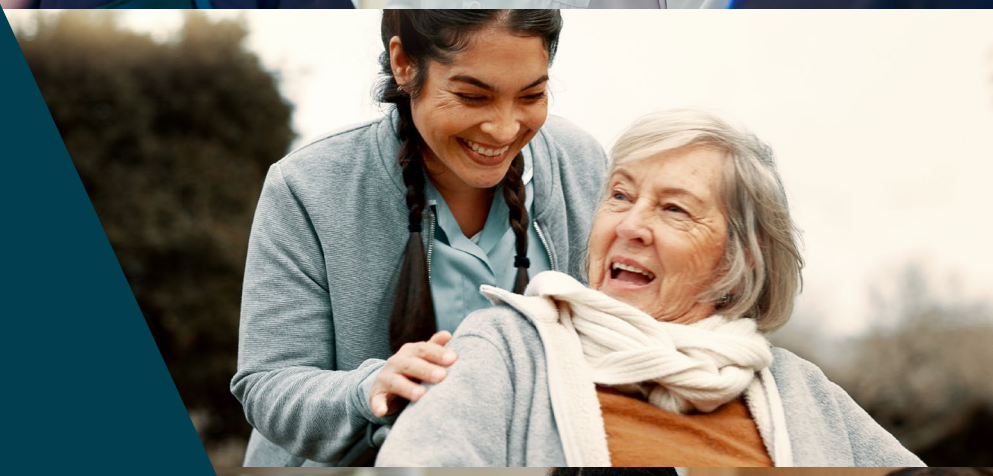
FLORENCE NIGHTINGALE FOUNDATION











Global talent, local impact

Retaining excellence, developing leaders and learning from the internationally educated nurse and midwife workforce.

Maranda Wheelock, Raluca Oaten, Lisa Plotkin and Adam Cunliffe

November 2026

Acknowledgements

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A note on terminology

There is no single agreed term for nurses and midwives who completed their initial professional education outside the UK. Across policy, research and practice, terms including **internationally educated, internationally trained, overseas qualified and internationally recruited** are used, sometimes interchangeably, although they describe different things and carry different connotations.

Language is also contested within the workforce itself. For some, identifying internationally educated nurses and midwives as a distinct group is necessary because it makes shared experiences, including transition into UK systems and non-recognition of prior expertise, visible. For others, continuing to apply an international label many years after someone has settled and built a career in the UK risks reinforcing a sense of difference or othering.

Having considered these issues, this report uses internationally educated nurses and midwives (IENMs). We use **educated** because the distinguishing characteristic for this project is where a person's initial professional nursing or midwifery education took place, rather than how they were recruited, their nationality or their current immigration status. It also places professional education and expertiseat the centre of the description.

For the purposes of this report, **IENMs are Nursing and Midwifery Council (NMC) registrants who obtained their initial nursing or midwifery qualification outside the UK,** including those who have subsequently undertaken further education, training or professional development within the UK.

This definition also establishes important boundaries. IENMs are a distinct group from colleagues in the global majority or Black and Minority Ethnic (BME) communities, although there is considerable overlap between them. Not all IENMs identify as part of these groups, but where they do, experiences can intersect and barriers may be compounded. This distinction is important to ensure that the specific challenges faced by IENMs are recognised in their own right, while also acknowledging where they intersect with those experienced by global majority and BME colleagues.

The study also does not include those working in the UK without NMC registration, including those working in support roles or awaiting registration. Evidence points to serious risks of recruitment and employment exploitation within parts of this workforce. Their experiences are important and urgent, but distinct from the questions examined here, and the findings of this study should not be generalised to them.

Two further terms are used throughout the report:

Diaspora communities

Defined here as individuals and communities sharing a country or region of origin, heritage or identity who are now living in the UK. Diaspora communities may include both internationally and UK-educated nurses and midwives, and participation in or identification with a diaspora community is not assumed simply because somebody is internationally educated.

Pastoral support

Defined here as the practical, emotional, social and wellbeing support provided before, during and after transition into UK systems and working life. This may include support with accommodation and finances, cultural adjustment, family wellbeing, psychological support, community connection and navigating everyday life alongside professional induction and transition.

Executive Summary

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About this report

Internationally educated nurses and midwives (IENMs) bring substantial qualifications, professional experience and international expertise to the UK nursing and midwifery workforce, but this contribution is not consistently recognised, developed or utilised. This report looks at the IENM experience across the whole professional journey — from transition into UK practice through workplace culture, career progression and retention — rather than examining a single stage in isolation. It treats IENMs as a diverse rather than homogenous group, with particular attention to how experience differs by ethnicity and by arrival cohort — from IENMs who registered before 2000 through to recent arrivals. This allows the report to show where conditions have genuinely improved over time, and where they have not, and for whom.

The findings are drawn from a UK-wide survey of 1,120 IENMs, undertaken by the Florence Nightingale Foundation (FNF) to understand how the UK can better retain, develop and learn from its IENM workforce. FNF is particularly well placed to undertake this work: 55% of our alumni community are IENMs, and we have a growing track record of IENM-focused research and policy work, including NMC-commissioned research on additional advanced practice regulation.

This report reflects FNF's wider approach to policy: listening to and learning from the voices and experiences of nurses and midwives themselves. Together, this experience provides a strong foundation for identifying where action is needed across regulation, employment, education and workforce planning to better support IENMs and strengthen their contribution to the UK workforce.

IENMs arrive with substantial qualifications and experience

IENMs are a highly qualified and experienced workforce. **97% held either a diploma or bachelor's degree,** while one-third held at least one specialist or additional qualification, including 11% with a Master's degree (n=1,120). Almost half (46%) had **at least seven years of qualified experience before moving to the UK,** including 28% with more than ten years (n=1,120). Among midwives, this rose to 33% (n=121).

Transition into UK practice remains challenging

Despite their existing expertise, transition into UK practice can be difficult. **85% reported cultural or workplace differences,** while 51% experienced a lack of recognition of previous experience or qualifications and 49% reported communication or language barriers (n=1,102). Racism, discrimination and bias are also a significant part of the transition experience. **41% of IENMs experienced racism, discrimination or bias when they began working in the UK (n=1,102), rising to 56% among Black IENMs (n=339).** Importantly, there was no discernible decline across registration cohorts spanning two decades.

These findings suggest that transition cannot be understood simply as an administrative or professional registration process. The experience of entering UK practice is also shaped by workplace culture, recognition of previous expertise and inclusion.

Structured support for IENMs has improved, with opportunities for better tailoring

There are signs of progress in structured support for IENMs. **72% received a full induction (n=1,102),** although provision varied between sectors, with 74% of NHS respondents (n=992) and 45% of those in social care (n=80) reporting a full induction. Preceptorship provision also increased substantially, from **43% among the earliest arrival cohort (n=70) to 77% among recent arrivals (n=472).**

However, increased provision does not necessarily mean that support is appropriately tailored to IENMs. Among recent arrivals, only **25% felt that their previous experience was completely taken into account during preceptorship (n=365).**

Revalidation was a relative strength: 77% felt at least somewhat supported by their employer and 76% rated their most recent revalidation positively (n=676).

The findings indicate that the infrastructure around IENM transition is developing, but there is still more to be done to move beyond helping IENMs adapt to UK practice towards recognising, assessing and building on the expertise they already possess.

Career progression and inclusion remain significant concerns

The challenges extend beyond initial transition. **One in three IENMs (34%) had never been promoted (n=1,102),** including one in five (21%) of those with at least ten years' UK experience (n=407).

There are also stark racial inequalities. Among IENMs with at least ten years' UK experience, **28% of Black (n=86) and 24% of Asian respondents (n=221) had never been promoted, compared with 5% of White respondents (n=79).**

Recognition of existing expertise is similarly limited. Only **38% felt their qualifications, experience and skills were fully or mostly recognised (n=1,102),** falling to 29% among Black IENMs (n=339) and 30% among midwives (n=98).

Only 25% felt included in their organisation's talent and leadership pathways, while 45% felt neutral and 30% did not feel included (n=1,102).

Psychological safety also varies depending on who IENMs are speaking up for. **Fewer than seven in ten (69%) felt consistently safe and supported to raise concerns about a patient or service user, and fewer than half (46%) felt able to do so about themselves or a colleague (n=1,102).** Black IENMs were least likely to feel safe speaking up in both contexts: 67% felt safe raising concerns about a patient or service user, while 31% felt safe doing so about themselves or a colleague (n=339).

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These findings point to a broader issue of workplace inclusion and progression, rather than a challenge confined to the point of entry into the UK workforce.

IENMs' international expertise is an underused workforce asset

IENMs bring knowledge and skills developed through their professional experience overseas. **87% drew on this international expertise in clinical practice and patient care,** while 65% used it in patient safety and quality improvement and 65% used it in education, training and knowledge sharing (n=1,101). **Yet 45% were never asked to share their international knowledge or experience (n=1,101).**

Global health partnerships are another missed opportunity: **79% wanted to participate, but only 3% had done so (n=1,101).** 58% said participation in global health partnerships would increase their motivation to stay in the UK, and 72% said it would increase their sense of belonging (n=1,101).

Diaspora communities are also an under-recognised asset. Only 19% felt their contribution was recognised well or very well, while 36% rated recognition as poor or very poor (n=548). Analysis of the NHS England Small Grants Programme shows their contribution in practice, with associations supporting IENMs through transition, pastoral and peer support, clinical readiness and digital resources.

Workplace experience has implications for retention

A significant minority of IENMs are considering leaving nursing or midwifery or moving abroad to practise. **16% intended to leave the profession within three years,** while 26% intended to move abroad to practise and 14% already had an application pending (n=1,102).

The strongest reported reasons for leaving the profession were **burnout and stress (59%),** workload and staffing (53%), racism or discrimination (44%) and bullying (28%) (n=174). In contrast, passion for the profession (53%), professional pride (44%) and pay and financial security (44%) were among the strongest reasons to stay (n=927).

Importantly, the findings also identify practical areas where organisations may be able to influence retention. Comprehensive induction, pastoral support, preceptorship, revalidation support and recognition of prior experience were each associated with a lower intention to leave the profession.

What the findings mean

IENMs are an established and essential part of the UK workforce, but their expertise is not consistently recognised or utilised. While experiences have improved in areas such as transition support and preceptorship, persistent challenges around recognition, racism and discrimination, career progression and psychological safety continue beyond initial transition. The findings point to **a shift from supporting IENMs primarily to adapt to the UK system towards creating conditions in which their existing expertise can be recognised, developed and fully utilised.**

Considerable work is already underway across the UK to improve IENM experiences. The recommendations below are intended to strengthen existing approaches, address remaining gaps and help ensure progress reaches IENMs consistently across professions, sectors and career stages.

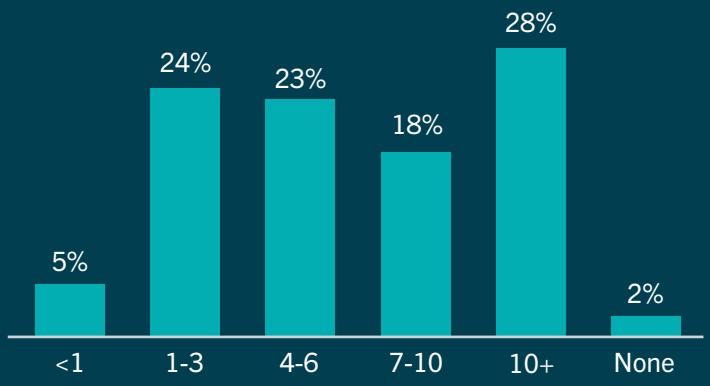
Recommendations

The findings point to a range of priorities for action, spanning regulators, employers, education providers, national workforce planners and FNF itself:

- **Clearer regulatory guidance from the NMC,** including IENM-specific resources on reflective practice, stronger links between preceptorship and revalidation, and clearer routes for recognising overseas qualifications and experience.
- **Better recognition of prior learning and experience,** with HEIs, employers and regulators avoiding unnecessary repetition of training where international qualifications or experience can be assessed for equivalence.
- **Stronger induction, preceptorship and transition support,** especially for IENMs outside the NHS and experienced recruits who may not currently receive structured support.
- **More active support for career progression and leadership,** including sponsorship into leadership roles and embedding IENM inclusion into national leadership programmes and workforce plans.
- **Sustained system-level infrastructure,** so that support for IENMs is embedded in commissioning, regulation, workforce planning and inspection frameworks, not lost between recruitment cycles.
- **Greater investment in global health and diaspora partnerships,** recognising diaspora associations as delivery partners and global health activity as part of professional development and retention.
- **Specific action across the four UK nations,** ensuring workforce strategies in England, Scotland, Wales and Northern Ireland address the existing IENM workforce, not just future recruitment.
- **FNF-specific commitments, including a dedicated IENM progression programme,** naming anti-racism within leadership development, monitoring differential attainment, and ensuring IENM representation in advisory structures.

Key Findings

IENMs arrive with substantial experience

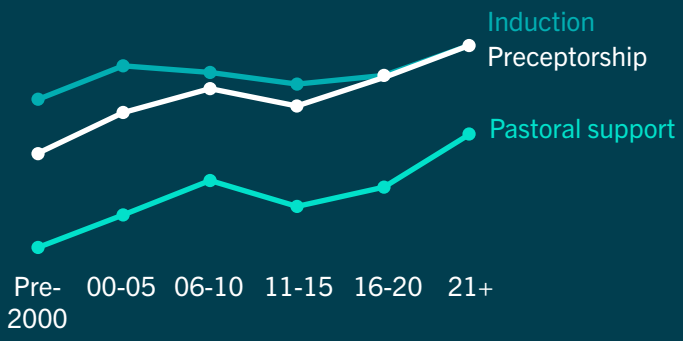


Nearly half of IENMs (46%) arrived in the UK with

7+ years

of qualified nursing or midwifery experience in their home country (n=1,120).

Structured support has improved over time

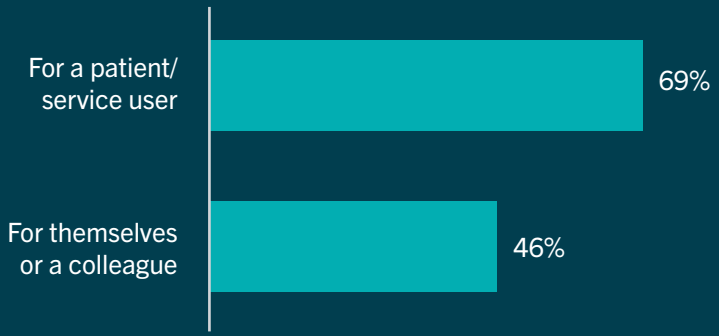


Preceptorship provision rose from

43% to 77%

between the earliest and most recent arrival cohorts (n=70 vs n=472).

Psychological safety depends on who IENMs are speaking up for



69% felt consistently safe raising concerns about a patient or service user, and

46%

felt able to raise concerns about themselves or a colleague (n=1,102).

Key Findings

Transition challenges have not eased in 20+ years

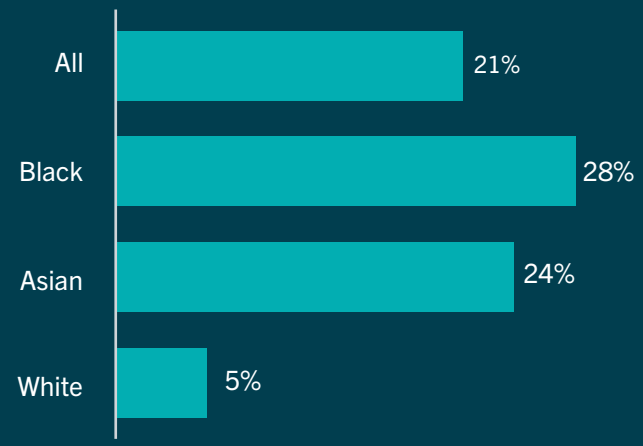


Cultural or workplace differences has been the top reported challenge for every arrival cohort since

pre-2000

— consistently around 85%, with no real improvement over two decades. Recognition of prior experience, communication and racism/discrimination remain common too (41–51%) (n=1,102).

Career progression remains uneven

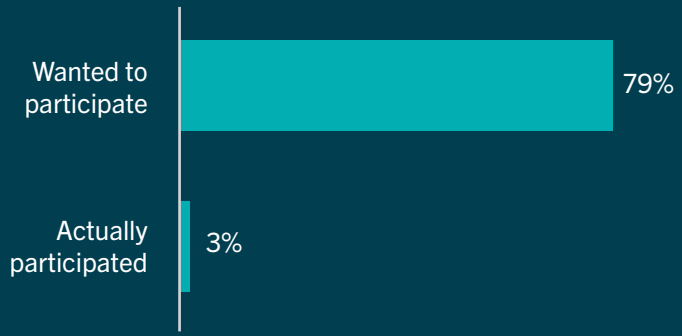


Among IENMs with 10+ years' UK experience,

1 in 5

had never been promoted — rising to more than 1 in 4 Black IENMs (n=407).

International expertise is an underused asset



79% of IENMs wanted to take part in global health partnerships, but only

3%

had actually done so — despite this being linked to greater motivation to stay (58%) and a stronger sense of belonging (72%) (n=1,101).

Foreword

At the Florence Nightingale Foundation (FNF), our mission is to support nurses and midwives to stay, thrive, lead and transform. This mission is especially relevant to internationally educated nurses and midwives (IENMs), who have long been central to the UK's health and care workforce.

From the Windrush generation to the present day, IENMs have brought clinical expertise, cultural insight and lived experience that have strengthened services and improved care. They are also a large and growing part of the FNF community. More than 3,000 IENMs have completed an FNF programme in the past five years, which reflects the ambition and leadership potential within this workforce.

Health and care are going through a period of significant change, and IENMs' voices risk being overlooked. As policy focuses increasingly on domestic supply, we cannot afford to neglect the hundreds of thousands of internationally educated professionals who are already here, already committed and already contributing.

To understand their experiences, FNF commissioned an independent evidence review and surveyed more than 1,100 IENMs across all four UK nations.

We also brought together diaspora leaders, employers, educators and IENMs themselves. They told us that barriers too often build on one another. Expertise is undervalued, racism and discrimination persist, progression stalls, and many consider leaving the profession or the UK.

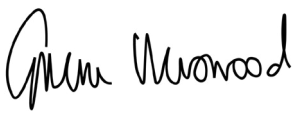
The report also shows that change is possible. Across the UK, diaspora associations, peer networks, employers and leadership programmes are providing culturally aware support that helps IENMs navigate systems, build networks and progress. These approaches should be recognised as essential workforce infrastructure.

Florence Nightingale used evidence to expose inequity and push for reform, and we are following her example. Alongside this report, we are publishing interactive data tables to help leaders and decision-makers make the case for change.

We all have a role to play in pushing forward this agenda. This report sets out clear calls to action for regulators, educators, employers and governments across all four nations, and for FNF itself. We will act on the recommendations made to us, and we call on others to do the same.

The expertise and ambition of IENMs are already evident across our health and care systems. Our task now is to create the conditions in which that talent can thrive. The evidence is clear, and now we must act.





Professor Greta Westwood CBE, RN, PhD, FAAN

Chief Executive
Florence Nightingale Foundation



01. Introduction

Introduction

FLORENCE NIGHTINGALE FOUNDATION

Internationally educated nurses and midwives (IENMs) have been part of the UK health and care workforce since the foundation of the NHS, but recent years have seen international recruitment on an unprecedented scale. International entry to the Nursing and Midwifery Council (NMC) register began rising markedly from 2018–19, interrupted by the pandemic, before accelerating sharply again in the early 2020s[1] as international recruitment became an explicit and substantial component of workforce strategy across all four UK nations.[2,3,4,5]

By 2023–24, internationally educated professionals accounted for around half of all new joiners to the NMC register for the first time. As of March 2026, more than 212,000 internationally educated professionals were on the register, representing almost one in four of the registered nursing and midwifery workforce.[6]

That trajectory is now changing. In 2025–26, the number of internationally educated professionals joining the NMC register fell by 47% compared with the previous year, as greater emphasis on domestic workforce supply coincided with recruitment controls and wider restructuring across health and care.[7]

At precisely the same time, there are warning signs around retention. In 2024, the Health Foundation analysed applications to the NMC for Certificates of Current Professional Status (CCPS), which nurses need when applying to register and practise in another country.[8] It found that more than 12,400 UK-registered nurses applied for a CCPS in 2022/23 – four times the number in 2018/19 – with internationally educated nurses accounting for seven in ten applications. Particularly striking was the growth in applications from internationally educated nurses who had only been on the NMC register for three years or less, suggesting that some recent recruits were already considering onward migration. While a CCPS application does not necessarily mean that an individual subsequently left the UK, it provides an important indicator of potential attrition.

The current shift has a historical precedent. Research on the nursing labour market has documented recurring cycles in which international recruitment expands when domestic supply falls short and contracts as workforce and financial circumstances change, only to then expand again when shortages re-emerge.[9] The early 2000s provide a particularly clear example: international recruitment was actively expanded as national policy to support rapid NHS workforce growth, before falling markedly from 2005 as financial pressures increased and staffing growth was curtailed. Analysis by the Migration Advisory Committee concluded that a lack of long-term strategic workforce planning had contributed to a "boom and bust" cycle in international nurse recruitment.[10]

This history matters now. A shift towards greater domestic workforce supply is both legitimate and necessary; sustainable health systems cannot depend indefinitely on recruiting from countries that may themselves face serious workforce shortages. But reducing future international recruitment does not diminish the responsibility to those the UK has already recruited, nor their importance to current services. Worryingly, we are seeing that now, as the infrastructure built rapidly during the recent expansion in international recruitment is beginning to recede. Dedicated international teams, transition support and centrally funded pastoral provision have reduced in some organisations and, in others, disappeared altogether.

The ethical challenge is therefore not only whether, when and from where the UK recruits, but what responsibilities follow once people have been recruited. International recruitment across the UK is governed by ethical principles intended to protect individuals and recognise the potential impact of recruitment on source countries.[11] These principles matter particularly in a global context in which workforce shortages are distributed profoundly unequally. They require recruitment to be fair, transparent and free from exploitation. Yet ethical recruitment cannot end when a nurse or midwife takes up their first UK post. It must also be reflected in what happens afterwards: whether previous expertise is recognised; whether people are supported to adapt without being deskilled; whether they have equitable access to education, progression and leadership; whether they are safe from racism and exploitation; and whether the knowledge and relationships they bring are valued.

That responsibility extends beyond the individual to the relationship between health systems. International recruitment creates connections between countries, and nurses and midwives educated overseas retain knowledge of, relationships with and often a strong commitment to the countries and communities in which they trained. Ethical workforce policy should therefore move beyond a one-directional model in which the UK recruits skills produced elsewhere. Reciprocal global partnerships offer a means of turning migration into continued exchange between health systems, supporting what is increasingly described as brain circulation rather than brain drain.

These questions also sit within a wider migration and immigration context that profoundly shapes the experiences and choices of IENMs. Visa conditions, routes to settlement, family migration rules and the relationship between immigration status and employment can affect wellbeing, mobility and decisions about whether to remain in the UK. Recent research has examined these issues in considerable depth, alongside concerns about >

recruitment fees, exploitation and the particular vulnerability that can arise where employment and immigration status are closely linked.[12]

This report does not seek to replicate that work. Instead, while recognising these wider structural influences, our primary focus is on the areas in which nursing and midwifery and the systems around the professions have direct responsibility and agency: how people are recruited and welcomed; whether prior expertise is recognised; how transition is supported; how organisations respond to racism and discrimination; who can access education, progression and leadership; and whether the international knowledge and relationships people bring are valued and used. The recommendations therefore concentrate on the practical changes that governments, the regulator, employers, educators and the professions can make.

What we already know

There is already a substantial body of evidence about the experiences of IENMs.[13] Research stretching back more than two decades has described adaptation to unfamiliar professional and organisational cultures, racism and discrimination, inconsistent induction and pastoral support, poor recognition of overseas qualifications and experience, and unequal access to career development and progression.

More recent work has added important depth. Research into the long-term career progression of international nurses working in the NHS has demonstrated slower and less frequent progression from Band 5 than among domestically educated nurses.[14] Stay and Thrive has identified the organisational behaviours and practices associated with more successful integration and retention, including social connection, mentorship and culturally informed support.[15] The Royal College of Nursing has documented racism, immigration pressures, exploitation and poor recognition of experience, and examined why internationally educated nursing staff may choose to leave the UK.[16] FNF research has identified particular barriers facing IENMs seeking to enter or continue advanced practice.[17]

An independent integrative review commissioned for this project reinforces that picture.[18] Across the studies identified in the review, internationally educated professionals were frequently found to arrive with considerable experience and ambition but encounter systems that did not fully recognise what they already knew. Discrimination, role downgrading, non-recognition of qualifications and experience, limited access to continuing professional development and inequitable promotion opportunities were recurrent barriers; culturally sensitive mentorship, supportive leadership, structured induction and peer networks repeatedly emerged as facilitators.

The problem, therefore, is not that nothing is known. It is that the evidence remains fragmented and uneven.

Much of the research examines particular stages of the internationally educated experience or specific workforce problems in isolation. Nurses working within the NHS dominate the evidence base. Internationally educated midwives are almost absent from the UK literature, and much less is known about IENMs working in social care, independent healthcare, higher education and other settings. Evidence across the four UK nations is also uneven. Relatively little research examines differences within the internationally educated workforce itself - by ethnicity, profession, country of education or training, sector or career stage - or asks whether experiences have changed across successive periods of international recruitment.

What this report adds

Global Talent, Local Impact was designed to provide a different kind of evidence. Rather than concentrating on one point in the internationally educated experience, the project looks across the professional journey: who nurses and midwives were professionally before coming to the UK; how they were recruited and prepared; their early experiences of UK practice; recognition of previous expertise; access to development and leadership; the contribution of international and diaspora knowledge; and, ultimately, the factors shaping whether they intend to remain in the profession and in the UK.

At its centre is a detailed survey completed by 1,120 NMC-registered IENMs, who answered more than 100 questions. Respondents worked across health and social care, across a range of sectors and settings, across all four UK nations, and included professionals who joined the NMC register across several decades. That breadth allows the analysis to move beyond treating IENMs as a single workforce. Where sample sizes permit, findings are examined by profession, ethnicity, country of education or training, UK nation, sector, band or equivalent and year of NMC registration. This enables the report to identify both widely shared experiences and differences that aggregate figures can obscure.

The granularity of the survey also allows the study to put numbers around phenomena that previous research has often identified qualitatively. Earlier studies have described internationally educated professionals being overlooked for promotion, having previous expertise discounted, experiencing racism or struggling to access development. This study helps establish how prevalent those experiences are, how they are distributed across different groups and how they relate to other parts of the professional journey.

A further distinctive feature is comparison between registration cohorts. This is not a longitudinal study and does not follow the same individuals over time. However, comparing the reported experiences of people who joined the NMC register in different periods provides an important lens on change. The policy, regulatory and migration environment encountered by someone joining before 2000 was very different from that experienced by someone recruited during the post-pandemic expansion. Recruitment routes and source countries have changed, as have the scale of recruitment, regulatory processes and the support infrastructure surrounding it. Cohort comparison therefore allows us to ask what appears to have improved, >

Introduction

what has changed, and what has persisted despite successive periods of policy attention and international recruitment.

Finally, the project is concerned not only with what the UK needs from IENMs, but what it can learn from and with them. It considers international expertise and diaspora networks as assets for leadership, patient and service-user care, workforce culture and global partnership, connecting the domestic workforce agenda with the wider ethical responsibilities created by international recruitment

The result is intended to be more than a description of problems. The recommendations draw together the survey findings, independent evidence review, stakeholder engagement, examples of practice, diaspora-led activity and the professional and lived expertise of IENMs themselves. They represent a practical response from within nursing and midwifery to issues that the evidence has identified over many years.

1.1 Project aims

The project is organised around three connected ambitions: to retain, develop and learn from internationally educated nurses and midwives across health and social care.

Retain. To better understand the factors influencing retention and workforce sustainability for IENMs across the UK, and to identify the changes needed at national, system and local levels to support them to remain, thrive and progress across diverse settings and sectors.

Develop. To explore the development opportunities, leadership aspirations and support needs of IENMs, including how organisations and systems can better recognise prior expertise, support equitable progression and strengthen access to leadership opportunities.

Learn. To understand how the global expertise, lived experience and international connections of IENMs and diaspora communities can contribute to more inclusive, sustainable and globally connected approaches to workforce development and reciprocal partnership.

1.2 About this report

The report findings are organised according to the following structure, to reflect the professional journey of IENMs:

Who took part describes the survey respondents.

Theme 1: Before arriving — professional lives and the journey to the UK examines respondents' qualifications, expertise and professional experience before migration; their motivations for coming to the UK; preparation and support before arrival; routes to NMC registration; and entry into the UK workforce.

Theme 2: Early experiences explores the first period of UK practice, including workplace and cultural transition, racism and discrimination and revalidation.

Theme 3: Development opportunities examines access to learning and continuing professional development, recognition of qualifications and experience, career progression, leadership aspirations and opportunities, and psychological safety.

Theme 4: Learning and global partnerships turns the conventional lens around, examining what UK health and care can learn from internationally educated professionals.

Theme 5: Retention examines respondents' intentions to remain in the nursing or midwifery profession and the UK, the reasons for leaving, and the factors associated with greater or lower intention to leave.

The Discussion draws the findings together and considers their implications for workforce policy and professional practice.

The Conclusion and Recommendations set out actions for governments, regulators, employers, educators, professional organisations and FNF.

1.3 Methodology

This report draws on a mixed-methods design combining a UK-wide survey of IENMs, an independent integrative review of UK evidence and structured stakeholder engagement. A fuller account of project design, governance, analytical methods, ethics and limitations is provided in the Appendices.

Survey

The survey was open to NMC-registered nurses and midwives whose initial nursing or midwifery qualification was obtained outside the UK, as well as members of nursing and midwifery diaspora communities.

In total, **1,120 respondents** completed the full survey and were included in the analysis. Participation was voluntary and informed, and survey data were managed in accordance with relevant data protection requirements.

Quantitative responses were analysed descriptively and, where sample sizes supported meaningful comparison, examined across characteristics. Statistical testing was used for selected comparisons in accordance with the analytical thresholds set out in Appendix 2. Free-text responses were analysed thematically and are used throughout the report to deepen interpretation of the quantitative findings and retain respondents' own explanations and experiences.

Independent evidence review

An independent integrative review examined peer-reviewed UK literature published between 2000 and 2025 on the experiences, integration, retention and career progression of IENMs. Thirteen studies met the final inclusion criteria. The review provides the scholarly context for the primary research and its methodology is reported in more detail in Appendix 2.

Supporting evidence and stakeholder engagement

The project also draws on case examples from across the health and care system, evidence from diaspora association activity and insight from Florence Nightingale Foundation >

Introduction

leadership programmes. Stakeholder engagement with IENMs, diaspora leaders, employers, educators and workforce and professional leaders was used to test and contextualise emerging findings. Dedicated engagement with respondents working in higher education and Northern Ireland was used to contextualise findings where survey samples were below the threshold for statistical comparison.

1.4 How to interpret the findings in this report

One of the strengths of this study is the granularity of the dataset. More than 100 survey questions can be examined across characteristics including ethnicity, country of education or training, year of NMC registration, professional registration status, sector, UK nation and band or equivalent.

Presenting every possible question and every possible comparison would be neither feasible nor analytically useful. The report therefore prioritises findings that are substantively important and sufficiently robust to interpret. Where differences between groups are meaningful and the underlying numbers support comparison, they are reported. The absence of a comparison should not be interpreted as evidence that groups responded identically.

Care is needed when interpreting differences between UK nations and registration cohorts. Policy, recruitment patterns and workforce conditions differ between the four nations and have changed over time. Cohort differences may therefore reflect changes in who was recruited and from where, as well as changes in experience or support. Where necessary, interpretation notes accompany findings to highlight relevant context or limitations. The full survey results are published separately as interactive data tables, allowing readers to explore questions and population groups beyond those selected for discussion in the report.

Using the data tables

The data tables hold the complete survey results and can be filtered to isolate any group of interest. A reader who wanted to see every result for respondents working in Wales or who are midwives, for instance, could filter to that group and read their answers to each question on their own; the same can be done for a single country of training, a particular band, a demographic characteristic, or a given registration cohort. This makes it possible to explore responses from a specific population, or to pursue a comparison of particular interest, directly against the underlying data.

Click to view interactive results





02. Findings

Who took part: demographics of survey respondents

Internationally educated nurses and midwives

1,120 IENMs with valid NMC PINs completed the survey and were included in the main analysis. Demographic data were collected using classifications aligned with those used by the NMC for equality and diversity monitoring. The full demographic breakdown for respondents is provided in Appendix 3.

Country of education or training

Respondents were asked to indicate the country in which they had completed their initial nursing and/or midwifery education or training. The top five countries of education or training are dominated by India (29%) and the Philippines (23%), which together account for more than half of the cohort, followed by Nigeria (15%), Ghana (6%) and Zimbabwe (3%).

To assess the representativeness of the sample, the distribution by country of education or training was compared against the NMC register, focusing on the 19 countries that collectively account for 90% of the IENM workforce on the register (see Figure 2). Our sample broadly corresponds to the register, with only a small number of countries slightly over- or underrepresented, providing reasonable confidence that the findings are generalisable to the wider IENM workforce.

Figure 1: Top countries of education or training

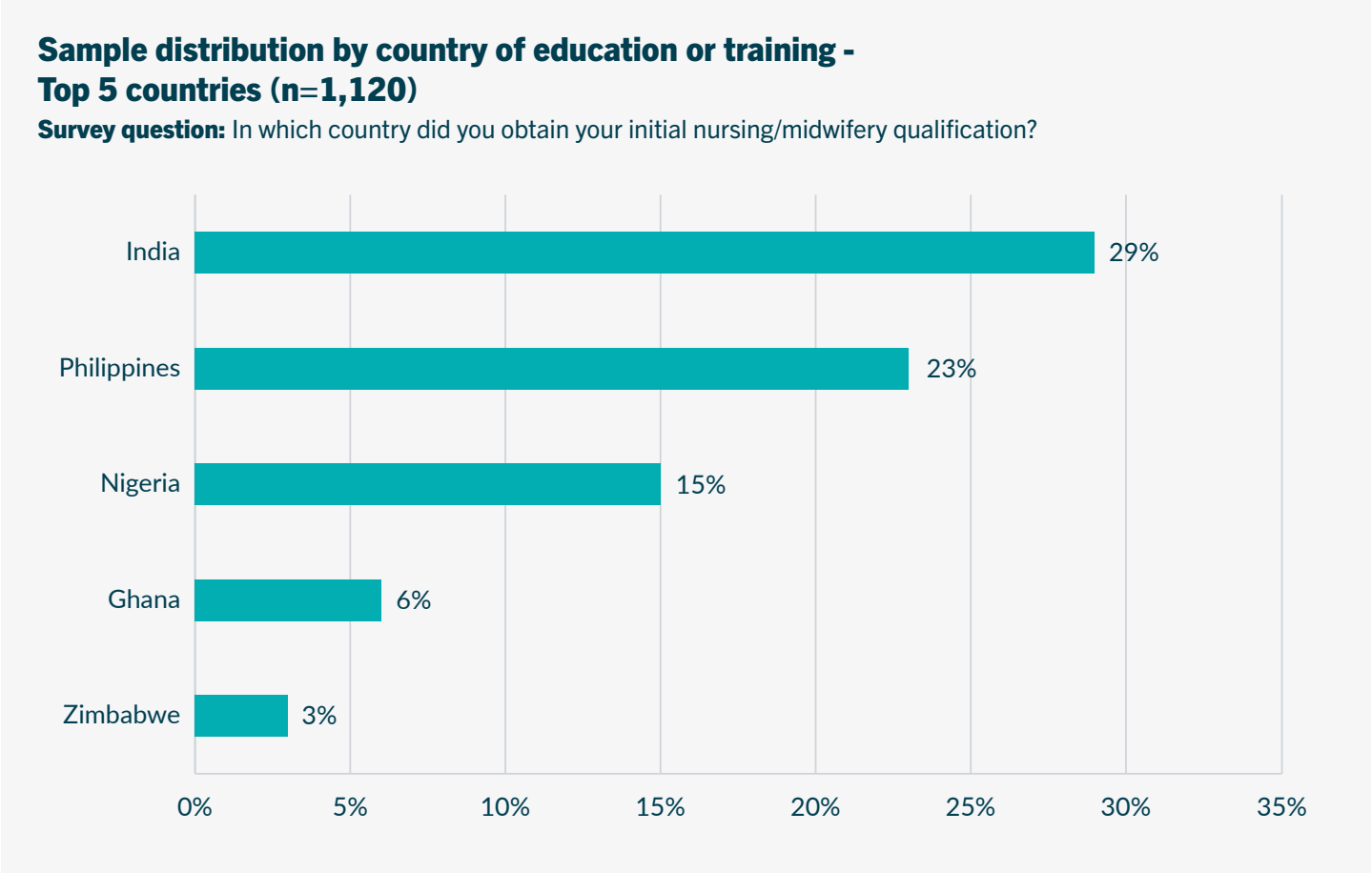
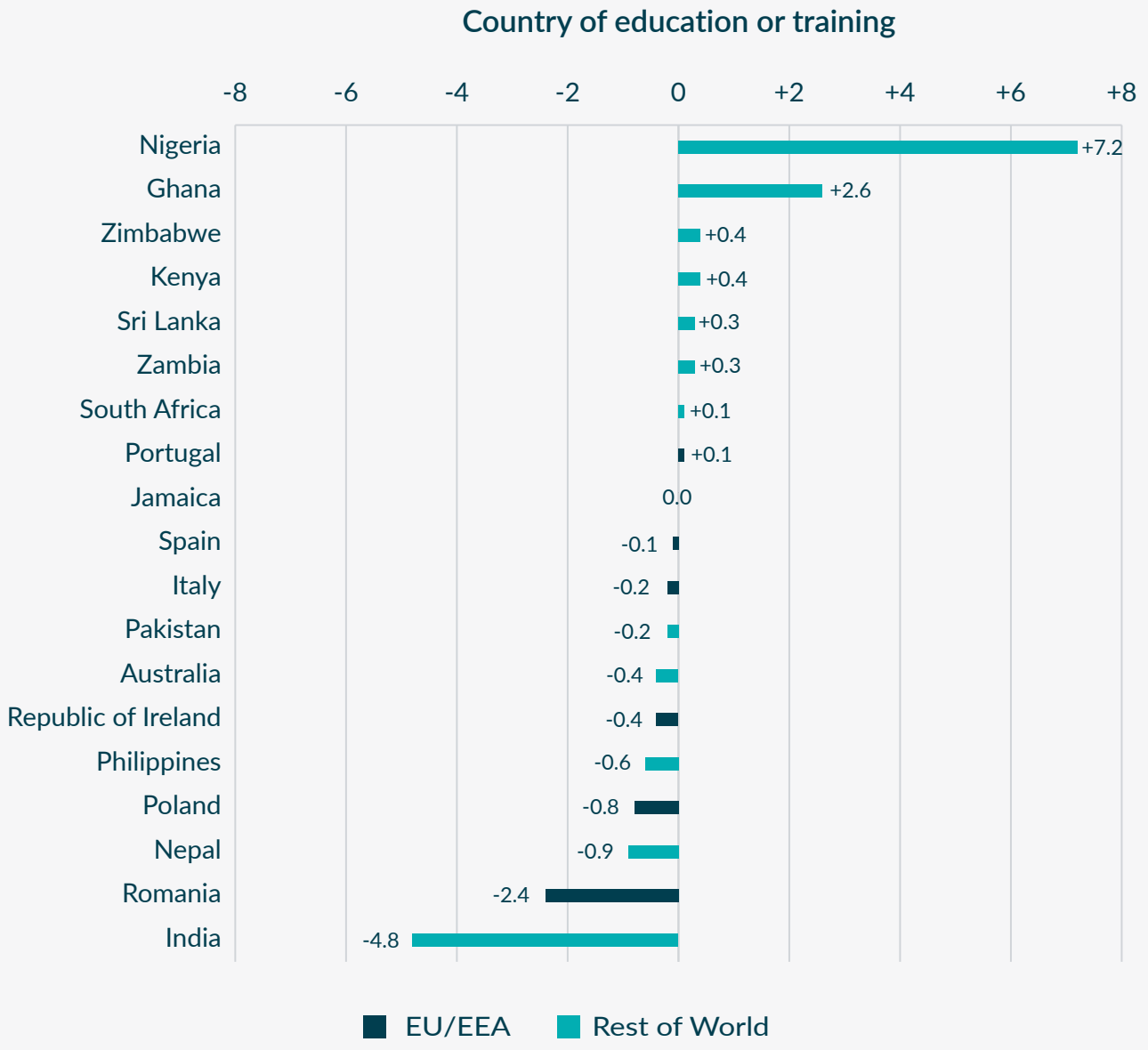


Figure 2: Sample profile compared with the NMC register

Sample vs NMC register by country of education or training

Percentage-point differences: positive values indicate overrepresentation in the sample; negative values indicate underrepresentation.



Ethnicity

Interpretation note:

Ethnicity shapes in part the experiences of IENMs in the UK, including the support they receive, the recognition afforded to their prior expertise and their opportunities for progression. For this reason, where relevant, we disaggregate results by ethnicity in the sections that follow.

Ethnicity was recorded using categories aligned with the Office for National Statistics (ONS) ethnic group classification used in NMC equality and diversity reporting. Because several of these categories contained too few respondents for reliable standalone comparison, results are generally reported using the broader Asian, Black and White groupings. Four subgroups, however, were large enough to analyse separately: (i) Asian-Indian, (ii) Asian-Filipino/a, (iii) Black-African and (iv) White-European. Where these subgroups reveal meaningful variation within their broader category, we report results at this more granular level; all other subgroups are analysed within their respective broader category.

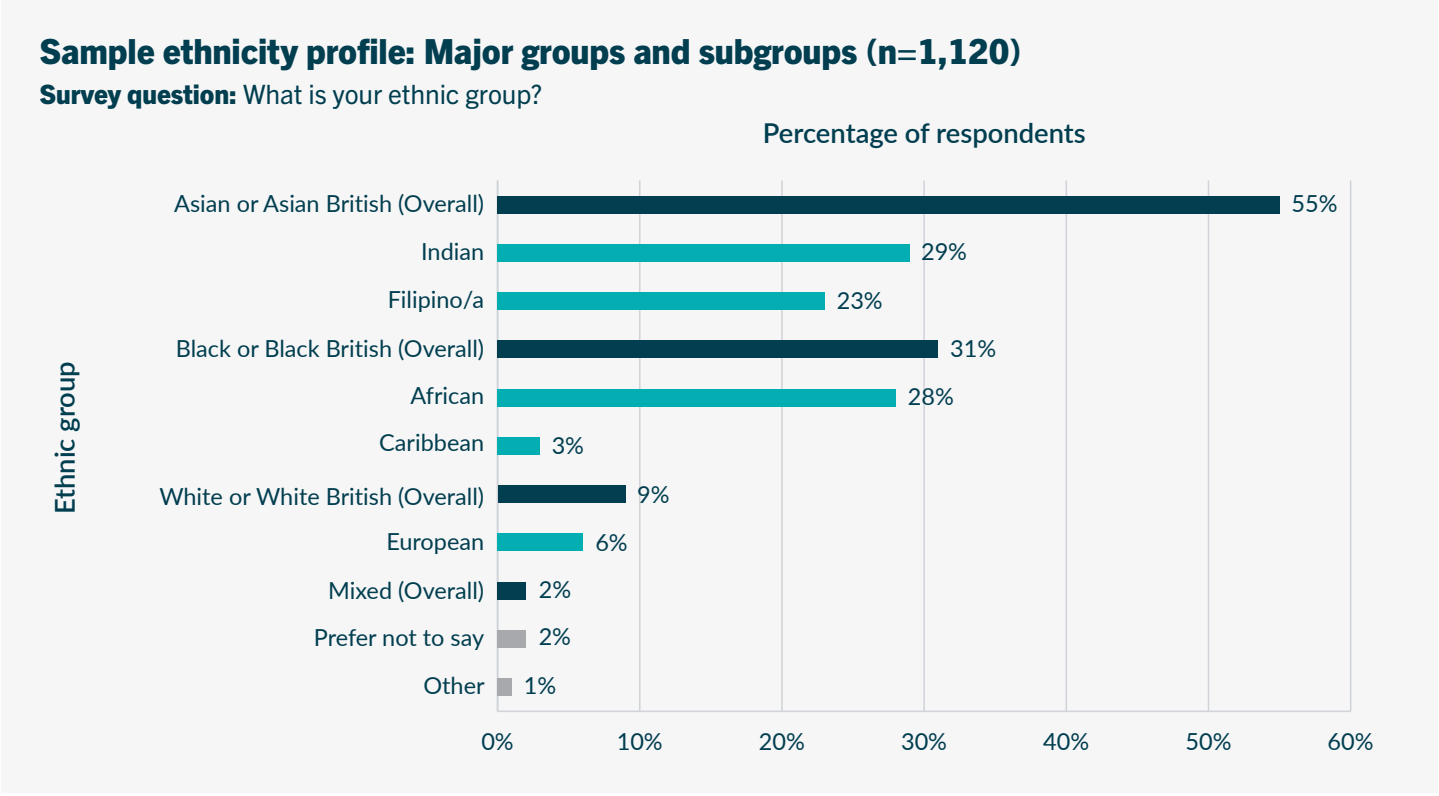
A feature of the White-European sub-group warrants caution in interpretation. The great majority of these respondents (96%, n=70) arrived prior to the UK's departure from the European Union, many under arrangements for free movement - a migration route materially different from those available to most other respondents, with correspondingly distinct recruitment and employment experiences.

For this reason, we exclude this group from certain analyses where its inclusion would confound comparison. On the same basis, and with sample size in mind, we report White-Irish respondents within the White-European group. We recognise that White-Irish is conventionally treated as a distinct category within UK ethnicity classifications; the decision here is a pragmatic response to small numbers rather than a suggestion that these identities are interchangeable, and we note it in the interests of transparency.

Sample breakdown by ethnicity

Respondents in our sample were predominantly Asian and Black. Respondents identifying as Asian accounted for the largest share (55%), with those of Indian (29%) and Filipino/a (23%) heritage forming the two largest subgroups. Black respondents made up a further 31%, the majority of whom were of African heritage (28%). Respondents identifying as White represented a comparatively small proportion of the sample (9%), the largest component of which were European (6%). Mixed, Other and 'prefer not to say' responses together accounted for the remainder. Figure 3 presents the full distribution, with a detailed breakdown provided in Appendix 3.

Figure 3: Ethnicity profile of respondents



Year of NMC registration

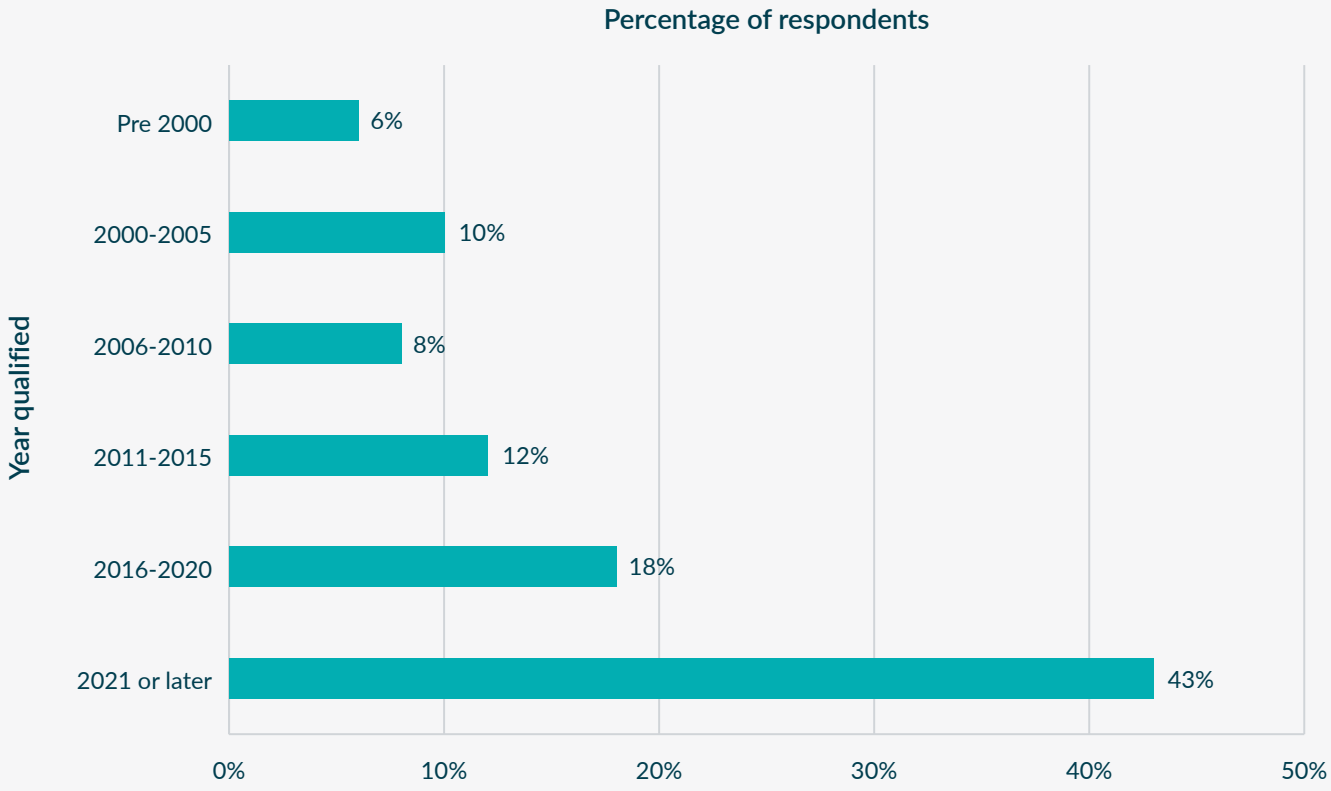
Respondents were asked when they received their NMC Personal Identification Number (PIN). Our answer choices split respondents into six different arrival cohorts, from "recent arrivals" who arrived in 2021 or later to "earliest arrivals" who came here before 2000.

The sample was weighted towards more recent arrivals: 43% received their PIN in 2021 or later, and 61% from 2016 onwards. The remaining respondents were distributed fairly evenly across the earlier arrival bands, each accounting for between 6% and 12%, giving a profile dominated by those who have joined the register within the last decade.

Figure 4: Year of NMC registration

Distribution of sample by year of NMC registration (n=1,120)

Survey question: In which year did you qualify as a nurse and/or midwife in the UK?

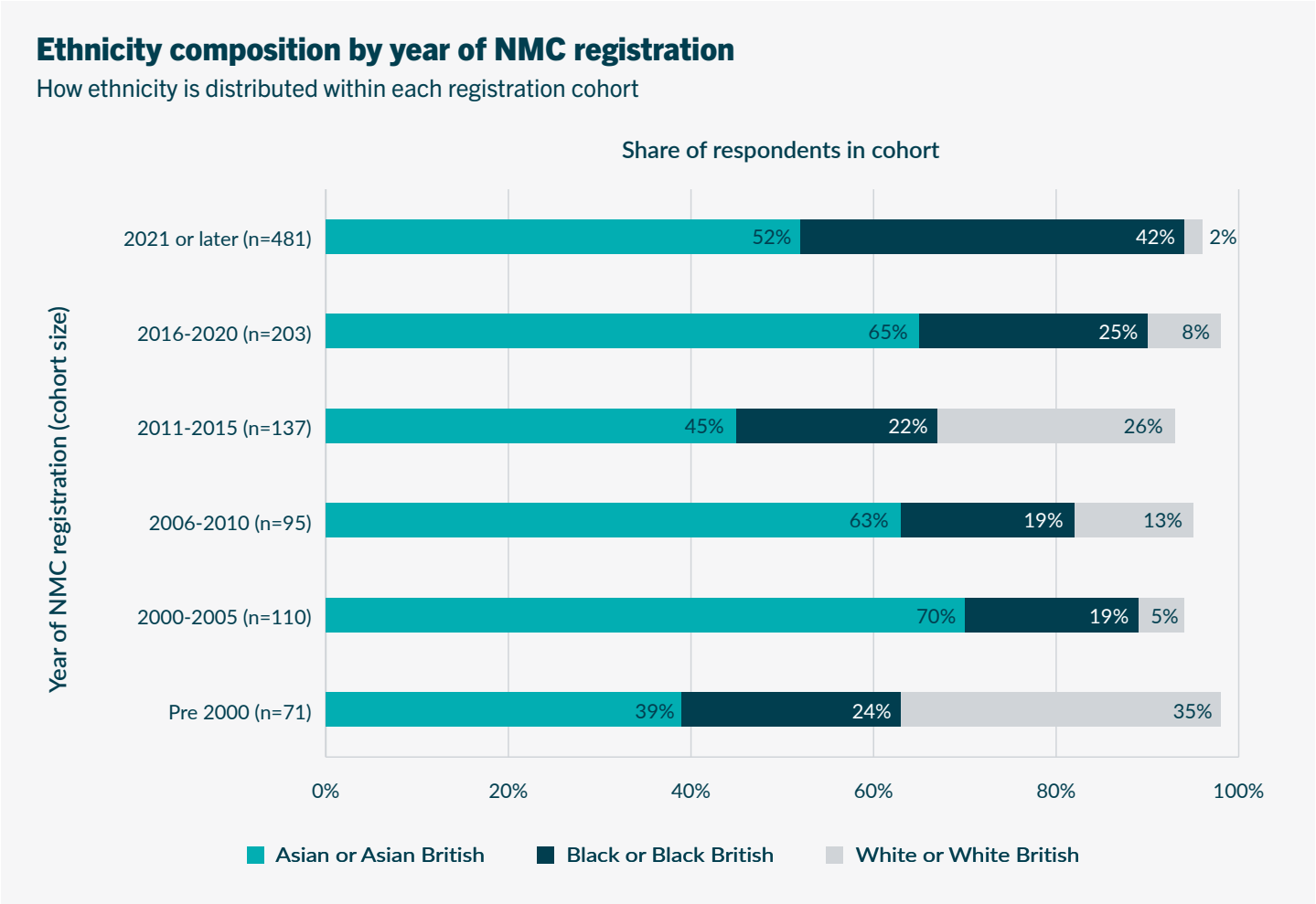


Year of NMC registration

The ethnic composition of the sample varied markedly by year of NMC registration (Figure 5), a pattern best understood as a reflection of shifting international recruitment trends rather than an artefact of the survey itself. Among respondents who registered in 2021 or later, the large majority identified as Asian (52%) or Black (42%), consistent with the post-pandemic expansion of recruitment from India, the Philippines and West Africa.

Earlier cohorts presented a more mixed profile: among those registering before 2000, White respondents accounted for over a third (35%). Because the sample skewed towards recent arrivals, its overall ethnic profile was correspondingly weighted towards this newer workforce.

Figure 5: Ethnicity profile by registration cohort



Professional registration status

Registered nurses made up the majority of the sample (89%), with registered midwives accounting for 9% and dual registrants a further 2%. Midwives and dual registrants therefore made up a higher proportion than in the wider IENM workforce, where midwives account for around 2% of IENM registrants and dual registrants 0.3%.

UK nation of work

Respondents were drawn from all four UK nations, though the sample was heavily concentrated in England (83%). Wales represented a further 10%, with smaller proportions working in Scotland (5%) and Northern Ireland (2%); the remainder preferred not to say. Figure 7 presents the full distribution.

Figure 6: Professional registration status

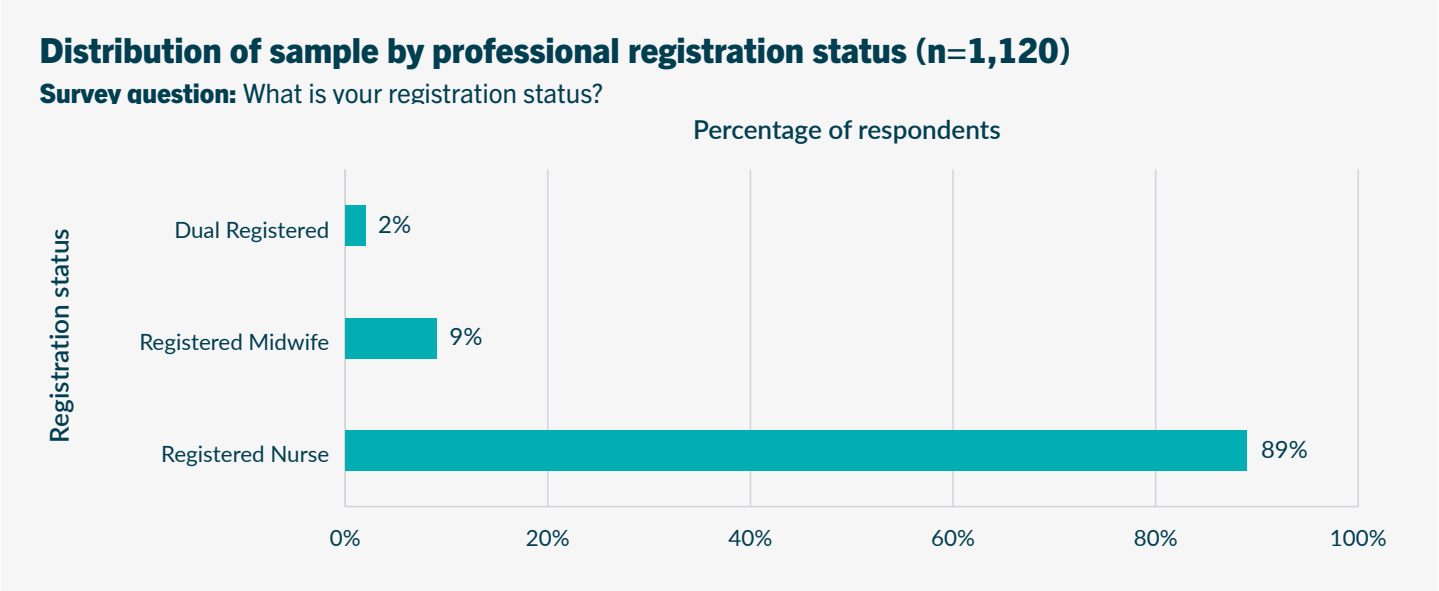
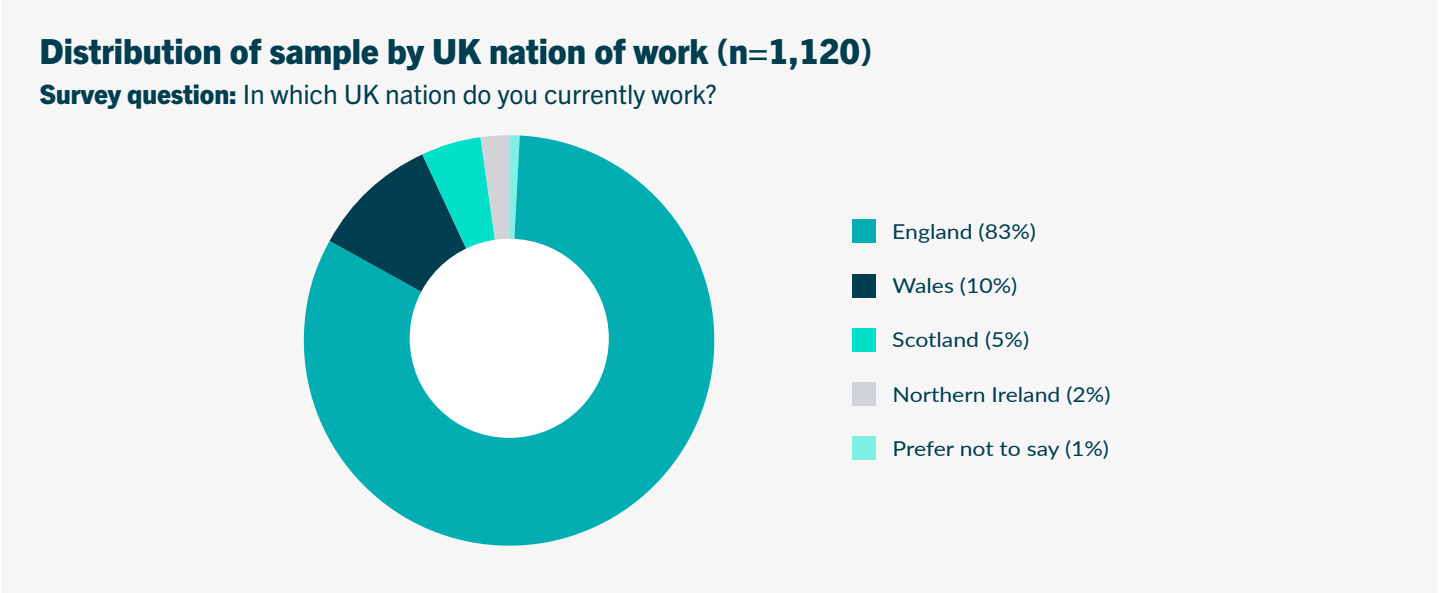


Figure 7: UK nation of work



Interpretation note:

UK-wide findings mostly reflect respondents in England. Samples for England, Wales and Scotland each exceeded 50, enough for nation-level analysis. The smaller Northern Ireland sample was supplemented by expert validation.

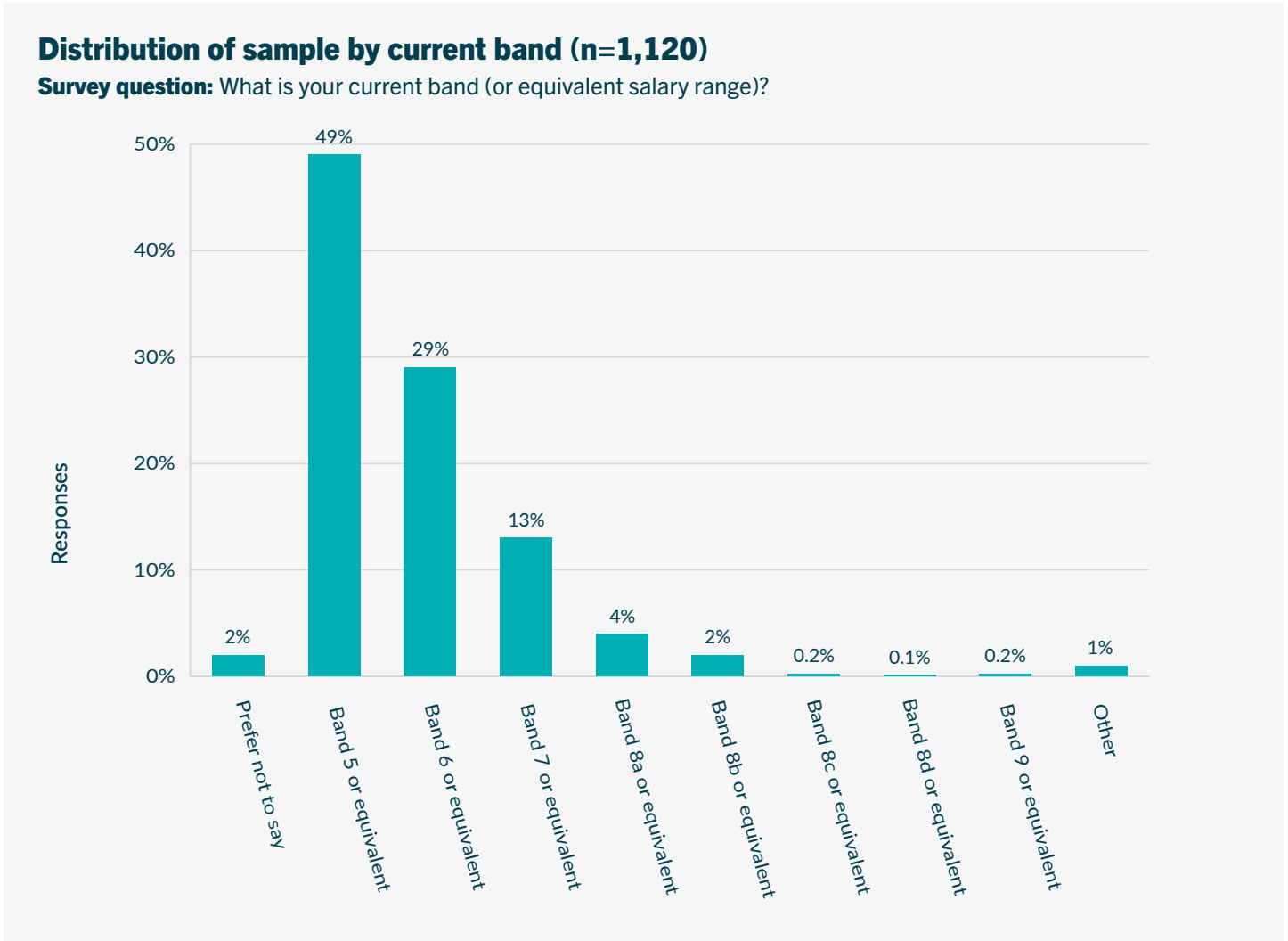
Sample profiles and policy contexts differ between nations, so we compare nations only where relevant, and those comparisons should be read with care.

Current band or equivalent

Respondents were concentrated in the more junior Agenda for Change bands (or equivalent). Almost half were at Band 5 or equivalent (49%), with a further 29% at Band 6 and 13% at Band 7. Representation at more senior levels was limited: 4% of respondents were at Band 8a and 2% at Band 8b, with very small proportions at Bands 8c, 8d and 9. The remainder selected 'other' or preferred not to say.

Among registered midwives, 75% were at Band 6, reflecting its position as the typical grade for registered midwives following completion of preceptorship. Figure 8 presents the full distribution for the whole sample.

Figure 8: Current band or equivalent



Findings

Members of a diaspora community

Interpretation note:

For a small number of questions in this survey, we allowed responses from respondents identifying as part of a diaspora, as defined earlier in this report, who were not necessarily IENMs. We did this because diaspora communities often hold the knowledge, networks and solutions these questions seek to understand, and because their experiences — while distinct from those of IENMs — are frequently related and relevant.

548 respondents identified as part of a diaspora, including 492 who were part of the IENM sample and 56 who were educated in the UK. Findings from these questions are discussed only in the Learning and Global Partnerships section (Theme 4) and should be read as reflecting this broader diaspora perspective rather than the views of IENMs alone.

Diaspora Respondents

The UK-educated diaspora respondents (n=56) were predominantly working in England (91%), and a majority were registered nurses (73%). They also tended to be relatively senior and experienced: over half were Band 7 or above (55%), and two-thirds had been NMC-qualified for more than ten years (66%, qualified in 2015 or earlier).

Their ethnic profile was also diverse, with respondents most commonly identifying as Black-African (52%), followed by Asian-Indian and Black-Caribbean (11% each), Asian-Filipino/a (9%), White-Irish (5%) and White-British (2%).



Findings

Theme 1: Before arriving – professional lives and the journey to the UK

Internationally educated nurses and midwives do not arrive as novices to their professions. Many bring substantial clinical proficiencies, specialist qualifications and leadership experience accumulated before coming to the UK. Yet the existing literature offers a limited picture of who these professionals are before they arrive and of the expertise they bring. This section begins to address that gap. It looks at who respondents were professionally before they arrived – their qualifications, prior roles and reasons for migrating.

Key Findings

- **Respondents arrived as a highly qualified workforce:** 97% held either a diploma (33%) or bachelor's degree (64%), and one-third reported holding at least one specialist or additional qualification, including 11% with a Master's degree.
- **Many brought substantial professional experience:** almost half (46%) had at least seven years of qualified experience before moving to the UK, including 28% with more than ten years. Midwives were particularly experienced, with 33% having more than ten years' experience.
- **Much of the expertise of nurse-midwives was not carried across into UK registration:** nurse-midwives were much more likely to register as nurses only, with lack of awareness, regulatory barriers and the cost or burden of the process accounting for nearly three-quarters of the reasons given.
- **Pre-arrival support was stronger for more recent arrival cohorts but remained predominantly focused on tackling administrative barriers rather than genuine preparation** for the transition to UK practice and life.
- **Most respondents began their UK careers in the NHS and remained there,** with initial job choice shaped primarily by practical considerations such as visa sponsorship and the first job offered.

Initial and specialist qualifications obtained in home country

Interpretation note:

These qualifications are self-reported and were obtained across a range of national education systems which are not always directly equivalent to UK qualification levels; the figures should therefore be read as indicative rather than exact.

We first asked respondents about the qualification that enabled them to enter nursing and/or midwifery in their home country. Across the full sample (n=1,120), the majority entered the profession through nursing qualifications: 76% held a diploma or bachelor's degree in nursing, and 15% a dual nursing and midwifery qualification.

To build a fuller picture of the expertise respondents brought with them, we also asked about additional specialist or higher-level qualifications obtained before coming to the UK. One third (33%) reported holding at least one such qualification, including 11% with a master's degree (n=1,120). The findings suggest that a substantial proportion of IENMs arrive with expertise well beyond the minimum required for NMC registration. Table 1 sets out the full range of initial and additional or specialist qualifications reported.

Table 1: Heatmap of initial & specialist qualifications obtained in home country

Qualification	Percentage of respondents
Initial Qualification (n=1,120)	
Diploma in Nursing	21%
Bachelor's degree in Nursing	55%
Diploma in Midwifery	3%
Bachelor's degree in Midwifery	3%
Dual qualification in Nursing and Midwifery (Diploma level)	9%
Dual qualification in Nursing and Midwifery (Degree level)	6%
Other	3%
Specialist or Higher-Level Qualification (n=1,120)	
Advanced Practice	1%
Clinical Nurse Specialist	2%
Specialty Certification	5%
Post-Basic Diploma	9%
Post-Basic Certification	5%
Master's Degree	11%
PhD	0.6%
Teaching / Education	6%
Other	5%

Note: Respondents could select multiple specialist or higher-level qualifications.

Professional registration status — home country vs UK

Single-profession registrants almost always registered in the UK in their own profession: 98% of nurses registered as nurses, and 97% of midwives as midwives. Nurse-midwives (n=255), however, did not. Despite holding both qualifications, the large majority registered as nurses only (85%), with just 12% registering as midwives and 3% as dual registrants.

Because most nurse-midwives registered only as nurses in the UK, a substantial amount of internationally recruited midwifery expertise is not reflected in the UK's registered midwifery workforce.

Nurse-midwives were asked why they had chosen not to pursue dual registration in the UK. Responses fell into six main themes, of which lack of awareness, regulatory barriers and cost and process burden together accounted for nearly three-quarters.

Theme 1: Lack of awareness (26%)

A striking number only realised after arriving that the dual role was theoretically possible, and many expressed regret. This points to a gap in pre-arrival information and onboarding.

"I never knew such exists in the UK, given a chance to choose, I would have chosen that."
A nurse-midwife trained in Eswatini now working as an RN in Wales

Theme 2: Regulatory barriers (25%)

NMC requires separate registration pathways, and respondents from countries where nursing and midwifery are integrated found this particularly surprising and difficult to navigate.

"The process of becoming a midwife looked taxing, and furthermore there is the issue of revalidation and getting all your hours. I was not sure if I could cope with all that since it was a new country for me."
A nurse-midwife trained in Nigeria now working as an RN in Scotland

Theme 3: Cost and process burden (21%)

This theme frequently overlapped with Theme 2. The financial cost of a second OSCE, reduced pay during adaptation programmes and the pressure of settling in a new country made dual registration feel impossible even for those who wanted it.

"Because the transition was quite rigorous with little to no support from the trust, having to write two different CBTs and OSCEs and having to pay out of pocket was too much."
A nurse-midwife trained in Nigeria now working as an RN in Wales

Theme 4: No opportunity offered (17%)

This theme highlights a recruitment level issue: trusts hired people into nurse-only roles, and the option of midwifery was never presented. Several respondents said they actively sought it and were turned down.

"I wasn't given the opportunity and I have shown interest with the international recruiter and lead matron for midwifery but was declined."
A nurse-midwife trained in Nigeria now working as an RN in England

Theme 5: Personal preference (8%)

This theme represents the minority who made a genuine, informed choice — often motivated by passion for a specific specialty or preference for their current area of practice.

"Because I enjoy providing midwifery care more."
A nurse-midwife trained in Nigeria now working as an RM in England

Theme 6: Qualification not recognised (3%)

This theme captures a distinct cohort whose midwifery credentials were flatly rejected, requiring lengthy bridging programmes that were financially or practically out of reach.

"No options, nurse midwifery certificate is not recognised, wants me to do a bridging course."
A nurse-midwife trained in India now working as an RN in England

Years of experience before moving to the UK

We asked respondents how many years they had worked in their home country as a nurse and/or midwife before moving to the UK. Respondents brought considerable professional experience with them to the UK. Across the full sample (n=1,120), the vast majority had practised as a qualified nurse, midwife or nurse-midwife before migrating: only 2% reported no post-qualification experience and a further 5% less than a year, while more than two-thirds had at least four years' experience (69%). Almost half had practised for seven or more years (46%), and more than a quarter for over ten years (28%) (Figure 9). Very few, in other words, arrived in the UK at the very start of their careers; most came as established professionals.

This pattern is more pronounced still among midwives (n=121), who tended to arrive with longer careers behind them. A third had practised for more than ten years (33%), over half had at least seven years' experience (52%), and around three-quarters had at least four years (74%).

Years of experience before moving to the UK by ethnicity

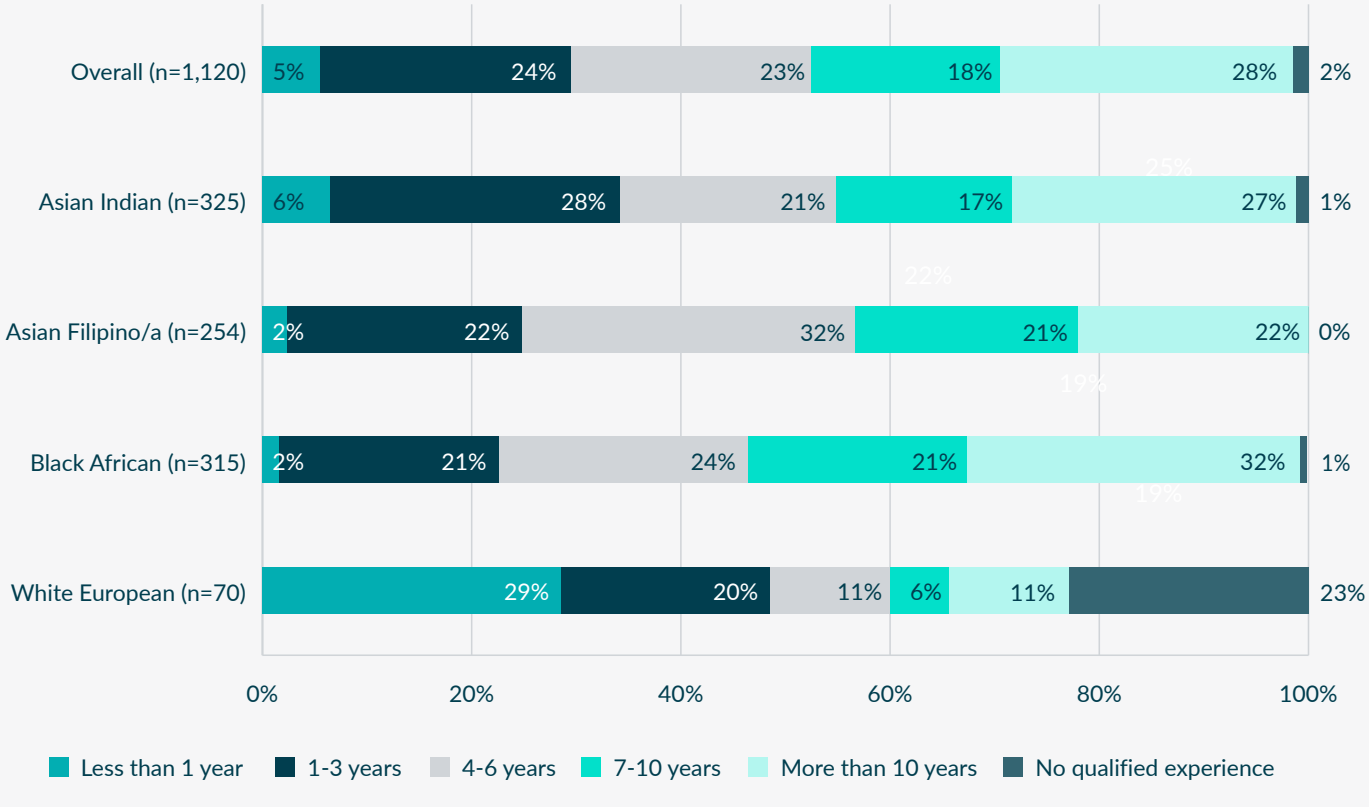
Prior experience on arrival varied considerably across ethnic groups. Asian-Indian, Asian-Filipino/a and Black-African respondents were highly likely to have arrived with several years of practice behind them: fewer than 3% of each group had less than a year's experience or none at all, and substantial proportions had practised for more than ten years — most notably Black-African respondents, a third of whom (32%) had over a decade of experience.

White-European respondents stood apart from this pattern. Almost half arrived with relatively little qualified experience – 29% with less than a year and a further 23% with none at all – a markedly higher share than any other group. This is consistent with the distinctive profile of the White-European group noted earlier: largely pre-Brexit arrivals under EU free movement, whose route into the UK differed from the recruitment pathways through which most other respondents arrived.

Figure 9: Prior experience before UK arrival

Qualified nursing and midwifery experience among IENMs before moving to the UK - Overall and by ethnicity

Survey question: Approximately, how many years did you work as a qualified nurse, midwife, or nurse-midwife before moving to the UK?



Years of experience before moving to the UK

Motivations for moving to the UK

We asked our survey respondents what motivated them to move to the UK to work as a registered nurse and/or midwife. Respondents (n=1,120) were motivated by a variety of reasons, but career development was at the forefront (65%). Other notable motivations included the desire to experience living and working abroad (55%) and better pay and working conditions than in their home countries (52%).

Preparation or support received before coming to the UK

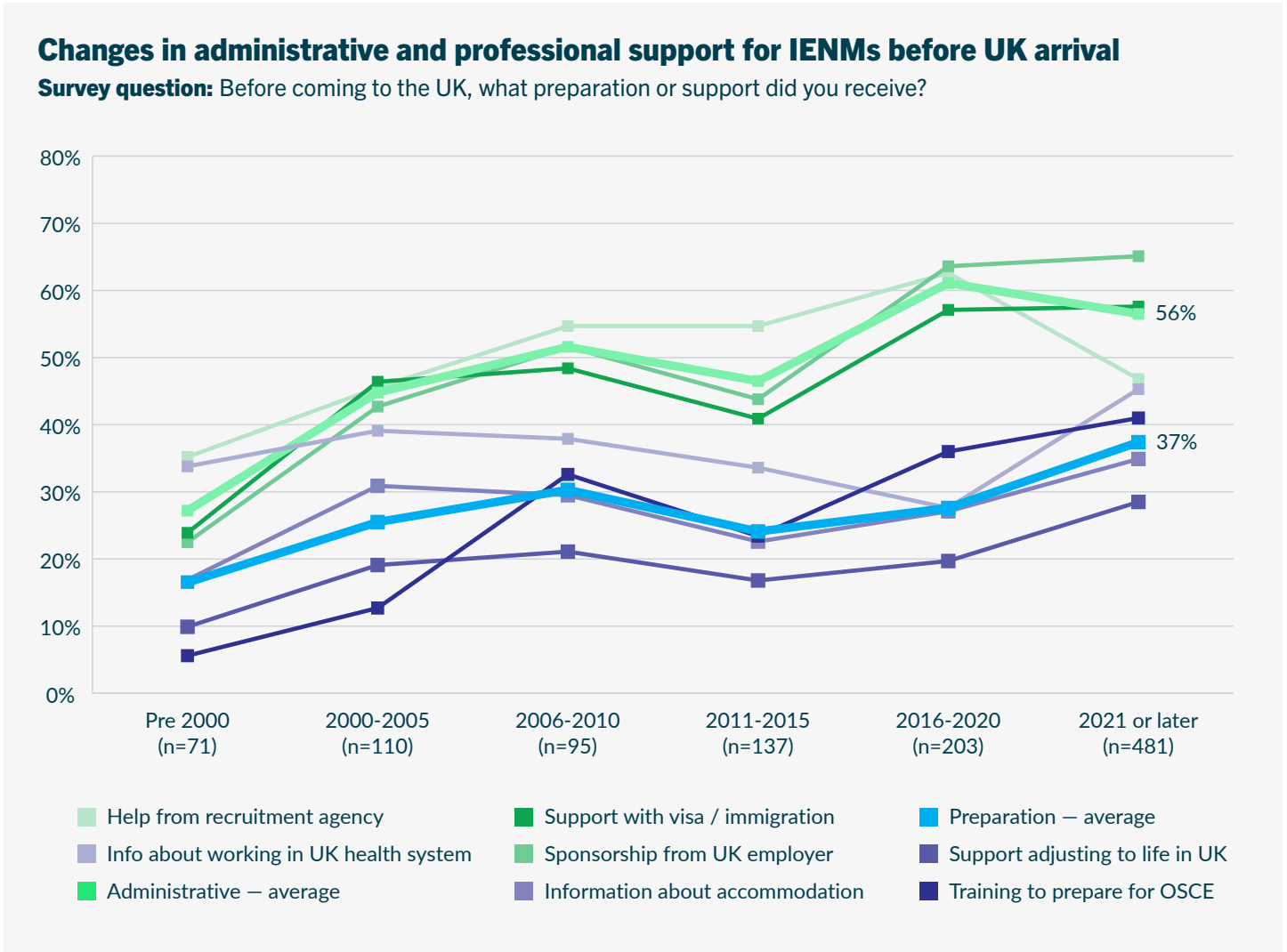
Respondents were asked what preparation or support they received before coming to the UK. Across the full sample, the most common forms were administrative: employer sponsorship (55%), visa processing (51%) and agency assistance (50%). Support oriented towards professional and cultural transition was markedly less common - only 25% received guidance on workplace culture, and 14% had contact with a nurse or midwife already working in the UK. Pre-arrival support was thus weighted towards the administrative processes of relocation rather than preparation for the realities of UK practice and life.

Preparation or support received before coming to the UK – changes over time

We wanted to understand whether this picture had changed over time. To do so, we grouped the different forms of support into two categories: an administrative average (agency help, employer sponsorship and visa support) and a preparation average (accommodation information, adjusting to life in the UK, health-system information and OSCE training).

Both have risen across successive cohorts, indicating that pre-arrival support has grown and professionalised over time (Figure 10). Administrative support has nonetheless remained consistently ahead of transition-focused support throughout: among those who qualified in 2021 or later, it exceeded preparation support by nearly twenty percentage points (56% versus 37%). This gap has begun to close in the most recent cohort, however, as preparation-focused support has risen more steeply, which suggests the balance may be shifting, even as administrative support continues to predominate.

Figure 10: Pre-arrival support over time



Time to acquire NMC PIN

We asked respondents how long it took after arriving in the UK to receive their NMC PIN and begin practising as a nurse and/or midwife. 44% of respondents received their NMC PIN within three months of arriving in the UK (n=1,120).

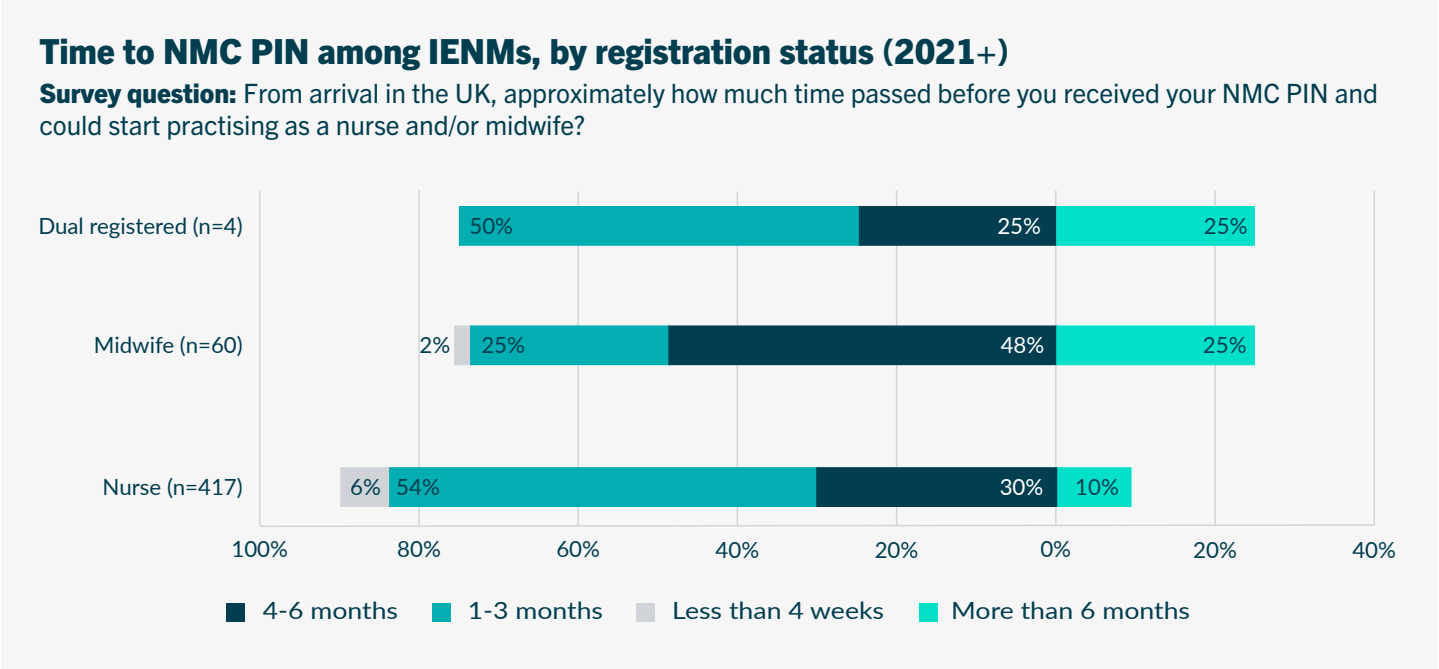
The remaining respondents waited longer, with 17% waiting more than six months. Among respondents who qualified in 2021 or later (n=481), nurses (n=417) were more likely than midwives (n=60) to receive their PIN within 1-3 months of arriving in the UK (54% vs 25%), while midwives were more likely to wait more than six months (25% vs 10%).

Support to acquire NMC PIN

Overall, 79% of respondents felt adequately supported to obtain their NMC PIN (n=1,120; agree or strongly agree). This support came primarily from employers (80%), though informal sources also played a substantial role: colleagues and peers (47%), family and friends (39%), and online resources (37%).

Among those who waited more than six months for their PIN (n=189), the barriers were largely administrative: delays in NMC processing (33%) and difficulties with paperwork or documentation (30%).

Figure 11: Time to obtain NMC PIN among recent arrivals



Initial place of work

We asked respondents who had secured a UK job after receiving their NMC PIN (n=1,102) three linked questions: (i) which sector they first worked in after registering as a nurse or midwife in the UK; (ii) whether they had changed sector since that first employment, either by moving completely to another sector or by splitting their time across more than one sector; and (iii) which sector they currently work in. Most respondents began their UK careers in the NHS (90%), with smaller proportions starting in social care (7%), independent healthcare (3%) and higher education (0.09%).

The most common reasons for choosing a first UK role were visa sponsorship (65%) and taking the first job seen or offered (34%), suggesting that early sector choices were often shaped by available entry routes into UK employment rather than specific personal or professional preference.

Sector mobility

To understand sector mobility, we examined both the proportion of respondents leaving each starting sector and, among those who moved, their destination sector. Across the full sample, 89% had worked in only one sector since first registering in the UK, while 9% had moved completely to a different sector and 1% were now splitting their time across sectors. Sector employment was most stable among respondents who began in the NHS (n=992): 96% were still working in the NHS at the time of the survey. Movement was more common among those who began in social care (n=80) and independent healthcare (n=29), where only 21% and 45%, respectively, remained in their starting sector.

Where movement did occur, it was most often towards the NHS. Among respondents who had left social care or now worked across multiple sectors (n=63: 59 full moves; 4 cross-sector), 90% were working in the NHS at the time of the survey; among those who had left independent healthcare (n=16 full moves), 88% were working in the NHS. Movement out of the NHS was more varied (n=40: 28 full moves; 12 cross-sector), with respondents moving into independent healthcare (43%), social care (18%) and higher education (20%).

Although the numbers are small, movement into higher education is notable. Only one respondent reported higher education as their first UK sector after receiving their NMC PIN, but 13 respondents were working there at the time of the survey. These respondents had moved from the NHS, social care and independent healthcare, suggesting that higher education was rarely an entry point into UK employment for IENMs but became a later destination for a very small group.

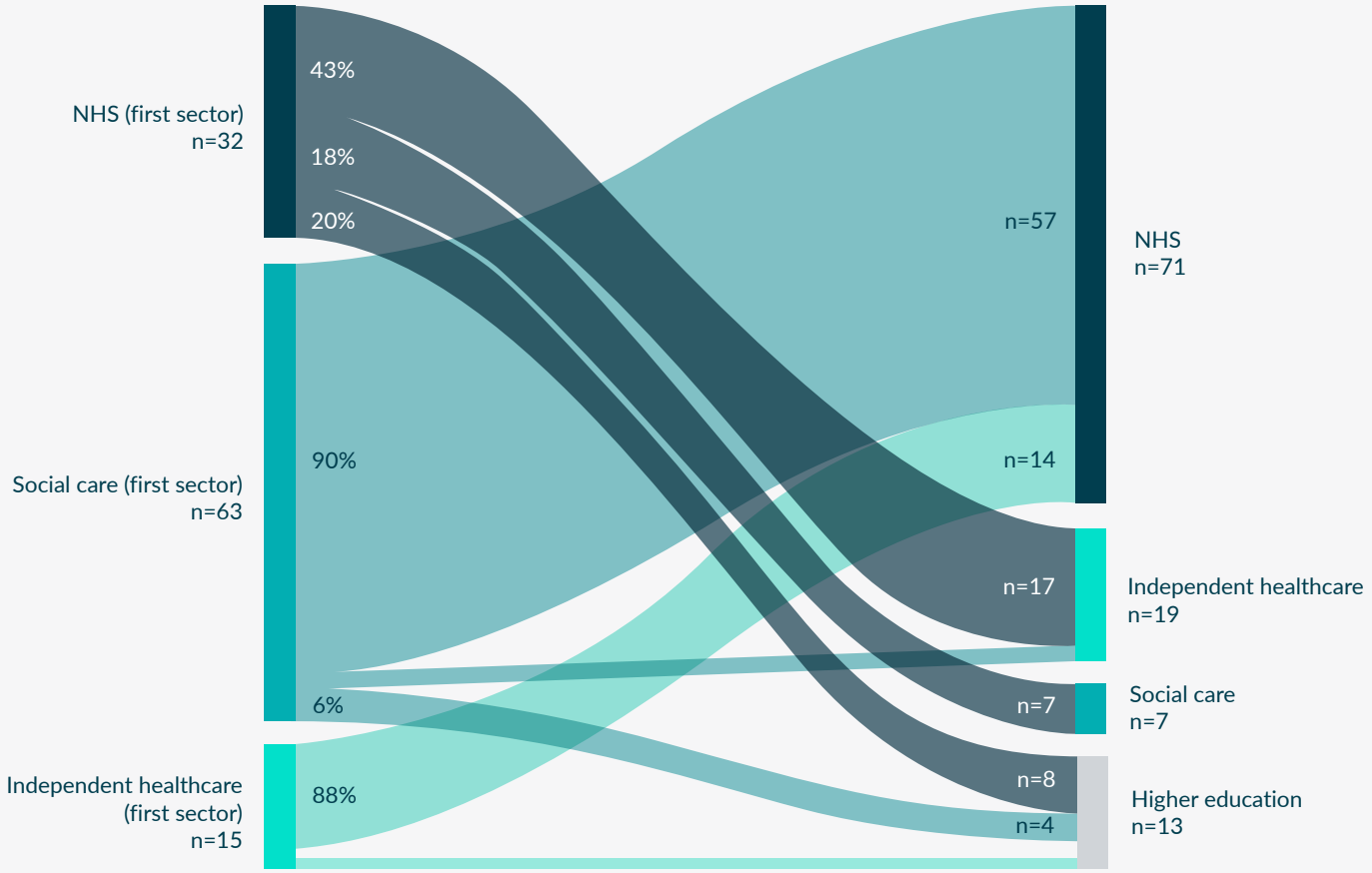
Career development and progression were key drivers of sector mobility, cited by 87% of those leaving social care (n=63), 82% moving into the NHS (n=71) and 92% moving into higher education (n=13). Among those moving into higher education, better work–life balance or flexible hours (69%) and a less stressful working environment (38%) were also important.

For those moving into independent healthcare (n=19), better pay or benefits was the main driver (89%), followed by better work–life balance or flexible hours (58%).

Figure 12: Sector movement after first UK role

Sector-to-sector movement among internationally educated nurses and midwives who have changed sectors since first working in the UK

Survey question: Since your first employment in the UK, have you changed sectors? What sector do you currently work in? If you selected that you work across multiple sectors above, please tell us the additional one you now work in.



Theme 2: Early experiences

For internationally educated nurses and midwives, arrival in the UK marks the beginning of a critical period of transition rather than its conclusion. The initial years in post are formative, shaping professional confidence, sense of belonging and, frequently, the decision to remain in the UK workforce. This section examines that early period, considering both the challenges IENMs encounter on arrival and the support available to them through induction, pastoral care, preceptorship and revalidation. Because experiences at this stage can influence the longer-term trajectory of a career, they bear directly on both retention and the extent to which the expertise of internationally educated staff is realised.

Key Findings

- **Transition into UK practice remained challenging:** 85% reported cultural or workplace differences, 51% lack of recognition of previous experience or qualifications and 49% communication or language barriers.
- **Racism and discrimination have not improved over time:** 41% of IENMs experienced racism, discrimination or bias when they began working in the UK, rising to 56% among Black IENMs, with no discernible decline across registration cohorts spanning two decades.
- **Structured transition support has improved but remains uneven across sectors:** 72% received a full induction, compared with 45% in social care and 74% in the NHS.
- **Preceptorship provision has increased substantially but does not consistently recognise IENMs as experienced professionals:** provision rose from 43% among the earliest cohort to 77% among recent arrivals, yet only 25% of recent arrivals felt their previous experience was taken into account.
- **Revalidation was a relative strength:** 77% felt supported by their employer and 76% rated their most recent revalidation positively, although barriers around reflective practice and consistent workplace support remained.

Challenges faced in early years of working in the UK

When asked about the challenges they faced on first starting work in the UK, respondents reported a wide range of experiences (Figure 13). Cultural and workplace differences were by far the most common, cited by 85% - some 34 percentage points ahead of any other challenge and close to universal among respondents.

Below this sat a broad cluster of difficulties, none clearly dominant: lack of recognition of previous experience or qualifications (51%), communication or language barriers (49%), cost of living (46%) and racism, discrimination or bias (41%). A further group, each affecting around a third of respondents, related to support and wellbeing: practical matters such as accommodation and registration (35%), lack of structured support such as preceptorship or mentorship (33%), burnout (32%) and mental health or wellbeing needs (27%). Visa or immigration issues were rarely cited (4%), and 2% reported no challenges at all.

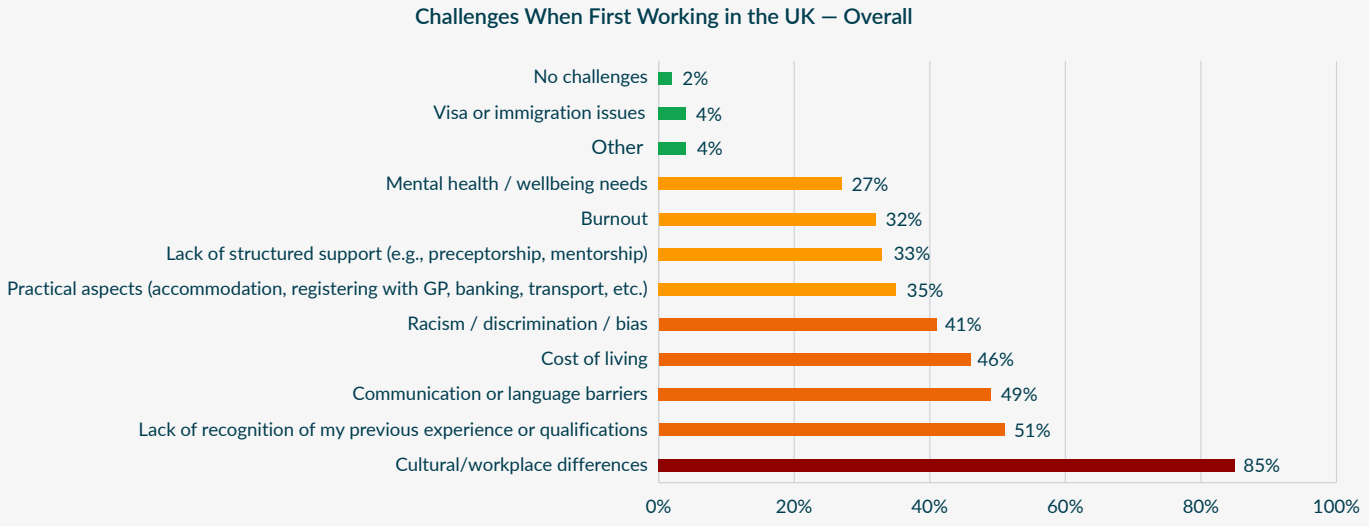
Transition into UK practice remained challenging:

85%	51%	49%
reported cultural or workplace differences.	lack of recognition of previous experience or qualifications.	communication or language barriers.

Figure 13: Challenges on entering UK practice

Challenges faced by IENMs on entering UK practice (n=1,102)

Survey question: What challenges did you face when you first started working in the UK?



Note: Respondents could select more than one option, so percentages do not sum to 100%.

Challenges differed by ethnicity and professional registration status

These challenges were not experienced uniformly across ethnic groups. Racism, discrimination and bias were reported by IENMs of every ethnicity, but Black-African IENMs were most affected: 54% reported it (n=309), significantly higher than among Asian-Indian (29%, n=319), Asian-Filipino/a (38%, n=254) and White-European IENMs (33%, n=70).

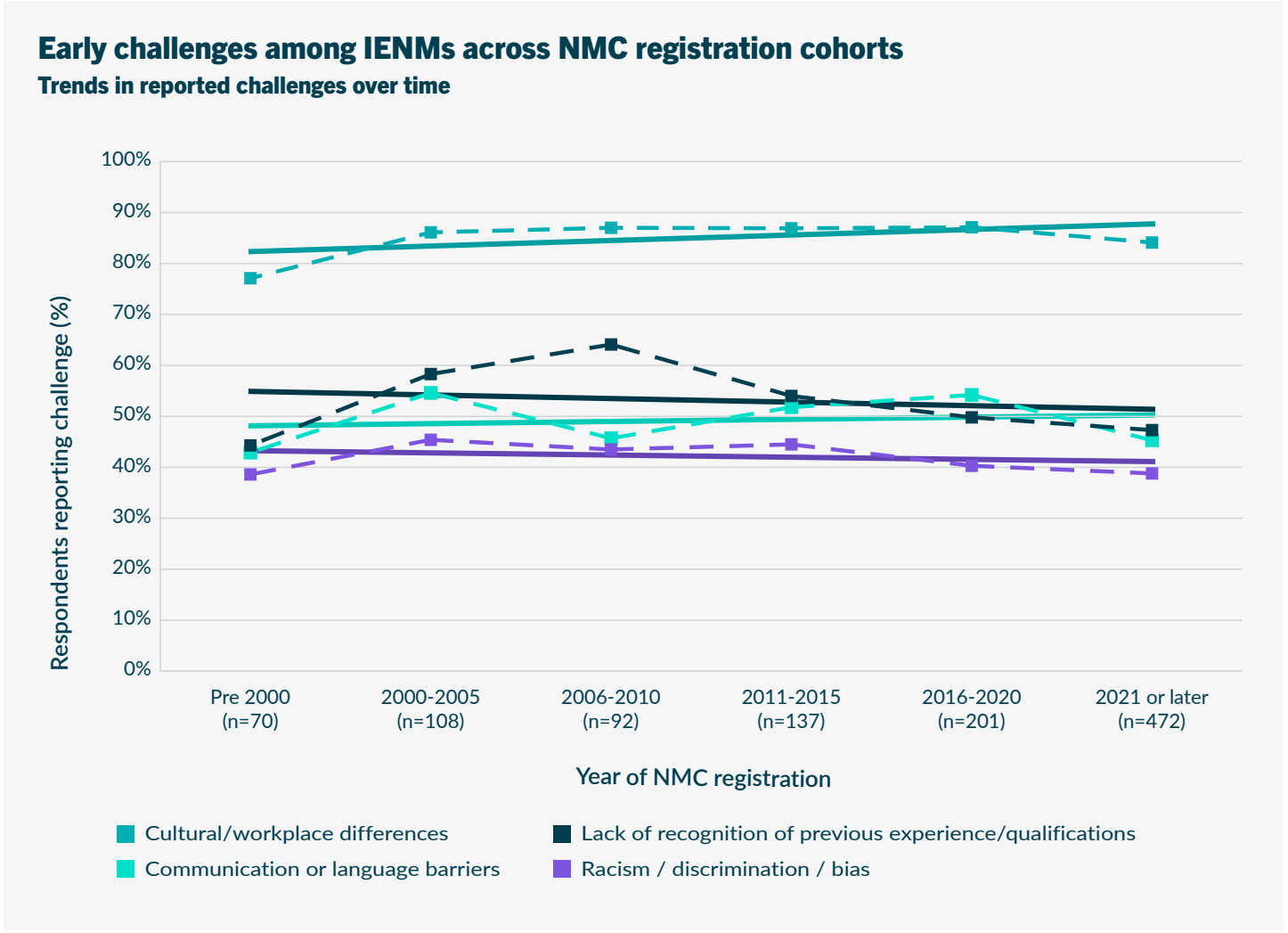
A lack of recognition of previous experience or qualifications was also particularly common among Black-African IENMs (59%), significantly higher than among Asian-Filipino/a (41%) and White-European IENMs (31%).

Differences were also evident by professional registration status. Registered midwives were more likely than registered nurses to report a lack of recognition of previous experience or qualifications (61%, n=98, compared with 50%, n=983).

Challenges persisting over time

Figure 14 shows that the main challenges facing IENMs at the start of UK practice have persisted across registration cohorts. The dotted lines show the proportion of each cohort reporting each issue, while the solid lines show the overall trend. Despite some variation between cohorts, the trendlines show little evidence of improvement, including for racism, discrimination and bias, which remains as common among recent registrants as among those who joined the register two decades earlier. This suggests that these difficulties are not confined to a particular recruitment period, but remain a feature of IENMs' early experiences in the UK.

Figure 14: Early challenges over time



Induction

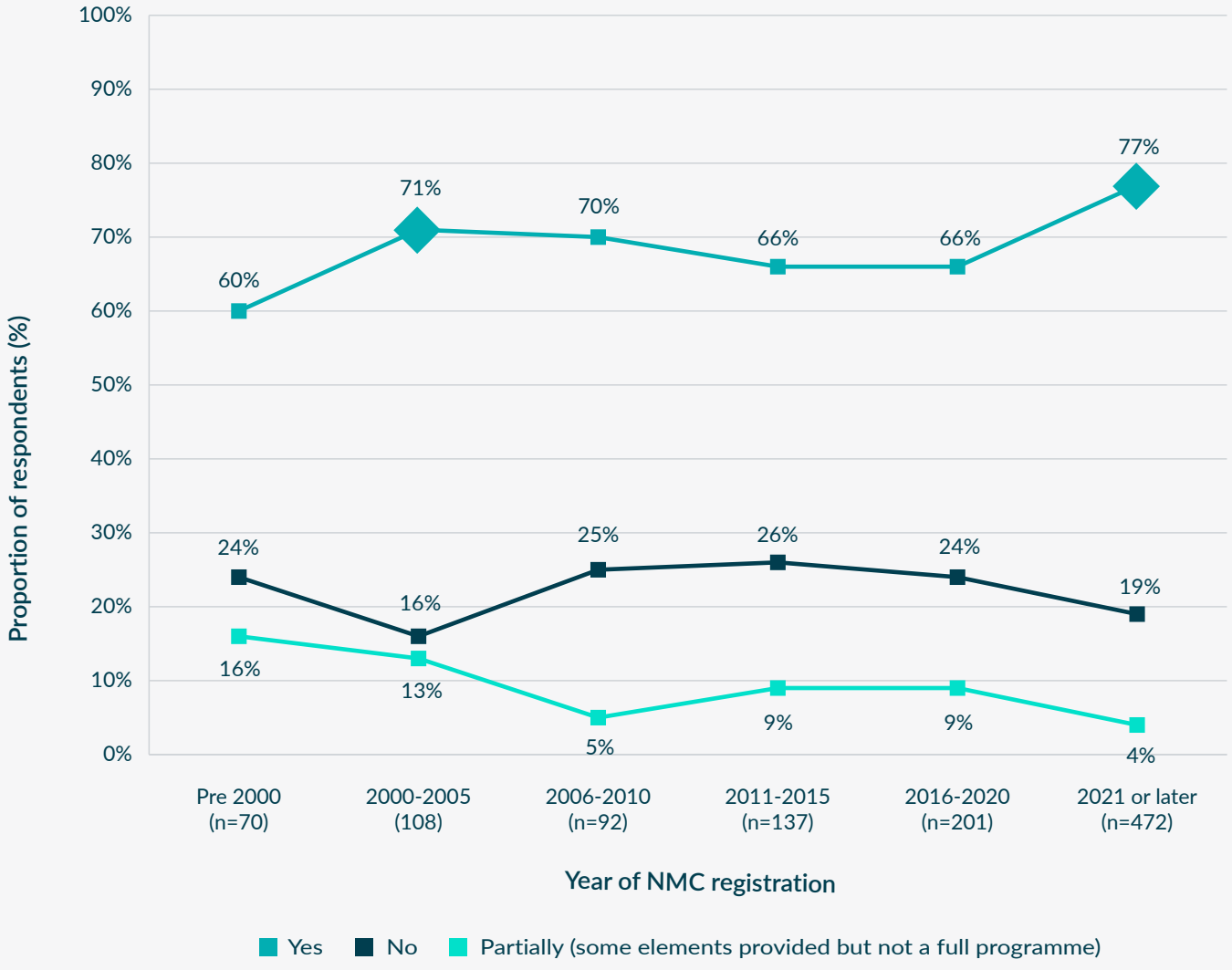
We asked survey respondents whether they received a full induction or orientation when they first started working in the UK. A clear majority did: 72% (n=1,102) reported receiving a full induction or orientation, while 21% received a partial one and 7% received none at all.

Structured induction has improved over time, though progress has not been steady. Figure 15 shows full induction provision rising from 60% among the earliest registered cohort (n=70) to 71% among those who registered between 2000–2005 (n=108). It then eased slightly across the intervening cohorts before rising to its highest level, 77%, among those who registered in 2021 or later (n=472).

Figure 15: Induction provision over time

Induction provision for IENMs across NMC registration cohorts

Survey question: Did you receive a structured induction or orientation when you started working in the UK?



Induction provision was lower outside the NHS

Full induction was far more common among those whose first job was in the NHS (74%, n=992) than among those who began in social care (45%, n=80) or independent healthcare (48%, n=29).

Within the NHS, induction provision has also improved over time. IENMs who joined the NHS in 2021 or later were more likely to receive a full induction than those who joined in 2020 or earlier (78%, n=458, compared with 71%, n=513).

Induction quality

Of those who received a full or partial induction, most said it was at least moderately effective (83%, n=1,025). Ratings were higher among respondents whose first UK role was in the NHS than among those who began in social care or independent healthcare (85%, n=937, compared with 70%, n=63 and 63%, n=24, respectively).

An analysis of 741 free-text responses showed a clear contrast between effective and ineffective induction. Effective induction was described as structured, supportive and practical, while ineffective induction was often rushed or generic, or left IENMs to work things out informally.

One respondent described an effective induction as:

> “The induction was very effective, detailed, and well-structured. It provided clear information and helpful resources to support new starters in settling into the Trust. From day one, the team was supportive and ensured that everyone had access to everything needed for growth and confidence in the role. We were given induction packs, learning guides, and information on where to find help, which made the whole process smooth and reassuring.”

A midwife trained in Nigeria now working in England

In contrast, another respondent described an ineffective experience:

> “It was rushed, was difficult to assimilate with the culture shock, unanticipated toxicity, indifference and hostility. A lot of information to process. Covid fears and scares. Being utterly alone though in a crowd.”

A nurse trained in Jamaica now working in England

Table 2: Differences between effective and ineffective induction in more detail

Effective induction	Ineffective induction
Welcoming support from mentors, managers, IENM teams and peers, with practical help settling into UK life.	Dismissive or impatient colleagues, poor management response and questions treated as incompetence
Clear structure, defined timelines, scheduled sessions and protected time to learn	Rushed, delayed, cancelled or poorly prepared sessions, often affected by staffing pressures
Practical guidance on NHS systems, local policies, documentation, escalation routes and day-to-day expectations	Limited explanation of role, scope of practice, escalation processes, paperwork, or how to function independently
Tailored support for IENMs, including OSCE preparation, transition into UK practice and recognition of different professional backgrounds	Generic induction designed for UK-trained staff, with little adaptation for international training, cultural transition or regulatory differences

Case Study: Comprehensive induction and OSCE preparation

Southern Health & Social Care Trust

The Southern Health and Social Care Trust provides healthcare and social services to over 370,000 people across acute hospitals, mental health facilities, community services and social care provision. Its workforce includes around 4,000 nurses and midwives. Since 2017, the Trust has supported 354 internationally educated nurses (IENs).

Established in 2022 following feedback on induction and preparedness, the International Nursing Team introduced a comprehensive 12-week Developmental Pathway for IENs. The pathway combines:

1. Pre-arrival and settling-in support

Teams meeting, airport information, WhatsApp peer groups, and Day 0 practical support with accommodation, groceries, appointments, BRP cards and local orientation.

2. Induction programme

Two-week, face-to-face simulated ward programme covering handover, ward routines, personal care, monitoring, delegation, recognising deterioration, the NMC Code and role expectations. Learning was reinforced through role play, phone call practice, scenarios and simulation.

3. OSCE preparation

Clinical Education Centre preparation followed by a Trust-led practice week using simulated stations, equipment, timers and patient roles, with targeted support for repeat attempts.

Support running throughout

Pastoral support addressed practical and personal barriers, while smaller cohorts enabled bespoke theatre and mental health programmes co-delivered with specialist services.

Core learning focus

Communication

Ward communication, local accents, colloquialisms and phone conversations.

Patient-centred care

Personal care, dignity, ward routines and what patients expect from nurses in Northern Ireland.

Role of a nurse in Northern Ireland

Professional expectations, scope of practice, delegation and the NMC Code.

Outcomes

Feedback was collected after each cohort and used to identify what nurses valued, what was less helpful, and where the pathway could be improved.

Nurses reported positive pre-arrival and social induction experiences, felt supported during induction, and described increased confidence and retention of clinical skills.

The blended practical and theoretical approach also helped shift the focus from passing exams to delivering high-quality, patient-centred care.

Pastoral support

When asked whether they received pastoral support during their transition into UK practice, only 38% of respondents said they had (n=1,102). Provision has risen substantially, from 14% among the earliest arrivals (n=70) to 50% among those arriving most recently (n=472) (Figure 16).

Where pastoral support was provided, it helped IENMs with both the emotional and practical dimensions of settling in: respondents said it helped them adjust to their new environment (68%) and feel emotionally supported (61%), while nearly half received help with practical matters such as housing, banking and transport (46%, n=423).

Among recent arrivals who received pastoral support (n=238), 21% accessed it through an International Nurse and Midwife Association (INMA), diaspora group or online community.

Figure 16: Pastoral support over time



Preceptorship

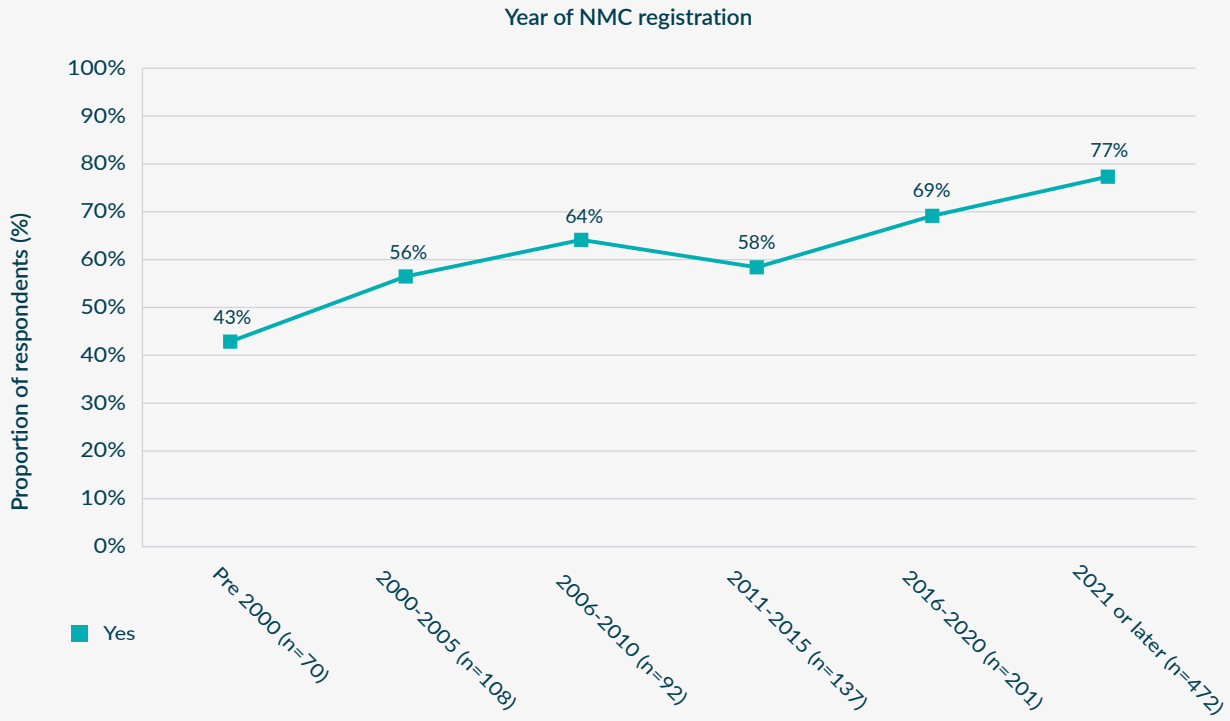
Respondents were asked about preceptorship after starting work in the UK; just over two-thirds had either completed one or were currently undertaking one (68%, n=1,102). Preceptorship provision increased from 43% among the earliest cohort (n=70) to 77% among the most recent arrivals (n=472). Despite some fluctuations between cohorts, the overall trend has been steadily upward (Figure 17).

Among recent arrivals who had not completed preceptorship (n=76), the most common reason was that it had not been offered by their employer (50%). Others reported a lack of information or awareness (25%), or said their workload or shift pattern made it difficult to take part (20%).

Figure 17: Preceptorship provision over time

Preceptorship provision for IENMs across NMC registration cohorts

Survey question: Did you complete or are currently undertaking a preceptorship programme following the start of your employment as a registered nurse/midwife in the UK?



Preceptorship quality and experience

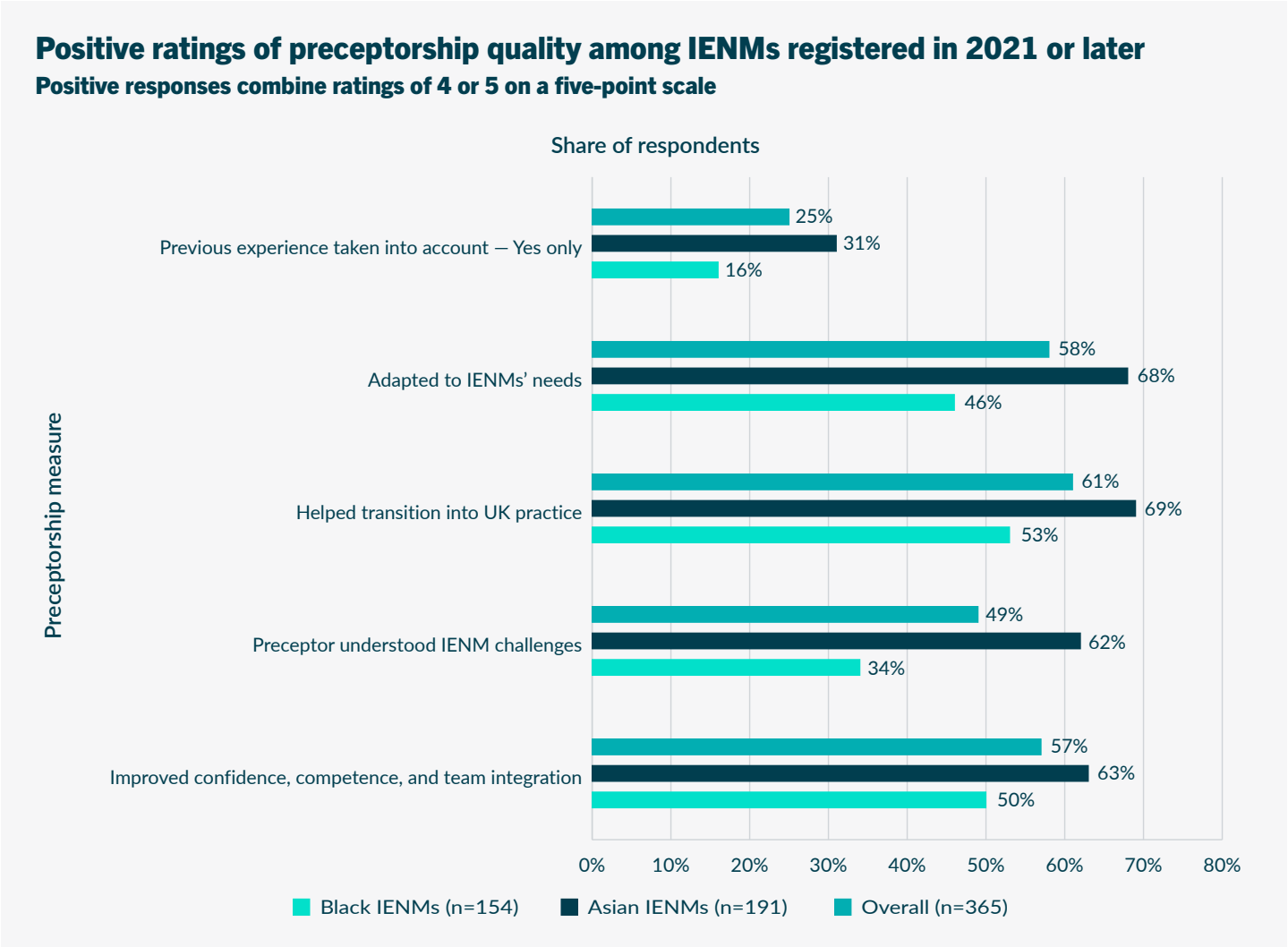
Interpretation note:

Because the preceptorship policy landscape has changed markedly over the past five years, this analysis focuses on recent arrivals. Figure 18 shows how recent arrivals rated different aspects of preceptorship, comparing the group as a whole with Asian and Black IENMs — the two groups with sufficient respondents for separate analysis.

We asked respondents whether preceptorship was tailored to IENMs' specific needs and how useful they found it (n=365). Overall, the results give a mixed picture of preceptorship quality. 61% said it was very or extremely helpful in easing their transition into UK practice, 58% felt it was adapted to their specific needs and 57% said it mostly or definitely improved their confidence, competence and team integration. Only 25% said their previous experience had been fully taken into account, with a further 21% saying it had been partially taken into account.

Black IENMs reported less positive experiences than Asian IENMs on every measure, often by a wide margin - the gap reaching 28 percentage points on whether the preceptor understood IENM challenges (34% versus 62%) and 22 points on whether preceptorship was adapted to IENMs' needs (46% versus 68%). Black IENMs also rated the recognition of prior experience only half as highly as their Asian counterparts (16% versus 31%).

Figure 18: Preceptorship quality among recent arrivals



Preceptorship provision for nurses versus midwives

Among recent arrivals, preceptorship was more common for midwives than nurses, likely reflecting the requirement for midwives to complete preceptorship before automatic progression to Band 6. In this group, 95% of midwives had completed or were completing preceptorship (n=60), compared with 75% of nurses (n=409).

We also asked recently arrived midwives about the breadth of their preceptorship experience (n=57). Almost two-thirds reported full exposure to different models of care during preceptorship, including antenatal, community, delivery suite and postnatal care (61%). However, 28% reported only limited exposure and 9% reported no exposure.

Preceptorship provision across the UK nations

Among recent arrivals, preceptorship provision appears broadly similar in England (80%, n=381) and Wales (78%, n=51), but respondents in Scotland reported notably lower rates (51%, n=35).

Interpretation note:

Northern Ireland is not reported separately owing to the small number of respondents. The small base for Scotland warrants caution; nonetheless, the difference may reflect variation in how preceptorship is organised across the four nations.

NMC Revalidation

We asked IENMs about their experiences of NMC revalidation. Among those who had revalidated at least once (n=676), most felt supported by their employer at least to some extent: 77% said they were supported fully, quite a lot, or somewhat, and 76% rated their most recent revalidation positively, giving it a good or very good rating.

We also asked what worked well, what challenges respondents faced, and what support made revalidation easier. Although most reported some degree of support, several recurring challenges emerged. The table below sets out these gaps alongside the forms of support that could address them, drawing on respondents' own accounts of what worked well.

Table 3: Support gaps in NMC revalidation and potential ways to address them, based on 676 free-text responses

Challenge identified	Support that could address it
Not knowing how to start or what evidence was needed.	Early orientation to revalidation requirements using NMC resources, employer-organised structured support, and examples from colleagues who had already revalidated.
Limited understanding of reflective writing or uncertainty about how to write reflective accounts.	Practical workshops, peer examples, preceptorship discussions, and protected opportunities to discuss reflection in a supportive environment.
Inconsistent employer or line manager support during the process.	Clear guidance for line managers on their role in supporting revalidation, including regular check-ins, timely confirmation conversations, and signposting to NMC resources.
Difficulty finding time to prepare evidence, complete reflections, or attend relevant CPD.	Line manager engagement to support planning, protected time within work plans, and employer-organised reminders for CPD, evidence preparation, reflective discussion, and revalidation administration.
Evidence, feedback, or CPD records having to be gathered retrospectively.	NMC templates, routine employer prompts, and peer advice from colleagues who had already revalidated to support ongoing recording of CPD, feedback, reflective accounts, and practice hours.
Reliance on informal support from colleagues who had already revalidated.	Formal peer or buddy systems that build on the value of colleagues who had already revalidated, supported by employer-organised structured revalidation support.
Financial pressure associated with maintaining registration.	Clear information about registration fees, payment options, and any available employer or professional support, shared through structured employer communication and line manager signposting.

Theme 3: Development opportunities

This section examines the professional development and progression of internationally educated nurses and midwives once established in the UK workforce. It explores their career progression, access to learning and development, the recognition of prior qualifications or experience and the routes into, and barriers to, leadership. It also considers psychological safety, given its central role in both effective leadership and patient, service-user and colleague safety.

Key Findings

- **Career progression remained limited even after many years in the UK:** One in three IENMs had never been promoted, including one in five of those with at least ten years' UK experience.
- **There were stark racial inequalities in progression:** Among IENMs with at least ten years' experience in the UK, 28% of Black and 24% of Asian respondents had never been promoted, compared with just 5% of White respondents.
- **Previous expertise remained substantially under-recognised:** Only 38% felt their qualifications, experience and skills were fully or mostly recognised, falling to 29% among Black IENMs and 30% among midwives.
- **Development was weighted towards the current role rather than future progression:** While 69% accessed mandatory and 63% role-specific training, only 46% accessed wider career, progression or leadership development.
- **IENMs were poorly connected to organisational leadership pipelines:** Only 25% felt included in their organisation's talent and leadership pathways, with Black IENMs consistently less likely to report encouragement, accessible leadership development and inclusion in talent pathways.
- **Psychological safety was much weaker when speaking up for themselves or colleagues:** 69% felt consistently safe and supported to raise concerns about a patient or service user, and 46% felt able to do so about themselves or a colleague, with Black IENMs least likely to feel safe speaking up.

Career Progression

Promotion

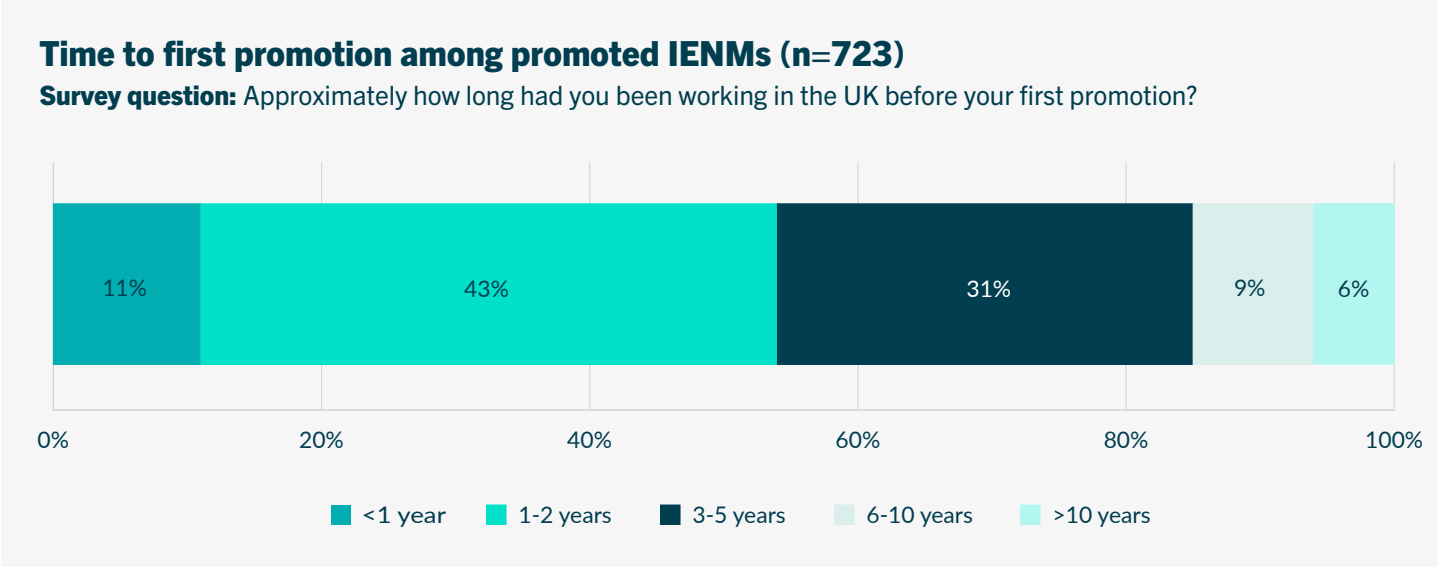
Interpretation note:

Promotion rates are shaped partly by the time a person has had to progress. We use year of UK registration as an approximate indicator of that time, recognising that individual career paths vary.

This matters particularly when looking at ethnic group differences, because arrival cohorts are not the same across groups: as the demographic profile shows [see Figure 5], Black and Asian IENMs comprise a higher proportion of recent arrivals than White IENMs. Any difference in promotion rates between groups will therefore reflect, in part, differences in how long each group has had to progress rather than differences in progression itself. This section presents the overall survey results first, then tests whether differences in promotion persist once time served is taken into account.

We asked respondents how long they had worked in the UK before receiving their first promotion. At the time of the survey, one in three IENMs had not yet been promoted (34%, n=1,102). Among those who had progressed, first promotion typically came within the first five years of UK practice (85%, n=723); beyond that point, the proportion recording a first promotion fell away (Figure 19).

Figure 19: Time to first promotion



Promotion by ethnicity

Across all IENMs, promotion rates differed by ethnic group: 44% of Black (n=339) and 33% of Asian respondents (n=602) had not yet been promoted, compared with 9% of White respondents (n=104).

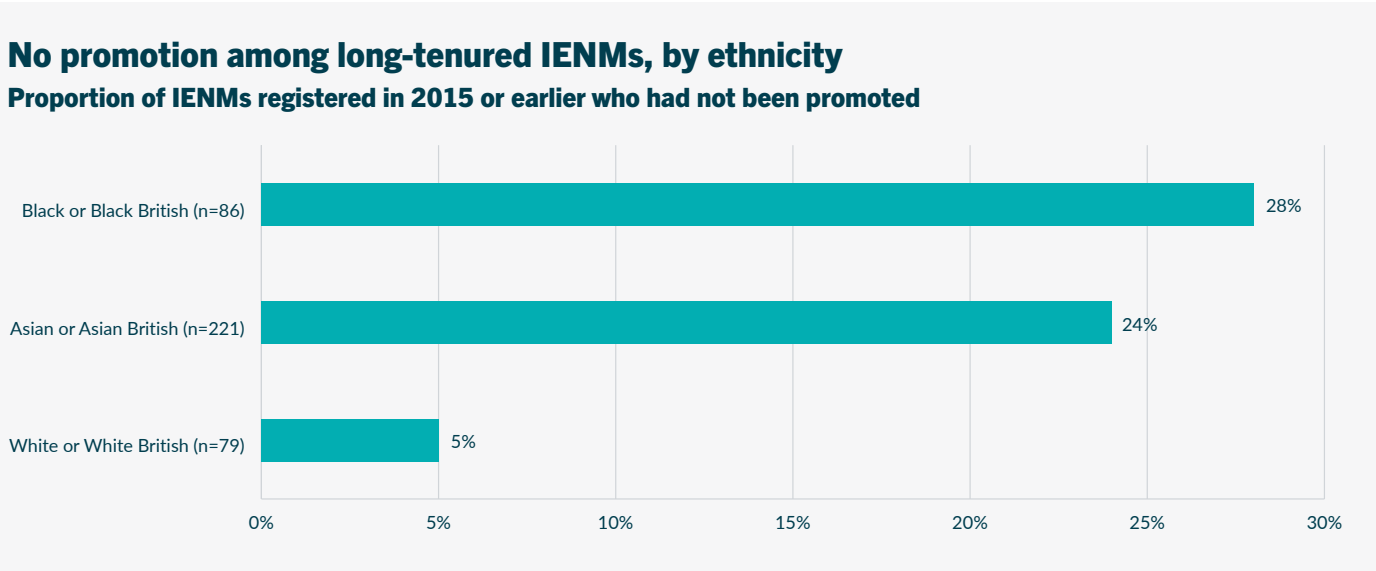
Long-tenured IENMs & promotion

To strip out the effect of time served, the following analysis is restricted to IENMs who registered in the UK in 2015 or earlier. Everyone in this group has had at least a decade to progress, well beyond the five-year point by which most first promotions occur.

Time served explains part of the overall picture. Among this long-tenured group, the proportion who had never been promoted falls to 21% (n=407), compared with 34% across all IENMs. This provides the clearest evidence that time to progress matters.

However, it does not fully explain the gap between ethnic groups, which narrows but remains. Among long-tenured IENMs, 28% of Black (n=86) and 24% of Asian respondents (n=221) had never been promoted, compared with 5% of White respondents (n=79). Set against the unadjusted figures, the gap closes only partly once time is accounted for (Figure 20).

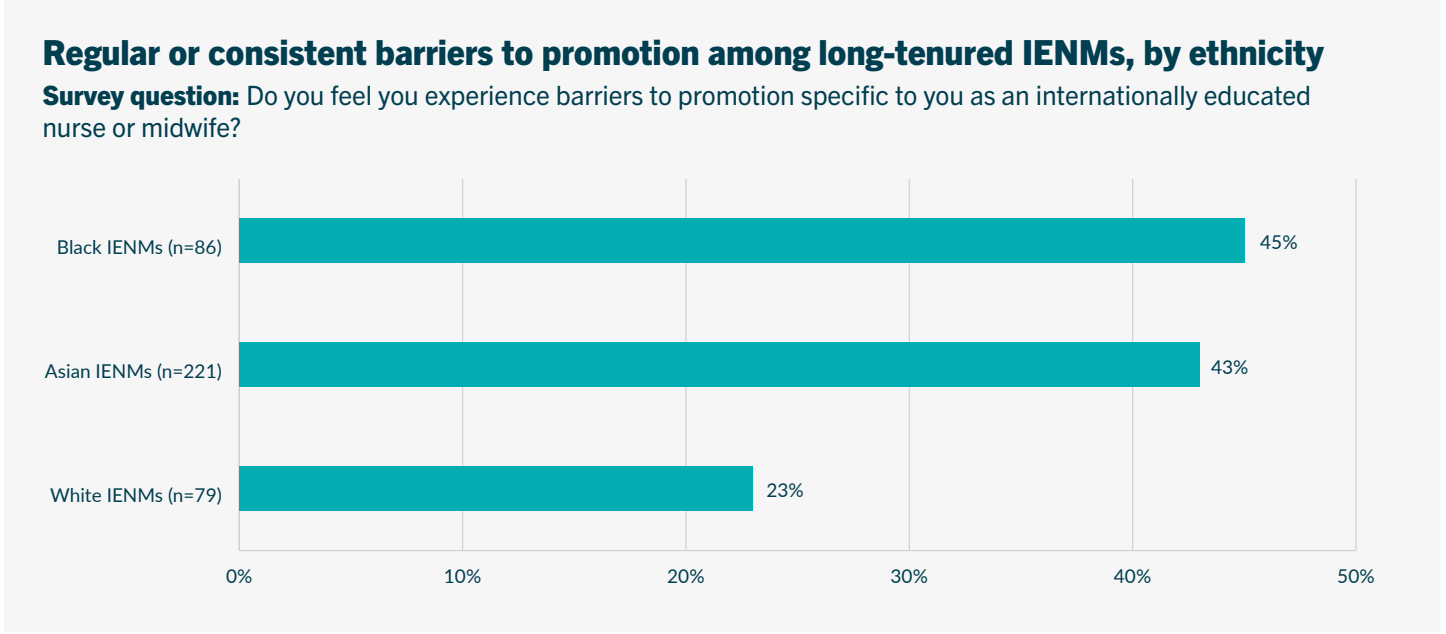
Figure 20: No promotion among long-tenured IENMs



Barriers to promotion

When asked about barriers to promotion related to being internationally educated, 75% of this long-tenured group said they had experienced barriers at least sometimes, and 40% described these barriers as regular or consistent. This too varied by ethnic group: Black and Asian IENMs were significantly more likely than White IENMs to report regularly or consistently experiencing barriers to promotion (Figure 21).

Figure 21: Barriers to promotion among long-tenured IENMs





Case Study: Career progression opportunities

NHS
United Lincolnshire Teaching Hospitals
NHS Trust

United Lincolnshire Teaching Hospitals NHS Trust serves a population of over 720,000 people across Lincolnshire. Since 2021, the Trust has recruited 800 internationally educated nurses.

The Trust identified that 85% of IENs had remained at Band 5. This gap analysis informed a career progression project designed to level the playing field and recognise the skills and expertise IENs bring to the organisation. The project included:

A bespoke career development workshop to signpost and offer insight into career progression pathways in the organisation.

- Where to find progression opportunities
- How to set up and use Trac accounts for job applications
- How to complete job applications
- How to use NHS language and terminology in applications
- Support with writing personal statements
- Opportunities to speak with senior leaders

Recruitment Champions who contribute to interviews and stakeholder panels to help embed equity and inclusion throughout the recruitment process.

Outcomes

The Trust has reported increased progression from Band 5 to Band 6, alongside a smaller increase from Band 6 to Band 7. Feedback from workshop participants highlights the role of the workshop in building confidence, morale and awareness of progression opportunities.

> “Every bit of the workshop is very significant.”

> “It is very insightful and empowering workshop for me. Very helpful.”

> “Really helpful for professional development and got to know about many opportunities and skills we need to develop as nurses.”

Learning and development

We asked our respondents about their access to learning and development. Results were mixed among respondents (n=1,102). It was most often focused on mandatory training (69%) and clinical development relevant to respondents' roles (63%), while opportunities linked to wider learning, career progression or leadership were less common (46%). A smaller but notable minority reported that access was constrained by their role or banding, or confined to training directly related to their area of work.

This suggests that while many IENMs had access to basic or role-related development, access to broader career development — wider learning, career progression and leadership development — was more limited. This held across all registration cohorts: access to broader career development ranged from 38% to 61%, with no consistent trend by time in the UK.This points to a general shortfall in development opportunities rather than a settling-in effect that resolves with time.

Table 4: Types of learning and development access reported by IENMs (n=1,102)

Type of learning and development access	% of respondents
Focused mainly on mandatory training	69%
Included some professional or clinical development relevant to role	63%
Included wider learning, career progression, or leadership development	46%
Limited or dependent on role or banding	25%
Restricted to training directly linked to area of work	12%

Note: Respondents could select more than one option, so percentages do not sum to 100%.

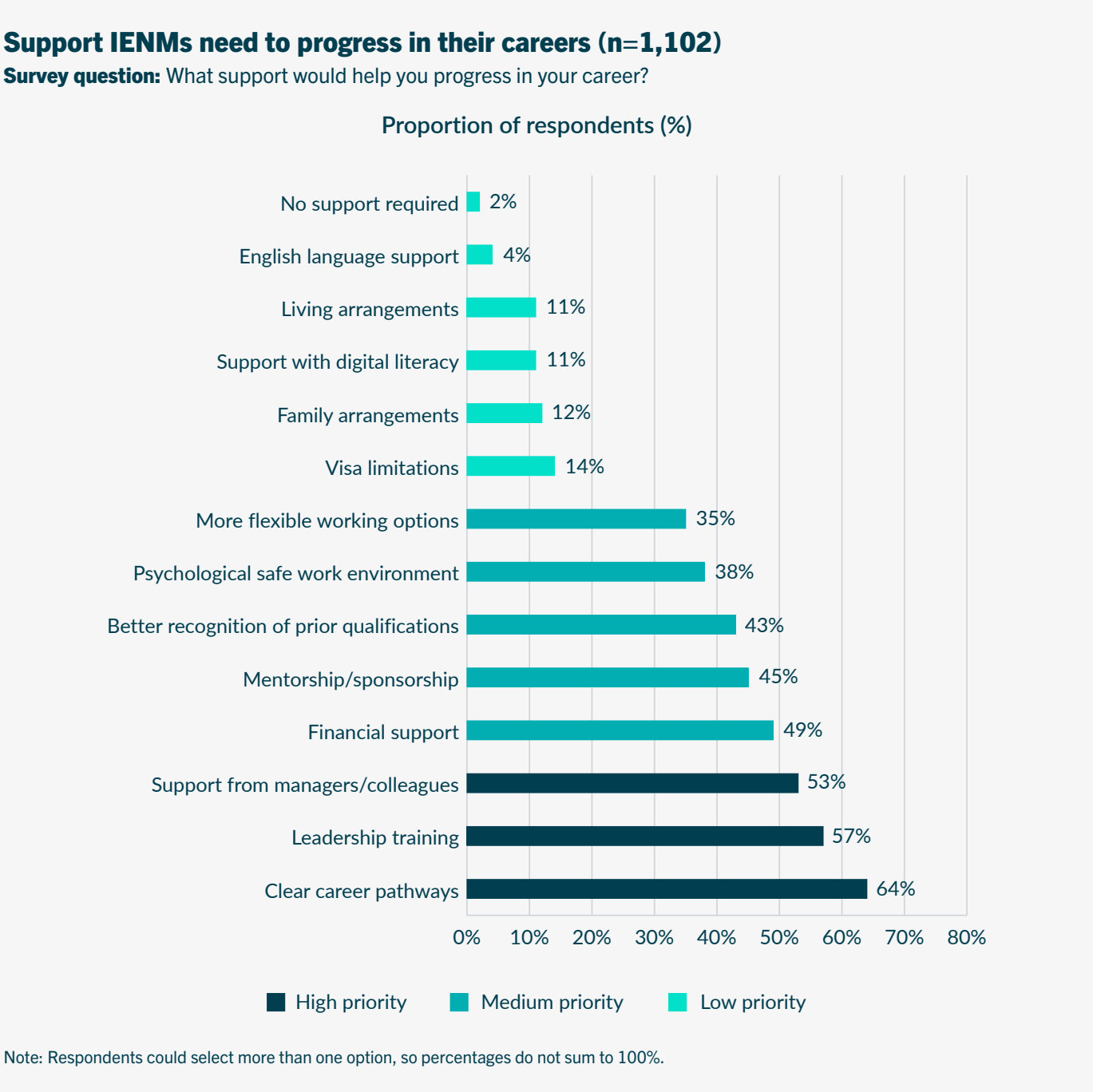


Support needed for progression

When asked what support would help them progress in their careers, IENMs most often identified clear career pathways (64%), leadership training (57%) and support from managers or colleagues (53%, n=1,102) (Figure 22).

These responses align with the earlier finding that access to broader career development was more limited, and suggest a continued need for clearer, more structured progression support.

Figure 22: Support needed for career progression



Note: Respondents could select more than one option, so percentages do not sum to 100%.

Qualifications achieved in the UK

We asked respondents what qualifications they had achieved since registering as a nurse or midwife in the UK, spanning both practice- and education-related qualifications. Figure 23 shows these across three broad categories: higher education, advanced or specialist practice, and professional development.

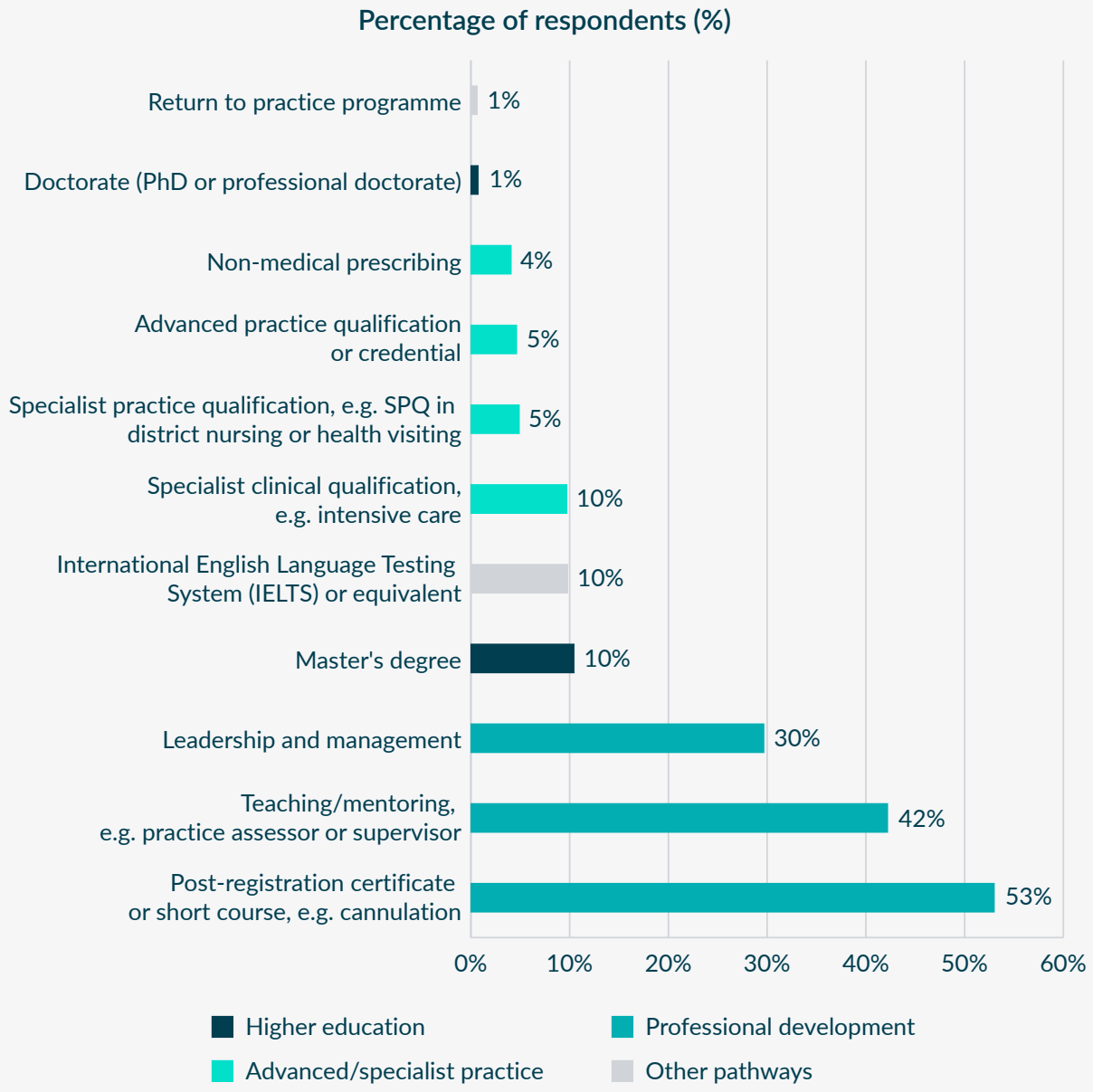
More than three-quarters of IENMs (78%) had achieved at least one further qualification since registering in the UK. Of the 22% who had achieved none, over half (57%, n=246) were recent arrivals, who will have had less time to do so.

The most common qualification was a post-registration certificate or short course (53%), followed by a teaching or mentoring qualification (42%). Fewer had gained a leadership or management qualification (30%).

Figure 23: UK qualifications achieved after registration

Post-registration qualifications achieved by IENMs in the UK (n=1,102)

Survey question: What qualifications (education or practice related) have you achieved since working in the UK as a registered nurse/midwife/nurse-midwife?



Note: Respondents could select more than one option, so percentages do not sum to 100%.

Access to further qualifications by ethnicity and registration status

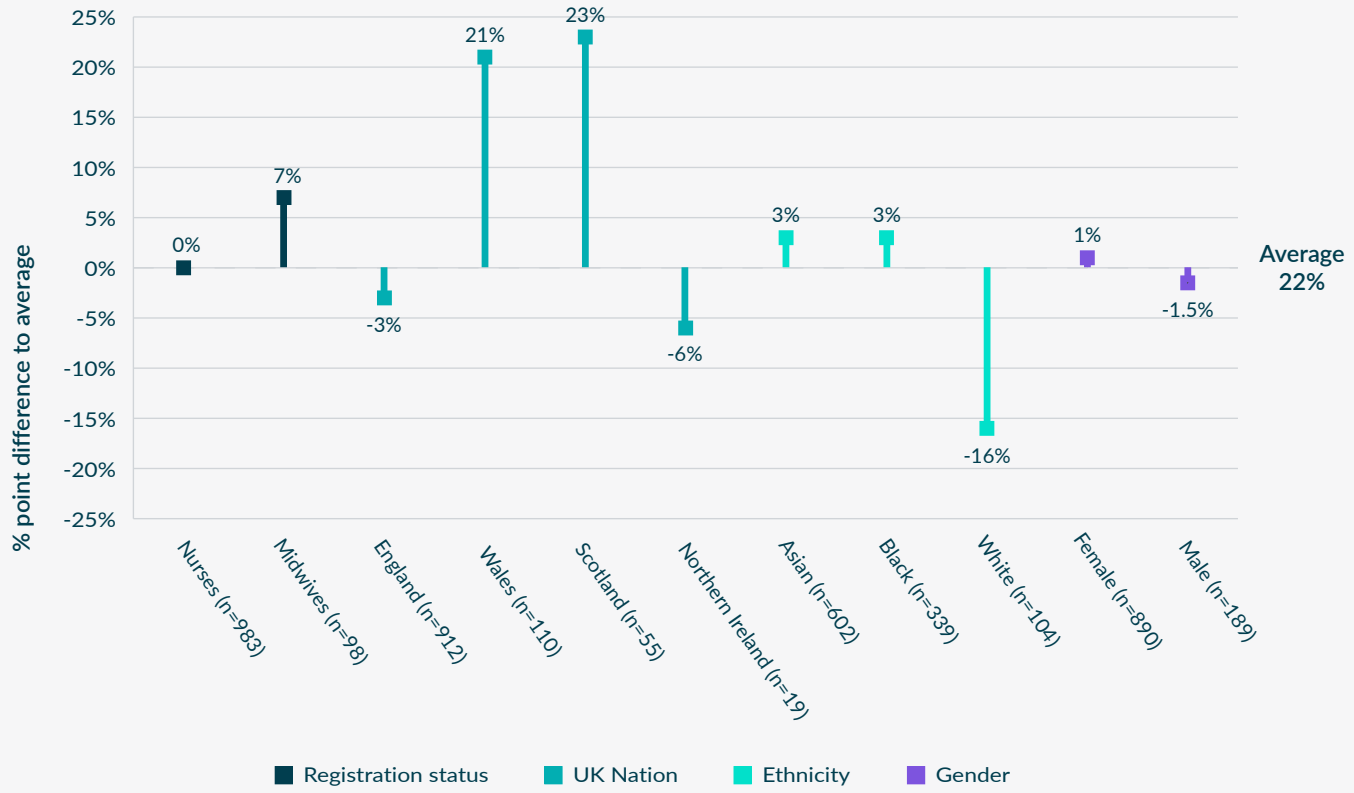
Access to further qualifications differed by ethnicity. Across the full sample, White IENMs were significantly less likely to report having no additional UK qualifications (6%, n=104) than Black IENMs (25%, n=339) and Asian IENMs (25%, n=602). This difference persisted after excluding recent arrivals, who may have had less time to gain further qualifications: 5% of White IENMs (n=95) reported no additional UK qualifications, compared with 21% of Black IENMs (n=136) and 19% of Asian IENMs (n=351).

Differences were also evident by professional registration status. Across the full sample, midwives were more likely than nurses to report having no additional UK qualifications (29%, n=98, compared with 22%, n=983). After excluding recent arrivals, this gap widened: 29% of midwives (n=38) reported no additional UK qualifications, compared with 16% of nurses (n=565).

Figure 24: No additional UK qualifications since registration

No additional UK qualifications among IENMs since NMC registration, by registration status, UK nation, ethnicity and gender

Difference in percentage points compared to the average response of achieving no qualifications when asked: 'What qualifications (education- or practice-related) have you achieved since working in the UK as a registered nurse, midwife, or nurse-midwife?'



Case Study: Education and postgraduate development

Northern Health and Social Care Trust

The Northern Health & Social Care Trust (NHSCT) is the largest geographical trust in Northern Ireland, delivering a range of health and social care services to a population of approximately 480,000 people across over 150 facilities. Nurses and midwives form a significant part of this workforce, supporting care across acute, community, mental health and social care services.

From April 2017 to March 2026, NHSCT recruited 286 IENMs. While NHSCT provides wider pastoral, clinical, and inclusion support, this case study focuses specifically on how the Trust enables IENMs to access postgraduate learning and development opportunities. NHSCT's support includes:

- Sharing education opportunities and access guidance in induction packs;
- Liaising with AEIs to identify suitable programmes for IENMs;
- Signposting to top-up programmes, including Queen's University Belfast's (QUB's) "Preparation for Degree Level Study" course, which supports access to degree-level study;
- Supporting IENMs who have completed the NMC OSCE programme to access academic accreditation through Ulster University (UU) and QUB;
- Advising on education routes, including how to obtain a UK ENIC Statement of Comparability; and
- Using the Northern Ireland Practice & Education Council (NIPEC) learning and development framework to map IENMs' future career pathway opportunities.

In their words

IENM reflections show the value of NHSCT's postgraduate learning support in practice — from strengthening clinical confidence and specialist knowledge to enabling longer-term career progression.

"

After completing my 2-year Specialist Practice in Older People Course, my clinical assessment and judgment vastly improved. I have my voice during multidisciplinary meetings/interactions and also, I was able to provide education and teachings to our staff about geriatric nursing. This course really improved my clinical assessment, my collaboration and communication with MDT and elevated my understanding.

"

Six years later, I've been blessed with so many opportunities, from completing my Emergency Nurse Practitioner course at Ulster University to now doing my prescribing course. I can say this with pride: I wouldn't be where I am today without the support of the people around me — my colleagues, my mentors, and the wonderful patients who remind me every day why I chose this path.

Findings

Support to achieve further qualifications

Among IENMs who had achieved further qualifications since registering in the UK, employer and manager support was the most commonly reported source of help: funded course fees (59%), line manager support (53%) and paid study leave (44%, n=858).

We also asked those who had not achieved any further qualifications what support they felt they needed (n=246). The most cited needs were better information about available opportunities (37%) and greater support from managers, peers and employers (30%), followed by financial support (26%) and protected time and manageable workloads (7%). A smaller number raised equal access and the recognition of prior qualifications and experience. These themes are summarised in the table below.

Table 5: Themes in support needed by IENMs who had not achieved further qualifications in the UK (n=246)

Support needs among IENMs who had not achieved further UK qualifications (n=246)
Information and opportunities **37%** Knowing what is available, how to apply, and who to ask.
Manager, peer and employer support **30%** Encouragement, sponsorship, signposting, and application support.
Financial support **26%** Funding for course fees, sponsorship, and study costs.
Time and workload support **7%** Protected study time, study leave, and manageable workloads.
Equal access and recognition **Small but distinct** Fair access and recognition of prior qualifications and experience.



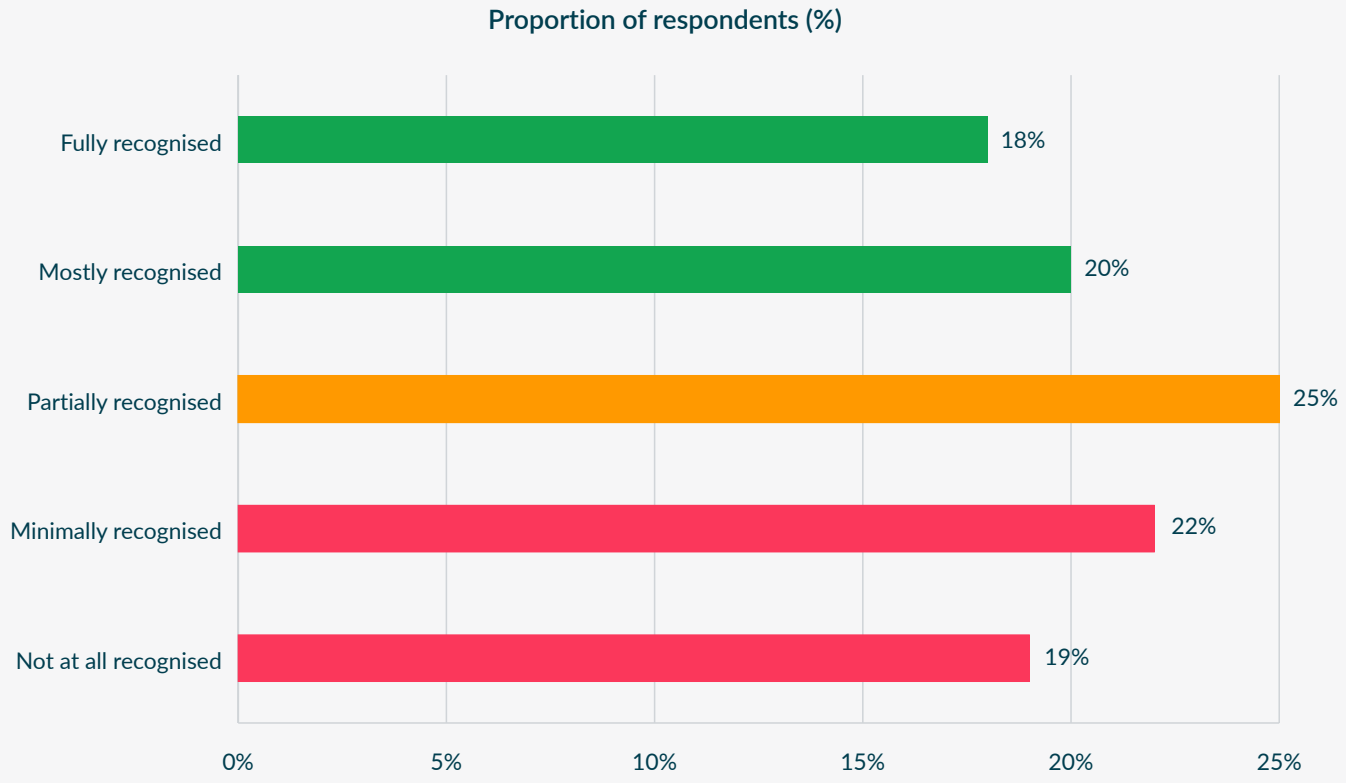
Recognition

We asked respondents the extent to which the clinical and academic qualifications, experience and skills they had gained in their home country had been recognised by their UK employer. Only 38% said their qualifications, experience and skills had been fully or mostly recognised (n=1,102).

Figure 25: Recognition of international expertise

Recognition of IENMs' international qualifications, experience and skills (n=1,102)

Survey question: To what extent have your clinical or academic qualifications, experience, and skills from your home country been recognised by your UK employer?



Where recognition differs

Recognition was lower among respondents who had completed a master's degree or PhD in their home country: 31% said their qualifications, experience and skills had been fully or mostly recognised, while 29% reported no recognition.

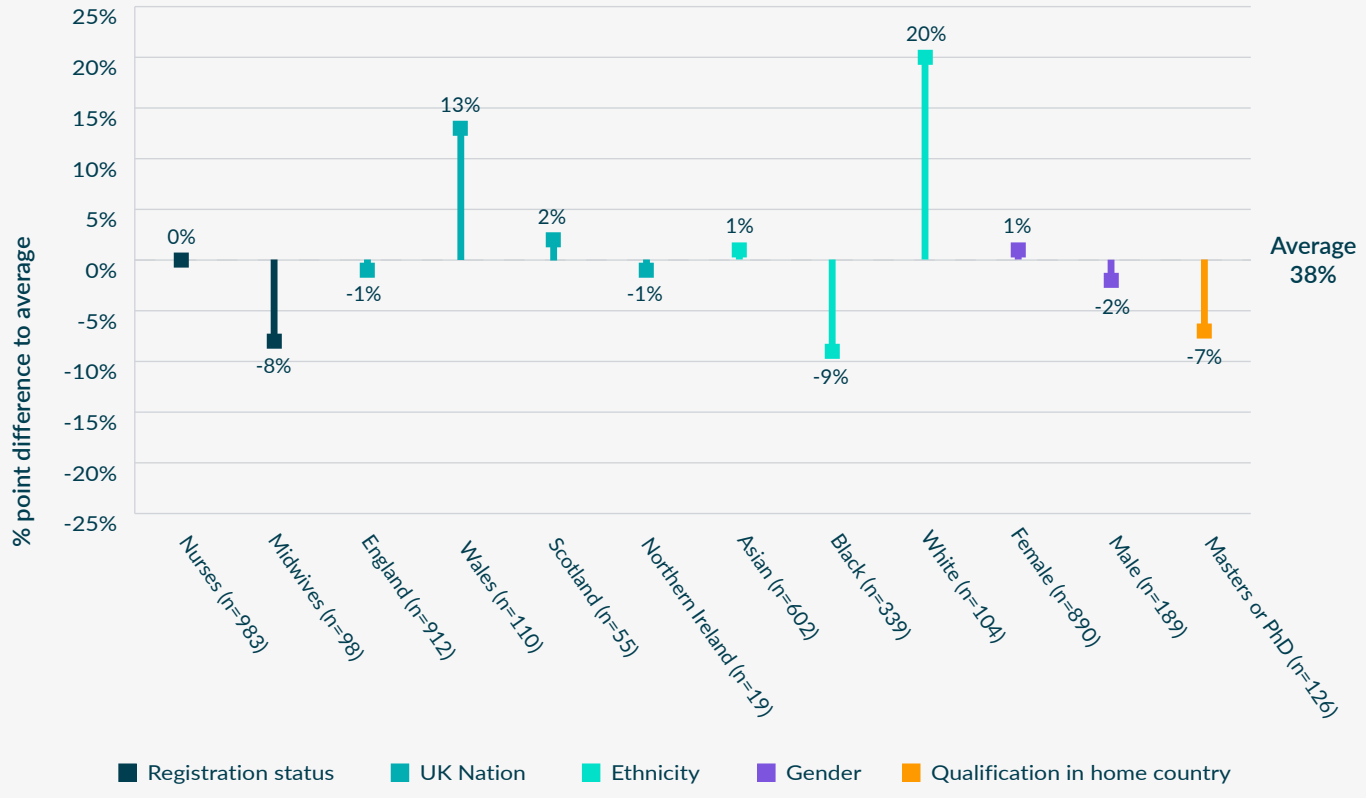
Recognition also differed by ethnicity. White IENMs were more likely than Asian and Black IENMs to report full or mostly full recognition (58% compared with 39% and 29%, respectively).

Registered nurses were also more likely than registered midwives to report full or mostly full recognition (38% compared with 30%).

Figure 26: Recognition of international expertise by respondent demographics

Recognition of IENMs' international qualifications, experience and skills, by registration status, UK nation, ethnicity, gender and home country qualification

Difference in percentage points compared to the average response of full or mostly full recognition when asked: 'To what extent have your clinical or academic qualifications, experience and skills from your home country been recognised by your UK employer?'



Leadership

Encouragement to apply for leadership roles

Respondents were asked whether they had ever been encouraged to apply for a leadership role since working in the UK. Just over half said they had (52%, n=1,102). When recent arrivals were excluded, this increased only slightly to 59% (n=608).

Encouragement by ethnicity

Interpretation note:

To mitigate the confounding influence of time since arrival, the following comparison is restricted to respondents who arrived in 2020 or earlier.

Excluding recent arrivals, encouragement varied markedly by ethnic group. White IENMs were substantially more likely to report having been encouraged to apply for leadership or supervisory roles (75%, n=95) than Asian (58%, n=351) or Black IENMs (53%, n=136). It mirrors the disparity seen in promotion: the groups least likely to be encouraged toward leadership are the same groups least likely to have progressed.

Accessibility of leadership development programmes

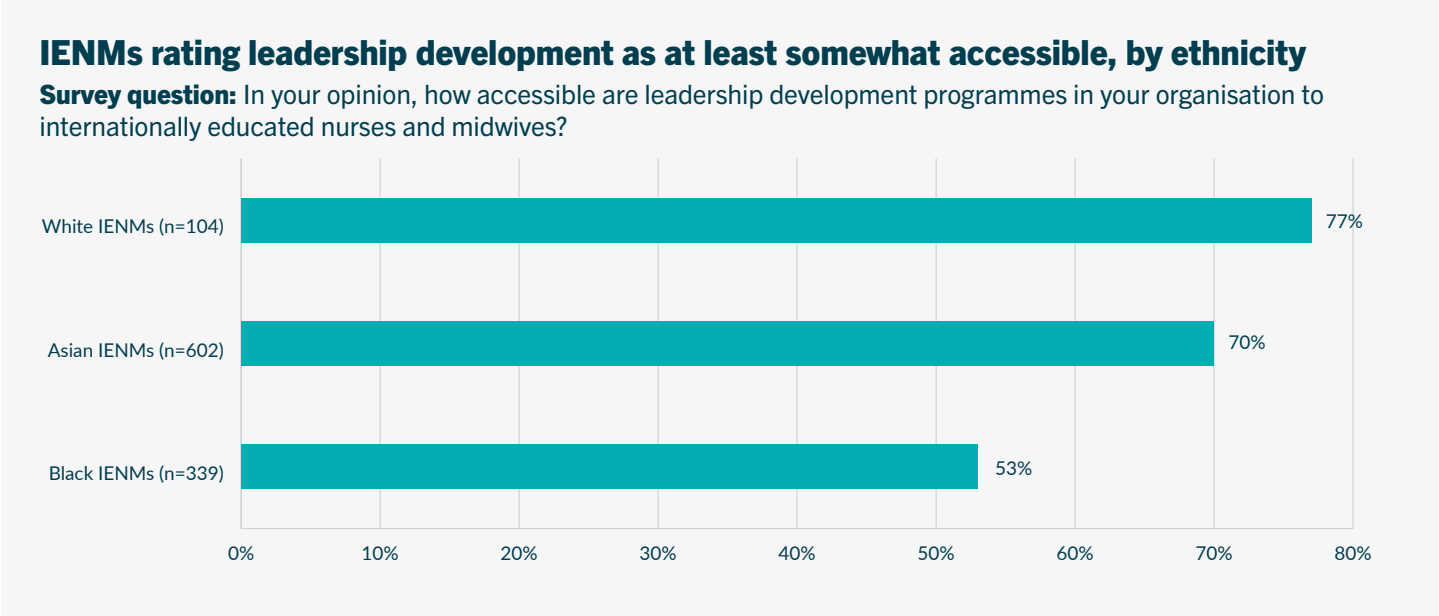
Respondents were first asked about the general accessibility of leadership development programmes in their organisation. Two-thirds rated these programmes as at least somewhat accessible (65%, n=1,102). However, a third either said they were not very accessible or did not know whether such programmes existed (35%), suggesting that access to general leadership development remains uneven.

We then asked whether employers offered leadership development specifically designed for IENMs. Access to this more targeted provision appeared more limited: only 23% said IENM-specific leadership development was available, while 32% did not know whether it existed (n=1,102).

Accessibility ratings by ethnicity

Ratings of accessibility differed by ethnicity. Black IENMs were less likely to rate leadership development programmes as at least somewhat accessible than White IENMs and Asian IENMs (Figure 27).

Figure 27: Access to leadership development by ethnicity



Barriers to accessing leadership development

We asked our respondents about the barriers they have faced when trying to access leadership development. Table 6 summarises the main themes from the free-text responses (n=1,102). Overall, the findings suggest that these barriers are not only a matter of individual confidence or awareness. Many respondents described structural obstacles:

unequal access to informal opportunities, limited sponsorship from managers and the non-recognition of prior international experience. Notably, even some of those who reported "no barriers" had not attempted to access development at all, anticipating refusal, exclusion or a lack of support.

Table 6: Summary of themes from free-text responses on barriers to accessing leadership development opportunities among IENMs (n=1,102)

Theme	%	What this shows
No barriers / not applicable	32%	Many had not tried to access leadership development, often because they did not expect support or had seen others discouraged. ***"I have not tried. I have observed what my previous internationally trained colleagues went through when they want a higher position. I will apply to a different trust should I want to go into leadership position. I will save myself from humiliation and verbal abuse at my trust."*** – A midwife trained in Ghana working in England
Structural and resource constraints	19%	Funding, time, staffing and study leave barriers were compounded by visa status and eligibility restrictions. ***"Clarity if NHS funded courses are termed as public funds."*** – A nurse trained in Nigeria working in Scotland
Lack of access, awareness and opportunity	18%	IENMs often lacked timely information about programmes and were less likely to hear about informal opportunities. ***"Information is not widely spread and accessible to us. We are always the last to know, and can be evident in the diversity of those who get access to development."*** – A nurse trained in the Philippines working in England
Individual and contextual barriers	16%	Confidence, language, childcare and visa issues were frequently shaped by workplace exclusion rather than personal limitation. ***"Due to visa requirements and being new to the country with no extended family to support childcare - there is hesitation to progress as most higher bands work office hours."*** – A nurse trained in India working in England
Discrimination and IENM-specific exclusion	14%	Respondents described differential treatment, racism, non-recognition of prior experience and programmes not designed for IENMs. ***"Interview results predetermined – local colleagues always been chosen. Our qualifications and previous work experience not recognised. Prejudice not being given the chance to available leadership development, not given the same opportunity compared to our ethnically white colleagues."*** – A nurse trained in the Philippines working in Northern Ireland
Lack of manager support	13%	Some managers blocked, discouraged or failed to sponsor IENMs into leadership development. ***"My previous line manager did not support me through leadership programmes as they said it was not relevant to my current role."*** – A nurse trained in Greece working in England
Work experience, banding and role restrictions	6%	Prior overseas experience was often discounted, limiting progression into leadership pathways. ***"Lack of confidence as constantly told my education is not at par with British education thus I need more education even after gaining NMC PIN."*** – A nurse trained in the Philippines working in England

Case Study: Leadership development for IENMs

With funding from the Burdett Trust for Nursing, the Florence Nightingale Foundation developed an online blended leadership programme for internationally educated nurses and midwives. First delivered in 2022–23, the programme continues to support participants to develop authentic leadership styles, strengthen their skills and improve career opportunities.

Co-developed with partners including Myers Briggs, RADA Learning and FNF subject matter experts, the 30-hour online programme combines reflective leadership development with practical skills-building.

Modules include:

- Personality preferences and team performance;
- Quality improvement;
- Presence, impact and communication;
- Influencing change; and
- Co-consulting and live action learning sets.

Outcomes

Career progression: Several participants emphasised that their involvement in the programme was a key step toward advancing their professional careers.

Develop leadership skills: For many, the programme offered a vital opportunity to not only develop these skills but also to observe their tangible impact on their readiness for more advanced roles.

Resonance: They felt a deep connection with the programme, recognising it as uniquely tailored to their experiences and challenges.

> “As someone who qualified in a different country, I have often felt hesitant to speak up, despite having the skills, experience, and passion to contribute. This course provided a safe, supportive, and inspiring space where my voice was valued and my potential as a leader was recognised.

> “The course was excellent and has really boosted my confidence. As someone from an underrepresented background, I found it particularly empowering and encouraging. The content was practical, engaging, and has given me greater confidence to apply what I’ve learnt in my role.

Inclusion in talent and leadership pathways

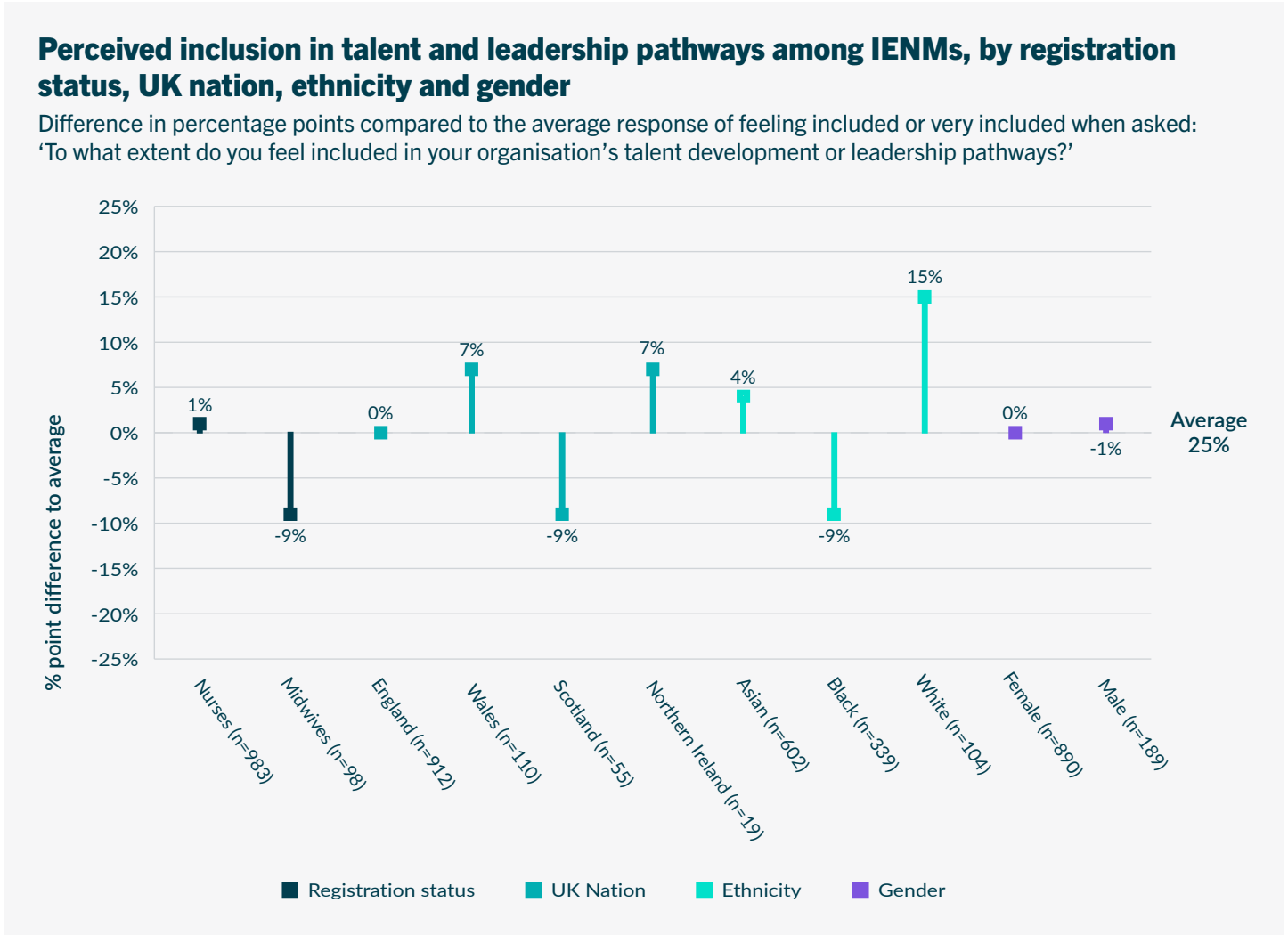
Respondents were asked how included they felt in their organisation's talent development or leadership pathways. Only one in four IENMs said they felt included (25%, n=1,102), while 45% felt neutral and 30% did not feel included (Figure 28). We also asked how confident they were that they could progress into a leadership role within the next three years, if they wanted to. Confidence was higher, though still mixed: 51% felt confident they could progress, 31% felt neutral and 18% were not confident. Together, these findings suggest that many IENMs feel uncertain about their access to leadership progression, even where they may have personal confidence in their ability to progress.

Inclusion by registration status and ethnicity (Figure 28)

Inclusion differed by registration status. Midwives were less likely than nurses to feel included in their organisation's talent and leadership pathways (16%, n=98 compared with 26%, n=983).

Differences by ethnicity were more pronounced. Black IENMs were least likely to feel included (16%, n=339), compared with Asian IENMs (29%, n=602) and White IENMs (40%, n=104).

Figure 28: Inclusion in talent and leadership pathways



Findings

Visibility of IENMs in leadership positions

Respondents were asked whether IENMs were visible in leadership or senior decision-making roles in their organisation, and whether any IENMs occupied senior leadership positions such as Chief Nurse or Director of Midwifery. Only 28% said IENMs were visible in leadership or senior decision-making roles, while 30% said IENMs were represented in their organisation's senior leadership team (n=1,102). A further 23% did not know whether IENMs held senior leadership roles, highlighting a wider issue of visibility.

Nurses were significantly more likely than midwives to report that IENMs were visible in leadership or senior decision-making roles (30%, n=983 compared with 10%, n=98). Nurses were also significantly more likely to report IENM representation in their organisation's senior leadership team (32%, n=983 compared with 12%, n=98).

Psychological safety in the workplace

Respondents were asked about two aspects of psychological safety in the workplace: whether they felt safe and supported to raise concerns about patients or service users, and whether they felt safe and supported to raise concerns involving themselves or colleagues.

Overall, 69% said they always or most of the time felt safe and supported to speak up about a patient or service user (n=1,102), compared with 46% who felt safe and supported to speak up about a concern involving themselves or a colleague.

Psychological safety differed by registration status and ethnicity

Differences were evident by registration status for concerns involving respondents themselves or colleagues, but not for concerns about patients or service users. Nurses were significantly more likely than midwives to feel safe and supported to speak up about themselves or a colleague (47%, n=983 compared with 34%, n=98). However, nurses and midwives reported similar levels of psychological safety when speaking up about patients or service users.

Differences by ethnicity were evident for both aspects of psychological safety. White IENMs were significantly more likely than Asian and Black IENMs to feel safe and supported to speak up about patients or service users (84%, n=104, compared with 68%, n=602 and 67%, n=339, respectively). Differences were also apparent for concerns involving respondents themselves or colleagues: Black IENMs were significantly less likely than both Asian IENMs and White IENMs to feel safe and supported to speak up in this context (31%, compared with 51% and 63%, respectively).



Findings

Theme 4: Learning and Global Partnerships

Internationally educated nurses and midwives bring more than the capacity to fill vacancies; they bring expertise formed in other health systems. This section examines that expertise: the skills and perspectives IENMs carry, the extent to which these are recognised and used, their appetite for global health partnerships, and the role of diaspora communities as a form of workforce infrastructure.

Key Findings

- **IENMs bring substantial international expertise into UK practice:** 87% drew on knowledge and skills gained overseas in their clinical practice and patient care, and 65% in both patient safety and quality improvement and education, training and knowledge sharing.
- **Much of this expertise remains untapped by employers:** Only 11% were regularly asked to share their international knowledge or experience, while 45% were never asked; free-text responses also described deskilling, loss of autonomy and expertise going unused.
- **There is a striking gap between appetite and opportunity for global engagement:** 79% wanted to participate in global health partnerships, but only 3% had previously done so.
- **Global partnerships could strengthen retention as well as reciprocal learning:** 58% said involvement would increase their motivation to stay in the UK, 72% their sense of belonging and 67% their ability to use leadership experience and knowledge gained overseas.
- **Diaspora communities are an under-recognised workforce asset:** Only 19% of diaspora respondents felt their communities' contribution was recognised well or very well, while 36% rated recognition as poor or very poor.



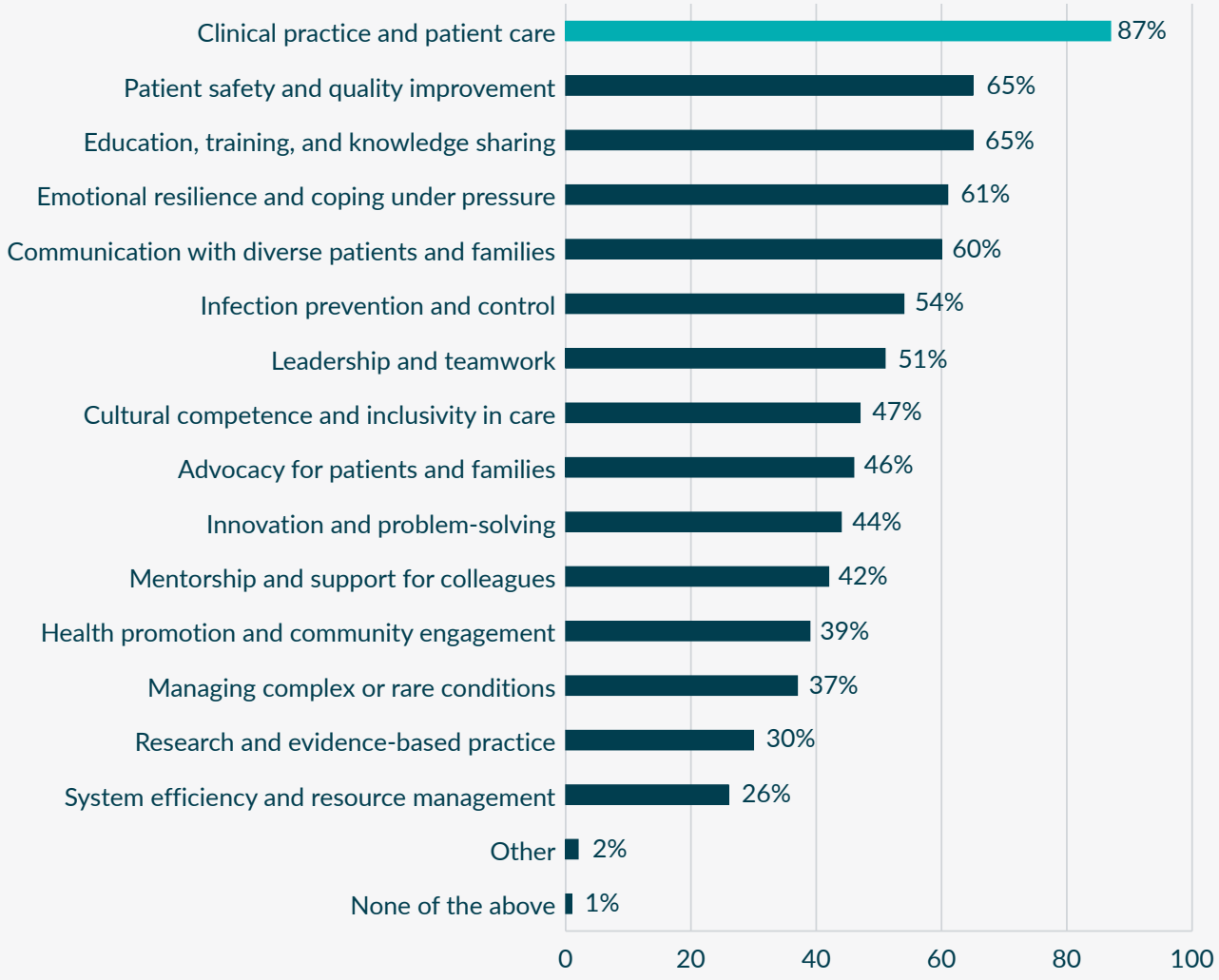
Applying international learning in UK practice

We asked respondents which aspects of their UK nursing or midwifery practice draw on the knowledge and skills they gained in their country of education or training (Figure 29). The most commonly reported was clinical practice and patient care (87%), followed by patient safety and quality improvement (65%), education, training and knowledge sharing (65%), communication with diverse patients and families (60%), infection prevention and control (54%) and leadership and teamwork (51%) (n=1,101).

Figure 29: Use of international knowledge in UK practice

How IENMs use international knowledge and skills in UK practice (n=1,101)

Survey question: In which of the following areas do you feel your international experience contributes to your work in the UK?



Note: Respondents could select more than one option, so percentages do not sum to 100%.

Skills and experiences brought to the UK

We asked respondents to describe, in their own words, the skills and perspectives they bring from their country of education or training. Table 7 summarises the main themes from these free-text responses, illustrating the breadth of skills and experience that IENMs reported bringing to the UK.

Table 7: Themes of key skills and perspectives IENMs reported bringing to the UK, based on 1,101 free-text responses

Theme	Description	Quote
Resilience and working under pressure **~35% of responses**	Respondents described experience of working in high-pressure settings, often with limited resources, as a transferable skill.	***"Working in a healthcare system with limited resources taught me to be flexible, resourceful and calm under pressure, while always prioritising patient safety and dignity."*** – A nurse trained in Nigeria now working in Scotland
Clinical skills, knowledge and breadth of training **~30% of responses**	Respondents highlighted broad clinical training across specialties, including medicine, emergency care, paediatrics, theatres, community, mental health and midwifery.	***"From my training in my home country I bring a broad and versatile clinical foundation across all patient groups and departments — including medicine, emergency care, paediatrics, adult care, theatres, community, mental health and midwifery."*** – A nurse trained in Portugal now working in England
Compassion, empathy and patient-centred care **~20% of responses**	Respondents described relational approaches to care, including compassion, patience, warmth and treating patients with dignity.	***"Culturally, we look after patients as if they were our own family or relations and that perspective has shaped my compassion, commitment and empathy that I bring to my role in the UK."*** – A nurse trained in the Philippines now working in England
Adaptability and flexibility **~12% of responses**	Respondents described adapting to new settings, roles and systems, drawing on experience from different health systems.	***"I have the experience from working in a different public health system and I can see the differences — this provides me with ideas to improve my team and department."*** – A nurse trained in Spain now working in England
Leadership, mentorship and education **~10% of responses**	Respondents described experience in teaching, mentoring, curriculum development, clinical skills training and leading teams.	***"My experience leading teaching, curriculum development, and clinical skills training in India has enabled me to support professional development, facilitate peer learning, and enhance the confidence and competence of colleagues and students within the UK healthcare system."*** – A nurse trained in India now working in England
Cultural competence and communication with diverse patients **~8% of responses**	Respondents described using language skills and cultural understanding to support communication with diverse patients and families.	***"I have offered different perspectives within my team on approaches to patient care with a unique understanding of cultural differences, which has increased patient outcomes and satisfaction."*** – A nurse trained in Nigeria now working in England

A clear distinction emerged between the skills IENMs bring and the extent to which these skills are recognised or used in UK roles. Around 15% of free-text responses referred to deskilling, including restricted autonomy, limited recognition of previous expertise and reduced opportunities to share international knowledge.

"After coming to my current Trust, I have been severely deskilled to the extent that I doubt myself and my ability." – A nurse trained in India now working in Wales

"Autonomy was taken from me. I came with a lot of skills, which when I came to the UK I was told I cannot do this and that." – A nurse trained in Zambia now working in England

"I have a huge amount of experience, which I am not encouraged to share." – A nurse trained in South Africa now working in Wales

This was also reflected in survey responses on knowledge sharing: only 11% said they were regularly asked to share international knowledge or experience, while 44% were asked occasionally and 45% were never asked (n=1,101).

Global partnerships

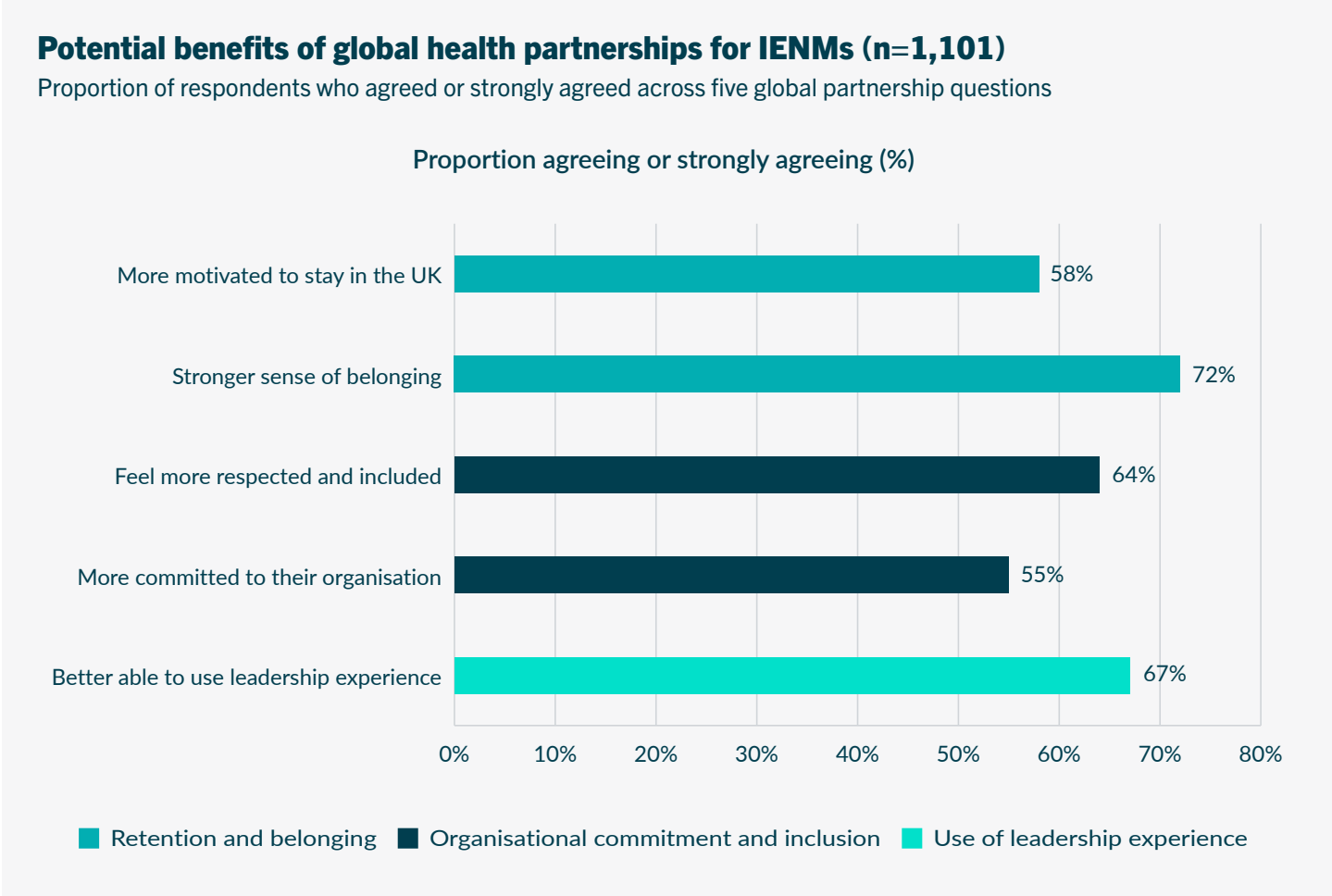
Global health partnerships are formal collaborations between health systems, institutions or professional bodies in different countries – often twinning arrangements, staff exchanges or joint training and capacity-building initiatives – through which knowledge and expertise flow in both directions. We asked IENMs whether they had previously been involved in this kind of partnership or exchange work, and whether they would like to be in future.

Only 3% reported previous involvement, while 79% said they would like to be involved (n=1,101). Respondents who had been involved gave examples such as:

- International childhood cancer research with St Jude's Children's Research Hospital
- UN project in Sri Lanka and the Maldives
- Trust twinning arrangement with St Vincent and Grenadines
- Perineal training sessions through diaspora engagements
- Shaping nursing education at universities in Sri Lanka
- International recruitment and mobility pathways through the ERASMUS programme
- One short secondment to NHS England's global programme

We also asked respondents about the potential value of global partnerships with their home countries. Figure 30 summarises responses across three areas: retention and belonging, organisational commitment and inclusion, and use of leadership experience.

Figure 30: Potential benefits of global health partnerships



Case Study: A whole-system approach to global partnerships

West Yorkshire Health and Care Partnership

West Yorkshire Health and Care Partnership (WYHCP) takes a whole-system approach to global partnerships, bringing together NHS, local government, VCSE, education, research and social care partners. Through its Global Partnerships Team and exemplar partnership with NHS England, WYHCP works with global partners to address shared workforce and service challenges through ethical collaboration, reciprocal learning and quality improvement.

Activities

Global partnerships

WYHCP's formal partnerships focus on shared priorities, QI and reciprocal learning. Current and developing partnerships include:

- Uganda: virtual training and an obstetric and neonatal care project in Kampala;
- Kerala: supports ethical migration pathways and Global Fellow QI projects, building on a longstanding NHS England relationship;
- Ghana: a new community mental health partnership, with plans for knowledge exchange, fellowships and observerships;
- Saint Vincent and the Grenadines: a managed education partnership involving observer cohorts and Global Fellow QI projects; and
- Montserrat: developing future fellowships, observerships and virtual knowledge exchange.

Virtual knowledge exchange

Online communities of practice connect West Yorkshire and global partners to share expertise, solve common challenges and support reciprocal learning, including IPC and English language development.

Global fellowships

West Yorkshire staff live and volunteer in partner countries, completing jointly planned QI projects with global partners and NHS England's Global Health Unit.

Observerships

Colleagues from partner countries spend one to two months in West Yorkshire to develop knowledge and skills, then apply their learning through QI work at home.

Global projects

Staff contribute through overseas volunteering, UK-based project support and fundraising for global health and development activity.

Benefits

Global partnerships strengthen cultural competence, leadership development, wellbeing and retention across West Yorkshire, while supporting reciprocal innovation, service quality and safe staffing through ethical recruitment.

They also promote equity by recognising and valuing internationally educated colleagues.

Diaspora

This section examines how IENMs describe the role of diaspora communities in global health partnerships, patient care and workforce culture.

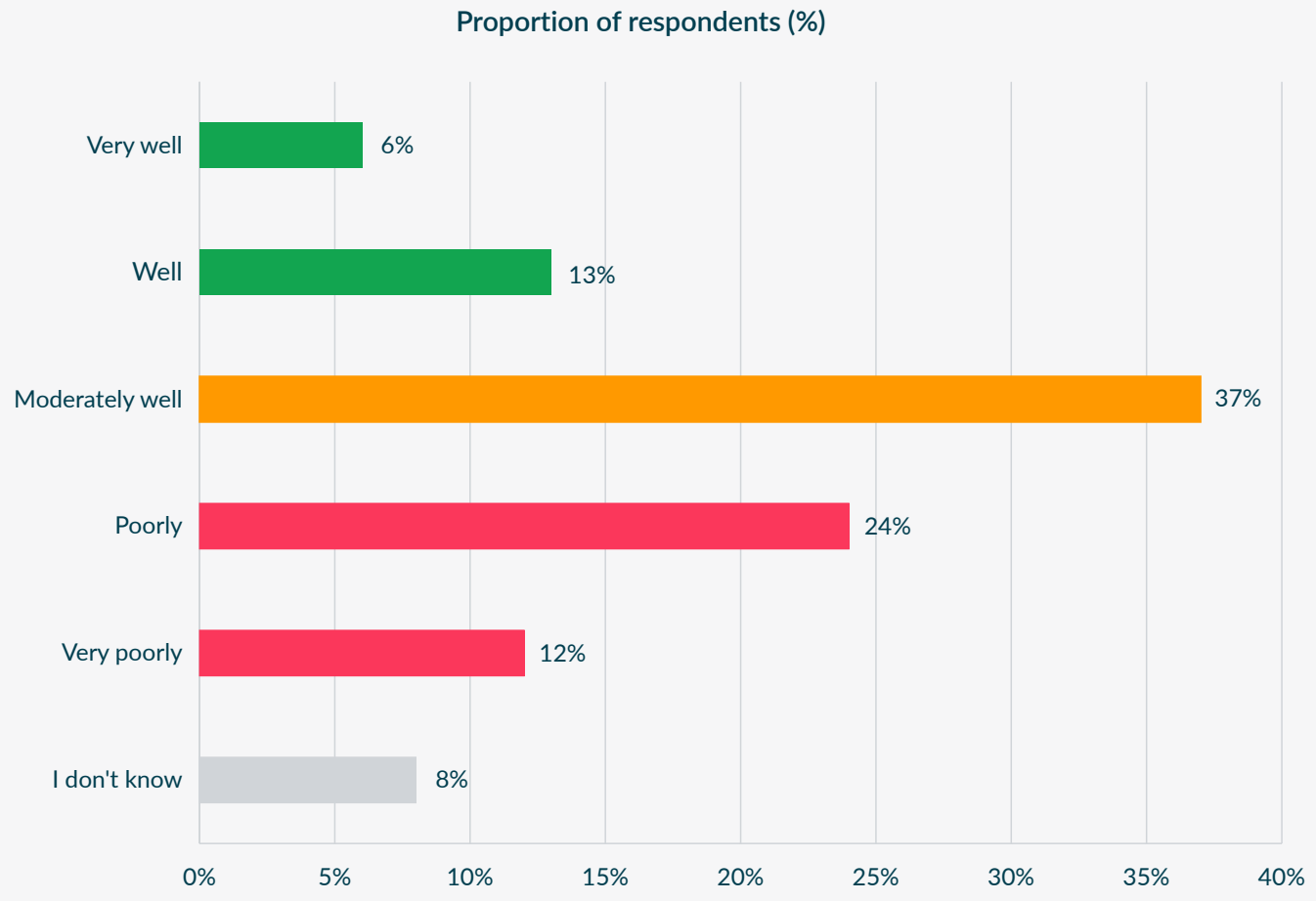
Recognition of diaspora contributions

Among IENMs who identified as part of a diaspora community (n=548), over a third rated recognition of diaspora contribution as moderate (37%), while 36% rated it as poor or very poor. Just 19% said their communities are recognised well or very well (Figure 31).

Figure 31: Recognition of diaspora contributions

Perceived recognition of diaspora communities' contributions to the UK health and care system (n=548)

Survey question: How well do you think the UK's health and care system recognises and values the contribution of diaspora communities in shaping health?



Role of diaspora in strengthening health partnerships

We asked IENMs who identified with a diaspora group what role diaspora communities could play in strengthening global health partnerships between the UK and other countries. Two main themes were identified from the free-text responses.

Table 8: Themes from free-text responses on the role of diaspora communities in strengthening global health partnerships (n=548)

Theme	Description	Quote
Bridging role **~30% of responses**	Respondents described diaspora communities as links between health systems, cultures, languages and countries of origin.	***"They can play a big role in strengthening global health partnerships because they understand both the UK system and the healthcare needs of their home countries. They can help bridge cultural gaps, support knowledge-sharing, and create connections for training, collaboration, and capacity building."*** – A nurse trained in the Philippines now working in England
Ethical reciprocity **~8% of responses**	Respondents linked diaspora involvement to fairer recruitment, shared learning and benefits for both the UK and countries of origin.	***"Diaspora nurses can help design ethical recruitment and retention strategies that balance workforce needs in both the UK and partner countries. They can advocate for bilateral agreements that include training investment and return pathways, reducing 'brain drain' while promoting 'brain circulation.' Their lived experience makes them credible voices in policy discussions about fair migration and global workforce sustainability."*** – A nurse trained in India now working in England



Harnessing these insights

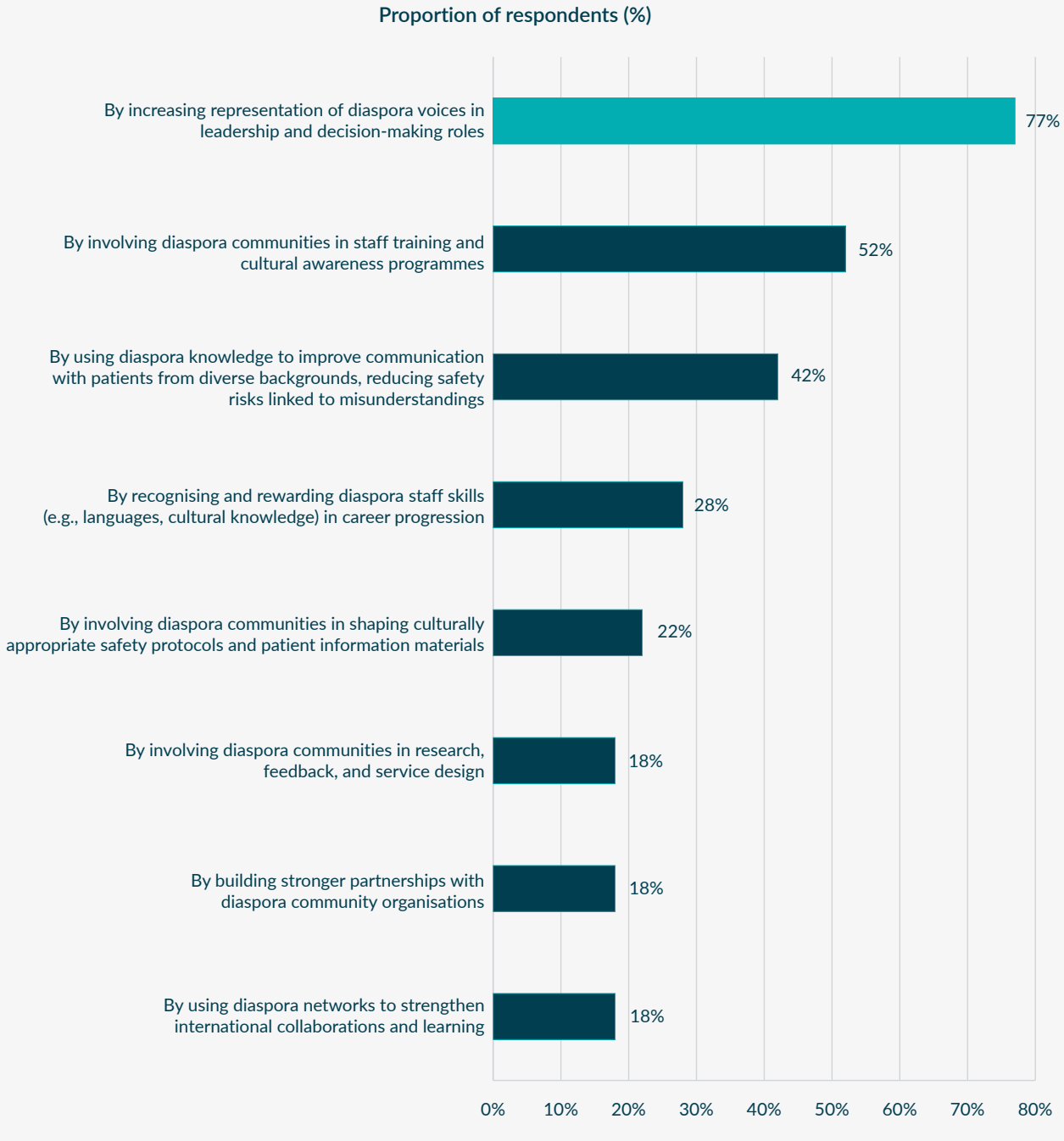
We asked IENMs who identified with a diaspora group how the health and social care sector could better use diaspora insights to improve patient care and workforce culture (Figure 32).

Most respondents selected increasing representation of diaspora voices in leadership and decision-making roles (77%), followed by involving diaspora communities in staff training and cultural awareness programmes (52%) and using diaspora knowledge to improve communication with patients from diverse backgrounds (42%, n=548).

Figure 32: Involving diaspora communities in care and workforce culture

How diaspora communities should be involved in improving care and workforce culture (n=548)

Survey question: How can the health and social care sector better harness the insights of diaspora communities to improve patient care and workforce culture?



Learning from the NHS England Small Grants Programme

To complement the survey findings, we undertook an analysis of projects delivered through the NHS England-funded Small Grants Programme for nursing and midwifery diaspora associations, administered by FNF. The programme provided direct funding to strengthen the support diaspora organisations offered to IENMs, while also building the capacity and sustainability of the associations themselves. Across the portfolio, four areas of activity were particularly evident: support for transition into UK practice; pastoral and peer support; clinical confidence and professional readiness; and digital tools for wider reach.

1. Early support for transition into UK practice

Across the portfolio, many diaspora associations supported nurses and midwives before arrival in the UK, on arrival, or during the early months of transition. Activities included orientation to UK professional expectations, signposting to housing and mental health support, access to community networks, and guidance on working conditions and regulatory processes.

Projects commonly described this support as peer-led, drawing on the lived experience of members who had already navigated the transition into UK practice.

2. Pastoral and peer support

Pastoral care was a common feature across the projects. Associations provided culturally sensitive spaces for IENMs to discuss professional concerns, workplace conflict, discrimination, bereavement, financial stress and mental health concerns.

Some associations also supported members through disciplinary processes, escalated safeguarding concerns, and liaised with employers, regulators and unions where needed.

3. Clinical confidence and professional readiness

Several projects focused on clinical confidence and professional readiness. Activities included OSCE preparation, interview skills, fetal monitoring, neonatal life support, human factors training and patient safety education.

Reported outcomes included improved confidence, high OSCE pass rates and faster progression into substantive roles. Many activities were delivered online, peer-led or outside standard working hours.

4. Digital tools and national reach

Several projects used digital tools to extend their reach. These included websites, handbooks, learning hubs, apps and video platforms.

Projects reported that digital delivery helped associations reach members across different regions, including rural or isolated staff, and maintain access to resources beyond one-off events. Some projects also used digital tools to support communication, data capture, resource sharing and evaluation.

Case Study: Diaspora-led support, leadership and retention initiatives

Three featured projects from NHS England's Small Grants Programme.

Full versions of these case studies are provided in Appendix 4.

Project	Focus and activities	Outcomes
Society of African and Caribbean Midwives	Integrated pastoral, psychological and professional support, including clinical and patient safety training, NHS orientation, coaching, psychotherapy and cultural intelligence workshops.	Greater belonging and psychological safety; stronger confidence in safe practice and wellbeing; improved understanding of the UK health and care system.
Contribution to the wider system: Strengthens retention, safe practice and inclusion through an integrated pastoral–clinical support model.		

Project	Focus and activities	Outcomes
British Indian Nurses Association	Pastoral, wellbeing and career support for newly arrived and internationally recruited nurses from India, including OSCE support, interview preparation, mentoring, coaching and wellbeing sessions.	Improved OSCE preparedness, career progression, wellbeing, integration and retention.
Contribution to the wider system: Demonstrates the role of diaspora-led support in recruitment, retention and wellbeing-focused workforce strategies.		

Project	Focus and activities	Outcomes
Filipino Senior Nurses Alliance UK	Leadership visibility, representation and career development for senior Filipino nurses and Filipino IENs, including the FSNA launch, FILAMENT scoping study, stakeholder engagement and mentorship planning.	Greater national visibility, membership growth, stronger leadership group and increased stakeholder engagement.
Contribution to the wider system: Strengthens leadership pipelines, role modelling and diaspora-led advocacy for experienced IENs.		

Theme 5: Retention

Retention brings together the themes explored throughout this report. Recognition, development, leadership, inclusion, involvement in global partnerships, workplace safety and transition support all influence whether internationally educated nurses and midwives remain in the profession and in the UK. This section examines intentions to leave, the reasons behind them and, crucially, the factors that encourage this workforce to stay.

Key Findings

- **A significant minority are considering leaving either the profession or the UK:** 16% intended to leave nursing or midwifery within three years, while 26% intended to move abroad to practise and 14% already had an application pending.
- **Commitment to nursing and midwifery remains a powerful reason to stay in the profession:** Passion for the profession (53%), professional pride (44%) and pay and financial security (44%) were among the most common factors supporting retention.
- **Working conditions and workplace culture were the strongest drivers of leaving leaving the profession:** Burnout and stress (59%), workload and staffing (53%), racism or discrimination (44%) and bullying (28%) were prominent reasons for intending to leave.
- **Support and recognition are associated with stronger retention:** Comprehensive induction, pastoral support, preceptorship, revalidation support and recognition of prior experience were each linked to a greater intention to remain in the profession.

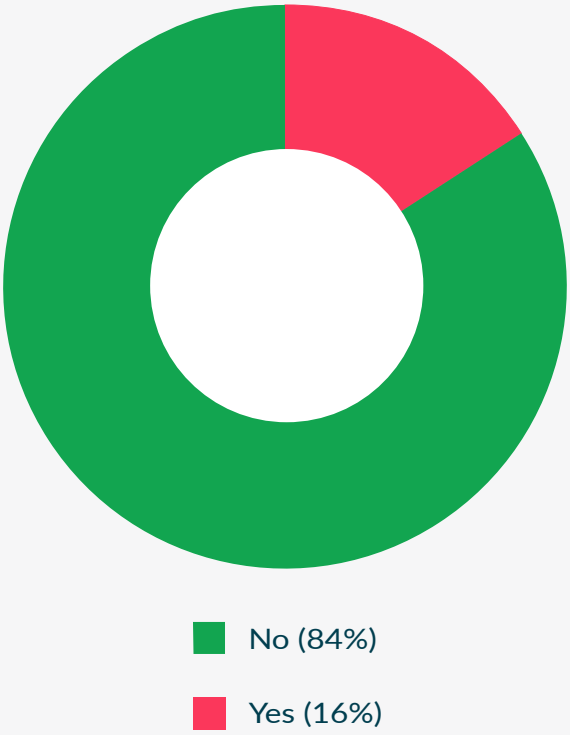
Intention to leave the profession

We asked IENMs whether they intended to leave the nursing or midwifery profession within the next three years. Overall, 16% said they intended to leave (n=1,102) (Figure 33).

Figure 33: Intention to leave the profession

Intention to leave the nursing or midwifery profession among IENMs (n=1,102)

Survey question: Do you intend to stop being a registered nurse or midwife in the next 3 years?



Retention risk was present at every band reported, with broadly similar proportions intending to leave at Band 5 (14%, n=542), Band 6 (18%, n=318), Band 7 (18%, n=148) and Band 8a (12%, n=49).

Reasons for staying in the profession

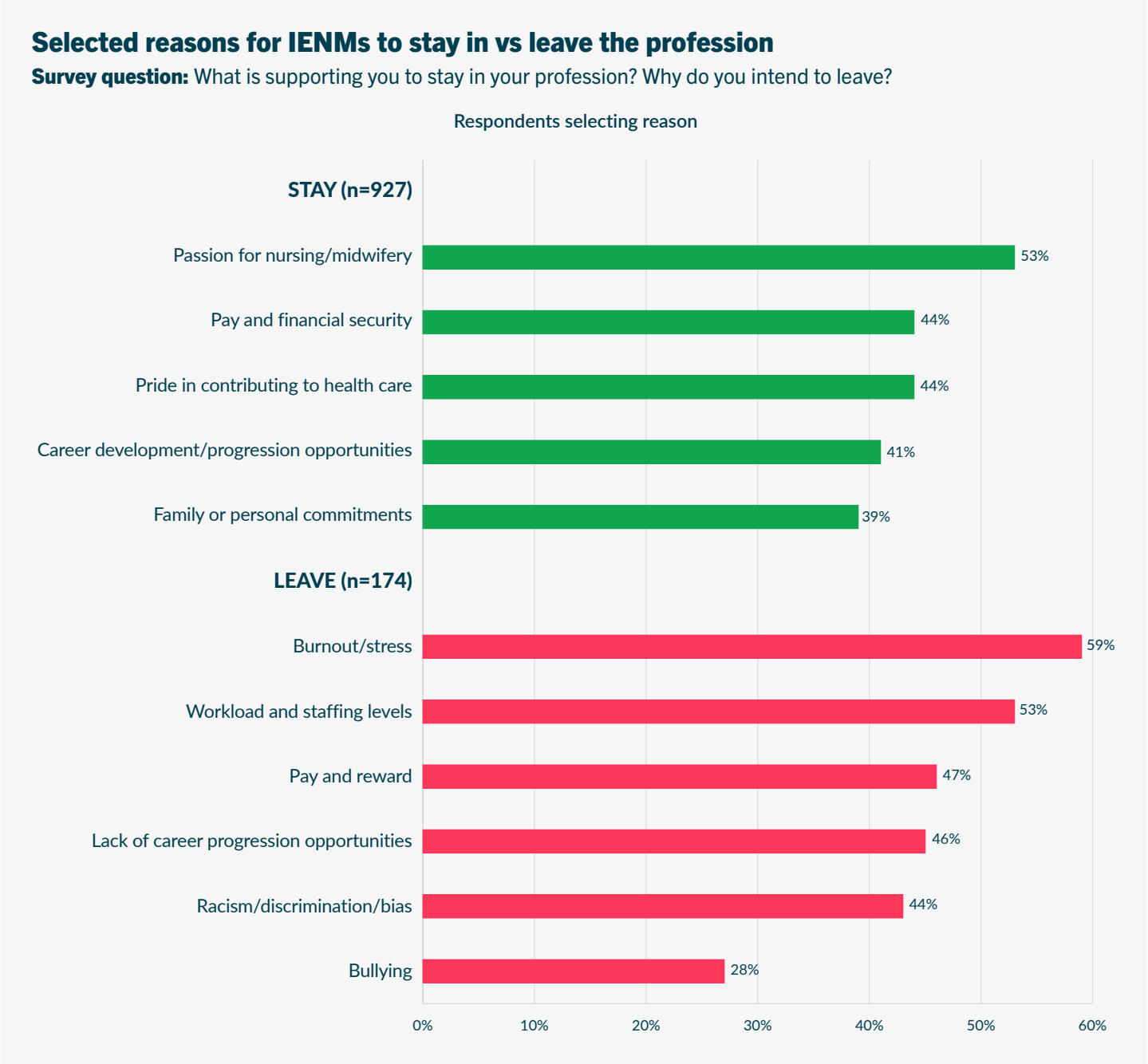
Respondents intending to stay in the profession were asked what factors were supporting them to remain. The most common reasons reflected both professional commitment and stability: passion for the profession (53%), pay and financial security (44%) and professional pride (44%) (n=927).

Reasons for leaving the profession

Respondents intending to leave the profession within the next three years were asked their reasons for leaving. The most common reasons were burnout and stress (59%) and workload and staffing levels (53%) (n=174). Workplace culture was also a major concern: 44% cited racism, discrimination or bias, and 28% cited bullying.

Figure 34 summarises this contrast. Reasons for staying were more strongly linked to professional identity and stability, while reasons for leaving were more strongly linked to working conditions and workplace culture.

Figure 34: Professional retention and leaving factors



Factors associated with intention to leave the profession

Interpretation note:

Wider evidence suggests that support during transition, access to development, recognition of prior experience, and workplace support can all influence whether nurses and midwives remain in the profession. We therefore examined whether these factors were associated with IENMs' intention to stay in the profession in our survey. These findings should be interpreted as associations, not causal effects.

Table 9 provides an overall summary of the relationship between IENMs' intention to leave the profession and selected aspects of their UK workforce experience, including transition support, professional development, recognition, leadership opportunities and psychological safety.

For each area, we compared intention to leave between those respondents who had more positive and those who had less positive experiences of that aspect of UK practice.

This included whether respondents had received specific forms of support or development, whether their previous expertise had been recognised, whether they had access to leadership opportunities, and whether they felt safe and supported to raise concerns. Most areas showed a significant association with intention to leave. The exception was further UK qualifications: respondents' intention to leave was similar whether or not they had achieved an additional qualification since registering in the UK.

Table 9: Associations between IENMs' UK professional experiences and intention to leave the profession

Section	Association with intention to leave the profession
Induction	Comprehensive induction was linked to lower intention to leave: 13% (n=788), compared with 20% for partial induction (n=235) and 33% for no induction (n=79).
Pastoral support	Pastoral support was linked to lower intention to leave: 8% (n=418), compared with 20% without support (n=684).
Preceptorship	Those without preceptorship were more likely to intend to leave: 22% (n=278), compared with 13% among those completing or who had completed it (n=750).
NMC revalidation support	Intention to leave rose as revalidation support decreased: 14% fully/quite supported (n=338), 19% somewhat supported (n=182), and 31% little or no support (n=156).
Qualifications since working in the UK	Intention to leave was similar with no further UK qualifications (13%, n=246) and with at least one further qualification (16%, n=876).
Leadership	Intention to leave was lower among those included in talent development or leadership pathways: 10% (n=280), compared with 18% among those not included or neutral (n=822). It was also lower among those who rated leadership development programmes as accessible: 9% (n=385), compared with 21% among those who rated them less accessible (n=638).
Recognition	Intention to leave was lowest when skills and experience were fully/mostly recognised (11%, n=413) and highest when minimally/not recognised (21%, n=441).
Psychological safety	Intention to leave was lower among those who felt safe and supported to speak up for concerns about themselves or a colleague: 9% (n=505), compared with 22% among those who felt safe sometimes, rarely or never (n=575). For concerns about a patient or service user, intention to leave was 11% among those who felt safe most or all of the time (n=764), compared with 28% among those who felt safe sometimes, rarely or never (n=325).

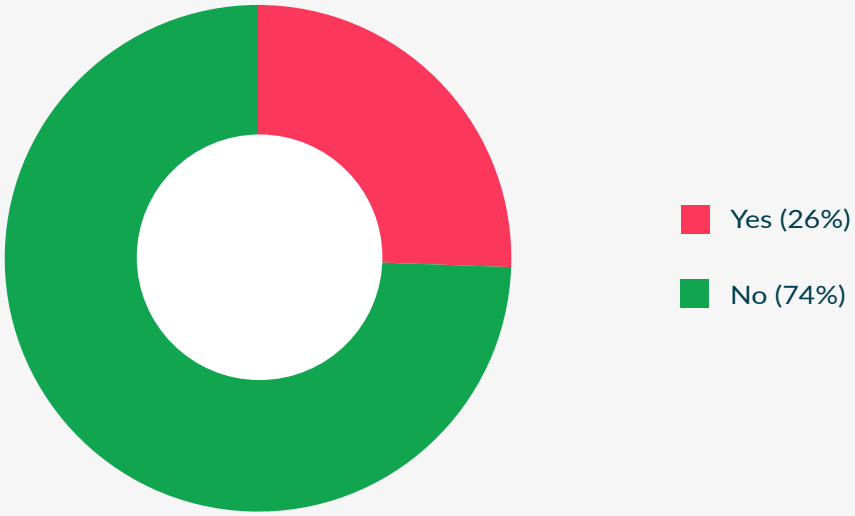
Intention to leave the UK

We also asked IENMs whether they intended to move to another country to work as a registered nurse or midwife within the next three years. Overall, 26% said they intended to move abroad, and 14% had a current pending application (n=1,102). (Figure 35).

Figure 35: Intention to move abroad to practise

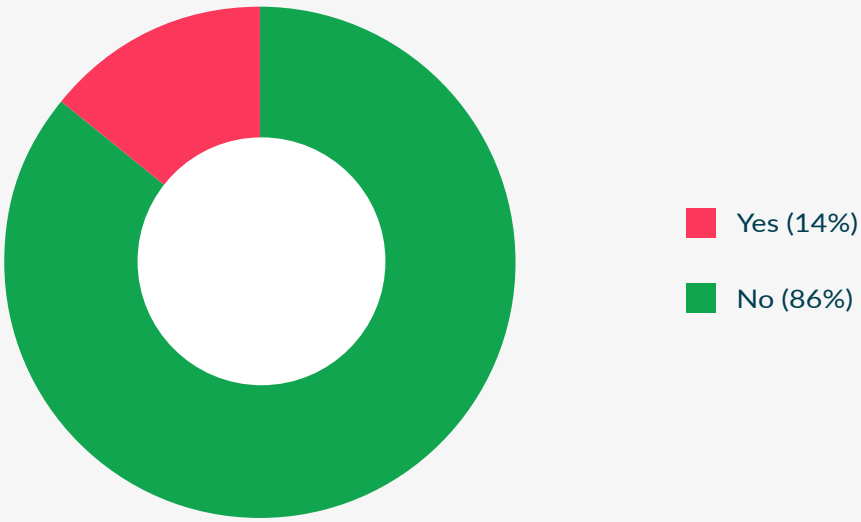
Intention to move to another country among IENMs (n=1,102)

Survey question: Do you intend to move to another country to work as a registered nurse or midwife in the next 3 years?



Pending application to work in another country among IENMs (n=1,102)

Survey question: Do you have a pending application to work as a nurse or midwife in another country?



Reasons for staying in the UK

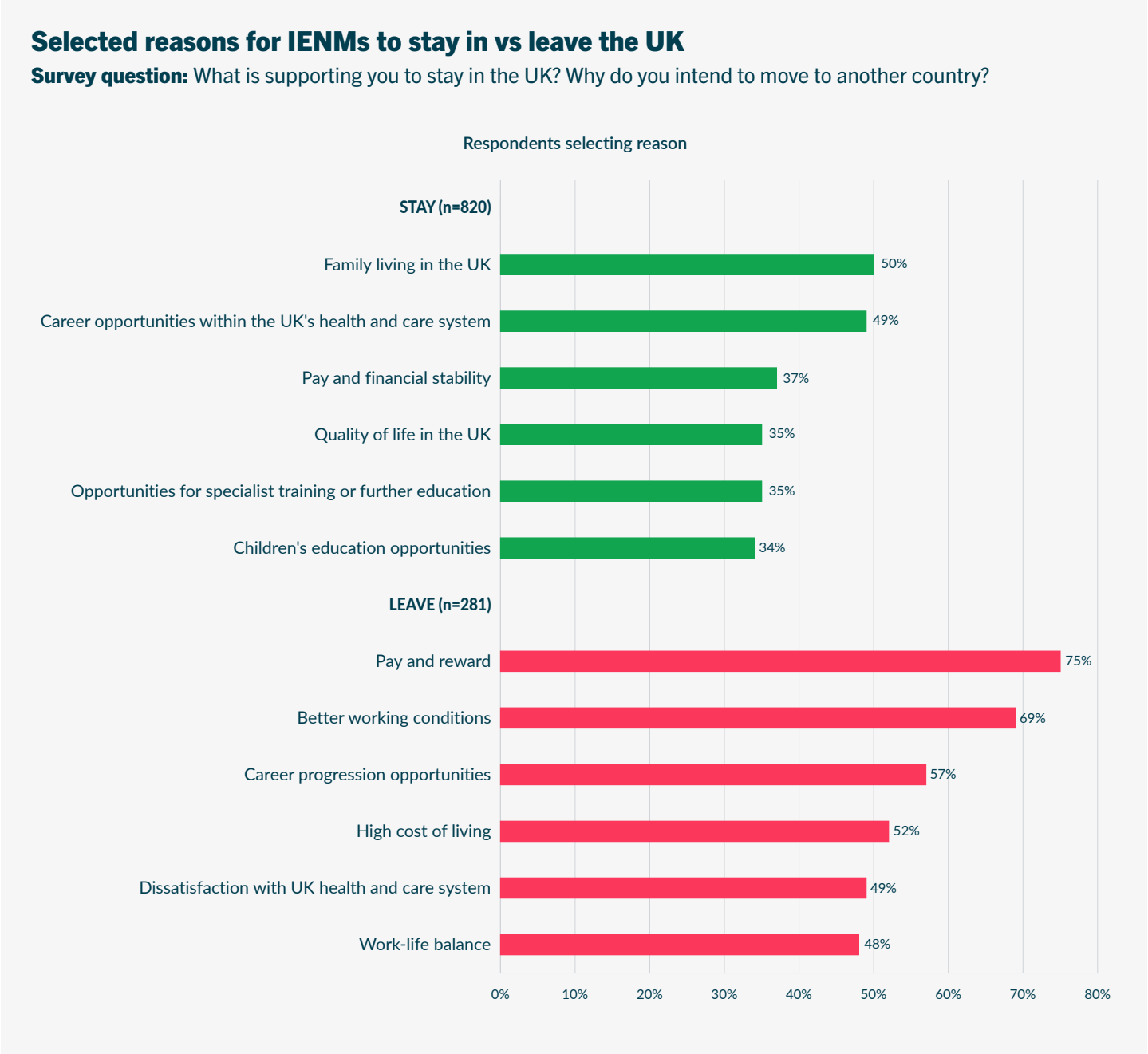
Respondents intending to stay in the UK were asked what factors were supporting them to remain. The most common reasons were family in the UK (50%) and career opportunities within the UK health and care system (49%) (n=820).

Reasons for leaving the UK

Respondents intending to leave the UK within the next three years were asked their reasons for leaving. The most common reasons were pay and reward (75%), better working conditions (69%) and career progression opportunities (57%) (n=281). As with intention to leave the profession, workplace culture was also an important factor, with 36% citing racism or discrimination as a reason for leaving the UK.

Figure 36 summarises this contrast. Reasons for staying were relatively evenly distributed across the top six factors, ranging from 34% to 50%, and reflected a mix of family, lifestyle, career and financial considerations. Reasons for leaving were more concentrated, with the top factors ranging from 48% to 75%, and were dominated by economic and workplace concerns. This suggests that staying reflects a web of personal and professional ties, while leaving reflects a narrower set of economic and workplace pressures.

Figure 36: UK retention and leaving factors





03. Discussion

Discussion

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IENMs now form almost one in four NMC registrants and are integral to the UK health and care workforce. The findings show both the contribution they bring and the extent to which that expertise is not always fully recognised or used. The discussion below draws out the main thematic areas emerging from the findings and considers what each means for policy and practice.

Recognition of prior qualifications and experience

Recognition of prior expertise emerges as a cross-cutting issue. Only 38% of respondents considered that their qualifications, experience and skills had been fully or mostly recognised. This sits uneasily alongside the expertise respondents brought to the UK. Almost half arrived with seven or more years of qualified practice, while lack of recognition was one of the most commonly reported early challenges.

The issue appears to be less an absence of mechanisms than their inconsistent use. Employers can recognise previous experience; higher education institutions can recognise prior learning; and routes exist for assessing qualifications. Yet the findings suggest there is no consistent expectation that international expertise will be identified and translated into UK career pathways.

Higher education has an important role here. IENMs are significant participants in UK professional education, with more than three quarters gaining further qualifications after registration, yet higher education was almost absent as an initial or subsequent career destination. There is a risk that IENMs are positioned and represented primarily as people who require further education rather than as potential educators, researchers and academic leaders. Better recognition of prior learning and clearer routes into academic and research careers would allow the UK to make fuller use of the knowledge already present within its workforce.

Transition support and revalidation

Preceptorship provides some of the clearest evidence that policy intervention can change experience. More recent cohorts were substantially more likely to receive structured transition support, most likely reflecting the introduction of national frameworks and clearer organisational expectations – including NHS England's National Preceptorship Framework and its associated Quality Mark[19], and the mandating of preceptorship and restorative clinical supervision across NHS Wales by the Chief Nursing Officer.[20] Where a workforce problem has been recognised nationally, translated into standards and, in Wales's case, made a national requirement, practice has changed.

The remaining challenge is quality and reach. Experienced international registrants are not making the same transition as newly qualified practitioners. They are adapting established expertise to a different regulatory, organisational and cultural environment. Support therefore needs to recognise their professional starting point rather than assuming they are beginning practice again. It also needs to extend beyond the NHS, where induction and preceptorship remain less consistent.

Revalidation is comparatively positive. More than three quarters of respondents who had revalidated felt supported and rated their experience positively, while targeted NMC support has shown that confidence in revalidation and reflective practice can be strengthened quickly. The NMC's current review of revalidation is therefore particularly timely. The remaining barriers identified in this study are relatively specific and addressable. The opportunity is to connect induction, preceptorship and revalidation into a more coherent transition pathway that continues beyond registration.

Midwifery

Internationally educated midwives emerge as a particularly important group. Despite holding both nursing and midwifery qualifications, 85% of nurse midwives in the survey registered only as nurses, commonly because they were unaware that dual registration was possible or found the separate process too burdensome. For those who did register as midwives, recognition of previous expertise was poorer, while psychological safety and access to leadership opportunities were lower than among internationally educated nurses.

These findings sit within an already difficult national context. UK evidence documents high levels of burnout, heavy workload and poor retention among midwives, with early-career midwives particularly affected.[21] Internationally educated midwives may therefore experience the combined effect of pressures affecting midwifery generally and additional barriers associated with entering the profession through an international route.

This is particularly significant given current efforts to strengthen the midwifery workforce. As the NMC consults on extending UK pre-registration midwifery education from three to four years – a substantial investment in developing the knowledge, skills and confidence of domestically educated midwives – substantial expertise already held by internationally educated colleagues is going unrecognised and, at registration, largely lost.[22] A more coherent pathway is needed that reduces the loss of midwifery expertise at the point of registration and ensures that subsequent support builds on what experienced midwives already know.

Racism, discrimination and belonging

Issues of racism and discrimination are among the most concerning findings of this study. 41% of IENMs reported experiencing racism, discrimination or bias when they first >

Discussion

began working in the UK, rising to 56% among Black IENMs, with no discernible improvement across registration cohorts spanning two decades. This is consistent with wider evidence of persistent racial inequalities across health and social care, but adds an important international dimension: racial inequality can intersect with the experience of entering an unfamiliar professional system, having previous expertise poorly recognised and, for some, being dependent on an employer for visa sponsorship.

These findings come at a point when expectations of health and care organisations are becoming more explicit. The NMC's new anti-racism principles recognise racism as embedded not only in individual behaviour but in structures, policies, processes, power and culture, and place psychological safety and organisational accountability at the heart of anti-racist practice.[23] The NHS England Staff Standards[24] similarly establish tackling racism as a minimum expectation of NHS employers in secondary care, while the Workforce Race Equality Standard[25] provides an established mechanism for measuring inequalities in workforce experience and opportunity.

The findings demonstrate why this shift matters for IENMs. Racism and discrimination were among the factors respondents associated with intentions to leave, alongside bullying, limited progression and wider workforce pressures. Among IENMs with at least ten years of UK experience, 24% of Asian respondents had never been promoted, compared with 5% of White respondents. For an internationally mobile workforce, unequal treatment and opportunity therefore carry consequences not only for equity and belonging, but for retention.

There are also important indications of what helps. Supportive managers and colleagues, pastoral and peer support, mentoring and diaspora networks all contributed to stronger experiences of transition and belonging. The challenge is therefore not only to eliminate discriminatory behaviour, but to build cultures in which IENMs are recognised, included and able to contribute fully. The emerging national frameworks provide a stronger basis for doing so; the test will be whether their implementation produces measurable improvements for those groups, including especially for Black IENMs, whose experiences remain poorest.

Psychological safety

Psychological safety is equally important. 69% of IENMs felt able to speak up on behalf of a patient, compared with 46% about a concern involving themselves or a colleague, with Black IENMs least likely to feel able to do either. The qualitative evidence suggests that visa dependency can create an additional constraint for some staff considering whether to challenge poor treatment.

Psychological safety may look different as IENMs progress into more senior roles. Although survey respondents were predominantly Band 7 or below, consultation with senior nursing leaders highlighted >



the particular challenges of speaking up in board-level and executive decision-making spaces. Those in an underrepresented position reported that speaking up in these contexts carries additional weight precisely because there is often no one else in the room with the same point of reference and lived experience as themselves.

Speaking up underpins safe care and a healthy workplace culture. NHS England's Freedom to Speak Up guidance links it to service improvement, staff satisfaction and safer patient care,[26] and recent reviews and inquiries have repeatedly highlighted its importance. Where IENMs feel less able to raise concerns, particularly about their own treatment or that of colleagues, organisations risk missing problems that affect staff and patients alike. IENMs need to be shown they can raise concerns safely, and to see them acted on.

Leadership and progression

Leadership emerges from this study as both an area of untapped potential and an important opportunity for workforce development. Many IENMs arrive with substantial professional experience, including leadership, supervisory and specialist responsibilities, yet this does not consistently translate into progression. One in three respondents had never been promoted and, even among those with ten or more years of UK experience, one in five had never progressed.

Consultation with senior IENM leaders also raised a question about what support is available at the most senior levels. Underrepresentation and isolation may become more pronounced in executive roles, where IENMs can lack peers with shared experience or established pathways to follow. Progression into senior leadership roles may, therefore, make these challenges less visible rather than resolve them.

These findings arrive as the national infrastructure for leadership development is being reshaped. In England, the new NHS Leadership and Management Framework[27] and the NHS College of Leadership and Management together establish, for the first time, a consistent set of national standards, competencies and career expectations spanning the full leadership pathway, alongside strengthened talent management and a recognised quality mark for leadership development. Northern Ireland has launched a Collective Leadership Framework for Nursing and Midwifery[28], and the Chief Nursing Officer for Wales's Strategic Vision for Nursing and Midwifery 2025–2030[29] places inclusive leadership pipelines at its heart. Each provides a national vehicle into which the equitable inclusion of internationally educated staff could be deliberately built, but they will only narrow the gaps identified here if it is implemented in ways that reach IENMs equitably, rather than reproducing the uneven access they already experience.

Leadership development programmes are vital in addressing this gap. IENMs are entering a new health and care system without necessarily having the professional networks, organisational knowledge and relationships accumulated by colleagues who trained in the UK. High-quality programmes can provide that bridge by helping participants translate existing leadership capability into a new context, build networks and confidence, gain visibility and navigate routes to progression.

A priority should therefore be to expand equitable access to leadership development and connect it more deliberately to mentoring, sponsorship, talent management and progression opportunities. As the new Framework and College embed nationally, and as their talent-management and appraisal expectations are adopted across organisations during 2026/27, there is a clear opportunity to ensure IENMs are explicitly included in the talent and leadership pathways the framework is designed to strengthen. Programmes should also recognise the leadership knowledge and experience IENMs already bring, rather than starting from an assumption of deficit.

Social Care

International recruitment has played an important role in strengthening the social care sector's workforce, but the findings suggest that recruitment has not always been matched by the professional infrastructure needed to support internationally educated nurses once they arrive.

Only 45% of respondents working in social care received a full induction, compared with 74% in the NHS, while access to structured transition support was also less consistent. Revalidation can present particular challenges where nurses work in smaller teams with few other NMC registrants. This is not an argument for replicating NHS structures in social care, but for equivalent professional support designed around the realities of the sector.

The strongest signal is retention. Most respondents remained within the sector in which they began their UK career, but social care was the clear exception: 77% of those who started there subsequently moved sector, most commonly into the NHS. Among those who left social care, 87% cited career development and progression as a main reason. This pattern sits alongside lower access to induction, preceptorship and other forms of professional support in social care.

This is particularly important as overseas recruitment into social care falls, and the sector continues to face significant workforce pressures. The direction set by Skills for Care — towards stronger retention, learning and development, career pathways and organisational leadership — is therefore timely.[30] The opportunity is to ensure that internationally educated nurses can build careers in social care, not simply enter the UK workforce through it. This requires high-quality induction and preceptorship, revalidation support, continuing professional development and visible routes for career and leadership progression, with parity of professional opportunity across health and care.

Retention

The reasons IENMs gave for considering leaving reflect many of the pressures affecting nursing and midwifery more generally. Burnout, workload, staffing, pay and >

bullying are prominent in national workforce evidence and were also among the main reasons identified here. The findings therefore reinforce the importance of addressing the underlying conditions affecting retention across the professions – pressures that IENMs share with the wider workforce, and that no amount of tailored support will offset if they remain unaddressed.

Alongside these shared pressures, the findings identify risks more specific to this workforce. 16% intended to leave nursing or midwifery within three years and 26% intended to move to another country to practise, while more than a third of those intending to leave the profession were recent arrivals. Racism and limited progression sit alongside the wider workforce pressures, and – unlike many domestically educated staff – IENMs also have ready access to an international labour market. The UK is therefore competing, on a global stage, to retain professionals in whom it has already invested through recruitment, registration and transition support.

It is important to be realistic about what the profession can do about this. These findings show that retention is shaped by much that lies beyond the reach of employers or systems. IENMs make decisions about where to build their lives for reasons that often have little to do with work – family, community, children settled in schools, and the ties established over years in the UK. Immigration and settlement policy sits in this category too: visa conditions, the cost and security of settlement and the rules governing who can bring or keep their families here shape people's decisions in ways the profession does not control. These factors carry real weight, and the profession should be honest that workforce intervention alone will not determine whether people stay in the country or leave it.

Within that picture, however, there is a meaningful set of factors the profession can act on. Intention to remain was associated with induction, pastoral support, preceptorship, revalidation support and, notably, recognition of the qualifications and experience IENMs already bring. These are the same forms of professional support that recur throughout this report, and they are largely within the gift of the organisations, regulators and systems that employ and register this workforce. Where IENMs move sector, as the outflow from social care discussed above illustrates, it tends to track weaker access to exactly this kind of support, suggesting that the pattern reflects the conditions people encounter rather than the sector itself.

The distinction matters for how the profession responds. Employers, regulators and educators cannot determine where people ultimately choose to live, and retention should not be framed as though they can. But they can determine whether the people who do stay feel recognised, supported and able to progress – and the evidence here suggests that this shapes whether they remain within nursing and midwifery, and within the settings that first recruited them. Recognising international qualifications and experience, in particular, is both one of the clearest signals of value that can be sent and one of the levers most directly within their control.

Global partnerships and diaspora contribution

The study also identifies an opportunity that is distinctive to this workforce. 79% of respondents wanted to participate in global partnerships, while only 3% had done so. 58% said involvement would increase their motivation to remain in the UK, 72% said it would strengthen belonging and two thirds said it would enable them to use leadership knowledge and experience gained overseas.

Global engagement should therefore be considered part of workforce development rather than separate from it. IENMs can connect UK organisations with health systems, academic institutions and professional networks in their countries of education, supporting reciprocal education, research, quality improvement and leadership development. This is a significant source of knowledge and connectivity within the UK workforce that is currently largely unused.

The West Yorkshire Health and Care Partnership demonstrates how this can be approached at system level.

Diaspora associations are central both to this opportunity and to the wider findings of the report. They provide pastoral support, professional orientation, mentoring, leadership development, advocacy and community connection, often reaching internationally educated staff in ways that individual employers cannot. NHS England previously recognised this contribution through central support for international nursing and midwifery associations, including grant funding to strengthen their pastoral support offer supported by FNF between 2020 and 2024.

The withdrawal of that central funding in 2025 therefore risks losing infrastructure that the NHS had itself helped to build. The findings from this study suggest that this would be a false economy. Diaspora associations contribute across many of the areas identified as important to retention, including transition support, belonging, professional development, leadership and psychological safety, while also providing a route into the global partnerships in which IENMs overwhelmingly want to participate. The case is therefore not simply for recognising diaspora associations, but for sustained investment in them as workforce partners.

The role of managers and colleagues

Many of the findings in this study cannot be addressed through interventions directed at IENMs alone. Their experience is also shaped by the managers, preceptors and colleagues they work alongside. This was particularly evident in the induction findings. Effective induction was associated with welcoming support from managers, mentors and peers, while poor experiences included dismissive or impatient colleagues, weak management responses and questions being treated as evidence of incompetence.

These findings illustrate the importance of recognising the responsibility of the systems and people which should be supporting IENMs. Induction, preceptorship and leadership development can help internationally educated professionals navigate an unfamiliar system, but they cannot compensate for previous experience being discounted, questions being >

interpreted as incompetence or managers failing to identify and support potential. Nor can interventions aimed at IENMs address racism or create psychological safety without corresponding changes in the teams and organisations in which they work.

Managers are central to this. When asked what would help them progress, IENMs most often identified clear career pathways (64%), leadership training (57%) and support from managers or colleagues (53%). Across the wider findings, managers emerged as a particularly important influence: they can provide encouragement, sponsorship and access to development, but can also restrict opportunities or leave IENMs to navigate progression without support.

The detailed findings point the same way. Weak management responses featured in poor induction experiences. Among respondents who had gained further qualifications in the UK, 53% identified line manager support as helping them to do so, while lack of manager support emerged as a barrier to accessing leadership development. Only one in four IENMs felt included in organisational talent and leadership pathways, with substantial ethnic differences in whether respondents had been encouraged to pursue leadership opportunities. Organisational provision therefore matters, but whether IENMs can access and benefit from it often depends on the support and advocacy of their manager.

We recognise that managers and leaders are under considerable pressure and have limited time. Even so, managers play a part in shaping the working environment, including how issues such as racism and psychological safety are handled.

Supporting IENMs also requires attention to the wider workforce around them. Managers, preceptors and colleagues all need to understand the transition IENMs are making and recognise the expertise they bring. The task is not only to support IENMs to adapt to UK practice, but to ensure that the workplaces receiving them are equipped to make full use of an internationally educated workforce.

Implications of these findings for the workforce as a whole

IENMs are a distinct part of the workforce, with needs that reflect their particular circumstances. They are navigating migration, NMC registration and an unfamiliar health and care system, and continue to face barriers to development and progression after they have started working in the UK. For many, visa dependency adds a further constraint. Much of what IENMs face is specific to being internationally educated, and this section is not intended to suggest otherwise.

However, many of the issues identified are also not unique to IENMs. Many nurses and midwives who are not internationally educated are likely to recognise these issues as reflective of their own experiences. Racism affects staff from ethnic minority backgrounds regardless of where they trained, including those who are second or third generation. Concerns that promotion is shaped by who people are rather than what they bring, and the limited access to development described by midwives, are unlikely to be confined to IENMs. The same is true in social care, where the absence of preceptorship and difficulty getting competencies signed off were also raised.

For this reason, many of the recommendations in this report would benefit the entire nursing and midwifery workforce, not only IENMs. Effective induction and preceptorship, fair access to development and promotion, and teams where people feel able to speak up and where racism is addressed are relevant to every member of the workforce.



04. Conclusion & Recommendations

Conclusion & Recommendations

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IENMs are an established and essential part of the UK workforce. The findings show that the challenge is no longer simply how to recruit them, but how to recognise and use the expertise they bring, support equitable development and progression, and create the conditions in which they can stay and contribute fully.

Considerable work is already underway across the UK to improve these experiences. The recommendations that follow are intended to sit alongside and support those efforts, focusing on practical actions that can strengthen existing approaches, address remaining gaps and help ensure that progress reaches IENMs consistently across professions, sectors and career stages.

The findings of this project require that racism and discrimination in all its forms is addressed directly and unambiguously. 41% of all IENMs reported experiencing racism or discrimination when they first started working in the UK. The qualitative evidence includes repeated accounts of overt racism that was ignored, minimised or dismissed by management, and of individuals who had stopped seeking progression opportunities within their current organisation because of what they had witnessed happening to colleagues.

All racism or discrimination experienced by IENMs is unacceptable. There are also important differences in outcomes and experiences by ethnicity, and these differences need to be recognised, understood, monitored and addressed if meaningful progress is to be made.

Inequalities were most pronounced among Black IENMs, who consistently reported poorer experiences across a range of measures compared with other IENMs. They were less likely to have their qualifications and experience recognised, less likely to feel their preceptorship had been adapted to meet their needs, and less likely to feel that leadership development opportunities were accessible to them. They were also less likely to have been promoted, and this difference remained after allowing for time since NMC registration.

Every recommendation in this report should, therefore, be implemented with the understanding that the internationally educated workforce is not a homogenous group. Organisations must routinely disaggregate their data by ethnicity and examine whether interventions are improving outcomes equitably. Progress cannot be assumed from aggregate figures alone. Action to address racism and discrimination must reach all internationally educated nurses and midwives, and its success should be assessed by whether outcomes improve for every group, including those where the evidence shows the largest gaps.

Recommendations

1. For the Nursing & Midwifery Council

The NMC's revalidation review should:

- **Develop accessible, IENM-specific introductory resources for reflective practice:** This project's findings consistently show that reflective practice does not feature in nursing or midwifery education in IENMs' countries of training, and that writing reflectively in English is a skills gap which employers rarely acknowledge. The NMC's revalidation guidance and worked examples should be supplemented with introductory resources on reflection, co-produced with IENMs and diaspora networks.
- **Make the link between preceptorship and revalidation explicit:** Many IENMs discover only by chance that preceptorship outputs can count toward revalidation evidence — and those who make this connection find it significantly reduces the burden of their first revalidation. This link should be made explicit in NMC guidance from the point of registration, not left for individuals to discover informally.
- **Address the reflective discussion access problem:** A recurring and specific barrier to a positive revalidation experience arises for nurses and midwives whose line manager is not an NMC registrant. While a non-registrant manager can act as confirmer, the reflective discussion must be held with an NMC registrant — leaving some to source a discussion partner independently. This may be straightforward in large multi-professional teams, but it is a particular problem in settings such as social care and primary care, where nurses and midwives may work with few or no other registrants. The review should consider whether current requirements inadvertently disadvantage those working in settings, or under management structures, where no registered nurse or midwife colleague is readily accessible.
- **Ensure NMC guidance clearly communicates that global health activity can count toward CPD:** Many IENMs maintain active professional connections with their countries of training, visiting, teaching, and practising in ways that develop clinical skills, leadership, and cross-system knowledge. While such activity can in principle count toward revalidation CPD, this is not widely understood. The review should ensure guidance makes this explicit and consider how evidencing global health activity can be made more accessible, both as a matter of equity and as a means of formalising the global partnerships IENMs are well-placed to build.

Conclusion & Recommendations

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More broadly, the NMC should:

- **Use its guidance and standard-setting role to drive greater recognition of IENMs' prior qualifications and experience:** The NMC does not directly determine how employers band or deploy IENMs, but it has significant influence through its guidance, approved education institution requirements, and public positioning — and should use it deliberately. The NMC should publish clear expectations for employers and HEIs on assessing prior international qualifications and experience, and signal unambiguously that treating an experienced IENM as the equivalent of a newly qualified UK-trained colleague is neither acceptable nor defensible.
- **Address the dual registration gap for nurse-midwives as a matter of urgency:** 85% of nurse-midwives in this survey registered only as nurses on arrival in the UK, driven by regulatory complexity, cost, and lack of awareness. This represents a significant and largely invisible loss of midwifery skills from the workforce. The NMC should review registration pathways for those holding combined nurse-midwife qualifications, assess whether a streamlined or bridging route is feasible, and publish clear guidance on dual registration options for use in pre-arrival and onboarding communications.
- **Ensure post-registration qualifications gained overseas can be assessed for equivalence rather than requiring automatic repeat programmes:** The NMC should commit to developing a competency-based equivalence process for post-registration qualifications, including prescribing and advanced practice, that maintains patient safety standards while avoiding unnecessary duplication for experienced registrants.
- **Develop minimum standards for IENM induction that are tailored to setting:** The GMC established minimum induction standards for international medical graduates in 2022, but no equivalent exists for internationally educated nurses and midwives, despite the workforce being significantly larger. The NMC should develop and publish induction standards that reflect the realities of different employment settings, including social care and primary care, recognising that what good induction looks like will vary, but that every IENM deserves a baseline regardless of where they work.

2. Higher education institutions

- **Establish a sector-wide standard for recognition of prior learning for internationally educated registrants:** IENMs consistently report being placed at lower academic levels than their experience warrants and being required to repeat qualifications they already hold. Recognition of prior learning processes are frequently either unavailable or applied inconsistently across institutions. This represents a significant and largely unexamined cost burden on internationally educated professionals. HEIs, working in partnership with the NMC and others, should together develop a sector-wide standard that ensures prior learning assessment is genuinely accessible, consistently applied, and capable of recognising qualifications and experience gained outside the UK. Adherence to the standard should be embedded in NMC programme approval criteria and commissioning expectations.
- **Use the global health and diaspora agenda as a research and partnership opportunity:** IENMs want to be involved in global health partnerships, and many bring direct connections to academic and research networks in their countries of training. HEIs should develop twinning arrangements, joint research programmes, and diaspora scholar networks that treat internationally educated staff as assets in building genuine global health research capacity.
- **HEIs and practice placement providers should jointly examine and address the barriers internationally trained registrants face in accessing advancement opportunities:** IENMs report significant barriers to accessing the opportunities that support professional and academic progression. These have not been systematically examined or addressed across the pathway as a whole. HEIs and their practice partners should undertake a joint review of where and how these barriers arise, with internationally trained registrants meaningfully involved in that process. The findings should inform shared commitments to removing structural obstacles to IENM advancement across both education and practice environments.
- **Charge home-equivalent fees for internationally educated nurses and midwives pursuing post-registration study:** Government regulations classify recently arrived registrants as international students, typically until they hold settled status. International fee rates frequently make employer sponsorship unviable, while visa status can rule out student loans. HEIs cannot change statutory fee status, but international fees are theirs to set, and some universities already charge home fees for post-registration courses where the applicant works in health and social care. This should become standard practice across the sector, extended to staff across health and social care.

Conclusion & Recommendations

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3. For employers and commissioners of health and social care services across the four nations

- **Sustain IENM support infrastructure between recruitment cycles:** Pre-arrival support and onboarding quality improved during high-recruitment periods and deteriorated when recruitment slowed. International recruitment leads represent institutional knowledge that cannot be quickly rebuilt. Employers should protect this infrastructure through periods of reduced activity and resist treating it as a variable cost. Commissioners should also recognise that this infrastructure barely exists outside large NHS organisations: social care and primary care employers are typically too small to build it individually, and should be able to draw on shared arrangements, commissioned at system or regional level, rather than being left to improvise.
- **Apply prior experience recognition provisions consistently and at scale:** Agenda for Change frameworks across all four nations already permit employers to take prior overseas experience into account when setting starting salaries and to recruit directly into senior bands where experience warrants it. NHS England's Accelerated Development Transformation Fund demonstrated in 2022 that this is deliverable. Nearly half of IENMs in this survey arrived with seven or more years of qualified experience. There is no justification for entry at the lowest spine point of Band 5 as a default.
- **Close the preceptorship gap for IENMs outside the NHS:** IENMs who started in social care were significantly less likely to have completed a preceptorship programme than those who started in the NHS. Access to preceptorship should not depend on employer type. Commissioners and system leaders should enable smaller social care and primary care employers to offer it through shared or hub-based models, so that where an IENM starts work does not determine whether they are set up to succeed.
- **Move from passive access to active sponsorship of IENM leadership potential:** IENMs need a development offer that starts from where they actually are: many arrive with substantial leadership experience from other health systems, and face the distinct task of learning to lead within an unfamiliar one. Employers rarely recognise the first or support the second, instead asking IENMs to accumulate UK experience before being considered ready and leaving them to self-navigate opportunities their UK-trained colleagues are sometimes sponsored into. Employers should make sponsoring IENM leadership potential an explicit expectation of line managers, recognise leadership experience gained outside the UK when assessing readiness, and actively seek out and commission leadership development designed specifically for IENMs.
- **Equip preceptors, managers and teams to support IENMs well:** Colleagues, preceptors and managers shape IENMs' experiences more than any programme. Too often the onus to adapt falls entirely on IENMs, but the workforce around them must change too. Employers should train preceptors and supervisors on what IENMs are navigating, from unfamiliar documentation standards to reflective practice as a new discipline; make responding to racism a managerial competency, with visible action when concerns are raised; and create structured ways for IENMs to teach as well as learn.

4. For all governments in the UK

- **Invest in global health partnerships as a retention and reciprocity strategy:** Over a quarter of IENMs intend to leave the UK within three years. Bilateral agreements, twinning arrangements, and exchange programmes would give IENMs a formal route to contribute to global health — and the evidence shows this would strengthen belonging and motivation to stay. But partnerships must also be genuinely reciprocal: the UK is recruiting at scale from countries that cannot afford to lose experienced health professionals. UK and devolved administrations should ensure bilateral agreements support bi-directional learning rather than one-way extraction.
- **Formally resource diaspora associations as system-level delivery partners:** Diaspora associations are performing functions that formal NHS infrastructure cannot replicate at scale: early intervention, pastoral care, and community belonging. UK and devolved governments should move beyond ad hoc acknowledgement to sustained commissioning, treat diaspora insight as an early warning system for workforce risk, and co-produce workforce policy with diaspora communities rather than consulting them as an afterthought.

5. For UK Department of Health and Social Care, NHS England and the Care Quality Commission (CQC)

- **Ensure the new NHS College of Leadership and Management embeds IENM inclusion from the outset:** The new College represents a significant opportunity to shape the leadership pipeline and culture of the NHS in England. As it develops its standards, programmes, and governance, it should explicitly address the structural barriers IENMs face in reaching executive and senior clinical roles, including prior experience recognition, anti-racism, and visible IENM representation in leadership pathways.

Conclusion & Recommendations

- E**nsure the forthcoming 10 Year Workforce Plan addresses the existing IENM workforce — not just future recruitment:** The 10 Year Health plan's ambition to reduce international recruitment to under 10% by 2035 risks creating a policy environment focused entirely on future pipelines while ignoring the needs of the workforce already here. Nearly a quarter of nurses and midwives on the NMC register trained outside the UK. The forthcoming workforce plan should set explicit commitments on IENM retention, progression, and equitable treatment and should not allow a shift in recruitment strategy to become a signal that the contribution of internationally educated staff is no longer valued.
- **Embed IENM support in CQC's new sector-specific assessment frameworks:** CQC is replacing its single assessment framework with dedicated frameworks for different settings, including adult social care and primary care, due for implementation by the end of 2026. The new frameworks should make explicit that, for providers employing internationally educated staff, being well-led includes structured induction, early-career support equivalent to preceptorship, and support to meet revalidation requirements.
- **DHSC and CQC should act jointly on the particular position of visa-sponsored staff:** The qualitative evidence includes IENMs describing how visa dependency constrains their ability to challenge poor treatment or to leave, and bullying is cited by more than one in four IENMs intending to leave. DHSC should strengthen and enforce the expectations placed on employers who sponsor internationally educated staff, including through the Code of Practice for international recruitment, so that sponsorship cannot be used to bind people to poor treatment. CQC's assessment of whether a provider is well-led should consider how sponsoring organisations manage this power imbalance — including whether internationally educated staff can raise concerns safely and access development opportunities on equal terms.
- **Make national preceptorship standards work for all settings:** Current frameworks take the acute NHS as their default, but excellence in social care may look different and is no less valid. This is not a call for a separate framework. NHS England — and, in time, DHSC — should adapt existing standards to reflect the realities of social care delivery, involve social care providers in piloting the National Preceptorship Quality Mark, and invest in emerging sector support such as Skills for Care's preceptorship resources.

6. For Scottish Government and NHS Scotland

- **Ensure implementation of the Nursing and Midwifery Taskforce recommendations explicitly addresses IENMs:** The Taskforce's 44 recommended actions, accepted in full by Scottish Government, take a whole-system approach spanning the NHS, social care and academia — and implementation planning is now underway, creating a clear window. The implementation workplan should include explicit IENM commitments, and the refreshed NMAHP career framework should be applied to internationally educated staff from the outset — including recognition of prior experience.
- **Close the structured transition gap for experienced international recruits:** Scotland's national early-career support is designed around newly qualified practitioners, leaving experienced IENMs — who arrive qualified but new to the Scottish system — without an equivalent national offer. NES and employers should ensure every IENM can access structured transition support regardless of their route onto the register, drawing on the survey evidence that such support both accelerates integration and eases first revalidation.

7. For Welsh Government and NHS Wales

- **Ensure the HEIW Strategic Nursing Workforce Plan (2025–2030) addresses the existing internationally educated workforce, not just supply:** The plan, aligned to the Strategic Vision for Nursing and Midwifery in Wales, sets a clear ambition for a sustainable, skilled and inclusive workforce — but risks focusing on recruitment pipelines while overlooking the IENMs already within NHS Wales. It should include explicit commitments on IENM retention, progression and equitable treatment, including recognition of prior experience, access to development and leadership opportunities, and targeted action on differential experiences by ethnicity.
- **Operationalise a whole-pathway workforce model, applied consistently to internationally educated staff:** The plan spans the workforce lifecycle, but its elements are not yet articulated as a single end-to-end pathway. HEIW and NHS Wales should define and implement that pathway — from pre-arrival and transition through to progression and leadership — and apply it consistently to IENMs, with clear expectations on recognition of prior experience, equitable access to opportunities, and visible representation in leadership.

Conclusion & Recommendations

8. For Department of Health (Northern Ireland) and Health and Social Care Northern Ireland (HSCNI), and NIPEC

- **Apply the new Career and Development Model for Nursing and Midwifery explicitly to internationally educated nurses and midwives (IENMs):** The model, commissioned by the Chief Nursing Officer and produced by NIPEC, sets out competency-based career pathways for the whole nursing and midwifery workforce across settings and sectors. The Department and NIPEC should ensure that the Career and Development Model and its associated Learning and Development Framework states that prior international competence and experience should be mapped against competency requirements rather than discounted. Employing organisations should be responsible for applying the model consistently from the outset of employment, ensuring that prior international competence and experience are appropriately recognised and that IENMs are supported to progress visibly across all three career pathways.

9. For the Florence Nightingale Foundation

- **Build on FNF's existing offer to develop a dedicated progression programme for internationally educated nurses and midwives.** FNF's current IENM offer supports transition into UK practice, but there is no equivalent for those seeking to move into more senior roles, or for those already in them. As part of this, FNF should develop its understanding of the experiences of IENMs in senior leadership roles.
- **Make anti-racism an explicit and named dimension of FNF's leadership development offer.** The FNF Scholarship, and all leadership programmes, should directly address racism, allyship, and the structural barriers IENMs face in progressing into senior roles.
- **Commit to ensuring internationally educated nurses and midwives are better and more proportionately represented amongst FNF scholars.**
- **Assess differential attainment across FNF's programme offer.** FNF should routinely analyse outcomes by ethnicity and country of training to ensure its leadership development programmes are working equitably, and use the findings to drive targeted improvements in access, experience, and programme content.
- **Actively showcase IENM leadership across FNF's programmes and platforms.** FNF should ensure IENMs from all backgrounds feature prominently as speakers, mentors, and case studies, and use its platforms to amplify IENM voices and stories.
- **Ensure IENM representation on FNF's Expert Professional Advisory Group.** FNF cannot credibly lead on this agenda without the voices and perspectives of IENMs shaping it at the highest level.



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FLORENCE NIGHTINGALE FOUNDATION



06. Appendix

Appendix

Appendix 1: Governance and ethics

Governance and oversight

The project was supported by a steering group and advisory group, which provided strategic oversight, constructive challenge, reflection and subject expertise throughout the project and report development.

The steering group brought together perspectives from across the four UK nations, with representatives from Florence Nightingale Foundation Academy member organisations and the wider health and social care system, including nursing, midwifery, education, workforce development, research, social care and internationally educated professional associations.

Acting in an advisory capacity, the steering group helped keep the project aligned with policy, practice and workforce priorities. Members advised on methodology and survey design, identified engagement and dissemination opportunities, challenged emerging findings and recommendations, and supported the project's wider visibility and influence.

The advisory group comprised internationally educated nurses and midwives working across different sectors, settings, roles and UK nations. It provided lived and professional insight to ensure workforce experiences, priorities and perspectives remained central to the report's development, interpretation and framing.

Together, this governance structure helped keep the project collaborative, reflective and grounded in lived and professional experience, while drawing on a broad range of perspectives across the internationally educated workforce landscape.

Ethical considerations

This project was conducted as a policy and workforce insight initiative rather than formal academic or clinical research. Participation in survey and engagement activity was voluntary, with clear information provided regarding the purpose of the project and intended use of findings. Care was taken throughout the project to ensure confidentiality, GDPR-compliant data handling and sensitive engagement with topics relating to workforce experience, inclusion, discrimination and professional identity.

Appendix 2: Methodology

We used a mixed-methods approach, combining quantitative and qualitative data with wider stakeholder engagement, leadership insight and workforce evidence. This appendix outlines the methods used: literature review, survey, stakeholder engagement and case studies.

Literature review

The literature review used an integrative design, informed by PRISMA and Whittemore and Knafl's framework, to bring together evidence on the experiences, retention, integration, and career progression of internationally educated nurses and midwives in the UK.

This approach was selected to support a timely and policy-relevant synthesis of evidence from diverse study designs. The search strategy drew on five electronic databases — Scopus, Web of Science, CINAHL, MEDLINE, and PsycINFO — and used Boolean combinations of terms relating to the target population, UK context, and workforce experience outcomes. Searches were limited to peer-reviewed studies published in English from 2000 onwards and focused on IENMs working in UK health and social care settings. Studies were included where they reported relevant evidence on experience, retention, workforce integration, career development, or progression, and excluded where they were outside the UK context, did not focus on IENMs, lacked sufficient methodological detail, or were not primary research. Screening was managed in Covidence through title and abstract review followed by full-text assessment, with each full-text article independently reviewed by two reviewers and disagreements resolved through discussion or a third reviewer. Following screening, data were extracted from 13 included studies, and quality assessment was then carried out using a structured Covidence template covering methodological transparency, reporting quality, potential bias, and transferability, with findings used to inform the interpretation and weighting of evidence rather than to exclude studies solely on transferability grounds.

Survey

The survey captured information about migration and transition experiences, development and leadership, use of previous expertise, global partnerships and retention intentions. It was designed for two respondent groups: NMC-registered nurses and midwives who qualified outside the UK, and members of nursing and midwifery diaspora communities. Respondents self-selected into these categories. IENMs working in any health or care setting across England, Wales, Scotland and Northern Ireland, and from any year of NMC registration, were eligible to complete the survey. Nursing associates were not eligible.

The online survey was open for sixteen weeks, from 23 October 2025 to 15 February 2026. It was disseminated through Florence Nightingale Foundation networks, newsletters, events, stakeholder networks, social media, media activity and interviews. Targeted efforts were made to increase responses from social care and the devolved UK nations.

The survey included multiple choice, checkbox, Likert rating and free-text questions. The data were cleaned to remove incomplete responses, defined as responses where the respondent did not complete all questions. Partial responses and ineligible responses, including those from respondents who did not fall into either of the two defined respondent groups, were excluded. A total of 1,176 completed responses were analysed, grouped as follows:

- **Group 1:** Internationally educated nurse and/or midwife with a valid NMC pin (n=1,120)
- **Group 2:** Nurse and/or midwife and identify as a member of a diaspora community (n=548)

Appendix

Respondents could select more than one group, so group totals do not add to the overall survey total. Of the 548 diaspora community respondents, 492 also belonged to Group 1.

The 56 diaspora community respondents who were not also IENMs were included within the total diaspora community group rather than analysed as a separate subgroup. Their demographic profile is presented separately in Appendix 3.

Data Analysis

Survey data were analysed using quantitative and qualitative approaches, as outlined below.

Quantitative analysis

Quantitative survey data were reported descriptively. Denominators were based on the number of respondents who answered each question, so they vary across the analysis and are reported throughout. For multiple-response questions, percentages may not total 100%.

Where relevant, differences between demographic groups and associations with selected outcomes were explored using statistical testing. Only subgroups that were particularly relevant to the question being asked or the wider objectives of the research were analysed and commented on in the report. All subgroup analyses were limited to groups with at least 50 respondents. The absence of a particular subgroup from the analysis does not mean that data were not collected about this group; full data are available in the data tables.

Two-proportion z tests were used to compare binary outcomes between groups, with Bonferroni corrections applied where three or more comparisons were made to reduce the risk of false positive findings. Statistically significant differences are reported where results indicate 95% confidence that the observed difference is unlikely to be due to chance.

Some figures show subgroup responses alongside the overall sample average to illustrate variation across respondent groups. These comparisons are descriptive and do not necessarily mean that differences between groups were formally tested.

Qualitative thematic analysis

Free-text responses were analysed using an AI-assisted qualitative thematic approach. The research team first coded 10% of responses to develop an initial thematic framework. AI/LLM tools were then used to support inductive thematic analysis by grouping responses according to the themes identified by the team.

Responses were anonymised before analysis in line with confidentiality assurances. AI-generated outputs were reviewed by the full research team, who checked the grouping of responses, agreed the final themes, and refined the wording using their judgement and contextual knowledge of the topic. Illustrative quotes were also checked for confidentiality before inclusion in the report.

Figure rounding

Text and data labels within the charts were rounded to the nearest whole number.

Stakeholder engagement

We carried out eleven formal roundtables, workshops and interviews with key stakeholders to discuss and validate emerging findings. Participants were identified through relevant professional, sector and stakeholder networks. Engagement was used mainly to validate and contextualise findings, test alignment with practice experience, and inform context-specific recommendations across sectors, professions and the four UK nations. Dedicated engagement also supported interpretation in areas where survey responses were more limited, including Northern Ireland and higher education. Stakeholder groups included:

- Higher education institutions
- Midwifery
- Global partnerships
- Northern Ireland
- Scotland
- Social care

Case studies

Organisations were invited to submit case studies showcasing approaches to support IENMs with retention, development and progression. Submissions were reviewed by a member of the research team and selected based on quality, relevance and fit with the report's key themes, including transition support, career development and leadership opportunities. Submitters were contacted to provide any additional information required and to confirm they were satisfied with the final written case study for inclusion in the report.

Ten case studies were submitted, of which three were selected. Additional examples were drawn from West Yorkshire Health and Care Partnership, FNF's IENM leadership development programme, and the NHS England-funded Small Grants Programme for nursing and midwifery diaspora associations. Selection aimed to provide diversity across themes.

Methodological limitations

This methodology has several limitations. The survey relied on self-reported data and open dissemination through professional and stakeholder networks, which means findings may be affected by self-selection bias, recall bias and uneven levels of awareness or confidence among respondents. Subgroup comparisons should be interpreted with care, particularly where sample sizes were small or where group composition differed. Statistical testing was only carried out where sample size allowed and where comparisons were considered meaningful, but significant differences may still reflect a range of contextual factors and should not be interpreted in isolation. To strengthen interpretation, survey findings were contextualised through stakeholder engagement, including roundtables, workshops and interviews.

Appendix

Appendix 3: Demographics of survey respondents

This appendix provides the full demographic breakdown of the survey sample, including both IENMs (n=1,120) and diaspora members who do not identify as IENMs (n=56).

Limitations

The respondent profile should be interpreted in light of the fact that not all demographic groups are equally represented. Responses were heavily weighted towards respondents working in England, those who registered with the NMC in 2021 or later, nurses, Band 5 staff and those working in acute care. This should be considered when interpreting findings across the wider IENM workforce, as IENMs work across a broad range of nations, sectors, settings, roles and levels.

Demographic tables for survey respondents

Group 1:

Internationally educated nurses and midwives (n=1,120)

Survey Question: What is your age?

Age	Percentage	n
Prefer not to say	0.80%	9
Under 18	0.00%	0
18-24	0.63%	7
25-34	34.64%	388
35-44	45.09%	505
45-54	14.55%	163
55-64	3.57%	40
65+	0.71%	8
Total		**1,120**

Appendix

Survey Question: In which year did you qualify as a nurse and/or midwife in the UK?

Year of NMC registration	Percentage	n
Prefer not to say	2.05%	23
Pre 2000	6.34%	71
2000-2005	9.82%	110
2006-2010	8.48%	95
2011-2015	12.23%	137
2016-2020	18.13%	203
2021 or later	42.95%	481
Total		**1,120**

Survey Question: What is your gender?

Gender	Percentage	n
Female	80.98%	907
Male	16.96%	190
Non-binary	0.36%	4
Prefer not to say	1.70%	19
Total		**1,120**

Appendix

Survey Question: Do you have a disability? For the purpose of this survey, "disability" is defined as "a physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Disability	Percentage	n
Yes	1.79%	20
No	95.80%	1,073
Prefer not to say	2.41%	27
Total		**1,120**

Survey Question: What is your registration status?

Registration status	Percentage	n
Registered Nurse	89.20%	999
Registered Midwife	8.84%	99
Dual Registered	1.96%	22
Registered Nursing Associate	0.00%	0
Not on the register	0.00%	0
Other (please specify)	0.00%	0
Total		**1,120**

Appendix

Survey Question: What is your ethnic group?

Ethnicity	Percentage	n
Prefer not to say	2.41%	27
Asian or Asian British - Indian	29.02%	325
Asian or Asian British - Pakistani	0.63%	7
Asian or Asian British - Bangladeshi	0.09%	1
Asian or Asian British - Chinese	0.18%	2
Asian or Asian British - Filipino/a	22.68%	254
Asian or Asian British - Other	2.32%	26
Black or Black British - Caribbean	2.50%	28
Black or Black British - African	28.13%	315
Black or Black British - Other	0.27%	3
White British - English, Northern Irish, Scottish, Welsh	0.80%	9
White British - Irish	0.45%	5
White British - Gypsy or Traveller	0.00%	0
White British - European	5.80%	65
White British - Other	2.23%	25
Mixed - White and Black Caribbean	0.09%	1
Mixed - White and Black African	0.63%	7
Mixed - White and Asian	0.18%	2
Mixed - Other	0.98%	11
Other	0.98%	11
Total		**1,120**

Appendix

Survey Question: In which UK nation do you currently work?

UK nation of work	Percentage	n
Prefer not to say	0.54%	6
England	82.95%	929
Wales	9.82%	110
Scotland	4.91%	55
Northern Ireland	1.70%	19
Other (please specify)	0.09%	1
Total		**1,120**

Appendix

Survey Question: In what type of health or care setting do you currently work? Tick all that apply.

Health setting	Percentage	n
Prefer not to say	1.25%	14
Acute care	60.36%	676
Community	9.46%	106
Primary care / general practice	4.91%	55
Mental health	5.09%	57
Maternity care	10.09%	113
Local authority	0.71%	8
National body	2.68%	30
University	3.04%	34
Social care / nursing home	2.14%	24
Private / independent healthcare provider	3.75%	42
Charity / voluntary sector	0.45%	5
Military	0.09%	1
Prison	0.18%	2
NHS - other	2.23%	25
Other (please specify)	1.96%	22
Total respondents		**1,120**

Appendix

Survey Question: What is your current band (or equivalent salary range)? Please note that the options are average indications as each UK country has different salary ranges. If you work in the NHS, please select the banding.

Band	Percentage	n
Prefer not to say	1.88%	21
Band 5 or equivalent	49.02%	549
Band 6 or equivalent	28.57%	320
Band 7 or equivalent (£48,000-£55,000)	13.48%	151
Band 8a or equivalent (£57,000-£63,000)	4.38%	49
Band 8b or equivalent (£66,000-£74,000)	1.70%	19
Band 8c or equivalent (£78,000-£89,000)	0.18%	2
Band 8d or equivalent (£92,000-£105,000)	0.09%	1
Band 9 or equivalent (£110,000-£125,000)	0.18%	2
Other	0.54%	6
Total		**1,120**

Appendix

Group 2:

Nurses and/or midwives that identify as members of a diaspora community and do not identify as IENMs (n=56)

Survey Question: What is your age?

Age	Percentage	n
Prefer not to say	5.40%	3
Under 18	0.00%	0
18-24	0.00%	0
25-34	7.10%	4
35-44	19.60%	11
45-54	50.00%	28
55-64	17.90%	10
65+	0.00%	0
Total		**56**

Survey Question: In which year did you qualify as a nurse and/or midwife in the UK?

Year of NMC registration	Percentage	n
Prefer not to say	8.90%	5
Pre 2000	14.30%	8
2000-2005	28.60%	16
2006-2010	8.90%	5
2011-2015	14.30%	8
2016-2020	21.40%	12
2021 or later	3.60%	2
Total		**56**

Appendix

Survey Question: What is your gender?

Gender	Percentage	n
Female	83.90%	47
Male	14.3%	8
Non-binary	0.00%	0
Prefer not to say	1.80%	1
Total		**56**

Survey Question: Do you have a disability? For the purpose of this survey, "disability" is defined as "a physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Disability	Percentage	n
Yes	10.70%	6
No	80.40%	45
Prefer not to say	8.90%	5
Total		**56**

Survey Question: What is your registration status?

Registration status	Percentage	n
Registered Nurse	73.20%	41
Registered Midwife	7.10%	4
Dual Registered	14.30%	8
Registered Nursing Associate	0.00%	0
Not on the register	5.40%	3
Other (please specify)	0.00%	0
Total		**56**

Appendix

Survey Question: What is your ethnic group?

Ethnicity	Percentage	n
Prefer not to say	1.80%	1
Asian or Asian British - Indian	10.7%	6
Asian or Asian British - Pakistani	3.60%	2
Asian or Asian British - Bangladeshi	0.00%	0
Asian or Asian British - Chinese	0.00%	0
Asian or Asian British - Filipino/a	8.90%	5
Asian or Asian British - Other	0.00%	0
Black or Black British - Caribbean	10.70%	6
Black or Black British - African	51.80%	29
Black or Black British - Other	0.00%	0
White or White British - English, Northern Irish, Scottish, Welsh	1.80%	1
White or White British - Irish	5.40%	3
White or White British - Gypsy or Traveller	0.00%	0
White or White British - European	0.00%	0
White or White British - Other	1.80%	1
Mixed - White and Black Caribbean	1.80%	1
Mixed - White and Black African	0.00%	0
Mixed - White and Asian	0.00%	0
Mixed - Other	0.00%	0
Other	1.80%	1
Total		**56**

Appendix

Survey Question: In which UK nation do you currently work?

UK nation of work	Percentage	n
Prefer not to say	0.00%	0
England	91.10%	51
Wales	7.10%	4
Scotland	1.80%	1
Northern Ireland	0.00%	0
Other (please specify)	0.00%	0
Total		**56**

Appendix

Survey Question: In what type of health or care setting do you currently work? Tick all that apply.

Health setting	Percentage	n
Prefer not to say	1.80%	1
Acute care	46.40%	26
Community	26.80%	15
Primary care / general practice	0.00%	0
Mental health	10.70%	6
Maternity care	12.50%	7
Local authority	0.00%	0
National body	1.80%	1
University	5.40%	3
Social care / nursing home	0.00%	0
Private / independent healthcare provider	3.60%	2
Charity / voluntary sector	1.80%	1
Military	0.00%	0
Prison	0.00%	0
NHS - other	0.00%	0
Other (please specify)	10.70%	6
Total respondents		**56**

Appendix

Survey Question: What is your current band (or equivalent salary range)? Please note that the options are average indications as each UK country has different salary ranges. If you work in the NHS, please select the banding.

Band	Percentage	n
Prefer not to say	3.60%	2
Band 5 or equivalent	14.30%	8
Band 6 or equivalent	23.20%	13
Band 7 or equivalent (£48,000-£55.000)	30.40%	17
Band 8a or equivalent (£57,000-£63,000)	12.50%	7
Band 8b or equivalent (£66,000-£74,000)	5.40%	3
Band 8c or equivalent (£78,000-£89,000)	1.80%	1
Band 8d or equivalent (£92,000-£105,000)	3.60%	2
Band 9 or equivalent (£110,000-£125,000)	1.80%	1
Other	3.60%	2
Total		**56**

Appendix

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Appendix 4: Diaspora association case studies

The following expands on three NHS England Small Grants Programme projects presented on page 67, showing diaspora associations' contributions in practice.

Project	Focus Area	Key Activities	Outcomes Delivered	Contribution To Wider System
Supporting the cultural transition and professional adaptation for **ALL** IEMs (Society of African and Caribbean Midwives)	Pastoral, psychological and professional support for **internationally educated midwives (IEMs)** **Patient safety and clinical competence,** including human factors and fetal monitoring **Cultural intelligence** and understanding of the UK health and social care system Wellbeing, psychological safety and **sense of belonging** Peer-to-peer support and community connection	Delivery of **human factors training** to increase staff awareness in care provision Delivery of **fetal monitoring and Neonatal Life Support (NLS)** training Provision of **psychotherapy and coaching sessions** Delivery of **Cultural Intelligence workshops** Facilitation of **Action Learning Sets** Delivery of **Patient Safety sessions** and sessions on how the NHS operates Hosting of **social events** to foster belonging and peer connection Ongoing **PMA (Professional Midwifery Advocate) sessions** Advocacy and escalation to NMC, NHS England and unions on behalf of IEMs	Delivery of multiple training and support sessions, including cultural intelligence, PMA, patient safety and wellbeing Improved s**ense of belonging and psychological safety** among IEMs Increased awareness of **patient safety, human factors and wellbeing** Enhanced understanding of the **UK health and social care system** Increased membership on both SoAC's main platform and its **dedicated IEM platform** Positive feedback and increased demand for further sessions Recognition of SoAC's work, including **invitation to His Majesty the King's reception**	Supports **retention and safe practice** of internationally educated midwives through combined clinical, cultural and pastoral support Enhances **patient safety and quality of care** by strengthening competence and confidence Provides a **diaspora-led model of psychological safety and advocacy** for IEMs Contributes to a more **inclusive and supportive maternity workforce** Strengthens collaboration across diaspora associations and national stakeholders Demonstrates the value of **integrated pastoral–clinical support model**s in international recruitment and retention
Wellbeing and pastoral support for international nurses (British Indian Nurses Association)	Pastoral support and wellbeing for **newly arrived nurses from India**	Delivery of **OSCE support sessions** (online and face-to-face)	Improved **confidence and preparedness** of overseas nurses for OSCE examinations	Supports **international recruitment and retention** by improving OSCE success and early career progression

Appendix

Project	Focus Area	Key Activities	Outcomes Delivered	Contribution To Wider System
(Continued)	**OSCE preparation and exam readiness** support **Interview preparation and career progression** support Mentoring and coaching for **professional development and retention** Building accessible **digital infrastructure** to support members	**1:1 interview preparation sessions** for BINA members Ongoing pastoral **support** across multiple NHS organisations Mentoring and coaching initiatives for career development Delivery of **health and wellbeing sessions,** including yoga and Bollywood dance Organisation of **BINA/BAPIO Conference (Oct 2023)** Organisation of **BINA 2nd Annual Conference (Dec 2023)** Work to **update and enhance the BINA website** Use of digital platforms and social media to promote engagement	Successful **career progression**, with members moving from Band 5 into higher bands Sustained delivery of **pastoral support** across NHS organisations Strong participation in mentoring, coaching and interview support Successful delivery of national conferences supporting collaboration and knowledge exchange Continued engagement in wellbeing and CPD sessions Positive testimonials reflecting **improved wellbeing, integration and staff retention**	Provides a **diaspora-led model of pastoral and professional support** for internationally recruited nurses Reduces anxiety and improves integration of overseas nurses into the UK workforce Strengthens workforce sustainability through **wellbeing-focused retention strategies** Contributes to **cross-association collaboration,** including work with BAPIO and other Indian Nurse Associations Enhances system understanding of international recruitment challenges through lived-experience insight
FSNA General Assembly, FSNA Launch & Mentorship (Filipino Senior Nurses Alliance UK)	Leadership visibility and **representation of senior Filipino nurses** in the UK Building a **national professional network** for Filipino senior nurses Mentorship, resilience, wellbeing and **career development** for Filipino IENs	Delivery of a **General Assembly** at the House of Commons (8 Feb 2024) Organisation of the **official launch** of FSNA UK Engagement of senior Filipino leaders, allies and speakers	**Successful General Assembly at the House of Commons, providing a platform for advocacy and visibility** **Increased membership growth (from 30 to 75 senior Filipino nurses)**	Elevates the visibility and contribution of senior Filipino nurses within UK healthcare leadership Strengthens leadership pipelines for Filipino IENs through mentoring and role modelling

Appendix

Project	Focus Area	Key Activities	Outcomes Delivered	Contribution To Wider System
(Continued)	Advocacy and influence within **national healthcare and policy spaces** Evidence-informed development of a **tailored mentorship model**	Development and implementation of the **FILAMENT** study (scoping exercise with 40 Filipino nurses) Hosting of a **virtual webinar** celebrating International Women's Day, spotlighting Filipino senior women nurses Stakeholder engagement to promote leadership, diversity and inclusion Planning of a **formalised mentorship programme** based on FILAMENT recommendations	Successful **General Assembly at the House of Commons,** providing a platform for advocacy and visibility Increased **membership growth** (from 30 to 75 senior Filipino nurses) Formation of a **core leadership group** with a shared vision and mission Increased **national visibility** of senior Filipino nurses through social media and national forums Strengthened engagement with stakeholders and allies across the healthcare sector Delivery of leadership-focused discussions addressing **gender equality, diversity and inclusion**	Elevates the **visibility and contribution of senior Filipino nurses** within UK healthcare leadership Strengthens **leadership pipelines** for Filipino IENs through mentoring and role modelling Contributes evidence to inform the design of **tailored mentorship programmes** supporting resilience, wellbeing and retention Demonstrates effective **diaspora-led advocacy** within parliamentary and national settings Enhances collaboration with other INMAs and national stakeholders Supports workforce sustainability by promoting leadership development and retention of experienced IENs

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