Integration of Internationally Educated Nurses to the UK: The lived experience of Nurses with Nigerian Heritage in the London Region.

A thesis submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Philosophy

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November 2021

ABSTRACT

This study explores the lived experiences of integration of internationally educated nurses (IENs) with Nigerian heritage into UK healthcare using an interpretive phenomenological analysis (IPA) approach. Semi-structured interviews with ten participants using open-ended questions were used to collect data for this study.

The analysis of the data resulted in five master themes:

- Individual opinions, concepts and experiences of integration
- Challenges to integration
- Personal and social integration
- Career progression
- Obstacles and measures to thrive.

Theme one examines understanding integration and the reality of integration**;** theme two explores experiences of social integration and discrimination issues; theme three explores immigration issues, social relationships, language and cultural currency and pension issues. Theme four explores issues around education, mentorship/access to coaching, and individual characteristics. Lastly, theme five explores employers' practices and discriminatory practices.

The study contributes to the sparse literature on the lived experience of internationally educated nurses (IENs) on integration into UK healthcare. It offers insight and further understanding into the post-transition phases and the long-term integration of the internationally educated nurse (IEN) with Nigerian heritage into UK healthcare. The findings suggest that integration in the UK and UK healthcare services is a complex phenomenon shaped by immigration processes, employers' practices, social capital, discrimination, mentoring and personal characteristics such as education, resilience, motivation and personal values. The findings from the sample also suggest that most of the highly successful IENs of Nigerian heritage in UK healthcare tend to be those who had tertiary education in Nigeria before becoming registered nurses in the UK.

In light of the findings, the recommendations include further research on understanding the concept of nurse integration and how internationally educated nurses to thrive in UK and UK healthcare.

ACKNOWLEDGMENT

I dedicate this thesis to my beloved parents, Mr Ugiagbe Edegbe and Mrs Alice Aiwekhoe Ugiagbe, for their effort in sending me to school. I appreciate you, and may your souls continue to rest in peace. Amen.

I am grateful to my dear wife, Fancy Ugiagbe, for her support and encouragement in completing this study. I am equally thankful to my children, Aisosa, Osafumen, Iwinosa and Osasuyi, for their encouragement. I am incredibly grateful to my daughter Osasuyi Serene for proofreading the manuscript numerous times during this study.

I want to thank Professor Helen Allan, Professor Mike Traynor, Professor Linda Collins and Professor (Emeritus) Kay Caldwell for providing me with expert supervision during this study. Your guidance, critique, and detailed and encouraging feedback gave me the impetus to complete this study on schedule. I am grateful to you for your support.

I am grateful to all the participants in this research for sharing their lived experiences with me during the interviews. Thank you very much for your participation in this project.

Above all, I thank the Holy Spirit for the prompts, direction and guidance in completing this study. May God's grace, mercy and love be multiplied unto me and my household continually. Amen.

KEYWORDS

Integration, Internationally Educated Nurses, Registered Nurse, IPA, Interpretative Phenomenological Analysis, Phenomenological, Overseas nurse, Recruitment, Migration, Career progression.

DECLARATION OF AUTHORSHIP

This dissertation is written by Iyore Monday Ugiagbe and has ethical clearance from Middlesex University. It is submitted in partial fulfilment of the requirements of the Faculty of Health, Social Care and Education and Middlesex University in partial fulfilment for the degree of Doctor of Philosophy (PhD) in Nursing (Adult).

The author is wholly responsible for the content and writing of the dissertation and reports no conflicts of interest.

Anonymisation and transcript conventions

Some of the participants during interview sessions mentioned names of individuals and organisations. Most names have been represented with xxx to preserve anonymity and confidentiality and ensure accurate idiographic representation of the lived experiences.

[comment] comment inserted by researcher

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… speaker pauses or drifts off

Bold letters Emphasise the word or phrase stressed by the participant during the interview.

ACRONYMS (Table 1)

ABBREVIATIONS	MEANING
AfC	Agenda for Change
BME	*British Minority Ethnic (BME) Group*
BAME	Black, Asian and Minority Ethnic
CRT	Critical race theory
DOH/DH	Department of Health
FtP	Fitness to Practice
IEHPS	Internationally Educated Health Professionals
IEN	Internationally Educated Nurse
IPA	Interpretive Phenomenological Analysis
IRN	International Registered Nurse
IT	Intersectionality Theory
NHS	National Health Service
NMC	Nursing and Midwifery Council
OECD	Organisation for Economic Co-operation and Development
ON	Overseas Nurse
ONP	Overseas Nurse Programme
PCT	Post-colonial theory
RCN	Royal College of Nursing
RN	Registered Nurse
TKI	Thomas-Kilmann Index
IT	Intersectionality Theory
WHO	World Health Organisation

This is the preferred term in this study instead of the usual term of Black and Minority Ethnic (BME) Group

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CHAPTER ONE

1.0: INTRODUCTION

International recruitment has expanded the nursing workforce in the UK and increased its diversity (Snow and Jones, 2011; Okougha and Tilki, 2010). This increasing diversity explains Barker's (2018) description of the UK National Health Service as "One NHS, many Nationalities". In 2013 non-UK-born healthcare professionals represented 25.2% of people in total employment in the UK (Rienzo, 2015). One-fifth (20%) of nurses in the UK are born abroad. In 2017, there were 139,019 staff from 200 non-British nationalities in the NHS, representing 12.5% of all staff for whom nationality is known (Sumption and Young, 2014; Barker, 2018). As of January 2020, 169,000 NHS staff report a non-British nationality, that is, 13.8% total NHS workforce (Barker, 2020).

Out of the 200 non-British nationalities in the NHS, only nurses and health visitors record a fall in the number of recorded EU nationals since the EU referendum. The EU/EEA nationals in these groups fell from 18% in 2015/2016 to 6.4% in 2019. Meanwhile, in 2019, 22.4% of joiners were from outside the EEA, representing an increase from 7.6% in 2015/16 (Barker, 2020).

There is ongoing support and initiatives toward producing homegrown nurses (Rafferty and Solano, 2007; Jayaweera and Oliver, 2013; RCN, 2016). Such recommendations and initiatives include recruiting more student nurses locally and developing new nursing programmes such as apprenticeship and nursing associate programmes (Audit Commission, 2002; Mullen, 2003; Gummer, 2015). Although there is a concerted effort to reduce overseas migration into the UK, international and local workforce projections point to the continued recruitment of nurses from abroad to ameliorate the shortage of registered nurses in the UK (Gray and Phillips, 1994; Snow and Jones, 2011).

Equally, many nurses presently in various nurse training programmes are from diverse British ethnic minority backgrounds, and pre-registration nurses from the black ethnic minority group were less likely to suffer attrition. These nurses are more likely to complete their nurse training than other students (Muholland et al., 2008). Thus, it is inevitable that continuing recruitment from overseas and the low attrition of ethnic minority group pre-registration nursing students will lead to increasing and continuing diversity and the multi-ethnic nature of the UK nursing workforce (Ugiagbe, 2005).

Internationally educated nurses (IEN) who register with the Nursing and Midwifery Council (NMC) eventually become part of the British Minority Ethnic (BME) group and are often difficult to distinguish from the UK-born BME group. Therefore, it is paramount that the contribution of internationally educated healthcare workers and best methods or practices to retain BME nurses in the healthcare system occupy a central position in discussing the UK healthcare nursing and midwifery developmental success (Snow and Jones, 2011).

Lim (2006) argues that because nursing shortages will continue in the UK, recruitment of international nurses into UK healthcare will also continue. Many other predictions support Lim's perspective. For example, the EU2020 strategy predicted that the UK, amongst other EU nations, would experience labour shortages after 2020. There is also the increasing global shortage of nurses and midwives, a projected global shortage of 12.9 million healthcare workers by 2035 (WHO,2013) and the 23% drop in the 2017/18 application in England for undergraduate nursing courses (Merrifield, 2017). The National Audit Office (2020: 11) reports that in 2017,

'*the number of applications for nursing degrees dropped significantly following the funding changes, and subsequent numbers of new students have been below the Department's targets. The number of applicants for September 2020 was still lower than the number of applicants in 2017.*'

Other examples of shortages include the increasing number of nurses and midwives leaving the NHS (House of Commons Health Committee,2018) and the prediction of continuing nursing shortfalls for the Organisation for Economic Co-operation and Development (OECD) countries as well as for the Arab States (WHO, 2017).

The number of nurses from the EU registering with the UK Nursing and Midwifery Council (NMC) following the Brexit Vote has continued to fall rapidly, causing even further nursing shortages across the National Health Service (NHS) and the private sector (Siddique, 2018). As of September 2019, the RCN advocated that UK healthcare was short of 40,000 nurses, increasing to 50,000 nursing vacancies in the NHS in the UK by 2020 (RCN, 2019, 2020). In 2019, the government made a policy commitment that by 2028 (NHS England, 2019), the nurse vacancy rate was to reduce to 5% and that the number of NHS nurses was to increase by 50,000 by the year 2025 (National

Audit Office, 2020). However, recent UCAS figures show that between 20221 and 2022, there was an 8% fall in applications to UK nursing programmes (RCN, 2022).

The shortage of nurses is not just a UK issue, and western economies have used a variety of methods in an attempt to become self-sufficient in the number of registered nurses. One common approach in each system relies on international or overseas nurses to resolve the acute shortage of registered nurses. However, international nurse recruitment initiatives in the UK have not always considered the nurse's motive for migration before recruiting. Research findings have shown that international nurses have a variety of motives influencing the decision to migrate. International nurses' intention to migrate may include motivation to make a permanent or temporary move (Buchan, 2007) and those inspired by personal, career, and financial reasons (Allan and Larsen, 2003). However, recruitment initiatives in the UK do not ensure that nurses recruited from overseas are those motivated to make a permanent move to help resolve the shortage. Rather than actively pursuing long-term plans with a clear policy on the long-term integration of the nurses into the UK, recruitment of international nurses has become an accepted recruitment initiative to ameliorate the immediate nurse shortage (Allan and Larsen, 2003: 2, Palmer et al. 2021). Mensah, Mackintosh and Henry (2005:3) contend that this international migration is a "*rapid integration and commercialisation of health service labour markets, in the context of high levels of international inequality".*

Some patriotic protectionism may influence the decision not to actively pursue long-term plans and policies in recruiting, retaining, and integrating international nurses into UK healthcare. This nationalistic protectionism will be discussed further in the review of literature dealing with the integration of international nurses in the UK.

1.1. A brief introduction to migration and integration:

The nationalistic protectionism influencing the recruitment and integration policies of international nurses into the UK healthcare services since the establishment of the NHS in 1948 appears to follow a repeated cyclical order. The British government's social, economic and political philosophy at any time directs this cyclical process and policies (Snow and Jones, 2011). A factor influencing successive UK governments' policy on international nurses seems to be the philosophy and the "*politics to concern itself with*

the immediate present at the expense of the future" (Telegraph.co.uk, 2007) because politicians have a short time to get a result (Spencer, 2011). Nair and Webster (2013) found in a study involving patterns of health professionals' migration that the Pacific island and Sub-Saharan Africa (SSA) had the highest rates of healthcare workers movement (13%) to the developed economies. Although several governments have shown concerted efforts to prevent or reduce migration from less developed countries to the western world, the 'push-pull' factors identified in the literature as reasons for the migration of healthcare workers are still at work (Moyce et al., 2015). Moyce et al. (2015: 3) identify some "push and pull" factors or reasons for migrating healthcare workers from one economy to another. These factors include the shortage of nurses, better working conditions, better career prospects in the developed economies, poor working conditions, lack of job opportunities, poor salary prevalence, and a search for better employment opportunities in emerging economies. International and national socio-political factors dictate these 'push-pull' factors and directly impact nursing recruitment, retention, and training policies and subsequently impact the integration of IENs into the healthcare workforce in the various host countries. The concept of integration and its relationship with recruitment, retention and patient care is deliberated in more detail later in this introduction.

Some developing countries, especially in Sub-Sahara Africa, have been officially identified as areas where UK healthcare should not recruit nurses (DH,2001). However, compared to the broader economy, the NHS has a higher proportion of staff from South Asia, Sub-Saharan Africa and South-East Asia (Barker, 2020) than the countries of China, India, Spain and the Philippines (Buchan et al. (2005) where the UK healthcare has an agreement to recruit nurses. As of January 2020, with 8,241 NHS staff members, Nigeria represents the most prominent African nation and the sixth-largest contributor to NHS staff behind the UK, India, Philippines, Ireland and Poland (Barker,2020).

Although in a recent Nuffield Trust study, Palmer et al. (2021) found that nurses from outside the EU remain longer in the NHS and other organisations compared to nurses with UK nationality and nurses from the EU, retention of IEN has become a concern in many countries because some of the Internationally Educated Nurses (IEN) either pursue other career options or return to their home country due to failure to integrate (Zizzo and XU, 2009). As opposed to the Internationally Educated Nurses (IEN) from nations without formal recruitment agreements with the UK, the Nurses from these

select countries may only want a temporary move rather than integrate to hold down permanent positions, thus continuing the international recruitment of nurses.

Jayaweera (2015) argues that there is a constant cycle of recruiting fluctuating numbers of internationally trained nurses to fill the care gap in UK healthcare. This recruitment occurs in reaction to national health workforce shortages and is an essential and recurrent strategy in the UK nurse recruitment policy (RCN, 2003). However, there is no clear-cut defined process or procedure for maximising the long-term benefits, such as retaining internationally recruited nurses post-NMC registration (Smith et al.,2008). One may argue that this lack of clear-cut strategy or policy challenges the level of commitment or seriousness of the various healthcare policy institutions to develop a sustainable solution to resolve the issue of nurse shortage that has been problematic since the inception of the NHS. The NHS was born on the back of a scarcity of staff in 1948 and attained an appreciable level of good health by recruiting nurses from former British Colonies (commonwealth countries) (Snow and Jones, 2011). Still, the shortage has become perennial and has so far persisted for over seven decades after the start of the National Health Service (NHS).

According to Espinova et al. (2011:9), globally, 630 million adults desired in the year 2010 to migrate permanently, and in 2015, there were 244 million international migrants worldwide. The number has maintained an upward trend since 2010, and in 2019, it reached 272 million (United Nations, 2019). Many of these migrants may have found their way to the UK. Any such new migrants need to integrate to make a meaningful positive contribution to society because it is an agreed objective across the region of Europe to promote "…*better integration of migrants into their host society"* (Macura, MacDonald, and Haug, 2005, P.15)

Jayaweera and McCarthy (2015, P.3) define *'integration' as "the relationship between migrants, and people and institutions in the receiving society"*. Migrants in this relationship are *'becoming like' members of the receiving society – that is, "integration is a one-way process towards a desirable outcome experienced only [by] migrants…. [There is] lesser emphasis on structural and individual barriers constructed in the receiving society"*. It is pertinent to be mindful that 'becoming like' is a process that could be facilitated to completion or obstructed from reaching the end. This 'becoming like'

integration process may occur in whole or in part or may not occur at all in the individual's lived experience.

In this study, integration is understood as a series of processes involving immigrants, migrants and receiving social institutions and residents (including employers and co-workers) which take place in the context of the structural, social, cultural, civic and political domains of the host country (Spencer, 2011) (A more detailed discussion in the context of migration, especially of the skilled and nursing migrants in the NHS and conceptual framework of integration will follow towards the end of this introduction and under the review of related literature).

1.2. The problem of the study:

The retention of IENs has become a concern in many countries partly because the IENs return to their home country following failure to integrate and partly because some IENs either pursue other career options or migrate to other countries (Zizzo and XU,2009). Reasons are unclear but may include the challenges IENs face, such as reduced progression and communication and organisational challenges when working in the UK healthcare service (Allan and Westwood, 2015b). Most IENs are from ethnic minorities, and studies have shown that ethnic minority nurses suffer discrimination and other barriers or challenges in the National Health Service (NHS) (Archibong and Darr, 2010; Kline, 2014). For example, compared to nurses of UK and EU origin, nurses from outside the EU and UK work 3-hours more per week (Palmer et al. (2021). There were 27,982 BME nurses in the London region compared to 24,847 white nurses as of May 2018, meaning BME nurses represent 52.96% of London nurses. Despite the high representation, BME nurses in the London region experienced the highest level of discrimination in the country (NHS Employers, 2017) and BME nurses in the London region had a 33% out of 60.8% COVID-19-related death rate among healthcare staff as of July 2020 (NHS, 2020).

Despite evidence of discrimination and failure to integrate, some ethnic minorities have attained senior grades or positions in UK healthcare services. There is a shortage of research about the lived experiences of these ethnic minority nurses and their interpretation of integration into UK healthcare services. There is also little known about

integration in different groups of IENs who successfully integrate and progress to senior positions in the NHS.

Employment is one of the discrete domains of successful integration (Ager and Strang, 2008), as success in employment assumes a degree of integration into the “ways of life” of the broader population. Thus successful progression or attainment of higher clinical and management grade of Agenda For Change (AFC) pay band seven and above (or its equivalent in non-NHS healthcare) in the course of IEN employment within the UK healthcare sector suggests ‘integration’ may include involvement and understanding of “ways of life” and therefore successful integration of IEN.

Although some international trained nurses are perceived to have integrated into the UK healthcare system since the inception of the NHS, IENs see their adaptation or integration as a process. This process is more than adopting UK ways of nursing; it *'challenges the normative UK value'* of nursing (Allan 2007, p2). This, in part, is because assessing the success of integration programmes has often been from employing organisations’ and institutions' perspectives (Jayaweera and McCarthy, 2015) with the primary objective of reducing the shortage of registered nurses. Little or no research is available about the judgement of the non-EU nurses' perspectives as to whether they see themselves as understanding integrated, their critique of integration, integrated or not. Understanding the lived experience of a group of IENs, nurses of Nigerian heritage, who have successfully navigated a career pathway in UK healthcare, is essential because of the increasing number of BME in UK healthcare and the need to understand how best to retain the nurses in the system. Although nursing education and culture in general of the BME nurses may not be the same as those of IEN from European countries (Likupe, 2006), these nurses constitute a significant force in the continuity of the function of UK healthcare. Therefore, the lived experiences of a group of African nurses might help us to understand how they have been able to navigate the pathway of their careers successfully. Furthermore, an example of an individual agency contributes to our understanding of how IENs negotiate integration in UK healthcare.

1.3. Purpose of the Study

This study aimed to explore the experiences of successful NMC Registered nurses who are Black African with Nigerian heritage and have progressed in their nursing careers to inform understanding of what integration means to them in UK healthcare. This study explores the participants' integration post NMC registration into UK healthcare and their sense of self while living in the UK. It offers an idiographic, phenomenological approach to position individual subjective experiences of Nigerian nurses defined as successfully integrated into UK healthcare on account of employment.

This qualitative study employs Interpretative Phenomenological Analysis (IPA) (Smith, 2004) in its approach. IPA combines a dedication to understanding the participant's 'lived' experience to believe that achieving such understanding requires interpretative work on the researcher's part. It offers a systematic approach with a commitment to idiographic inquiry (Lamiell, 1987; Smith, Harre, and Van Langenhove, 1995; Smith and Osborn, 2007; Smith,2004). In this approach, the researcher checks individual cases in great detail, and general claims may then use extracts from the participants' narratives.

This study aims to inform theory and practice to promote knowledge and develop best practices in training, a managerial and continuous professional development framework for integrating non –EU trained nurses into the UK healthcare post-NMC registration. It may also influence the professional understanding in policy formulation regarding recruitment and retention of international nurses into UK healthcare.

The participants in this study were nurses of Nigerian heritage employed in UK healthcare for between 5-30 years. This period covered when internationally educated nurses were not required to undergo a period of adaptation by the nurse registration body before registration (pre-adaptation era). It also includes the years when internationally educated nurses were required to undergo a period of adaptation deemed fit by the employing organisation (adaptation era). The period of compulsory adaptation was termed the Overseas Nurse Programme (ONP) by the NMC (Overseas Nurse Programme (ONP) era). The participants were nurses of different specialisms who were employed as band seven and above in the NHS Agenda for Change (AFC) pay band. Most of the nurses in this study are in leadership positions and consist of three men and seven women. The study data were collected by interviews using open-

ended questions and were audio-recorded (see appendix 2). Participants were encouraged to talk about their lived experiences and how they dealt with the challenges, barriers or difficulties in their career pathways and life.

1.4. Research Question:

What are the lived experiences of integration for IENs with Nigerian heritage into UK healthcare services following registration with the Nursing and Midwifery Council (NMC)?

1.5. Significance of the study:

The concept of workplace integration for international nurses is poorly understood (Ramji and Etowa, 2014). International recruitment and integration of nurses into UK healthcare is a complex, sensitive and potentially contested issue. For example, Allan and Larsen (2003) show that colour, culture and language are important factors affecting the integration experiences of internationally educated nurses. They state further that there were layered complexities of differences between racial groups that affected their experiences during the initial integration period, i.e. period of supervised practice programme or adaptation to gain NMC registration. It will be relevant to explore whether these complexities continue to impact African nurses with Nigerian heritage after achieving NMC registration and the impact or implication on their career progression and integration into UK healthcare. Several pieces of research have investigated the motivating factors for nurse migration (Wheeler et al., 2013; Moyce et al., 2015), motivations and challenges faced by the nurses (Higginbottom, 2011; Allan and Larsen, 2003) and acculturation (Ramji and Etowa, 2014). However, there has not been any research on the lived experiences of integrating African nurses of Nigerian heritage into UK healthcare post-NMC registration. Equally, there is a lack of a clear-cut strategy for integrating international nurses into the UK healthcare sector. Most studies on the integration of migrant workers have been quantitative studies conducted from an economic perspective (e.g. Villosio, 2015). This qualitative study focuses on the subjective and how the broader social context shapes the personal. It explores the micro--level and the impact of issues from the macro and micro levels on integrating the registered non-EU nurses into the UK healthcare setting from the structural, social, cultural, civic and political perspectives. It is a study that gives voice to individuals whose

experiences have not been studied concerning integration in the workforce and society. This study focuses on the lived experiences of UK nurses with Nigerian heritage working in UK healthcare as registered nurses and their integration into UK healthcare following registration with the Nursing and Midwifery Council (NMC).

This study's findings may indicate the steps or practices other ethnic minority nurses may have to take to navigate the career pathway successfully and contribute towards changing the label of the NHS as institutionally racist in, for example, the opportunity to gain promotion by ethnic minorities. This researcher was a member of the UK Department of Health Committee on the Supervised Practice/adaptation programme and was listed contributor in the resulting policy document on professional standards for the Supervised Practice Programme for Overseas trained nurses (DH, 2001). The experiences of that committee and subsequent development in international nurse recruitment are part influencers or drivers of this research.

1.6. Overview of the research method and design:

This study explores the lived experiences of integrating UK nurses with Nigerian heritage into UK healthcare using an interpretive phenomenological analysis approach. Nurses of Nigerian heritage are the sample in this study for many reasons. Nigeria is 'the giant of Africa' and is the most populous African nation, with over 180 million people. More than 90 million are children and young people under 18 years of age (JPAS, 2009, p. 3). The diversity of Nigeria is evident in the country's over 250 ethnic groups, 500 indigenous languages, and 7% of the world language present in Nigeria. The three main languages of Nigeria are Igbo, Yoruba, and Hausa, but English is the official language spoken in Nigeria. Nigeria has an extensive colonial history and ties to the UK. The British NHS's historical ties in recruiting nurses dating back to the 1950s following the establishment of the NHS (Kushnick, 1988).

Nigeria was an economic necessity created by the British from the remnants of formerly thriving empires such as the Great Benin kingdom, the Oyo kingdom, the Sokoto caliphate, and others following the amalgamation of the Northern and Southern Nigeria Protectorates in 1914 (Eric, 2016). The resultant merger was named 'Nigeria' meaning; "Niger Area", by Flora Shaw, who later became the wife of Governor-General Lord Lugard (Eric, 2016). Nigerian Nurses in the UK represent the largest ethnic African

group in the NHS (Siddique, 2014), with 8,241 Nigerians in the NHS workforce (Barker, 2020). The British healthcare system discriminates against ethnic minorities (Kline, 2019). Compared to other regions of the world, nurses trained in Africa suffer more discrimination in disciplinary proceedings, promotion prospects, training, and recruitment (West et al., 2017; Archibong and Darr, 2007). However, some Nigerian nurses have successfully progressed and appear integrated into the NHS despite institutional racism. This study seeks to interpret the lived experiences of nurses perceived to have navigated the challenges and integrated into the UK; to understand 'the 'how' of workforce race equality' (WRES, 2019:5).

The researcher's epistemology is a significant determinant in choosing the method of studying a social phenomenon (Holloway, 1997). The epistemological position of this study is that the wealthiest and most relevant data are within the participants' perspectives with whom I engaged in collecting the required data (Groenwald, 2004). This study is an opportunity for the African nurses who have 'successfully integrated' to share their stories or lived experience and share their roles or strategies in becoming integrated into the UK healthcare services.

The research methodology in this study is the interpretivist qualitative approach and involves individual interviews using open-ended questions, descriptions and interpretation of results. In an interpretivist approach, Walliman (2011:22) explains that our experience of the world is through 'our perceptions influenced by our preconceptions, beliefs, *and values; we are not neutral, disembodied observers but part of society'*. Walliman argues further that the researcher is in a world that is already interpreted and must reveal the meanings created by others. Therefore, there is not one fixed interpretation or perspective of any given phenomenon.

In a positivist (scientific) quantitative approach, the focus of the study is usually on what can be measured objectively using data drawn from experiments, surveys, structured interviews or published data sets (Cottrell, 2014). A quantitative approach generates large amounts of data which may be analysed using statistical packages or other relevant software. A quantitative approach also makes formulating hypotheses and produces possible answers, leading to generalisable conclusions or solutions to establish patterns, trends, or universal laws (Cottrell, 2014). Positivist paradigm studies

involving human subjects are often more complex and may draw conclusions or answers to formulate universally applicable laws (Cottrell, 2014, p. 98).

A qualitative research paradigm is ideal when the feelings, attitudes, and emotional responses of subjects involved in a study are under exploration (Bragge, 2010). In qualitative research, the sample size determines the scope and nature of the study, data quality, design, and shadowed data (Morse et al., 2001).

Phenomenology, ethnography, pragmatics, discourse analysis, participatory action design, grounded theory, historical, and biographical research designs are qualitative research designs (Denzin and Lincoln, 2011; Trainor and Graue, 2013; Savin-Baden and Major, 2013).

Phenomenology, discourse analysis, and grounded theory are qualitative research methods to study people's lived experiences (Denzin and Lincoln, 2011). These methods are rooted in different intellectual traditions but similar in developing their ideas. Discourse analysis enables the generation of an identifiable social process for studying the subjects in their natural setting to understand the social function and the cultural process that is the basis of the action (Cresswell,2013). Grounded theory systematically gathers and analyses data to derive a theory from studying a phenomenon or case (Savin-Baden and Major, 2013; Bowling, 2014). It is a method suitable for building a thematic structure or theory (Creswell, 2014). Grounded theory is the choice method where the intention is to generate theory 'through inductive and deductive reasoning that can explain a process, action or interaction regardless of time and place' (Savin-Baden and Major, 2013, p. 183).

Ethnography originated from anthropology and sought to understand people, cultures, and values under study. It requires an in-depth, long-term study of a particular context or group of people (Savin-Baden and Major,2013).

Phenomenology seeks to reveal what is common in the research participants' experience of a phenomenon under study (Creswell, 2007). It aims to explain the 'what' and the 'how' of the individual's experience. It is ideal for exploring the lived experience of a social phenomenon of individuals (Giorgi, 2009). The objective of phenomenology is to '*describe and interpret the meaning of the lived experience of a phenomenon* (starks and Trinidad, 2007). Phenomenology suits this study better than other methods,

such as discourse analysis and grounded theory. This study intends to illuminate and understand (Groenewald, 2004) a direct description and interpretation of the nurses with Nigerian heritage first-hand primary lived experience of integrating into the UK healthcare services post registration with the NMC and may contribute to understanding extant theory and contribute to developing a theory of necessary social process of integration of IENs.

Specifically, this study uses the interpretive phenomenological approach (IPA), which combines a dedication to understanding the participant's lived experience. It believes that achieving such understanding requires interpretative work using a systematic approach on the researcher's part (Smith and Osborn, 2003). Using phenomenology afforded prevention or restriction of the researcher's biases (Groenewald, 2004) and explored taken-for-granted assumptions, meaning and universal features, or essences, of an experience or event through close examination of individual lived experiences (Starks and Trinidad, 2007).

The primary data collection method in this Interpretative Phenomenological Analysis study uses open-ended questions in a recorded semi-structured interview. There are several IPA studies in healthcare, education and other areas of study (Smith,2014), but this is the first study as far as the researcher is aware of using this approach on the lived experiences of integration of international nurses with Nigeran heritage into UK healthcare. This study fills the research gap that exists in this dimension.

1.7. Introduction to the conceptual framework of integration

Authors may define and describe theoretical and conceptual frameworks differently (Crawford, 2020). A detailed guide on how to approach the conceptual and theoretical framework in any study is offered by Crawford (2020). Some authors consider conceptual and theoretical frameworks synonymous (Merriam and Tisdell, 2016; McCarran, 2016; cited in Crawford, 2020), and some research design authors avoid defining either conceptual or theoretical frameworks (Marshall and Rossman, 2016, cited in Crawford,2020). In line with Crawford's (2020) advice, I do not consider the conceptual and theoretical frameworks synonymous. A theoretical framework is 'an element of a conceptual framework that situates the relationships explored in the study into the context of developing or testing formal theories' (Crawford, 2020, p. 38). A

theoretical framework, according to Ravitch and Riggan (2017), serves *to "identify theory clusters, identify theories relevant to the specific cluster, identify the theory for the study and specify the specific theory used, the propositions of the theory in the study, and review of theories using that theory as well as highlights how the study contributes to the body of knowledge related to the theory"* (cited in Crawford, 2020:39). The theory clusters in this study are theories rooted in emancipation with a fundamental scheme of their critique of oppression (Wesp et al., 2018). In this study, I use Critical race theory (CRT), Post-colonial theory (PCT) and Intersectionality theory (IT) perspectives to promote steps in emancipatory reasoning and influence discussion concerning integrating IEN in the UK healthcare setting. These theoretical perspectives inform and critique current structures, processes, and practices by reviewing the history and challenging existing policies and procedures on international nurses' recruitment, retention, and integration. This approach is applied in challenging the current integration discourse and status quo and interrogating the social, economic and political dimensions of international nurses' employment and integration in UK healthcare. The study contributes to using the emancipatory theories for understanding and explaining the lived experiences of the IEN in UK healthcare (I offer a further discussion of CRT, IT and PCT in the literature review section of this thesis).

According to Miles and Huberman (1994:20), the conceptual framework is the 'current version of the researcher's map of the territory under investigation. It is a discernible product that "*explains, either graphically or in narrative form, the main things to be studied— the key factors, concepts, or variables— and the presumed relationships among them*" (Miles and Huberman, 1994: 18). It may qualify as *"a structure for organising and supporting ideas; a mechanism for systematically arranging abstractions; sometimes revolutionary or original, and usually rigid"* (Weave-Hart; 1988:11 cited in Baden and Major; 2013:138). Maxwell (2005) states that conceptual frameworks help assess and refine goals, develop research questions, select appropriate methods, and identify potential threats to validity and justification. Crawford (2020:42) suggests that the purpose of conceptual frameworks should include "argumentation, explanation and generation… that will aid in justifying the study, clarifying the relationships explored in the study and aligning design elements".

A researcher's personal experience, literature and theory are the three interdependent sources or impetus for a conceptual framework (Crawford, 2020). The purposes of conceptual frameworks include argumentation, explanation and generation rooted in experience, literature and theory. As I stated above, the theoretical framework is a part of the conceptual framework that shows 'how the study relates to generating or testing theory and explains the relationships explored in the study" p.47.

There are many conceptual frameworks on integration relevant to this study, for example — Etzinger (2000), Threadgold and Court (2005), Ager and Strang (2008), Joppke (2013), Penninx and Garcés-Mascareńas (2015), Spencer and Charsley (2016). A summary of some of these conceptual frameworks follows below.

Etzinger (2000): Etzinger (2000) Identified three main analytical dimensions of integration: the legal-political, the socio-economic, and the cultural-religious. Etzinger states that the integration process may consist of three dimensions-- state, the market and the nation. The dimensions Etzinger explains interplay with immigration and the integration processes.

Threadgold and Court (2005)

To define integration, they identified six themes in their model. They point out the lack of operational definition for integration in the Ager and Strang (2008) Model. Threadgold and Court (2005) identified the domains of integration: housing, health and social care, safety, child welfare, interaction and community cohesion, employment training and lifelong learning, and education as essential themes in discussing the exclusion and deprivation of refugees.

Penninx and Garcés-Mascareńas (2015)

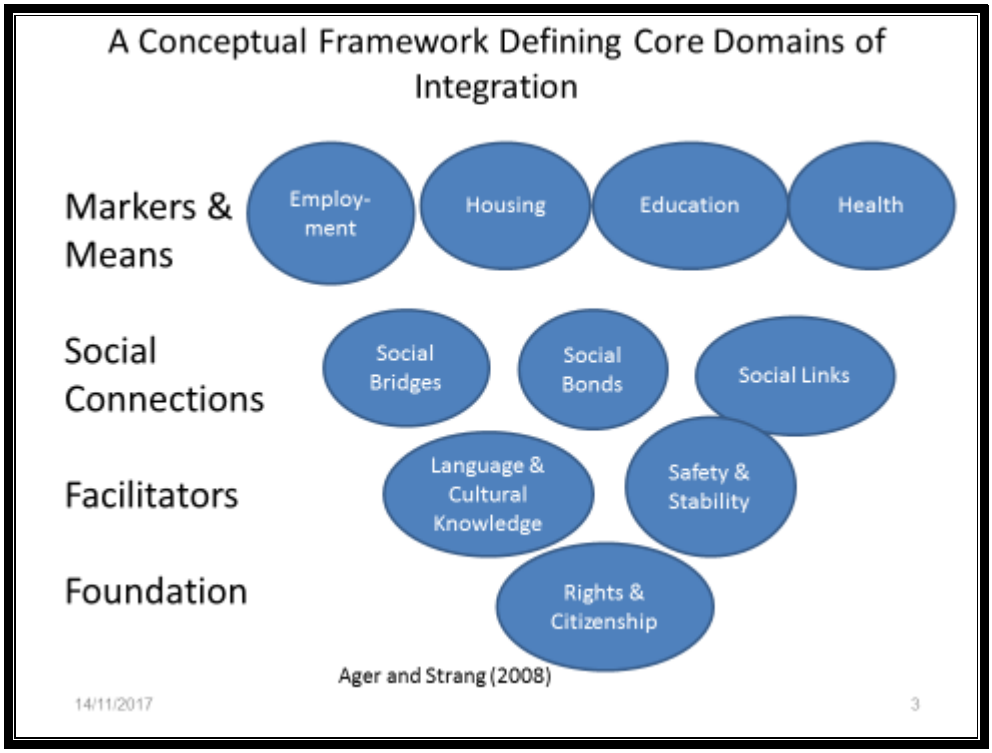
Their framework states that the legal-political, socio-economic, and cultural-religious dimensions are the analytical dimensions in the definition of integration. They define integration as "the process of becoming an accepted part of society". They argue that their definition emphasises the process character rather than an end situation of integration and does not specify beforehand the degree of or the requirements for societal acceptance. This framework identifies the immigrants and the receiving society

as relevant parties involved in the integration process, and this they state occurs at the individual, organisation and institution levels.

Spencer and Charsley (2016) A heuristic model proposes that the Integration process is an interrelated, multi-directional process across spatial and temporal dimensions. They identified effectors or facilitators and barriers to integration. The five effectors include individuals, families and social networks, societal opportunity structures, policy interventions and transnational factors. They cited Heckmann's (2006) barriers to include discrimination, non–recognition of educational qualifications and restrictions related to immigration issues. Spencer and Charsley propose integration as processes and effectors in the structural, social, cultural, civic, political, and identity domains. They argue that although the analysis of the integration process may include normative assumptions, processes may be explored 'without making assumptions on whether a right outcome has emerged' (p.6).

The conceptual framework for analysing integration in this thesis will be developed by Ager and Strang (2008). The Ager and Strang (2008) model is holistic and developmental, i.e. it is built on a human rights perspective which can serve as the basis for social integration. The Ager and Strang (2008) framework has successfully been used in several studies, and it offers a conceptual structure for considering what constitutes the critical components of 'successful' integration' (p.167, 184) and serves as a 'middle-range theory' to promote understanding of the critical elements of integration (p.167). Ten core domains are proposed by Ager and Strang (2008) as discrete themes that are recurrent despite differences in focus and analysis of different stakeholders to understand and define 'integration'. The degree of achievement and access to the domains help judge integration as 'successful' or not 'successful'. The discrete themes from the study are shown in Figure.1 below. The main domain most relevant and primary to IEN in this thesis is employment in UK healthcare which is one of the primary markers or means of migrant integration.

Fig.1



The Ager and Strang (2008) framework allows one to reflect on different or various assumptions and values by including relevant factors that may apply to micro and macro dimensions. The framework has been involved in several settings, such as being used to '*influence the development of local indicators of integration, … in discussion regarding integration that is accessible to policymakers, researchers, service providers…influenced national and regional policy formulation*…' (p.185).

Although Ager and Strang's framework is an outcome of a study conducted mainly on refugees, the discrete themes identified as the critical components of integration also apply to other migrants who were not refugees. Some internationally educated nurses may be recruited directly from overseas to the UK or may travel independently and be

recruited in the UK. Therefore, they are not the same as refugees in several areas, for example, employment; this will be clearly stated and discussed in this thesis.

The Ager and Strang (2008) framework has a limitation that is not exhaustive in evaluating integration; for example, it does not include the impact of changing socio-political and economic developments of refugee or migrant's country of origin in its discrete themes. The socio-political and economic progress of migrants' countries of origin may be relevant to this study because nurses' migration motives vary. It may be for permanent migration, temporal move (Buchan, 2007), or deliberate decision driven by personal, career and financial reasons (Allan and Larsen, 2003).

The Ager and Strang framework align with the argument of Spencer (2011) that integration is a series of processes involving immigrants, migrants and receiving society institutions and residents. This process occurs in the structural, economic, social, cultural, identity, civic and political domains (Entzinger, 2000; Heckman et al., 2006, cited in Spencer,2011). The framework provides a comprehensive focus as an objective and theoretical construct suitable for use in diverse contexts, such as studying the concept of integration and lived experience. The researcher will use the Ager and Strang conceptual framework aided by the emancipatory theoretical framework of CRT, IT and PCT to understand, analyse and interpret the experiences of integration of the International nurses with Nigerian heritage into the UK healthcare services post registration with the Nursing and Midwifery Council (NMC).

1.8. A Brief Overview of The Thesis:

Chapter two offers a literature framing of the research on nurse migration to the NHS, integration and lived experiences of International nurses. The thrust of the argument is that there is a need to review the current approach to international nurses' recruitment and integration post NMC registration. The current international recruitment practice has not shown much difference from the previous practice since the establishment of the NHS. This continuity is the main reason for the continuation of recruitment of international nurses as an accepted solution to the perennial shortage of registered nurses in UK healthcare.

Chapter three offers a more detailed discussion of the research method, design of the study, research question, the study population, sample, sample method and data collection instrument. It also consists of a section on reflexivity, positionality, ethical issues such as consent, confidentiality, validity, and data analysis of this study.

Chapter four discusses the study data and how I applied Smith's heuristics framework to analyse the data. In Chapter Five, I presented the findings from data derived from the interview at a group-level analysis.

In Chapter Six, I discuss the findings of this study with existing literature. A critical reflexive evaluation of the methodology and method's strengths and weaknesses follows and ends with a concluding section of a reflexive account of my experiences while writing the chapter.

In Chapter seven, I discuss the contribution of this study to the nursing literature and knowledge of integration of international nurses into UK healthcare, the study's validity, and limitations, proffering some suggestions and suggesting possible areas of further research. I conclude the chapter with a reflexive account of my writing experiences and a summary and conclusion of this study.

CHAPTER TWO

2.0. LITERATURE REVIEW

This literature review is an iterative process brought about by several factors, including the changing historical and contemporary developments in the UK polity, influenced partly by the enforcement of the BREXIT vote by a Conservative government. This theme is affected by a historical and traditional belief in understanding the present and possibly projecting future trends and practices; namely, over 70 years of recruiting internationally educated nurses (IEN) to deal with the UK's chronic shortage of home-grown NMC registered nurses.

The main influencing theoretical frameworks in this literature review are Critical race theory (CRT), Postcolonial theory (PCT), and Intersectionality theory (IT). These theoretical perspectives are discussed in this review to inform and critique current structures, processes, and practices by reviewing the history and challenging existing policies and procedures on international nurses' recruitment, retention, and integration.

In this review, I engage Post-colonial theory (PCT), Intersectionality theory (IT) and Critical race theory (CRT) to explore the integration of IEN in the UK healthcare setting. Using these emancipatory theories provides a more comprehensive understanding to challenge the current integration discourse and status quo. It explores existing social, economic and political dimensions and discourse on discrimination against internationally educated nurses' employment and integration in UK healthcare.

This review uses theoretical perspectives to critique the philosophy and practice of international nurses' recruitment and integration processes into UK healthcare post-NMC registration. The thinking goes beyond what is evident on the surface to analyse the roots of international nurse recruitment and integration into UK healthcare. A brief discussion of CRT, IT and PCT is offered below, and a summary of the central tenets of PCT, IT, and CRT is represented in fig. 2, page 41.

The end section in the introduction of this thesis discussed the conceptual framework for understanding integration as applied in this study. The review will focus on shifting definitions of integration at the macro-level (state discourse) and the micro-level (UK healthcare sectors) concept of integration from the inception of NHS till the first quarter

of the 21st Century. Following Ager and Strang (2008), the researcher will also discuss the relationship between the macro perspectives critically interpreted as indirectly controlling and enforcing the model for integration at the micro-level (healthcare sector) for international nurses with Nigerian heritage. This review focuses on international nurses' integration into the UK healthcare sectors, the lived experience of international nurses, and the relevance of integration to nurse recruitment and retention in the UK. The main themes in the literature review section include:

- Overview of the theoretical perspectives: CRT, IT and PCT
- International Migration: A critical review of migration, especially of the skilled and nursing migrants in the NHS.
- Defining integration
- The historical context of nurse recruitment;
- Lived experience and integration;
- Role of NMC in Integration of international nurses: Pre and Post NMC registration of international nurses and their lived experience;
- Challenges to international nurse integration and their lived experience

Overall, the thesis argues that the effective integration of internationally educated nurses is a significant ingredient for addressing nurses' shortages and improving quality patient care. The thesis informs current literature by a focus on the lived experience of migrant nurses and how social structures shape subjectivity and agency in migrant nurses' integration and career progression.

2.1. **Overview of Theoretical Perspectives: CRT, IT and PCT-**

Critical Race Theory (CRT):

The origin of CRT is traceable to the work of progressive African American legal scholars dedicated to eliminating racism and the commitment to eradicate every form of subordination (Matsuda, 1991). CRT's genealogy is interdisciplinary and draws from thinkers like Du Bois, Martin Luther King, and Malcolm X, 'who provided the foundations for theorising race in U.S. society and interdisciplinary perspectives (Delgado and Stefancic,1993). CRT belongs to the stable of critical postmodern theories that "attempt[s] to understand the oppressive aspects of society to generate societal and

individual transformation" (Tiemey, as cited in Solórzano and Bernai, 2001: 311). Proponents of CRT promote progressive race consciousness and employ CRT to redress racial inequity (Capers, 2014).

Although CRT is rooted in the ideas of emancipation and critiques the processes of oppression, it offers a comprehensive set of approaches to inform how healthcare professionals such as nurses may comprehend cultural competency and improve clinical practice. CRT is used increasingly in nursing to examine ideological, structural and institutional racism (Ackerman-Bargar et al., 2019; Bennet et al., 2019) and to explicate colonial power and racism within the institutional realm of the NHS and nursing (Brathwaite, 2018).

The five central tenets of CRT include the concept of 'ordinariness', the idea of ''interest convergence'', the concept of race as a social construct, the idea of 'storytelling and counter-storytelling'; and "the notion that Whites have been recipients of civil rights legislation" (Wesp et al., 2018; Hartlep, 2009 cited in Crew, 2021).

In the concept of 'ordinariness', CRT argues that although racism is an everyday occurrence for the non-white which is often not acknowledged, it is, however, 'everyday reality but in more subtle, invisible, and insidious ways in contrast to the past' (Savas,2013:508). The proponents of CRT advocate that non-acknowledgement of racism makes it difficult to eliminate and manifests as colour blindness. Bonilla-Silva (2017) explains that we live in a 'milieu of racism without racists' and that colour-blind racism manifests itself when white individuals claim that they do not see any race or colour, just people, and therefore "is not racist" because they do not display racism in their overt actions. Proponents of CRT argue that racism is the norm in society, and non-whites only succeed when they concur with the White agenda (Delgado & Stefancic, 2017). Critical race theory 'suggests that because racism is defined so narrowly, whites have little to no language to discuss racism as a systematic and widespread ideology' (Wesp et al., 2018: 321). In contrast to this tenet of CRT in a recent study, the NHS Confederation (2022) asserts that staff from minority ethnic backgrounds find conversations about racism in the NHS difficult mainly because of the lack of diversity in NHS leadership.

The tenet of "interest convergence" claims that because racism benefits the more significant white majority economically and psychologically, the whites do not have an

interest in the abolition of racism in society. The benefit is evident in the reluctance or refusal to change society's rules and attitudes toward racism, the preference to position racism at the individual level (micro level) rather than the functioning of racism in society (Macro level), and the acknowledgement or consideration of its institutions (Savas, 2017).

The tenet of race as a social construct argues that race is designed to benefit the non-racialised dominant group (Wesp et al., 2018:320-321). The concept of race has no basis in biology or genetics, and the categorisation and stratification of groups of people are designed to make non-whites subject to the dominant whites in power (Savas, 2017). The categories and definitions of race change regularly and are manipulated to benefit the non-racialized dominant group (Delgado and Stefancic,2017). Race as a social construct significantly affects the life chances of non-whites, and our social relations are affected directly or indirectly by this racialised social structure (Savas,2017).

CRT maintains that the concept of race promotes using physical racial features to group people, manipulate and define, structure, and organise relations between dominant and subordinate groups (Ackerman-Barger and Hummel, 2015). CRT originated to examine, uncover and disrupt processes of racism in legal studies (Bell, 1995; Bryder,1998 cited in Ugiagbe et al.,2022) and sets forth an emancipation agenda highlighting race as an analytical tool. The concept of race and racism have real and significant consequences on people's life chances and promote racial categories or races, which in turn create the racialised structuring of the economic, political, social and ideological levels (Bonilla-Silva, 1997 cited in Savas,2013). This racialised structuring seems to favour whites and propagates disadvantaged life chances for non-whites (Bonilla-Silva 1997).

Within this context, the concepts of white fragility, white privilege, white supremacy and racism are crucial in contemporary society. White privilege is an ambiguous and enduring matter which is often not discussed to enable the whites to continue to enjoy the myth of meritocracy (McIntosh, 1988) and the "belief in objectivity, coupled with positioning white people as outside of culture (and thus the norm for humanity), allows whites to view themselves as universal humans who can represent all of the human experience" (McIntosh,1988:2). Whiteness is equated with normality and as such it does not need definition. Thus 'being normal' is colonised by the idea of 'being white." (Back

and Solomos, (2000:22) which brings about "…clear binaries, in essence creating a bicultural situation of Self and Other, Us and Them that leaves little room for negotiation, hybridity, or fusion of cultures" (Kirkham and Anderson, 2002:6).

CRT seeks to promote an understanding of the consequences of harmful treatment of marginalised groups by white privilege and white supremacy (Crewe, 2012). White supremacy is a racist ideology based on asserting that whites are superior to non-whites. The term is specifically used to define a political ideology that suggests the social, economic and political dominance of whites (Bonilla-Silva 1997) which has shaped the reality of non-whites for generations. For example, Devey (1993) asserts that the majority of low-wage workers continue to be non-whites, Horton and Thomas (1995) forecast that the continuing inequality of income and reservation of 'white-collared' jobs for white people will persist into the 21st century and more recently, the disproportionate impact of COVID-19 on black and minority ethnic staff and patients in the NHS (NHS Confed, 2022) confirm the assertion of social, economic and political dominance.

The concept of "storytelling and counter-storytelling" includes the idea of differential racialisation by whites of different groups at different times. The storytelling component of CRT emphasises that the non-dominant groups have distinct and unique histories and experiences of oppression and racism. They can recount their experiences with racism from their unique perspective, which the whites do not know, have not experienced and are unable to support (Delgado & Stefancic, 2017). Different differential racialisation includes racial profiling and poor treatment of people with Chinese heritage following the Coronavirus Pandemic in the USA, the anti-black lives matter movement, and the ill-treatment of Muslims during the 911 attack (Loyds and Murray,2021). Critical Race Theory helps to understand individuals and institutional and societal racism and can bring about required changes in many ways (Salvucci & Lawless, 2016).

The notion that Whites have been recipients of civil rights legislation informs CRT perspectives that racist social assumptions were the bedrock of judicial conclusions and that racism was enshrined in the legal and social structures of the society (Bell, 1992). Proponents of CRT are also committed to social justice, projecting the voice of the

marginalised and employing the concept of intersectionality (Delgado & Stefancic, 2001; Solórzano & Yosso, 2001, Cited in Ortiz and Hills, 2010).

Post-Colonial Theory (PCT)

PCT refers to “theoretical and empirical work that centralises the issues arising from colonial relations and their aftermath; PCT concern extends to the experiences of people descended from the inhabitants of colonial powers’ territories and their experiences within “first-world” colonial powers” (Kirkham and Anderson, 2002:2). Postcolonial theory offers a critical and emancipatory scholarship and discourse with its interpretations of race, racialisation, and culture. PCT may assist in interrogating the ethical ways literary and cultural studies contribute to sustaining or questioning unequal global relations (Mukherjee,2001:556). It offers powerful analytic tools to build on the foundation for incorporating cultural aspects into nursing care and scholarship.

Postcolonialism directs attention to the convergence of several factors within the specific domain of nursing science and the larger arenas of health care and social inquiry. Postcolonialism equips us to meet the epistemological imperative of giving voice to subjugated pieces of knowledge and the social mandates of uncovering existing inequities and addressing the social aspects of health and illness (Kirkham and Anderson, 2002). Postcolonial discourses are an alternative to the culturalist approaches that predominate current nursing theory (Anderson, 2000; Brathwaite, (2018). It offers the critical platform to evaluate the everyday life experiences of oppression of marginalised racial groups and marginalisation influenced by micro-politics of power and macro-dynamics from the historical and structural perspectives (Kirkham and Anderson, 2002:2). In sum, PCT is currently aimed at “theorising the nature of colonised subjectivity and the various forms of cultural and political resistance” (Kirkham and Anderson, 2002:3).

Intersectionality Theory (IT)

The term ‘Intersectionality’ was coined by Crenshaw (1989) and developed to inform critical thinking about and interaction of factors on how a matrix of oppression exists between and within categories of race, gender, and class (Wesp et al., 2018). IT is historically grounded in the strategies and insights of resistance movements and has

recently developed for use in research to inform inequity in public health and nursing scholarships (Wesp et al., 2018)

The three central tenets of IT include that different oppressions mutually constitute one another to sustain a complex power matrix. Intersectionality theory highlights the examination of the ways structures and dominant ideologies such as colonialism, racism, and capitalism) occur in multiple co-occurring ways (Dhamoon and Hankivsky, 2011).

Secondly, IT believes that the status quo of inequity is sustained because the complex matrix of power privileges those in the mainstream while “othering” those on the margins. The oppressed group are 'othered' in 'multiple co-occurring ways' (Collins and Bilge, 2016).

Third, intersectionality theory highlights “that people experiencing co-occurring marginalisation are navigating multiple experiences of oppression; therefore, looking at only one aspect of their social location may not reveal the simultaneous processes” (Collins and Bilge, 2016, cited in Wesp et al., 2018: 321). The marginalised group have embodied knowledge about the multiple interactions of systems in limiting opportunities; therefore, emphasising these group provides the chance to engage in the main theatre of policy discussion and formulation and their personal experiences about defeating oppression (Dhamoon and Hankivsky, 2011).

These three theories (CRT, IT, PCT) from the same epistemological tradition are employed in this thesis to critically explore the oppression, exploitation and discrimination of nurse migrants and their struggle against exploitation, as well as promote emancipatory reasoning concerning the integration of IEN in the UK healthcare setting. These theoretical perspectives are significant influencers of the researcher’s epistemological position in the conduct of this study and influence the understanding of the lived experiences and discussion perspectives in this study.

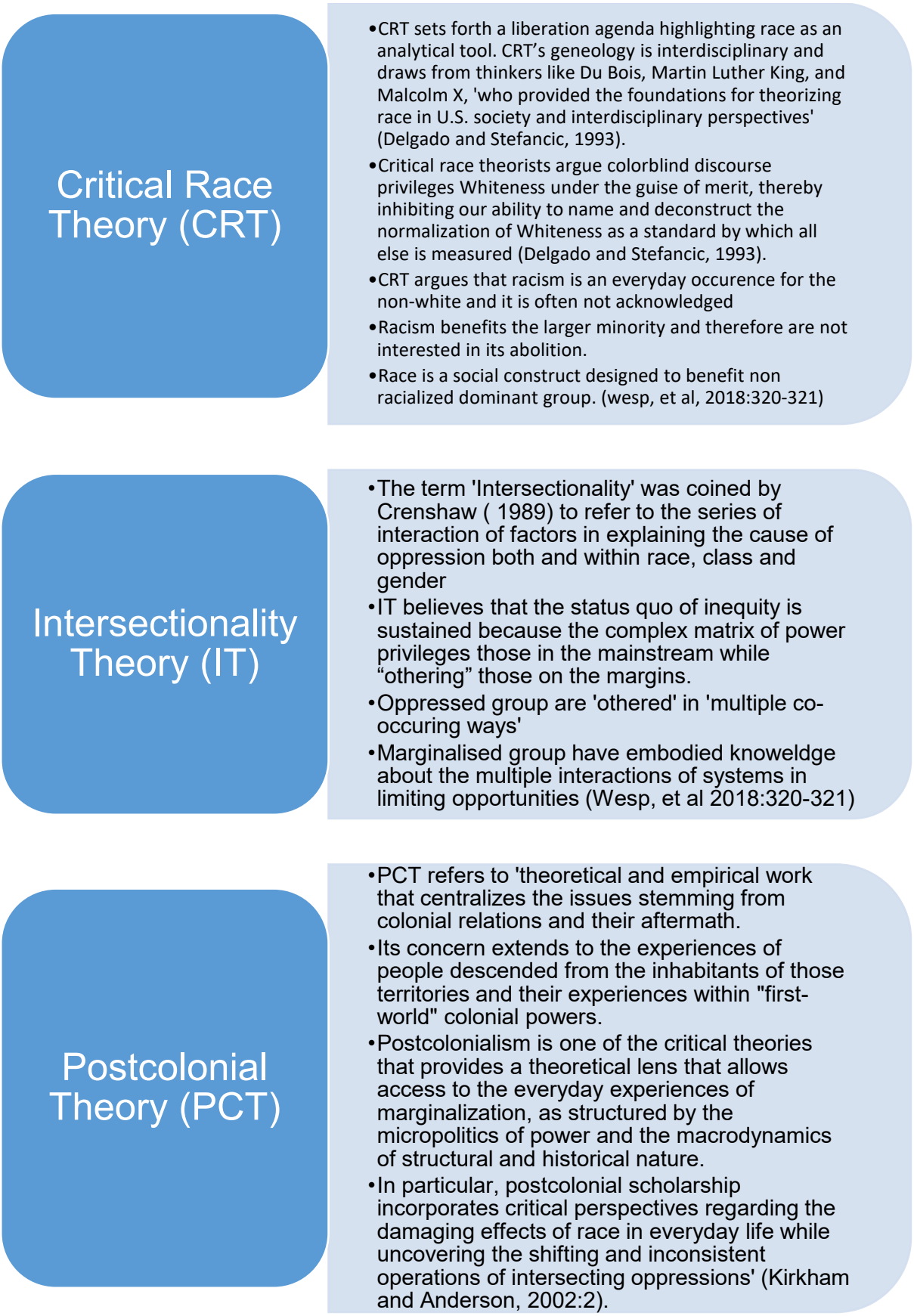


Fig: 2- Summary of theoretical perspectives

2.2: **International Migration: A critical review of migration, especially of the skilled and nursing migrants in the NHS.**

In this review, the focus is to offer a critical and extensive literature review to place the thesis in the context of migration, emphasising skilled nursing and other migrants in the NHS. Identifying the thesis in the context of health care workers' migration, especially nurses, will enable us to understand and compare the process and dynamics of integration of these migrants into UK healthcare. In this section, I offer a brief discussion of the concept of skilled migration and skilled migrants, the impact of migration, and the changing history of nurse migration to the UK as influenced by political, economic and social factors within and outside the UK pre and post establishment of the NHS.

The globalisation of services and skills has facilitated and contributed to international migration and movements aided largely by improved telecommunication, more accessible transport opportunities and expansion of goods and capital markets (Simic, 2018). The World Health Organisation (WHO) forecasts the creation of 40 million jobs by 2030 due to the increasing demand for health and social care staff (Drennan and Ross, 2021). And of the health and social care professional staff, registered nurses constitute half the global healthcare workforce and are the largest professional group in most countries (Drennan and Ross, 2021). However, the World Health Organisation (WHO) predicts a global shortage of 7.6 million of these professionals by 2030 and with a disproportionate impact on the continent of Africa (Scheffler et al. 2018). Nair and Webster (2013) found in a study involving patterns of health professionals' migration that the Pacific island and Sub-Saharan Africa (SSA) had the highest rates of healthcare workers movement (13%) to the developed economies. According to Espinova et al. (2011:9), globally, 630 million adults desired in the year 2010 to migrate permanently, and in 2015, there were 244 million international migrants worldwide. The number of international migrants rose by 50% to 232 million between 1990 and 2013 (UN,2013), and the number has maintained an upward trend since 2010, and in 2019, it reached 272 million (United Nations, 2019). As this upward trend continues, a sizeable number of these migrants may have found their way to the UK. In this 'age of migration' (Castles and Miller, 2014), many of these migrants are of the female gender. Movement is now mainly from the global south to developed countries of the global north, such as the UK, and there has been a surge in immigrants arriving in the UK in the last 50 years

(Simic,2018). Before this ‘age of migration’, nuns were the workforce face of transnational healthcare female worker migration in the 19th century, and migration was from the global north to the global south (Yeates, 2012). International healthcare worker migration has substantially changed in the 21st century—female migration in the health sector is now from the global south to the global north (Drennan and Ross,2020).

The nature, scope, and routes of migrants to the UK are dynamic and are influenced by economic and political factors on a global and local level. According to Kofman (2014), immigration policies promote power inequalities based on gender, class, race, nationality, and age. Simic (2018) argues that specific skills mainly possessed by women are downgraded to promote the skills possessed by men. It is not in doubt that nursing is a female-dominated profession (Drennan and Ross,2020). Since the nursing profession consists of male and female professionals with the same skill sets leading to their professional registration and practice, it’s questionable whether the view expressed by Simic (2018) that skills possessed by women are downgraded to promote the skills possessed by men holds in all cases.

There are three different types of immigrant workers. Each has other motives, needs and attitudes regarding the work and integration context’ (Baruch et al., 2013; Haines et al., 2008, cited in Farashah and Blomquist, 2019). The groups include assigned expatriates, self-initiated expatriates (SIEs) and immigrant workers (Farcas and Goncalves, 2017, cited in Farashah and Blomquist, 2019). An assigned expatriate is a migrant worker compulsorily transferred and supported for a specific mission from a corporate organisation's initial country of work to an overseas subsidiary organisation (McNulty and Brewster, 2017, cited in Farashah and Blomquist, 2019). A SIEs migration is unsupported by any corporate organisation but is a voluntary decision to work overseas temporarily (Farcas and Goncalves, 2017, cited in Farashah and Blomquist, 2019). In contrast, an immigrant worker is unsupported by any corporate organisation at the time of arrival but intends to permanently reside in the host country and eventually acquire citizenship (Przytuła,2015, cited in Farashah and Blomquist, 2019).

Simic (2018) offers a distinction between skilled migrants and skilled migration. Skilled migration is a ‘proxy for a flow of migration comprising labour migrants arriving in the host country on work visas (if needed)’. A labour migrant may be a skilled migrant with

or without a work visa and may have or have not used the skills before migration (Simic, 2018).

According to Farashah and Blomquist (2019:1), "*qualified Immigrants have diverse attributes in terms of reasons for migrating, level of human capital or social connections, degree of cultural closeness to the host culture and level of motivation to integrate. They … are considered to have some common attributes, such as agency in their international relocation with the intention to enhance their career*". There is a paucity of research on the gendered migration of highly educated, skilled migrants (Dumitru, 2017) but there is increasing research on international registered nurses categorised as highly educated skilled migrants (Ramji and Etowa,2014). The transnational migration of these female migrant workers at all skill levels in sustaining the well-being of the household and society is well documented (Wojczewski et al.,2015, Christou and Kofman, 2022). A dominant pattern of international migration of health workers is the movement of healthcare workers from the global south to the global north (Siyam and Dal Poz 2014), and Africa has the highest percentage of highly educated women migrants (Dumont et al. (2007). This pattern of women migration has contributed to the rapid increase in female migrants to the Organisation for Economic Co-operation and Development (OECD) countries from the global south. A large proportion of fifty per cent of the world's transnational migrants, mainly in the care sector, are women and often lead migrants in families [Morrison et al., 2008, Wojczewski et al., 2015]. Around 65,000 African-born physicians and 70,000 nurses were working overseas in the year 2000 (Clemens and Pettersson, 2008) and a large percentage of these were women. Most of these women take up a diaspora position to provide for the family economically, and some either migrate alone, accompany or join their spouses in the diaspora (Wojczewski et al., 2015). The female gender as lead migrants from African countries like Nigeria continues to increase, and are often entrepreneurial women or students [Makinwa-Adebusoye, 1994 cited in Wojczewsk et al., 2015).

The primary informal caregivers to children, the elderly and the sick worldwide are women; in Europe,75% of the health workforce in 2010 were women (Eckenwiler, 2011). In the UK, almost 80 per cent of non-medical health service staff in 2008 were women (NHS 2008), and in 2021, 78 per cent of the health and care workforce were female (NHS Confederation, 2022). Since the inception of the NHS in 1948, Migrant health

professionals have become an essential and significant part of the UK healthcare workforce (Jayaweera and McCarthy, 2015). The emigration and loss of the skills of health professionals, including nurses from the southern global countries to the global north, hurt the national health sectors and training resources of the countries for these professionals (Aluttis, Bishaw, and Frank 2014). Mensah, Mackintosh and Henry (2005) argue for the reparation of costs by the more prosperous global north to the international southern countries where these professionals originate. Thompson and Walton-Roberts (2018) describe this loss as a 'brain drain' and a 'perverse form of reverse aid'. Mensah et al. (2005:4) argue that this 'perverse subsidy is indefensible, contributing as it does to worsening the huge inequality in health services between the UK and developing countries…'. However, there is a positive side to the emigration of these professionals, including nurses. For example, the emigration of these professionals benefits economically in many developing countries, as evidenced by the diaspora remittances to Sub-Saharan Africa (SSA). There was a 14.1 per cent leap to $49bn in the year 2021 remittances to Sub-Saharan Africa (SSA). Nigeria recorded the highest diaspora remittance by an 11.2 per cent rise to $19.2bn in 2021 (Olarewanju, 2022). The diaspora remittances have soared over the past few years due to migration and the globalisation of services and skills. As of January 2020, Nigeria had 8,241 NHS staff members in the UK National Health Service and represented the most prominent African nation and the sixth-largest contributor to NHS staff behind the UK, India, Philippines, Ireland and Poland (Barker,2020). Alderwick and Allen (2018) argue that the NHS needs more migrant staff and estimates that additional 5,000 international nurses are required to be recruited yearly until 2023/24 to sustain the NHS. There are other benefits derivable from transnational migration, such as improved sharing of healthcare knowledge, equipment and resources, development of exchange programmes and enhanced opportunity for improved bilateral and multilateral agreements on recruitment of international health professionals, respecting the freedom of health workers to migrate and circular or return migration for critical skills. According to Christou and Kofman (2022:34), "although migrants may face exploitation, deskilling and over qualification in their workplaces, emancipation, empowerment and the fulfilment of personal projects may also be the outcome of migratory trajectories". Despite the presumed benefits for the migrants' homeland, Mensah et al. (2005) argue that the problems suffered by migrants and by the families left behind outweigh the benefits of emigration, and

migration contributes to denying the population adequate health services in the countries of origin, while in the destination countries migration improves health services. Wojczewski et al. (2015) suggest Africa suffer multiple loss because they not only lose their female care workforce, the African migrants end up not adequately integrated into the labour markets and civil societies of the destination countries. Article 12.2 of the International Covenant on Civil and Political Rights, Article 13 of the Universal Declaration on Human Rights and article 12:2 of the African Charter on Human and Peoples Rights stipulate the right of individuals to migrate. However, at different times, coercive measures to prevent departure from countries losing their healthcare staff in the global south and immigration protectionism of many developed western nations in the global north have contributed to stifling the individual exercise of these rights (Wojczewski et al.; 2015).

The numbers of migrant health workers, particularly nurses, have fluctuated over time, influenced by the national health workforce shortages and concerted government recruitment drives abroad (Jayaweera 2015). Before the establishment of the NHS in 1948, the dominant migrant workers were of Irish descent. They were considered ‘European insiders, but cultural outsiders, differentiated by and discriminated against based on their nationality and religion’ (Batnitzky and McDowell, 2011:182). The European volunteer Migrant scheme prompted by the UK labour recruitment post-second world war policies led to the recruitment of several refugee women as economic migrant women from the Eastern European Baltic states between 1946 and 1949 and many of whom became nurses (McDowell 2005 cited in Batnitzky and McDowell, 2011) in the NHS. The establishment of the NHS in 1948 and the effects of the second world war contributed to the migration history of several minority ethnic groups in the UK. Nurses from the British colonies (now part of the commonwealth of nations) formed the bulk of migrant nurses recruited between the late 1940s and the late 1970s. They were considered non-white and cultural outsiders (Batnitzky and McDowell, 2011). Several racist immigration policies propounded (Gentleman, 2022) following the UK's admission to the European Union (EU) and the UK 1971 Immigration Act curtailed overseas nurse recruitment from the Commonwealth (Snow and Jones, 2011; cited in Reynolds, 2019). The number of migrant nurses registered in the UK between 1999 and 2002 was 42,000, and more migrant nurses than the NMC-registered British-educated nurses in the 2001-

2002 registration cycle (Aiken et al., 2004). By 2015, EU-trained migrant nurses comprised 4.5% of the NMC Registered Nursing and Midwifery workforce compared with 8.2% from non-EU countries (Maranzagov et al., 2016). However, following the Brexit referendum, the number of nurses from the EU registering with the NMC to work in the UK fell dramatically by 96% in 2017 (Siddique, 2017). The recruitment of non-EU Overseas Registered Nurses continues to rise, with more nurses migrating to the UK than emigrating to work overseas (Gillin and Smith, 2020, cited in Ugiagbe, 2022).

On the establishment of the NHS in July 1948, there were 54,000 nurse vacancies in NHS, predominantly in the services for mental health, chronic sick, and geriatric care (Batnitzky and McDowell, 2011). The response of the UK government was to recruit migrant workers mainly from the Caribbean, Africa and other British Colonies from the 1940s to the 1970s. The migration of health workers to the UK was primarily due to direct government recruitment centres in various nations, and some commonwealth citizens applied for training as nurses in UK hospitals or nursing positions in the UK (Batnitzky and McDowell, 2011). The recruits from the colonies were steered away from the Registered Nurse (SRN) nursing training programmes into the less-valued State Enrolled Nurse (SEN) nursing training programmes that disadvantaged their overall career progression in the NHS. Through institutionalised and systematic discrimination and everyday practices on the wards, non-white nurses found that their career opportunities or trajectories within the NHS were more restricted than those of white British women (Batnitzky and McDowell, 2011). International migration of nurses to the UK continues to take place in the context of racism towards migrants both in the NHS and in the wider UK society (Allan et al., 2004; Smith et al., 2008; Brathwaite, 2018; Reynolds, 2019; Migration Observatory, 2020 cited in Ugiagbe et al., 2022).
Migrant nurses' recruitment to the UK was traditionally limited to former UK Colonies and Protectorates (Solano and Rafferty, 2007 cited in Ugiagbe et al. 2022), and the nurses from these countries were not required to take a compulsory English language proficiency test. Still, mandatory English language tests for these countries were introduced in 2005 (NMC,2017). The introduction of a compulsory language test for migrant nurses trained in commonwealth countries, Ugiagbe et al. (2022) argues, is an example of one of the discriminatory and racist impositions put in place since the 1970s, following the dwindling UK's global post-colonial economic position leading to increased

calls for protectionism and reduced immigration amidst waves of anti-migrant rhetoric and feeling (Ugiagbe et al. 2022, Reynolds, 2019). Unsurprisingly, international nurse recruitment has become an accepted, essential, and significant part of the UK healthcare workforce (Jayaweera and McCarthy, 2015). It takes three years to train a registered nurse in the UK at the cost of about £50,000 to £70,000, whereas it costs between £10,000 and £12,000 to recruit an overseas nurse, but employers can save £18,500 in agency nurse costs in the first year alone (Das, 2022) Therefore, international recruitment of nurses in the UK is economically and politically beneficial to the NHS and offers a ready supply of migrant nurses in times of acute shortage of nurses in the UK.

Despite the evident economic benefits of international recruitment to the NHS, institutionalised and systematic discrimination and everyday racial harassment, bullying and discrimination, racism, and intimidation towards migrant nurses are still evident in the 21st century in the NHS (Kline,2020; Bornat, Henry and Raghuram, 2009; Coker, 2001; Healthcare Commission,2006). In his paper, 'Disengagement and demoralisation', Henry (2007) illustrated the discrimination of Ghanaian nurses working for the National Health Service in the UK. Leroi Henry interviewed nurses and midwives who trained in Ghana but now work in Britain. The nurses and midwives migrants feel discriminated against because they feel that promotion was not on merit. The feeling was that "promotion into management (grade G and above) involves navigating systems of patronage and sponsorship based on meeting subjective and culturally specific criteria". Henry (2007) concluded that racism in the workplace exists was not a figment of imagination by the nurses because the existence of racism in the National Health Service is real. He advocates that to eradicate racism and discrimination in health services, an analysis of why racism occurs and how individual nurses at different levels of the hierarchy respond to it needs to be conducted, and practical steps to prevent workplace racism must be implemented. Nurses should not only advocate for their vulnerable patients; they should advocate for colleagues and not subject them to racism. Introducing compulsory English language proficiency tests in the first quarter of the 21st century exemplifies a post-colonial structure and institutional racism fuelled by whiteness and white privilege. This works against migrant nurses recruited to work in British health services and is facilitated and normalised in a professional discourse led

by the NMC, which reproduces the historic and pervasive oppression of non-white nurses in the NHS (Ugiagbe et al., 2022).

In subtle post-colonial policy exploitation, in the year 2021, the UK promulgated a new immigration policy to recruit migrant nurses from around the globe following the inclusion of Nursing in the revised UK shortage occupation list for Tier 2 visas. The government introduced temporary changes to the UK health and care visa requirements to make social care workers, care assistants and home care workers eligible for 12 months in the UK (DHSC, 2021). It states that the care staff were added to the shortage of occupation list in response to pandemic pressures to boost the adult social care workforce and to 'make it quicker, cheaper and easier for social care employers to recruit eligible workers to fill vital gaps' (DHSC, 2021:1). Migrant carers under the Shortage Occupation List visa scheme get an annual salary of £20,480 and the Health and Care visa will allow applicants and their dependents to benefit from fast-track processing, dedicated resources in processing applications and reduced visa fees. Health and Social Care Secretary Sajid Javid believed that the Health and Care Visa would enable the government to sustain health and social care and success in the long-term vision to build social care. The annual salary fixed for the migrant workers confirms an unexpressed sublime conservative government political ideology to sustain the social, economic and political dominance of whites (Bonilla-Silva 1997) which has shaped the reality of non-whites for generations. The fixed salary attached to the UK shortage occupation list for Tier 2 visas is deceptive and designed to lure the unsuspecting migrant worker from poorer countries of the global south. The monetary exchange rate of the British Pound (a hard currency) in the poorer countries makes the salary tantalising and fascinating. However, the reality of the pound's purchasing power becomes a reality and a shock once the migrant nurse arrives in the UK.

Consequently, this salary will ultimately increase the numerical strength of low-wage workers who are primarily non-whites and the continuing social, economic and political dominance. The UK shortage occupation list for Tier 2 visas becomes operational in the summer of 2022. There is no available research on the UK shortage occupation list for Tier 2 visas known to this researcher at the time of writing (July 2022). I project that, in part, the unstated expectation of the government is that the majority of the migrant health and social workers will most probably arrive from anglophone commonwealth countries because their education is in the English language. This expectation may

explain the non-inclusion of compulsory English proficiency tests in the requirements announced.

The history of migrant nurses' exploitation by the social agencies of the NHS (Allan et al., 2004, Henry and Raghuram, 2009; Kofman, 2014; Allan and Westwood, 2015b) is again on the rise in the first quarter of the 21st century. Unfortunately, post-pandemic healthcare employers seem to be facilitating and deeply involved in a combination of institutionalised and systematic discrimination and exploitation, as demonstrated in the denial of migrants' rights and freedom. Recent reports indicate that international nurses working for UK healthcare are becoming trapped in their jobs by contract clauses requiring them to pay thousands of pounds if they exercise their rights to change their position (Das, 2022). This is further evidence of post-colonial exploitation and discrimination of migrant nurses from commonwealth countries (previous British colonies). Das (2022:1) explains that the contract clauses were "*designed to retain staff and recoup recruitment costs; they often cover hiring expenses such as flights to the UK, visas and the fee for taking language and competency exams. In many cases, they also include mandatory training costs, which workers hired in the UK are not routinely required to pay*".

2.3. Defining Integration:

This section provides a general definition, a general review of some theoretical debates and discusses what policies or models the nation-state employs at the national, regional or local levels to promote integration in the UK. Part of the discussion shows the chronology of its policy usage – along with critical commentary influenced by the CRT, IT and PCT on the various purposes of its use and a summary of how academics have used the term and its use by government and other agencies.

It is expedient to indicate that there is no commonly accepted definition of integration, and the concept of workplace integration of international nurses is poorly understood. Despite the nursing literature showing increasing interest in international nurses, there remains a lack of research and nursing literature on the post-transition phases or the long-term integration of overseas nurses (Ramji and Etowa, 2014). Therefore, much of the nursing literature reviewed on integration mainly concerns the period of adaptation

(initial integration leading to NMC registration), which may impact the long-term integration of overseas nurses.

This section of this thesis will use the conceptual framework of Ager and Strang (2008) to critically inform the discussion of integration, impact and implication of the nation-state perspectives on the lived experiences of the international nurses with Nigerian heritage on integration into the UK healthcare post-NMC registration. There will be an analysis concerning the discrete themes identified in the traditional perspectives of pluralists and assimilationists on integration. These macro perspectives will then inform the discussion of the lived experiences of International nurses with Nigerian heritage in UK healthcare.

The word integration derives from the Latin *integrātiō,* meaning renewal. This meaning has shifted over the years to mean "to render (something) whole," from Latin integratus, past participle of 'integrare' "make whole," ... meaning "to put together parts or elements and combine them into a whole" (Online Dictionary). The dictionary suggests that integration implies an incompleteness and a need to "make whole" the subject to be integrated into a given milieu.

The term integration connotes the '*insertion of a group or individual into an existing entity (a society, bounded by a nation-state)' (*Favell, 2010 cited in Spencer and Charsley 2016:3). According to Threadgold and Court (2005), integration is "…*the process by which immigrants and refugees become part of the receiving society"* (p.8). To Garcés-Mascareńas and Penninx (2015:14), it is "the process of becoming an accepted part of society". It refers to the *process of settlement, interaction with the host society, and social change that follows immigration* (p.11)

With this concept of acceptance by the host community, Shadid (1991) sees it as the participation of ethnic minorities in the host society's social structure with the prospect of retaining their own culture and identity. Harrell-Bond reasons that integration refers to *'a situation in which host and refugee communities are able to co-exist, sharing the same resources - both economic and social - with no greater mutual conflict than that which exists within the host community*' (1986:7). This view is similar to Bulcha (1988) observation that integration '*implies a mutual "live and let live" attitude based on tolerance of differences, solidarity and positive interaction. This does not suggest a*

harmonious equilibrium or a static balance between the different groups. Conflict is naturally part of the relationship' (Bulcha, 1988:86 cited in Kuhlman, 1999:4).

Many scholars employ alternatives to the term integration. Examples are 'inclusion' and incorporation, accommodation, absorb, integrate, and assimilation (Weiner, 1996; Hochschild et al., 2013), but they are either unclear, too complicated, specific, or ignore agency and do not clarify the nature of the process involved. Therefore, the term 'integration' may be the best on offer. Like Spencer (2011), I use the term integration in this study because there is no acceptable alternative to the term integration. It is understood and used in continental Europe as a multi-dimensional process in the structural, social, cultural, civic and political, economic, and maintain own identity domains (Spencer, 2011). The UK cohesion agenda means achieving the government's desired state of a community where peace reigns. It is expedient to indicate that although integration is a community-based concept, individuals constitute a community. Therefore, the individual needs to integrate into the community as much as the population becomes part of the individual (see appendix 11a for alternative terms for integration suggested in conferences).

2.4. Integration policies/ Models of Integration:

Traditionally, integration models may include pluralist and assimilationist (Gaans, 2005; Spencer, 2011) models of integration. The pluralist models include differential exclusionist, multiculturalism, citizenship, and *laissez-faire* Integration.

There are two kinds of integration policies ---targeted and general (Alessio, 2008). Targeted policies relate to immigrants and their descendants, and public policies relate to '*all (potentially) disadvantaged members of the host population*' (Alessio, 2008:1862). Irrespective of the policy types, international nurses from non-EU countries are likely to be affected either way because they are immigrants and are likely to be disadvantaged because of being non-white, amongst other factors. Spencer (2011) states that in integration policy intervention, there are four types of policy intervention: Policy with a focus on individual or minority communities, economic policies, social or cultural integration policies targeted at migrants only, and policy on voluntary or mandatory language and civic course. From these policy classifications, Spencer (2011) outlined, the various types of policy intervention will undoubtedly have direct or indirect implications for the internationally educated nurse.

Hersi (2014) argues that there are three categorisations of migrant integration discourse in the literature: the nation-state, academic, and media. The integration model adopted by its nation-state partly influences the discussion in academia and the media. The model adopted by the nation-state ultimately determines the process of integration internationally educated nurses may experience. And by extension, the process will eventually shape their lived experiences and integration into UK healthcare.

The existing political and social reality influences a nation-state's adoption of a model of integration. The most common themes in the literature concerning nation-state discourses about integration are the models of assimilation, integration, multiculturalism and citizenship (Hersi, 2014). There are varied interpretations of the integration process in each of these models. A variety of factors influence the process by which integration takes place. Some see this process as a unidirectional, bi-directional or multi-directional process. (Alba and Nee, 1977; Ager and Strang, 2008; Spencer, 2011. Joppke, 2013; Garcés-Mascareńas and Penninx, 2015; Spencer and Charlsey, 2016).

Assimilation is the oldest model of integration (Castles and Miller, 1998) and describes a one-sided adaptation process: it requires immigrants to give up their distinctive linguistic, cultural or social characteristics and become indistinguishable from the majority population (Castles, 1999). According to Legrain (2006), there are differences in how different nation-states practice assimilation. In the French assimilation model, integration impacts '…*personal freedoms, by striving to erase cultural differences, without delivering the equality and national cohesion it espouses'* (Legrain, 2006:266). Assimilation is a system that thrives on 'violence, repression and coercion to absorb minorities into majority culture' (Doomerick and Knippenberg, 2003 in Hersi, 2011:592). The practice of assimilation as a model in colonial Africa required the Africans in the Francophone countries to 'think French, talk French, eat French, live French, dress French and dream Paris'; the Africans must become more like the people from the colonising group. Although Kivisto (2005) states that there is some disagreement about what assimilation means and may be contentious, it is back in attempting to become prominent. Hersi (2011) disagrees and says that assimilation is irrelevant in modern integration practices due mainly to technological, communication, and transportation development.

The Pluralist models Hersi (2011) states mainly describe citizenship and multiculturalism. There seems to be some overlap between multiculturalism and other models of immigrant incorporation. For example, citizenship and the application and impact of multiculturalism by a nation-state may differ (Hersi, 2011; National Multicultural Advisory Council, 1999). In multiculturalism, the nation-states believe it is unrealistic to expect that the new arrivals would wholly adopt the dominant culture (Castles and Davidson, 2000). Hersi argues that although multiculturalism is a popular model, it has come under pressure and attacks as culpable for the terrorist attacks in the USA (2001), London (2005) and Madrid (2004).

The laissez-faire immigrant integration system is a new system that functions on the premise that '*an individual migrant's choice, plus a framework of individual rights and anti-discrimination legislation, will result in the incorporation of new immigrants into a unified citizenry'* (Bloemraad 2006, p.233). This approach on its own may contain elements or systems of multiculturalism.

Integration from the state perspective is a one-way process where the migrants are accountable and responsible for integrating into the host society (Erdal and Oeppen, 2013). Still, it may also be a two-way mediation process and relationships between the migrant as individuals and groups and the host society (Ehrkamp,2006). However, the UK is a welfare state that practices the multicultural integration model with prevailing political and cultural realism. The UK's practice is heavily influenced by its indirect rule in its colonial territories, which metamorphosed as the Commonwealth of Nations. Spencer (1997) states that multi-cultural Britain was an unintended outcome of British policy. This legacy, up until the 1980s, shaped the Citizenship law and right of residence in Great Britain (Dőrr and Faist, 1997). For example, the nationality laws of Great Britain granted Citizenship rights to British Empire Citizens (Commonwealth) until the 1962 enactment of the commonwealth immigrant Act. The Act was to continue to allow the flow of skilled commonwealth country citizens into the UK while restricting the access and rights of other citizens (Solano and Rafferty, 2007). The unintended consequence brought about by British policy seems to have occurred. It continues either as a refusal to understand its old colonies' migration perspectives or underestimating the effects or consequences of the UK government marketing the brand 'London' worldwide.

The UK nation-state and Integration:

Although the UK government has not explicitly defined integration, Bulcha's view or definition seems to reflect the government's cohesion agenda. The UK government cohesion agenda is an offshoot of the government's approach towards promoting peaceful co-existence in response to the series of riots and disturbances in some northern cities of the UK in 2001 and was reinforced by the London Underground terrorist attack in July 2011. For example, the Government response to the commission on integration and cohesion under the Labour party in 2008 states:

'A key contributor to community cohesion is integration, which must happen to enable new residents and existing residents to adjust to one another. Our vision of an integrated and cohesive community is based on three foundations:

- *People from different backgrounds having similar life opportunities*
- *People knowing their rights and responsibilities*
- *People trusting one another and trusting local institutions to act fairly.'*

(Dept. of Communities and Local Government, 2008:10)

and in 2019, the UK's government, led by the Conservative party in its Integrated Communities Strategy Green Paper, stated that it does not intend to define the term integration. Still, the government recycled the perspective of Labour's 2008 strategy stating:

'*We define integrated communities as communities where people – whatever their background – live, work, learn and socialise together, based on shared rights, responsibilities and opportunities*….' (p.7).'

Equally, it seems that the position of the government agrees with the perspective that *'integration is achieved when migrants become a working part of their adopted society, take on many of its attitudes and behaviour patterns and participate freely in its activities, but at the same time retain a measure of their original cultural identity and ethnicity* (Bernard, 1987:87 cited in Kuhlman, 1999).'

The Cambridge Online Dictionary defines integration as:

a) *'the action or process of successfully joining or mixing with different groups of people: racial/cultural integration;*

b) *The action or process of combining two or more things in an effective way...'*

The Merriam-Webster Dictionary defines integration as:

1: the Act or process or an instance of integrating: such as

a: incorporation as equals into society or an organisation of individuals of different groups (such as races)

b: coordination of mental processes into a normal effective personality or with the environment.

The definition from the root origin of the word indicates a change, responsibility and process or action. Still, it is unclear whose responsibility it is or the 'how' or 'why' of the process. The term integration flows from the original meaning of '*an expectation that migrants will become culturally similar to the host population and, as a policy objective, they should*' (Brubaker, 2001, cited in Spencer, 2011). This expectation aligns with the definition of European academic and policy literature, where the concept of '*integration' is widely accepted as the 'evolving relationship between migrants and the 'host society'* (Spencer, 2011:202). The term is less accepted in the UK because integration connotes 'assimilation' (Spencer, 2011). However, one must be quick to point out that 'integration' is not 'assimilation'. The UK's multicultural policies foster absorbency between cultures. They do not protect the boundaries between cultures (Spencer and Rudiger, 2003), and integration is a process with many diverse dimensions that can be evaluated using defined criteria (Kuhlman, 1999). In his study of refugees, Kuhlman defines integration '*as the process of change caused by the settlement of migrants in a plural society'. Kulhman (1999) reasons that refugees are truly integrated if:*

1. *refugees are able to participate in the host economy in ways commensurate with their skills and compatible with their cultural values;*
2. *refugees attain a standard of living derived from economic activities and having access to amenities such as housing, public utilities, health services, and education*

3. *refugees are able 'to maintain an identity of their own and to adjust psychologically to their new situation';*
4. *the standards of living and economic opportunities for members of the host society have not deteriorated due to the influx of refugees;*
5. *if friction between the host population and refugees is not worse than within the host population itself;*
6. *and if the refugees do not encounter more discrimination than exists between groups previously settled within the host society.*

Although Kuhlman's study is on Refugees, the criteria to judge the degree of integration seem to be factors that will align well with the aspirations of the UK government. The UK definition in the cohesion agenda is integrated communities where people – whatever their background – live, work, learn and socialise together, based on shared rights, responsibilities and opportunities (2019:7).

Hersi argues that the terrorist attack on the New York twin tower on September 11th. 2001, introduced the nation-state, academia and the media as important 'actors and players in the process of defining integration' (Hersi, 2014: 590). As previously indicated, at these three fundamental actor levels, the concept of integration is widely accepted in European academic and policy literature (Spencer, 1997, Spencer 2011). More recently, the UK Government, in its Integrated Communities Strategy Response (2019:7), acknowledged the importance of '*having a definition of integration that everyone can unite behind.* However, it avoided defining integration and stated that *'…On balance, having considered the wide variety of views expressed about how to define integration, the Government considers that its vision, as set out in the Green Paper, outlines as clearly and succinctly as possible what we want to achieve and we do not intend to add further detailed references to it'* (HM Govt. 2018). Therefore, it is evident that the government's cohesion agenda concerns itself with promoting a 'live and let live' peaceful, maintaining a status quo atmosphere as its primary target or mission for new migrants and other members of society.

Policy on the integration of work migrants to the UK is not a central issue to a large degree (Spencer, 2011). There is deference to debates on the number of migrants entering the UK. Where policy exists on the issue, there is a '*lack of coherence on policy*

across government and … between government at national and local level' (Spencer, 2011:201).

Spencer argues that this is due to a lack of consensus on the meaning of 'integration' and history in that the '*policy paradigm had its origins in the post-war era and has not adjusted to the migration patterns of modern times'* (p.201). Spencer (2011) states further that in Policy debates, 'Integration' may be used to exempt the government from accountability and responsibility in migrant's integration and responsibility for integration is shifted solely to the migrant. Concerning nurse recruitment into UK healthcare and migrant nurses fitting into the system, it is deliberately ignored and seen as the migrant's responsibility to acknowledge the cultural differences in the order (Allan et al., 2004). By extension, acknowledging and accepting the cultural differences in the system by the migrant may also imply that the migrants accept that the perspectives of the majority population in the UK are objective. Acknowledging the views may also mean that it represents reality and sees the majority population as '*universal humans who can represent all of the human experience'* (DiAngelo, 2011:59). This view may also ensure that concerted integration of other races into the UK may further increase the inability of the dominant population to tolerate racial stress. This inability may, in part, be the rationale for the protectionist attitude of the government that prevents it from offering a clear definition for integration.

As previously indicated, as alternatives, many scholars use the terms 'inclusion' and 'incorporation' amongst others (Hochschild et al., 2013). Integration is '*the inclusion (of individual actors) in already existing social systems*' (Esser, 2004:46). However, these alternative terms, for example, 'inclusion' depicts integration as a one-way process that ends in an enclosure and does not note '*the two-way process of mutual change in which migrants are engaged* (Spencer, 2011:201) and is therefore not a suitable alternative. The study of issues to do with integration is not new. The scientific study of the settlement process of migrants in host society started well before it was made famous in the early 20th century by the Chicago School of Urban Sociology (Pennix and Garċes-Mascareńas, 2016:11). Spencer (2011:201) attempts to rationalise the lack of definition of integration by the UK government. Spencer argues that the "*policy paradigm had its origins in the post-war era and has not adjusted to the migration patterns of modern times"*. This argument is shallow and is not a satisfactory rationale for why the UK

government has no clear definition for integration, avoiding engaging the topic directly and shielding it into its cohesion agenda. According to Spencer (1997:21), '*to all outward appearances, during this first post-war decade, British subjects from all parts of Empire/commonwealth remained free to enter the United Kingdom as and when pleased. However, in practice, rather than in theory, British immigration policy operated in a way intended to make it difficult for Asians and Black British subjects to settle in the United Kingdom'*.

In applying the postcolonial theory perspective, this researcher's view supports the proposition that the typical British socio-political style of 'indirect rule' used in the administration of its colonies dictates the integration involving international nurses from the erstwhile colonies and the other nationals. The purpose of the 'indirect rule' is best summed in the review of Rt. Hon. W. Ormsby-Gore, M.P. (1935) quote the words of Sir Donald Cameron. G.C.M.G (Colonial Governor of Nigeria) that:

"*Indirect administration ... is designed to adapt for the purposes of local government the tribal institutions… moulded and modified as they may be on the advice of British officers and by the general control of those officers….The centuries which lie between ourselves and the Native in point of development cannot be bridged in a generation or two. ... and we are using in this scheme of Native Administration an instrument which is being carefully and patiently fashioned for our purpose."*

Similarly, Reynolds (2002:281) argues that the colonial system was '…*as a form of economic and class stratification'* to breed ready workforce *'…to be employed as clerks and teachers whose labour would generate value in international circuits'*.

It is clear from the excerpts above that the primary purpose of indirect rule was to fashion a native administration with a local face for the benefit and use of the colonial government only. This policy is not different from the current advocacy of 'multicultural' integration to promote cohesion in the community by the government. It promotes cohesion despite recognising that barriers prevent integration and opportunity in the wider society. For example, Bosswick and Heckmann (2006) argue that society is heterogeneous and has social class differentiation. Therefore, how the 'host community' migrant is required to integrate is not explicit, and the existence of sub-cultures within the society may result in 'segmented assimilation' (Bosswick and Heckmann 2006: 11).

Vasta (2009:20) argues that there is a need to redistribute power and resources in promoting social solidarity. It was equally needful to note that there are fundamental differences in class, gender, ethnicity, age, place, etc. Vatsa further states that *"inequalities are seen as socially rather than politically and economically constructed".* Therefore, the Cohesion agenda is seen as unidirectional and assimilationist. Responsibility to integrate is seen solely as that of the migrants, and migrants should accept the existing inequalities. Thus, cohesion is a misnomer because the government tacitly understands that 'multicultural' integration is a policy that does not promote mixing cultures (Spencer and Rudiger,2003). It has an *unexpressed preference for migrants becoming more 'culturally similar to the host population and, as a policy objective, they should* '(Brubaker, 2001 cited in Spencer, 2011) while migrants must accept their inequalities.

Academic discourse:

The term 'integration' is also not popular with critics in academia and with civil society groups because of the *'emphasis on race relations, cultural change and the agency of migrants rather than on the systemic barriers to participation that minorities can experience' (Hersi, 2011:202)*

The discourse in the academic sphere centres on concepts of transnationalism, post-nationalism and cosmopolitanism. The academic discourse is about integration theories, and much scholarly literature supports the pluralist notion of integration. The main view tilts towards promoting cohesion in the social order and social change (Hersi, 2014).

Cosmopolitanism is described by Hersi (2014) as an abstract and functional theory that emphasises the global connectedness of the world. This theory sees the world as a global village with blurred boundaries and expresses the need for individuals to identify beyond the artificial borders of nation-states. Cosmopolitanism believes that many individuals perceive themselves as 'citizens of the world and their native country' (Skrbis and Bean, 2008b Cited in Hersi, 2014). This cosmopolitan idea is not in practice in any nation-state to date. Still, the theorists are hopeful this is not an impossibility and cite as hypocrisy the low-level acceptance of immigrants in some societies but accepting

international travel as a good thing and openly accepting international cuisine as food in these same societies (Hersi, 2014).

Post nationalism academic scholars argue that immigrant incorporation is not solely in or utterly dependent on granting of citizenship and associated legal rights and status. The “theories of post-nationalism challenge the idea that citizenship remains linked with state membership, be it territorialised or not (Bloemraad,2004: 392). Post-nationalist argues that the concept of international human rights has undermined the traditional ideas of citizenship due to ‘their power as an accepted normative framework and through their institutionalisation’ (Bloemraad, 2004: 392-396). Critics of the post-nationalist model argue that it is suitable only for first-generation migrants. The critics state that first-generation migrants have the ‘illusory’ conception of returning home in the distant future. Furthermore, the use of the practice of assimilation violates the dignity of individuals. It does not support the constitution as a vehicle meant to protect the individual liberty of becoming a citizen (Joppke (1999, cited in Hersi, 2014).

Transnationalism is a concept that allows individual migrants to have multiple attachments (Hersi, 2014). Some academics argue that the idea of transnationalism does not support integration and citizenship but may interact with the process of migrant integration. It is politically sensitive, but some elements in some nation-states may exploit it for adverse impact. Some scholars believe that migrants may develop ‘multiple attachments to local and global allegiances’ as found in the study of Clark (2009), and therefore some argue that it undermined a dedicated link to a defined sovereign state by the individual and hence denial of citizenship to such individuals was justified (Bloemraad, 2004 cited in Hersi, 2014)

Erdal and Oeppepen (2013) identified four positions in the literature studying the relationship between integration and transnationalism. The position includes the alarmist view, which sees the migrants as having divided loyalty between their place of origin and their host community. It also consists of the pessimistic view, which believes only individuals with less human and cultural capital become integrated. The interdependent third view believes in the mutuality of integration and transnationalism. The last view sees transnationalism and integration as not mutually exclusive (Hersi, 2014). Study shows that general transnationalism does not impede integration (Snel, Engbersen and Leerkes, 2006).

There are some advantages cited in the transnationalism literature, such as Anghel's (2012) study of ethnic Roman migrants to Germany and Italy 'that migrants' transnational involvement plays a crucial role in their status and sense of success at a national level' (cited in Hersi, 2014:9). Transnationalism also promotes 'international trade and helps provide an income strategy for underprivileged migrants, however at the same time, it impedes adequate incorporation into the host society (Snel, Engbersen and Leerkes 2006 cited in Hersi, 2014:9).

Thus, from the above, the common thread of the academic discourse is their pluralistic and universalistic nature and the concept of universal human rights (Hersi, 2011). These discourses are not models adopted by nation-states as policies of integration.

Media discourse:

Media discourses on integration focus on the portrayal of immigrant integration and migration debates in general. Hersi (2011) argues that the media's role in this discourse, often hostile, contributes to a sense of social cohesion or lack of Social cohesion. Although the media can frame the agenda for the nation and influence public opinion on discourse concerning integration, it tends to represent adverse news reporting about ethnic minorities (Christoph, 2012). Hersi (2014) argues that the media discourses are modulated purely by considerations of economic benefit since most of its readership is the majority of the host community.

Common characteristics of Integration:

From the discussion on integration, there is a clear consensus on shared characteristics and the desired outcome. These common characteristics are summarised and represented in Figure 3 (see appendix 11b: Common characteristics of integration and its desired outcome).

So, in line with the vision of the UK government in its Green paper (HMG, 2018), integration is seen in this study as a series of processes involving IENs and receiving society institutions and residents taking place in the structural, economic, social, cultural, civic and political domains (Spencer 2011 Cited in Jayaweera and McCarthy

2015:4). An integrated healthcare setting is thus a healthcare setting where all the healthcare workers – whatever their background – live, work, learn and socialise together, based on shared rights, responsibilities and opportunities' (p.7). The desired outcome of the cohesion agenda for the UK government is peaceful co-existence between the host community and the migrants. This view is not different from what UK healthcare expects of international nurses- the desired outcome is for the internationally educated nurse to gain registration with the NMC, become familiar with the nursing practices, and provide care to a designated group of patients as required.

According to Hersi (2011), the national integration debates tend to be influenced heavily by politics and sensationalised at the media discourse level. The academic level is elaborate, but there is a complete absence of '*individual migrant's understanding and experience of integration about their families and household experiences'* (Hersi, 2011:601). This thesis addresses this gap and offers a voice to some individual migrants who are not refugees. These migrants also have a good level of professional education and practice experience and share their lived experiences, understanding and interpretation of integration into the UK healthcare sector and the UK society.

The Ager and Strang (2008) framework identify many domains in the integration process. This study explores the employment domain focussing on international nurses' integration into the UK healthcare sector in the discussion section of this thesis.

2.5. The historical context of nurse migration, nurse recruitment, integration, and lived experience.

This literature review has discussed and identified some common characteristics in the shifting definition of integration at the macro level. It has attempted to suggest that the government's main plan is not so much about integration but promoting 'a live and let live' philosophy while maintaining the status quo with its attendant inequalities.

In continuing application of the underpinnings and tenets of Critical Race Theory (CRT), Intersectionality theory (IT) and Post-Colonial theory in this review, I will now relate the government's perspective to the concept of integration and lived experiences of international nurses at the micro-level (UK healthcare sectors) since the start of the NHS in 1948 to the first quarter of the 21st Century.

Historical factors connected to nation-building and historical legacies of colonialism are essential drivers in integration models adopted by nation-states (Emilsson, 2016, Hansen, 2002). In line with Post-Colonial theory, my perspective is that the vestiges of colonialism are evidently at work in the dealings of the UK government with the previous British Empire nations. These nations are now 'rebranded, packaged or aligned' as the present-day Commonwealth of nation-states of which Nigeria is a prominent member.

This historical knowledge is necessary because the '…*low awareness of the historical importance of overseas recruitment to the NHS… has contributed to the failure to tackle the discrimination experienced by these workers in training and career opportunities'* (Snow and Jones, 2011:2). This knowledge has contributed mainly to the continuing problems with nurse recruitment and retention in UK healthcare. This researcher believes that the macro perspectives encapsulated in immigration debates and policies for immigration and migrants largely dictate, control, and enforce the model for integration at the micro (healthcare sector) level for International nurses.

It is expedient to indicate here that the absence of a singularly accepted definition of integration and the dearth of research on International nurses' integration contributes to creating an imbalanced view of international nurses within the nursing literature (Ramji and Etowa, 2014). There are three significant themes in the nursing and healthcare literature on integrating internationally educated nurses or overseas nurses: policy and ethical issues in recruitment, experiences while undergoing the registration process and transition or adaptation programmes in the workplace (Ramji and Etowa, 2014). The section dealing with the role of the registration body, NMC, in the integration of International Nurses will discuss these significant themes.

Bourne (2018) identifies many highly influential nurses who worked in UK healthcare before the foundation of the NHS in 1948. Some of these nurses include Princess Tsehai. She was the daughter of the Ethiopian King Haile Selassie and worked at the Great Ormond Street Hospital for Sick Children from 1940- 1941. Others include Nurse Ademola from Nigeria, who trained as a midwife at Guy's Hospital during the Second World War and one of the all-time notable nurses Mary Seacole (Anionwu, 2016). Historically, the creation of the NHS in the mid- 20th Century relied on the recruitment of many nurses from commonwealth regions (Snow and Jones, 2011). Local selection committees were in place in Nigeria, Sierra Leone, British Guyana, Mauritius, and

Trinidad and Tobago in 1948 to help recruit staff for the new NHS (Kushnick, 1988) by the British government. Nurse recruitment from overseas in the 1960s and 1970s continued as part of government policy to solve Britain's labour shortages (Beishon et al. 1995 cited in Lupike, 2006). Health Minister Enoch Powell, who was to later give the infamous 'Rivers of Blood' Speech on 20 April 1968, championed the recruitment of overseas nurses in the early 1960s. The policy executed by Enoch Powell was to ensure that "the *British colonies and former colonies provided a constant supply of cheap labour to meet staffing shortages in the NHS* (Snow and Jones, 2011:2). And as a result, some 3000-5000 Jamaican nurses worked in British hospitals by 1965, and 10,566 overseas student nurses from the colonies by 1972. By 1977 international nurse recruits represented 12% of Britain's student nurse and midwife population (Snow and Jones, 2011:2).

Due to racial prejudice, Spencer (1997) reports that though Prime Minister Atlee gave a public welcome to the black passengers aboard the Empire Windrush, *the British government, in a period of acute labour shortage,' did not turn to its empire for additional labour'*. The discriminatory attitude and preference for European Volunteer Migrant (EVM) over black migrants by the UK government post-second world war was the reason behind the refusal to recruit more nurses from the Commonwealth despite the availability and willingness of nurses in the region populated by black nurses to join the UK nursing workforce (Solano and Rafferty, 2007).

Favell (1998:2) argues that the ruling party's contrasting understandings of citizenship and nationality influence immigration policies. However, Spencer (1997: 55) differs by stating that the 'attitude and approach to immigration taken by the Labour government of 1941-1955 had *little difference in character from that of the Conservative successors'.* This understanding may mean that there are fundamental agreement and belief to continue the discriminatory policy laid down by the Labour government led by PM Atlee and assiduously executed by PM Winston Churchill. It may also explain why Spencer (2011) stated in her book 'Migration Debate' that the *policy paradigm had its origins in the post-war era and has not adjusted to the migration patterns of modern times'* (p.201). The immigration policy in practice from 1945-1955 is

'the myth of Civis Britannicus sum' because '*the British immigration policy operated in a way that was intended to make it difficult for Asian and Black British subjects to settle in the United Kingdom*' (Spencer,1997: 21).

Thus, black nurses were needed in UK healthcare but were not 'wanted' in the UK. This discriminatory attitude is fundamental to the current preference for international nurse recruitment from the Philippines and India (Donnelly, 2017). This preference lends credence to the belief that the degree of skin pigmentation or 'shades' of skin is a determinant of discrimination (Allan and Larsen,2003; Likupe, 2006), and perhaps the nationals preferred to work in the UK healthcare sector.

2.6. Role of NMC in Integration of international nurses: Pre and Post NMC registration of international nurses and its impact on lived experiences:

In this section, the focus is on the role of the NMC in translating the macro (government) policy on integration to the micro (healthcare) level and its impact on the lived experiences of nurses in recruitment and retention. This translation underlines the vital role of the policy formulated and executed by the nurse registration body in addressing the nurse shortage in the UK. Since its establishment in 1919 by the UK government, the national nurse registration body has formulated policies on nurse training and recruitment in line with changing immigration policies.

2.6.1 Integration in Nursing and lived experience:

Some initiatives and programmes support the orientation and transition of international nurses to the workplace. However, understanding of the concept of integration into the workplace is poor within healthcare (Ramji and Etowa, 2014). The UKCC, now the NMC, introduced a period of adaptation for the overseas nurse wishing to register in the UK. Whereas the registration body recommended between 3-6 months as a period of adaptation and, in some situations, 12 months (UKCC, 1999) for overseas nurse adaptation, Yu (2008) classifies this as covering the period of initial adaptation/transition or short-term adaptation. According to Yu (2008) adaptation process may be divided into a period of transition (initial adaptation) which is short-term, and a period of integration (long-term adaptation). Yu (2008) asserts that IENs become functionally proficient in nursing duties and obtain their registration within the first year of recruitment. There is a shortage of nursing literature focusing on post-NMC registration

integration of international nurses. Whereas there is a concentration of research on international and ethnic nurses, there is very minimal research into the lived experiences of African nurses in the United Kingdom (Likupe, 2006) post NMC registration.

Most studies on the integration of migrant workers have been quantitative studies conducted from the economic perspective and their impact on the general society (Jayaweera and McCarthy, 2015). Some literature identifies the challenges and difficulties experienced by international nurses during the initial integration period. These include problems fitting into the new and alternative work environment, language difficulties, communication challenges, language barriers, lack of support from management and employment structures, struggle to adapt to new systems and procedures, poor utilisation or non-utilisation of nursing skills, etc. (Moyce et al., 2016, Henry, 2007; Allan et al., 2004, Alexis and Vydelingnum, 2004, Allan and Larsen, 2003). Most available nursing literature focuses on initial adaptation (short-term integration). It describes the programmes put in place to help with the adaptation or transition of international nurses into the workplace from the perspectives of various stakeholders. For example, Gerrish and Griffith's (2004) evaluation research using focus and in-depth interviews of multiple stakeholders identified criteria the participants used in judging the adaptation programme as successful. They find five meanings of success: '*gaining professional registration, fitness for practice, reducing nurse vacancy ratio, equality of opportunity and promoting an organisational culture that values diversity' (p*.579). In a systematic review of the literature, Moyce et al. (2017) discuss international nurses' lived migration and acculturation experiences. These experiences include barriers concerning migration, licensing as a registered nurse, and difficulty with communication. Other experiences include racism and discrimination, skill under-utilisation, problems in acculturation, and the role of the family. Most of the discussion of Moyce et al. (2017) referred to periods leading to formal registration in the country of migration and did not cover the years after registration, as is the case in this study.

Although several overseas trained nurses are perceived to have integrated into the UK healthcare system since the inception of the NHS, international nurses see their adaptation or integration into the UK healthcare as a process that 'challenges the normative UK value…' (Allan 2007: 2). The evaluation of the success of integration programmes have been from employing organisations and institutions perspectives

(Jayaweera and McCarthy, 2015) charged with reducing the shortage of registered nurses. Little or no research is available about the non-EU nurses' views on whether they see themselves as successfully integrated. This study offers the opportunity to a set of non-EU, specifically UK registered nurses with Nigerian heritage, who appear integrated into the UK healthcare services to tell their lived experiences.

International recruitment has been ongoing for over seven decades. Only within the last few years have the DOH Health England published its framework on 'Supporting Safe Transition for Internationally Educated Health Professionals (IEHPS) working in the NHS in London' (DOH, 2015). The framework states it recognises and values the IEHPs' contribution. The framework enables clinical managers, educators, and supervisors to '*support the safe transition of IEHPs to working in the NHS in London*' (p.1). While it is laudable to have this framework, it is necessary to emphasise that nursing shortages are not only London area or NHS issues. Integration is not limited to the few months following recruitment because transition does not equate to integration. The DOH (2015) framework is generic and gives the wrong impression that all healthcare professionals have similar challenges in integration into UK healthcare. Equally, there is currently no available research on the level of awareness or use of the framework by healthcare managers to influence their role in adapting IEHPs. Therefore, it is evident from the preceding that there is a considerable gap or lack of understanding, research, and development of an adequate national or professional guideline for integrating internationally educated nurses post NMC registration into the UK healthcare workforce.

Whereas the term integration appears in nursing and healthcare literature, the term is not defined. Most of the literature on the integration of international nurses is mainly concerned with pre-migration, pre-registration, and these nurses' early orientation periods. There is a lack of research on the post-transition phase or long-term integration of international nurses (Adams and Kennedy, 2006; Ramji and Etowa, 2014).

According to Jayaweera and McCarthy (2015), the UK does not have explicit policies on integrating migrant healthcare workers. Spencer (2011) states that the employer must formulate its integration policies at the work level. For example, employers' responsibility is to ensure that overseas registered nurse (ORN) gets the appropriate support to improve their language skills through the transition to working in the UK (NHS Employers 2017). In line with its cohesion agenda, the UK government promotes

equality legislation to deal with discrimination issues in the workplace. This plan is in its Equality Act 2010, which prohibits discrimination in the workplace based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. The Equality Act also includes a public equality duty that requires public authorities to '*have due regard to eliminate discrimination... advance equality of opportunity... foster good relations'* (Anderson 2010). This duty applies to all public authorities, including all NHS Trusts and other bodies that perform public functions and private organisations providing services on behalf of a public organisation.

Schilgen et al. (2017) argue that a significant amount of evidence suggests that the extent of discrimination experienced by immigrant nurses in the host country negatively impacts immigrant nurses' health. Despite the good intention of the Equality Act, which forbids discrimination based on the nine protected characteristics, discrimination against British Minority Ethnic (BME) nurses in UK healthcare is rife and well documented (Lukipe, 2006, Archibong and Darr, 2010, Kline,2014). For example, the NMC study shows that BME nurses, especially Africans, have a higher risk of referral to the NMC through the Fitness to Practise (FtP) process. The risk of the case going to the adjudication panel increases by the region of a nurse's training (West et al., 2017), and in this case, Africa is the most affected region. This factor and the fact that the Philippines and India (Donnelly, 2017) are the current preferred areas of international recruitment to the UK further lend credence to the belief that the degree of skin pigmentation or 'shades' of skin is a determinant of discrimination (Allan and Larsen, 2003; Likupe, 2006) in the UK healthcare.

2.6.2. Factors that facilitate and factors that hinder International nurse integration and lived experience:

Emerson (2007) describes the acculturation process of international nurses as 'difficult, complex and multi-dimensional'. However, there is an excellent benefit to ensuring that international nurses are adequately supported to become fully acculturated into their new environment. Successful acculturation leads to positive outcomes for the internationally educated nurse and the employer. International nurses will likely retain their employment for much longer and contribute to better quality patient care if they are satisfied with their jobs and personal lives (Emerson, 2007).

Societal and individual factors are two essential elements that determine the success or otherwise of an individual's integration into a new society. Toosi et al. (2017) used acculturation theory and transitions theory to explain the impact of these two factors on promoting successful immigrant integration. According to Yu (2008), long–term adaptation or integration is a progressive process occurring after the initial period of adaptation or transition. The transition process is not foreseeable, and it is not successive.

Toosi et al. (2017) explain what contributes to effective transition and state that personal, community and societal factors influence transition into new cultures. Toosi et al. demonstrate that personal factors such as individual expectations, perceptions of the transition experience, knowledge and skills, preparation and planning before and during the transition, and emotional and physical well-being may influence the transition into a new culture. In addition to these personal factors, socio-cultural and environmental factors, including prevailing economics, politics, and existing support systems in contemporary society, Toosi et al. further explain, are equally significant for a successful transition.

Acculturation theory is a cross-cultural perspective for explaining the transition process. It involves the '*social and psychological exchanges through ongoing contacts between individuals of different cultures that result in changes to both groups'* (Caolan, 2007 in Toosi et al., 2017:231). Acculturation is '*bidirectional and bi-dimensional, generating mutual changes between cultures'.* The process involves initial contact, conflict and adaptation (Berry,1997, cited in Toosi et al., 2017:231). It is a complex, multidimensional, and bidirectional process. It involves adopting and relinquishing the behaviours and attitudes of both the host and original cultures (Emerson, 2007:4). The acculturation process is dynamic, and its success may result in psychological success at the individual level. This success may be the individual developing positive self-esteem or sense of well-being or sociocultural success, for example, the effective development of a positive interpersonal relationship between the migrants and others in the new society (Toosi et al., 2017). The hallmark of integration in the new society is not assimilation or marginalisation. According to this theory, it is demonstrated by the migrant's retention of some elements of '*original cultural integrity and also striving to be part of a larger society*' (Berry, 2008). Factors that promote acculturation of individuals

will be discussed further under the discussion of findings in this thesis. The focus will use the Ager and Strang (2008) framework because the acculturation and transition theory factors align with the discrete themes in the Ager and Strang (2008) framework.

Yu (2008:2) indicates that during long-term adaptation (integration), the international nurse strives to develop improved language efficiency and competence, management and leadership skills, conflict management and resolution, and other work-related competencies. In addition, integration also involves accumulative knowledge about the host culture over time. The hallmark of integration is that international nurses can function independently as full members of the workforce in the work environment, just as other domestic nurses. The indicators of complete integration include a sense of belonging and job satisfaction; feeling valued and respected by staff, peers, and managers. It also consists of the administration's comfort, making reasonable and necessary requests, selection to clinical leadership and promotion to management or leadership positions, among others.

In summary, I have, in this review of related literature, provided a critical review to place the thesis in the context of migration, emphasising skilled nursing and other migrants in the NHS to enable us to understand and compare the process and dynamics of integration of these migrants into UK healthcare. I have defined integration as applied in this study. This definition concerns nursing and healthcare and has demonstrated that the UK government has not provided a clear explanation of integration, preferring to list the characteristics of what constitutes an integrated community in its cohesion agenda. This review has demonstrated that since its establishment in 1919, the UK nursing body has mirrored the national government in formulating nursing policies on training and recruitment for international nurses in line with changing immigration laws. It has not pushed for the need to define or encourage the integration of international nurses into UK healthcare but has facilitated and supported initial adaptation. The registration body and the employers of labour appear to be concerned with programs that will yield short-term immediate transitional needs so that international nurses can be put to work as soon as practicable and maintain the staffing level in the care setting. There appears to be a concerted effort to ignore the benefits of integration in the lived experience of international nurses. This approach is fundamental to the continued experience of nurse

shortage in the UK health care sector and the tag of an institution discriminatory towards ethnic minorities.

CHAPTER THREE

3.0: Methodology

This study explores the lived experiences of integration of UK registered nurses with Nigerian heritage into UK healthcare using an interpretive phenomenological analysis (IPA) approach. This chapter includes a more detailed discussion of the research method, design of the study, research question, the study population, the study's sample, sample method and data collection instrument. It also consists of a section on reflexivity, positionality, ethical issues such as consent, confidentiality, validity and the data analysis process of this study

3.1 Research Methodology:

There is increasing support for using various approaches to research questions instead of traditional quantitative and qualitative methods. The quantitative approach has a positivist philosophical origin. Conversely, a qualitative approach has been considered to proceed from an interpretivist philosophical background and is constructivist (Guba and Lincoln, 1994). In its broad sense, Interpretivists 'believe that the social world needs interpretation to be understood… [interpretivists] tend to focus on language, perceptions and experience to understand and explain behaviour' (Moule et al. 2017: 153).

Qualitative research is a form of social inquiry that 'focuses on the way people make sense of their experiences and the world in which they live' (Holloway and Wheeler, 2010:3). In this study, semi-structured interviews using open-ended questions with prompts where necessary were held with the participant to explore the interpretations of their experience of their lived world. The researcher is central to collecting vibrant and in-depth data from the participants in a study, which results in the generation of concepts from the understanding gained from experience (Holloway and Wheeler, 2010).

In qualitative research, the research moves from the specific to the general, and it is inductive in which there is movement from 'data to theory or analytic description' (Holloway and Wheeler, 2010:4). Qualitative research usually provides 'descriptions or interpretations of the participant's experiences and the phenomenon of study. Qualitative research aims to gain an in-depth understanding of the social phenomenon

under study, and this may be through the use of research questions and interview questions that are often open-ended and requires the researcher to become familiar with the participant's experiences (Holloway and Wheeler, 2010; Shank,2006). This research used the qualitative research method to obtain rich data about the participants' lived experiences on the subject of study.

Using quantitative methods to elicit any data on lived experience is impossible. Therefore, it is impossible to use the quantitative approach to gain the depth of information gathered from the participants about their lived experiences. In quantitative research, responses are often from a representative sample, and the researcher may become detached from the process (Moule, Aveyard and Goodman, 2017).

Quantitative research may address hypotheses 'that look to measure cause-effect relationships, seeking to measure the correlation between two different phenomena or wanting to describe phenomena about which little is understood' (Moule, Aveyard and Goodman, 2017:159). Silverman (2010) states that testing hypotheses to establish variables' associations or correlations is suitable.

3.2 Research Design:

There are different types of research methods used in a qualitative research study. Phenomenology, discourse analysis, and grounded theory are qualitative research methods that study people's lived experiences. These methods are rooted in different intellectual traditions but similar in developing their ideas. Phenomenology, discourse analysis and grounded theory approaches may be different at the beginning of the research. They 'converge in the analytic phase, sharing methodologies for decontextualising and then re-contextualizing data. They then diverge again in the post-analytic phase, in which the research findings are framed and packaged for the target audience' (Stark and Trinidad, 2007:1).

Stark and Trinidad (2007) offered some characteristic differences between phenomenological, grounded theory and discourse analysis studies. In a phenomenological and grounded theory study, the objective of the interview is to elicit the participant's story. In grounded theory, the research aims to develop an explanatory theory of basic social process; in discourse analysis, the goal is to

‘understand how people use languages to create and enact identities and activities (Stark and Trinidad, 2007). In phenomenology, the objective is to ‘describe and interpret the meaning of the lived experience of a phenomenon.’

Phenomenology suits this study better than both discourse analysis and grounded theory because this study intends to provide illumination, understanding and emergence of the essence (Groenewald, 2004) of a direct description and interpretation of nurses with Nigerian heritage first-hand primary lived experience of their successful career progression on Integration into UK healthcare services post registration with the NMC rather than develop an explanatory theory of basic social process.

International recruitment and Integration of nurses into UK healthcare is a complex, sensitive and potentially contested issue, and phenomenological investigation may usefully address such matters (Streubert-Speziale and Carpenter, 2007). Phenomenology helps prevent or restrict researchers’ biases (Groenewald, 2004) and explore taken-for-granted assumptions, meaning and standard features, or essences, of an experience or event through close examination of individual lived experiences (Starks and Trinidad, 2007). Phenomenology can ‘refer to a philosophy or a research method’ (Dowling,2007: 3). Phenomenology ‘provides us with a rich source of ideas about how to examine and comprehend lived experience’ (Smith, Flowers and Larkin, 2012:11). Phenomenology is well suited for experiential work. It provides an opportunity to explore specific experiences. It is not suitable for generalisations about resulting structures, nor does it identify the most relevant phenomenon to the participants (Mayoh and Onwuegbuzie, 2015).

One of the greatest strengths of phenomenology is its flexibility and adaptability. Despite its long ‘philosophical tradition, the phenomenological method is still malleable, and can be adapted to incorporate (or be incorporated within) emerging movements within the field of research methods, such as mixed methods research’ (Mayoh and Onwuegbuzie, 2015:). However, a mixed-methods version of phenomenological research is in its infancy in development and conceptualisation (Mayoh and Onwuegbuzie, 2015). This drawback explains why this study has not used the mixed-method approach.

3.3 Phenomenology-- My ontological and epistemological position:

A significant determinant in a researcher choosing the method of studying a phenomenon is the researcher's epistemology (Holloway,1997). My epistemological position regarding this study is that the wealthiest and most relevant data are from the participants' experiences (Groenwald, 2004). Engaging with participants to obtain the necessary information takes cognisance that I have to interpret what the participants have understood and made available to me in the interview as the researcher. Epistemology may be classified into realism, contextual constructionism, and radical constructionism (Thomas, 2017). Realism opposes the epistemological stance of idealism. Realism holds that our conceptual schemes, perceptions, linguistic practices, and beliefs exist independently of our minds. It argues that our sensory data simply reflects or corresponds to a world where truth consists only in the mind's correspondence to reality" (Thomas, 2017:56). Idealism proposes that what one knows about an object exists only in one's mind. Contextual constructivism contends that knowledge formed by an individual is influenced by the broader contexts surrounding learning and that individuals may have a '*point of view'* and a '*personal truth'* (Thomas, 2017). Radical constructivism maintains that the perception of the phenomenon is subject to the construction of knowledge based on the individual's experiences. Radical constructivism believes *"that any kind of knowledge is constructed rather than perceived through the senses and that no matter how it is defined within the individual, that person has no option but to construct what he or she knows on the basis of his or her own experience."* (Thomas, 2017:58).

Ontology seeks to unravel the nature of the social world. It requires researchers to unravel whether the phenomenon under study is "*independent of human thinking and interpretation or whether such phenomena exist only as a result of a process of construction by researchers" (Pope and Mays, 2020:17).* Ontology in research is usually proposed as either philosophical realism or idealism (Pope and Mays, 2020). Realism argues that an external reality exists beyond the individual attempting to understand it. Materialism is an example of realism and explains that "there are infinite, multiple realities created by unique subjective understandings" (p 17). Idealism argues that there is no reality outside our subjective understanding and sense-making". Post-modernism is an example of idealism and argues that there are

“multiple social worlds, socially and contextually created by multiple individuals’ constructions of culture and identity” (Pope and Mays, 2020:17).

An ontology may best be imagined as a continuum with realism and idealism at the opposite end of the spectrum (Pope and Mays, 2020). Ontology is located nearer the realist end of the continuum if the study focuses primarily on people and objects and nearer the idealist end of the spectrum if the study is about the analysis of accounts of experiences or feelings (Pope and Mays, 2020). This study explores the lived experiences of IEN of Nigerian heritage and is therefore nearer the idealist spectrum of ontology.

A significant determinant in a researcher choosing the method of studying a phenomenon is the researcher's epistemology (Holloway,1997). Epistemology implies an ethical-moral stance towards the world and the researcher’s self (Denzin and Lincoln, 2005: 157). Ontology is concerned with the nature of reality or the social world. It seeks to answer whether social reality exists independent of individual perception, experience and interpretation of the experience or whether there is a combination of shared social reality, multiple, individual or context-specific realities (Ormston et al. 2014, cited in Visser, 2019). My epistemological position regarding this study is that the wealthiest and most relevant data are from the participants' experiences (Groenwald, 2004) and that participants have their own ‘*point of view’* and a ‘*personal truth’.* My epistemological position aligns most closely with the contextual constructionist position because I see the “*individual as creating, rather than discovering, their personal and social realities, where knowledge is viewed through a viability lens, as opposed to a validity one*” (Thomas, 2017:57). Engaging with participants to obtain the necessary information takes cognisance that I have to interpret what the participants have understood and made available to me in the interview as the researcher. In my approach to this research, my viewpoint is that ‘*truth exists as a subjective reality. For knowledge to become known, the relationship between the research participants’ experiences and the context within which these occur needs to be considered by both participant and researcher*’ (Willig,2001 cited by Thomas, 2017:58).

Crotty (1998:9) argues that “*there is no meaning without the mind. Meaning is not discovered, but constructed*, “ and we interpret the phenomenon as socially constructed. My social constructionist epistemology indicates that different people

may create meanings about the same phenomenon. The kind of knowledge this study aimed to demonstrate is in tandem with a social constructivist perspective, and it's about the lived experiences of integration and career progression of nurses with Nigerian heritage in UK healthcare. My ontological position is that the participants have a combination of shared social reality and multiple, individual or context-specific realities (Visser, 2019). My epistemological position permits me to engage the theoretical frameworks in framing my understanding, analysis and discussion in this research, and it fits the use of the study's Interpretative Phenomenological Analysis (IPA) approach. A researcher's values, interests, and beliefs may impact the research objectives (Cousin 2009) and engaging in reflexivity may facilitate making explicit the positionality of the researcher, which may be influenced by ethnicity, age, life experiences, social identity, role and personality in varying degrees (Jootun et al., 2009). However, the factors' level may vary depending on the most relevant factors and the research objectives. Research quality, trustworthiness, rigour and accountability increase with disclosing a researcher's positionality and experience in reflexivity (Mann, 2016). I am a member of an ethnic minority group researching my community group, which poses a challenge to me as the researcher. A researcher's personal experiences, interests, negative or positive organisational outcomes, challenges in areas of work or issues that require proof or lack answer may form the basis of research [Robert (2010); Lipowski (2008)]. This study is framed around my clinical experiences and professional development as a registered nurse and senior manager in the NHS for many years. I have read about and have had first-hand experiences in my role as a senior manager in the NHS of negative experiences or challenges such as marginalisation, prejudice, and racial discrimination encountered by individuals of British Minority Ethnic (BME) groups and, most specifically, by ethnic minorities of African descent. There are increasingly more BME staff in London NHS. For example, as of May 2018, there were 52.96% BME nurses and 43.9% British Minority Ethnic (BME) staff in London NHS, and only 3% of black/black British and 4% of Asian/Asian British are in bands 8a to 9 (NHS Employers, 2017). Since 2018, there has been a 16% increase in BAME working in London NHS. In 2020/21, 67% of staff were Black Asian and Minority Ethnic (BAME).

The low percentage of BME staff in the senior AFC Pay band in part confirms the conclusion of Ashraff (2013) and Kline (2013) that despite several positive action

projects, discrimination against the BME group was still pervasive in the NHS, especially in the promotion and recruitment to leadership and management positions. My main interest in this study was to ascertain the lived experience of how black/black British nurses [NHS Employers (2017)] are integrated and broke through the concrete ceiling in UK healthcare to attain senior management and leadership positions and sustain those positions.

This study sought to provide a platform for UK registered nurses with a Nigerian heritage who have 'successfully integrated' to promote understanding by telling their stories or lived experiences. While doing this phenomenological study, I always had to think phenomenologically and did phenomenological writing (Berndtsson et al., 2007, cited in Tuohy et al., 2013). This approach promoted the understanding and interpretation of the lived experiences of IENs with Nigerian heritage who have 'successfully integrated' into UK healthcare. Therefore, I had an excellent opportunity to understand the phenomenon under study and the research process (Watt, 2007) using personal and epistemological reflexivity (Dowling,2007). I discuss more of my epistemology and ontology under the reflexivity and positionality section later in this chapter.

3.4 Types of Phenomenology:

There are two main streams of phenomenological inquiry: Husserlian or descriptive (eidetic) phenomenology and Heideggerian or interpretative (hermeneutic/existential) phenomenology. Each of the streams of phenomenology is grounded in different epistemological and ontological assumptions (Converse, 2012; Mayoh and Onwuegbuzie, 2015).

Husserlian or descriptive phenomenology, has four significant characteristics in its inquiry. Giorgi (2009) identifies these to include first 'Intentionality, which is the manner of existence of the objects in the individual's consciousness. Secondly is the descriptive element, and thirdly is 'reduction', which uses bracketing prior knowledge and focus and consciousness of the data for the phenomenon under study. The fourth is articulating the phenomenon's essence and describing the common themes from the lived experience.

The underlying philosophy in this study derives from the hermeneutic or existential interpretive phenomenology, an offshoot of Heideggerian philosophy. In particular, the

Interpretive Phenomenological Analysis (IPA) will be the Hermeneutic version of this study. Smith and Osborn (2007) stated, “IPA is useful where the topic under study is dynamic, contextual and subjective, relatively under-studied and where issues relating to identity, the self and sense-making are important”. The topic under study is under-researched and poorly understood; this represents a gap in understanding the integration experiences of IENs recruited into UK healthcare (Ramji and Etowa, 2014) and is well suited for IPA.

The hermeneutic phenomenological approach is a qualitative research methodology used ‘when the research question asks for meanings of a phenomenon with the purpose of understanding the human experience’ (Crist and Tanner, 2003; P. 202). Tuohy et al. (2013) argue that interpretative phenomenology is suitable when the researcher aims to determine the meaning of participants’ experiences through understanding and to interpret the lived experiences. Smith, Flowers and Larkin (2012) argue that the participant's account of their experience reflects their sense of the experience. Access to the participants’ experience depends on what they say about it. The researcher’s role in IPA is to interpret that account from the participant to understand their experience. Smith, Flowers and Larkin (2012:3) refer to this interpretation as double hermeneutic because the ‘researcher is trying to make sense of the participant trying to make sense of what is happening to them’.

The ontological and epistemological differences between descriptive (eidetic) phenomenology and interpretative (hermeneutic) phenomenology philosophies may be summarised thus:

Descriptive (eidetic) phenomenology:

'In Husserlian or descriptive phenomenology, the phenomenon is believed to be reality – a truth that exists as an essence and can be described. The essence of the phenomenon exists independently of the researcher and can be discovered through 'bracketing' out the researcher's preconceived assumptions of the phenomenon'.

Interpretative (hermeneutic) phenomenology

*In Heideggerian or interpretive phenomenology, humans exist in a world that they experience and interpret (Heidegger 1962). Heidegger was concerned with being, and with the meaning of being. This shift moves the focus of the researcher from revealing the essence of the phenomenon to understanding the phenomenon in relation to the researcher (*Converse, 2012. P.30).

Husserlian phenomenology aims to reveal the phenomenon's essence and come to a new understanding. This approach focuses on a phenomenon's cognitive and non–cognitive meaning (Tuohy et al., 2013). Heideggerian Phenomenology aims to reveal the 'being' of the phenomenon and understand what makes entities what they are. Whereas 'Husserl's notion of intentionality removed the person from the world of phenomena, Heidegger placed being in the world … (and)… believed that the world was an essential part of our understanding of the meaning of being and was not separate' (Tuohy et al., 2013).

IPA combines a dedication to understanding the participant's lived experience to believe that achieving such understanding requires interpretative work on the researcher's part and offers a systematic approach to doing this (Smith and Osborn, 2007). It is committed to "idiographic" inquiry, where each case is examined in great detail as an entity in its own right. There is then a move to more general claims in a narrative account that includes detailed extracts from the individual participants' accounts' (Smith and Osborn, 2007: 520).

By adopting the Interpretive Phenomenological Analysis (IPA) approach, this study is on the lived "experiences focussing on emotions, feelings, beliefs, and perceptions" (Cottrell, 2014: p.103), the professional and inter-personal relations as lived by UK nurses with Nigerian heritage post-NMC registration. This qualitative Interpretative phenomenological study aimed to explore the relationship from an idiographic, phenomenological perspective between the participants' integration post NMC

registration into UK healthcare and their sense of self. Achieving such understanding will require the researcher's involvement in interpretive work using a systematic approach (Smith and Osborn, 2007) because human beings are inherently self-reflective and strive to make sense of phenomena in life.

In IPA, the role of the researcher is to enable the participants to tell their own stories, and the researcher makes sense of the interpretation of the participant's account. This double hermeneutic process aligns with Heidegger's hermeneutic phenomenology (Smith, Flowers and Larkin, 2012).

IPA is a variant of hermeneutic phenomenology that explores individuals' perceptions and experiences. It focuses on individuals' cognitive, linguistic, affective, and physical being using an idiographic approach' (Finlay and Ballinger, 2006). The interpretative phenomenological analysis also involves a two-stage interpretation process described as 'double hermeneutic' (Smith, 2004), through which the researcher tries to interpret the participant's sense-making activity. Therefore, it is impossible to remove preconceptions to understand people in their world, and the researcher will need reflexivity to become aware of assumptions (Flood 2010 cited in Converse 2012.p. 30).

In Husserlian phenomenology, the researcher, through bracketing, tries to do the impossible to be detached from their presuppositions (Hammersley, 2000). However, in Heideggerian phenomenology, reflexivity is used to enable '… the researcher to make clear his or her thoughts, ideas, suppositions, or presuppositions about the topic, as well as biases' (Streubert-Speziale and Carpenter, 2007. p.26). The double hermeneutic process in IPA enables a better position to approach the topic honestly and openly' (p.27). I consider myself having the adequate cultural competence required to 'infuse and suffuse the entire research process of planning, theory development, instrumentation, analysis, and interpretation to ensure cross-cultural validity and reliability' (Brandt, 1999 cited in Archibong and Darr 2010, p.15). I consider myself adequately culturally competent to be 'thinking phenomenologically while doing phenomenology' and writing phenomenologically while doing a phenomenological study (Berndtsson et al. 2007, cited in Tuohy et al. 2013, Globe,2012).

The use of IPA positions me to be able to use reflexivity to define my positionality. It promotes honesty and openness in using double hermeneutics to offer interpretations of the phenomenon under study.

As previously indicated, my epistemological position in this study is that the wealthiest and most relevant data are within the participants' perspectives; I have to collect the required data (Groenwald, 2004). Engaging to obtain the necessary data took cognisance that the researcher interprets what the participants understood and made available to the researcher. In this case, the participants are registered nurses with Nigerian heritage working in the UK healthcare services for the past 5-30 years and have a live registration with NMC. The participants share their career progression strategies to integrate into the UK healthcare services. I had a more significant opportunity to understand the phenomenon under study and the research process (Watt, 2007) by using personal and epistemological reflexivity (Dowling, 2007). This approach helps gain a clearer understanding, illumination, shaping or interpretation of the Integration of Nigerian nurses into UK healthcare and may be used as 'the basis for practical theory, … to inform, support or challenge policy and action' (Lester, 1999. P.1).

3.5. Research Question:

Research questions help guide the direction of the study, and they must align with the study (Hinchley, 2008). Personal experiences, interests, challenges in areas of work, negative or positive organisational outcomes or issues that require proof or lack the answer may influence the basis of research questions (Roberts, 2010, Lipowski, 2008). 'Problems and questions that emanate from clinical experience, professional development, an examination of theories and policy' (Moule, Aveyard and Goodman, 2017:120) tend to give the best research questions for research. They may enable the researcher to use a new perspective to rethink learning and knowledge in the investigation.

In IPA, research questions need to be grounded in an epistemological position and an 'assumption about what the data can tell us' (Smith et al., 2012:47).

In this study, the main research question was:

3.5.1: What are the lived experiences of Integration for IENs with Nigerian heritage into UK healthcare services following registration with the Nursing and Midwifery Council (NMC.

The research sub-questions were:

3.5.2: What do IENs with Nigerian heritage understand by integration into the British healthcare sector following registration with the NMC?

3.5.3 What are the lived experiences of IENs with Nigerian heritage career progression on integration into UK healthcare services following registration with the NMC

3.5.4. What obstacles do IENs with Nigerian heritage encounter, and what measures do they develop to obtain and thrive in senior positions (Agenda for Change Band 7 and above) in UK healthcare?

3.5.5. What relationships exist between successful integration into work and personal and social lives for the nurses?

3.6. Access and Sampling:

Purposive sampling is an essential kind of non-probability sampling used to identify the primary participants in phenomenology (Groenewald (2004). The sample was selected based on my understanding of the lived experience of the NMC registered Nigerian nurse of the phenomenon under study. My role in the Nigerian community as a registered nurse born in Nigeria but trained in the UK gave me access to participants.

In Phenomenology, the study method is determined by the phenomenon under investigation, which may influence the type of participants in the study (Groenwald, 2007, P.45). Networking and snowballing strategies are one of seven different approaches in a phenomenological study to gain access to participants (Sixsmith et al., 2003). In this study, networking and snowballing strategies were used to gain access to participants and rapport was established with the participants by showing a sense of interest and concern (Streubert-Speziale and Carpenter, 2007).
In snowballing, one informant or participant recommends others for interviewing. Those through whom the researcher gains entry are the gatekeepers, and those who volunteer assistance are key actors or insiders (Groenwald, 2007).

I am a UK Nursing and Midwifery Council (NMC) Registered Nurse/Lecturer/Practice Educator. Although currently in the academic nursing sector, I have years of experience in clinical and managerial nursing roles in the NHS and actively worked with and developed internationally educated nurses to obtain NMC registration. I was born in a member country of the Commonwealth of Nations with early education in Nigeria, and had personal, professional and community networks from which the samples derive. There were, therefore, no designated gatekeepers in this study, partly because of my links and because the participants worked in different organisations.

3.7 Study Population and Sample Size:

Informed by an interpretivist qualitative approach, individual semi-structured interviews were conducted in this study. In qualitative research, the method and type of study participants are determined in many cases by the phenomenon of study (Hycner, 1999). Although the minimum number of samples and kinds of sampling units required cannot be determined a priori (Sandelowski, 1995), the scope and nature of the topic of study, data quality, design of the study and shadowed data (Morse et al. 2001) may determine the sample size. Equally, Bragge (2010) recommends using a qualitative research paradigm when the feelings, attitudes and emotional responses of subjects involved in a study are under exploration.

In phenomenology, the study aims to determine the sample size and number of interviews, and large samples are not necessarily needed to generate rich data sets. The sample size is adequate when interpretations become visible with no new meanings or findings (Starks and Trinidad, 2007). One to ten participants are a typical sample size sufficient in a phenomenological study (Boyd, 2001; Stark and Trinidad, 2007), but “long interviews with up to 10 people” is recommended by Creswell (1998, pp. 65 and 113). Goble et al. (2012.P.8) suggest that study ‘participant numbers can range from a small group of four to a nearly unmanageable 20 people’ using in-depth interviews. However, Smith, Flower and Larkin (2012) state that in IPA, “the issue is quality, not quantity” and suggested 3-6 participants for a student project but did not give set numbers for a PhD study. Smith, Flower and Larkin (2012) argue that since there is time to analyse more cases in a PhD study and greater flexibility in doctoral research, they suggest an average of between eight to ten participants.

In this study, the researcher had a schedule to interview up to fifteen participants to make room for subjects who may not complete the study. The interview sessions lasted, on average, between 60-90 minutes. Ten participants were interviewed, which fits the sample size suggested for a PhD study by Smith, Flower and Larkin (2012).

In qualitative studies, demographic characteristics should not be the only factor used for sampling to ensure informational and size adequacy. Still, they may be used for sampling when such attributes are 'deemed analytically important and where the failure to sample for such variation would impede understanding or invalidate findings' (Cannon, Higginbotham and Leung, 1988 cited in Sandelowski,1995. P.3). As this is an IPA study, sampling was consistent with the qualitative paradigm with IPA orientation (Smith, Flower and Larkin, 2012). Sampling was purposive, and a homogenous and snowballing approach was used to recruit participants.

For this study, semi-structured interviews were conducted individually with nurses in each of the three categories of IEN with Nigeria heritage in UK healthcare:

i. IENs with Nigerian heritage registered with the NMC who had education and initial nurse training in Nigeria,
ii. IENs with Nigerian heritage registered with the NMC who had education in Nigeria but nurse training in the UK.
iii. IENs with Nigerian heritage registered with the NMC born in the UK, educated in the UK or Nigeria and with nurse training in the UK

Exclusion Criteria:

i. IENs with Nigerian heritage registered with the NMC in the last 1-5 years or greater than 30 years.
ii. IENs with Nigerian heritage with employment for less than five years in NHS or non-NHS healthcare role
iii. IENs with a Nigerian heritage that had not attained at least the equivalent of NHS Agenda for Change Band 7 in the UK healthcare service.

IENs with a Nigerian heritage registered who do not possess the above characteristics are not in this study.

Table 2. Sample characteristics.

Item	Characteristics	Remark
Number of interviews conducted	10	7 Female 3 Male
Number per ***geo-political zone	**2 (South-South) 6 (South West)** **2 (South East) 0(North East)** **0 (North West) 0(North Central)**	
Grade/Title	**Band 7= 4**	Practice Educator, Advance Nurse Practitioner, District Nurse Team Leader, Community Registered Nurse
	Band 8= 6	Assistant Director, Nurse Lecturer, Advance Nurse Practitioner, Nurse Manager, Senior Research Nurse, Public Health Specialist Nurse ---- NHS Acute Trust, Community, Trust, Independent, University).

******Geo-political zones represent areas in Nigeria with similar ethnic groups or history crafted to promote a sense of inclusivity and include: South-south, South West, South East, North West, North East and North Central zones.***

3.8 The rationale for Inclusion Criteria:

The study sample included NMC registered nurses with a Nigerian heritage in the NHS pay band 7 (agenda for change- see appendix 10) or above in the UK healthcare sector and have been employed for 5-30 years post-NMC registration. The NMC Registered nurses included practitioners in primary (community), secondary (acute) healthcare settings and educational institutions. They consisted of nurses recruited into or trained in the UK between 1985 and 2015. This period represents the pre, during, and post Overseas Nurse Programme (supervised practice programme) era in internationally educated nurse recruitment to the UK. This period also aligns with UK nurse education changes (Pre- Project 2000, Project 2000, Post Project 2000 and recently 2013 onwards –degree). The rationale for limiting the study to these years may provide an overview of whether the recruitment period into UK healthcare affects long-term integration. And may offer a more in-depth understanding and interpretation of how the nurses become successful in their careers and integrated into UK healthcare.

The sample consisted of men and women nurses with Nigerian heritage to encompass a variety of experiences and to maximise the representation of diversities (Polit and Beck 2011) using a homogenous group. These are nurses with senior roles within UK healthcare and aged up to 65 across different nursing sub-disciplines (see table 1, page 49). The participants participated in Individual and in-depth semi-structured interviews.

I undertook interviews about their lived experiences navigating their career pathway in a health care system labelled as institutionally racist (Kline,2014). In the interview, I sought to ascertain how they became integrated or not into the UK (Gerrish and Griffith, 2004). These nurses in the sample reflected the diversity in language, culture and practices in Nigeria. The sample selected was from three out of the six geo-political zones of Nigeria and was reflective of Nigeria in terms of nurse training and practice, nurse education development and practice in Nigeria and history of immigration and migration to the UK healthcare service by Nurses initially trained in Nigeria. Most Nigerian Immigrants in Europe and the US are from Christian-dominated southern Nigeria; most Muslim northern Nigerians prefer the Gulf States (Hernandez-Coss et al. 2006*)*.

3.9 The rationale for the choice of the population of study:

Nurses with Nigerian heritage are of choice in this study for many reasons. Nigeria is often referred to as 'the giant of Africa' and is the most populous African nation, with over 180 million people. More than 90 million are children and young people under 18. There are over 250 ethnic groups in Nigeria, 500 indigenous languages, and 7% of the world language is in Nigeria (JPAS, 2009).

The three main languages of Nigeria are Igbo, Yoruba, and Hausa, but English is the official language in Nigeria (Eric, 2016). Nigeria has extensive colonial history and ties to the UK. The British NHS has relations with Nigeria in the recruitment of nurses dating back to the 1950s following the establishment of the NHS (Kushnick, 1988).

Nigeria was created by the British following the amalgamation of the Northern and Southern Nigeria Protectorates in 1914 and was named 'Nigeria' by the wife of Governor-General Lord Lugard (Eric, 2016). Nigerian Nurses in the UK represent the largest ethnic African group in the NHS (Siddique, H, 2014) and currently have 8,241 Nigerians in the NHS workforce (Barker, 2020). The UK healthcare system discriminates against ethnic minorities (Kline, 2019). Compared to other regions of the world, nurses trained in Africa suffer more discrimination in disciplinary proceedings, promotion prospects, training, and recruitment (West et al., 2017, Archibong and Darr, 2007). Some Nigerian nurses have successfully progressed and appear integrated into the NHS despite institutional racism. This study seeks to elicit and interpret the lived experiences of nurses perceived to have navigated the challenges and integrated into the UK; to understand 'the how' of workforce race equality (WRES, 2019).

The three groups of nurses in this study had, in common, a Nigerian heritage because of their parental nationality. In group one, the nurses were born in Nigeria. They had their primary and secondary education and initial nurse training in Nigeria and are registered with the Nigeria Nursing and Midwifery Council. This group went through the Supervised Practice (Adaptation) programme in the UK to attain the UK NMC registration as registered nurses. They arrived in the UK with Nigerian passports on a visitor or student visa.

In group two, the nurses were born in Nigeria and had their primary, secondary and tertiary education in Nigeria. This group came to the UK with Nigerian passports either as a visitor or a student. They trained in UK Universities and attained registration with the NMC.

The third group were born in the UK but were taken to Nigeria by their parents in early childhood. They attended primary, secondary and tertiary education in Nigeria. They returned to the UK with British passports in their young adult years and trained in UK universities as registered nurses with the NMC.

As of the time of this study, all the participants now have dual citizenship of Nigeria and the United Kingdom and have a subsisting NMC nurse registration.

3.10 Data Collection:

The primary data collection method was conducting and recording open-ended semi-structured interviews (Smith. et al., 2012). Interviews were held in the participant's preferred venue and a conducive and relaxed atmosphere. There was a good rapport between the participants and myself. The participants had an informed consent form containing an introductory statement about the study. After a brief discussion of the interview layout or schedule, the participant had the opportunity to ask questions about the study (A copy of the interview schedule is in appendix 4, p.240).

In line with my ontology and epistemology, I applied reflexivity and declared my intentionality and positionality in the discussion. My ontological perspective that it is a combination of the shared reality of the phenomenon on multiple, individual or context-specific informed my interest in understanding the phenomenon under study through the idiographic and group interpretation of the lived experience. Before each interview, I reflected on every personal and probable general opinion about the phenomenon under study. I used reflexivity to make myself/ participants aware of my understanding and existence in the phenomenon by acknowledging my possible influence and bias. The interview progressed to enable the participants to tell their own stories or lived experience. The participants were asked probing and follow-up questions to gain additional clarification, details and a more in-depth understanding of the lived experience

3.11 Data collection and Analytic Methods:

The data collection method was recorded semi-structured interviews using open-ended questions supported by prompts. According to Allan and Westwood (2015b), the researcher's background may shape the research process. They state that ethical and methodological issues need to consider non-members of ethnic communities researching other ethnic communities. Denzin (2000) says that the researcher is expected to examine the political nature of their research work because 'all research represents a political enterprise that carries significant implications' (Streubert-Speziale and Carpenter, 2007:19).

I am a member of an ethnic minority group researching my community group, which posed a different challenge to me as a researcher. I used reflexivity and declared my intentionality and positionality in the discussion, data collection, and analysis to maintain objectivity and professionally offer sound interpretation using a phenomenological approach rather than a multiple–method approach in data analysis.

Data capturing was '…an interchange of views between two persons conversing about a theme of mutual interest' where the researcher attempts to "understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences" (Kyale; 1996: 1-2 cited in Groenewald, 2004). During the research project, I wrote down some ideas as they occurred as short notes or memos, which helped in analysis and helped discover the researcher's otherwise hidden knowledge (Watt, 2007). I also used my journal before and after interviews to clarify how I know and how I came to know and help check bias, feelings and thoughts. This practice enabled me to control how this impact or influences the research and promote openness to public inspection (Watt, 2007).

To reflect on and analyse 'how people experience the world', I used the heuristic framework of Smith et al. (2013), building on van Manen's (1990) fundamental life-world 'existential themes'. The themes involved 'lived space', 'lived time', 'lived body' and 'lived human relation' (van Manen and Adams (2010), van Manen (1990) cited in Tuohy et al., 2012). As a result, using personal and epistemological reflexivity (Dowling, 2007) provided a more significant opportunity to understand the phenomenon under study and the research process (Watt,2007).

I employed an analytical technique to manipulate the data for discussion, which required familiarity with the transcript and identifying key themes to form a coding frame. It also included indexing material according to the coding structure, mapping the data and interpreting the findings (Ritchie and Spencer,1994; Smith, Flower and Larkin, 2012). Thus I used an iterative and inductive process of 'de-contextualization and 're-contextualization to engage in an interpretive analysis of the data captured. The interpretation comes from identifying themes, patterns or commonalities in the text. The understanding was promoted by the 'circular process of continuous re-examination of propositions' (Converse, 2012). To discover the true meaning of the Integration experience in UK and UK healthcare, the hermeneutic circle prompts questions to understand the essence of 'being' (Integration). Through dialogue and openness between the researcher and the participants, the researcher hopefully became part of the historical, social, and political world of the participants which resulted in better understanding and discussion, leading to the 'mutual construction of the reality and identification of 'the meaning or essence of the experience'(Tuohy et al., 2012). The researcher worked out and came to know his 'fore-having, fore-sight, and fore-conception' before entering a 'circle of understanding that interprets while investigating the meaning of being of an entity' (Heidegger, 1962 cited in Converse, 2012). Smith (2007) states that IPA is an iterative and inductive cycle that proceeds by drawing on a repertoire of innovative strategies.

3.12 Reflexivity and positionality

Reflexivity is "…*the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome*" (Berger, 2015: 220). Reflexivity provides an avenue for improving self-awareness in any study. This process enables the researcher to elucidate the positionality and how formulating views concerning individuals' values, interests, and beliefs may impact the research objectives (Cousin 2009). As previously indicated in the ontology and epistemology section, a researcher's positionality may be influenced by ethnicity, age, life experiences, social identity, role and personality to varying degrees (Jootun et al., 2009). However, the degree to which these factors are considered critical depends on the relevance of the factor and the research objectives. Research quality, trustworthiness, rigour and

accountability increase with disclosing a researcher's positionality and experience in reflexivity (Mann, 2016). I am aware of the new challenge posed by my membership of the British minority ethnic (BME) group that I am researching and my first-hand experiences as a senior manager in the NHS of negative experiences or challenges such as racial discrimination.

Most of the research on race often refers to all racial minority groups as Black and Minority Ethnic (BME) or Black Asian Minority Ethnic (BAME) groups (Rollock,2021). I refer to them in this thesis as British Minority Ethnic (BME) groups and, most specifically, as ethnic minorities of African descent rather than Black and Minority Ethnic (groups) or Black Asian Minority Ethnic (BAME) groups. I will explain the rationale for this preference further in the discussion section of this study.

3.13. Reflexivity in this Study

A possible controversy that may arise in this study but is usefully resolved and addressed through reflexivity is maintaining a non-partisan view in the analysis by objectively and professionally offering a sound interpretation. In this double hermeneutic interpretive phenomenology, the researcher does not bracket his preconceptions or theories. The researcher uses reflexivity to be fully aware of his meanings of the real world and his existence in the world of study (Johnson, 2000; Lowes and Prowse, 2001). McConnell-Henry et al. (2009) state that the researcher's previous understanding and knowledge help interpretation, and they maintain that bracketing has no place in interpretive phenomenology, but Finlay (2008) disagrees.

Finlay (2008) argues that a type of bracketing or reduction involves the researcher acknowledging his influences and possible bias in interpretative phenomenology. The researcher used reflexivity to encourage participants to share their reflections on the value of their integration process. Allan and Westwood (2015b) stated that reflexivity is less often seen in practice than in theory. They explained how reflexivity might help confront social stereotyping and prejudice biases and as co-producers of the data. Self-critique and self-appraisal with an explanation of how 'own experience has or has not influenced the stages of the research process' (Dowling, 2006:8) inform the use of reflexivity in this study.

Mann (2016) advocates using a research journal as the primary tool to encourage reflexivity in studies such as IPA. In addition to maintaining an e-journal, I have engaged in the reflexive interview and data analysis, discussion and review of comments from my supervisory team, and discussions in conferences and with professional colleagues to ensure reflexivity in this study. My ongoing reflexivity is in the e-journal, which exemplifies my reflection in this study (an extract is in appendix 12, p. 264-267).

A personal journal may serve as a valuable and positive means for constructing knowledge (Brydon-Miller and Coghlan, 2014). I have kept a personal e-journal since the start of this research. The journal has so far proved very useful in reminding me of meaningful discussions and issues that occurred and made the descriptions of the event complete and easy to remember.

The central aims of an IPA study analysis include understanding the participant's world and its description as well as a clearer and open interpretative analysis with a descriptive focus on the social, cultural and theoretical context in addition to the participant's sense-making of the lived experience (Larkin et al. (2006).

An IPA study is committed to idiographic inquiry (Lamiell, 1987; Smith, Harre, and Van Langenhove, 1995; Smith, 2004) and examines individual cases in great detail. In IPA, general claims results using extracts from the participants' narratives, and the 'double hermeneutic' is always an account of how 'the analyst thinks the participant is thinking' (Smith et al., 2012:80).

Analysis in IPA involves the application of the etic (outsider) and emic (insider) approaches. Pringle et al. (2011) argue that direct quotes affirm what the participants describe as their lived experience in IPA. This approach involves the etic (outsider) position (Biggerstaff and Thompson, 2008). The emic (insider) approach consists of the researcher's interpretation of the participant's lived experience. In this stance, the researcher applies their interpretations and theoretical ideas but uses verbatim quotes to ground these interpretations in the participant's actual experience' (Reid et al.,2005). The researcher maintains an understanding, stays curious concerning the phenomenon, and uses reflexivity to minimise the influence of his personal experiences and prior knowledge, influencing data analysis (Le Vasseur, 2003, Finlay 2008). Rodham et al. (2013) state that the researcher needs to monitor their personal beliefs, bias, and research experiences. In descriptive phenomenology, the researcher must put

aside or bracket their preconceptions. The double hermeneutic concept in IPA requires the researcher to understand prejudices and potential influences. The researcher becomes aware by maintaining a curious stance and using reflexivity in engaging with the data (Rodham et al., 2013, Smith et al., 2012). Reflexivity is a detailed evaluation of the self' (Shaw, 2010:234). It enables the researcher to acknowledge that their actions and decisions will inevitably impact the meaning and context of the experience under investigation (Horsburgh,2003, p. 209).

The IPA researcher needs to become fully aware of the actual and potential factors that may impact the way the data may be approached and must be clear about the process of engagement with the data as well as provide an audit trail to increase the level of trustworthiness of the research (Rodham et al. 2013).

3.14. Ethical Considerations:

Autonomy, non-malfeasance, beneficence, and justice are core ethical principles essential in research to improve quality and safeguard the public (Wright et al., 2010). The Middlesex University Research Ethics Committee granted ethical approval for this study (appendix 1), and individuals participating in the study were not subjected to any physical or psychological harm. Every legal requirement concerning health and safety regulations, data protection, confidentiality and anonymity, and signed consent to participate were taken into due consideration.

Ethical considerations also include avoidance of misinterpretation of intentions of the UK government/institutions. The researcher avoided sentiment or bias in analysis and discussion through reflexivity. As an insider, there was a potential risk that the researcher may have the challenge of maintaining a loss of self and distance (Drake and Heath 2010). However, as this is an Interpretive Phenomenological Analysis study, lucid awareness and knowledge of this possible challenge merged with adequate positional clarity, understanding of relevant research and literature was used to resolve this challenge (Sikes and Potts, 2008).

3.15 Informed Consent and Confidentiality:

Confidentiality is the basis of trust in a patient-practitioner-researcher relationship and must be protected (Holloway and Wheeler, 2010). The researcher in qualitative research must be aware of the social and cultural context and take on a holistic perspective of active and interactive human beings. This study involved interviews, and according to Butler (2003) cited in Holloway and Wheller (2010), an interview might provoke distressing memories and strong emotions. There was a discussion of the research aim. The participants were informed that they were under no obligation to continue with the interview should they feel uncomfortable at any point. Participants were aware that there were able to end the discussion and withdraw from the research at any time (see appendix 2 – participant information sheet).

A priority step in collecting data for research is informed consent, the first principle governing participation in research. Consent by the participants of this research was informed, voluntary and given by mentally competent individuals without being subjected to implicit or explicit pressure (Streubert-Speziale and Carpenter, 2007, Moule, Aveyard and Goodman, 2017).

Information about this study to participants was in the English language. Participants signed the informed consent form approved by the Middlesex University Ethics committee. The consent form indicated the purpose of the study, the possible duration of the recorded one-on-one semi-structured interview and that the participant would interview at a location of choice. All participants in this study gave their voluntary consent to participate in the study. They were not subject to any implicit or explicit pressure. Participants were given written information about this study and offered the opportunity to clarify their understanding through a phone call or face-to-face discussion. Participants' written information about this study was in the English language that they could understand to enable participants to know what to expect (see appendix 2). The consent form indicated the purpose of the research and the possible duration of the recorded one-on-one open-ended semi-structured interview at the participant’s preferred location. The participants were not obligated to continue with the interview and were free to end the interview and withdraw from the research at any time. There were no risks associated with participants' participation, and contact details for support agencies and counselling services were made available to participants for their

use if needed. The researcher and the supervisory teams' contact details were available to participants should they have any queries or questions about the research at any time. Participants signed the consent form after review and at the start of interviews (see appendices 2 and 3).

The Code (NMC,2018) specifies that nurses must respect people's right to confidentiality, and in this study, participant confidentiality is central to ethical consideration. I assigned pseudonyms to the participants to maintain confidentiality in line with the code (NMC, 2018) requirement. I used encryption and ‘PIN’ code access to secure all electronic materials and the audio recording for the interview sessions.

CHAPTER FOUR

4.0. Data Analysis:

Smith et al. (2012) argue that there is no single prescribed analysis method for working with data in an IPA study; analysis is an iterative and inductive cycle. Smith et al. provide a six-step heuristic framework for analysis and recommend that IPA's idiographic focus requires data analysis from one case to another. The researcher is to start with the most detailed, complex and engaging interview. I applied Smith's heuristics framework to analyse the data because I found it more helpful in analysing the data. The framework provides an opportunity to embark on a step-by-step process to analyse the data correctly.

The six steps in the Smith et al. heuristic analysis framework are non-prescriptive and dynamic. The stages in IPA analysis comprise:

Step 1: Reading and re-reading
Step 2: Initial noting
Step 3: Developing emergent themes
Step 4: Searching for connections across emergent themes
Step 5: Moving to the next case
Step 6: Looking for patterns across cases

In brief, I read the transcript repeatedly and engaged in the initial noting of exploratory comments in the first stage. In the next step, I transformed the initial notes into themes. Following this, I engaged in grouping the emergent themes into clusters. After that, the focus was on developing the relationship between the superordinate themes and subthemes. Then, a descriptive and interpretative analysis of the identified superordinate themes and subthemes using extracts from the transcripts. Figure (003) below summarises the data analysis process, and each step is discussed.

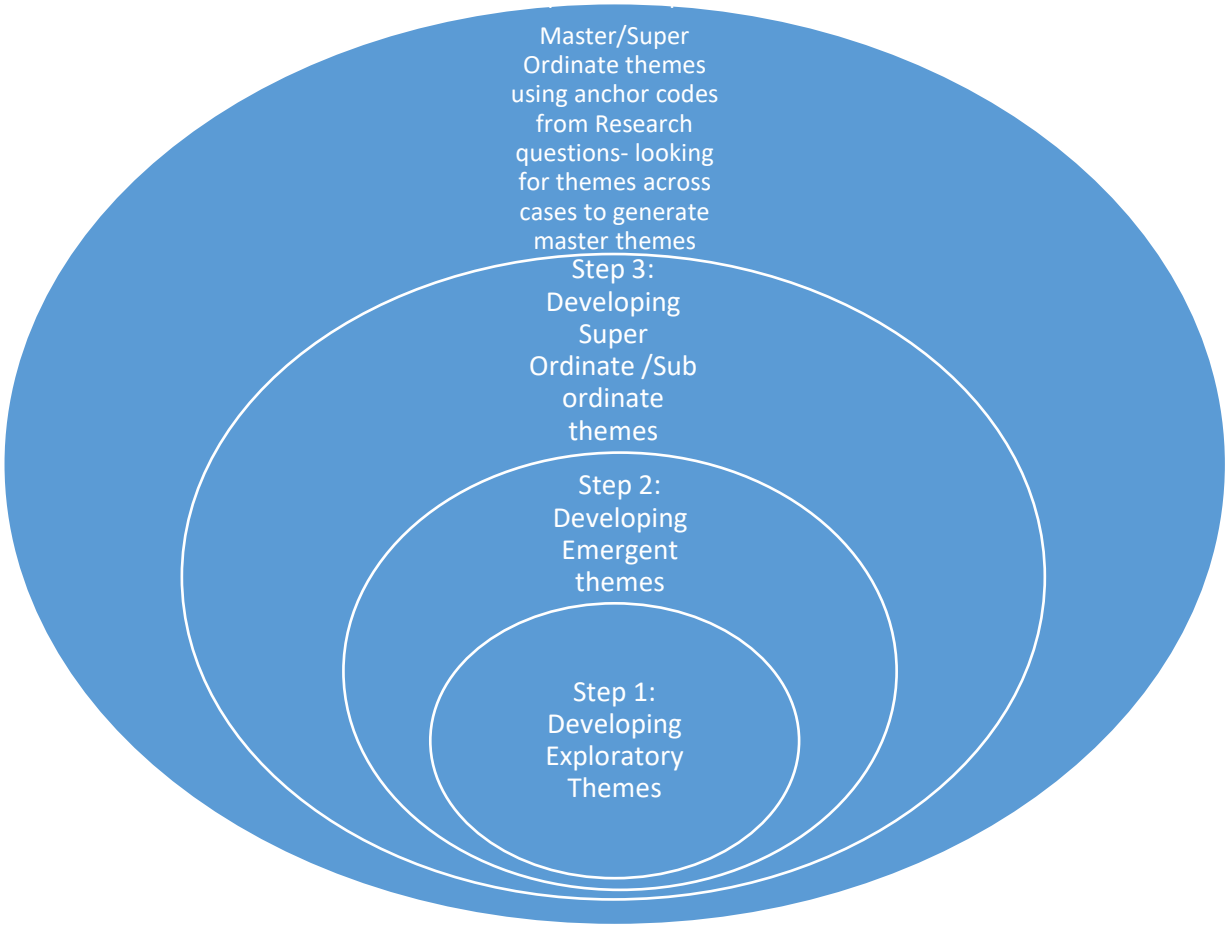


Figure 003: *Summary of Steps in data analysis*

4.1. Reading and re-reading and Initial noting.

I began the data analysis following the steps identified in Smith et al. (2013) heuristic framework after transcription and verification of the interview data. I repeatedly listened to the audiotaped interview and read each interview transcript 2-3 times in reading and re-reading. In this repeated reading, I became more aware and familiar with the data by immersing myself in the transcript. Before engaging in the first level manual coding exercise (Adu,2019) and familiarising myself with the data, I discussed with two supervisors in May 2018 the transcript and reflexive evaluation of the interviews from 3 participants. NVivo12 was also used to run an example of a 'word cloud' and 'word tree' using 'integration' as a keyword (see ‘word cloud’ in appendix 14) to indicate the words commonly used by the participants. This word cloud and word tree were helpful in

exploratory textual analysis of the terms most widely used in the interview and assisted in generating themes during data analysis.

The second step is the first-level coding. Saldana (2013:14) describes a code as a researcher's construct that symbolises and thus attributes interpreted meaning to each datum for ‘later purposes of pattern detection, categorisation, theory building, and other analytic processes. Coding is a cyclical developmental exercise between data collection and more extensive data analysis (Saldana, 2013). Coding may be done manually, by software, or a combination of both. Manual coding is useful for small data sets and initial data analysis when familiarising oneself with the data (Adu, 2019). Software coding is suitable for extensive data that are transcribed. In line with Saldana's (2013) and Smith et al. (2012) suggestions, I carried out manual coding first in this research. I then decided against using software such as NVIVO 12 to promote my understanding of data analysis as a beginner researcher.

The initial coding exercise highlights statements concerning the central phenomenon that the researcher considers significant. I marked the significant statements using different colours for easy identification and reference exercise. The exploratory comments consist of descriptive, linguistic, and conceptual comments (Smith et al., 2013). I worked through each transcript line by line, using the MS Word comment function to write exploratory comments. I conducted the initial coding by moving from one case to another until I analysed the ten cases. This first exploratory process resulted in several exploratory comments or statements directly from ten interview transcripts related to the ten respondents' lived experiences. Table 002 below is an example of exploratory comments or opinions extracted in steps 1 and 2 of the Smith et al. (2013) heuristic framework from two interview transcripts (Osato and Ese):

Table: 003 Initial Comments

Original Transcript	**Exploratory Comment** D= descriptive comments, L=linguistic comments C=conceptual comments
OSATO: Yeah, because I have a British passport, but I am not English! We try to integrate. Integration, I think, is more a grammatical phenomenon rather than a reality. Integration, as long as you are not the same. Every human being is a political animal; no one is the same as the other. The more closely…, the more you look like each other, the more comfortable you are. The more colour close you are. The Caucasians prefer the Indians, and Asians because they are closer. The further your colour, the more threat you are to them.	C=Is there an underlying resistance to being British despite having a British passport? L= 'I am not English'- C=Is being British synonymous with being English? C= Is this an indication of immigration and rights issues? D=Integration is a grammatical phenomenon D=Integration—Seeing himself as a foreigner, Issue of Colourism and Racism
ESE: So outside of work, number one, because I have a life outside of work, I didn't depend on my professional colleagues as my social friends, if you know what I mean. I have a church family, I have my family, and I have my in-laws. So I had friends, you know, so for me, taking friends from the work place and taking them home with me was not something that I developed. I would say; obviously, I was not being antisocial; we went for Christmas meal with them, leaving do we would do all of that together, but personally, I probably had one	D=Maintaining social relationships outside of work

friend. She was my mentor, actually. So up until now, how many years on, twelve years on, we are still friends. So she is the only one that I have kept even after leaving that hospital. She's the only one that I am still in contact with, and she was the only person that I had as well as a work relationship, a personal relationship with in terms of social relationships. So for me, it did not matter to me, so it was all about my patients. When I was at work, it was all about my patients. You are not my friend. I am not here to make friends with you; I am here to do what I need to do for my patients. ESE: For me, that kind of enhanced our relationship because they felt that I was there when nobody was there. And because they would ask us. I would always say to them; please call me anytime. Even if it was three o'clock in the dead of night…. So their mum had been there for me. You know she's a white woman, but she would come, and they were not kind of those white people who were naïve	L=Mentor as a friend. C=Barrier between personal and work life? C=Was this reciprocal? Is this an expression of difference from the others-'they', them'? Is this sign of acceptance or Integration to the local ways?

4.2. Developing Emergent themes:

After completing the transcription of interviews and exploratory commenting, I developed conceptual or emergent themes (referred to as experiential statements in the Smith et al. (2022:76), 2nd edition). The focus was on discrete chunks of the transcripts whilst paying close attention to the context in the transcript. After that, the focus was across all the transcripts. I recorded the conceptual or emergent themes in the right-hand side margin of the transcript. The focus was to reduce and map the initial notes whilst maintaining 'the interrelationships, connections and patterns' between the exploratory notes. According to Smith et al. (2013), turning commentary notes (see table 003) into themes involves producing 'a concise and pithy statement of what was

important in the various comments…the focus is on capturing what is crucial at this point in the text but inevitably … influenced by the whole text' P. 92.

The emergent themes (experiential statements) represent a shared description and interpretation process, reflecting my engagement and understanding of the participant's story (Smith. et al., 2013). In this process, reference was made to the original text to maintain the hermeneutic interpretation cycle in IPA.

Examples of significant statements (exploratory comments) and initial emergent themes (experiential statements) during steps 1, 2 and 3 of the Smith et al. (2013) heuristic framework from two scripts are in table 004 below. I sent scripts Osato, Ese, and Osaro to the supervisory team for cross-checking and commentary. Consequent to the supervisory team's report, I analysed the remaining transcripts by moving from one case to another until the ten cases were investigated. I treated each transcript or case on its terms in keeping with the idiographic component of IPA. The process resulted in extracting initial themes (see Table 004 and appendix 5) from the ten interview scripts. The next step in the analysis involved a two-step approach, determining the recurrence of the themes across cases to develop super-ordinate themes (Personal Experiential Theme) and subordinate themes.

Table 004 (example of an extract of initial themes)

Initial **Theme**	Line	**Original Transcript**	**Exploratory Comment**
issues of Integration Integration sceptic	OSATO 188 192	Yeah, because I have a British passport, but I am not English! We try to integrate. Integration, I think, is more a grammatical phenomenon rather than a reality. Integration, as long as you are not the same. Every human being is a political animal; no one is the same as the other. The more closely…, the more you look like each other, the more comfortable you are. The more colour close you are. The Caucasians prefer the Indians,	Is there an underlying resistance to being British despite having a British passport? 'I am not English'- Is being British synonymous with being English?

Communal social Integration	ESE 55.	Asians because they are closer. The further your colour, the more threat you are to them So outside of work, number one, because I have a life outside of work, I didn't depend on my professional colleagues as my social friends, if you know what I mean. I have a church family, I have my family, and I have my in-laws. So I had friends, you know so for me, taking friends from the workplace and taking them home with me was not something that I developed. I would say I was not being antisocial. We went for a Christmas meal with them, leaving do we would do all of that together, but personally, I probably had one friend. She was my mentor, actually. So up until now, how many years on, twelve years on, we are still friends. So she is the only one that I have kept even after leaving that hospital. She's the only one that I am still in contact with, and she was the only person that I	Is this an indication of immigration and rights issues? Integration is a grammatical phenomenon Integration—Seeing himself as a foreigner, Issue of Colourism and Racism Maintaining social relationships outside of work is more important? Mentor as friend A barrier between personal and work life?

	59.	had as well as a work relationship, a personal relationship with in terms of social relationships. So for me, it did not matter to me, so it was all about my patients. When I was at work, it was all about my patients. You are not my friend. I am not here to make friends with you; I am here to do what I need to do for my patients. For me, that kind of enhanced our relationship because they felt that I was there when nobody was there. And because they would ask us. I would always say to them; please call me anytime. Even if it was three o'clock in the dead of night…. So their mum had been there for me. You know she's a white woman, but she would come, and they were not kind of those white people who were naïve.	Was this reciprocal? Is this sign of acceptance or Integration to the local ways?

4.3. Searching for connections across emergent or conceptual themes:

1) **Identifying Recurrent Themes**:

The next step in the analysis was to determine the degree of recurrence of the initial themes across cases to develop super-ordinate and subordinate themes.

In looking for patterns and connections between emergent themes, Smith et al. (2013) suggest using any or combination of abstraction, polarisation, subsumption, contextualisation, numeration or function. Abstraction involves developing a 'super-ordinate theme by an emergent grouping of similar themes and giving it a new label. An emergent theme may become a 'super-ordinate theme (referred to as Personal Experiential Theme in Smith et al., 2022:76) in bringing together related themes in subsumption. Polarisation involves looking for oppositional relationships in the

emergent themes that may organise the themes for analysis. Smith et al. (2013) further explain that contextualisation involves identifying contextual or narrative elements within an analysis by looking for the relationships between emergent themes. Numeration consists of the frequency of emergent themes in the transcript analysed, and function involves examining the specific role of the emergent themes within the transcript. According to Smith et al., abstraction, polarisation, subsumption, contextualisation, numeration, or function are not mutually exclusive.

This exercise resulted in the development of 49 emergent themes. I created clusters based on the emergent themes' similarities, numeration, commonality, and polarities, ensuring that the clusters reflected the participant's experience. I then gave the cluster a working label. A super-ordinate theme was classed recurrent if the theme was present in at least half of the participants' interviews (see appendix, table1b- identifying recurrent themes).

The extent of recurrence is one way to enhance the validity of the findings in this study. The is no prescriptive way to develop a mapping of how the emergent themes link together. This step partly depends on the research question, and some initial emergent themes may be left out if necessary (Smith et al., 2013). At this stage, I did not discard any of the emergent themes.

To promote internal consistency, the relative vastness or accuracy of the 49 initial emergent themes and the thorough analysis of the emergent themes (Smith. et al. (2013), I had to put the initial themes for all the respondents in a table (see appendix 05) to determine the degree of the initial emergent theme recurrence. As previously stated, an emergent theme was classed recurrent if the theme was present in at least half of the participants' interviews (see appendix table 006 - identifying recurrent themes). The extent of recurrence is one way to enhance the validity of the findings in this study.

ii) Developing Superordinate Themes (Personal Experiential Themes):

This stage is an inductive process to develop the super-ordinate and subordinate themes from the clusters. I put the clusters in chronological order to sort and integrate the clusters across all the transcripts. Using patterns and connections between emergent cluster themes, I applied abstraction, subsumption, and contextualisation to

develop eleven super-ordinate themes (see table 005 below). In engaging the hermeneutic circle, I maintained the internal consistency or coherence of the cluster themes whilst exploring new ideas by moving between the discrete chunks (individual or lower level) of the text and the greater whole of the cluster. I employed a thematic structure rather than chronological ordering to produce the interpretations and connections between the superordinate theme and the descriptive working titles.

Table 005: TABLE OF SUPER ORDINATE THEMES FOR THE GROUP

SUPERORDINATE THEMES	EMERGENT THEMES
Understanding integration	Challenges of Integration Housing and social challenges Location and social connections Environment Citizenship/Integrated person
The reality of integration	Social Integration, Loyalty issue, Cultural and Social Integration Transference as a coping strategy Cultural difference/contrast of nationality Personal interest/perception, Degrees/components of integration, Social mobility Experiences during Supervised Practice placement
Discrimination	Experiences of multiple migrations, racism Overt discrimination, knowledge and discrimination
Immigration Issues	Immigration and nationality, Contrast of nationality/Ethnicity
Social, Language and Cultural Currency	Identity, belonging and diasporas/communities.

	Social relationship Economic and social issues
Pension Plans	Development in the home country, Conception of Integration Political development, Pension and retirement
Education	Grade level, Continuing professional development, training, Career Planning/choice/pathway Educational method/learning styles
Mentorship/Coach	Conflict handling mode/styles Sponsorship/Mentorship
Personal Characteristics	Resilience, motivation, Emotional intelligence, Political astuteness/ political intelligence, intelligence quotient, Communication skills Attitude to work, Professionalism, self-esteem, Knowledge and skill, Assertiveness and negotiation
Employers Practices	'Guinness effect', Selectivity NHS Manager's Management of discrimination Sponsorship/ Selective support/nepotism, Immigration challenges Job satisfaction/ Agency nursing, Career progression Organisational objectives
Discriminatory Practices	Management styles/management of discrimination

	Prejudice, stereotype, labelling Association of name with race or nationality, barriers to education

4.4. Master Themes:

Smith et al. (2013) counsel that this task can 'particularly be a creative task'. Master themes, Smith et al. state, may enable an analysis to become more theoretical by recognising how 'participants represent unique, idiosyncratic instances and higher-order qualities. Therefore, in developing the master themes, I looked for subordinate and super-ordinate patterns across all the cases to generate the master themes by applying the strategies above. I created five anchor codes (see Table 006, appendix 8) from the research questions to form the master themes (Adu, 2019). This stage involves looking across the themes, evaluating their connections, and how one theme illuminates another or a particular theme's potency. The master table of themes for the group is below:

Table 006: MASTER TABLE OF THEMES FOR THE GROUP

MASTER THEMES	SUPERORDINATE THEMES	EMERGENT THEMES
A. OPINION, CONCEPT AND EXPERIENCES OF INTEGRATION	**Understanding integration**	Challenges of Integration Housing and social challenges Location and social connections Environment Citizenship/Integrated person
		Cultural and Social Integration

	The reality of integration	Transference as a coping strategy Cultural difference/contrast of nationality Personal interest/Perception/ Degrees/components of Integration Social mobility Experiences during Supervised Practice placement
B. **CHALLENGES TO INTEGRATION**	**Experiences Of Social Integration**	Social Integration Loyalty issue
	Discrimination	Experiences of multiple migrations, Racism Overt discrimination Knowledge and discrimination
C. **PERSONAL AND SOCIAL INTEGRATION**	**Immigration Issues**	Immigration and nationality The contrast between nationality/Ethnicity
	Social, Language and Cultural Currency	Identity, belonging and diaspora/communities. Social relationship Economic and social issues

	Pension Plans	Development in the home country Conception of Integration Political development Pension and retirement
D. **CAREER PROGRESSION**	**Education**	Grade Level Continuing professional development, training Career Planning/choice/pathway Educational method/learning styles
	Mentorship/Coach:	Conflict handling mode/styles Sponsorship
	Personal Characteristics	Resilience, motivation, Emotional intelligence, Political astuteness/ political intelligence, intelligence quotient Communication skills Attitude to work, Professionalism, self-esteem, Knowledge and skill, Assertiveness and negotiation

E. **OBSTACLES AND MEASURES TO DEVELOP AND THRIVE**	**Employers Practices**	**Employers Practices** 'Guinness effect.' Selectivity NHS Manager's Management of discrimination Sponsorship/ Selective support/nepotism Immigration challenges Job satisfaction/ Agency nursing Career progression Organisational objectives
	Discriminatory Practices	**Discriminatory Practices** Management styles/management of discrimination Prejudice, stereotype, labelling Association of name with race or nationality, barriers to education

CHAPTER FIVE

5.0: Findings of the study

In this chapter, findings from data derived from the interview are considered in a group-level analysis. The primary aim of the interviews was for the participants to describe in as detailed a way as possible their experiences of integration into the UK and UK healthcare as a nurse with Nigerian heritage.

5.1: Description of the sample:

Participants were given pseudonyms (Nigerian names) to maintain confidentiality whilst protecting their identity (NMC, 2018). Table 007 below shows the demographic characteristics of the participants.

Table 007: Respondents' Demographic Characteristics.

Name	**Sex**	**Age**	**Title**	**AFC Band**	**Country of Birth**	**National Region of Origin**	**Country of initial registration**	**Qualification**
OSATO	Male	55-60	Advance Nurse Practitioner	8a	Nigeria	South-South	Nigeria	Master's Degree
ADA	Female	40-45	Practice Educator	8a	UK	South-West	UK	Master's Degree
ESE	Female	35-40	Advance Nurse Practitioner	7	UK	South-West	UK	Bachelor's Degree
EFE	Female	50-55	Public Health Specialist Nurse	8a	UK	South-West	UK	Master's Degree
UWA	Female	60-65	Specialist Health practitioner	7	Nigeria	South-West	Nigeria	Master's Degree

EHI	Female	55-60	District Nurse Team Leader	7	Nigeria	South-South	Nigeria	Bachelor's Degree
EDE	Female	45-50	Research Nurse Specialist	8a	UK	South-East	UK	Bachelor's Degree
OSARO	Male	55-60	Assistant Clinical Director	8c	Nigeria	South-West	UK	Master's Degree
OSAMA	Male	45-50	Registered Nurse	7	Nigeria	South-East	UK	PhD
OSUYI	Female	60-65	Lecturer	8a	Nigeria	South-West	Nigeria	Master's Degree

Seven of the participants are female, and three are male. Three participants were born in the UK but grew to early adulthood in Nigeria before relocating to the UK. OSATO, UWA, EHI, and OSUYI had their tertiary and initial nurse training in Nigeria. The remaining six had tertiary education in Nigeria before training as nurses in the UK and included ADA, ESE, EFE, EDE, OSARO, and OSAMA. The participants' ages ranged from 35 to 65 years. The participants had worked in clinical management/leadership positions in UK healthcare for up to 25 years.

OSATO had his initial nurse training in Nigeria before undergoing supervised practice to gain UK NMC registration. Currently, he works as a band 8a Advanced Nurse Practitioner specialising in neurology. He had worked as a consultant and specialist nurse before his current post. He holds a master's degree in nursing and originates from the South-South geopolitical zone of Nigeria.

ADA: Although she was born in the UK, her parents took her back to Nigeria at four years. She attended primary, secondary and tertiary institutions in Nigeria before training in the UK as a registered nurse. Currently, she is a band 8a nurse in an NHS acute trust hospital. She holds a bachelor's degree in nursing and a post-graduate

certificate in education. She currently works as a Nurse Practice Educator and originates from the South-West geopolitical zone of Nigeria.

ESE is female and is from the South-West geopolitical zone of Nigeria. She was born in the UK and went with her parents to Nigeria at about two years. She attended primary, secondary, and tertiary institutions in Nigeria before training in the UK as a registered nurse. She holds a Master's degree in nursing and currently works as an Advanced Nurse Practitioner in a central London hospital.

EFE is female and is from the South-West geopolitical zone of Nigeria. This candidate is a band 8a registered specialist public health nurse in an NHS community care Trust. She was born in the UK and went with her parents to Nigeria at about two years. She attended primary/secondary and tertiary institutions in Nigeria before returning to the UK in her twenties. She studied nursing after engaging in other jobs in the UK. EFE has a Master's degree and is currently a locality manager.

UWA is a specialist public health nurse and a team leader. She is a registered Practice teacher, holds a master's degree in nursing, and had her initial nurse training in Nigeria before undergoing supervised practice to gain the UK NMC registration. She is from the South-West geopolitical zone of Nigeria.

EHI is a registered District nurse and is currently a team leader in an NHS Trust. She had her initial nurse training in Nigeria before undertaking a supervised training programme in the UK. She holds a Bachelor's degree and is originally from the South-South geopolitical zone of Nigeria.

EDE is from the South-East geopolitical zone of Nigeria. She was born in the UK and went to Nigeria in childhood with her parents. She had a Bachelor's degree in English before training as a registered nurse in the UK. She holds a master's degree and works as a senior research nurse in an NHS Trust.

OSARO is a registered mental health nurse. He hails from the South-West geopolitical zone of Nigeria. Before training as a Mental Health Nurse in the UK, he had a structural engineering degree from a European country. He has a master's degree and works as an Assistant Clinical Director of Nursing.

OSAMA is a registered Public health nurse. He is from the South-south geopolitical zone of Nigeria. He had a Bachelor's degree in Nigeria before training as a registered nurse in the UK. He holds a PhD in nursing and works as a Public Health Nurse in an NHS Trust.

OSUYI is from the South-West geopolitical zone of Nigeria. She had her initial nurse registration in Nigeria and practised as a Nurse tutor before undergoing a supervised practice programme in the UK. She holds a master's degree and currently works as Nurse Lecturer.

5.2: Overview of thematic analysis:

Five master themes and twelve superordinate themes resulted from analysing of the data collected from the interview in this study. The themes indicate what appears significant to the participants' recollection of their lived experience in the UK. This study sets out to answer specific research questions, so I directed my analysis to answer the research question. Consequently, this analysis does not cover every area of the lived experience of the participants because the experiences centred on are to answer the research question. Therefore, this analysis is one possible account of the lived experiences of the participant's integration into UK healthcare following their registration with the Nursing and Midwifery Council (NMC). In line with IPA, I have used quotes to give context and discuss the coherent story and the primary analytical findings about the respondents in this study.

The master themes generated from the data and sub-themes include:

Master Theme 1**:** Opinion, concept and experiences of integration

- **Superordinate theme 1.1:** Understanding integration
- **Superordinate theme 1.2**: The reality of integration

Master Theme 2: Challenges to integration

- **Superordinate theme 2.1:** Experiences of Social Integration
- **Superordinate theme 2.2:** Discrimination

Master Theme 3: Personal and Social Integration

- **Superordinate theme 3.1:** Immigration issues
- **Superordinate theme 3.2:** Social, Language and Cultural Currency
- **Superordinate theme 3.3:** Pension issues

Master Theme 4: Career Progression

- **Superordinate theme 4.1**: Education
- **Superordinate theme 4.2**: Mentorship /Coach
- **Superordinate theme 4.3:** Personal Characteristic

Master Theme 5: Obstacles and Measures to Thrive

- **Superordinate theme 5.1:** Employer Practices
- **Superordinate theme 5.2**: Discriminatory Practices

5.3. Master Theme 1**:** Opinion, concept and experiences of integration

This Master's theme is about the nurses' experience of integration into the UK and the healthcare service. The data relating to this theme came from participants' responses to the general question on how the nurses see themselves as integrated into UK healthcare and how they believe the UK has lived up to their career expectations and integration into society. The main analytical findings about the three groups of IENs with Nigerian heritage (see pages 85, 112-115 for a description of the sample) show differences in the participants' understanding and opinions, concepts, and integration experiences. There are two subthemes under this master theme, and these will now be presented in turn.

5.3.1.1: Understanding integration

The participants have some similarities yet differences in their understanding or expectation of integration. In this study, some of the participants' opinions of integration cut across their insight, experience, and definition of integration within UK society and their work environment in UK healthcare. One of the participants was sceptical about the concept of integration. Some others explained their understanding of integration in general terms of how they believed integration should occur at the individual and societal levels. These individuals did not define integration but had their views and experiences.

Osato's opinion was evocative. Osato's view was that integration is a hoax; integration is not visible, not tenable, and not encouraged in practice because skin colour or pigmentation was central to integration in the NHS and UK society. Osato is sceptical

about the idea of integration and explains his understanding of integrating and integration thus: -

> *"We try to integrate. Integration, I think, is more a grammatical phenomenon rather than a reality. Integration, as long as you are not the same. Every human being is a political animal; no one is the same as the other. The more closely…, the more you look like each other, the more comfortable you are. The more colour-close you are, the Caucasians prefer the Indians, Asians because they are closer. The further your colour, the more threat you are to them" (Page 20, line 192).*

Osato's understanding and explanation are influenced by his experiences of the treatment of people according to their skin pigmentation by groups or individuals in society. Osato believes that even if the integration model is by assimilation, there will always be a natural characteristic that will emerge and be identified as different. Osato backs up his explanation by assuming that the white British populace should avoid prejudice and readily understand what obtains in parts of the Commonwealth. This reasoning seems to think that because the Queen Elizabeth of England is the head of the Commonwealth of Nations, UK citizens should be well informed on the need to avoid prejudice. His views are informed by the fact that most commonwealth countries were British colonies. By this affinity, these countries form the core of the organisation referred to as the Commonwealth of Nations. Osato reasons that the refusal of the white British populace to understand the feeling of affinity to the United Kingdom by the Anglophone nations makes integrating these black people into the UK an impossible task. Osato's referral to his being a 'commonwealth citizen' seems to claim to belong to a nation with close affinity and yet different from the UK. Osato explains what informs his thinking thus:

> "*Because of the relationships I have gone through and my experience. They are more comfortable with Filipino because of their relative lightness. I mean, when they bleach their hair, they may be mistaken for English than a black man. A black man will always be a black man. Like they say in those films, 'blame it on a black man'. It sticks out. Even what I think, this is not even what I am saying; this is reality when a white man sees you… when a white man sees you without knowing you before, the idea is 'this is a dunce who has got no sense'!. Maybe they think your brain is black as well. Until when you speak. When a patient asked me on the*

ward, "how come you speak very good English?" I thought I am a Nigerian, but I have been here for so many years. I am supposed to be a commonwealth citizen. Some of them tell me that I oozed with confidence and was I born here?. But that is just my personality. It is from work experience and life experience that I happen to be practising at this stage. They say I am oozing with confidence as people of my colour is not always having these skills. If I hadn't opened my mouth, that guy would have thought this is a black man with a black brain!" (Page 20, line 194).

Ese believes in integration and stated that integration was primarily cultural adaptation. It depends on the migrant to selectively imbibe new cultures or characteristics in addition to the migrant's existing culture. Ese did not distinguish between integration into the healthcare environment and the larger community. To Ese, the migrants' responsibility is to display their beliefs or cultures excellently to make it attractive enough for the indigenous population to emulate and imbibe a new culture. Ese proffered her opinion and understanding of integration by defining integration and knowledge of how it takes place. According to Ese,

My view of integration is actually: you have got a culture, you come into another culture where they do things differently, you look, and you observe, you learn, you then think which of these things I am imbibing. Which one is necessary, which one is not necessary? For me, integration is being able to adapt to a place, however knowing what you pick and what you unpick, then using that for your own self-development and for the development of people around you and being a role model. So that yes, I have my own culture, but I still come in, integrate into that environment, but I am not sucked in. Integration is not bringing my own culture and trying to impose it on other people because when you talk about integration in that sense, I hope I am answering this correctly. When you are coming in, it is like someone coming into a different setting that has been established. … So I think integration is a two-way street however it is not each party lording it over each other….'(Page 20, line 794).

According to Efe, integration is for the migrant to accept her difference from the indigenous larger population. Efe believes in 'when in Rome, act as the Romans do'. To Efe, It behoves the migrant to embrace and imbibe the prevalent culture. Efe reasons:

"*I think integration is accepting the fact that you are different, you have a different culture, you have different norms and values, but you are living away from that culture in a multicultural society and just embracing the differences that you have in the culture and trying to understand the other people's cultures, the other people's values and respecting it"(Page 6, line 298).*

Interestingly, EFE clarified that integration was not a one-way street but emphasised the need for the migrant not to give up their identity whilst appreciating the culture and values of the larger indigenous population. It is, according to EFE, ***'****embracing who I am and embracing the differences we all have in all the different cultures. (Page 7, line 314).*

Ede has a similar perspective to Efe but with a difference. Ede emphasises that it behoves the migrant to integrate by becoming more like the larger population. According to Ede, '*Integration is how you can blend with… because… integration arises when you are foreign. Somebody who is in this place cannot be said to be integrating, so it is when you are an outsider that the word integration arises. How have you adapted to your now present society once you have moved from somewhere else (Page 8, line 277).*

The views of Osuyi and Osama appear similar to Efe's; their view differs slightly. It stems from their expectation of individuals and their understanding of their local community practices in shaping their integration. Osuyi sees integration as freedom and opportunity to act freely; Osama sees it as 'live and let's live'.

According to Osuyi: '…*My definition of integration is being free, to express yourself, being free to live peacefully with others in the area, contributing to discussions in the area, being able to be advocates for others who are not able to do so. So that is, that is my own idea of integration. I think I have been able to get, but I will say that there still need to be improvement in some areas' (Page 10, line 477)*

Osuyi cherishes the ability of individual freedom to self-expression and
not to be seen as the second rate to other individuals or groups. Osuyi's verdict is that the current system and practice need improvement. Osuyi's view expresses the relevance of dominance and power play which may adversely affect individual integration in the healthcare setting.

Integration, Osama, states that promoting cohesion and peaceful coexistence in a multicultural environment requires everyone to have a deeper understanding and appreciation of one another.

Osama says, '*It is understanding of people's different cultures and being able to apply that understanding for the benefit of people who are living in the same culture and for your own benefit as well—gaining a better understanding of ourselves and being able to live peacefully with each other" (Page 8, line 323).*

In summary, the respondents' explication of integration varies but with some similarities. The respondents' explication is firmly shaped by their personal experiences living and working in the UK. The coherent story and the primary analytical findings under this theme are that the respondents mainly prefer multiculturalism in integration and that racism and discrimination are evident and contribute to shaping the feeling of prevailing political and cultural realism in the three groups of IENs with Nigerian heritage and their integration or non-integration in the UK healthcare.

5.3.1.2: The reality of integration

All the respondents had divergent views on the process of integration. Their opinions varied according to whether they saw this from the community level or the work (ward/practice area) level. However, the common threads revolve around personal experience, self-interest, interpretation and coping methods, cultural and social integration and social mobility within the community. The unique knowledge and understanding of the integration process informed the definition of integration proffered by the participants. For example, Osato, who was sceptical about the concept of integration, declares that his experience does not support any process since it is impossible for integration. Osato believes that prejudice and skin colourism prevent proper integration in the work environment and the community. Osato thinks there is a hierarchy in the relationship between the white indigenous population and other groups. Osato believes that the lighter or less pigmentation on your skin, the greater the chances of acceptance and perhaps the chance for integration.

Osato states: '*Prejudice definitely. That you cannot rule out!... I will prefer to call it 'colour privilege' than 'white privilege' because even Indians use it as a privilege. Because they are closely related, some try and play one against the other. But one*

thing I have also experienced is that when they have finished with the black, the next people, they take them on, and they now group them together. When it is them, they see them as ethnic minorities. Whether you are green or black, if you are not white, you are black (Page 21, line 198).

Osato emphasises the relevance of colourism in the process of integration. He states metaphorically that non-Africans prefer a Nigerian who is 'light-skinned or albino, over a Nigerian [*who does not have albinism*]. In his words: '*Even the original black man who is fair from 'Onitsha', then there is white 'Onitsha'. They prefer them* [light-skinned or is albino] *to someone who is typically black…Yes. They can even mistake an albino and like an albino than someone with pigmentation'(Page 21, line 204).*

In explaining the integration process, Efe believes it was for the migrant to learn the ways of life of the new culture and adapt to it. Efe had returned to the UK in her early twenties after her departure at age two for Nigeria. Efe states it is:

"Embracing it but actually without completely changing your own identity. So I am still who I am, and I embrace my identity. I recognise that I am different but actually embracing the same. Other people are different, and those are their values and their culture, and you do things the way it is being done here. I respect them, but I also embrace my own identity" (Page 6, line 310).

Efe struggles to position herself by emphasising and referring to migrants as 'people from another country'. For Efe, integration involves making decisions to learn or not to learn new ways and understanding or appreciating cultural differences. Efe stresses that while it was their responsibility to learn and adapt, maintaining and retaining their culture was their responsibility. Efe states:

'People from another country, yes. They say, "*when you go to Rome, you behave like a Roman". So if you come over here and you don't learn how they do things here, you will struggle. It is a different culture entirely, so you will definitely struggle. So yes, on the part of the migrant, they need to. … There will be certain things that will be acceptable in your culture, in the country that you are coming from, that will not be acceptable here, and you have to learn those things*

(Page 7, line 320).

Efe expresses that it was essential that the migrant actively engage in the integration process but must not completely change their own identity in learning and adapting to the new culture. Efe emphasised:

"Embracing it but actually without completely changing your own identity…. I would never give up my identity. That in itself is discriminating. It is embracing who I am and embracing the differences we all have in all the different cultures" (Page 7, line 314).

Osuyi explains that the migrant's previous education and knowledge of the new environment help shape how the individual integrates into the environment. Osuyi explains that although it is essential, prior knowledge may not be all required.

Osuyi states: "*Yeah, I think because I have had contact with the British kind of education in Nigeria before coming to the UK, I had that kind of experience back in Nigeria. I had contact, I thought I understood how things worked before coming here, but they are different on coming here. Because you see that they are not actually the same way from what you have learnt and from what you see on ground here, they are different, right. Because you just see sort of a few. But you are able because with the education, with development, with the kind of training provided, you are able to get on with your work, you are empowered to integrate into the society, and you get accepted" (Page 10, line 466).*

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Ede explained that the integration process depends on the migrant changing to adapt to the new environment and, to a lesser extent, the dominant group to understand the migrant ways of doing things. According to Ede:

'*You should be able to. If you leave your country and come to somewhere, you need to be able to understand society, understand them and learn to adapt to their way of living. I feel that in order to integrate, yeah… the other people should understand that you yourself are coming from a different background and, number one, you may not be used to their way of thinking or way of life'(Page 8, line 283).*

From the individuals' perspectives, the integration process for the UK registered nurse with Nigerian heritage is not straightforward or linear. The process may be affected by the inherent power relationship in the system and the individual's determination, knowledge, and motivation to integrate despite the opportunity or barriers that may

facilitate or limit integration. The coherent story here and main analytical findings about the three groups of Nigerian nurses are acceptance of the existence of racism, discrimination and the attempt to rationalise the existence of discrimination in society and UK healthcare. The identifiable differences between the three groups of nurses are discussed in greater depth in the discussion section.

5.4: Master Theme 2: Challenges to integration

This master theme is closely linked to master theme one. Participants explain the concept of integration and the impact of discrimination on their feeling or knowledge of integration into the UK and the healthcare service. The participants had differences in their understandings and experiences of integration.

The factors that influenced the responses were individual experiences of multiple migrations, social integration experiences, loyalty issues, level of knowledge, racism, and discrimination experiences. The two superordinate themes from the master theme include experiences of social Integration and discrimination.

5.4.1. Superordinate theme 1: Experiences of Social Integration

The description of individual experiences or views on integration revolves mainly around social integration. It reflects the individual's opinion and experiences of integration, as discussed in the main theme above.

The existing societal structures, government policies, and individual Nigerian nurses' personality preferences may streamline the degree of integration. There is the belief that integration into the clinical practice area, the larger or local society may be shaped by allegiance to the country of birth, participant's gender and life experiences. The coherent story here and main analytical findings about the three groups of Nigerian nurses is that the CRT tenet of the 'concept of ordinariness' of racism, 'interest convergence' and racism as a social construct are dominant factors in the continuity of racial discrimination and inequality in the society. Osato, male and born in Nigeria, stated that integration was a grammatical expression and not wholly achievable. He believes that the system lacks equal opportunity, which makes the realisation of full integration impossible. He emphasised the role of skin pigmentation in fostering racism, discrimination and integration. Osato applies his nursing knowledge to bolster his integration description regarding a black albino over a black man who is non-albino. A

person with albinism may be a black or white man who suffers from a congenital lifelong medical phenotypic condition called albinism. In Albinism, the production of melanin which determines skin colouration is very low or completely absent. The hair colour of Albino depends on the quantity of melanin in their body. A person with albinism may have white or very light blonde hair, and some may have brown or ginger hair. This perspective supports the CRT tenet of race as a social construct. CRT maintains that the concept of race promotes using physical racial features to group people, manipulate and define, structure, and organise relations between dominant and subordinate groups (Ackerman-Barger and Hummel, 2015), and this significantly affects the life chances of non-whites and our social relations are affected directly or indirectly by this racialised social structure (Savas,2017). Osato states:

"*Yes, yes. It is an unachievable phenomenon, as well as equal opportunity. There will be no equal opportunity in the next seven hundred years. More of what should be written on a paper for legality purpose"(Page 22, line 216).*

As stated under Master theme one above, Osato emphasised that the larger white population 'can *even mistake an albino and like an albino more than someone with pigmentation'.* This preference for a black man with less pigmentation proves Osato's discrimination and a pointer to preventing people of colour's full integration into the work environment or the larger society. Osato believes this practice derives from mistrust, prejudice, and knowledge about human existence and interdependence. According to Osato:

''Yes, *yes. I think it is just colour threats. They fail to realise the need for integration. They need to know (pointing to an advert in the Metro newspaper which reads) - 'We are not an Island. We are a Colombian coffee-drinking, American movie watching, Swedish Flat-pack assembling, Korean tablet tapping, Belgian striker supporting, Dutch beer cheers-ing, Tikka Masala Eating, Wonderful Little lump of land in the middle of the seas. We are part of something far, far bigger' (HSBC UK, 2018)" (Page 22, line 208)*

Osaro, also male and born in Nigeria, believes it is a long way to achieve full integration in the UK. Osaro reflects his conception of integration by describing how some minority groups from commonwealth countries were treated during the 70th. NHS anniversary

celebration. He doubts whether Nigerians could integrate fully into the healthcare system as he believes the treatment of Nigerian nurses by the NHS management could be much better. This type of treatment, Osaro reasons, affects the degree to which people feel integrated. He stated:

> *"Two things that I will say, possibly not as well as it could be. I'll give you the 70 years of NHS anniversary celebration as an example. And that's happened recently. Then, what was really done for Nigerians who are here? The answer is nothing. Now they were talking about what is it -- the 'Windrush'?. There was a lot of campaign and things done for that group of people, but what about Africans in the real sense of it?*

Osaro recognises that the willingness of migrant to be a part of the new society is a vital determining factor of integration or non-integration. The central tenet is that migrant nurses care conscientiously and effectively for patients and expect fair and equal treatment to feel integrated into UK healthcare. According to Osaro,

> *Do we want to integrate? We're trying to integrate, but you know, if we work for NHS without causing harm, why couldn't every nation be represented, why can't NHS say take this… and Nigerians we decided to do the 70th anniversary by themselves, which cost every member, everybody that attended to pay 75 pounds, we contributed to honour ourselves, so to speak. And we say, let us walk into NHS England, let us walk into different people if they could support, nothing came from any one of them!". The Prime Minister says, 'well done, Nigeria', just one sentence! What came from them is very difficult to bear, especially when you give, give, give, and there isn't any acknowledgement. You know, we are grateful people, so to speak. I'm grateful for what I've achieved in this country. And but we work, double it in double the time too to get to a level to the level that we are in. We always remain grateful for the United Kingdom. I say, Oh, but are we genuinely integrated? And my answer will be, it could be done better. I think we could be a long way ahead") (Page 14, line 53).*

The views of Osama, who is male and born in Nigeria, oppose the other two males in the study. In part, he admits that society has structures that may not foster integration, but the individual must work to break those structures. Osama believes it is for Nigerian

nurses to convince the larger population about their ability and integration. To be fully integrated, the migrant must package and market their skills and be proactive in the work area and the larger society. According to Osama:

‘’Someone who is not fully integrated still has their different opinions and expressions; they are more with negative thoughts and negative feelings. They are not satisfied; they always complain about society and authorities.

Those structures are there, and we are here to break those structures and make the best out of it. So even though people are discriminating, and some may experience racism, which is integrated in some cultures, let it not be a barrier for us to excel or for us to succeed. Once we have established what we want to do and once we have established that, we have a product to sell. We have sat in our closet, assembled this product and put it together, then take the product and convince the people. Once they use the product, which is you, they will be convinced that what you have to offer is greater than what they would have felt would’ve been available’ (Page 9, line 349).

For Efe, a female born in the UK, she referred to Nigeria as “back home”. Her concept of integration was linked to or shaped by difficulties she experienced settling into the UK on her return from “back home” to the UK. According to Efe:

"I was born here in the sixties, precisely 1966. My parents took us back home to Nigeria in 1968; at the time, I had a younger sister. Then twenty years later, I came back into the country. By this time, I think I was about twenty-two years of age. Integration was difficult because although I was born here, it was difficult for me to relate and integrate straight away. I had some difficulties career-wise. I realised that I actually needed to change careers. … So I didn't feel fulfilled, but because I had been away from the country for so long, when I first came, I had to take menial jobs…” (Page 1, line 8).

Osuyi, a female, believes that the individual must be proactive to integrate but that the larger society could enable the individual’s proactive effort to be fruitful.

‘I would… Say that I am integrated to a certain level. But more could be done. I will say that there are options there within the area where I live, you know, for people

to volunteer or to join groups to make yourself known and acceptable. I believe that it is only by putting yourself forward sometimes that you are, people are able to know you and who you are and what you can do (Page 10, line 466).

In summary, the respondents are willing and understand the relevance or need to integrate into the work and the larger society. They each recognise the presence of barriers or challenges such as colourism and racism, systemic institutional barriers such as NMC, NHS England, to full integration and the role of the migrant and the host society in promoting or preventing integration at the personal and interpersonal levels. The coherent story here and main analytical findings about the three groups of IEN with Nigeria heritage are that integration should be a bi-directional approach by the individuals and a multi-directional effort by the institutions to promote equality and fairness in the society. The findings here confirm that whereas the UK multicultural policies foster absorbency between cultures, they do not protect the boundaries between cultures (Spencer and Rudiger, 2003), and integration is a process with many diverse dimensions.

5.4.2. Superordinate theme 2: Discrimination

This Superordinate theme is shaped by social integration (filial, national affiliation, loyalty to nationality issue), experiences of multiple migrations, racism, overt discrimination and cultural knowledge and discrimination practices in the larger society.

The coherent story here and main analytical findings about the three groups of nurses with Nigerian heritage include that all the participants agree that discrimination was evident in society and the healthcare sector. The participants have dual nationalities, consisting of those born in the UK and Nigeria. The UK-born participants had similar views on discrimination, which differs in interpretation or explanation from the participants born outside of the UK but have all now acquired UK citizenship. The difference in the two groups seems to link with the degree and feeling of filial affiliation and attachment to the UK compared to Nigeria, which all participants referred to as the ‘home’ country. There seems to be an acceptance of learning to manage and deal with the challenges posed by discrimination and discriminatory practices in the workplace

and the larger society. The individual's coping style to this menace is related to experiences of multiple migrations and direct or indirect experiences of discrimination.

Experiences of multiple migrations, reasons for migration and expectations from migrating to a new environment tend to shape the explanation of the participants on how they see the issue of discrimination in the workplace and the larger society.

Osaro is an example of one with experience of multiple migrations. He studied in Bxxxxxxa, where he fell in love with a female Gxxxxn student and moved over to Gxxxxxy on completion of study in Bxxxxxxa. He had to relocate to the UK hurriedly to save his life from a racist death threat. Osaro left Nigeria at about twenty-two years of age on a scholarship to study Structural Engineering in Bxxxxxxa. His mother tongue is Yoruba, one of the three main languages in Nigeria. He studied English up to the Higher National Diploma Level in Nigeria before his sojourn to Bxxxxxxa. To successfully pursue his Structural Engineering programme, he had to learn the Bxxxxxxan language in Bxxxxxxa. His experience of discrimination and racism in Bxxxxxxa made him conclude that racism and prejudice were commonplace in Bxxxxxxa and cannot be compared with the level of racism in the UK. According to Osaro, nationals from African countries were openly referred to as 'Monkeys', and other racist languages were common by his Bxxxxxxan colleagues. Osaro recounts:

'*without, without a shadow of a doubt, for two reasons. And I remember when we went to* Bxxxxxxa*, because we have, like, people call you monkey, openly. And you know, …if you could deal with that…*

''Yes, yes, everybody will have their personal experience, there is no single person that will be a black person... that will not have, that will not have that personal experience'. (Page 10, line 33).

Osaro recounted another episode to explain his experience and the effect of direct discrimination on people.

According to him: '*' but I remember a particular girl whose name is 'MXXXXa ', which is a Muslim name, something like that. MXXXXa , means monkey in the* Bxxxxxxan *language!. Now this lady came, and everybody knew that name within a day. There was 'MXXXXa', 'MXXXXa ', 'MXXXXa ' everywhere she went, and she thought she was popular. And she came to the students' village. She said, 'this country,' they can*

pronounce my name everywhere … and they are very good. They are very friendly. They are very good in this part of the world', but she had no idea!
One of the Nigerians said, 'yes, because you don't know the meaning of your name in Bxxxxxxa*. Your name is monkey. What they are, what they had the licence to do is calling you monkey without you being affected'!.*

That was it; the girl was in tears and before sharing it in her diary. She was from a very comfortable home, very well to do family, she was taken away, she didn't last a month. She went back to Nigeria; that was how bad it was"(Page 12, line 39).

Osaro further recounted his personal experience with his Gxxxxn student girlfriend to drive home his first-hand experience of direct discrimination and racism and how this prepared him for integration into the UK. The Gxxxxn girlfriend had a prejudiced view that Osaro had a tail like a monkey because he is African. Osaro recounts:

''You want to belong, but let me give you a quick example where I was told 'monkey, where is your tail'? Yeah, they think, yeah. …
That was a question from a Gxxxxn girlfriend. Well, dear friend, yeah. You know, you 'Where's your tail? Because they didn't know. And then, at times, there is in the attempts they don't think actually before saying this thing, I laughed. 'I said, you see, my tail is not bad, it is in the front'. Yeah. Sorry for the joke. Yeah. At another time, I had to show her my backside to see that there was no surgery to remove a tail!''
But you know that this is how they perceive us. And I then said, 'when your president, I said, 'do you remember when the President of Bxxxxxxa *went to Nigeria on his visit? I said, Do you know where your president slept, slept? She says, where? I say they had to take, you know, monkeys sleep on trees, and they had to help your president climb the tree and stay there!. Those were the kind of jokes that they are not happy about; they will frown! But gradually, it does because when if you have gone through that and somebody at that stage and age and I remember being in the bus and this very young child came to me; he was rubbing my hands thinking that I have not bathed and that is why I look dark, to see whether there was dirt that keeps me the colour that I am. I had to explain because he was a young child, as you know, there's black, there's white, and then I am black. It is not that I bathe every day, possibly more than your parents, but they are white, and I am black. And again, I don't think they are*

innocent. And because there have been loads of foreigners who have gone to all these countries to study, which they don't want to accept and the funniest thing is the girl; we were together for seven years, we were more or less like husband and wife really. I mean, even when I was here [London], she came, and she stayed with me for some time. But one thing is when the parents discovered, and so that was the reason I came here, to be frank, discovered that I finish my education now. I should be good to go back. The impression was that I will go back to Africa and leave their daughter. They knew of our relationship; they will visit when I was in Bxxxxxxa *. I was looking after them. During that period, they would stay with us in our apartment., but the moment we finish, and I was not going, and I went to Gxxxxxy with her, the father came to me and put a gun on my head.*

…my head. Oh, he says, 'leave my daughter, next time 'boom'!. And I, you know, the only job I've ever done as an engineer was in Gxxxxxy for six months with Txxy Wxxxxxw. And he went to where I was working to tell them if I don't leave her daughter alone that he will kill me. And that was it, and that was the time that I decided because when a Gxxxxn says he will do something, he will surely do something wrong. And that was how I came to the United Kingdom because I was afraid for my life''(Page 18, 19 line 72,75)

The experiences of Osaro in Bxxxxxxa and Gxxxxxy may be extreme compared to his experiences in the UK. However, Osaro does not support discrimination but prefers overt discrimination over covert discrimination that pervades the UK society and healthcare settings. According to Osaro, '*No, it is not as bad as it was there, I mean it's not hopefully, it's I would call it covert discrimination which happens and at times, and I think that is where we are all different as individuals, I like people to be openly rigid towards me than to be covert to do it. And that is very common in the United Kingdom in my view'*. *(Page 13, line 45).*

The coherent trend and main analytical findings about the three groups of IEN with Nigeria heritage indicate that discrimination experienced by the nurses in the UK healthcare services is manifest in a range of discriminatory practices such as prejudice, double standard, and patronising statements displayed in assessing the quality of work of the nurses during the period of supervised practice or adaptation, appraisals from managers, lack of support and cooperation by professional colleagues in the clinical

area. Ehi recounted a case of prejudice and double standard where the patients' preferred her white nurse colleague to black nurses despite the perceived shortcomings of those white nurses:

''I remember, there was a lady. She was supposed to be a Lady, a titled person. She would say that she doesn't want us [black nurses]. The nurse that she was accepting was into drugs. They were all trying to get her [the white nurse] out. Yes. She was white, and her dressing was like a punk. Some patients would even complain as they were scared of her coming in. But they never reported her [the white nurse]. She [the white nurse] would tell them that I [EHI] am a very good nurse, and I [EHI] dress better than her [the white nurse]. She [the white nurse] would come back to base, and she would tell me that she didn't know what was wrong. That we [black nurses] dress more than her [the white nurse]. You will see her [the white nurse] with her dirty boots and whatnot" (Page 2, line 89).

There were also reports of discrimination by patients, primarily community-based patients. Of particular note was that some discriminatory patients against black community nurses were prominent political figures. The involvement of political figures in this discriminatory practice was disconcerting to the nurses. Ehi recalls the discriminatory practices she experienced working as a community nurse in a part of London:

" We [black nurses] all met with some resistance from some of the patients. Then, over there, it is a political seat. So you have a lot of political people there. You would go in without knowing whom you are seeing. You are very sceptical about what you are doing and whether you are safe there. You would see some top politicians there like [Exxxh Pxxxxl] on our caseload. He was on our caseload, so even me going…." (Page 3, line 102).

The black nurses refused assignment to provide services to some important past political figures because of the prejudice against the nurses. The nurses' action was informed by the antecedents of some of the politicians during their active years in politics on issues regards Black and Minority Ethnic Groups. Ehi refused her allocation to the influential retired politician as she believed this patient's discriminatory attitudes would not have promoted good clinical practice and social integration.

She stated:

"When they allocated me, I said no! I was not going there. So they asked the white girl to go. I couldn't go because somebody who has openly said he doesn't want black people, why would I go to him? Whatever assessment I do there, it would not be accepted because we could have worked there in partnership. So it wasn't there. So, I don't think there was good integration like you were saying between us- the patients and the nurses there. Because, if they don't accept us, as a colleague, how would we work together there?'' (Page 3, line 107).

The practice of discrimination in the clinical environment was between white nurses/patients and nurses/patients of colour. The nationalism and discrimination prevalent among some nursing staff may impact service delivery and prevent integration in the clinical environment. According to Ede:

''So they are not integrated, but they are together. No matter what. If you go to a ward where there are mostly Filipino nurses, you will feel like you are lost there. Nobody is helping you. If you are asking a question, they might even laugh at you. So the Filipinos would all go to one side. If there were white people, they would be together. Everybody… the impression is that everybody is kind of covering their own, but Africans would kind of… Africans would try to join the other groups if they are new which would make them feel really isolated, which is sad. Nobody would take them under their wing. I am not saying anybody should do country by country. People should just take you under their wing, but this is what happens literally. People will just stick together, and sometimes I just wish I was Filipino as I knew I would be more successful than I felt that I was. If I were English, I would not have had that issue. Then come to the Africans, you … once they hear that you are Nigerian, the Ghanaians don't like you, the other African country doesn't like you. You know it was just so hard to be a Nigerian nurse, to be honest''(Page 3, line 102).

Although all the participants in this study have dual British and Nigerian citizenship, the coherent story in this theme and main analytical findings about the three groups of Nigerian nurses is that nurses born British were hesitant to discuss discrimination issues. They preferred to discuss how they dealt with issues of prejudice rather than how they felt or perceived the actions done by the perpetrators. They gave examples of

Nigerian nurses' behaviours or practices, which seemed to justify prejudiced behaviours from patients or colleagues, at least in their eyes.

In discussing the issue of prejudice, Ese stated:

''Sometimes, when you work with elderly people, they try to make it seem like they cannot understand you at all, and they will make you feel like you are not speaking English. It is, but because of their own prejudice, they want you to feel little. I didn't let that actually stop me, but I would make myself as clear as possible. Because I have worked with different people, even people from Nigerian heritage and we still up until now have that challenge where they're talking to you, and it's as if they're fighting, they are loud, and people will misconstrue that for a lot of aggression or a lot of that''(Page 16, line 629).

In discussing how she managed issues of patient prejudice, Ese indicates the importance of resilience and staying focused by making an effort to communicate with patients 'as clear as possible'. Ese distinguishes her communication style as British-born compared to nurses born in Nigeria. She seems to lend credence that elderly patients may be justified in their prejudice because of the communication style of the nurses born in Nigeria.

Efe, another British Nigerian, did not interpret her having to work twice as hard as her colleagues as discrimination. She saw it as a way to prove her worth but did not discuss why she needed to prove her worth. Efe stated:

''At the time, it was before the agenda for change, so I started as a grade D qualified. Then in my third year, I was promoted to a Grade E, but I felt that I had to work hard to prove my worth, so to speak. Because at the time, when I first qualified, during the day, I would say I was the only black nurse in that ward. But I think because of my work ethic and my can-do attitude, they embraced me. I wouldn't say I suffered any discrimination due to my skin colour on that particular ward. But I did feel like I had to work hard to gain their respect and the confidence they gave me. I had to work really hard and double to prove that worth''(Page 1, line 34).

Efe explained her need to work 'really hard and double to prove that worth' as a valued ability rather than discrimination resulting from racism. This preference may be linked to

her being British-born rather than Nigeria born. Therefore, Efe sees herself as British and needs to integrate wholly into British society as her home country.

In the quote below, Efe gave her lived experience of organisational or institutional racism and discrimination. Although Efe believes in research evidence of bias in healthcare settings, she claims she has not suffered discrimination. Yet, she postulates that discrimination within the healthcare system may be covert and subconscious, not direct or overt bias. According to her:

"I am going to say that collectively. …The evidence is there through research, and undoubtedly we do see evidence that there is a ceiling for ethnic minority" (Page 7, line 339).

The coherent story here and main analytical findings about the three groups of Nigerian nurses is that the organisational practice recounted by Efe is similar to the experience of a number of the other participants. This corporate practice is evident in the understanding of Osaro, who describes this institutional practice as the 'Guinness effect' in UK healthcare institutions and gives examples of the absence of equal opportunities in access to the funding training programmes as a discriminatory practice that contributes to promoting the concept. It is not the absence of policy in organisations to promote equal opportunity among the staff. Still, some managers' discretionary discriminatory interpretation and application of the guidelines continue to perpetuate the inequity.

According to Osaro:

"*…, I don't know whether you, you, must have heard what they call 'Guinness effect' I can talk about mental health nursing education; in mental health, the majority of people going into mental health in any year is majorly of ethnic background, black. Despite that, when you look from band 8A and above, in any organisation, in most cases, I find myself as the only black face; even when I was in band 8A, I found myself as the only black sitting with the senior management team.*

And that has been my experience all along."

Now, if the population of staff going into Mental Health training in percentage is over 80% and are of ethnic minority, why do we actually have few in management; if at all not because they don't know; and training, we are not integrated in training. We are

not given the equal opportunity. I know of a colleague of mine recently who was given twenty-three thousand pounds to do one programme without contributing to it. When I did my MBA, I contributed 50% of thirteen and half thousand pounds. I contributed half of it to do MBA, but for another colleague, he was given one hundred percent; yes, …?" (Page 15, line 55).

Osato, emphasise that discrimination is not simply a case of the white race against people of colour. He explains that senior managers use it sophisticatedly during restructuring by influencing managers of colour to discriminate against other people of colour. He gave examples of how this is used in restructuring roles and positions to remove people of colour from senior positions. Often, white senior managers also restructure the amenable tool (manager). According to Osato:

'… the internal system was a corporate kind of witch-hunting to get rid of black people at 'HHHHHHHHH' (hospital) then because it was a case of starting from anyone who was band 8, you are coming to band seven and going to downgrade your job. The director of nursing then, one 'sxxxxd' Gxxnxxxxn woman, who thought she was doing a good job, succeeded in getting rid of all the community band eight and senior nurses for them, only for them to then fire her and get rid of her!... Including the director of nursing. When they finished with band 8, then they advertised for a director of nursing for both 'HHHH' Hospital and primary care, and they went, and they gave the position to a junior person who was white' [page 10, line 86].

In summary, the respondents are aware of, have experience, and are ready to discuss discrimination in the system. The coherent story here and main analytical findings about the three groups of Nigerian nurses are that discrimination was systematic and institutional and that the prevalence of different variants of discrimination was a major driving force in affecting the integration of migrant nurses in UK healthcare and the larger society.

5.5.: Master Theme 3: Personal and Social Integration

This master theme derives from three superordinate themes. It describes the relationships between successful integration into work and personal and social lives for these nurses. The findings are presented thematically under each of the themes developed from participants' experiences, including the degree of belonging to the diaspora communities in the UK, the existing contrast of nationality and ethnic identity, and the individual's social relationship in the clinical environment and the larger society. It also stems from the individual lived experience or interpretation of integration, political development in the UK and the healthcare environment, socio-economic development in the home county, and the importance of pensions and retirement from service. The logical and consistent story of this master theme and main analytical findings about the three groups of Nigerian nurses is that immigration and nationality issues and social connections; one of the discrete domains of integration identified in Ager and Strang's (2008) framework, is influenced by the degree of social bridges, social bonds and social links that are available and utilised by the participant.

5.5.1: Immigration issues

Immigration and nationality, economic and social issues are significant factors affecting the integration or non -integration of the nurses in the healthcare settings and the larger society.

Many nurses in this study express that they are seen as foreign nurses in healthcare settings, which they believe negatively affects their social integration in society and the healthcare setting. They think that the issues affecting their integration are the issues of colourism. This view surmises as 'colour before perception; sight before sound' irrespective of some of the nurses being born British and, with time, the others acquiring British citizenship. In contrast with the prejudicial perspectives that several Nigerian nurses were trained in Nigeria and recruited by recruitment agencies directly from Nigeria, eight of the ten participants in this study resided in the UK under varying circumstances and motives before becoming UK NMC registered nurses. Only two respondents came directly to the UK to become UK NMC registered nurses.

How a person feels about their lived experience may be influenced by immigration and nationality issues. Immigration and nationality are complex, sensitive, and political,

driven by national laws, policies, and regulations. These laws, policies and guidelines confer some advantages to some migrants especially returning migrants. They may affect the degree to which the individual interprets their integration into society.

Efe states: *"I didn't have any challenge in terms of finding a job because I came back to the country with a British passport. … when we went back to Nigeria, we were in on my mother's passport to travel to Nigeria. To come into England, I came with a British passport. So, I never had immigration problem, but even still, it was a different culture entirely" (Page 2, line 71).*

Osaro qualified as a structural engineer from University in Hungary and had six months of working experience in a top engineering firm in Gxxxxxy. Osaro fled to the UK from Gxxxxxy to escape the threat to his life and had to apply for political asylum in the UK.

According to Osaro, *"That is, when I came to the country, You know, I applied for political asylum straight away so that I don't have to be running around". (Page 8, line 17).*

Ehi came to the UK as a visitor. She was already qualified and employed as a registered nurse in Nigeria. Before embarking on the Adaptation programme, she worked as Health Care Assistant (HCA) to become registered in the UK. According to Ehi, **"***No. I did not even do my nursing here. So, when I came over as a visitor to the UK in 1988, I started working as an HCA and… Yes. It was quite challenging a bit, but for them not knowing my background, I could see them saying, "oh, she is quite good in her work," without them knowing that I was actually qualified to do the work. I was doing it as an agency and they would book me more shifts because I was good at that work. But immediately after that I did my adaptation, it was during my adaptation that I started facing challenges" (Page 1, line 15).*

Ehi's working as an agency HCA was acceptable without any challenge until she formally integrated as a Supervised Practice (Adaptation) programme nurse student into the clinical environment. This lived experience demonstrates the role of structural barriers in the healthcare system in integrating these nurses with Nigerian heritage.

Osato represents nurses who came to the UK on a study programme but stayed back to register and practice in the UK. Osato's reason for coming to the UK informs the importance of considering the different reasons for migrant nurses coming to the UK. It

also underscores the importance of considering this in planning pre-integration programmes.

According to Osato,

"I came to the UK in the first place from the Transocean drilling, which was the last thing they brought before I left Nigeria on a study sent by the drilling company because they needed me in the industry to upgrade in accident and emergency nursing. Upon completion of the course in the UK, that is when I thought I should get experience in work in the western world. And that was when I got a work permit to work at a nursing home where I was in charge of night duties in elderly care and nursing home to gain experience. And because of the work pattern which was quite different from what I was used to, independent nursing in Nigeria, I decided to work in the NHS at the Cxxxxxl Mxxxxxxxx hospital after two years" (Page 4, line 31).

Osuyi represents the typical overseas nurse recruited by recruitment agencies to work in the UK (Likupe,2008). Some internationally recruited nurses are senior nurses, experienced and often among the privileged middle-class nurses. The decision to come to the UK underlies the importance of considering nurses' fundamental rights and their rights to choose where they want to work and live.

According to Osuyi, *"I had qualified as a nurse and midwife, and as Nurse tutor, in Nigeria and in the year 2000 I decided to come to the UK to work, and in that situation, I had to go through the Nursing and Midwifery council to know how much time I will need to do what is called then the Adaptation programme. So, in 2001, I started the three months adaptation programme with an agency which came to recruit us in Nigeria, and I started off with the academic bit at Sheffield, and I needed some hours to do the clinical aspect of the programme, so I was taken down to the South West of England, Torquay, Devon to do the practical placement of the clinical part of the programme, you know, for the clinical, which I did for three months and thereafter I was admitted onto the register of the Nursing and Midwifery Council as a registered nurse" . (Page 1, line 12).*

Osuyi stated that the recruitment agency applied for their student visa to the UK after passing an English language and mathematics test. However, the nurse had to pay the visa fee, which was quite substantial. This recruitment confirms the existence of sharp practices by private recruitment agencies that disregard the government policy of no

recruitment from the countries the UK government does not have a formal agreement to recruit registered nurses to the UK (DH, 2001).

According to Osuyi, "*I think the visa was, I think it was something like students, adaptation nurse Visa; something like that. Not much challenge. Because the agency was able to, I think that was that arrangement between the agency and the home office, as well as placement area, where we all have clinical. …So that was it. So, when it was not that difficult once you have passed the test, paid the amount and then yeah, yeah, you have been put forward. I think that was it" (Page 1, line 34).*

It follows from Osuyi's account that her coming to the UK was a rational decision. Her experience of navigating the legal barrier to integration was not much of a challenge. This experience may motivate her to integrate into UK healthcare to fulfil her desire.

Overall, it is expedient that the nurses in this study had various immigration challenges resolved differently. The nurses' experience included those who arrived in the UK with British Passports because they were born British, those who came as nurse students, and those who transited from visits to become registered nurses.

5.5.2: Social, Language and Cultural Currency

The data under this superordinate theme describes the expression of an individual's identity, belonging and relationship to the diaspora communities, the social connection that the nurse had and developed upon arrival and economic and social issues which serve as the driver for the individual respondent. The logical and consistent story of this subtheme and analytical findings about the three groups of IEN with Nigeria heritage is that social connection, which is one of the discrete domains of integration identified in Ager and Strang's (2008) framework, is influenced by the versatility of the individual's social currency, language and cultural currency and connection in the new environment and its contribution to a society shaped by the degree of social bridges, social bonds and social links that are available and utilised by participants.

From Efe's experience, the social connection and cultural practice and expectation of the younger ones to be cared for by older siblings may have informed Efe's parents' expectation to seek out an adult to help shape their lived experience in the course of integration to a new society. The unpleasant experience of Efe may have fostered her determination to learn and work her way to integrate into society quicker.

Efe, who returned to the UK as a British citizen, stated: "*Housing was very difficult. It was extremely difficult, actually… So, the person that owned the accommodation, we never knew that person. He had put it in charge of a cousin. It was the friend of the friend of the person who owned the accommodation that we knew from Nigeria. She comes over here; she stays about six months, then comes home. It was this person that we knew, and our parents wanted us to stay with them because they felt that they were not here, but at least there was an adult who would keep an eye on us. But you know we stayed there, but this person taking the rent from us was not paying the council. That went on for about three years, well over two years" (Page 2, line 86).*

In the case of Osaro, who had to apply for political asylum in the UK, his experience was a struggle that prepared him to face the challenges later on in life in the nursing career and living in the UK.

The experience of Osaro during his visits was drastically different from his experience when he finally came to settle in the UK. The challenging experience of having to fend for himself to survive and the presence of a family here in the UK may have reinforced his determination to work harder to succeed and become integrated into society.

"*Okay, because since I was a student in Bxxxxxxa, I've been coming to the UK on a yearly basis to family friends. Now when I came, finally, I went to stay with them until I started a job, then I rented my own, but it was tough, and for many people, and in terms of I remember the first house that I rented, the cockroaches that were inside the place; It was not maintained…That's why Yes, yes, it was because I couldn't afford the flat, you know to afford the flat. I had to stay in one room. And I couldn't continue after a while. I moved to another when there I didn't have a bed. I had an inflatable mattress that would go down by the time I wake up in the morning, and that we thank God. It was tough…" (Page 9, line 21).*

Osaro describes his experiences further:

"I think there were two things that impacted on me, …And you see that, for example, most of the people who came from abroad and are on low paid jobs, they've taken some money to come here. And to go back is not an option" (Page 9, line 27).

The lived experience of the respondents strengthens the relevance of an individual's identity, belonging and relationship to the diaspora communities, the social connection that the nurse had and developed upon arrival, and economics. It emphasises the relevance of ability and determination in adapting to unexpected life changes, determination and resilience to survive and thrive in any new environment and integration into contemporary society.

5.5.3: Pension issues

The response to plans regarding pension and plans to continue living in the UK or leave the UK on retirement influenced this subtheme. The response of the respondent was affected by the awareness of development in the home country, individual's opinion and explication of Integration in the UK, political development in the UK and the individual plans for pension and retirement.

Osato stated that he does not intend to remain in the UK once he stops working. Osato had indicated that integration was a 'farce'. He plans to return to his home country but reflected that his travel or stay in the UK has been worthwhile.
According to Osato: "*Yes, I have thought about that several times. The day I stopped working for the NHS was when I decided that if I can work for as long as I can, next four, five years if I am able to sell my house, get my pension, establish one thing or another if possible if I can afford it. If not, I will just live on my pension" (Page 22, line 201).*

On his overall sojourn to the UK, Osato reflected that:

"*There are pluses, and there are regrets as well. So far, so good. I think the pluses outweigh the regrets. I achieved my educational and professional purpose, and at least I did my best to get to the highest I could, even with those trials and tribulations. Up till now, I cannot say I failed because I have achieved most things I wanted to achieve in life. If I had stayed at home, my life would have been in another direction, looking at the people I left at home. They have survived. Some of them are better off, and some are worse off. What mine would have been? I can't tell you. But I am happy I took the decision to come here, and I achieved what I wanted to achieve." (Page 23, line 218).*

The plan for retirement for Osato is not surprising considering the initial reason for his coming to the UK, his decision to stay and his view that integration was a farce and unachievable phenomenon. The plans for retirement for a number of the participants was not clear-cut. The plan included working part-time in the healthcare setting or returning to Nigeria to use the experiences gained in the UK to provide healthcare-based services to the Nigerian society.

For example, Osuyi stated that: *"I am looking into, into all the options out there, maybe will work a few days in a week, you know, may take my retirement, work a few days. And reduce the number of days I work. Working from home is another option that I'm looking at, and being able to use some of the experiences that I have gained here abroad, and giving something back there to the Nigerian society, where I am able to do so those are the plans I have for my retirement" (Page 10, line 453).*

The above may suggest that the respondents' degree or dimension of integration into the UK society may be a driving force in their decision regarding their retirement plans. The individual's retirement preference may have influenced the degree of their effort to integrate into the local society.

5.6: Master Theme 4: Career Progression

This master theme is about the lived experiences of nurses with Nigerian heritage career progression on integration into UK healthcare services following registration with the Nursing and Midwifery Council (NMC). It explains the steps and factors they believed contributed to their career progression in the UK healthcare service. Three subthemes are derived from the analysis: education, mentorship/coach and personal characteristics or behavioural preferences. I will now discuss the lived experience of

integrating UK registered nurses with Nigerian heritage into UK healthcare. The logical and consistent story of this theme and analytical findings about the three groups of IENs with Nigerian heritage is that career progression in employment and education are significant components of the discrete domain markers and means of integration.

5.6.1: Education

All the participants, including the ones born in the UK to Nigerian parents, had primary, secondary and tertiary education in Nigeria. The participants had their primary, secondary, nursing and university education in English but can speak and understand a Nigerian language they agree is their mother tongue. The respondents, including the British-born, believe their education in Nigeria prepared them for survival and success in the UK. The respondents equate having qualifications and certificates from educational institutions as keys to career advancement and promotion. They believed in the importance of securing a higher education certificate to position them for promotion when the time arises.

According to Osaro: "*And I did my primary, secondary and tertiary institution to a level back in Nigeria. And I was a teacher for a couple of years before travelling to Bxxxxxxa, where I did a master's degree in civil engineering, I came to the United Kingdom in 1991*" *(Page 2, line 3)*.

Osuyi was a qualified registered nurse, midwife, and Nurse tutor in Nigeria. She decided in 2000 to come to the UK to work, and "*in that situation, I had to go through the Nursing and Midwifery Council to know how much time I will need to do what is called then the Adaptation programme" (Page 1, line 13)*.

Osama had a second-class honours upper degree in Accounting from a University in Nigeria. He came to the UK in furtherance of his accounting career. In his words: "*I came to the UK in 1998, and I had come to further my studies in accounting. Yeah, I think I came to do my ACCA. So, when I came subsequently, my father became quite ill, and the tensions of the school fees and everything became a challenge, so I started, but I couldn't pursue that pathway of career*" *(Page 2, line 50)*.

Ede had a degree in English in Nigeria before transitioning to the UK. Ede did not see her ability to communicate in English as a problem. She says: "*In those days, there were few private schools. So, you had some excellent private schools. So, my primary education was good. My secondary was equally good. Then I attended the University of Nigeria as well. I read English, so in a way, maybe because I had that background, coming into the UK, at least I have no problem with the language." (Page 1, line 27).*

Before becoming nurses, they all had some educational background or had higher degrees relatively quickly on their qualifications. They embrace the availability of continuing professional development and training in UK healthcare to achieve higher degrees because they believe this contributes to career progression.

There were some obstacles or barriers, such as refusal by management to grant them study leave and support with funding for the courses. Many nurses overcame such barriers by sheer determination to succeed and personal sacrifices. They used their days off duty and money to sponsor their education or training. In the discussion section, I will explore the effect of these experiences and how they may have promoted or hindered the integration of nurses in UK healthcare.

For example, Osaro, currently an Assistant Director, states: "*I know of a colleague of mine recently who was given twenty-three thousand pounds to do one programme without contributing to it. When I did my MBA, I contributed 50% of thirteen and half thousand. I contributed half of it to do an MBA, but for another colleague he was given one hundred percent; yes, then as much as I say 'yes', I'm grateful for the half, which is the normal policy, that when the person was telling me oh, they paid for the whole thing, I challenged it" (Page 15, line 56).*

Previous educational background served as a building block for career progression for Osuyi. According to her*:*

"It's been ups and downs regarding negotiating career progression. But one thing that worked in my favour was the fact that looking at my qualification from Nigeria and my experience of teaching, so the first manager saw that even though I expressed to work in another part of that particular NHS, he showed interest in me because of my background in supporting learning in practice, you know, so, he explained that to me, and I was happy to go on to his ward, on to this specialist area, which was continuing health care and it was from there that he explained to me how I could use, transfer my, you know, transfer my experience of being a teacher, back in Nigeria, in this environment,…." (Page 3, line 122).

Osama is currently rounding up his PhD programme. His determination to be self-actualised and be the best in his profession was a driver for him. Using his educational certificate from Nigeria, he secured admission to study nursing.

In his words: "*There was a huge shortage of nurses in the NHS. So, I said to myself that I should take advantage of this and try this new area of profession and see how I can develop myself. So, in 2001, I decided to enrol in… you know, I brought in all of my qualifications in Nigeria, and I was accepted in 'Mxxxxxxxx' University to do my HE Diploma, nursing training in 2001". (Page 2, line 61).*

Osama qualified as a registered nurse in the UK and has changed his career from accounting. He worked for a year as an Adult Registered Nurse, switched to training as a Midwife, practised, and completed his Master's degree. He was refused support to pursue his Master's degree despite his offer to use his finance and private time. He resigned and went to another organisation that gave him the opportunity. Currently, he is studying for his PhD.

Osama explains his tale of determination, belief and commitment to surmount the challenge:

"I practised for about a year or a year plus; then I moved forward to do midwifery. So, I then resigned and moved on to midwifery to sort of have a broader experience within the care setting. So, I completed my pre-registration… post-registration, that is, the midwifery one for eighteen-month training… And then, I practised for about a year to two years plus. Then, I wanted to do my masters… just sort of actualising in what I am doing…. Still, the unfortunate thing was that when I went, I applied to 'Hxxxxxxn' to maybe give me some support or time off to do my masters in 'Mxxxxxxx' as well; they sort of said that I wasn't qualified for that. So, I said to them, "why wouldn't I be given that support?" So, after negotiations, it wasn't forthcoming, so I decided that even though funding was private and personally funded, and they even refused to give me time off, I sought a different care setting…. And then, just to bring in all these and integrate them into a strong and purposeful and bring meaning into my profession, I pursued all these in a PHD course, a program where I am almost rounding up now. You see that this is sort of a summary of my journey". (Page 3, line 86).

In addition to the individual commitment to study and effort to overcome the challenges, availability, knowledge and choice of career pathway was a way the nurses used to attain higher professional grades. A number of the nurses progressed to take up a

position in areas where there were nurse shortages, such as Care of the elderly, health Visiting, District Nursing, practice education and Forensics.

The nurses reported finding the UK's educational method/learning style different from the usual method within Nigeria. They made a conscious and concerted effort to adapt to the new way of learning. They had obstacles in the system because some Lecturers were prejudiced against their ability and the quality of their work without considering their previous educational background.

For example, Osaro states: *"But at the same time you have people with Degrees and Masters, who are, they pass easily. …I remember personally when I did the drug calculation when I was doing my training, and my lecturer felt, you know, 'how could you, you must have seen this paper somewhere, you know, and as an engineer, I should do better.*

As an engineer, …in my own case, I'm an engineer; I deal with figures then, is different, …you know, you can't do those courses without knowing what you are doing." *(Page 1, line 13).*

Ede, who had a degree in the English Language before her nurse training, recounted her experiences: "*So when I went into school, I was a bit frustrated because sometimes you write essays and you feel that you should get more, but you don't really get more. And once I went to my personal tutor to say that I was really… I didn't complain about the mark; I just explained that I really worked, and I expected more… to get an 'A'. But she was like that 'I should be satisfied with what I had, and I do not need to get an 'A' really, it is not a big deal'. But I said to her, "it is a big deal to me. I aim to be the best, so I want to get the best". You see, that's another thing. Whether it is a cultural issue in because you do not have… people just perceive that you should… sometimes when you write your essay, they feel like you didn't write it yourself because it is of a high standard. That is the impression I get. It is of a high standard, but they feel that you probably didn't write it yourself, so you do not need that many marks. … So you start to get it even from the universities. You feel that if you were of a different colour, maybe you would have placed higher. But the good thing was, I still came out with a First Class. So, I was glad, and I proved to myself and to them that I could do it" (Page2, line 51).*

A number of the nurses believed that there were insurmountable obstacles for them to get promotions in particular clinical areas readily. The solution to this challenge was to

pursue higher education or specialised training to better position themselves for advancement.

According to Ehi: *"No. I don't think so. Like becoming a District Nurse now and becoming Band 7, I knew I would never get a promotion to get there. I knew I had to do the training. When we came, our qualification was regarded as level 1, and we needed to do modules to bring it to level 2". ..RGN. Just having RGN qualification without a degree backing it. Even if you had a degree back home, it was still not recognised here. So, all of our RGN qualification from Nigeria is regarded as Level one" (Page 5, line 230).*

This subtheme explains that all participants believe having higher education and training was a surer way to career progression. All participants also had a higher level of education in Nigeria before proceeding to the UK to work or train as registered nurses. The lived experience of education was partly a reflection of their experiences in the broader community on issues of prejudice and discrimination. The lecturers in their education programme in the UK may not have cognisance of the nurses' previous experience and educational background in Nigeria. This lack of awareness or acknowledgement advanced by prejudice may have caused the general disbelief or suspicion of these nurses' high level of academic performance in UK tertiary institutions.

5.6.2: Access to Mentorship/Coaching

This superordinate theme describes the experience of the importance of mentorship and access to coaching in helping the nurse in their career progression and managing conflicts in the clinical environment. The background on the relevance and how to gain access to and use mentors' knowledge and guidance contributed to the nurses' ability to advance and navigate the obstacles in their career pathways. All the nurses did not have access to coaching, as many only discussed the role of a mentor in their career progression. However, awareness and access to a coach rather than a mentor widened Osaro's reflection and horizon of understanding and opened the door for his advancement to a higher grade.

Osaro explains how he had spent years in the same grade mentoring junior nurses, only for these junior nurses to become senior to him.

Osaro states: "*And I saw that very early in my job that most of the people I trained are favoured. And then realise irrespective of how highly people think of me in terms of my*

job, I discovered that those people I was training and that came shortly after me, will be recruited and, you know, going above me". (Page 3, line 4).

According to Osaro, he had come to understand the three levels of knowledge that was relevant to his career progression. The three levels of knowledge were ['normal' intelligence, i.e. intelligent quotient (IQ), Emotional Intelligence (EQ) and Political intelligence] Osaro states:

"*I strongly believe that knowledge [education] helps people of an ethnic minority to a certain level, and that same knowledge is what stops some of this ethnic minority from moving forward and to some degree, and I always categorise this into three perspectives that we may have a … I am…. Is…. (interruption)… I am sorry about that. I was talking about three levels of intelligence, and one is the normal intelligence (i.e. intelligence quotient; I.Q) [education] And people with that will go as far as where that level of education will take them, with today and quickly because they know what they're doing, the modus operandi procedures they need to follow. And in most cases, you see the majority of people from an ethnic minority, myself included, became an 'H' grade just over six years of post-qualification. But after that, I agreed, it was more or less stagnant for a very long period" (Page 1, line 4).*

Osaro's moment of eureka came when he had a period of self-reflection. Osaro states: "Wh*at is it? And I started looking at myself first. What am I doing? That puts me in this same position. I was a service manager for nearly 15 years. And before becoming an Assistant Director, and some of the people that I trained, that I managed, and some of them are Director of nursing, some of them Director of services all around, then I realised then that the culture, the way people were in the society is keeping quiet, not saying much, and do what you are told, which didn't resonate with me that much. After a discussion with one of the senior managers within the trust, I decided to go outside my organisation to see this person and to seek his views, and he's a coach. And he made me realise that as long as I continue the way I was describing, it will be very difficult actually to move up. (Page 3, line 7).'*

This self-reflection facilitated by a coach provided the avenue for Osaro to reflect on and reshape his conflict-handling mode or style. Before accessing a coach, he was more comfortable using a direct approach to confront and discuss issues. As a result of his

access and consultation with a Coach, he understood and learned to change to engage his negotiating, compromising and collaborating conflict-handling mode more than his previous use of open, confronting, and competing approaches to handling issues.

Efe had a personal mentor, a medical consultant, who helped her set her career goals. According to Efe: "*Prior to qualifying, I had a mentor who was also a Nigerian but an Anaesthetic Consultant who was always challenging me and would set me a five-year goal. So, by the time I qualified as a nurse, I had a five-year goal to be able to go into health visiting or district nursing" (Page 1, line 44).*

A more fundamental experience that helped Efe was her resolve to learn the culture of the predominant population and speak with less accent. The decision and effort to "…*integrate myself into the English culture did pay off and pave the way. It did".* Efe explains:

"I think that if I had gone into nursing as soon as I came into the country, I would have struggled. I think the going to work for a few years in an environment where it was predominantly white people helped me to learn and listen. So, by the time I actually got into nursing, which was a few good years, this was 1988 I came to the country, and I did not start until 1997, so that is about nine years. So that is plenty of years to have learnt how they speak, how they listen.

And I have been able to show that I use all that because now, as a manager, I am managing people from different cultures, and certain behaviours were not acceptable at work. So, I learnt all that in that nine years. It was a good learning curve. So, by the time I went into University, I could understand what was said, and it didn't have an impact". (Page 6, line 266).

Ese discussed the importance of sponsorship and mentorship in career progression. She believes that it is necessary to understand and clarify career pathways, make oneself visible, and get the right help to achieve your desire for career progression. According to Ese

"I *think again; I don't want to sound like a broken record; it is knowing what you want and finding the people to help you to get to where you want to get to and making yourself accessible… So anyway, going back to what we were talking about, she saw*

that potential in me; I didn't shy away from the fact that I could do it, though it took a bit of prompting, me knowing what I wanted to do. She was the one that kept telling me that I could do this at a higher level, and I thought when the time comes" (page 17, line 678)

Ese's access to a mentor helped her learn the necessary skills to navigate and make herself accessible and available when opportunities became available for promotion to higher positions.

5.6.3: Personal Characteristics

All the participants agreed in different ways that the individual's characteristics concerning professional practice have a lot to do with breaking through professional barriers or dealing with challenges to achieve higher grades. Personal factors also help the ethnic minority nurse to utilise or take on the available opportunity and become successful in gaining higher grades and sustaining the position. This subtheme of personal characteristics revolves around resilience, intrinsic motivation, and the ability to use the different types of intelligence, including emotional intelligence, political astuteness or political intelligence, and good natural intelligence. Other critical personal characteristics include effective communication skills, 'the right attitude' to work, high self-esteem, assertiveness and effective negotiating skills, requisite knowledge and clinical skills, and excellent professionalism in clinical practice.

Resilience: Awareness of challenges or barriers to promotion and self-resolve to break the barrier to change the status quo are essential in achieving the desire to get higher grades. Uwa advises that it is not for the nurse to expect to be told what and how to solve existing problems. She believes that it is the nurse's responsibility to find and resolve the challenge. According to Uwa:

But nobody will tell you about these things, you have to learn it yourself, and this affects the extent of your integration. Anyway, I finished my nursing training, and I saw that I am an adult learner, and for me to move forward, I need to do something about it. Because when I was doing healthcare assistant and I was overhearing some of the staff nurses saying "oh we don't get promotion". I was thinking, why is that? Why would you not get promotion? What are these other people doing that you are not doing? If you

want to move forward, you have to do something different. You can be doing training to improve yourself. These were the questions I was asking them…" I was telling my peers when there were no promotion opportunities that "listen, if you are here, then I am moving along. I am going forward. I am not stopping here because this is about opportunities". It was a land of opportunity for me and for the things I wanted to achieve in my life." (Page 2, line 49).

Osaro advocates that the nurse needs to stay focused and resolve problems without giving up. The nurse must avoid aggravating issues like housing, health, employment or other challenges distracting from the commitment to achieving the goal. The individual must not give up and must strive to resolve the challenges. Osaro recalls his experiences which, on reflection, he believed may have affected his mental health, but the understanding that giving up was not an option kept him through and sustained him. With the same spirit, he continues to deal with the problems affecting his career progression. According to Osaro,

"*I think there were two things that impacted me, and I always say before I started nursing I had to pay my rent at one stage that there was no job. I had to go into street sweeping. And I did that for three months. And I won the 'best cleaner of the month' award for two months consecutively. And but the third month, I think there was, and it was depressing, I could say now what was going on and now being a mental health nurse, I think what I was going through that time, could be considered a very low time, because I remember I will sweep the street, and it was cold weather, a cold period around December, January, February. And on my way home, I would buy a few cans of beer, just to drink and asleep.*

And I remember the money that I take after paying my rent; I only buy bread, put some sneakers or mars bar, inside it, that is food. And then and technically, if one can look back now, thank God, the way things has taken me now, that I could consider this period as a very, very depressing time of my life. I think my health was affected; my confidence went down. And you see that, for example, most of the people who came from abroad and they are on poorly paid jobs, they've taken some money to come here. And to go back is not an option" (Page 9, line 27).

From the above experiences, it is clear that the individual nurse must be motivated, resilient and dedicated to make the needed effort to overcome the challenges and become successful in the new environment.

Intrinsic motivation:

Self-motivation to succeed is a critical factor in dealing with the barriers or challenges to career progression. The participants believed getting a higher education and training was essential to getting a promotion. Managers often deny the nurse's support with finance, study time, and accurate and suitable references. Most of the nurses applied the solution to pay their fees and use their days off or holidays to attend study programmes, and as a last resort, they moved to other clinical areas. The central motivation was that having the requisite qualification for a role was a set towards getting the job. As explained previously by Osaro, it is also the belief that returning to Nigeria despite the hardship in the new country was 'not an option' that serves as propelling factor to achieve and progress in the career.

Osato explains: *"When I came in, my self-development to get into a diploma in nursing studies to become a Registered Nurse was all my money. I paid by myself. I used my off time to get that initially. Because I knew when I had that, nobody would be able to tell me you don't have qualification… No, I did not wait for sponsorship. But that was because I was working in the private sector then. (Page 16, line 144)."*

Ede believes that self-determination by individuals not to remain in the lower grade and have a clear map of career pathways and boldness to succeed were necessary to excel.

"*From the minute I entered nursing school, I knew my plan and what I wanted to do. I wanted to either be a nursing lecturer, or I just wasn't going to sit down and work in the wards.*

That was why I changed my jobs for the first six months. I think another six months after, I changed my job again until I found what I was comfortable doing. …That is my forte- it is that I like to teach, I like to talk. People should not think they should just sit in one place without enriching themselves, trying to develop themselves, and moving on. People just think it is all about just sitting." (Page 9, line 354)

Levels of intelligence:

All the participants believed that a good level of intelligence [education] was necessary to attain higher positions or grades in the clinical area. The participants essentially referred to having 'intelligence' as having the ability to succeed in formal education and a good education level. This general belief is evident in the respondents' interest in further education, engaging in continuous professional development (CPD), and acquiring certification, which they believe enhances their promotion chances. All the participants had a first degree; the majority had postgraduate degrees and readily made themselves available for further training. The belief among the participants in this study is that success requires 'normal' intelligence (intelligence quotient (IQ) [education]. The participants believe that acquiring higher education and training will enable the nurse to become proficient in communication skills. They also think that the essential factors in gaining promotion include having the right attitude to work, having high self-esteem and becoming more assertive. Other factors include developing practical negotiating skills and having the requisite knowledge and clinical skills reflected in an excellent display of professionalism in clinical practice. The participants believe that acquiring a higher level of education will enable the ethnic minority nurse to gain promotion to higher positions or grades.

Many respondents believe that in addition to a high intelligence quotient [education], an additional level of intelligence was required to attain higher grades. According to Osaro, three levels of intelligence and the practical application of each group determine the opportunity available to the individual. The three levels of intelligence include what he calls 'normal intelligence', perhaps casually, as 'IQ', emotional intelligence and political intelligence or political astuteness. Osaro explains that how the 'Guinness effect' is sustained in the healthcare setting may partly be attributable to a culturally preferential lack of knowledge and practical application of emotional intelligence (EQ) and political intelligence or political astuteness by ethnic minority staff in a management position. Osaro states:

"Which brings me to the issue of political intelligence. And I think Political intelligence, we lack it. And I will tell you how that act. And that is one thing that I just want to say that that is one thing that the majority of ethnic minorities lack. IQ will take us to a level, good, and our emotional intelligence and conducting self, where we are not

affected by the feeling for those around us, will take us to such a level, but that will not take us to where we are supposed to be, what would take us to where we are supposed to be, and that I found out that very late was political intelligence…

I used to say it and that my experience, my knowledge, my this, is enough to take me to whatever level; No, it doesn't" (Page 6, line 9).

Osaro explains that his access to a coach and the teaching on combining emotional intelligence with political intelligence gave him the needed key to unlock the barriers to attaining his current position as an assistant director. The effective deployment of political intelligence paved the way for sponsorship, which led to his new post after several years to a much higher grade. Osaro emphasised the relevance of sponsorship in his promotion and sustenance by citing how he was headhunted for a role despite having just suffered a life-threatening medical condition that influenced his decision to consider early medical retirement. On his sponsorship to his current position, Osaro states:

"… but my line manager knew that most of those things were coming from me, and so when this job came in terms of who could do this, my name came forward. Now from the service manager of 15 years, I was promoted to assistant clinical director; then it tells me what good skills and political intelligence can do… And eventually, I later found out that the person who suggested my name was my director from the other Trust, which has helped" (Page 6, 10).

5.7.0: Obstacles and measures to develop and thrive

This master theme interprets the obstacles, barriers, and challenges on the nurses' career pathway, institutional or organisational obstacles that the nurses encounter and the nurses' measures to develop their career to obtain and thrive in senior positions in UK healthcare. It explains the macro or organisational obstacles, barriers and challenges on the nurses' career pathway and how they dealt with the barriers and thrived in their positions. There are two subthemes derived from the analysis, and this will be discussed below. The subthemes are employers' practices and discriminatory practices within healthcare settings. Each of the subthemes will now be explained in turn.

5.7.1. Employers' Practices

The subtheme analyses institutional practices that constitute barriers to career progression for nurses with Nigerian heritage. It also analyses the steps taken by the nurses to deal with the overt or covert obstacles within the system.

i) "Guinness effect":

Participants recognise the tacit organisational support of continuing the 'Guinness effect' in staff grades within an organisation as an essential barrier to career progression. Organisations promote this practice in different ways, such as creating policies that exclude a service grade, making it nearly impossible for the staff to surpass the grade to a higher one. The role of some senior managers in promoting institutional barriers to career progression was also identified. For example, managers create secondment opportunities for and encourage ethnic minority staff to apply. The minority staff is used to hold the position for another favoured candidate, often a white staff from another organisation who ultimately comes to take over the place once advertised as a permanent role.

Efe cites a practice in her current employment, also identified by the Care Quality Commission (CQC), a healthcare regulatory body." *I say this because the nurse managers are predominately ethnic minority people, and that's Band 8a. If you look at anything above band 8a, there are no ethnic minorities. Now, in our organisation right now, the next level should be band 8b; actually, we haven't got band 8b; in the community, it is band 8c. So, for those of us who are an ethnic minority, who are nurse managers at a level of 8a, it will be very difficult for us to jump from band 8a to band 8c. They have refused to create that spot, band 8b, that we can grow into to be able to. So, it is like a ceiling. In my organisation, you look at the executives, and you will hardly find one ethnic minority there. Secondly, we had somebody who had applied for that post of band 8c. Initially, they didn't give it out and said nobody made it. Eventually, they allowed her to do it for six months as an acting post. After six months, the job went out, and people applied, and the next day we had a white manager who came and took the position. So the person who practised in that post for six months did not get it. Even the CQC identified that there were no ethnic minorities in senior management and after the CQC, is when*

this happened. So even with that CQC report, it still didn't affect the fact that they should have looked like this person should get the job because they have been acting in it. So, a white person came and took over the job. So, it is happening. (Page 7, line 339).

Another practice is the offer of selective support by managers in an organisation which perpetuate advantages for specific groups. Osaro recounts his experience thus:

"*You must have had what they call 'Guinness effect'. … We are not giving the equal opportunity. I know of a colleague of mine recently who was given twenty-three thousand pounds to do one programme without contributing to it. When I did my MBA, I contributed 50% of thirteen and half thousand. I contributed half of it to do MBA, but for another colleague, he was given one hundred percent; ..." (Page 15, line 55)*.

ii) Selective Sponsorship/ Selective support/nepotism

Some managers in organisations selectively sponsor their preferred candidates for higher positions. Such managers pretend to support equal opportunities for staff but perpetuate the discriminatory practice discreetly. They often encourage ethnic minority staff to apply for higher jobs when they have no intention of appointing them. They are interested in using an ethnic minority for statistical purposes and evidence to promote diversity and equal opportunity in their department or organisation. A number of the managers head-hunt their candidates before advertising a position. The search for a suitable candidate seems open to everyone, but a specific individual is prior designated for the job in reality. Osaro recounted his experience in which his manager encouraged him to apply for a position. Unfortunately, the manager had announced that the role was for Osaro's white colleague in a senior management meeting. The leak from the meeting gave Osaro the information that it was a position earmarked for his colleague. Osaro cited this experience to reflect on how he changed his conflict-handling mode and his political intelligence growth.

Osaro states: *"Now because I was told by one of the men about this 'Mark' bidding to get the same job that I was doing, I said to my director, what is this job being created? And my director now said, 'Oh, we are advertising this job after they've approved the listing, please apply. And I said, what position are you talking about? You are talking*

about Mark's job. Did you not say that is Mark's Job when the matter was discussed at NHS England?

She was red because she couldn't understand how I got the information, and I said you were at the meeting. I tell you are aware; you were present, and the clinical director and the Deputy Director of Finance were present. Did you say Mark's job in NHS England, or didn't you? This was my issue before.

He said, 'What are you talking about? I said you are red already. I said the truth is you should know me by now. I say it as it is. I wasn't there. If you ask those people I have mentioned, none of them has spoken to me. But you need to understand that I've worked in most of the London Mental Health trust trusts. Now, most of the details that you think are confidential, people will talk. Not in a negative way. It is a question of did you know this bit. You are now asking me to be part of the statistics. This person, Mark, got that job" (Page 14, line 49).

iii) . NHS Manager's Management of organisational objectives

One organisational practice of discrimination by employers is the use of some managers of departments during re-organisation exercises to strengthen the discriminatory 'Guinness effect'. Osuyi, who currently works as a University lecturer and nurse consultant, recounts her bitter experiences in a re-organisation effect:

"… Because it was like a nurse of my colour should be providing hands-on care without actually relating to the experience that one has had in the past, to the extent that some within the organisation later expressed the fact that they never knew that I had such experience and that I could even work in the ward because they have been seeing me in the education role. And it was a shame that at a point in time, that education department was dissolved, and it turned out to be a horrible incident because I was de-banded. I don't want to repeat this story because it will cause pain; it was part of it. I mean, being de-banded from a band seven to a band five was so demeaning.'' (page 4, line 146).

Osato recounts an organisational conspiracy to sustain the 'Guinness effect' by making corporate decisions to restructure jobs and associated bands. The practice often uses ethnic minority managers to restructure some roles, and after that, management gets rid of that ethnic minority manager.

Osato explains in very emotive language: *"No. The internal system was a corporate kind of witch-hunting to get rid of black people at Hxxxxxxn then because it was starting from anyone who was band eight. You are coming to band seven and going to downgrade your job. The director of nursing then, one stupid Gxxxxxxn woman, who thought she was doing a good job, succeeded in getting rid of all the community band eight and senior nurses for them only for them to then fire her and get rid of her!'' (page 10, line 86)*

iv) Job satisfaction/ Agency nursing

This subtheme concerns the manager's manipulation of staff appraisal regarding the quality of job performance and how agency nursing staff are employed and treated. For example, other influential professional colleagues, such as consultant medical staff, may also use complaint tactics against ethnic minority nurses' job performance to create obstacles to career advancement for senior ethnic minority nurses. Some of these nurses have often resolved this challenge by becoming agency nurses in the same clinical environment or relocating to other organisations to continue their practice. Osato recalled working in a specialist clinical role with a medical doctor, the consultant in neurology. According to Osato, the working relationship between him and the doctor was good when working together.

Still, the relationship deteriorated in the last two years of work "*because he had somebody in mind to bring in, so we never agreed at all. After a while, I said I can't continue like this. Initially, it was good, but as we continued working for the last two years, he asked for the impossible. Err… I belong to a union…they even advised me that if I have a chance, I should just go and do something else… The internal system was working with the… both the consultant and the nursing directorate." (Page 10, line 80).*

Osato resolved this problem by resigning from the NHS role to work as an agency consultant nurse, earning more than he made in his full-time NHS role.

According to Osato*, "That was the last straw. Whereas I could do locum and get six hundred pounds per week. So how can you pay me that for five weeks? So, there was no need for me to waste my time. I just did agency.*" *(Page 12, line 102).*

v) Immigration challenges

This subtheme relates to challenges posed by the requirement of the participants to meet the immigration requirement to have access to health, housing, education, work and other social and welfare services on arrival from countries outside the UK. Broadly, participants in this study came to the UK with a visa using a Nigerian Passport, and those who came without a visa used a British passport. Generally, the participants who were born British and returned to the UK with their British passports had fewer challenges accessing the social, health and economic provision available in the country.

Efe states, "*I was born here in the sixties, precisely 1966. My parents took us back home to Nigeria in 1968; at the time, I had a younger sister. Then twenty years later, I came back into the country... when I first came, I had to take menial jobs. I did things like cleaning jobs early morning; it used to be called in those days, from about six in the morning to eight. Then I would also go to another job which was eight-thirty to four-thirty as a kitchen assistant at London transport in Westminster. I think I had three jobs" (Page 1, line 8).*

Efe was able to secure jobs quickly because there was no immigration restriction on securing a job. She nevertheless could not obtain an appointment with her Higher Diploma in Hotel and Catering Management from Nigeria but had to settle for three different menial jobs.

Efe confirms that: *"I didn't have any challenge in finding a job because I came back to the country with a British passport…To come into England, I came with a British passport. So, I never had an immigration problem, but even still, it was a different culture entirely" (Page 2, line 78).*

Ese, born in London, returned after graduating in Biochemistry and doing the compulsory one-year youth service in Nigeria. She is married to another British Born Nigerian and is grateful for having obtained a degree first in Nigeria before coming to the UK. Ese did not have any Immigration issues on returning to the UK with her British Passport. Still, the driver of her success is primarily attributed to her parent's insistence on studying to a degree level before returning to the UK.

According to Ese: *"Oh God, it helped me because now, when I came back, and I saw people who were born here and didn't go back, I could see the difference, I could see*

the difference. And one thing which I always say is that I share my testimony and thank my parents for taking me back to Nigeria. If they didn't, I don't know what would have become of me" (Page 13, line 542).

All the participants who came to the UK with Nigerian passports had different visa types on entering the UK. Some had a student visa for study, some were in the UK as a visitor but became nursing students, and some sought political asylum and became nursing students. The challenges experienced by each of these groups vary according to the individual social network and support available to them.

Osuyi, who came to the UK on a student visa for the adaptation programme, had to pay the agency a substantial sum of money to process her Visa. She was also given a work permit visa on her registration with the NMC by her employer. This Visa was for five years, which dictated whom they may work with during the life span of the work permit.

According to Osuyi: "*So we just needed to complete the immigration application forms, completed those, and then, you know, we were given a date to come to them, and …, then we were allowed to proceed to pay some amount because we have to pay quite an amount and then proceed to obtain a visa. So that was it…. After registration with the NMC, the organisation applied because they wanted to employ me. So, that organisation applied after my adaptation. They applied for me with the Home Office, and I was given two years. It's a long time now. So at least the organisation applied, and I got the visa, yes, I think it was five years, yes*." *(Page 1, line 40).*

Ehi, a registered nurse in Nigeria, came to the UK as a visitor and became a UK registered nurse with the UK nursing and midwifery council (NMC). She was assessed by the UKCC (now NMC) and given clearance to do the adaptation programme before becoming registered in the UK.

Ehi said, *"So I took it to the home office, and they gave me the student visa. So, when I finished and got my first job, they changed it to a work permit for me. It was for a year. After a year, it was renewed to three years, and then I got my stay. I followed the stages as long as you don't break the law" (Page 6, line 293).*

Osaro represents the group that came to the UK as a visitor but applied for political asylum before becoming registered nurses in the UK.

According to Osaro, "*That is, when I came to the country, you know, I applied for political asylum straight away so that I don't have to be running around… When I applied to do my nursing, they didn't want to allow me to do it. And because I was, you know, political asylum, my solicitor had to say, you cannot deny the educational right. And that is how I entered into nursing training and completed, yet it affects a lot of people" (Page 8, line 17).*

The above experiences suggest that it may not be necessary to travel overseas to recruit nurses for nurse training. Migrants are living in the UK or can come to the UK interested in training as registered nurses if there are no immigration obstacles that prevent their application and training.

5.7.2: Discriminatory practices within the healthcare settings

This subtheme explains the obstacles caused by discriminatory practices within organisations in healthcare settings. It looks at discriminatory practices in managers' management styles, such as prejudice, stereotyping, labelling, marginalisation and discriminating use of staff names, race and nationality to build and enforce obstacles to staff retention and career progression.

i) Management styles/management of discrimination

The management styles employed by some managers did not promote the inclusivity of staff from different ethnic or national backgrounds. The management and administration of basic entitlements such as redeployment in restructuring exercises, study leave, access to training and similar entitlements by these managers were influenced by discrimination. Osuyi, a registered nurse tutor in Nigeria before coming to the UK, recounts her experience of disestablishing her role in a re-organisation exercise. Her role was downgraded from band seven as Clinical Skills Facilitator to a band 5 Registered Nurse on the ward resulting in her eventual resignation from the organisation.

According to Osuyi: "*But … it seemed that it was the kind of culture in that organisation whereby people of my type, people of my colour were not expected to be in certain positions, like the high position because it was something that eventually panned out to be right… I don't want to repeat this story because it will cause some pain; it was part of it. I mean being de-banded from a band 7 to a band 5, it was so*

demeaning… but it was the fact that I was in that area of speciality, even before coming to this country" (page 4, line 146).

Ehi recounts the discriminatory attitude of her manager whilst working as a band 5 in the community. Whereas her white colleagues were being sponsored to train as registered district nurses after qualification became band 7, ethnic minority nurses were denied sponsorship to train. When granted, they were put in band six on qualifying as a registered district nurse.

According to EHI, *" I applied for all these…. To get my training done. I didn't get it then. Two or three applications I made, and none were granted, so I left" (Page 2, line 74).*

ii) Prejudice, stereotype, labelling and association of a name with race or nationality.

Many respondents identified having African names as a barrier to career progression because of many managers' prejudice and stereotype of Africans. The solution to this problem was either anglicising or changing the pronunciation of their name, abbreviating or shortening the name to ease pronunciation. Some of the nurses with non-African sounding names discussed the discrimination they experienced while attending interviews. Osaro recounts his experience before training as a nurse. He was invited for an interview but waited without being interviewed when they saw a black man. Osaro states:

"*I remember even attending an interview with a vacancy for a role. Because my name is very confusing, my name is xxxxxx. xxxxx is Greek, and xxxxx is Italian. And I think there is also a Dutch element. I don't know whether these guys say Italian; the interviewer will get it. .. I was invited for an interview, and I was sitting down; people were passing by. And eventually, they told me that, you know, when I requested what was happening and that I have been sitting to be interviewed. 'Oh, are you so and so person? That the job was not available. And they've already taken it off the market and wanted to apologise to me, a role for which I've been sitting for more than an hour! And when they've been going up and down past me. And that is part of our experience" (Page 2, line 4).*

As if it was premeditated, I came across a publication on ‘History Ville’ after the interview with Osaro. Applying the lens of Postcolonial Critical Theory, it is evident from the magazine that the discriminatory, prejudicial practice Osaro experienced has a long history. The ‘History ville’ publication may readily align with the everyday experiences of marginalisation by people of African descent in the UK society, as structured by the micro-politics of power and the macro-dynamics of structural and historical nature. The publication was about the treatment of Nnamdi Azikiwe, the man who later became the first President of Independent Nigeria by the Colonial government. It states:

‘’Nnamdi Azikiwe was selected to represent Nigeria in the long-distance running events of the 1934 British Empire Games in England but was rejected by the British organisers because he dropped his Christian name, "Benjamin".

Azikiwe was actively involved in sports at every stage of his life and was successful in many events that he participated in. He was a Boxing and High Jump champion (1925, 1926), Gold Medallist in Swimming (1927), Captain of a Football team (1930), Marathon winner (1933) and Tennis Champion (1938)’’. #HistoryVille (accessed 31/8/ 2018).

Ironically, what happened over eight decades ago still happened to OSARO. He was not interviewed when the organisers saw that he was an African, which did not match his Italian/Dutch name in their warped imagination.

5.8: Summary:

The findings have presented five master themes and discussed them under the superordinate themes within and across the interviews as a group of study participants. The three groups of IENs of Nigerian heritage had different expressions and examples of their experiences in the course of integration into the UK. The respondents confirmed from their experiences that issues of discrimination, racism, colourism, systemic barriers to integration exemplified by the roles of organisations such as NHS England, NHS Trust, employers, structural barriers as presented in their immigration challenges, and personal and interpersonal obstacles. Their expressed lived experiences demonstrate the complexities of discrimination in the clinical environment and the wider society. The difference in how the participants expressed their experiences is a significant finding.

There will be further exploration and discussion of the similarities and differences between the three groups of IENs with Nigeria heritage findings in the discussion chapter of this thesis.

5.9. Reflections.

In doing this IPA study, one of my challenges has been the necessity to maintain my positionality. My ability to engage at this research's etic' and 'emic' levels sustained my drive to analyse this study. I have constantly monitored my personal beliefs, bias, and research experiences. The double hermeneutic concept in IPA helped me become aware of preconceptions and potential influences on the research.

I approached this study with the assumed belief that the nurses were born in Nigeria. I was proved wrong as the interview revealed that three of the ten nurses in this study were born in the UK but spent their childhood, teen years, and young adult years in Nigeria before returning to live in the UK. I was richly educated by the experiences shared by all the participants (who now have dual Citizenship –Nigerian and British).

I could readily see the similarities and emerging differences between the nurses born in the UK and those born in Nigeria and how this reflects their integration. I noticed the difference in the display of emotions and how both groups tried to rationalise the similar experiences they had or were having in the healthcare system.

I was immersed in the participants' level of trust in sharing their experiences with me as an ethnic minority researcher. I was happy to be involved in their life experiences. I struggled not to share my personal experiences to validate their experiences or support or encourage their spirit in their quest to remain successful in their professional pursuit.

It was interesting to observe how the participants used their words and the level and depth of the general issues they chose to discuss. I made every effort to conceal my emotion and provided a listening ear, and I was sure that my recording devices were on and recorded correctly.

Transcribing the interviews took longer than expected, but I listened to the participants several times. I paid attention to the tone and re-visualised their bodily expression during the interviews. Reflecting on the interview process and analysing the interview made me query why I had not asked some participants for more explanations. In another stance, I am happy that I have guided myself not to stray too far from the research questions, as this may have produced very emotional data with little or no relevance to the study.

As a researcher new to IPA, it was challenging but not impossible for me to move between the idiographic component and establish convergence and divergence, commonality and individuality within the data generated. On analysis of the data, my iterative engagement with the analytic process and keeping ideographically close to the research participants brought me closer to the participants' lived experiences. I have made a great effort to retain an idiographic voice whilst maintaining a joint claim for the participants in this study.

Interpreting data and writing the analysis of the interviews has been challenging as I had to search for commonality across the participants' experiences and use the most reflective account. I also 'choose some atypical extracts to illustrate contradiction and complexity' (Smith et al., 2014: 116). I am aware of lengthy quotes in the write-up of the findings. Still, these differences in the length of quotes emphasise the idiographic element in individuals' interpretation of their lived experiences because of their differences in expression or description of their lived experiences. I have engaged in some iterative accounts to be more interpretative of the respondents' lived experiences

in ways that recouple themes and relate to the fundamental analysis to develop across the different sections of this study.

CHAPTER SIX

6.0 Discussion of Findings:

This study aimed to explore the lived experiences of integrating IENs with Nigerian heritage into UK healthcare using an interpretive phenomenological analysis (IPA) approach.

In this chapter, I discuss the five key themes from the findings (Chapter Five) concerning what these contribute to integration theory. The five master themes, made up of twelve superordinate themes (with emergent sub-ordinate themes), resulted from a double hermeneutic interaction with the respondents' interview accounts. I begin this chapter by discussing the findings of this study in relation to existing literature and then link this to relevant aspects which help explain the links to integration. Under each theme, I explore the subordinate themes through the literature using CRT, IT, and PCT (see pages 34-41) to help clarify and explain the lived experience around the integration of the respondents in this study. A critical reflexive evaluation of the methodology and method's strengths and weaknesses follows and ends with a concluding section of a reflexive account of my experiences while writing this chapter.

6.1: Discussion of the themes:

In this section, I discuss how each of the five master themes with the twelve super-ordinate themes complements and offers the key analytical findings in interrogating the research results and how these are linked to integration theory. In this discussion, reference is made to extant literature that may not have been cited in this study's introduction and literature review section because of the emergence of themes unanticipated in the interviews. The five main themes which I discuss in turn are:

Master Theme 1: Opinion, concept and experiences of integration

Master Theme 2: Challenges to Integration

Master Theme 3: Personal and Social Integration

Master Theme 4: Career Progression

Master Theme 5: Obstacles and Measures to Thrive

6.1.1: Opinion, concept and experiences of integration.

According to Farashah and Blomquist (2019), the theories for studying qualified migrant experiences in the literature may be called content or Process theories. The content theories “concentrates on the type of variables explaining antecedents of the migration decision and particularly on the consequences of immigration in terms of employment and career outcomes” (p.4). Examples of content theories include human capital theory, career capital theory, intersectionality and cultural identity transition. The process theories include the theory of practice, sensemaking and social identity theory, and they are “characterised by a focus on the acculturation process, the challenges for immigrants and their host society, and the coping strategies” (p.5):

The lived experiences of the respondents in this theme may be interrogated under the content theories or process theory. The respondents' lived experiences of integration revolve around the superordinate themes of understanding integration and the reality of integration. This study's three groups of respondents had diverse integration experiences into the UK and UK healthcare. These divergent experiences support the extant literature on the diverse nature of integration.

As I highlighted in chapter two, there are divergent views on defining integration. The lived experiences in this study suggest that integration may mean different things to different people. Robinson (1998:18) argues that integration “is individualised, contested, and contextual”. However, the findings suggest that individuals may share similar experiences, as highlighted in chapter five. The opinion, concepts, and integration experiences among these ten respondents in this study may be classed into three groups. Some respondents see the integration process as unidirectional in one group. In this sense, integration was the responsibility of migrants to adapt and understand the ways of the larger population with retention of some of their cultural practices that are not in opposition to the larger population. The second group believes that the integration process should be bi-directional, with the migrant group and resident group learning about and accepting the culture of each other group. The third group believes integration is impossible because of the prevalence of discrimination in British society.

As discussed in chapter two, from the state perspective, integration is a one-way process where the migrants are accountable and responsible for integrating into the host society (Erdal and Oeppen, 2013). However, Ehrkamp (2006) states that integration may also be a two-way mediation process and relationships between the migrant as individuals and groups and the host society. Some others see the integration process as unidirectional, bi-directional or multi-directional (Alba and Nee, 1997; Ager and Strang, 2008; Spencer, 2011. Joppke, 2013; Penninx and Garcés-Mascareńas, 2015; Spencer and Charlsey, 2016).

The views of group one and group two respondents align with the extant literature. However, as indicated in chapter two, IENs see their adaptation or integration into UK healthcare as a process that 'challenges the normative UK value…' (Allan 2007: 2). This perspective is most vital in the third group's thoughts that integration into the UK and UK healthcare is complex, a 'farce', not reality and unreal. This is an unexpected finding and challenges a different interpretation of the government cohesion agenda (see literature review) that as long as there is the maintenance of a peaceful civil and social status quo in the community, immigrants must have become integrated. This third group's perspective is similar to the view of the father of CRT, Derrick Bell, that the American [*British*] society was a place "*where liberalism is a façade, a place where racial inequalities will never be rectified and only addressed to the extent that Whites see themselves as threatened by the status quo*" (Closson, 2010:4). This third group's perspective also challenges the view held by Ager and Strang (2008) that for a migrant to become successful in their new environment, there must be a degree of integration into the larger population's "ways of life".

Some literature agrees that integration is a series of processes that takes place in the structural, economic, social, cultural, identity, civic and political spheres involving immigrants, migrants and receiving society institutions and residents (Entzinger,2000; Heckman et al., 2006 cited in Spencer,2011). These factors and multi-directional interaction align with the use of intersectionality theory in explaining the lived experiences of some of the respondents in this study. Some of the respondents' experiences of co-occurring marginalisation with examples of multiple experiences of oppression, for example [see the findings under master theme 1; Opinion, concept and experiences of integration; page 116], may have contributed to their view of integration

so as not to reveal to them the simultaneous process of integration observed by the other two groups of respondents. The marginalised group have embodied knowledge about the multiple interactions of systems in limiting opportunities; therefore, emphasising these group provides the chance to engage in the main theatre of policy discussion and formulation and their personal experiences about defeating oppression (Dhamoon and Hankivsky, 2011).

i. In-group similarities:

The respondents who believed that the integration process was primarily unidirectional were born in the UK but went to Nigeria in childhood. These respondents returned as young adults to the UK as British Citizens with a British passport. Their feeling and acceptance of 'Britishness' may not be in doubt because they could get jobs in the UK without much struggle. It is not surprising that they believed the state's perspectives that integration was unidirectional and that it was the migrant's accountability and responsibility to adapt and understand the ways of the host society. When referring to Nigeria, these respondents use the term 'back in Nigeria' instead of the second stream respondents who said: "back home". This reference is significant in filial attachment to the UK and Nigeria. This concept of "back home" and "back in Nigeria" underlies the degree of filial affiliation to the UK and Nigeria and how the individual deals with discrimination, resilience and other personal characteristics, discussed under relevant themes in this study.

The respondents who believed that integration was not wholly unidirectional but bi-directional, with the migrant group and resident group learning about and accepting the culture of each other group were born in Nigeria. They have all acquired dual nationality and are now citizens of Nigeria and the United Kingdom. They arrived in the UK with a Nigerian Passport with Visas either as a visitor or a student who later trained or did the adaptation programme to become registered with the UK Nursing and Midwifery Council. This group expresses their culture's relevance more in explicating their quest and lived experience to integrate into the UK. The cultural influence of their lived experience is also reflected in their expectation and management of challenges regarding discrimination, resilience, and other personal characteristics.

The lack of formal integration policies in the UK healthcare for nurses may explain why the third group of the respondents believes that integration was a 'farce' and non–existent phenomenon- "*more a grammatical phenomenon rather than a reality". The* respondents in this group were born in Nigeria but had experience working in multinational companies operating in Nigeria before their sojourn to the UK. Their work experience in Nigeria had put them in contact with nationals from countries such as the UK, USA, Arab nations and other European nations. This exposure to varying citizens while working in Nigeria may have broadened their perspectives to interpret integration into the UK society as a non-existent phenomenon. Applying an IT perspective, it is likely that this third stream of respondents may have experienced multiple co-occurring marginalisations and may have navigated several experiences of numerous oppressions in their work lives with different international communities.

Most of the nursing and healthcare literature on integrating international nurses is mainly concerned with pre-migration, pre-registration and the early orientation periods of Internationally Educated Nurses (IENs). There is a lack of research on the post-transition phase or long-term integration of international nurses (Adams and Kennedy, 2006; Ramji and Etowa, 2014). Although there are no explicit policies in the UK on the integration of overseas healthcare workers (Jayaweera and McCarthy, 2015), it is the employer's responsibility to formulate its integration policies (Spencer, 2011). As regards overseas nurses' integration, it is the responsibility of the healthcare employer to ensure that the overseas registered nurses (ORN) receive support to improve their English language skills through the transition into working in the UK (NHS Employers, 2017). Even after the nurse's appointment, the responsibility lies with the employer to support the individual in gaining the appropriate language and communication skills (NHS Employers, 2017).

Interestingly, none of the nurses in this study received any support in their language and communication skills during their adaptation (pre-integration) or post-registration with the NMC. These nurses considered themselves educated in the English language in Nigeria and considered themselves proficient in the English language. Equally, their employers regarded their language skills as not requiring support.

Two of the respondents in this study had a supervised practice programme, which lasted for 3-6 months before gaining the NMC registration. The remaining eight respondents

had one form of bachelor's degree or another before their pre-registration nurse training in UK universities. They had no language or communication difficulties completing their academic or clinical placement during the pre-registration programme. Therefore, this may imply that requiring a formal standardised English language competency test for individuals educated in Nigeria requiring registering with the NMC or studying in the UK is not justifiable (Ugiagbe et al., 2022).

In the EURO 2020 football event, Italy defeated England. The racial backlash following the England defeat on 11th. July 2021 supports the belief of the third stream that integration was a 'farce' and non–existent phenomenon—"*more a grammatical phenomenon rather than a reality".* This group believe that if they spent over 100 years in the UK, people would still query their origin by asking, 'where are you originally from?'. Concerning the comments by the recent past UK Home Secretary (Priti Patel) and the previous Prime Minister (Boris Johnson) on the England defeat fall-out, an England Team Football player states:

"you *don't get to stoke the fire at the beginning of the tournament by labelling our anti-racism message as 'Gesture Politics' and then pretend to be disgusted when the very thing we're campaigning against happens"* (Tyrone Mings, 2021).

Gary Neville, a former England football team player, further stated: "*The prime minister said it was OK for the population of this country to boo those players [taking the knee] who were trying to promote equality and defend against racism. It starts at the very top. I wasn't surprised in the slightest that I woke up to those headlines; I expected it the minute the three players missed" .*

From the CRT perspective of the concept of "storytelling and counter-storytelling", it is evident that the experiences of these patriotic England players support the idea of differential racialisation by whites of different groups at different times. The storytelling component of CRT lends credence to the third stream's respondents as a non-dominant group with distinct and unique histories and experiences with oppression and racism. This may have informed their unique perspectives, explication of integration in the UK and UK healthcare, and the social assumptions that racism is enshrined in the UK social structures.

Barker (2020) reports that the NHS records may sometimes reflect a person's cultural heritage rather than citizenship or country of birth. Nigeria is the fifth-largest staff in the NHS and the largest at 8,241 staff of all African Countries listed. The fact that a group of nurses believes that integration was a farce emphasises the need for a further and more detailed inquiry into the view of this stream.

In the UK cohesion agenda, integration is about achieving the government's desired community state where peace reigns. It is expedient to note that although integration is a community-based concept, individuals constitute a community. Therefore, the individual needs to integrate into the community as much as the population becomes part of the individual. As Etzioni (1988:9) argues, "the individual and the community make each other and require each other". Social capital is *'the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit. Social capital thus comprises both the network and the assets that may be mobilised through that network*' (Nahapiet and Ghoshal 1998:243). The individual's social capital and the overall social capital of the community where the migrant work or lives influence the individual's opinion, concept or explanation of integration.

6.1.2: The reality of Integration

The superordinate themes generated in understanding the lived experience of the integration process from the analysis include issues of the social impact of integration and discrimination. I developed these superordinate themes from recurrent but discreet themes with divergent focus and perspectives in integrating the nurses. The discreet themes include experiences of multiple migrations, experiences of racism, the experience of overt discrimination, and individual level of knowledge and understanding of discrimination in work and society. These discreet themes fit into the content theory category and specifically the Human capital theory in explaining the theory of studying qualified migrants. The Human capital theory has its origin in Economics and focuses on "Individual-level knowledge, skills, abilities, personality and social attributes as determinants of migration and its consequences…" (Farashah and Blomquist, 2019:6),

In an ECRE study on integration, the respondents stated, 'To me integration is work, if we work we are integrated' (ECRE 1999: 42). This finding, in part, informs the view of

Ager and Strang (2008) that employment was one of the means and markers of integration. In discussing employment as one of the four discrete domains of means and markers of 'successful' integration, Ager and Strang (2008: 170) state that employment is central to 'prom*oting economic independence, planning for the future, meeting members of the host society, providing an opportunity to develop language skills, restoring self-esteem and encouraging self-reliance* (Africa Educational Trust 1998; Bloch 1999; Tomlinson and Egan 2002)'. The degree of the importance of gainful employment in promoting integration in the life of a refugee may be at different levels of significance between refugees as in Ager and Strang's study and the Nurses represented in this study. The difference may be traced to the migration of refugees and internationally educated nurses. From the human capital theory perspective, migration of IEN is a logical decision and pertains to the rate of return from migration. It is an "investment, and individuals may migrate and sacrifice short-term security for the sake of future pecuniary and non-pecuniary returns, such as higher salaries, better employment opportunities and better quality of life" (Farashah and Blomquist, 2019:7).

Ager and Strang (2008) state that although refugees were highly educated compared to other immigrants, they had difficulty securing employment because employers often refused to recognise their qualifications and work experience. This often results in refugees' under-employment and, by extension, lower earnings. This observation of Ager and Strang partly applies to the nurses in this study. All the nurses had degree-level equivalent education before becoming registered with the NMC after their pre-registration nurse training. The respondents in this study did not have difficulty securing a job as registered nurses upon registration with the NMC. However, no favourable consideration or advantage was given to the nurses' earlier qualifications or academic study before training as Registered nurses. This non-consideration of the previous educational qualification confirms that 'the*re is a tendency internationally to employ overseas nurses on a lower grade than their skills and experience may otherwise suggest'* (Allan, 2010: 604) in UK healthcare. From CRT perspectives of the tenet of "interest convergence", the economic benefits to the more significant white majority of the UK healthcare management promote the reluctance or refusal to change society's rules and attitudes towards non-recognition of the previous academic qualifications in employment by the healthcare institutions.

According to Ager and Strang (2008), the degree of achievement and access to employment may help judge integration as ‘successful’ or not ‘successful’. On the strength of this assertion, one may say that respondents in this study are integrated into UK healthcare because they have secured senior positions in UK healthcare. However, this contrasts with the findings that some participants do not perceive themselves as integrated into the UK healthcare and UK society and that integration was a farce and non-existent. Some perceive integration as bi-directional, and some perceive integration as a unidirectional phenomenon. Integration is more than securing employment and points to the complexity of defining integration and that it is shaped or constrained by discrimination and racism. According to Ager and Strang’s (2008) conceptual framework, Rights and Citizenship was the foundation of integration. However, all the respondents at the time of the interview have dual citizenship in Nigeria and the UK, yet they have divergent explications of the concept of integration.

This study assumes that for IEN to become successful in UK healthcare, there must be a degree of integration into the broader population's “ways of life”. This assumption aligns with the conceptual framework of Ager and Strang (2008) and applies the theoretical underpinning of Critical Race Theory (CRT), Intersectionality theory (IT) and Post-Colonial Theory (PCT). From the CRT perspective, because whiteness is construed as a standard in society, non-whites only succeed when they concur with the White agenda (Delgado & Stefancic, 2017). PCT because having a degree of integration into the broader population's ‘ways of life’ may help the IEN to evaluate the everyday life experiences of oppression of marginalised racial groups and marginalisation influenced by micro-politics of power and macro-dynamics from the historical and structural perspectives (Kirkham and Anderson, 2002:2). Gaining employment and becoming successful in work is one of the discrete domains of successful integration (Ager and Strang, 2008). The IEN in this study are not refugees but are professionals with a university first degree and higher degree level of education and were employed directly as registered nurses by the UK healthcare on gaining their NMC registration in the UK. Some nurses had immigration challenges during their stay in the UK. This immigration issue affected their career progression and their feelings of integration. Simic (2018:15) distinguishes between the concept of skilled migrants and skilled migration. A skilled migrant possesses specific skills before migration to the destination country, which s/he may not be able to use in the destination country. However, skilled

migration is a proxy for a migration stream comprising labour migrants arriving in the host country on work visas (if needed). The participants in this study were a mix of skilled migrants and those who came as part of skilled- labour migrants.

It is evident from the findings that although gainfully employed at the idiographic level, individual nurses have different experiences and views about integration. Their explications range from 'integration' as non-existent to partial integration and total integration. This varied interpretation may be attributable to the absence of consistent and explicit policies on integrating migrant healthcare workers in the UK (Jayaweera and McCarthy, 2015). Spencer (2011) states that the employer must formulate its integration policies at the work level. For example, in developing language skills, employers' responsibility is to ensure that the overseas registered nurse (ORN) gets the appropriate support through the transition into working in the UK (NHS Employers 2017). However, the evidence shows no consistent or standard support in the UK healthcare sector (Allan and Westwood, 2015a).

As the findings in this study show, three nurses who completed the adaptation or supervised practice programme before gaining NMC registration did not get any language support in their transition to employment. They were offered admission into UK universities to pursue their degree and post-graduate studies without a formal standardised English language test but on the strength and validation of their previous studies. The other respondents who studied nursing in the UK gained admission into the University based on their initial education in Nigeria. Indeed, one of the respondents earned a Bachelor's degree in English from a Nigerian University before training and registration with the NMC as a registered nurse in the UK. These experiences support Ugiagbe et al. (2022) argument that *"there is no justifiable rationale for the inclusion of countries where primary, secondary and pre-registration nursing education is the English language in the list of countries required for language competency (NMC, 2017). By compiling a list of countries which are considered to have English as a first and native language but excluding African countries such as Nigeria, Ghana, Kenya, Zimbabwe and South Africa, where primary, secondary and nursing education is in the English language gives the impression of institutional bias and racism".*

O'Neill (2011) reported that nurses who were non-native speakers of the English language struggled with communication and conversation with patients and colleagues. This communication problem with patients also challenges the workforce integration of ORNs (Allan et al., 2004; Smith et al., 2008; Allan and Westwood, 2015b). This study has not identified such problems with the nurses who attended a supervised practice programme before registration with the NMC. The nurses prided themselves in speaking and writing English proficiently and did not have communication difficulties that they could not resolve quickly. The other nurses who did their pre-registration training in the UK did not have such problems in their clinical placements and academic endeavours. Indeed, one of the respondents had a first-class classification in her Pre-registration nursing degree.

The impression of institutional bias and racism may explain why Osato is sceptical about 'integration' because he believes there was an absence of equality in the work environment. In his view, integration was more a grammatical expression, and equal opportunities were more of a legal requirement on paper which is not achievable. He believes that the absence of equal opportunity in the system makes the realisation of full integration impossible. He emphasised the role of skin pigmentation in fostering racism and discrimination and preventing integration. This view seems to judge the NHS employers' effort in promoting workplace equality required by the Equality Act (2010) as ineffective in tackling racism and discrimination in the work environment. The Equality Act (2010), effective 1 October 2010, prohibits discrimination in the workplace and larger society based on the nine protected characteristics, which include: age, disability, gender, marriage and civil partnership, pregnancy and maternity, race (including colour, nationality, ethnic or national origin), religion and belief, sexual orientation, gender reassignment. The Equality Act also includes a public equality duty that requires public authorities to '*have due regard to eliminate discrimination... advance equality of opportunity... foster good relations'* (Anderson 2010).

Although the Equality Act (2010) is in place, a respondent's experience in this study demonstrates that institutional bias and racism may be fostered by government actions at both the macro and micro levels. Osaro cited the example of the NHS 70th anniversary celebration, where there was a deliberate attempt to sideline or downplay the contribution of nurses from the commonwealth countries except the Caribbean. This

promotion of the Caribbean over other commonwealth countries enabled the UK conservative government to gain political traction because of the scandal regarding the immigration problems with the descendants of the 'empire Windrush' migrants from the Caribbean. In line with Critical race theory, I reason that downplaying the contribution of other commonwealth nations such as Nigeria in the NHS in the 70th-anniversary celebration is a continuation of 'historical racism' which, as Olusoga (2020:2) states, "set a trap for those who had lived and worked here legally nearly all of their lives".

According to Byrne et al. (2020:4), "*Anniversaries and memorialisations, then, offer not only a chance for celebration but reflection and re-evaluation. Rather than definitive and timeless landmarks, they provide staging posts in the national (hi)story, providing the opportunity to pause, consider distance travelled, examine where we are, and to (re)consider the road(s) ahead. They offer the chance to excavate hidden or forgotten stories, to revisit familiar stories, to rewrite (or rethink) the national story as we know it, and to imagine new and better ones*". From the lived experience of the respondents in this study, it appears that the celebration of the NHS 70th anniversary may not have looked to make a better history of the experience of all the minority groups, especially the African nurses in the NHS, in the years to come. As discussed in the literature review, this action mimics the UK conservative party's 'indirect rule' approach. The government is interested in using the skills and labour of nurses with Nigerian heritage but does nothing to promote their integration into UK society. Historical factors, links to nation-building and historical legacies of colonialism are critical drivers in integration models adopted by nation-states (Emilsson, 2016, Hansen, 2002). As previously stated in the literature review, in line with Post-Colonial theory, my perspective is that the vestiges of colonialism are evidently at work in the dealings of the UK government with the previous British empire nations. In the year the NHS was formed, the immigration policy in practice was 'the myth of Civis Britannicus sum' because "*the British immigration policy operated in a way that was intended to make it difficult for Asian and Black British subjects to settle in the United Kingdom*" (Spencer,1997: 21). Thus, black nurses were needed in UK healthcare. Still, they were not 'wanted' in the UK. This discriminatory attitude is central to the present-day preference for international nurse recruitment from the Philippines and India (Donnelly, 2014). This preference lends credence to the belief that the degree of skin pigmentation or 'shades' of skin is a

determinant of discrimination (Allan and Larsen,2003; Likupe, 2006), and perhaps the nationals preferred to work in the UK healthcare sector.

The literature review section in this study states that the UK is a welfare state that practices the multicultural integration model in line with its prevailing political and social conditions. The UK's practice has been heavily influenced by its indirect rule in its colonial territories, now the Commonwealth of nation-states. Spencer (1997) states that multi-racial Britain was an unintended outcome of British policy rooted in the British Nationality Act of 1948. Olusoga argues that this Policy ensured '*frictionless travel for the large white populations of Canada and Australia. "No one imagined that black and brown people from Asia, Africa and the West Indies would use their rights under this act to come and settle in Britain"* (Olusoga, 2020: 2). By implication, the government in their planning may not have envisioned settlement for the nurses that helped the NHS in its fledgling years. This initial practice has influenced the continuing action of the government in maintaining a non-committal approach to integration.

According to Castles and Davidson (2000), it is unrealistic to expect migrants arriving in society to adopt the dominant culture in multiculturalism wholly. This is in line with the thinking of some of the respondents in this study. Osama believes that migrants need to adjust to the existing way of their new society and make an effort to surmount whatever opposing structures or barriers are stopping their integration in the work environment or the larger community. Osama believes it is for Nigerian nurses to use the skills they already have or have developed to their advantage in the work environment. Osama's view is a positive note of looking at deskilling caused by international nurses' employment to roles they are more qualified for in UK healthcare (Allan, 2010).

West et al. (2017) report that the NMC practices were structurally and institutionally racist. Braithwaite (2018) confirms institutional racism toward ORN, continuing a disregard and unbiased approach in criticising and recognising extant racism in nursing. Despite the number of BME and overseas nurses working in UK healthcare, there is institutional racism in the NHS (Archibong and Darr, 2010, WRES, 2019). It seems to contribute to the 'successful or non-successful integration of the nurses in this study.

One protected characteristic under the Equality Act (2010) is race (including colour, nationality, ethnicity or national origin). The act forbids discrimination based on a person's colour, nationality, or ethnic or national heritage in the workplace and the larger society. From respondents' lived experiences in this study, all the participants agree that discrimination was evident in community and healthcare. They described practices that appeared racist, but not all of them were comfortable with labelling their experiences or what they observed as racism. The concept of "ordinariness may have influenced this practice". According to CRT, although racism is an everyday occurrence for the non-white and often not acknowledged, the non-acknowledgement of racism makes it challenging to eliminate and manifests as colour-blindness.

The findings in this study show that issues around allegiance to national origin, ethnicity and nationality matters affected the interpretations of each individual's experience of discrimination in the NHS and the wider society and, therefore, their explication of integration. It is expedient to emphasise that although the NHS is tagged institutionally racist (Kline, 2019), the lived experience of the majority of the respondents in this study supports the belief that discrimination in the NHS is not a case of white staff against black staff. Colourism powerfully shapes experiences of racism and discrimination in the NHS. Discrimination in the setting is influenced by a matrix of factors and our living in the 'milieu of racism without racists', propelled by colour-blind racism that is not displayed in overt behaviours. This may explain the attempt to resolve racism in society by the government grouping colour, nationality, ethnicity or national origin under race as protected characteristics (Equality Act,2010).

Discrimination means mistreating a person for their identity or because they possess specific characteristics. Discrimination occurs when person X treats person Y less favourably or unfairly because they are or have particular features. Comparing the case of persons of different factors must be such that the relevant circumstance in one case is the same or not materially different in the other. Less favourable treatment does not necessarily amount to a detriment. The issue is whether a complainant might reasonably consider that he has been disadvantaged when he has to work because of the act complained of. The lived experience of the respondents shows that employees of the same race may discriminate against each other based on nationality or differences in characteristics. According to Wesp et al. (2018: 320), Intersectionality

Theory (IT) maintains that the status quo of inequity persists because the complex matrix of power privileges those in the mainstream while "othering" those on the margins.

For example, a white Scottish man privileged by power can discriminate against a white English man and vice versa. Equally, an African from Nigeria privileged by power may discriminate against an African from Ghana or vice versa. It is not a case of difference in race and or ethnicity only. This practice confirms that *difference based "solely on skin colour is not the only cause of discrimination in the health services; foreignness and accent also affect integration into host workforces"* (Allan, 2010:604). It confirms the CRT reasoning of Solórzano (1997:8) that racism, whilst endemic in society, extends beyond the Black-White binary. This partly explains why I prefer to use the word discrimination rather than racism in describing the prejudicial and illegal practices between people of the same or different races in this study.

CRT argues that whites have been recipients of civil rights legislation and that racist social assumptions were the bedrock of judicial conclusions. CRT believes that racism was enshrined in society's legal and social structures (Bell, 1992). This belief may have a bearing on how the IEN make use of formal complaint or tribunal proceedings in tackling issues concerning discrimination or racism in the workplace. For example, Osato believes that during restructuring exercises in NHS Trusts, "… *the internal system was a corporate kind of witch-hunting to get rid of black people…".* Equally, he had no confidence in support of trade unions in resolving work-related problems. According to Osato*, "Err… I belong to a union…they even advised me that if I have a chance, I should just go and do something else… The internal system was working with the… both the consultant and the nursing directorate." (Page 10, line 80).*

Allan et al.'s (2010) study on race and bullying cites Einarsen (2004) that work-related conflict often triggers bullying in the workplace. Bullying practices have evolved, but the ultimate result of workplace bullying is often the expulsion of the individual suffering the bullying. Although Osato did not specifically see his treatment by his manager as bullying, his lived experience confirms a case of an African Manager with power privilege discriminating against an African employee. Osato's lived experience demonstrates one critical method for restructuring roles and positions within the UK healthcare setting. His lived experience explains a mixed form of discrimination, which has evolved and seems like racial bullying (Allan, Cowie and Smith, 2009), that senior managers use during

organisational restructuring. From Osato's lived experience, highly placed senior white managers often influence and use willing managers of colour to discriminate against other staff members of colour. In an organisational restructuring exercise, these willing managers are encouraged to unfairly dismiss staff members of colour from their roles. The four-yearly changes at the macro-level of the UK healthcare setting driven by political changes at the national level after most national elections often result in restructuring at the micro-level of the NHS with the consequent effect that '*despite London trusts generally having the highest proportion of BME staff in the country, representation at the senior band is very low'* (WRES, 2019:16). This managerial practice partly explains why discrimination against the BME group was still pervasive in the NHS despite many positive action projects, especially promotion and recruitment to leadership and management positions (Ashraff;2013, Kline; 2013). This managerial practice also contributes to the 'Guinness effect' described by Osaro on how the discretionary discriminatory interpretation and application of organisational policies designed to promote equal opportunities by some managers continue to perpetuate inequity in promotion and recruitment to leadership and management roles in UK healthcare.

The lived experience of Ehi (see pages 131-134) confirms historical racism in healthcare. Although other respondents had reports of discrimination from patients, primarily community-based patients, of particular note was the discrimination against black community nurses by prominent political figures who facilitated migrant nurses' recruitment policies informed by racist ideology in the early years of the NHS.

The different types of discrimination recognised by law include direct, indirect, associative, perception, harassment, victimisation, and disability (Equality Act, 2010). In this study, the respondent's experience of discrimination is mainly about direct and indirect discrimination.

The discrimination experienced by the nurses in the UK healthcare services is manifest in a range of discriminatory practices such as racism, prejudice, double standard, and patronising statements, displayed in assessing the quality of work of the nurses during the period of supervised practice or adaptation, appraisals from managers, lack of support and cooperation by professional colleagues in the clinical area. There were also reports of discrimination from patients, primarily community-based patients. All the

respondents admit that there was discrimination in UK healthcare (Kline,2020), but their experiences of discrimination differ. Most respondents prefer to deal with direct discrimination because it is visible, and they can develop strategies to deal with it. Indirect discrimination is more subtle, but it is prevalent in UK society and difficult or impossible to eradicate (Allan, 2010). Trueland (2016: 15) *states 'In three-quarters of acute trusts BME staff were more likely than white staff to report being harassed, bullied or abused by staff; in almost 9 out of 10 acute trusts (86%), BME staff were less likely to believe their organisation offered equal opportunities for career progression or promotion compared with white staff; and more than 8 out of 10 acute trusts reported that BME staff were more likely to have experienced discrimination from a manager, team leader or colleague than white staff".*

According to the NHS London strategy workforce report (NHS, 2020*), 'Despite some improvements in recent years, there is no sign of the paradigm shift. We need to change things. Every survey over the last decade and every workforce race equality standard (WRES) report has shown that in shortlisting, appointment, promotion, and disciplinary processes, the effects of discriminatory systems are undeniable for BME staff' (p.7).*

Although Efe believes that research evidence of discrimination in the healthcare setting exists, she claims she has not suffered any direct discrimination. Indirect discrimination within the healthcare system may be covert and subconscious but not direct or overt discrimination. Efe gave an example of her lived experience of organisational or institutional practice, which perpetuates and fosters indirect discrimination in the NHS. There seems to be a resignation to learning to manage and deal with institutional and structural discrimination challenges. The individual's coping style to this menace of bias is related to experiences of multiple migrations and direct or indirect experiences of discrimination.

I recall a Nigerian nurse discussion discussing one of the coping measures for some ethnic minority nurses. This nurse was to be part of the respondent in this study. However, he could not participate because his two-year position was restructured in an organisational restructuring from Band 8 to band 6. In a reflective statement, he stated: *'I should not have aspired to become a manager. I should have remained clinical… on reflection; I should have worked to become a specialist nurse and remain there. Since working as a clinical staff on my current band with this fanciful title… do not be deceived;*

*I am a band 6; I have peace of mind' (*recorded in my e-journal kept as part of this study). However, this self-preservation practice supports the persisting impression amongst managers that Black, Asian, and Minority Ethnic nurses are less motivated to progress (Deegan and Simkin, 2010).

6.1. 3: Personal and Social Integration:

Personal and social integration is not a linear concept. It is affected by many factors, such as the lived experience of immigration, nationality challenges, and economic and social issues.

In an earlier study, Ager and Strang (2008) discussed social connection in the conceptual framework of integration, stating that social bonds, social bridges, and social links were essential facilitators of promoting integration in society. Social bonds describe '*connections that link members of a group, and social bridges indicate connections between such groups; social links refer to the connection between individuals and structures of the state, such as government services'* (pg. 16). In the Ager and Strang study, their interpretation of integrated community was one where there was harmony between the different groups—the conflict was absent, and groups tolerated one another. The second interpretation of an integrated community was a society where different groups mix freely. Some other understanding was that there is a feeling of 'belonging' by the individuals. Ager and Strang emphasised that in an integrated community, there were "*links with family, committed friendships and a sense of respect and shared values". Such shared values did not deny diversity, difference and one's identity within a particular group but provided a wider context within which people had a sense of belonging'* (pg. 13)

This study finds that the versatility of the individual's social, language and cultural currency in the new environment contributed to integrating into UK healthcare and the larger society. However, the more significant number of nurses in this study express that despite having dual nationality of British and Nigerian, they are seen as foreign nurses in UK healthcare settings. They believe that the issues affecting their total integration are that the larger society tends to be prejudicial despite their professional status as registered nurses. It was a case of 'colour before perception; and 'sight before sound', and this prejudicial attitude denies full acceptance of diversity and their identity

within the clinical setting and in the larger society. This assertion supports the CRT perspective that racism is endemic in society and is an everyday experience for people of colour (Solórzano, 1997). In recognising the importance of this practice in diversity and identity, I prefer to address the minority groups as the British Minority Ethnic group (BME). This preference contrasts the usual practice in research on race that often refers to all racial minority groups as Black Minority Ethnic (BME) or Black and Asian Minority Ethnic (BAME) groups (Rollock, 2021). This practice of referring to racial minority groups as Black Minority Ethnic (BME) or Black and Asian Minority Ethnic (BAME) groups is divisive. It promotes discrimination and inequality in society. It creates a feeling of 'them' versus 'us' in the psyche of the minority and majority groups. It sets up and reinforces the other minority groups against the Black people- (Black vs Minority Ethnic group) rather than the British Minority group, which sees every minority ethnic group as a British Minority. This Black and Minority Ethnic group or Black and Asian Minority Ethnic group label rather than British Minority Ethnic group continues to promote institutional racism. It continues to sustain discrimination and racism as an existential part of the daily working life of the ORNs' in UK healthcare (Larsen et al., 2005; Smith et al., 2008). As stated above, one of the interpretations of an integrated society was the absence of conflict and tolerance of the different groups, mixing of people from other groups and feeling of belonging (Ager and Strang,2008). The respondents in this study employed the conflict-handling modes of avoiding, collaborating and accommodating and less competing in the clinical environment because they wished to avoid conflict and possibly further discrimination. Despite suffering discrimination, prejudice and poor treatment, they worked with other groups without complaining, mainly because of the NMC Code (2018) requirement to work cooperatively as a team member to benefit patient care. The respondents had a mixed feeling of belonging in their environment and the clinical setting. Still, they expressed their sense of integration differently, as discussed in the early part of this section.

6.1. 4: Career Progression

This part discusses the lived experiences of IENs with Nigerian heritage career progression on integration into UK healthcare services following registration with the Nursing and Midwifery Council. This theme on career progression was to ascertain the lived experience of how nurses attained senior management and leadership positions and sustained the roles. Studying examples of success may teach us examples of good practices and other positive outcomes rather than the (usual) focus on barriers towards minority ethnic groups in UK healthcare. Women represent half of the world's transnational migrants, and in the care sector, many of these women migrants are lead migrants, and some migrate as accompanying spouses (Farashah and Blomquist, 2020). International studies have generally defined Nursing as a female-dominated occupation analogous to relatively low-status roles due to gender and income levels. They are influenced by '**cultural** perceptions of social status, the nature of the work and sexuality (Oddvar, 2014). From a human capital theory perspective, the decision to migrate by IEN is a rational choice, and it's a consideration of investment and rate of return from the migration. Human capital refers to the knowledge, experience, skills, abilities and other characteristics that individuals learn and develop through education and training. Workplace gender discrimination is rife in the UK. It refers to the gender-based practice of subjecting workers to a subordinate or disadvantaged position, not because of the human capital for the job but because of the sex of the individual (Newman, 2014 cited in Gauci, et al.; 2021). In the UK, men occupied 75% of senior positions despite 89.6% of nurses being women (Randstad Care, 2016), and a considerable number of women in the labour market are affected by workplace discrimination because women comprise the most significant number of nurses internationally (World Health Organisation, 2016). Workplace gender discrimination is social justice and a life-long economic issue for women (The World Bank, 2019 cited in Gauci et al.; 2021).

There are three subthemes derived from the analysis that relate to nurses' roles. This will be discussed where I use structure and agency in analysing workplace inequities and challenges. The themes relate to human and social capital: education, Mentorship/coaching and personal characteristics or behavioural preferences. The

respondents in this study had tertiary education outside of the UK before gaining NMC registration in the UK. Farashah and Blomquist (20201) define immigrants with a foreign university education who have moved permanently to reside and work in countries other than their own as qualified immigrants. They have some common attributes, such as agency in their international migration and a desire to enhance their career (Doherty et al., 2013).

Skilled or qualified migrant's foreign education often equates to "higher unemployment and a larger earnings gap between recent immigrants and native-born citizens, whereas local education decreases this gap" (Banerjee and Lee, 2015; Mahmud et al., 2014, cited in Farashah and Blomquist,2020:3). International nurses' integration may be cumbersome due to the lack of support from employers and regulatory bodies on how previous studies or qualifications by IEN may be recognised in Britain (Winkelmann-Gleed and Seeley (2005). However, in this study, the respondents attest to the importance of education as promoting academic knowledge and enhancing their professional skills and competence; education, they emphasise, prepares them to be ready and available to apply for promotion when vacancies become available. The relevance of education is demonstrated in resorting to self-funding of their education and training when managers fail to support their quest for further studies.

The respondents in this study may be classed as 'highly successful' nurses of Nigerian heritage in UK healthcare. They all had received tertiary education in Nigeria before becoming registered nurses in the UK. The motives for nurses' migration may be permanent or temporal moves (Buchan, 2007) and maybe deliberate decisions driven by personal, career and financial reasons (Allan and Larsen; 2003). The motive to migrate is often explained by either the equilibrium or structural standpoint (Alexis and Vydelingum,2004). Either of the two views is influenced by the socio-political and economic development of the migrant's country of origin. These factors, including educational preparation, shape the value of the IENs with Nigerian heritage on issues related to education and training in the destination country. These factors are classified under the content theories, which include human capital theory (HCT), career capital theory (CCT), intersectionality (IT) and cultural identity transition (CIT) (Farashah and Blomquist, 2020). HCT focus on individual-level knowledge, skills, abilities, personality and social attributes as determinants of migration and its consequences. CCT focus on

Individual human, social and motivational capital in interaction with organisational characteristics and strategies, determining migrants' career prospects. IT focus is on the Intersection of individual gender, migration status, country of origin and religion with institutional and cultural pressures that affect power relations in the host society; CIT Identifies different outcomes of acculturation and the associated antecedents and career outcomes (Farashah and Blomquist, 2020:6).

The educational system in Nigeria up to the late 1970s mirrored the UK education system. Post-1980, the educational practices metamorphosed into a mix of western educational systems dominated by the UK and American systems. This confers on the Nigerian Nurses the benefit of some level of readiness to fit into the UK educational system relatively well. This level of similarity in the educational system may have contributed to the motivation of these nurses to study for certification and choose career pathways where they felt gaining promotion to higher grades where possible. A number of the nurses progressed to more elevated positions where nurse shortages, such as care of the elderly, health visiting, district nursing, practice education and forensics (Snow and Jones, 2011). However, some nurses reported finding the educational method/learning style in the UK different from the method they were familiar with within Nigeria; they made a conscious and concerted effort to adapt to the new learning method. They had obstacles in the system because some Lecturers were prejudiced against their ability and the quality of their work without considering their previous educational background. The determination to weather the storm, overcome the challenges and hope for a better future (Meleis, 2010) may have become their personal goals and propeller to complete their studies despite the barriers.

The indicators of complete integration for international nurses include *'… selection to clinical leadership; and promotion to management or leadership positions, among others (Yu; 2008:2). In an earlier study* on how some Ghanaian nurses and midwives have experienced a system of processes and practices related to career progression, Henry (2007) found that the nurses had difficulties ascending into managerial positions in the NHS. The reasons for this difficulty included trouble integrating into the system of promotion in the UK which was different from the automatic promotion system based on experience in Ghana. Henry (2007) also found that the lack of upgrade to higher grades was caused by cultural differences, especially communication skills and an inability to

express their knowledge, skills, attitudes and other social characteristics in a way germane to the system. There was an endemic institutionalised managerial and organisational lack of support for the nurses and a lack of commitment to resolving the challenges.

Brathwaite (2018:254) argues that because BAME women are both female and are a non-white ethnic group, they are subject to ‘double colonialism’ (Peterson and Rutherford, 1986 cited by Brathwaite; 2018:254). Brathwaite, therefore, disagrees with the neo-liberal assumption that there is an “equality of inequality between BAME women and men in the workplace and the nursing profession”. However, in ‘Race in the workplace: The McGregor-Smith review’, BME women were more likely to get promoted than BME men (BME women’s overall promotion rate was 7.3% compared with 6.4% for BME men). In a King’s Fund study on ‘making the difference: diversity and inclusion in the NHS’, men were more likely than women to experience discrimination based on gender and more likely to experience discrimination based on ethnicity (6.1%) than women (3.7%) [West et al.; 2021: p.59]. This current study has not sought to investigate whether discrimination was experienced more by the men or the women in the study sample. However, the common thread in the lived experience was that all the participants in this study had experiences of discrimination in their career progression, which they had to resolve.

The relevance of institutionalised managerial commitment and organisational support to migrant nurses’ career progression is, in part, confirmed in this study. In this study, the respondents' career progression was influenced by the availability of necessary support to surmount barriers that would have otherwise prevented or truncated their career progression. The nurses who had access to career mentors/preceptors or coaches could plan their career pathways and experienced progress relatively quickly. The concept of mentorship related more to pre-registration nursing education and was first applied in the 1980s in the clinical environment. Allan (2010) argues that despite cultural diversity and ethics teaching within nursing curricula since the 1990s, discrimination against ethnic minority nurses was still endemic in mentoring relationships in the clinical area. These discriminatory practices were barriers to effective mentoring overseas nurses during the supervised practice programme in UK healthcare. Allan’s (2010) study reveals a lack of awareness about the effect of cultural differences on mentoring and

learning for overseas nurses during their period of supervised practice. Overseas nurses have been subject to discrimination and racism since the foundation of NHS (Snow and Jones, 2011). For example, migrant nurses were treated as students during supervised practice programmes, disregarding their previous educational and professional qualifications (Allan, 2010).

Preceptorship applies more to support and is available to newly qualified nurses, and its objective is to offer support and guidance to the newly qualified nurse. Therefore, it suggests that preceptorship is not designed to provide long-term support and may not significantly affect career progression and advancement. However, access and use of informal mentors and preceptors outside the nurses in this study's immediate workplace were very useful in enhancing the IEN knowledge in career progression planning and implementation. The mentors/preceptors offered guidance that contributed to the IENs' ability to advance their careers and navigate the obstacles in their career pathways. Significantly, the mentor and mentee were of the same cultural background; one was a medical doctor and the other a nurse. This access strengthens the relevance and importance of interprofessional learning and mentorship in career advancement.

From this study, the most significant benefit to the nurses at the Agenda for Change band 8 level is the need for coaching. From the lived experience of one of the respondents, coaching was suggested to him by one of the non-ethnic minority senior managers. The organisation did not offer coaching services, so the respondent had to pay for the services of a coach. This decision was wise as the coaching session provided him with the required skill and attitude to reflect on and analyse his use of conflict-handling modes in relationship with the senior managers in the organisation. This specialist's support, input and coaching enabled him to understand how to constructively use his emotional and political intelligence to break the glass ceiling that had kept him at the same grade for over eleven years.

In explaining the reasons for nurses' migration, equilibrium and structural perspectives (content and process theories) explain the reasons for the individual migration of nurses (Alexis and Vydelingum, 2004). According to the equilibrium perspectives or human capital theory, individuals are logical in their decision to migrate. Individuals will often count the costs and benefits before migrating to any country (Buchan and Secombe, 2005). The structural perspective uses the 'push and pull factors to explain the migration of nurses from developing nations to the Western world. From these perspectives, individuals relocate to other countries to take advantage of what is lacking in their home countries (Kline, 2003).

From the lived experience of the respondents in this study, the reasons for migration support the equilibrium perspectives rather than being influenced by "push and pull" effect perspectives. However, the rational explanation for migration may have been influenced partly by the 'push and pull' factors. Two respondents were born in England and taken to Nigeria by their parents. They returned as young adults because they felt that they belonged to the UK rather than Nigeria at that point in life. They studied Hotel and Catering Management and Biochemistry in Nigeria before becoming registered nurses in the UK.

Two out of the remaining eight respondents were registered nurses in Nigeria and had different reasons for coming to the UK. One was recruited internationally via the adaptation programme for work, and the other was on sponsorship by his employers, an oil corporation operating in Nigeria, for professional development training.

The remaining six arrived in the UK under varied conditions, mainly as visitors to their families and stayed in the UK for one reason or another. They all decided to train as registered nurses in the UK after their arrival and stay in the UK.

From the above, there are many reasons why people migrate from one region to another. It confirms that the motivations influencing overseas nurses' intention to migrate may include those driven by the decision to make a permanent or temporal move (Buchan 2007) and those inspired by personal, career, and financial reasons (Allan and Larsen; 2003).

Most of the respondents stayed in the UK to practice and build their careers in Nursing. This balances the concern that some IENs pursue other career options or return to their

home country due to failure to integrate (Zizzo and XU, 2009). These migrants eventually become part of the British Minority Ethnic –BME group and may not be distinguished from UK-born BME. From the findings of this study, most of the respondents trained in the UK as registered nurses and according to Muholland et al.; (2008), ethnic minority pre-registration nurses were less likely to suffer attrition and are more likely to complete their training in comparison to other groups of students. Thus, it is inevitable that the initiatives to train locally recruited people primarily aimed at increasing the number of nurses available in UK healthcare may further increase the multi-ethnic nursing workforce in the UK. Equally, the increasing diversity of healthcare staff in developed countries and the growing importance of diversity issues (WHO, 2014; Johnson et al., 2021) support the importance to emphasise the need to understand 'the 'how' of workforce race equality in the UK (WRES, 2019:5).

All the participants agreed in different ways that the individual's characteristics concerning professional practice have a lot to do with breaking through professional barriers or dealing with challenges to achieve higher grades. Personal factors also help utilise or make the most opportunities to gain higher grades and sustain the achieved position.

Hope, self-efficacy, coping, control, competence, flexibility, adaptability, hardiness, sense of coherence, skill recognition, and non-deficiency focusing (Simoni et al. 2004, Ablett and Jones 2007, Gillespie et al. 2007, Hodges et al. 2008) are examples of major personal characteristics that promote resilience.

In the many definitions of resilience, a central theme is the strength and ability of an individual to persist in overcoming challenging barriers (Hart et al., 2014). Resilience is inherent in individuals and describes when a person recovers easily and quickly from setbacks in life (Zautra, Hall, and Murray 2010).

All the respondents in this study demonstrate resilience in their effort to settle into society and career progression. Although in previous research cited by Hart et al. (2014), the age, experience and education of a nurse were not the determinants of resilience, this current study seems to offer a consideration of the importance of the experience of discrimination and multiple migrations in developing resilience in some of the nurses in this study. The case of Osaro in this study demonstrates how the

experience of overt, direct discrimination in Eastern European countries has contributed to his resilience in tackling the barriers to his professional advancement in the UK healthcare setting.

According to Hart et al. (2014), hope, self-efficacy, and coping are the three most essential variables in resilience. Hart et al. explain further that hope contributed the largest to the development of resilience. In dealing with organisational challenges and maintaining resilience, hope and optimism were vital factors. According to Hart et al. (2014:8), '*nurses who were able to recognise and identify their own situational concerns, reframe, adapt, and look forward to a time when the current situation might be altered were typically associated with higher levels of resilience. Additionally, nurses who buffered their current situation by considering the future and using coping mechanisms to aid in "moving through" (Hodges et al. 2008)* were described as those who exhibited greater resilience.

Despite living in harsh and challenging circumstances, some respondents' lived experience supports the importance of hope and coping mechanisms to aid in overcoming obstacles. They had hope and were optimistic for a better tomorrow, and there was no going back. For example, Osaro, currently an Assistant Director of Nursing, recalled his experience '*… I remember the money I take after paying my rent; I only buy bread, sneakers, or a mars bar inside it; that is food. And then, and technically, if one can look back now, thank God, the way things have taken me now, I could consider this period a very, very depressing time of my life. I think my health was affected; my confidence went down. And you see that, for example, most people who came from abroad and are in low-paid jobs have taken some money to come here. [**And to go back is not an option].***"

According to Glass (2009), flexibility, adaptability, and emotional intelligence are essential components of resilience. All the respondents in this study were adaptable and flexible to the challenging clinical environment and developed their emotional intelligence to advance their careers. However, one of the respondents argued that in addition to these qualities, ethnic minority nurses needed to apply emotional intelligence (EQ) and political intelligence or political astuteness to advance their careers and sustain their position when they attain a management position. The nurses' application of adequate human capital was paramount in dealing with institutional discrimination

and social practices of colleagues, managers and patients in making positive use of career opportunities.

6.1.5: Obstacles and Measures to Thrive

This section discusses the nurses' obstacles and the steps or factors that the respondents believed contributed to their career progression in the UK healthcare service. The obstacles or barriers include macro, organisational or structural and personal or individual level barriers and challenges on the nurses' career pathway.

The organisational barriers include employers' and discriminatory practices within the healthcare settings. Reduced progression rate (WRES, 2019, Johnson, 2021), communication, and organisational challenges in UK healthcare service (Allan, 2015) are some of the difficulties experienced by BME nurses in UK healthcare. BME nurses in the London region experienced the highest level of discrimination in the country (NHS Employers, 2017). This study was conducted in London. One of the findings in this study is corporate participation in promoting reduced progression rate by phasing out a string of Agenda for Change pay band 8b from some organisations. This practice creates an even more significant challenge for ethnic minority nurses to advance to the higher echelons of band 8.

Johnson et al. (2021) report that racial inequalities in career progression exist internationally across organisational sectors. In STEM (science, technology, engineering and math) careers in the USA, white workers earned more than Black and Hispanic workers by more than 15-19%, 27-33% higher in non- STEM jobs (PRC, 2018). In Europe, Black, Asian and Minority Ethnic workers are less likely to be recruited than white workers and have lower wages and lower hierarchy jobs (ENAR, 2017). IEN foreign education equates with higher unemployment and a more significant earnings gap between recent immigrants and native-born citizens. In contrast, local education decreases this gap (Banerjee and Lee, 2015, cited in Farashah and Blomquist, 2020). Equally, there are racial inequalities and discrimination within the healthcare systems (WRES, 2019, Deegan and Simkin, 2010; Larsen, 2007). According to Moore and Continelli (2016), other than discrimination, it is not clear why BAME nurses perceive fewer career development opportunities in their work and receive lower pay. In the UK, a recent report by BME Leadership Network; titled "Shattered-hopes-BME-leaders-

glass-ceiling-NHS" indicated that 50% of the BME NHS leaders in their survey had considered leaving the service in the last three years because of their experience of racism, and 90% of the survey sample did not believe that the NHS was fulfilling its commitment to fight institutional racism and reduce health inequalities. Also, about 75% of the respondents believed that their organisation has no robust talent management practice in developing diverse talent (NHS Confederation, 2022: 3-4).

From the nurses' lived experience in this current study, the factors that enforce obstacles to staff retention and career progression include management styles of managers, discriminatory practices exemplified by prejudice, stereotyping, labelling, marginalisation, and prejudicial use of staff names, race and nationality. This may explain why BAME and migrant nurses perceive fewer career development and progression opportunities in the UK healthcare system.

BAME staff in the NHS are 15% less likely to have professional training than white staff (WRES, 2019). This supports an earlier finding by Alexis et al. (2006) that managers discriminate against migrant nurses in granting access to professional development opportunities. Black, Asian and Minority Ethnic and migrant nurses express that healthcare managers facilitated discriminatory practices favouring their white colleagues to attain senior positions, higher pay, and tasks assigned to their white colleagues (Deegan and Simkin, 2010; Larsen, 2007). In another study, West et al. (2021) found that developmental work with challenging experiences, which are likely to result in professional growth, learning and positive development for BME staff, were more available to BME men than BME women and that BME men were assigned more challenging work than BME women. The lived experience of the respondents in this study supports these earlier findings. There is also a belief that BAME nurses may be more reluctant to apply for promotion than White nurses and midwives and that this could contribute to slower career progression than white nurses (Alexis et al., 2006; Larsen, 2007). Respondents in this study report that some managers selectively sponsor their preferred candidates for higher positions in the organisation. This favouritism partly explains the reluctance of BAME nurses to apply for promotion.

Although the quantitative study conducted by Johnson et al. (2021) demonstrates no significant difference in the perception of managerial support between BAME and white nurses, the findings from this study suggest that organisational support was skewed in

favour of white nurses. The reluctance of some BAME nurses to apply for positions may be due to the belief that while some managers support equal opportunities for staff, they perpetuate discriminatory practices discreetly. From the findings in this study, some managers often encourage ethnic minority staff to apply for higher positions when they have no intention of appointing them. Such managers are interested in using the ethnic minority application for statutory statistical purposes and evidence of the organisation or department's steps to promoting diversity and equal opportunity. A number of the managers head-hunt their candidates before advertising a position. The search for a suitable candidate seems open to everyone, but a specific individual is prior designated for the job in reality. The above may, in part, explain the recent finding in Johnson et al. (2021) study that the application success rate was higher for whites (55.1%) compared to 50% for BAME and that there was a higher likelihood of success for white participants in interviews than for BAME nurses. The number of posts applied for before success was also higher for blacks than for white. The number of applications before success was statistically significant between white and BAME nurses.

Some measures IENs with Nigerian heritage use to obtain and thrive in the senior position include but are not limited to applying for clinical/specialist-oriented jobs. Institutional culture is the totality of the beliefs and values that guides the organisation (Nelson, 2006). Nigerian heritage nurses often seek out organisations known to be equality–focused with a culture that encourages professional development and supports career progression for ethnic minority nurses.

From the findings of this study, there is a general mistrust of Human Resources and Trade union support where conflict exists between the nurses and their managers. The nurses often avoid litigation and prefer to leave the organisation. Some respondents use working as Agency consultants to obtain higher grades and use the flexible nature of their role to negotiate their movement between one organisation and another. The respondents claim they get higher pay than they may have received as permanent staff. Many respondents identified African names as a barrier to career progression because of managers’ and some professional colleagues' prejudice and stereotype of Africans. The solution to this problem was either anglicising or changing the pronunciation of their name, abbreviating or shortening the name to ease pronunciation. Self-actualisation is not an end state but is always in a continual process of becoming. People who were

‘fulfilled and doing all they could qualify as self-actualised persons (Hoffman;(1988) cited in McLeod, 2018). It is the need for the Nigerian nurses to become self-actualised that often propels the nurses to see obstacles as challenges or opportunities to thrive, and this aids the development of their intellectual and personal energy and, as a result, can develop their professional values and skills (Domino, 2005).

6.2: Implications of the study for organisational and clinical practice

The findings from this study have contributed to the concept of workplace integration for international nurses. Most studies on the integration of migrant workers have been quantitative studies conducted from an economic perspective (e.g. Villosio, 2015). This qualitative research examines the lived experience from structural, social, cultural, civic and political views on integrating the registered BME nurses of Nigerian heritage into UK healthcare. It offers insight and further understanding into the post-transition phases or the long-term integration of BME nurses (Ramji and Etowa, 2014). This study informs IEN integration theory and practice to promote knowledge and develop best practices in training, managerial and continuous professional development framework for integrating nurses with Nigerian heritage into the UK healthcare post-NMC registration. The findings of this study are significant for nurses and policymakers in UK healthcare. It is relevant to Nigerian and minority nurses on the process, practice, or strategies to attain higher grades within the UK healthcare industry. For example, the findings indicate that ethnic minority nurses may benefit from coaching sessions, effectively using emotional and political intelligence to establish relationships with managers, pursue education, and become more motivated and resilient.

The findings from this study reveal that there are three different group beliefs around the concept of integration. Some see integration as an impossibility because of discrimination in the workplace and the larger society. Some of the respondents see integration as a unidirectional process in which migrants must make an effort to understand and integrate. The third stream sees it as bi-directional learning of each other’s culture and accommodation of cultural differences. The larger population should learn about the migrant and help with the integration. The findings from the first stream that integration is a farce and impossible because of discrimination in the workplace and the larger society is peculiar to this study and a significant contribution to knowledge.

The policymakers and curriculum planners may promote a professional understanding of nurses' integration in policy formulation regarding recruitment and retention of nurses into UK healthcare by creating programs and processes that foster the long-term integration and professional development of British minority ethnic nurses.

The findings may also indicate the steps or practices other ethnic minority nurses may have to take to navigate the career pathway successfully and contribute towards changing the label of the NHS as institutionally racist in, for example, the opportunity to gain promotion by ethnic minorities.

From the finding on how ethnic minority nurses navigated their career pathways, managers in organisations may better understand and promote equality, diversity and inclusion practices. Managers may promote a new understanding that BME nurses are well motivated and not shy to aspire to promotion.

The results of this study also indicate the need to promote organisational transparency in promoting equal opportunities. From the nurses' lived experience in this current study, some NHS Trust phase-out AfC band 8b position, thus making it more challenging for staff to move from band 8a to 8c. The equalities commission and other regulatory bodies must realise that collecting statistics on the workforce alone cannot promote effective development and management of the staff. There is a need to encourage managers to give a detailed breakdown of the ethnic groups of the occupiers of each pay band. The managers should also justify or offer a rationale for each staff's ethnic group of occupiers in the agenda for change pay bands. Therefore, organisational practices need to be revisited to understand 'the 'how' of workforce race equality in UK healthcare (WRES, 2019:5).

The factors that enforce obstacles to staff retention and career progression include management styles of managers, discriminatory practices exemplified by prejudice, stereotyping, labelling, marginalisation, and prejudicial use of staff names, race and nationality. This may explain why Black Asian Minority Ethnic and migrant (BAME) nurses perceive fewer career development and progression opportunities in the healthcare system. This practice requires self-introspection, training, assessment, and evaluation by the management team to promote equality within the organisational space.

6.3. Methodological considerations and critical reflections: Strengths and limitations

The primary data collection method in this Interpretative Phenomenological Analysis study uses open-ended questions in a recorded semi-structured interview. There are several IPA studies in healthcare, education and other areas of study (Smith,2014), but this is the first study, as far as the researcher is aware, that uses this approach to the lived experiences of integration of internationally educated nurses with Nigerian heritage into UK healthcare.

This study adds to the current body of research by exploring the integration experience of a group of nurses with Nigerian heritage practising in UK healthcare. The study offers a lived experience account and exposes the dynamic, phenomenological layers of what integration into the UK healthcare and UK post-NMC registration is like within the life world of nurses with Nigerian heritage within the UK.

This study offered nurses of Nigerian heritage the opportunity to promote understanding by telling their stories or telling their lived experiences. The participants were able to share their career progression strategies in becoming integrated into UK healthcare services. This study has used personal and epistemological reflexivity (Dowling, 2007) to offer a significant opportunity to understand the phenomenon under study.

Through dialogue and openness between researcher and participants, I have become part of the participants' historical, social, and political world, which has led to the ‘identification of ‘the meaning or essence of the experience’ (Tuohy et al., 2012). Smith (2007) states that IPA is an iterative and inductive cycle that proceeds by drawing on a repertoire of innovative strategies. This study is innovative in illuminating the complexities of the integration phenomenon for IENs with Nigerian heritage in UK healthcare. It underlined the relevance of understanding the lived experience of integration into UK healthcare post-NMC registration and how this impacts the nurses worldwide. There is a need to continue to probe the lived experience of integration to promote understanding and increase knowledge of the process within UK healthcare and the larger society.

During the interview analysis, I understood and was curious about the phenomenon under study. I had to use reflexivity to minimise the influence of my personal experiences

and prior knowledge influencing data analysis (Le Vasseur, 2003; Finlay, 2008). Analysis of the lived experience was multi-layered and presented at the descriptive and interpretative levels.

In engaging in the hermeneutic circle, I maintained the internal consistency or coherence of the cluster themes, which involved 'lived space', 'lived time', 'lived body' and 'lived human relation' of the respondents (van Manen,1990 cited in Tuohy et al., 2012). The circle enabled me to move between the text's discrete chunks (individual or lower level) and the greater whole of the cluster (Gadamer, 1997). I constantly reminded myself of the need to maintain a reflexive relationship with the text to sustain closer affinity with the phenomenon and thus promote transparency in analysing the data. My personal and epistemological reflexivity (Dowling, 2007) gave me a more significant opportunity to understand the phenomenon under study and the research process (Watt,2007). The respondents expressed their experiences as emotionally compelling, evocative, and sometimes exhausting. The findings provided a detailed description of the respondents' lived experiences at the idiographic and group levels.

The methodology of this study is IPA. The method recognises the role of the researcher as a foundational aspect of good research (Smith, 2010). It is a method suitable for a topic that is 'dynamic, contextual and subjective, relatively under-studied and where issues relating to identity, the self and sense-making are important (Smith and Osborn, (2007). This current study is under-researched and poorly understood and represents a gap in the integration experiences of internationally educated nurses into the recruiting healthcare (Ramji and Etowa, 2014) and is therefore well suited for IPA.

According to Cottrell (2014: 103), the disadvantages of phenomenology include the '*generation of unusable information that is time-consuming to work with, differences of experiences that may not be representative of others' experience and the difficulty of identifying the impact of the researcher's subjective role*. Giorgi (2010) argues that IPA is weak in methodology because it is not replicable. Smith (2010) disagrees with these arguments because IPA is not prescriptive and is a qualitative rather than a quantitative method; therefore, these criticisms are farfetched.

IPA researchers focus on 'theoretical transferability rather than empirical generalizability' (Smith, 2009). In IPA, broad generalisations may not be possible, but

findings may lead to valuable insights with more general implications (Reid et al., 2005). IPA aims not to generate ‘Theory’ with a capital ‘T’, but the findings from IPA studies may ‘influence and contribute to theory in a broader ‘lower case’ sense (Caldwell; 2008 in Pringle et al. 2011:21), sometimes known as ‘mid-range theory’

The research had a sample of ten respondents selected using purposive sampling. In this study, networking and snowballing strategies were used to gain access to participants and rapport was established with the participants by showing a sense of interest and concern (Streubert-Speziale and Carpenter, 2007). The participants' interviews resulted in a deeper understanding of the lived experience of integration into UK healthcare. The aim was to contribute to existing knowledge and inform other research areas on integration for internationally educated nurses. A sample of ten participants may seem small. Still, this small number is advantageous because it enables the researcher to engage in a more detailed and in-depth analysis and give voice to the individual’s lived experience (Smith, 2009; Wagstaff et al.; 2014) as researchers are encouraged to ‘go beyond’ immediately apparent content (Smith et al., 2012) in analysis and discussion of findings.

The participants shared common characteristics as nurses with Nigerian heritage working in UK healthcare and a leadership/managerial position of minimum AfC band seven. The participants were employed in UK healthcare and lived within the London area. Pringle et al. (2011) argue that when a sample is too narrow and homogenous, it may raise the question of transferability and applicability to other areas or groups. However, acknowledging and clarifying the limitations relating to the participants may resolve this drawback.

I used recorded semi-structured one-to-one interviews and a diary to collect the data for this study. The in-depth interview allowed the participants to “give a rich, detailed, first-person account of their experiences” (Smith et al., 2012:56).

I used an interview schedule to help me prepare for the interview's likely content and set a loose agenda for the interview (Smith et al., 2012). In conducting a pilot study, I knew the limitations of my interview design during the pilot study. I was able to rectify the limitations in the actual interview sessions.

I used open-ended questions in the interview. Secondary prompt questions were asked not to influence the respondents' narratives but to encourage them to share their ‘’what it is like’’ experiences. On reflection, it was essential to use the interview schedule as it prevented straying away from the lived experience that the study sought to generate. It enabled me to keep the respondents emotionally safe and get as much information as possible within the interview time frame of 45-90 minutes (Smith et al., 2012) in a passionate, sensitive, reflective interview session.

As previously indicated, I was immersed in participants’ level of trust in sharing their experiences with me as one of their ‘own’. I was consciously aware of the possibility that respondents may struggle to offer their narrative so as not to be seen in a bad light, as I have known some of the respondents in my work life in the NHS. I had to declare upfront my intentionality and positionality in the discussion. I had to build rapport to promote comfort and encourage them to know what the interview was about, the rationale for the interview, and to trust me. As previously indicated, I made sure that I did not share my personal experiences to validate their experiences or support or encourage their zeal to continue their determination to continue their career progression. I made every effort to conceal my emotion and provided a listening ear, and I was sure that my recording devices were on and recorded correctly.

My choice of IPA as a methodological approach has provided me with an opportunity to a better position to approach the topic honestly and openly’ (Smith et al.; 2012:.27). My cultural competence has helped to ‘infuse and suffuse the entire research process of planning, theory development, instrumentation, analysis, and interpretation to ensure cross-cultural validity and reliability (Brandt, 1999 cited in Archibong and Darr 2010:15). IPA as a methodological approach recognises the personal and professional influence of a researcher’s experiences on the research process (Smith et al., 2014).

I recognise that this study has to answer specific research questions, so I directed my analysis to answer the research question. Consequently, another researcher can identify different themes and findings within the lived experience of integrating nurses with Nigerian heritage. Therefore, this analysis is one possible account of the lived experiences of the participant’s integration into UK healthcare following their registration with the Nursing and Midwifery Council (NMC).

As outlined in chapter four (Analysis), Smith et al. (2012) argue that there is no single prescribed analysis method for working with data in an IPA study. However, I followed the Smith et al. six-step heuristic framework for analysis to be creative and maintain an idiographic focus on the data.

The heuristic framework facilitated a step-by-step guide to analysing the data and remaining attentive to participants' narratives' idiographic nature. It enabled me to step in and step out of an interpretive, reflexive stance (Finlay, 2011) and thus engage in the epoché of the phenomenon. My professional and educational background helped me maintain my connection and attention to the data at the idiographic level. It helped me support a phenomenological mindset whilst applying an existential viewpoint in this study. I consider this quality as one of the essential characteristics that are strengths of this study.

In my attempt to achieve balance, I reminded myself that reflexivity is "…the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015: 220). This provided me with an avenue for improving self-awareness in the study. Through reflexivity, I maintained a balanced view in the analysis by objectively and professionally offering a sound interpretation. In this study, I used a type of bracketing or reduction advocated by Finlay (2008) that involves acknowledging influences and possible bias at each stage of this study.

I used a research journal as the primary tool to engage in reflexivity, as Mann (2016) advocated. In addition to maintaining an e-journal, I have engaged in the reflexive interview and data analysis, discussion and review of comments from my supervisory team, and seminars in conferences and with professional colleagues to ensure reflexivity in this study.

6.4: Reflexive Account writing the chapters

In writing this chapter, I have had to dialogue between my findings and the extant literature to illuminate or problematise what was found in other studies (Smith et al., 2014) and identify my study's contribution to this literature. Writing this chapter was a challenging experience and revelation.

In writing the chapter, I had to do an extra literature search to frame the new angles resulting from the study's analysis section. The challenging experience stems from the absence of a structure to follow, as in Smith et al.'s (2014) heuristic model in the analysis chapter. Another problematic issue was finding literature that resonated with the findings in the discussion section. This search was more of a problem because of the absence of enough current literature regarding Nigerian nurses. I turned this into an opportunity to gather my thoughts and state what I saw as essential aspects of the nurses' lived experience in this study. I engage reflexivity to engage more in what had been unearthed by the analysis concerning the extant literature. In appreciating the methodology used in this study, I was more aware of the relevance of stating my ontological and epistemological position in conducting this research.

I wrote a chapter at a time and obtained feedback from my supervisory team on each chapter. In writing each chapter, I had to sustain my line of thought without straying into unrelated territories. The discussion chapter allowed me to produce more profound interpretations of the study's findings. I read the introduction and literature review chapters several times in writing the discussion chapter, reflecting and questioning what I had previously written. I had to read some new research to source adequate citations for unexpected findings from the data analysis. This process gave me a richer understanding and became better acquainted with the participants' lived experience at the idiographic and general level of this study. In doing this, the entire essence of the study as a cohesive whole rather than a segregated chapter or unit started to emerge and take shape.

It was challenging and fulfilling to link the emerging themes with the theoretical base of this research. I have used the tenets of CRT, PCT and Intersectionality theories in my reasoning to discuss or challenge standard or popular interpretations in the literature. This approach assisted me in feeling the importance of the hermeneutic cycle in more

excellent dimensions through my engagement in a constant process of reflexivity. It enabled me to become a part of the historical, social, and political world of the participants resulting in a ‘mutual construction of the reality and identification of ‘the meaning … of the experience’ (Tuohy et al., 2012) and understanding and discussion of integration into the UK and UK healthcare of IEN with Nigeria heritage post-NMC registration.

CHAPTER SEVEN

7.0 Contributions, Validity, Limitations, Recommendations and Conclusion

I begin this concluding chapter by discussing the original contributions of this study, validity issues, limitations of the study, some recommendations and suggesting possible areas of further research. I conclude the chapter by offering a reflexive account of my experiences while writing this thesis and a summary and conclusion.

7.1. Original contribution to knowledge

There are several IPA studies in healthcare, education and other areas of study (Smith,2014), but this is the first study as far as the researcher is aware of using this approach on the lived experiences of integration of international nurses with Nigerian heritage into UK healthcare. This study fills the research gap that exists in this dimension.

The concept of workplace integration of internationally educated (IEN) nurses is poorly understood. Despite the increasing nursing literature and interest in IEN, there remains a paucity of research and nursing literature on the long-term integration of IEN (Ramji and Etowa, 2014). My study contributes to the sparse literature on the lived experience of IEN in long-term integration into UK healthcare. It offers insight and further understanding into the post-transition phases or the long-term integration of the BME nurses (Ramji and Etowa, 2014) in UK healthcare. As revealed in the literature review, there are some common grounds for defining integration, but there is no singularly accepted definition of integration. The findings from this study reveal that participants experienced and viewed ‘integration’ in three different ways. Some see integration as a farce, and an impossibility, because of discrimination in the workplace and larger society. This perspective is a new, distinctive and significant contribution to knowledge on the explication of integration. Some respondents in this study see integration as a two-way process in which the migrants must make an effort to understand and integrate; the larger population learn about the migrant and help the integration. The third stream sees it as bi-directional learning of each other’s culture and accommodation of cultural differences. This third stream’s perspective confirms Morris’s (2002) view that integration is a two-way process in which immigrants are acknowledged for who they

are, despite being different. These bi-directional perspectives or streams confirm what is already known in the literature on integration.

The study suggests that highly successful nurses of Nigerian heritage in UK healthcare tend to be those who had received tertiary education in Nigeria before becoming registered nurses in the UK. This finding is a new, distinctive and significant contribution to knowledge on integrating IEN into UK healthcare. This finding supports earlier views that employers often disregarded previous experiences or qualifications of IEN, resulting in their employment in lower grades in UK healthcare (Allan, 2010: 604).

Although the NHS is institutionally racist (Kline, 2019), the respondents' lived experience in this study suggests that discrimination in the NHS is not simply an issue of staff of white race against the staff of black ethnicity. The findings describe the complexities of racism and discrimination and how it affects the working lives of the IEN and, subsequently, their integration. This lived experience of racism and discrimination supports the effort to tackle inequality in the workplace and society, resulting in the grouping of colour, nationality, and ethnic or national origin under race as protected characteristics (Equality Act, 2010).

This study indicates general mistrust for Human Resources and Trade union support where conflict exists between the IEN and their managers. The nurses often avoid litigation and prefer to leave the organisation.

This study contributed to knowledge by eliciting some measures used by some nurses with Nigerian heritage to obtain and thrive in a senior position in UK healthcare. This finding may also benefit other ethnic minority nurses in navigating the career pathway successfully and contributing towards a change of the tag of the NHS as institutionally racist in, for example, the opportunity to gain promotion by ethnic minorities.

A further contribution from this study is that the respondents use working as Agency consultants to obtain higher grades and use the flexible nature of their role to negotiate their movement between one organisation and another. This practice influences how nurses feel integrated into the clinical environment and the larger society.

The study suggests that training and applying for jobs that are clinical/specialist oriented was a strategy to get higher grades in UK healthcare. The general feeling from the

respondents indicates that staying in clinical roles was a safer option than discriminatory organisational practices.

The study suggests that using the services of a coach and/or mentor was essential to obtain and thrive in senior positions in UK healthcare. The access and use of informal mentors and preceptors outside an ethnic minority nurse's immediate workplace may assist in career progression. This raises the relevance of interprofessional learning, coaching and mentorship in career advancement. This interprofessional collaboration and practice may promote support and integration into the professional setting and UK healthcare.

The study suggests that nurses of Nigerian heritage often seek equality–focused organisations with a culture that encourages professional development and supports career progression for ethnic minority nurses. Successful integration helps staff retention in an organisation and benefits the individual with job satisfaction and better patient outcomes.

The study suggests that personal characteristics were important in gaining higher grades, sustaining the position and becoming integrated. Examples of such personal characteristics revolve around resilience, intrinsic motivation, and the ability to use the different levels of intelligence, including emotional intelligence, political astuteness or political intelligence, and good natural intelligence or intelligence quotient [education]. Other critical personal characteristics include effective communication skills, the right attitude to work, high self-esteem, assertiveness and effective negotiating skills, requisite knowledge and clinical skills, and excellent professionalism in clinical practice.

The study suggests that Nigerian nurses' motivations to migrate to the UK support the equilibrium perspectives more than the ‘push and pull’ effect. It indicates that IEN migration is a planned and calculated measure to promote individual development and progress. This planned migration suggests that individuals may decide or determine the extent to which they want to become integrated into their new environment.

The study suggests that Nigerian nurses pride themselves on speaking and writing English proficiently and do not have communication difficulties that they cannot resolve quickly. The historical link between the UK and Nigeria and respondents’ confidence in having received formal education in the English language in Nigeria are significant

factors in their choice of the UK as a destination country. Therefore, it is intriguing that some respondents claim that integration was a farce and an impossible phenomenon.

All but one of the ten respondents in this study arrived in the UK without being recruited overseas. It is significant to consider a review or rethink the practice of travelling from the UK overseas to recruit Internationally educated nurses for nurse training. There are migrants in the UK or migrants that can come to the UK that are interested in training as registered nurses if there are no immigration obstacles that prevent their application and training and will reduce the cost involved in international recruitment.

From this study, all the Nigerian nurses have dual nationality from the United Kingdom and Nigeria. The dual nationality of the respondents influenced their integration into UK society and, consequently, their retirement plans. For a number of the participants, the retirement plan was not clear-cut. The plan included working part-time in the healthcare setting or returning to Nigeria to use the experiences gained in the UK to provide healthcare-based services to the Nigerian society.

7.2. Issues of validity and quality of the research.

In discussing the process of assessing validity, Smith et al. (2012) discussed how Yardley (2000, 2008) approaches might evaluate the validity and quality of qualitative research. Yardley (2000) proposed four broad principles for assessing the validity and quality of qualitative research. The four principles are:

- Sensitivity to context
- Commitment and rigour
- Transparency and coherence
- Impact and importance.

In addition to the approaches proposed by Yardley, Smith et al. (2012) added independent audit as a fifth principle. I will now discuss one after the other how this study has satisfied the four principles or guidelines discussed by Yardley (2008) and the independent audit practice.

7.2.1: Sensitivity to context:

This study demonstrates sensitivity to context in the socio-cultural milieu I have set this study. I began showing sensitivity to context in choosing IPA as a method because of my conviction that the wealthiest and most relevant data are within the participants' perspectives to collect the required data (Groenwald, 2004).

I engaged with participants to obtain the necessary information taking cognisance that I have to interpret what the participants have understood and made available to me as the researcher. This approach promotes a focus on the idiographic and the particular in analysis and interpretation of the data.

I held Interviews with the participants in their preferred venue and a conducive and relaxed atmosphere. There was a good rapport between the participants and myself to promote dialogue in encouraging the narratives to run smoothly. The participants had an informed consent form containing an introductory statement about the study. After a brief discussion of the interview layout or schedule, the participant had the opportunity to ask questions about the study. I applied reflexivity and declared upfront my intentionality and positionality in the discussion. Before each interview, I reflected on every preconceived opinion about the phenomenon under study. Through my engagement in an extensive literature review, I had the requisite information to consider the social context of the research. I made a good grounding of the analytic claims in my findings using ‘verbatim extracts from the participants’ material to support the argument being made’ (Smith et al., 2012:180). This idiographic approach gave the IEN with Nigerian heritage a voice in the study and gave the reader the leverage to check the interpretations I have made in the study. The interpretations made in this study are not definitive and are presented cautiously to the readers. The findings were contextualised in discussion and dialogue using relevant extant literature to the phenomenon of study.

7.2.2: Commitment and rigour

According to Smith et al., 2012: 181, ‘… a demonstration of commitment can be synonymous with a demonstration of sensitivity to context’. I was attentive to the participants' comfort and stories during data collection and analysis on a case-by-case basis. Rigour refers to the thoroughness of the study (p,181).

I employed purposive sampling from a homogenous sample of participants that meets the study's inclusion criteria. I chose the homogenous sample carefully to match the research question. I used the interview schedule to conduct in-depth interviews to address the research question and the participants' lived experiences of integration into UK healthcare.

In the analysis, I maintained rigour by engaging in a multi-layered data analysis process using the Smith heuristic model framework to offer beyond a 'simple description of what there is to an interpretation about the particular individual participants and something important about the themes they share' p. 181. The emergent themes from the study are supported by a judicious selection of suitable and representatively appropriate illustrations or quotations from the account of the respondents and relevant current literature.

7.2.3: Transparency and coherence.

To ensure transparency in this study, I have made every effort at each research stage to describe the process in as detailed, concise, and explicit language as possible.

In promoting transparency, I have described carefully how the participants were selected, how the interview schedule was constructed, the process involved in conducting the interview and the steps in data analysis. Examples of the interview schedule, the transcript from the interview, and elements of the analytic process are all in the appendix of this study.

In ensuring coherence in this study, I have maintained a close fit in the report to be consistent with the underlying principles of IPA. This tight fit ensures that the phenomenological and hermeneutic domains are evident in the write-ups. The focal topic was the experiential phenomenon of integrating a homogenous group of nurses with Nigerian heritage into UK healthcare. As advised by Smith et al. (2012), I have made an effort in the write-ups to attend to the phenomenon closely and have been nuanced and cautious. I have been conscious of the third hermeneutic level (Smith et al., 2012). Thus, I have always imagined the reader's interpretations being 'positioned as attempting to make sense of the researcher trying to make sense of the participant's experience' p. 182.

My supervisory team monitored and offered suggestions at each stage of the process in this study. The supervisory team also served as independent auditors in promoting the study's validity. I have also provided ongoing reflexive accounts of the study's process as a further testament to validity.

7.2.4: Impact and importance

A test of a study's level of validity is the dimension to which the findings are useful, important or interesting to the readers (Smith et al., 2012). I consider the findings in this study to have illuminated the integration of internationally educated nurses into UK healthcare.

This study's full impact, contribution, and importance will become evident with time. As it stands, I am conscious that I can only discuss the potential impact and significance of this study; it is time that will prove the impact and importance.

7.2.5: The Independent Audit

An independent audit is an important way of checking the validity of a study. The independent audit's primary objective is to ascertain that the report of a study is plausible or credible about the study's data. It also ensures a logical step-by-step path through the chain of evidence (Smith et al., 2012:183).

I have maintained a 'paper trail' of all the data in a file on a password-protected computer from initial documentation to the final report, as Smith et al. (2012) suggested. I have a clear record of initial notes on areas to research, initial notes on the research question, and the research proposal with comments from supervisors. I also have a record of the interview schedule, interview tapes, transcripts of interviews, annotated transcripts, tables of themes, draft reports with comments from supervisors, a reflective diary and the study's final report.

I sent the first three transcripts of this study with my reflexive account to my supervisors to review what may qualify as 'mini audits'. The supervisors' comments and suggestions helped confirm the validity of data from the interviews and the approach used in the study. The supervisors offered suggestions and comments on each study chapter as and when submitted. The comments informed part of the discussion during the supervisory meetings.

The supervisors also offered their suggestions and observations about what they saw as exciting and essential in the data during my analysis, especially in the process leading to generating emergent themes and findings.

The independent audit process has helped me demonstrate my commitment to this study's quality and validity.

7.3: Discussion of limitations of the study.

Although I have taken some steps to promote the validity of this study, I understand, as Goes and Simon (2012) stated, that every study has limitations. The intractable problems that are the limitations of this study which I will discuss in turn include:

- Recruiting participants for the study
- The sample size in an IPA study:
- Lack of prior research using IPA in area of study
- Criticism of the difficulty in achieving rigour and criticism of subjectivity
- Data collection method
- Research bias

Recruiting participants was a limitation in this study because few senior BME nurses of Nigerian descent (band eight and above) agreed to participate. Recruiting participants was not easy, especially matching possible participants with the inclusion/exclusion criteria. Whereas many participants have been very enthusiastic about learning by participating, a few have been wary and not so bold in talking about their experiences in their integration and career progression. Some may have been concerned with their emotional interest and may have reservations about their lived experience in greater depth.

Another limitation is the sample size in IPA studies. There were 10 participants in this study which is judged adequate by Smith et al. (2012) for a PhD study. This criticism of the small sample size in IPA may also be a strength because it allows for deeper analysis past the immediately visible content (Smith et al., 2012). Another limitation is that the sample size in the study limits the generalisability of the research findings. This study was conducted in London, where most participants had career experiences. The levels of international recruitment vary from 30% to 36% in London regions to 5% to 8% in the northeast, northwest, and Yorkshire and Humber regions (NAO, 2020:8). The

nurses' lived experience may be different from others living in other areas of the UK. However, BME nurses in the London region experienced the highest level of discrimination in the country (NHS Employers, 2017). The study may be limited because the nurses come from different parts of Nigeria, have differing migration experiences and have different experiences in the acculturation process (Thompson, 2013).

The lack of prior research using IPA in the study area of nursing was a further limitation. A search of the literature database using CINAHL, BNI, Medline, Internurse, etc. and hand searches through books and journals in the university library revealed little research on long-term integration lived experiences of African nurses in UK healthcare, and none used IPA. There was no IPA research on African nurses lived experience post NMC registration, and indeed, none on IENs with Nigerian heritage lived experience in UK healthcare.

A criticism of IPA is the difficulty in achieving rigour and criticism of subjectivity in the study. I have discussed how I have ensured this study's rigour and advanced validity in the earlier part of this chapter. I have used the interview method supported by an e-journal to collect data for this study. Other methods that may be used as IPA data collection methods include diaries, narrative accounts, email discussions, and focus groups (Brocki and Wearden, 2006). Whereas IPA allows the use of the diversity of collection methods, Brocki and Wearden (2006) argue that researchers do not often report the limitations inherent in their data collection methods in detail.

Another limitation associated with the use of IPA is research bias. I have used reflexivity at each stage of this study, especially data collection and analysis, to address research bias. I have endeavoured to give a rich and transparent account in line with extant literature to enable the reader to make a fair assessment of the significance and transferability of this study to inform and contribute knowledge to an existing or new theory on the integration of British Minority Ethnic nurses.

7.4: Recommendations for Future Research:

Most studies on the integration of migrant workers are quantitative studies conducted from an economic perspective (e.g. Villosio, 2015). However, understanding of the concept of integration into the workplace is poor within healthcare (Ramji and Etowa, 2014). Most available nursing literature focuses on initial adaptation (short-term integration). Some describe the programmes put in place to help with the adaptation or transition of international nurses into the workplace from the perspectives of various stakeholders. For example, [Allan and Larsen (2003); Allan et al., (2004); Gerish and Griffith (2004); Moyce et al., (2007); Alexis and Vydelingnum (2004); Moyce et al., (2016)]. Whereas there is a concentration of research on international and ethnic nurses, there is minimal research into the lived experiences of African nurses with Nigerian heritage in the United Kingdom (Likupe, 2006) post NMC registration.

Equally, there is a shortage of nursing literature focusing on integrating international nurses post-NMC registration. The few studies on post-NMC registration focus on areas other than long-term integration. For example, Smith et al.; (2006) focused on post-NMC registration and career progression, and sampling was not purposive but was sampled through NHS trusts and Care homes and not at the individual or ethnic group level. The closest to my study is Winkelmann-Gleed's (2005) discussion paper on 'Migrant nurses in the UK: facets of integration'. The article did not use the IPA method and was not on IENs with Nigerian heritage. It was a discussion paper from an empirical research study on the experiences of internationally qualified nurses who had migrated to Britain and were working in London.

This IPA study is qualitative and focuses on the lived experiences of UK nurses with Nigerian heritage after they arrive in the UK and begin to work in UK healthcare as registered nurses. It is about their integration into UK healthcare following registration with the Nursing and Midwifery Council (NMC).

This study has contributed to knowledge on the integration of internationally educated nurses by narrowing the gap in the literature. However, more research on nurses' lived experiences from different African countries are required to understand these nurses' integration into UK healthcare. The theoretical generalisation of Africans as a single group in analysis and discussion is an insensitive, disrespectful and gross display of a

lack of understanding of the differences between the various African countries' perspectives on issues as sensitive as integration.

This study was conducted in the London area of the UK. To determine the applicability or generalisations of the findings of this study, it may benefit from repeating the research in other areas of the UK. Using a quantitative or mixed-method approach may also be necessary to study the phenomenon concerning nurses with Nigerian heritage. It may be essential to carry out a comparative study between countries of Africa and Asia and their integration into UK healthcare.

It may be necessary to study the lived experience of IEN in Agenda for Change pay bands lower than band 7 to illuminate and understand why these nurses with a similar number of years working in UK healthcare as those in this study have not attained higher grades in their career. This may help understand the 'how' of workforce equality in UK healthcare.

Ramji and Etowa (2014) state three main themes on internationally educated nurses or overseas nurses in the nursing and healthcare literature. These themes include policy and ethical issues in recruitment and experiences while undergoing workplace registration and transition or adaptation programmes. There is a lack of research on the long-term integration of IEN into UK healthcare. Most of the research on IEN integration of migrant workers is quantitative studies conducted from an economic perspective (e.g. Villosio, 2015). This may connect with the complexities of funded research and unwritten philosophy of successive UK government's policy on overseas nurses, which revolves around the philosophy and the '*politics to concern itself with the immediate present at the expense of the future'* (Telegraph.co.uk, 2007) because politicians have a short time to get a result (Spencer, 2011).

Given the belief in nurse shortage since the establishment of the NHS, there is a need to study how the UK healthcare system has thrived. Are we short of nurses, or is it a case of political and economic manipulation and driving the available workforce to double their effort to meet the work requirement? For example, the UK healthcare agreement is to recruit nurses from China, India, Spain, and the Philippines (Buchan et al.,2005). Although UK healthcare forbids recruitment from Sub-Saharan Africa, South East Asia, and South Asia, compared to the broader economy, sub–Sahara Africa is

one of the areas with a higher proportion of staff in the NHS (Barker, 2018). The excuse for not having recruitment agreements with countries in Sub-Saharan Africa, such as Nigeria, is the touted concern about brain drain and depletion of human resources in the country's healthcare system. This excuse is shallow and does not tell the complete story. I suggest that there is a need to study how the international community may contribute to developing the workforce of the Sub-Saharan countries and continue to legally satisfy the requirement and recruitment of workforce from these countries into UK healthcare to resolve the problem of registered nurse shortage.

7.5. Reflections on the Research Experience:

This IPA study on integrating the UK registered nurses with Nigerian heritage into UK healthcare was challenging, exciting and fulfilling. Significant events in the years of this research contributed to making it challenging and exciting. At a time of nationalistic patriotism, the start of the research proposal was fuelled by the BREXIT vote in 2016 and uncertainties of the European union's final political severance on the 31st. January 2020. The COVID-19 pandemic and accompanying national lockdown effective March 2020 altered the usual method of teaching and learning in UK universities. As a Lecturer and module leader in one of the courses, the change from classroom face-to-face learning to virtual online education resulted in greater demand and more time planning and delivering teaching sessions for the students. The first-year students were new to the University and the evolving way of learning online. I had to restructure my work schedule dutifully to create time to continue my research study and complete it to the required standard.

I was able to conduct a face-to-face interview with the participants of the study before the COVID-19 lockdown. The interview sessions were exciting and fulfilling partly because of the common ethnic background I shared with the participants. All the participants had common characteristics as nurses with Nigerian heritage working in UK healthcare. Like many participants in the study, I had a post-graduate degree from Nigeria before training in the UK to become a registered Adult Nurse/Practice Educator with UK Nursing and Midwifery Council. As a result of the commonality in the background with the participants, I had to religiously apply reflexivity to maintain self-

awareness and a balanced view in the analysis to offer an objective and professional interpretation of data.

My experience of writing a chapter at a time and getting feedback from my supervisory team helped me sustain my interest in the study, challenge my line of reasoning constantly, and offer new and better iterations of the account. It also has served as a way to ensure this study's academic rigour and validity.

The participants shared their lived experiences of integration into UK and UK healthcare in a very candid and passionate manner. At the outset of this study, I intended for the thesis to be oriented around positive stories of ‘successful’ ‘integration’ and provide a platform to tell how they succeeded. The lived experience shared and how they managed the situations were very remarkable. I may compare the process to trying to unravel the meaning of Samson’s Biblical parable of ‘out of the eater came something to eat and out of the strong came something sweet’ (The Holy Bible; NKJV, Judges 14:14). Just as the answer to the parable was not easy, so it was that the stories generated were not positive as expected. Still, they were stories of tribulations, ingenuity, resilience and turning adversity into victory.

For example, one participant emphasised that “…going back was not an option”, indicating the rationale and the driving force for the nurses to face the challenges in the system squarely and resolve to conquer and overcome any barrier in the path of their career advancement. The participants demonstrated the steel of resilience and hope in their resolve to use the experience in dealing with the difficulties they encountered to obtain senior positions in UK healthcare and thrive within the system.

At the start of the study, an assumption was that a degree of integration into the ‘ways of life of the larger population was necessary to become successful as an employee in UK healthcare. Equally, at the outset of this study, I intended for the thesis to be oriented around positive stories of ‘successful’ ‘integration’. This study has challenged these assumptions and calls for a deeper reflection on how the respondent thrived in UK healthcare but claimed that integration was a farce and an unachievable phenomenon in UK healthcare.

The participants in this study arrived in the UK at different times and with other motives. The connection was their decision to train to become UK registered nurses. The ten

participants now have dual nationality of British and Nigerian. The majority of the participants have not made a definite choice as to where they intend to spend their retirement. Their decision of where to spend their retirement is significant to them. They concede that they must decide when ready, considering the government rules on pensions and other personal and life issues.

I am impressed with the IPA study method I used for this study. The Interpretive Phenomenological Analysis (IPA) approach offered me the best opportunity as a researcher to '*understand the innermost deliberation of the 'lived experiences of research participants'* (Alase, 2017:10). It has enabled me to interpret the participants' lived experiences of integration into the UK healthcare and contribute to knowledge and the sparse nursing literature on the integration of IEN into the UK healthcare post-NMC registration.

I am satisfied that this study has achieved the objectives of this research which are:

-To promote an understanding of the lived experience of IEN

-To understand how the nurses have successfully navigated the pathway of their career.
-To inform theory and practice in promoting knowledge and contribute to the development of best practice in training, a managerial and continuous professional development framework for integrating non–EU trained nurses into the UK healthcare post-NMC registration
-To influence the professional understanding in policy formulation regarding recruitment and retention of international nurses into UK healthcare.

7.6. Summary and Conclusions

This IPA study explored the lived experiences of integrating UK registered nurses with Nigerian heritage into UK healthcare after registering with the Nursing and Midwifery Council.

The data collection method was conducting face-to-face recorded semi-structured interviews using open-ended questions supported by prompts with ten participants.

The participants discussed their lived experiences on integration into UK healthcare freely and in detail. The recorded interviews were transcribed verbatim and analysed to generate themes, answering the central research question and sub-questions.

The findings from the study were presented in Chapter Five, and a discussion of the study results was presented in Chapter Six.

The themes discussed with extant literature and argument were underpinned and influenced by CRT, PCT, and IT tenets. These perspectives offered me theoretical reasoning and an emancipatory approach to generate a unique perspective on the existing and dominant discourse on integration and how IEN obtained and thrived in senior UK healthcare positions. In Chapter Six, I discussed the implications of the result of the study for clinical and organisational practice.

In Chapter Seven, I discussed the contributions of this study to knowledge, the validity of this study, and the limitation of this study. I offered some recommendations based on the results of this study. Some suggestions for future research included conducting more research into the lived experiences of African nurses and their integration into the United Kingdom healthcare post NMC registration. It is also recommended that this study be conducted across all the UK areas and use a quantitative or mixed-method approach to study the phenomenon concerning nurses with Nigerian heritage. It may be necessary to carry out a comparative study between countries of Africa and Asia and their integration into UK healthcare to deepen the understanding of the ‘how’ of race equality in UK healthcare. Overall, the thesis supports the view that the effective integration of internationally educated nurses is a significant ingredient for addressing nurses’ shortages and improving quality patient care.

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APPENDIX

Appendix 1- Ethical Approval

Middlesex University London

Health and Social Care REC

The Burroughs

Hendon

London NW4 4BT

Main Switchboard: 0208 411 5000

20/02/2018 **APPLICATION NUMBER:** 2442

Dear Monday Ugiagbe

Re your application title: Integration of International Nurses

Supervisor: Helen Allan, Kay Caldwell, Linda Collins

Co-investigators/collaborators:

Thank you for submitting your application. I can confirm that your application has been given approval from the date of this letter by the Health and Social Care Ethics Sub-committee.

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

Also, please note the following:

1. Please ensure that you contact your supervisor/research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.

2. You must notify your supervisor/REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.

3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.

4. Please quote the application number in any correspondence.

5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.

6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

Good luck with your research.

Yours sincerely

Gordon

Dr Gordon Weller Chair: Health and Social Care Ethics Sub-committee

Appendix 2: Participant Information Sheet

Middlesex University London

Date: 02 February 2018

Version number: Nur03

PARTICIPANT INFORMATION SHEET (PIS) AND CONSENT FORM

1. **Study title:**

Integration of International Nurses to the UK healthcare Service following registration with the Nursing and Midwifery Council (NMC): The lived experience of Nigerian Nurses

2. **Invitation:**

You are being invited to take part in a research study. Before you decide, you need to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you want to take part.

You will be given a copy of this information sheet and a signed consent form to keep.

Thank you for reading this.

3. **What is the purpose of the study?**

This study aims to understand the process of successful integration of international nurses into UK healthcare using the lived experiences of Nigerian Nurses.

The study will explore the lived experiences of Nigerian nurses who have successfully integrated into UK healthcare.

On a global level, it will promote knowledge and contribute to developing best practice training, managerial and continuous professional development framework for integrating non-EU trained nurses into the UK healthcare post-NMC registration.

This study will contribute to developing a template for successfully integrating international trained nurses into the UK healthcare workforce once they gain NMC registration.

This study will also influence professional understanding in policy formulation regarding recruitment and retention of international nurses into UK healthcare.

4. Why have I been chosen?

You have been chosen to participate in this study because you have been identified as a UK registered nurse with Nigerian heritage and have satisfied other inclusion criteria. There are a select number of not more than fifteen (15) participants of nurses with Nigerian heritage in this study, and a professional colleague has referred you to us for possible inclusion in the research.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you choose to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. However, the withdrawal will only be possible up to one month after the interview, after which time data will have been amalgamated and anonymised.

6. What will happen to me if I take part?

You will be required to participate in one-on-one semi-structured interviews of one or more but not more than three sessions. Each interview session will have a duration average of 60-90minutes.

You will be asked questions on your lived experiences as a registered nurse and will be encouraged to describe your lived experience of integration into UK healthcare.

Before commencement of the interview, you will be required to sign a consent form, and the process will be explained clearly to you. The interview session will be recorded, and confidentiality will be maintained at all times after the interview.

7. What do I have to do?

If you consent to participate, you will participate in a semi-structured interview lasting on average 60-90minutes per session. During the interview, you will be required to give full attention to the interview as much as possible.

8. What are the possible disadvantages and risks of taking part?

There are no lasting side effects envisaged in this study. However, suppose in the interview, you feel overwhelmed by recall of your lived experience or any other emotional impact. In that case, you may decide to end the interview at that point until you are ready to commence. If you become concerned with the research/researcher and wish to speak to another person or if an emergency arises, please talk to the Supervisor of this research as indicated at the end of this information sheet.

9. What are the possible benefits of taking part?

Your participating in the study will contribute to a better understanding of how Nigerian nurses with UK registration have been successfully integrated into UK healthcare. The information we get from this study may help us to develop training templates, managerial knowledge, and recruitment and retention policies for future international recruits to UK healthcare.

10. Will my taking part in this study be kept confidential?

All information that is collected about you during the research will be kept strictly confidential. Any information will have your name and address removed so that you cannot be recognised from it.

All data will be stored, analysed, and reported to comply with the UK Data Protection Act (1998) and NMC Code (NMC, 2018).

In accordance with the UK NMC Code (2018), we are to report any information disclosed during the interview which we believe may put someone at risk of harm to an appropriate authority.

11. What will happen to the results of the research study?

The results of this research will be published as part of a research degree dissertation in 2022. Publications will also be made in journals and used in seminars/workshops/conferences to inform discussions/debates. Participants' confidentiality will be maintained, and you will not be identified in any report/publication. Participants may contact the researcher for the results of this study.

12. Who has reviewed the study?

The Middlesex University,

Health and Social Care Ethics Sub-committee.

13. Contact for further information

1, Iyore Monday Ugiagbe

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4. **Dr Linda Collins**

Associate Professor

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5. Professor Michael Traynor

Professor of Nurse Education

Middlesex University

Hendon Campus

Hendon, Barnet

NW4 4BT

Please ensure that the researcher gives you a copy of this information sheet and a signed consent form.

Thank you for taking part in this study.

Appendix 3: Consent Form

Participant Identification Number:

CONSENT FORM

Title of Project: Integration of International Nurses to the UK healthcare Service following registration with the Nursing and Midwifery Council (NMC): A lived experience of Nigerian Nurses

Name of Researcher: Iyore Monday Ugiagbe

1. I confirm that I have read and understood the information sheet dated .....……..…for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I agree that a designated auditor may see this form that bears my name and signature.
4. I agree that my non-identifiable research data may be stored in the National Archives and be used anonymously by others for future research. I am assured that my data's confidentiality will be upheld by the removal of any personal identifiers.
5. I understand that my interview may be taped and subsequently transcribed.
6. I agree to take part in the above study

_____	_____	
Name of participant	Date	Signature
_____	_____	
Name of person taking consent (if different from the researcher)	Date	Signature
_____	_____	
Researcher	Date	Signature

One copy for the participant; One copy for the researcher

Appendix 4: Interview Schedule

INTERVIEW PROMPT SHEET-(NURS 01): 02/02/18

In phenomenology research, there is no structured interview schedule as such. The interview focuses on the lived experiences, and the interview question for this research was around:

A. Can you please describe as detailed as possible your experiences of successfully negotiating/developing a living in the UK as an internationally educated nurse in UK healthcare?

NOTE:

Central themes for discussion with the participants included the following: ('it was not intended to be prescriptive and certainly not limiting in the sense of overriding the expressed interests of the participant ...' (Biggerstaff and Thompson, 2017).

Key domains of integration to be discussed:

1. Employment, housing, education and health: Achievement and access across these sectors

2. Citizenship and rights: Immigration challenges and resolution, Allegiance

3. Relationship within and between groups within the community: Professional relationship with colleagues; Relationship with neighbours and its impact on professional life, Social life

4. Issues of language, culture and the local environment: structural barriers: Access to professional development and success with the application for promotion, Pension plans, etc.

Interview Schedule:

1. Please could you tell us how you came to the UK?
2. How did you come to join the NHS? PROMPT: What did you do before joining the NHS? Could you describe your relationship with colleagues, access to training, etc.?
3. What has been your experiences of working in the NHS?
4. How have you negotiated your career progression to date?
5. What challenges have you experienced settling in the UK- in terms of:

PROMPTS: Immigration, housing, health, relationships, etc.

6. What problems or barriers did you encounter in career progression in the NHS, and how do you deal with these?
7. To what extent has the UK lived up to expectations regarding your career, integration into society? Plans on retirement?

Appendix 5: Sample Initial Emergent Themes

OSATO	ADA	ESE	EFE	UWA
ANCHOR CODES: **Integration Experiences** **Career progression** **Obstacles and measures to develop and thrive** **Personal and Social integration** **Perception of integration** **EMERGENT THEMES:** Environment, Mentorship, Location and Social Connections, Personality Differences Employer's Practices Motivation to succeed Resilience Personal values Personality types Immigration matters Dealing with discrimination Employer's practices Education Resilience Attitude to work Education Managing conflict Personality/Attitude	**ANCHOR CODES:** **Integration Experiences** **Career progression** **Obstacles and measures to develop and thrive** **Personal and Social integration** **Perception of integration** **EMERGENT THEMES:** Barriers to integration Social issues Language issues Continuing professional education Racism Discrimination Job satisfaction Resilience Determination to succeed Education and training Resilience Knowledge and Skill Organisational practices Social relationship in integration Immigration challenges	**ANCHOR CODES:** **Integration Experiences** **Career progression** **Obstacles and measures to develop and thrive** **Personal and Social integration** **Perception of integration** **EMERGENT THEMES:** Education Career choice Career pathway Mentorship Cultural difference Level of motivation Mapping career pathway Resilience Conflict handling Cultural challenges Mentoring or coaching Professionalism Social integration Social relationship Level of self-esteem Definition of integration	**ANCHOR CODES:** **Integration Experiences** **Career progression** **Obstacles and measures to develop and thrive** **Personal and Social integration** **Perception of integration** **EMERGENT THEMES:** Immigration and nationality Employment Discrimination issues Mentorship Immigration and nationality Housing issues Social relationship Cultural issues Social Integration Cultural changes Personality preferences Training issues Resilience and persistence Language issues	**ANCHOR CODES:** **Integration Experiences** **Career progression** **Obstacles and measures to develop and thrive** **Personal and Social integration** **Perception of integration** **EMERGENT THEMES:** Education Barriers to integration Social issues Language issues Continuing professional education Racism Discrimination Job satisfaction Resilience Determination to succeed Language issues Discrimination Dealing with discrimination issues Immigration issues Social issues Social mobility

Conception of Integration Discrimination issues Integration sceptic Pension issues Integration Development in the home country		Social relation Immigration issues Societal influences Language issues Managing prejudice Self-esteem Sponsorship or mentorship Personal interest Political development Defining integration Degrees of integration Cultural challenges Immigration issues Cultural challenges Personal perception Career planning	Integration issues Discrimination Resilience and persistence Pension and retirement Mentorship Immigration	Definition of integration Cultural issues Social relationship Personal motivation Educational method

Appendix 6: Identifying Recurrent Themes

Appendix 6: Identifying Recurrent Themes [x=NO, √=YES]

THEME	OSATO	ADA	ESE	EFE	UWA	EHI	EDE	OSAMA	OSARO	OSUYI
Challenges of Integration	√	√	**X**	√	√	√	√	√	√	√
Housing and social challenges	√	√	√	√	√	**X**	**X**	**X**	√	√
Environmental impact	√	√	√	**X**	√	√	√	√	√	√
Citizenship/Integrated person	√	√	√	√	√	√	√	√	√	√
Social integration, Loyalty issue,	√	√	√	√	√	√	√	√	√	√
Cultural and social integration	√	√	√	√	√	√	√	√	√	√
Resilience as a coping strategy	√	√	√	√	√	√	√	√	√	√
Cultural difference/contrast of nationality	√	√	√	√	√	√	√	√	√	√

Personal interest/explanation Degrees/components of integration	√	√	√	√	√	√	√	√	√	√
Experiences during Supervised Practice placement	√	√	**X**	√	**X**	√	**X**	**X**	**X**	√
Social mobility	√	√	√	√	**X**	**X**	√	**X**	√	√
Experiences of multiple migrations	√	**X**	**X**	√	**X**	**X**	√	**X**	√	√
racism Overt discrimination	√	√	√	√	√	√	√	√	√	√
knowledge and discrimination	√	√	√	√	√	√	√	√	√	√
Immigration and nationality	√	√	√	√	√	√	√	√	√	√
The contrast of nationality/Ethnicity	√	√	√	√	√	√	√	√	√	√
Identity, belonging and diasporas/communities	√	√	√	√	√	√	√	√	√	√
Social relationship	√	√	√	√	√	√	√	√	√	√
Economic and social issues	√	√	√	√	√	√	√	√	√	√

Development in the home country	√	**X**	**X**	√	√	**X**	√	√	√	√
Political development	√	**X**	**X**	√	√	**X**	**X**	√	√	√
Pension and retirement	√	√	√	√	√	√	√	√	√	√
Conception of Integration	√	√	√	√	√	√	√	√	√	√
Grade level, Continuing professional development	√	√	√	√	√	√	√	√	√	√
Training, Career Planning /choice /pathway	√	√	√	√	√	√	√	√	√	√
Educational method /learning styles	√	√	√	√	√	√	√	√	√	√
Conflict handling mode/styles	√	√	√	√	√	√	√	√	√	√
Sponsorship/Mentorship	√	√	√	√	√	√	√	√	√	√
Resilience,	√	√	√	√	√	√	√	√	√	√
Motivation	√	√	√	√	√	√	√	√	√	√
Emotional intelligence	√	√	√	√	√	√	**X**	√	√	√
Political astuteness/ political intelligence,	√	√	√	√	√	**X**	**X**	√	√	√

intelligence quotient										
Communication skills, Attitude to work, Professionalism	√	√	√	√	√	√	√	√	√	√
Self-esteem	√	√	√	√	√	√	√	√	√	√
Knowledge and skill	√	√	√	√	√	√	√	√	√	√
Assertiveness and negotiation	√	√	√	√	√	√	√	√	√	√
'Guinness effect', Selectivity	√	√	√	√	√	√	**X**	**X**	√	√
Sponsorship/ Selective support/nepotism	√	√	√	√	√	√	√	√	√	√
NHS Manager's Management of discrimination	√	√	√	√	√	√	√	√	√	√
Immigration challenges	√	√	√	√	√	√	√	√	√	√
Job satisfaction/ Agency nursing, Career progression	√	√	√	√	√	√	√	√	√	√
Organisational objectives	√	√	√	√	√	√	√	√	√	√

Management styles/management of discrimination Prejudice, stereotype, labelling	√	√	√	√	√	√	√	√	√	√
Barriers to education	√	√	√	√	√	√	√	√	√	√
Association of name with race or nationality	√	√	√	√	√	√		√	√	√

Appendix 7: Table of Superordinate and Subordinate Themes

SUPERORDINATE THEMES	EMERGENT THEMES
Understanding integration	Challenges of Integration Housing and social challenges Location and social connections Environment Citizenship/Integrated person
The reality of integration	Social Integration, Loyalty issue, Cultural and Social Integration Transference as a coping strategy Cultural difference/contrast of nationality Personal interest/perception, Degrees/components of integration, Social mobility Experiences during Supervised Practice placement
Discrimination	Experiences of multiple migrations, racism Overt discrimination, knowledge and discrimination
Immigration Issues	Immigration and nationality, Contrast of nationality/Ethnicity
Social, Language and Cultural Currency	Identity, belonging and diasporas/communities Social relationship Economic and social issues
Pension Plans	Development in the home country, Conception of Integration Political development, Pension and retirement

Education	Grade level, Continuing professional development, training, Career Planning/choice/pathway Educational method/learning styles
Mentorship/Coach	Conflict handling mode/styles Sponsorship/Mentorship
Personal Characteristics	Resilience, motivation, Emotional intelligence, Political astuteness/ political intelligence, intelligence quotient Communication skills Attitude to work, Professionalism, self-esteem, Knowledge and skill, Assertiveness and negotiation
Employers Practices	'Guinness effect', Selectivity NHS Manager's Management of discrimination Sponsorship/ Selective support/nepotism, Immigration challenges Job satisfaction/ Agency nursing, Career progression Organisational objectives
Discriminatory Practices	Management styles/management of discrimination Prejudice, stereotype, labelling Association of name with race or nationality, barriers to education

Appendix 8: Developing Anchor Codes

Research Questions	**ANCHOR CODES:**
What are the lived experiences of integration for nurses with Nigerian heritage into UK healthcare services following registration with the Nursing and Midwifery Council (NMC)?	**OPINION AND EXPERIENCES OF INTEGRATION**
What are the lived experiences of for nurses with Nigerian heritage career progression on integration into UK healthcare services following registration with the Nursing and Midwifery Council?	**CAREER PROGRESSION**
What obstacles do nurses with Nigerian heritage encounter, and what measures do they develop to obtain and thrive in senior positions (Agenda for Change Band 7 and above) in UK healthcare?	**OBSTACLES AND MEASURES TO DEVELOP AND THRIVE**
What relationships exist, if any, between successful integration into work and personal and social lives for these nurses?	**PERSONAL AND SOCIAL INTEGRATION**
What do for nurses with Nigerian heritage understand by integration into the British healthcare sector following registration with the Nursing and Midwifery Council (NMC)?	**CHALLENGES TO INTEGRATION**

Appendix 9: Master Table of Themes For The Group

Table 006: MASTER TABLE OF THEMES FOR THE GROUP

MASTER THEMES	SUPERORDINATE THEMES	EMERGENT THEMES
B. OPINION, CONCEPT AND EXPERIENCES OF INTEGRATION	**Understanding integration**	Challenges of Integration Housing and social challenges Location and social connections Environment Citizenship/Integrated person
	The reality of integration	Cultural and Social Integration Transference as a coping strategy Cultural difference/contrast of nationality Personal interest/Perception/ Degrees/components of Integration Social mobility Experiences during Supervised Practice placement
	Experiences Of Social Integration	Social Integration Loyalty issue

F. CHALLENGES TO INTEGRATION	**Discrimination**	Experiences of multiple migrations, Racism Overt discrimination Knowledge and discrimination
G. **PERSONAL AND SOCIAL INTEGRATION**	**Immigration Issues**	Immigration and nationality The contrast of nationality/Ethnicity
	Social, Language and Cultural Currency	Identity, belonging and diaspora/communities Social relationship Economic and social issues
	Pension Plans	Development in the home country Conception of Integration Political development Pension and retirement
H. **CAREER PROGRESSION**	**Education**	Grade level Continuing professional development, training Career Planning/choice/pathway Educational method/learning styles

	Mentorship/Coach:	Conflict handling mode/styles Sponsorship
	Personal Characteristics	Resilience, motivation, Emotional intelligence, Political astuteness/ political intelligence, intelligence quotient Communication skills Attitude to work, Professionalism, self-esteem, Knowledge and skill, Assertiveness and negotiation
I. **OBSTACLES AND MEASURES TO DEVELOP AND THRIVE**	**Employers Practices**	**Employers Practices** 'Guinness effect.' Selectivity NHS Manager's Management of discrimination Sponsorship/ Selective support/nepotism Immigration challenges Job satisfaction/ Agency nursing Career progression Organisational objectives

	Discriminatory Practices	**Discriminatory Practices** Management styles/management of discrimination Prejudice, stereotype, labelling Association of name with race or nationality, barriers to education

Appendix 10: Agenda For Change (AfC) Pay Scale

The table below shows the values of the NHS Terms and Conditions of Service (Agenda for Change) pay points from 1 April 2019. Full details of the payment arrangements are available in the NHS terms and conditions of service handbook.

Spine points are no longer used following the 2018 changes to the NHS Terms and Conditions of Service, but for ease of reference, the table below contains the previous spine point that corresponds to the new pay structure value

Band	Previous spine point	Minimum years of experience	2019/20 annual value (£)
Band 1	2	< 1 year	17,652
	3	1+ years	17,652
Band 2	2	< 1 year	17,652
	3	1 - 2 years	17,652
	4	2 - 3 years	17,652
	5	3 - 4 years	17,652
	6	4 - 5 years	17,652
	7	5 - 6 years	17,983
	8	6+ years	19,020
Band 3	6	< 1 year	18,813
	7	1 - 2 years	18,813
	8	2 - 3 years	18,813
	9	3 - 4 years	18,813
	10	4 - 5 years	19,332
	11	5 - 6 years	19,917
	12	6+ years	20,795
Band 4	11	< 1 year	21,089
	12	1 - 2 years	21,089

	13	2 - 3 years	21,089
	14	3 - 4 years	21,819
	15	4 - 5 years	22,482
	16	5 - 6 years	22,707
	17	6+ years	23,761
Band 5	16	< 1 year	24,214
	17	1 - 2 years	24,214
	18	2 - 3 years	24,214
	19	3 - 4 years	26,220
	20	4 - 5 years	26,220
	21	5 - 6 years	27,260
	22	6 - 7 years	28,358
	23	7+ years	30,112
Band 6	21	< 1 year	30,401
	22	1 - 2 years	30,401
	23	2 - 3 years	30,401
	24	3 - 4 years	32,525
	25	4 - 5 years	32,525
	26	5 - 6 years	32,525
	27	6 - 7 years	33,587
	28	7 - 8 years	34,782
	29	8+ years	37,267
Band 7	26	< 1 year	37,570
	27	1 - 2 years	37,570
	28	2 - 3 years	37,570
	29	3 - 4 years	37,570
	30	4 - 5 years	38,765
	31	5 - 6 years	38,765
	32	6 - 7 years	40,092

	33	7 - 8 years	41,486
	34	8+ years	43,772
Band 8a	33	< 1 year	44,606
	34	1 - 2 years	44,606
	35	2 - 3 years	44,606
	36	3 - 4 years	46,331
	37	4 - 5 years	48,324
	38	5+ years	50,819
Band 8b	37	< 1 year	52,306
	38	1 - 2 years	52,306
	39	2 - 3 years	52,306
	40	3 - 4 years	55,226
	41	4 - 5 years	58,148
	42	5+ years	60,983
Band 8c	41	< 1 year	61,777
	42	1 - 2 years	61,777
	43	2 - 3 years	61,777
	44	3- 4 years	64,670
	45	4 - 5 years	69,007
	46	5+ years	72,597
Band 8d	45	< 1 year	73,936
	46	1 - 2 years	73,936
	47	2 - 3 years	73,936
	48	3- 4 years	77,550
	49	4 - 5 years	81,493
	50	5+ years	86,687
Band 9	49	< 1 year	89,537
	50	1 - 2 years	89,537
	51	2 - 3 years	89,537

52	3- 4 years	93,835
53	4 - 5 years	98,339
54	5+ years	103,860

Source:

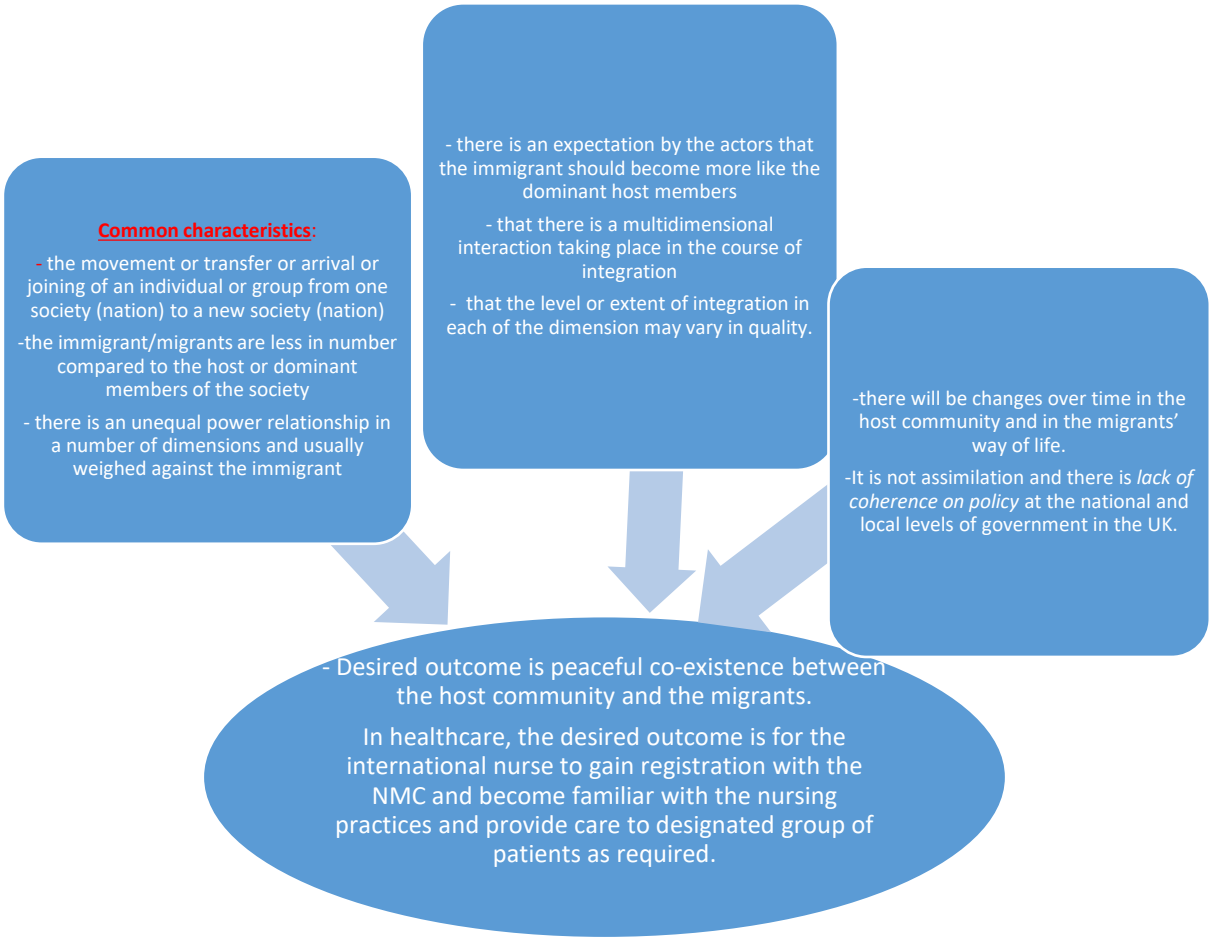
https://www.nhsemployers.org/pay-pensions-and-reward/agenda-for-change/pay-scales/annual

Appendix 11a

Fig. 1: alternative terms for integration suggested by conference attendants in 2019.

Appendix 11b

Figure 2: Common characteristics of integration and its desired outcome below:



Appendix 12: Extract from e-diary

 # Date: 25 JULY 2018—Reflection on 2018 World Cup

France won the world cup trophy on Sunday, 15 July 2018. In winning, the world cup, France did not register a defeat. More significantly, nine out of the eleven French players on the pitch and 12 of the 23 French players to the World cup were of African descent.

The guardian online reported the fallout from the France World Cup win on the 20th: July 2018.

"Dear France,
Congratulations on winning the #WorldCup.
80% of your team is African; cut out the racism and xenophobia.
50% of your team are Muslims; cut out the Islamophobia.
Africans and Muslims delivered you a second World Cup, now deliver them justice."

Khaled A. Beydoun, a US law professor, made the tweet above, and he is the author of American Islamophobia: Understanding the Roots and Rise of Fear.'

The tweet was retweeted 50,000 times within an hour, and in a few days, it was retweeted 218,000 times and liked more than half a million times.

The tweet was referenced by Trevor Noah on an American Television international show, "The Daily Show". Trevor Noah's statement "Africa won the World Cup" prompted a response of the French ambassador. The ambassador retorted that "Unlike the United States of America, France does not refer to its citizens based on its race, religion, or origin. To us, there is no hyphenated identity."

https://www.theguardian.com/commentisfree/2018/jul/22/trevor-noah-world-cup-france-africa

In another online post titled:
"France, the world cup last 'African' Team: 13 of the 23 French players boast African ancestry from nine nations across the continent",
Beydoun, K.A, traced the ancestry of the French players:
'Kylian Mbappe, the 19-year-old forward of Cameroonian and Algerian descent,

Samuel Umtiti and Adil Rami are two rocks of France's solid defence, Cameroon and Morocco descent.

Ousmane Dembélé having roots in Senegal, Mali and Mauritania.

Senegal's Benjamin Mendy and Djibril Sidibe and the Democratic Republic of Congo's Presnel Kinpembe.

French-Congolese goalkeeper Steve Mandanda.

The dabbing midfield dynamo Paul Pogba, whose parents hail from Guinea.

Blaise Matuidi, who is original of Angolan and Congolese descent.

N'Golo Kante, who rounds out France's African midfield, is of Malian extraction. Karim Benzema, Nabil Fekir are of Algerian origin ….'

It was Benzema, after all, who before the 2014 World Cup stated that "**If I score, I'm French … if I don't, I'm an Arab,"**

https://theundefeated.com/features/france-2018-fifa-world-cup-last-standing-african-team/

Reflection:

The views expressed by Karim Benzema "If I score, I'm French … if I don't, I'm an Arab," directly queries the colour-blind narrative of the French government represented by the French ambassador's reaction to the tweet of the law professor Beydoun and Trevoh Noah's comment. He asserts that "Unlike the United States of America, France does not refer to its citizens based on its race, religion, or origin. To us, there is no hyphenated identity."

What does this say about the French concept of assimilation and integration?

EXTRACT FROM E-DIARY

Date: 11 JULY 2021—Reflection on 2020 EUR0 Cup: England Loss!

Italy defeated England on the 11th. July 2021 in the European football finals!

England players Marcus Rashford, Jadon Sancho, and Bukayo Saka missed the penalty shoot-out in the football tournament finals.

The young England footballers suffered a torrent of racism on social media after England's defeat in the Euro 2020 final.

However, some politicians tweeted support for the BME England footballers, but the Home Secretary (a BME Politician of Indian descent) had a different perspective which resulted in an England player's comment;

"you *don't get to stoke the fire at the beginning of the tournament by labelling our anti-racism message as 'Gesture Politics' and then pretend to be disgusted when the very thing we're campaigning against happens"* (Tyrone Mings, 2021 in https://www.theguardian.com/politics/2021/jul/13/england-tyrone-mings-criticises-priti-patel-over-racism-remarks)

Gary Neville, white and a former England football team player, states: "*The prime minister said it was OK for the population of this country to boo those players [taking the knee] who were trying to promote equality and defend against racism. It starts at the very top. I wasn't surprised in the slightest that I woke up to those headlines; I expected it the minute the three players missed"* *http://www.theguardian.com/politics/2021/jul/13/england-tyrone-mings-criticises-priti-patel-over-racism-remarks).*

Reflection:

I reflect and query our understanding and practice of integration further. Many football-related events influence my reflection. These include what happened in 2018 after France success at the world cup; the statement of Mesut Ozil, an international footballer, that 'I am German when we win, an immigrant when we lose,' and

subsequently his resignation from international football and what happened in England after the loss at the EURO 2020 tournament.

It is painful to lose but has this hostile, discriminatory expression released the hidden or pent up feeling of discrimination and racism? It seems that the concept of assimilation practised in France is truly reflected in the ambassador's comment following the insinuation of ‘Africa’ winning the world cup for France in 2018 (see e-dairy of 25/7/18). The views by the UK Prime Minister and the Home Secretary appears to reflect the official UK government position on integration as in promoting a multicultural UK society in maintaining a peaceful co-existence rather than actively promoting equality. Are people of colour genuinely integrated into the UK? Will they be truly integrated? Is this a UK issue or a European or worldwide issue?

Reference:

https://www.itv.com/news/2018-07-22/mesut-ozil-statement-quits-german-national-team

Appendix 13.

Method of literature search

A repeated search of the University electronic literature database (1990-2022) was conducted using the cumulative index to nursing, and allied health literature (CINAHL), British Nursing Index (BNI), Medline, Internurse, PsychInfo. Further search includes using Cochrane Library, Google and Google Schooler, and a university-specific search engine. Furthermore, I conducted hand searches through books, newspapers and journals in the University Library, UK and international peer-reviewed material, and grey literature such as web resources related to government departments, professional organisations, i.e. NHS England, NMC, RCN in the UK.

The search words used on different occasions included: registered/educated/ nurse (IRN, IEN, OEN), immigr*, emigra*, migrat*, migrant*, Africa and Immigration", "Immigrants", language, integration*, assimilation, incorporation, inclusion*, nurses IPA*, Nigeria nurses*. In line with Ellis (2019) suggestion, Boolean operators 'OR', 'AND' were used to focus, including the search, reducing synonyms and streamlining the searches to promote a focus on relevant articles.

My investigation revealed little research on the experiences of African nurses during the early phase of integration in UK healthcare, and none of the studies used Interpretative Phenomenological Analysis (IPA) approach. There was no research on the integration of Nigerian nurses lived experience post NMC registration in UK healthcare. The search was limited to full text and peer-reviewed primary and secondary research articles in the English language, mainly from 1990 to 2022. The target population focus on Internationally educated nurses and international recruited nurses.

Appendix 14:

Fig. 6 –sample word cloud