The implications in North West England of the migrant cap on non-EU workers

A case study of the health and social care sector

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This report is based on research undertaken by the study team and the analysis and comment thereafter does not necessarily reflect the views and opinions of the research commissioning body. The authors take responsibility for any inaccuracies or omissions in the report.

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1. Introduction

In June 2010 the coalition government in the UK announced the introduction of a temporary cap on the number of workers from outside the European Economic Area (EEA) allowed entry into the UK. This is to be followed by a permanent cap that will be introduced from April 2011. The immediate net result of the temporary cap has been a 5% reduction (1,300 individuals) in the numbers of highly skilled migrants and skilled workers in other categories of job allowed into the UK between July 2010 and March 2011. Subsequently, the government has taken advice from the Migration Advisory Committee (MAC) – through a consultation – on where the permanent annual cap should be set, taking into account both the potential *economic* impact on employers (and particularly those in 'migrant dense' sectors) as well as *social* impacts; for example, pressures on schools, hospitals, social housing and other public services (Home Office, 2010; Migration Advisory Committee, 2010).

Despite the government arguing that the permanent cap would be imposed in a 'flexible' way to aid the economic recovery, employers have raised concerns about the detrimental impact this will have on their competitiveness. Indeed, the recent Migration Advisory Committee report (2010: 10) highlights widespread concern amongst employers, who argued that 'the restrictions could affect businesses' ability to be competitive, stunt economic recovery and lead to reduced investment'. Scepticism has also been raised in relation to the ability to train indigenous British workers to fill vacancies that become available. Furthermore, the MAC report highlights gaps in the existing evidence base, particularly in relation to the social and public service impacts of migration (2010: 17).

Given this context, this report presents the findings of research focusing on the economic and social implications of the temporary and proposed permanent cap on non-EEA workers in the North West of England. The research was commissioned by Migrant Workers North West (MWNW) in July 2010 and conducted by researchers from the School of Public Policy and Professional Practice at the University of Keele and the Salford Housing & Urban Studies Unit (SHUSU) at the University of Salford. The overall aim was to consider the impact of the cap being imposed on employers and their perceptions, experiences and future aspirations in respect of the use of migrant labour and business competitiveness. The research explored the Health and Social Care sector as a case study area, given the historical reliance within this sector on international labour. This report presents the findings of this research.

2. The changing policy landscape

2.1 Introduction

According to Anderson and Ruhs (2009: 2) 'the regulation of labour immigration is one of the most important and controversial public policy issues in high income countries'. Indeed, as migration has increased over the past few decades, public demands for 'managed migration' have risen (Chappell and Mulley, 2010).

In the UK, it was felt that the arrival of increasing numbers of Central and Eastern European (CEE) migrants would enable the phasing out of low skill immigration schemes for individuals from other parts of the world (Home Office, 2006). Consequently, a key element to this managed migration system in the UK was the introduction – from February 2008 – of the Points Based System (PBS) for migration from outside of the European Economic Area (EEA). In summary, the PBS consists of five tiers:

- Tier 1: highly skilled individuals to contribute to growth and productivity;
- Tier 2: skilled workers with a job offer to fill gaps in the UK labour force;
- Tier 3: limited numbers of low-skilled workers needed to fill specific temporary labour shortages (currently suspended – EEA workers identified as being able to fill such vacancies);
- Tier 4: students; and
- Tier 5: youth mobility and temporary workers.

In addition, there was also the introduction of the Resident Labour Market test, requiring employers to demonstrate that they have failed to fill vacancies from within the UK and EEA before they are able to recruit from outside Europe (UK Border Agency, UKBA, 2008).

The global economic downturn has added further momentum to the debate about the impact of labour migration (Anderson and Ruhs, 2009). Subsequently, as highlighted previously, in June 2010 the coalition government introduced a temporary cap on the number of non-EEA migrant workers – followed by a permanent cap to be introduced from April 2011 – in order to restrict entry only to those who can make a 'real difference' (UKBA, 2010a: 4). The new restrictions on non-EEA migration – in the first instance – relate to tiers 1 and 2 of the PBS (with Tier 3 being indefinitely suspended). In summary Tiers 1 and 2 relate to the following:

- Tier 1: Visas for highly skilled migrants, entrepreneurs, investors and foreign graduates of UK educational institutions;

- Tier 2:
  General: for people coming to the United Kingdom with a job offer to fill a gap that cannot be filled by a settled worker which may or may not be on the Shortage Occupation List

  Intra Company Transfers: for employees of multi-national companies who are being transferred by an overseas employer to a skilled job in a UK-based branch of the organisation;

Sports People: for elite sportspeople and coaches whose employment will make a significant contribution to the development of their sport at the highest level; and

Ministers of Religion: for those people coming to fill a vacancy as a Minister of Religion, Missionary or Member of a Religious Order.

A key question which therefore arises is the extent to which EEA workers will fill any gaps created by the new restrictions? This research seeks to explore this issue in more depth as some of the existing evidence that is available suggests that CEE workers have tended to concentrate in elementary occupations (Scullion and Morris, 2009). Moreover, even the Migration Advisory Committee (MAC - 2010: 10) has highlighted 'uncertainty' and 'lack of control' in relation to EEA migration and the impacts of such migration at a local level.

2.2 A closer look at the migrant cap

In November 2010, the government made a decision on the changes to the PBS and the level at which the migrant cap is to be set. From 1st April 2011, the cap will be set at 21,700 skilled non-EEA migrants. Within this figure, 1,000 migrants will be allowed into the UK under Tier 1 – '*the exceptionally talented route*'. However, this only applies to entrepreneurs, investors and 'exceptionally talented individuals' (UKBA, 2010b).

The remaining 20,700 migrants will be allowed entry under Tier 2 – "*the skilled route*". The requirements remain the same in terms of individuals:

i) having to apply through the points-based system;
ii) having to be of graduate level;
iii) having to be sponsored by an employer; and
iv) points being awarded based on scarcity of skills and salary.

However, they will now be competing against other applicants for a visa to enter the UK and, in months when the limit is oversubscribed, those with the most points will qualify for one of the certificates of sponsorship available each month (UKBA, 2010b).

Although there appears to be a degree of acceptance of the need to reduce net migration (Sachrajda, 2010), it has been highlighted that this cap will have little overall impact. Indeed, the MAC report (2010: 13) suggested that closing all non-EEA *work-related* migration routes would not bring net migration down on its own (this would contribute 20% of the government's target to reducing immigration from 196,000 in 2010 to 'tens of thousands' by 2015). Consequently, it is proposed that achieving the other 80% will come from reducing student immigration (40% reduction of the 325,000 who arrive in the UK each year) and through restricting family reunification and long-term rights to settlement. Nevertheless, the latter actions will clearly take time to filter through the system.

2.3 Implications of the cap: health and social care perspective

While the restrictions on Tier 1 and Tier 2 are seen to have little impact on reducing overall migration figures, the impact on employers reliant on these workers is causing concern. Looking at the example of the health and social care sector, recent figures from the National Minimum Data Set for Social Care (NMDC) showed that more than a third of adult social care workers in England (35%) recruited in the 12 months to June 2010 were from outside the EEA (Lombard, 2010). Furthermore, Labour Force Survey (LFS) analysis suggests that almost one third of medical practitioners and approximately one fifth of nurses, dental practitioners and pharmacists currently working in the UK were born outside the EEA – a large proportion of which were from India (MAC, 2010).

While efforts are being made to increase the domestic supply of skilled labour in the medical profession, there are concerns about the length of time it takes to train people to the required skills levels. Indeed, a *Skills for Health* representative who took part in the MAC consultation on the migrant cap stated that:

> 'It is possible for the health sector to reduce its overall dependence on Tier 1 and Tier 2 migrants. However, to train and develop a health care professional can take years – and for those in consultant roles, sometimes decades' (MAC, 2010: 172).

Furthermore, concerns have been raised by NHS Employers (2010), who argue for the need to ensure that the UK remains an attractive destination for highly skilled clinical staff. They make reference to the global shortage of healthcare professionals and also highlight the active global recruitment campaigns of other countries (such as Australia and Canada). Consideration is needed, therefore, of the attractiveness of the UK compared to other countries – particularly as it becomes more difficult to enter.

From a social care perspective, the sector is reliant on non-EEA labour to fill senior care worker shortages. Evidence from *Skills for Care & Development* in the MAC consultation suggested that a number of employers would not be able to continue to provide care services safely and legally without the continued recruitment of migrant workers. Furthermore, employers indicated that increasing pressure on the social care sector may place further demands on NHS hospitals, as the closure of care homes may mean that vulnerable patients need to stay in hospital for longer.

The Association of Directors of Children's Services has also urged ministers to rethink the migration cap, with concerns that they will be unable to recruit experienced practitioners (such as social workers) – particularly in London and other metropolitan areas. This highlights the need to take 'regional variance' into account when considering the need for migrant workers and the roles they are required for. Furthermore, the Association of Directors of Children's Services stated that policy-makers had not taken into account the importance of staff from countries with similar training and legal systems to the UK (Lombard, 2010).

Given such perspectives, it is suggested that a more detailed insight into the health and social care sector – due to its reliance on non-EEA and EEA migrant workers alike – is required. Such research is discussed in the following chapter.

3. Findings

3.1 Introduction

The study used key informant interviews with health and social care employers in the North West of England. The North West was a suitable case study for the research given that the region has experienced a three per cent decline in population over the last twenty years, which coupled with an ageing population and a 12 per cent decline is forecast in those aged 16-24 by 2020, means that there is an increasing reliance on migrant workers to fill job vacancies (North West Development Agency, 2006).

A total of **16** health and social care employees were interviewed via telephone, representing 13 different organisations across the North West. This included a pilot interview which enabled us to understand/identify the correct interviewees (in respect of their roles and remit) within organisations to take part in the research. The stakeholders who took part were primarily Human Resources or Equality and Diversity representatives. The interviews took place between September and November 2010. In most cases, the interviews were recorded and transcribed verbatim. On average, the interviews lasted for about 30 minutes. The interviews included: the role of the respondent in relation to overseas workers; perceptions on the organisation's reliance on overseas workers; the advantages/disadvantages of international recruitment and the consequences/impacts emerging of recent changes in immigration policy (i.e. PBS and cap on immigration).

In addition to the interviews we also held a regional workshop involving a wide range of key stakeholders whose role involved working with migrant populations ('on the ground' and at a strategic level). The purpose of the workshop was to consider, elucidate and validate the perspectives of the interviewees; enable discussion on the current/future implications of the migrant cap; and identify what changes might be required.

3.2 Respondent information

Of the 16 interviewees, the majority (13) worked for NHS trusts in either Human Resources (HR) or Equality and Diversity-type roles. Their work was therefore generally focused on workforce planning and recruitment (including medical and non-medical staffing), with some having more specific responsibilities for employing migrants via the Sponsor Management System. With regards to the geographical coverage of their respective organisations, there was a variety of territorial scales apparent ranging from regional coverage through to sub-regional, county and specific sites of activity (see appendices for a breakdown of interviewee characteristics and responses).

In terms of the remaining social care interviewees, all were either directors or managers of care/nursing homes, but in contrasting urban, semi-rural and rural localities throughout North West England.

3.3 The extent of reliance on non-EEA workers and the characteristics of such individuals

In parallel with national Labour Force Survey (LFS) figures, the respondents highlighted that their organisations were reliant on non-EEA migrant workers and had been for a considerable period of time. Those within NHS Trusts found it more difficult to define exactly how many non-EEA migrant workers were currently employed (and previously) due to much of their data being collected on the basis of ethnicity rather than nationality. However, across the sample, the suggestion was that around 10 to 15 per cent of their workforce was currently drawn from outside of the EEA. Many had been employed for a considerable period of time in line with previous UK state policy (and the NHS Plan, Department of Health, 2000), which had actively encouraged international recruitment between 1997 and 2004 in order to fill shortages in certain medical and non-medical specialisms (such as nursing). Furthermore, those in more specialised/senior posts (for example, consultants) were identified as having stayed much longer, as it was claimed that many had exerted their 'agency' to secure their 'leave to remain' in the UK. This was in contrast to those in more junior/training positions whom it was suggested were more likely to leave the UK once they had completed their education training/post qualification experience.

However, since 2004, international recruitment has fallen sharply as government priorities have shifted from staff growth to curtailing staff expenditure (Bach, 2010). It was therefore perhaps unsurprising to note that the majority of NHS respondents identified that they had been much less engaged in overseas recruitment over the last few years and that overall numbers of non-EEA workers employed were lower than in the earlier part of the decade.

Interestingly, the reduction in recruitment of non-EEA workers, according to respondents, had not necessarily been accompanied by an associated increase in the number of EEA workers recruited since the enlargement of the European Union (EU) in 2004. Again, this parallels findings at a national level and will be discussed in more detail later in the report; suffice to say at this point that the skills sets of these different groups of labour migrants may not necessarily 'match up'.

Those involved in social care had a more detailed breakdown of the numbers and characteristics of non-EEA workers employed within each respective nursing home / care home. Many had again been employed for a considerable time (between five and ten years) and currently constituted between five per cent and 33 per cent of the total workforce. Nevertheless, the recruitment of such individuals had been curtailed recently (see next section), with questions being raised in terms of the ability of employers to retain such individuals given the imposition of the PBS since 2008 and the points now required for non-EEA workers to retain a work visa, as well as the fact that many roles have not been included on the government's Shortage Occupation List.

In terms of the nationality of non-EEA migrant workers, the majority of those employed by both the NHS Trusts and care homes came from the Indian sub-continent (doctors and consultants notably from India and Pakistan), the Far East (Filipino nurses) and Africa (doctors from Nigeria and Sudan). This is not wholly unexpected given the UK's historical links with such areas and the fact that English is the most commonly-used second language in these countries.

3.4 Recruitment and training issues of relevance to non-EEA workers

With further reference to the rationale for non-EEA migrant recruitment and associated methods that have been utilised, the overwhelming response was that such individuals are required to fill skills shortages that cannot be readily filled by domestic workers. Specific examples that were identified in respect of ongoing skills shortages included medical specialisms such as Ear, Nose and Throat (ENT) consultants, cardiac nurses and middle grade doctors to work in Accident and Emergency (A&E) departments. From a social care perspective, shortages of skilled nurses/care workers were noted, with the situation being compounded by the fact that the latter had now been omitted from the Shortage Occupation List due to it being primarily a non-graduate role.

Recruitment of non-EEA migrant workers appeared to vary: some Trusts and care homes had gone abroad to recruit; others had used websites that could be accessed from anywhere in the world whilst more recently the emphasis has been on recruiting existing non-EEA workers from within the UK. This is a key point as it led many respondents to raise concerns about increasing competition between Trusts and care homes for non-EEA workers to fill skill shortages. Moreover, from a geographical perspective some of the more remote rural employers felt that they were less likely to be able to entice such individuals and, therefore, argued that the PBS needed amending to respond to geographical variations in labour market conditions and the supply and demand of both (skilled) domestic and migrant labour.

Common recruitment problems identified by interviewees included defining and assessing the training compatibility of non-EEA migrant workers, linguistic barriers (although this was argued to be much more of a problem for EEA migrant workers who were less likely to be subject to relevant language proficiency ‘tests’), cultural barriers in respect of differentiation in medical and nursing practices (for example), the costs associated with international recruitment and the time associated with international recruitment (including delays in the application/sponsorship/visa process and filling gaps in the interim). Additionally, for employers in less accessible/more remote rural areas, the ability to both recruit and retain such workers in the medium term was again referred to.

To overcome some of these problems, there was evidence that certain employers were offering adaptation courses and additional help in terms of outlining NHS ethics/ work protocols, etc. Some also claimed to be providing help with migrants’ accommodation and welfare needs and had assigned ‘buddies’ or personal mentors to support a smoother integration through the recruitment and appointment phase.

Compared to the overall workforce in the NHS Trusts/care homes being focused upon in this research, it was noted that non-EEA migrant workers were more likely to be highly qualified and experienced, with above average retention rates for such individuals. This point has wider resonance with the fact that there are currently 320,000 non-UK doctors working within the NHS. It also illustrates the value of such workers to these sectors and the problems that would emerge for the effective provision of health and social care in the UK if the use of such labour was inappropriately restricted.

But what of the domestic workforce and the whole notion of effective long-term workforce planning to address these skills gaps/deficiencies? In the words of one HR representative:

> '*We always seem to do things after the event…the NHS doesn't plan far enough ahead…we don't target our schools enough and people are not aware of the right career path, what qualification and training that is required, etc*' (HR representative 1, NHS Trust, North West England).

Thus one key recommendation is the need for much better long-term workforce planning for sectors that have acute shortages of certain types of skills. However, in order for this to work it would need to be informed by national immigration policy – both now and in the medium-longer term in order to define the exact balance of skilled migrant labour/skilled domestic workers required. In addition, a fundamental rethink on how the medical profession is governed and regulated may also be necessary as it was suggested that the Royal Colleges (of medicine) were in essence controlling the supply of medical staff to NHS Trusts and keeping demand (and wages) high in order to maintain the profession's elite position.

3.5 The advantages and disadvantages of employing non-EEA workers

The advantages of employing non-EEA migrant workers ranged from addressing vacancies where skills were not available from the domestic UK population through to bringing new ideas and expertise and new ways of working (particularly in relation to the NHS). In the words of one interviewee:

> '*They have a different background and experience that we can learn from'* (HR representative 3, NHS Trust, North West England).

Relating to the above perspectives, the availability of such labour was also viewed as being an important tool in reducing the costs of NHS Trusts and care homes that would otherwise have to employ locums or agency staff:

> *'If we can't fill the positions we have to rely on locums; these are so expensive and cost the Trust an absolute fortune'* (HR representative 3, NHS Trust, North West England).

But geography was again deemed to be important in that restrictions on non-EEA migrant labour in more remote rural areas (coupled with general problems of recruitment to attract such individuals to these locations in the first instance) was making it much more difficult for them to be competitive and to reduce their costs. This was in comparison to employers in (more accessible) urban areas which potentially had a wider pool of labour to draw from:

> *'The system doesn't taken into account geography – areas like Cumbria should get exemptions – people want to work in cities so if the rules were relaxed a little for rural care homes or NHS Trusts we would be more likely to recruit [non-EEA migrant workers] and maintain our competitiveness'* (HR representative 3, NHS Trust, North West England).

> *'You get people who come to the UK and they really want to be in London and they arrive here and find that we are in the middle of nowhere and so some have absconded and we have found it difficult to replace these workers'* (Nursing Home Manager, North West England).

> *'The medical staff who come from big cities – and that's not just cities in this country, cities in other countries – [a rural town] seems very much a sleepy little backwater, a lot of people will go and have a look, but when they find out where it is they decide not to go'* (HR representative 1, NHS Trust, North West England).

Avoiding the use of temporary agency staff *vis a vis* permanently employed non-EEA migrant staff was also deemed to be advantageous for the continuity of care for patients as well as helping to ensure that the UK's increasingly diverse population could be supported by a similarly diverse workforce:

> *'We have patients from different cultures and backgrounds and I think it probably helps them when they come into hospital and they see somebody who may understand their thought processes and culture'* (HR representative 10, NHS Trust, North West England).

Several disadvantages of employing non-EEA migrant workers were also raised by those interviewed, primarily relating to the 'process' rather than problems with the individual workers that were recruited. For example, problems included planning and preparation time to complete applications for certificates of sponsorship and dealing with the Home Office; delays in the appointment process; and the retention of such labour once their education/training had been completed. A small number of respondents made reference to some cultural differences in migrants' ways of working and issues relating to the 'whiteness' of EEA migrants as opposed to those from non-EEA countries, which had led in a number of instances of racism towards non-EEA migrant staff by patients (see Pemberton and Stevens, 2010 for further details):

> *'EU workers are not 'visibly' a minority group whereas someone from Pakistan or India might well be…some elderly patients will not want to be seen by a Black doctor or by a Filipino nurse or whatever'* (Workforce and Education representative, NHS, North West England).

One further issue that was referred to by both interviewees and those who attended the regional workshop was the uncertainty people had in terms of whether they were interpreting immigration legislation correctly. Indeed, it was argued that since the introduction of the PBS in 2008, employers – and especially those in the private sector – had become much more cautious about recruiting non-EEA migrant workers even where fundamental skills gaps existed. Moreover, it was claimed that across North West England there have been a number of examples where employers have 'shedded' non-EEA workers for no reason apart from uncertainty over their rules of employment. Consequently, it is important that clear and informative guidance is readily available to prevent further gaps in provision emerging, which could ultimately impact on the quality of health and social care services provided.

3.6 Changes to UK immigration policy, the migrant cap and the impact on ways of working by employers

The extent to which employers suggested that they were likely to become more or less reliant on non-EEA migrant workers in the future was inexorably bound up in the government's policies for managing migration to the UK. Most interviewees highlighted that they had a general understanding of how the PBS and the temporary /permanent cap were being implemented, although there appeared to be conflicting perspectives on how such legislation was being interpreted and implemented both across and within different sectors and that this was leading to a great deal of uncertainly on recruitment decisions. Indeed, some respondents felt that there was something 'arbitrary' about the decision making process:

> '*According to the letter that we received, they [the Home Office] looked at how many certificates of sponsorship we received last year – five – and then they just took one off…but this isn't representative of the situation as before the PBS was introduced in 2008 we had many more visas that had been granted [15 visas]*' (HR representative 8, NHS Trust, North West England).

Most respondents suggested that the absence of a skilled domestic workforce to address existing vacancies in the short-medium term would therefore necessitate a reliance on international labour migrants to fill such gaps. But the key issue was whether they would be pushed towards EEA migrants as opposed to non-EEA migrants due to the restrictions that were being imposed. In this respect – and in line with recent work by Crisp (2007) and Bach (2010) on the nursing sector – there was a degree of scepticism that EEA migrants offered a suitable alternative due to their differing skills sets and experiences, their linguistic capabilities and their propensity to seek work in particular sectors:

> *'If you compare the types of training that doctors in Eastern Europe undertake, it is very different as they all work in small units and they don't have acute-type hospitals. So it is very rare that you find somebody with the right skills – it is about skills, experience and qualifications…so it is far more appropriate to take people from Pakistan, India and Dubai as their skills are more transferable'* (HR representative 7, NHS Trust, North West England).

> *'We have had limited people from Poland, and limited people from places like Romania, Hungary, but not huge numbers. I don't think we saw, for example, in terms of everything you saw on the news a few years ago about a lot of Poles coming to work in the UK, I think probably we had two or three at the most, they didn't tend to come for jobs in the NHS, so we didn't really see much impact from that at all'* (HR representative 3, NHS Trust, North West England).

Many employers also perceived the introduction of the temporary and permanent cap on non-EEA migrant workers as simply adding to a 'tightening up' of the use of such labour that had already become apparent since the introduction of the PBS in 2008. In essence, the new restrictions were compounding problems of recruiting individuals into vacancies that they had already been struggling to fill. Some even commented that the UK's new 'managed migration' policy would deter suitably qualified and experienced applicants from applying in the future, as respondents claimed that those who traditionally had viewed the UK as a preferred destination were now actively seeking employment elsewhere in the world. Moreover, this argument can be

corroborated if reference is made to Bach's (2010) research on nurse recruitment in which he uses the following quote by a South African nurse on the UK's changing immigration rules:

> *'They [non-EEA migrants] feel that it is not quite right that they came into the country [the UK] and filled the gap that was there and then suddenly nobody is concerned about their contribution now [in theory] that they can use EU nurses – [they have] dumped us, that is what I feel"* (South African nurse quoted in Bach, 2010: 259).

Consequently, there appears to be a risk of a decline in the general quality of applicants seeking to work in the UK and indeed such a reduction in demand could adversely impact on the effective operation of the PBS and Shortage Occupation List. This is because both are primarily based around the notion of being able to draw upon a skilled pool of international migrants to fill skills shortages as and when required by UK employers, in the absence of skilled domestic and/or EEA workers.

However, what employers also pointed out was that alongside lower numbers of non-EEA migrant workers entering the health and social care professions, they were also having problems retaining existing non-EEA individuals when their existing visas or certificates of sponsorship expired (and where they had not been granted 'leave to remain'). A reduction on the reliance of such labour was therefore being promulgated from two different (yet related) legislative processes:

> *'If we find that some of the Filipino nurses have gone and we've lost more than previous records have shown, it could cause problems then if we're limited in the number of people that we can bring across and we have insufficient numbers already within the UK'* (Equality and Diversity representative, NHS Trust, North West England).

The obvious organisational impact of both recruitment and retention difficulties that NHS Trust interviewees drew attention to was the quality of care that they will be able to provide and the potential of being increasingly dependent on agency locums, which would be prohibitive, particularly in the current economic climate. Equally, those managing nursing/care homes highlighted the detrimental impact on service provision and their ability to remain competitive:

> *'If you're saying that the changes will mean that we won't be able to have any more [non-EEA] migrant workers then it will have a catastrophic effect…I don't know how we'll staff completely….in the long term I think that the owners will have to look at the viability of the business'* (General Manager, Nursing Home, North West England).

One further dimension already referred to – but which interviewees again focused upon in relation to the impact of the migrant cap – was geographical variation in respect of the ability of Trusts to compete for increasingly scarce skilled labour (including non-EEA migrants, EEA migrants and/or domestic employees). This was seen to be an inevitable outcome of the further immigration restrictions being imposed as health and social care employers competed with each other to fill vacancies, with claims that intra and inter-regional disparities in the recruitment and retention of such individuals were becoming evident between more remote (rural) areas and more accessible (urban) areas, as highlighted above.

Having discussed such impacts, attention turned to respondents' views on what needs to change in respect of the current policies of 'managed migration'. In this respect, there was a unanimous consensus that more flexibility was required on how the migrant cap from April 2011 should be implemented across the UK. Put simply, it was argued that it needs to be more responsive to the specific needs of labour markets and employers that varied according to 'place' or 'territory', as well as according to the needs of particular sectors.

Second, it was felt that the Shortage Occupation List was already outdated, that it needed to be much sharper in identifying speciality areas where labour shortages already exist. Definitions of occupations on the list need to be more reflective of the diversity and specificity of roles within the health and social care sector, and that there should be a further system of review for 'one-off' situations, with greater flexibilities being granted for certain professions over others:

> *'[The Government] need to think about the Shortage Occupations, the hard to recruit jobs, especially the highly skilled jobs that we've got in the NHS, and make some consideration about that before they make their decision. We hope that…there will be some sort of caveat in terms of NHS organisations'* (HR representative 3, NHS Trust, North West England).

> *'They've just dumped everybody in the same boat…I was talking to somebody from UKBA about trying to employ a [non-EEA] doctor and he said 'well, we don't just look at the NHS separately from chefs'…so there you are, a doctor is [now] in the same category as a chef who is coming to work in your local restaurant and it seems a bit bizarre'* (HR representative 5, NHS Trust, North West England).

Nevertheless, some of those who attended the Regional Workshop disagreed with such a perspective and argued that there did need to be an element of competition between different professions and that it was fair to consider the merits of each and every trade, occupation or profession within the context of the PBS and the migrant cap.

Third, it was advocated that there needs to be greater clarity on how the government's new immigration policies are to be implemented so that any discrepancies in respect of the current and future use of non-EEA labour by different employers could be justified and interpreted more easily. Enhanced communication between the Home Office/UKBA with local employers was also deemed to be vital. In turn, it was stated that there was a need for the government to try and look at the needs of each sector in their own right (i.e. the NHS/Social Care) rather than each employer. This, it was claimed, would help to reduce competition between employers for existing skilled non-EEA workers and that where transfers of such individuals between Trusts did take place, existing certificates of sponsorship should transfer with the individual rather than the new Trust having to apply for another certificate:

> *'What we find is that if we have a [non-EEA] doctor who works in Southampton and we have a vacancy up here [North West England], he or she can't just move because we have to sponsor them first'* (HR representative 5, NHS Trust, North West England).

This latter point could become even more important in an era of financial austerity, with the reorganisation of health care in England leading potentially to new bodies working jointly with each other to recruit skilled staff in order to deliver services.

A failure to impose the majority of the above reforms – but critically more flexibility in the implementation of the cap and use of non-EEA labour – was viewed by employers as leading to a situation where the quality of service delivery would be compromised, or worse still, completely withdrawn. Additionally, it was identified that an associated increase in the use of temporary (agency) labour to meet skills gaps would also impact on the viability of many social care employers, and with NHS Trusts having to make difficult decisions on which services to support and which to withdraw.

Finally, employers pointed out the need for a greater emphasis to be placed on planned recruitment, so that vacancies could be filled much more quickly and strategically as soon as an existing member of staff had decided to move on. They also perceived enhanced (long-term) workforce planning (linked to immigration policies/procedures) as being key to addressing existing skills shortages. In essence, this would help to ensure that current pupils and students in secondary, further and higher education were suitably aware of the opportunities on offer within sectors traditionally reliant on skilled migrant labour, and that individuals were also aware of the relevant training opportunities to subsequently engage in such work. As one interviewee highlights:

> *'We used to get involved with sort of open days, with Job Centres, and with the local community. So you'd have jobs fairs, where there'd be representatives from NHS, the army, big employers in the area…and it would be information to younger people. We used to go into schools and target people who are perhaps going to be doing their exams*…but we don't do that now*'* (HR representative 1, NHS Trust, North West England).

3.7 Support required by individuals and organisations for employing EEA and non-EEA workers

The final section considers the types of support that both health and social care employers defined as being currently available, what gaps they felt currently existed and how (and by whom) such gaps should be addressed.

Generally, the bulk of the interviewees within the NHS Trusts identified that they used the NHS Employers website for advice and information on employing both EEA and non-EEA migrant workers, coupled with the websites of the Home Office and the UKBA (and the Sponsorship Management website). A few also noted that they drew upon professional bodies such as the Chartered Institute for Personnel Development (CIPD) and regional migration fora, such as the North West Regional Strategic Migration Partnership. Those operating in the social care sector were slightly more varied in their response; one used the Registered Nursing Housing Association for advice, whilst two others stated that they had received information direct from the Home Office in relation to specific certificates of sponsorship.

However, even with such support, most interviewees claimed that it was incredibly difficult to interpret immigration policy/laws for employing migrant workers and that the recent changes had made things even more difficult to follow. As a result, a call

was made for more support on recruitment processes, how to act appropriately within the existing legislation and how to appeal against decisions (rejections) that had been made. If this was provided face-to-face by Home Office staff (or at the very least if assistance by telephone was more accessible) then it was suggested that the whole process of recruiting international workers – and especially those from beyond the EEA – could be quickened and in turn facilitate the filling of key vacancies:

> *'They started off by saying 'well, if you want to ask for a certificate and you haven't got any then you can send this form to us and we will look at it whenever'. They then sent it back saying that they were not looking at it outside panel meetings which are held on the first Wednesday of every month. So we sent it in to coincide and then they said 'no, we've changed it now and we now look at things in the middle of the month'. But they didn't tell us beforehand that they were making these changes'* (HR representative 5, NHS Trust, North West England).

> *'I'd love to see them put more resources into actually someone you can speak to at the end of the phone, a human being you can speak to…give you some kind of guidance or some kind of help if employers are struggling, because the whole point of asking advice is because we don't want to make mistakes'* (HR representative 4, NHS Trust, North West England).

How likely this can be achieved in a period of civil service cutbacks is uncertain. Indeed, 7,000 jobs are due to be cut within the Home Office over the next three years (politics.co.uk, 2010).

A 'simple' (!) guide to interpreting immigration policy of relevance to EEA / non-EEA migrant workers was also defined as being a useful aid, along with examples of good practice for employing EEA/non-EEA migrant workers within different sectors. In addition, to try and address the time spent on administrative tasks employers felt that a central body that undertook eligibility/qualifications and Criminal Record Bureau (CRB) checks on migrants would be of considerable benefit.

More broadly, if the future directions for UK immigration policy could be mapped out at an early stage, it was strongly argued that this would help with medium to long-term indigenous workforce planning by employers who were currently reliant on international migrant workers to fill skills shortages.

3.8 Summary

This chapter has set out some of the key findings from the research with health and social care employers across North West England. It has illustrated that employers have, and continue to be reliant on skilled migrant labour to fill specialist vacancies. More importantly, the substitution of one group of migrants (non-EEA migrant workers) for another (EEA migrant workers) to meet the current and future demands of employers in the health and social care sectors (and arguably beyond) is not as straightforward as it might first appear given differences in their relative expertise, qualifications, cultural attributes, linguistic capabilities and propensity for seeking work within particular sectors of the UK economy (for example, the relatively modest numbers of EEA workers who have taken up employment within skilled occupations within the NHS).

This chapter has also clearly identified geographical differences in respect of the demand and supply for migrant labour. Indeed, the imposition of the PBS and migrant cap has – and will continue to – produce uneven outcomes in terms of the ability of employers both within and between different regions of the UK to draw upon and benefit from such labour (and non-EEA migrants more specifically) unless there is a greater degree of flexibility in respect of its implementation. This point will be debated further in the context of London and the uneven benefits accruing from inter-company transfers in the final chapter of this report.

Without changes to the current legislation, most of the employers that we spoke to suggested that they would find it difficult to maintain the same level of service provision, let alone the quality of such services. Financially, they were also concerned that in the absence of skilled domestic workers, the increased competition for those non-EEA migrant workers who were eligible to work in the UK would increase competition between providers and raise costs. Once again, such impacts would be likely to impact unevenly, with employers in areas which had tighter labour markets being more likely to struggle in respect of remaining competitive (for example, those in the social care sector) or having to rationalise service provision (NHS Trusts).

Longer term, there is also the issue of how the new system of ‘managed migration’ will impinge on the attractiveness of the country to international migrant workers as a place to live and work. This needs further reflection – along with workforce planning initiatives targeted on domestic workers – as a failure to engage with debates of relevance to either could undermine national competitiveness.

4. Conclusions and policy recommendations

The research findings presented in Chapter 3 are illustrative of some of the key issues that appear to be important to employers in the context of an evolving Points Based System of migration and in a period of considerable economic turbulence. They provide a very interesting insight into both the current and potential future issues that are of relevance to employer competitiveness. In addition, this study goes beyond a simple documentation of employer or employee experiences to consider how the changing nature of state policy is a major influence in shaping the utilisation of both non-EEA and EEA migrant workers in both the health and social care sectors. In particular, the introduction of the PBS in 2008 and the subsequent temporary and permanent caps that are being implemented are having a significant influence on employers' recruitment and retention practices. We must also adopt a relational approach to understand the consequences of the policies and politics of 'managed migration'. There is evidence from our research that employer preferences, as well as individual migrant agency, will also be important in determining the outcomes that emerge. Similarly, the extent to which such factors interrelate and shape the way that the state may privilege certain actors, institutions, time horizons and spatial scales of activity and intervention over others. Perhaps this is currently most evident in the way that the state appears to have relaxed its approach to inter-company transfers to the UK, following much lobbying by the business community reliant on such labour in London and South East England. This point will be returned to below.

The study itself is not without its limitations. It is based around a fairly selective sample of key informant interviewees working in the health and social care sectors in North West England. Furthermore, whilst an attempt has been made to distinguish some of the key differences emerging between each of these sectors in respect of employer perceptions and experiences, the small number of interviewees has meant that broader generalisations based on all of the interview material have inevitably emerged. But we do need to be aware of where such differences may be relevant and important. For example, Manthorpe *et al* (2010) suggest that in contrast to the NHS, the employment of both non-EEA and EEA international migrants in social care appears to have not been explicitly designed or managed by the sector or by the state. Whilst our study would perhaps question the extent to which even the NHS has been explicitly targeted, it is clear that the presence of the NHS Plan (Department of Health, 2000) did provide a workforce strategy framework. This is in contrast to the social care sector where a social care workforce strategy has only recently been published in 2009 (Department of Health, 2009), with recruitment and retention practices appearing to evolve organically within the sector.

Further, our study has not really picked up that the size and previous experiences of employers in terms of their use of migrant labour may be important in terms of their ability to understand and adjust quickly to the changing nature of UK immigration policy. However, this has proved to be important in other studies (again, see Bach's 2010 study of the nursing sector). Nor has our research highlighted the extent to which non-EEA migrants working in the social care sector may increasingly seek to secure skilled work in the health care sector (and specifically the NHS) as they become more experienced and as their language skills improve. In so doing, they may subsequently be able to utilise their skills in line with the Shortage Occupation List in order to remain within the UK and to receive higher wages. Consequently the issue of competition *between* sectors – as well as *within* the health and social care sectors for skilled non-EEA workers – warrants further attention.

With regards to the use of non-EEA international migrant workers to fill skilled vacancies within the health and social care sector, there appears to have only been a relatively modest substitution to date. Our research indicated that this may be due to a number of factors, such as variation in their generic and job-specific skills and the decisions of EEA migrants themselves in respect of their employment choices and the sectors in which they have actively sought work. Similarly, Bach (2010: 260) draws attention to the fact that in contrast to non-EEA nurses that were often recruited directly into acute hospital settings, many EEA nurses were initially recruited to work in care homes as healthcare assistants, with such experience being less suitable for work in acute hospital settings. However, this situation may change over time if greater numbers of migrants from the EEA (and specifically Eastern Europe) settle permanently in the UK. Certainly, whilst numbers arriving in the UK have slowed there is no evidence of 'mass return migration' (MAC, 2010). The imposition of the migrant cap on non-EEA workers may also shift the balance in respect of it increasingly constraining their ability to enter/remain within the UK.

If the study was broadened out to look at the use of international migrant labour to fill any type of labour shortage (skilled or unskilled) then the substitution effect appears to have been much stronger. Indeed, with the suspension of Tier 3 of the PBS, there has been much use of EEA workers from Eastern Europe to fill vacancies in sectors such as social care and where local citizens have often been unwilling to work due to poor working conditions and low pay and status (Eborall and Griffiths, 2008). But even here, there are issues over language proficiency and cultural competency 'as EU staff may not be as familiar with the English language, idioms and culture as Commonwealth citizens' (Manthorpe *et al*., 2010: 404).

Before moving on to discuss the explicit policy issues/recommendations that emerge from the research, one other point needs to be mentioned – undocumented working or unofficial employment. Whilst this is widely acknowledged to be taking place throughout the EEA (Markova and McKay, 2008), the imposition of the migrant cap in the UK may considerably exacerbate such issues – both in the context of sectors with general labour shortages, as well as those reliant on non-EEA migrant workers to meet skills shortages. Both of these categories may increasingly apply to social care providers if non-EEA staff are restricted from working in this sector and/or seek employment elsewhere.

Recommendation 1: Developing a better awareness of the impact of changes to UK and EU immigration policy and broader changes in EEA/non-EEA labour market circumstances

State policies, especially immigration legislation, can strongly influence the utilisation of international migrant labour by employers (Bach, 2010). Our research has clearly shown how the introduction of the PBS and the migrant cap on non-EEA migrant workers has had an impact on the use of such individuals by health and social care employers in North West England, with further changes envisaged as the permanent cap on non-EEA migrant workers comes into existence from April 2011 onwards.

But there is also a need to consider how the removal (in 2011 and 2012 respectively) of the transitional arrangements regulating the free movement of migrant labour from the EU accession countries (the 'A8') and those from Romania and Bulgaria (the 'A2') to the UK will impact/interrelate with current UK immigration policy. Will it lead to

an even greater reliance on such labour to fill skills/employment shortages or will such labour move elsewhere within the EEA?

Equally, labour market circumstances are already changing across the EEA (and beyond) and consequently employers of international migrant labour may again respond quickly and opportunistically. For example, the global economic recession and the recent financial crises that has affected countries such as Greece, Ireland, Spain, Portugal (and to a lesser extent, Italy) has led to a situation where there have been deep cuts in public sector expenditure. Indeed, respondents who attended the regional workshop highlighted that Liverpool has already seen increasing numbers of migrants from Ireland, who have been affected by cuts in public sector employment in their home country and who were now searching for new (skilled) employment in the public sector in the UK.

In theory, these individuals are able to fill skills gaps and would not be subject to restrictions on working in the UK as they are full EEA citizens. Nevertheless, the extent to which such individuals would be able to fill highly skilled roles needs further exploration and if we move beyond a focus on Ireland, traditionally there is much less history of immigration to the UK from Southern European countries. Will this change in the current economic climate and will this lead to further restrictions on the use of non-EEA migrant labour in due course?

In addition, there is also a geographical issue to consider – the arrival of new EEA individuals/migrant communities may impact more on areas within the UK that have a history of accommodating migrants or where existing ties / relations are in evidence. Consequently, will areas that have not experienced previous immigration, such as some rural or more inaccessible areas find it more difficult or will new patterns of immigration emerge, as was the case following European enlargement in 2004 and the movement of Central and Eastern European migrants to the U?

Finally, such arguments segue into debates of community cohesion and the impact of the Comprehensive Spending Review (CSR2010) on public sector cuts and the increasing competition between different sets of labour migrants/UK-born individuals for both public and private sector employment in a period of economic uncertainty. Hence without careful consideration of the impact of such changes, there is a real risk of civil unrest and disturbance at a local community level, especially as the private sector has been identified by the government as being able to provide new employment for UK nationals made redundant from the public sector.

Recommendation 2: Greater flexibility in the implementation of the PBS and migrant cap

Immigration and its effects are not a uniform national experience. The research presented in the report identified that there were intra and inter-regional differences in the attraction of some localities to both EEA and non-EEA migrant workers over others. In particular our work drew attention to the problems that some of the more remote rural employers highlighted in respect of competing for increasingly scarce skilled labour – non-EEA migrants, EEA migrants and/or domestic employees alike. Calls were therefore made for the PBS to be more flexible in order to respond to geographical variations in labour market conditions and the supply and demand of both (skilled) domestic and migrant labour.

However, whilst accessibility may be an important issue, the effective operation of the PBS/migrant cap also needs to take into account other factors which may impinge on employer's use of migrant labour and subsequent productivity. These include costs of living, local variation in the types of services required and the impact of increased use of flexible working practices, especially in the health and social care sectors.

Additionally, there is some evidence of the above arguments being reversed in terms of social care provision within the public sector. For example, due to the size and volume of caseloads that social workers frequently face in urban areas, a number of metropolitan local authorities have strongly argued for a relaxation in the number of permits/certificates of sponsorship they can secure from the Home Office in order to ensure that they have enough skilled social workers/care workers to meet existing demands (Lombard, 2010).

With respect to such demands, Howell (2005) suggests that the state is not impervious to employer, trade union or business influence. Instead it seeks to craft alliances to ensure their acquiescence with state policy. Consequently access to the UK labour market by international migrant workers is regulated as an outcome of such alliances. The most obvious example of this currently relates to the concessions given around inter-company transfers. Thus, after intense lobbying from many companies within the City of London (as well as umbrella-organisations such as the Confederation of British Industry), Tier 2 of the PBS now excludes non-EEA employees transferred by UK-based companies from abroad (MAC, 2010). Such individuals can now stay for up to 5 years in the UK if their salary exceeds £40,000 per annum, whilst firms are also allowed to bring members of staff to work in the UK for up to a year if their job is in ICT and their salary exceeds £24,000 per annum (MAC, 2010).

To summarise, it appears that concessions on the implementation of the PBS may be privileging certain territories and actors (businesses) operating in particular sectors over others, with London and the South East of England most likely to benefit from the above changes compared to other parts of the UK. This issue needs to be debated further in respect of how 'skills shortages' are being defined and the extent to which institutions and actors in other parts of the UK are likely to achieve such concessions in the future in respect of the use of non-EEA migrant labour.

Recommendation 3: Assessing the relative competencies of UK nationals and EEA and non-EEA migrant workers to fill labour and skills shortages

In parallel with national findings, the research in North West England showed that a reduction in the recruitment of non-EEA migrant workers, according to respondents, has not necessarily been accompanied by an associated increase in the number of EEA workers recruited since the enlargement of the European Union (EU) in 2004.

A variety of important factors are of relevance to explaining this lack of substitution within higher skilled employment. These include the differing linguistic capabilities of EEA migrants, their cultural attributes and their differing skill sets and experiences, as well as their desire and aptitude to work in certain sectors that have traditionally been filled by non-EEA migrants.

Thus, whilst the government has argued that there is a need for UK-born workers to fill such gaps in the longer-term (and through more effective workforce planning that relates directly to immigration policy), in the short-medium term there is a need to recognise the difficulties associated with trying to address skills shortages through use of one set of migrants (EEA) over another (non-EEA). This is an important point in the context of the PBS and migrant cap, as well as the fact that it can take up to 13 years to train up a UK-born medical consultant! Set against this, current UK immigration policies now set out that non-EEA migrants have to re-apply for 'leave to remain' in the UK every three years, rather than every five years. So there appears to be an inconsistency evident in terms of the matching up of timescales for the use of domestic labour *vis a vis* non-EEA migrant labour.

Recommendation 4: Myth-busting and addressing public and employer perceptions of the status of international migrants

Following on from the previous recommendation, both the general public and the business community need a greater understanding of the rights, responsibilities aptitudes and experiences associated with different groups of migrants (i.e. EEA migrants, non-EEA migrants, asylum seekers, refugees, etc), as well as the costs and benefits associated with each group. Indeed, the recent cap that has been announced on non-EEA workers within Tiers 1 and 2 of the PBS will actually have a minimal impact on reducing net migration to the UK (by around one to two per cent on average; MAC, 2010).

In contrast, reducing student immigration is likely to have a much bigger impact in terms of numbers (around 300,000 currently study in the UK on average under Tier 4 of the PBS), whilst it must be recognised that over one million migrants from Central and Eastern Europe have already come to the UK since 2004 and indeed EEA nationals will continue to have freedom of movement. Nevertheless other studies – as well as our own – have noted the cautious attitude to date of many UK employers towards the recruitment of EEA workers to fill skilled vacancies in the health and social care sectors. Notwithstanding this, things may now be changing – as was referenced by both interviewees and those who attended the regional workshop – with some employers now becoming more reluctant to recruit and retain non-EEA migrant workers due to uncertainty over their eligibility to work. Therefore, it is important that clear and informative guidance is made readily available to prevent further gaps in provision emerging.

Recommendation 5: Addressing illegal working and the potential abuse of the PBS/immigration cap

Finally, the imposition of any cap on migration from beyond the EEA will need to be consistently reviewed in order to prevent an increase in undocumented or illegal working within sectors reliant on such labour. Setting the cap at too low a level or imposing rigidity/inflexibilities on the Shortage Occupation List could lead to more illegal working. This may be particularly pertinent in relation to the effective regulation of migrant workers involved in social care provision within the NHS, where over 90 per cent of such work is outsourced.

Similar regulation will be required in terms of the actions of recruitment agencies that may emerge to exploit employers and international migrants alike by promising visas

/certificates of sponsorship on the (false) premise of finding loopholes in the current legislation. The national minimum wage and conditions of work for migrants and non-migrants will also need to be vigorously policed to ensure that there is no undercutting or exploitation of individuals.

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Appendix 1: Background and numbers of employees

Interviewee Number	Department / position	Geographical area	Role of interviewee	Employees and non-UK national employees
Pilot	Equality and Diversity (NHS).	North West.	N/A.	N/A.
1	Workforce and Education (NHS).	North West.	Workforce planning and education/ training.	210,000 staff in NHS in North West England. Can't break data down by nationality but can by ethnicity. Local NHS Trusts may have this information.
2	Human Resources (NHS Trust).	Cumbria	Recruitment and employment of staff.	6,500. 8 key workers (medical staff) from beyond EU; more from the EU.
3	Equality and Diversity (NHS Trust).	Lancashire.	Human Resources.	4,500 – No specific breakdown but Filipino and Spanish nurses prominent.
4	Human Resources (NHS Trust).	Cheshire.	Resources for Accident and Emergency (A&E), Medicine and Paediatrics.	3,500. No figure for non-EU nationals.
5	Human Resources (NHS Trust).	Cumbria.	Responsible for recruiting and retaining Doctors.	4,500-5,000. Not sure how many are non-EU but high percentage are employed in the medical workforce.
6	Human Resources (NHS Trust).	Greater Manchester.	Recruitment/overseas recruitment	3,800. Less than 5% non-UK nationals.
7	Human Resources (NHS Trust).	Cheshire.	Human Resources.	4,000. About 80 non-UK nationals are employed.
8	Human Resources (NHS Trust).	Greater Manchester.	Medical staffing.	1,800. Not sure how many non-UK nationals employed.
9	Human Resources (NHS Trust).	Greater Manchester.	Non-medical staffing.	1,800. Not sure how many non-UK nationals employed.
10	Human Resources (NHS Trust).	Derbyshire/ Greater Manchester.	Human Resources business support including responsibility for sponsor management system.	2,300. 10-15% of workforce is non-White.

11	Human Resources (NHS Trust).	Derbyshire / Greater Manchester.	Strategic and specialist medical Human Resources support and advice.	2,300. 10-15% of workforce is non-White.
12	Human Resources (NHS Trust).	Cheshire.	Mental Health and Learning Disabilities.	2250 (Full Time (FT) = 1692; Part Time (PT) = 558). 18 Non-UK nationals employed. 90% male.
13	Director of Nursing (Care Home).	Cumbria.	Nursing Care.	600 (480 FT). 32 non-UK nationals. 12 nurses (of 80); 20 health care assistants. 75% female.
14	General Manager (Nursing Home).	Cheshire.	General recruitment and staff management at nursing home for elderly and mentally infirm.	48-50. 30 full time and 20 part time. 5 Filipinos. 2 Chinese. 2 Thai. 1 Indian. 1 Pakistani. 11 in total - carers. 10 female migrant workers; 1 male.
15	Registered Manager (Nursing home).	Merseyside.	Health and nursing management.	45; 50% FT; 50% PT. 15 non-UK nationals.

Appendix 2: Numbers of non-UK nationals and recruitment issues

Interviewee Number	How long non-UK nationals worked?	Where from?	Change in numbers over time and why?	Recruited overseas or UK?	How recruited?	Why recruited?	Recruitment problems?
Pilot	N/A.	Indian sub-continent. EU now (surpluses); non-EU as last resort.	38% Black and Minority Ethnic (BME) workforce in NHS; 42% in North West England; less from Indian sub-continent now – only if can't fill from within EU.	N/A.	N/A.	When required.	Modernising Medical Careers agenda – foundation course now 2 yrs and overseas individuals not able to come in until year 3. Problems of training compatibility and language barriers with EU staff – not required to do language tests like non-EU medical staff. Many of the latter also follow the UK model due to historic links with UK health service – therefore deemed more compatible.

1	Not sure.	EU and non EU (e.g. Filipino nurses).	Anecdotally, increase in numbers of EU and non-EU migrants – especially in support services where it is more difficult to recruit.	Both overseas and UK.	Going overseas is last resort. Use advertising media; overseas recruitment campaigns and recruitment agencies.	When shortage in medical specialities. In urban areas there is a ready labour market to fill lower-skilled posts; not the same in rural areas and so may be more reliant on migrant labour due to competition for indigenous labour.	Problems of written English being better than spoken English.
2	Years and Years.	India (Doctors).	Less from beyond EU due to restrictions imposed by the Government on numbers of sponsorships that can be offered. EU migrants increased. Electronic application system has facilitated more applications – can apply from anywhere.	Both overseas and UK.	Send teams abroad. But issue of obtaining sponsorship now, so less emphasis as would not be allowed to appoint in many instances.	Difficult to recruit in more remote areas, especially with lower banded grades and indeed can be competition for indigenous and migrant labour in tourist areas. Also issue of getting indigenous labour to work in more remote areas. Can't get indigenous medical staff.	Those from EU don't always apply for posts that they are qualified for. Many apply but have no idea of where job is and have no hope of getting sponsorship. Have to re-apply for those from overseas working somewhere else in the UK as they can't use their sponsorship

							somewhere else. Agencies charge a 'finders fee' of £8,000.
3	2002 – 2004 most arrived.	A lot of medical doctors come from India. Nurses from Spain and the Philippines. Physios, dieticians and nurses from Poland. But greatest numbers are nurses from the Philippines.	Recruitment of Saudi nurses then Filipinos.	Philippines and Saudi Arabia recruited overseas.	Managers went out to Philippines with some clinical staff and recruited directly. Matron went to Saudi Arabia to recruit some nurses.	Filipino nurses see nursing as a vocation. Even whilst more effort made to recruit from indigenous workforce, still vacancies in certain areas – medicine, cardiac and midwifery. Problems of attracting individuals who want to work in a remote area. Medicine is main area where there has been a struggle to recruit from indigenous workforce. Recruiting midwives and cardiac nurses can also be a problem.	Have included additional incentives to entice people. Also reviewed culture of organisation to support recruitment. Delays in international staff commencing duties a problem.

4	Varies. Higher grade posts permanent (e.g. Consultants). Majority fixed-term due to being rotational/ training posts – 2 – 12 months. But some non-EU staff in lower banded roles are permanent too. Such individuals tend to remain long-term.	Doctors from Pakistan, India, Sri Lanka, Poland, Romania, Bulgaria, China and Nigeria. Majority of non-EU come from India and Pakistan. Those from Pakistan often come for training and better quality of life.	Don't know.	Don't recruit directly from overseas. Use NHS Jobs – internet based system. But may have to recruit directly as calibre of staff has deteriorated – appeal of posts lessened? Some non-EU nationals apply whilst already residing in the UK. Skype for interviews not possible due to security reasons.	N/A.	To fill gaps.	Delays in applying for and receiving Tier 2 sponsorship.
5	Varies – 6 months to 3-4 years. No typical time. Some come to obtain clinical English language skills.	Asian sub-continent – India, Pakistan, Bangladesh and Sudan. Also people from the Middle East, Poland and Romania.	Increasing numbers from Sudan. Regulations changed 2008 and led to a dramatic drop in overseas doctors when tier system was introduced. Organisation used to have 800 applications for	Workers are recruited from within the UK and overseas.	Direct recruitment in India with support from an international recruitment agency.	To fill long-term gaps – primarily medical.	Individuals accepting a position but then turning it down due to family reasons and subsequently having to cancel a visa that has been granted.

			middle grade doctors; now has 100 applications per annum. But people within EU don't often have skills required.				
6	Normally system allows sponsorship for two years and then Home Office considers an extension. But more difficult to get sponsorship now for doctors and consultants. Less nurses from Philippines now as not classified as a "hard to fill" occupation. But many of these are also British citizens too so no longer classified as	Not many EU workers – a couple from Romania and a couple of German doctors. The majority of overseas workers are from India and Pakistan. Tends to happen as they have a good standard of English. New immigration rules strict on English so tend to get migrants from areas where English is a	More difficult to employ now. Electronic system only partially helped. Feels that there is a need to jump through hoops to get individuals into post quickly. Massive shortage of middle grade doctors in the UK and can't fill such posts from within the UK.	Generally UK wherever possible.	Not undertaken direct recruitment for quite a while. Recruitments are now through NHS Jobs. There is a need to go through NHS Jobs even when it is clear that the post cannot be filled unless it is advertised overseas.	To address "hard to fill" vacancies.	N/A.

	non-UK nationals. Non-UK nationals fill temporary and permanent posts.	second language.					
7	Since around 2002/03 when nursing shortages first emerged in the UK.	Philippines (nurses); India (doctors).	Fewer now because of restrictions.	Generally UK – not recruited overseas for some time.	NHS Jobs.	Clinical roles biggest gaps to fill in this area (in terms of vacancies).	To obtain Tier 2 Sponsorship Certificates will be very difficult.
8	Depends on grade of staff – often indefinite. Training grades often involve shorter periods of employment.	Indian and Pakistani. Czech Republic also provides Doctors.	Applications for medical posts have decreased quite dramatically.	Not recruited directly overseas but considering doing this to fill one or two specialities – middle grade doctors in A&E and Ear, Nose and Throat (ENT).	Not applicable.	To fill gaps.	Not applicable.
9	For quite a while. They tend not to leave as their migrant 'agency' increases.	EU and non-EU – a good cross-section.	No change in numbers appointed but there has been a decline in the number of applications received. More non-EU nationals who	Recruited overseas in the past but no plans to do this in the future.	Not applicable.	To fill gaps.	Not applicable.

			already reside in the UK are coming to work.				
10	Varies – between 12 months and years.	Doctors come from Asia – India and Pakistan, and Dubai. Some nurses are from the Philippines. Small numbers of staff from the EU generally.	N/A.	All jobs placed on NHS website – worldwide.	Targeted recruitment campaign and through use of NHS website.	To fill medical vacancies.	N/A.
11	The more junior the role, the more likely individuals will come for a fixed period of time. Non-UK doctors come for a fixed period of time to do their training. Consultants more likely to stay in the longer term.	A few from Africa and Sudan. But mostly from India and Pakistan.	Yes – since the introduction of tier system in 2008 – resulted in problems of recruitment at a lower level for medical occupations. Now a much smaller pool from which non-EU staff can be recruited, but this isn't compensated with EU or UK workers with skills to fill such	All jobs placed on NHS website – worldwide. Have worked with advertising agencies targeting overseas countries – e.g. Dubai to recruit Doctors.	Target recruitment campaign and through use of NHS website.	Lots of vacancies are medical as pool of medics from UK has dropped significantly – middle grade doctors a real problem to find. Cost of using agency doctors is prohibitive. Shift to females in medical school – flexible working required – their contribution is a bit diminished.	N/A.

			posts. Modernising Medical Careers limited the routes into which medics could move into different fields of training. Also removal of free training visas – organisations have had to apply for work permits subsequently for such individuals from 2007 onwards.			But always relied on overseas staff in the NHS. But training roles for many overseas doctors not available in the UK now so numbers also diminished.	
12	From 6 months to 2 years.	EU – Poland. Non-EU – India.	Quite static – turnover is about 10% per annum. Not as many individuals leaving at present in the current climate so recruitment has fallen.	Recruited in the UK through NHS Jobs.	Not applicable.	To obtain skills to fill posts that we cannot fill from within the UK.	No.
13	1-10 years; average of 5-6 years.	Philippines mainly. African sub-continent.	More nurses from non-EU countries before as there was a nursing shortage in the UK.	Tried to recruit overseas from Bulgaria and Philippines. But most EU and	BUPA sponsored agency to recruit from the Philippines and Bulgaria (£1500); adaptation course	To address nursing shortages in the UK.	Language and integration can be a problem.

		Poland.	More UK trainee nurses since 2004/05 but move to all graduate profession will cause problems. Sponsorship licence cut from 8 non-EU nurse recruits per year to just 1 – if application rejected; cannot appoint anyone from outside EU. Recruited more local nurses.	non-EU workers recruited directly from home countries via an agent.	at the University of Sunderland. 3 months accommodation costs as well as registration costs for NMC.		
14	3 years – 3 year visas. 2 Chinese staff have received extensions to stay up to 5 years.	Asia and Far East. Also had more from India and Pakistan previously but were not qualified enough to go into new tier system introduced in 2008. 2 more	Consistently at around 20% of overall workforce but variation in make-up of migrant workforce – more non-EU reliant at present.	Directly from their countries. Jobs Fair in Poland. Filipinos through using an agency in the Philippines. Rarely take somebody already in the UK.	Jobs Fair in Poland. 500 applicants – 6-7 offered employment. Word of mouth subsequently helped with recruitment. Filipinos and Chinese came through agencies – some of the Chinese have	To address shortages of English staff. – Many posts not attractive financially to potential English staff. No trouble recruiting for housekeeping staff – chefs etc.	Forged papers sporadically; agencies mislead migrants about locations of employment – some absconded in night to move to larger cities in England.

		Africans and 1 Zimbabwean also moved on. Previously had 10-11 Poles who have now all left.			extended their visas and work/ undertake training (15-20hrs work and 15-20hrs a week training). Candidates pay the recruitment agencies. Agency acts as the sponsor – they take on all of the bureaucratic tasks – cheaper.		
15	Over five years for some; others have joined more recently.	Thailand, the Philippines, Portugal and Poland. Fewer overseas workers employed in the past.	Employ more migrant workers currently. Not as many UK residents applying for posts.	Workers recruited locally.	Recruited through the local press.	To fill vacancies in care work, laundry and kitchen duties.	Language barriers – context is a problem sometimes. Cultures can be very different too – for example, washing patients.

Appendix 3: Training, advantages and disadvantages of employing non-UK nationals and future employment

Interviewee Number	How do international workers compare to overall workforce (age etc)	Work-related training for international workers?	Any additional help for international workers?	Main advantages of employing?	Main disadvantages of employing?	How reliant and more or less reliant?	Likely to employ in the future?	Where from and why?
Pilot	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1	Don't know.	Some experiential training and some supervised training.	High turnover if not a lot of time spent on induction. Help with finding housing; form filling; 'buddying up'; intensive training in policy and procedures.	Filling vacancies; reducing overtime costs of indigenous workforce. Can be more aware of the needs of the local migrant population.	Cost, time and effort; planning and preparation time – costs of checking qualifications; induction support etc. Also some middle-grade Doctors from overseas undertake training to go back to home country eventually. Language and accent problems. But still cheaper than	Pretty reliant.	Not sure.	Not sure.

					paying indigenous locum overtime. Can be racism towards non-EU migrant employees			
2	Qualifications have to be recognised by appropriate bodies. More male dominated and more professional / skilled end stays longer.	Yes, general and specific to the job.	Not very good at this. Accommodation is sub-standard and this may not help with retention rates.	Avoids use of locum agencies that hold organisations to ransom. Can help with understanding of needs of local multi-ethnic population.	Those from beyond EU come to get experience and training but want to go back and so the knowledge is not really put to good use. Communication /language problems, especially in respect of older patients.	Problems in filling vacancies on medical side and in respect of paediatrics. So reliant in these areas particularly.	Yes – a lot of indigenous doctors wish to work in the larger cities in the UK – so young medical staff tend to come and go quite quickly and thus reliant on migrants to fill.	N/A.
3	More females than males. Highly qualified in many instances. Mix of singles and families.	Six month adaptation course offered. Have English exams as part of this before they arrive.	Support with accommodation, occupational health, counselling – "staff advocates" to point migrants in the right direction.	Skills.	Problems/ issues of qualification conversion. Standard of English is often misjudged.	Depends on the medical area/ speciality. Paediatrics and general surgery are easier to fill.	Yes.	Depends on the speciality required – for cardiac nurses go back to Saudi Arabia.

4	Stay in posts longer.	Yes – relevant training provided to all.	Provide single and married accommodation; advice on general accommodation needs.	Hardworking and willing to progress. Stay in employment for longer and wish to remain insitu to obtain experience rather than move to other cities.	Delay in recruitment process and to apply / be granted Tier 2 sponsorship. Can be costly filling posts whilst waiting.	Trust only applies for Tier 2 sponsorship. Especially reliant on medical staff from overseas – not enough UK Doctors coming through the system. Why? Media perceptions, lack of awareness of career paths etc. Reliance has increased over time.	Yes as number of UK Doctors is reducing. Cap is going to affect the Trust in a negative way.	Don't know.
5	Qualifications very reasonable. Asian migrants better in respect of linguistic capabilities and skills than those from the EU. Many are	3 month (longer) induction period to support settling in.	Non-EU doctors are given £2,500 to help them settle in for air fares, accommodation. A personal mentor is also assigned.	Different backgrounds and experiences. Helps to draw future migrants into vacancies through 'word of mouth'. Also avoids paying	Can work if there is a robust recruitment system. But some locums from overseas have been unsafe and have needed extra training.	Quite reliant.	Don't know.	Don't know.

	taught in English so this Is not a barrier.			locums which are very expensive.				
6	Mix. Quite a spread of males and ages.	English language speaking test administered by UK Border Agency.	Support with accommodation; packs of information on day-to-day living drawn up.	Pool of talent – only way to fill many posts.	Can take up to 4 months to get an individual into position following request for references, getting Criminal Record Bureau (CRB) checks; sponsorship approved etc. Need to have more 'planned recruitment' to fill shortages asap. Communication difficulties; rules of employment can be complicated so timescales for appointment can be very slow.	Don't know.	Possibly less.	Don't know.
7	Generally the same as overall workforce –	N/A.	Some support with finding accommodation.	Helps address gaps in the sector – UK is not	Language barriers, especially with elderly	More reliant but more difficult to fill given current	Likely to employ.	Not sure given restrictions.

	including qualifications.			good at channelling individuals in the right way and sending good students to medical school. Non-UK workers also bring diversity and different ideas.	patients.	restrictions.		
8	99% of overseas non-EU staff are male from a medical side. Most are better qualified than an equivalent UK post holder.	Standard training is available for all.	Specific induction if overseas recruitment goes ahead will be provided – orientation into the NHS and UK generally. The Royal Medical Colleges offer something similar in respect of accommodation and welfare / location.	To fill vacant posts – shortage specialities across the board – failure of workforce planning. Many vacancies are not popular with UK trained doctors – many are non-training posts, which make them less attractive.	Different ways of working – need a good orientation to the NHS. Many doctors from EU are more difficult to understand as they haven't had to go through the same level of English proficiency as those coming over from Asia. Many from Asia have often been taught in English too.	About the same.	Not sure. More difficult as sponsorship has been taken away unlimited certificates of sponsorship. However half of workforce will still probably be from overseas.	N/A.

				For example, ENT is historically filled with doctors from Asia, as is A&E.				
9	Mixture. 50:50 male/female split. A lot are overqualified for the post they are applying for – trying for anything and then better themselves once in post – EU and non-EU workers.	No – standard training is available for all.	No.	To fill vacant posts.	Language.	Same as before.	Probably not but will still employ individuals under Tier 1 and Tier 4 – but from existing pool of EU / non-EU nationals currently working in the UK.	N/A.
10	More male orientated – to do with cultures in Asia – more likely for males to work. Age range is 30-40.	N/A.	N/A.	Continuity of care for patients. Reduction in costs against locum costs.	Longer settling in period. Investment in the induction period.	More reliant because barely running medical services in some areas.	But not likely to recruit as many because of restrictions.	N/A.
11	Previously, predominantly	Period of induction to	How to register children with	Continuity of care for	Longer settling in period.	93% vacancy factor in A&E	But not likely to recruit as	N/A.

	male but now 60:40 split in respect of non-EU doctors coming.	the NHS which is tailored to the individual.	local schools; information on suitable areas to live and local areas. 'Buddy' system to support – use existing staff from same area of origin.	patients. Reduction in costs against locum costs.	Investment in the induction period.	in this area at present – having to cover with locums. Very reliant on overseas workers in some specialities at consultant level – e.g. radiology.	many because of restrictions.	
12	Similar age but more male than average indigenous workforce. More qualified on average.	General induction for all employees.	Support with accommodation.	Skills – non-EU migrants are highly qualified.	Language barriers. Cultural barriers. Ways of working in the NHS.	Quite reliant as work is less attractive than other forms of work in the health sector.	Probably.	Shortage of staff to fill specialised medical vacancies.
13	Age – no difference. Gender – more female but same for general indigenous population. Qualifications – have to be qualified to at least degree	Yes – work related training (but same for all).	Register migrants with a local GP, dentist and optician and offer English lessons too. A mentor system is also in place. Adaptation course at University of	To fill vacancies and commitment.	Language barriers and the expense of recruitment/ visas and adaptation courses.	Significantly reliant but depends on other factors, such as availability of jobs in other hospitals – if there are vacancies, UK workers will go there.	Less likely due to sponsorship situation.	From EU due to sponsorship situation for non-EU workers.

	level (so higher on average compared to rest of population). Retention – stay in posts for a longer period on average.		Sunderland.					
14	More female than male. More qualified on average; more experience on average; more likely to be retained than English staff.	Generic training programme that all staff participate in.	Polish needed a lot of help on accommodation and welfare etc as lack of networks when they first arrived. Filipinos needed less help when they first arrived as they were able to tap into family networks.	Reliability – same level of commitment not available from English staff.	Many have to return once visa runs out – frequently this occurs after training has just been completed.	Highly dependent – reliant on recruitment agencies finding loopholes in Government legislation to employ non-EU migrants. Costs will impact on business sustainability.	Yes if possible.	Where already recruited from – within and outside the EU.
15	Similar in respect of age, gender, qualifications. More likely to be retained in the longer-term.	General induction provided for all staff.	No additional support offered.	Reliability. UK workers frequently wish to "work to rule".	Indigenous population and EU workers now in the minority – feel pushed out a little. Clique-ishness.	More reliant as indigenous population do not wish to apply for posts in this sector.	Yes.	From UK and using indigenous workers to balance the nature of the workforce out.

					Also some non-EU migrant workers do not appear to understand what they have been asked to do.			

Appendix 4: Operation/impact of Points Based System (PBS) and the migrant cap

Interviewee Number	Understand changes in relation to PBS and temporary cap?	Impact on organisation?	Anything that needs to change in relation to the PBS / cap?	Impact of further restrictions (permanent cap)?
Pilot	N/A.	N/A.	N/A.	N/A.
1	Yes, broadly.	Number of medical vacancies struggling to recruit to.	Need exemptions where cannot fill from indigenous workforce, especially in more remote areas of the UK.	N/A.
2	Yes. Some information appears to be conflicting. Interpretations of the guidance can vary widely too.	Minimal to date but will have a big impact going forward especially as will then be more dependent on agency locums and costs would be prohibitive in current economic climate.	Need more flexibility to run services and appoint necessary staff. More strategic long term planning required to develop indigenous skilled workers to fill vacancies. Need more scenario planning in the mid-long term to ensure suitably trained indigenous workforce.	Would not be able to run certain services.
3	General understanding. It is about breaking the link between migration and settlement and filling vacancies with indigenous workers wherever possible.	Little short term impact as already appointed a number of non-EU workers. But possible problems of retaining and replacing such workers in the future.	N/A	More emphasis on retaining indigenous staff and up-skilling.
4	Yes – will have to apply for certificates etc. Allocations may be based on whether the organisation is a new or existing sponsor; whether the organisation is defined as a 'Band A' rated sponsor (no	Risk of losing existing staff and appointing new non-EU staff. Delays in decision making by Home Office will not be helpful in supporting such individuals.	Look at specialities and where shortages exist. Shortage Occupation List needs looking at. – A lot of training grade doctors appear to not be on the Shortage List.	More advertising campaigns would be required. Restrictions on Junior Doctors in Tier 2 will hit hard. Skills and experience will suffer, as well as patient care.

	evidence of abuse/correct systems in place) and the particular shortages that exist. But delays between making applications for 'exceptional circumstances' and allocation of certificates may make a difficult situation worse. Home Office will look at things on a Trust by Trust basis…individuals may move to another country or decide to get a job in their own country as Doctors don't normally apply just for one job. Staff may be lost to other Trusts in the UK – competition within the UK?		Communication between the Home Office and NHS Trusts needs to be better.	
5	Yes.	No immediate impact. But problems emerged initially with the tier system brought in during 2007/08. If existing sponsorship certificates are not used then they may be taken away. Problems of geographical isolation so tend to have many vacancies. Also, doctors may be deterred from applying if they are not sure that they can obtain a certificate.	Shortage Occupation List needs to be looked at again. It isn't looked at in respect of sector or geographical area. Some areas have constant recruitment problems due to their geographical isolation – need more flexibility in appointing non-EU staff into such positions.	Problems of obtaining certificates and filling vacant posts.
6	Yes.	Sponsorship Certificates have been reduced from 12 to 5.	Clarity in terms of how it operates as it is too	Need to have more flexibility to appoint

		Now any new appointments over this level will need to be defined as an "exceptional application". This will slow the whole appointment process down.	complicated. It is hard to understand and follow – both for employees and employers alike. Also needs to be more flexibility on "hard to fill" jobs.	individuals into posts which are "hard to fill". Otherwise it may not be able to provide a good service in many areas.
7	Yes. But everyone may have been placed in the same boat.	Yes – making it more difficult to apply to sponsor such individuals and to secure certificates. Potential appointees are looking elsewhere because it is taking so long to secure Sponsorship Certificates and to make an offer of employment.	There is a need to look at the NHS in its own right and not make each individual hospital compete with each other. Transfers between hospitals in the UK need to be more straightforward rather than having to apply for another sponsorship certificate if somebody wants to move to fill a vacancy in a similar post somewhere else in the UK.	NHS needs more flexibility to fill vacancies with non-EU workers quickly.
8	Yes.	Not had an impact at the moment. Not had to use certificates of sponsorship in the last 12 months. Problem is that allocations have - now have to apply under 'exceptional circumstances' or else cannot recruit non-UK nationals to fill posts. So mid-longer term it may have more of an impact. But also depends on how the workforce is managed in the future.	Needs to be slightly more realistic – there will always be speciality areas that cannot be filled through use of UK labour. If certain wards and medical areas wish to continue to operate then the cap will need to be lifted. Going back to the old permit system and where each case was reviewed on its own merits would be better.	More reliance on indigenous workforce.
9	Yes.	Not had an impact at the	N/A.	N/A.

		moment. Not had to use certificates of sponsorship in the last 12 months.		
10	Yes.	Basically looked at how many permits allocated last year and took one off! But year before that there were 15 extra workers on permits. So decision-making appears to be very haphazard.	Need to be realistic in reassessing the Shortage Occupation List and coming up with a new list.	Greater reliance on agency locums and significant increase in costs to NHS Trusts.
11	Yes.	Impact quite significant – advised could have 4 non-EU workers between August 2010 and April 2011. But lower numbers from this point expected. 4 Permits against 14 vacancies in A&E – spent time recruiting overseas but cannot now appoint. Lots of trusts appear to be in the same position. Vacancies within NHS Trusts do not appear to 'marry up' with those on the Shortage Occupation List.	Need to be realistic in reassessing the Shortage Occupation List and coming up with a new list. Existing Shortage Occupation List appears to have been cut over the last two years. There is no point in restricting work permits for speciality areas with current shortages in staff.	Greater reliance on agency locums and significant increase in costs to NHS Trusts.
12	Yes.	Cap is going to prevent skilled non-EU workers being appointed to fill vacancies – could impact on quality of patient care.	Need to relax rules in whatever way is possible.	Impact detrimentally on medical recruitment and possibly non-medical as well. Ultimately it could impact on the quality of staff

				employed.
13	Yes.	Problems due to being allowed only one application to bring in non-EU workers.	Should be more exemptions where impossible to recruit into shortage areas from within UK/ EU. There should be a system of review for one-off situations.	Significant vacancies that would impact on standards of care.
14	Not wholly conversant.	Catastrophic effect if not allowed to employ any migrant workers at all – more reliant on EU workers?	Non-EU migrants have to earn a lot more to be a senior carer - which is on the Shortage Occupation List. Difficult for many employers to pay such wages thus problems of retaining such labour.	Struggle to recruit staff and fill vacancies impacting on the productivity of the business.
15	Don't know.	Will impact on filling vacancies – indigenous population will not be a substitute.	Don't know.	Yes – makes it even more difficult to recruit non-EU workers to fill vacancies.

Appendix 5: Further support to employers

Interviewee Number	Main source of information?	Support required?	Who is suitably placed provide such support?	Any other changes to immigration system required?	Any other comments?
Pilot	N/A.	N/A.	N/A.	N/A.	N/A.
1	NHS website.	N/A.	N/A.	No.	No.
2	NHS Employers website and Home Office and the UK Border Agency.	Law for employing migrant workers – it changes frequently and can be interpreted in different ways.	Home Office.	No.	More long term planning to address vacancies by ensuring suitably trained indigenous workforce.
3	Chartered Institute for Personal Development; Personnel Today; NHS Employers; European Human Rights Commission.	Support on actual recruitment processes and how to act within the legislation.	Foreign Office. More regional support.	Geographical variability in application of PBS dependent on local/ regional needs – greater dispensation to certain localities with greater needs.	No.
4	From searching on the internet and looking on the Home Office website. Also non-EU Doctors can inform of their position. Also used the Sponsorship Management System website.	Home Office need to explain changes at the local level and what else may be changing in the future.	Home Office – but there needs to be much better communication.	Better communication. Ability to transfer sponsorship from one Trust to another – costs time and money to re-apply at present. Consequently, the system needs revising. To help employers and Non-EU employees.	Struggle to recruit non-EU workers generally in rural areas; migrant families want to live in the larger cities – makes it difficult to recruit and retain such individuals (especially). But this is more the case when they already reside in the UK.
5	Updates from UKBA (UK Borders Agency) North West/North East Regional Strategic	No need for much more support.	No need for much more support.	System needs to take more account of geography – should be some exemptions for	No.

	Health Authority meetings. National Association of Medical Personnel. NHS Employers website.			isolated areas that have constant recruitment problems – most individuals want to be in the main cities such as Newcastle or Manchester.	
6	Sponsorship Management System. UKBA website. NHS Employers – useful in that they provide clarity to statements issued by UKBA.	Need more face-to-face support. It can take a long while to have a direct conversation with somebody employed in UKBA.	More human resources at a national level to support employers by UKBA.	More flexibility of PBS/Cap restrictions to address 'hard to fill' vacancies.	EU migration made little impact as international recruitment outside EU has been the main area of overseas recruitment. Most EU workers did not come to the UK to work in the NHS.
7	UKBA.	UKBA need to make the whole appointment process for non-EU workers much simpler – takes too long to appoint at present – too complicated.	N/A.	Need to look at the need for appointing new employees quickly by organisations reliant on non-EU labour to meet skilled job shortages that cannot be filled from within the UK/EU.	EU migration made little impact as migrants did not tend to be doctors who wanted to work in the NHS or were workers who were required to fill other shortages in the NHS.
8	Department of Health. Updates from NHS employers.	Don't know.	N/A.	One kind of stamp in a passport which shows eligibility of non-UK nationals to work. But this may be unrealistic.	Good access to work/ facilities is important in recruiting and retaining non-UK medical staff.
9	Department of Health. Updates from NHS employers.	More affordable training sessions.	N/A.	Making the information a little easier to find.	Location does make a difference in respect of recruitment of non-UK nationals and also the extent to which you can rely on the

					indigenous workforce.
10	UKBA website or call centre.	Understanding immigration law. Understanding how immigration will work in the future so that the Trusts can engage in workforce planning.	N/A.	Limited applications from EU countries for higher grade posts in particular and more generally – and also lack of skills.	
11	NHS Employers. NHS bulletins to staff.	How to go through the implementation of immigration laws and procedures. How to appeal against decisions – clearer guidance.	N/A.	Rarely get doctors from EU countries (lack of suitable skills and experience – not just qualifications required – tend to have less transferable skills and have worked in very different environments to the NHS). Many EU workers tend to move to a lower level to gain confidence. Cap on non-EU workers needs to be more flexible; otherwise problems financially and/or providing continuity of care to patients. Speculative applications were made by EU workers following EU enlargement – but this didn't follow through.	No real movement of non-EU nationals between Trusts except in respect of those working in A&E where there is national UK shortage of staff. Rural areas find it more difficult to recruit and retain non-EU staff and their families.
12	NHS Jobs Bulletin.	Immigration legislation.	UKBA.	Not sure.	No.

	NHS Employers. Medical Human Resources Manager also provides guidance from a regional network.	Better information on what other NHS Trusts are doing in respect of employing migrant workers.			
13	Contacted directly by the Home Office as in receipt of a certificate of sponsorship.	None – have undertaken such activity before.	Not required.	Easier access to individuals in the Home Office – very difficult to get through by phone.	Qualified nurses need to be viewed as a special case in respect of exemptions to recruit non-EU nurses under the migration cap.
14	Immigration Matters emails. Home Office also visits.	Help for understanding immigration rules and regulations.	No idea.	Don't know.	No.
15	Through the Registered Nursing Housing Association.	Nothing specific.	Sponsors/agencies should provide employers with more support.	Supporting body to undertake checks – CRB/ qualifications/legal status of migrants etc.	No.