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UNIVERSITY OF WOLVERHAMPTON

Final Report

Home from home?: A case study of the first year settlement experiences of EU nurses working in one NHS Trust

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This work is solely the endeavour of the researchers and does not carry HEE endorsement or represent HEE policy

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Abstract

The UK nursing workforce is facing significant change; it is aging, demand for part-time work is increasing and traditional entrants are choosing alterative careers. Recruiting nurses from the EU can help, but such arrangements are not without their challenges.

The arrival of a cohort of 35 EU nurses in January 2015 provided The Royal Wolverhampton NHS Trust [RWT] with an unprecedented opportunity to add to the much needed national body of knowledge concerning the motivations and settlement experiences of an EU nursing cohort. We therefore carried out an 18-month investigation with 20 EU nurses recruited from the January 2015 cohort at the RWT. The aim of the research was to gain insight and understanding of EU nurses' experiences of settlement into the community, and employment in the NHS. To our knowledge, this study was the first to examine this topic in detail.

An instrumental case study was selected for its focus on investigating a particular case [EU nurse]. The case encompassed the first year of nurses' employment at RWT. Each nurse was studied as a single case and emergent issues collectively integrated for the purposes of policy recommendation and implementation. Data collection methods included prospective, serial, semi-structured, qualitative interviews with participants, in conjunction with a questionnaire comprising four Likert-type scales that measured acculturation and adaptation.

Participants' motivation to migrate, was driven by two key findings; financial austerity that they were experiencing in their home countries and a personal desire to obtain work and new sociocultural, educational and life experiences. The participants were very family orientated and leaving their families and friends was the main loss to the individual. The ability to keep in contact with their families via Skype and social media helped them feel less isolated from their home country. Climate factors and the sociocultural environment of an industrial landscape appeared to play key roles in early acculturation of recruits.

Participants desired a more personalised induction but were very appreciative of the support afforded to them by members of the Nurse Education Team and their mentors/buddies in clinical practice. Participants were frustrated and disappointed with the often protracted wait for NMC registration which meant they were functioning below their skills set and this appeared to impact on the development of trusting relationships with ward/unit staff. The reported reaction of workplace staff to EU nurses' arrival was mixed and raised questions as to whether and how ward/unit staff had been prepared, how informed they were about the clinical capabilities of EU nurses, and their patient-centred orientation. To assist acculturation and adaptation, it is imperative that all parties have a clear understanding of EU nurses' scope of practice and anticipated duties in the workplace. Formal and informal mechanisms of support are essential to making migration a lasting, positive and enriching experience for EU nurses.

Even with the constraints of a single research site, a particular cohort of nurses and longitudinal methodology, the study generated a rich data source that provides a platform for future workforce development, education and research.

Acknowledgements

The Research Team thanks all the people who helped to bring this project to completion. Foremost, we would like to thank the EU Nurses for sharing their settlement experiences. We thank our Advisory Team for their expert advice and encouragement through all phases of the investigation.

We thank the members of our Administration Team at the University of Wolverhampton and The Royal Wolverhampton NHS Trust who patiently and graciously facilitated all our requirements. We also thank The Transcription Company UK for prompt transcriptions of interview audio-recordings and professional service; importantly also Kali Demes and Nicolas Geeraet for permission to use their acculturation questionnaire (2014).

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Our sincere thanks to you all.

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'Some great wins. We've got some fabulous staff that are very passionate…they've helped our workforce. We have needed them.'

Nurse Educator on EU nurses' contribution to The Royal Wolverhampton NHS Trust

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Abbreviations	Meaning
EU	European Union
HCA	Health Care Assistant
NI number	National Insurance Number
IV	Intra-venous
NHS	National Health Service
NMC	Nursing and Midwifery Council
NMC PIN	Nursing and Midwifery Council Personal Identification Number
TP	Time Point
RWT	The Royal Wolverhampton NHS Trust

Definitions

English people	The researchers believe that where participants refer to 'English people' this means people who live permanently in the UK and share British standards, traditions and values.
Mentor/buddy	These words are used interchangeably as a person who supports the nurse in clinical practice.

1.0 Background

The European Union [EU] faces fundamental change in the health systems labour market. Opportunities for mobility of health professionals have been created by expansion of the Union and effects of recent economic crisis, which first became evident in 2008. The PROMeTHEUS studies (Wismar et al 2011, Buchan et al 2014) carried out on behalf of the European Observatory on Health Systems and Policies highlighted that health professional mobility will continue to be a persistent phenomenon and policy-makers will have to maintain their capacity to capture its changing trends and impact, to balance the ethical and efficiency considerations that this issue gives rise to. Although health professional mobility has reached the international policy agenda, there is still a need for more concrete action. Unless countries invest time and money in better workforce intelligence systems, large gaps in our understanding of health professional mobility will remain. If we are to find effective responses to health professional mobility in a changing Europe, we need to better understand these individuals regarding their motivations and experiences.

The United Kingdom [UK] has been an important destination country with a long-standing tradition of recruiting foreign-trained health professionals. This is one of the major reasons why more than a third of all medical doctors and every tenth nurse, practicing in UK, is internationally trained (Buchan et al 2014). Recruiting internationally educated nurses to work in the NHS has its roots in the 1940s when the NHS was first incepted (Obrey 2013). The UK nursing workforce is facing significant change; it is aging, demand for part-time work is increasing and traditional entrants are choosing alterative careers (Buchan et al 2014). Recruiting nurses from the EU can help, but such arrangements are not without their challenges. Important among these challenges are the impact of migration and settlement experiences of nurses from mainland Europe into the NHS health system and what support they may need to make this a lasting, positive and enriching experience.

A comprehensive search of the literature revealed that there is a dearth of robust data of EU nurses' experiences within UK (NT 2014). Most studies reflect the North American (i.e. USA and Canada), New Zealand and Australian experiences of nurses from countries such as the Philippines, Japan and China (Zhou et al 2011, Neiterman and Bourgeault 2013, Kishi et al 2014, Pitman et al 2014, Stankiewicz et al 2014). A sole integrative review on facilitators and

barriers to adjustment of international nurses carried out in the USA (Kawi and Xu 2009) confirmed the overall scarcity of information in this arena. UK studies have mainly considered countries outside the EU, such as African or Asian regions focusing on the migrant experiences of ethnic minority groups from Asia, Africa and the Caribbean (Alexis and Vydelingum 2005, Blacklock et al 2014, Winkelmann 2006, Likupe 2006, Alexis et al 2007) and adaption programmes (Gandhi and French 2004). These studies are older, most carried out in the early 2000s prior to active migration from EU countries. Deeper insight and analysis about the objective or subjective motivations and experiences of migration for EU nurses is lacking. Subjective personal reasons and experiences of migration therefore remain a subject for research (Pukas 2008).

Turning to the specific case of EU migrant health professionals Buchan et al (2014) suggested that for the individual, mobility may be voluntary but it is rarely uncomplicated**.** Moving countries is far from always an easy or happy experience for the individual, with implications for the systems involved. Migration appears to be littered with often difficult choices, frustration of having to leave to find something better and challenging circumstances in the new country. Integration into a new health system and the role of the individual within that system play a key role in their experience. There is compelling evidence that foreign health professionals are at greater risk of being required to work below their skill level (Stuart 2012), which can then lead to disappointment for the individuals involved and to suboptimal wasteful situations in the health systems (Buchan et al 2014). Discrimination and unfavourable working conditions also appear to disproportionally affect foreigners. However, the free movement of health professionals does not have only disadvantages. In particular, the chances for international education, the intensified exchange of knowledge and skills, return of more highly qualified professionals to their home country and the increased rapid implementation of new medical procedures can improve the quality of health care. It is therefore important that UK nursing administrators understand, in the light of increasing migration from EU countries (Buchan et al 2014), the migration and settlement experiences of nurses from the EU to facilitate clement and effective adjustment to their new work environments.

The process of adapting to a new cultural context is termed acculturation and includes; sociocultural adaptations which refer to the practical and behavioural differences which an individual would need to adjust to, and psychological adaptation which refers to the extent to which the individual feels comfortable in the new culture or whether the changes imposed by the culture are dissonant with their own beliefs and feelings (Berry 1997). Individuals may accept and adopt the 'host' culture to varying degree through this process of acculturation, and the extent to which they experience change and feel comfortable with the host culture has important implications for their psychosocial well-being (Demes and Geeraert, 2014). Better adaptation, that is acceptance of the host culture, and positive thoughts about the host culture, is associated with positive outcomes with regard to wellbeing, whereas perceiving more distance between one's original and the host culture is associated with lowered well being. Using acculturation theory as a framework can therefore provide us with valuable insight into explaining individual differences in EU nurses' settlement experiences in the UK.

The arrival of a cohort of 35 EU nurses in January 2015 provided The Royal Wolverhampton NHS Trust [RWT] with an unprecedented opportunity to add to the much needed national body of knowledge concerning the motivations and settlement experiences of an EU nursing cohort. We therefore proposed an 18-month investigation into the settlement experiences of EU nurses in one NHS Trust. To our knowledge, this study was the first to examine this important topic in detail.

2.0 Study design

2.1 Aim and objectives of the study

Aim

To gain insight and understanding of EU nurses' experiences of settlement into the community, and employment in the NHS, during their first year in Wolverhampton.

Objectives

1. To understand the everyday life of nurses in their home country, including their working lives;
2. To describe the nature and meaning of the migration experience for nurses and their significant others;
3. To identify whether life adjustments occur;
4. To explore the 'push' 'pull' factors that motivated individual nurses to seek employment at RWT;
5. To explore nurses' expectations of the community and employment and whether these were met;
6. To identify the enablers and blockers to settlement either social or employment based;
7. To assess the need for support and extent of any met/unmet needs;
8. To identify whether coping strategies were utilised;
9. To identify key motivators to the retention of EU nurses;
10. To identify any life enhancing factors that may add quality to the lives of EU nurses.

2.2 Methodology

An instrumental case study (Stake 1995, 2000) was selected for its focus on investigating a particular case [EU nurse] for the purpose of providing insight into an identified issue of critical importance to NHS workforce planning and development [first year settlement experiences into the community and the workplace]. Data collection methods included prospective, serial, semi-structured, qualitative interviews (Kvale and Brinkmann 2009) and quantitative measures of acculturation and adaptation (Demes and Geeraert 2014) were chosen to capture the personal perspectives of EU nurses, giving full representation to their

experiences and concerns. The case encompassed the first year of nurses' employment at RWT. Each individual nurse was studied as a single case and emergent issues collectively integrated for the purposes of policy recommendation and implementation.

2.3 Ethical issues

Permission to carry out the study was approved by University of Wolverhampton Faculty of Education, Health and Wellbeing Research Ethics Sub-panel [Appendix 1] and the RWT R&D Directorate [Appendix 2]. Approval to interview two members of RWT Nurse Education Department responsible for setting up the induction programme for EU nurses was also approved following a request for minor amendment to the research [Appendix 3].

In undertaking the research, we ensured that priority was given to the dignity, rights safety and wellbeing of participants and those involved in the conduct of the research. Ethical conduct in respect of gaining informed consent included the provision of explicit information about the research. Participants were assured that their personal anonymity and confidentiality would be maintained and also made aware of the option to withdraw from the study at any time.

Written consent [Appendix 4] to take part in the study was obtained immediately prior to the beginning of the first face to face interview and confirmed verbally, and audio-recorded, at each subsequent interview. Participants were given or sent by email, a copy of their signed consent form. Participants were anonymised by assigning a study code, i.e. Participant 01-20 [P01-P20]. Personal information was securely stored in a locked cabinet and electronic data were password protected.

Support for participants

There is always potential for participants to feel some distress when discussing aspects of their experiences. If the participant became distressed during the interview, the researcher would offer to pause the recording and discuss continuation of the interview. Participants were told at recruitment that the interviews could be emotive and tiring, and that there was a need for them to establish a line of support. Information about local support organisations would be offered to participants at each interview or sent to them, if they thought it helpful.

Study participants were sent a personal letter of thanks [Appendix 5] and offered a summary of the study in acknowledgement of their contribution.

Support for researchers

The nature of the interviews made it essential for the researchers to have their own support from an individual with whom they felt comfortable, and who was suitably qualified to support them, e.g. a member of the University support system. Appropriate independent 'clinical supervision' was also accessible, providing opportunity to reflect on aspects of the research process such as interviews and data analysis.

2.4 Project management, roles and responsibilities

Prof. Sque had overall leadership and management responsibility for the project in the role of PI. She brought to the investigation many years of experience working with qualitative research methods and leading sensitive projects. Prof. Sque was accountable to Health Education England [North West], the Advisory Team and RWT. She worked in close liaison with co-investigators, Dr. Walker and Ms. Rodney, who are also experienced researchers. Regular meetings to review the progress of the project took place between the researchers.

An Advisory Team supported the development and progression of the project. Membership from RWT included: Mr. Rui Costa an EU nurse who was established in practice. He acted as nurse advisor to the project; Ms. Lorna Southan, Head of Nursing – Education [Acting] [during the study period]; Ms. Lynne Fieldhouse, Acting Deputy Chief Nurse and Head of Safeguarding [during the study period]; Dr. Cheryl Etches OBE, Chief Nurse and Deputy Chief Executive; Ms. Karen Bowley, Senior Matron for Rehabilitation and Ambulatory Care; and from the University of Wolverhampton: Researchers Prof. Sque, Dr. Walker, and Ms. Rodney; Dr. Wendy Nicholls, Senior Lecturer in Psychology; and Professor Dariusz Galasinski, Professor of Discourse and Cultural Studies. Prof. Galasinski, an academic with considerable expertise in research methodology, discourse, cultural identifications and analysis, challenged our thinking and acted as a critical reviewer.

In line with our principles for the conduct of the research, ideas from involved participants were sought and taken into consideration in shaping the investigation, at all stages.

Meetings of the Advisory Team provided a means for reporting the progress of the project and a forum for discussions that might have affected its direction and progress. The Team met four times during the study, and consultation took place between meetings, as necessary. Minutes of the meetings were circulated via email to members and stored electronically. These records also contributed to an audit trail of the investigation.

2.5 Case study site

RWT was established as an NHS Trust in 1994. It is a major acute Trust, comprising community, secondary and tertiary services for a catchment population of approximately 336,000. The Trust is the largest teaching hospital in the Black Country, providing teaching and training for doctors, nurses, midwives and allied health professionals. The Trust has an operating budget of in excess of £486 million, more than 800 beds and employs more than 8,200 staff. From a virtual standing start, the Trust has developed a strong portfolio of research and innovation, and since April 2014, has hosted the West Midlands Local Comprehensive Research Network.

2.6 Participant sampling strategy and recruitment

Sampling strategy

We sought to recruit a convenience sample of 20 nurses from a cohort of 35 nurses from mainland Europe arriving at RWT in January 2015. A sample of 20 nurses was considered a feasible recruitment target, and a manageable data source within the timescale of the study.

Recruitment procedure

Research participants were recruited by Education Managers at RWT Nurse Education Department on behalf of the researchers. This involved the distribution of 35 recruitment packs between March and April 2015. Each pack contained: a letter of invitation to join the study [Appendix 6]; an information sheet explaining the study [Appendix 7]; a reply slip [Appendix 8] and an addressed envelope for the return of the reply slip to the Principal Investigator [PI]; and the email address of the PI should they have preferred to reply via the electronic mail system. Potential participants were invited to contact the PI if they wished to discuss any aspect of the research before making up their mind to join the study. The

information sheet also drew attention to a website about the Centre for Health and Social Care Improvement where researchers from the University were based. If a nurse decided to participate they were asked to return the reply slip in the addressed envelope to the PI within seven days or confirm their wish to participate by email. Return of the reply slip or email confirmed the nurse's willingness to join the study.

Once the research team received confirmation from a nurse that they were willing to join the study, the researcher contacted the nurse by their preferred mode of contact. Participants were given the opportunity to ask any questions or clarify any concerns about the study, and a convenient date, and time and place for a face to face interview was arranged. A list of potential interview dates was prepared by the research team, but with the proviso of flexibility. The dates were chosen so as not to coincide with any significant events e.g. training, courses or clinical commitments. It was agreed that if there were any changes in the plans of either the participant or researcher, then the respective party would get in touch. A contact telephone number and email address for the researcher was given to the participants. The day before the interview, participants were contacted by the researcher and final arrangements confirmed. Participants preferred mode of contact was via email.

2.7 Data collection

Interviews

Qualitative, semi-structured, audio-recorded interviews were used to collect data. Prof. Sque [MS], Dr. Walker [WW] and Ms. Rodney [AR] were responsible for carrying out the interviews on four occasions during the 13-month data collection period. Interview time points [TP] of six weeks, and 6, 9, and 13 months were chosen to give a relatively even spread across the 13-month period. MS and WW tracked six nurses each and AR tracked eight nurses. This arrangement was helpful in building trust in the research relationship and thus adding quality to the outcome data. All first interviews were carried out face to face. Subsequently, participants were given the choice of a face to face or telephone interviews. Both methods have been successfully used with adult participants (Sque 2000, Sque et al 2003, 2008, 2013). In this study, all interviews were carried out face to face in accordance with the preference of participants. Interview Guides of topics to be explored at each

interview were developed and used to ensure completion of the research agenda [Appendices 9-12]. The focus for each interview Time Point [TP] was, with reference to Table 2:

1. [TP1: 6 weeks] To learn about participants' background, their reasons for coming to the UK, their expectations and early experiences of being in Wolverhampton.
2. [TP2: 6 months] To explore what it was like being a new starter in the workplace.
3. [TP3: 9 months] To explore their social settlement and sociocultural experiences.
4. [TP4: 13 months] A reflection on their first year living and working in Wolverhampton and to confirm the researchers' interpretations of their experiences.

Questionnaire

Participant data were also collected using a self-completion questionnaire [Appendix 10]. The questionnaire comprised four Likert-type scales, designed to measure sociocultural adaptation, psychological adaptation, perceived cultural distance, and acculturation orientation (Demes and Geeraert 2014). The four subscales measured the following:

1. Sociocultural adaptation

The Brief Sociocultural Adaptation Scale asked participants to: [Think about living in [host country]. How easy or difficult was it for you to adapt to…]. Participants then rated the following 12 items on a 7-point Likert-type scale from 1 = very difficult to 7 = very easy. A higher score indicated they found it easy to adapt.

2. Psychological adaptation

The Brief Psychological Adaptation Scale asked participants to: [Think about living in [host country]. In the last 2 weeks, how often have you felt…]. Participants responded to the 8-item, Likert-type scale from 1 = never to 7 = always. A higher score indicated more positive adaptation.

3. Perceived cultural distance

The Brief Perceived Cultural Distance Scale asked participants to: [Think about [home country] and [host country]. In your opinion, how different or similar are these two countries in terms of…]. Participants then rated the 12 items on Likert-type scale, from 1 = very similar to 7 = very different. A higher score indicated they perceive MORE difference.

4. Acculturation orientation

The Brief Acculturation Orientation Scale compared items between home and host country: [e.g. It is important for me to have [home/host country] friends] on an 8-item, 7-point Likert-type scale, from 1 = strongly disagree to 7 = strongly agree. There was a score for 'home country' and a score for 'host country'. A higher score indicated orientation towards that culture.

It was previously found that the wellbeing scales (sociocultural and psychological adaptation) were predicted by perceived cultural distance (Demes and Geeraert 2014) and so this was expected in the present study. The questionnaire was administered immediately prior to the start of each interview, and completed in the presence of the researcher. The purpose of the questionnaire was to capture individual differences in acculturation and to profile change over time.

Interview encounter

All interviews were carried out in a private space on RWT premises. The University of Wolverhampton's Centre for Health and Social Care Improvement [CHSCI] policy for researcher's working alone was implemented to ensure safety in the interview encounter. Table 1 provides details of the number of participants during the 13-month period of data collection, and the average length of the interview encounters.

Table 1. Number of participants and average length of interviews

Interview schedule	Number of interviewees	Average length of interviews
TP1: Six weeks	20	74 minutes
TP2: 6 months	17	49 minutes
TP3: 9 months	12	50 minutes
TP4: 13 months	4	53 minutes

Interviews at TP2-4 were notably shorter, which the team, in part, associated with improved fluency in conversation on the part of the participant. Despite repeated researcher/ participant contact to agree and confirm suitable dates for interviews, some participants did not respond to follow-up communication [n=3], were non-committal [n=2] or failed to

attend a scheduled interview [n=1]. One participant formally withdrew from the study. Relocation to a different part of England and securing employment in an alternative organisation [n=9] was the commonest reason for study attrition.

Immediately prior to each interview the researcher discussed how the interview would proceed, gave the participant an opportunity to ask any further questions they had about the study and confirmed their consent. At the end of the first interview, participants were offered a notebook to record anything they thought important to share with the researcher at successive interviews. On questioning, and in reality, there was little evidence of the notebook being used as a research journal. Following the first interview the researcher contacted each participant by email within 48 hours to check on any issues the interview may have raised for them. Following the first and final interview, participants were invited to complete a short evaluation questionnaire of their research experience [Appendix 11]. This information kept the research team informed about the impact of participation and served as a developmental tool for the researchers. No issues of concern were identified.

2.8 Data analysis

Interviews

Interview data were transcribed with the support of a reputable transcription company in a requested format of intelligent verbatim, and checked for accuracy by the researchers while listening to the audio-recording. The first stage of analysis involved reading and re-reading the transcripts to become familiar with the participants' responses. Familiarity allowed recognition of important ideas and patterns such as sequencing or repetition of experiences. Notes were made to capture first impressions and primary thoughts. This was followed by content analysis using a directed approach (Hsieh and Shannon 2005). Data was reduced using a systematic process of coding of the text and the extraction of salient issues to provide 'emic' summaries of participants' accounts.

The coding framework [Table 2] was based on pre-established criteria taken from the Acculturation Measures Questionnaire (Demes and Geeraert 2014), specifically the Sociocultural Adaptation Scale and the Brief Psychological Adaptation Scale. This allowed for analysis and interpretation of interview data in the context of quantitative data derived

from the questionnaires. Coding criteria regarding Migration and Workplace Adaptation were derived from the interview topic guides and salient issues arising from a sample of interview transcripts. All codes were clearly defined to promote consistency and accuracy in coding, both individually and across the team of three analysts [MS, WW, AR].

Table 2. Coding framework

Coding categories	Coding criteria
Migration	Motivation to migrate Perceived gains/losses Pursing employment in the UK Expectations on arrival
Workplace adaptation	Induction Support Relationships Communication Identity Practise/Practice Duties Training
Sociocultural adaptation	Climate Social environment Living Practicalities Family life Friends Language
Psychological adaptation	Excited about being in England Fitting into English culture Being away from home country Adapting to England Day-to-day life in England

The transcripts pertaining to each participant were analysed to form an individual case. Individual cases were presented at the fourth interview consistent with the principles of member checking; a technique for establishing the validity of an account (Morse and Field 1996, Hansen 2006). Particular importance was placed on participant validation in this study due to communication and translation issues identified at interview and on reading transcripts. Each participant was asked to reflect on their case, and invited to provide any further information about their settlement experience. Additional data obtained at TP4 was

coded and incorporated into the case. Individual case analyses were then subjected to inter-case analysis.

Questionnaires

Data from the acculturation scales were pooled and entered into The Statistical Package for the Social Sciences [SPSS]. Analyses were conducted to explore whether there was a change in acculturation over time, and if so, when the critical period for this change occurred. To achieve this, non-parametric tests were applied to the pooled data set to examine change in acculturation over time. The independent variable was the 'time', measured over four instances, and the dependent variable was the score on the acculturation subscale. These analyses were run separately for each of the subscales. A Bonferroni correction was applied to take account of the multiple analyses. In addition, it was of interest to profile participants individually to identify those who experienced a change in their acculturation or adaptation over time, and the specific elements of the host or home culture where change occurred.

The final stage of data analyses involved the integration of textual and statistical data. This resulted in the development of four individual case studies of EU nurses who participated in the study at all four TPs [see section 3.4].

2.9 Trustworthiness of the study findings

Reflective and reflexive field notes and memos were written about each stage of the research to form a credible audit trail of the investigation (Malterud 2001). Explicit detail regarding the case study site [situated in an industrialised area of England] was provided to promote transferability of the study findings to similar care settings in comparable localities. The researchers individually recorded the context in which data collection took place, implementation issues and decisions impacting on the research process. To ensure the truth value of interpretation (Lincoln and Guba 1985, Tuckett 2005), transcripts were analysed between the three researchers and any discrepancies discussed and agreed. Particular attention was paid to the researchers' personal preconceptions and values and their potential impact upon the research findings. Preliminary outcomes of analysis from the first interview held by each researcher suggested several areas of consensus in the findings. A collective consensus was established during cross-case analyses. The design feature of

methodological triangulation, comprising quantitative and qualitative methods provided comprehensive data, the confirmation of findings and enhanced understanding. Analyses and interpretations are presented in-depth to assist the reader in making naturalistic generalisations from the case study findings (Stake 1995).

3.0 Findings

3.1 A preface to the study findings

This section provides a background to: Nurse Recruitment from overseas at RWT; Care on arrival in the UK, Induction and support. The content was derived from an interview held with a member of staff based at RWT Nurse Education Department. The depth and breadth of information provided by the participant was meaningful to the research team, and helped to place the study participants' experiences in context.

Nurse Recruitment from overseas at RWT

RWT recruited a total of 99 EU nurses. The first cohort of EU nurses arrived in June 2014. The Trust has seen most recruitment uptake from Spain and Portugal, a fair uptake from Italy and the least from Greece. Most recruits were six to 12 months qualified. Around 10% to 15% of potential recruits chose not to take up the offer of a job. The Trust has also experienced some attrition. Cohort 4 of EU nurses arrived in January 2015. This was the largest cohort to date comprising 35 nurses from Italy, Greece and Cyprus. The participant was actively involved in the recruitment of EU nurses from inception.

> '*If I'm honest, at first I kept thinking,* '*Gosh, we're going out to recruit from Europe.'...One, I'm taking individuals away from those countries, but we're allowed to. And, secondly, am I putting people into jobs that British nurses could have? But if they* [locally trained nurses] *don't meet the standard here and actually we haven't got enough nurses then I felt okay to go out and do that. And I was really quite surprised with the standard* [of EU nurses] *to be fair*'

The Trust talked with employees about what their plans for recruitment from overseas and why. Locally, the recruitment pool of newly qualified nurses and initiatives such as 'return to nursing' failed to meet the workforce needs. There was also a requirement to increase the number of qualified nurses following recommendations in reports by Willis (2012), Francis (2013) and Keogh (2013). A recruitment team from RWT generally comprised senior nurse representatives from clinical practice and education. It was acknowledged that senior clinical nurses were '*desperate to get people in*' but equally there was vested interest in '*getting the right calibre of nurse*.' The preferences of EU nurses were taken into consideration but popular choices like surgery, intensive care and accident and emergency were not necessarily where the Trust needed recruits. It was deemed important to recruit

EU nurses that were at least on par with new recruits, due to a perceived lack of staff, time and resources '*to bring them up to the bar*.' The Trust strategy was to have best team fit and a win-win situation.

> '*We went out there with a very big dream…that we were going to go out and get experienced nurses to come over here. I think the one big gap that nobody figured was that they've got very, very different healthcare systems out there. Working in an acute ward environment isn't the norm. They do have acute wards but a lot of them were employed either privately...or looking after a patient at home who's got dementia and assisting the family*'

Recruitment was seen to be competitive. Incentives were part of the Trust recruitment strategy and some nurses negotiated different salaries. There was a perceived need to discuss what Wolverhampton had to offer in a constructive way.

> '*Nothing against Wolverhampton, I've lived in Wolverhampton and around Wolverhampton all my life but it's not your first…If you were living in another country you wouldn't pick out and go, 'Oh, Wolverhampton. I must go there.' You wouldn't, would you? So we had to talk about some of the unknown things that people who have worked in Wolverhampton for years and haven't seen...We talked to them about the travel networks and they've got Birmingham close and all of that kind of social, that did appeal to them. So they might not like Wolverhampton itself but...where they can get to in a short period of time. That was attractive to them*'

Recruits from the first three cohorts recommended Wolverhampton to some of the EU nurses in Cohort 4, and that was viewed as '*being sold in a good way*.' Potential recruits were also made aware that the Trust funded English language lessons. It was perceived that this provision was important to overseas nurses and the British public in terms of reassurance.

A budget allowed the Trust to invest in the services of a recruitment agency. The same agency was used on four occasions and they were described as '*very professional*.' The agency comprised two companies; one company coordinated the recruiting organisations to arrive at a destination and the other coordinated the interviewees. EU nurses were assessed for employment by the Trust in three ways:

1. A numeracy test with 100% pass rate. If they got one or two questions wrong, they could repeat those.
2. Written scenarios based on the targeted recruitment areas (specialities). The scenarios tested EU nurses' skills of documentation, knowledge base and clinical decision making.
3. Face-to-face interview, which was about verbal reasoning and problem solving in the context of their clinical practices.

Experience of recruiting locally trained Band 5 staff nurses over a period of 10 years informed the development of numeracy and literacy tests to reflect the standards and expectations of the Trust and to ensure recruitment was pitched at the right level. The numeracy and the scenario tests were supervised under conditions similar to an exam situation. EU nurse performance in the numeracy test '*I must say…wowed us*.' From the written scenarios it was perceived that EU nurses were trained within a medical model. Some recruits could write English very well, but when they came to verbalise, it was difficult to understand, particularly if their accent was strong and they talked at a fast pace.

Recruitment was described as '*quite intensive*' and '*exhausting*.' Around 10 to 12 individuals were interviewed in a day. The interviewers sought to achieve consistency and fairness by rotating to form different panels. It was suggested that recruits had prepared for interview; '*They'd done their homework. They'd looked up about the Trust. They'd looked up about some of the Government initiatives.*' Care, passion and commitment were observed attributes in the personal stories that recruits shared.

> '*For example, the Greek nurses were going into work and not getting paid because they didn't want to lose their skills...I wonder if any of our nurses would work for nothing. I don't think so...It was the passion, the commitment and I believe we've recruited some absolutely wonderful people*'

The Trust Human Resource Department obtained references and checked these along with the equivalent of Criminal Records Bureau/Disclosure and Barring Service clearance. There were questions raised about the authenticity of some references, but this was determined as being down to the writing style. The manuscripts of EU nurses' curriculum also required translation.

Care on arrival in the UK

The RWT organised for the cohort of EU nurses arriving into the UK to be collected in one coach for camaraderie and support. An evening event was also organised as a welcoming gesture. A month's advance salary was arranged. The RWT [in partnership with the University of Wolverhampton] provided initial accommodation, assisted new arrivals to find housing and essential equipment such as crockery was funded. Wi-Fi was also installed in the Trust library to provide overseas nurses with access to an internet connection. Initial orientation included a paper trail to find certain places within the organisation, a trip to Bentley Bridge, an area for shopping and eating out, and a 'Take you out and about Wolverhampton' event. The new recruits were also introduced to some 'no-go areas' in recognition of their potential vulnerability.

Induction and support

A six-week induction programme was provided by the RWT Nurse Education and Human Resource Departments. The induction team comprised educators and one person responsible for coordination. The content of the programme had changed over time due to knowledge, understanding and experience of inducting overseas nurses. For example, the team realised that anatomy and physiology knowledge of EU nurses was '*second to none.*' The revised focus was more on clinical governance, mandatory training such as manual handling practices, data protection, confidentiality, the importance of completing NHS documentation, and embedding the regulation of the Nursing and Midwifery Council [NMC].

> '*I think what they're also not aware of here is our litigation society and that is the other thing to make them aware of*'

Equally, it was perceived that EU nurses were 'q*uite blown away*' with the healthcare system in the UK, particularly due to differences in the role of the registered nurse, the ratio of trained to untrained staff and the more dependent, acutely ill patient. Their practice was medically orientated, and the fundamentals of care like washing patients and mouth care were skills they had to learn. Infection prevention was also described as a '*different world*' with the use of gloves and access to hand gel another learning curve. The recruitment of nurses who had attained high levels of academia and were motivated to learn was acknowledged.

> '*They'd done research. They'd undertaken research and been published. And they always want to seek to learn. They always want to try something new*'

EU nurses were introduced to the clinical setting during induction. Their first visit was brief, about half an hour to an hour to meet the staff and have a look around. Then the next time they spent a whole morning with their buddy and had a checklist to complete for orientation and familiarisation of the ward layout and equipment etc. It was acknowledged that some nurses had more exposure to practice than others due the requirement of completing manual handling training before working on the ward. Formal support came in two guises; a buddy and practice placement facilitators. EU nurses were assigned a 'buddy' in the practice area and that person was responsible for taking them through two competency documents. The first competency document was 'fundamental care skills' to be completed within a six-to-eight-week period. The second was a preceptorship document with the development of associated competencies some six months' post-employment. Practice support facilitators visited clinical areas every week, either to assist the buddy or to work with an EU nurse if requested. In some cases, there was a perceived lack of supervision by ward staff to support the achievement of fundamental competencies. There was also some disappointment in staff's reaction and attitude towards EU nurses and concern that this may have contributed to attrition.

> '*They're just so full of 'Can do. Let's do it. We'll try.' And they push forward. They bring something to us, which I think is absolutely all inspiring. But I think sometimes it might be not a nice pill for some of our staff to swallow, because they're not everybody's cup of tea...Some people embraced people fabulously. Some people didn't*'

An example was given of new recruits talking quite direct when literally translating, and it was felt that staff could have been more understanding about communication and language barriers. EU nurses were relocated if they were experiencing difficulty in settling in or fitting into a team. The premise was '*let's keep them and let's put them somewhere else*.'

EU nurses were initially employed and paid as a Band 2 Nurse. The Chief Nurse of RWT had to write to the NMC about experienced delays in EU nurses receiving their Personal Identification Number [PIN]. This was particularly problematic for Italian nurses because

their training is linked to two universities; one for practice and one for academia. The process was described as four stages, and fall out at any one of those stages meant that recruits had go back to the beginning again. It was suggested that it usually took about 16 weeks for EU nurses to obtain their PIN.

> '*Why systems at the NMC weren't in place was a big disappointment and it left a lot of our nurses financially deprived*'

A cohort of 35 was considered a large group that could be '*unintentionally disruptive*' during induction lessons due to different levels of ability to speak and understand English language. English lessons for cohorts 1-3 had been provided during the four-week induction. However, the appropriateness of this was questioned as the only people EU nurses were talking to was each other. In cohort 4, English lessons commenced after induction, when EU nurses were employed in the clinical setting and '*having to speak English*.' It was perceived that learning would be more integrated and meaningful. A private company who completed bespoke individual assessments provided English lessons for Cohort 4, whereas previously EU nurses were taught by a number of University tutors and this was regarded as quite disjointed and task orientated. There was a recognised need to evaluate the two modes of delivery to understand which achieved the best outcomes. An overall evaluation of the induction programme was carried out, but the potential for bias was recognised. EU nurses were described as '*so polite...They don't want to be critical*.' An independent evaluation through research inquiry was endorsed.

3.2 Participants

A total of 22 EU nurses responded positively to an invitation to join the study. As the recruitment target was 20 participants, two nurses who were the last to reply were thanked and offered a 'reserve position' should there be attrition from the study prior to the first interview. Characteristics of the study sample can be found in Table 3. The sample comprised 15 females and five males. Participants were representative of three nationalities; Italian, Greek and Cypriot. All had a Bachelor of Nursing degree qualification acquired in their home country. The length of time qualified and sum of individual nursing experience was variable. Some participants were newly qualified on arrival to the UK, or lacked experience as a qualified nurse due to difficulties in securing employment in the

profession. The sample was representative of EU nurses working in a variety of clinical settings in an acute hospital or rehabilitation hospital that formed part of RWT.

Table 3. Participants' characteristics

Gender	№
Male	5
Female	15
Nationality	№
Italian	14
Greek	4
Cypriot	2
Clinical setting	№
Elderly Care	3
Medical	4
Surgical	2
Theatre	3
Rehabilitation	3
Paediatric	4
Neonatal	1

3.3 Interview study findings

The coding categories of Migration, Workplace adaption, Sociocultural adaptation and Psychological adaptation as illustrated in Table 2, provided a theoretical framework for the presentation of interview study findings. Exemplar quotes are presented as evidence to support data interpretations. The source of participant quotes can be identified by the code used to anonymise participants and when the interview took place, for example, Participant 01, Time point 1 ($P01^{TP1}$).

3.3.1 Migration

Motivation to migrate

Participants' motivations to migrate were driven by need and desire. Many spoke of financial austerity in their home country leading to a job crisis in nursing. Securing paid employment was explained as a key reason for relocation.

> '*It wasn't my first choice to come here, but once I had one strong motivation, the work, I accepted it well enough…I thought a long time about it, and after one year I took the decision to come...I'm here because I needed to work*' ($P09^{TP1}$)

Participants also appeared to be motivated by a personal desire to obtain new work, cultural and social life experiences. Some were looking for a personal change or saw migration as an opportunity to mature and develop independence. There was some evidence of discontent with working practices in participants' home country, and perceptions of a good standard of healthcare and nursing in the UK that presented opportunities to learn.

> '*I wanted to do something different. I was thinking about it one or two years ago, thinking about it and thinking about it just, it would be nice to have some new experiences in a new country, to learn a total different language, make some new acquaintances…And when my father died I was thinking like, this was it; I definitely needed to change things, to move on to something else, to do something else. And to learn the job here also and gain some experience from how are you doing things here, because I've read and heard that the system of the healthcare system here is much better than we have in Greece*' (P02^{TP1})

The motivations of some participants had been affirmed by friends who reported a positive experience of working as an EU nurse in the UK. The ease with which participants could travel to their home country influenced their resettlement destination.

Perceived gains/losses

Closely linked to participants' motivations to migrate were perceived gains such as: new acquaintances, learning a new language, improving English language skills, career prospects and professional development in the UK.

> '*I'm here for a better future and try to study something more so that I will be specialised in something*' (P06^{TP1})

> '*I grow as a person in a professional way because in Italy there isn't the possibility*' (P14^{TP1})

The majority of participants were family orientated, and a sense of closeness among relations was apparent. Many described the environment where they lived with passion, and recalled social occasions with feeling. Sometimes, such recollections resulted in participants becoming distressed. The importance of family and friends was clear, and accounted for a key area of loss through migration.

> '*I miss all of my family and friends...It's the same thing with my family and friends; because it is difficult for me, it is difficult also for them. It could be simple if my family and friends were here but it isn't possible*' (P08^{TP1})

Pursing employment in the UK

Informed decision-making was a feature of participants' descriptions of pursuing employment in the UK. Information was obtained from a variety of sources including the internet, social media, via a Primary Care Recruitment [PCR] agency and the recruiting NHS Trust, and from EU nurses in the UK.

> '*I think the best way is to know someone who has done the same experience before you*' (P12^{TP1})

Participants also appeared satisfied with the support available to them. Preparation for an employment interview was positively remarked upon.

Expectations on arrival

Despite apparent informed decision-making, some participants talked about not knowing what to expect on arrival to the UK or in hindsight, realised misconceptions. A notable mistaken belief was that people in Wolverhampton [including work colleagues] would be friendly. Many participants anticipated that they wouldn't have a problem making friends in the UK and were surprised at how difficult it was to meet people. The environment of Wolverhampton was also a feature of discussion with expectations of a bigger and nicer City with more nightlife, or the converse of '*a nice village with some sheep*' (P10^{TP1}).

3.3.2 Workplace adaptation

Induction

Participants felt very protected and nurtured within the induction programme, but it did not prepare them all sufficiently for work in the clinical area. Opinions of induction ranged from, '*had all the information she needed at induction*' (P17^{TP1}), '*It was perfect…it was really good with really friendly people*' (P18^{TP1}) to a participant being so unprepared for entry into the clinical setting that he described this experience as, '*a punch in the face*' (P02^{TP1}). He continues below:

'[In the induction] *I was feeling good and protected and I was asking everything I wanted, like I had freedom to ask everything even if it was something stupid. I felt comfortable to ask with the people there...I was feeling very secure with them and then when I came to the department it was like the opposite. I was feeling scared to ask. I was feeling judged for what I know. I was feeling like all this time I didn't have anything information about the department, how is the department and how will be the work there, how will be the work and everything like this*' (P02^{TP1})

Participants also had differing expectations of induction believing it to be a time where they would have had a focus on learning some English before going on the wards. Introducing English lessons with more medical terminology was judged to be beneficial. It was also mentioned that the meanings of abbreviations would be useful before they started in clinical practice.

'*They use many, many abbreviations here at handover, 'That patient had a TTO and needs a Section 2 and he's going for that and he's going for that' and go to the next patient*' (P06^{TP1})

Participants desired less theory, and more about hospital policy e.g. sharps injury and practical skills including management skills such as patient discharge and completing documentation. A participant recounted that they were given a lot of materials to study among them various charts e.g. fluid balance charts and drug charts that would need completing but not how to complete them.

'*It's useful that you give me these things but I don't know how to use them…It would also be easier to get in the ward knowing,* '*Okay, this paper you use to do this, this paper you use to do that. These notes, you have to write here at this time. You have to write these things.*' *It would be easier*' (P17^{TP1})

Participants who were newly qualified nurses, where this was their first nursing post, found benefit in many of the clinical skills taught at induction.

'*I learned many things in the induction. I learned about these socks, the white one for the legs to stop clotting the blood. I didn't know many things about that, but I learn things in the induction. He learned us to use the blood pressure machine, the thermometer, but it's electronic here. He learned us to complete the obs* [observation] *form. And all of that was useful for me because I use it almost every day*' (P03^{TP1})

Clinical skills such as blood glucose monitoring were welcomed by the more experienced nurse as it was done differently in their home country.

Overall participants desired a better balance between theoretical, practical and workplace induction. They would have found it helpful to have small windows of time spend in their allocated clinical setting interspersed with theoretical input. P16 suggested that induction be split into three weeks of theory and three weeks on the ward, with a shorter common induction for everyone. Such an arrangement would have enabled staff in the clinical areas and participants to get to know one another and begin to build trusted working relationships. This could have also helped with matching suitable mentors, and might have helped participants learn the ward routines. Participants would also have been able to bring questions back to tutors on the induction programme, where they felt safe rather than seeking answers from ward staff once they moved into clinical practice.

Participants also thought that induction would have been more effective if it had been individualised, as each nurse had different needs. More thought should go into matching the individual induction to the needs and specialty and clinical areas. It was suggested that the group was, '*too big...there was paediatric nurses, medical nurses, surgical nurses and operating nurses and obviously we have different needs'* (P08^{TP2}). Participants thought they would have found it helpful to work in smaller, own discipline groups with input from clinical staff.

> '*I think they have to divide us in small groups. For example, I am in elderly care. I think they have to divide us in the people who went to elderly care, they should be taught by nurses or sister in charge that work in that department, so she can tell them how to do the things...before we went to the ward...because we went to the department after the induction and we don't know anything about the department, the nurses were there, and it was difficult at the beginning. Very difficult*' (P01^{TP2})

Practical procedures participants would have found helpful at induction were:

- Logging onto the Trust systems
- Ward policies and procedures
- Information about clinical systems e.g. VitalPAC
- Explaining different roles and duties of staff

- Information about different professional organisations
- Career opportunities [what the RWT could offer]
- Inspirational speaker about Wolverhampton
- English language course during induction [two-three hours a day] rather than after would be useful and could help the cohort to understand information. Participants generally thought the language course, though helpful, came too late; '*four months is quite late for an English class…classes were helpful but they came too late*' (P04^{TP2})
- Review of skills due to gap between induction and practice e.g. how to use an infusion pump
- Information about the different units of measurement [e.g. kilogram/stones, metres/ feet]; '*simple things, but differences between countries*' (P12^{TP2})

Participants found help with the NMC, accommodation cost paid for the first month, arranging of NI and help with setting up bank accounts very positive. Also meeting members from previous groups where they were placed with their own language group.

> '*They explained to us and told us what to do because we were scared about the new because, okay, where do we go? What can we do? How can we search for a house, and the furniture for the house? And so on. This was very, very good*' (P01^{TP1})

Overall length of the six-week induction was considered appropriate but the length of the day, perceived to be 8am-5pm was too restrictive and not conducive to maximising concentration and learning. The long days also made e.g. finding accommodation and shopping difficult. There was also anxiety expressed that due to the effort made to grasp the information being given in English it was very hard, and concentrating for so long was tiring and there was the worry that important information was being missed.

> '*For example, the long days at the start where we* [were] *here from eight o'clock in the morning until five in the afternoon...But because we were here for just one week, we didn't have the ear for the English language and, okay, I speak English, not perfect, but I speak it, but after three hours that I hear English spoken, my brain is too tired* [laughter] *because I have to connect everything with my language*' (P05^{TP2})

Support

Nurse education team

Participants found the Nurse Education Team extremely supportive and helpful. One participant described them as '*angels*' and the co-ordinator as a '*wonderful man*'. There was a perceived need for ongoing [in practice] support from the Education Team. This support appeared to give participants confidence as they were able to work one-one with the clinical tutor and get feedback on their progress, feedback, which appeared to also be appreciated by clinical staff.

> '*She* [clinical tutor] *came into the department to help us with the drug assessment and she said, 'You can do it four times with me and when you have your PIN number, we can do fifth time and then you can go alone to do the drug assessment' but I saw this month, that they trust me with more things. At the beginning, I was with someone; now, they're starting to leave me alone and when it's the time of the drugs, they call me and they say, 'Okay, come with me. We do it together, the drugs*" ($P01^{TP1}$)

Mentors

All participants were allocated a mentor or buddy when they started in clinical practice, however this arrangement was implemented through several different models, some helpful and constructive and others less so. Arrangements differed from ad hoc allocation of having a different person [mentor] to work with on each shift to having one mentor who worked with participants for most of the time.

> '*We didn't have mentors. During every day we had a different mentor for the first month, I think. So it wasn't so good because every different mentor didn't know what we know, what we have learned, what we are doing, you know, different person, like, starting from zero again, zero point*' ($P02^{TP1}$)

This daily arrangement was described by another participant as, '*every day is a fight*' ($P10^{TP1}$). The above participant was finally allocated a mentor after a number of weeks.

> '*Anyway, she was great. I think she was the best mentor for me. They put her like it was only her who could manage with me, I think. Her personality, her knowledge about the work, her attitude with me. It was like very good cooperation and she was also not like so bossy or something, which I don't like having. She was very nice with me*' ($P02^{TP1}$)

Mentors appeared to work with participants for varying periods of time, however, by TP2 most participants were working confidently on their own. P09 who worked with a mentor, on the same shifts, for the first month of their clinical experience reported at TP2:

> '*I think now I'm quite…I'm independent, so I think I can do most of the things on my own. I think I'm settling now*' ($P09^{TP2}$)

P01 considered herself fortunate to have had an Italian mentor who was from her language group and whom she found very helpful.

Issues with having different mentors or changes of mentors did lead to feelings of a lack of support. This participant had an unfortunate experience with her allocated mentor.

> '*I felt bad actually when I had been there for the first week and they told me to be with one nurse and since I've been there, she had a student, the matron who said 'Go with her to explain and the time that you're with the student to explain to you'. I have been there but I didn't know then, so it was like my second or third day. It was really new for me and she started to say, 'I don't want you.' It was like 'You know something; I have a student now so I don't have time for you.' I said, 'Why? Is it too hard for you to explain to me but you have time to explain to the student? Just so I don't disturb you?' She said 'No, I don't want you. Find someone else. I have a student and I can't explain anything to you.' I remember I called to* [name] *and I said 'I want to leave. I don't want to stay here and I want to go back' because I also found Wolverhampton hard as a city. I didn't find it friendly and safe. It was grey, everything. It was grey for me*' ($P18^{TP1}$)

Some participants found the first day on their wards really difficult. This in the main appeared to be due to shortage of staff. They were also scared as they were left alone, did not know what to do or where to find equipment.

> '*Yes, because you're supposed to have a mentor but we don't have when we start. So the first day they don't have staff in the ward so they just leave us alone and it's really hard. When I came back home I cry, oh, I don't want to stay here because I really feel alone. They leave me alone with the patients and I don't understand anything so I'm really scared to do anything wrong*' ($P13^{TP1}$)

On the whole however, mentors appeared to be well regarded and participants learned a lot from them and were grateful for their input. This participant had only three days of mentorship.

'*But the three days with my mentor were more helpful than the two months without mentor, because the mentor is a person that can learn you a lot of things. And if you have just one person that learn you something, you can learn more than four persons that try to teach you something*' (P10[TP2])

Ward/unit staff

Participants described support from staff but not all staff. A newly qualified nurse found her colleagues very supportive.

'*Very nice. A big part of them it's very friendly with me. They helped me to start to work like a nurse, to make things like a nurse. They helped me very much with the medication. They helped me to learn controlled drugs, and now they are trying to make me to start from answer to the phone, because I didn't, I'm afraid with that. So actually they are very helpful and friendly with me*' (P03[TP1])

Other participants reported how the staff and their mentors helped them to settle into the ward by gradually increasing responsibility, through intensive coaching and by being available to help.

'*They left me the right time to settle in the right way. So I was like under a mentor, so getting started to know about the English NHS system. Then I got my own patients, but not high-dependent patients. So they prepared me to be confident at the beginning with the basic things, and then build up a few more and more skills*' (P07[TP4])

'*Always open and available to help me. They know that we come from Italy and things are different, so they are willing to help. But all the same, you feel this feeling to be a nuisance, even if they are open and available to you*' (P09[TP2])

Relationships [co-workers, hospital staff, patients and families]

Relationships with hospital staff were dependent on who they were working with. There was a perception that some staff were not very friendly. Initial difficulties also arose as participants felt hospital staff did not know them or were unfamiliar with their capabilities.

'*I think sometimes they have a lower expectation of us, or maybe they don't want us here. I don't know. But I think they think, they saw us as student nurses, not nurses. So they think that we have to learn everything, but they don't realise that we are already nurses. We know how to do the things. We studied for years. They think we are not capable to do our job, but it's not like this*' (P01[TP2])

Initially relationships were more difficult with other nurses due to a lack of trust. Sometimes felt the staff, '*haven't enough trust in me…maybe because I'm new, maybe because I foreign…maybe because I'm not speaking English very, very, very well.'* (P07 ^{TP2}). Seemingly nurses took some time to get to know participants, what they were capable of and therefore to trust them.

> '*I get the impression that my other colleagues are starting to appreciate me a bit...that they now trust me when I do something. At the beginning when I do something they are check and check, check, check again, and its fine, it's normal. And now they check less, they are happy and they told me that I am good, so I am happy*' (P11^{TP2})

Most participants were able to build relationships over time with nurses, doctors and patients. At TP2 P10 reported:

> '*I feel good because there a lot of colleagues…they're kind persons. So they help me with everything. They joke with me and I like that. And we are four males in my ward and all the other nurses are female, so it's better for me. Because I'm like the brother, the son, you know…Here I haven't seen a lot of male nurses, and in Italy we are 60:40. Here, 80:20…Now I can talk with them* [work colleagues]*…They are more open. Not a lot, but now I can speak with them about everything…the job, the work or the personal life…Now all the doctors know my name. They ask me something about the patient and now I can answer them…When I arrived I was scared about the doctor. Now, no''* (P10^{TP2})

And he spoke of a patient's gratitude:

> '*One day I had a patient, it was just for half day, and the day after I met him, I found him in the main corridor. I was talking with my colleague and he started to shout, started to say* [name, name] *Oh, Italian! Italian!*' *And he said to me,* '*Thank you for everything, take care, bye bye*' *and was very…what's the word when you are… grateful … He was grateful for me*' (P10^{TP2})

> '*At the beginning it was very difficult...I had the impression that they don't trust me, they had the impression that I am not very good, but now starting to be easier because the other staff members know me and they trust me and they talk with me. They try to feel me part of the group. And now I know better the case, I know the preference of the surgeon, the environment...so it's easier for me*' (P11^{TP2})

The key to unlocking the trust of hospital staff appeared to be the acquisition of a PIN [please see section on Identity, page 34].

Participants did form good working relations and some friendships with colleagues. A participant suggested that her friendships with colleagues started when they first trusted her as a nurse. Friendships outside of work were perceived by participants to be difficult to form as the workforce was somewhat older, also staff appeared very private and not keen to open up to relative strangers. This participant was very happy with her colleagues and expresses her appreciation.

> '*They were by my side trying to encourage me and teach me with patience and show me thing, go through documents that we had to complete…they've been really, really helpful…so I've been in a very good place for my placement…I feel like I've been blessed*' (P06^{TP2})

A participant reported at TP2 that she was touched at the response she had from her colleagues when she was unwell.

> '*Now there are some nurses that I can consider maybe – not friends, but very nice. For example, I was ill a week ago, I was very ill, and some nurses sent me a lot of messages to ask me if I am better, how was going my illness, if the temperature was going down, and it was nice 'cause we meet just in the ward and we don't have a lot of time to speak or to discuss. That is nice*' (P05^{TP2})

Relationships with patients and their families were somewhat easier as participants were used to working closely with patients and their families in their home countries. Participants recounted that they asked for their patience in terms of the language use and understanding for as well as trying to understand English participants often had to decipher through another accent.

> '*It was a true problem to talk with English people because with foreign people, everybody has a different accent and people have different accents. Pakistani people have a different accent, Italian people, Spanish, everybody has different accents and nobody talks proper English, so you can't understand everybody [laughter]. With the English people, they have Black Country accents. We are not used to listening it, so the first month was a real problem to follow everybody*' (P04^{TP1})

P08 recalled a memorable experience from the first day on the ward. She perceived a cultural difference in the nurse-patient relationship between the host and home country.

> '*I was doing the obs* [observations]*...He* [patient] *responded to me that he always wanted to marry an Italian woman and it was quite strange to see a person with this modality to propose to you...It was the first time that I saw that patient so I haven't relationship*' (P08^{TP1})

Communication

Participants had problems with keeping up with handovers and understanding acronyms and abbreviations. This did cause them some personal discomfort.

> '*Sometimes I don't know the English words for their illnesses or all the things that are referred to me from the hand over. I don't have the time to translate or I don't have the time to look through the patient's notes what's going on, so I'm feeling stressed during the day*' (P02^{TP2})

> '*I listened to the handover. I couldn't understand anything. They talk very, very quickly, so I didn't understand anything about it*' (P07^{TP1})

Telephone conversation was perceived as '*difficult*' and was often the last skill in which participants felt confident.

> '*It took five months to get very good communication on the phone, but now it's a normal thing to do at work*' (P07^{TP4})

This participant had a preference for night duty as, '*You have not to speak with relatives*' (P10^{TP2}). At TP3 he reported:

> '*Yesterday was the telephone day for me because I had eight patients and I think that all the relatives for the eight patients called me. I received something like 30-40 calls and now I'm alright*' (P10^{TP3})

Participants initially found it difficult to have a conversation with patients and staff due to the language differences and especially the Black Country accent. '*Sometimes, some of the patients, it's really hard to understand them because they speak the Wolverhampton accent*' (P09^{TP1}). Understanding the patient was a concern of participants. '*This is one of my worse*

worries, because I worry that I don't understand the patient' (P13[TP1]). One participant spoke about an encounter with one of the porters on the ward.

> '*He talks very fast and really heavy because it's Black Country's slang so we just told him can you repeat and he just starts shouting to me and to my friends, 'I don't want to talk with foreign people' and he'd just go away. But it's crazy* (P13[TP1])

Some participants thought that the extensive paperwork nurses have to complete on the ward often got in the way of patient care and communication; '*You spend a lot of time to complete these papers. But honestly; sometimes I haven't the time to stop two seconds… What are the real needs of the patient?*' (P08[TP3]). Similarly, another participant observed that nurses could spend too much time looking at paperwork and '*don't really look at* [or talk with] *the patient*' (P13[TP1])

Participants perceived their practice to be more person-centred than their 'British' counterparts*.*

> '*We talk with the patient and we try to understand what they feel. Here, it's not so...the nurses don't talk too much. They don't ask too much what they think or what they feel*' (P01[TP1])

Participants were acutely aware of their responsibility for person-centred care.

> '*Sometimes we are very, very busy we don't have the time to think properly to the things because you think, 'I have to do this, this, this, this,' and then you cannot think, 'Okay, this is my patient. And what can I do for the patient? What are the real needs of the patient?*' (P08[TP3])

Participants also observed that nurses did not appear to focus much attention on encouraging the patient to self-manage.

> '[In Italy] *we do specific exercise for the patient with the pillow in a specific way to help this patient if this patient must stay in the bed. Also we do a specific dressage, very hard because you have to help the circulation of this patient. So we do a lot of things. We teach the patient and also to the care giver how he has to eat, how he has to move, how he has to dress because you can't, for example, wear very small shoes if you have got an oedema on your foot*' (P15[TP1])

A perceived lack of communication and relationships was also observed between doctors and nurses.

> '*They* [doctors] *say to you that what they have decided and that is it…In Italy, when the doctors do their round, the nurses go with them to decide together what will be the plan for the patient. So it's different from here…I think it's better* [in Italy] *because you decide together and…The nurses spend more time with the patients, so they may know better than the doctors*' (P09^{TP2})

There was a preference to keep working life and home life separate the long term aim to avoid burnout.

Identity

Participants were very proud of their profession and professional standards. The key to assuming a professional identity in the UK was the acquisition of an NMC PIN. Participants were all keen to get their PIN. Most participants had encountered difficulties with the NMC in getting a PIN. P17 thought that she would have her PIN by the end February but was still waiting for it at TP1 as NMC had lost her documents twice already, including all the translated documents, which had cost her over 80 euros for translations. She found the whole process very slow. When she arrived in the UK NMC sent everything back to her parents in Italy. She had requested that they send everything to her and not her parents, but [name] phoned later to say that the NMC could not find an address for her.

At TP4 some participants were still waiting. Until they received a PIN participants felt they were working below their skill level and were frustrated they could not use the full range of their professional skills, or be paid a registered nurse's salary.

> '*And they say without the PIN number, you are an HCA; you are not a nurse. You can't do the nurse's things so you have to do these as HCAs. I don't like this and I'm quite frustrated about this, because I'm a nurse*' (P01^{TP2})

> '*About not having the PIN. That's very difficult because of the money. The wages matter is very important and it's getting harder and harder…and if I don't have the PIN soon, I'm going to have a problem*' (P06^{TP1})

It was reported that doctors tended to overlook participants in preference to working with student nurses. It was thought that in these cases participants' professional identities were not clear.

> '*I saw that doctors as well prefer to ask students for help, students that maybe are there from two days and hello, I'm a qualified nurse, I can help you, but they don't…but I think is normal, they need time to know us and sometimes because now I have the white uniform because I am waiting for my PIN and so maybe they think I'm overseas student, not an overseas nurse*' ($P05^{TP1}$)

These participants who received their PIN describe the difference its receipt made to their working lives compared to above.

> '*So it is better* [having a PIN] *because the other nurse consider me as a nurse*' ($P14^{TP3}$)

> '*I have got the PIN number. Yeah, so I've started to do things by myself, to have my own patients and it's very good because I'm free to do the things as I want and no one has to tell me,* '*Do this. Do that.*' *I do it by myself and manage my patients, my things and my work every day... Now that I have the PIN, to manage my things, to do the things in my way and I'm very fine and very well. I'm happy*' ($P01^{TP3}$)

> '*You can organise your job by yourself and sometimes its better* '*cause if you're organised with your times, you can have time for other things. But sometimes it's better too because if you're very busy, you can share what you have to do*' ($P05^{TP2}$)

Having a PIN also appeared to be a lynchpin to being seen as trustworthy and improving working relations with staff. Participants' professional identity was also secured by the change of uniform to a blue staff nurse's dress. P05 expresses below the difference that receipt of a PIN and a change in the colour of her uniform made to working relationships with both staff and patients.

> '*So they trust you more…And so with patients it is a bit different, but as well with nurses, because now that I have a PIN they consider me in another way* '*cause, I don't know why, they changed. It's like they've changed idea and now they think that I am a nurse and not before. But I am the same person as before. I have just a coat [blue staff nurse's uniform], so it's nothing different in reality*' ($P05^{TP2}$)

Most participants had joined either the RCN or UNISON.

Practise/Practice

Participants were surprised to find that nursing in the UK was '*totally different*' (P08[TP1]) from what they had expected and what they were used to.

> '*I have seen here it is different. Either a little different, more different or much, much different, it's different*' (P02[TP1])

They imagined that British nursing was very autonomous and technical. Participants were used to carrying out technical procedures such as cannulation, phlebotomy and administration of intravenous drugs and were very concerned they would lose their technical skills. They missed this part of their practise and were all keen to complete the courses that would allow them to reengage with these procedures.

> '*I'm asking them,* '*Please put me into that course. I need to have it as soon as possible, asap*' *because I don't want to forget what I know and also, it's something that I like. Every person likes different things. I like taking blood... they are things that I like and things that I used to do every day in A&E*' (P06[TP1])

> '*These things* [technical procedures] *about being a nurse, I miss too much because I studied to be a complete nurse. Here, to be a complete nurse, you have to do a lot of training after you've graduated. These things shocked me at the beginning*' (P01[TP1])

> '*In my country, when we finish our studies and we have the degree, we are allowed to do the IV fluid, to take the blood and all this stuff. Here, to do all these things, you have to pass the training. I wasn't impressed with that*' (P18[TP1])

One participant found it frustrating that the cohort was not made aware of the differences in practises and suggested this was, '*one of the worst thing for all groups*' (P13[TP1]) of EU nurses at RWT.

> '*I can't do the things that I'm doing in Italy, because our competencies are different. Because for example, in Italy we do cannulation, we take blood samples, we take arterial blood and here we have to have a training to do this*' (P13[TP1])

While workloads in some areas were much less than participants were used to e.g. caring for a bay of seven patients as opposed to being one of three nurses caring for a ward of 50, the workload was augmented by the amount of paperwork that had to be completed. Participants were indeed surprised at the amount of documentation that nurses had to write; the paperwork is '*too much*' (P06[TP1]).

Participants' impression was that nurses practised in a climate of litigation.

> '*What is really different is, you have a lot of policies, and you are strict about that. Double-checking these things, all these things…I can understand why you have these policies, but in Italy we don't have and nothing bad happens without them*' (P09[TP1])

One participant spoke of a dependency on equipment to assess the clinical condition of the patient rather than using clinical judgement.

> '*In Italy, we have to look at the patient and we have to have a clinical eye... Here, the nurses focus on the VitalPAC, they don't look at the patient, they don't say, 'Okay, this patient doesn't need it every six hours. It's okay just for once a day'. They focus on the VitalPAC and they don't look at the patient, for me. I think they lose their clinical eyes, they lose the contact with the patient, and they are more focused on the VitalPAC…I think the VitalPAC should be an accessory, not a God!'* (P01[TP1])

She continues:

> '*They (nurses) don't say,* '*Okay, she doesn't need so I can leave it.*' *No, because they are scared that the clock is red and they're scared that there could be a compliance about this, so they are more scared about a compliance because they don't do their job to look at the patient and say,* '*It's okay*' *or* '*It's not okay''* (P01[TP1])

Participants also found the practice of checking all medication with another nurse frustrating and in their eyes in most cases unnecessary. A major idiosyncrasy of British nursing was looked upon as wholly unhelpful.

> '*Something like stupid, I might say, because in the department they have keys for the drugs and they are like one pair of keys for all the drugs and all the things they have in the stockroom and they are all the time trying to find who has these*

keys. Stupid things like this, which you might have spent the 30% of your shift trying to find this person with these keys. Which is not helpful because you are spending too much time for something that's not important' (P02[TP1])

Participants also had to get used to working 12-hour shifts as they previously had only worked eight hour shifts in their home country.

[12.5hr shift] '*very strange for us…I say* '*Oh no, how can I manage this thing?*' (P07[TP1])

Some found the long days tiring but mainly they enjoyed the consolidated time off and often used this time to travel home for the duration.

'*It's a nice shift because you have lots of free time to travel and every time that I can I'm going somewhere* [laughs]' (P05[TP1])

Participants also had to get used to very different clinical practices and Trust policies e.g. with regard to infection prevention such as wearing aprons and the practice of isolation techniques. Practices also varied with regard to aseptic technique, pre-operative, intra-operative and post-operative care. Some participants wanted to challenge practices and offer alternative ways of working. However, they appeared cautious and considerate about the right time to make suggestions.

'*If they have an emergency...they take up the drape, take out the arm and work on it...I think I have other ideas, but what can I do*?...*I need to have more experience to say something*' (P11[TP2])

Participants were amazed at the variety of specialist nurses.

'*So they need someone for the diabetic,* '*We are going to call the diabetic team and the diabetic nurse. We need someone for the stockings and for that, we're going to call a specialist for that.*' *Every single little thing has its own specialist. We don't have this in Cyprus*' (P06[TP1])

Some of the ward decorum was also strange to participants.

'*Every day the Sister in Charge, when I finish my shift, they tell me,* '*Thank you for everything*' *and all my colleagues as well, they tell me,* '*Thank you for everything;*

thank you for your help'. *It's strange for me because in Italy, nobody tells you,* '*Thank you for your job*' *or* '*Thanks for your help*'. *It's a job and I have to do it*' (P10[TP3])

Duties

Nurses generally felt very frustrated by not having their PIN and having to work as an HCA.

'*So sometimes I feel not helpful…I am happy for everything, it's just my PIN*' (P16 [TP3])

'*I'm not a real nurse, so I can't do the IV fluids, I can't do the IV meds, so I'm doing just the - I'm a sort of HCA*' (P17[TP2])

Another perspective however was provided at T4.

'*I can tell you that it was frustrating, the fact that I wasn't allowed to do IV, that in Italy I used to do. Now, after one year, I can tell you that was a really good choice, because I had six months' time to get my basic level patient and to settle my English, to settle with the environment, to get prepared*' (P07[TP4])

With the PIN came the opportunity to practice as nurse and grow in personal confidence.

'*I feel quite happy now and more relaxed because I have my type of way to do everything, my way to do everything, so if I want to start doing medication at this time because I want to do it I can do it. I don't have to wait for my tutor to come and stay with me. So it's getting easier for everyone, I think'* (P17[TP3])

Training

Participants were keen to apply for courses that would allow them to use their technical skills and expand their practice. Generic courses such as: tissue viability, blood transfusion, cannulation, iv and end of life training, and those specific to their clinical speciality e.g. care of the patient with dementia, had been applied for. Participants however were disappointed at the length of time, in some cases several months, they had to wait to access these courses.

'*It's almost one year since I'm here, after one year I'm doing the IV training. So everything looks a little bit slow*' (P15[TP3])

'*In order to give tablets I have to be assessed five times by one of the sisters ...To give IVs I have to do a training and usually you need to book months and months before because it's always full. For everything you want to do, you have to do a training before. So catheterising, you have to do a training. Taking bloods you have to do a training and then be assessed five times…I can do these things and they want me to do the training*' (P09^{TP2})

Participants were concerned about the potential loss of skills, yet recognised and were grateful for the opportunity to refresh their skills.

'*For example, now, I'm scared to forget to insert a cannula, 'cause for me it was normal to insert a cannula. I inserted cannulas in every way, every day, in every kind of children. I've inserted cannulas in children in Africa, as well. So, for me, it was absolutely normal. Now it's six months that I can't insert cannulas, 'cause here they don't do it. So I think maybe I can't forget how to do it, but for me it's strange because sometimes I see that it is difficult for a doctor to insert, but I think in my mind that I usually use another kind of approach to insert it. But I can't go to the doctor to say, 'Sorry, I think that you have to do it this way*'' (P05^{TP2})

'*For me now, it's better because I almost forget everything, without practise*' (P17^{TP2})

Other participants were keen to improve their English language and engaged with the course put on by the RWT, which they found to be excellent. Others had ambitions to study for Masters programmes or move to working on cruise liners or to another country, e.g. Australia but only after they felt sufficiently confident in the use of the English language.

3.3.3 Sociocultural adaptation

Climate

All of the participants came from a Mediterranean background and were therefore used to a much warmer climate. The absence of sunshine along with the lack of warmth and the increased rainfall was noted by most participants. Some participants found it easier than others to adjust to the colder and wetter climate, but eventually the majority felt that they had become acclimatised to the British weather.

'*This is the worst…my colleague told me that this is summertime…and when she told me that, I wanted to run away*' (P10^{TP1})

'*I feel more comfortable now. I'm getting used to the temperature, to the weather…and when I go back to Italy I would start to feel really hot and warm*' (P17[TP3])

Natural environment

Some participants said that they had not expected Wolverhampton to be so industrialised. Others reported that they were not happy with the natural environment in general and particularly missed the sea.

'*I don't like Wolverhampton at all, I don't like the life here, I don't like the place, I don't like the mood of the environment. I want some sea. I want more green around me. I miss so much the sea and the green around me and I realised it even more when I went back. I was like, 'Oh, I'm relaxed here inside nature*'' (P02[TP2])

The pollution, particularly the traffic pollution was reported by a few participants as being particularly unpleasant. While some gradually began to accept their new surroundings, others struggled to come to terms with their new environment and found it difficult to adjust.

Social environment

Many participants described the city Wolverhampton as a '*little town'* or a *'small town'* with not many amenities particularly for young people. They spoke about having to search for something to do, and many were frustrated with the lack of places to socialise with other young people. This was compounded by early closing times across the city, which meant there was nowhere for them to go after 5.00pm or 6.00pm. Many were familiar with cafés and shops opening until late evening in their home country or in some places, into the early morning. Some participants suggested it would be ideal to have some places opened till later, such as museums, art galleries and cafes.

'*Everything finish at 5 o'clock, everything and everywhere so if you like to have a coffee at 6 o'clock you can't, where can I go?*' (P05[TP1])

'*Here if I go to the city centre it's not something I'm glad to see again and again*' (P18[TP2])

A lack of amenities along with the early closing times reduced participants' ability to have an active social life. Some of the terms used to depict their social life were: '*isolated*', '*boring*', '*lonely*' and '*flat*'. Birmingham was perceived as a larger city with more amenities for young people. Many spoke about their visits to other cities, and some were considering relocating.

> '*Because here there is no life. For example in Birmingham there are pubs, there is much more...would like to go somewhere where there is more shops, more bars*' (P14^{TP3})

> '*I would like to stay here* [in Wolverhampton] *to be honest. I can spend my life just going to work, coming back home and watch the TV and call some Italian friends because you are completely alone, completely…I am a bit too young to have this life*' (P15^{TP3})

Living

On arrival, participants were provided with accommodation within a university. While some were content with this arrangement and enjoyed having an opportunity to meet other EU nurses, others were apprehensive and conveyed a more negative impression of their living conditions. Phrases such as '*a little bit dirty'* reflected some participants expressed need to find their own place as soon as possible. The following quotes illustrate the different attitudes of participants towards their initial accommodation.

> '*Awful means we share 20 people two showers and two toilets. I don't care about my room. It was nice, I had my desk, I had my wardrobe and I had my bed, but I didn't like because I shared two toilets and two showers, 20 people. It was unhealthy first of all and awful because we were so many people and we didn't have time to use the toilet because we are many. The kitchen was nice, but the main problem is the loo*' (P03^{TP1})

> '*For the first month, we were in accommodation. For me, it was a nice environment because I like to know everybody before I choose somebody to live with. It was helpful for that. It was helpful, like a school trip for the first month because you live together with people*' (P04^{TP1})

> '*Chaotic, because we were a lot of people sharing the same bathroom and the same kitchen. But it was funny because we had time to meet each other. We were 35 people*' (P09^{TP1})

The search for accommodation was equally mixed. Some participants were able to secure their accommodation relatively easily. They appeared particularly happy with the help they had received from the RWT and the Nurse Education Team, particularly the Coordinator. Others complained about the difficulty they had in finding suitable accommodation. Two participants recalled how challenging it had been to find part or fully furnished accommodation. One participant reported that she had to seek financial help from her mother in Italy to furnish her flat. Others recalled some difficult encounters with estate agents and landlords. They spoke about the language barriers they had faced when trying to secure accommodation, or when reporting faults in their rented accommodation.

> '*For example, when I was looking for a house the agency spoke with me over the telephone but when they understood that I was Italian, that I was looking for a house because I'm a nurse, they put down the mobile. They closed the telephone. It's hard. You feel it's racist*' (P15^{TP1})

> '*Don't give me a lot of attention maybe because I'm not very clear when I talk...I try to ask if they can fix this boiler a lot of time but they don't care about me*' (P11^{TP1})

Another concern that was mentioned relatively frequently was the issue of safety. Many suggested they not feel particularly safe in Wolverhampton, and felt restricted as they did not feel comfortable walking around the city especially in the evenings. One participant described the streets as '*very, very dark at night*' (P07^{TP3}), while another, who had lived in Chester previously, reported '*you don't feel really, really safe like in Chester*' (P18^{TP1}).

> '*I didn't feel very sure, very safe because I don't like the people who live in Wolverhampton. 5 o'clock everyone is drunk*' (P15^{TP1})

> '*When I go out, during the night [which is very rare] I prefer to go with my boyfriend or with some other guys. I don't feel very safe sometimes. It's not about my street; where I live, my street is safe. It's full of cameras in every corner so, of course, it's safe if I have any pro*blems *but if we go outside without a taxi and we walk, I prefer that somebody gives me a lift*' (P11^{TP3})

> '*I go around the city and I'm scared but I'm not scared for me; I'm scared for her* (girlfriend) *because I'm not short, so nobody tells me anything but sometimes, she's had some little problems. So someone came to her to say something and I'm scared of it. I think that I'm not feeling safe for her at this moment*' (P10^{TP3})

One participant recalled an unpleasant experience at his first house.

> '*I moved from there. I couldn't stay any more there. It was horrible sometimes. We had plenty of incidents with the landlord, with drunk people getting inside this property and doing inappropriate things; plenty of things anyway. I was working during the morning or working during the night and I could never sleep there*' ($P02^{TP2}$)

Practicalities

Most participants were able to open a bank account, get a national insurance number and sign a work contract within the first few weeks. Many reported that they were happy with the '*efficient*' transport in the UK with some explained how they had specifically chosen to come to Wolverhampton due to the '*very good transport'*. Some participants acknowledged that one of the advantages of living in Wolverhampton was the ability to travel to other parts of the UK relatively quickly.

> '*I like to travel by train in England, it's good*' ($P13^{TP1}$)

> '*The timetable in the bus station, if they give you a time the bus arrives at the time due. And this is a good thing. In Italy sometimes you can wait and wait and wait forever for a bus*' ($P08^{TP3}$)

> '*The very different thing that we have here in England is the buses and transportation that we don't have in Cyprus. That is very helpful, especially to us, now that we don't have our personal car. That's very, very helpful...and the trains and all this*' ($P06^{TP1}$)

While some were happy with transport in Wolverhampton [apart from Sunday] and links to different parts of the country, others felt restricted due to not owning a car.

> '*I think the major problem here is that I have no car, so I can't go to beautiful places that are close to here*' ($P10^{TP3}$)

Most participants were keen to obtain their accommodation within the vicinity of the hospital to cut down on time and travel expenses. One of the participants' main complaints were the early closing hours of shops and amenities, '*Life ends of half past five*' ($P10^{TP1}$).

'*I work every day from 8.30 until half past five and the shops close at half past five…this is the only problem that I have*' (P11^{TP1})

Food and eating

For most participants, food was a very important component in their lives. The majority enjoyed cooking and eating Mediterranean food. Most participants stated that they were missing their home cooked food.

'*Next week I have got leave and I am going back to Greece. I think that every day, every night I will be out eating*' (P20^{TP1})

'*I miss my pasta. I miss all the things that my mum cooked for me*' (P13^{TP1})

'*I miss the food…I miss some particular things, for example, you have tomatoes but the taste is different. We have tasty tomatoes. When I arrived in Italy, in the first day, I went to a restaurant and I ate a tomato and I was like, 'Oh! I miss it so much*' (P10^{TP3})

Many participants observed that mealtimes and eating out in the UK were generally less of a social gathering in comparison to Mediterranean countries.

'*You can see English people go to the restaurant and sit, eat the meal and go away. I won't get used to that. Probably not*' (P07^{TP4})

'*In England, you have tea time. You don't have a proper dinner…When I am on a long day, I'm on till 9 o'clock and my colleague asked me,* '*Have you brought something for your tea?*' *And I said,* '*No, I'll have my dinner at home*'*. They say* '*At 9 o'clock? It's late'. No, not for me, it's not late…In Italy, we've got two main meals; it's the lunch and the dinner*' (P11^{TP3})

Family life

The majority of participants came from very close family networks. Many spoke about how much they missed their families and equally how their families missed them. Generally, most participants were happy with the relative ease with which they could keep in contact with family and friends. Different forms of technology enabled regular contact; in some cases, participants' contact with their family was on a daily basis. Many expressed how grateful they were to be living in a technological age.

> '*Thank God for Skype so we can see. Also my family, I taught my father how to use the PC, so we can see each other*' (P17^{TP1})

> '*We have so many ways to talk and see each other even if we don't touch each other*' (P06^{TP1})

Along with communicating through social media many participants had visited their families several times in the first year, and for some, family members had visited them in the UK.

Social norms

Participants reported that they were surprised at how early young people started families in the UK in comparison to places like Italy where women had children at a much later age. Many also appeared shocked at the high levels of alcohol consumption and associated untoward behaviours.

> '*I don't like this drink thing here. I hate seeing people around me drinking so much and even women in the road. It's like, they're drunk and I don't like it at all. I thought we had, in Greece, drinking problems but I realise that we're not even drinking* [laughter]*...The women in Greece are not drinking and even if they drink, it's like slightly drinking. Here, the women are drinking so much. It's so ugly when you see a woman being drunk and doing awkward and weird things in public*' (P02^{TP2})

Participants also observed how differently English people socialise, often reporting how they found English people more reserved and less 'noisy' in a social environment.

'*I don't want to say that English people are boring, not those things. We make a noise. I can recognise that when I'm in the street and I talk on the phone or with my housemate we speak with a lot of noise and the people watch us...Or when we go to the restaurant we speak during the dinner a lot, making a lot of noise, and the other people sitting at the near table are more quiet*' (P08^{TP3})

Some participants described how they had adapted to the English norms and values, such as forming queues, to such an extent that when visiting their home country they became uncomfortable with the non-compliance. One participant recalled how after a few months [to her parents' dismay] she had got used to walking around without a coat in relatively cool weather.

People

Some participants had expected people in Wolverhampton to be much friendlier. Adjectives such as '*closed*' '*unfriendly*' and '*unhappy*' were commonly used. Many concluded this was a '*problem*' particular to Wolverhampton having found that people from other cities had been much more welcoming.

'*All my neighbours are very, very closed. I don't think they like to speak too much because I say 'Hello' and they sometimes, don't answer me*' (P10^{TP3})

'*If you go outside and you smile to someone, they're not smiling at all it's like an unhappy face everywhere, I can't get used to it*' (P18^{TP3})

'*I thought that the community was more open but in truth maybe it's a problem of Wolverhampton because it's not so easy*' (P15^{TP1})

One participant explained how her enthusiasm about meeting new people in Wolverhampton had changed.

'*When I came of course I was enthusiastic and I was looking for opportunities to meet new people, to spend some time together with some other people from England. Then when I didn't receive a good answer about that I didn't carry on looking for these kinds of things. I just spend my life at home, at work. I do my shopping, and that's it*' (P15^{TP4})

Friends

Many participants spoke about how difficult it was for them to make new friends the UK. Many expressed their disappointment or frustration at not being able to form new friendships; and for some, this was the case even after nine months of living in the UK. Many of the friendships formed were with other EU nurses living in Wolverhampton or working at the hospital.

> '*It's difficult to have new English friends. I've got some friends; the Greek guys who work with me or some colleagues, the young ones, are nice but I cannot say that we are friends. We are good colleagues but not friends*' (P11^{TP3})

Participants identified barriers to forming friendships, such as working long shifts, the social environment, their culture, communication skills, shyness, and the unfriendliness they had encountered in Wolverhampton. In some cases, this had resulted in a desire to move to another city.

> '*I mean I think because I'm Italian and I'm a different culture, so sometimes it's very difficult to make relationships or to make friends…I saw my friend, who lives in Manchester, and he said that he was happy because after two years, he had an English friend* [laughter]*. Yes*!' (P14^{TP4})

> '*I don't know if it's something about this area of Wolverhampton because…for example, when I went to Manchester, the people were friendlier than here. I don't know if it's just my impression or it's real; probably, because here, it's not a tourist place, so maybe the people are very closed. It's not...how can I explain? They don't open up themselves to others*' (P10^{TP3})

Language

Most participants perceived speaking in English to be a particular '*problem*' or '*concern*'. They talked about '*feeling stupid*', '*a lack of confidence*' and '*making mistakes*' when trying to communicate. A language barrier had impacted on various aspects of their life; in the workplace, making friends and generally integrating into the 'English' way of life. One participant reported feeling that her lack of English had made it much harder to make friends '*maybe not everyone is happy to have a hard conversation with me*' (P15^{TP3}). The Black Country accent was identified as a particular barrier to communication. Many participants assumed that the London accent would have been the 'normal' accent in

England, and were therefore surprised to encounter the Black Country accent. Others explained that the English they had been taught was very different to the Black Country accent and therefore it had generally taken longer to communicate with people from Wolverhampton.

> '*When I studied, they taught me that butter…you have to say batter not booter; the bus is the bus and not the boos. These are silly things that you can understand but it's just an example because many pronunciations are said and I'm like 'can you repeat please' not once but twice*' (P17^{TP1})

One participant, after living and working in Wolverhampton for eight months felt that it was easier to understand people outside Wolverhampton and was therefore considering leaving Wolverhampton as she felt that communication would be better in another city.

> '*We spoke with the people [from Tenby] and they could understand us and we could understand them. It was really nice to communicate with people but when I came back here, no, nothing. It was impossible*' (P11^{TP3})

Some participants indicated that they had attended language courses in their home country to improve their English before arriving in the UK. Many spoke about taking responsibility for developing their English language skills by watching movies with subtitles, reading books and using forms of technology such as a translator app on their phone. Some participants had tried to find private tuition classes to help develop their spoken English. After six to eight months most participants were comfortable with conversing in English and were able to understand the Black Country accent. There was a self-recognised progressive growth in confidence and ability to communicate more effectively both within the workplace and socially. The following quotes illustrate the communication problems encountered by the participants and their development over time.

> '*I remember the first day that I came here. I couldn't understand anything. I said 'what will I do now? How will I discuss with someone?*' *The first week, I was very close to myself. I didn't speak a lot*' (P19^{TP1})

> '*We listened to some speech in Black Country accent and so now I can speak with my colleague and its easier, but I think that now after six months I am starting to*

understand. Not to talk, I don't want to talk with Black Country accent, but just to understand and answer' (P10[TP2])

'*When I start working in the Black Country was only sounds; 'yes, yes, yes but I don't understand anything you said'…Now I understand it better*' (P16[TP3])

Only a few participants commented that they still encountered communication problems.

'*I continue to have some problems with the verbs but the problem is that I know the grammar. It's when I speak I make mistakes*' (P08[TP3])

'*Sometimes I really don't understand but maybe because I am tired, especially during the night shift…I think it's normal because when you are really, really tired, especially after the second night shift or third. You are very, very tired and you need to speak in English* '*Oh Gosh*' *Okay, okay. Just one moment. Okay, wait. What are you saying?*'' (P14[TP4])

3.3.4 Psychological adaptation

Excited about being in England

Some participants suggested apprehension about moving to England, whereas others expressed their enthusiasm and excitement about starting a new life in England, and had a very positive outlook from the outset.

'*It was a little bit scary…Now I am very calm and relaxed and enjoy my new life and new experience*' (P16[TP1])

'*It's exciting, because it's a new country, a new way of life, new people, new language and a new house. I think England can be an exciting move*' (P07[TP3])

Fitting in with English culture

Some participants compared local customs and rituals in the UK to their home country, and discussed how they found some of the differences unusual or strange.

'*If you want to go in a pub to drink a beer, you can find friendly people, without any clothes on. For me it's really strange in January with sandal, without tights, without anything. I was with this woolen jacket*' (P15[TP1])

Being away from home country

The majority of participants talked about a loss of physical contact with their family and friends in their home country. For some, this resulted in feelings of homesickness and/or mixed emotions.

> '*Sometimes I'm homesick. My homesickness is about my friends*' (P12^{TP1})

> '*I feel sad because I'm leaving my home, my family, my boyfriend, but I'm feeling quite happy…I like working here. So I have these two feelings and emotions*' (P17^{TP3})

Participants also expressed a specific yearning for their home country when speaking of the food and the weather. The environment and social activities such the 'happy hour' were also recalled with enthusiasm and nostalgia.

> '*I miss the culture basically. I miss the things that I used to do when I was in Italy, like happy hour with my friends, going out with the car and going wherever I want, the weather, of course, the food, of course. I miss my family*' (P11^{TP3})

> '*If sometimes I just see a picture from Rome. Oh, I miss Rome! I miss this park, I miss this square*' (P13^{TP1})

Adapting to England

Relocating to England with a partner or being joined by a partner appeared to positively influence settlement and adaptation. Although most participants appeared to gradually adapt to their work life and the working environment, they appeared less accepting of their social environment and personal life. Many complained about being unable form friendships with English people, particularly in Wolverhampton, and a frustration with this situation was apparent throughout the interviews. This negatively impacted on the settlement experience for some participants, who looked to move to another city.

> '*I can't live only for work and I think really that if I can't make new relationships, feel good, I would like to move to another city, yeah*' (P15^{TP1})

> '*My job is good but my social life and my personal life is not so good. I don't live happy here*' (P18^{TP2})

One participant indicated a preparedness to adapt when reflecting on their settlement experience.

> '*Everything is different. It's hard. But if you can adapt yourself to another lifestyle it's okay. I try to adapt myself to the English lifestyle, everything like that. So it's hard in that moment that you leave for the first 10 days after you leave, but after it's okay because you think about yes, my life now is in UK so I don't need to compare, you know, the two types of lifestyles because now I'm living in UK so I need to accept this type of lifestyle. And it's okay*' (P16^{TP1})

Day to day life in England

As the interviews progressed, there was an apparent sense that participants were experiencing settlement in their day to day life in England. However, participants' often explained how they felt 'at that moment', which gave the impression of anticipating or planning change.

> '*I just want to maximise my experience here now…When I will be better with the language, I will think of somewhere else but not at the moment*' (P04^{TP2})

> '*Yes, I prefer here because at the moment I have a home. I have a job and I am trying to build a life here because I want to stay here...Because in Italy there is no space for younger or for a nurse*' (P14^{TP3})

> '*I'm feeling good in England at the moment. I am happy to be here. I am happy to have a good job; a good paid job and with a no-ending contract, it very important for me*' (P12^{TP3})

3.4. Questionnaire results

3.4.1 Pooled results

It was hypothesised within the literature (Demes and Geeraert 2014) that those who are orientated towards the host culture [i.e. having a high score], and perceived less social distance, have better psychological and sociocultural adaptation. As can be seen from the descriptive statistics [Table 4] the pooled data demonstrates a flat profile over time with regard to sociocultural and psychological adaptation.

Table 4. Mean score (SD) over time

	Time	N	Mean	(SD)
Sociocultural Adaptation	1	20	4.22	(.89)
	2	17	4.02	(.90)
	3	12	4.11	(.86)
	4	4	4.56	(.49)
Psychological Adaptation	1	20	4.44	(.94)
	2	17	4.59	(.73)
	3	12	4.22	(.59)
	4	4	4.72	(.79)

Sociocultural adaptation examined how easy it was to adapt to various facets of the host culture [e.g. food and drink, family life, social norms, natural environment, climate]. A higher score indicated adaptation to be perceived as easier. The maximum possible score for this scale is seven; therefore, on average most individuals were scoring just above the midpoint. The psychological scale examined the emotions that are associated with migration such as loneliness, frustration, happiness, and excitement. As a higher score indicated more positive adaptation [e.g. absence of negative emotions and presence of positive emotions] the mean score, which is just above the midpoint, indicates that there were no strong emotional tendencies in either direction. Due to the attrition of participants, data analysis on the pooled dataset was only conducted up to TP3 of the data collection. Non parametric analyses indicated that there was no significant difference in either variable over time.

It was of further interest to examine whether we could predict psychological and sociocultural adaptation at an early stage, with the aim of identifying those individuals who may be at risk of poor psychosocial outcomes. Correlations therefore, were examined between the psychosocial outcome at TP3 [psychological adaptation and sociocultural adaptation] and predictors were the orientation towards the home or the host culture, and perceived cultural difference at TP1 and TP2. No significant correlations were observed therefore it was concluded that psychosocial outcomes could not be predicted by these acculturation variables at an earlier time.

Using a pooled dataset can mask individual differences, and therefore it was of interest to explore individual case studies using the questionnaires to profile changes in acculturation variables over time.

3.4.2 Individual case studies

Case study 1

Code	Gender	Nationality	Speciality	Workplace
Participant 01	Female	Italian	Care of the elderly	New Cross Hospital

Background

P01 is an only child who lived with her mother in a small city near Rome, with her grandmother and father in close proximity. She enjoyed the company of a few close friends around whom her social life revolved.

P01 trained as a nurse for three years, had a year off at home before being employed, for one year, in a small hospital run by the Church, a job she thoroughly enjoyed. As she only had a short term contract she had to leave at the end of the year. During her time at the hospital she worked with patients who had cancer and thought that she would like a career in oncology nursing. Italy did not provide opportunities for her to develop a career in this speciality. She knew that England did offer such opportunities and this became the driving force, to develop her career, underpinning her decision to come to England. The employment crisis in Italy also meant that she was now out of work and being at home with no prospects of employment was difficult.

P01 found out, via a friend of her fathers, about the recruiting agency. The agency arranged an interview with her to assess her English language spoken and written skills. As these were found to be satisfactory she was invited to an interview with nurse recruiters from RWT. Following the interview P01 was offered a job in care of the elderly, which she accepted. To prepare for her move she asked the agency a lot of questions about RWT and Wolverhampton and she was able to access the RWT website and see what it was like. The agency also provided information about salaries, a map and a little history about Wolverhampton.

It was a very difficult decision to leave her '*beautiful home*' to come to England but she felt that she had no alternative as staying in Italy she would not be able to work as a nurse or

increase her career prospects. England was her first choice as it was close to Italy and both her family and herself could travel easily to be together. Also she did not need to take further examinations as she would have done had she chosen to go to USA or Australia. Findings from the questionnaire data confirm this positive outlook at the commencement of PO1's transition to England. Her high scores on psychosocial adaptation [Figure 1.1] and stable scores on variables such as homesickness and generally being happy and excited about the move [Figure 2.1] seem to point to an overall favourable outcome for this nurse.

Workplace adaptation

P01 found some things in the induction very helpful, for instance, meeting nurses from a previous own language group who were able to advise about how to secure accommodation and answer her many questions. Information with regard to NMC and how to open bank accounts and get an NI number were also helpful. However, she would have appreciated small windows of time on her assigned ward so that when she started clinical practice staff would have had an opportunity to get to know her, trust her and would have built up a relationship with her, as she had found her first days on the ward very difficult. Also to be taught is smaller groups according to their speciality. She felt there was too much theory and the clinical skills were mainly things participants were already familiar with. Overall, a more individualised induction would have been helpful.

P01 found the support and encouragement of the clinical tutor invaluable. The tutor's assessments of her work gave her confidence in expanding and developing her role. She had an Italian mentor for the first month on the ward, which she reported was very helpful. By the TP2 interview she was working on her own. P01 was frustrated that she could only work as an HCA and not as a professional nurse, this came as '*a shock*' to her. She missed the role she had in Italy where she would have been involved in many technical care practices such as phlebotomy, cannulation, administration of IV medication etc. She also observed that nurses appeared to work in a climate of litigation driven by the requirements of machines e.g. VitalPAC rather than using their clinical judgement to make decisions about care.

Relationships with hospital staff were initially difficult as she felt hospital staff did not know her or her capabilities and therefore did not trust her. This all changed once she got her PIN

and her blue staff nurse's uniform, at seven months. It was as if she had earned the respect of the staff, as she reported she could now plan her own care for patients rather than being told '*to do this*' and '*do that*'. Her difficulties and frustration may underpin 'feeling out of place' as reported in the quantitative data [Figure 1.2], an improvement in which coincides with the receipt of the PIN.

Sociocultural and psychological adaptation

Responses to the psychological adaptation scale demonstrated that P01 experienced more positive emotions towards life in England as time went on [Figure 1.1]. At TP2 [June] P01 was enjoying the warmer weather and had used it to travel about the country however at TP3 [October] she was missing the Italian weather and food. P01 reported greater cultural difference at TP3 [Figure 1.3] when it was cold and wet in England, and the least at TP2, which coincided with the warmer English season, indicating that the climate was a key factor.

Figure 1.1 Changes in sociocultural and psychological adaptation (P01)

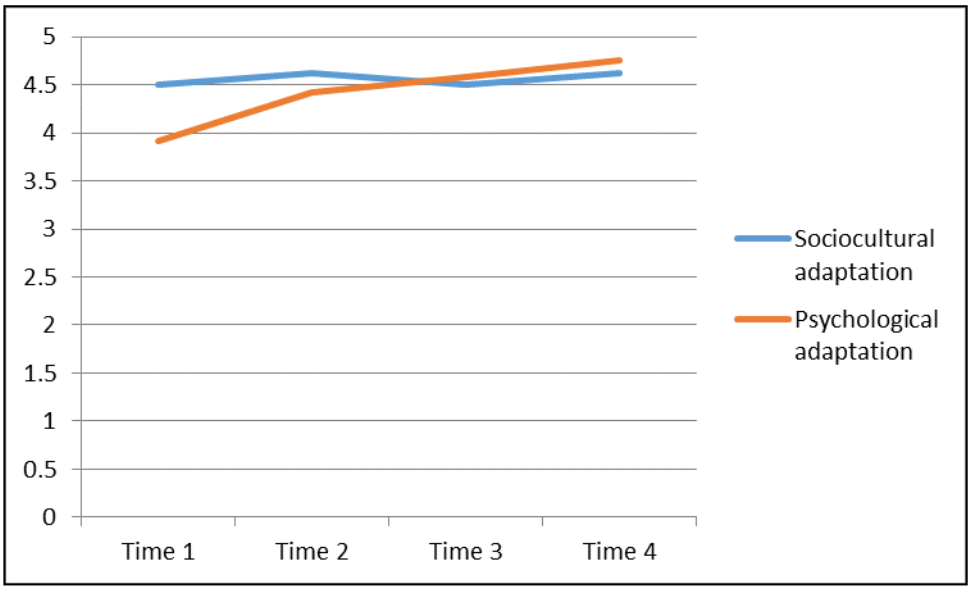
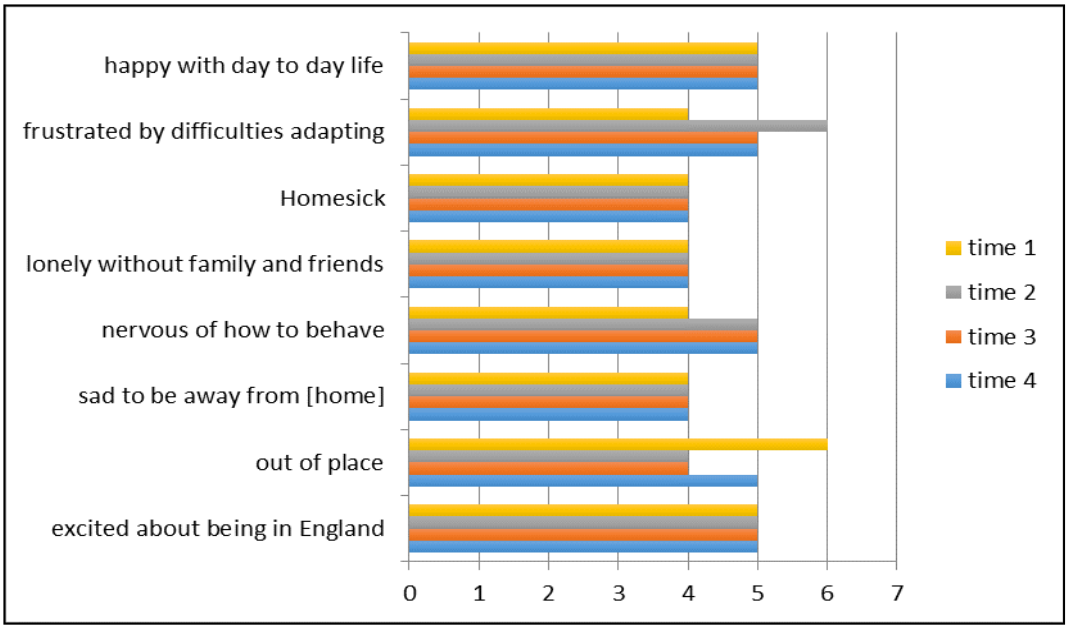


Figure 1.2 Changes in psychological adaptation (P01)



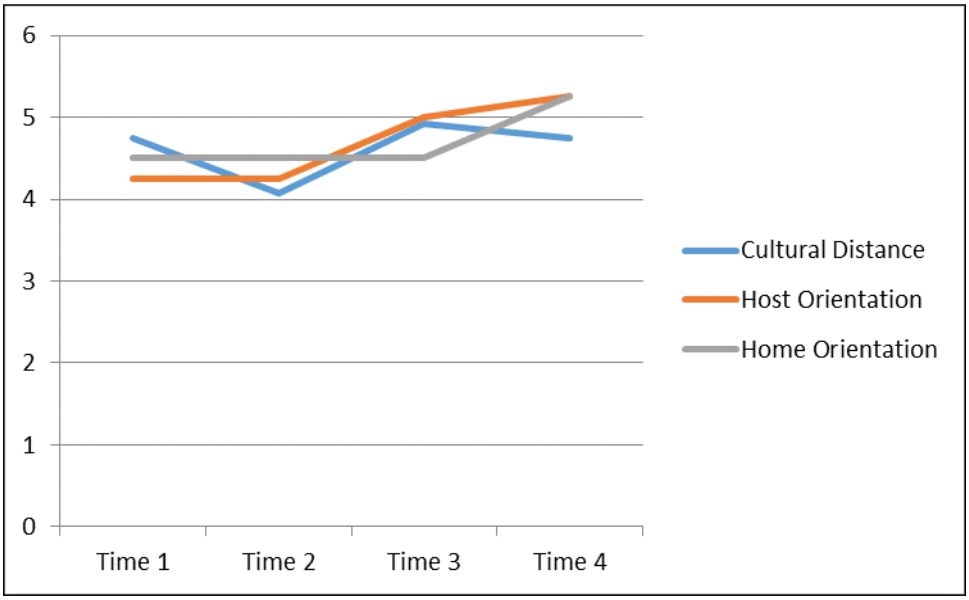
P01 regarded Wolverhampton as a stepping stone to the rest of the UK. She had been to Scotland on a previous visit to the UK and '*fell in love with Scotland*' and thought that she might like to end up working there, although she was mindful of the often inclement weather. She initially found Wolverhampton bereft of social activities, but by the TP3 interview she had started going to the cinema, the gym, bowling and dining out.

P01 found the accommodation offered for the first month totally unsatisfactory. Sharing toilet and bathroom facilities with a large number of strangers was difficult and made her angry as some nurses did not wash up their dishes or clean the bathroom after use. The good thing was however, she got to know other nurses who had high standards and was able to identify future housemates.

With the friends she made during that first month she was able to find a '*very beautiful home*' near to the hospital. She did not see this as a lasting arrangement and fully expected that at the end of their year's contract that they would go their own ways. By the 13-month interview she was happily living in her own flat in Birmingham and commuting to work at New Cross Hospital.

Keeping in touch with her family was key and initially she spoke to them every day via Skype. Both her parents and an aunt had been to visit during the year and their minds were put at rest to know she was settling in and doing well. She had also been back to Italy for annual leave. Indeed, her orientation to her home culture and the importance of this to her remained steadily high throughout the duration of the study, peaking at TP4 [Figure 1.3].

Figure 1.3 Orientation to host and home cultures and perceived cultural distance (P01)

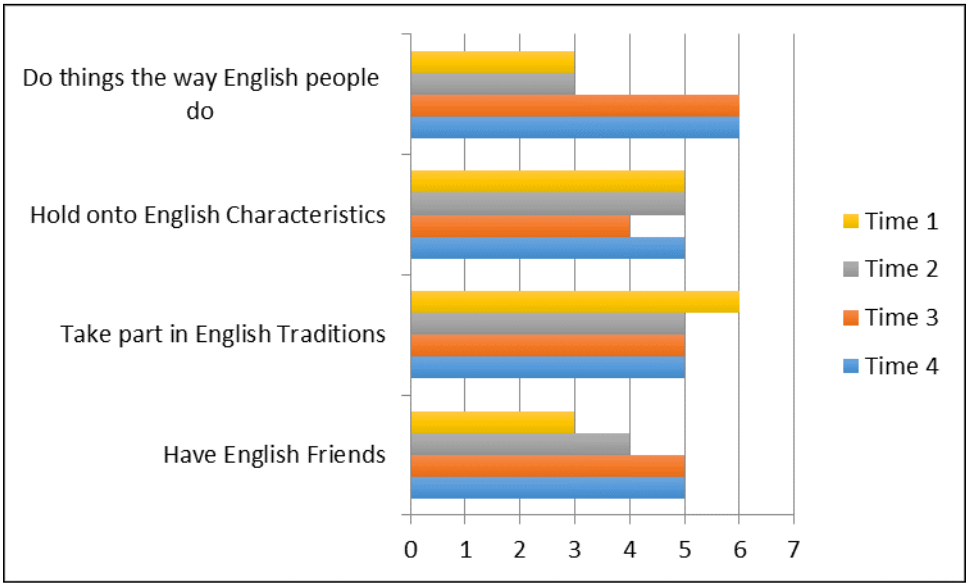


At TP2 and TP3 she reported feeling increasingly settled and in fact recounted how on her visit to Italy how disorderly she found the Italians who would not stand in a queue and often did not respect rules or each other. She reported that she was focusing on '*English rules to live*'. This is reflected in quantitative measures of P01's orientation towards each of the host and home cultures. A peak in orientation towards the host culture at TP3 [Figure 1.3] may have exposed P01 to the English culture sufficiently to establish this integration of the two cultures, which she speaks of. In support, the quantitative measures demonstrated that orientation towards both cultures was held equally at the conclusion of the study [Figure 1.3].

The increasing desire to do things the way English people do and have English friends [Figure 1.4] demonstrated an acceptance of the host culture, but it is of note that the home culture is not compromised in doing this. P01 appeared to have perceived the cultural differences but accepted these and held each equally, seemingly finding a positive balance

between the two. This is a difficult cognitive task to achieve and requires integrating a new culture into one's social identity.

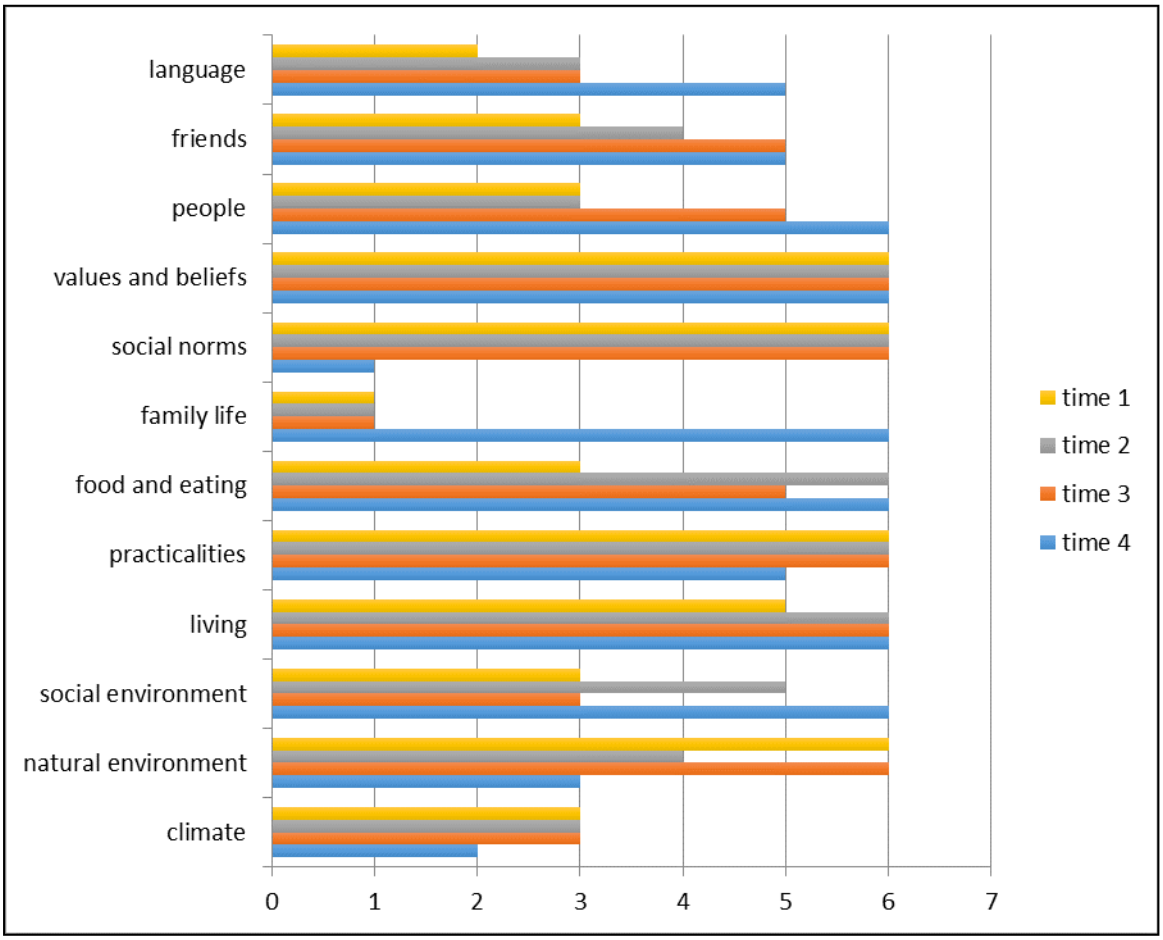
Figure 1.4 Orientation towards the host culture (P01)



P01 admitted that it was difficult to be away from her Italian friends however they kept in touch via Skype and various forms of social media. She had not made any English friends as it appeared that people in the hospital kept work and social life separate. She also found that staff she worked with appeared a lot older so may have had different interests. She also thought that it took English people a longer time to get to know you.

Although the profile for sociocultural adaptation scores changed very little over time, this masks some differences in the profile of individual items on this scale over time [Figure 1.5]. Overall a positive outcome is observed and nine out of the 11 elements of the culture indicate easier adjustment to life in England. Of these, a positive shift is observed in comparison to TP1 for adaptation to the language, friends, family, people, and food. Adjustment to the social and natural environment varied over time; qualitative findings indicated that this variation is a response to the opportunities afforded to P01 by way of socialisation [e.g. going to the cinema as mentioned above] and exposure to the natural environment over the course of the study.

Figure 1.5 Changes in sociocultural adaptation (P01)



An increase in ease with adaptation to the host language was reported in the quantitative measures. The biggest concern of P01 had been her language skills, but she had been going to English movies at the cinema to help improve. She had also attended English classes at the Trust, which she found very helpful, especially the input concerning the Black Country accent.

Reflections at 13 months

P01 reported that for her it had been a positive choice coming to the UK as there were many young people in Italy looking for work. Working as nurses they had little prospect of developing their career; whereas she now had lots of possibilities. Overall P01 reported a positive shift in psychological adaptation [Figure 1.1], which may have been an outcome of her planned career development.

P01 identified that a lot of things she said at the first interview she did not feel any more. For example, she felt that she now had good team working relations with her colleagues, was more relaxed with them and often able to '*have a laugh*' with them. She thought the three sisters on the ward were very supportive and helpful.

She believed that there was still much to change about the induction. She was aware that a new group of nurses had arrived and one or two were expected to be allocated to her ward yet she had not seen them on the ward, which made her think the hospital had not changed their induction practice, i.e. giving more exposure to the wards during the induction.

Her advice to other nurses coming to UK was that they should be positive, as at first they may find it very difficult to start a new life in a different culture without direct family support. However, if they took their time and remained positive each month would be better and they would see their life in a more positive light. Relating to herself she stated how at her first interview she was very negative but how she had now made a new life and was happy and positive. It is interesting that although P01 recalled being negative at TP1, the first interview, her scores in the psychometric tools indicate positivity, excitement and happiness.

To adapt to the new social environment, she suggested that time was needed to get to know what was available and depending on your character it would take time to get to know people but in the end everyone can find their way and everything would be fine.

She remained at RWT when so many of her colleagues had left because she liked her job, liked her ward, liked to be with her colleagues, and liked it in England. For the future she was still keen to have a career in end of life nursing. A move to another part of the country remained a possibility but for the time being she was happy in her job.

Case study 2

Code	Gender	Nationality	Speciality	Workplace
Participant 07	Female	Italian	Paediatrics	New Cross Hospital

Background

P07 lived in a town by the sea, with her parents and twin sister. She enjoyed socialising with Italian friends, and had a boyfriend in Italy. Motivation to migrate was driven by an employment crisis in Italy, and perceived career opportunities. Building a career and learning about the English system of nursing were perceived gains. Migration was more about settling into a different way of working rather than losing something. News of a potential job in the UK was found via the internet and was pursued with a recruitment agency. The agency provided information, carried out a pre-assessment of English language skills and supported preparation for interview. A key contact person at the agency was perceived as very helpful. A Facebook group called 'Information in UK' shared a lot of information about the UK healthcare system. It was suggested that further information about the hospital ward, the community system of care, and arrangements for annual leave at the recruiting hospital would have been helpful; the latter in relation to return trips to Italy.

She was a newly qualified graduate nurse on arrival to the UK. The flight from Italy was paid by the hospital and this was positively remarked upon. It was apparent that some expectations on arrival were not met, for example, the sharing of accommodation with so many people, the size and appearance of the city, the lack of friendly colleagues in the workplace, and a lack of discussion about the patient between doctors and nurses.

Workplace adaptation

P07 suggested an induction in smaller groups, specific to the speciality of paediatrics, less theoretical and more orientated to the workplace. There was a perceived need for further information about: hospital policies and procedures, the roles and main duties of hospital staff, paediatric liaison roles such as social worker, child protection, youth worker, different professional organisations, clinical and academic career opportunities, and what the hospital had to offer.

When recalling her first day on the ward, there was a perceived lack of support with no-one to shadow. Subsequently, help and support came from a mentor and from senior nursing staff who were responsive to questions. Communication in the workplace was difficult at the outset, particularly when listening to handover and when using the telephone. Problems were exacerbated by people talking very quickly, their accents, and the use of slang or dialect. She suggested that it took five-months before communication on the telephone became a normal activity at work. Obtaining registration with the NMC and waiting 4-months to receive a PIN was perceived as a hindrance to settlement in the workplace. There was a requirement to work at Band 2 until the NMC PIN arrived.

The different coloured uniforms used for role designation, the doctor without uniform and the pay band system were new experiences in the workplace. The unfamiliar work-pattern of 12.5-hour shifts also caused some initial anxiety. However, three long days and four days off for rest was positively evaluated by TP3. Some practices in the clinical area were either new experiences [e.g. nurses wearing aprons], performed differently than in Italy [e.g. aseptic technique] or were not allowed despite competence e.g. administering IV medication. With this came some surprise, questioning and frustration. She said it was not easy to suggest alternative ways of working in clinical practice, and argued that suggestions should be evidence-based.

There was an apparent acceptance of the requirement to complete mandatory training such as hand hygiene, observations, collecting a patient from theatre and giving medicines. She described a competency book, with different levels of achievement [1-4] associated with working more independently. A desire to complete non-mandatory training such as IV drug administration required the ward manager's approval and was dependent on the needs of the clinical environment. On reflection at TP4, not being allowed to administer IV medication was positively remarked upon, as this allowed time: to learn basic care duties, to develop English language skills, to gain personal confidence/competence, and to settle in the workplace. There was a reported opinion of being given the right time to settle, in the right way. It was perceived that friendships in the workplace were formed once trust as a nurse had been established. At TP4, work life was described as wonderful, and she spoke of receiving very positive feedback. Opportunities and achievements had been forthcoming.

She had completed Good Clinical Practice [research] training, and submitted a research grant application with the support of the ward manager and matron. She had also co-authored a journal publication and submitted a paper for an AIDS conference in South Africa.

Sociocultural and psychological adaptation

As shown in Figure 2.1, P07 experienced a slight decrease in the ease with which she adapted to life in England at TP02 [sociocultural adaptation] but overall adaptation to the English way of life became easier as time progressed. P07 initially experienced positive emotions in response to her life in England [psychological adaptation], but experienced a dip at TP2 and TP3, with a return to baseline by the completion of the study. This 'dip' manifested as feelings of less happiness with everyday life, feelings of nervousness over how to behave, frustration with adapting, sadness of being away from home, and feeling out of place [Figure 2.2]. Negative changes were also observed; over time P07 became less excited about being in England.

Figure 2.1 Changes in sociocultural and psychological adaptation (P07)

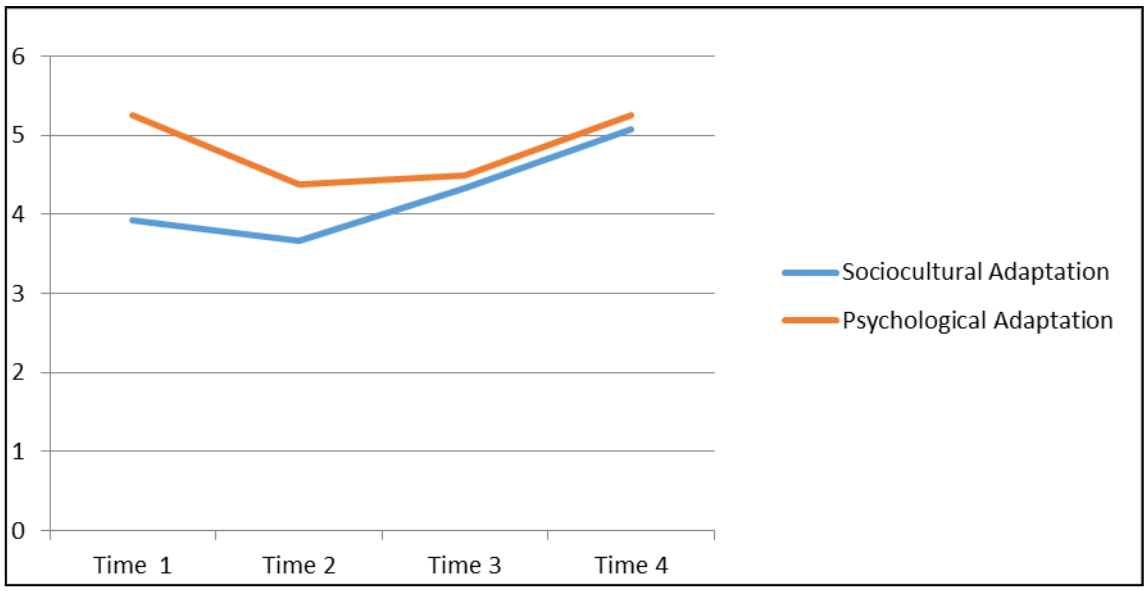
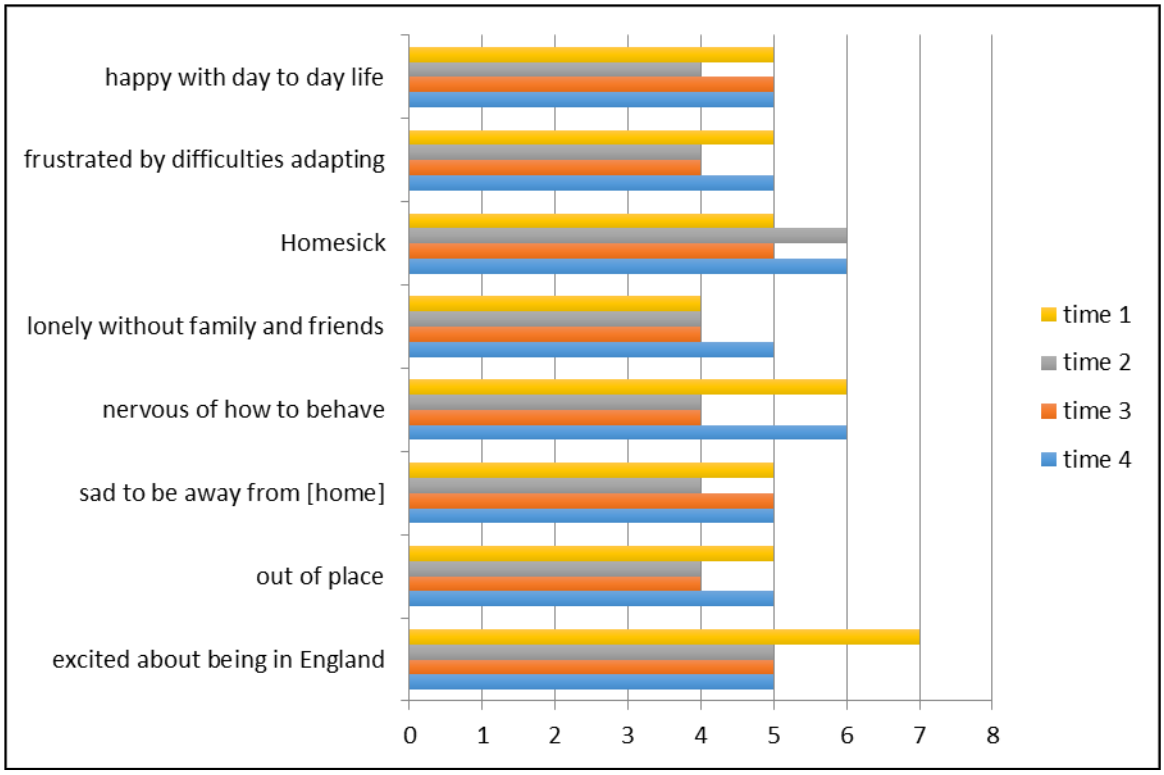


Figure 2.2 Changes in psychological adaptation (P07)

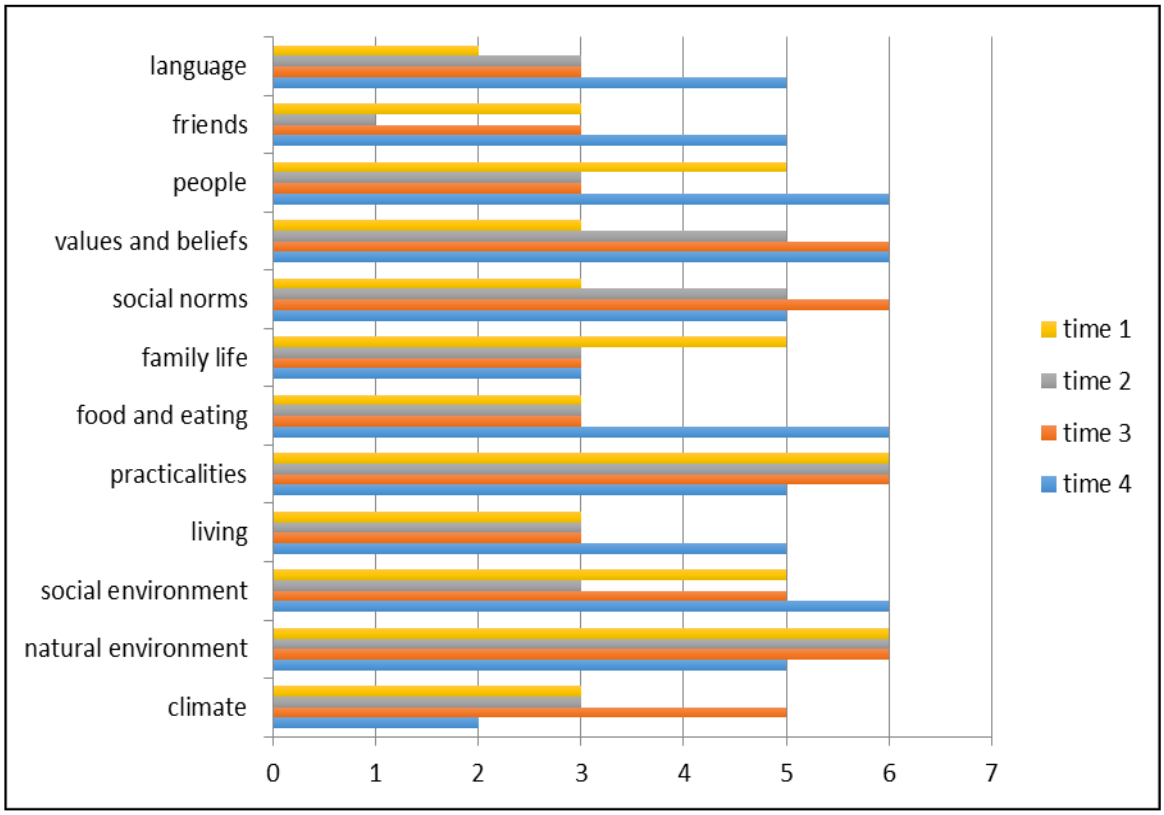


[*NB. A higher score infers more positive adaptation]

Adaptation to the climate in the UK was apparent, but some discontent remained. As can be seen in Figure 2.3, adaptation to the climate was easiest at TP3 after experiencing the summer in England. The city of Wolverhampton was perceived as small, with dark streets at night and lacking in amenities for young people. Communication and language barriers were remarked upon, and compounded by the different dialects and accents. Help had come in the form of English lessons provided by RWT, although it was suggested that it would have been more helpful to start the course sooner. Adaptation to the English language became easier over time according to responses on the sociocultural adaptation scale [Figure 2.3].

Temporary university living accommodation was supplemented by shared accommodation with three female Italian nurses from the same cohort. Finding suitable accommodation appeared a challenging experience with estate agents failing to attend appointments. Communication via telephone was described as more difficult than a face-to-face, particularly when opening accounts for utilities. A second move into a one-bedroom flat was portrayed as one's own place and a real home, which may account for the reported increase in the ease of adaptation to 'living', which was reported at TP4 [Figure 2.3].

Figure 2.3 Changes in sociocultural adaptation (P07)



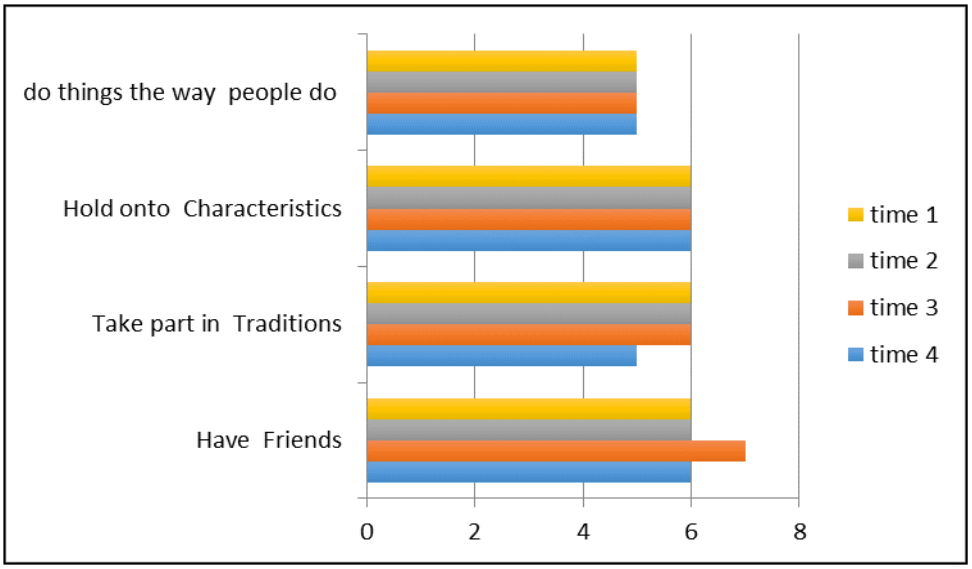
P07 appeared satisfied with the environment where she lived, but believed some quarters of Wolverhampton were not very safe. Birmingham was identified as a desirable place to live as more populated, with more attractions and more things to do. The practicality of living in an alternative city was hindered by not owning a car. The commute to work was by bike. Other practicalities such as opening a bank account, receipt of NI number, and signing a work contract were achieved in the first week of induction, and finding a GP was regarded as easy via the internet. Conversely, the hospital address which was initially used for post was problematic as mail was not always received. Despite these adversities, P07 reported ease of adaptation to the practicalities of living in England [Figure 2.3].

With regard to food and eating, there was a choice to keep eating Italian food. Eating in a restaurant was observed as less of a social gathering in England compared to Italy, and adaptation to this was regarded as unlikely. P07 reported an increase in the ease of adaptation to food and drink in England at TP4; this may coincide with her living independently and having more opportunity to prepare her own meals. There was also

surprise about the amount of alcohol that English people appear able to drink, as experienced at a '*hen party*'.

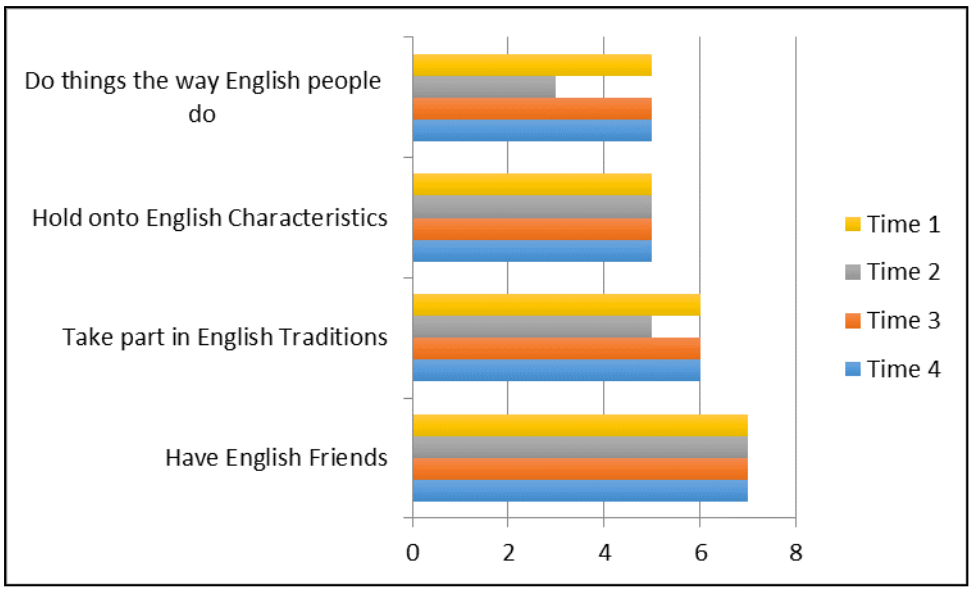
Regular contact with her Italian family was maintained; daily via WhatsApp, twice a week with Skype and through trips home to visit her family, friends and boyfriend. It was suggested that Italian friendships had changed through distancing. Nonetheless, P07 did not vary in her reporting of the importance of having friends from the home culture over the duration of the study [Figure 2.4]. Her twin sister travelled to London for a short break and her boyfriend also travelled to England.

Figure 2.4 Orientation towards the home culture (P07)



Making friends with people in England was described as very hard, but consistently reported as being very important to her [Figure 2.5]. She suggested this could be due to own shyness. She described a happy, simple social life that over time had improved. There was mention of local social activities such as the cinema and travel to Wales and Southern Ireland. By TP4, her boyfriend had moved to England and was working in Birmingham. This had positively resulted in social gatherings with a work colleague and her partner as a foursome. The variation in opportunities to socialise over time may explain the changeable reporting of her ease of adaptation to the social environment as observed in Figure 2.3.

Figure 2.5 Orientation towards the host culture (P07)



P07 spoke about her excitement of being in a new country, experiencing a new way of life, new people, new language and a new house. At TP3, she spoke of her '*old life in Genoa*.' There was some evidence of homesickness, particularly when recalling trips to the sea, by the coast, with friends. However, she suggested homesickness was rare; alternatively, '*a sadness*.' At TP4 it was claimed that feeling sad was short-lived, and that after one second she was happy again. A beautiful job, new friends and living with her boyfriend in England were identified elements of a nice life.

An analysis of the items within the host orientation scale [Figure 2.5] shows that P07 reported a roughly consistent orientation towards the facets of the host culture over time, with the exception of a dip in the importance of being engaged in English traditions and in doing things the way English people, do, which corresponds with the dip in psychological adaptation observed at TP2 [Figure 2.1]. This shows that P07 was most strongly biased in orientation towards the home culture at TP2 [Figure 2.1] and may indicate a critical period where an intervention may be introduced. By TP4, P07 is more strongly biased toward the host culture.

Reflections at 13 months

The advice P07 would give to other nurses would be to learn English before coming to the UK and not to think that relocating is to have fun; rather it is to work in a new country. She

recommended '*don't be shy*' in the workplace and to try your best to communicate with everyone. Moving into a house was regarded as '*the key*' to starting to settle. However, she recommended no more than two roommates as relationships with and between four people had a negative impact on her settlement.

She believed it would probably have been easier to have fun outside of work had she known about the many things to do in the in West Midlands such as climbing, safari, the canal, a park or going to the theatre. Information of this kind had been provided during induction, but not embraced at the time, partly in the absence of fully understanding what was written.

She was happy in the ward where she worked; was keen to gain more experience/to learn. Future training plans included undertaking courses in high dependency and mentorship. Support to develop her interest in research contributed to her settlement at New Cross Hospital. She and her boyfriend had plans to maybe buy a car, and to buy a house rather than rent. She spoke of maintaining her friendships and of travel to visit other countries in the world.

Case study 3

Code	Gender	Nationality	Speciality	Workplace
Participant 14	Female	Italian	Paediatrics	New Cross Hospital

Background

P14 had lived with her parents and her brother in a small city near Venice. Once she had finished studying she had tried to look for employment in neonatal nursing. In the mean time she worked in a restaurant and also had a job looking after an elderly man.

She graduated in technical biology and then went on to complete a nursing degree. She explained that it was when her grandmother became ill that she was 'inspired' to train as a nurse. She expressed that she really enjoyed working in the neonatal field and was happy to come to Wolverhampton because it was recognised for its excellence in maternity services. She was also motivated by the further opportunities in the UK such as the Nursery Assessment and Certification Programme [NIDCAP]. A lack of jobs for neonatal nurses in Italy was also another incentive to look for jobs further afield. P14 exclaimed that she needed a change in her life '*a shock*' and wanted something more from her life. She related that she felt that she needed to '*grow*' professionally and did not see any opportunities in Italy for her to develop her nursing career. She also perceived the role of nurses in the UK to be much more '*valued'* than in her own country. Another incentive was to have opportunity to develop her language skills. She concluded that she did not feel that moving to another country was for everyone as it was because she was working in three jobs and her boyfriend was in another country that was her main motivation. She emphasised that she felt that moving to another country depended on the '*personality of characters*'.

P14 decided to send her CV to the Primary Care Recruitment [PCR] as she felt that she needed a change in her life. She was then contacted by the PCR to attend interview in Milan. When she attended the interview in Milan she completed both a written and verbal exam. PCR provided information about Wolverhampton and other documentation for example NMC details. P14 reported that she had downloaded her CV on LinkedIn to circulate for further opportunities after her first year in Wolverhampton. Initially she had

planned to stay in Wolverhampton for a year before moving on to another part of the UK. She had also undertaken English lessons in the summer holidays prior to travelling to the UK.

Workplace adaptation

P14 found the induction generally useful in terms of getting to know the City and the Trust as during the induction participants were taken on public transport and shown the '*good*' and not so '*good*' areas in Wolverhampton. She felt that one month was adequate for the induction as it gave them enough time to understand more about the organisation as a whole. She felt however, that the induction was more suited to adult nurses rather than neonatal nurses and suggested that more training should be provided for paediatric and neonatal nurses on a local induction ward. She would have also liked to have had some specific training on the machines used on the neonatal wards.

P14 was very happy with her mentor whom she had for three months. She explained that her mentor was very helpful '*with everything*' such as going through abbreviations. At TP3 however, she was less positive and related that she had little contact with her mentor as her mentor worked in intensive care and she worked in special care. She expressed that she did not find the other nurses on the ward very helpful such as when needing assistance with the machines. She perceived there to be a lot of bureaucracy with the ward manager and felt that many of the other nurses were unhappy with their shifts or policies around sickness and holidays, which she felt had impacted on the general dissatisfaction on the ward.

Initially she found the staff very helpful; however, when she had moved to another ward at TP2 she was less satisfied with her colleagues and expressed that she felt her colleagues did not trust her. She also expressed her frustration with the other nurses as they often forgot that she was a qualified nurse. She often felt that her colleagues would ask the other nurses to carry out tasks when she was available '*ask me. I am here*'. She ultimately concluded that she had felt more appreciated in Italy than in Wolverhampton but acknowledged that this was only one hospital in one city. By TP3 and TP4 she was less disconcerted with her work colleagues and related that she was '*happy to talk*' to talk with them. She explained that she now felt more comfortable with communicating with the other nurses. P14 however, spoke

about how difficult it still was to make English friendships as she felt that there was still a cultural gap and had found it difficult to make meaningful conversation with work colleagues.

P14 also explained the difficulties that she had communicating with both patients and staff on the ward. Although she related that once rapport was built up with the patient, communication was much easier. Initially, P14 had struggled with the various accents in Wolverhampton and had found it especially difficult at the end of a long shift or when she had to communicate over the phone. After 13 months she had felt that her English had improved but still spoke of the difficultly she had in understanding what people were saying particularly on a night shift when she was very tired. She attended an English Language course provided by the Education Team but felt that there needed to be more emphasis on conversational English. Figure 3.3 shows the ease with which P14 adapts to the English varies over time.

P14 related her frustration of attaining the PIN as she had had a few set-backs. At TP3 she had obtained her PIN and felt that the other nurses had only now recognised her as a qualified nurse but felt that nothing else had changed '*too much*' since she had received her PIN. She also observed that, in comparison to Italy, staff tended not to work as a team. Generally, she felt underutilised on the ward as she could not use many of her skills and therefore felt that the system in Italy was preferable as they were trained to undertake a variety of skills from an early stage in their training career. She also felt that in Italy there was more communication between the doctors and nurses, which she felt was ultimately more beneficial to the patient.

P14 explained that she had undertaken several training courses such as blood transfusion, feeding, delivery, ventilation and infection prevention, which she found generally useful but in some areas such as learning about the risk of blood transfusion she would have preferred to receive more specific information such as what the procedure actually was.

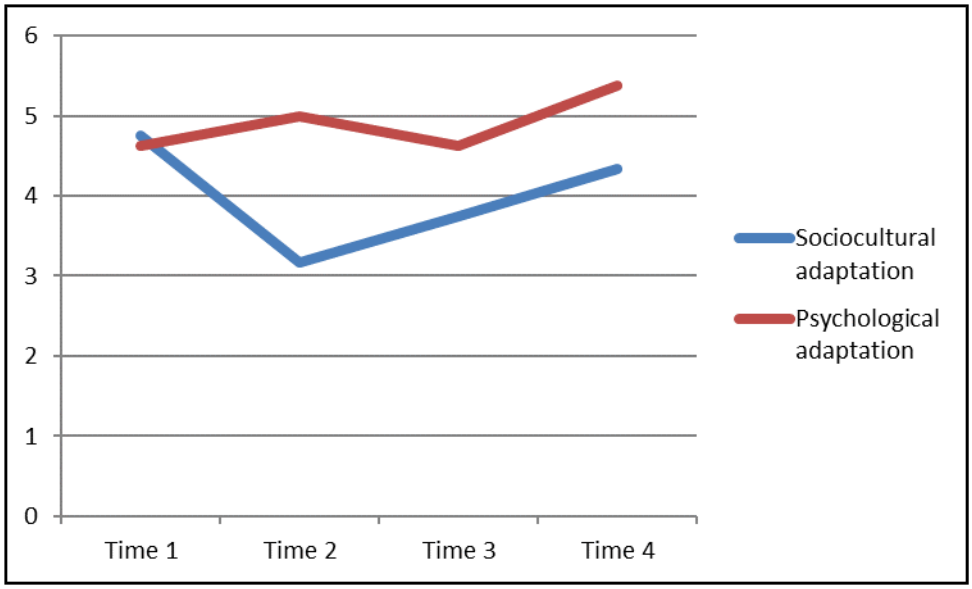
After 13 months she had moved to Birmingham with her boyfriend and was commuting to New Cross Hospital by car. She had also started a foundation course in Stafford, which was

one day a week for six months. After that she would have to take and exam and if she passed all her exams she would receive a diploma which would enable her to work in intensive care with a mentor. However, she was still searching for another job nearer Birmingham as she was finding the daily commute strenuous.

Sociocultural and psychological adaptation

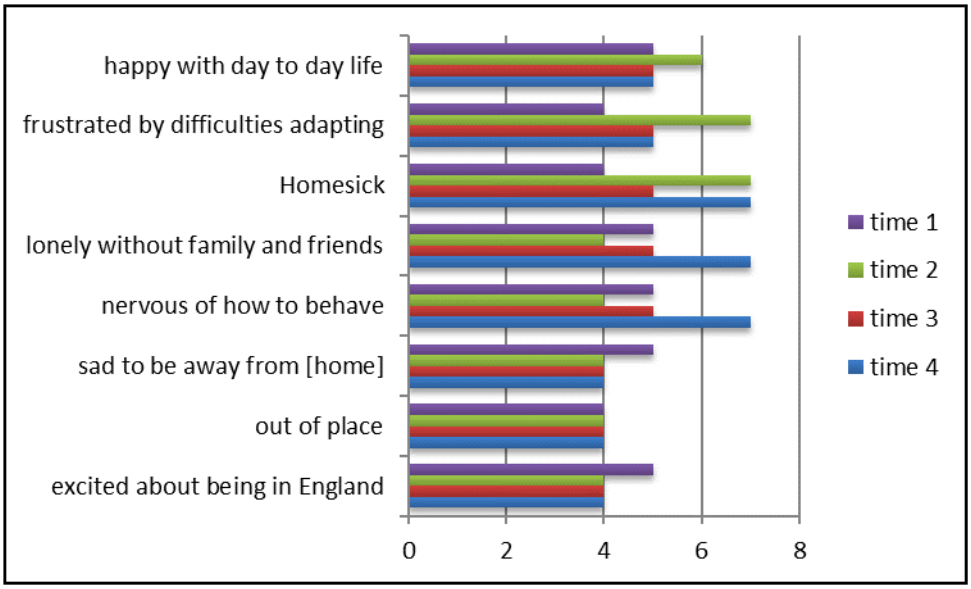
As shown in Figure 3.1, P14 demonstrated an increase in positive emotions towards adaptation to life in England [psychological adaptation] at TP2, with a return to baseline at TP3, and a further increase at TP4. Overall, there was an improvement in psychological adaptation over time.

Figure 3.1 Changes in sociocultural and psychological adaptation (P14)



An analysis of the items on the psychological adaptation scale [Figure 3.2] indicated a positive shift for P14 at TP2, expressed through less homesickness, frustration and feeling happier with day to day life than at baseline. P14 was the least lonely, least nervous of how to behave at TP4 and had a positive shift away from homesickness at this time too, demonstrating positive outcomes at the end of the study period on these items. Negative shifts were observed with regards to sadness and feelings of excitement about being in England, where the most positive outcomes were at baseline and then a lower score was constant over time. Feelings of being out of place were consistent over time. Overall, P14 experienced a cluster of positive outcomes at both TP2 and TP4.

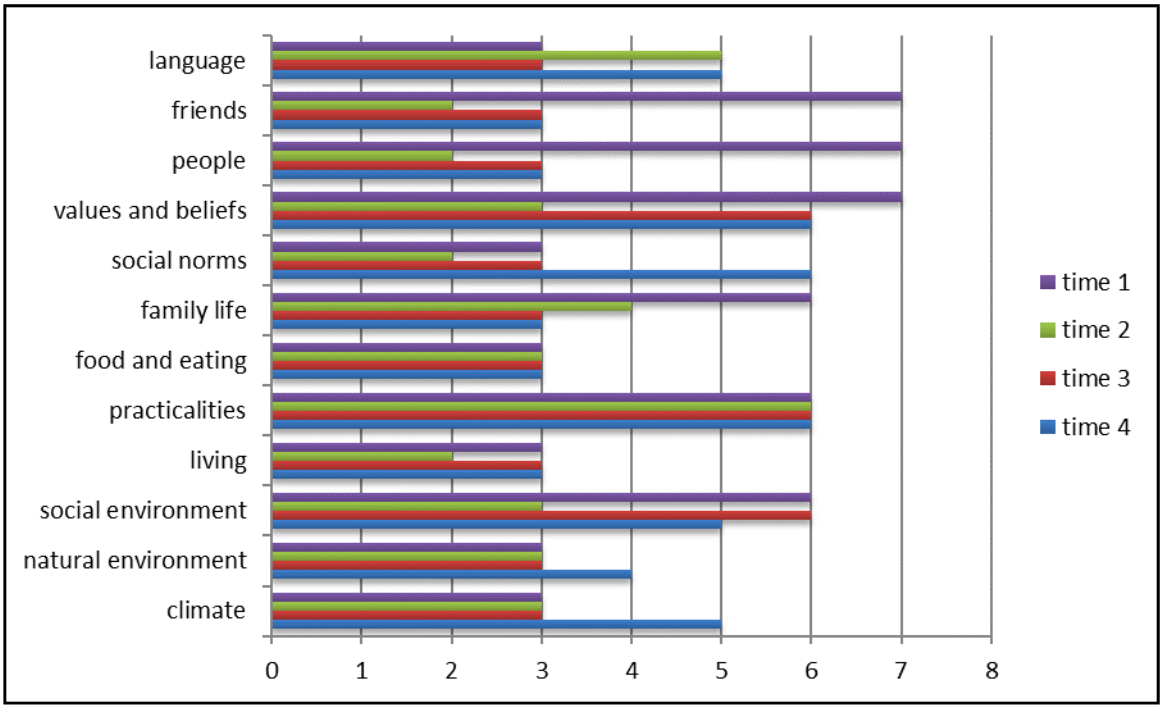
Figure 3.2 Changes in psychological adaptation (P14)



[*NB a higher score infers more positive adaptation]

P14 spoke about the weather and the people being different. But related how she slowly learnt '*step by step*' about the English culture and the people. At TP1 she was quite positive about her impressions of Wolverhampton and expressed that she was pleasantly surprised at the social mix in the UK, which she had not experienced in her own country. At TP2 she was much more neutral and said that Wolverhampton was '*not much good and not much bad*'. This was reflected in her reported ease of adapting to life in England as measured on the sociocultural adaptation scale. A clear decrease is observed at TP2 [Figure 3.1]. She also reported that she was surprised at how early people in the UK started a family as in Italy people concentrated on their careers and had children later. She also perceived there to be more social problems in the UK in comparison to Italy. These sociocultural observations may reflect exposure to different social groups in host vs home experiences i.e. how well matched are the home town and the host town in terms of indices of deprivation. By TP4 however, P14 reported adjusting to the social norms more easily when compared to earlier in the study [Figure 3.3].

Figure 3.3 Changes in cultural distance, host and home orientation (P14)



After a trip back to Italy she explained that it had made her appreciate her opportunities in the UK such as her job, her career, the money and her life in general. She was also surprised to observe the confusion at the train stations in Italy and realised that she was now used to the '*English order*'. P14 also spoke about the lack of amenities in Wolverhampton and indicated that she would prefer a city which had more shops and bars. She had enjoyed visiting London as she had some Italian friends at St George's hospital. By TP4 P14 had moved to Birmingham with her boyfriend. Like other case studies reported here, the variation in ease of adapting to the social environment as observed in Figure 3 is likely related to the opportunities afforded at the differing times of the year.

When she arrived at the hospital she had initially found it very difficult to live with 34 other strangers as she always lived at home with her parents. She was therefore much happier when she found a house together with three other Italian friends. They often travelled into Birmingham together on their days off and generally enjoyed going out either shopping or to the gym. She also explained that they were very supportive when she needed help with the NMC documentation. They had looked for accommodation that was nearby to the hospital as it was more practical to walk or cycle to the hospital. At TP3 her boyfriend came to live in the UK, which may offer an explanation for the cluster of positive outcomes

observed at TP4, as mentioned above. As he had a car they were able to visit other places in the UK together in their days off. P14 indicated that she had found it strange that people in the UK did not appear to travel around the UK more as there were such '*beautiful places*'.

P14 spoke about her love for Italian food and was always happy to return home for her home cooked meals. She pointed out how much she had missed her family and friends but was in regular contact on Skype, letter writing and on the internet. P14 also spoke of how much she had changed as a person when she went back to Italy to visit family and friends. Responses to the psychometric tools show an interesting pattern, which indicated how P14 had changed in her orientation to the host and home cultures over time that may explain the differences she saw in herself. With reference to Figure 3.4, at TP2 and TP4 more difference was perceived between the host and home culture and P14 was more strongly orientated towards the home; this corresponded with the positive psychological outcomes at these times, which were noted above.

Figure 3.4 Orientation to host and home cultures and perceived cultural distance (P14)

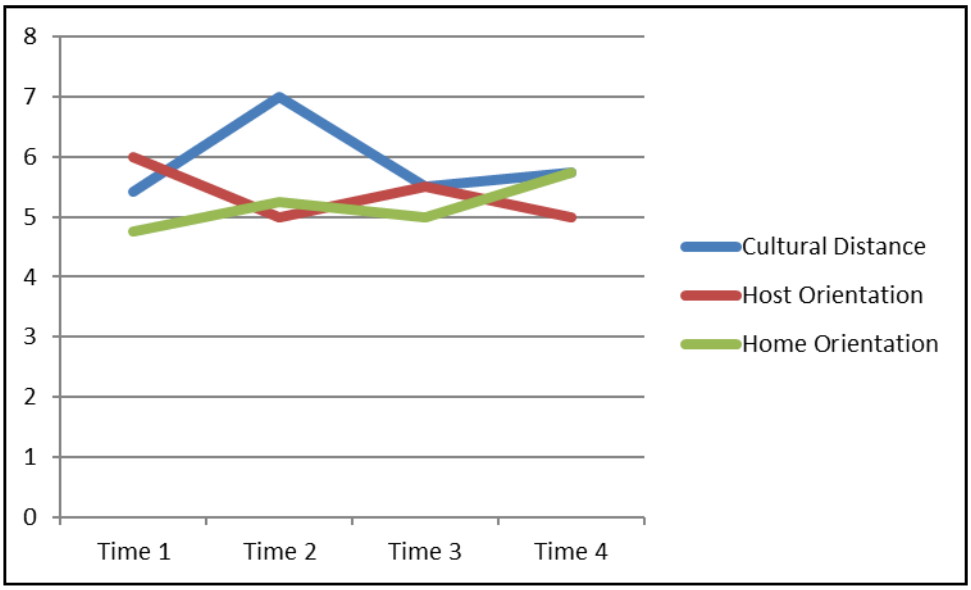
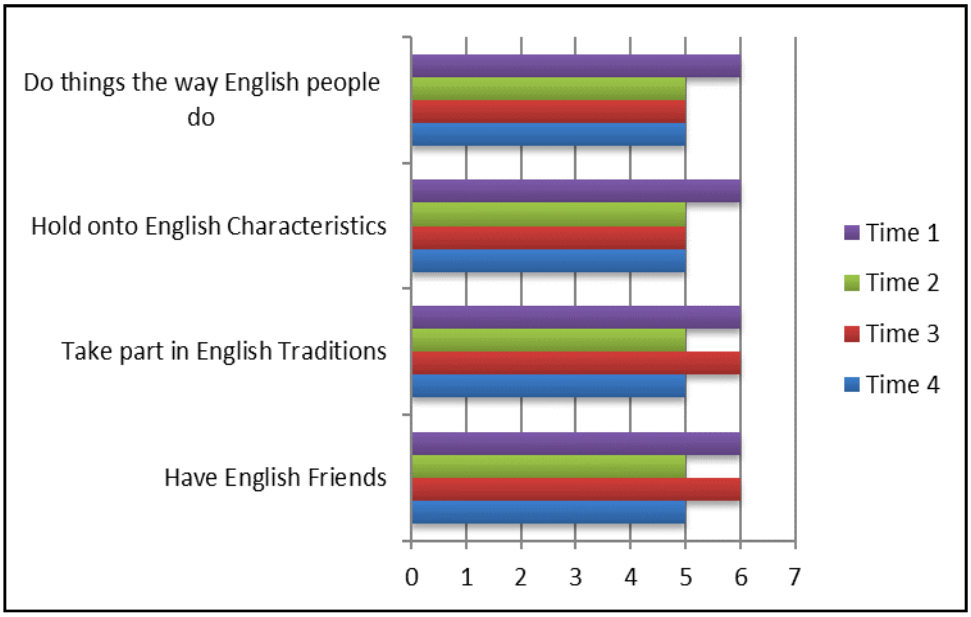


Figure 3.5 Orientation toward the host culture (P14)



After 13 months she still found that it was difficult to make English friends but accepted that this was probably '*normal*' for anyone that was '*new*'. Making English friends was consistently important to P14 [Figure 3.5]. She had also observed that many English people were '*closed*', which made it difficult to communicate with them. Nevertheless, she was still grateful to be in the UK as she surmised at TP3 she was happy to have a home, a job and a future in contrast to Italy where she felt there is '*no space for younger or for a nurse*'.

Reflections at 13 months

P14's main advice would be for nurses to study English before coming to the UK. She also explained that it was important to not be afraid to '*ask*'; the nurse recruitment agency or when on the ward. She reported that having a good mentor really helped and she was able to ask '*every single thing*'.

P14 indicated that it was very much up to the individual to make the best of their experience and to '*force yourself*' to stay and to do something that is '*different from Italy*'. She admitted that when she originally arrived she wanted to go back to Italy but she was determined that she would be strong enough to stay in the UK.

In the future she indicated that she would like to move away from Wolverhampton with her boyfriend and relocate to somewhere in the south.

Case study 4

Code	Gender	Nationality	Speciality	Workplace
Participant 15	Female	Italian	Care of the elderly Rehabilitation	New Cross Hospital moved to West Park Hospital

Background

P15 was from a small town in the north east of Italy. Previously, she had lived at home with her parents. She had one brother who lived with his wife. She spoke about enjoying her social life in Italy, for example, inviting friends around for pizza.

P15 had initially undertaken a Law course for three years but had not enjoyed the course and decided to change to nursing. She studied for three years at her home university and then worked for one year in a variety of government and private hospitals.

P15 was particularly impressed with the high standards of nursing in the UK, Australia and the USA and was keen to gain further experience overseas in her nursing career. Before leaving Italy she had undertaken some research on nursing in the UK and had been impressed that the UK was one of the countries where '*best practice*' in nursing had derived from.

P15 said that she felt that it was a good time in her life to make a change and to experience living away from her home as she was still young and not married. She related that she would miss her two cats and her family greatly, however the chance to study and '*learn more*' as well as having the flexibility to work in a variety of specialities [which she was unable to do in Italy] was a great opportunity. She had also wanted to travel to other countries and places and was keen to come to the UK as she was informed of how efficient the public transport was in the UK. Another motivation to come to the UK was the positive impression that she had been given of Wolverhampton from the nurses who had come to recruit from the RWT.

P15 explained that she had initially contacted the Primary Care Recruitment [PCR] to enquire about recruitment of nurses to the UK. The PCR contacted her via Skype and carried out an initial interview to assess her English language skills. An interview at the hospital in Milan was then arranged by the PCR. Once the interview had been completed everything moved '*very quickly*'. P15 explained that she had not received a lot of information, apart from the NMC process. P15 however, was informed that she would be provided with further information such as housing and opening bank account once arrive in the UK.

When she arrived in Wolverhampton it was a '*cold snowy and windy*' day and she was not impressed with the overall appearance of the city. She expressed that she did not expect the accommodation to be so 'dirty' and over-crowded.

Workplace adaptation

P15 explained that generally she felt that the induction was not really useful. She felt that the induction was disorganised and needed greater structure. She also felt that the time was not effectively used and that the content was often too basic. She felt for example, that having to get up at 6.00am for an 8.00am to receive '*only*' a printed handout to identify the anatomy of the body was not very constructive. P15 also suggested that one month was not long for training and that the information was not suitable for nurses in her field. She therefore recommended that the groups should be smaller and that the training should be more specialised. P15 emphasised the difficulties of arriving in a new country with limited English skills and having to attend long sessions in another language. She suggested that sessions should be shorter and that the English lessons should be more integral to the induction rather than being introduced two months following the induction.

The first day on the ward P15 described that she felt very '*anxious*' as she was very conscious of her responsibilities and did not want to make any mistakes. She related that her mentor was very busy and had instructed her '*to clean*' the patients without any explanation of where equipment was on the ward. P15 explained that she generally felt isolated on the ward and observed that the other nurses were '*slow*' and '*lazy*' leaving her to do a lot of the work. She also perceived that the nurses were generally checking on her and felt that they did not trust her. Initially she did not find them very helpful as she could

not understand why they could not find five minutes in a 12-hour shift for her when she required some assistance. She reiterated that she was keen to form friendships with her colleagues but found that most of them were older with families and perceived it to be generally unusual for colleagues to form friendships outside of their working environment.

P15 expressed that when she had first arrived she had been particularly unhappy about her post on her assigned ward and felt that she had been misled by the team educator who had described the ward in favourable terms.

On the ward P15 was surprised at the lack of consistency of abbreviations in comparison to Italy where they had a book of abbreviations which they could refer to. P15 also indicated that she found it frustrating that she had to wait for her further training to undertaken tasks that she had already accomplished in Italy.

She was also concerned about the lack of self-management that the patients were provided with at the hospital. As she explained that the patients and carers in Italy would be told what specific exercises they should undertake, what to eat, how to dress etc. and related how surprised she was that the diabetic patients were given sweets or sugar with their coffee.

A few months later P15 moved to rehabilitation at West Park Hospital, which was smaller and where she felt the team was more supportive. P15 explained that she had felt a lot more involved with the rehabilitation team as she was included in family meetings with the other staff members. She also highlighted the fact she enjoyed having greater contact with the patients as communication with the rehabilitation patients was easier than the patients on the previous ward. At TP3 she said that she was much happier and more familiar with her tasks and her responsibilities on the ward. She still related however, that she still did not feel a part of the nursing community in Wolverhampton and socialised only with her Italian colleagues.

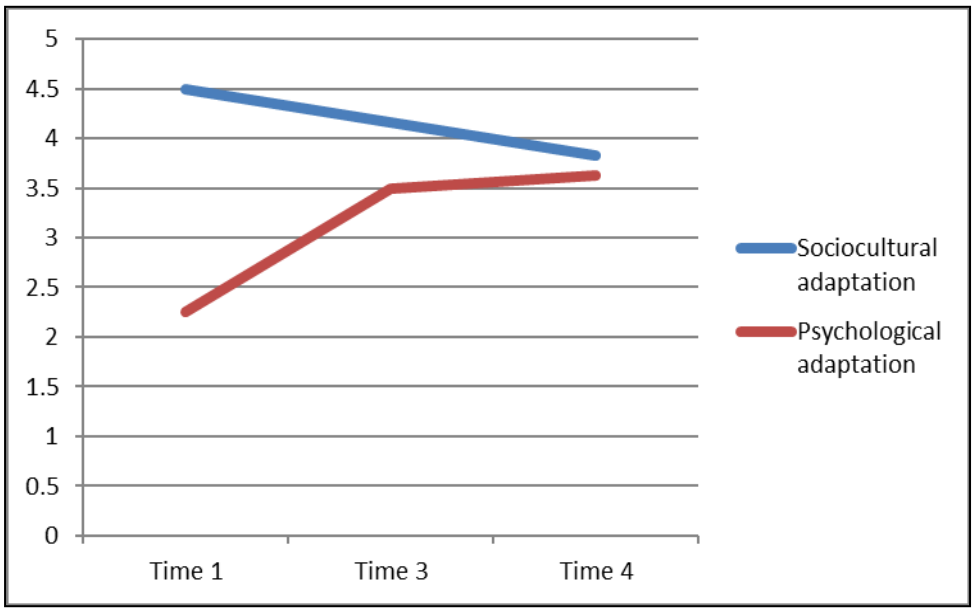
Overall, she preferred her work in rehabilitation, but was disappointed with the training opportunities available as she had to wait almost a year before she had undertaken her

course on IV fluids. She also highlighted the fact that there was less communication in rehabilitation about the availability of courses on offer. She was particularly disappointed that there were no opportunities to train in neurological skills and therefore the opportunity to develop a greater knowledge of the vocabulary in rehab. P15 indicated that she felt there was a lack of opportunity to gain greater experience or undertake further studies at the RWT, which she was keen to do.

Sociocultural and psychological adaptation

Quantitative data were available for P15 at TP1, TP3 and TP4. Scores on psychological adaptation [Figure 4.3] were below the midpoint for the duration of the study for this nurse, and appeared to suggest that an initially poor psychological adaptation was sustained for the duration of the study. P15 reported a slight decrease in sociocultural adaptation over time [Figure 4.1], indicating comparatively more difficulty in adapting to English life at TP4 relative to TP1. The most striking decrease in sociocultural adaptation refers to the language and the practicalities experienced [Figure 4.2].

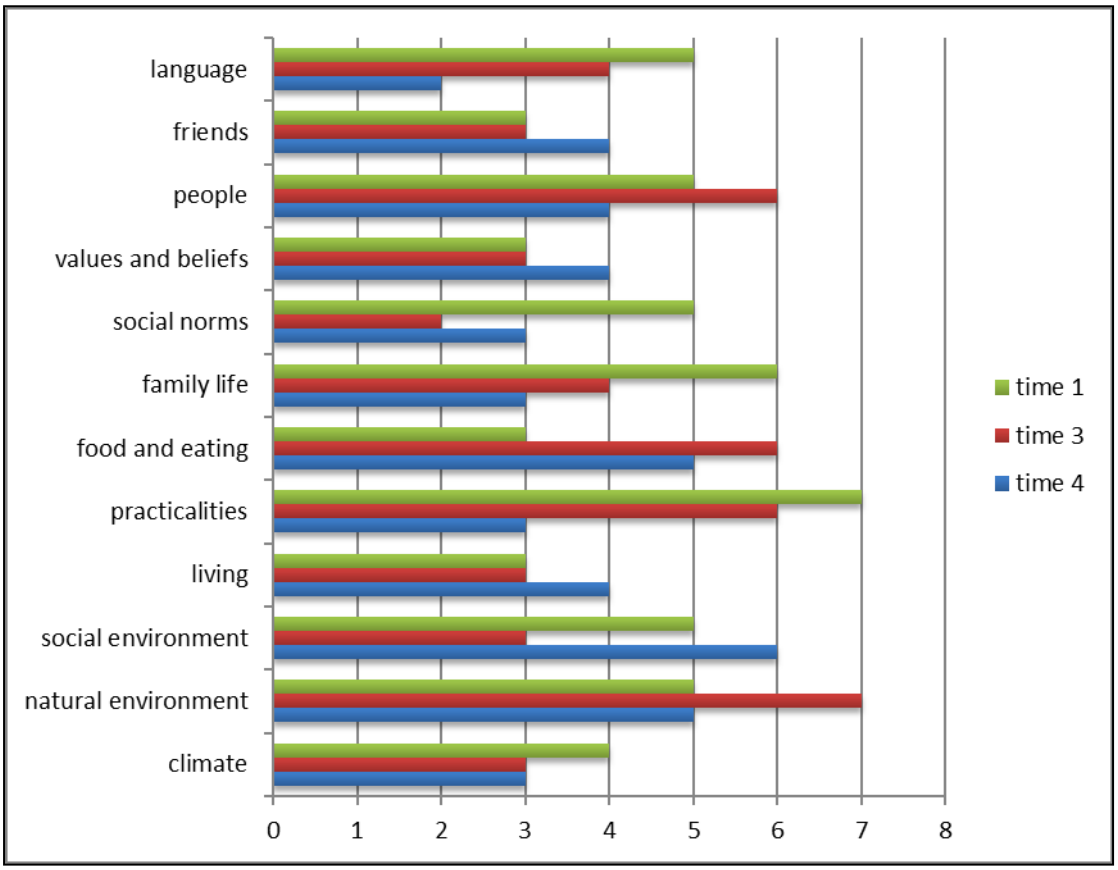
Figure 4.1 Changes in sociocultural and psychological adaptation (P15)



P15 explained that the weather where she lived in the north east of Italy was similar to the weather in Wolverhampton. Her first impression of Wolverhampton was that it was full of drunken people with little clothing on for a cold day in January. At TP3 she explained that she did not feel that Wolverhampton had much to offer and would prefer to go somewhere

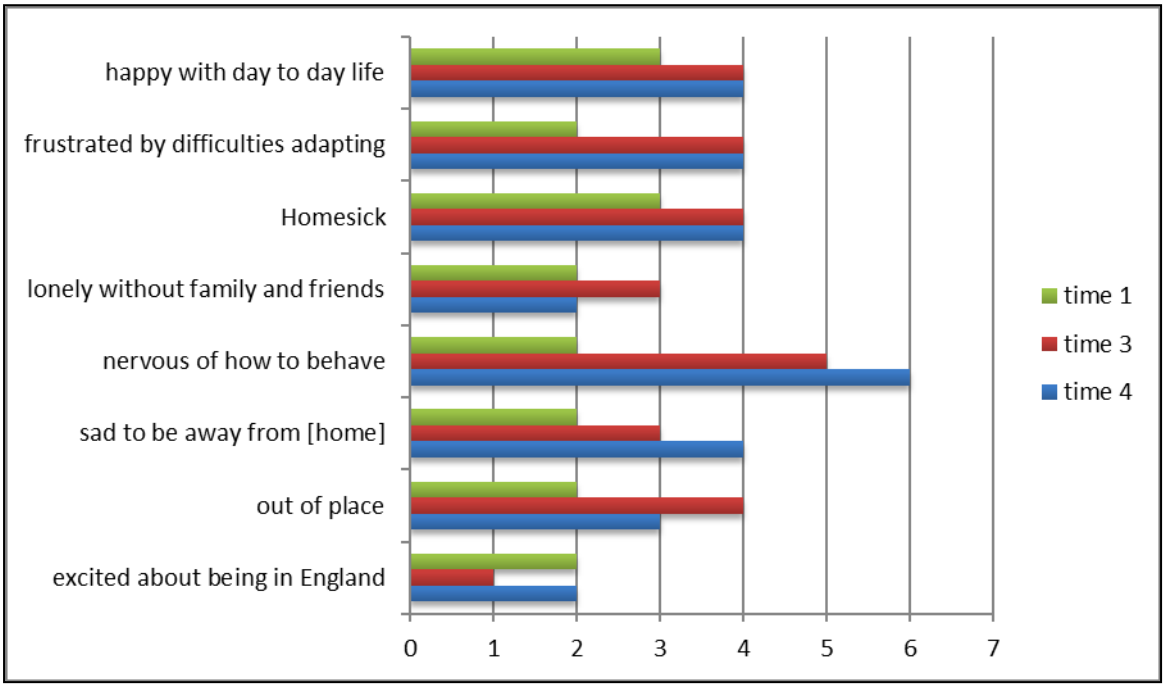
with a '*bit more life*'. She was particularly frustrated that most places closed at 5.00pm in the evening in comparison to Italy where some places were still opened until 2.00am in the morning. P15 did not express much excitement over her move [Figure 4.3]. On the whole, we observed an increase in positive emotions over time at TP4 relative to baseline. This manifested as feeling happier with day to day life, less frustration, less homesickness, less nervousness of how to behave and fewer feelings of sadness about being away from home. P15 felt marginally less lonely at TP3 but returned to baseline levels of loneliness at TP4 [Figure 4.3].

Figure 4.2 Changes in sociocultural adaptation (P14)



Overall it became more difficult for this nurse to adapt to various facets of the host culture over the duration of the study. In particular the language became harder, perhaps reflecting difficulties with local dialect, being used to the people and social norms also became harder, as did family life, practicalities of daily life [Figure 4.2].

Figure 4.3 Changes in psychological adaptation (P14)



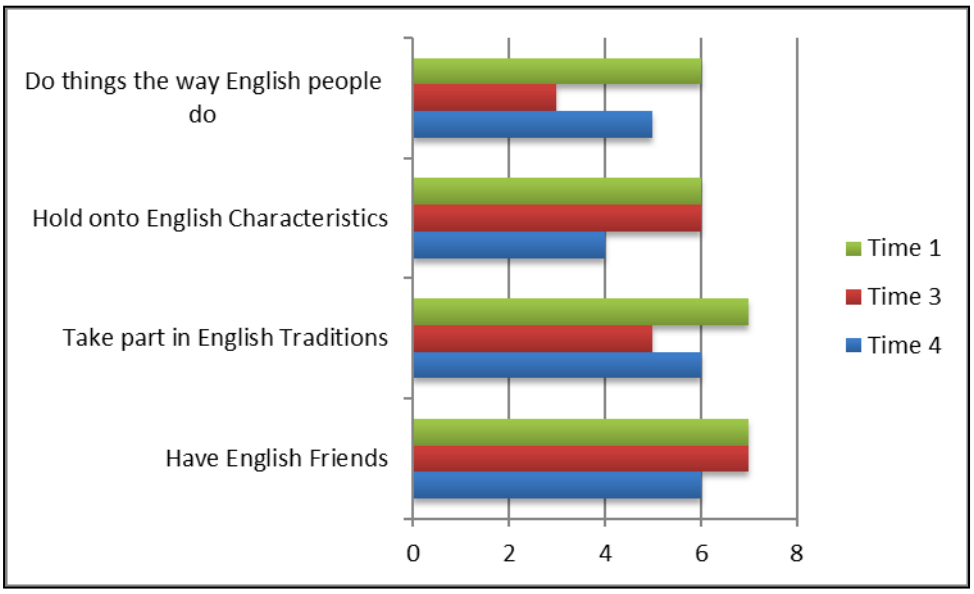
[*NB a higher score infers more positive adaptation]

On her arrival she explained that she did not feel very safe in Wolverhampton as there were a lot of drunken people around. She was initially disappointed with the accommodation as she felt that the facilities were not adequate for so many nurses as there was only one toilet for 20 people. She also did not find the accommodation very clean and was keen to find her own accommodation fairly quickly. She reported the difficulties that she had experienced in finding accommodation and gave an example of when she phoned to enquire about a house, how she had been disappointed when the agent had put the phone down once he had heard her accent. This may explain her feelings of being out of place and homesick, but also her difficulty with the practicalities of the host culture.

P15 was very close to her family and spoke regularly to her mum via Skype. She related that she missed her family along with her two cats and was going to drive to Italy and bring her two cats back to Wolverhampton. Over the summer her mum came from Italy to stay with her for two months. P15 explained that after living in Wolverhampton for two months her mum was happy when she heard that P15 was leaving Wolverhampton as she had been concerned for P15's safety, particularly at night.

P15 initially found the norms and values difficult to articulate as people often did not mean what they did or said as they would in Italy. P15's adaptation to the social norms of England worsened over time [Figure 4.2]. At TP4 she demonstrated that she was now more familiar with British nuances and understood that that if some said '*are you alright*?' they didn't necessary mean it as they often did not stay to hear the answer. It is of note that regarding orientation towards the English culture i.e. doing things the way English people do became less important at TP3 [Figure 4.4].

Figure 4.4 Orientation towards the host culture (P14)



At the beginning she had anticipated that people from Wolverhampton would be very friendly. After being in the UK however, for a few months she acknowledged that she had been very enthusiastic about coming to Wolverhampton and meeting new people. When she had not received a similar response she had made a conscious decision to spend more of her time at home or work. Making English friends only became marginally less important over time [Figure 4.4]. However, she explained how difficult it had been to make English friends and felt that everyone in Wolverhampton looked '*closed*'. P15 explained that she had even tried joining the gym to meet new people; she however, eventually stopped going as she had still not made any friends. She also pointed out that her English may have been a barrier to making English friends as she perceived that they may not have wanted to make an effort to communicate with some with who was not fluent in English. When she had arrived in the UK she was keen to improve her English. After a few months in the UK she

had felt that her English had improved and felt much more confident speaking English. Interestingly, sociocultural adaptation to the language decreased in ease over time [Figure 4.2].

P15 also explained how disappointed she was when she arrived in the UK because she was expecting that the UK would be '*better*' than her own country '*my dreams were different than the real*'. Initially she was positive and made an effort to adjust to her new culture but at TP3 she still did not feel settled and wanted to move to another city as she had still not found any English friends. She described her social life as 'boring'. P15's enthusiasm is mirrored in her orientation towards the host culture at TP1, which is unusual, with most preferring their home culture initially. P15 experienced a stronger orientation towards the home culture for the remainder of the study. It appears to point to an ambivalent identity where neither culture has particularly 'won out' over the course of the acculturation process. This can have consequences for the social identity of the individual concerned who can feel 'lost' and a lack of belonging.

Reflections at 13 months

P15 had been very enthusiastic when she had arrived in the UK but over the following months she had become more disillusioned with her move to the Wolverhampton. As time progressed however, P15 had gradually begun to accept her new circumstances and concluded that there were both pros and cons of working in another country. While her working environment improved [particularly once she moved to work in rehabilitation] her social situation had not changed from when she arrived in the UK. P15 felt that given her experience it was very important for other EU nurses coming to the UK to actually visit the country before applying for the post. She felt that this was important as she had assumed that everywhere would be like London. Therefore, she felt this would minimise, '*wasting time'* in a place that was not suitable, given that there were so many other places to apply for work in the UK.

She proposed that RWT could produce some paperwork or a video that would explain to other nurses the duties/practises nurses undertook in the UK. This she felt would help prepare nurses from overseas to understand what they would be expected to do once they

arrived in the UK. She also felt that it was important for English classes to be available to nurses once they arrived and not two months later.

She was now looking forward to moving to [location] Hospital in a few weeks' time. She was particularly enthusiastic about meeting new people and being part of a wider community. She felt reassured as she had visited the hospital and had met some of the staff, some of whom had been there between 6-20 years. By comparison to RWT where she felt there was a high turnover of staff and was therefore pleased that people appeared more 'stable' in [location]. Although this time, she related, she would be more cautious and not expect too much - '*so I prefer to be careful*'. Nevertheless, she was still optimistic that she would make some English friends and have a happier social life.

4.0 Discussion and recommendations

4.1 Introduction

The study sought to gain insight and understanding of EU nurses' experiences during their first year of settlement into the community of Wolverhampton and employment in the NHS, working at the RWT. In summary our objectives were: to uncover what everyday life in their home country had been like; to describe the settlement experience for both participants and their significant others; to identify any life adjustments and 'push' 'pull' factors that motivated participants to seek employment in the UK. We sought to explore participants' expectations of the community at Wolverhampton and their employment and whether these had been met. We were keen to identify enablers and blockers to settlement and whether these were sociocultural, psychological or employment based. We wished to assess participants' need for support and the extent of any met/unmet needs. It was important to identify coping strategies utilised and the motivators to retention of EU nurses, particularly with regard to any quality of life enhancing factors.

The reported findings we believe to be the first to address the stated objectives of rigorously examining EU nurses' settlement experiences. The study therefore makes an important contribution to the body of knowledge available and may have implications for EU nurse recruitment in light of the continuing shortage of nurses in the UK (Marangozov et al 2016) and may indeed have implications for Brexit (Lintern 2016, Merrifield 2016). We therefore discuss our findings in the context of improving nurses' settlement experiences by examining in detail participants' accounts. We present our discussion of the findings followed by our recommendations in each section.

4.2 The migration and settlement experience

4.2.1 Participants' background

Participants were young people who came from what they described as beautiful home locations with a Mediterranean climate, of which they were very fond. They were from close knit families and friendship groups. Overall, the decision to leave their home had been a difficult one but was driven by the need for employment, a desire to advance their careers, which were not available to them in their home countries, and to learn English, which they viewed as a useful attribute for further travel or career advancement. Professionally, they

were mostly newly qualified nurses or with one or two years post qualifying experience. They appeared to be extremely proud of their profession and reputably had a high level of clinical nursing skills commensurate with the extended scope for nursing practice in the UK. It is not surprising therefore that one of two major issues for participants was relocation to an industrial city in the centre of England without many perceived amenities for young people or the familiarity of beautiful surroundings and a 'café society'. Participants did express, particularly in the later interviews, that they were happy with their working environment but less satisfied with their social and home environment. The perceived lack of amenities and the industrial environment appeared to lead to attrition of the study sample as nurses relocated to work at hospitals in what they perceived to be more attractive parts of the country such as Brighton, Canterbury, Cambridge and Bournemouth.

Recommendations

1. Full information about the relocation area (i.e. Wolverhampton) needs to be provided at the recruitment interview so there are no misconceptions about the host environment.
2. At induction get a well-informed person to come and talk about the City of Wolverhampton and the surrounding areas and all they have to offer in terms of interest and entertainment.
3. The Trust needs to consider Tie-in contracts.

Second, were the frustrations participants experienced of having to work as a HCA rather than as a registered nurse (Stuart 2012) until such time as they were able to acquire a NMC PIN. Subsumed within this frustration was the poor understanding of how nursing was organised and delivered in the UK.

Recommendations

4. Early acquisition of a NMC PIN. Preferably to have the process well underway or completed prior to arrival in the UK.
5. Develop a video in local dialect available on YouTube and/or the Trust website (so it can be accessed unlimited times) for potential recruits to engage with, so there is a clear understanding of the work they will be expected to carry out and the

accompanying restraints until they get their NMC PIN. There also needs to be information about the type of work nurses do in the UK, shift patterns, the Pay Banding system, the colour of uniforms related to professional hierarchy, roles such as nurse specialists etc.

4.2.2 Arrival in the UK

One of the collective views was about the accommodation that was provided for the cohort on arrival in the UK. It appeared to be important for the cohort to be accommodated in the same location. A number of participants commented on the fact that this proximity was useful to identify future housemates and to form supportive friendships. However, bathroom, toilet and cooking facilities needed to be appropriate for the size of the cohort.

Recommendation

6. Accommodate recruits in one location but ensure that there are sufficient bathroom, toilet and cooking facilities for the number of recruits.

4.2.3 Induction

Participants reported feeling nurtured and safe during induction, which was quite different to some of their initial ward experiences where they felt underprepared, unsure and unsupported at times, reporting a lot of anxiety and frustration, these feelings had led to a desire to return home and crying in their rooms when they came of a shift.

Participants had a variety of views and suggestions about the induction programme. There was however consensus about: the useful length of the six-week induction however, what was perceived as 8am-5pm days was considered too restrictive; participants expressed the need for a more individualised programme; better balance between theoretical, practical and workplace induction; more visits to assigned wards/units prior to starting clinical work as this could potentially help with building trust, as the ward/unit staff would have the opportunity to get to know the nurse and the nurse could be better prepared and confident about starting in clinical practice [the lack of trust and confidence were significant issues for participants starting in clinical practice]; making learning more relevant by teaching in discipline groups and having clinical staff lead on teaching; the need for English classes to be

incorporated into the induction programme. The English language course had the positive endorsement of the majority of participants but they expressed disquiet that the course came too late, especially as participants generally found the most difficult language task in clinical practice was managing telephone conversations.

Recommendations

7. Shorter days or split days that could have an element of English language classes
8. A better balance between theoretical, practical and workplace induction
9. Individualised induction programme
10. Work in smaller, own discipline groups with input from clinical staff
11. More help with completing clinical documentation
12. Provide a handbook of acronyms/abbreviations
13. Provide opportunities to practice mock telephone conversations

4.2.4 Support

Participants had support from a number of sources during their settlement experiences. Informal support was provided by family and friends. Participants talked about how they kept in touch with family and friends in their home country via a variety of technological means including social media. Participants also made friends in their cohort group and many shared accommodation and spent their days off together.

Formal support was provided by Education staff and the Group Coordinator. Participants found the support of the Education staff and the Group Coordinator to be particularly helpful and spoke very highly about them in this regard. The support of Clinical Tutors was also commended. Other formal support was provided in the clinical area by mentors or buddies, via a number of different models.

What should be important about any of these models is the availability of support to new starters in the workplace on their first shift in clinical practice. This arrangement could have gone some way to avoid the anxiety and distress experienced by some participants through a perceived lack of planned support. Mentors were seen to be very helpful and participants learned a lot from them. What was not evident was the role of the buddy.

Relationships with and support from ward/unit staff attracted mixed reactions but participants felt that over time they were able to build relationships with fellow nurses and doctors. The acquisition of a NMC PIN appeared to be the key to securing the trust, confidence and friendships of staff and participants' confirming their identity as a qualified, registered nurse. Difficulty in establishing new friendships, particularly with English people, impacted participants not feeling totally integrated into English society.

Recommendations

14. EU nurses need both a mentor who will support them and provide guidance about the differences in clinical practice, and a buddy to advise about settlement issues that may concern sociocultural adaptation.
15. Careful thought needs to be given to the matching and allocation of mentors and buddies. The mentor and buddy require knowledge of professional and cultural differences between the home and host country that may affect EU nurses' workplace adaptation acculturation.
16. Mentors should be available to new starters for their first engagement with the workplace, with subsequent supportive arrangements that are amenable to the new starter, the mentor and the clinical setting.
17. The Trust could canvas staff interested in a buddy role and not restrict it to those in the discipline of nursing. This potentially could help EU nurses with the process of making English friends and integration into English society.
18. Need to prepare Trust staff about what to expect in terms of capabilities EU nurses bring to clinical practice.
19. Early access to training courses would allow nurses to reengage with clinical skills that they have previously been assessed as competent to perform, and to utilise those skills for the benefit of patient care.
20. Development of a questionnaire that could readily test adaptation to the workplace.

5.0 Critique of the study

While nursing practice was not the focus of this research the findings revealed a number of issues that concern the practice of nursing at one NHS Trust. The highlighting of these issues by the EU nurses may indeed be of concern to other groups of nurses in the UK, and may be worthy of further investigation in relation to education, policy development, service delivery and research. A list of these areas are presented below.

- The design and content of EU nurses' pre-registration training curriculum: The question must be asked why UK nurses' NMC pre-registration training does not facilitate the acquisition of clinical skills that EU nurses have at graduation such as intravenous cannulation, intravenous drug administration.
- Drug storage in hospital ward/units: Is 'Where are the keys?' an outdated time waster? What are the modern alternatives?
- The amount of time nurses spend on the completion of paperwork: Is this really necessary?
- Use of VitalPAC: Has an apparent dependency on VitalPAC dulled nurses' clinical eyes and judgement?
- Nursing practice: Is the nursing being practised truly holistic?
- Facilitative ward/unit environment: What would be the best way to develop a climate in which nurses, who are new to an organisation, are encouraged and supported to challenge clinical practice and be made to feel comfortable to suggest alternative ways of working for the benefit of patient care?

The planned sample of 20 participants was achieved by a robust recruitment strategy implemented via the Nurse Education Department at RWT. The relatively small sample afforded the opportunity to generate a rich, extensive database of qualitative interview findings and quantitative information from the acculturation questionnaire. This was a case study about one NHS Trust, however, we believe the study findings to be transferable and to potentially have relevance to other Trusts recruiting EU nurses, particularly in industrial areas of the UK. The research should however, be viewed within the constraints of the study sample and size.

Participants joined the study for a variety of reasons. Some of these reasons were to help other nurses who will come to UK in the future, and to help hospitals understand what they as EU nurses '*really felt*' and what they '*really needed,*' what was good about their experiences and where improvements could be made. Participants also chose to use the opportunity to practice their language skills. There was also the idea that if their way of nursing could be integrated with UK nurses' way of working we could potentially provide much better services for patients.

The method of interviewing and the use of the acculturation questionnaire produced rich data that contributed to our understanding of the study aims and objectives. The option of telephone interviews was declined by participants possibly due to their awareness of language difficulties. Sharing the interviews between the three researchers, each tracking a group of participants, can be positively remarked upon. This enabled the researchers to develop perceived trusting relationships with the participants and also brought to the encounter the researchers' own experience and perspectives that were discussed and agreed in meetings.

Using psychometric measures in an attempt to profile individual acculturation strategies was successful to some extent, however the use of a measure that specifically addresses adaptation to the workplace might be more useful in an applied setting such as this. It would be hoped that such a tool could be used to identify those at risk of poor psychosocial outcomes, with a view to implementing an intervention, to ameliorate any negative effects of the move to the host culture. The tool used was not helpful in predicting the long term psychosocial adaptation. Although with a small sample, data are limited, it may also be that a tool that is more specific to the sample in terms of their motive for moving and in terms of their occupation would have more success in predicting long term outcomes, and this is a possible avenue for future research.

Understanding participants' language was an issue for the researchers in the early interviews and required much clarification and rephrasing of questions and assistance with comprehension. It is acknowledged that the researchers may have unintentionally led or influenced participants' responses to questions through their efforts to support individuals

who were determined to understand and respond. Over the course of the study the researchers were able to recognise improvement in participants' verbal communication skills, particularly in terms of speaking more fluently in English. One participant for example had used his phone to translate words at the time of the first interview but was able to command a fluent conversation by TP3.

Attrition is a recognised problem in longitudinal studies (Parahoo 2014). The loss of participants from our investigations started after TP2 and was mostly due to participants relocating to work in hospitals or private healthcare. To the best of our knowledge they were all still working in the UK.

The researchers also observed a 'laissez faire' attitude among participants to keeping interview appointments. Many of these had to be rescheduled. We remain however grateful to our participants for giving up their time to provide us with a wealth of knowledge that we anticipate will impact positively on the experience of EU nurses seeking an employment future in the UK.

6.0 Conclusion

We believe this to be the first, in-depth case study of EU nurses' first-year settlement experiences of working in the NHS, within the industrial landscape of the city of Wolverhampton. The study provided qualitative and quantitative data for both an integrated perception of participants' collective experiences and four detailed, individual case studies.

It is clear that for the foreseeable future UK will continue to recruit nurses and other health professionals from overseas to meet recruitment targets which facilitate the efficient functioning of the NHS. This research has demonstrated that the view of UK from abroad is that it remains an attractive work destination from the viewpoint of creating best practice, leading on the development of health services and career advancement opportunities. It was therefore disappointing to participants in this study to find that on arrival they could not use their advanced skills and were unprepared for the social environment they encountered.

There is a need to ensure that overseas nurses have the best chance to clearly understand their scope of practise and what their anticipated duties will be within their workplace. Seasonal factors may very well play a key role in early acculturation of recruits from warmer climates. Whilst there may not be a definitive answer some consideration needs to be given to bringing new cohorts of nurses to UK in the middle of January, into wards and units experiencing winter pressures.

Clearly clean, welcoming accommodation needs to be provided with an induction programme that broadly caters to the different needs and levels of the experiences of recruits. An induction programme that incorporates early and 'bite size' exposure to the workplace throughout, supported by English language classes. Retention could potentially be encouraged with early access to courses that allow nurses to reengage with their advanced skills. It is possible too that nurses having a definitive career plan in mind helps formulate a positive transition, rather than feeling forced into the situation.

Participants were very appreciative of the support afforded to them by members of the Nursing Education Team and their mentors/buddies, when they had them. The reaction of workplace staff was indeed mixed and signals as to whether and how wards/units had been prepared for participants' arrival and how much knowledge they had of the skills and capabilities of these nurses, who were extremely proud of their profession, their skills and their patient-centred orientation.

Even with the constraints of a single research site, a particular cohort of nurses and longitudinal methodology [e.g. attrition] we were able to generate a rich data source that provides a platform for future studies to draw upon. There is a need for development of an acculturation questionnaire that focuses on workplace experiences providing a clearer focus and which could indicate when extra pastoral care might be required.

And finally…

> '*I'm quite happy...at work now with my colleagues…I am quite good, because now I know how to do it. I know how to connect with the patients, with the relatives, how to speak to them, how to say, what to say, what not to say, how to do the things...Now they* [ward staff] *know me, they know the way I work and they trust me. They talk with me, they are joking with me and I'm fine...also with the HCA I have a good relation. They say 'I prefer to stay with you…you are good, I trust you. So I'm fine now*' (P01^{TP2})

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Appendix 1

Date 18.02.15

Magi Sque
University of Wolverhampton
Faculty of Education, Health & Wellbeing

Dear Magi Sque

Re: Home from Home?: A case study of the first year settlement Experiences of EU migrant nurses working in one NHS Trust.

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your submission**.**

On review your Research Proposal was passed and the Panel believes that the ethical issues inherent in your study have been adequately considered and addressed. Therefore the Panel is giving you full ethical approval for your study (**Code 1 - Approved**). We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – Ethics Panel

D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE, CPSYCHOL.
Chair – Ethics Panel

Appendix 2

The Royal Wolverhampton NHS
NHS Trust

9 March 2015

Research & Development Directorate
The Chestnuts
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 695065
Fax: 01902 695682

Professor M Sque
Professor of Clinical Practice and Innovation
The Royal Wolverhampton NHS Trust
New Cross Hospital
Wolverhampton
WV10 0QP

Dear Professor Sque

Research Project: Home from home? A case study of the first year settlement experiences of EU migrant nurses working in one NHS Trust
R&D Project No: 15NURS02

The above research project has been reviewed by the Trust through the Research & Development Directorate for R&D approval (NHS Permission).

All documents have been received including the approval letter from the main Research Ethics Committee and the Site Specific Information Form for the Trust.

Documents and Versions reviewed:

Document Name	Document Version	Date
Protocol	2	24 November 2014
Participant Information Sheet	2	9 March 2015
Consent Form	2	9 March 2015
Participant Invite Letter	2	9 March 2015
Reply Slip	2	9 March 2015
Interview Guide	1	2 June 2014
Questionnaire Demes Geeraert Scales	-	-
Questionnaire Post Interview	1	2 June 2014
Participant Thank You Letter	2	9 March 2015

Trust R&D Approval has been granted for the project on the following basis:

1. **Research Personnel Approved to Work on Project:**
   - Prof Magi Sque
2. **Research Specific Training:** As Dr Wendy Walker and Amanda Rodney have not provided evidence of GCP training to the R&D Directorate in time, unfortunately she will not be able to collaborate in this project until such evidence has been provided to the R&D Directorate and an Honorary Contract/Letter of Access has been issued by the Trust.
3. **Study Equipment:** Any loan equipment provided by the Sponsor must be registered with the R&D Governance Team.

4. **External Researchers:** If researchers are coming to conduct the research on Trust premises, a Letter of Access/ Honorary contract **must** be obtained prior to initiation of research on site. If researchers have not yet received a copy please contact the R&D Directorate in order for one to be issued as soon as possible. The department lead, where your research is to take place, will request evidence of a letter of access/ honorary contract signed by the R&D Directorate Manager being in place. If they do not hold a letter of access/ honorary contract they will not be insured.

5. **Amendments:** You are required to submit all amendments to the project, including the changed documents, notification of amendment form and REC approval letter (once received) to the R&D Directorate for approval. New versions of documentation can only be used once you have received notification from the R&D Directorate.

6. **Recruitment and Project Timelines** – Please provide the R&D Directorate with the following information to ensure that the Trust is fully compliant with Research Governance and DoH reporting:
   - The date of the Initiation Meeting
   - The number of subjects recruited into this project when we contact you.
   - When the project has closed to recruitment with final recruitment numbers
   - When the project has finished.

7. **Safety Reporting** – Please notify the Research & Development Directorate of any SUSARs (Serious Unexpected Suspected Adverse Reactions) within 24 hours of you becoming aware of the event, by sending a copy of the report form to the attention of R&D Governance Team, Research & Development Directorate.

8. **Monitoring Reports** – Please send a copy of the monitoring reports completed by the Sponsor monitor/ representative to the R&D Governance Team, to ensure compliance with research guidelines.

9. **Dissemination of Research Findings:** As with all NHS research, it is expected that the results of this project will be published in a reputable journal, may be presented at various meetings and will influence decisions on best practice. Please keep the R&D Directorate informed of any publications, presentations and how the results of this research have been implemented into practice once the research has finished.

On behalf of the Research & Development Directorate, I would like to wish you every success with your research project.

Best wishes

Yours sincerely

Sarah Glover
Research and Development Directorate Manager

c.c. Lynne Fieldhouse, Deputy Chief Nurse
Debbie Scriven, Clinical Trials Assistant, R&D

Appendix 3

Decision of Faculty of Education, Health and Wellbeing
Research Ethics Sub-Panel

Date: 30/4/15

Dear Magi

Re ethics proposal titled: Home from home?: A case study of the first year settlement experience of EU migrant nurses working in one NHS Trust

Thank you for notifying the Committee about your request for minor amendments to your research. I understand that you now wish to extend the research to interview two members of the RWT Academy who are responsible for setting up the induction programme for EU nurses. I can confirm that there is no need for these changes to be submitted for formal review, we have made note of this on our records and you can go ahead with these amendments.

Thank you for notifying the Committee I hope these needed changes will help to inform your research.

Yours Sincerely

H. Paniagua and *D. Chadwick*

Chairs of FEHW Research Ethics Sub-Panel

Appendix 4

Professor Linda Lang PhD
Dean of the School of Health and Wellbeing
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Telephone Codes
UK: 01902 Abroad: +44 1902

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Internet: www.wlv.ac.uk/shaw

Research Participant Consent Form

Study No:
REC Reference Number:

Study Title: Home from home?: A case study of the first year settlement experiences of EU migrant nurses working in one NHS Trust.

Please initial box

I confirm that I have read and understood the Information Sheet Version dated 29/09/2014 Version 1 for the above study. I have had the opportunity to consider the information, and have had the opportunity to ask questions have had these answered satisfactorily.

Yes ☐

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason.

Yes ☐

I agree that anything I may say during the course of the interview may be used as anonymous quotes in any presentation of the research (verbal presentation or written publication).

Yes ☐

I agree to take part in the above study and to the interview being audio-recorded.

Yes ☐

Name of Participant Date and signature

Name of Researcher Date and signature

---

1 copy to remain with Participant, 1 copy for Researcher

Version 1, 02/06/14

Appendix 5

(Insert address and date)

Professor Linda Lang PhD
Dean of the School of Health and Wellbeing
Mary Seacole Building
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Telephone Codes
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Internet: www.wlv.ac.uk/shaw

Participant Thank you Letter

Study No:
REC Reference Number:

Study Title: Home from home?: A case study of the first year settlement experiences of EU migrant nurses working in one NHS Trust.

Dear [name with appropriate title]

This letter is to say a personal thank you for sharing your experiences, which concerned your settlement experiences with me, and for so generously giving up your time.

The Research Team would be grateful for some feedback on your impression of the interviews. It would be helpful to know your feelings about what it was like to take part in the research.

I have sent two copies of the Post interview questionnaire. Could you please return one to Professor Sque with your comments, the other is for you to keep. I have enclosed a stamped, addressed envelope for your reply.

I would like to take this opportunity to thank you, once again, for all your help.

Kind regards

Name Researcher

Version 1, 02/06/14

Appendix 6

Professor Magi Sque
University of Wolverhampton
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Internet: www.wlv.ac.uk/shaw

Study No:

REC Reference Number:

Study Title: Home from home?: A case study of the first year settlement experiences of EU migrant nurses working in one NHS Trust

Dear

I am a Professor in Clinical Practice and Innovation, based in the Centre for Health and Social Care Improvement at the University of Wolverhampton. I am writing to request your participation in a research project.

The Research Team has been funded by Health Education England (North West) to carry out research into the 12-month settlement experiences of EU nurses recently arrived in Wolverhampton and working at the Royal Wolverhampton NHS Trust. By learning about what you experience we hope to find out more about the practical and psychosocial supports that enhance your settlement experiences and adjustments to working in The Royal Wolverhampton and the NHS and any met/unmet needs you may have. We are therefore asking you to share your experiences and any issues of concern related to your settlement.

The aims of the research are detailed in the enclosed Participant Information Sheet. We would be grateful if you would read this information before deciding whether you would be willing to participate in this research. The Information Sheet also outlines what your role in the research would be, if you agree to participate.

I am happy to speak with you, to answer any questions you might have, before you make up your mind. My contact details are above and included in the Information Sheet. If you would like to know more about the Researchers you can access this information via the University of Wolverhampton, Centre for Health and Social Care Improvement website:
http://www.wlv.ac.uk/default.aspx?page=10071

If you are willing to participate, please complete and return the enclosed Reply Slip within the next 7 days, either in the prepaid envelope, or reply by email to m.sque@wlv.ac.uk

On receiving your Reply Slip, a researcher will contact you to make the necessary arrangements.

Thank you for taking the time to read this letter.

Kind regards

Professor Magi Sque
Principal Investigator

Version 1, 02/06/14

Appendix 7

Professor Magi Sque
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Research Participant Information Sheet

Study No:
REC Reference Number:

Study Title: Home from home?: A case study of the first year settlement experiences of EU migrant nurses working in one NHS Trust

This information sheet explains the purpose of the study, why we are asking you to take part, and what is involved. Please read this and discuss it with others if you wish. Please take time to decide whether or not you want to take part. We will be very happy to explain anything that is not clear.

What is the purpose of the study?
The overall aim is to gain insight and understanding of EU migrant nurses' experiences of settlement into the community, and employment in the NHS during their first year in Wolverhampton. The information gained from your experiences will help to inform planning and policy aimed at developing effective services that meet the needs of participants and provides an unprecedented opportunity to add to the much needed national body of knowledge. It is important for UK nursing administrators to understand, in the light of increasing migration from EU countries the migration and settlement experiences of migrant nurses, to facilitate clement and effective adjustment to their new work environments.

Who is running the study?
This research project is being carried out by a team of researchers based in the Centre for Health and Social Care Improvement (CHSCI) at the Faculty of Education, Health and Wellbeing, the University of Wolverhampton. The research is funded by Health Education England. Approval to conduct the study has been granted by the Royal Wolverhampton NHS Trust Research and Development Directorate.

Why have I been chosen for this study?
You have been chosen to take part in this study because you are a nurse recently arrived from mainland Europe to work at the Royal Wolverhampton NHS Trust. By sharing your experiences you could help us to further understand the needs of EU migrant nurses and how best to provide settlement care and support.

Do I have to take part?
No, it is your choice whether you would like to take part. You are under no obligation to do so. It is something you may want to discuss with your family or friends. If you agree to take part you can withdraw at any time without giving a reason.

What would happen to me if I take part?
We are asking you to share your experiences over 12-month of settlement in the community of Wolverhampton and at the Royal Wolverhampton NHS Trust. This would be done through 4 serial interviews with a researcher (at six weeks, 4 months, 8 months and 12 months). The interviews would be carried out at a time and place convenient to you and the researcher. The first interview will be conducted face to face and three subsequent interviews may be face-to-face or over the telephone, as you prefer. The researcher would explain the study before starting the interview and you would have the opportunity to ask questions. We will then ask you to sign a consent form to show that you have agreed to take part in the study. Your continuing consent will be affirmed verbally at each subsequent interview. You would be given a copy of the signed Consent Form. The interview would be audio-recorded to provide an accurate record of the experiences you share with us. At each interview we will also ask you to complete a questionnaire about the cultural aspects of your settlement.

During the interview we will discuss with you:
- your life and work in your home country
- the nature and meaning of the migration experience for you and your significant others
- 'push' 'pull' factors that motivated you to seek employment at the Royal Wolverhampton NHS Trust.
- expectations of the community and employment and whether these are being met.
- enablers and blockers to settlement either social or employment based.
- key motivators to your retention.
- any life enhancing factors that may add to your quality of life

The interviews are expected to last no longer than two hours. However if you wish to take a break or to finish the interview at any point, you only need to tell the researcher and do not need to give reasons for stopping the interview.

Interviews can be emotionally tiring and we recommend have someone whom you can talk to afterwards. The researcher's contact details are given at the end of this information sheet should you wish to contact her after the interview has taken place.

Would my taking part in this study be kept confidential?
Anything you say would be treated as confidential. All information collected would be kept in the strictest confidence. Your name is not recorded anywhere within the study and no individual would be identifiable from the published results.

After the interview
After the interview the audio-recording will be listened to and the information in it transcribed. The transcription of the interview will then be analysed by the researchers. Audio-recording will be retained for a minimum of two years in accordance with University of Wolverhampton regulations and then destroyed. The questionnaire will be analysed using statistical measures and the information interwoven with the qualitative findings to produce a full account of participants' experiences.

You will receive a thank you letter from the Research Team when the interview sequence is completed. We will also ask you to fill in a short questionnaire in which we ask you to give us some feedback about your experience of being involved in the interviews; after interview 1 and 4. This feedback also acts as a development tool for the researchers. As appreciation of your participation we will be happy to provide you with a summary of the research at the completion of the study.

Complaints about any aspect of this project should be addressed to:
Professor Linda Lang
Dean, Faculty of Education, Health and Wellbeing
Mary Seacole Building
University of Wolverhampton
Direct Dial: 01902 51 8623
Fax: 01902 51 8660
E-mail L.Lang@wlv.ac.uk

Contact for further information

If you would like to discuss anything or have further questions at any time, please contact Prof. Magi Sque, Principal Investigator to the project.
Professor Magi Sque
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Centre for Health and Social Care Improvement
Faculty of Education, Health and Wellbeing
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Thank you for taking the time to read this information.
This Information Sheet is for you to keep.

Version 1, 02/06/14

Appendix 8

Professor Magi Sque
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Internet: www.wlv.ac.uk/shaw

Reply Slip

Study No:
REC Reference Number:

Study Title: Home from home?: A case study of the first year settlement experiences of EU migrant nurses working in one the NHS Trust

I am willing to talk to about my experiences in a face-to-face or telephone interview

Your name: Please print .....

Signature: .....

Your telephone contact number: .....

Your email address: .....

Your postal address: .....

.....

.....

.....

Best time to contact you and preferred contact method [e.g. Telephone or Email?]:

.....

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Appendix 9

TP1 Interview guide

Focused on Participant background; Motivation to migrate; Decision-making process around migration; Expectations; Settlement experiences so far; Closing

Participant background:

- Tell me a little about: your everyday life in (home country); your working life. (prompts: family life, living arrangements, urban rural settings, social activity, nursing qualifications, employment arrangements)

Motivation to migrate:

- What motivated you to seek employment at the Royal Wolverhampton NHS Trust?

Decision-making process around migration:

- How did you arrive at your decision to move to UK?

- Tell me about the recruitment process:
  - What information did you receive at recruitment? (prompts: the processes and timelines involved in the relocation to UK, NMC, Housing, National Insurance Applications, Bank Accounts)
  - Is there further information you would have liked before making your decision?
  - How did you feel about the information provided by the Trust?
  - Would this have influenced your decision-making?
  - What needs (if any) did you have at the time of making your decision?
  - Were these needs met?
  - What about your needs following your decision?

- What else did you consider prior to a move to UK?

  - Did you have to make any special arrangements to organise family life?
  - Did you feel there was anything to lose?
  - What did you hope to gain?

Expectations:

- How did you imagine a nursing job in the UK?
- What were your expectations of the community of Wolverhampton?
- What were your expectations of your job, of your colleagues?
- In what way have these expectations been met/not met?

Settlement experiences so far:

- What was your first day here like?
- What was surprising, interesting, significant, frustrating about that first day?
- Tell me about your settlement experience so far:
- What could the Trust have done differently to make the move to UK easier for you?
- How do you feel about the facilities that were provided for you?
- How do you feel about your six-week induction programme? (too long, too short, just right, benefits if any, what could be done differently)
- How did you feel hospital staff treated you?
- What has helped you the most during your settlement experience so far?
- Have there been any concerns?

Closing questions

- How did you feel about receiving a letter inviting you to participate in this study?
- Did you discuss your participation in this interview with anyone else?
- Is there anything else you would like to tell me about your initial experience about settlement and employment in UK?

Appendix 10

TP2 Interview guide

Introduction
Welcome back and thank you for coming.
Reaffirm consent

1. How have you been since we met at the first interview?
2. How are you settling in now? Are there any issues or concerns? If so...
3. Social life - Any UK visits/holidays/home visit?
4. Work life - Are there any changes to where you are working at the Trust?
5. Have you used your diary?
    - If yes, in what ways?
    - If no, any particular reasons for non-use?

Introduce the focus of this interview: To explore your experience as a new starter in the workplace.

- Can you tell me a little bit about the ward/department/environment where you work?
- How are you settling in right now?
- Did you work in this kind of nursing before coming to the UK?
- Did the induction programme prepare you fully for the workplace? Yes/No
- Yes: How did the induction programme prepare you?
- No: What more could have been done to prepare you for the workplace?
- What is your opinion about the induction to the ward/department/environment by the staff where you work?
- What was it like to join a new workplace team?
- How were you made to feel?
    - By staff
    - By patients
- What has been your experience of having a mentor/buddy/preceptor been? Can you tell me about their role in supporting you?
- Was/is mentorship helpful to you? In what ways?
- What patient care duties have you carried out since starting to work in this area?
    - Management duties
    - Administrative duties
- Are these duties similar to what you would expect to do as a professional nurse in your home country?
- Have you received any training since starting to work in this area?
- Do you have any outstanding training needs?
- Is there anything else you would like to share about your experience as a newcomer in the workplace?

Appendix 11

TP3 Interview guide

Introduction

1. Welcome back and thank you for coming.
2. Reaffirm consent
3. How have you been since we met at your second interview?

Introduce the focus of this interview: To explore your settlement experiences at nine/10 months.

- How do you feel now about living in England?
- How do you feel about living in Wolverhampton?
- Have your impressions of the city changed?
- How satisfied are you with your living conditions?
- Have there been any changes in your living arrangements since we last met?
- How would you describe your social life: (Prompts if needed: active, quiet, boring, busy)
    - What are the reasons you feel that way?
    - Have you made English friends?
- How do you feel about returning to UK after visits to your home country?
    - Is there anything you miss about your home country?

Explain that the next part of the interview will focus on work life. Ask the participant if they can share experiences of their work life when responding to questions.

(If examples are not naturally forthcoming, ask the participant if they are able to provide an example from practice)…

- How do you feel about your work life now?
- What makes you feel that way?

Either way, do you have any issues or concerns about your work life? If so what?...

Do you feel supported in the workplace? If yes...

- In what ways and by whom?
- If no...
- What kind of support would be helpful?

Have you joined any nursing organisations other than NMC?

- If so what and why?

Do you feel part of the nursing community at the Royal Wolverhampton NHS Trust?

Do you have any outstanding training needs? If so what?

Is there anything that the workplace could do to improve your settlement experience?

Is there anything else you would like to share about your experiences?

Plan for February interview.

Appendix 12

TP4 Interview guide

For this fourth and final interview participants were encouraged to review and discuss their information collated over the three preceding interviews. They were asked to reflect on their year of settlement in the UK and working in the NHS. Key points of exploration were:

1. If you were to give advice to other nurses planning to come to the UK, what would be your top three suggestions?

2. Reflecting on your year in the workplace, what three things would have made your adaptation/adjustment to work easier?

3. Reflecting on your first year in the UK, what three things would have made adaptation/adjustment to living and social life easier?

4. Why are you still working RWT when so many of your cohort have left?

5. What are your plans for the future?

Appendix 13

Acculturation Measures
[Demes & Geeraert, 2014]
- English version –

Brief Sociocultural Adaptation Scale

Instructions: Think about living in *England.* How easy or difficult is it for you to adapt to:

Anchors:
1 very difficult
2 difficult
3 somewhat difficult
4 neither
5 somewhat easy
6 easy
7 very easy

Items:

☐ **climate** (temperature, rainfall, humidity)

☐ **natural environment** (plants and animals, pollution, scenery)

☐ **social environment** (size of the community, pace of life, noise)

☐ **living** (hygiene, sleeping practices, how safe you feel)

☐ **practicalities** (getting around, using public transport, shopping)

☐ **food and eating** (what food is eaten, how food is eaten, time of meals)

☐ **family life** (how close family members are, how much time family spend together)

☐ **social norms** (how to behave in public, style of clothes, what people think is funny)

☐ **values and beliefs** (what people think about religion and politics, what people think is right or wrong)

☐ **people** (how friendly people are, how stressed or relaxed people are, attitudes towards foreigners)

☐ **friends** (making friends, amount of social interaction, what people do to have fun and relax)

☐ **language** (learning the language, understanding people, making yourself understood)

Brief Psychological Adaptation Scale

Instructions: Think about living in England. In the last 2 weeks how often have you felt:

Anchors:
1 never
2 very rarely
3 rarely
4 sometimes
5 frequently
6 usually

Items:

☐ excited about being in *England*

☐ out of place, like you don't fit into English culture

☐ sad to be away from [home country]……

☐ nervous about how to behave in certain situations

☐ lonely without your [home country]……. family and friends around you

☐ homesick when you think of [home country]……...

☐ frustrated by difficulties adapting to *England*

☐ happy with your day to day life in *England*

Brief Perceived Cultural Distance Scale

Instructions: Think about [home country name]…….. and England.
In your opinion, how different or similar are these two countries in terms of:

Anchors:
1 very similar
2 similar
3 somewhat similar
4 neither

Items:

☐ **climate** (temperature, rainfall, humidity)

☐ **natural environment** (plants and animals, pollution, scenery)

☐ **social environment** (size of the community, pace of life, noise)

☐ **living** (hygiene, sleeping practices, how safe you feel)

☐ **practicalities** (getting around, using public transport, shopping)

☐ **food and eating** (what food is eaten, how food is eaten, time of meals)

☐ **family life** (how close family members are, how much time family spend together)

☐ **social norms** (how to behave in public, style of clothes, what people think is funny)

☐ **values and beliefs** (what people think about religion and politics, what people think is right or wrong)

☐ **people** (how friendly people are, how stressed or relaxed people are, attitudes towards foreigners)

☐ **friends** (making friends, amount of social interaction, what people do to have fun and relax)

☐ **language** (learning the language, understanding people, making yourself understood)

Brief Acculturation Orientation Scale

Instructions: Think about being in *England.* How much do you agree with the following sentences? When in *England,* it is important for me to…

Anchors:
1 strongly disagree
2 disagree
3 somewhat disagree
4 neither
5 somewhat agree
6 agree

Items:

☐ have [home country adjective]…….. friends

☐ take part in [home country adjective]…….. traditions

☐ hold on to me [home country adjective]…….. characteristics

☐ do things the way [home country adjective] …….. people do

☐ have *English* friends

☐ take part in *English* traditions

☐ hold on to (or develop) my *English* characteristics

☐ do things the way *English* people do

Reference: Demes K.A. and Geeraert N. (2014) Measures matter: Scales for adaptation, cultural distance and acculturation orientation revisited. *Journal of Cross-Cultural Psychology,* 45, 91-109.

Appendix 14

Post interview questionnaire

1. Did you feel that you were able to cope with the length of the interview/s?

Yes, quite easily ☐

Only just ☐

No ☐

2. Did you find talking to the researcher in the interview/s helpful?

Yes, very helpful ☐

Yes, a little ☐

No ☐

3. Did you feel the interview/s caused you distress?

Yes, a lot ☐

A little ☐

No ☐

4. Did you feel that the researcher was understanding during the interview/s?

Yes, very understanding ☐

Yes, a little ☐

No ☐

5. Did you find it easy to talk to the researcher during the interview/s?

Yes, very easy ☐

Difficult at times ☐

Extremely difficult ☐

Please add any further comments you may have.

Thank you for completing the questionnaire.

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