. Indeed, this study heard how acknowledging previous expertise would improve the experiences of international nurses working and living in England. Whilst there are still improvements that can be made, there were clear accounts of where this was being supported and done well. Subsequently and yet interrelated, there is an opinion in the global literature that international nurses are underrated in their competence (Dahl et al., 2017). This is a theme that also came through in the findings but what was undoubtedly also evident was that international nurses are highly skilled and experienced and how for most international nurses' experiences of issues such as language barriers and learning different nursing routines are transient and time limited to a finite period while adjusting to new professional realities (Adhikari and Melia, 2015; Pressley et al., 2022).

In abridgement of the discussion on the professional integrations chapter, there is a mixed picture of experiences of provision and a variability in existing employer offers of support to realise career aspirations, suggesting that whilst for some, ambitions are on track to being achieved; for others, there is an urgency to resolve matters. Usefully, findings gave insight into the prerequisites and constraints of professional nurse integration post-migration in England and made recommendations to optimise future working experiences. However, while important to characterise and understand in the context of this study, none of our findings extended into the realms of new knowledge in this field (Dahl et al., 2021; Davda et al., 2018).

Just as there is a multiplexity of issues facilitating the realisation of successful professional integration, findings show that experience of life outside of work is also multifaceted and complex. Going on to explore international nurses' life outside of work, it was clear that personal integration and life outside of work is just as important, if not more so, than professional integration. And yet this is where the body of global evidence remains under researched, inviting our research findings' contribution to new knowledge. The previous studies that claim to examine the experiences of international nurses are employment-focused (Adhikari and Melia, 2015; Dahl et al, 2017; Salma et al., 2012) with just one paper by Dahl et al. (2021) that explores international nurses' life outside of work but limits exploring quality of life to a social support evaluation rather than a cost of living or housing perspective.

What is clear from our study is that international nurses are not a homogenous population and have vastly different family and social circumstances, and employment and personal needs, and yet describe receiving an almost universal initial employment offer from the English healthcare system. Whilst not the case for all, as many international nurses as appeared satisfied working and living in England, our study took account of international nurses appearing to be in a state of flux in the first two years after migration and describing housing as transient and temporary with expense and compromise, reprehensively compounded by cost of living. And yet what was not determined was when issues would be resolved, or for how long individuals would continue to make compromises, or if indeed events would ultimately result in a termination of employment. That said, nothing in the findings was seemingly definitively propositioned as a terminal challenge for more than a few individuals.

There is evidence on a macro level that more international nurses are happy with the decision to migrate than are not. Those who reported being happy with their decision to migrate to England have significantly higher mental wellbeing scores than those who were not happy with their decision. Whilst we can only take our findings on face value, we see an unexplained narrative of more nurses being happier with their decision to migrate than with housing circumstances and cost of living. It is thus propositioned that allowances may be needed for

confirmation bias and that experiences may be transiently interpreted more positively during the adaptive phase of adjusting to living and working in new circumstances (Peters, 2020). Contention of confirmation bias, through experiences told in this study poses how long will international nurses' beliefs of social hope and happiness and focus on the future continue to affirm their own story and believing that they have made the right decision to migrate to live in England? (Dahl et al., 2022).

This study highlights the importance of understanding the nuances of individual motivations and circumstances and the adage this can realise in supporting international nurses to have a positive experience of working and living in England. International nurses often migrate from countries where nurses are paid equal or better salaries to England, and that for many the choice to move on, and to work in a different country was now based on their family priorities. This being the case, knowing that adjusting in a different culture without family is one of the most difficult factors of migration (Dahl et al., 2022): how long would nurses tolerate remaining separated from families and children when they wanted to live united? (Adhikari & Grigulis 2013). The answer to this issue raised in our study remain unanswered. What is known is that research shows that family separation because of parental migration can have adverse effects on the well-being of children and even though these effects may be cushioned by the family's economic resources and support systems, they are often underestimated (Jones et al. 2004; Pottinger 2005). Children are the most affected in such instances especially when the migrant nurse is female. The nurses themselves bear the 'emotional cost' of migrating (Bond, 2022). A study by Li et al. (2014) also added that majority of nurse immigrants suffer from the emotional loss of their families. This suggests that for the nurses in this situation, an urgent resolve needs to be actualised.

A potentially transferable finding from Li et al. (2014)'s study into England's healthcare system is the suggestion that, the international nurses already have plans to relocate their families. This may give them the hope of reunification and hence lessen the emotional cost they must pay, irrespective of the challenges that will be involved in the relocation process. This is why as suggested, the merit of this study may be captured in the minorityism narrative, as this is where the irredeemable barriers to working and living as an international nurse in a host country may be mostly found. The reality is that healthcare systems must have sight of these issues and other situations that significantly challenge the experience of international nurses' happiness and have plans to resolve them if they are to secure the longer-term retention of this important workforce.

A limitation of this study is that the timeline of up to two years working and living in England does not capture any mandated point in time events, such as renewing employment visas, or events when international nurses must make active decisions forcing determining if they will continue with employment in England. This, and the highlighted gap in evidence in international nurses' lives outside of work, suggests a need for further research. As it is surmised, the ultimate threat to retention may be found further along the migration experience timeline.

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