Multilingualism in UK

Practices and Perspectives

Nurses in the NHS: A London case study

By

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1 Overview of the company/sector

The NHS is one of the five largest employers world wide (the other four include McDonalds, Walmart, the US Dept of Defence and the Chinese People's Liberation Army). It was founded in 1948 with the aim of providing health care free at point of use and paid for out of general taxation. Over its almost 70 year history the NHS has gone through a succession of changes, the most significant of which reflect the shift towards a service driven by neo-liberal economics and under-written and promoted by both Labour and Conservative/Coalition Governments.

Key changes include:

*The marketization of health care through the splitting of health service into commissioning/purchasing and providing services and functions;

*The creation of NHS Foundation Trusts, established from the early 2000s and regarded as something of a hybrid of the public and private health care sectors. Foundation Trusts have more autonomy in recruitment, employment contracts and governance. Of approximately 250 NHS Trusts around 150 had achieved Foundation Status by 2013;

*The growing emphasis of the patient as consumer;

*The growth in reliance on private recruitment companies to provide temporary staff, costing the NHS over a growing % of its budget (see for example Kings Fund, 2015), and elsewhere, the growth of: private finance initiatives to fund hospital buildings; private provision of elective surgeries; private hopsitals, care homes and social care services; the outsourcing of cleaning and supplies, and the growth of companies coordinating health related services.

The NHS in England employs 1.5m people, of whom 400,000 are nurses, with a budget of £116 billion in 2015-16. The supply of UK trained nurses has declined for a number of reasons, including: the age profile of the workforce with a number reaching retirement age, the high turnover of staff in part due to competition from elsewhere including the private sector. The decision to end bursaries or grants in the Government's Comprehensive Spending Review 2015, and replacing them with loans may exacerbate the decline, alhtough it might also mean that only those with a commitment to nursing (hence leading to higher retention rates) will apply to study. The shortfall in supply thus has fuelled a demand for nurses from outside the UK. According to ONS data for 2013, 22% of nurses were born abroad, a much higher % than for the UK workforce overall (14%). The numbers and proportion of EU and non EU nurses has fluctuated over time with changes in regulations and controls and in realtionship to vacancy levels in the NHS. According to Mark Dayan (2016), one such shortage, after 2000, witnessed an increase in Non EEA recrtuitment (up to 15,000 each year), whereas the more recent crisis non EEA has remained below 1000 but EEA has expanded to around 7000. In the case of the latter, its growth through accession, the free movement of workers and mutual recognition of qualifications underpinned the significant increase in the proportion of EU nurses. According to Dayan 4% of nurses in NHS England are from the EU (2016) and has been increasing proportionately to those trained in Britain as well as from non EEA countries. However, the introduction of a language test for all those applying for NMC registration after February 2016, is very likely to impact on EU recruitment. The restrictions on recruitment from outside the EU, including: computor based, clinical observation and language tests; a certificate of sponsorship (which requires passing the computor test and have an offer of employment) and successfully complete the OSCE or clinical observation test). Those who fail the test (and up to three attempts are allowed) will be unable to complete the NMC registration process, lose their right to work and be required to leave

the country immediately. In October 2015, against a backdrop of continued pressure from the health sector and the risks associated with staff shortages and highlighted in critical audit reports, the Government confirmed that nursing would join the Home Office list of shortage occupations, although employers will be required to carry out a Resident Labour Market Test for any non EU appointment from October 2016.

From 2016, therefore all nurses from within and outside the EU are required to pass an IELTS test at level 7. Although the standard of English language has been called into question, particularly in the case of some staff from the EU, so too has the usefulness and relevance of the test, particularly in terms of its ability to prepare and test staff for the demands specific to a health care setting.

According to an NHS survey in 2014, the overwhelming majority of overseas nurses were recruited from EEA countries, notably Spain, Portugal and Ireland. (Jayaweera, 2015:20) The Philippines provide the highest number of qualified nurses, midwives and health vistors

The principle of a formal relationship between NHS employers and TUs has been a feature of the NHS from the outset. The major health unions include UNITE, UNISON, GMB and professional associations include the BMA (Doctors) and RCN (Nurses) and RCM (Midwives) (*Glossary?*). An important feature of this relationship is the NHS Staff Council, made up of NHS employer representatives (senior managers from NHS Trusts), and recognized trade unions (UNISON, UNITE, RCN, RCM, CSP, GMB, and representatives of TUs from Scotland, Wales and Northern Ireland) which is responsible for pay and conditions across the different sectors of the NHS. Whilst not prescribing local practices, the Council has declared its commitment to replicating this partnership in the workplace, in the interests of effective employee relations and improved services for patients and service Users. In keeping with this principle, the local Trust has a number of committees and groups where both management and unions are represented. The Joint Board Committee which meets monthly and which is chaired alternative months by UNISON and the Director of HR and where the directorate of all departments provide reports and address concerns and issues raised by Trade Unions. There is also a Policy Group which also has Trade Union representation and is chaired by the HR directorate and considers policies in such areas as paternity rights, whistlblowing, disciplinary procedures, leave and work capability. (Interview, UNISON Representative). UNISON has two representatives on the Policy Committee one of whom has an equality brief and is particularly concerned with reviewing obligations under equalities legislation including the impact of policies on those groups identified in the Equalities Act 2010 with protected characteristics.

2. Fieldwork conducted

The decision to focus on a south London hospital trust emerged from a series of meetings with UNISON representatives and Filipino health care workers from across the UK.

In addition to data taken from the Trust's website and some documents provided by local managers, a number of interviews were held with staff in management positions with responsibility for education/training, recruitment and nursing management, equality and diversity and the Matron responsible for two acute care wards

A number of those present identified problems that they associated with a lack of English proficiency, particularly associated with those recruited from the EU. They gave a number of examples (e.g. a case where the wrong dosage of medication was prescribed, instances where staff with good English skills were in greater demand and leading to inequities of work loads, of poor communications with cancer patients and in A&E where speed of treatment was considered critical. Despite these problems, they

argued, there was little language support offered in health care settings. As these workers came from both hospital and social care settings, one option was to look at the social care sector, which is also heavily reliant on a workforce, many of whose first language is not English. However, the potential difficulties of access to predominantly non-unionised companies, largely operating in the private sector, might well have taken the case study beyond its timeframe and over budget. Likewise, the parameters of a case study could have been extended to other Trusts/hospitals, and indeed some evidence from elsewhere is provided but, given the proposed scale of the case studies in the project, it was agreed to focus on two hospitals in a single NHS Trust. Similarly, it would have been interesting to look at more than one occupation, for example Health Care Assistants, Doctors or cleaners, all of whom rely heavily on multi-lingual staff, but also have distinct (language) entry requirements and (language) related work issues. In their favour, nurses represent the largest group of employees both in the NHS (see above) and in the case study, where there were approximately 3000 on band 5.

Attitudes to English language support vary between Trusts. Some administer their own tests and those failing are required to meet the threshold within the first six months of their appointment. Others, following complaints from patients have provided ESOL classes which, until 2010, had been funded by Government. Since then, courses have either been funded by the Trust or by employees themselves and either in their own time or, in some cases, during working hours. There are various models of English Language support, some Trusts are outsourcing ESOL to local colleges, others are facilitating more informal conversation clubs within the hospital which raises the question as to what kind of English language support is appropriate. Colloquial English is not always the best preparation for IELTS, which is regarded as a more academically oriented test, but it may be more relevant in communications with colleagues and patients. Furthermore, general proficiency in English does not necessarily equip staff with vocabulary specific to a health care and hospital setting, and at least one Trust/ hospital has provided a tailored course in hospital English to address this. Other than English language issues, the need to respond in other ways to the presence of a diverse multi or plurilingual community, has been confined to a consideration of patient needs, so that for example, NHS Choices provides a google translate in 90 languages. The Trust uses Language Line Solutions but apart from informal adhoc arrangements, does not draw in any formal or systematce way on the langauge expertise of staff to address communications issues with patients. Elsewhere, research commissioned by NHS Manchester led to the production of a series of online videos and animations in various languages that provide health care advice. There are a number of charities, too, working on behalf of migrants and refugees that provide multilingual resources to ensure that those whose first language is not English are supported in accessing the most appropriate health care, depending on their needs. (Hogg, *Cultural Awareness in Health Care and Nursing*, second edition.). The situation in Wales provides an interesting point of comparison with over 20% of the population speaking their first language (i.e. Welsh) and a number admittedly a minority with little English language proficiency. In a recent survey, many respondents felt more at home speaking to health care workers in Welsh. The Report therefore recommended that bilingual speakers should somehow identify themselves so that Patients/service users were made aware of that option. (http://www.wales.nhs.uk/sites3/documents/415/welshinthehealthservice.pdf)

3. Professional and linguistic biography of interviewees

TUC, Policy Officer, Unionlearn (first langauge English)
UNISON Officer (first language Tagaolog)
Nurse, Band 4/5 appointed 2015 (first language Tagalog)
Nurse, Band 4/5 appointed 2015 (first language Tagaolog)
Nursing Education Lead, NHS Trust

Equality and Diversity Officer, NHS Trust
Support Worker School Nurses Unison Rep & Equality Officer NHS Trust (First Language Yoruba)
Head Of Nursing Workforce and Education, NHS Trust (first langauge English)
Matron, NHS Trust appointed 2000 (first language Tagalog)
Focus Group 12 Unison members (first language Tagalog)

4. Languages, organisation of work and day to day work relationships

Whilst overseas nurses have always been a feature of the NHS, a number of more recent factors over the last 10 years prompted the decision to embark on a series of recruitment drives, both within the EEA and beyond. The factors responsible for the decline in the number of 'home' qualified nurses included: the view that bursaries arguably attracted student nurses for the wrong reasons, and hence led to high attrition and low completion rates, a high turn over of staff partly due to the competitiveness of the sector and lure of more favourable contracts; the proportionately high numbers reaching retirement age; and the cost of agency nurses. A number of these factors were associated with work-related stress exacerbated by high vacancy rates and which in turn have led to the diminishing attractiveness of the profession. For example the vacancy rate in the Trust was currently running at around 250-300 out of 3,000 band 5 nursing posts in 2016). According to the lead manager, the decision to recruit from the Philippines in 2014, was made on business grounds. The basis of the business case was made in terms of the relative costs of agency staff (in 2016 running at £1.5m) versus the costs of recruiting a nurse from the Philippines (estimated at almost 3.5k per capita with costs of sponsorship tests, visas, accommodation and health checks, some of which took the form of loans to be paid back by the nurses). Moreover, the fact that Filipino nurses came with a high standard of English ('98% are fluent' according to the lead in education and training), with several years health care experience and retention rates of around 97% after 5 years, were all additional points in the business case. In the recruitment mission of 2014, 145 nurses were appointed in a week. EU nurses applying to the NMC after January 18th 2016 are required to pass an English language test (IELTS at grade 7), a policy that hitherto had only applied to non EU staff. Consequently, insofar as there were perceived problems with English, these were generally associated with EU nurses recruited for example from Spain, Portugal and Italy. In the words of one of the managers, "in the case of European nurses fluency is quite individual (and those from) Spain struggle with fluency more than other countries, and …. struggled to understand range of accents of colleagues" She continued, "the Trust has very diverse staff group,…… for example Nigerian nurses speak very fast and their pronunciation is very distinct'. EU staff in contrast to non EU nurses were younger, newly qualified, had higher attrition rates (often temepted by a better contract offer elsewhere), and were 'not committed career nurses'.

Filipino nurses who were interviewed, whilst acknowledging their competence in English, also recognized their own limitations in the language. For example they sometimes felt uncomfortable answering the phone, in case they were unable to understand the caller. They also readily admitted that they spoke informally with other Filipinos in their first language, despite the English- only policy. Doing so, they suggested, made communication easier, and made them feel less isolated and more 'at home'. They often socialized together outside of work, sometimes at parties and social events and sometimes at church. Although their standard of English was high, they had difficulties with accents and colloquialisms and hence their overall confidence was less than might be expected. In this respect IELTS clearly only provides part of the overall capacity to communicate in English. What is missing are familiarity with different accents and styles and speeds in speech, use of idioms and colloquialisms and different demeanors and body language. The ease, convenience and comfort speaking in their first language encouraged them to speak Tagalog in coffee and lunch breaks, despite the management

instruction that all communications, formal and informal, should be in English. The nurses were aware that there was a price to pay for this practice. In the view of one Filipino nurse, other staff saw such behaviour as snobbish and gave the impression that Filipino nurses were better then the rest. Indeed, according to one manager, such practices can ‘alienate the group from other staff’ whilst another said that she found ‘it really offensive’ and that patients would also not understand and this may cause anxiety and suspicion. In another case, the UNISON equality representative, herself of African background and whose first langauge is Yoruba, also noted the importance of informal communications in her first langauge amongst friends and relatives, with colleagues from work but outside the work context, and when the need arises, with patients.

The ways that the Filipino and Nigerian nurses use language are summarised in the following table:

	Superiors And Subordinates	Professional Colleagues	Patients	Fellow workers from Philipines /Nigeria at work	Fellow workers from Philipines/Nigeria outside work including workbreaks	Family and friends
1 Yoruba (Nigeria)	No	No	Sometimes	Sometimes	Yes, sometimes	Yes
2 Tagalog (Philippines)	No	No	?	Yes	Yes	Yes
3 English	Both 1 and 2	Yes for both groups	Yes for both groups	Sometimes		Sometimes

5 & 6 Language training and other initiatives and Policies to deal with Multilingualism at the Workplace (From both Employers and Trade Unions)

There was some divergence of view as to how to respond to these perceived language difficulties. For example, the manager responsible for nurse education and training (clinical) introduced in-house language support for those nurses with particularly poor English. Support comprised an external consultant with a TEFL background who came into the hospital for two hours per week. According to the manager, “she is working with them on one to one basis. She is also a former nurse, now an independent consultant who works alongside them, checking their understanding and helping with communication. She also sees them outside work too…. we’re also going to put them on a ESOL course, my impression is they speak good English but don’t understand different accents including patient accents which could compromise patient safety”. Some consideration was also being given to providing ESOL more widely and the business case for various options was under consideration. However, amongst more senior staff there was a view that employees themselves, and not the Trust, were responsible for ensuring their competency in English. As one senior manger put it, “ I really do feel strongly that if you take a job abroad, you have to take responsibility to learn the language”. Senior staff also felt that to provide ESOL for one group would be unfair as there were other groups who could

argue they also needed support with English language. According to the Head of Nursing Workforce and Education who sits on Corporate Nursing, “we have 1000s of staff whose first language is not English, where does it stop, are we going to run English classes for everyone?”

In contrast, in the case of the Hospital’s two acute wards, there was an acknowledgement that the plurilingualism of the staff (there were 117 staff on these wards) was a resource that could work to the benefit of patients. The Matron for these wards, herself a Filipino, cited the case of a Congolese nurse, who spoke French and Italian and a Sri Lankan nurse who spoke German and English, both of whom were able to interpret for European patients. She also understood, that in some circumstances it was important to speak in their first language. In her view, “they want to talk about things back home, the weather, show business, politics, they will obviously feel more natural and at ease speaking in their own language”. However, she also noted that this could cause friction and misunderstanding and emphasized the importance of explaining to anyone present that they were just talking about the Philippines, not about the hospital or any member of staff. This particular ward Matron came in the first recruitment from the Philippines in 2000 as part of the Adaptation Programme. This experience informed her understanding of the significance of language and culture and also the discrimination (she was described as ‘the little Chinese nurse’ until nurses from Malaysia, Vietnam and Nepal arrived and assumptions about nationality became harder to make). She found ways of supporting nurses who struggled with English. She would encourage them to read notes, observe interactions between other staff and patients and attend study skills days on communication. Outside the hospital she worked within her local community (centred around the (Catholic) church) to provide what was regarded by those nurses interviewed as invaluable support to newly arrived Filipino health care workers.

It was interesting to note that language did not feature within the Trust’s approach to diversity and equality, and whilst data was required by the DoH on equality standards, as well as an annual staff experience survey, language was not included in the standards or in the survey questions. Indeed the workforce equality data, in common with monitoring practices elsewhere, included black African, African Caribbean and British Black for whom English may or may not have been their first language and white included groups whose first language was not English. Data is available by continent of origin and this confirms that whilst nurses and midwives from Britain make up 85% of the workforce, a further 10% are from the remainder of Europe and 8% and 5% from Africa and Asia respectively. It is easier to infer linguistic differences from this data than the equalities data but linguistic competence (or lack of it) in English cannot be assumed. The size of the Trust (6000 staff), the volume of data collection, monitoring, and the time-consuming processes of intervention through extensive discussions with individual hospital departments, meant that language had not been prioritized within equality and diversity agenda. (Interview, Trust Head of Quality and Diversity). The staff experience survey confirmed higher than national average numbers of staff reporting bullying harassment, discrimination by other staff or patients and higher levels of stress had hitherto only be considered in terms of gender and ethnicity but not linguistic difference. Likewise, language per se had cannot be considered in terms of factors responsible for differences in numbers of disciplinary actions for different groups (see NHS study XXX), or for the uneven distribution of staff at different levels of seniority within the Trust. In the meantime, there is anecdotal evidence from interviews (see below) to suggest that language is an important source of discrimination and disadvantage.

The NHS Workforce Race Equality Standard Indicators (April 2016) is concerned with recruitment, subject to disciplinary procedures, access to training, experience of bullying and harassment, promotion and Board representation. The findings confirm a number of issues of concern, including underrepresentation of BME staff in more senior positions, the disproportionate numbers of BME staff

who experienced discrimination in the last twelve months (over twice as many as white staff) and bullying and harassment (1.23% higher). It would be useful to consider these indicators in relationship to the experiences and outcomes for different linguistic groups amongst staff, assuming the data collected provided an opportunity to self identify by first language. Multivariate analysis could explore associations between language and these indicators but also link them to other background factors, such as BME status, gender and disability. The intersectional relationships between these factors could then be considered with language alongside other discriminatory markers.

The local Induction Programme for Internationally Trained Nurses reiterated the policy of 'English-only' communications. Sessions concerned with cultural differences and understanding and communication had been introduced more recently and the manager responsible for their introduction acknowledged the influence of a Professional Development conference 'Safe Transition for Internationally Trained Health Professionals' in November 2015, which had emphasised cultural understanding and communication as a significant part of the transition process.

There was an awareness that the use of language, voice tone and body language all played a part in communication. For example, managers were interested in the different uses of English words; a 'toxic' ward for example, was used by Filipino nurses to mean busy, not that the ward had suffered a spillage of poisonous chemicals. Other terms were used in particular contexts that might appear unnecessarily aggressive or confrontational. Interestingly one senior manager referred to the use of cockney expressions and idioms used widely in London schools to illustrate the challenges of language. And the Filipino Matron, when she first arrived, had been advised to watch the TV soap Eastenders to familiarize herself with local phrases and accents. There have been numerous research studies illustrating the dynamic patterns of language development, (particularly, but not only in the context of the globalization of electronic media) the ways in which words, phrases etc. from other languages are adopted and new syncretic forms and hybrid cultures result. There are numerous examples of such linguistic mergers, another would be the 1000s of Spanish and English words in Tagalog, dating back to colonial periods in the history of the Philippines. The insistence on monolingualism and the imposition of rigid language barriers in the workplace arguably limits cross cultrual communication and understanding. *(More to say here)*

There was a consensus amongst management that, with one exception, no effort had or should be made to promote multilingualism or plurilingualism in the workplace. On the contrary for some to do so would detract from the policy that requires staff to communicate in English at all times. The one exception was the provision of interpreting and translation services for patients. Two managers did raise the possibility of making greater use of the linguistic diversity amongst staff to support communication with patients but as yet no initiatives have been taken. The principle of viewing linguistic diversity as an asset and resource rather than in deficit terms, which was implied in these comments by managers, would make good business sense and build confidence and morale amongst the Trust's multilingual workforce.

Both the TUC and UNISON at national level have taken initiatives to support multilingualism. The TUC has translated number of documents relating to employment rights, health and safety, etc. into 13 languages and has a dedicated officer responsible for supporting ESOL. UNISON has worked with employers to support ESOL and has been successful in at least one other hospital, but is reliant on employers to fund and/or time off work to undertake the classes. UNISON runs a forum for Filipino workers.

The other relevant trade union/professional association is the Royal College of Nursing. Although not TUC affiliated it has 370,000 members. It has run a project 'Is That Discrimination?', which is part

awareness raising, part capacity building and part recommended guidelines on bullying and harassment, though the latter makes no reference to particular forms of harassment, e.g. racial and sexual, and only passing reference to disabilities. Nurses interviewed described examples of alleged bullying by a line manager and overhearing comments about particular language/ethnic groups, but the extent to which these are directly langauge related and not tied to more general forms discriminatory treatment (racial, gendered), is hard to guage.

Trade Unions are less visible around language issues in the workplace which may, in part, be linked to their general lack of presence as far as staff are concerned. Unions are represented on the Equality Steering Group, but the latter to date has not seen language issues per se as part of their remit. Trade Unions also have a slot in the Induction and Clinical Orientation Programme for Internationally Trained Nurses. (LGT Trust, 2015:5). Likewise, the RCN learning representative, who is also responsible for nursing induction and training, has brought in external expertise to support English language and has proposed more extensive ESOL support, but not considered raising such issues with her professional association or in her capacity as union representative. At a ward level, too, although there are union members amongst the staff, unions have no formal role in ward decisions, on language or other matters, apart from representing individuals on grievance, disciplinary issues, etc.

One of the Filipino nurses recalled a talk by the UNISON at induction and another given by a union representative at a reception at the Philippine Embassy on her arrival and, accordingly, joined the Union. However, unions, she too suggested were less visible when it comes to day to day workplace issues. The nurses interviewed were either in UNISON (or, in the case of senior staff in the RCN) and had either met or were aware that UNISON has a network of Filipino health workers and a fulltime officer of Filipino background, but in addition to being less visible locally, there was much less sense or understanding of the role of the UNISON at local level. This can be illustrated with reference to two examples. In one case, problems with NMC registration led to delays in being moved formally from band 4 to 5, though, like her peers, she had been working at band 5 since arrival. Both in this case and in another, one of alleged bullying, the nurses did not approach their local union representative (they were not aware who to contact), but raised the matter, instead, with a senior colleague.

7. Language command and access to labour rights

The issue of the relationship between language and culture and discrimination was raised by the UNISON Equality representative. She illustrated this with reference to her own first language, Yoruba and the case of a band 6 nurse of African background who was on a disciplinary for refusing to administer bandages to a patient. Her inability to articulate her reasons to the satisfaction of management was at the root of the issue and the reason itself was to do with her strong sense of job roles and responsbilities (bandaging was not in her JD) and respect for authority which had to be considered both upwards and dowwards. Language thus is seen as an expression of culture and the latter can sometimes acta s a barrier to effective communications in English. In her view it was the responsibility of the individual staff member on a lower band to undertake this task. Such cases in part explain the higher numbers of disciplinary proceedings brought against BME groups in the Trust (Archibong, U. and Darr, A. 2010).

8. Language and integration within trade unions

Industrial Relations works at two levels, one nationally, in which pay and conditions are secured through a joint union/employer Staff Council and locally in which trade unions act as advocates in individual cases, sit on the Policy Group, the Joint Board Committee and Equalities Steering Committee. Those interviewed confirmed that language issues per se have not been addressed through these industrial

relations structures. This is in part because they are understood more in terms of the Trust's equalities agenda and in particular are subsumed under the broad heading of culture. This gap has meant that corporate nursing management, and those managers responsible for training have taken the lead on language issues at Trust level. Whilst there is a dedicated staff member responsible for equality and diversity (for all 6,000 staff), and an Equality Steering Committee chaired by the Trust's Chief Executive, there is no specific reference to language in the staff survey or in equality standards both DoH requirements and hence reflect the absence of such issues both at a national and local levels.

The Trust has a clear English-only policy in the workplace, that the recently introduce more stringent language entry requirements for EU nurses (already applied to non EU nationals) has been welcomed by management. The corolloray of this policy has been to deliberate on what English support is reasonable to provide and here opinion is somewhat divided, the more senior managers taking the view that the responsibility for English language proficiency lies with the employee. The lead fornurse education and training took the view that support, where needed, could be provided by the Trust whether this took the form of one to one on the job coaching or ESOL classes. The English-only policy applies to informal communications in the hospital too and managers are sympathetic to staff who complain that other languages are spoken in coffee breaks, in the staff room, etc. Such hostility and suspicion may well fuel discrimination and harassment, but as no records are kept it is hard draw this conclusion, although at least one interviewee spoke about the harassment of a more senior nurse which may or may not have been related to the English only language policy and the resentment to those like the Filipino nurses whose English is excellent, who invariably have several years of experience in health care and yet who communicate in informal settings in their own languages.

There is a further corollary of the English only policy, there are no circumstances considered by management in which the use of other languages could or should be encouraged, the only exception being interpreting and translation for patients or service users, with an insufficient grasp of English. Otherwise to promote multilingualism or plurilingualism would only interfere with the main policy objective which is to assimilate staff into the English linguistic community and the standards of behavior and conduct deemed professional in a UK context. As one manager reported in the case of Spanish nurses, "It's disappointing as they have only been in UK for two months and they are living with other Spanish nurses and speaking in their native language. They need to think in English".

Further Comments

Filipino nurses who were interviewed, whilst acknowledging their competence in English, also recognized their own limitations in the language. For example they sometimes felt uncomfortable answering the phone, in case they were unable to understand the caller. They also readily admitted that they spoke informally with other Filipinos in their first language, despite the English- only policy. Doing so, they suggested, made communication easier, and made them feel less isolated and more 'at home'. They often socialized together outside of work, sometimes at parties and social events and sometimes at church. Although their standard of English was high, they had difficulties with accents and colloquialisms and hence their overall confidence was less than might be expected. In this respect IELTS clearly only provides part of the overall capacity to communicate in English. What is missing are familiarity with different accents and styles and speeds in speech, use of idioms and colloquialisms and different demeanors and body language. The ease, convenience and comfort speaking in their first language encouraged them to speak Tagalog in coffee and lunch breaks, despite the management instruction that all communications, formal and informal, should be in English. The nurses were aware that there was a price to pay for this practice. In the view of one Filippino nurse, other staff saw such behaviour as snobbish and gave the impression that Filipino nurses were better then the rest. Indeed, according to one manager, such practices can 'alienate the group from other staff' whilst another said

that she found ‘it really offensive’ and that patients would also not understand and this may cause anxiety and suspicion. In another case, the UNISON equality representative, herself of African background and whose first langauge is Yoruba, also noted the importance of informal communications in her first langauge amongst friends and relatives, with colleagues from work but outside the work context, and when the need arises, with patients.

It is important to view policies and practicies surrounding the recruitment and treatment of international nurses in a wider ethical framework, from the consideration the impact of recruitment on the source countries through the process of registration to day to day treatment to ensure that groups treated equitably and not disadvantaged. (Buchan, et al. ,2005).

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