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Internationally recruited nurses and their initial integration into the healthcare workforce: A mixed methods study

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ABSTRACT

Background: Nursing deficits are growing, and healthcare providers in developed countries must address the challenges of ethically building a sustainable workforce without a continued excessive reliance on overseas recruitment. To secure this, a focus on long-term retention of international recruits is paramount.
Objective: To explore the migration motivations and experiences of initial integration for internationally recruited nurses within the healthcare system (England).
Design: A mixed methods survey.
Setting(s) and participants: 655 internationally recruited nurses who had recently commenced work in England completed the survey.
Methods: qualitative and quantitative data was gathered to explore internationally recruited nurses' demographics and professional backgrounds, migration motivations, application processes, arrival and settlement and initial experiences of integration into the workforce alongside their support and future aspirations.
Results: The quantitative results revealed a population of international nurses that were highly educated and vastly experienced, with career development and desires to improve quality of life being the primary motivations for migration. Participants indicated a perception of being well supported during initial application and arrival stage, however, did experience some degree of challenge during workplace integration involving fluctuating levels of support and appointments into positions that did not match their years of experience and previous qualifications. This data was reinforced further detailed by the qualitative feedback that illuminated the difficulties nurses can face during initial arrival and integration and the apparent impact on mental well-being.
Conclusion: This paper, contextualised with an international literature base verifying the experiences of internationally recruited nurses, argues that it is the consistent responsibility of employers in developed countries to protect the experiences of international recruits. This can be done by investing in solutions as a key retention strategy.

What is already known

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In global markets where demand for nurses outstrips domestic supply, there is competition to recruit international nurses.

International nurses are highly mobile and extremely desirable and can choose where to migrate and work.

The supply of international nurses is not infinite and there are ethical implications of recruitment cycles.

What this paper adds

This paper offers explanation of experiences of new international recruits, enabling a detailed understanding of their migration challenges in readiness of optimising longer-term retention outcomes.

The needs of international nurses during the initial onboarding phase are nuanced from the challenges pertaining determining multiculturalism. This paper offers valuable insight into the individual needs of international nurses in the initial post migration assimilation phase.

In challenging and changing global healthcare markets where demand for nurses outstrips domestic supply, this paper adds new knowledge in the under researched field of international nurse retention.

1. Introduction

It is increasingly challenging for developed countries to recruit and retain nurses. The growing attrition of nurses is driven by a combination of burnout, low pay and retirement, an issue exacerbated by increased demand on health services owing to living longer but not healthier lives (Uthaman et al., 2016; World Health Organization (WHO), 2020a; Marufu et al., 2021). The pace and scale of nurse migration has grown significantly over recent years as developed countries look to recruit from global markets to meet workforce shortages. In 2019, the United States (US) had the largest distribution of internationally recruited nurses in selected Organisation for Economic Cooperation and Development (OECD) countries (41 %), followed by Germany (15 %), the United Kingdom (UK) (11 %), Australia (7 %) and Canada (5 %) (OECD, 2019). These trends have been described as 'supercharged' by the COVID-19 pandemic, as developed countries rely on international recruitment to cope with the impact of the pandemic on healthcare human resources (Buchan et al., 2022).

From the perspective of nurses from low and middle-income countries, working in developed countries is an attractive proposition as it can provide comparatively better pay and working conditions, as well as opportunities to progress careers in advanced healthcare systems (Bond et al., 2020; Dahl et al., 2022; Pressley et al., 2022). In theory, international nurses can also ease workload pressures in developed countries in the short-term, whilst affording the time required for these healthcare providers to enact domestic workforce plans in the medium- and longer-terms. However, as international recruitment brings benefits, it simultaneously threatens nursing shortages in lower- and middle-income countries anticipated to feel the brunt of future health crises (Drennan and Ross, 2019; WHO, 2020). Presently, these concerns are to some degree mitigated by the agreement of bilateral treaties and the introduction of a World Health Organisation's (WHO) Code of Practice on international recruitment (WHO, 2020b). The treaty constrains active recruitment of health workers in 'red list countries' (Shaffer et al., 2022) to protect against the loss of skilled health workers (colloquially termed 'brain drain') and incite developed countries to invest in growing their domestic supply.

Healthcare providers in developed countries are urged to meet the challenge of building and sustaining nursing workforces by effectively leveraging international recruitment without an over-reliance or a tendency to view global markets as a 'quick fix' (Laws, 2022; Buchan et al., 2022). Although there is a body of literature on the experiences of international nurses who have chosen to work overseas (Bond et al., 2020; Dahl et al., 2022), greater insight into how to *retain* international nurses may in the longer-term decrease the continued needs of developed countries to recruit globally; avoiding persistent cycles of overseas recruitment and therefore the worst damages of brain drain (Drennan and Ross, 2019; Pressley et al., 2022).

It is proposed that to reveal a replete consideration of how to retain international nurses there should be a greater focus on appreciating integration from the perspective of assimilation being relational. Presently, typically, studies report on the asymmetrical characteristics of migration whereby most of the adaptation is executed by international nurses themselves to the oversight of reflecting how established populations can embrace multiculturalism to support integration (Bond, 2022). Therefore, in readiness to assist healthcare systems to respond, this research explores the migration motivations and experiences of initial integration for internationally recruited nurses within the healthcare system in England.

2. Methods

2.1. Overview of survey

A mixed-method survey was designed to enable the combination and interweaving of quantitative and qualitative data. This mixed approach allowed research breadth through collecting quantitative data from a relatively large number of international nurses, whilst also retrieving in-depth responses and narratives related to specific aspects of their arrival and integration (Creswell and Plano Clark, 2018). Combining the benefits of both approaches provided 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.

2.2. Eligibility criteria

Study participation was open to all internationally educated recruited nurses within their first four months commencing employment in England.

2.3. Survey promotion and distribution

The survey was open for responses between November 2021 andtFebruary 2022 respectively. Convenience sampling was adopted to obtain as many respondents as possible. Information about the survey and internet link to completing the survey were widely distributed through social media (Twitter) and by email from key nursing leaders responsible for international nurses employed across NHS regions (North East & Yorkshire, North West, Midlands, East of England, London, South East and South West) in England. A reminder email was sent approximately half-way through the survey period. No incentive was offered for completion.

2.4. Survey design

The survey items were developed following a systematic review of the current evidence and designed to explore the pertinent gaps in the knowledge base. It was identified having a greater insight into individual and organisational preparedness, communication and the art of language, principles and practices of nursing, social and cultural realities, equality, diversity and inclusion, and facilitators of integration and adaptation could make valuable contribution towards improving international nurse experience at work and retention (Pressley et al., 2022). The draft questionnaire was piloted reviewed for content, accuracy, and quality control by an expert advisory group and experienced international nurses. A 5-point Likert scale (Strongly disagree, Disagree, Neither agree or disagree, Agree, Strongly agree), closed choice items and open text boxes were used throughout the questionnaire. The final version of the questionnaire titled "International Nurses and their Integration into the Health Workforce" consisted of 8 sections as detailed in Table 1.

2.5. Data analysis

Descriptive processes provided the initial analysis of the quantitative data, including frequency summaries of individual variables and cross-tabulations/ 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).

To examine associations between categorical predictors, outcomes were assessed for significance using the chi-squared test for association: country/region of origin (condensed and categorised as Africa, India, Philippines or Rest of the World) versus motivation factors, route of entry to work in England (categorised as via agency, on an individual basis, or other), satisfaction with decision to move to England, whether applicants found the application timely and affordable, and communication ability; satisfaction with accommodation versus family status (categorised as children under 18 years in England or no children under 18 years in England). The direction of any effect was noted, and the magnitude of any effect was reported. Associations involving items measuring motivation were reported for each such item on an individual basis. The associations between the outcome of satisfaction of decision to migrate and multiple and/or numerical and predictors and categorical outcomes were assessed using logistic regression methods.

Table 1
Survey sections.

"International Nurses and their Integration into the Health Workforce"	
1) Demographical background	14 items; including age, gender, country of birth, religion, marital status, languages spoken, region of work and family status.
2) Nursing background	8 items; including country and year of first nursing registration, academic qualifications, area of nursing and other countries where respondents had worked in as a nurse.
3) Application and interview process	9 items; including how respondents applied their job, whether England had been their first-choice location, and the extent to which respondents found the application process understandable, affordable and timely.
4) Motivations for migration	7 items that sought to engage the extent to which economic factors, desires to improve quality of life, desires to travel and advance nursing careers had informed respondents' migration decisions.
5) Initial arrival and settlement experiences	11 items asked how prepared respondents felt to travel, communication with employers and colleagues prior to travel, if the arrival process was clear and welcoming, duration intended to stay working in England, and if they felt settled post migration.
6) Working life	14 items sought to gauge if colleagues and managers were perceived as friendly and welcoming, whether training programmes prepared respondents for nursing in England; if respondents felt previous skills, qualifications and experience were matched to current role and salary, perception of communication barriers, any perceived experience of discrimination or racism; and satisfaction with housing and accommodation.
7) Support and future aspirations	9 items; explored if colleagues recognised respondents' learning needs, if they felt valued by employer, if and who they would speak to if something at work worried them, whether they felt work patterns enabled them to maintain a good work life balance; and if career aspirations were known and were being supported by employers.
8) Overall experience	6 items desired to gauge respondents' overall experiences of working for NHS England and the extent to which they felt happy with their decision to migrate.

Two analyses were conducted using: age and motivation; and family status (categorised as above) and marital status (categorised as single/divorced/widowed/separated or married/living with partner) as predictors. Significance levels, odds ratios and associated 95% confidence intervals were reported for all analyses.

Qualitative data analysis was informed by Braun and Clarke's (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 and synthesised with the quantitative findings.

2.6. Ethical considerations

Ethical approval was received from the University's School Research Ethics and Integrity Committee prior to dissemination of the survey. The research was confirmed by the Health Research Authority tool as not requiring formal NHS Research Ethics Committee approval as it was not medical research or clinical trial and did not involve service users. The survey required informed consent prior to commencing the questionnaire, and respondents were assured that confidentiality and anonymity would be maintained, and individuals would not be identifiable in any publications from the research.

Table 2
Demographic profile of the sample

Variables and selected categories	Frequency (valid %)
Age range	
21–25	61 (9.3%)
26–30	172 (26.2%)
31–35	256 (39.1%)
36–40	102 (15.6%)
41–45	45 (6.9%)
45–61	19 (2.9%)
Gender	
Female	551 (84.1%)
Male	104 (15.8%)
Country/region of birth	
India	252 (38.6%)
Philippines	149 (22.7%)
African countries	224 (34.1%)
Rest of the world	30 (4.6%)
Family status	
Married or civil partnership	408 (62.4%)
Single, never married	211 (32.5%)
First language	
English	232 (35.4%)
South Asian-based language	225 (34.3%)
Filipino-based language	142 (21.6%)
African-based language	15 (2.3%)
Number of languages spoken (after first language)	
Language option not provided	
No additional languages	9 (1.4%)
1 additional language	136 (20.7%)
2 additional languages	318 (47.2%)
3 additional languages	104 (15.8%)
	98(14.9%)
Years since first nursing qualification	
1982 - 1994	8 (1.2%)
1995 - 2000	24 (3.7%)
2001 - 2005	52 (7.9%)
2006 - 2010	194 (29.6%)
2011 - 2015	202 (30.8%)
2016 - 2021	143 (21.8%)
Previous highest nursing position before migrating to England	
Staff nurse/registered nurse	334 (50.9%)
Senior clinical level	118 (18.0%)
Management	39 (5.9%)
Educator	20 (3.1%)
Highest academic qualification	
Postgraduate diploma	41 (6.2%)
Master's degree	77 (11.8%)
Bachelor's degree	318 (48.5%)
Pre-university qualification	176 (26.8%)

3. Results

3.1. Demographic profile

In total, the survey received 705 responses, with 55 considered inadmissible (incomplete responses (n = 30) or not internationally recruited nurses (n = 25) (93 % admissibility rate) (n = 655). The predominance of women reflects the gender distribution of all nurses who joined the Nursing and Midwifery Council (NMC) register for the first time between March and September 2021 (85.2 % female versus 14.8 % male) (NMC, 2021). The ages of respondents ranged between 21 and 61 years with a mean age of 32.7 (SD: 5.8). The demographic profile is outlined in Table 2. Valid percentages in the table are based on all valid categories including supressed categories.

3.2. Nurse migration flows

Table 3.

455 respondents had migrated to England after being recruited by an employer or third party such as a recruitment agency (69.4 % of valid responses). 133 had applied for their job independently (20.3 % of valid responses), and within this subsample, 92 respondents (69.6 % of subsample responses) had applied from 'red list' countries (Ghana, Nigeria, Pakistan, Somalia and Uganda). The recruitment activities of employers and recruitment agencies are banned in these countries by the WHO's Code of Practice (2010) on the international recruitment of health workers. However, the Code does not prevent health workers in 'red list' countries from applying independently to work in a different country.

567 respondents (86.6 % of valid responses) had worked in another country as a nurse prior to migration (including their country of origin) and 131 nurses (20.0 % of valid responses) said they had worked in their home country followed by one or more countries in the Gulf Cooperation Council (GCC) (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates). When combined with nurses who had only worked in the GCC (and not their country of origin after obtaining their first nursing qualification), this equated to 215 nurses (32.9 % of valid responses). 117 respondents (17.8 % of valid responses) reported that England had not been their first-choice destination after deciding to apply for nursing employment in a different country. Of these, 38 nurses (5.8 % of valid responses) listed the United States as their preferred destination, 34 nurses (5.3 % of valid responses) listed Canada, 17 (2.7 % of valid responses) listed Australia, 16 (2.4 % of valid responses) and 10 nurses listed New Zealand (1.6 % of valid responses).

In total, 408 respondents (62.4 % of valid responses) were married and 325 nurses (49.7 % of valid responses) said they had children aged eighteen or under. However, 228 of these respondents (70.4 % of the subgroup with children) had migrated to England without their children. Overall, 305 of these nurses (93.8 % of those with children) said they would have liked their families to have travelled with them.

3.3. Migration motivations

The quantitative items sought to uncover the respondents' motivations for migration and the relative importance of differing factors (see Table 2). As noted, 567 nurses (86.6 % of valid responses) selected a positive response to 'career development' which corresponded with findings revealed by the qualitative data, in which nurses discussed in detail how career development had been a significant motivator to travel and work abroad. In the qualitative phase of the analysis, nurses cited specific factors of job stability,

Table 3
Summary of Likert responses to migration motivation items

Items and selected categories	Frequency (valid %)
Career development	
Positive response	567 (86.6%)
Neutral response	27 (4.2%)
Negative response	3 (0.5%)
Improve quality of life	
Positive response	561 (85.7%)
Neutral response	40 (6.2%)
Negative response	53 (8.1%)
Improve salary and pay	
Positive response	442 (67.6%)
Neutral response	94 (14.4%)
Negative response	117 (18.0%)
Lifestyle change and travel	
Positive response	356 (54.4%)
Neutral response	173 (26.5%)
Negative response	125 (19.1%)
Family and friends in England	
Positive response	216 (33.0%)
Neutral response	121 (18.5%)
Negative response	318 (48.6%)

career opportunities within specialist practices, career openings into management or education positions, and the opportunity to be able to work in a developed country with state-of-the-art technology that could provide high quality care and opportunities to learn cutting-edge skills. This view was reflected by a nurse who reported: "*my ambition is to work in one of the best healthcare systems in the world providing a first-class care without discrimination*". These views were appreciated in part, by comparison to the few opportunities to develop nursing careers in their countries of origin, as well as under-resourced healthcare systems and challenging working conditions.

561 respondents (85.7 % of valid responses) selected a positive response to the need to 'improve quality of life' item. In the qualitative responses, factors perceived as improving quality of life included free health care, work-life balance and general improvement of living standards. Nurses also discussed the quality education for children with some believing that the UK was the best place to raise a family. A safer, secure life was the wish for others, highlighting the instability and security concerns in their country of origin: *"[I came] to work in a society that protects my rights, appreciates the work I've done, pays me well and offers a work life balance."* The odds of a respondent being '*happy with their decision*' to move were approximately 2.4 times higher in nurses who had decided to migrate to England to improve their quality of life.

A lower figure of 442 respondents (67.6 % of valid responses) selected a positive response when asked whether their migration had been motivated by the need to improve their salary and economic circumstances. In the qualitative responses' nurses explained how they migrated to financially support their families 'back home' or, longer-term, to bring their family to live with them. However, not all international nurses migrate purely for economic reasons: indeed, one respondent reflected that "*we actually earn more from where we previously worked but the UK offers a better life*".

356 nurses (54.4 % of valid responses) selected positive responses to the 'desire to travel and experience a different lifestyle' and 216 (33.0 % of valid responses) selected a positive response to 'family and friends' items. It was noted that predominately, younger respondents who had worked as a nurse in a country before migrating, answered favourably to statements that having family and friends in England motivated their migration. Years of experience was also revealed to be significantly associated with motivation-related items. In all areas, older nurses were less likely to report positive responses to the motivation questions, with each year of experience associated with a reduction in the odds of a positive response.

3.4. Job applications

522 respondents (79.7 % of valid responses) returned a positive response to the statement asking whether the application process had been clear and understandable, and 448 nurses (68.4 % of valid responses) returned a positive response when asked whether the application process was affordable. Consistent with quantitative items, analysis of the qualitative data found that jobs application were perceived as clear, understandable and timely, with the process on average taking between 3 and 6 months. Application experiences with agencies and employers were in general positive, and any delays were not system-related and reported to be because of the pandemic or individual health issues, although some frustrations were reported with delays to emails. Responses from respondents who indicated that the application process had not been affordable centred on upfront fees which recruitment agencies had provided through loans or employers and provided refunds/reimbursements on commencement of employment. Other respondents reported that only partial, or no up-front fees were required, as visas and air tickets were paid for by employers. Affordability challenges were recognised in terms of the requirement of up-front funding and the process being financially demanding from application to arrival, in recognition of nurses recruited from developing countries with low economic status.

3.5. Arrival experiences

487 nurses (74.7 % of valid responses) returned a positive response when asked whether they felt prepared to start a new life in England prior to travelling, and 332 respondents (50.8 % of admissible responses) agreed with the statement that they had a good understanding of British culture before making the journey.

Moreover, 503 respondents (77.3 % of valid responses) answered positively to a survey item probing their satisfaction with their travel to England, and 506 (77.2 % of valid responses) felt they understood what would happen once they arrived. Despite challenges due to the pandemic and quarantines, qualitative responses were overall positive. There was recognition of the difficulties of reuniting with family due to visa problems, an experience which, overall, resulted in feelings of isolation, anxiety and stress. However, many respondents described positive elements, stemming from efforts by employers to make overseas recruits feel welcomed upon arrival. These included being met by an enthusiastic employer at airports, timely transportation to accommodation where they were given something to eat, being shown around the local amenities such as churches and shopping facilities, and the practicalities of registering with doctors and opening bank accounts.

The challenge of finding accommodation in the early arrival stage was made clear. After an initial one-to-four months employment, international nurses in England are frequently expected to find ongoing housing for themselves within local private-rented housing markets, something that was particularly difficult for some to arrange. The reported concerns were mainly around availability of suitable accommodation, landlords' requests for guarantors and credit checks, and difficulties associated with costs (including both up-front fees and monthly rent and utility costs).

3.6. Communication

315 respondents (48.2 % of valid responses) returned a positive response when asked whether they had any problems communicating with patients and colleagues. In the qualitative data, difficulties were related to the understanding of accents and slangs;

perhaps only in some contexts, or with some patients and colleagues, but not all. The association between country/region of origin and whether nurses were able to understand accents and slang when communicating with patients was assessed using a chi-squared test for association. The association was significant, with a substantially higher proportion of nurses from the Philippines reporting communication difficulties than nurses from elsewhere. Whilst all internationally recruited nurses in England complete the international English Language Test (IELTs) and can speak and read English to a proficient standard, conversation speed, accent, abbreviations and regional dialects are understood to be the main barrier to communication, as reflected in the following quote: *"I am still trying to cope with the accent, it seems they are too fast. The employer has been very supportive in every way and that makes easier for me to settle in"*. Further comments *"Communication barrier to some of our patients due to their accent and old age [are challenges] I guess. Through more exposure to them, I am expecting that I will be able to fully communicate with them effectively"*.

3.7. Experiences of support

Support for international nurses usually includes pastoral care, training and development opportunities and involvement in specific staff networks. 472 nurses (72.1 % of valid responses) returned a positive response when asked whether they felt the employer understood their challenges and had provided them with excellent support. When exploring support mechanisms, 363 (55.5 % of valid responses) identified work colleagues (55.5 %) as their main source of support if something at work worried them. 251 (38.4 % of valid responses) identified a combination of work colleagues, family and friends as a source of support, and 40 (6.0 %) said that they would only speak to their family and friends. The support infrastructure for new international nurses appears to have met and, in some cases, exceeded expectations: *"My pastoral counsellor is a unique individual who has shown me support beyond expectations, she has been like a mother, not to only me but to other international nurses."*

However, for others, there was the suggestion that more support was required: "I have mixed feelings about my experience working here. On the one hand, I'm happy to be learning new ways of doing things, but on the other hand, I feel thrown at things without any proper coaching or support from my colleagues." For the small number of nurses who felt they had received inadequate support, this was tied closely to negative mental health outcomes such as stress, depression and isolation: "More supportive and checks on international nurses are required. Support should be individualised rather than generalised. For some there is no difference, yet others drown in depression, regret and indecisiveness. Even the strongest nurse breaks when faced with the realities of migration, and I am no exception."

It is worth noting that most nurses felt patients did not treat them differently from colleagues based on nationality, ethnicity, or religious beliefs. When the same question was asked about whether they perceived colleagues treated them differently, the proportions were broadly similar and on the whole overwhelmingly positive. The qualitative responses were mixed, with some nurses praising the zero-tolerance policy in their workplaces with one nurse saying it *"helped me feel valued and appreciated"*. However, another said they perceived themselves as being bullied through their colleagues' actions, whilst others were frank about their experience of racism at work and within wider UK society. One nurse explained the difficulties of motivating UK-born staff: *"Those on lower bands don't respect you, don't take instructions and help out with the work because you are not British. When they work with seniors who are British, they do their jobs without being told."*

3.8. Deskilling

As noted in Table 2, the majority of respondents had been qualified in nursing for a considerable amount of time prior to migration. However, 166 respondents (25.4 % of valid) selected a negative response (strongly disagree and disagree) when asked whether they felt previous experience and qualifications were matched by their current role. Many narratives were presented about experienced nurses with management expertise or specialist clinical skills that were not recognised or transferred into their current roles. In many cases, international nurses were being allocated to areas solely based on where the vacancies existed, without consideration of past experience and suitability. One international nurse who had decades of nursing experience reflected on a recurrent issue: *"I am in the graduate programme, which is meant for newly qualified nurses, however I have close to two decades of nursing experience and many of these have been in critical care.* Limited freedom to choose a specialty area left another nurse questioning her role, and concerned about the lack of structured career pathways for international recruits: *"I feel I am not in the right role and there is no clear pathway for advancement as an international nurse."* No matter how many years of experience or their previous qualifications, international nurses seem to be placed in junior positions. Lack of recognition of experience and qualifications combined with this entry level pay appeared to leave the nurses feeling unsettled, dissatisfied and frustrated: "*I have 17 years of experience and a nurse who is just passed out of college are kept in the same band 5 with no pay or position difference.* This in turn, led to lack of fulfilment in roles, with some indicating a potential impact on factors that affect international nurse retention such as job satisfaction: *"My current role does not satisfy me. My role and payment do not reflect my years of experience, my qualifications and my skills. It is painful and it makes it difficult for me to experience job satisfaction"*.

3.9. Plans to stay

323 respondents (49.3 % of valid responses) expressed a desire to stay in England for the long-term and 171 nurses (26.1 % of valid responses) were 'undecided', a measure we perceive as representing hesitancy about long-term plans to stay. Similarly, 350 nurses (53.5 % of valid responses) returned a positive response when asked whether they felt settled in their new life. The nurses were also asked if they were happy with their decision to move. Despite the mixed picture in the qualitative data, 552 respondents (84.3 % of valid responses) returned a positive response, 62 nurses (9.6 % of valid responses) returned a neutral response and 24 (3.8 % of valid

responses) returned a negative response.

4. Discussion

Globally the pace and scale of nurse migration has grown significantly in recent years as developed countries have turned to international recruitment to mitigate domestic workforce shortages, determining that presently nurse migration is at an all-time high (Buchan et al., 2022). In view of this, it is cautioned reliance from developed countries on overseas recruitment has ethical ramifications and poses the ongoing threat of depleting other nursing workforces (Laws, 2022). Healthcare systems are thus counselled against predominantly considering this short-term solution to the detriment of distracting focus from longer term stability options such as prioritising efforts to advance growing the domestic workforce (Davda et al., 2018). A further essential consideration is that supply of international nurses is not infinite, and globally there are far reaching implications of continuous recruitment cycles. It is therefore advised a proactive move towards viewing recruitment and retention as symbiotic could ensure greater and more principled stability within individual healthcare systems to impact reimbursing and strengthening the whole of the global nursing workforce position (Buchan et al., 2022; Pressley et al., 2022).

It is accepted that in principle, nurse migration is mutually beneficial to both host and healthcare provider nations, as recruitment from low-and middle-income countries offers opportunity to better the lives of individuals and families of migrating nurses, whilst at the same time meeting healthcare workforce needs (Stokes and Iskander, 2021). While there is undoubtedly a matrix of proposed opportunity bourn of migration, incentives must be realised in the reality of the experience of the individual nurse living and working in a host country (Adhikari & Melia, 2015). In view of the importance of realising migration aspirations, this study set out to explore the initial integration of international nurses and motivations for migration within a developed nation's healthcare system (England). Overall, findings on the professional challenges new recruits experienced when initially starting work in England were broadly similar to the experiences of international nurses reflected in the wider global literature (Bond et al., 2020; Davda et al., 2018; Newton et al., 2012). This study presents a picture of most international nurses being well supported by employers during initial application and arrival stage, something that appeared to temporarily offset feelings of isolation, anxiety and stress in the short term (Leone et al., 2020; Alexis & Shillingford, 2015),

Migration may be negatively experienced for individuals that experienced a degree of challenge during workplace integration with fluctuating levels of support and if appointed into positions that do not match their years of experience and previous qualifications (Pressley et al., 2022; Palmer et al., 2021; Salma et al., 2012). This study highlights that many International nurses initially experienced difficulties with communicating at work due to idiosyncrasies such as speed of conversations, colloquialisms and accents, reported as being a confidence barrier and perceived cause of cultural displacement, recognised as obstacles to career progression and truly fitting in (Chun et al, 2019; Al-Hamdan et al., 2015; Allan and Westwood, 2016). That said, what is apparent from insights is that negative experiences are wholly reported in the minority and there were many constructive recounts of excellent support offers and efforts being made to ensure positive experiences of international nurses in the initial integration phase of the first four months post migration.

Understanding demographic profiles, personal circumstances and migration motivators advises a host country on plans for supporting longer term settlement needs. In the case of this study, large numbers of international nurses reported wishing to be reunited with displaced families and there was a recognised difficulty with this repatriation acknowledged to be due to the restrictions of visas (Humphries et al., 2009; Kingma, 2018). International nurses also highlighted concerns around availability of suitable accommodation, traversing landlords' requests for guarantors and credit checks, and difficulties associated with costs. Findings suggest a background of conditions that within the first four months of recruitment could be navigated or even accepted as transient, however in the longer term, if not effectively resolved may compromise ability to remain working in a healthcare system. Hence, perhaps the reason a proportion of participants reported being undecided about longer term plans to stay. Furthermore, perhaps resulting from compounding issues, our findings showed where difficulties are faced during initial arrival and integration there is an apparent potential detrimental impact on mental well-being (Alexis & Shillingford, 2015). These findings suggest there is a need to explore further the international nurse's life outside of work and over a longer period of time.

Setting this abstract in the wider context of the findings reveals in the main, a population of international nurses that are highly educated and vastly experienced, with career development and desires to improve quality of life being the primary motivations for migration. What is not clear from our study and other studies is at what point in time or event migration motivations are perceived as being vociferously realised. If as suggested migration aspirations are achieved through international nurses accessing professional development to influence career fulfilment and when satisfied with the quality of lives they are living in host countries, it is reasoned this may only be accurately measured extending beyond the timeframe of this study (Shaffer et al., 2022; Bond et al., 2020). This limitation suggests that whilst insight into initial integration of international nurses can be, and is reported in the findings, longer term likelihood of successful enculturation and ultimately longevity of retention outcomes through migration aspirations being realised are seemingly not identifiable beyond conjecture due to this studies timeline.

Assuming international nurse health professionals are a homogeneous group would imply that they leave, return and stay for the same reasons which as this study suggests is not an accurate representation and could lead to a misinterpretation and oversight of distinctively individual important issues (Pressley & Garside, 2023; Young et al., 2014). What's more, system level insight into knowing whether international nurses are on a trajectory to successfully attain migration aspirations must not be dismissed if it is at all possible to determine. Indeed, the consequences of migration aspirations remaining unmet can lead to feelings of frustration, resentment, disillusionment and ultimately dissatisfaction known to correlate with nurse intention to leave. This, if scaled up to the size of the recent recruitment efforts could impact catastrophically and damage both the short term and longer term sustainability

within whole healthcare systems (Buchan et al., 2022; Leone et al., 2020; Alexis & Shillingford, 2015; Young et al., 2014). Therefore, proactively reflecting on what is identified within the albeit bounded reality of this study allows us to ascertain an appreciation of holistic migration needs with a view to considering forecasting in this somewhat unchartered territory of evidence what multi-policy interventions healthcare systems can offer in a bid to retain the international nurses currently working in our healthcare systems.

It is manifested from this study's findings that choosing to work in a particular healthcare system and being afforded, should one wish, to stay in the longer term are not unanimously linked. The needs of international nurses during the initial onboarding phase captured within this study such as engendering inclusion, promoting the feeling of being valued, growing individual confidence and building a sense of agency in the workplace are universally acknowledged (Alexis & Shillingford, 2015; Leone et al., 2020). Yet these are nuanced from the challenges of circumnavigating the longer-term settlement needs such as career development obstructions, feeling professional talents are overlooked and maximising potential; means to affordable appropriate housing, support with visas, and repatriation with loved ones (Pressley et al., 2022; Leone et al., 2020; Alexis & Shillingford, 2015; Young et al., 2014). Without suggestion these reimbursements are looked to be endorsed through interventions and system change that will ultimately improve quality of lives, it is beyond the scope of this study to offer opinion (Buchan et al., 2022).

Indeed, reflectively as we draw this discussion to a close, literature describes how international recruits have faced similar experiences in England for some time and whilst employers are making progress in some areas, they are continuing to fall short in others, suggesting that applications to ensure positive migration experiences are met are not universal (Nichols & Campbell, 2010; Bond et al., 2020). Bond (2022), invites debate that issues are not profession specific and are indeed reflected in the wider sphere of international migration. That said the size and scale of nurse migration to work in England in recent years imparts a growing urgency for the healthcare system to independently respond (Buchan et al., 2022). Nurses in low- and middle-income countries have skills, experience and knowledge that makes them highly employable in developed countries. This affords them future licence to move around healthcare systems at liberty and employers should be alert that in an employee's market, this proven transient workforce could readily onward migrate again should interventions not serve to coalesce all that happens into one connected whole that realises the ability to thrive at work and live well in England.

5. Conclusion

This research offers an insight into international nurses' experiences of initial integration with the healthcare system of a developed country (England), and it is suggested there is merit in the transferable relevance extending the profession of nursing. That said, as the synthesis of the discussion unfolded it was acknowledged that whilst findings provide valuable insight, they were somewhat transactional with narratives often descriptive, perhaps limited by the time period of just considering the first four months post migration. It is reflected how the study captures assimilation but does not extend to determine a true perspective on multiculturalism, thus limiting abilities to advise with certainty at this point what experiences correlate with retention in the longer term (Bond, 2022). The study considers issues raised during initial integration period that may present barriers to securing longer-term retention and highlights opportunities to improve migration experiences but what was not captured was the intrinsic reality of migration experience such as living in a transnational family and how issues such as these may surface more as the busyness of initial migration settles into everyday routines (Bond, 2022). It is therefore suggested this study could be complimented further by exploring unknowns such as life outside of work and how experiences of international nurses will change over a longer period of time. Adding this knowledge to insights could ultimately advise achieving the outcome of global sustainability and self-sufficiency of nursing workforces through increasing retention capabilities within individual healthcare systems.

CRediT authorship contribution statement

Charlene Pressley: Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration. **Dillon Newton:** Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration. **Joanne Garside:** Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration. **John Stephenson:** Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration. **Joel Mejia-Olivares:** Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration.

Declaration of Competing Interest

None.

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Supplementary materials

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