DIVERSITY WORKS

Research report on work placements for refugees in the NHS

RAGU (Refugee Assessment and Guidance Unit)

August 2006

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AIMS, OBJECTIVES AND CONTEXT

'The overall implementation of any sort of policy on diversity needs to be more inclusive, it needs to accept the basic differences of humanity of people in the workforce.'

NHS Manager

Project aims and objectives

'Diversity Works in the NHS' was a pilot project led by the RAGU, (Refugee Assessment and Guidance Unit), at London Metropolitan University in partnership with National Health Service (NHS) employers. The project was funded by the Learning and Skills Council, London Central, from June 2003 to Dec 2004.

The **aims** of the Diversity Works project were to:

- Pilot measures for professionally qualified refugees to promote access to employment in posts commensurate with their skills and experience, primarily in the health sector.
- Actively address the Equality and Diversity Agenda by working with NHS employers.
- Raise awareness of employers, particularly in the health sector, of the benefits of professionally qualified and experienced refugees as a skilled and valuable human resource, untapped by the labour market.

The project achieved these aims through the following **objectives**:

- Develop and manage work placements for refugees to develop existing and new skills, and to build professional and personal confidence.
- Enable refugees to gain UK work experience and references from UK employers.
- Enable refugees to develop language, communication and professional skills in line with their career aims.
- Provide high quality careers advice and guidance.
- Research factors which work for and against the successful recruitment and retention of refugee professionals at levels commensurate with their qualifications and experience by evaluating work placements in NHS Trusts.

The context

The Diversity Works in the NHS project sought to address the employability needs of refugee health professionals (HPs) and allied health professionals (AHPs) as well as the Equality and Diversity Agenda of the NHS. The project, delivered by RAGU together with NHS Trusts, worked within an adverse socio-economic climate for refugees and one of structural change for the NHS. These contexts are discussed below.

RAGU (Refugee Assessment and Guidance Unit)

RAGU, a specialist refugee agency, has operated within this adverse climate since 1995. Uniquely placed within a university, RAGU delivers services to refugee professionals and those with high-level qualifications. RAGU provides specialist guidance and training courses to refugees to enable greater access to appropriate employment, training and education. Other work includes research, advocacy and networking at national and international levels.

RAGU has been involved in establishing successful, structured work placement programmes since 2001. The Diversity Works programme has set up and managed numerous work placements in the public, voluntary and private sector for refugee professionals. The Diversity Works in the NHS project has given specific impetus to focusing on the challenges facing refugee health and allied health professionals in accessing employment in the health sector.

The NHS

The NHS faces workforce shortages, in particular within the skilled health and allied health professions. Additionally, since the Race Relations (Amendment) Act 2002, equality and diversity have been considered paramount in relation to improving standards of health care and also for recruitment and retention of a diverse NHS workforce. In October 2003 the Department of Health produced its vision for taking forward equality and diversity within the NHS. This was in the form of a major consultation document - *Equalities and Diversity in the NHS - Progress and Priorities*, backed up with a draft *Equalities and Diversity Strategy and Delivery Plan to Support the NHS'*[1] to redress the "inequality of employment in the NHS". The strategy recognised a climate within the NHS where there is:

> *reluctance by Trusts to address equality and diversity matters based on a **lack of direct evidence** of a particular issue and inconsistencies by some NHS employers to recruit and develop certain people (e.g. refugee health professionals).*

[1] Department of Health., 2003. *Equalities and Diversity Strategy and Delivery Plan to Support the NHS.* Available at: www.dh.gov.uk/Consultations

DoH., 2003. *Equalities and Diversity Strategy and Delivery Plan to Support the NHS.*

To this end, the Strategic Health Authorities' *Race Equality Guide* [2] states in the performance framework the expected outcomes following implementation as:

- *Staff reflect the community they serve at all levels in the organisation*
- *Recruitment rounds lead to ethnic minority candidates gaining jobs at all levels and in all areas of the trust's activities*

Significantly, evidence of progress of the framework in practice includes these among other measures reported in the guide being:

- *Refugee health professionals are supported and encouraged to seek work in the organisation*
- *International recruitment procedures are balanced against ethical and race equality considerations.*
- *The organisation links with local economic regeneration activities to ensure its recruitment strategies support local employment needs.*

This signals a significant shift in attitude by the government in recognising refugee professionals as valued workforce contributors.

Partnership with NHS Trusts

The project was delivered as a partnership between RAGU and two NHS Trusts: Newham Primary Care Trust (PCT) and the Royal Free Hampstead Trust (RFH).

Newham PCT employs just over 1000 staff in the most culturally diverse of all the London boroughs. The PCT provides primary and community health services to a population of a quarter of million people. The key objective of the PCT is to "improve the health of the local population and address health inequalities" and within this is a commitment to workforce development through recruitment, retention, training and development.

The Royal Free Hampstead NHS Trust (RFH*)* employs around 4,500 people providing 1000 beds. Services includes accident, surgery and medicine, paediatrics, elderly and psychiatry. RFH is a medical training and research centre.

RFH is one of 12 sites leading on the **national NHS programme** "**Positively Diverse".** [3] The RFH Trusts partnership with RAGU has

[2] NHS Strategic Health Authority (2004): *Race Equality Guide 2004, a performance framework.* Available at: www.cre.gov.uk/downloads/sha_race_equality _guide.pdf

been part of their Equal Opportunities strategy to further community opportunities and in particular refugee employment initiatives.[4]

Refugee health professionals (HPs) and allied health professionals (AHPs)

Refugee HPs include professions such as medical doctors, surgeons, dentists, nurses and midwives. Refugee AHPs include professions such as biomedical scientists, medical engineers, radiographers, physiotherapists, pharmacists, dieticians, occupational therapists and psychologists. Refugee HPs and AHPs often have many years' experience and are nationally, and sometimes internationally, well known.

Establishing how many refugee HPs and AHPs (with or without UK registration) there are in the UK is proving challenging. The British Medical Association (BMA) and Royal College of Nursing (RCN) have established national databases for refugees in their respective professions. However, by 2005 there were only 231 nurses registered, whilst in North East London alone the number of enquiries to the Workforce Confederation from overseas-qualified nurses was 400.[5]. With 1098 refugee doctors on the BMA database, yet only 93 in medical practice at August 2006, there are clearly a large number of refugee HPs and AHPs available for work but not yet integrated into the labour market at appropriate levels.

In the last 4 years, progress has been made in the recognition by the DoH that refugee professionals constitute an untapped skilled workforce,[6]. Considerable work has been carried out by refugee agencies, professional bodies such as the BMA, RCN, specific workforce confederations, London deaneries and individual Trusts to develop strategies to encourage refugee health professionals entrance into the workforce. Yet, as this report will show, there remain real barriers for refugee entry into the NHS: individual, structural and governmental.

In addition to refugee health professionals there are numerous refugee professionals with skills and experience in a wide range of professions, such as, finance, information technology, engineering, management and administration. All are potential contributors to the workforce and in particular

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[3] Positively Diverse is a "process that helps organisations establish the connections between communities served and the people who deliver the service, in order to improve patient care" (DOH). www.nhsemployers.org/excellence/excellence-449.cfm

[4] Nightingale H., 2004. *Annual Report on Equal Opportunities.* Royal Free Hampstead NHS Trust

[5] Employability Forum., 2004. *Strategy and Conference report: Silver Lining, integrating refugee skills into the workforce – a strategy for refugee nurses*

[6] Department of Health., 2003. *Equalities and Diversity Strategy and Delivery Plan to Support the NHS.* Available at: www.dh.gov.uk/Consultations

to the NHS. The Skills Audit of Refugees (Home Office in 2004)[7] indicated that of over 1000 respondents, 51% had occupied employment prior to the UK in positions of management, professional and technical occupations, and administrative posts.

Barriers to appropriate employment for refugee professionals

The unemployment rate among refugees is disproportionately high compared with ethnic minority groups. In 2002 the Department for Work and Pensions survey[8] indicated that only 29% of refugees were working compared with 60% of people from ethnic minorities as a whole. Yet 30% of the refugees in the survey held high level or professional qualifications. However the nature of work that many refugees access is frequently temporary, part-time and well below their skills level. This work cannot be considered appropriate in terms of their professional expertise, aspirations or career development. Furthermore those refugee professionals in employment are effectively trapped in low level unskilled work with insufficient time or funds to re-qualify, and unable to leave work, resume training or access appropriate work experience as benefits will not be resumed immediately.

Bloch[9]details the barriers refugees experience in accessing employment. Her findings show language to be the single most detrimental factor affecting labour market participation. However in RAGU's experience of working with refugee professionals since 1995, those refugees with high levels of proficiency in English language are also barred from appropriate employment because of a range of equally significant barriers. These barriers include:

- psychological trauma
- immigration status (delays in Home Office decisions)
- non-recognition of overseas qualifications
- non–recognition of overseas experience
- employer discrimination
- lack of familiarity with the UK labour market and access to information
- lack of UK work experience
- unfamiliarity with UK work culture, systems and technology
- lack of UK references
- childcare – no family and extended networks

Refugee professionals experience all the above. In addition those in regulated professions (e.g. doctors, nurses, teachers, lawyers) face hurdles in the re-qualification and registration process. Few professional bodies have

[7] Kirk R., 2004. *Skills audit of refugees.* Home Office

[8] Bloch A., 2002. *Refugee's opportunities and barriers in employment and training*. Dept. for Work and Pensions, Research Report No.179

[9] Bloch A., 2004. *Making it Work, Refugee Employment in the UK.* Institute for Public Policy Research

attempted to address these hurdles despite the clear cost benefits to supporting refugee professionals through the process and into work. The research carried out for this project and described in the following chapters, serves to highlight many of the obstacles refugee professionals experience entering employment.

How the report is organised

Chapter 1 provides an overview of the structure and nature of the work placement programme, the placement roles and the research methods employed within that framework. Questionnaires are included in the Appendices.

Chapter 2 brings together the findings from interviews with NHS managers and refugee professionals prior to and following work placements and identifies significant changes as a result of programme participation. Two case studies are included.

Chapter 3 serves as a toolkit for the development and management of work placement of refugee professionals. We identify examples of good practice and the specific challenges of managing work placements for refugee professionals in the NHS. These findings are relevant to the practice of work placements in other large public sector organisations.

Chapter 4 presents the case for inclusion and development of refugee employment in the NHS in terms of workforce issues and managing diversity. Secondly the chapter provides practical steps to facilitate the recruitment and retention of refugees including overcoming some of the structural barriers within the organisation.

Chapter 5 groups the recommendations arising from the research for NHS Trusts, refugee agencies and policy makers.

Public sector employers and voluntary sector employers will find much that is transferable from this study in the NHS to their own organisations.

Chapter 1

RESEARCH METHODOLOGY

Chapter 1
RESEARCH METHODOLOGY

1.1 Introduction and aims

This chapter describes the methodology of tracking seven refugee health professionals (HPs) and refugee allied health professionals (AHPs) and seven NHS managers on work placements in two NHS Trusts. In addition interviews were held with two NHS Human Resource Managers and two NHS refugee employees.

The **research aims** were twofold:

1. To investigate the impact of work placements on refugee professionals and on the NHS as an employer in order to:
   - Identify some of the individual and structural barriers to the inclusion of refugees into the NHS workforce
   - Identify good practice in establishing work placements in the NHS
   - Identify factors that work for and against the successful recruitment and retention of refugee professionals in the NHS at levels commensurate with their qualifications and experience

2. To flag up the extent to which work placements are an opportunity for the NHS to:
3.
   - Establish a Positive Action (PA) programme for socially excluded groups
   - Address their equality and diversity strategy in relation to NHS workforce development and the delivery of health care
   - Source a pool of skilled Health Professionals (HPs) and Allied Health Professionals (AHPs) for skills shortage areas in the NHS

RAGU has specialised in establishing structured and managed work placements for refugee professionals for 4 years across different employment sectors, with the aim of increasing refugee professionals employability in the UK labour market and specifically in the NHS. Evaluations by RAGU of previous work placement projects suggest that work placements in the NHS could provide refugee professionals with opportunities to:

- Gain up to date work experience in the NHS (pre-clinical)
- Maintain professional skills and develop new skills in order to contribute to the NHS workforce
- Familiarise themselves with the NHS culture and practice
- Develop communication skills and confidence building within a work setting
- Access current UK employer references
- Access networking opportunities, labour market information and vacancies within the NHS

- Continue their careers and/or explore alternative careers in health

1.2 The work placement programme: structure and strategy

The research methodology hinged on the structure of the work placement programme and the nature of the involvement of refugees and NHS managers in this programme.

1.2.1 Structure

RAGU's experience of managing work placement projects has indicated the importance of an assessment and selection process to ensure that the work placement programme is appropriate for the refugee professional. For this reason RAGU conducts thorough assessments in English language and I.T., as well as a 'job-readiness' assessment. For some, a work placement may be premature in their progression towards their career and they are better served with one to one careers guidance and other support. The job-readiness assessment seeks to assess the following:

a) commitment to consistent attendance
b) ability to represent the refugee professional community as a positive role model to employers who have little experience of a skilled refugee workforce and are often exposed to negative media images
c) whether access to education and training is appropriate before attending work placement
d) whether intense supported job search is more appropriate than work placement

Following the selection successful candidates attended a two-week pre-work placement training with presentations by NHS managers, employers, refugee professionals with experience of work placement and RAGU. The training sessions identified by the seven participants of particular value were:

- Communication in teams
- NHS organisation and structure
- Cross-cultural issues
- Assertiveness
- Organisational cultures
- NHS recruitment process

In addition refugees accessed one to one guidance sessions with RAGU career advisers to discuss their career aims and routes, prepare CVs and prepare for work placement interviews.

Work placements were for 3 months duration and for a minimum of 3 days a week. Work placements were unpaid, (travel expenses were reimbursed and lunch costs were covered by one of the Trusts).

Initial interviews with the work placement manager, the refugee professional and RAGU took place following extensive negotiations with each Trust. Work placement guidelines and the contract developed by RAGU, were agreed and signed by all parties at the start of work placements. The contract included

agreed practice by employer and placementee, codes of behaviour and supervision details.

During the work placement RAGU attended monitoring visits at 2 weeks and at 8 - 9 weeks into the placement to discuss progress with the NHS managers supervising the placement and the refugee themselves in confidential sessions. Telephone contact was maintained throughout and exit interviews were conducted at the close of placement.

1.2.2 Establishing work placement within the Trusts

Once partnerships with the NHS Trusts were fully established by March 2004 detailed discussion between RAGU and NHS Human Resource (HR) managers took place over the following 3 months, in order to identify strategic processes to set up the work placements.

Publicity material prepared by RAGU for the project was circulated within each Trust by the HR departments. One Trust disseminated this information across the organisation thereby generating some, though limited interest, before the refugees had been selected. In this Trust initial expressions of interest by managers did not however necessarily reflect teams within which refugees could easily be placed on the basis of the refugees' interests and skills. Once the individual refugees had been selected onto the project and their skills and experience reviewed, HR managers were able to identify specific team managers for contact. Two methods to contact NHS managers were used: in one Trust HR specifically asked RAGU to contact NHS managers, in the other Trust HR initially contacted managers. Detailed negotiations were then carried out between all NHS managers and RAGU.

NHS managers were provided with the following information:

- Project publicity with aim and objectives
- Frequently asked questions about refugee professionals
- Individuals' CVs
- Placement documentation including contract and guidelines

Managers interviewed individual refugees and in all cases accepted them onto placement. Placement roles were mapped out before work placements commenced, in discussion with RAGU, HR, NHS managers and some refugees. Roles were based on existing job descriptions, or newly developed.

The roles negotiated (see below) reflect the range of responsibility Trusts were able to provide for individual refugees based on:

- Individual refugee's skills and experience
- How job descriptions could be adapted to meet the NHS team's needs
- Managers previous experience of work placements
- Regulatory bodies' criteria for non registered professionals
- Staffing levels in the team and development opportunities in the team

All seven refugees were informed by RAGU at the start of the project that work placements were not clinical attachments, nor part of a professional registration process. By implication this meant that work placements would involve clearly defined and limited clinical practice and client contact for legal reasons. However participants would be expected to practice within a team, undertaking routine work and clinical observation.

1.3 Research methodology

The research fieldwork funded by the Learning and Skills Council, was conducted between May 2004 and December 2004. As action research, findings from the research interviews were inputted into the project while the project and specifically the work placements were ongoing. For example the views of refugees and managers participating on work placement elicited during interviews and visits were incorporated into the placement management support by RAGU careers advisers order to raise awareness of key issues and develop practical steps to enhance placements and resolve problems.

Qualitative research methods were used in order to explore issues in depth and to access a richer understanding from participants' perspectives of how they experienced the work placement process from start to completion. Interviews were conducted with refugees and NHS managers. All interviews were semi-structured face-to-face interviews, tape recorded and transcribed. Data was analysed on a thematic basis.

Consent from all respondents was obtained in order to use anonymised interviews and other material for the research. Participants also reserved the right to ask for interview recording to stop, although this was never requested. Confidentiality was respected at all times by the interview team. A majority of interviews were conducted by three female careers advisers (white UK origin), with additional interviews carried out by two female and one male careers adviser (non-UK origin).

1.4 Identifying refugee professionals for the research

For this study a total of nine refugee professionals were interviewed:

- Seven refugee professionals on work placement via Diversity Works in the NHS
- Two refugee professional currently employed in the NHS

The seven refugee professionals were selected from sixty refugees who attended the assessment process to join the Diversity Works in the NHS work placement programme in April 2004. Fifteen candidates were taken onto the programme of which the seven identified for the study were Health Professionals (HPs) and Allied Health Professionals (AHPs) who specifically

attended work placements in the NHS during the period in which the research was conducted.

Seven refugee professionals were interviewed prior to the start of the work placement programme, before they had attended pre-work placement training at RAGU. Second interviews took place from the 8th to the 10th week of the work placement start.

Interview questions explored the following topics: participants professional and educational background; their experience of seeking work in the UK and of employment in the UK compared to their country of origin; knowledge of the NHS; expectations of work placements; long and short term plans and developmental needs and the impact of the work placement on knowledge and experience,

In addition to the interviews, material for the study was sourced from:

- Written records of discussions with refugees on work placement during two monitoring visits carried out by RAGU careers advisers at approximately 2 weeks and 9 weeks into the work placement. Text from these records were included in the analysis
- Written action plans arising from one to one careers guidance interviews with RAGU careers advisers and the refugee. Text was included in the analysis
- Field notes and observations made by careers advisers as the project progressed

The profile of the refugee professionals in this study was as follows:

- Gender: five males and four females
- Ethnicity range included: Middle East, West Africa, Horn of Africa, North Africa and Central Asia
- Work experience in the UK: four had worked in Britain (two employed by the NHS, one in the private sector, and one in the voluntary sector)

None of the respondents were registered with the relevant UK professional bodies at the time of the research, although seven were actively working towards registration and had reached different stages of this process. However all, except for two of the refugees, were qualified and registered professionals in their own countries, except for two. Seven out of the nine refugees had degrees and post-graduate qualifications.

All the refugee professionals had permission to work: seven were unemployed and two refugee professionals were employed in the NHS. The refugees' overseas work experience in their professions ranged from 1 to 15 years.

The following table shows the work placement roles developed for the seven refugee professionals.

Previous profession	Work placement roles
Medical Engineer Technician	Placed in 2 hospital engineering departments. Carried out servicing, repairs and maintenance of a range of equipment, wrote reports, department administration including data input, training of staff to use equipment, patient interaction on wards, extensive team working.
Biomedical Scientist	Worked as medical laboratory assistant in two hospital sections, carrying out extensive team working, monitoring stocks, handling enquiries, and laboratory administration.
Dental Surgeon	Primarily an observation role in a range of dental clinics and mobile units in the community dental service. Networked with dentists and dental nurses, reception activities, visits to general dental practitioners conference, attendance at professional body conferences and events, health promotion, discussion on modernisation of the service and an introduction to a consultant in the specialist field. Limited contact with patients, no clinical experience in dental nurse role (this could have been developed).
Nurse	The role developed from Health Care Assistant to a student nurse role on an inpatient ward: direct patient contact pre and post-operative care, extensive team working and use of digital equipment.
Medical Doctor	Undertook observation in nurse practitioner and GP clinics, patient reception work with direct patient contact, inputting data, case histories, taking vital signs, medical tests, case discussions and applying dressings
Medical Doctor	Observed child health doctors and other health professionals in community settings; clinic and home visits – limited patient contact restricted to taking vital signs and urine tests
Medical Doctor	Observation of consultant's and doctor's clinics, direct patient contact in allergy testing, blood sampling and checks, patient administration and computerisation

A description of how these roles were developed follows in chapter four, section 5.5.

1.5 Identifying NHS managers for the research

All seven NHS managers who supervised the NHS work placements agreed to participate in the research without objection. These managers were interviewed one week before the work placements started (except for one

manager interviewed in the second week of the work placement for logistical reasons). All managers had had access to written material about the Diversity Works project from RAGU and the refugees' CV before the first interview. Second interviews took place from the 8th to the 10th week of the work placement.

In addition two HR managers, one from each Trust, were interviewed once towards the end of the work placement programme. Both had been central to the work placements project being incorporated into their Trusts and involved in initial negotiations to set up the projects. They had therefore been exposed to discussion and information about workforce, diversity and refugee issues prior to the interview. It was felt of real value to interview HR managers for two reasons: first in order to gain insight into the views of those managers with specific responsibility for development of policy and practice in equality and diversity issues in the NHS workforce and secondly to compare these with the views of NHS managers with hands on experience of supervising refugee professionals on placements.

Interview questions with NHS managers included the following topics: participants' professional background, their knowledge and experience of equality and diversity issues in relation to the workforce, knowledge and experience of refugees in the labour market and workforce, expectations of work placements, support needs during work placement and the impact of the work placement on their professional knowledge and experience.

The range of professions and specialisms of the NHS managers included:

- Senior nurses
- Managers of specialist departments in the Hospital Trust.
- Managers of Primary Care Trust teams
- Human Resource Managers

All the managers had responsibilities in recruitment and retention of staff in their teams. All managers supervising work placement had experience of working with refugees as patients. Four managers had previous experience of working with refugee staff. Further break down was as follows:

- Gender: two managers were male, seven female.
- Ethnicity: black African, black UK and white UK.

Chapter 2

VIEWS AND EXPERIENCES OF NHS MANAGERS AND REFUGEE PROFESSIONALS

Chapter 2

VIEWS AND EXPERIENCES OF NHS MANAGERS AND REFUGEE PROFESSIONALS

Personally it was very beneficial to me, and I'm sure it was very beneficial to them. I enjoyed it, it was really good experience for me.

Refugee professional

I'd never met a refugee before as a professional person, as a patient yes, and it's very good to see him here he is with all his skills…. and he is putting them towards something he knows. I value him personally and he is valued on the ward by the staff, he's very capable and willing to help.

NHS Manager

Contents:

This chapter reports and contrasts the experience of refugee professionals and NHS managers before the work placement and after the work placement and describes the outcomes for the refugee professionals following work placement. The findings focus on refugee professionals' and NHS managers':

- **prior knowledge and perceptions** of each other before the work placement.
- **perceived benefits and learning** as a result of participating on a work placement programme.
- **outcomes following work placements** for the refugee professionals

PART A: NHS MANAGERS

2.1 NHS managers' knowledge of refugee professionals.

Research findings are drawn from interviews with NHS managers who supervised the work placements. The findings can be set in the context of the Department of Health (DoH) Equalities and Diversity Strategy and Delivery Plan to Support the NHS. The DoH, recognising that a lack of knowledge within the NHS can serve to reinforce obstacles to employment for refugees and other socially excluded groups cites:

> *…reluctance by Trusts to address equality and diversity matters based on a **lack of direct evidence** of a particular issue…*
>
> DoH Equalities and Diversity Strategy and Delivery Plan to Support the NHS (2003)

The views expressed by seven NHS managers in this study about refugees, prior to their contact with a refugee on work placement, may serve as evidence of the extent of knowledge and the perceptions held by NHS managers and NHS practitioners on equalities and diversity issues more generally. Managers were not self-selected and their views about refugees unknown. The findings identify and provide information about the factors that can influence the relationship between the NHS and refugee professionals as a potential workforce.

RAGU's prior experience of managing work placements across a range of employment sectors supports the notion that organisational knowledge held by managers and front line staff about specific groups in relation to the workforce is fundamental to bringing equality and diversity strategies into practice.[10]

In this study four out of nine managers stated they had previous experience of working with refugees as staff members, and six managers had contact with refugees and asylum seekers as a patient group.

The study sought to determine the extent of NHS managers' knowledge prior to contact with refugee professionals on work placements. This knowledge of refugee professionals can be summarised as:

- Overseas professionals face re-qualification hurdles. However no reference to issues specific to refugees was cited such as: funding, language barriers, and qualification equivalence
- Language and communication skills may be insufficient for the work place and prevent entry
- Adaptation to culture and organisational practice was essential and may pose problems for refugees without UK experience. (This was not cited as an issue for overseas recruits in general and suggests an unacknowledged prejudice)
- Long-term career goals versus the short term reality may conflict for refugees
- Refugees are forced migrants, not voluntary overseas recruits.
- Refugees face uncertainty and stress in relation to their immigration status
- Refugees may have experienced considerable trauma

Findings also show that **NHS managers demonstrated limited knowledge or awareness** of employment issues that impact adversely on recruitment and retention of refugee professionals. These specific issues are:

- Re-qualification obstacles faced by refugee professionals and not experienced by overseas NHS recruits
- Recruitment practice may prevent entry for refugee professionals to the NHS unfamiliar with the process and without professional networks

[10] Heard S., Salmon L., 2004. *Diversity Works Report 2004.* The Refugee Assessment and Guidance Unit, London Metropolitan University

- Rights and entitlements of refugees to work in the UK
- Intermediate or alternative roles for refugee HPs and AHPs

Set against this limited knowledge, five work placement managers demonstrated remarkably **high levels of empathy in regard to refugee professionals experience** of living in the UK and being professionally 'disenfranchised' as shown by the comments below:

> *everyone has turmoil in their lives but nine times out of ten our turmoil is controllable something within the home, but if something is going on, so many miles away…*
>
> *The one thing you'd want to know is that your family's safe and happy, really, safe and well….and it's the one thing you can't find out, an awful situation …*
>
> *It's difficult for someone who's been a doctor with so much autonomy and so much influence in the community to be starting from scratch. …If they want to get there then whatever it takes they will.*

Employment is known to be a significant factor in the settlement of refugees[11]. In addition to empathising with refugees, four out of seven work placement managers clearly identified employment as an important factor in the integration of skilled refugees into UK society. One manager commented:

> *All that experience and skills going to waste if you don't incorporate them in the labour market. The person's coming to work, to learn some skills and earn a living and contribute to the country, they're trying, and they're there for the bigger picture. Like the rest of us eventually they'll earn a living and pay tax and be integrated into schools and whatever they want to really do in life.*

Prior to placement all managers expressed **positive views of the contribution refugees** could bring, (alongside a real concern about refugees' level of language skills). These positive views are described below.

Five work placement managers identified the role refugee professionals could fulfil in the NHS workforce **meeting specific NHS skills shortages at professional level**, as well as in the wider labour market.

> *The people arriving in the UK are qualified professionals that may need assistance to demonstrate it. At the moment we've got a deficit of dental nurses and this programme highlighted to me that perhaps we need to be looking at programmes or organisations to see if maybe we can increase the number of dental nurses.*

[11] Carey-Wood J., Duke K., Karn V., 1995. *The Settlement of Refugees in Britain.* Home Office Research Study 141

In a lot of the professions in the NHS, it's difficult to recruit. Historically the NHS has been regarded as the workforce with low pay, so people coming out of college or deciding on a profession will go for something which perhaps is going to give them more remuneration. So introducing refugees into the NHS I think is very positive in as much as it gives us another possible avenue in which to recruit.

In addition to refugee professionals contributing skills and expertise to the existing labour market, four out of nine NHS managers (two Human Resource managers views are inputted) identified that **refugees bring 'added value'.** This was cited in terms of refugees bringing additional community language skills, diverse clinical experience and knowledge of diseases and resourcefulness.

…refugees can show us other ways of doing things. We are so reliant on the technology - it's good to be there with the patients instead of relying on the machine for all your answers.

Refugees were not only viewed by NHS managers as a skills bank for the workforce. Four work placement managers expressed positive attitudes in relation to **refugees' high level of motivation**:

If somebody's got the guts to get out of the country, to put up with all the crap that goes around getting out of the country then they're likely to be motivated and possibly able to very easily fulfil the job.

The process through which an overseas qualification is achieved takes a lot more skills and practice - there's an extensive discipline that goes into learning from a developed country …… I am speaking from experience.

Finally two managers commented on the fact that refugees in the workforce were valued as **refugees' retention rates are higher than overseas recruits**. One manager explained:

Refugees from my experience of working haven't got the same level of confidence (as Australians) but they're here to stay. If you're getting Australians, they're coming over for their two-year European trek and they work hard and they're good workers. But for the refugee workers for most of them this is going to be their permanent place of living….

NHS Managers' positive perceptions of the contributions of refugees play an important factor in enabling refugees to compete in the recruitment process on a more level footing. NHS managers views, elicited prior to placements, were enhanced after they had managed refugees in work placements.

By contrast with many positive perceptions, NHS managers indicated concerns and negative perceptions about incorporating refugee professionals into the workforce. We suggest that **managers' lack of knowledge and**

unacknowledged prejudice and may offset managers' positive perceptions and impact indirectly on the recruitment and retention processes.

Some NHS managers presented negative perceptions as an institutional or societal prejudice, though it is unclear to what extent this masks personally held views. Over half the NHS managers expressed a range of views highlighting refugees' 'otherness' and difference in terms of their skills and experience. They valued 'seamless integration' as illustrated by one manager who stated after the start of the work placement that the refugee:

> *came in quite seamlessly, fitted in very well in the team*

Evidence of NHS managers sense of refugees as 'other' may also explain the majority assumption that refugee professionals' language fluency would present problems for those placed in their teams, even though most managers had neither met nor interviewed the refugee to be placed in their team. It was not only language skills that NHS managers questioned. Although all managers recognised that the refugee professionals were skilled, having seen their CVs, there was an assumption openly expressed by one manager that the refugees' experience would not be of equivalent value to UK experience.

> *If they (refugees) do have experience but they're coming from another country, one tends to assume that their experience is going to be somewhat limited and some countries do obviously vary quite significantly from others. So there's if you like you are always going to treat it (refugees) with an element of reservation.*

Recent research[12] suggests that an 'ethnocentric credentialism' operating in the labour market results in **employers consistently undervaluing refugees' overseas qualifications and experience in relation to UK experience.** This inadvertent racism is further evidenced by managers' comments.

Managers expressed views prior to work placements, which clearly indicated a preference for working with a team members 'like us'. Three managers positioned the organisation and society, rather than themselves as individuals, as placing greater value on a refugee who fits in and contributes as a means to reducing prejudice targeted at refugees. We suggest that this view inevitably places refugees as responsible for reducing prejudice, rather than societal attitudes transforming.

> *If the first refugee is going to be their flag flyer if you like and if they fit in well and are seen to be a positive enhancement to the organisation, then the people that follow them are going to get a lot easier ride.*

[12] Archer L., Sheibani A., et al., 2005. *Challenging Barriers to Employment for Refugees and Asylum Seekers in London.* Institute for Policy Studies in Education and the Refugee Assessment and Guidance Unit. London Metropolitan University

If refugees can be seen to be participating and fully functioning and taking their role within society then the prejudice from the general population does reduce.

In recognising cultural and experiential differences managers also identified the need for refugees to receive appropriate support. As one manager explained:

they (refugees) will have to be integrated into the NHS through support, educational, social and economic support.

The view that refugees are different to 'us' and therefore not valued unless they are seen to 'integrate seamlessly', fit in and participate fully sits uncomfortably with views on how group differences can be met in terms of meeting individual needs and developing a truly diverse practice.

2.2 NHS managers' experience of work placements

At the start of the work placement all managers expressed positive expectations about what they and colleagues would learn about and from refugees.

Hopefully he will actually talk about things and bring up things from his own experience that will open people's eyes.

It will be a very good experience for me and an eye opener in terms of understanding the needs of refugee qualified medical practitioners from other countries and how disadvantaged they are.

The study shows the impact of the work placements on NHS managers is twofold:

a) Work placements significantly changed NHS managers' attitudes: managers' stereotypes were challenged and refugee professionals were seen more clearly as a pool of skilled labour for the NHS; managers were more aware of diversity issues and the barriers faced by refugees entering employment in the NHS. Furthermore there was an increased awareness of the issues that refugee patients experience.

b) Work placement directly benefited NHS managers and their teams by increasing skilled staff in the teams and providing professional development opportunities for the team members. Additionally NHS managers observed team members increased appreciation of the UK health systems equipment and resources in comparison with that available in some developing countries. Managers also identified work placements as a useful recruitment tool for their teams and the organisation.

These two findings are now explored in more detail.

2.2.1 Work Placements Change NHS Managers' Attitudes

- **Managers' stereotypes are challenged**

After the work placement, six out of seven work placement managers said how well the individual refugee fitted in with the team. This may suggest that they anticipated this would not happen or would be a potential issue, that the refugee would not be 'one of us'. The discourse used by employers[13] about the need for 'seamless integration' can be understood as unwittingly racist. These positive comments support the finding that work placements changed NHS managers' attitudes towards refugees:

- *A very valued member of the team*
- *He has made a real contribution to the team, his personality has made it easy to accommodate him…. Staff are very admiring of him*
- *He settled in so well that I think neither he expected to go at the end of it or the staff here didn't expect him to go at the end of it*
- *He's very very helpful, he works very nicely alongside the trained staff.*
- *It's been very positive. He was a good first person to have because he's interested, he's keen to get on and he's taken charge in some respects and if we were short he said oh would you like me to do that and I can do this as well. So he's worked part of the team, very much so and I think that's really good*

By contrast one NHS manager did not express the view that the work placement had benefited her team in the short-term, but that it would in the long term. This arose from a specific experience on the work placement related to cross cultural issues and explored later.

In the same vein concerning notions of refugees 'fitting in', NHS managers expressed varying levels of caution before the work placements in terms of refugees' ability to communicate, their ability to adapt to the culture of the organisation and the value of overseas experience.

After the work placements NHS managers demonstrated a shift in perception about refugees' abilities and skills levels as evidenced by the following statements.

> *I find XXXX (name) very similar in his capabilities to the overseas nurses that come and I was well surprised that he's as capable as they are.*

[13] Archer L., Sheibani A., et al., 2005. *Challenging Barriers to Employment for Refugees and Asylum Seekers in London.* Institute for Policy Studies in Education and the Refugee Assessment and Guidance Unit. London Metropolitan University

(communication) was going to be one of my reservations to begin with because I thought there would be a lot of problems trying to understand each other and them trying to understand us, and also to fit in the culture and we didn't experience any of that at all with KKKKK (name).

With the experience that we've had we would consider people such as our placementee in a more positive light.

This latter comment suggests the manager still holds ideological reservations and stereotypical views despite the positive experience of working with a refugee. It is illustrative of the racialisation of 'refugee' identity and the difficulties that individual refugees experience in breaking through to mainstream employment.

One manager was open in acknowledging her own and others possible prejudice about seeing refugees as low skilled and 'rubbish'.

….the last person we had from there was rubbish, they couldn't this, that or the next thing, even though they said they were a qualified nurse, doctor or whatever else. So it's about being very clear that the people actually can carry out the skills that their qualifications pose that they can because it's a bit like the ambassadorial thing isn't it. People are, we're all a bit prejudiced to some extent and if they come across something they think, oh well.

Managers regarded refugee professionals in the workforce as role models for the refugee community, placing a disproportionate burden of responsibility on the individual representing a socially excluded group. One manager voiced this with some underlying concern:

If the first refugee is going to be their flag flyer and if they fit in well and are seen to be a positive enhancement to the organisation, then the people that follow them are going to get a lot easier ride. But if you get a couple of people who come in and are actually quite difficult to work with, for whatever reason, regardless of the fact that they're refugees, then the ones that come in after are going to have a difficult job.

These views underpin the importance of providing both refugee professionals and NHS managers with training before work placements start in order to raise awareness of each others' culture and a reflective space to understand underlying prejudices and fears that each group may have about the 'other'.

The racialistion of 'refugee' identity was illustrated clearly in the issue of how to introduce a 'refugee' to the team. This was discussed during an initial interview, before the work placement began with one manager. The manager reflected openly on her own reservations in introducing a 'refugee' to the team and whether using this term would evoke a negative response:

I would really not like to introduce the person as a refugee particularly, just someone from another country who needs work experience. But if I

use the word 'refugee' I think that's quite an emotional word to use and that could, I don't know what that might bring up because I've not worked with refugees and I don't know how other people would feel. But, if I did use the word 'refugee' then I'd get an idea really of how they were feeling about it.

The manager introduced the refugee as an experienced health professional on work placement, not as a refugee. During the course of the work placement the refugee shared his experiences as a 'refugee' with colleagues who asked. He felt accepted into the team and commented:

> …no such difficulties in my placement, there was no cultural differences, it was just straight away looking at our job. Everybody was helpful, helping each other.'

It is worth questioning however whether a 'colour blind' approach was being used here in order to 'ease' a potentially difficult situation, rather than using the experience to develop NHS employees awareness of diversity issues and specifically of refugees.

Following the work placement the same manager's perceptions had changed from her initial views.

> I'd never met a refugee before as a professional person, as a patient yes, and it's very good to see here he is with all his skills…. he is putting them towards something he knows. I value him personally and he is valued on the ward by the staff, he's very capable and willing to help.

This manager's openness and willingness to reflect on her personal perceptions from the start was a significant and positive factor in making this particular work placement successful and effective for the individual and the team. It demonstrates **the value of work placements in exposing NHS teams to refugee professionals as a mechanism to raise their awareness of a socially excluded group and challenge unconscious racist perceptions.**

Another manager presented an apparently contrasting view in introducing refugees to the team:

> *The tag 'refugee' is to some extent a positive thing because it says if somebody is prepared to come and do this* (an unpaid work placement) *then the likelihood is they are prepared to work, fit in and to get on…*

On the face of it this is a positive view of refugees and their ability to adapt. However it repeats the idea that refugees hold the responsibility to change and 'fit in'. 'Fitting in' is a pragmatic strategy, adopted by many refugees. However an acceptance of this mechanism by organisations leaves the perception of refugee as 'other' unchallenged, and counters serious attempts to introduce workable diversity management programmes. Individual NHS

managers and staff participating in work placement programmes can assert positive organisational change in attitude to racial and cultural diversity through their experiences.

Mutuality in terms of cultural adaptation places the responsibility for diversifying a workforce at the individual and the organisational level. An appreciation of this was illustrated by one work placement manager discussing the changes that both the refugee and staff had needed to make for the work placement to be effective.

> *…. language, communication, and culture to the placementee are a culture shock. For the staff who are already in that environment it's also a culture shock to them. The staff are adapting and the placementee is also adapting to be able to meet on a neutral ground.*

This is a clear demonstration of how effective the work placement experience was in challenging and changing attitudes.

One of the key aims of the Diversity Works project is to practically address the NHS equality and diversity agenda by initiating a positive action programme. In the single issue of how to introduce a refugee on work placement into the team there is scope for a targeted NHS employee and organisational awareness raising by challenging perceptions. For many staff a refugee professionals on work placement may be the first time that they are aware of working alongside a refugee in their team. In our experience however, it is not unusual for refugee staff within existing teams to conceal their status and specific needs, because of racist attitudes. Work placements are an opportunity for the NHS to learn about refugees' professional and personal needs in order to develop practical measure to enable refugee professionals to contribute to the workforce more effectively.

Mechanisms for raising awareness in the team can be through a number of channels: primarily from the refugee themselves as an educator and secondly through Trust-wide promotion of the project through newsletters, RAGU meetings with teams and managers beforehand and team members' access to information about the project. A range of these approaches will increase awareness in all sections of the Trust.

Following work placement, managers' statements indicated that initial perceptions and stereotypes had been challenged and changed. This is highly significant in terms of developing a more socially inclusive workforce. Two managers commented that their own perceptions and that of their team members had changed as direct result of contact with a refugee professional.

> *It's been a learning curve - someone destitute but with skills and a professional background.*

> *It also helped the rest of the staff and myself to understand that refugees, even if they're only here for a few days a week can be very effective part of the team.*

Very significantly changed perceptions and increased knowledge can positively impact on managers recruitment practice. As one manager commented:

> *It will be more possible to address 'apprehensions' in a panel, with regard to recruitment of applicants from overseas.*

Although she said she would still shortlist on the basis of a refugee's skills and experience meeting the person specification.

These comments should encourage organisations committed to implementing equality and diversity practice to participate in work placement projects as a tangible means to change staff attitudes.

- **Work placements increased awareness of NHS equality and diversity policies in practice**

Prior to work placements all managers, except one attended their Trusts Equal Opportunities and Diversity training and all managed multicultural teams. There was a consensus by managers that training was of limited use and they wished for more hands-on experience and monitoring of processes. Following work placements, four managers spoke about how the experience helped them reflect on issues in relation to Diversity Management within their teams. For example, in reviewing an individual placementee's needs one manager found herself reflecting more specifically on her existing staffs' individual needs. A second manager felt that it would help to have more information about the specific support needs of refugees as staff members:

> *We need some awareness what it means to be a refugee, in the press the information is very negative…… I would like some stories of what motivates people and how best to support them. We know what support staff with bereavement or divorce need, but this maybe is another need of support.*

The views of managers indicated that following work placements they were engaging with diversity issues in relation to refugees and their staff more consciously.

By contrast one manager's comment seemed to show a lack of awareness of diversity issues and individual needs following work placement:

> *It is no different to the things that we do for anyone coming from abroad, they may have one more thing to encounter …. their refugee status.*

This was the same manager who had not accessed Diversity training. We suggest that providing staff with effective training, plus drawing on managers' work placement experiences is important if the NHS Equality and Diversity

Agenda is to become an integral practice in the NHS.

- **Increased knowledge about issues impacting on refugees as workers and as patients**

Eight out of nine managers said that as a direct result of the work placement, they and their teams had gained an increased knowledge and awareness about refugee professionals, the obstacles refugees experience and the support they need in order to enter work in the NHS. Some managers reflected on the adjustments and challenges of refugees leaving secure jobs, their countries and a new life in the UK:

> *I now perhaps perceive more the difficulties that they must encounter not only coming to this country but being able to live here and get employment.*
>
> *They (the team) find him really fascinating because they do respect the knowledge that he's got and the fact that he's actually left and come over to England. When they speak about him it's very admiring what they're saying, you know how hard it is, so I think that's really positive.*

Other managers commented on the difficulties of refugees gaining UK work experience recognised by an employer, (with the notion of credentialism of experience), and the difficulties of gaining inside information about people and organisations:

> *I can see why the placements are important in as much as that one of the first thing I think a prospective employer does look at is a person's experience. It's not only the experience of actually related work, it's actually working in an environment similar to the one you are in.*
>
> *(Knowledge of refugees) …it's gone from zero, I wouldn't be presumptuous enough to say that it's 100% because I think what it's done is opened my eyes to the issues that people can face if they come to the NHS but also their lack of knowledge of institutions in the UK.*

Even with increased awareness of the issues refugees face entering the NHS, several managers said that if faced with recruitment of a refugee they would not change their recruitment practice, they would recruit according to equal opportunities practice and not feel justified to fast-track refugees.

Five out of seven managers said that their awareness of what refugee patients may be going through had increased as a result of hosting a refugee on work placement.

> *….you don't appreciate the hardship that's happened that you don't know about…….just looking at someone dressed well and looking clean and tidy and everything else you can't appreciate what a struggle it's been to get into there really. ……..even me actually just looking at*

a patient, as a refugee I was very sympathetic but now I think it's quite admirable really to think that they've actually got this far'

This is an additional benefit in NHS staff delivering equality of health care to a socially excluded group that they may not have had information about.

2.2.2 Work placement directly benefited NHS managers and their teams

All nine managers recognised refugees professionals as a pool of skilled labour for the NHS and commented how they had benefited from the contribution of a skilled and experienced refugee within their team, (prior to work placement six managers had identified these points).

Two managers said that the work placements had reinforced their perceptions that skilled refugees need to be invested in to address NHS skills shortages and empower the individual.

The project (Diversity Works in the NHS) has convinced me even more that we accept refugees with skills and then prevent them exercising these skills. If we accept refugees we need to invest in them not accept people into a culture of dependency. They will bring real benefits to the workforce.

From the time (refugees) arrive in the country their skills should be identified and their professional background - how can we utilise it. Because there is a deficiency within the healthcare profession and to let a refugee go through a long process and protocol it's of benefit to no one and important so they don't lose their skills.

Five out of seven work placement managers described the benefits of having a skilled extra staff member especially during summer vacation time.

There's always a staffing crisis in our service in as much that we had an extra person who was able to fit into the team and be a valuable part of that team and that in itself helped us enormously. We would be getting extra help at no cost to ourselves….

Managers view work placements as a useful recruitment and professional development tool for their teams and for the NHS. Three managers viewed the work placements as a cost-effective tool to induct potential recruits and assess their employability before employing them.

We have used this type of avenue in the past as a form of recruitment.

Work placement is a luxury induction….

Three managers considered how they could retain the refugee within the team or encourage their return after work placements. Six managers said they would be prepared to write references if asked by the refugee.

> *I would like [him] to join the staff, I think he would be very beneficial joining the staff here. And that would be an advantage to the Trust because, well for one thing they can advertise internally, and he would see the job you know without costing them money it would just be their own advert from Human Resources. And he's got a lot of how the Trust runs and how the ward runs, information from being here for so many weeks now, so he's already got a very good induction…*

Managers already considered Positive Action programmes and in particular, work placement as beneficial in terms of additional staffing and a source of potential skilled recruits prior to placements. Work placements reinforced this view:

> *Certainly it's good that we know about these opportunities.*

NHS team members benefited from supervisory opportunities made available during the work placements which provided professional development as explained by one manager:

> *We have someone able to contribute, albeit supervised and it's very helpful to the team. The cost is the time spent to explain. However the cost is up front and staff benefit from explaining what they are doing. It improves their practice in the process of answering intelligent questions.*

Furthermore as a result of NHS staff talking with the refugees they gained an increased appreciation of the UK health systems equipment and resources. For example three managers commented that as a result of discussing comparative clinical experiences in different countries, teams' awareness and appreciation of the equipment and facilities available in the NHS had greatly increased.

PART B: REFUGEE PROFESSIONALS

2.3 Refugees professionals' knowledge of the NHS

One of the factors that may mitigate for or against refugee professionals accessing vacancies in the NHS is their prior knowledge about the organisation as an employer, as well as how to access and apply this information in the job search process.

Interviews with seven refugee health professionals (HPs) and allied health professionals (AHPs) were carried out prior to their exposure to the NHS through participation on the work placement programme. These findings may also indicate a more general level of knowledge within the refugee community.

Prior to work placement the seven refugee respondents demonstrated very limited knowledge of the following:

- Access to NHS vacancies via web sites
- Access to information via Workforce Development Confederations
- Structure of the NHS: PCT, acute and foundation hospitals
- Policies, protocols and developments e.g. CHI, NICE, Patients' Charter
- Communication routes within the NHS
- Career routes and specialist vocational training
- Importance of and access to professional networks
- NHS recruitment procedures and networking skills.

A minority of refugee respondents knew about NHS web sites advertising vacancies. However none were aware of the relationship between HR departments, Workforce Confederations and Strategic Health Authorities, their respective roles in processing recruitment and how to approach Trusts effectively, (although this is also manifestly confusing to many members of the public).

Refugees accessed information through refugee agencies, friends, and specialist training for refugee health professionals. Few had were aware of or had looked at NHS or DOH websites. The ROSE website, (www.rose.nhs.uk), developed by the NE London Workforce Confederation, is a valuable tool filling this gap for refugee professionals and for refugee agencies and NHS managers.

This limited knowledge of how to access NHS vacancies impacts directly on the exposure to vacancies among the refugee community. The NHS therefore has a role promote recruitment in the ethnic minority press by networking with refugee community groups and refugee agencies.

Only one refugee was clear about professional routes and alternative careers in the NHS prior to the work placement programme due to previous attendance on a structured orientation programme for professional refugees at RAGU.

However, most respondents cited that the NHS was the largest employer in the UK, and the environment was seen to be progressive in terms of jobs and training. All respondents were aware of the technological differences and cultural differences in terms of greater levels of organisation and teamwork in the UK compared with their experience in their countries of origin. Two refugees commented:

> *They [NHS employees] concentrate on working in teams and working under supervision*.
>
> *They can expect me to work in a team, to accept the NHS policies, to respect my colleagues, to behave particularly with my patients and help them, to stick to time……*

All respondents were aware of the shortage of a skilled workforce in the NHS though not the specific professions where shortfalls occur. There was implicit frustration that their skills could not be used to fill these posts as evidenced by one refugee:

> *on the one hand they have shortages but also they (the NHS) make obstacles*

All respondents recognised the role they could contribute in addition to their professional expertise. One of the refugee NHS employees interviewed cited:

> *Especially in London it's a multicultural society and they have patients from all over the world so I think it's very useful also to have employees from different cultures, different backgrounds.*

Some refugee respondents demonstrated awareness of the cultural differences for example in the relationship between doctors and patients, in the UK compared with that back home, although they had no direct experience except as patients themselves. As one refugee explained:

> *Back home he (the patient) relies totally on you, he says you are my doctor. In my country the environment is totally different and the hierarchy is very high.*

There are few refugee professionals working in the NHS at grades commensurate with their experience. Additionally the difficulty refugees and asylum seekers experience accessing health care may reflect the lack of targeted health promotion within refugee communities.

The findings in this section demonstrate the importance for the NHS in raising its profile both as an employer and health care provider informed by equality and diversity practice within refugee communities. NHS Workforce Confederations and individual NHS Trusts will need to network effectively into local communities to reach socially excluded groups. The findings also highlight just how important it is for refugee HPs and AHPs to research the NHS as an employer using a variety of tools.

2.4 Refugee professionals' aims in NHS work placements

The seven refugee professionals participating on work placements were unanimous in their desire to gain work experience, specifically in the NHS. They identified their learning aims prior to the start of the programme as:

- **NHS specific skills and knowledge**:
  This included a wish to experience UK team working: specifically relationships between health professionals and with patients, to experience new technology, clinical equipment and systems, to

understand NHS organisation and its culture, policies, procedures and protocols. Two refugees stated this as:

> *I never had the opportunity to work with patients.*
>
> *I would like to find information about how hospitals in the UK work and how do I deal with staff in the hospitals, techniques and technologies in the hospital*

- **Generic skills for the labour market:**
  This included communication skills appropriate to the workplace, to create networking opportunities, to experience problem solving opportunities and to demonstrate initiative and an ability to work under pressure.

- **Career information** including access to vacancies and knowledge about progression routes in the NHS.

All refugee respondents recognised their assets for the NHS in terms of contributing community languages, professional experience and knowledge.

2.5 Refugee professionals' experience on work placements

All the refugee participants enjoyed the work placement and found it to be a significantly positive experience.

The findings show that all the opportunities originally identified by RAGU and the refugees as likely benefits for refugee professionals on work placements were achieved. In summary these are:

- Increased knowledge about the NHS as an employer, the structure and culture, career paths and networking opportunities
- Experience in UK clinical practice including patient interaction, specialist technology and equipment
- Increased levels of confidence in terms of gaining UK work experience, language and communication skills

Most significantly following work placement refugees **identified three additional benefits** summarised as:

- Improved health during the work placement
- Opportunities to represent refugee professionals in the work place
- Experience of working in a multicultural team

Each of these three additional benefits is considered first in more detail below, followed by a discussion of the other benefits.

2.5.1 Improved health while on work placement

There was a hugely positive impact on refugees health as a direct result of making headway in employability and experiencing a return to the work place. This is supported by RAGU's experience over several years of managing employment programmes. In our experience many refugees present a 'brave face' on their situation and frequently do not wish to focus on or discuss how their situations place strain on their mental health. Research shows that refugees and asylum seekers may present with high levels of mental health problems[14] as result of their experiences prior to the UK and in settling in the UK. The findings from this study show that refugees derive health benefits from participating on work placements as clearly illustrated by these comments:

> *The work placement was a good experience, it kept me busy every day, that helped me psychologically and rescued me from a depression.*

> *……to be honest I was depressed, I was tired, all those things, despite that I was helping, working in my community. But I still had that feeling deeply in my heart of working as a proper doctor…. I didn't know exactly what was the placement but now, I can see the difference of my intentions at the beginning and now, it's great.*

If the mental health of refugees improved during the work placement then refugee agencies need to be alert to what follows after. As one refugee respondent commented:

> *1000 refugee doctors and only 50 who are working, that's not very helpful. I don't want to go back to my depression no way but it just seems, to think of it is difficult after the work placement.*

Sound follow-up after work placements is vital. Guidance by specialist agencies to support the refugee in their continued career development, building on their confidence and positive experience is an important aspect of managed work placement programmes. Several managers also highlighted this view during exit interviews.

2.5.2 Opportunities to represent other refugee HPs

RAGU has made clear to refugee professionals on work placement projects that they may find themselves perceived as representatives of the refugee community in the UK in organisations where there is no experience or knowledge of working with refugees. This representational role can be burdensome or very rewarding. The latter was experienced very clearly by a refugee who attended meetings and professional seminars with his manager.

[14] Burnett A., Peel M., 2001 (b)., *The health needs of asylum seekers and refugees.* BMJ 322:544-7. Available at: www.bmj.bmjjournals.com

He took the opportunity to raise issues about obstacles faced by refugee professionals entering employment in his field of work.

> *I attempted at the (professional body) meetings, PCT meetings and Community Care meetings to put my suggestions and I tried not to be ignored as a refugee (professional) speaking for other professionals in this work.*

This suggests that a powerful tool in tackling barriers to employment is the promotion and support of refugee health professionals to represent and advocate for refugees themselves with NHS managers and policy makers.

2.5.3 Working in a multicultural team for the first time

Six out of seven refugees found themselves working in multicultural teams, of which they expressed a real appreciation. A majority of those interviewed had worked in relatively mono-cultural work environments in their countries of origin so this was a significant and new experience for them as they explained.

> *….I have never been working in such a multicultural community. It has been beneficial for me, I learnt a lot of things.*

> *It's really multicultural and diverse backgrounds, I never work in such a multicultural team……It was really interesting, because everybody was sharing the things about their countries, about their traditions, sometimes even in family situations….., and that has really opened my mind, I really liked the team…….*

One of the aims of the project was to promote the diversity and social inclusivity within the NHS workforce. The project served to expose both refugees and NHS staff on the project to an increased experience of multicultural team working. Refugees attending RAGU's pre-placement training are also introduced to discussion and role- plays to highlight multicultural approaches to team-working.

2.5.4 Increased knowledge about the NHS: service provider and employer

The findings demonstrate a considerable increase in knowledge and experience of refugees about the NHS as a service provider and as an employer are a direct result of attending the work placement. This increased knowledge suggests that refugees may be better equipped to compete in the general labour market and specifically in the NHS recruitment process. These areas of increased knowledge are detailed below.

A. NHS as a Health Care provider

A majority of the refugee respondents were impressed by the standards and delivery of the health service provided by the NHS, even though some had 'inside' knowledge as patients. For example this was highlighted in the comparison of health professionals per patient ratio observed in one team which was enormously higher in the UK than in Ethiopia. Most refugees recognised that differences were probably a direct result of the economic status of the UK in comparison with their countries of origin.

Three refugees were strongly impressed and surprised by **the level of commitment** demonstrated by the health care professionals in the UK.

> *When I am seeing how people are, they are working very hard and they don't consider what they are earning doing the job. They are giving their skills, giving their talents…..I see a nurse working more than 12 hours a day, I see this is a sacrifice, giving all your time to save people's lives….*

After several weeks a refugee commented that while he had high expectations of NHS health care and excellent facilities available, he came to observe first hand the problem of staff shortages and the reality of patient waiting lists:

> *In my work placement and in hospitals, the treatment process for patients takes a very long time but in my country the treatment process is very rapid. That's because of bureaucracy and paperwork. I think the main part of waiting list in the NHS is because of paperwork. Otherwise, I saw a great profession, excellent equipment and materials.*

All refugees commented and were repeatedly impressed by the **patient centred service** they observed and the focus on preventative health care.

> *I love that the service is first for children, elderly and disabled people which I met here. In my country the Government doesn't care about pensioners or children.*
>
> *I realised that they work on prevention more than treatment and that was great.*

These comments suggest the experience that refugees gain first hand during work placements may act as a powerful tool in promoting the NHS to the refugee community as a health provider. Indeed one refugee said he would relay his positive views to refugee friends and thereby increase access to health services within his community.

B. NHS as employer: work culture and cross-cultural learning

How important is it for refugees to gain experience of the NHS work culture? One of the HR managers commented in a published article after the work placement programme that:

> *"… refugee candidates are often turned down for work in the NHS because of a lack of understanding of the work place culture, rather than lack of skills….the workings of the NHS can be seen as complex and heirachical by people who have never worked in the this country before"..*[15]

The findings demonstrate how the work placements provided all the refugees with opportunities to learn about cross-cultural issues: some similarities but mostly differences in practice were identified by all the refugees in relation to team working, patient and management relationships. This is valuable information for refugee agencies and NHS Trusts who establish work placement programmes to take account of (for example on pre-placement training).

Four out of the seven refugees, for example, commented on the **open management style** operating in the NHS which they enjoyed. This is for most a significant difference from the management styles they experienced in their countries of origin which are more authoritarian. Comments included:

> *Here, he (the manager) is part of team and open, there, it is more directive and hierarchical.*

> *…coming from my country the manager doesn't have to come to the workshop he is just sitting in his office and giving orders. In the UK the manager is one of the team, working with you trying to fit himself with you at your level, trying to do everything with you, to be more related to you ….*

> *The GP is working as a team with the nurse, even the receptionist is taking part in the team. We don't have that back home.*

Four refugees commented on the **high stress levels of NHS staff** they both observed and experienced and the long hours of work in the NHS, although they did not suggest that this had put them off working in the NHS.

> *It's more stressful, here, a greater work load.*

> *it's very different to me because here it's very different in the way they treat the patient and the way they, especially work..... work*

[15] Redford K., 2005. Positive Approach Reaps Benefits. *Personnel Today*. 23rd August 2005

placement is very very useful to see because since nine o'clock to six o'clock sometimes, seven o'clock, if the patient, all patient is not seen, nobody will move from there. I was very surprised to see this.

Although refugees commented on the cultural differences compared with 'back home' and their positive appreciation of those differences, this has implications for the way in which they would need to adapt their practices as health professionals as demonstrated by the comment below regarding **patient interaction**:

British people are very aware about their health. If you, I wouldn't say commit a mistake, if you say to him his diagnosis the next time he will come to you with knowledge, information and you start having a lot of questions! At home they see you like the god, whatever you say to them, they follow and they listen to you. If you say you have high blood pressure and you say look you have to do this, oh yes and he goes and he does everything. (Here) they tend to question, to argue your management and I think it's good because people are, it's much better if they are aware about their body, their health, and don't just leave it to somebody else to control.

The extent to which the refugees felt culturally integrated and able to adapt to a 'new' culture within the team was evidenced by several comments indicating that it was not an issue of great concern to this group. For example three refugees talked about the importance of 'fitting in'.

Coming from a different culture, you have to just fit your culture in. I learnt how other people think, all those things.

…. there were no cultural differences, it was just straight away looking at our job. Everybody was helpful, helping each other, they didn't look at where are you from, why have you come, what you are doing, what is your culture, nobody asked you, they are just working in the job, they are helping each other.

However there needs to considerable caution in reading refugees' efforts to 'fit in' as support for a process of 'seamless integration' of refugees into the workforce espoused by employers in recent research. [16] It flies in the face of NHS Equality and Diversity policies.

Nonetheless findings from this research demonstrate just how well **refugee professionals adapted to the teams** in which they were placed as evidenced by NHS managers comments. This can be attributed to refugee professionals' considerable efforts and desire to use work placement as experiential learning.

[16] Cf: Archer L., and Sheibani A., et al., Challanging Barriers to Employment for Refugees and Asylum Seekers in London.

C. The NHS structure and organisation

Most refugees commented on an increased knowledge and awareness of NHS protocols and policies with an appreciation of the quality systems in place to record data (patient or technical data). Four refugees commented on the extent and rapidity with which procedures change and the importance of continuous professional development.

> *I have noticed with NHS there is a lot of changes, too many, maybe every year or two years they are making changes. They don't give us time to breathe! The limited amount that we learn and as soon as we learn things they are making changes*
>
> *The difference it's busy and the technology keeps changing, you always have to update your skills.*
>
> *It was very useful and it gave me a lot of background and recent information working for the NHS.*

Key learning for refugees included an appreciation of how the **roles differed in the UK compared with those of refugee professionals overseas**, for example the responsibility and professional relationship between nurse and doctor. One refugee cited the case of nurses in Ethiopia whose role includes prescribing drugs and undertaking medical tests, while in the UK these responsibilities are assigned to medical doctors. UK doctors were also observed taking on responsibilities usually ascribed to nurses in their own countries and considered more 'junior' tasks. As one refugee stated

> *….it's really helpful for me for my future employment because I've got an overview of the UK, how it works here and how the National Health system is, the differences from the country where I came from, what are the responsibilities, how are they divided.*

Other refugees became aware of 'new' roles for example that of nurse practitioner, and of specialist opportunities available that they had not been aware of (for example in Ear Nose Throat).

All the comments refugees made about the NHS were gained from first hand experience and participation in NHS roles within work placements. This highlights the impact of work placements on increasing refugee HPs and AHPs' knowledge base in attempting to gain entry to the NHS.

D. Increased information about career paths, access to employment and networking opportunities in the NHS

Following work placements, all the refugees were much better informed about the roles and responsibilities, about their career paths and employment routes, including specialist training.

Three refugees stated that the work placement increased their knowledge about the reality of routes into and through the NHS, which they had not understood before work placements, as one refugee explained:

> *I am making more informed choices. Having the background information that I gained from the work placement gives me more assurance what I am doing is it right*.

None identified radically alternative careers they wished to follow as a result of work placements, rather all were more confident to identify their specific needs. One refugee stated that his work placement in a specialist unit had helped him consider alternatives to GP work, though in medicine, another identified a previously unknown route to pursue while undertaking registration.

> *At first, when I came here I thought I can go directly to hospital to start my work as a surgeon, and during this time I understand I have to go to some exams or work experience like clinical attachment. And the final decision for me has changed to become staff grade in surgery.*

Three respondents commented on an increased knowledge of NHS grading and structures. One refugee expressed dismay about the low salary in her field of work and re-considered whether this was the correct profession for her. However by the end of the placement she had confirmed that, despite the pay, this was the right choice for her.

As the work placements progressed the refugees came to realise and value the context of their work in relation to their professions. However this was a gradual and experiential process. In one case a refugee questioned the relevance of the work placement role as the responsibilities were less than her work overseas. As the work placement continued, she learnt more and came to understand that this more 'junior' role was in any case an essential pre-requisite experience in her career and future training that she would have to undertake.

> *You are supposed to know all the things that a Medical Laboratory Assistant (MLA) does if you are starting as a Biomedical Scientist. Now whenever I start as a biomedical scientist I have that advantage of knowing the MLA's background.*

Other benefits included ***NHS staff providing refugees with in-house job search advice*** *and support. Three refugees received advice about how to target their CVs, while another was provided with interview practice and information on the most likely interview questions by the NHS staff in his team.*

Work placements also provided four refugees with **valuable networking opportunities** in terms of making professional contacts in their immediate teams and also in related departments. In one case this was extended to external contacts by attending conferences and seminars. With support

from his manager the refugee concerned was able to establish contact with a senior consultant which subsequently led to an opportunity to present his cases and attend professional practice meetings at a teaching hospital. The refugee was appreciative of the opportunities given to him:

> *The work placement was very beneficial for people like me who want to join this profession. I think 3 months work placement is great and I gained a lot. I made my professional relationships and networking which I am very pleased on this work placement.*

2.5.5 Experience gained in UK clinical practice

As discussed, the extent to which refugees undertook clinical responsibilities on work placement was necessarily limited by regulation and experience. Nonetheless six out of seven refugees highlighted the value of gaining UK clinical practice skills, opportunities for observation, use of specialist equipment and materials and familiarity with computerised systems for handling patient and resource administration and coding. This is clearly illustrated by the following statements:

> *I learnt that there are a little more tests that they were doing in the lab than we were. Maybe it's due to the technical advances, maybe more sophisticated machinery. More or less the technique was the same but some of the things they were different. It was very interesting.*
>
> *Biomedical Scientist*

> *….it was something more than what I had done before. I started in the EEE unit, servicing the machines and then I moved to the CCC department, calibrating, servicing, and trying to train the nurses and doctors how to use the electronic equipment.*
>
> *Medical Engineer Technician*

> *I am sitting and observing, with professors and consultants and patients with different medical conditions, sometimes they allow me to examine and to give my opinion what I think I know, so I had a very good experience .....*
>
> *Medical Doctor*

> *My experience within this three months is great because people were helping me, and I was interested to ask them, to know everything. This technology, it is different in this country and they were helping me to know about the materials, the medical equipment*
>
> *Nurse*

As a result of the work placement one refugee, previously turned down at job interviews, for the first time since his arrival in the UK came to understand why he had not been accepted for jobs on the basis of his lack of experience of UK equipment and technical knowledge.

In addition to technical experience, most of the refugee professionals gained experience in patient interaction, especially important as none had previous UK experience working directly with patients. At the start many were keen to gain this experience, expressed as a willingness to learn and adapt to these interactions in a positive way as one refugee explained:

> *My focus was how to deal with the patients, with the staff and to exchange, to absorb their skills and knowledge….. for the first two weeks how to care for that patient, how to make him ready, psychologically and everything for the surgery, for the theatre, and then after he comes back, how to help him post- surgery…*

The ability to interact successfully and confidently with UK patients was real achievement for some of the refugee health professionals as evidenced by a statement:

> *.... It has been beneficial for me, I learnt a lot of things, how to deal with patients, how to communicate with patients here, how to deal with difficult situations for example patients will come who don't like the system or the policy…..*

2.5.6 Increased confidence : language and communication skills, gaining UK work experience

Four out of seven refugees specifically commented on the value of work placement to develop language skills, specifically medical English and communication skills in the work place commensurate to their role.

> *First of all the work placement improved my English, and I got contact with English people and my work placement environment. The second was to become familiar with the NHS system and to compare it with my previous experience….*

> *I feel better because I can explain things, call them their name because I've got the technical language - that's something positive I have learnt from the work experience…*

> *After 2 to 3 weeks I started to have conversations with staff and to listen how they communicate with patients, what kind of questions they ask. I know what they have to ask but in English, their conversation and the understanding between patient and doctor and staff was very useful.*

In addition to language skills all the **refugees experienced significant confidence building** through gaining professional and personal skills by attending work placements. This was expressed in terms of realising that their existing skills were valued by managers, and the recognition of new skills learnt, as their comments demonstrate:

Before I started in the job I was scared because maybe if I go somewhere and see some professionals how could I cope with them? It was scary for me because I don't know the practice of this country. When I saw what they are doing, as soon as they show me those changes in practice, it was easy, so there was no stress, I was happy in the work.

I am different from before because I got some experiences. I am ready for a job now because I got enough experience from the hospital, they taught me a lot and I have developed my previous experience more.

I was really happy getting that placement because we are nurses back home theoretically we know everything, but practically there are some differences between our experience and this country's experience.

We would suggest that confidence building is fundamental to the progression into appropriate employment by refugee professionals. It empowers individuals with a greater clarity in decision making, enabling increased access to professional support, information and networking, stronger presentations in recruitment processes, with increased assertiveness and enquiry in the workplace.

2.6 Outcomes from the work placements

One year after the work placements, three refugees are in employment, one has completed a vocational degree, two have passed professional registration exams, four are seeking employment.

- Following work placement, the **Biomedical Scientist** entered the final year of a biomedical degree, using her previous experience and qualifications to access the course via an APEL route (Accreditation of Prior Experiential Learning). She achieved a good degree and is now employed as a trainee Biomedical Scientist in the department where she carried out her work placement.

- The Hospital Trust provided match funding with a charity to enable the **Medical Engineer** to attend a specialist clinical training course. He continued in his work placement for a total of eleven months before successfully applying for the post of Medical Engineer Technician in an NHS Trust.

- After extending the work placement to six months a refugee **Nurse** was successful in applying for the post of Health Care Assistant in the same Trust. He is continuing his process to be become a registered nurse in the UK.

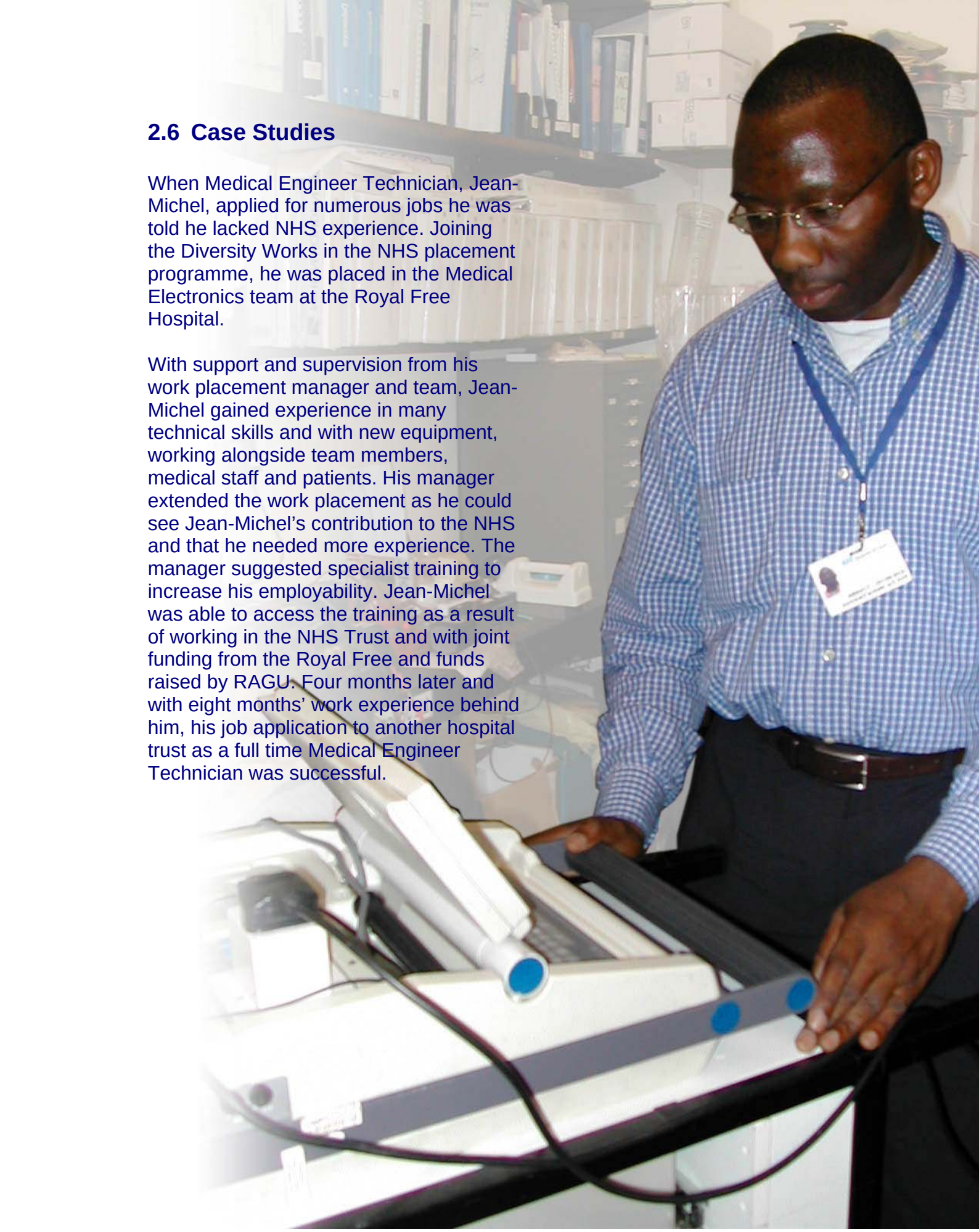
- As a direct result of the work placement a **Dental Surgeon** was introduced to a teaching hospital, invited by the consultant to attend weekly meetings for his health specialism and to take up a clinical attachment. Due to regulations by the Faculty of Dental Surgeons he was unable to take up the clinical attachment as he was assessed to be too highly qualified. He is still currently looking for clinical attachments and applying for Senior House Officer posts. His attempts to apply for Dental Nursing posts have been unsuccessful. He is working towards the IELTS exam and Dental registration.

- 2 **Medical Doctors** continued their re-qualification process by completing PLAB 2 and are looking for entry level posts. The third doctor is working towards the IELTS exam and wants to enter appropriate employment in an intermediate role.

2.6 Case Studies

When Medical Engineer Technician, Jean-Michel, applied for numerous jobs he was told he lacked NHS experience. Joining the Diversity Works in the NHS placement programme, he was placed in the Medical Electronics team at the Royal Free Hospital.

With support and supervision from his work placement manager and team, Jean-Michel gained experience in many technical skills and with new equipment, working alongside team members, medical staff and patients. His manager extended the work placement as he could see Jean-Michel's contribution to the NHS and that he needed more experience. The manager suggested specialist training to increase his employability. Jean-Michel was able to access the training as a result of working in the NHS Trust and with joint funding from the Royal Free and funds raised by RAGU. Four months later and with eight months' work experience behind him, his job application to another hospital trust as a full time Medical Engineer Technician was successful.



Robel, (not part of the research but on the Diversity Works in the NHS programme), is currently working at the London Health Observatory (LHO) as a Data and Information Officer, following a 4 month work placement there in 2004. A graduate in Maths and Statistics, he undertook intensive job search with support from RAGU, attended many interviews but was consistently told he needed UK work experience first. At this point he joined the placement programme. Within 5 months of the work placement the LHO had a vacancy, advertised externally, for which Robel successfully applied. He has now been an employee in the NHS for nearly 2 years.

2.8 Summary

2.8.1 Views and experiences of NHS managers

a) NHS managers have some knowledge about refugees and the barriers that restrict refugees' entrance to the NHS. However clarity about the differences between overseas recruits and refugees in relation to re-qualification and entitlement to work and residential status was specifically lacking.

b) NHS managers hold positive perceptions about refugees in terms of professional skills and additional skills (language and clinical), motivation levels and retention rates

c) Work placements were experienced as beneficial by the managers and their teams they provided increased staffing, development opportunities for staff in diversity and cross-cultural awareness, opportunities to supervise, a recruitment tool and increased appreciation of NHS resources.

d) Work placements enabled increased knowledge about the barriers refugees experience entering work and about issues that are relevant to refugee and asylum seeker patients accessing NHS services.

e) Work placements increased awareness about NHS equality and diversity policy.

f) Work placements challenged NHS managers' attitudes in relation to refugee professionals contribution and capacity to integrate successfully.

g) NHS Managers expressed views that are illustrative of the racialisation of 'refugee' identity and the difficulties that individual refugees' experience in breaking through to mainstream employment

2.8.2 Views and experience of refugee professionals

a) Refugee professionals have a positive view of the NHS as an employer committed to equality and diversity and workforce development. This knowledge is limited by a lack of work experience and lack of information about the NHS. Specifically refugees lack information about accessing vacancies in the NHS.

b) Benefits and learning from attending work placements in the NHS were:

- Increased knowledge about the NHS as an employer: NHS structure and culture, career paths, networking opportunities and employer references.
- Increased experience of cross cultural working practice
- Gained experience in UK clinical practice including patient interaction, specialist technology and equipment
- Increased levels of confidence and assertiveness in terms of gaining UK work experience, language and communication skills
- Improved health and wellbeing during the work placement
- Opportunities to represent refugee professionals in the work place
- Experience of working in a multicultural team

c) Refugee professionals assess themselves to have proficient levels of English language and the communication skills to carry out appropriate work recognise the need for continual language development. NHS managers with experience of working with refugee professionals confirmed this view

d) Refugee professionals experienced job outcomes as a direct result of participating on work placements.

Chapter 3

HOW TO MANAGE WORK PLACEMENTS SUCCESSFULLY IN THE NHS

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HOW TO MANAGE WORK PLACEMENTS SUCCESSFULLY IN THE NHS

…the refugee health professional from overseas who has fitted into our department has been a great asset and it has been good for the staff to see what value he could add to the department. There is a pot of candidates that could fill NHS vacancies.

In the long term the NHS will be getting more skilled workers with a lot of valuable, relevant experience from abroad. On a day to day basis it gives our managers the opportunity to gain experience working with people from different cultural backgrounds and different origins.
NHS managers

This chapter discusses the key issues and practicalities in establishing and managing work placements for refugee professionals in the NHS based on the research findings.

3.1 Engaging the NHS and NHS managers in work placement programmes

Exploring how the two NHS Trusts and managers came to engage with the Diversity Works programme gives important information for establishing future work placement programmes.

Initial contact with the two Trusts at senior management and Trust Board level was established in 2002 and 2003 from RAGU's previous employment and training programmes. From early 2004 a more strategic approach to identifying placements in the Trusts was discussed, using two methods defined by the Trusts themselves.

a) Human Resources managers in the PCT, identified key staff members for RAGU to contact once the individual refugees professions had been clarified. In this Trust information about Diversity Works had already been circulated on the intranet. Three PCT managers took on placements, though up to ten were contacted
b) In the Hospital Trust Human Resource managers identified and contacted departmental managers to ascertain their interest and capacity for providing a work placement. Managers had access to information about Diversity Works and refugees' CVs. Five managers took on placements. (A

further placement was arranged but was not included in the research as it started 4 months before)

From a strategic point of view the latter method proved more successful. NHS managers with direct contact with senior HR staff responsible for Trust policy on Equalities and Diversity management were being 'sold' the programme from within the organisation, and **top down communication and commitment to the ethos of the Diversity Works programme** was more tangible. As one manager asserted:

> *…. you have to have a really strong lead into the project with the right people engaged in it, rather than just HR trying to drive it through; it would need real champions to take it from top level management.*

However in both Trusts recruitment of managers to the project was challenging at a time when major NHS practices (Agenda for Change[17] and Improving Working Lives)[18] were being implemented. Work placements presented real additional workloads for managers. HR managers from both Trusts identified this as the key obstacle to engaging managers on the projects:

> *I think all managers are motivated and keen to do it. I think a lot of them are really just struggling with other work pressures at the moment and I think the time constraints upon them are immense. I think that's no reflection on the programme.*

To offset this perceived obstacle to manager participation one HR manager suggested promoting the project to managers in terms of having additional resources within the team. However this approach to work placements is double-edged. If unpaid work placement projects are promoted to managers as a free opportunity to fill shortages it will fail to address:

- the actual needs of refugee professionals entering the NHS.
- the opportunity of awareness raising on Equality and Diversity issues for NHS staff.

HR perceptions' about managers' limited time were frequently echoed by NHS managers during the work placements. However findings show that managers had a broader range of considerations in agreeing to engage with work placements. This included their professional development, benefits to the NHS and their relationship with HR:

> *A learning opportunity for me as well as raising awareness, it's an*

[17] Agenda for Change: Agenda for Change is a pay review process which aims to pay for work of equal value for all NHS staff within secondary and community care from 2005

[18] Improving Working Lives: performance standards for NHS employers, designed to improve the working lives of NHS employees as an integral element of the NHS Plan. Dept. of Health: www.dh.gov.uk/PolicyAndGuidance

unknown territory.

We could gain more from supporting and training refugee professionals, which would be an advantage to the NHS and that is the angle that I followed, not a personal commitment.

I did it to curry favour with the HR department.

Managers' motivation levels also ranged, and it became clear that at least three felt some level of coercion by HR into taking part in the programme:

I had no real choice and would have liked some input into the job description.

I was not given much information, just asked if I would supervise.

I felt I would have to come up with a reason not to accommodate the work placement.

These comments came from managers in both Trusts. While they expressed reserve at the process of engaging in the programme, all supervised effective work placements. Managers' comments suggest the need for greater top-down communication and planning between Trusts' HR and clinical departments in order to get managers on board. If NHS managers are not engaged in the work placement process from the start, their understanding and commitment may be compromised.

There were significant gaps in top-down communication in both Trusts about the project, reflecting the relatively short time in which the project was implemented and major NHS initiatives happening simultaneously. An HR manager outlined the ideal plan as having:

….a Trust communication, to have a formal strategy for this, to have briefing groups with managers to tell them about the strategy.

Information gaps identified by HR managers also included information about other employers' experiences hosting work placements, in terms of roles and positive role models of refugees who had progressed to employment as a result of work placements.

Broadly all work placement managers that the project information they received was effective and informative. Four managers would have preferred induction training about the project aims and more information prior to their interview with the refugee. Information gaps occurred when work placement managers devolved responsibility and supervision roles to colleagues, who were not provided with access to all the information and in three cases were uncertain about the aims of the project. All staff participating in work placement must have access to information about the project as part of their Equalities and Diversity training.

Successfully **embedding work placements within in an organisation** and individual refugee professionals within NHS teams is critical in order to maximise effective work placements. From the research findings it is evident that greater involvement by line managers and HR departments with the placement managers is important. Managers want to be asked about work placement progress and their additional work to be acknowledged, although in neither Trust did HR managers appear to be aware of this communication gap:

> *……..as long as the placement is successful for the individual and for the manager, I don't feel that I necessarily need to be involved*

This is contrasted by NHS managers views:

> *I would like recognition from the HR department that this is taking place, perhaps looking to my job description as an additional role.*
>
> *I am grateful for the team's collaboration, as it is the whole team attitude that matters. There has been no contact with HR and it would have been nice if they had rung up and kept in the loop.*

An active interest taken in the process by line managers and HR, particularly while managers are charting new territory for their individual Trusts, is important. **Managers' contribution in developing Equality and Diversity practice needs to be acknowledged**.

These findings show that in order to increase NHS manager participation in work placement programmes the following activities are important:

- Incorporate work placements into a positive action strategy publicised in each Trust
- Develop a realistic and strategic planning process for HR and managers in order to maximise placement, alongside appropriate training and support
- Identify a champion for refugees in the Trust possibly at different levels
- Develop focussed publicity within the Trusts in order to engage managers with enthusiasm, which could include targeted training and briefings
- Develop closer links between work placement managers and HR during work placements
- 'Reward' work placement managers, acknowledge their work, and develop a recognised continuing professional development plan including information on, for example, supervisory responsibilities
- Provide sufficient resources for managers to engage fully, for example, time allocation and line management supervision

3.2 Structuring and managing work placements

All NHS managers found the structure of the work placement project developed by RAGU was workable and effective. Managers found the **initial interview** with the refugee professional was an important part of the process:

> *The essential part is actually being able to interview and talk to them to confirm what sort of experience they've had, and assess their communication skills as well.*

> *It's key that managers are given a lot of information about the individuals beforehand and also the opportunity that they've had with RAGU to meet the individuals on an informal basis to make sure that any placement or indeed any substantive job they're going to do is appropriate for the skills and experience that they are bringing to the organisation.*

Managers' views on the Work Placement Guidelines and Contract produced by RAGU varied. Most managers appreciated the **role definition and structure** outlined within the document:

> *I think that the agreement is very important and it's very important that they (refugees) be shown or be told what is going to be expected of them.*

However one manager felt that the contract was *'too much, too tight'* and restricted his use of the refugee professionals placed in his team. This view arose from the staff shortages in his team and the supervision time he had agreed to and which proved difficult to fit into his workload.

The majority perception by NHS managers was that **the more days per week the refugee was able to attend the greater the opportunities** available to integrate within the team. Most managers felt fine accommodating a placement for three days a week, however one manager commented that he would have preferred a full time arrangement:

> *Our experience has been that people who come here one or two days a week, it's just not really effective at all because by the time they come back they need to be re-familiarised with what they're doing and it's uphill. So that's one of the reasons I said was that three days would be the absolute minimum and hopefully full time would be ideal.*

Three managers found the three-month duration of the work placement too short especially in NHS teams operating a three-month rotation, which limited the work placement experience to a single area of responsibility. Previous experience from RAGU's projects demonstrates that **a work placement duration of 3 to 6 months is of greater benefit** to the refugee and the team in which they are placed, with the proviso that roles are developmental and not only observational, so that refugees do not get *'bored'.* Employment

outcomes from the work placements were directly proportionate to duration of work placement.

All NHS managers and refugee professionals found the **regular monitoring visits** by RAGU a useful and supportive process. A manager commented:

> *I did find that knowing that you (RAGU careers adviser) were coming and were interested really in both the placementee and me, how I was finding it that was very nice actually I must say.*

A refugee professional on work placement commented on monitoring visits positively:

> *It is good to show you the place I'm working in so you can see how it is and what I am doing. I want to talk to you about the things I have done – maybe you can advise me what I can say to the manager to have more work opportunities with the patients.*

Experienced careers advisers used the monitoring visits to discuss the work placement in confidence with the manager and refugee. The sessions with the refugee were used to review and reflect on their skills development and experience, identify areas to gain more experience, support refugee's to negotiate with managers, address any difficulties. Managers used monitoring sessions to discuss the refugee's progress, and how to support the individual in a variety of ways, issues they experienced with work placement and strategies to deal with this.

3.3 Addressing cross cultural issues: assertiveness, confidence and communication

In RAGU's experience from ten years of managing refugee employment programmes, refugees (refugee women especially), from diverse cultural backgrounds, often from countries with repressive social/political environments, may be less willing to freely state their needs and assert their roles, especially in an unfamiliar culture. Although they are skilled and experienced, many refugees are new to the UK work environment and culture, and face new terminology and systems. Additionally many experience similar confidence issues that long-term unemployed people face after several years out of professional practice. Cultural differences in communication and behaviour from the dominant culture combined with low confidence can mark out refugees as 'different' and make their entry and integration into the work place very challenging.

The findings from this study have identified how cross-cultural issues arising in work placements with refugee professionals and NHS managers may impact on the working relationship. The findings lend weight to the importance of refugees and managers becoming critically aware of these issues in order to increase the success of work placements.

For example lack of **assertiveness and initiative** by refugee professionals was perceived by several managers as ambiguous, frustrating and of concern in the search for employment:

> *He is enthusiastic but because he's very quiet and softly spoken, he looks like he's taking a step back but he's not, but he looks like he is. He would pass that (job interview) with flying colours but at the same time he may not come over that he knows it because he's very gentle and very unassuming really.*

Managers' felt challenged that refugees did not demonstrate the same levels of initiative that they would have expected from staff and this realisation took some adjusting to both from the refugee's and the staff's point of view:

> *'Pro-activeness wasn't there so we had to keep pushing on that. There are a lot of areas where I expected her to use that initiative, to take steps, but she still saw herself as an underdog, so it's kind of trying to push her forward and it's about adapting, the staff are adapting and the placementee is also adapting to be able to meet on a neutral ground.*

These views highlight how refugees may be marked out as 'other' or perceived as 'underdog', compared with a dominant more assertive culture in the NHS, which tends to be taken for granted by non-refugees. Notably one manager addressed the 'otherness' of the refugee directly with her staff in order to encourage more integration:

> *We (staff) talked about a dress code, we talked about a way of communicating with people, which people might find somehow strange but this is this person's culture, this is this person's traditions, so it's about adapting.*

Findings show that while some managers and staff may be well informed about diversity issues, the practice of familiarising and accommodating the needs of a refugee professional could be challenging and need to be discussed before and during work placements with managers and refugees.

Examples of refugees, NHS managers and RAGU learning to cross these cultural barriers are highlighted in the following 3 case studies:

Example 1

A refugee successfully negotiated additional supervision and training in specific skills from the manager after a team member complained that the work carried out was incorrect. (The refugee used unfamiliar equipment). The manager's input, resulted in increased team working interaction as he encouraged the team members to reflect on how they could support a refugee professional on placement facing a new work environment. The refugee explained that the manager had asked the NHS colleague:

What can you offer to him, he is coming to help you, what can you offer to him back as well.

The refugee professional felt valued by his colleagues who took time and patience to explain and demonstrate procedures to him. The manager and team members spoke very positively about the refugee on work placement.

Example 2
A refugee felt bored in her placement without opportunities for development, and raised this with a careers adviser at RAGU. RAGU provided guidance and coaching to encourage the refugee to speak directly with the manager in order to negotiate a role development, which the refugee was successful in achieving. RAGU simultaneously provided support and encouragement to the manager to identify opportunities for the refugee. The manager placed the refugee in a new section with wider responsibility and experience. Both were very satisfied by the outcome.

Example 3
As a result of attending the work placement a refugee experienced a significant increase in confidence and well being. The refugee felt confident to ask the manager with help to network with consultants, was proactive in asking health professionals he observed for contacts and wrote to the Minister for Health about specific issues for refugee health professionals.

Effective cross-cultural communication is important for establishing good working relationships on work placements. Findings from this study and experiences from RAGU's previous work placement programmes indicate that misunderstandings due to different cultural expectations in work placements is not unusual. This can be illustrated by one case. The refugee professional informed a work placement manager (a doctor), that she was not able to attend work placement for a period of time. The abrupt disruption frustrated two managers who had set aside time to create and supervise the work placement. The refugee had not been aware she needed to communicate with both managers as agreed and furthermore had chosen a doctor rather than a Nurse Lead to speak with based on her cultural assumptions about roles. The manager felt there had been a '*breakdown in communication.'*

The issue was explained to the refugee who took steps with RAGU to resolve matters and successfully re-negotiate the work placement. However the incident served as an opportunity for both the refugee and NHS managers to learn about cross-cultural communication and diversity in the work place.

Even with clearly written work placement guidelines and signed contracts, difficulties arise due to cross-cultural issues. Refugee Agencies need to have effective mediation skills in these situations. The value of the work placement is the mutual learning of different cultural expectations. This enables refugee professionals to familiarise themselves and feel increasingly confident to adapt to common UK working practice, and for managers to learn about diverse approaches to working practice.

Support and encouragement for refugee professionals on work placements by managers who can empathise and are aware of cross-cultural issues is of immense value. If refugee professionals gain confidence in the work placement before facing the pressures and expectations of paid employment, their retention rates and progression, once employed, will be higher.

3.4 Maximising attendance on work placements

The study highlighted how unforeseen circumstances disrupt work placements in 2 ways: a) the refugee experiences external pressures that affect attendance or b) internal issues in the organisation create confused work roles:

- **Refugees face external issues to work placement**

Inevitably, refugees are faced with a raft of issues such as housing, health, benefits, immigration, family reunion and re-qualification. These issues may prioritise over the work placement, sometimes suddenly, and affect the refugee's attendance. When this happened it was both challenging and frustrating for all parties, especially once the placement had started. A refugee commented:

> *….completely private issues have an impact on this process. For example, family problems, financial matters , all this comes together….*

During the project, two refugee doctors took the PLAB exam (re-qualification for doctors which they passed). One refugee, stopped attending work placement for 5 weeks while she revised, thus breaking the placement contract. The other doctor's work placement was held over for 1 week.

In RAGU's experience, many work placement managers, especially those in the public and voluntary sector, show considerable empathy and find practical solutions to support the refugees so that work placements continue - as was the case on this project. It is rare for work placements to be terminated early, leaving employers and refugees with a negative experience.

- **Organisational disruptions**

During a work placement, a supervisor went on sick leave leaving the refugee without a work plan and in some confusion about their activities. This was only picked up after 2 weeks. In previous work placement programmes it has not been unusual for work placement supervisors to change without informing RAGU and leaving the refugee uncertain. New supervisors may not be clear what the intended aims of the work placement are and may not understand the issues pertaining to refugees who are new to the work place.

Other examples of disruption (from RAGU's previous placement projects) have arisen when team workloads change and with it the work placement role. This can be a good opportunity for the refugee professional to demonstrate

flexibility and teamwork, to re-negotiate and reflect on their needs. However if refugees on placement are not informed clearly, problems occur

Ensuring paperwork can be efficiently processed prevents delaying work placement starts. In both Trusts there were delays in processing Occupational Health forms as the relevant sections were not aware in what capacity the individual was brought into the organisation and forms were mislaid. Other documentation requested included a Criminal Record Bureau (CRB) check (which was carried out smoothly by the PCT) and Medical Insurance. The latter was not required once it was clarified that roles on work placement would not involve unsupervised clinical practice and would therefore not present liability to the Trusts.

The study shows that refugees and employers on work placement schemes need to demonstrate a high level of professional commitment throughout and inform each other and the refugee agency of difficulties and changes promptly.

3.5 Developing work placement roles

The study shows there is a delicate balance between meeting the refugee's professional needs on a time limited work placement and meeting the needs of the team in which they are placed. As noted in the managers' interviews, refugees in this project contributed significantly to their teams work during work placement. At best needs are mutually inclusive to the refugee and NHS team, as clearly demonstrated in four of the work placements, while others were compromised by the reality of what was 'on offer' subject to staff availability.

Creating **realistic yet developmental work placement roles** is central to the success of work placements. For example one manager highlighted the challenge of developing such a role:

> *…it needs to be stimulating – but also what he is allowed to do within the constraints of regulations.*

In one case the individual's needs were set against serious staff shortages. The manager expressed some concern that the refugee on work placement undertook 'boring' work while appreciating a 'free pair of hands' in a crisis:

> *…we were in a position where she had to fit into the team quickly because she came when we were in a staffing crisis and it was a matter of sink and swim. She managed to pick things up very quickly and started swimming very well indeed. As time went on we were giving her responsibilities which she carried out very well. She was extremely good, highly respected and considered really to be part of the team.*

The refugee turned what could have been a difficult situation of limited responsibility and routine work into a positive experience as she explained:

> *…..it was the summer vacation time and they were really short staffed they ended up giving me responsibilities that I think normally they wouldn't have. And it kind of helped me, it was difficult to cope at first but I just got on and it was good for me, I disregarded it as a problem, although it was really stressful because they were under staffed and everybody was busy and you could feel ignored but I wasn't……*

The work placement changed after a few weeks when the crisis was over to include more responsibility.

A balance needs to be struck: refugee professionals need assurance from NHS managers that the work placement will provide genuine learning opportunities for them alongside their own contribution to the team in routine activities.

One measure to avoid compromising work roles was used effectively by two managers facing staffing issues. They created a model for a work placement within a super-numerary posting, (i.e. additional to recognised staffing numbers), as one manager explained:

> *He was super-numerary so he's never been part of the establishment, he was extra to my numbers so he was never used as a workforce person, he was always there as extra really so that he could be as slow as he wanted to be and he could be guided and supervised all the time.*

This arrangement allows time for the refugee to settle as part of the team without experiencing the pressure of work responsibility until they are ready and gives them time to network and familiarise with NHS procedures and policies.

The research demonstrates that effective management of placements required ongoing discussion between managers and RAGU. RAGU's monitoring visits to review appropriateness of work placement roles in relation to the refugee's skills and development opportunities of benefit to both the employer and refugee were helpful. In three cases, when managers became aware of the individual's skills level after some weeks, job descriptions were adapted to extend their role and responsibilities.

Examples of work placement roles that were adapted include:

- A nurse placed in a health care assistant role was allowed to take on student nurse responsibilities.
- A highly experienced dentist, primarily asked to observe, was later asked for his professional verbal assessment of cases during consultations
- A doctor started taking patient case histories after several weeks

One refugee commented appreciatively on the work placement role and range of activities made available:

> *I had opportunity working and observing, working directly with patients and observing professors with senior house officers and registrars so I had the opportunity to see the staff, the management, ….that encouraged me and that helped me to settle very well in the team and in the hospital.*

In previous work placement projects run by RAGU, some employers have provided preliminary skills assessments in IT skills and financial skills to develop roles commensurate with the individual's skills. Skills assessments for refugee HPs and AHPs could include IT, language, taking vital signs, laboratory tests, knowledge of electrical circuits and so on. Competence could be assessed more easily after 4 weeks on work placement, as was the case on this project.

3.6 Negotiating issues around clinical experience

Without UK registration, clinical experience on work placements is frustratingly limited for all refugee HPs and AHPs. All refugee professionals enrolling on the project were aware of this. Work placements were described as pre-clinical, as distinct from clinical attachments and any clinical exposure was an asset to gaining experience in the NHS for refugees. However even with this clear information managing refugee professionals' expectations and hopes was challenging. A refugee medical doctor commented on his initial work placement role:

> *You are going to have to do something like a healthcare assistant (HCA), it doesn't matter you know as work, but psychologically you know it affects you.*

Developing work placements commensurate with refugees' work experience is dependent on their profession. For example for medical doctors and dentists this was especially challenging. For example a dentist's work placement was mostly observational which though useful, was limiting for an experienced professional. These health professionals need to be flexible and open to undertaking roles below their professional expertise Managers voiced their concern about providing clinical experience at the right level:

> *I think perhaps it's more difficult if you've got a doctor who isn't allowed to do clinical practice….. we don't want to be using people as interpreters and general dogs-body in the office.*

However a refugee nurse was given maximum opportunities within a supervised capacity, taking on a student nurse role to care for patients on the ward, which benefited both the NHS team and the refugee.

It is crucial that refugees' expectations are listened and responded to in order to avoid disappointment. This is especially the case in relation to gaining and clinical and generic experience. In the case of the doctor undertaking HCA work, after a few weeks the manager developed the role to include more clinical work, which he was very pleased with. A second medical doctor questioned why she should learn procedures used by nursing staff when she would not be called on to undertake this in her future profession. Once she understood the value of using the experience as a means to develop skills working with patients, she was satisfied.

Observation formed a substantial part of activities for the doctors and dentist, while other professions had a higher proportion of their work as hands-on experience. Developing work placement roles that more closely model intermediate roles will provide refugee HPs with more clinical exposure.

3.7 Managing staff expectations within NHS teams

The study also showed the importance of managing staff expectations. Some managers were cautious about taking on a work placement from the perspective of how their existing staff would feel, as a manager's comments shows:

> *If someone's dealing on a one to one basis with someone and they're not sure what the parameters are, they tend to be a bit protective, they don't know if that person's gonna go back and report that they only see three patients a day or something like that.*
>
> *The refugee may find that some individuals feel threatened because he is very highly qualified*.

Clearly it is important to induct all NHS team members into the project so that both they and the refugee feel comfortable in negotiating observations and levels of participation to mutual benefit. If NHS team members are unsure why a refugee professional is joining them, it may affect their receptiveness to the refugee. It is an important aim of the project that information is disseminated to all staff as part of their Equality and Diversity practice and awareness.

During one work placement, an interesting situation arose in relation to team dynamics. After two weeks the manager 'promoted' the refugee (an experienced nurse) to undertake a student nurse role, and not to be restricted to Health Care Assistant (HCA) role. As a result the HCA employees questioned their own limited role. The manager dealt with the situation employing diversity management skills very effectively:

> *I think it was a bit of, if I say envy. I don't know if it was envy that he was now being treated differently and he was no longer an HCA. He still did their jobs as well…. but the trained staff do the paperwork and he was doing that too. And it was well, if he can do that, we can too. I said no, you can't do that, he is a trained nurse albeit not in England*

and all he needs is supervision and he's actually learning to be a trained nurse so that he can actually be more skilled.

3.8 Avoiding exploitation of refugee professionals

Unpaid work placement aim to be developmental both for the refugee professional and the NHS. The study highlighted the need for employers, unions, refugees and refugee agencies to be aware of avoiding using unpaid work placements in roles, which should be paid vacancies. As one manager cautioned about this potential exploitation of refugee providing free labour:

Unscrupulous employers who are just using this as a way to boost their own workforce.

The same manager empathised with refugees working alongside employees while they were on unpaid work placements:

….perhaps they feel somewhat dissatisfied if they're doing the same job as somebody who's earning that salary.

Nonetheless in a contradictory statement the same manager used the business case to encourage his team members to take on a work placement:

The angle that I used, that we would be getting extra help at no cost to ourselves. We would possibly have the flexibility if things didn't work out of going back to our previous status. And, that if they were good then they could possibly be candidates for recruitment.

This view of the potential dispensability of a refugee on work placement is both concerning and at complete odds with a programme to promote Diversity. Yet these apparently contradictory statements reflect a real dilemma. If NHS experiences difficulties in recruiting skilled workers it could make sense to develop unpaid work placements for skilled members of socially excluded groups in order to bridge the gap and act as a potential springboard for entry to the NHS via equal opportunity practices.

In one Trust the Union raised the concern that work placements would be a 'back door' to paid vacancies that should be advertised. In the team that was short-staffed, a vacancy was indeed advertised internally and was therefore open for the refugee professional to apply for, which she could not have done without being on a work placement. However internal applicants still compete within Equal Opportunity recruitment process.

The study suggests that bringing the Unions on board at the start is helpful in promoting the project amongst its members.

None of the NHS managers suggested payment to refugee professionals in their teams for their contribution, (though this has been the case with previous

work placement projects). However receiving small payments may adversely affect refugee professionals' receipt of benefits.

3.9 Maximising supervision on work placement

In spite of RAGU contracting with the managers as to the frequency and approximate content of their supervision with refugees on work placement, widely varying levels of commitment and success were achieved in this role

Findings demonstrate just how essential **maximising the use and experience of supervision** sessions for the refugee and the NHS managers is, through training and ongoing support. Managers have very limited time to supervise additional staff, and this may create problems, compounded by confusion as to who is carrying out the supervision with the refugee.

The extent to which refugees made use of supervision by the managers on work placement varied greatly. For some refugees the supervision process, and the reflective learning model introduced by RAGU, is relatively new and only became clear during the work placements. The study shows therefore that supervision training needs should be incorporated into the pre-placement training programme.

Refugees on work placement were encouraged by RAGU to maintain learning logs to support their supervision and development. However the take-up for this was inconsistent. Only one refugee continued this record after a few weeks. This suggests that RAGU and the NHS might need to develop strategies to assist refugee professionals to record and engage in reflective learning methods.

It is vital that refugee HPs and AHPs feel confident to engage in effective employer supervision as part of their professional development. Clinical supervision is an increasingly important part of health practice alongside supervision of soft skills. Furthermore it is an essential skill in an increasingly performance driven culture, highlighted by the NHS Agenda for Change.

Managers similarly showed a range of views and understanding about the purpose of their supervision with refugees. One manager in a unit where supervision is integral to working with challenging case loads, viewed supervision as an essential part of practice and her role in supervising the refugee professional. Other managers were unclear and saw supervision as a formality.

Supervision was used by managers to discuss a range of issues: progress on the work placement and to plan roles; training routes; CV's; application forms and to provide interview practice; to assess clinical knowledge and to discuss team interactions. On a short work placement of 3 months it becomes even more important to have effective supervision for skills development and reflection, information exchange, feedback, discussion of issues and coaching.

The research shows that both NHS managers and refugees benefit from clear learning objectives to provide structure and focus for the planned activities. RAGU are in the process of developing supervision guidelines to include hard skills (clinical) objectives as well as soft skills (for example presentation skills, team interactions, communication skills, use of IT if relevant and knowledge of NHS' structure and procedures).

For NHS supervisors without supervision experience, the work placement provides a valuable opportunity to gain this experience. It could be seen as part of an accredited training within their own personal development plan in the NHS.

A majority of managers experienced difficulty finding time to provide structured one-to-one supervision in addition to their heavy workload. This was acute in teams with significant staff shortages and subsequently impacted on the role the refugee undertook. Most managers had daily contact with the refugee, however, in a more informal role.

If Trusts commit to work placements, individual managers will need resources to enable them to provide the refugee professionals with adequate supervision. RAGU recommends a 20-minute session every 2 to 3 weeks in a 3-month placement, so that there will at least three supervision sessions.

Three managers highlighted that **refugee health professionals specifically benefit from dual supervision, a clinical supervisor and a practice supervisor** to discuss issues such as team-working, communication NHS culture, policies, developments and to co-ordinate the placement. It was viewed that it was too much to expect clinical supervisors to play a major-part in co-ordinating activities. Dual supervision works well with a co-ordinated approach. However, two managers expressed concerns that the refugee had *'fallen between two stools'* as a result.

Frequently supervision was devolved to colleagues who worked directly and on a daily basis with the refugee. This worked well where regular feedback was given to the team manager. However in cases where feedback was not communicated, this distanced the manager from the progression of the refugee, leaving refugees out on a limb. In two cases this was picked up at a monitoring visit with RAGU.

3.10 Costs and benefits for NHS managers

Six out of seven managers viewed induction and supervision of refugees on work placements as a serious consideration. One manager commented at the start:

> *The CV is important so we can see whether they are, it's relevant to us perhaps taking on the placement in the first place.*

Other comments highlighted this manager's reluctance to take a work placement on:

> *The people perhaps require an element of training and unless we have a reasonable amount of time, we can get into a position where we actually get nothing back. In other words it's probably more hassle than it's worth, hence where I was rather keen that we should have (the client) for at least three days, ideally it should be for five days.*

This manager persuaded his team members to participate on the basis of an extra pair of hands rather than social issues.

Viewing the placement only in terms of how the team and service benefit in the short-term will limit managers' participation in the NHS on Positive Action schemes. It demonstrates the importance of HR departments to promote programmes like Diversity Works in a broader light, looking at longer-term work force benefits to the team and the NHS.

In complete contrast, another manager viewed the costs for supporting work placements as an investment and positive for staff development

> *We have someone able to contribute, albeit supervised and its very helpful to the team. The cost is the time spent to explain. However the cost is up front and staff benefit from explaining what they are doing. It improves their practice and in the process answering intelligent questions.*

3.11 Funding issues for Trusts offering unpaid work placements

It is common practice for organisations within the public and voluntary sectors accommodating, volunteers, or unpaid work placements, to contribute to travel and lunch expenses. In this project travel payments and lunch expenses were funded by only one of the Trusts. In addition and exceptionally, RAGU negotiated with one refugee's Job Centre for travel costs to be paid under New Deal. Only one refugee required childcare payments and these were met through RAGU's project funding. Single parents need to be included in planning positive action programmes to enhance their inclusion in the workforce.

The study show that the key issues in relation to funding for refugees were that some experienced delays receiving travel payments. This is especially difficult for individuals receiving limited incomes on Job Seekers Allowance. Processes should be devised to enable access to timely reimbursement.

The study also demonstrates the importance of finding sources from within the NHS to commit to work placement projects. An HR manager commented:

> *We're currently paying travel costs and lunch costs and that money is coming out of a sort of time limited budget. But for the purposes of*

this project, that has not presented us with a problem and if we were to do a bigger project in the future we'd have to address the funding issue for that.

For Refugee Agencies projects with such positive outcomes should be funded from from mainstream sources.

3.12 Developing successful partnerships with Job Centres

All the refugees interviewed received Job Seekers Allowance (JSA) and experienced varying levels of pressure from their Job Centres to secure employment. After 13 weeks on JSA, mandatory guidelines direct some benefit claimants to take up any form of employment, regardless of the individual's professional backgrounds. A refugee doctor explained:

Because the Job Centre and Job Centre Plus start doing the same interview, every two weeks, saying you have to get even cleaning things, even you know shop assistant job.

One refugee health professional had benefits cut for 2 weeks, while attending pre-placement training for refugee health professionals, on the grounds that his attendance prevented him from attending a basic ESOL class. He was also told to apply for agricultural work. RAGU was involved in lengthy advocacy to restore his losses but without success.

However not all Job Centres were obstructive. One refugee professional had her travel paid for under New Deal. This was significant in that it represented an individual Job Centre adviser working creatively within mandatory guidelines to create opportunities for the client to enhance her employability. This type of flexibility by a Job Centre is commendable and rare.

The findings demonstrate that a strategic approach at policy level could streamline matters. For example NHS Trusts and other employers with work placement schemes could provide references for the client to take to Job Centres as evidence. Workforce Confederations can work with DWP and therefore Job Centres to support local Trusts' positive action programmes to promote entry into NHS employment. Likewise refugee agencies should advocate and develop arrangements with New Deal managers to view the work placement as a significant step towards employability for refugees and a part of their mandatory training. The DWP is proposing changes to the New Deal programme to become more tailored to individual needs from 2006 and to accept non-accredited employment support measures.

3.13 Developing successful partnerships with NHS Trusts

RAGU engaged with NHS Managers at different levels of the organisation: HR, departmental heads and team leaders. RAGU acted as an intermediary to manage all aspects of the work placement project from start to finish.

Eight out of nine managers commented that they felt supported by RAGU and were confident to use them as a resource.

> *RAGU have been extremely courteous during the project, very patient and very helpful in all of the projects ……*
>
> *I know RAGU are there and I can contact you easily when I need to.*

The study illustrates that NHS Trusts wishing to develop work placement schemes for refugees should work with specialist refugee agencies with experience in managing work placements for three reasons*:*

1. It is essential for Trusts to have accurate information on the key issues faced by refugee HPs and AHPs. Agencies can promote the project in the refugee communities, and provide confidential supervisory support to managers and refugees.
2. To support individual refugees to establish contacts, network and negotiate work placements in the NHS.
3. To provide quality careers guidance, a selection and assessment process to ensure work placements are appropriate for the refugee professional at that time.

The study demonstrates the result of a refugee agency, RAGU, working in partnership with one large employer, the NHS, via two Trusts. RAGU's key observation was that individual managers' vision, commitment and understanding of Diversity issues was central to the success of the work placement programme. This was regardless of level of seniority and of centralised NHS strategies.

At management level RAGU experienced a majority of the NHS managers supervising work placement demonstrated a great deal of commitment and time alongside their already heavy workloads. Their commitment seemed motivated by personal interest and enthusiasm for the individual refugee and the project, rather than being driven by organisational commitment or directives to meets Equality and Diversity issues.

Findings illustrated how at organisational level each Trust has an individual culture and set of priorities, reflected in their different response to the project. Even with a centralised NHS Equality and Diversity Strategy, each Trust implemented this strategy in individualised practices in relation to the work placement of refugee professionals. One Trust (Royal Free Hospital) demonstrated a marked commitment to funding the work placement and incorporating the project into their equalities and diversity strategic plan. The other Trust did not. The difference could be explained by the senior managers' and Trust Boards' individual understanding and commitment and the resources made available for such projects. This highlights the need for champions of refugees at Board and senior management level.

These findings should alert the NHS and individual Trusts to how they propose to implement diversity practice in a cohesive way throughout the workforce. If they rely solely on individuals' commitment, Equality and Diversity practice will be patchy and inconsistent.

3.14 Post work placement support

Three managers cited the importance of continued support for the refugees to build on the work placement experience and maintain motivation levels:

> *It would be a shame to let him go, just walk out of the door. If there was some opening or other that he could be fitted into, it would be beneficial for this Trust to keep him.*

> *It's not enough just going through the process (work placement) and then not take it forward. It will be useful to know that they will be able to find a job somewhere so that they can utilise the training they have acquired and can continue to utilise their skills ….*

RAGU and refugee agencies managing work placements need to secure funding for continued careers guidance work with refugee professionals after work placements end. Long-term findings (see outcomes in the chapter on Research methodology) clearly demonstrate that work placements increase refugees' employability.

In the same vein two managers identified the value of specialist support from organisations like RAGU, for newly employed refugee professionals to promote their integration and professional development. One manager commented:

> *Refugees need to be followed through to make sure that they are secure in their professional life before they are left alone. Because even if they get a job they wouldn't last six months if they have not acquired enough in terms of confidence and interpersonal relations to be able to adapt.*

A second manager felt that both managers and refugee would benefits from specialist external support to promote the retention of refugees:

> *having a support where the manager can go to for advice about specific refugee issues because it's going to take HR a little time to get the experience and knowledge that they need. There needs to be an external agent so that the refugee clinician can feel they can go out and talk to someone else about issues that are happening in the workplace, knowing that it's confidential and that they can explore those issues….*

3.15 SUMMARY

3.15.1 Establishing work placements in the NHS Trusts

a) A more strategic approach, incorporating schemes into the Trusts equality and diversity practices, developing top down communication was seen to be helpful by NHS managers.

b) NHS manager want training, programme induction and involvement and decision making from the outset, as well as induction for their team members. Lines of communication in the Trusts and access to information about the work placement project was uneven.

c) NHS managers want support and acknowledgement from HR and line managers in relation to time allocated. Managers raised concerns about the cost versus benefits to the individual teams although they recognised the benefits to their teams.

3.15.2 Managing the work placement

a) Initial interviews and monitoring processes worked for both refugee professionals and the NHS manager. Work placement agreements with role definition was seen as a useful contract and guidance. NHS managers preferred work placements of longer duration than 3 months, as did some refugees.

b) Negotiating and developing meaningful and appropriate work placement roles for refugees balanced with the NHS team's needs, is critical. Clinical roles for unregistered professionals was limited

c) Ensuring that work placements were not vacancies that should be advertised and that refugee professionals were not exploited while on work placement was essential.

d) Work placements led to increased cross-cultural learning for refugees and managers in relation to confidence, communication, assertiveness and initiative

e) Understanding how external issues may interrupt work placements for refugees for unavoidable reasons was important as well as working out how to resolve this.

f) Effective work placement supervision was valuable, both clinical and general. Both refugee professionals and managers can be provided with more guidance on this process within the work placement.

g) Funding was available from one Trust for travel and subsistence. There will be a future need to secure funding streams to support projects of this nature.

h) Paperwork (CRB checks, immunisation schedules) created delays in work placement starts, but in general were well managed.

i) Post-placement support and guidance for refugee professionals is an important element.

j) Partnerships with Job Centres to support the work placement programme varied from highly supportive to refugee participants having their benefits cut.

Chapter 4

RECRUITMENT AND RETENTION OF REFUGEE PROFESSIONALS IN THE NHS

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Let's not put up barriers to prevent people getting in. Let's put structures in place which enable people in to work more effectively and to develop inside the job.'

NHS manager

Thank you for giving me chance for doing this work placement and this experience because I think not only as a professional, as you know, the personal, it's encouraged me to continue my career and my professional development, not to give up.

Refugee professional

In the light of the research findings this chapter discusses the key factors that need to be considered in creating opportunities for refugee health professionals (HP) and allied health professionals (AHP) entry to the NHS. The factors fall into two broad groups:

A. Factors that promote the case for the inclusion of refugees in the NHS workforce.
B. Factors that facilitate the process of recruitment and retention of refugee professionals in the NHS.

A. Factors that promote the case for the inclusion of refugees in the NHS workforce

4.1 Social inclusion and refugees' access to health and wellbeing

Three key determinants of health outlined in the London Health Strategy[19] are unemployment, poverty and social exclusion. The link between unemployment rates among the refugee population, (disproportionately higher than for BME groups) and health status is of increasing concern in London and nationally. Therefore initiatives that enhance the employment of refugees are desirable and directly address:

- Health inequalities of refugee and asylum seekers

[19] NHS Executive London Regional Office., 2000. *The London Health Strategy: outline strategic framework 2000.*

- NHS proposals in the Equality and Diversity Strategy[20] in relation to service provision
- The NHS Health Strategy for London

Two NHS managers raised this important issue:

> *… it's important that they (refugees) are working here because it impacts on their health. So somebody who is out of work is likely to be far less healthy or even mentally less healthy and that impacts on their family, so the community in Newham can benefit if refugees are at work.*

Findings show that employing refugee professionals into the NHS increases equality of access to health care by refugee and asylum seekers groups. The refugee community benefits three-fold by refugees attending unpaid work placements:

- Individual refugees experience improved health and well being
- Individual refugees provide information and promote the NHS services within their own communities.
- Informing the NHS workforce on issues relating to the patient group

Five refugees stated the **significance of their work placement and employment on their health and wellbeing.** Two refugee professionals on work placement commented on this link as follows:

> (benefits of work placement are)…….. *not only financial, it's a kind of education because I'm learning and getting experience for my future - this is helpful, it's helped me generally psychologically I am less stressed now, I feel less desperate.*

> *…working for the NHS helped me to have a better psychological well being and because expectations are kind of met because of my background in health and helping people.*

Following work placement a refugee said that he would be better able to recommend the NHS services to his friends. This view is echoed by an NHS manager:

> *….they (refugees) represent their communities as well so that they are able to give you a better insight into the needs of that local community and an understanding perhaps of why they're not taking up health services, also link into that local community to explain to them what they have available to them.*

[20] NHS Strategic Health Authority. 2004. *Race Equality Guide 2004, a performance framework, June 2004*

The positive impact of providing an unpaid work placement to a refugee in the NHS increases once the refugee professional achieves paid employment in the NHS.

A majority of NHS managers identified that refugees within the NHS workforce act as an information resource, informing the NHS workforce about refugee and asylum seekers, the issues they are dealing with and medical conditions they may present with:

> *….when you bring refugee professionals into the NHS they are not only coming to support the professional achievement, but also to facilitate cultural awareness in the field.*
>
> *They're bringing in fresh ideas, they're not NHS culture wise, they're hopefully bringing in new blood …into the (NHS) culture (which) will be a definite advantage to the Health Services.*

4.2 The NHS Workforce: diversity and skills shortages

Refugees are a valuable source of skilled labour in an organisation with chronic skills shortages. All but one manager cited this as a positive impact of employing refugee professionals in the NHS:

> *…the dentist from overseas who has fitted into our dental department has been a great asset and it has been good for the staff to see what value he could add to the department*
>
> *The project has convinced me even more that we accept refugees with skills and then prevent them exercising these skills. If we accept refugees we need to invest in them not accept people into a culture of dependency. They will bring real benefits to the workforce.*
>
> *In the long term the NHS will be getting more skilled workers with a lot of valuable, relevant experience from abroad. On a day to day basis it gives our managers the opportunity to gain experience working with people from different cultural backgrounds and different origins. And that will certainly help the managers in terms of their knowledge and understanding of the sort of issues that come up when they're dealing with patients as well.*

Employment of refugees impacts positively on the NHS in relation to **ethical recruitment practice**. One manager identified this clearly:

> *…the reason the refugee project would help with (skills shortage areas) is that under DoH guidance we're very limited in terms of which countries overseas we can recruit from because we have to be sure that we're not depleting the resources within those countries.*

Refugee professionals are the refugee community. They are a multilingual, culturally and ethnically diverse group of people, well placed to understand and serve the diverse needs and concerns of their own communities. One refugee NHS employee enthusiastically voiced his experience within the NHS working as Refugee Health worker:

> *……in the team and I think the job what they (refugees) have been doing is great, because refugees are a bridge between the NHS as a big organisation and the refugee community they are working for. So they can in one way talk, speak on behalf of refugees and asylum seekers, at the same time they are helping the NHS to better serve that community.*

This view was strongly advocated by four out of seven managers, valuing **diversity in the NHS workforce as a tool to reflect and benefit a health service committed to meeting communities' needs:**

> *…our workforce should reflect the communities that live locally and therefore that involves actively going out and actively recruiting into those areas.*

> *…communities would be able to talk to somebody in their first language who would have an understanding of where they've come from, what they've gone through, what their previous services were, who would be able to educate around what the services are in the UK in a much better way'*

> *We took a nuclear scientist here ….. and that chap had very specific knowledge and understanding of the culture from which he came, which was then useful in terms of his interaction with patients.*

One refugee NHS employee empathised with how stressful working with asylum seekers could be for a non-refugee employee unfamiliar with all the issues:

> *….people are always complaining about the pressures, because an asylum seeker has come to see you not just with one problem, that's what makes them different. They've got quite a lot of problems, a lot of issues so I understand that for non-refugees nurses it is difficult.*

> *…….when I help somebody to get somewhere and get the service they need, that makes me happy and I don't feel any pressure at all because maybe I have the same background I can cope, I have gone through this difficult process so I understand people's problems better than somebody who is just a worker.*

Refugees bring added value not only in terms of additional language skills and diverse cultural awareness but also by providing overseas clinical experience not readily available in the UK, yet needed by patients. Access to specialist clinical skills and knowledge of patients from overseas was

recognised by several managers as highly advantageous. For example, one manager cited the case of an NHS colleague unable to re-qualify as a medical doctor, who had transferred her extensive experience to a project working on female genital mutilation. Highly regarded in the field and frequently consulted by medical colleagues, she is regrettably unable to undertake clinical procedures in which she is experienced without first re-qualifying as a doctor in the UK.

4.3 The business case for employing refugee professionals

There is a strong business case for creating employment opportunities for refugee professionals in skills shortage areas. Refugees were seen by NHS managers as a loyal workforce and provide greater retention than money invested into recruiting overseas staff:

> *Staff from abroad who are mainly from Australia tend to come for a two year period then they want to travel, so we do have to broaden our horizons further*.

> *……the stop gap approach of international recruitment is very costly in many ways …..financially it's excessively costly and the time limits and everything that managers have to put in, it's difficult to justify it because they only stay a few years, whereas if you're actually putting in people who are in your community then that - I know it's a challenge, it's not easy - but that's what we're here for.*

While many refugees bring professional skills, they initially find work in NHS at levels below their work and responsibility held overseas. If Trusts invest in these employees and support re-qualification as part of the NHS Skills Escalator, recruitment into skills shortage areas will be addressed cost effectively and quickly. One manager identified the economic benefits of employing and up-skilling refugee professionals as:

- reduced recruitment costs as there would be less need to recruit agency and bank staff and pay for advertising in the national press
- reduced levels of absence in departments with permanent staff

> *Where there are few temporary staff there tends to be less sickness absence because the workforce is more consistent and there is less pressure on the substantive individuals.*

Integration of refugee professionals into the UK labour market is positive for the individual and the economy. NHS managers highlighted this aspect:

> *… you reduce the level of potential dissatisfaction of people that come into the country….you provide, or you offer, work , you offer status, you offer income. They cease to be a refugee, they start to become an employee with a job title and through work to integrate with our society …*

There's a lot of people that could contribute to the productivity of the country.

The Diversity Works placement project demonstrates that, in many cases, while many refugees possess skills, a range of barriers prevents them exercising these and forcing them into a culture of dependency. The research interviews and project outcomes illustrate how skilled refugees bring real benefits to the workforce.

B. Factors that facilitate the process of recruitment and retention of refugee professionals.

4.4 NHS managers: promoting inclusion, challenging prejudice

As NHS managers become more informed about refugees, their potential contribution and the barriers refugees face entering employment, the greater the possibility for the inclusion of refugees in the workforce. NHS managers demonstrated some knowledge and understanding of refugees before they had had significant contact with refugee professional colleagues. Via training and direct contact with refugee professionals on work placements this knowledge base increased.

NHS managers' knowledge of refugee professionals included:

- The recognition that refugee professionals have skills that can meet the skills shortages in the workforce – and at levels commensurate with their knowledge and experience
- Refugees bring added value in terms of wide clinical experience, community languages and resourcefulness
- Refugees are a highly motivated group
- Retention rates for refugees are higher than for overseas recruits

An increased understanding of refugees as workforce contributors may influence policy and practice to operate more inclusively.

Conversely lack of knowledge may feed into unacknowledged prejudice and serve to undermine processes that enable refugee professionals' entrance to the labour market. One manager frankly expressed stereotyped views:

If they (refugees) do have experience but they're coming from another country, one tends to assume that their experience is going to be somewhat limited and some countries do obviously vary quite significantly from others. So if you like you are always going to treat it (refugees) with an element of reservation.

The same manager also acknowledged a challenge to these held assumptions as a direct result of supervising a refugee on work placement:

> *I don't know obviously whether XXXX (name) is representative of the type of people that you've had in general, but we would consider XXXX (name) as quite exceptional.*

All NHS staff need supervision and training to challenge stereotyped views that may impact on recruitment practice.

Research[21] shows that many refugee professionals' employment aspirations are also well below their previous work. This is unsurprising when facing numerous obstacles, including prejudice, to enter meaningful employment commensurate with their skills, in addition to any trauma they have experienced.

Another manager directly addressed the problem of prejudice openly:

> *… if they're the first person you've ever met who comes from Nigeria, Kenya, Somali or even Manchester, and those personal skills are not particularly fantastic, then that gives one a perception, albeit flawed, of what you know where people are coming from. The same if their clinical skills aren't very good …. it's human nature.*

Unacknowledged prejudice, individually or collectively within the NHS presents itself as restrictive recruitment practice. Likewise unless NHS managers practice supervision informed by a diversity awareness and knowledge of refugees, retention and promotion of refugees in the NHS workforce will be limited.

Several NHS managers commented on the levels of prejudice refugees face within the NHS as well as the potential to challenge their own perceptions, those of their staff and the public perception, if refugees enter the NHS workforce.

> *If (refugees) can be seen to be participating and fully functioning and taking their role within society then prejudice from the general population does reduce.*

> *We need some awareness what it means to be a refugee, in the press the information is very negative… I would like some stories of what motivates refugees and how best to support them.*

From the refugees perspective only one respondent cited experience of racism at work (non-NHS):

[21] Bloch A., 2004. *Making it Work, Refugee Employment in the UK.* Institute for Public Policy Research

.... I went to one job. On that day I felt guilty because when I spoke with one man he said, "you see all these refugees, when they come to this country, they take all our jobs, and everything" , and I felt guilty that I was the one.

He also contrasted this with the positive experience he had received from other employers. However it is well documented that many refugees face discrimination at every stage of the recruitment process[22]. Neither of the two refugees employed in the NHS had experienced or identified any form of discrimination while working in the NHS. However four out of seven refugees on work placement identified specific areas in which discrimination directly affected their access to their profession, this included:

- Professional bodies requiring less rigorous criteria from EU citizens compared with refugees. (For example refugees marrying EU nationals could be exempted from language re-qualification criteria)
- Two cited the English level required for doctors and dentists (IELTS score of 7.0) was prohibitively high. One NHS Trust had said they would accept a score of 6.0
- Non–recognition of overseas experience by employers

While refugee professionals and NHS managers agree about some of the factors working against refugees' entry to the NHS, refugees highlight additional factors which NHS managers demonstrated limited knowledge**.** These factors include prolonged immigration process, psychological trauma, time away from clinical practice, cross-cultural issues in the workplace and in recruitment practice, re-qualification, rights and entitlements to work.

***Re-qualification*:** NHS overseas recruits and refugees face the same issues in relation to language barriers, recognition and equivalence of qualifications. However additional hurdles refugees face include funding issues and the reality that many are unlikely to have current clinical experience.

***NHS Recruitment process*:** Refugees often find it hard to promote themselves in a conventional Equal Opportunities recruitment process in preparing application forms and during interviews. Refugee professionals with substantial experience may feel reticent about 'not boasting'; have low confidence, poor presentation skills, and unfamiliarity with employers' expectations. NHS managers need to be aware of this during recruitment; refugees need to seek employment support.

Rights and entitlements of refugees to work: while HR managers were relatively informed, only one work placement manager had knowledge of employment issues relating to refugees. Most managers assumed refugees, like overseas recruits, required work permits, which they do not. This led three managers to inaccurately express concern about applicants' temporary stay

[22] Bloch A., 2002. *Refugee's opportunities and barriers in employment and training*. Dept. for Work and Pensions, Research Report No.179

and the time taken to apply for permits. Two managers cited the costs of recruiting staff with temporary admission as a consideration in their decisions, even though this factor does not apply to refugees.
Lack of information has a bearing on managers' assumptions during the recruitment processes and adversely influences a recruitment decision.

Immigration process: Asylum seekers may wait years to receive a final positive decision from the Home Office thereby gaining leave to remain in the UK with permission to work. During this time they are de-skilled and confidence is eroded. A refugee on the work placement project waited 11 years to receive a decision after his asylum application was first refused. One refugee waited for over 2 years and commented:

> *You have a lot of restrictions and limitations on what you can do…*

Appeal processes can take from months to years and the psychological and practical barriers presented during waiting period are considerable. The appeal process delays refugees' access to appropriate training, education, re-qualification and entrance to meaningful employment.

Post-traumatic stress: NHS managers' comments demonstrated some understanding of refugees experience of post-traumatic stress on arrival in the UK following experiences in their home countries, compounded by settling into a new environment, language and culture. Trauma markedly delays refugees' integration and entry into employment, as one refugee explained.

> *I had difficulties, my husband was not well, he had depression, because at that time (my country) went through a lot of crisis, a lot of killing and political problems and he wasn't well. I stopped taking the PLAB and studying but still I was contributing for the (my country's) refugees and helping them and taking a lot of part in this movement.*

4.5 Refugee professionals work experience promotes inclusion

All refugees interviewed described their lack of UK work experience and therefore no access to UK employers' references, lack of professional contacts and networking opportunities, as major barriers to employment. Others cited barriers as a lack of knowledge of the NHS, lack of updated job specific skills and core skills such as IT.

> *The barriers I feel is the lack of experience, also the lack of knowing the system which is different. After all these years I still don't understand the system, the British system, how it works.*

> *I call it a vicious circle, you are asked to have experience but you cannot have any experience if you don't work actually.*

Refugees interviewed were frequently offered work at grades well below their previous work experience. Employers in general often discount overseas work experience. This has a profoundly detrimental impact on individuals' confidence.

Refugees views are echoed by NHS managers: five out of seven managers stated that without specific experience in the NHS entrance to jobs would be restricted to lower grades, though one manager commented optimistically on the acceptance of overseas experience.

> *In the Health Service we tend to say a minimum of six months' NHS experience. If they're a health professional they would have that - it's not in the NHS, it's in their own country but that shouldn't prohibit it.*

Two refugees employed in the NHS attributed their entry in to the NHS workforce to unpaid work experience. Both applied successfully for jobs advertised within the team in which they had been placed, in contrast to their numerous unsuccessful applications for the same jobs prior to work placement. Following the Diversity Works work placement programme three refugees found employment in the NHS, largely attributed to increased relevant work experience of the NHS and concomitant increased knowledge.

Managers are realistic - few would select a doctor with years of overseas experience against a doctor with experience gained in the UK, however limited. As one manager realistically said:

> *What could work against (refugees) would be the formal interview situation. Certainly a lack of UK experience which some managers still look at and also perhaps a lack of knowledge and understanding of working in the NHS and working in a large organisation within the UK, and that's why a work placement programme prior to any permanent jobs would seem like a good idea.*

4.6 Knowledge and practice of equality and diversity issues

All the NHS managers interviewed voiced concern about the capacity of the NHS Equality and Diversity Strategy to promote inclusion of refugees and other socially excluded groups into the workforce. A majority of NHS managers raised the thorny question of how the NHS could translate policy to practice at organisational level and management level. This is of particular relevance as all the managers interviewed had active roles in the recruitment and retention of staff. One manager observed:

> *We have a very diverse workforce but we don't have a diverse workforce across all strata of the organisation.*

The same manager highlighted routes into management and higher grades that appeared to exclude BME groups and women. Both groups as well as the disabled are priorities within the NHS Equality and Diversity Strategy.

One mechanism for monitoring diversity in the NHS workforce is the national NHS Positively Diverse Programme (Royal Free Hospital is a national lead site for the programme). Yet disappointingly only three out of nine managers interviewed at the time of the research had heard about the programme. Several managers felt that diversity issues and programmes were cascaded insufficiently to middle managers:

> *It's no longer sufficient to sit in an office and propose strategies or schemes that seem to tick the boxes you know, you have to go out and actively engage and find the people to participate in your forums and your steering group.*

While eight out of nine managers had attended training on 'Equality and Diversity', either through corporate training or in individual supervision, a majority said awareness came from the experience of managing diverse teams rather than the training and questioned the relevance of training, one suggesting she preferred regular monitoring and supervision.

Several NHS managers supervising work placements questioned the extent to which the equality and diversity policy is actually dependent upon the individual's principles. As one manager put it:

> *… every member is charged with going on certain mandatory courses and one of them is Equality and Diversity. But it's not something that to me is a theme in our working environment for people to consider it to be a part of their terms and conditions of how they work. I don't see that in myself. What I tend to personally rely on is my own character and I hope and trust that I reflect those principles in the way that I am.*

In RAGU's experience work placements for refugee professionals often stand or fall on the individual managers' commitment and attitude to inclusive practice.

However managers' comments also positively reflect their views and understanding of diversity issues and how this may impact on refugees:

> *The overall implementation of any sort of policy on diversity needs to be more inclusive; it needs to accept the basic differences of humanity of people in the workforce.*

> *As a general manager I see myself at the forefront of taking policy forward with regards to equality and diversity…. This has an effect on the staff as well as patients and other visitors to the centre in ensuring that there is fairness in the service that we provide, ensuring that there is equal opportunity within the staff team.*

Despite these positive views there also appears to be real ambiguity and an underlying distrust about the extent to which diversity practices should be mainstreamed in Trust policies on recruitment. For example one of the Trusts

did not at the time of the research operate positive action programmes. In several interviews with NHS managers there appeared confusion as to whether positive action programmes were even desirable, as evidenced by their comments:

> *…positive action for one group in society can become negative action against another and in London, particularly this part of London, which is completely multicultural.*

> *… no real need or justification for positive action, because …. equalities are meant to be all inclusive.*

These comments suggest an underlying a lack of understanding of the importance of developing a Diversity Management strategy alongside Equalities in the Trust. This attitude does not bode well for the inclusion of refugees or other socially excluded groups into the NHS workforce.

If managers express ambiguity in relation to Diversity practice, refugees on work placement did not experience this. One of the NHS employees was surprised and delighted that her manager facilitated her religious practice.

> *It was very good, downstairs we have a big mosque where I can pray in my lunchtime, on Fridays. I talked to my manager because in the winter the prayer was every two hours, and she said I can use an empty room here any time - even when I am fasting. Now, me and my colleague, we are Moslems so we have to have our tea break in the afternoon a bit later…*

Refugees may not express their cultural or religious needs openly if they are not aware of their employment rights, so managers need to encourage individuals to feel confident to enquire about how their diverse needs may be met.

Findings demonstrate that where the NHS can promote themselves as model employers within the refugee community in relation to Equality and Diversity, this will also encourage applications from refugee professionals. One refugee NHS employee said how impressed he had been by the opportunities available for training and development. It is perhaps easier to identify facilities to support say a range of religious practices, far more taxing to develop cohesive diversity management which celebrates and accommodates diverse cultural approaches which may be less transparent, such as team working.

4.7 Structural obstacles to social inclusion

Three key structural barriers were identified by NHS managers, which serve to reduce opportunities for refugee entry into the NHS workforce. These are:

- Time and staff resourcing for programmes
- Communication barriers

- Lack of champions for refugees whilst the NHS continues to recruit overseas health professionals.

***Time management and staff resourcing**:* All managers supervising work placements raised this concern, in terms of who takes the responsibility for providing additional training required by refugee professionals. This was brought into sharp relief when compared with the recruitment schemes for overseas staff who access adaptation courses via the Trusts. One manager described what is perceived as additional work as a 'burden':

> *The burden of having to train people to do a job without having the resources. From an employer's perspective, the fact that this person is highly skilled but they may well not have the experience of working in exactly that situation than somebody who's home grown, giving a bit more support. It's how much time do people have to give that support that might be an issue.*

Another manager commented on the lack of commitment by managers to take on board schemes for refugees:

> *Some people are more keen to, let's say, to help out at the very beginning. And some people will say well I don't want to do that because that's too much like hard work and I'll have them when they're ready.*

This comment also illustrates the prevailing view that refugees bear responsibility for integrating rather than steps being taken to ensure employers accommodate differences.

Individual Trusts' commitment to Equality and Diversity initiatives will reflect in the level of resources they make available for example on PA programmes.

Communication barriers and difficult access to appropriate NHS staff: Refugees often experience difficulties locating the most appropriate contact within the NHS for recruitment and networking. One manager advocated on behalf of a refugee placed in her team with difficulty:

> *….after three months I have not got to the bottom* of it (locating relevant NHS staff)*. How can we expect someone who's outside of the organisation to get involved, know who to contact and get through the communication processes? I don't think it's something that's specific to international recruitment or refugees, I think that's indicative of the whole NHS.*
>
> *It's an obstacle course; it relies very much on networking, finding the right person that will help you along, keeping close ties with the existing practitioner network. So you really do have to work on getting in first any way that you can.*

It is desirable that there are clear and identifiable channels of communication and that NHS staff are charged with supporting refugees and other socially excluded groups into employment in NHS Trusts, Workforce Confederations and Strategic Health Authorities.

Champions of refugees within the NHS have already made a substantial difference. Individuals charged with promoting refugee HP and AHPs in Trusts, Deaneries, Workforce Confederations and professional bodies have significantly changed the climate for in the last 8 years. However there are relatively few champions operating within the NHS as a whole. NHS managers interviewed recognised the need for more champions of refugees at Trust level to advocate and develop processes to support refugees' entrance into the NHS:

> *There has to be an understanding of the expectations of somebody who's joining the health sector from this particular group and how they could be assisted to move along a career path'*
>
> *The problems are whether the health sector recognises and have the processes in place to assist refugees…*

Champions for refugees in the NHS need to assert positive statements about refugee professionals as distinct from overseas recruits as illustrated by this comment from one NHS manager:

> *Often refugees have had such a bad press that the title, when you're talking about overseas-qualified professionals, gives it a different flavour.*

Champions need to be located at strategic positions in the NHS and at different grades in order to successfully influence, inform and advocate for refugee professionals. NHS managers' comments suggest three clear roles for champions:

a) Addressing NHS managers' lack of knowledge about where refugees come from (as an ethnically diverse and heterogeneous group).
b) Developing strategic innovative approaches to structural barriers in the NHS and professional bodies in order to tackle unemployment and draw the local community in to promote inclusion from all sectors of the community.
c) Long term investment in refugee professionals at all levels. For example one manager stated his concerns about the financial implications of employing unregistered refugee HPs.

> *…. they need to be state registered and there are cost implications.*

Yet it is known that short term funding does have long-term benefits. Dr Edwin Borman, chair of the BMA International Committee calculated:

it costs £250,000 to train a British Medical student to become a doctor, but as little as £10,000 to prepare a refugee doctor to practice
BBC news story 16/06/2004

The research findings pose three questions in relation to structural barriers:

- How can NHS managers be persuaded to invest in programmes to facilitate this adaptation period for refugee professionals within their teams and within their budget constraints?
- How can managers be supported within their NHS Trusts to engage in long-term investments to address skills shortages in their team?
- How to identify resources, human and financial, to invest in the promotion of refugee health professionals into the workforce in skills shortage areas top down, from the DoH to Workforce Confederations to individual NHS managers.

4.8 Positive action (PA) programmes and diversity management

Findings and project outcomes demonstrate tangibly that well managed positive action programmes, such as work placements, provide significant opportunities for refugees, consistently excluded from the labour market, to gain work experience and access to employment opportunities, as a refugee currently employed in the NHS explained:

I did a good job for more than one year, the first as a volunteer on work placement and then I joined the same team, as a paid worker for an agency, and I really liked the job there. I was really fitting the post, and it fitted with my personal experience.

One of the NHS HR managers identified the need for PA programmes:

The probability of an individual from a Black and Minority Ethnic (BME) group being successful in the selection process was less than that for a white person and therefore it wasn't just sufficient for us to keep recruiting, we needed to look at some local positive action initiatives'

PA programmes such as **work placements provide a mechanism for challenging unacknowledged prejudice** in the NHS and introducing managers and staff to potential recruits who might not otherwise access NHS vacancies. Following the work placement one manager's views about refugees had shifted to a more positive light.

….with the experience that we've had certainly we would consider people such as (this placementee) in a more positive light.

All NHS managers cited the advantages for PA programmes, as beneficial to the NHS and the individual placed. Most managers understood PA

programmes as work placements, however two managers extended this to include mentoring schemes, and networking opportunities. Importantly three managers spoke of the potential to create vacancies in 'intermediate roles' (see 5.9), to assist recruits such as refugee professionals into the NHS.

> *…it's about looking at people's skills and knowledge and where they want to go and supporting them from whatever background they're from because quite a lot of the people who work in East London actually haven't had a very good start in life.*
>
> *(Work placements) …are going to benefit the organisation they go into because a lot of the induction and the background work will already have been done.*

As NHS managers' knowledge and awareness of the issues refugees face increases, they will be more able to identify creative responses such as intermediate roles for refugees and be more effective in their advocacy role within the NHS. Managers can influence HR departments regarding staffing issues and act as local champions for refugees within their Trusts.

One manager suggested PA programmes could include specialist supervision by refugee agencies for newly employed refugee professionals to support them and aid retention by providing time to discuss non-clinical issues.

> *From a managerial perspective to ensure that if issues come up they can be explored and dealt with at the time…….there may be issues of culture, they may not have understood or it may be particular difficulties that they are having, taking into account that some refugees have had quite severe traumas and that there may be times when those traumas catch up with them.*

The specific benefits of the work placement programme as part of PA programmes were viewed by managers as:

- An unpaid induction programme
- Additional staffing to address acute staffing shortages
- Enhancement of the organisation and the service provision
- Reflection of the community accessing health care
- A potential source of recruits from an untapped pool of skilled workers
- Accelerated integration for refugees

Managers summarised the benefits of PA programmes as:

> *The project (work placements) has convinced me even more that we accept refugees with skills and then prevent them exercising these skills. If we accept refugees we need to invest in them not accept people into a culture of dependency. They will bring real benefits to the workforce.*

I think this is one of the things we've got to look at as a luxury induction programme into the NHS and its associated partner agencies.

However two managers, both working in community care settings, cautioned against the importance of not alienating sections of the community by introducing PA for exclusive groups and the need for careful management of the process.

Another beneficial dimension to PA programmes, such as work placement, lies in the refugees' increased access to internal vacancies. In order to promote the diversity of the workforce in one of the Trusts, recruitment for non-specialist posts occurs initially internally. This is followed by progression to staff grades in line with the personal development plans and the NHS Skills Escalator[23]. This process would clearly provide opportunities for refugees on work placements who would otherwise not access Trusts' internal vacancy listings.

Work placement managers recognised the need for refugees to be provided with specific support to enable them to take up positions relevant to their professions:

… this person may well be highly skilled but they may not have the experience of working in exactly that situation, so giving a bit more support has to be an understanding of the expectations of somebody who's joining the health sector from this particular group and how they could be assisted to move along a career path.

Diversity management is about supporting and managing different perspectives and views and diverse needs within a workforce.

4.9 Intermediate roles: creative ways of working

Intermediate roles offer a creative way to engage refugee HPs in middle grade posts and enhance their employability in the NHS. Intermediate roles already developed, such as nurse practitioners contribute cost-effective and innovative measures to the NHS service delivery. These roles fall neatly within the recruitment and retention initiative of the Skills Escalator outlined in the NHS Plan 2002 and the NHS Equality and Diversity Strategy. The Skills Escalator aims to:

Enable staff within the NHS to develop new skills….and move into new roles…... to assist recruitment to the NHS while tackling long-term

[23] The Skills Escalator is one of the four pillars in the NHS Plan to ensure that NHS staff are encouraged through a strategy of lifelong learning to constantly renew and extend their skills and knowledge, enabling them to move up the escalator. Dept. of Health: www.dh.gov.uk/PolicyAndGuidance

unemployment and social exclusion.

NHS Equality and Diversity Strategy 2003

Refugee medical doctors without UK registration may undertake intermediate roles such as Physicians Assistant or Health Care Support worker. These roles operating within regulatory guidelines, and therefore restricting clinical practice, nonetheless provide refugees health professionals with:

- Understanding and experience of the NHS: structure and policies
- Cultural familiarisation: for example, practice related to patient choice, quality assurance, team-based work
- Familiarisation of procedures and protocols, both clinical and administrative
- Enhanced work based communication skills
- Prevent loss of clinical skills and 'gap' in work experience while undertaking re-qualification
- Access to mid-grade level posts as a first step into the NHS workforce
- Up to date technology - equipment and computer based systems

Developing a wider range of roles readily accessible to refugee HPs and AHPs in the process of re-qualifying is therefore a highly desirable.

Work placement managers identified the value of intermediate roles for refugees:

> *If we're talking specifically about medical laboratory assistants, they will bring skills with them that are directly transferable to the workplace.*
>
> *….you would have to give that person some kind of career structure whilst they're working through their re-qualification rather than saying you know, come in at the lowest level and stay there for the next three years.*
>
> *…. there may be people who were at a dentist's level in another country that may be quite happy to come and do hygienist and therapist work because it doesn't take all the qualification hoops to jump through to get to be a dentist, and they can take their time to work themselves back up to being a dentist.*

The last manager gave an example of mini-projects in general dental practices set up for overseas qualified dentists on an individual basis while they re-qualified and this could be extended to refugee dentists.

However structural barriers in the NHS were cited as the main obstacle to developing these roles by one manager:

> *The intermediate role, depends how you interpret that really. I think under organisational development, looking at creative resourcing within the NHS, we probably need to look at that but it is quite difficult*

as yet to see how we fit it in.

4.10 Facilitating the conversion of overseas qualifications

Lack of recognition of overseas qualifications by employers combined with the hurdles of professional re-qualification is arduous for experienced refugee professionals. Re-qualification is costly, pre-requisite language exams delay many proceeding further and finding clinical attachments is competitive.

Seven out of the nine refugees interviewed had professional qualifications or a degree combined with substantial professional experience. None of their qualifications were recognised in the UK at the same level of equivalence. All cited re-qualification as necessary to gain full registration with the UK professional bodies, and thus a major obstacle to entering employment at levels commensurate with their previous qualifications and experience.

The non-recognition of overseas qualifications by employers has a profoundly negative impact on refugee professionals as one refugee commented:

> *…….when I came here I wanted to know how I could use my background in medicine, but then I found it very difficult because my qualification back home wasn't recognised. I lost confidence. I basically thought I could not do a job in this country unless I completed a degree in the UK…*

Several refugee professionals felt that the re-qualification process established by some professional bodies was inherently discriminatory. For example the General Dental Council under European law exempts EU nationals (and refugees married to EU nationals) from the IELTS exam for English language, but not refugees in Britain. Likewise EU nationals (and refugees married to EU nationals) have access to an alternative and free re-qualification route via individual assessment, which is not accessible to refugees in Britain, (they have to sit the International Qualifying Exam, which is prohibitively expensive for many refugee dentists). These type of ambiguities need to be addressed by health professional bodies.

Many refugee professionals arrive without the documentation of their professional qualifications and training. Employers have an important role in this process, as explained by one refugee respondent:

> *We are refugees; we have no line to communicate in our country's training centres or universities. Our knowledge in this case are only in our mind, because we fled from our country, we are wanted people, how could you produce that paper, references, it's too difficult … Even for simple jobs they need papers so it's difficult to reflect your profession. What we need is let employers see us, putting us somewhere and give us something to do, then they can determine what we are. Because we have got skills.*

Processes, which enable the recognition, transfer and development of overseas qualifications, skills and experience into the NHS, will enhance the recruitment of refugees. Several managers presented creative ways in which to overcome the qualification barrier in the NHS. For example in one Trust, overseas recruited staff were sent on adaptation courses with costs covered by the departments. This could be extended to refugee professionals employed in the NHS.

However another manager commented on the need for joined up thinking between DoH, NHS executives and professional bodies and the structural barriers that need to be overcome:

> *I know the DoH at a senior level is looking at the re-qualification delay, but as an organisation we're powerless to do anything about that. We can't speed up that process. That doesn't just apply to refugees, it also applies to people who already have the right paperwork so therefore it must be so much harder for refugees.*

4.11 Specialist employment support for refugees

Seven out of nine refugees cited support from specialist refugee agencies (RAGU, RETAS, Refugee Council and Praxis were named), as a key factor in helping them towards employment. All respondents have been clients at RAGU and found significant help from one to one careers guidance, English for Health Professionals courses and the specialist re-orientation courses for refugees – Accreditation of Prior & Experiential Learning (APEL).

> *It (APEL course) helped me to explore everything about myself, my experience, my knowledge, and how to present it to the employer, how to go to a job interview and tell them exactly what I know, what I can do for them and how I can use my knowledge and experience to help them in the job. The most helpful part was sending me to work placement.*

However in the absence of knowing where to access employment support, many refugees rely on friends for advice with mixed results. One refugee on advice from a friend soon after her arrival was told: *' I shouldn't go to be a doctor again……'* and as a result had spent years *not* pursuing her previous profession.

It is vital that refugee agencies promote and maximise access to their services across all refugee communities to support refugee professionals into the NHS.

However even with this support there are structural barriers. For example the bottleneck of newly re-qualified refugee doctors seeking first appointments in competition with British graduates for limited entry-level posts. In addition refugee health professionals often need support in their first postings to substantive career posts. St Mary's Hospital, London, recognised this need

and developed the first refugee doctor GP Vocational Training schemes. These have proved very successful in enabling refugees into posts.[24]

A key barrier to passing the recruitment process and working in the NHS cited by refugees and managers is lack of job search and presentation skills.

Another manager suggested that the process of Equal Opportunities recruitment posed in itself a major obstacle in applications, and stressed the importance of refugees accessing support for this process:

> *Having good assistance and support in ensuring that their applications stand out - most of them do have the skills but, putting it down in writing tends to fail them….*

NHS recruitment teams should be active in sign-posting all enquiries to refugee agencies providing specialist quality employment support.

4.12 Language and presentation skills

Language barriers are cited as the key reason that refugees are unable to access employment.[25] However all the refugees interviewed stated that they felt they had sufficient communication skills to undertake work competently. However when it comes to competing in equal opportunities recruitment procedures, alongside candidates with English as their mother tongue, refugee professionals felt they faced little chance of success. All the refugees interviewed recognised the need to further develop their language skills, while also feeling confident to undertake appropriate employment.

Refugee confidence in their language skills was endorsed by most managers. Managers assumed language fluency would present problems with the refugee professionals placed in their teams, however this proved not to be the case. Nonetheless all managers recognised that language and communication skills present a hurdle to refugee professionals speaking with a diverse range of people as one manager commented:

> *The problems of communication skills across a diverse range of people and of being able to develop somebody who has English as a second language sufficiently well that they can communicate with other people who have English as a second language.*

However this view pre-supposes that it is harder for refugees than non-refugees to communicate across linguistic barriers. Similarly two managers raised the issue of accents.

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[24] Jackson N, Carter Y.,ed., 2004. *Refugee Doctors, support development and integration in the NHS.* Radcliffe Publishing

[25] Bloch A, (2002), *Refugee's opportunities and barriers in employment and training*, Dept. for Work and Pensions, Research Report No.179

It isn't a problem staffing wise, the fact that they've got a different accent, they've been training somewhere else, it's very common in this part of London.

It is not uncommon for a predominantly white British workforce to assume that their accents are homogenous, (which is clearly not the case), while overseas employees are perceived as having accents. This misconception works against many refugee professionals, who may have perfectly competent language skills.

4.13 SUMMARY

4.13.1 Conclusion

The case for the social inclusion of refugee professionals into the NHS workforce is that it leads to:

- Increased health and well being of refugee professionals
- Meeting skills shortages in the NHS workforce are met
- Diversity in the workforce, reflecting the diversity of service users
- Greater understanding of NHS staff towards refugee and asylum seekers accessing the NHS.
- Better staff retention and added value (community languages and overseas clinical experience)

4.13.2 For refugee professionals (RP)

a) Refugees identified areas of discrimination specifically related to re-qualification.

b) Access by RPs to work experience in NHS and other PA initiatives to familiarise them with NHS culture and practice considerably enhances their opportunities to compete fairly in the labour market and enter the NHS workforce.

c) Access to information on NHS skills shortages, access to recruitment processes and vacancies, effective job search and employment support serve to increase opportunities from refugee HPs and AHPs.

4.13.3 For NHS managers

a) Increased knowledge and experience by NHS managers involved in the recruitment process about the specific needs of RPs as potential recruits, their rights and entitlements to work will enhance recruitment of RPs into the NHS and reduce acknowledged prejudice.

b) Positive perceptions and awareness by NHS managers, at all levels, about the contribution RPs make in terms of skills, expertise, cultural awareness, languages, knowledge of refugee community health needs, commitment, motivation and resourcefulness enhances opportunities for RPs to enter the NHS.

c) Champions of refugees in the NHS at strategic positions and at varying levels of management will bring greater opportunities for refugee professionals' recruitment and retention in the NHS.

d) Development of new intermediate roles in the NHS appropriate for refugee HP and AHP will create genuine entry-level posts for refugee professionals.

e) Removing the structural barriers in the NHS that prevent the smooth re-qualification of refugee HPs and AHPs whilst they undertake intermediate roles, (along the lines of overseas recruits) promotes opportunities for their progression and retention.

f) NHS managers' increased knowledge and commitment to effective equality and diversity practice in team management, individual supervision, staff training (including their own) and development of staff all serve to promote progression and retention of refugee professionals in the NHS.

g) Refugee HP and AHP employees in the NHS need support once in post to address cultural adaptation, updating of clinical skills and post-traumatic stress, without which retention is reduced.

h) Post-traumatic stress compounded by the strain of adapting to entirely new work environment, culture and language delays refugee professionals' settlement and integration into the general labour market and especially into appropriate employment in the NHS demanding emotionally charged case work.

i) Language and communication skills commensurate with the job are pre-requisites to successful applications and entering the NHS at appropriate skills levels. Refugee professionals need to access opportunities for language development in structured training as well as in the work place.

4.13.4 For policy makers

a) Lengthy immigration processes and lack of early skills assessment of asylum seekers and refugee HPs and AHPs increases the time away from clinical practice, delays re-qualification, and may, in fact, bar them from re-qualification.

b) Re-qualification processes are expensive, lengthy and can be excessively rigorous, creating a major obstacle for experienced refugee HPs and AHPs to return to their profession. Ambiguous guidelines from professional bodies on re-qualification hamper attempts to re-qualify and unreasonably favour those with EU nationality (refugees or otherwise).

Chapter 5

RECOMMENDATIONS FROM THE RESEARCH STUDY

Chapter 5
RECOMMENDATIONS FROM THE RESEARCH STUDY

5.1 Recommendations for NHS Trusts

1. Trust Boards are recommended to **develop refugee specific strategies** within the Trusts' Equality and Diversity strategy to include:

    - Training delivered by refugee agencies for all NHS staff on refugee issues, as a patient group and as a workforce.
    - A range of Positive Action initiatives, including work placement, designed to meet the needs of refugee HP and AHP in consultation with refugee agencies experienced in the delivering employability programmes
    - Working groups focusing on specific socially excluded groups (e.g. refugees, disability) to: a) identify structural barriers and strategies to promote recruitment and retention for refugees and b) promote strategies for more equitable health care access and provision by refugees and asylum seekers

2. Trusts need to **raise the NHS profile to refugee professionals and the refugee communities** to promote NHS as an employer committed to Equality and Diversity practice in the workforce, inform communities about vacancies, promote access to employment initiatives and to signpost candidates to specialist refugee agencies for employment support in their recruitment application packs

3. NHS needs to work with refugee agencies in **training for Trust staff to raise awareness and promote refugee professionals** (including HPs and AHPs) as a skilled, experienced and untapped workforce

4. Trusts need to **identify key structural barriers to recruitment and retention of refugee** professionals into the NHS and address these through practical measures within the NHS Equality and Diversity agenda, (to include re-qualification processes)

5. Trusts are recommended to **develop adaptation and re-qualification programmes** for refugee HPs and AHPs along the lines of overseas recruitment programme, which includes induction to the NHS and support to attend training and liaison with professional bodies.

6. Trusts need to **develop strategic Positive Action initiatives for refugees**, including work placements, across departments and at different grades in partnership with refugee agencies.

7. Trusts need to develop **partnerships with refugee agencies** who have expertise in **managing work placement programmes** for refugee HPs

and AHPs in order to develop a range of work placements across departments. This would include:

- Develop a strategic approach to initiate, promote and manage work placements
- Engage NHS managers supervising work placement programme
- Provide sufficient resources for manager for supervision for work placements
- Reward NHS managers supervising work placement, acknowledge their work, and develop a recognised continuing professional development plan including information on, for example, supervisory responsibilities, and developing closer links between work placement managers and HR
- Use corporate training to enhance refugees' work placements
- Develop strong links and support for the project from the Unions to ensure unpaid work placements are not vacancies and refugee professionals are not exploited while on unpaid work placement
- *Identify funding sources to meet work placement costs, drawn from budgets to promote Diversity. Trusts initiating these projects should be rewarded by the DoH for actively promoting the Equality and Diversity Strategy*

8. NHS Trusts recommended to **identifying champions within the NHS**, (executive, senior management and team leaders in clinical and non clinical roles), to address refugee workforce issues for existing staff and to promote entrance to the NHS in refugee communities by developing intermediate posts, entry-level posts for refugee professionals commensurate with their skills.

9. NHS Trusts need to **conduct research on the contribution of refugee HPs and AHPs** currently employed in the NHS in relation to:

- Levels of qualifications, skills and experience
- Grades at which they are employed, and number of years at these grades
- Access to professional development and promotion
- Impact of refugee professionals in the workforce on reducing health inequalities

10. Trusts with Workforce Confederations should **identify and develop a range of intermediate role** vacancies throughout the NHS, to provide access to NHS for skilled and experienced refugee HPs and AHPs undergoing re-qualification

11. Trusts should work in **partnership with Job Centres** to develop employability programmes for refugee HP and AHPs for appropriate level employment, (already begun in some Trusts for lower grade posts)

12. Trusts are recommended to work with refugee agencies to provide **specialist guidance supervision services to new and existing refugee employees** to aid retention and progression

5.2 Recommendations for refugees agencies

1. Refugee agencies need to **develop partnerships with NHS Trusts**, across London, to deliver quality work placement programmes for refugee health professionals (HPs) and allied health professionals (AHPs) in primary, acute and secondary care.

2. Quality and well managed **work placements for refugee professionals need to include**:

    - Careers guidance matched with appropriate selection and assessment procedures: refugee agencies are responsible for ensuring as far as possible that individuals are suitable for work placements in terms of their career paths and their capacity to act as role models for the refugee community in the UK labour market

    - Pre-placement training including cross cultural communication to prepare refugee professionals fully

    - Negotiated work placement roles that maximise opportunities for refugee professionals and for the NHS teams in which they work, modelled on intermediate roles for health professionals and developed by refugee agency and NHS work placement managers

    - Work placements should be no less than 3 months for 3 days a week and preferably longer in order to increase the range of activities and experience

    - Reflective work placement supervision guidelines and support to refugee professionals and managers in this process to maximise mutual learning and development

    - Opportunities for refugee professionals and work placement managers to discuss issues as they arise in a supportive and constructive environment

    - Strategies to assist refugee professionals to record and engage in reflective learning methods while on work placement. Learning objectives should be identified by refugee agencies and NHS managers for each work placement so that refugee professionals and managers have clarity and are able to carry out effective supervision and initial assessments after 3-4 weeks. Objectives could include specific skills and familiarisation with equipment needed for roles, as well as knowledge of NHS structure, protocols, and policies in practices

- Project steering groups to guide work delivery of placement projects to include refugee agencies with experience in running programmes, refugee professionals who have attended work placements, NHS managers with experience of work placements and NHS managers with responsibility for delivering equality and diversity agenda

- Refugee agencies should extend and develop quality guidance, specialist training and employment support to refugee professionals following work placements

3. As part of NHS Equality and Diversity Strategy, refugee agencies with refugee HPs and AHPs, are best placed to **deliver training to NHS Trusts** on promoting refugee professionals as skilled and experienced contributors to the workforce. This training would inform NHS managers on refugees' rights and entitlements to work, raise awareness of cross-cultural issues, processes to manage refugee work placements projects, develop briefings to the NHS to include refugee case studies and employers experience

4. Refugee agencies need to **continue to lobby DoH and Department for Work** and Pensions (DWP) to develop a cohesive and integrated policy and practice in relation to refugee HPs and AHPs

5. Refugee agencies need to **conduct more extensive research with Trusts participating on work placement programmes** to find out if the recruitment of refugees to the NHS increases, and at what grades and to research refugee employees' retention and progression within the NHS.

6. Refugee agencies to **research alternative pathways** for HPs and AHPs and the development of intermediate roles.

7. Refugee agencies need to **develop partnerships with social service departments and voluntary sectors** across London, to deliver well managed work placement programmes for refugee HPs and AHPs for those who wish to transfer expertise and skills to related and alternative career paths

8. Refugee agencies are recommended to **develop programmes for new and existing NHS refugee professional employees** with Trusts, to provide careers guidance and counselling to increase retention rates and further their progression

9. Refugee agencies need to work in **partnership with Job Centres** to develop specialist employability programmes as part of New Deal training and provision for refugee HPs and AHPs, to enable attendance on work placements without loss of benefits or pressure to enter inappropriate employment

5.3 Recommendations for policy organisations

1. **Confederations should work with DWP** to support local Trusts' positive action programmes to promote entry into NHS employment

2. **Professional bodies should identify barriers to re-qualification** for refugee HPs and AHPs and create transparent and fair processes that enable and support for registration of refugee professionals while maintaining professional standards of practice

3. **Job Centres should facilitate processes for refugee professionals** to access appropriate training, employment support, work placements and pathways into meaningful and sustainable employment and ensure that those on these programmes are not obstructed in their progress

4. **Department of Health (DoH) should create funding streams** to encourage Trusts to develop Positive Action programmes as part of the Equality and Diversity Strategy, for initiatives such as work placements and mentoring, so that programmes have sufficient resources to be delivered effectively

5. **DoH and DWP should develop integrated policies** to enable refugee HPs and AHPs to access training, and work placements while on Job Seekers Allowance in order to gain access to appropriate jobs in the NHS and contribute to NHS workforce shortages

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APPENDIX 1

GLOSSARY

Allied health professional
Allied health professionals include arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, medical engineers, occupational therapists, orthoptics, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists.

Asylum seeker
Asylum seekers are people who have made a claim for asylum, but whose case has not been decided by the Home Office.

Health inequalities
Health inequalities are the differences witnessed in health indicators such as cause of death, risk of death from particular diseases and life expectancy. They are used to study why such differences exist and inform decisions likely to have an impact on particular groups.

Health professional
Includes professions such as medical doctors, nurses, and midwives.

Hospital Trust
Hospital Trusts usually offer a general range of hospital services to meet most people's needs. Some trusts also act as regional or national centres of expertise for more specialised care, while some are attached to universities and help to train health professionals.

IELTS
International English Language Testing System. The test covers all four language skills: Listening, Reading, Writing and Speaking.

Equalities and Diversity: Strategy & Delivery Plan to Support the NHS (October 2003)
This draft publication details how the Department of Health can help NHS organisations meet their legal and statutory duties and obligations in respect of equality and diversity. It also outlines how the Department of Health intends to approach some of the key equalities and diversity issues and challenges over a five year period. The DoH will be preparing their final plan in 2006.

Refugee
A refugee is a person who has been granted asylum by the Home Office. In this report the term is also used to refer to those granted Exceptional Leave to Remain (ELR), Humanitarian Protection (HP), or Discretionary Leave (DL) to remain in the UK.

PLAB
Professional and Linguistic Assessment Board test, which demonstrates that an individual has the necessary skills and knowledge to practice medicine in the UK. The General Medical Council uses the PLAB test to ensure that overseas doctors have the basic medical competence and communication skills to work at Senior House Officer (SHO) level.

Positively Diverse
The Positively Diverse programme was developed in the NHS to encourage equality and diversity in the workplace. In order to improve patient care, this programme helps organisations establish links between communities served and those involved in service delivery.

Primary Care Trust
Primary Care Trusts, (PCTs), provide services in the community. They are called primary care services because they are often the first point of call e.g. GP practices, pharmacists, dentists and opticians. PCTs also manage community services such as district nursing, community hospitals and clinics.

APPENDIX 2

INTERVIEW SCHEDULES FOR REFUGEE PROFESSIONALS

First Interview: BEFORE WORK PLACEMENT BEGAN

General

1. Tell me about your education, qualifications or training that you have had?
2. How do you feel about your English language skills for work?
3. What sort of work (if applicable) did you do before arrival in Britain?
4. Could you tell me about your experience of trying to find work in the UK?
5. Did you get any help in finding or applying for jobs?
6. What is your experience of the process of applying for jobs?
7. Have you experienced barriers or difficulties in trying to find work?
8. Have you experienced any racism or discrimination when enquiring or applying for a job? Please explain.
9. What are your short-term and long-term employment plans?
10. Are you aware of any differences or similarities in the work environment between this country and your own country?
11. And specifically in terms of your skills and knowledge in your field of work, how will these be useful in the UK?

Work placement questions

12. What are your expectations of this work placement?
13. What do you believe the employer might expect from you? Which skills would you like to develop in the work placement?
14. Why do you want to work in the NHS?
15. Are there any particular adjustments you need to make for this work placement?

Second Interview: 3 MONTHS INTO the WORK PLACEMENT

1. Firstly please tell me how you feel being on Diversity Works has gone.
2. Now you have completed your placement please tell us how useful, or otherwise, the individual RAGU training sessions (see below) were for you in preparing you for work placement in the NHS.
3. Are your short-term and long-term employment plans the same or different from our first interview? If different, how have they changed?
4. Please describe some of the key similarities and differences you have experienced between this UK workplace and your previous experience overseas.
5. Since being on work placement what have been your key learning experiences in about the NHS?
6. Since you have begun a placement, what are the key things you have learned in relation to your current short-term and long-term career plans?
7. What have been the main benefits of the work placement for you?
8. Did the work placement present you with any problems? How did you resolve these?
9. What changes would you recommend to the work placement programme?
10. What are your main training / development needs in the short-term and long-term in terms of finding employment?
11. What factors may make it difficult to achieve the above? Would you like now to work in the NHS? Why / why not?
12. Would you recommend this programme to others?

INTERVIEW SCHEDULES FOR NHS MANAGERS & HUMAN RESOURCE MANAGERS

First Interview: BEFORE WORK PLACEMENT BEGAN

Equality and Diversity policies and the Positively Diverse programme

1. Could you briefly describe your own role and responsibilities in the organisation?
2. How does the Trust ensure Equality and Diversity policies are implemented at all levels of the service?
3. What is your role in implementing Equality and Diversity policies in your team / organisation?
4. What is your role in implementing the Positively Diverse programme in your team / organisation?
5. What training have you had in the implementation of Equality and Diversity policies and the Positively Diverse Programme?
6. What management support would you like to have to assist you in the implementation of Equality and Diversity policies and Positively Diverse Programme?

Refugees and Asylum Seekers

7. What is your experience of hosting refugees/asylum-seekers on work-placements or any other initiatives in your team?
8. In your view what do you think are the pros and cons of positive action strategies to encourage the employment of refugees and asylum-seekers, in general, in the UK Labour Market?

8. What do you think are the pros and cons of positive action strategies to encourage the employment of refugees and asylum-seekers in the NHS?

9. In your view are there advantages and /or problems associated with employing refugees / asylum seekers in the health sector?

10 a) What do you think are the factors that work with and against the successful recruitment and retention of refugee professionals?
b) What is the likely impact of employing refugees?

10. Are you aware of the rights and entitlements to employment of refugees and asylum seekers?

Work Placement Questions

12 a. What support is available to you while managing a work placement?
b. Is there any further support you need / would like?

13. How were you asked / persuaded to become involved in the Diversity Works project? - what info were you given? was it sufficient? in a manageable format?

General

14. In your view what similarities and or differences do refugee staff bring compared with regular BME staff in your work force?

Second: 3 MONTHS INTO the WORK PLACEMENT

Refugees and Asylum Seekers

1. Prior to the Diversity Works in the NHS project with RAGU what was yours / Trust's experience of hosting refugees/asylum-seekers on work-placements or other positive action strategies to encourage the employment of refugees in the NHS?
2. In your view what are the pros and cons of positive action strategies to encourage the employment of refugees and asylum-seekers in the NHS?
3. In your view are there advantages and /or problems associated with employing refugees / asylum seekers in the health sector?
4. In your view what are the factors that work with and against the successful recruitment and retention of refugee professionals?
5. What is the likely the impact of employing refugees
a) on the NHS workforce? b) on NHS services?

6. What steps do you take to keep up to date regarding rights and entitlements to employment of refugees and asylum seekers?

Work Placement Questions

7. What has been your role in the management of the work placements since they began ?
8. In hindsight how sufficient, manageable was the information given to you prior to the project?
9. What were the main issues for you in setting up the placements? Do you recommend any changes to this?
10. How much involvement have you had in the management of the work placements since they began?
11. What have been the benefits so far of providing the placement opportunities to skilled refugees for: yourself / team /NHS in general?
12. Were there any problems associated with providing placement opportunities to skilled refugees, and how did you seek to resolve these?
13. Would you consider offering further placements to skilled refugees?
    a) If not why not?
    b) If yes what changes or recommendations do you have for making the existing programme more effective?
14. Are there other positive action strategies the Trust would consider to promote employment opportunities for skilled refugees?
15. What would be the advantages / disadvantages for your Trust in developing intermediate roles for health professionals?

INTERVIEW SCHEDULES FOR REFUGEE PROFESSIONAL NHS EMPLOYEES

General

1. Describe your own role and responsibilities in the organisation? How long have you been in post?
2. Could you briefly tell me about your education, qualifications or training that you have had?
3. What work (if applicable) did you do before arrival in Britain?
4. Could you tell me briefly about your experience of trying to find work in the UK?
5. Have you experienced barriers or difficulties in trying to find work in your profession?

Recruitment and Retention in the NHS

6. Why did you chose to work in the NHS?
7. Were there any factors that worked to help you enter the NHS as an employee?
8. Were there any factors that worked against you in entering the NHS as an employee?
9. As a refugee professional in the NHS what specific issues or needs do you have?
10. As an NHS employee how are you being supported to deal with these issues?
11. Have you experienced any racism or discrimination within the NHS?
12. What are your short-term and long-term employment plans within the NHS? How are you being supported to achieve these?
13. In view of your experiences, what recommendations would you suggest to your NHS employer to encourage the employment of skilled refugees into the NHS?

Diversity Issues

14. In your view what are the advantages to employing refugees in the NHS?
15. What if any are the disadvantages of employing refugees in the NHS?
16. How has employment in the NHS impacted in a helpful or unhelpful way on your own well being and health?
17. a) How familiar are you with the Trusts Equality and Diversity Policy / Positively Diverse?
    b) Have you had any training in any of these areas?