

**Report on  
English language  
consultation  
October 2017**

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### **Introduction from Emma Broadbent, Director of Registration and Revalidation**

We exist to protect the public by regulating nurses and midwives in the UK. We do this by setting standards of education, training, practice and behaviour so that nurses and midwives can deliver high quality healthcare throughout their careers.

This includes our standards for English language as it is essential that nurses and midwives can communicate effectively with patients, the public and other healthcare professionals.

We also want to make sure that the standards we set are fair and do not create unnecessary barriers for those who want to work in the UK.

Our Council asked for a stocktake of our English language requirements for nurses and midwives who trained in the EEA and outside the EEA in May 2017. We knew that a sensible starting point would be to align the evidence of language competence as far as possible.

We wanted all nurses and midwives who trained outside the UK to have the same opportunities to satisfy us of their language competence. Alongside this, we wanted to explore the range of English language tests available and whether they provide a reliable measure of English against our criteria.

The feedback we received during our consultation with stakeholders was largely positive and supportive of the proposed changes. As a result, I am happy to announce that we will align our English language evidence requirements for all nurses and midwives who want to come and work in the UK from 1 November. We will also now be accepting the Occupational English Test (OET), alongside the International English Language Testing System (IELTS) and will continue to review other English language tests with a view to expanding the list of tests we accept.

I would like to thank the people who took the time to meet with us, engaged with us, gave their views and suggested ways forward.

These changes represent the outcomes of the first stage of our English language review. The next stages include evaluating other types of evidence, developing additional support for applicants and exploring the writing element of IELTS.

## Background and context

Nurses and midwives play a vital role in providing healthcare in the UK. In order to practise safely and ensure the wellbeing of those in their care nurses and midwives must be able to communicate clearly and effectively in English, both verbally and in writing, with a range of people across healthcare settings.

Public protection is our priority. All nurses and midwives must uphold [the Code](#) which requires them to have the necessary command of English in order to practise safely. In addition, in order to register with us, nurses and midwives must satisfy us that they have the necessary knowledge of English.<sup>1</sup>

We want to take a proportionate approach and minimise the barriers that may prevent competent nurses and midwives from working in the UK. With this in mind, in May 2017 we committed to complete a stocktake of our English language policies for nurses and midwives who trained outside the UK wishing to join our register.

We must be satisfied that any changes we make to our policies and requirements will not put those people who nurses and midwives care for at risk. This consultation report sets out our proposals for the evidence we would accept, consultation feedback, what our new requirements will be from 1 November 2017 and the next steps in our review of English language.

## Proposals to align evidence requirements and accept English language tests

Before our consultation, nurses and midwives from the EEA could demonstrate that they had the necessary knowledge of English to practise in the UK in one of three ways, while applicants from outside the EEA could only submit one type of evidence (IELTS). In our consultation we proposed that all of these nurses and midwives should have the option of submitting the same range of evidence.

In addition, we proposed expanding the number of English language tests we accept. In order to demonstrate transparency and ensure public protection any test we accept would have to map against pre-defined criteria (Annexe 1). This includes testing at an academic and/or healthcare setting; measuring reading, writing, speaking and listening appropriately; maps to IELTS level 7; and that the results are verifiable.

We proposed accepting:

- Evidence type 1: Achievement of the required score in IELTS or in one of the other English Language tests accepted by the NMC
- Evidence type 2: A recent pre-registration nursing or midwifery programme that has been taught and examined in English, or
- Evidence type 3: Registration and two years of registered practice with a nursing or midwifery regulator in a country where English is the first and native language.

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<sup>1</sup> Article 9(2)(ba) of the Order

## **Consultation methodology**

The first stage of the consultation on our proposals to broaden our English language evidence requirements took the form of engagement with representatives from key stakeholder organisations across the UK. The consultation focused on:

- exploring English language tests that we would accept in addition to IELTS
- aligning the evidence requirements for overseas applicants (those trained outside the EEA) with the requirements for applicants trained in the EEA.

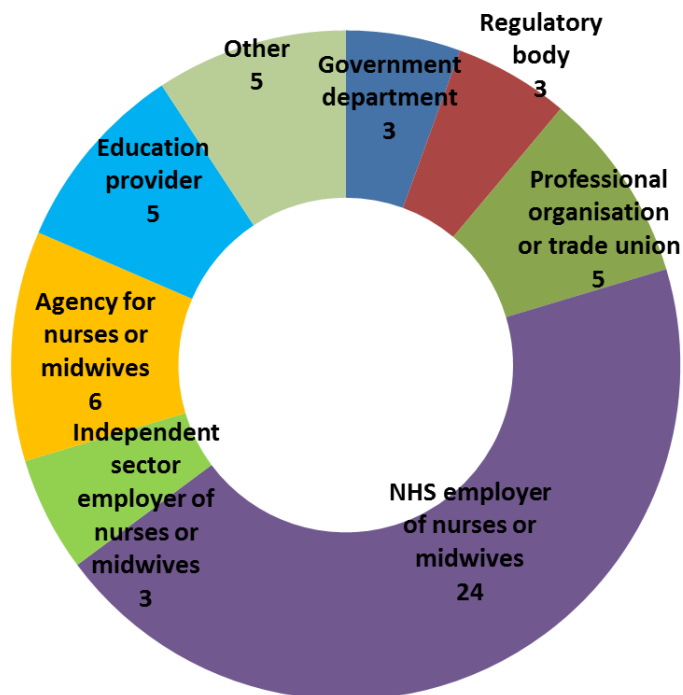
We consulted stakeholders on the draft guidance and proposed policy changes through a mix of face-to-face meetings, telephone meetings and webinars. We also sent out a survey to all these people with detailed questions about each aspect of our proposals.

## **Respondent characteristics**

The consultation participants included representatives from patient groups, NHS organisations, professional bodies including the Royal College of Nurses (RCN) and Royal College of Midwives (RCM), trade unions, language testing organisations, recruitment agencies for nurses and midwives, government departments, directors of nursing from NHS trusts, and the Chief Nursing Officers from the four UK countries. A full list of participants can be found in Annexe 2.

Figure 1 shows the breakdown of the types of organisation that responded to the survey. The charts in this report present quantitative data on levels of agreement with our proposals. They include the organisations that responded to the survey. The qualitative comments in the report include comments from the survey, meetings, phone calls and webinars.

**Figure 1: Breakdown of organisation types for survey respondents**



Respondents were able to select as many categories as applied to their organisation, so some selected more than one option.

## Overview of responses

The majority of stakeholders we consulted were in favour of the proposals, provided that we get the implementation of the policy right in terms of assuring ourselves of the quality of evidence. A small number of stakeholders opposed the proposals, because they believed that we should simply reduce the level of IELTS we require, rather than accept other types of evidence.

Almost all stakeholders agreed in principle with the proposal for evidence type 1, which was to consider accepting other English language tests, provided they meet our criteria. There was strong support for the OET among those who agreed with the proposal, mainly due to its applicability to healthcare settings. However, there were some concerns expressed that it costs more than the IELTS, and has fewer test centres available across the world. A number of other commonly used tests were suggested by stakeholders, such as the Test of English as a Foreign Language internet based test (TOEFL), the Pearson Test of English (PTE Academic), the Cambridge English: Advanced test (CAE) and the Canadian English Language Benchmarks Assessment for Nurses (CELBAN). Most stakeholders agreed with the criteria for accepting other English language tests, subject to the NMC ensuring the quality and security of these tests. It was felt that this would give nurses and midwives from outside the UK greater choice and some felt that in time this change may have a positive impact on the workforce. There were few concerns around public protection with regards to this evidence type.

Our proposal for evidence type 2 is to accept a recent pre-registration nursing or midwifery programme that has been taught and examined in English. The majority of stakeholders were in favour of this evidence type in principle, while raising some concerns about quality assurance of the evidence. Most survey respondents felt that it was fair to align this requirement for EEA and non-EEA applicants and that it offered alternative routes to registration for those who would otherwise have had to sit a language test, even if they were native English speakers, such as Australians. At the same time, several participants were keen to stress that it was very important to have robust governance arrangements about the type of evidence we would accept. For this reason, some expressed uncertainty about whether this evidence type would provide sufficient public protection. There was also some questioning of the part of the requirement that states that at least 75 percent of the clinical interaction of the course should be in English. It was questioned how an applicant would provide evidence for this, particularly in countries where English is not the first language, such as India and the Philippines.

Our proposal for evidence type 3 was to accept applicants who have been registered and undertaken two years of registered practice with a nursing or midwifery regulator in a country where English is the first and native language. Again, the majority of stakeholders were in favour of this evidence type in principle, while raising the issue of quality assurance. Similar to evidence type 2, most people were in favour of aligning this requirement for EEA and non-EEA applicants, as it was seen as opening up more opportunities for registration. There were some queries about why two years' practice was required, as many felt that one year of practice would be sufficient to assure us of an applicant's competence. Several stakeholders made comments about the need for robust procedures around this evidence type, for example around employer references and the evidence provided by other regulators. Participants wanted to be reassured that we had worked out the details of implementing the policy so that there were robust governance arrangements in place.

There was also some feedback that we should consider the policy in the light of the fact that in Wales, English is not the only first and native language. Some nursing and midwifery courses in Welsh universities are partly taught in Welsh, and the NMC needs to consider this in future.

When asked whether the proposals would have an impact on groups with the protected characteristics under the Equality Act, most people did not think there would be a great deal of impact. The main issue that was highlighted by several participants was around the socioeconomic status of people from particular countries, who might find it difficult to access tests that cost more than IELTS.

## **Summary of responses related to evidence type 1**

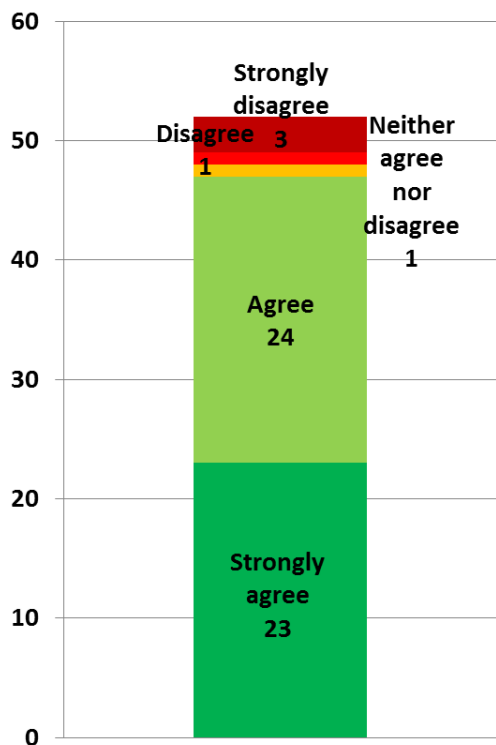
**Achievement of the required score in IELTS or in one of the other English language tests accepted by the NMC.**

### **Levels of agreement with the proposal**

Feedback from the stakeholder meetings, phone calls, and survey responses indicates that the majority of stakeholders are in agreement with the proposal to accept English

language tests other than IELTS. Figure 2 shows that 47 out of 52 (90 percent) survey respondents said they either agreed or strongly agreed with this.

**Figure 2: Survey responses to Q8 – do you agree that we should we accept language assessments other than IELTS?**



Those who supported the proposal indicated that they believed it to be fairer than the current English language requirements, and that it could impact positively on the nursing and midwifery workforce.

‘We agree on the statement that the NMC should accept other language assessments than IELTS as this will allow nurses more choice.’  
*(Written response, director, independent care organisation)*

‘Any opportunity to increase the workforce of registrants whilst maintaining standards is welcome.’  
*(Survey response, nurse director, NHS Trust)*

### **Views on the IELTS level**

Despite the fact that the IELTS level we have set is not in the scope of this consultation, there has been considerable comment about it from a range of stakeholders. There were a small number of stakeholders who were opposed to our proposals to extend the evidence for demonstrating English language competence that the NMC would accept, as they felt that we should simply lower the IELTS level required from 7.0 to 6.5, particularly for the written element of the test. Several other stakeholders, while supportive of the proposals overall, were keen to express the view that the IELTS level could be lowered. they believed that such a move would make it easier for applicants

trained overseas to gain registration in the UK, without compromising patient safety.

‘Reducing the level to overall 6.5 and/or considering the ‘general IELTS’ test over the academic test will still ensure resident safety but allowing care homes to recruit the best talent for their services.’

*(Written response, director, independent care organisation)*

However, this view about reducing the IELTS level was not unanimous; there were three organisations which were not in favour of an immediate reduction in the IELTS level. For example, the representative of one of the patient organisations said that they were opposed to any lowering of the score, as they felt that this might result in patient safety issues. The issue of a possible reduction in the IELTS level will be explored in more detail in the next phase of reviewing our English language requirements.

## **Support for the OET**

There was strong support for the OET as an additional test we would accept. Of the 52 survey respondents, 43 (83 percent) selected the OET as an alternative test. Many of the supportive comments about the OET were around its applicability to the healthcare context. In this respect, it was often seen as a more appropriate English language test for nurses and midwives than IELTS, which uses more generic or popular science scenarios. For example, one care provider noted that the academic IELTS does not have much relevance to how nurses use English at work, and does not include how to communicate with service users who are confused or distressed.

Supportive comments about the OET included the following:

‘It is more role-specific and I feel would result in a higher pass rate.’

*(Survey response, head of nursing, NHS trust)*

‘OETs assess comprehension of relevant occupational context with scenarios that enable individuals to demonstrate their understanding of health related information and summarise it in a timely way, to interact effectively with patient / carer and to communicate relevant detail. This is essential in maintaining patient safety.’

*(Survey response, director of nursing, NHS trust)*

‘The subject matter in existing tests is based on scenarios often outside of the candidates experience adding another stressor within the process - impacting negatively. This is very frustrating when good nurses proving themselves already in practice then fail - very demotivating for all concerned.’

*(Survey response, director of nursing, NHS trust)*

It was also mentioned that the OET was considered an appropriate English language test by other healthcare professional regulators across the world. For example, one stakeholder noted that both the OET and IELTS are recognised in Australia and New Zealand as robust assessment tools for health professionals.

At the same time, some stakeholders pointed out drawbacks to the OET, the primary one being its cost compared to the IELTS test. There were a number of comments that this could disadvantage those in particular countries. In addition to this, it was pointed



out that there were currently fewer test centres for the OET than IELTS, especially in some countries, which would make it more inconvenient and more costly – in terms of travel and accommodation – to take these tests:

‘The cost of the alternative OET is prohibitive as for example nurses from India or the Philippines will need to work for 6 weeks in order just to pay the fees which are more expensive than IELTS.’  
(*Survey response, director, recruitment agency*)

It was also noted by one of the survey respondents, and by one of the webinar participants, that nurses and midwives trained outside the EEA would already have had to pass the IELTS in order to get a visa to enter the UK, so would end up having to pay for both language tests in order to work in the UK. Further comments about the impact of alternative tests and other evidence types on groups with protected characteristics and socioeconomic disadvantage can be found below.

## **Other English language tests suggested**

A number of other English language tests were suggested by stakeholders. For example, one stakeholder noted that the General Medical Council’s (GMC’s) study on IELTS equivalence acknowledged both the OET and the CAE as being equivalent to IELTS. She argued that both these tests meet our standards and that the GMC’s study had considered them to be either equivalent to or higher in standard than the IELTS. The RCN cited several other English language tests which are used internationally to assess the English language competence of nurses – TOEFL, PTE Academic and CELBAN. However, they advised that some of these tests – the OET, the PTE Academic and the CELBAN – had been developed in the specific language contexts of Australia and Canada respectively. Therefore the NMC should carefully consider whether the differences in types of English (compared to UK English) would raise any public protection issues or have any impact on people with protected characteristics.

The CELBAN was also suggested by one stakeholder as a possible alternative for applicants from Canada; however, since it is only administered in that country, it could not be used more widely for applicants from other countries.

Stakeholders also stressed the importance of other tests being equivalent to the level of IELTS we are asking for, with several giving the example of the Common European Framework of Reference for Languages (CEFR) for mapping test scores.

Two stakeholders recommended the use of ComForPro, a communication training programme for healthcare professionals who use a second language in a medical context. This programme aims to help healthcare professionals to function effectively in a new workplace by providing them with language tools and support.

Some stakeholders considered that a master’s degree from a UK university would be appropriate evidence of English language competence. One care organisation gave the example of nurses who qualified overseas working as competent healthcare assistants in the UK, who may have a bachelor’s or master’s degree; they felt that such people should be able to prove their competence through their existing qualifications.

## Levels of agreement with our criteria for accepting tests

The guidance document lists the proposed criteria for accepting other English language tests. Figure 3 shows that 44 out of 52 (85 percent) survey respondents said that they either agreed or strongly agreed with these criteria.

Several survey respondents agreed that the rationale that we had provided for accepting tests were reasonable.

‘The rationale provided in the webinar, appeared robust and acknowledged that there is a need for "academic" English skills in view of an all graduate profession.’

*(Survey response, nurse director, NHS trust)*

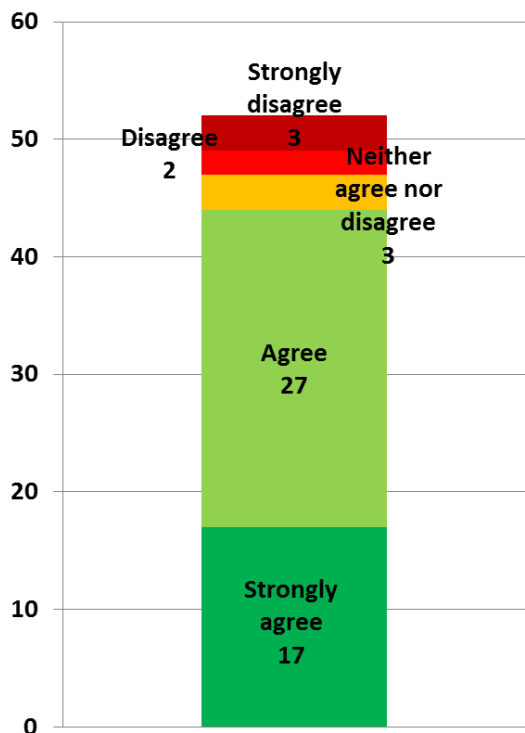
‘As all four domains (reading, writing, speaking and listening) are tested I believe this is an appropriate alternative. I think there are advantages to the speaking element being tested face-to-face and not via a computer test.’

*(Survey response, director of nursing, NHS trust)*

Stakeholders were keen to stress the importance of the NMC ensuring the quality and security of tests. For example, the Council of Deans representative said it was important that the NMC should think about how they would prevent fraudulent language tests from being used. Another organisation suggested that the NMC should consider various aspects of research into the robustness and reliability of the test and the dependability of test scores.

Several of those who disagreed or were unsure about our criteria for accepting tests did so because they felt that the NMC simply needed to adjust the IELTS level rather than accept other tests. Another stakeholder who disagreed was from a language testing organisation. They argued that it was not necessary to have face-to-face testing of English speaking, as they claimed that the organisation had developed a robust way of measuring this without a face-to-face component.

**Figure 3: Survey responses to Q12 – do you agree with our criteria for accepting tests?**



## Public protection

Again, the majority of survey respondents indicated that they felt that the criteria provided sufficient public protection, with 42 out of 52 (81 percent) survey respondents either agreeing or strongly agreeing that they did (Figure 4).

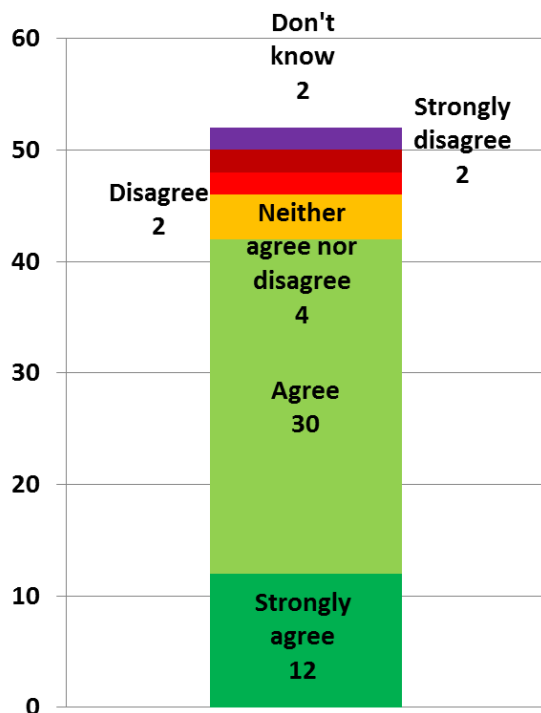
A number of stakeholders in the meetings and survey responses emphasised the importance of English language competence and good communication skills for nurses and midwives. This was stressed by both the patient organisations that took part in the consultation:

‘Poor communication is the most common issue in complaints about family and childcare services. It is essential that patients and clients can effectively communicate with health professionals and that there is clear understanding.’  
*(Survey response, policy manager, Patient and Client Council, Northern Ireland)*

Other stakeholders were in agreement with this, with one of the care providers stating that they felt that great communication and person-centred care was at the heart of being a nurse, and that an understanding of the English language was essential for safe and compassionate practice. For this reason, they felt that language testing should continue and should be done through recognised/accredited agencies.

Of those participants who did not agree that the proposed criteria provide sufficient public protection, one expressed concern about the risk of fraudulent use of test results.

**Figure 4: Survey response to Q13 – do these criteria provide sufficient public protection?**



## Summary of responses related to evidence type 2

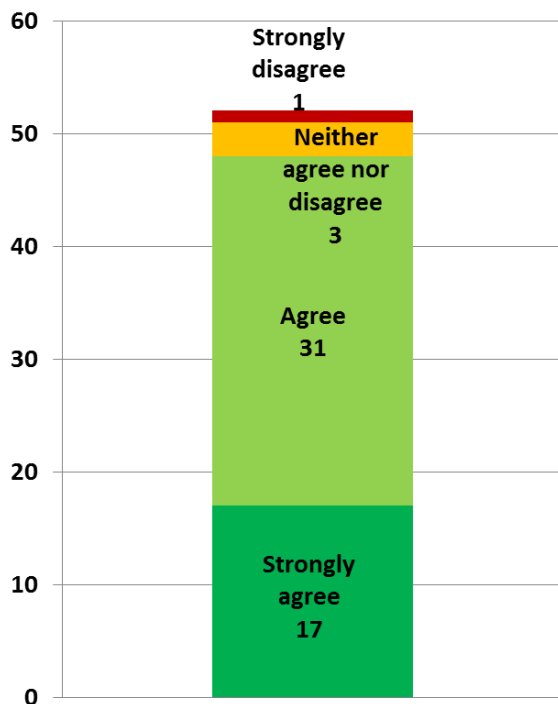
**‘A recent pre-registration nursing or midwifery programme that has been taught and examined in English (and must have been composed of at least 50 percent clinical interaction and that 75 percent of this clinical interaction was with patients, service users, their families and other healthcare professionals must have taken place in English).’**

### Levels of agreement with the proposal

The consultation has indicated that there is general support in principle for this evidence type from most stakeholders, provided that we can set up robust quality assurance procedures to make sure we are only accepting applicants who have undertaken appropriate programmes.

Most stakeholders are in agreement with the principle of aligning our language evidence requirements in this respect for those wishing to join the register from the EEA and those wishing to join from outside the EEA. This is shown from the survey responses in Figure 5 below, with 48 out of 52 (92 percent) respondents agreeing or strongly agreeing with this.

**Figure 5: Survey response to Q15 – should the language evidence requirements for those wishing to join the NMC's register from the EU/EEA and those wishing to join from overseas (non-EU/EEA) be aligned in this respect?**



### Supportive comments

There were a number of comments in support of the alignment of the requirements for EEA and for overseas (non-EEA) applicants. NHS Employers noted in their survey response that they were ‘supportive of an equitable and fair approach to assessing language competence for all those on the register including those from non-EEA countries.’ The Association of UK University Hospitals agreed that the proposal to align requirements was ‘fair and objective’. They also pointed out that this would remove the current requirement for applicants from English-speaking countries such as Australia to have to do a language test such as IELTS – they felt that the requirement to pass an IELTS test was preventing many highly skilled nurses from practising in the UK.

Other stakeholders who were in favour of this evidence type argued that the fact that a nurse or midwife had undertaken a programme in English provided sufficient assurance of their English language competence. For example, a representative from one of the education providers pointed out that Higher Education Institutions (HEIs) will require students to demonstrate ability to use English, and that this is tested throughout their course. Several care providers and an agency for nurses also pointed out that, in addition to fulfilling the requirements for evidence type 2, people applying to the register would have to go through a number of tests of their nursing or midwifery skills which should provide assurance of their English language competence:

'The NMC should bear in mind that the applicant also has to pass the following assessments before she/ he will get registration which will most certainly highlight any deficiencies in the level of English:

1. Interview with UK employer
2. Pearson CBT test
3. Clinical OSCE exam'

*(Survey response, managing director, recruitment agency)*

## **Concerns about the proposal**

A number of organisations stressed the need for the NMC to set up robust procedures for checking the quality of overseas programmes and ensuring that they were at the same level as UK programmes. For example, one stakeholder stressed the importance of having the right governance systems in place to support evidence types 2 and 3. She wanted us to make sure that other regulators and education institutes, whose evidence we might accept, have the same standards as the NMC. Similarly, the representative from the Council of Deans said that she felt that the NMC would need to ensure that the quality of education for applicants from overseas countries is at the same level as UK programmes.

Some stakeholders indicated that they would be more comfortable accepting this type of evidence where English is clearly the first and native language of the country, such as Australia. However, there is a bit more uncertainty about accepting this if the training institution is in a country where English is not the first language. One participant said that in cases where the training institution is in a country where English is not the first language, the NMC would need to assure that the levels of English are validated for those institutions. Likewise, another stakeholder expressed some concerns about the type of English from some countries, where English terminology may be used in a different way to English-speaking countries. She did, however, feel reassured by the requirement that 50 percent of the course should compose of clinical interaction.

The RCN was concerned that the requirement for 50 percent of the course to compose of clinical interaction might exclude some groups, for example those from Australia, whose courses may not be easily presented in this way. However, the issue that has caused the greatest questioning of this evidence type is the requirement for at least 75 percent of the course's clinical interaction with patients, service users, their families and other healthcare professionals. The main reason for this is that people are not clear how applicants would prove this, particularly those applicants from countries for whom English is not the first language.

'I think it is really difficult to police this. Perhaps what you should be asking is that interactions with other healthcare professions are always in English.'

*(Survey response, head of clinical education, NHS trust)*

'We have concerns regarding how easy this would be for the applicant to evidence. ....the NMC would need to consider if the overseas HEIs will be able to cope in supplying the information required by the NMC - as the current process is problematic and they do not provide this additional information in the correct format or a timely manner when this is required.'

*(Survey response, NHS organisation)*

One stakeholder, a recruitment agency for nurses and midwives, felt that the requirement for 75 percent clinical interaction to be in English unfairly disadvantages those candidates from non-English speaking countries, as they may not have the opportunity to use this as evidence. However, there were other stakeholders that were in support of this requirement, it was noted by one participant that the GMC has the same requirement.

## **Public protection**

The survey responses showed that the majority of respondents felt that this evidence type provided sufficient public protection. However, around a third (17 out of 52, 33 percent) had some concerns, indicating that they neither agree nor disagree, disagree, or don't know (Figure 6) that this evidence type provides sufficient public protection.

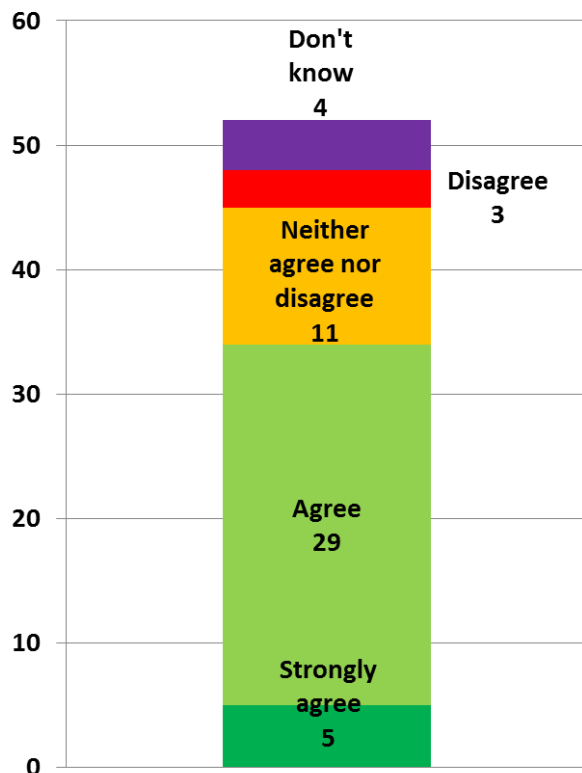
Some of the concerns around public protection have been discussed in the section above and centre on the need for robust governance around the validation of evidence. The NHS Education for Scotland representative gave the view that in order to ensure public protection, there needs to be a quality assurance process associated with the requirement. This would ensure that the requirements are met, and can be proved and approved by the NMC to provide employers with confidence in the applicant's registration and English language competence.

One independent sector organisation stated that:

'....we believe that consultation and further discussion with providers on the validation process and evidence requirements would be necessary in order to confirm there is sufficient public protection.'

*(Survey response, independent sector organisation)*

**Figure 6: Survey response to Q17 – if applicants are seeking to rely on a pre-registration nursing or midwifery programme which has been taught in English outside the UK...Do you agree that these criteria provide sufficient public protection?**



## Other comments

Some organisations queried whether the introduction of this evidence type for all applicants would have much impact on the workforce. For example, the survey response from one NHS organisation said that ‘it’s not clear at this stage how many nurses are likely to be affected’.

On the other hand, other stakeholders did think the proposals would make a positive difference to the workforce, at least in the long term, and were keen for them to be implemented as soon as possible:

‘These [proposals] need to be approved and implemented at pace.’  
*(Survey response, director of nursing, NHS trust)*

‘..if only 10% more nurses pass the recommended OET compared to the current IELTS requirement, it will make a big difference. Without action now staff shortages will worsen.’  
*(Survey response, Independent sector organisation)*

Another point made in relation to this evidence type was by a representative of a care provider who highlighted in both the meeting and her survey response that assuring



English language competence of nurses and midwives trained outside the UK was a shared responsibility.

‘I think there should be flexibility dependent on candidate so maybe an OET would be advisable in some instances, the shared responsibility being with the employer and NMC for requiring this.’

*(Survey response, independent sector organisation)*

## **Summary of responses related to evidence type 3**

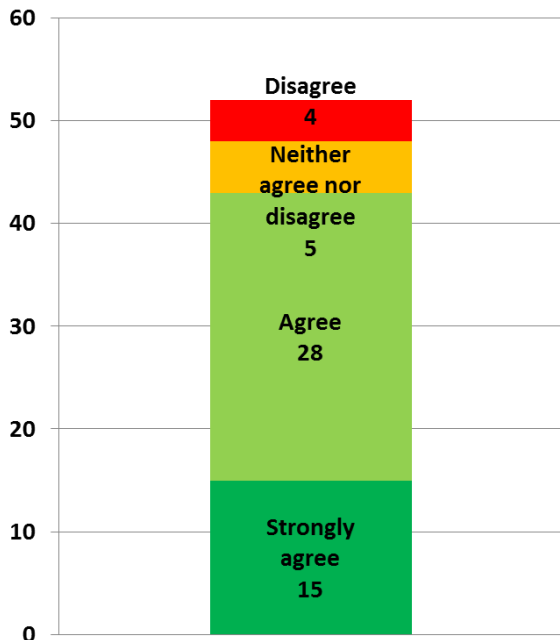
**‘Registration and two years of registered practice with a nursing or midwifery regulator in a country where English is the first and native language.’**

### **Levels of agreement with the proposal**

The majority of stakeholders supported this evidence type in principle, again subject to the NMC underpinning it with robust quality assurance around the verification of evidence. In addition, a number of people queried why we were requiring two years’ practice.

Most stakeholders are in agreement with the principle of aligning our language evidence requirements in this respect for those wishing to join the register from the EEA and those wishing to join from overseas (non-EEA). Figure 7 shows that 43 out of 52 (83 percent) survey respondents either agreed or strongly agreed with this.

**Figure 7: Survey response to Q19 – should the language evidence requirements for those wishing to join the NMC's register from the EU/EEA and those wishing to join from overseas (non-EU/EEA) be aligned in this respect?**



### **Supportive comments**

There were a number of supportive comments about this evidence type and the proposal to align the requirement for EEA applicants and non-EEA applicants. For example, the Association of UK University Hospitals agreed with the alignment of requirements in this respect, noting that the option to use different types of evidence appeared 'fair and objective'. One respondent from an NHS trust felt that this evidence type would give applicants good experience in colloquial English, which she said that is something which EEA-trained nurses often struggle with.

The RCN, in its survey response, supported this evidence type, noting that it was similar to models in other English-speaking countries.

'We support this proposal since we are aware that numerous other English speaking countries operate similar models including Australia, Canada, New Zealand and the United States among others.'  
(Survey response, RCN)

At the same time, it asked for greater clarity on the varieties of evidence the NMC would accept around this requirement.

Another NHS organisation noted that this proposal was positive in that it opened up opportunities for recruitment from the USA and Australasia, if applicants have worked for in a country where English is the first and native language.

## Concerns about the proposal

Similar to evidence type 2, some stakeholders stressed the need for robust quality assurance around this evidence type. For example, the NHS Education for Scotland representative pointed out that the IELTS requirement in the Republic of Ireland was lower than the UK. They felt this would mean we would need additional assurance of an applicant's English language competence.

'Where other English speaking EU/EEA countries have lower IELTS score (Ireland – has lower requirements in reading and writing), two years registered practice does not always ensure contextual use of the English language within practice. Evidence of equivalent standards for IELTS would be required, for example, employer's declaration of use of English language.'  
(*Survey response, NHS Education for Scotland*)

One care organisation representative, while supportive of the proposal, said that the issue around it would be how we gain assurance that the requirement had been met. For example, we might need a very robust process around the references we would accept. A representative from one of the professional organisations gave the view that it would be important for the applicant to have to give evidence of their hours of practice.

The representative from the Chief Nursing Officers' BME group also said that we would need to be confident that the regulator with which applicants had been previously registered was on a par with the NMC with regards to language testing.

Another issue that was queried frequently by stakeholders was the two years' registered practice in an English-speaking country. Several people asked what the rationale was for the NMC proposing two years; some made it clear that they felt that one year of registered practice would be sufficient to assure a nurse or midwife's competence, including their English language skills:

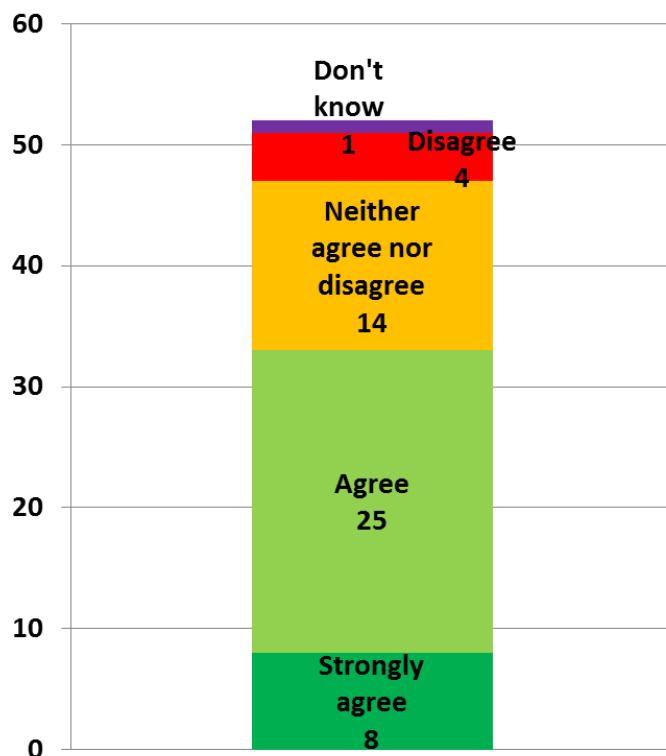
'Yes, however I believe that one year of practice, so that preceptorship is complete is adequate.'  
(*Survey Response, director of nursing, NHS trust*)

'Surely if a nurse is from a recognised English native speaking country and has completed a degree in that language, it is not necessary for them to have been working in registered practice for 2 years as well?'  
(*Webinar comment, recruitment agency*)

## Public protection

The survey responses showed that the majority of respondents felt that this evidence type provided sufficient public protection. However, just over a third (19 out of 52, 37 percent) had some concerns, indicating that they neither agree nor disagree, disagree, or don't know (Figure 8) that this evidence type provides sufficient public protection.

**Figure 8: Survey response to Q21 – do you agree that this evidence type provides sufficient public protection?**



Similar to evidence type 2, some of the concerns around public protection centre on the need for robust governance around the validation of evidence. The RCN stated that they believed that this evidence type does allow for sufficient public protection, however, they advised that we should consider bolstering it further by requiring other forms of supplementary evidence such as employer references. As noted above, the NHS Education for Scotland representative was concerned about ‘lower standards’ of IELTS acceptance in other countries; for this reason she said that:

‘Evidence of equivalent standards for IELTS would be required, for example employer’s reference/ declaration of use of English language in practice context would be required to ensure public protection.’  
(Survey response, NHS Education for Scotland)

Another NHS organisation pointed out that English is not spoken or written in the same way across the world. For example, miscommunication may occur because of the difference in accepted abbreviations between countries. The organisation also expressed concern about the variation in requirements for IELTS scores in different English-speaking countries, with Ireland and the USA requiring lower scores than the UK:

‘It is with this in mind that a standardised approach across English speaking countries would solve some of the recruitment challenges and therefore be most welcome.’  
(Survey response, NHS organisation)

Other stakeholders, however, did not appear to have great concerns about this type of evidence in terms of public protection. One participant, for example, stated that he felt that it was reasonable to rely on the robustness of other regulators for this type of language evidence – regulators will need to have similar standards across the board.

A consultation response from another organisation agreed that this evidence type was sufficient for ‘most standard clinical interaction’. At the same time, they felt that where applicants were working in more complex clinical situations, such as communicating upsetting news or working in specialist healthcare fields, they should have to give evidence of post-registration training as well as registered practice conducted in the English language.

## **Other comments**

Similar to evidence type 2, there were a number of stakeholders who queried whether extending this evidence type to non-EEA applicants would have much impact on the workforce:

‘Whilst we accept that this evidence type would be a positive move by the NMC, it would be unlikely to have a significant impact on increasing applications to the register from these countries to come and work in the UK.’  
*(Survey response, NHS organisation)*

A small number of stakeholders also questioned why evidence type 2 and type 3 were different, in terms of evidence type 3 requiring two years’ practice.

There were some queries about which countries this evidence type would apply to. For example, one of the webinar participants asked whether this evidence type would be considered for applicants from the Middle East, where in some cases practice takes place in English. Several people also asked us to confirm what we meant by an ‘English-speaking country’ – they asked whether we were using the UK Visas and Immigration list, which we are.

## **Other evidence of English language competence**

We asked stakeholders whether there were any other types of evidence that the NMC could consider which would satisfy our requirements for English language competence.

Several people suggested employer references as a way of evidencing English language competence. One pointed out that the reference would have to be clearly defined and the level of the individual who signed it clearly outlined.

As noted in the section on evidence type 2, others have suggested that the existing assessments that overseas nurses have to currently undertake to gain registration, such as OSCE exams, should contribute to assurance of an applicant’s English language capability.

Other suggestions include face-to-face interviews, clinical documentation from practice which has been verified by a senior practitioner and a top-up bachelor’s or master’s degree in nursing completed in the UK. Several people expressed a desire to support

people working as healthcare assistants in the UK to gain English language competency in order to be able to register as nurses. They suggested that there should be programmes to help these people, which are supported by portfolios and referenced evidence as well as testing.

Two stakeholders indicated however that they would not be comfortable with us accepting any other evidence than the three main types, as they felt this would be risky. One stakeholder gave the view that it would be difficult to ensure that the same standard was applied by all sources providing other evidence.

## **Overall comments about public protection**

A number of stakeholders expressed the view that the proposals would not have a negative impact on public protection. For example, one participant said that the consultation period will ensure that people have assurance in the proposed changes which cover a great deal of their concerns. One UK-wide organisation said that it did not feel that providing alternative testing options would have a negative impact or pose a risk to public protection.

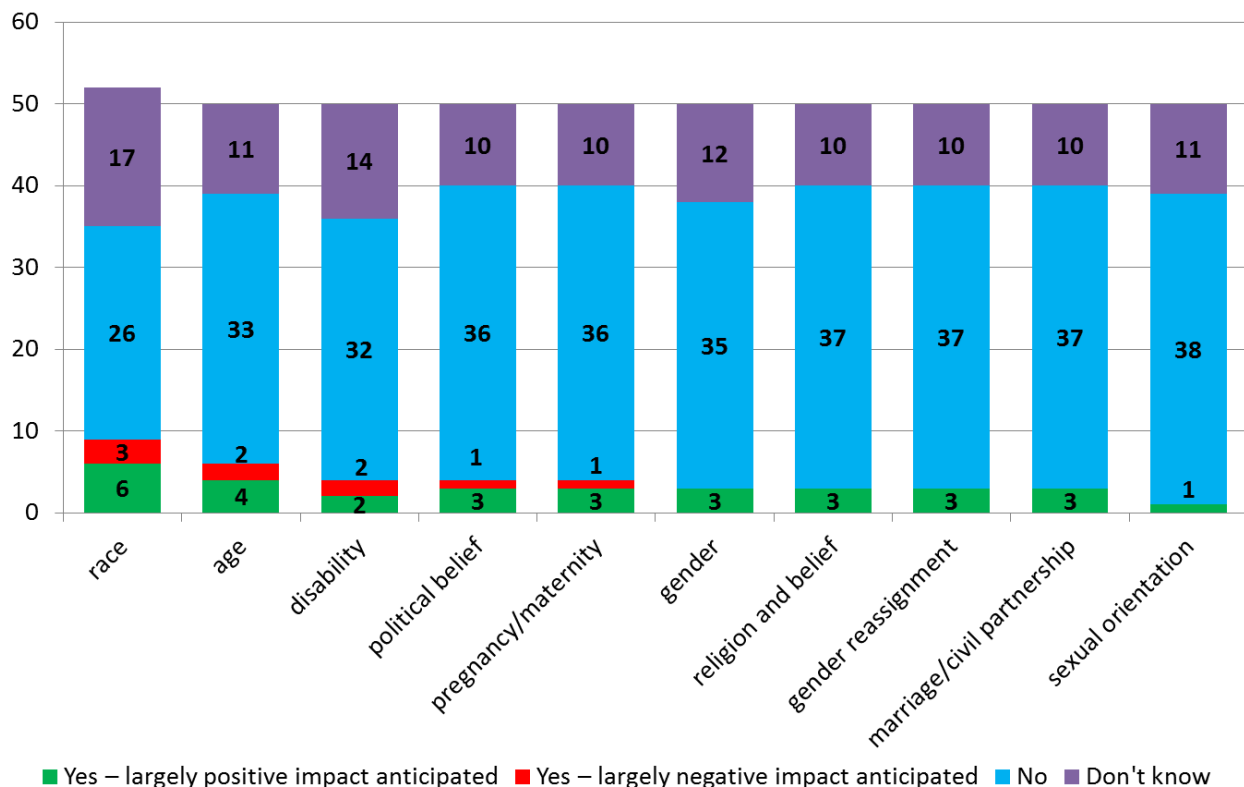
There have also been comments with regards to the needs of service users and patients, some of whom may be older and have complex needs. For example, one patient organisation stressed the importance of nurses having good English skills in order to be able to care for elderly people and people with learning difficulties who may struggle to understand. It would be difficult to carry out a test for dementia, for example, if there are language barriers.

Two stakeholders, who were of the view that the NMC should simply lower the IELTS level, stated that they thought our current position on IELTS was actually having an adverse effect on public protection, as it was having a negative impact on the size of the nursing workforce.

## **Impact assessment**

We asked participants in the consultation whether they thought any of our proposals would have a particular impact on any groups with the protected characteristics under the Equality Act. Figure 9 shows the responses to this question from those who completed the survey.

**Figure 9: Survey response to Q24 – will any of our proposals have a particular impact on any of these groups with protected characteristics?**



The majority of people responding to the survey answered no or don't know when questioned whether the proposals would have an impact (positive or negative) on groups with the protected characteristics.

The protected characteristic which the largest number of people thought would be impacted was race – six thought this would be positive and three negative. There were a number of comments in the survey responses, meetings and phone calls which explain this.

The anticipated positive impact on race and other characteristics seems to be because some stakeholders think that the proposals are fairer in terms of aligning the requirements. For example, the representatives from one NHS organisation said that they thought that the proposals bring a greater level of equity and fairness than the current rules. One stakeholder said that she thought the proposals were fairer than the current system, although she noted that they might benefit nurses and midwives from countries like Australia and New Zealand more in the early stages of implementation. The stakeholder from the Chief Nursing Officers' BME group agreed that the changes might initially benefit countries like Australia, New Zealand and Canada where there are potentially more academic nursing pathways which fit more with our evidence requirements. However, she also thought that the changes were potentially beneficial for applicants from Caribbean countries, and some African countries, and talked about ways in which we could help applicants from countries which might find the language test harder, but who have excellent practice skills.

The main concern, as previously noted in the section on evidence type 1, is around the potential cost of other tests, which may disadvantage people from poorer countries. Several stakeholders stressed that the NMC needs to think about the potential costs for candidates from countries like the Philippines and India, and also the availability of test centres in some countries. The representative from the Council of Deans also emphasised that we need to think about the potential impact on women, if we introduce alternative English language tests that are more expensive than IELTS.

There have also been a small number of comments about the fact that people with dyslexia may find language testing challenging.

‘Standardized testing is challenging for individuals with learning disabilities (e.g. dyslexia) and older individuals who have been away from academia for several years.’

*(Survey response, language testing organisation)*

‘Possibly an issue for applicants with dyslexia but if they are able to provide evidence other than a test that may be helpful.’

*(Survey response, Unison)*

Representatives from several organisations – the RCN, NHS Employers and the Chief Nursing Officers’ BME group – have stressed the importance of the NMC monitoring the data on people entering the register from outside the UK, to ensure that there are no unintended consequences for people with the protected characteristics,

‘We recommend therefore that the NMC ensure that it has a robust monitoring system in place and that data on this area is published openly and transparently.’

*(Survey response, RCN)*

## **Four country implications**

We asked participants whether they thought that our proposals for the English language requirements would have any implications for the four countries of the UK.

Most survey respondents either left this question blank, or indicated that they did not think there would be any implications for the different countries of the UK.

The representatives from the RCN, RCM, Healthcare Inspectorate Wales and NHS Wales urged the NMC to be aware of Welsh language issues. Some of the points raised by the NHS Wales participant were:

- the NMC needs to think about how we deal with a part of the UK where English is not the sole first language and how this fits in with the English language policy
- there are a number of pathways to nursing offered by Welsh universities that are taught and examined in Welsh
- in some areas, the majority of clinical interaction may be in Welsh, which would not fit in with evidence type 2.



The other issue that was mentioned came from a representative from Health Improvement Scotland. He said that there is greater integration between healthcare and social care in Scotland than the other UK countries. He wondered whether we needed to consider if the proposed changes may indirectly affect English language in social care. He pointed out that there might be a misalignment in practice in the community if the language proposals were to go ahead for nurses (but not for social care workers).

## **Key policy changes based on consultation feedback**

### **Evidence type 1: OET**

#### **Evidence Type 1: Achievement of the required score in IELTS or in one of the other English Language tests accepted by the NMC**

Most stakeholders were in favour of us accepting other tests which mapped against our criteria and many gave the OET as an example of a test we should explore. Based on positive consultation feedback and evidence that the OET maps onto our criteria we will be accepting the OET from 1 November. Grade B in OET maps onto IELTS level 7.0. Applicants would need to get a grade B in all four areas of the test (reading, writing, listening and speaking).

While some stakeholders raised that there are fewer test centres with the OET and costs were higher, they were still of the view that offering the test is a positive move. The OET is being offered in addition to IELTS and we will continue to review other English language tests for nurses and midwives who are seeking to join the NMC register. However, this must be balanced with our duty to protect the public. We note that concerns regarding the cost of OET have been raised. Language tests are independent of the NMC and we do not set the costs for these. The OET assures us that test centres could be opened in response to demand.

We are continuing to assess the evidence provided by other test providers with a view to accepting other English language tests that meet our criteria.

### **Assessing evidence type 2 and 3**

**Evidence type 2:** A recent pre-registration nursing or midwifery programme that has been taught and examined in English (and must have composed of at least 50 percent clinical interaction and that 75 percent of this clinical interaction with patients, service users, their families and other healthcare professionals must have taken place in English).

**Evidence type 3:** Registration and two years of registered practice with a nursing or midwifery regulator in a country where English is the first and native language.

Consultation responses indicated broad support for us introducing evidence types 2 and 3 to nurses and midwives trained outside the EEA. This means we now have one set of English language requirements for all non-UK trained nurses.

One issue of importance mentioned was the need to ensure we have robust procedures for assurance that 50 percent of a nursing or midwifery programme was clinically based

and that 75 percent of this clinical interaction with patients, families and healthcare professionals was in English. We currently have a system for assessing these two evidence types for nurses and midwives trained in the EEA and we have been working with the other healthcare professional regulators to ensure this process is fit for applicants trained outside the EEA. We will monitor applications to ensure they are being assessed in line with our requirements and work closely with stakeholders such as recruitment agencies and overseas health and workforce organisations to gather intelligence and make sure our processes are proportionate and fair.

We have considered the requirement for two years' practice as part of evidence type 3 and considered whether it was appropriate to remove this altogether. However we agree with those respondents who raised concerns that not all overseas regulators require the same entry standards for language (for example Republic of Ireland ask for a 6.5 IELTS), that it is important to have a period when language skills can be consolidated and developed in a practice setting.

Our general policy for overseas applications specifies that applicants must have one year of practice before they apply to join the register. The NMC has therefore previously taken the view that one year's practice is sufficient to identify any issues with a newly qualified nurse or midwife and it would be consistent to take the same approach to consolidation of English language skills.

We therefore consider that reducing the requirement to one year will give us the additional assurance we are looking for, while at the same time remaining proportionate. We will retain the option of seeking references from employers to confirm that this practice was in English.

## **Equalities impact**

These changes are designed to remove unnecessary obstacles to meeting our English language requirements. On the basis of data so far, there is no evidence to suggest that aligning our English language requirements and accepting the OET will have a negative impact on any group with protected characteristics. However, some stakeholders raised that the socioeconomic status of people from some countries may impact on access to the OET.

We will work with test providers to ensure we have accurate data on areas such as access to test centres and statistics on protected characteristics to allow comparison before and after the changes. This is one way of reviewing where the changes are having an impact and therefore how we might ensure equality appropriately across all cohorts of people and countries. We will also monitor the other routes for proving language alongside listening to those applicants in the registration process.

## **What we intend to do**

From 1 November 2017 we will have one set of evidence requirements for all nurses and midwives who trained outside the UK. We will also be accepting the OET alongside IELTS as an English language test.

From 1 November, if applicants can supply one of the following types of evidence listed, they will meet our requirements for English language competence:

**Evidence type 1:** Achievement of the required score in IELTS or in one of the other English language tests accepted by the NMC. Currently we will accept IELTS level 7.0

**Evidence type 2:** A recent pre-registration nursing or midwifery programme that has been taught and examined in English

**Evidence type 3:** Registration and one year of registered practice with a nursing or midwifery regulator in a country where English is the first and native language

Finally we asked a question about what other evidence we might consider accepting for overseas applicants. We had a range of responses (including employer references) which we will explore as part of our wider review of our overseas policy.

## **Next steps**

This has been the first stage in our review of English language requirements for nurses and midwives who want to work in the UK.

We are committed to exploring other aspects of these requirements and the next stages will include reviewing other types of evidence which we could accept as demonstrating English language competence. However, for now, applicants from outside the EEA can only submit evidence type 1, 2 or 3.

The next stages of our English language review include evaluating other types of evidence, developing additional support for applicants and exploring the writing element of IELTS.