WORK→INT

Assessing and enhancing integration in workplaces

RESEARCH REPORT

WORKPLACE INTEGRATION OF MIGRANT HEALTH WORKERS IN THE UK

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1. Introduction and methods

1.1 General design and research objectives

In the last decade, the healthcare sector in Europe has undergone growing labour shortages, which have been increasingly filled by international migrants, although with significant differences according to the various national contexts. Institutional and regulatory framework of the national health systems, highlighted shortages of national staff in the health sector, national policies aimed at filling them and at regulating the recognition of educational and professional titles of EU and non-EU migrant health workers (MHWs) and their access to the health labour market vary sensibly according to the different European countries (see Background national reports). As a result, non-EU and EU MHWs contribute to different segments of the health industry, with highly varying degrees of integration into this sector[1], according to the different European contexts.

While most of the studies on the economic integration of migrants into the European labour market and its impact on the broader society has been mostly concentrated on the macro level, mainly using quantitative approaches, little empirical evidence is available on the micro-level, namely in workplaces. However, the contexts where the integration into the receiving economies and the interaction between immigrant minorities and native majorities take place and can be primarily tackled is within firms and specific workplaces.

Furthermore, the research available on the foreign labour force in European countries has been mainly focused on the supply side, i.e. on the analysis of the processes and outcomes of insertion of immigrant workers in European labour markets, while the perspective of the demand, i.e. of employers, but also the concurrent role of other relevant actors, such as trade unions, professional associations and other civil society organisations has been generally downplayed. The latter are key actors in the dynamics of labour market integration of migrant workers at different levels and their perspective and role need to be integrated more systematically in the study of migrants' integration in workplaces.

The WORK-INT project aims at contributing to the broader scientific debate on the labour market integration of migrants in the health sector in Europe, by adopting a research approach, which is *qualitative*, i.e. allowing in-depth insights on the phenomenon; *micro-level*, i.e. taking workplaces (hospitals) as a main context of analysis; *multi-stakeholder*, where the role, the perspective and the professional and inter-personal relations are taken in consideration according to the different involved actors (employers, national, EU and non-EU employees, trade unions, professional associations, etc.).

The MHWs' integration at a workplace level was studied, in particular, as based on four main dimensions (Zincone, 2009): the *systemic dimension* (health care firms' policies or specific measures concerning the recruitment and integration of MHWs and impact of MHWs on the competitiveness and efficiency of health care services); the *individual dimension* (subjective wellbeing, perception and degree of satisfaction of own

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[1] See Villosio, 2015 for a comparative statistical analysis on Migrant Health Workers in the health sector in the 5 target European countries, based on Eurostat Labour Force Survey (EU-LFS) data.

integration within the workplace, etc.); the *relational dimension* (considering horizontal and vertical relations, i.e. with colleagues in equal and higher/lower positions); the *transnational dimension* (declined as the ties with the health workers' community in the country of origin and/or in other countries, the contribution to the origin country as a professional while abroad and the intentions to return as a health worker in the country of origin or to re-migrate elsewhere)[2].

The WORK-INT research is an EIF-EU Commission funded project aimed at assessing and analysing the integration of immigrant workers in private and public health structures (hospitals) in five European countries: Ireland, Germany, UK, Spain and Italy[3].

As a first step, background reports were prepared in each target country, with the objective of providing an overview of: the institutional and regulatory framework of the health system in each target country; the shortages of national staff in the health sector and the national policies aimed at filling this gap; the active admission policies of non-EU MHWs; the policies regulating the recognition of educational and professional titles of EU and non-EU MHWs; the regulations concerning the access of MHWs to the health labour market in each country.[4]

As a second phase, a fieldwork research was undertaken in 5 medium-large European cities hosting large numbers of migrant workers: Dublin, Hamburg, Oxford, Madrid and Turin[5]. In each city two health structures (hospitals) were selected as case studies. Managers, human resource officers, non-EU/EU/national workers were interviewed using a common protocol of research, including common qualitative guides for interviews for national/foreign workers, managers and other stakeholders.

1.2 The UK context

Migrant health professionals form an important and numerically significant component of the UK health sector labour force and have done so since the Second World War. As described in the UK WORK-INT background report, actual numbers, particularly of migrant doctors and nurses who are the subject of this research report, have fluctuated over time according to national health workforce shortages and concerted government recruitment drives abroad (Jayaweera 2015). In 2013 while the share of non-UK born people in total employment in the UK was 15.2%, migrants were over-represented among health professionals - 25.2%

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[2] For further details, please see Castagnone and Salis, 2015.

[3] For further information, see: www.workint.eu

[4] All reports from the WORK→INT project can be downloaded here: http://www.work-int.eu/research-materials/

[5] In each city, the study was undertaken by a local research institution, which is partner of the WORK-INT project: FIERI in Turin, COMPAS in London, Universidad Complutense de Madrid in Madrid, Hamburgisches WeltWirtschafts Institut in Hamburg, Trinity College of Dublin in Dublin. The project includes also a policy dialogue component, coordinated by the IOM Regional Office in Bruxelles.

(Rienzo 2014). More specifically around a fifth of nurses and a third of medical practitioners in the UK are born abroad (Sumption and Young 2014).

The UK background report highlighted the continuing importance of doctors and nurses from outside the UK for the healthcare sector. But it also suggested that at present there is a qualitative shift away from a reliance on high-skilled 'foreign' labour to a 'native' workforce educated and trained in the UK, manifested in government rhetoric on health sector workforce planning, and language around increasing immigration restrictions on entry and settlement of high-skilled workers under-pinned by a rationale of achieving better integration of migrants (Jayaweera and Oliver 2013). At the same time there is evidence of emigration: UK born and qualified doctors and nurses going abroad to work in countries like Australia, New Zealand, Canada, and increasingly East Asia for doctors (General Medical Council 2014; Royal College of Nursing 2014). The background report also showed that there is a quantitative shift recently from the prevailing pattern in post-war Britain of recruitment of doctors and nurses from Asia, Africa, and the Caribbean countries – many, but not all, former colonies – to those from European Economic Area (EEA) countries.[6] Some of this has taken the form of active recruitment campaigns, particularly of nurses in the EEA. Some of the factors associated with this shift are the freedom of movement rights and automatic recognition of qualifications of EEA nationals coupled with the enlargement of the European Union (EU) and the current economic crisis in some countries, and adherence to the WHO Code of Practice on not depriving developing countries outside the EEA of essential healthcare practitioners (Jayaweera 2014). EU registrants to the Nursing and Midwifery Council (NMC) register made up 7% of new overseas registrations in 2003/4 but reached 87% in 2013/14 (Royal College of Nursing 2014 (Royal College of Nursing 2014). In the General Medical Council (GMC) register the proportion of EEA graduates has grown by 19% between 2010 and 2013 compared to a growth of 2.8% for (non-EEA) International Medical Graduates (IMGs) in the same period (General Medical Council 2014). Nevertheless, the stock of doctors and nurses originating in countries outside the EEA still exceed that from within the EEA (Sumption and Young 2014): for instance, 10% of all doctors in the medical register in 2013 had their primary medical qualifications in an EEA country while just over a quarter (26%) were IMGs (General Medical Council 2014).

This research report is about the integration of migrant health professionals specifically in UK healthcare sector workplaces. In accordance with the aims of the larger European project we focus on doctors and nurses in hospital workplace settings; and specifically on one public (NHS) hospital, and one private hospital in a city in the South East of England.

1.3 The analytical framework

The term 'integration' refers to the relationship between migrants, and people and institutions in the receiving society. As Spencer (2011) states, in the use of the term in UK debates more than in Europe there have been connotations of migrants 'becoming like' members of the receiving society – that is, integration as a one-way

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[6] The EEA combines the countries of the European Union and member countries of EFTA (European Trade Association).

process towards a desirable outcome only for migrants, and with lesser emphasis on structural and individual barriers constructed in the receiving society. In this report, following Spencer we conceptualise integration not as a single process but as a series of processes that are two-way – i.e. undertaken by both migrants and receiving society institutions and residents – and taking place in several domains. These have been denoted as structural (e.g. participation in employment and education); social (interactions and relationships between migrants and established residents); cultural (referring to values, attitudes, behaviour of both newcomers and established residents); civic and political (participation in community life and political processes) and identity with people and places (Spencer 2011).

The integration domains can all be applied specifically to the workplace, for instance structural (e.g. recognition of qualifications, career progression), social (workplace relationships), cultural (e.g. changes in attitudes, work practices, and receiving country work colleagues' attitudes towards migrant colleagues), civic/political (participation in workers' organisations) and identification with those in receiving and/or origin countries. Factors that facilitate or impede integration processes (Spencer 2011) are: those relating to migrants (e.g. qualifications/skills, receiving country language fluency, work motivation); those relating to the receiving society (e.g. opportunities for career progression, institutional discrimination, attitudes of colleagues and managers); and policy levers such as immigration rules and those imposed by the professional regulatory bodies, as well as policies and measures relating to equality and diversity in employment and workplaces. In the light of the findings of qualitative interviews with managers, migrant doctors and nurses and their British colleagues in the hospitals we will consider the extent to which, and how, integration may be occurring in and through the workplace.

The key research question framing the project was: what are the factors that affect the workplace integration of migrant health professionals? Some of the factors that were considered were the role of migration and ethnic background and the impact of changing immigration rules on integration across different domains. Attention was also paid to how specificities of the health sector and the specific organisation of each hospital impacted on workplace integration. The analysis also considered whether there were similarities or differences in integration patterns between health professionals from the EEA and those from outside the EEA, whether there were notable differences in integration processes between the NHS hospital and the private hospital and whether there were differences between doctors and nurses. Finally, the analysis also paid attention to the relationship between equality and diversity policies and the reality of incorporating diversity in the workplace.

1.4 Methods

In the UK, two hospitals in South East England were selected for the workplace case studies. One institution was a large public hospital in the National Health Service (NHS), the other a smaller private hospital which formed part of a larger organisation providing private healthcare around the UK. Management of each institution was approached with an invitation to participate in the research. In addition, for the public NHS hospital, further permission to conduct research was given by the University Central Ethics Committee and the research office of the relevant NHS Trust. Gaining this permission required extra paperwork and transposing

of the original research framework into a NHS research framework and added considerable time delay to the start of the fieldwork.

In each institution the aim was to interview representatives of management, migrant health workers (specifically doctors and nurses) and British health workers in order to gain multiple perspectives on the integration experiences and challenges faced by migrant health professionals. In total 41 interviews were conducted. All interviews were anonymised.

Twenty-two interviews were conducted in the smaller privately-run hospital, including three interviews with senior management staff and human resources (HR). Owing to the nature of the services offered at this hospital, very few doctors were employed directly by the organisation. As a result the majority of our interviews in this hospital were with nurses. The HR manager organised all interviews for us and provided a room on the premises in which the interviews were conducted. Staff to be interviewed were recruited from the two main areas within the organisation, the theatres and the wards. Staff were invited to take part by the HR manager and provided with the information sheet about the research and the consent form. At the beginning of each interview, each participant was fully briefed, given an opportunity to ask any questions and told they could withdraw from the study at any point. Written consent was obtained from each participant. All interviews were audio-taped and fully transcribed.

Table 1: Number of interviewees by region of origin in the private hospital

Region	Number
UK	11
EEA	6
Outside of the EEA	5

Table 2. Number of interviewees by occupation in the private hospital

Occupations	Numbers
Nurses	15
Health care assistants	2
Management	3
Administrative staff	2

We were able to interview a range of nationalities across a range of grades within the private hospital but our access to participants was mediated by HR. While this greatly facilitated our ability to contact people and actually arrange interviews in working hours, it could have a number of implications for the research findings. One possibility is that participants may have been selected on the basis of whether they would provide positive responses about the hospital, although interview responses showed that this was not always the case. Participants may also not have made up the most representative sample of the staff population. These potential limitations were kept in mind during analysis of interviews and writing of the report.

Once permission was granted for the research to be conducted in the NHS hospital, and following three interviews conducted with HR and senior management, recruitment followed a snowball sampling method. Heads of targeted directorates (see Section 2.1) were approached and asked to circulate the call for participation. Management also provided some key initial contacts. As a result, the participants were focused in two broad clinical areas: children's and women's medicine; and acute medicine. As fieldwork in the private hospital had focused on nurses, doctors were more deliberately targeted in the NHS hospital. Interviews were conducted outside of work time, often on the premises or in a convenient location near to the hospital. Participants were usually sent the information sheet by email in advance of the interview, and then briefed and given an opportunity to ask any questions before the interview began. As in the private hospital interviews, written consent was obtained and interviews were audio-taped. In total 19 people were interviewed in the NHS hospital.

In the NHS hospital, it was much harder to recruit participants to the study. Despite numerous emails going out on different channels, very few responses were received. Of those that were received, it is likely to have been a somewhat self-selecting group, those with stories to tell, or who had an interest in the research for some personal reason. Finding British colleagues was particularly challenging, perhaps because they did not feel that the research project was relevant to them. As a result we relied heavily on participants asking their colleagues to participate. Finally, senior doctors (consultants) are overrepresented in our sample. This is likely to be due to the fact that at more senior levels many (although not all) doctors have more regular working hours, whereas junior doctors are working very long shifts and/or anti-social hours. Unfortunately, due to limitations in the time available for fieldwork, it was not possible to seek other ways to try to recruit under-represented groups.

Table 3. Number of interviewees by region of origin in the NHS hospital

Region	Number
UK	7
EEA	3
Non-EEA	9

Table 4. Number of interviewees by occupation in the NHS hospital

Occupation	Number
Nurses	4
Doctors	12
Management	3

Across both organisations, interviewees were predominantly female, with only eight male participants in total. This reflects the fact that women are over represented in the health sector workforce and also formed the majority of the workforce in both hospitals (see Section 2.1). In total across both organisations interviews took

place with individuals of the following nationalities: Australian, British, Canadian, Ecuadorian, Filipino, Hungarian, Indian, Italian, Maltese, Portuguese, Singaporean, Spanish, Sri Lankan, Zimbabwean. For the remainder of the report we will use the categories of British, EEA and non-EEA to avoid identifying participants. A full anonymised list of interviewees can be found in Appendix A. One limitation of the study is that interviews were only conducted with staff directly employed by the organisations, and so no agency or bank staff were included in the analysis. Although bank and agency staff play an important role in health sector workplaces in the UK (see Section 2.1), limits of time and access meant that it was not feasible to include them within the scope of this research.

Interviews followed the interview guide that had been developed prior to the fieldwork being conducted. Each interview lasted between 40 and 60 minutes. Interviews covered the following main themes: career background and educational history; relationships in the workplace; opinions on diversity in the workplace; experience and opinion of equality and diversity policies. Interviews with migrant health professionals also included questions about their intentions to return to their country of origin. All interviews with health professionals were fully transcribed and were analysed using NVivo qualitative software, Version 10.

In addition, stakeholder interviews were carried out with representatives of nine organisations working in the health sector in areas of relevance to project's aims. These included representatives from organisations representing overseas doctors, NHS Employers, the British Medical Association, the General Medical Council, the Department of Health, the Royal College of Nursing, Thames Valley Health Education England (see Appendix A for full list). For these interviews, a specific interview guide was written for each organisation. The interviews were typed up in note form.

The rest of the report is organised as follows. In Section 2 we describe the organisational structure of the two case study hospitals, present available data on characteristics of the workforce in each hospital and examine their policies, practices and discourses around recruiting and employing migrant doctors and nurses. We also discuss policies supporting workplace integration at national, health sector, and hospital levels. Sources of information for Section 2 include documentary evidence and interviews with clinical and HR management in the two hospitals. In Section 3 we analyse perspectives of interviewees – migrant workers, UK colleagues and managers – regarding experiences of and factors affecting the integration of migrant doctors and nurses in the workplace. In the concluding section of the report we discuss the evidence for the workplace integration of migrant health professionals in relation to the concept of integration as a two-way process and with reference to the different domains of integration.

2. Systemic integration of migrant doctors and nurses in the hospitals: policies, practices and discourse

2.1 Organisational structure, recruitment and employment of doctors and nurses

2.1.1 The NHS Hospital

This hospital is part of one of the biggest NHS teaching trusts[7] in the UK. It provides services across most acute medical and surgical specialities and contains the region's main accident and emergency department. Medical teaching, training and research are an integral element of the hospital's organisation and are linked with the two main universities in the city.

Overall the Trust employed 11,657 people as of August 2014. Of these 7,102 were employed in the hospital. Clinical services in the Trust are distributed across five main divisions (most of which are included in the hospital) headed by a triumvirate of divisional medical doctor, nurse, and manager. Under each division, there are 2 – 4 clinical directorates led mostly by a doctor but in some cases an Allied Health Professional (AHP), and supported by a Matron. These directorates encompass most areas of medicine within which specialities - led by clinical leads, usually Consultants[8] - are organised. As one of the management interviewees pointed out, while the workforce in the hospital is very diverse in terms of ethnicity and nationality, "*the level of diversity diminishes somewhat as you get more senior within the organisation*." Right at the top, the Trust Board at present is not only all White, but also predominantly male. A little lower down, the Consultant body as a whole is quite diverse, but leadership roles are less so.

In August 2014 there were 7102 staff employed in the hospital, and three quarters (76%) were women.[9] In this, the hospital is representative of the NHS in England as a whole: women make up 77% of the total NHS workforce.[10] Over three fifths of all staff in the hospital occupied clinical roles: 16.7% were medical or dental, 33% were registered nurses or midwives, and 12.6% were in clinical support roles such as healthcare assistant, helper, phlebotomist.

Table 5 gives the top 10 countries of birth of hospital staff. It is noteworthy that nearly 64% of all staff chose not to state their country of birth, therefore the information is somewhat limited. However, we can see that the top five countries other than the UK replicate current key national patterns of recruitment and employment of overseas workers from the EEA and outside Europe in the UK health sector (Sumption and Young 2014).

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[7] Hospital Trusts in England are organisations commissioned to provide secondary health services within the National Health Service (NHS).

[8] In the UK a Consultant is a senior hospital-based doctor who has completed speciality training, holds a Certificate of Completion of Training and is on the GMC Specialist Register.

[9] All the data in this section was directly provided to us by the Information and Data Quality section of the Trust HR division.

[10] http://www.nhsemployers.org [accessed: 06/02/2015]

Table 5. Top 10 countries of birth of all staff

Country of birth (total n=7102)	%
Unknown	63.7
United Kingdom	23.8
India	1.9
Spain	1.3
Philippines	0.9
Portugal	0.7
Ireland	0.6
Poland	0.5
Germany	0.4
South Africa	0.4
Nigeria	0.3

Source: hospital HR division

Table 6. Top 5 countries of birth of medical/dental and nursing/midwifery staff

Medical and Dental (total n=1266)*		Registered Nursing and Midwifery (total n=2354)*	
Country of birth	%	Country of birth	%
Unknown	41.8	Unknown	62.0
United Kingdom	34.8	United Kingdom	21.4
India	4.8	Spain	3.8
Ireland	1.2	Portugal	2.8
Sri Lanka	1.2	India	2.4
Germany, Greece, Italy, Australia	1.0% each	Philippines	1.5

* In these staff roles there are small numbers in each country except UK, therefore numbers are not given in the table to protect anonymity of individuals. Source: HR division

Table 6 gives the top five countries of birth of doctors and nurses only. Again, the largest proportion did not state their countries of birth, as this question was optional. Nevertheless, the patterns in the table are interesting – for instance the relatively larger proportion of nurses from EEA countries at present, and the countries of origin of doctors reflecting both current and past recruitment patterns – and confirm accounts of recruitment given by hospital managers and health professionals in the interviews, as shown below. An analysis of the distribution of UK and non-UK born staff within clinical directorates in the hospital also

demonstrates that the main countries of birth shown in Tables 5 and 6 – especially India, Philippines, Portugal and Spain - are fairly evenly distributed across clinical areas.[11]

Table 7. Clinical directorates in which there are >50 non-UK nationals

Directorate (total)	Non-UK nationals
Acute Medicine and Rehabilitation (n=1146)	178
Anaesthetics Critical Care and Theatres (n=634)	99
Children's (n=760)	69
Specialist Surgery (n=489)	67
Cardiology Cardiac and Thoracic Surgery (n=497)	63
Neurosciences (n=409)	63

Source: HR division

Table 7 shows the clinical directorates with the largest numbers of staff with non-UK nationalities. While nationality is a better indication of more recent migration than country of birth, again the information is not very indicative of actual patterns because of high missing numbers for this variable. However it does show the substantial presence of non-UK nationalities in the main clinical directorates in the hospital.

Table 8. Ethnic groups with more than 1% medical and dental staff*

Ethnic origin (total n=1266)	%
White – British	47.9
Not Stated	13.5
Asian or Asian British – Indian	11.5
White - Any other White background	11.0
Asian or Asian British - Any other Asian background	3.0
Chinese	2.5
White – Irish	1.9
Asian or Asian British – Pakistani	1.7
Any Other Ethnic Group	1.7
Mixed - White & Asian	1.2
Black or Black British – African	1.2

* There are small numbers within some ethnic groups, therefore numbers are not given in the table to protect anonymity of individuals. Source: HR Division

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[11] Data not shown so as to protect anonymity of individuals in clinical directorates.

Table 9. Ethnic groups with more than 1% registered nursing and midwifery staff*

Ethnic origin (total n=2354)	%
White - British	58.9
White - Any other White background	9.2
Not Stated	8.1
Asian or Asian British - Indian	6.4
Asian or Asian British - Any other Asian background	6.4
Any Other Ethnic Group	2.2
Black or Black British - African	2.1
White - Irish	1.4
White Other European	1.2

* There are small numbers within some ethnic groups, therefore numbers are not given in the table to protect anonymity of individuals. Source: HR Division

As a result of the UK's equality legislation and the requirements for public sector employers to monitor race discrimination against staff, staff ethnicity data is much more complete with a far smaller percentage of 'not stated' compared to data for country of birth or nationality. Even taking into account missing data on ethnicity, the fact that significant proportions of the medical and nursing workforce in the hospital are not of White British origin strongly attests to the diversity of the workplace. In England and Wales as a whole, 14% of the population were of Black and Minority Ethnic (BME) origin in the 2011 Census.[12] The local county within which the hospital is located was less diverse, with 9% of the population of BME origin but there was more diversity within the city itself: 22% BME origin.[13] The fact that the diversity of the local potential patient population does not quite match the diversity of the health care providers may have implications for the acceptance and integration of the latter as we shall see later in the report.

Even though ethnic origin is not an indication of whether an individual is a migrant or not, as many minority ethnic origin doctors and nurses may have been born in the UK, the patterns in Tables 8 and 9 are interesting and replicate patterns in tables above in showing the predominance of Indian origin and European origin medical and nursing staff, as well as other Asian nursing staff. Data published by the Trust itself shows that the proportion of BME staff was less among 'senior staff' (Band 8a and above) than among 'staff' (Band 7 and below), and was also less among consultants compared to doctors. The equivalent proportions of the White (other) category which includes most EEA origin staff, do not fluctuate between more senior and less senior grades to the same extent as do proportions of BME staff.[14]

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[12] http://www.ons.gov.uk [accessed: 09/02/2015]

[13] Trust Equality and Diversity Annual Progress Report 2012-2013

[14] Trust Equality and Diversity Annual Progress Report 2012-2013

Recruitment of staff is undertaken at Trust, rather than hospital level. Most vacancies for permanent and fixed contract posts in all sectors and levels are advertised on the Trust website and are open to international applicants although immigration and professional accreditation requirements vary (Jayaweera 2015). Doctors on specialist training schemes are appointed to the hospital through the local education and training board (Deanery).

Historically across the NHS, as well as in this Trust specifically, there have been a variety of recruitment drives to employ international workers for medical and nursing/midwifery jobs at different times and from different parts of the world. For instance, a considerable number of nurses came over from the Caribbean to work in the city hospitals in the 1960s and 1970s. According to the Trust managers and associated stakeholders that we interviewed, these recruitment processes continue but take different forms for nurses and doctors based on different underlying mechanisms.

As far as nurses are concerned, over the past decade or so there have been concerted recruitment drives by the Trust in the Philippines and in Ireland, and most recently, in European Union countries, principally Portugal and Spain. Management and HR interviews suggest that these recent EU recruitment drives derive on the one hand, from a mismatch between staffing needs and labour supply at a local level. Under-commissioning of nurse training for several years nationally has been exacerbated by recent focus on ensuring 'safe staffing levels' arising from reviews of the quality of care and treatment in a number of hospital trusts in England.[15] Another, local, factor feeding into this mismatch between demand and supply is the ageing of the nursing workforce particularly in some specialities such as Maternity, and the consequent gap particularly in middle level grades. On the other hand, there is a strong awareness, as in other Trusts, that there is currently available a ready supply of EU workers from countries such as Spain that are experiencing economic difficulties:

> *Some of the people we've recruited have just graduated and don't have a job to go to or they are working in care homes and they don't want to, that's the only job they can get. Or they may have two jobs which are very far flung, or not in the area they want to work, because their economic market has meant that there's absolutely no posts available for them. For reasons of economy, they're forced to go and work in other countries. And a lot of Trusts have been recruiting in Spain and Portugal.* (Clinical manager, NHS hospital NHSUKMG2)

Freedom of movement within the EEA and quicker, more straight-forward recognition of professional qualifications by the Nursing and Midwifery Council (NMC) than for nurse applicants from outside the EEA, add to perceptions of not depriving countries of origin of indispensable workers: "*there's something ethically more comfortable about that*" (*clinical management interviewee*). In 2013, this particular hospitals trust, working through an agency with links in Spain and Portugal, directly recruited a large number of nurses for various departments and is in the process of recruiting more. Earlier recruitment drives centring on the Philippines and Ireland have led to variable longer-term outcomes. Many Filipino nurses have stayed on in the hospital,

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[15] http://www.nursingtimes.net

brought their families over to the city and formed local communities, whereas Irish nurses have tended to leave after a while citing reasons of homesickness or work being available for them back home. Lack of a strong Irish community locally may also be a contributory factor; another management interviewee gave the example of Irish nurses in a nearby hospital who tended to leave to join hospitals in East London where there was a close-knit Irish community. Some EEA nurses in the hospital have not directly come from countries of origin but have moved on from working in the UK.

Apart from permanent contracts, the hospital – in common with all other hospitals, both public and private – also necessarily relies on temporary nursing staff to fill short term service gaps or to cover for illness. These groups are obtained in two ways: through 'banks' of available pools of workers and, more expensively, through agencies supplying temporary workers usually on a daily or shift basis. The 'bank' that the Trust works with is NHS Professionals, a public sector company owned by the Department of Health, whose remit is to manage and supply temporary staff from healthcare professionals who want to work flexibly.[16] 90% of bank staff in the Trust is booked through NHS Professionals; it is well-established for nurses and within the past 12 months for locum doctors as well. Our interviews with nurses suggest that there is also a diversity of origins among both bank and agency staff, perhaps even more so than among permanent staff.

There have been significant national changes over the past decade in the immigration and professional regulatory framework surrounding the employment of overseas qualified doctors, and recruitment patterns in the Trust and the hospital have changed accordingly. Most doctors recruited internationally enter as individuals in response to job advertisements, although there are instances of larger active recruitment trips for specific programmes (MTI programme, emergency doctors). Before the UK points-based system was introduced in the late 2000s, it was possible for non-EEA qualified doctors to enter the UK on a short-term non-work visa and apply for jobs while in the UK. This was the process followed by several of our longer-resident interviewees:

> *I initially came over on a holiday really, I had long service leave. And then I organised a highly skilled migration visa while I was here…people I worked with in [country of origin] knew someone who worked in the department here…So I sort of approached that person, and got the job lined up before I applied for the visa…I think they had to sponsor me. And then yeah I had to briefly leave the UK to then re-enter, not on a tourist visa. So I went to Paris and came back on the new visa to start the job.* (Non-EEA speciality doctor, NHS hospital NHSMD7)

The requirement more recently for a firm job offer on the basis of the Resident Labour Market Test (RLMT) and a Certificate of Sponsorship (CoS) from the employer has had the effect of a reduction in the employment of non-EEA doctors in the hospital and a focus on very specific modes of entry. The application of the RLMT for doctors qualified in non-EEA countries to progress beyond the initial stages of speciality training schemes sponsored by the postgraduate deaneries (See Jayaweera, 2015) has also meant that it is now largely 'home grown' doctors who can enter a linear training pathway in the hospital.

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[16] http://www.nhsprofessionals.nhs.uk/nhsp/Pages/default.aspx

> *The immigration laws have changed, and it's virtually impossible for trainees to come from abroad and do what I did. That's all gone now. So the system has completely shut down for overseas doctors apart from the Medical Training Initiative Scheme which is quite a bespoke scheme. It allows you to only come for 2 years and you can't join the National Health Service as a permanent trainee at least. And so you don't have a career prospect.* (Non-EEA consultant, NHS hospital NHSMD8)

The existence of only a limited number of training posts ('training numbers') for each specialist department means that there is always a requirement for non-training doctors, often for finite periods. Interviews with senior consultants and management in the hospital suggest that the current immigration restrictions have negatively impacted on medical staffing levels.

> *When they changed immigration rules it made it very difficult for people to come into the country for non-training posts for fixed periods of time. And that had a huge impact on us locally, because we absolutely relied on people coming for six months or a year to do our non-training posts. And we have a large number of non-training posts because we couldn't make them training posts for various reasons…but then we couldn't get people to fill them as non-training posts and then we couldn't run the service. So it was a huge problem.* (British Consultant NHSUKD1)

The Trust and specific departments in the hospital have been working creatively to address such staffing needs including actively bringing in temporary recruits through the Medical Training Initiative (MTI) as stated above, from countries such as India and Sri Lanka which have UK compatible medical education systems; placing advertisements globally to recruit to shortage areas such as Accident and Emergency; and creating more consultant level posts, some of which are being filled by EEA-qualified doctors.

2.1.2 The Private Hospital

The private hospital in the city is part of a healthcare and social enterprise charity, at present one of the largest not-for-profit healthcare providers in the UK. In addition to providing medical care through its 31 hospitals across the UK, the organisation also provides more general wellbeing services such as health assessments and physiotherapy treatments within hospital locations. It can also provide NHS funded care through the government's 'patient choice' initiative.

The policies and governance practices of the private hospital in common with all the other hospitals in the group, are defined by the broader organisation (see Section 2.2). Its services, as in the case of all public and private health and social care providers in England, are monitored, inspected and regulated by the Care Quality Commission, the independent regulator of health and adult social care services.

The management of the hospital is undertaken by a team of three people: the hospital director, the financial director and the Matron. All clinical staff report to the Matron. The vast majority of the clinical staff is made up of nurses. Medical services – consultations and surgical procedures – are provided by consultant physicians,

many of whom also work as consultants in the nearby NHS hospital. Therefore they are not included in the staff roll of the hospital. There is however, a 24 hour Residential Medical Officer based in the hospital.

In mid-November 2014[17] there were approximately 350 staff members on the pay roll including both clinical and non-clinical staff. As in the NHS hospital over three-quarters were female (78.5%). The private hospital has a generally older workforce than the NHS hospital: 48.4% were aged 41- 60 (50% of women and 43% of men) compared to 40.3% in the NHS hospital; and 16.7% were aged 21-30 compared to 26% in the NHS hospital. Around 80% were permanent staff, the rest were temporary staff employed generally through bank or agency. Approximately 72% of staff were employed in clinical areas. The two largest clinical divisions in the hospital are 'wards' and 'theatres'. These incorporate all specialities. The other, smaller, divisions are outpatients, intensive care/trauma unit, radiology, diagnostics and cardiology, and pharmacy. We were told that ethnic origin of staff is not routinely entered in the electronic staff database although it is recorded in individual hard copy job applications. Thus, for 98% of the hospital staff there is no ethnicity information. In addition, there is no systematic recording of country of birth or nationality of staff.

> *We go across the hospital and it's hard to, it's less obvious to find somebody whose first language is English and who was born here than it would have been five years ago.* (HR manager)

The private hospital largely replicates the recruitment patterns over time in the NHS hospital, although as discussed below, recruitment seemed to be a bigger challenge in the private hospital than in the NHS. Both public and private health (and care) sectors in the UK draw upon the same pool of nursing staff, and nurses often work inter-changeably between the two sectors during their working lives, including in bank and agency working. Our interviews with hospital staff showed that this was the case between the two hospitals we studied. The private hospital has, over the last decade, employed nurses from Australia, New Zealand, the Philippines and Ireland. Some of the Filipino nurses actively recruited 10 years ago still remain in the hospital although some have used their experience as a stepping stone to move to the US. This seems to be a more general pattern among Filipino nurses coming to the UK as shown in other research (Buchan et al. 2006). More recently the hospital, working with the larger healthcare organisation it is part of, is seeking to recruit nurses from Europe and there are already some Spanish and Portuguese nurses in the hospital. One of the local dimensions that is a driver in overseas recruitment – also applying to the NHS hospital – is the high cost of living in the area which is almost equivalent to London:

> *I've seen such a rise in overseas nurses, but our need, our dependency on them has also grown. I suspect because I've lived and worked in other areas of the country, I think it's more of problem here…It's possibly cost of living. Because we're not so affordable…the cost of living possibly prohibits other home grown...Possibly. So we are working with a lot more overseas. It used to be*

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[17] Note that staff numbers fluctuate constantly. The numbers in this section were accurate for 19/11/2014. Also note that medical doctors apart from the Residential Medical Officer, are not included – see above. The data in this section was provided to us by the HR division of the private hospital.

predominantly Filipino and now I think that's no more, it's maybe more now Portugal, Bulgaria, Hungary that sort of things. (Senior British nurse, private hospital PUKN2)

The shifts in geographical emphasis in recruitment has a similar rationale to that of the NHS hospital, including changes in immigration requirements that make access to the workforce much easier for EEA nurses than for their non-EEA counterparts, and ethical considerations around not depriving countries of much needed healthcare providers.

I think it's also about what's happening in the country at the time. Certainly we've targeted Portugal because of the economic crisis…I believe it's something like 20,000 nurses out of work so that's a really good resource for us to tap into. I think it's similar in Spain. Ireland was another place a few years ago that we tried to tap into because there was a lot of unemployment there. So we kind of try to think about what's happening in the country at the time before we go and recruit. (Clinical manager, private hospital PUKMG1)

According to management, planning for recruitment in the private hospital can in general be more complicated than in the NHS as 'activity fluctuates':

So where you think you might be planning for, you might actually not get there or there might be a big spike and you get there a lot sooner. So that does make planning quite difficult.

Recruiting to specific specialist areas of nursing such as cardiac theatre and intensive care has been particularly challenging, and there is a reliance on agency staff for these areas. In terms of career pathways, nurses in these specialisms prefer to gain experience in acute medicine in a large public hospital.

I think the difficulty we have is that our ITU is not open 24/7 and actually there is still that feeling that you need to work in a big NHS hospital in order to get the experience and for it to be recognised. Private hospitals historically have a much, people think if you work in the private it's just hip and knee factory and you don't do any of the complex work. Things are changing but I think there is still a bit of that reputation out there. (Clinical manager, private hospital PUKMG1)

Managers felt that agency and particularly bank staff – "*because they are known to us*" – and who tend to be of diverse origin, are as integrated within the workforce as far as it can be expected.

I think we integrate them just as we do other staff, so they come in, they know us. If they don't, they're all introduced. They're already sound in their skill set. And in terms of the mix, I would probably say from international backgrounds, EU or whatever. (Manager, private hospital PUKMG2)

There was a perception that agency nurses who come to work in the hospital are more likely to be migrants and there could be financial motive for them to opt for these temporary jobs.

They have a different work ethic sometimes, their rationale for coming to work is different. (…) I do find the migrant workforce, 37.5 hours a week is like a half week. They're much more used to putting in more hours and earning more money, I think quite a few are sending money home,

supporting family, so I think there's a different work ethic. It's not always a great one. Because quite often we have 37.5 hours for a reason and that is to protect the staff and the patients. (Clinical manager, private hospital PUKMG3)

These views about the place, role and diversity of temporary nursing staff in the private hospital replicate what we heard in interviews with managers and nurses in the NHS hospital.

2.2 Policies Supporting Workplace Integration

In the UK, there are no explicit national policies to promote the integration of migrant workers in the health sector or indeed in any sector. Integration policies at the workplace level are a matter for each individual employer, although the government has tried to encourage employers to play a more active role, such as by providing initiatives such as English classes for speakers of other languages (Spencer 2011). Nevertheless, the UK has strong equality legislation which prohibits discrimination in the workplace and thereby should ensure equal treatment of migrant workers. Since 2010, a number of disparate pieces of anti-discrimination legislation have been brought together in a single Equality Act 2010.

The Equality Act (Anderson 2010) prohibits discrimination on the grounds of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation. It is worth noting that 'race' as defined in the Act includes colour, nationality, ethnic or national origins, although this is usually interpreted as ethnicity. The act also includes a public equality duty which requires public authorities to 'have due regard to eliminate discrimination... advance equality of opportunity... foster good relations'. This duty applies to all public authorities, which includes all NHS Trusts, and other bodies that perform public functions. The same duty applies to private organisations providing services on behalf of a public body, for instance in cases where the NHS commissions a private organisation to provide care. The introduction of a single Act replacing nine other pieces of legislation was designed to streamline and simplify the legislation (Hepple 2010). However, some have argued that in replacing legislation, detailed and specific duties relating to publication of data on race and ethnicity have been weakened (Kline 2013).

2.2.1 Equality and diversity in the health sector

In the UK a number of recent studies have linked good equality and diversity practices to better outcomes for patients (Dawson 2009, West et al. 2012) and the NHS remains committed to improving equality and diversity outcomes[18]. Nevertheless, research indicates that black and minority ethnic (BME) staff continue to face disadvantage in a number of areas. These include recruitment and appointments (Coker 2001, Kline 2013); representation at senior levels such as on hospital boards (Kline 2014); and involvement in disciplinary procedures (Archibong and Darr 2010). A very recent online GMC report showed that BME doctors were less

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[18] http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/ [accessed 12 February 2015]

likely than White doctors to obtain a GP or speciality training place and to pass speciality examinations.[19] Partly as a response to research, the NHS England has been taking action in this area. In 2013 NHS England issued a toolkit, the Equality Delivery System 2 (NHS England 2013) designed to be used with the input of relevant stakeholders including staff, patients and members of the community, to assess how well an organisation is performing on meeting equality and diversity objectives, including specific objectives for the workforce. Objectives within this group are focused around fair recruitment leading to a representative workforce; equal pay; opportunities for training; the elimination of bullying, harassment and abuse and opportunities for flexible working. In summer 2014, following the publication of figures showing the lack of diversity at Trust board level (Kline 2014), and in recognition of the fact that the current approach had not yielded results, NHS England went one step further by pledging to introduce a National Workforce Race Equality Standard[20] which will be included in all standard contracts from April 2015. This will make it mandatory for NHS organisations to show how they are complying with the Standard and improving representation of black and minority ethnic staff. NHS England will be working with regulators (including the Care Quality Commission) to ensure that compliance with the Standard is included in assessments of whether organisations are 'well led'.

Beyond equality and diversity initiatives which arguably impact on a wider population, increasing attention has been paid in the last five years to how best migrant health professionals can be supported in their transition into the British health sector. In particular this work focuses on the need for specific induction packages and extra support in the initial period after entering the UK. Although there has been online advice and information pages available from many organisations[21] for a number of years now, it seems there is increasingly a recognition that more could be done. NHS Employers has played an active role in this regard, by providing guidance to employers and promoting best practice[22]. They regularly publish case studies of what employers around the country are doing to provide suitable induction to their overseas staff and foresee this will be an area where work is likely to continue and are considering investing in research to establish the link between good induction programmes and care outcomes.

A recent example is a framework produced for educators and managers of internationally educated health professionals produced by the Professional Development Unit of the London Postgraduate Medical and Dental Education working with a number of London Trusts. This framework, first published in November 2014,

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[19] http://www.gmc-uk.org/education/14105.asp [accessed 30 March 2015]

[20] http://www.england.nhs.uk/wp-content/uploads/2015/03/wres-technical-guidance-2015.pdf [accessed 19 March 2015]

[21] The British Medical Association has an online guide for doctors new to the UK covering immigration, registration, access to training, indemnity, contracts and working conditions, as well as where to seek further information. Members can also seek advice from the BMA's immigration services. The Royal College of Nurses (RCN) offers a similar service to nurses and midwives: an online 'frequently asked questions' page for nurses and midwives from overseas is complemented by an immigration advice service offered to members. The RCN provides its workplace stewards and representatives with a briefing highlighting some of the specific needs of migrant health professionals and where further information can be found, so that RCN reps can adequately support staff members.

[22] Interview with NHS Employers 21/08/2014

provides a guide to educators and managers to support overseas health professionals' induction, development and learning, termed 'safe transitions' and is supported by two online podcasts, and will be supported by online e-learning modules. The framework has been designed around 5 domains: communicative and cultural capability; clinical capability; professional culture; developing resilience; and teaching and learning. Importantly the framework also aims to, "raise awareness of managers' and educators' own deeply held cultural values and related assumptions that may lead to misinterpreting the behaviour or reactions of others" (Professional Support Unit 2014 p.1).

In addition to these employer lead initiatives in 2013, the General Medical Council (GMC) ran a pilot programme: Welcome to UK Practice[23] aimed at supporting overseas doctors to understand the ethical and professional framework in which they operated. The programme consisted of a series of one-day training events as well as an online film and an online self-assessment tool which presents doctors with a range of ethical situations. EEA doctors as well as doctors from outside the EEA who had joined the GMC's register within the last 2 years were invited to attend. After a full evaluation[24], the programme is to be continued and to be rolled out in partnership with other bodies and agencies. It will also be opened up to a wider audience, so as to include any new or recently returned doctors to the register and not simply internationally trained doctors.

In addition to these initiatives and programmes, Trusts or Local Education Training Boards may decide to run programmes targeting specific cohorts. This might include a programme for doctors entering on the Medical Training Initiative (see section 2.1) or for groups of internationally recruited migrant nurses. Nevertheless, it seems clear that support provided in this area remains patchy. As migrant health professionals enter through a number of different routes it is not clear how extensive take up of these programmes is. Much comes down to the local employer and there are no clear guidelines on what should be offered. There is also a tension that arises about whose responsibility providing this sort of support is, especially in a context in which resources are limited.

2.2.2. Policies supporting integration in our case studies

<u>NHS hospital</u>

The NHS hospital organises an induction for all new staff. Whilst there are core components that are mandatory, such as fire safety, these programmes seem to vary considerably according to each team. Mostly these do not seem to include specific elements for migrant health workers, but are standard for all new staff members. For nurses, this includes a two week supernumerary[25] period. For doctors the induction programme seems to vary considerably. Whilst this flexibility may be appropriate in many cases, the feedback from doctors was that induction is not very helpful. An exception is made for recruitment of larger cohorts of migrant

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[23] http://www.gmc-uk.org/doctors/WelcomeUK.asp

[24] http://www.gmc-uk.org [accessed 02 February 2015].

[25] A period in which the nurse is 'extra', an additional person on the rota

workers. Following a large recruitment exercise abroad, a specific programme is organised. Most recently this included a two induction period during which the nurses received training in order to have certain skills recognised and their competencies signed off. This was followed by a four to eight week supernumerary period. These nurses were also offered a ten week English course for free and were provided with more practical pastoral support. For overseas doctors entering on the MTI programme, once again a more specific programme is put in place. This includes a workshop on communication, a specific contact person who can provide practical and pastoral support, and a slower induction period with a few days observing, then a period of buddying before being put on the rota directly. The MTI mentor explained some elements of the programme:

> *A lot of phone conversations, a lot of reassurance. When they come here they need bank accounts, they need to understand what an Oyster card is, they need to understand what 'cash back' is. So a lot of things are very new procedurally. A lot of things are very new culturally. They are put on the [name of speciality] unit with a specific programme of slow integration, where they observe for a few days and they take part as a buddy and then they go on the rota depending on their own abilities. There's always guidance and mentorship throughout.* (Non-EEA consultant and MTI mentor, NHS hospital NHSMD8)

As is required by legislation, the public hospital has a comprehensive and publically available Equality and Diversity policy in place. This policy is supported by a number of other relevant workplace policies including (but not limited to) a Bullying and Harassment Policy, Conduct and Disciplinary Action Policy and Management of Conflict Guidelines. The policy outlines its scope, provides definitions, responsibilities and lists how compliance with the policy is to be monitored. It also outlines six specific objectives for 2012-2016 and provides some examples of how to deal with an issue. The policy makes a specific link between equality and diversity in the workforce and positive outcomes for patients.

Work on equality and diversity is led by the Equality and Diversity Steering Group, which includes board members, senior members of management, and representatives from specific communities such as the Lesbian Gay Bisexual Transgender (LGBT) and BME communities. Moving down the organisation there are a number of Equality and Diversity Leads. This policy is transmitted through mandatory, three-yearly equality and diversity training for all staff. This training can take two forms – online e-learning module, or studying an equality and diversity handbook and taking a written form of assessment. There is also a higher level of equality and diversity training that is promoted to line managers. The policy is reviewed once a year and an annual progress report is produced monitoring progress against the six objectives. In addition to these measures and in accordance with the Equality Act (2010) the Trust is also required to conduct an Equality Analysis for any new policy. This form requires the author of the new policy in question to consider and specify whether the proposed new policy would have any adverse impact on members of one of the groups with protected characteristics and how this would be mitigated.

Whilst all these measures suggest a robustness in the way that the public hospital is tackling equality and diversity, a number of issues remain. One identified in the hospital's own interim report (and mentioned above) is the observation that although the workforce is very diverse, senior management remains less diverse. This

issue was also highlighted by one of the senior managers, who was quite frank about the need for the hospital to re-consider its approach to equality and diversity to ensure that it is relevant. She highlighted a recent case of a transgender patient which had been mishandled and the learning that was being taken forward from that including that diversity training was integrated into wider training programmes. She explained that the hospital was trying to learn from other organisations' experiences of dealing with equality and diversity in order to learn from best practice. She also mentioned that until recently multi-faith prayer facilities had not been available at all sites, although this is now being rectified.

<u>Private hospital</u>

In the private hospital induction is also provided to all new staff. Similar to the public hospital, induction programmes are created with the input of the manager of the team and include some core training components as well as some additional elements, meetings or trainings that may be relevant to the role. In general this also includes a two week period in which the nurse acts as a supernumerary. Induction plans seem to be the same for all new staff members regardless of whether the staff member is from overseas. Practical or pastoral support appears to be offered on an ad-hoc basis or through informal networks. Once again, it seemed that in the past, when a large recruitment drive to the Philippines had resulted in a number of new nurses starting at the same time, a more specific programme was provided. As overseas nurses at that time had to undergo a specific adaptation programme, it is unclear whether much of the induction programme provided was above and beyond what was required, although accommodation was initially provided to this group.

The private healthcare provider has a comprehensive equality and diversity policy in place which is applied across the group of institutions including in the private hospital in which we were conducting research. This policy specifically makes mention of the fact that the diversity of backgrounds, skills, learning and thinking styles 'will add value to the business'. The policy also makes specific reference to nationality, and to work status (part time or fixed term status). Another important difference is the fact that this hospital's policy explicitly applies to bank and agency workers as well as to permanent staff. Once again the policy is complemented by a range of other policies including Relationships at Work, Disciplinary and Grievance Policy, and Bullying and Harassment Policy. As part of new staff member's induction programmes, they are obliged to take a workshop on Customer Care Training part of which covers elements of equality and diversity. Further training on the matter does seem to be available, although it was not clear how often it has been taken up.

However, this policy does not include any objectives, and it was unclear whether the hospital itself has any specific objectives regarding promoting equality and diversity or improving outcomes. In addition, data collection on protected characteristics seems to be much less comprehensive in the private hospital (see Section 2.1.2), which would obviously have implications for monitoring the success of the policy. In fact, the policy does not seem to include clear measures against which success could be measured. Whilst it may be that certain data were simply not made available to us, as a private organisation the hospital does not have the same statutory duty to collect and provide data as is done in the public sector.

In both organisations, the extent to which the policies have resulted in real change for staff and patients is very hard to gauge. There have been some studies that suggest that equality policies can remain 'empty shell' policies, either without substantive measures behind them or without all staff being able to access the measures (Hoque and Noon 2004). Most staff in both organisations considered the policy to be 'common-sense' and not necessarily directly relevant to their day to day work. A few commented that it was important that the protection was there, and that both organisations were creating an environment where it is explicitly stated that discrimination is not accepted.

One of the issues that came to our attention was that the relevance of equality and diversity policies to migrant health professionals was very rarely articulated by our interlocutors. This is despite the fact that as mentioned above the term 'race' is given a broad definition to include national origins. In neither organisation were migrant health professionals specifically mentioned despite both organisations having significant numbers of migrant workers. Whilst this is perhaps unsurprising, given that immigration status is not mentioned in the Equality Act, and that the UK has a sizeable British BME population; it also highlights how actors tend to see the issue of 'race' and 'migration' as separate despite often a considerable intersection and how accessibility of the policies for migrants new to the country is not a consideration. As a doctor said:

> *The problem with this sort of legislation is usually people who need it the most are the ones that are least able to access it. (…) They don't know the system, their English isn't so good, if you give them a long document that tells them how to pursue harassment it's not something they are necessarily going to use* (Non-EEA registrar, NHS hospital NHSMD1).

It also shows that despite the rhetoric of public equality duty requiring organisations to enhance opportunities, organisational actors see equality and duty responsibilities as essentially passive duties (to prevent discrimination, rather than to enhance opportunities). In fact this was explicitly laid out by a consultant who was responsible for providing support to overseas doctors who came mainly from India on a specific training programme:

> *Equality and diversity is how you treat people and their differences. It's not even, it's not that branched out into defining people that accurately, whether you are a Medical Training Initiative or whatever. I think it's much more generic in terms of race, colour, ethnicity, and protected characteristics. But it's very generic, I can't see any overlap with what I do.* (Non-EEA consultant and MTI mentor NHSMD8)

Given the health sector's continuing reliance on migrant health professionals and a continuing failure to improve outcomes for BME staff in particular (many of whom will have come from overseas) it seems that a more joined up approach which looks at these two issues in tandem could be helpful. This would not of course negate the need for more specific work on other diversity issues to be continued.

3. Workplace integration: interviewees' perspectives

Using a mix of sources, principally relevant documents and interviews with managers and senior staff, Section 2 set out policies and practices in recruitment and employment of migrant health professionals in the two hospitals we are studying: NHS and private. It included a consideration of induction processes for newly arrived migrant staff, and the application of the framework of national equality and diversity policies in the specific case of the hospitals. We found both similarities and emerging differences in the practices of the two hospitals, and gaps in the application of policies in the incorporation of overseas doctors and nurses.

Section 3 focuses on key aspects of the integration of migrant doctors and nurses in the workplace by exploring the views of our interviewees in the hospitals, principally the migrants and their UK colleagues including hospital managers, and drawing out similarities and differences between the hospitals and the workers. Analysis of interview findings revealed themes around both structural elements of integration, and social and cultural aspects. Thus this section is organised into two main sub-sections: factors relating to career progression, and those relating to working together. The section concludes with a consideration of whether migrant health professionals are perceived as an asset in the workplace, by managers, stakeholders and the workers themselves.

3.1 Entering and progressing

3.1.1 Doctors

The pathways through which doctors enter the UK health sector have significant impact on their opportunities for career progression generally and in the particular hospital. In this the main differences appear to be between a) those from outside the EEA who entered when immigration and qualification recognition rules were less restrictive and those entering more recently; and b) those with medical qualifications obtained in EEA countries and those with qualifications from outside the EEA. Doctors arriving from outside the EEA have to sit the Professional and Linguistic Assessments Board (PLAB) exam[26] as well as an International English Language Testing Systems (IELTS) exam. Doctors from within the EEA, on the other hand, can get previous qualifications recognised automatically, although since 2014 they also need to prove English language competence through the IELTS. However, there are also some commonalities in the experiences of all migrant doctors.

While the non-EEA Consultants we interviewed who had entered the UK health system in the 1990s definitely had more circuitous pathways to get to the senior positions they currently occupy compared to equivalent UK colleagues, they were clearly helped by the greater flexibility of the system at the time.

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[26] Although there is currently a proposal to replace this exam with a single National Licencing Exam that would be sat by all those wishing to gain GMC registration, including UK medical graduates. See http://www.gmc-uk.org/news/25493.asp [accessed 30/03/2015].

When I was about to finish my registrar job in [country of origin] my boss, the consultant, she had been to the UK previously just for a visit. And she recommended that…I should go and get some experience in [specialism] in the UK. So she suggested that I should apply to [the] overseas doctors scheme. So I was given a PLAB waiver, so I didn't have to take the PLAB. I applied from there and I got a job directly in [another area in the UK] (…) My first job was for 6 months. My plan was just to get some more experience in [the specialism], because my first job was in the district general hospital. So I wanted to have more experience in a teaching hospital so I did it for 3 years. And then when I got that, I was offered a place, a permanent job here, at the time it was a staff grade position (…) And then they offered me a place at a specialist training rotation (…) And then I got hooked. So when I finished my training they offered me a consultant position so that's how I ended up staying. (Non-EEA consultant, NHS hospital NHSMD9)

This doctor, like most of the other doctors coming to the UK at that time had little difficulty in obtaining a visa or employer sponsorship: "*I think those were the good days*" –

And I think probably people are not being offered jobs, you know career jobs, straightaway, even if they are coming on training. I think probably it is more restrictive now than it used to be in those days. (Non-EEA consultant, NHS hospital NHSMD9)

These comments indicate that doctors arriving from outside the EEA now face a more complex set of immigration as well as regulatory requirements than was the case twenty years ago.

The clear-cut split that currently exists in the regulatory framework between migrant doctors qualified within and outside the EEA as mentioned above, strongly impacts on ease of getting access to the workplace and career ladders. This is an issue that affects nursing staff as well as we shall see later. First, our interviewees spoke of the UK language requirements that make a distinction between EEA and non-EEA doctors regardless of their own knowledge of English.

Well it was quite funny. Because I had just done a PhD written 50,000 words in English and then I was told that in order to validate my medical degree the first thing I had to do was do an English exam…I had to go and do an IELTS test, which I passed straight away but it was quite funny to be sitting there with some Japanese teenagers. (Non-EEA registrar, NHS hospital NHSMD3)

They wanted me to do an English exam. And I was just outraged that I was going to have to pay £70 to sit an English test so I could get registration so I complained and eventually they [the GMC] agreed that if my hospital in [country of origin] would write a letter saying that English was the first language spoken in the hospital, I would not have to sit it…I don't know if it's changed, but if you were coming from the EU, where genuinely your first language wasn't English there was no requirement to pass an English test which is just ridiculous.[27] (Non-EEA speciality doctor, NHS hospital NHSMD7)

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[27] Since June 2014 there is a new GMC requirement for EEA-qualified doctors to demonstrate that they have a sufficient knowledge of the English Language to practise medicine in the UK – see background report (Jayaweera 2015).

A second barrier for doctors who have qualified outside the EEA compared to those who are EEA qualified is that their qualifications are more often scrutinised and less often recognised. As set out in the background report, under EC Directives of 2005 and 2013[28] there exists a process of automatic recognition of qualifications for EEA qualified health professionals (see Jayaweera 2015). While both categories are disadvantaged in gaining access to linear training pathways and posts that have in-built career mobility prospects compared to UK colleagues, non-EEA doctors are more likely to make slower progress or get stuck in a series of temporary positions they feel do not match their expertise.

I did a locum consultant job because I couldn't work, I could only work in a locum capacity, because I hadn't sat either the English training programme or got a conversion, I think it was called article 14 at the time, which is when you get what you have done in your country recognised…I was going to have to fill out this massive log book for years, and get people to sign off that I could put a cannula in and I could do all this really trivial stuff when I was actually trained to a much, much higher level. (Non-EEA speciality doctor, NHS hospital NHSMD7)

This is despite the recognition by senior UK colleagues and managers that colonial links with Britain have made medical training systems in some non-EEA countries more compatible with British systems and therefore transition for doctors could in practice be quicker and easier.

And in terms of graduates that fit in best, I think it is really South African, Australian, Indian sub-continent, they're trained in the same way. They do things in the same way and their expectations are the same. The ones from Europe often find it hard and it always struck me as illogical, that when they changed immigration rules so we had to take the ones from Europe first, we know that they'd struggle to fit because of the language, because of the different ways of doing medicine. (British consultant, NHS hospital NHSUKD1)

The more recently arrived overseas doctors we interviewed, wherever qualified, had invariably started – and often continued – their medical careers in the UK in either fixed term or permanent posts that disadvantage them in many ways but were useful to the hospital for filling gaps in staffing. Variously designed as trust grade, staff grade, associate specialist, speciality doctor, locum, clinical fellow etc. depending on grade, and changes in terminology over time, these posts generally have fewer straight-forward opportunities for career progression, study leave, conference funding, personal development, regular appraisal, and updating of skills, than do training posts. Other research has shown that there is a greater tendency for overseas qualified doctors than UK qualified doctors to be in such posts (Oikelome and Healy 2007). But there is an under-representation of doctors who had qualified outside the EEA in the UK Speciality and GP registers and an over-representation in the category of other doctors. In 2013 doctors who had qualified outside the EEA made up 30% of all doctors on the entire UK medical register, but only 24% in the Speciality register and 17% in the GP register, while they made up 57% of doctors who were in neither register. EEA graduates were less disadvantaged with similar proportions in the speciality register and non-speciality register (15%) although

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[28] http://ec.europa.eu [accessed: 09/02/2015]

representation in the GP register was low – 6% (General Medical Council 2014). A very recent GMC online report showed that doctors with an undergraduate medical degree from outside the EU were less likely than UK graduates to obtain a speciality or GP training place.[29] The work histories of our diverse interviewees suggest that this may only partially be explained by immigration regulations such as the application of the labour market test for entry to training schemes.

Partly because these positions traditionally have not had training built into them and are not part of clear, progressive pathways, the skills of these doctors and the experience they bring may not be fully recognised and acknowledged by management and colleagues.

> *Training posts are generally seen as more desirable because you get study leave, you get funding for conferences and for your personal development and they often come with pre built-in support in the forms of a supervisor and timelines for when you should get things done. And they are often taken as, they're a label you can bring to say you've had X amount of training. It's a recognised product. Posts that are outside of them don't get recognised in the same way.* (Non-EEA registrar, NHS hospital NHSMD1)

> *I think speciality doctors are looked on negatively, by, that would be my perception. Training doctors think 'you're a speciality doctor, you don't know anything'. I think there is a real element of eating humble pie working as a speciality doctor.* (Non EEA speciality doctor, NHS hospital NHSMD7)

Efforts have been made to try to improve the situation of these doctors and in 2008 the BMA negotiated a contract for all staff grade doctors[30]. There are patient safety issues at stake in not promoting updating of skills, and the recent GMC requirement for revalidation of fitness to practice of all licensed doctors[31] may eventually provide more opportunities for doctors in 'service' posts in the hospital to gain access to training courses and appraisals more routinely.

In this particular Trust (and hospital) there appear to be efforts – perhaps in some departments – to redress this balance between training and non-training posts in terms of opportunities to progress. One interviewee among UK colleagues, a registrar on a training programme mentioned that two of her colleagues in her department who were not trained in the UK "*still come to all our teaching, they still get a study budget*". A couple of other non-EEA qualified interviewees were able to acquire specific locum appointments for training (LAT), the time periods for which are counted towards speciality training once they are finally able to get a training number. Nevertheless being able to take training courses for doctors in these positions is dependent on the team being able to release them. In a context of chronic staff shortages in certain departments, this meant that for one of our interviewees this was simply unfeasible.

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29 http://www.gmc-uk.org/education/14105.asp [accessed: 30/03/15]

30 http://bma.org.uk/practical-support-at-work/contracts/sas-contracts [accessed 8 February 2015]

31 See Jayaweera 2015

There was never any time to go on courses and there's this clause for study leave, so you've got to do all this stuff to get CPD [Continuing Professional Development] points, to get through your appraisal to get revalidated. But if you read all the study leave policies in the Trust, there are all these clauses that said 'you can only do this if you can be accommodated by your team'. And we were just so understaffed it was just constant. You can't. (Non-EEA speciality doctor, NHS hospital NHSMD7)

Overall, the detailed work histories of several non-EEA and some EEA doctors we interviewed suggest that there is a mix of factors that place these migrants less or more favourably in hospital career structures and that affect them even beyond initial restrictions around immigration status and recognition of qualifications. Having networks seemed to play a positive role in gaining access to the UK health sector labour market. As one stakeholder described it, "*medicine is quite closed, personal networks are quite important, where you were trained, who you've worked with*"[32] Several of the migrant doctors we spoke to had used existing contacts to find out about or access their first positions in the UK. For instance the supervisor of one non-EEA doctor in their home country had had previous contact with a consultant in the hospital where she ended up working. Later in the report we will consider further issues around team working and communication which also impact their ability to progress in the workplace.

As mentioned in Section 2 a method currently used by some departments in the hospital to address shortages in middle grade level staffing within the framework of current immigration restrictions beyond the EEA is the Medical Training Initiative (MTI).[33] As an 'ethically acceptable' rolling scheme to temporarily attract doctors with training needs from countries like India and Sri Lanka, there are question marks around their structural integration in the workplace, such as ambiguities around deanery responsibilities for their professional development and the way the Trust sometimes takes advantage of their availability and skills. These are issues that are somewhat parallel to those faced by other non-EEA doctors as shown above.

Yes these are fellow posts but these are highly motivated people who have come, they come with an expectation of the training, they are sold as training positions by the Royal Colleges, MTI – medical training initiative it's in the name. And yet we've got the deanery saying 'oh we can't be responsible for them, somebody in the Trust will take care of it'. So there isn't that robustness. (Non-EEA consultant, NHS hospital NHSMD8)

There was one colleague who came from [same country of origin] like that [on the MTI programme] and he was not given, at least they should get a study leave budget or something, but he was not given it (…) The next year they keep the job and they're paid by the hospital. But then they pay a very low salary, the starting registrar's salary. (Non-EEA registrar, NHS hospital NHSMD4)

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32 Interview with academic professor specialising in migrant health workers 17/09/2014

33 See Jayaweera, 2015

An interesting question is whether doctors from non-EEA countries who go through medical school and the postgraduate foundation (internship) programme in the UK are more likely to progress in their careers in ways similar to UK peers. Our interviews with these doctors suggest that while they are better positioned to succeed within the hospital structure than their counterparts trained abroad, they may face more barriers than their UK born/UK national counterparts. Even though non-EEA national students who have trained in UK medical schools can apply for speciality training on the same basis as EEA nationals, immigration rules do have some negative impact on speciality training opportunities and thus career prospects, since at present there are limitations on being able to change employers (see background report). This sometimes leads to applicants having to choose specialisms that are less likely to be over-subscribed or considering moving to less popular geographical areas.

> *What I have seen people do is to pick a speciality that they may not be interested in order to increase their chances. So what it in effect it does is although it's a level playing field at the point of application and interview, it becomes an additional barrier later on, so people make choices usually prior to that in order to increase their chances of being able to stay. And what I have done personally, generally we rotate around from different environments and different people, I have chosen to stay quite near to where I trained, being able to know a place well and be aware of opportunities and be a strong candidate within a system, I have chosen to stay somewhere a bit longer.* (Non EEA registrar, NHS hospital NHSMD1)

Within the Foundation or speciality training programmes in the hospital there may be more apparent benefits of UK qualifications and of positioning in linear training pathways. A non-EEA doctor who had been through the Foundation stage in the NHS hospital said: "*It's subtle. It's complex. There is an extent to which the fact that I had done a medical degree in the UK gave me legitimacy in people's eyes*".

> *If you haven't trained here, it's a nightmare. (...) I met doctors [from same country of origin] who find themselves working in cities they don't want to be in but they just can't get jobs anywhere else (…) If you have trained here a lot of the red tape has been removed, but I think the barriers are a lot less visible.* (Non-EEA former registrar, NHS hospital NHSMD10)

For all overseas qualified doctors ease of transitioning to the new, unfamiliar workplace structure and the local area can depend on support provided by induction programmes and processes in the Trust and in the hospital. Most of the doctors we interviewed did not feel that this type of support existed in a way that helped them to progress in the hospital.

> *Induction is so that somebody sits in an office somewhere and says that they've ticked all these things that they're supposed to have told you so that if you screw up later it's not their fault.* (Non-EEA registrar, NHS hospital NHSMD1)

> *I think that probably a bit of induction on how the system is run, how the network works, what a failure of the network can be that could affect your daily routine with the patients, and other aspects about breakdown in communication…That would have been more use than the induction itself. It was really just a waste of time.* (EEA consultant, NHS hospital NHSMD2)

At the same time senior UK colleagues in some departments do appear to make an effort to provide a relevant introduction to the work process.

> *For the doctors who have come from abroad…We do make a bit of extra effort. And we do make an effort to ensure there's some kind of mentor, supervisor even though in non-training posts you don't need that.* (British consultant, NHS hospital NHSUKD1)

3.1.2 Nurses

As in the case of doctors the differences between those entering from EEA countries and countries outside the EEA, impact on nurses' entry experiences and opportunities to progress. An adaptation period of between 3 and 6 months in a hospital working at a supernumerary or less than registered nurse level – e.g. unregistered nurse or healthcare assistant (HCA) – has, until a few months ago, been a long standing requirement for nurses coming to the UK from outside the EEA.[34] This requirement has affected the early experiences of even some of the long-established non-EEA nurses we interviewed. However, several of the nurses in the private hospital who were part of a concerted recruitment drive 10 years ago by the hospital in the Philippines have mostly had the opportunity to progress to more senior positions. Some, such as the individual quoted below, may not have taken up these opportunities for family reasons (see section 3.1.4).

> *In the beginning we worked as a HCA. Actually we worked as part of the staff nurses, but the pay was like a HCA because we didn't have the PIN number[35] at the time. I was staff nurse for a few years and I was given the opportunity to apply for senior staff nurse.* (Non-EEA nurse, private hospital PMN10)

The automatic recognition of qualifications gained in an EEA country, not having to undergo English language testing, and not being subject to immigration rules have clearly benefited the EEA nurses we interviewed in both the private and NHS hospital.

> *No problems. Since I sent all my documents, I had to get them all translated and authenticated by a lawyer. We have a lot of documents to translate. That's a big process. But after I sent all the documents, after 2 months I had my PIN.* (Senior EEA nurse, private hospital PMN3)

This clear demarcation between EEA and non-EEA entrants with regard to the regulatory framework around entry into nursing jobs is obviously a big consideration for management in both hospitals in targeting present-day recruitment drives in EEA countries (see also Section 2.1). As in the case of doctors, some resentment is apparent among non-EEA nurses particularly regarding the differential rules around English language testing.

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34 Since October 2014, new applicants from outside the EEA for nursing posts need to sit a theory and clinical examination similar to the PLAB examination for doctors qualified outside the EEA, to obtain registration in the Nursing and Midwifery Council and seek to practice. They do not then require an adaption period (see Jayaweera, 2015).

35 The PIN number is the registration number given to nurses on registering with the Nursing and Midwifery Council (NMC)

We share, my other country men, share the same sentiments, how come they don't have an English exam, and most of them don't speak proper English. If it's applicable to us who speak English, although it's not the way the English people speak, and even those coming from other parts from America, how come we have to comply with that? How come those people don't have to take an English exam this is what I don't understand. That's why it's frustrating. (Non-EEA senior nurse, private hospital PMN1)

The management staff in the two hospitals also spoke of the illogical rules applying to those coming from countries where English is the first or common language: "*But of course they've got to do English tests and things like that, whereas of course if you're Spanish you don't which is nonsensical but that's the way it works*." (Clinical manager, private hospital PUKMG1). There was also concern among interviewees in both hospitals about the negative clinical implications of admitting EEA recruits with insufficient English language fluency, and concrete steps are being taken at recruitment and induction stages at hospital level to address these limitations in the interests of patient safety. These include more rigorous testing of language skills relevant to clinical practice at recruitment interviews, the provision by the NHS hospital of a free 10 week English course in partnership with the city council for new entrants, and the adjustment of adaptation periods in the private hospital to meet individual competencies particularly in communicating in English.

We have had a case recently with an [EEA] nurse, very good technically, but communication skills possibly weren't quite up to the level that we would want. So we've extended her supernumerary period to a month, so she's just got that longer period of supervisory period. There is an induction period but it's very much tailored to each nurses individual needs. (Clinical manager, private hospital PUKMG3)

For EEA nurses the automatic recognition of qualifications means that it is easier for them than for non-EEA nurses to start work at the level to which they are already qualified. This has impact on the speed at which they can achieve career progress compared to their non-EEA counterparts who experience more de-skilling initially. A non-EEA interviewee at the private hospital with a nursing degree from her country of origin had been unable to get NMC recognition to work as a registered nurse and so had to undergo further education while working as a care assistant in a care home. At the time of interview she was working as a health care assistant (HCA) in the hospital while she is being supported by the hospital with regard to meeting both sponsorship requirements and the training necessary to become a fully registered nurse.

While EEA nurses benefit from recognition of qualifications, the different system of regulation of competencies in the UK means each skill has to be demonstrated and formally signed off before a nurse is allowed to perform certain procedures by himself or herself. Therefore while there is recognition among supervisors and managers that clinical training in some European countries may in fact be more extensive at an earlier stage of training than in the UK, the formal requirements do not allow the nurses to undertake procedures that they may already be competent in.

There's a four year graduate programme which is different to ours, ours is three years. And they come out with clinical skills that exceed ours. And the level of compassion that they're able to

demonstrate is amazing. They do need buddying and support. And they can't be unsupervised for, well it depends on the individual, 6 to 8 weeks but sometimes longer. For them and their confidence but principally for patient safety. (Clinical manager, NHS hospital NHSUKMG2)

Such delays and questioning of competencies have led to frustration among some of our interviewees.

We can nurse anywhere, a nurse is a nurse, the only thing is, to get our head around what we're not allowed to do, when we do so much at home is the worst part. We can get into the routine of the ward very easily. But it's just so automatic to do certain things, and someone says, 'no you can't do that, you've got to call a doctor for that'. (EEA senior nurse, private hospital PMN5)

One of the major differences between the private and NHS hospital relates to structures of pay and progression for nurses. As a public sector employer the NHS Trust within which the hospital is located conforms to a national system of grading (banding) with a commensurate progressive pay structure through which nursing staff move incrementally.[36] At present, progress within a grade and increases in pay are not performance-related although promotion to a higher grade depends on appropriate training and gaining of further qualifications. One stakeholder suggested that previous research had indicated a 'glass ceiling' for nurses from overseas.[37] The private hospital on the other hand does not work with a similar banding system, although there is a clear hierarchy of seniority in roles – e.g. staff nurse, senior staff nurse, sister, theatre manager etc. There is a more performance-related approach to pay increases in the hospital that is dependent on individual assessments done by line managers and hospital managers.

Yes very different [to the NHS] because they have grades and bands. But if you're a band 6 you can fluctuate from the bottom of the band 6 to the top and the top band 6 is halfway up the band 7 scale. And you also get annual increments in the NHS, you don't here. You have appraisals and then you will have a pay rise based on your appraisal. So it could be 1%, 2% it goes up to 4%…So if you don't perform you just stay on the same grade. (Senior British colleague, private hospital PUKN4)

As a result of the lack of banding system and because of the way in which pay was linked to performance, there was less transparency overall about levels of pay and conditions in the private hospital. There were also some cases of employees on different contracts with different conditions as a result of historical mergers in the private health sector. In addition there was greater flexibility for management to offer different packages to recruit new staff. Senior colleagues and managers showed awareness of the equality implications of such decisions and the impact on staff morale.

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[36] Qualified nurses – i.e. those with a nursing degree and registered with the NMC in the UK – start at staff grade band 5 in terms of pay and can progress in seniority of role until the grade of Matron or Nurse Consultant, band 8. Health Care Assistants (HCAs) can progress through obtaining a nursing degree to becoming qualified nurses. http://www.nhscareers.nhs.uk/explore-by-career/nursing/training-to-be-a-nurse/ [accessed: 31/03/15]

[37] Roundtable discussion with stakeholders on project findings and recommendations, 11/03/15.

They're on a lot higher pay than people who were here. They do have a pay rise every year but they still don't match and jump. Because if you don't offer a competitive wage now, you're never going to get people in, but of course it's leaving people behind. (Senior British nurse, private hospital PUKN1)

The nurses we interviewed had mixed views on opportunities to progress and whether these were better in the NHS or private hospital. Several interviewees, both migrant and UK born had had experiences of working in both hospitals in the city and in both NHS and private healthcare sectors more widely.

And there's also this myth that the NHS, well I don't know if it's a myth, that people think it's better to work for the NHS…The NHS publicises that it does a lot of training, but I don't know whether you go there and then you just have to wait for it. And here it's just a question of them asking for it, if they want it, and they can give something back to the hospital, the hospital has never said no. (EEA senior nurse, private hospital PMN5)

The only good thing about the [private hospital] is when you do your PDA [personal development assessment] every year, you still get your salary increase. And if you're doing well, they give you a better compensation for it. So it's not actually fighting for a position. As an individual you have to do your best in your job. (Non-EEA senior nurse, private hospital PMN8)

There was a general sense that in a small, more intimate working environment as in the private hospital there is a greater opportunity for individualised, innovative working practices which are more visible to and rewarded by the management. Another area in which working in the private hospital appears to have an edge over the larger NHS hospital with its array of departments in different buildings, is in the availability of more continuous opportunities in the private hospital to work across different specialities especially within theatre nursing thereby gaining a broader set of competencies.

Because you have to be, you can't just say, if there's no [one speciality] case and they put you in another area, you can't say, 'oh this is another area, I don't know what I'm doing'. You know that when you come to a private hospital you're expected to work with the rest of the areas. (Non-EEA senior nurse, private hospital PMN8)

On the other hand, there was a recognition that opportunities for progress offered by the private hospital were too limited for some newly arrived EEA nurses and this impacted on retention of staff.

I think for them, core training isn't enough. They really want to progress and fast track. And I really understand it, they're young. And we don't have a lot more opportunities apart from the surgeries and procedures that we do. A lot of people want to move on and fast track that's not something we can offer. And even if they want to become senior, they're pretty much waiting for one of us to leave. So there aren't those opportunities either. Whereas in a big organisation like the [NHS hospital] they would probably get there much sooner. (British senior nurse, private hospital PUKN2)

A stakeholder we interviewed from a nurses' organisation also spoke of nurses working in the private sector coming to them for advice on employers' taking advantage of their immigration status and requirement for sponsorship to limit changes in roles and advancement opportunities.[38]

3.1.3 Equality and discrimination

There is long-standing and considerable research evidence in the UK of institutional race discrimination in the NHS, despite the plethora of policy initiatives on promoting race equality in the workplace (see Section 2.2). Studies refer to discrimination in pay, grading, promotion and career advancement including attitudes of recruiters and supervisors (Coker 2001, Kline 2014, Oikelome 2007) . Much of the evidence relates to BME staff irrespective of whether they were born outside or in the UK. However, there is also evidence that there is an 'undervaluing of relevant experience and overseas qualifications' (NHS Institute for Innovation and Improvement 2009) and the over-representation of overseas qualified doctors in disciplinary hearings (Humphrey, Hickman and Gulliford 2011).

Data from the Annual Staff Survey (2013) according to the 'protected characteristic' of race (see Section 2.2) was supplied to us by the NHS hospitals Trust within which our case study hospital is located.[39] The broad categories of 'Asian or Asian British ', 'Black or Black British' and 'Chinese and other' staff were less likely than White staff to state they had experienced 'no discrimination from manager/team leader or other colleagues' but it is noteworthy that at least four fifths of all three ethnic minority groups felt they had not experienced such discrimination. However, Black, and 'Chinese and other' staff were less likely than Asian staff to state that they had had 'no harassment, bullying or abuse from manager/team leader or other colleagues'. A comparatively low percentage of Black staff claimed 'no discrimination from patients/service users, their relatives or other members of the public'. It is also interesting that only 33% of Black staff compared to 51% of Asian, 50% 'Chinese and other' and 64% of White staff felt that the organisation acts fairly in relation to career progression.

There was little mention of explicit institutional discrimination at work among the migrant doctors and nurses we interviewed, although as shown, there was a clear sense of (complex) barriers to progress in the workplace that have reference to non-UK backgrounds and training. There was far more voicing among the interviewees of the existence of race discrimination on the part of patients which will be considered later in this section. However, for many migrant interviewees becoming established as a health professional in the UK and progressing in the hierarchical hospital structure felt harder than they felt it is for their UK counterparts, something that has been found in other studies (Legido-Quigley, Saliba and McKee 2014).

> *Sometimes I see warmth in people. And I think that warmth you have to make extra effort to create if you're an overseas doctor…you have to work extra hard to get the same kind of respect*

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[38] Stakeholder interview 19/09/2014.

[39] Data supplied by HR division. Categories refer to all staff and not by profession, role or grade.

that would be coming to you automatically if you were just a good enough doctor of British origin. That's how I feel. (Non-EEA consultant, NHS hospital NHSMD9)

Some doctors suggested that until they had demonstrated their skills in practice, they would not be trusted, as training standards in other countries were not seen as equivalent to UK standards.

Initially it was a problem because many people from the UK would not trust my background or my clinical skills, I guess they think you've just come from Spain or Italy or wherever. It's difficult to make them understand that a consultant in [home country] would do the roughly same as a UK consultant, so that was a problem. (EEA consultant, NHS hospital, NHSMD2)

Such views are also seen in comments of some UK colleagues.

I would like to say [that migrant doctors are treated equally to UK born doctors in the work place] but I'm not quite convinced. Um. I think mostly, that's true. I think there are a couple of occasions where I've heard people, where people have not trusted people, or have said well I don't think he's not that great, and I just wonder whether 'he's not that great' because he's not from England and he's got a strong accent that's difficult to understand what he's saying even though what he's saying is absolutely correct. There's this slight distrust of people from the outside and they possibly have to work a bit harder to prove that they're ok. (British consultant, NHS hospital NHSUKD1)

At the same time the historical connections between Britain and former colonies that have seen migrant health professionals firmly entrenched within the NHS over more than the last quarter of a century, have created a somewhat unique situation in terms of familiarity leading to acceptance. This was voiced by a non-EEA consultant:

Europe is not all flat I can tell you that. Britain is unique, I mean we are way ahead on this. I wouldn't get a job in Spain, I wouldn't get a job in Italy. I can be a PhD, double PhD whatever. No hope in hell. It's a very different thing. I think there is a background, there is a history of engaging with the Commonwealth and there is a past that we have in Britain. There is a shared history, Asian people and black and minority ethnic people have been part of British society for generations. So there isn't that otherness. (Non-EEA consultant, NHS hospital NHSMD8)

There was also a perception among interviewees that the very nature of the role of doctors and their position in the hierarchy and authority structure of the hospital worked in their favour compared to nurses. There was an element of this difference with regard to the workplace power structure – as one doctor said "*The medical professional is very hierarchical, within doctors and between doctors and other health professionals*". But it was manifested more in discrimination from patients.

I always got the sense it was much worse for the nurses, experiences of racism. Because being a doctor you have much more power…It can't be overstated, you have so much more power once you have that stethoscope round your neck. Even at a junior level. You can prescribe, make decisions, your role is less circumscribed. My sense was that that power was something that

shielded me from a number of things that I felt that some of my nursing colleagues, some of the nonsense and rubbish and crap they had to put up with. (Non EEA former registrar, NHS hospital NHSMD10)

3.1.4 Family constraints on work and career progression

A recurrent theme among migrant interviewees - both doctors and nurses – was the way family considerations affected their ability to perform in their jobs and progress in their careers. Much of this related to living far away from families of origin and not having flexible support for childcare in employment situations that required long hours, shift work and unpredictable patterns of working.

> *I would say one thing in terms of being an immigrant here and working here, is that having young children here without extended family was a real issue. We were very isolated. In the first year or two when we came to [the city], I was working very hard and doing those 24 hour shifts. And we didn't have extended family around and that was very, very hard.* (Non-EEA consultant, NHS hospital NHSMD6)

A non-EEA nurse had struggled to overcome immigration restrictions on family migration as well as her own situation as a single mother, to bring her children to live with her in the UK when she separated from her husband back home.

> *If I had brought them when they were younger, how would I be able to look after them? How would I be able to feed them if I didn't work full time? So who would have taken them to school or brought them home. So those were the concerns I really had, so I let them grow a bit older so it wouldn't be so difficult when they came. In the end I managed to bring them over here.* (Non-EEA senior nurse, private hospital PMN8)

Others spoke of the anguish caused by difficulties in obtaining sufficient leave from work to visit sick family abroad or for family emergencies: "*So I didn't have any choice, I just had to rebook my flight and come back because they said you have to come back.*" (Non-EEA senior nurse, private hospital PMN9)

> *It seems like it's just the migrant workers who are having the problems but everyone's got them it's just the English have the back up to help them. It's not always raised as an issue with them.* (British HCA, private hospital PUKN5)

So far we have examined perspectives of interviewees regarding entering and progressing in the structures of both hospitals. We have found interesting similarities but also some significant differences, for instance between doctors and nurses, EEA and non-EEA migrants, migrants and UK colleagues, and between the NHS and private hospital, that we will discuss further later in the report. We next move on to perspectives on 'working together', encompassing team dynamics, impact of language differences and communicating culture.

3.2 Working together

3.2.1 Working in teams

Most of the doctors and nurses we interviewed felt they had positive working relationships within their (multicultural) teams. The nature of the working environment – long shifts, high pressured decisions at times affecting life or death for patients, continual staff shortages – means that getting along as well as possible is imperative.

> *I think you really rely on each other. You're focused on that patient, it's someone's mum or sister, or someone's dad, so you really focus on that and sort of pull together.* (British Senior nurse, private hospital PUKN8)

The diversity of staff teams in both the NHS and private hospital was generally welcomed. Senior staff of whatever nationality felt that often migrant nurses especially brought in new skills and new ways of working that were beneficial for teams.

> *Yes actually they bring ideas about certain ways, even about simple things. Even like managing how to take care of a crash trolley for instance, the system here is a copied from one hospital to another. And then you'll get a nurse from Portugal who will come along and say this how we do it in Portugal, and it's simple things.* (EEA senior nurse, private hospital PMN11)

> *Some nurses, the standards in their countries are higher than here. I find Australian nurses very good. They come with their own values and they show you things. You learn different ways of doing things. I think it's nice for patients sometimes to be cared for. Some cultures just have a more a caring ethos than our own. We're not abrupt, but they're very, very nurturing. Like the Indians and those groups, they're very family oriented so they're very caring and that comes across in the way they care for patients*. (British senior nurse, private hospital PUKN1)

The migrants themselves spoke of frustration they sometimes felt when confronted with team working practices in the UK hospital they felt were less positive for both staff and patients. For instance, several migrant doctors, both EEA and non-EEA, said that there was less commitment to continuity of care and sharing of patient responsibility between UK doctors.

> *In [country of origin] it's all very consultant led. If you're the consultant if something goes wrong, even if you don't know about it, you're not on call, it's kind of your responsibility. So the consultants are like 'call me, call me, call me'. Whereas the consultants here are like 'don't call me, don't call me, don't call me, why are you calling me? You should be able to make the decision.' And it's just like 'don't you want to know?'.* (Non-EEA speciality doctor, NHS hospital NHSMD7)

> *I mean for example, if a consultant is off because of annual leave what would happen in [country of origin] is that everyone would accommodate so that the patients wouldn't be cancelled. That doesn't happen here. If a consultant is off on annual leave, the activity is cancelled. I think this is*

a very ineffective way of using our facilities. And just because the consultant does the work on their own. (EEA Consultant, NHS hospital NHSMD2)

Both nurses and doctors needed to adjust to differences in roles of team members in the UK hospitals, for example HCAs undertaking more clinical tasks than in European countries, or a lesser hierarchy at least at the level of decision-making relating to patients, between doctors and nurses in the UK hospital compared to hospitals in some Asian countries.

Even the nursing care is different here, because you have HCAs with different roles here than they have in my country. The HCAs here have clinical tasks. In [country of origin] they don't do clinical tasks only the nurses do clinical tasks. So this is very different, and needs to be approached in a different way. (EEA senior nurse, private hospital PMN3)

[Country of origin] is very different there's a hierarchical system between nurses and doctors. Nurses can make tea for doctors, they don't do it here. It's a very hierarchical system. But here it's very plain [flat] a nurse can speak up and tell you not to touch a baby and they can feel a bit odd about that. (Non-EEA consultant, NHS hospital NHSMD8)

3.2.2 Communication

If your language barrier is bigger, it will hinder the process of integration. And in a job like ours, which is quite delicate, (...) If you get something wrong in a hospital, some misinformation on a patient or something, there's the life of a person in the middle. (EEA nurse, private hospital MN11)

One of the main challenges to integration that was repeatedly identified by both British and migrant staff was around communication. In particular, many people identified what they described as the 'language barrier'. As discussed above, there are different rules in place regarding the language requirements placed on an individual depending on whether they are coming from within or outside the EEA. Nevertheless, it seemed that there was much more to this 'language barrier' than simply language competence which could be measured by a test. In fact, the issues seemed to break down around three main themes: cultural forms of communicating; knowledge of idiom, colloquialisms and terminology; and accent. There is also the issue of using other languages in the workplace. This section will explore each of these in turn and discuss the different impacts on integration raised by each.

Many elements of communication are influenced by cultural factors, and these can play a role both within language groups but also between groups speaking different languages. Increasingly, attention is paid to this in the health sector, particularly in the UK where an emphasis is placed on communicating care plans and shared decision-making with patients (Department of Health 2013). The importance of cultural dimensions in the integration of overseas health professionals has also received attention and particularly the way that culture may impact on migrant health professionals' communication styles and learning styles (Illing 2009, Slowther et al. 2012, Morrow et al. 2013).

Unsurprisingly, this was also something raised in our interviews by both migrant health professionals themselves and by their British colleagues. Often these issues focussed around norms of communicating politely and British expectations of what polite communication looked like. One doctor, a representative of an overseas doctors' association, who had come from outside the EEA and had been in the UK for a long time, described how early on this had been brought to his attention:

> *One nurse told me, she said 'Doctor you're very rude' and I was shocked! I said why, she said 'you don't say please and thank you'. (...) Because in [country of origin] you don't say please and thank you, this is like a formal language.* (Representative of overseas doctors' association)[40]

Use of 'please' and 'thank you', smiling, and other polite forms were raised in a number of interviews as something that migrant health professionals themselves had found difficult or as a problem they noticed in their colleagues. One more senior nurse in describing a newly joined junior colleague said,

> *Because I know nursing skills wise she's brilliant, but delivering the message in a way so English people don't find it offensive. Simple please and thank you.* (Non-EEA nurse, private hospital PMN1)

Directness was another issue that was raised. One EEA nurse commenting on her own directness said,

> *There are many languages in England (...) There are so many ways of speaking in England. You can offend people very easy in this country, and they get offended.* (EEA nurse, private hospital PMN7)

Many of these communication cues may be extremely subtle as has been identified in the Safe Transitions Framework (Health Eduation North Central and East London 2014). They include things like use of silence, choice of vocabulary, tone and volume of speaking, along with elements of body language such as eye contact, gestures and head movement, elements that most of us take for granted and do not give a second thought to.

British colleagues tended to agree with this although varied in the degree to which they were able to explain what the issues were. One example that had been fed back by a trainer who had provided induction for a cohort of Spanish nurses in the NHS hospital was given:

> *Spanish nurses when they understand something they 'tut' and do that [gestures with head.] That is them saying, 'oh yes we understand that', but whereas in our culture that would be, you are dismissing this, you are not listening, or you think it's unimportant.* (British manager, NHS hospital NHSUKMG1)

British colleagues described some of their migrant colleagues as 'abrupt', 'direct' 'harsh' or 'matter of fact' in their communication style. This could potentially cause an issue with patients.

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[40] Stakeholder interview 10/06/2014.

It's not that they don't care or aren't compassionate, but it's the ability to demonstrate that. I would suggest that for some patients there's a barrier there. Because communication is so...it's absolutely fundamental in nursing. (British clinical manager, private hospital, PUKMG3)

These issues seem to have been raised more in the private hospital, where a larger proportion of the staff was from overseas. British staff described working closely with migrant colleagues, providing guidance in order to encourage changes in behaviour. It seemed this could be successful as long as the person in question was aware of their own communication style. These varying styles of delivery could also occasionally cause issues with other colleagues. One British colleague described having to act as mediators between staff members from different cultural backgrounds:

Communication is key and to keep stressing at staff meetings that people are from different cultures and to respect one another and to work as a team. (Senior British nurse, private hospital PUKN1)

In the private hospital, there was perhaps a more understanding of the fact that these differences were likely to be the result of different cultural backgrounds and not linked to the individual's attitude or personality.

One element that can affect how much this is made an issue of is the degree to which British colleagues themselves are aware of the particularities of British cultural modes of communicating as well as aware of the cultural context from which colleagues are arriving. One EEA doctor described receiving a popular anthropology book '*Watching the English*' from a colleague and how this had helped him to understand better some of the nuances of the culture around him which many of his British colleagues were probably unaware of:

I think that makes your life a lot easier if you understand, yes language is one barrier, but there are cultural differences. And when I read that those cultural differences, and it was my educational supervisor who was [a native English speaker from overseas] who gave it, which clearly shows it's not just the language which is a barrier, but many other things that probably half of the Brits are not even conscious or aware of that stuff. (EEA consultant, NHS hospital NHSMD5)

In both institutions, managers made reference to the fact that it would be useful to take forward learning from their experience with current staff for future recruitment and induction exercises. This ranged from ensuring there was better language testing, or changing how language testing was done at recruitment, to ensuring that expectations of roles were more clearly communicated in advance. One more senior nurse also commented that particularly for large scale nurse recruitment, understanding the context that nurses had come from could be helpful:

I think that's really important [understanding the context that migrant workers have come from]. I must confess, I don't know a huge amount, and it's made me think as we've been talking, actually I should understand a bit more. Because I would about patients, I'd understand their background,

> *I understand what it was that was making them tick and why are they feeling like that. So I think*
> *we should try for the nurses as well* (British clinical manager, private hospital PUKMG3)

As mentioned above, an individual's cultural background can influence a range of other areas, which although not directly about communication, may present in the form of communication challenge. For instance, the fact that learning styles are more didactic in other parts of the world can lead to health professionals asking fewer questions in learning situations. As exploring, challenging and asking questions are valued in British health learning environments this could result in them creating a less favourable impression among mentors and educators (Morrow et al. 2013). The role of different professionals within a system also potentially creates different expectations around communication styles. As one doctor described it,

> *Different societies are more or less patriarchal in terms of the role of the doctor and also how the*
> *doctor is perceived. And this is nothing to do with medical knowledge at all but about how you*
> *interact with your staff and patients. And this can cause friction for sure.* (Non-EEA registrar, NHS
> hospital NHSMD1)

All of these issues are playing out in extremely high pressured environments in which life and death is hanging in the balance and communication needs to be handled extremely sensitively. One migrant doctor, himself a native speaker of English, commented that he had occasionally been asked by patients to explain things as they had not been able to understand their previous doctor. Some migrant doctors described strategies for dealing with the issue. One said she had learnt to put aside any embarrassment and simply ask for further clarification until everything was completely clear. Another described emphasising non-verbal cues, and trying to ensure that another doctor or nurse was also available for difficult conversations.

> *Because communication is such a key thing, and people may have quite a good command of*
> *language when they're in control but a lot of the situations in nursing you're not in control. You're*
> *having to deal with very complex, very tense stressful situations where people are about to die*
> *and communicate very effectively with medical staff explaining exactly what's wrong with the*
> *patient and things like that. And I think that's been an issue in some places.* (Senior British nurse,
> NHS hospital NHSUKN2)

Adapting to this type of cultural communication is undoubtedly a challenge for migrant health professionals. It also clearly occasionally leads to difficult situations, either between staff or between staff and patients. However, none of the situations described to us had resulted in any obviously adverse consequences. Nevertheless, awareness of these issues, including more explicit awareness on the part of British colleagues on the range of subtleties could undoubtedly help to smooth and speed this process of adapting. In particular, it is important to ensure that this is understood by other colleagues so that issues in this area are not simply assumed to be part of someone's personality or an attitude problem.

Another major issue that migrant health professionals confront when they arrive to work in the UK is realising that the English being spoken by patients is not the English that they have been taught (or may have been tested on). As one EEA nurse put it, "*Because yes I studied so many years English but it's not the English that I heard here. It's totally different.*" (EEA nurse, NHS hospital NHSMN1). It can be different for a number of

reasons. Firstly, there may be pronunciation or lexical differences, such as for those who have learnt American English in the Philippines. Secondly, and perhaps more importantly, patients and staff often use a range of idioms and colloquialisms and it can take some time for migrant health professionals to learn these. As one doctor commented,

> *I think people think they're speaking English, but they don't realise how much of it is colloquialisms, 'go on then' means a variety of things in different contexts.* (Non-EEA registrar, NHS hospital NHSMD1)

One nurse also gave the example of a patient asking to 'spend a penny' (go to the toilet). Having no idea what the patient was really trying to say the nurse innocently suggested the patient might like to go to the canteen, whilst the patient became more distressed trying to convey their need. These difficulties were also picked up by British colleagues.

> *It's generally much more in the, they understand the little nuances, if somebody has asked for something very British, they wouldn't have a clue what they were talking about.* (British senior nurse, private hospital PUKN2)

A separate but related problem is medical terminology, acronyms and abbreviations. One non-EEA doctor described this,

> *I remember one of the main problems was not the language, but the medical lingo...It took me a while to figure out what all the acronyms mean and we talk a lot in acronyms.* (Non-EEA consultant, NHS hospital NHSMD3)

One of the British nurses working in the private hospital also commented on this,

> *They do struggle a little bit with abbreviations, sometimes orders that doctors write. They do all seem to have a little bit of a worry.* (British senior nurse, private hospital PUKN2)

Although these issues are usually resolved after a period of time, in the private hospital there were more proactive steps to support migrant staff in this area.

> *We've got lots of abbreviations all printed out for them and some of our Filipino nurses have done a list of very specific words that English people use and so we've got a lovely little team going that help them out that way.* (British senior nurse, private hospital PUKN2)

This was an example of a simple initiative that probably was very helpful for newly arrived staff.

A further issue identified by participants which falls under the 'language barrier' was pronunciation difficulties on the part of migrant health professionals and understanding of different accents. Occasionally, migrant health professionals' pronunciation difficulties when speaking English did seem to impair communication in some instances, particularly with patients. This is how one non-EEA doctor described it,

> *But I think that accent more than necessarily how you look probably matters a bit more nowadays...One key thing that came up again and again in the patient response survey was that:*

it would be really helpful if we could understand what our nurse was saying and if they could understand what we are saying. (Non-EEA registrar, NHS hospital NHSMD1)

Nevertheless, the effect of this was limited and not all British colleagues raised this as an issue. This is how one British nurse described it.

The only time when English as a foreign language has become a real difficulty is if the accent, if the non-English accent is particularly strong and then some words get lost and that sort of thing. But for the most part you can work through it. It's never massively awkward or problematic. (British senior nurse, NHS hospital NHSUKN1)

However, an additional element in this discussion did not relate directly to understanding of an individual but rather to a patients' expectations of that health professional's competence. This seemed to particularly be an issue in the private hospital, where many of the British colleagues commented on it. In this case speaking with a 'foreign language' accent can become a marker of difference. One senior British nurse said:

A lot of patients they do put a barrier up when they hear a different accent, there is a tendency to put a barrier. (British clinical manager, private hospital PUKMG3)

And one of the things that I know is a bit of an issue, particularly in the private sector, is patients' perceptions of them when they don't speak very well. That's quite an issue. (...) But certainly here, some of them [migrant workers] have found people [patients] can be quite rude, they really can be quite rude, and not very patient and tolerant of them [migrant workers] (British nurse, private hospital PUKN2)

It seemed that these comments from patients ranged from small comments 'oh finally an English nurse', to complaints about not understanding, to outright racism. In many comments, nurses working in the private hospital emphasised that because patients were paying, they had different expectations.

What I call the middle class Brits, and again I'm generalising, have an impression of what they expect from a private hospital. And they kind of expect to be looked after by middle class, mature lady nurse. And so we have had a couple of complaints about the nationality of our nurses which I find quite interesting because in the NHS you don't really get it. (Clinical manager, private hospital PUKMG1)

These complaints obviously made some staff feel slightly uncomfortable. Whilst there was degree of understanding from staff towards patients, because patients were sick or elderly, it clearly was also difficult to handle. It seemed that in the private hospital, deciding whether or not to remove the nurse from care of the patient was done on an ad hoc basis.

It touches on an intolerance from the patient really. We did recently have one gentleman who made some really quite horrendous comments about only wanting to be treated by an English nurse, and I just can't tolerate that. But as I say, there is an understanding there as well, I think it's down to the communication and wanting to be heard and wanting to be understood properly. (British clinical manager, private hospital PUKMG3)

As mentioned above, this issue was raised less frequently in the NHS hospital, although it did come up:

> *There's also an element very, very, very occasionally an element of the patients not trusting the overseas doctors. And again that often comes down to how integrated they are perceived to be, which often comes down to the strength of the accent and the use of the English language.* (British doctor, NHS hospital, NHSUKD1)

> *You do get patients who are quite prejudiced and that comes out in the complaints. And that's quite difficult because how do you change somebody's views, but not appreciate them or advocate them? So I guess it's about having an understanding, because when people are unwell they don't always behave as they normally would. However, some of these are just downright bigoted sort of prejudice.* (Clinical manager, public hospital, NHSUKMG2)

Nevertheless, on the whole, this behaviour seemed less tolerated. Simply put, patients in the public hospital did not get to choose who would look after them. Nevertheless, it remained unclear the extent to which this behaviour was overtly challenged by more senior colleagues and the degree to which support was offered to those migrant workers who had to face it. As one doctor described it:

> *I think racism from an older generation, particularly when they're unwell, it's seen as distasteful but it's seen as, like we [migrant/minority doctors] should be able to tolerate it. Because they don't know any better and they're unwell.* (Non-EEA former registrar, NHS hospital NHSMD10)

A final issue that was raised around communication in the workplace was the use of other languages by migrant colleagues. This was raised mainly by British colleagues, but also by some migrant health professionals themselves, particularly those that were in the minority in terms of their nationality. British colleagues tended to emphasise that this was an issue that could potentially affect patient safety, because if for example two nurses were discussing a patient in another language, a British colleague might miss an important piece of information. Others, however, talked about how it impacted on team spirit.

Once again this appeared to be more of an issue in the private hospital where more of the staff were from overseas, and where there were larger groups of specific nationalities. This also did not come up in any interviews with doctors, almost certainly as a result of different recruitment patterns not usually leading to groups of doctors of the same nationality working in the same area.

> *The biggest bugbear is the way that they speak in their own language in the middle of the corridors which is very rude. They can do what they like in the coffee room, but in the corridors they tend to gather round and speak in their own tongue and it's quite rude.* (Senior British nurse, private hospital PUKN4)

Whilst everyone was clear that this was unacceptable in the workplace whilst working, people expressed different levels of understanding about it. This nurse from within the EEA recognised that it was problematic for the English speakers but felt that it was a natural impulse, and was not done maliciously.

> *But if we join a group of Romanians they'll speak Romanian. And the British people don't like it, you're in England you should speak English. It's a natural tendency and people don't understand*

it. They're not talking badly about you. But sometimes that generates a bit of conflict on the ward. (Senior EEA nurse, private hospital PMN5)

There was a mixed feeling about speaking other languages in break times. Most people, including British colleagues seemed to accept that it would happen during breaks, but a few commented that even in breaks it created a negative atmosphere and was isolating. One migrant nurse commented:

Because what they do in the coffee room they sit in little groups, and talk in their own language. So what am I going to do just sit and talk to myself in my language? It ruins the social thing of the group in the coffee room. (EEA nurse, private hospital PMN7)

This seemed to be an issue that affected different people to different degrees. Whilst most seemed comfortable with how the issue was being handled, perhaps more explicit understanding of the rules - such as does the corridor fall into the same category as the coffee room? - as well as a degree of leadership in trying to promote understanding on both sides could help to resolve this issue.

As we have seen, communication plays a key role in health care and was consistently raised as one of the main challenges for migrant health professionals arriving to work in the UK. Communication skills were key for working together with other colleagues as well as for patient relationships. Nevertheless, as this analysis has demonstrated, there were different elements that feed into the 'language barrier' which require a nuanced response. Often it seemed that it was not as simple as there being a problem with language ability, but rather with sociolinguistic cues linked to cultural forms of communication. In addition, there were issues with particular lexical sets, and British idioms and colloquialisms. These were usually resolved with time as the migrant workers learnt common British expressions. Accent came up as issue both in that it affected understanding but also in how patients reacted to migrant workers with accents. Whilst accent can impair communication, it's also important to recognise that people can speak a language to a very, very high standard and still retain an accent. Clear rules on how to deal with patient prejudice seemed to be lacking, despite both hospital's equality and diversity policies referring to staff harassment not being tolerated. Finally, the use of other languages by some migrant staff was raised as an issue particularly in the private hospital where there were larger groups of specific nationalities.

3.2.3 Socialising

Building team dynamic at work can also happen outside of the workplace and one of the areas that the project explored was how socially included migrant health professionals felt. As such, we asked people about how much they interacted with their colleagues when they were not working together. Broadly we did not find many differences between British colleagues and migrant health workers in reported levels of socialising. Nevertheless, some differences did emerge around expectations of socialising and different forms of socialising.

The majority of our interviewees did socialise with their colleagues on occasion. This seemed to be particularly when there were work related events such as leaving parties. In the private hospital there were more reports of

larger social events, such as a summer party, organised by the hospital which most staff attended. In addition, some teams organised more informal get-togethers, going out for dinner or perhaps a party at someone's house. There did not seem to be a difference in the frequency of socialising reported by migrant workers or by British people, and no indications that people were excluded in either hospital. The frequency did vary, however some form of socialising once every few months seemed to be the norm. Some people offered reasons for the infrequency of social activity, saying that time constraints (working long shifts) as well as family constraints were the main reasons why there was less participation in social activities than might have been expected. There were some reports of workplace socialising – such as bring and shares at which everyone brought a dish for a shared lunch.

Several people also recognised how important socialising as a team could be for team morale. One nurse mentioned that this was particularly important in the situation of staff shortages:

> *So one way of venting your frustrations, you know people like to grumble, is to go outside and have fun and it's a recharge day.* (Non-EEA senior nurse, private hospital, PMN1)

One exception to the general pattern of socialising may exist among the junior doctors on training programmes. Whilst there were not that many junior doctors in our sample, it appeared that the social bonds formed through training together may have been more significant.

> *For lots of us, our colleagues do play a significant part in our social lives because they're often the ones who have the same time off as you do.* (Non-EEA registrar, NHS hospital NHSMD1)

Some more senior doctors also reported that their closest friends were those that had been made whilst training. This pattern of forming closer social bonds could potentially impact negatively on overseas doctors who were not on a training programme, particularly those who were working in staff or associated specialist grades.

> *I think if you've trained here and you've got friends and you're already established here I suspect you socialise more. I suspect if you're outside or you maybe live in hospital accommodation it's maybe different.* (British registrar, NHS hospital NHSUKD2)

> *I don't think that white trainees socialise very well with Asian trainees as much. I don't think it's that they don't like them, it's just that they are unknown to one another. I think they grow to know each other in two years and that interaction begins. But it's not natural to begin with. Because the UK trainees have got their own social structures. So it's not a lack of welcoming but it's just awkwardness.* (Non-EEA consultant, NHS hospital NHSMD8)

Whilst obviously levels of socialising will vary between teams and based on a range of factors, it was true that some of the migrant health professionals in our sample felt that there was less socialising than there would have been in their home countries. Some put this down to 'English reticence', and to different expectations in the level of social interaction that you have with your colleagues.

> *In [home country] when we had visiting trainees, everyone would make sure that they were invited out to drinks or invited over, but that did not happen in reverse.* (Non-EEA consultant, NHS hospital NHSMD6)

Forms of socialising could also be different and so affect how likely people were to engage socially with their colleagues. As one migrant doctor put it,

> *The culture is a bit different. We're not used to going to pubs for example.* (Non-EEA registrar, NHS hospital NHSMD4)

Although this wasn't really raised as a complaint, it was obviously something that did affect people perhaps particularly on arrival. It also appeared to be more of an issue for doctors than for nurses.

> *Here you're expected to keep a distance. You don't really socialise with your colleagues, at least I haven't seen it much. Occasionally someone brings some cupcakes. I once saw a palliative nurse team meeting, and I couldn't believe it because they sat there and talked about personal things, and I was like, nobody has ever asked me anything about my family, they don't care about it. And you just go on like that for years, that's just the way it is but I have realised that it does affect me.* (Non-EEA registrar, NHS hospital NHSMD3)

Whilst it was unclear exactly why this should affect doctors more than nurses, it could be related to the nature of nurse recruitment. It is more likely that migrant nurses arrive as part of a group or are able to find a community of co-nationals in the local area. This does happen with some groups of doctors particularly on specific programmes such as the MTI.

These differences in expectations were balanced on the other side by a feeling among some British colleagues that certain migrant workers tended to form cliques. This was raised more in the private hospital and more among nursing staff.

> *We want to integrate them and make them feel comfortable and they want to integrate. But I think because there are groups of Filipinos, there's groups of Portuguese, there's groups of Polish so they all clump together in their little groups.* (British health care assistant, private hospital PUKN5)

The fact that this was more commented on in the private hospital may be linked to the higher proportion of migrant professionals working there as compared to the NHS hospital. The perception of cliques is also related to the use of languages other than English in the work place as discussed above. It seemed that these cliques were identified by certain staff and commented on, they were not necessarily seen as something that resulted in conflicts, but perhaps led to a certain level of discomfort for other staff. It was also recognised by one British colleague who had worked abroad, that similar situations would arise with British people working abroad:

> *They can be quite cliquey as well. I don't think that's any different from when I worked overseas and the English people being quite cliquey in another country.* (British nurse, private hospital)

Social elements of work are fundamentally important perhaps particularly in health care which is a high pressured work environment. Whilst most of our interviewees did not feel that there was any issue in this

respect and there was no evidence of deliberate exclusion, there did seem to be differences of expectations on both sides. These differed between doctors and nurses. For doctors, the structures/routines in which social bonds were formed were linked to medical school and training programmes, an area where some overseas doctors may be unintentionally excluded. There was some evidence that for some migrant health professionals, the level of socialising was not what they would have expected in their home country and this was put down to British reticence. Finally, some British colleagues commented on cliques among migrant health professionals, however, this did not seem to lead to conflicts in the workplace.

3.2.4 Participation in workers' organisations[41]

We asked whether the doctors and nurses we interviewed in both the NHS and private hospital were members of any organisations such as unions that represented workers. There was a mixed response in both categories of workers and between the hospitals. The main organisation to which the doctors belonged was the British Medical Association (BMA) but only a third of migrant doctors were members, and responses among all interviewees, whether migrant or not, were lukewarm. Similarly, among nurses where membership was with the Royal College of Nursing (RCN) or UNISON, around half of both migrant nurses and British nurses in the private hospital were members. We interviewed fewer nurses in the NHS hospital but even among those we interviewed union membership was less than among half the interviewees. There was a general sense that these workers' organisations were not entirely effective in representing them and there was not much to be gained in joining them apart from tradition or a somewhat vague awareness that they may be able to provide support if necessary, beyond the professional indemnity protection they already had. For instance, the following responses from a British doctor in the NHS hospital and a migrant nurse in the private hospital were typical.

> *I think when you finish being a medical student, everyone joins and then you realise it's not terribly useful. It is occasionally useful, for instance I'll look at their website for things like rules about contracts and that sort of thing. So you can get some useful information from them on occasion. I've never had occasion to go to them to say look I'm being unfairly treated but I suppose that's one reason I keep on paying because maybe one day it'll be necessary.* (British consultant, NHS hospital NHSUKD1)

> *Actually it's just to protect my licence as a nurse. And in case I have any future problems in the workplace, they can advise me what to do.* (Non-EEA nurse, private hospital PMN10)

Doctors particularly, but also some nurses in both hospitals preferred to channel their resources to gaining admittance to specific professional organisations (such as the Royal Colleges for doctors) as membership is important for training and career progression generally. This element of training provision was one reason why some of the nurses chose RCN over UNISON. Those who were not members of any workers' associations

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[41] The focus here is on organisations such as unions that represent the interests of workers to employers, and employment policy makers at a national level, and promote practices and training that are beneficial to workers.

justified not joining on the basis of finances, especially as there were numerous organisations that were either necessary or in their interests for career development to join.

It's too much money [laughs] when you subscribe to all the others it's a lot of money every year. And I'm not sure what they do for me. (British registrar, NHS hospital NHSUKD2)

Well, see the only time it sort of occurred to me that they might give some support is when I went to this SAS doctor (specialist and associated specialist) development day…That was where there was a BMA rep and she couldn't believe that I didn't have the 4 hours of non-clinical time that I'm entitled to and yeah that was the first time that I realised there's this group that will beat a drum for you if you need it. I think I would just be thinking it's just another bill to pay. (Non-EEA speciality doctor, NHS hospital NHSMD7)

3.3 Are migrant health professionals an asset in the workplace?

For most interviewees the answer to this question was an unequivocal 'yes'. There were similar responses from UK colleagues and managers, and stakeholders we interviewed, as well as the migrant doctors and nurses themselves. Several different reasons were given for why migrant workers might be considered an asset, in what ways they might be seen to improve hospital structures and the healthcare system more generally.

Firstly, as we have already seen, migrant doctors and nurses are perceived to improve the hospitals' performance of service provision by bringing in different skills, procedures and practices. These different ways of working cut across nationalities and training systems. For instance, a British doctor in the NHS hospital spoke about the performance of nurses from the Philippines:

Sometimes the nurses are great. They're better trained than the British nurses. The Filipino nurses are fantastic. You know they get on and they do cannulas, they can do everything and some of them are very, very competent. Whereas here they finish their basic training and then if you want to give intravenous drugs you then have to do more training which to me sounds crazy, and if you want to do cannulas they have to do more training. So some of our nurses when they finish their training they're not at the same level. (British registrar, NHS hospital NHSUKD2)

These sentiments are almost entirely echoed with reference to nurses from Portugal by a clinical manager in the NHS hospital:

Definitely. And interestingly once they are adapted in a way and feel comfortable, they bring up the standards. In terms of the technical side of things, for instance their clinical skills, nurses from Portugal are able to cannulate, put in needles for drips and things, they're able to do venopuncture to take blood, they could do what's called arterial stabs which our nurses never, which means you stab into to get down to an artery to take blood. That's quite difficult to do missing all the other bits and pieces. And that's routine, that's what they're taught in their graduate programme. (Clinical manager, NHS hospital NHSUKMG2)

Skills and insights brought by doctors were also commented upon, particularly in relation to diagnoses.

I think there are some individuals who make a very definitive, very positive contribution because of where they have worked before and insights and information they can bring and that can be very helpful…I was thinking of a South African doctor and a sick child came in and she was like 'this is obviously malaria' and we were like 'what?' because we're not used to it. But she was right. So things like that. (British consultant, NHS hospital NHSUKD1)

The second reason for seeing migrant workers as an asset was more utilitarian. It ranged from views on the importance of migrant doctors and nurses in filling shortages to how the health service would collapse without them: "*If you ask all IMGs to leave tomorrow, the NHS would come to a standstill*" (stakeholder in association representing doctors).[42] Migrant doctors, both from within and outside the EEA, were seen as essential in particularly filling the middle bulge in non-training service posts in the hospital that we have already discussed earlier in this section.

In the middle grade we have quite a few European doctors who haven't gone through the formal, who have got a lot of experience on the continent and then come here, whether for personal reasons their partner gets a job or something like, and then they fill the middle grade posts not on formal training programme. They've been incredibly useful to the NHS, to us, because they're in a post and don't have to be turned around every 6 or 12 months, they're capable, good, get on with the job, will be there for a few years and then presumably move on. They're not looking to make their career here but are looking to work and be useful for a few years. And that's actually a real asset from our point of view. (EEA consultant NHSMD6)

Some interviewees were sceptical that it was an essential need for compensating for lack of UK trained health professionals rather than an appreciation of the value in terms of skills and qualities of migrant health professionals that was the driver for perceiving the latter as an asset.

I think it probably is [recognised by the Trust] but I think the basis for it…is pragmatic. I'm not sure, I don't know if we had a situation where we had sufficient nurses trained here that people would be saying well yes but I think for cultural diversity we should actually not employ one of the nurses trained here but we should bring someone in from overseas. I don't think that would happen. I think it is because we haven't got enough nurses trained here. (British senior nurse, NHS hospital NHSUKN2)

OK let me put it that way: I think they need them. And as long as they need them and they fulfil that requirement, they are valued. But I wouldn't necessarily say that they are valued for who they are or where they come from. (Non-EEA consultant, NHS hospital NHSMD9)

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[42] Stakeholder interview 17/09/2014

The third main reason for seeing migrant health professionals as an asset was couched in terms of patient demography, that is, having a service delivered by a workforce representing the diversity of the community that is being served.

> *Being able to see staff that look like you when you're not feeling very well is quite nice.* (Non-EEA registrar, NHS hospital NHSMD1)

> *It can be really nice if you have a patient you know, and maybe their English is not that great, and we have a list of the nurses with the different languages. That can be a real asset. The fact that I can't communicate or something but they can, that can be really nice.* (British senior nurse, private hospital PUKN8)

Where there were concerns or qualified views, these mainly related to communication obstacles, in particular initial difficulties with English fluency that are causing tensions at present.

> *So we got some very mixed stories. But there was certainly in a couple of areas, where actually in medicine them saying they've really come with high standards of care and they've really raised the game with our UK counterparts because they are introducing standards that we've lost a grip on. There were other areas that were saying the English is problem, who interviewed them? They can't speak English, they can't understand anybody. So there have been some people saying that. And other areas saying that you know you just need to give them two or three weeks. We accepted that in interview you can brush up on your English get through that, but actually living in a language and working in a language is totally different and we were happy to give them some time. So there was sort of two boats …* (British manager, NHS hospital NHSUKMG1)

In this section we have examined opportunities for and barriers to integration in the workplace for migrant doctors and nurses through perspectives of the diverse range of interviewees and taking into account differences between EEA qualified, non-EEA qualified and UK qualified health professionals, and between the private and NHS hospitals. We have identified issues around career progression and working together that will be taken up in the concluding section where we will address the question of what all the evidence means in terms of integration in the workplace.

4. What is the evidence for the integration of migrant health professionals in the workplace?

In this concluding section we review the analysis of interview material presented in previous sections to attempt to answer the question of whether migrant health professionals are integrating in the workplace. We think that it is most useful to consider this question with reference to the domains of integration that we described in Section 1 and as applied to the workplace. These domains are: structural, social, cultural,

civic/political and identity. And we need to consider the factors – migrant, receiving society, and policy related – that facilitate or impede workplace integration in these domains (Spencer 2011).

4.1 Structural integration

There appear to be limits to structural integration in terms of opportunities to progress in the workplace. This seems more the case for migrant health professionals coming from non-EEA countries than from within the EEA; and, to an extent, for doctors more than nurses. Automatic recognition of EEA qualifications, formally less stringent English language testing and lack of immigration restrictions make the transition to a British hospital, whether public or private, more straight-forward for entrants from EEA countries. EEA nurses more than non-EEA nurses are able to start work at the level to which they are already qualified. Until very recently, the compulsory adaptation period of 3 to 6 months required for non-EEA nurses could be seen as a de-skilling barrier initially at least; this requirement impacted the early experiences of some of the long-established nurses from outside the EEA we interviewed although several of them have now reached senior levels. It would be interesting to see how the recent replacement of the adaptation period by a PLAB type examination impacts on career progression for nurses coming from outside the EEA in the future. A further factor that is likely to impact the integration of nurses from outside the EEA in the coming years will be the income threshold for settlement[43] which is due to be introduced from April 2016. This will mean nurses and health care assistants on Tier 2 visas will be unable to apply for permanent residence after five years unless they are earning £35,000 or more. This is currently beyond the pay levels of most nursing staff in the UK.[44] The different entry requirements for EEA vs non-EEA nurses also potentially affects differential participation in health sector employment as hospital managers are currently concentrating nurse recruitment drives in (mainly economically strapped) EEA countries such as Spain and Portugal. Our interviews with both private and NHS hospital managers revealed a move away from earlier recruitment patterns focused in other parts of the world, a move that is in keeping with adherence to the ethics of preventing the erosion of health professionals in developing countries. But the interviews also revealed that while EEA nurses benefit from recognition of qualifications, the different system of regulation of competencies in the UK compared to countries of origin means that these nurses experience barriers in being able to practise their skills independently until they are formally signed-off, and this leads to some degree of frustration.

Both EEA and non-EEA doctors (including to an extent non-EEA doctors trained in the UK as we saw) struggle to get on linear training paths and posts characteristic of the British medical ladder, compared to British colleagues, and are more likely to occupy middle grade non-training posts with fewer in-built training and career prospects. Recognition of qualifications does appear to favour EEA doctors in moving upwards to permanent consultant roles. Non-EEA doctors we interviewed who had entered the UK medical system more

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[43] https://www.gov.uk [accessed: 31/03/2015]

[44] Currently a nurse would be required to be at a high level of seniority (Band 7) to meet this minimum income requirement. http://www.rcn.org.uk [accessed: 31/03/2015]

than a decade ago had undoubtedly reached senior positions and were happy with their progress although they recognised there were barriers in their career pathways as highlighted in other research (e.g. Oikelome and Healy 2007, Kline 2013) and felt they had to work harder than British colleagues to prove themselves. In contrast, within the far more restrictive immigration framework at present, non-EEA doctors entering on the specific short-stay medical training initiative have no opportunities to progress within the hospital and are more likely to fill temporary service gaps with fewer inherent training prospects in the limited time they are allowed to remain in the UK.

We found that there were differences between public and private health sector workplaces in relation to structural integration of nurses but they did not seem to disproportionately impact on migrant nurses. These included differences in pay structures and conditions: that is, less transparency and more performance-related individual judgement by managers in the private hospital. At the same time several interviewees valued the opportunities for more individual innovative working practices that are recognised by management and more chances to work across different specialities available in the smaller working environment of the private hospital. But there was also a perception that opportunities for career progression may be faster in the larger NHS hospital. A theme common to both migrant doctors and nurses and across both workplaces was the way family responsibilities and lack of extended family support in the receiving context negatively impacted on career progression given long hours and shift work characteristic of health sector employment.

Overall, even though both migrant doctors and nurses highlighted barriers to structural integration that related to their non-UK backgrounds and training as shown above, there was little explicit mention of institutional discrimination. Discriminatory or racist attitudes, behaviour and language were most strongly reported in the case of some patients and where institutional factors may have played a part was in the responses of clinical leaders and managers to patient bias. While there was little tolerance of this kind of discriminatory behaviour it was not clear to what extent racist attitudes of patients were excused with reference to age and illness and whether there was support for migrant workers around this issue. Equality and diversity policies while used extensively in training of staff in both hospitals were largely seen as common sense by the latter and not directly relevant to day to day work practices and experience. There was clearly a mismatch between 'race' and 'migration' in the policies and relevance to migrant workers in the health sector was not explicit.

4.2 Social integration

Evidence on social integration of migrant health professionals and factors supporting or impeding this was gained from perceptions around working together and social interaction within and outside the workplace. Most interviewees talked about the importance of close working in a team and 'pulling together' in an environment where the lives of patients often hang in balance, and experiences were largely viewed positively by migrant doctors and nurses and their British colleagues and managers. Social integration as a two way process was manifested in the value British colleagues placed on new skills and different working practices brought in by migrant health professionals. There was also evidence of some – at times difficult – adjustment on both sides

to differences in team dynamic although inevitably it was the migrant health professionals who had to adapt more.

Both the migrant health professionals and British colleagues seemed happy with the level of informal social interaction across and within nationalities and ethnicities, both in and outside the hospital. Work and family constraints affected socialising among both migrants and British colleagues. However, there were some differences around expectations and different forms of socialising. Doctors tended to socially interact within friendship groups formed in medical school and training programmes and therefore migrant doctors coming from outside may have been somewhat excluded. There was also a perception among some migrant health professionals of British aloofness and differences in forms of sociability. The formation of country of origin/ethnic cliques among some migrant health professionals, especially where there were several staff members from the same country, was mentioned by senior British colleagues particularly in the private hospital but while this was considered somewhat divisive particularly when languages other than English were involved, it was not viewed as necessarily conflictual in the workplace.

4.3 Cultural integration

The interviews with both migrant health professionals and British colleagues showed how communication within work teams and with patients, was an integral element of hospital life and threw up many challenges and solutions as highlighted in other studies (Winkelmann-Gleed 2005, Illing 2009, Slowther et al. 2012, Morrow et al. 2013). Most interviewees identified 'a language barrier' but what this constituted was much more complex than an English competence test at entry for migrant health professionals could cover. Issues around language and broader 'cultural communication' identified by interviewees included receiving society expectations of polite forms of speech and body language; knowledge of idioms and colloquialisms, and of terminology; accent; and using languages other than English in the workplace. Some of these issues did, initially at least, constitute barriers to working together and for effective patient care, but there was evidence of willingness to adapt on the part of the migrants, and understanding and support on the part of British colleagues, trainers and hospital managers, including with regard to awareness of differences between migrants originating in a variety of countries with different training systems and forms of communication. Measures of support included tailored induction, mentoring, compilation of lists of medical and common English abbreviations, and were mentioned more in the private hospital. The use of country of origin languages by some migrant staff was raised as an issue particularly in the private hospital where there were larger groups of specific nationalities and again there were measures that tried to balance freedom of expression in break times and language use that might impair team working. More generally, in terms of working together, some interviewees, both migrants and British colleagues highlighted the importance of learning from each other particularly in relation to working practices as mentioned above and ways of communicating with patients beyond language limitations. Thus, there was a sense of a two way process of communication that went beyond adaptation by migrants, and understanding and provision of support by

receiving society colleagues, in the workplace. This has been less highlighted in other studies on cultural communication relating to migrant health professionals in the UK health sector.

4.4 Civic/Political integration

Our questions as regards political integration were limited to those on membership of and participation in organisations representing workers and within the remit of the project we were not able to explore issues of wider political participation. There was overall a lukewarm response among both migrant health professionals and British colleagues to membership of and active participation in unions such as the BMA for doctors and the RCN or UNISON for nurses, and there were no differences between categories. Most doctors and nurses who were members had joined because they felt they may benefit from added support in professions where there was a high degree of risk in providing service to the public and/or because they felt they could benefit from negotiations between the unions, employers and government to improve pay and working conditions although there was a degree of scepticism about the effectiveness of the latter. Given the financial outlay involved in membership of the multiple organisations associated with health sector employment both migrant health professionals and British colleagues expressed a preference for membership of professional organisations associated with training requirements.

4.5 Identity

Most migrant health professionals showed a high degree of pride in their occupation and commitment to the work they do, and most seemed happy in the working environment provided by the hospitals. We did not ask questions on national identity or belonging. However, we did ask about transnational work engagement particularly in relation to country of origin health sector, interaction with colleagues in country of origin and elsewhere, and intentions to return or move elsewhere. Transnational engagement was overall limited both among doctors and nurses, most of whom had either settled, or had intentions of settling, in the UK at least for the time being. These included many of the EEA migrants. There were nostalgic views of home and extended family left behind, as one of the non-EEA interviewees said, 'the immigrant's Friday night dream' of eventual return. But most had migrated with immediate family or had been joined by spouses and children or formed families and relationships in the UK. There was also relatively limited professional engagement with home countries, although many migrant health professionals maintained personal ties with colleagues and friendship groups formed as students back home. Intentions to return or move on were also limited, and some mentioned that efforts to have their qualifications recognised had been difficult so that they did not want to start the process all over again in another country.

Conclusion

This report has examined processes of integration of migrant health professionals, specifically doctors and nurses in the workplace. By undertaking a qualitative case study focused in an actual working environment of health professionals, in this case two hospitals, one public (NHS) and one private, in an English city, we are contributing to and taking forward existing research in the UK on the positions and experiences of migrant health professionals and factors that facilitate or impede their societal integration more generally. In the course of our examination of hospital documents and interviews with managers, migrant doctors and nurses, and their British colleagues we have found both similar and different experiences and perspectives around integration between migrants and UK born interviewees, migrants originating in different parts of the world (in particular those coming from EEA and non-EEA countries), doctors and nurses, and the NHS and private hospital. Structural barriers, particularly as they relate to entry requirements and career pathways continue to have an impact on the integration of migrant health professionals. The lack of attention paid to migration backgrounds in equality and diversity policies in hospitals also means that these are not effective tools for integration. In other domains, such as social and cultural, integration as a two way process, involving both these highly skilled migrants and receiving society residents and institutions does seem to be occurring. In particular, positive assessments of the new working practices brought by migrant health professionals indicate a willingness on the part of British colleagues to adapt and incorporate new ideas in their workplaces. Nevertheless, overall there remains an inconsistency as to how integration is approached in different hospital workplaces and how much attention is given to ensuring it is a two-way process in which migrant health professionals are fully valued.

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APPENDIX: List of Interviewees

List of hospital interviewees

Code	Position	Region of Origin	Hospital
NHSUKMG1	Manager	UK	NHS hospital
NHSUKMG2	Clinical manager	UK	NHS hospital
NHSUKMG3	Clinical Manager	UK	NHS hospital
NHSMD1	Registrar	Non-EEA	NHS hospital
NHSMD2	Consultant	EEA	NHS hospital
NHSMD3	Registrar	Non-EEA	NHS hospital
NHSMD4	Registrar	Non-EEA	NHS hospital
NHSMD5	Consultant	EEA	NHS hospital
NHSMD6	Consultant	Non-EEA	NHS hospital
NHSMD7	Speciality doctor	Non-EEA	NHS hospital
NHSMD8	Consultant	Non-EEA	NHS hospital
NHSMD9	Consultant	Non-EEA	NHS hospital
NHSMD10	Former registrar	Non-EEA	NHS hospital
NHSMN1	Nurse	EEA	NHS hospital
NHSUKD1	Consultant	UK	NHS hospital
NHSUKD2	Registrar	UK	NHS hospital
NHSUKN1	Senior nurse	UK	NHS hospital
NHSUKN2	Senior nurse	UK	NHS hospital
NHSUKN3	Nurse	UK	NHS hospital

PUKMG1	Clinical manager	UK	Private hospital
PUKMG2	Manager	UK	Private hospital
PUKMG3	Clinical manager	UK	Private hospital
PMN1	Senior nurse	Non-EEA	Private hospital
PMN2	Nurse	EEA	Private hospital
PMN3	Senior nurse	EEA	Private hospital
PMN4	Nurse	EEA	Private hospital
PMN5	Senior nurse	EEA	Private hospital
PMN6	Health care assistant	Non-EEA	Private hospital
PMN7	Nurse	EEA	Private hospital
PMN8	Senior nurse	Non-EEA	Private hospital
PMN9	Senior nurse	Non-EEA	Private hospital
PMN10	Nurse	Non-EEA	Private hospital
PMN11	Senior nurse	EEA	Private hospital
PUKN1	Senior nurse	UK	Private hospital
PUKN2	Senior nurse	UK	Private hospital
PUKN3	Administration	Non-EEA	Private hospital
PUKN4	Senior nurse	UK	Private hospital
PUKN5	Health care assistant	UK	Private hospital
PUKN6	Senior nurse	UK	Private hospital
PUKN7	Administration	UK	Private hospital
PUKN8	Senior nurse	UK	Private hospital

List of stakeholder interviewees

10/06/2014	Organisation representing internationally trained doctors
17/06/2014	Organisation representing internationally trained doctors
18/08/2014	Health Education Thames Valley
21/08/2014	General Medical Council
21/08/2014	NHS Employers
17/09/2014	Academic professor specialising in migrant health workers
17/09/2014	British Medical Association
19/09/2014	Department of Health
19/09/2014	Royal College of Nursing and Midwifery
26/09/2014	Migration Advisory Committee