English Language Proficiency Survey - October 2023

Individual or Organisation

Are you responding to this consultation on behalf of an organisation?
Yes

Organisation Respondents Details

Please tell us the full name of your organisation.
Nursing and Midwifery Council

Please select the category below that best describes your organisation.
Other (please specify): UK healthcare professional regulator

Where is your organisation active?
UK-wide

Please tell us the contact email for your organisation
policy@nmc-uk.org

Consultation Document Questions - 1

Question 1.

Do you agree or disagree with the proposal to remove self-declaration of English as a first language language as evidence allowing international applicants to join the register?

Fully agree

Please explain your reasoning below.
We support HCPC's proposal to remove self-declaration as an evidence option, in favour of a more rigorous approach to assessing English language proficiency.

Our view is that the evidence requirements for applicants seeking to demonstrate language proficiency should be fair, objective, proportionate, and verifiable by the regulator. Effective communication is vital for patient safety, so regulators must be able to show objectively and with sufficient assurance that their registrants have the required level of English language competence. We recognise the risks of self-declaration identified by HCPC and agree that other evidence types are likely to provide more objective standards for assessing language competence, promote greater public confidence in the proficiency of internationally educated HCPC registrants, and improve patient safety.

We also support HCPC's intention to remove unnecessary barriers for those who are proficient in English but do not speak it as a first language and recognise the importance of these efforts from an equalities perspective. Evidence we considered in our own English language equality impact assessment showed that people who are multilingual should not be presumed less adept at English than someone who speaks only English, and that the linguistic skills of those who speak English as a first language can still deteriorate with lack of practice. On that basis, we would avoid making assumptions about proficiency based on whether English is spoken as a first or second language.

In summary, we believe that this proposal would support HCPC's stated aims of building more consistency with other regulators in the sector, and of considering applicants fairly and equitably, according to objective criteria.

a) Show that they are proficient enough in English to practise safely and effectively?

Agree

b) Feel confident in their own English proficiency?

Neither agree nor disagree

c) Easily join the register?

Neither agree nor disagree

Question 3:

We are proposing the adoption of a list of majority English speaking ("qualifying") countries in which international applicants could show that they have gained a primary qualification for their intended registered role. This would then evidence their proficiency in English.

Would a 75% English speaking population be an appropriate test for countries to be on our qualifying list?

Neutral / unsure

Please explain your reasoning below, and suggest any alternatives if applicable.
With regard to Question 2, we agree in principle with the proposal to accept primary qualifications from countries where English is the majority-spoken language, provided there are clear processes in place to verify that the qualification has been taught and examined in English, and has included sufficient interaction in English with people who use services and other healthcare professionals. This requirement forms part of the NMC's current English language policy. HCPC should take care to have objective methods of assessing whether the course is taught and examined in English as this can be hard to verify. We are working on this at the NMC and would be happy to share our learning.

Regarding Question 3, we note the reference in the consultation document to the NMC's own list of accepted countries (countries where we consider English to be a majority-spoken language). Through our English language consultation process in 2022, we encountered strong views on how a 'majority English-speaking' country could be defined. The NMC's accepted countries list was disputed by some participants, on the basis that English may be widely spoken in certain countries not included on our list, even if English is not classified as their primary language. We would anticipate that reception to this policy change is likely to rest on how robustly HCPC is able to evidence and articulate the criteria for its own 'qualifying countries' list.

The NMC's list is primarily based on the former UK Border Agency's list of majority English-speaking countries, with the addition of a small number of countries that the Border Agency would not need to consider because their nationals do not need to apply for a visa for UK immigration purposes. We understand that the Border Agency's minimum threshold for its own countries list is that at least 51% of the country's population should speak English. In practice, therefore, this is the benchmark for the majority of countries on the NMC's list. For the additional countries we have chosen to include, we have relied on independent expert evidence to establish that the population is majority English-speaking. For the avoidance of doubt and given the potential impacts on public safety, we have chosen to adopt a more conservative approach for these additional countries by setting a higher threshold for inclusion, requiring that at least 75% of the population should speak English. This aligns with our criterion for accepting that a qualification was taught in English that at least 75% of the clinical interaction with patients, service users, their families and other healthcare professionals must have been in English.

We recognise the challenges in identifying an appropriate threshold for a list of this kind, and the value in learning from other regulators' decision-making and outcomes in this space. HCPC may find it helpful to know that we receive a small number of fitness to practise (FtP) referrals relating to English language: between 2017 and 2021, just 0.6% of our total FtP referrals related to concerns about English language proficiency, and we are continuing to monitor our fitness to practise data following our recent policy changes. We take reasonable assurance from this evidence that our current criteria are fit for purpose from a public safety angle.

Given that population demographics can shift over time, we would propose that HCPC's qualifying countries list should be periodically reviewed, to confirm whether the listed countries continue to meet the agreed criteria and ensure that subsequent additions or removals can be made as appropriate. This should help to support confidence in the policy overall and in the professionals who register via this route.

Regarding the potential impacts of this policy change on applicants, our view is that it is not necessarily the role of HCPC to influence how confident applicants may feel in their own English language proficiency (per Question 2), but to ensure that the regulator can draw sufficient assurance from its controls and improve public confidence in the professions. However, we recognise the importance of removing unnecessary barriers for internationally educated applicants and providing multiple options for individuals to demonstrate their English language competence through a fair and robust process. We support HCPC's efforts to strengthen its policy in this regard, and we agree that the proposed changes should enable greater confidence that its registrants are capable of safe and effective practice.

Question 4:

Separately to considering where qualifications are gained, should we accept evidence of registered work experience in a listed country where English is spoken by a majority as their first language?

Yes

Please explain your reasoning below.
While we broadly agree with this proposal, we would seek clarification as to whether the suggested requirement is for practice in a majority English-speaking country, previous registration in such a country, or both (for example, whether an applicant who has registered but never practised would be able to use this evidence type). Our view is that an agreed period of clinical practice should be required, in addition to registration, to ensure the applicant has been able to put their English language skills into practice in an appropriate setting. For clarity and to ensure the applicant's professional experience is relevant in this context, we would propose describing this requirement as 'clinical practice in a health or care role' (specifying whether this should be regulated) or similar, rather than 'work experience'.

We would suggest considering whether applicants must have completed an English language assessment as part of their original registration to be able to use this evidence type (as is a requirement under the NMC's policy), and whether their practice must have been in a regulated role. HCPC may wish to note that we accept non-regulated practice for nursing associate applicants to our register, in recognition of the fact that this role is not regulated outside England. We would also suggest HCPC considers recency of practice as a condition of accepting this form of evidence; for example, by requiring applicants to have completed the period of registered practice within an agreed number of years prior to registration with HCPC. This is to provide assurance that the applicant's English language skills have remained current.

We would also propose specifying the minimum period of employment required (instead of or in addition to the required period of registration), whether this must be full-time work, and whether the practice must be in the role/profession for which the applicant is seeking to register with HCPC. On the latter point, we recognise there may be benefit in allowing some flexibility, given potential variation in how roles are defined across different countries. We also suggest requiring proof of employment in an appropriate role for the agreed minimum employment period, in addition to proof of registration.

Subject to the caveats above, we would agree in principle with a proposal to accept clinical practice in a health or care role in a country where English is the majority-spoken language.

Question 5:

Separately to considering where qualifications are gained, should we accept evidence of work experience in the UK if this has been supervised by a registered health and social care professional?

Neutral / unsure

Please explain your reasoning below.
We would need a greater level of detail to understand whether these measures could provide adequate assurance of English language proficiency, as opposed to more general workplace experience. Our view is that supervised clinical practice in a health or care role in the UK, which involves substantial interaction with people who use services and is supported by employer references, could provide some evidence of English language competence. However, we would query whether supervisor references can safely be accepted as standalone evidence. In the interests of public safety and confidence, HCPC may wish to consider accepting references only in tandem with other forms of evidence or additional assurances (e.g. the applicant holding a qualification taught in English in a country where English is not the majority-spoken language).

If HCPC chooses to accept this form of evidence, we would question whether the testimonial of a single individual can provide enough assurance of the applicant's language skills. We also recognise the potential risks of bias and discrimination if this evidence rests on only one person's assessment. HCPC could rectify this by requiring more than one reference (for example, from both a supervisor and a suitable counter-signatory) to ensure this evidence is fair and robust.

The framing of 'work experience' could also be seen to encompass a broader range of non-clinical roles, which may not be relevant for HCPC's purposes even when the role is supervised by a health and care professional. It may be helpful to define these requirements more precisely, and to articulate how a given role could be considered to draw on the 'knowledge, skills and experience' of the relevant regulated profession. We would propose that this form of evidence should require employment and practice in an unregulated health and care role, involving substantial clinical interaction in English with people who use services, their families, carers, and other healthcare professionals. We would also suggest specifying the minimum period of employment required, whether this must be full-time work etc.

Lastly, we would suggest clarifying who can and should provide the 'certificate of supervision'. The consultation document suggests this could be 'a registrant with another statutory regulator in the health and care sector' but separately advises the applicant must be supervised by 'a HCPC registrant who is registered on the same part of the register as the applicant is applying for'. Our own findings have indicated that there may be practical challenges in seeking to verify references from registrants with other regulators, which could undermine the robustness of this evidence type. HCPC may wish to further investigate the viability of this route, to understand other regulators' willingness to facilitate such measures and the feasibility of systematically checking regulation status for non-HCPC registrants.

If HCPC were to accept references only from its own registrants, this evidence could be more readily verified, and referees could also be expected to have sufficient awareness of the relevant regulatory standards to assess other prospective registrants fairly. However, it is possible that implementing tighter restrictions (by only accepting references from registrants on the same part of the register that the applicant is applying for) could prevent applicants who are competent in English and have suitable experience in a clinical setting from using this evidence type, if they are unable to gain employment with a registrant from the relevant part of the register.

Subject to the considerations above, we broadly support the use of employer references from HCPC registrants as evidence of applicants' English language competence, but only where these are considered alongside additional forms of evidence. We recently introduced a similar evidence type (supporting information from employers), whereby applicants who meet certain requirements can provide employer references confirming their competence in English, as a supplementary form of evidence. To be eligible to use this evidence type, applicants must either have narrowly missed our required scores on an accepted English language test, or have completed a pre-registration qualification taught in English in a country where English is not the majority-spoken language. We are closely monitoring the implementation of this new process, and are carrying out evaluation and research to understand its impacts. We will be happy to share our experience and learnings with HCPC, should they decide to proceed with this proposal.

Question 6:

Do you agree or disagree with our proposal to expand our list of approved test providers? Please explain your answer.

Neutral / unsure

Please explain your reasoning below.
HCPC may wish to consider whether other tests/providers fulfil the necessary criteria to be included on their list of approved test providers. As the consultation document sets out, an expanded list could offer increased flexibility for applicants, helping to remove unnecessary barriers to registration for those with the right skills. However, we do not consider that HCPC is under any statutory obligation to expand its list or consider additional test providers.

If a decision is taken to expand the list, setting clear and robust criteria for accepted test providers will be critical to ensuring there are no negative impacts on public protection, and that there is an appropriate threshold for inclusion. HCPC may wish to consider providers' testing mechanisms (including whether speaking tests are conducted 'live' with an examiner), security and fraud prevention measures, provision of free candidate support materials and accommodations for those with additional needs (see Question 10), and global availability of test centres. Last year, we commissioned some research into how we might look at criteria for accepting tests and would be happy to have further discussions with HCPC on this subject.

We agree with the proposal that this list should be exhaustive. This would support a more rigorous and proportionate approach, enabling the regulator to systematically evaluate whether language test providers meet required standards, without individually assessing multiple tests on an ad hoc basis. This should streamline regulatory activity, enable more consistency in how international registration applications are assessed, and ensure the requirements for applicants are clear up front.

Building trusted relationships with approved test providers can also strengthen the assurance received from language tests, enable greater transparency and insight into testing processes, and provide the opportunity to build meaningful data around candidate demographics. It can facilitate swift action and cooperation between the regulator and test provider, if and where issues arise, helping to protect public safety. It can also enable employers and other stakeholders to support test-takers more effectively. On that basis, we support the proposal to limit accepted language tests to those on HCPC's agreed list.

Question 7:

In addition to our current approved providers, are there any other test providers whose tests we should consider accepting as evidence of English language proficiency?

If so, please give details in the box below.

The NMC accepts two English language tests: the International English Language Test System (IELTS) Academic and the Occupational English Test (OET).

Question 8:

Should our list of approved tests be exhaustive?

Yes

Question 9:

Please tell us which of the below statements you agree with the most:

Statement 1) Overall, these proposals provide greater assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively

Statement 2) Overall, these proposals provide the same assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively

Statement 3) Overall, these proposals provide less assurance that applicants' proficiency in English is sufficient for them to practise safely and effectively

Statement 1

Question 10:

In addition to the equality impacts set out in the Equalities Impact Assessment, can you identify any further impacts relating to protected characteristics that we should consider?

The protected characteristics are:

• Age
• Disability
• Ethnicity
• Gender reassignment
• Marriage and civil partnership
• Pregnancy and maternity
• Religion or belief
• Sex
• Sexual orientation

You may also consider other ways people's background might mean an adverse impact, for example if applicants are refugees or forcibly displaced people, or how their socio-economic status might affect things.

Do you have any suggestions about how any negative equality impacts you have identified could be mitigated?

Having reviewed the Equality Impact Assessment, we would suggest giving further consideration to the possible impacts on individuals working in certain employment settings, particularly with regard to Proposal 3 (accepting previous registration in a majority English-speaking country or supervised work experience in the UK). We are aware that professionals in some work settings, such as bank or agency staff, may face challenges in using their practice as a form of evidence, if they are unable to gain enough supervised practice hours to secure an employer reference. This could have disproportionate impacts on those with certain protected characteristics (for example, insights from NHS England indicate that those from a minority ethnic background make up a high proportion of bank-only workers [https://www.england.nhs.uk/long-read/workforce-race-equality-standard-wres-indicators-for-the-nhs-bank-only-workforce/#the-demographic-of-bank-only-workers]). Relying on testimonials from a single individual/employer could also create risks of bias or discrimination. It may also be helpful to consider any impacts on people who use health and care services, and on overseas-educated applicants who already reside in the UK, who may be more vulnerable to certain risks (particularly if they are working in unregulated areas of practice and are reliant on their supervisors supporting their registration).

HCPC could also explore any implications for people who may experience communication barriers within testing systems, such as those who are autistic, have learning difficulties or people with other communication needs. These groups, as well as those who speak with different accents and dialects, could experience disadvantage when taking language tests or providing other forms of language evidence, particularly if there is a risk of bias or discrimination within the assessment process. When assessing new test providers, HCPC could also explore how test providers support other neurodivergent and mental health conditions (such as those with ADHD or anxiety, who may be affected by question types, test length etc.) within their testing programmes.

We note that the costs of providing language evidence (e.g. language test fees) may be a barrier for some based on their age, sex and sexual orientation, in addition to the other protected characteristics (gender reassignment, pregnancy and maternity) already identified through the EQIA. Additionally, for individuals who have undergone gender reassignment, providing proof of name change for the purpose of identity checks could incur an additional cost, so it may be helpful to consider what forms of documentation could be accepted, including any lower-cost options.

We support HCPC's approach of seeking input on potential equality impacts through this consultation process. We have published our own equality impact assessment on changes to the NMC's English language policy, which is accessible at <https://www.nmc.org.uk/globalassets/sitedocuments/english-language-consultation/english-language-eqia-summary.pdf>. However, the insights we provide cannot substitute views directly gained from people with protected characteristics and/or those that advocate on their behalf. As such, we would also recommend seeking views from groups who have the respective protected characteristics, or who have experience and understanding of the issues faced by these groups, such as advocacy networks.

Question 11:

Do you have any further comments to make about the proposals and information in the consultation?

In summary, we would broadly expect HCPC’s proposals to provide greater assurance of applicant’s English language proficiency, but welcome further detail on the proposed new measures (as set out in our earlier responses) to ensure these are fully articulated, fair, and robust. In particular, we feel there is a need for more clarification and specificity in the ‘work experience’ proposals, to ensure these provide sufficient assurance of language competence.

Submit response

This is the end of the survey. Please indicate select "Submit my responses" once you are ready to end the session.

Submit my response.