WORK-INT

Assessing and Enhancing Integration in Workplaces

POLICY BRIEF

ENGLAND: Consistent Support and Mutual Learning Required

KEY POINTS

- Integration in the workplace is a two-way process and requires learning and adapting on both sides. There were many good examples of this in our case studies
- There is an inconsistency in the level of support provided for newly arrived migrant health professionals in the workplace
- All staff need further support on the impact of cultural communication styles to avoid misunderstandings and conflicts
- There continue to be barriers to career progression particularly for migrant doctors
- At no level is a link being made between equality and diversity policies designed to promote equal opportunities and the need to support migrant health professionals to facilitate integration

WHY IS WORKPLACE INTEGRATION OF MIGRANTS IMPORTANT?

Much discourse on immigration and migrant economic integration focuses on policies to attract and select the "right" economic immigrants and on ensuring employment of working-age foreigners of all admission categories. To this end, facilitating access to work is seen as one of the cornerstones of successful integration policy, supporting migrant self-reliance, acquisition of new skills and socialization in the new environment. Far less is known about the reality of workplace experiences of migrant workers and whether having a job indeed supports integration beyond ensuring economic independence. In fact, at times effective integration in the workplace is taken for granted in the broader policy debates. Improved knowledge on the role of workplace processes and employer practices in immigrant socio-economic integration could enable governments and employers to create better conditions for best use and development of immigrant skills, as well as improve retention of foreign skilled workers.

WORK-INT is a European research and advocacy project aimed at better understanding, increasing awareness and improving policies and practices on workplace integration of migrants working in the health sector based on primary research carried out in in Dublin (Ireland), Hamburg (Germany), Oxford (UK), Madrid (Spain), and Turin (Italy). See www.workint.eu

ENGLISH CONTEXT

The health care system in England is characterised by the dominance of the National Health Service, with private provision playing a small part. The health sector is also distinct in the UK labour market, as it has attracted and relied upon migrant health professionals for many decades and the workforce is made up of a high proportion of migrant health professionals (approximately a third of doctors and a fifth of nurses). Other factors that affect the current study of the health sector are:

- Major structural changes have been undertaken in the last five years to the organisation of the NHS, and there are currently intense staff shortages in many specialties
- There is continuing criticism from within and outside the health sector of the lack of progress on equality and diversity objectives, which has led to the recent introduction of a NHS Workforce Race Equality Standard.
- Regulatory requirements for EEA and non-EEA migrant health professionals differ. EEA nationals benefit from automatic recognition of qualifications and no immigration restrictions. EEA nurses also do not have to prove English language competence in order to gain registration.
- Partly as a result of different regulatory requirements, there has been a marked shift in migration patterns to the health sector, from non-EEA migration to EEA migration.

SPOTLIGHT ON EVIDENCE

ENTERING & PROGRESSING IN THE HEALTH LABOUR MARKET

In England both migrant doctors and nurses face barriers in progressing in the labour market. Migrant doctors continue to face difficulties in progressing in linear medical training pathways towards consultant positions in hospitals. Data indicates that migrant doctors are over-represented in lower status 'service' posts (specialty and staff grade positions) associated with little prospect of progressing. While both EEA and non-EEA doctors struggle to get on training paths compared to British colleagues, non-EEA doctors are more likely to fill temporary service gaps because of current stringent immigration rules and different regulatory requirements between those from outside and within the EEA. Immigration restrictions on transfer of status can also limit career trajectories for those from outside the EEA who have trained in the UK. In addition, many migrant doctors said they felt they had to work harder to be trusted: ***"You have to work extra hard to get the same kind of respect that would be coming to you automatically if you were just a good enough British doctor."***

VIEWS OF UK BORN STAFF

Whilst a number of studies have looked at migrant health professionals few had explicitly sought the views of their UK-born colleagues and managers. The views of UK born staff from our research are summarised below:

- Most expressed an appreciation of staff from other countries and considered that migrant health professionals add value to the service provided
- There was a perception that existing differences for language requirements between EEA/non-EEA nursing staff were 'nonsensical'
- It was suggested that some nursing staff from other parts of the world have a higher standard of clinical training that bring up standards
- The adaption period or supernumerary period for new staff (particularly nurses) can put pressure on existing staff
- Some commented on the fact that with large groups from one country, a feeling of 'cliques' could develop, particularly when migrant staff spoke in other languages. Whilst this did not lead to outright tensions, it was perceived negatively.

For nurses from outside the EEA access to the labour market has until recently involved a period of de-skilling in the form of the adaptation period during which they worked at a lower level whilst waiting for registration. Nurses from outside the EEA also have to sit a language exam in contrast to nurses from within the EEA, leading to some perceptions that the current rules are unfair. All nurses also need to have certain competencies 'signed off', sometimes leading to frustration as they are not allowed to perform certain procedures that they have been trained to do. Some stakeholders also suggested that there is a 'glass ceiling' for nurses from overseas, with these nurses being underrepresented in more senior positions.

Newcomers' experiences of induction provided by employers varied widely depending on the team. Doctors on the whole felt that induction had not been helpful: "it was really just a waste of time." Nevertheless, there were examples of good practices, particularly for induction programmes put in place for large cohorts of nurses being

recruited in the EEA. These included pastoral support, access to English classes and specific programmes for signing off nursing competencies.

Both migrant doctors and nurses described how living in a country without family support networks could place an additional strain on their ability to progress in their careers. Although issues around childcare were also raised by British staff, having a support network meant it was less likely to impact on their career. Getting adequate time off to travel home in the event of a family emergency could also be an issue for some migrant health professionals.

WORKING TOGETHER

There was a strong sense from all respondents about the importance of team working and a commitment to putting the patient first. Many managers and senior British staff talked of the positive contribution migrant workers made to teams (see box). In the private hospital, examples were given of new ways of working introduced by migrant health workers that brought improvements to care.

The issue of the 'language barrier' was raised as a concern by many British and migrant health professionals alike. On analysis, this seemed to break down into three main areas: cultural communication, idioms and terminology, and pronunciation difficulties. Whilst knowledge of idioms, terminology and to some extent pronunciation are more strictly linguistic issues, and are likely to be resolved over time, norms around cultural modes of communicating are more subtle and are not strictly linked to competence in the language. Often difficulties experienced by migrant staff were associated with British norms of communication and the importance of non-verbal cues, such as tone of voice. This led to some migrant health professionals being described as too 'brusque' or 'direct' by colleagues. Managers seemed to recognise the importance of taking forward learning on this and working with staff to ensure that these issues were addressed: that is, a two-way process of communication. Nevertheless, this seemed a fairly new area in which work was being done.

EQUALITY AND DIVERSITY

The UK has a clear framework of legislation for addressing discrimination on a number of grounds including 'race' and public bodies have a duty to promote equality between different groups. The definition of 'race' within the legislation includes nationality and ethnic or national origins, although often equality and diversity policies are more narrowly focused on ethnicity. Nevertheless, research indicates that there continue to be adverse outcomes for black and minority ethnic staff in a range of areas including recruitment and promotion, representation at senior levels, access to non-mandatory training and bullying and harassment.

The majority of staff in both private and public hospitals did not see the relevance of current equality and diversity policies nor perceive much value in the training provided on these issues. No link was made between equality and diversity policies and the obligations to promote opportunities for, or provide support to, migrant health professionals.
The issue of prejudice or discrimination from patients was raised in both hospitals. Particularly in the private hospital where patients were paying, staff felt that patients had unrealistic expectations about being treated by British nurses and these would be expressed in a range of comments and complaints. Speaking with a foreign accent also became a marker of difference. Whilst senior staff all acknowledged this as an issue, processes for dealing with it did not seem clear. In many cases this behaviour seemed to be excused on the grounds that patients were elderly and/or unwell, as reflected in the following comment: ***"Racism from an older generation, particularly when they're unwell, it's seen as distasteful but it's seen as, like we [migrant/minority doctors] should be able to tolerate it."***

POLICY RECOMMENDATIONS

INDUCTION FOR HEALTH PROFESSIONALS

1. Trusts and hospitals should develop induction packages that are based on the **inclusive values** of the organisation and the NHS Constitution. These should be designed through consultation with a range of stakeholders at all levels, including ward managers, trade union representatives and other professional organisations. Induction should be provided to both migrant and UK staff and should include examples of behaviour expected of all individuals. As part of this, and given the diversity of the workforce and the patient population, a **mandatory course on how culture impacts on communication** would help staff be more sensitive to differences in communication styles and lead to better outcomes for patients and staff.

2. A greater role should be played by NHS England/NHS Employers or Health Education England to coordinate and **share resources on induction** across organisations. Currently a number of organisations have programmes in place to support newly arrived health professionals from overseas but this support is not joined up and so is not being consistently accessed.

3. In addition Local Education Training Boards should put together **specific induction packages taking into account particular needs of migrant health professionals**. In particular, clearer information on how local systems work, the roles of different actors and institutional bodies, local support networks and an overview of patient demographics were identified as lacking by migrant health professionals. Practical resources for new staff members on medical terminology, local colloquialisms and abbreviations can be very helpful. A named contact point for pastoral/practical support would also reduce isolation.

TRAINING & SUPPORT

4. **More training opportunities** should be made available for doctors who are not on formal training pathways and Trusts must ensure that these doctors are able to take their Continuous Professional Development (CPD) hours. All medical staff would benefit from a mentor or educational supervisor to support them in developing their career and navigating pathways.

5. There should be a greater recognition of the contribution of longer stay nursing staff through opportunities for career progression. Nurses (as well as doctors) would benefit from **greater access to flexibility in working schedules** to juggle the demands of family and working life. When undertaking large scale recruitment exercises in the EEA, attention must be paid to ensure that language skills of new recruits is adequately tested.

6. All staff would benefit from **an extended bereavement leave**. This is particularly relevant to migrant health professionals who may have to travel long distances to be with their families.

EQUALITY & DIVERSITY

7. All hospitals, including those in the private sector, should ensure that **data on country of birth and nationality of staff currently being collected is as complete as possible**. Wider use of such data would give employers a more nuanced understanding of their workforce and would illuminate the barriers that certain groups might face. Collection of data at the NHS Trust level would also ensure that policy makers and regulators are able to build their understanding and awareness of new diversity within the workforce which may not be captured by ethnicity data.

8. The recent introduction of the **National Race Equality Standard** in all NHS contracts is to be welcomed. All hospitals should ensure that they are **complying with the Standard and that data collection on ethnicity is as complete** as possible.

9. Trusts and private hospitals should **review equality and diversity policies and training with explicit awareness of the needs of migrant workers**. Forums for engaging staff in more meaningful conversations about equality and diversity should be devised. Conditions for paid time for trade union activity should be extended to include trade union Equality and Diversity Representatives.

10. Trusts and private hospitals should put in place **clearer guidelines for senior staff to deal with patients' abusive and/or discriminatory behaviour**. Senior staff should demonstrate that they are there to support staff that experience this type of behaviour.

LEARNING ON BOTH SIDES

11. NHS England should work with Trusts to uniformly **cultivate a culture of working that is open to new ideas** and new ways of working that migrant health professionals can bring. Hospitals and Trusts should build on emerging new initiatives to **develop British staff's awareness of their own culturally situated knowledge and modes of understanding**, in order to ensure that a genuine two process of learning and adapting is taking place.

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Policy brief authors:
Helen McCarthy, 1helenmccarthy@gmail.com
Hiranthi Jayaweera,
hiranthi.jayaweera@compas.ox.ac.uk