Original Article

An interpretative phenomenological analysis (IPA) study of the integration and career progression of internationally educated nurses (IENs) in UK healthcare: the lived experience of UK registered nurses with Nigeria heritage in the London region

Iyore Monday Ugiagbe^

Department of Adult Nursing and Midwifery, Middlesex University, London, UK

Correspondence to: Iyore Monday Ugiagbe, PhD, MSc, MEd, PGDip, RN, SFHEA. Department of Adult Nursing and Midwifery, Middlesex University, Williams Building, Hendon, London NW4 4BT, UK. Email: M.ugiagbe@mdx.ac.uk.

Background: Internationally educated nurses (IENs) form a significant number of British minority ethnic (BME) group in the UK healthcare service. Discrimination against the BME group is pervasive in the National Health Service (NHS), especially in promotion and recruitment to leadership and management positions. However, some BME nurses in UK healthcare achieve and sustain senior management and leadership positions.

Methods: This qualitative study employs an interpretive phenomenological analysis (IPA) approach to explore the participants perspectives on integration and how they attained, sustained and thrived in senior clinical and management positions in UK healthcare in the London region.

Results: The themes derived from the analysis are education, mentoring, coaching, and personal characteristics or behavioural preferences. These themes and analytical findings are significant markers and means of integration and career progression in UK healthcare in the London region. The findings reveal that all the highly successful registered nurses with Nigeria heritage had tertiary education outside of the UK before gaining Nursing and Midwifery Council (NMC) registration or progressed to attain a degree or postgraduate degree on qualification as a registered nurse. The study indicates that respondents' career progression to senior position was influenced by the availability or access to a mentor and, or a career coach. All the participants agreed that the individual's characteristics and personal factors concerning professional practice helped to break through professional barriers, and in dealing with challenges to achieve higher grades or bands.

Conclusions: The experiences of these BME nurses with Nigeria heritage might help us understand how some IENs successfully navigated the pathway of integration and their career progression in UK healthcare.

Keywords: Career progression; integration; internationally educated nurses (IENs); interpretative phenomenological analysis (IPA); recruitment and retention

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^ ORCID: 0000-0002-0991-3266.

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Introduction

The recruitment of internationally educated nurses (IENs) has remained an essential and significant part of the UK healthcare workforce policy [National Health Service (NHS)] (1). IENs' recruitment and integration policies are influenced by successive UK governments' political, social and economic policies (2). Still, the recruitment and integration policies appear to follow a repeated cyclical order since the establishment of the NHS. At any given point, the ruling political party's contrasting understandings of citizenship and nationality influence immigration policies (3) and, by extension, the recruitment and integration of IEN into the UK healthcare system. Significantly, the philosophy and implementation of immigration policies of the political party at the inception of the NHS had no significant difference from the succeeding political party (4), and the policy paradigm on the establishment of the NHS has not shifted in tandem with the changing migration patterns in the present day (5). The immigration policy in practice from 1945–1955 was 'the myth of Civis Britannicus sum' (4), IENs of African descent were needed in UK healthcare but were not 'wanted' in the UK (4). This discriminatory attitude was fueled by colorism and discrimination, which underlies the current preference for international nurse recruitment from the Philippines and India (6) and, recently, from Nepal. This preference lends credence to the belief that the degree of skin pigmentation or 'shades' of skin is a determinant of discrimination (7,8), and perhaps the nationals preferred to work in the UK healthcare sector. In the recently updated code of practice for the international recruitment of health and social care personnel document (9), India, Malaysia, Philippines, and Sri Lanka are examples of countries with an agreement with the UK government for managing international health and care workforce recruitment. However, Nigeria and nearly all the African countries are on the red list. Despite the lack of inter-governmental agreement on recruiting trained staff, in the year 2020, Nigeria, represented the sixth-largest contributor to NHS staff behind the UK, India, Philippines, Ireland and Poland (10). In 2022, this African country, Nigeria, is reported to be the fourth largest staff in the NHS and the largest at 22,851 staff of all African countries listed (11).

Most IENs are ethnic minorities and suffer discrimination and other barriers or challenges in the NHS (12,13). IENs from outside the European Union (EU) and UK work 3 hours more per week (14). Although, this study was conducted in London, where the levels of international recruitment vary from 30% to 36% compared to 5% to 8% in the northeast, northwest, and Yorkshire and Humber regions of England (15), British minority ethnic (BME) nurses in the London region had a 33% out of 60.8% coronavirus disease 2019 (COVID-19)-related death rate among healthcare staff as of July 2020 (16,17). BME nurses in the London region experienced the highest level of discrimination in the UK despite constituting 52.96% of the nursing population in the area (18), and '*despite London trusts generally having the highest proportion of BME staff in the country, representation at the senior band is very low*' (18). The literature on experiences of IENs is replete with the problems suffered by ethnic minority nurses and

Highlight box

Key findings

- Education, mentoring, coaching, and personal characteristics or behavioural preferences are significant markers and means of integration and career progression.
- The highly successful internationally educated nurses (IENs) had tertiary education outside of the UK and progressed to attain a second degree or postgraduate degree on qualification as a UK registered nurse.

What is known and what is new?

- International nurse recruitment is an essential and significant part of the UK healthcare workforce policy.
- Some IENs believe that because of discrimination, integration into the UK is a farce and non-existent.
- Discrimination against the British minority ethnic group is pervasive in the National Health Service, especially in promotion and recruitment to leadership and management positions.
- The education of IEN before arriving UK prepared them for survival and success in the UK.
- Many nurses overcame their career barriers by sheer determination to succeed and making personal sacrifices.
- Access to a coach facilitates development and appropriate use of political intelligence enhances career progression for IEN.

What is the implication, and what should change now?

- 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.
- Availability of a career coach should be made available to IEN nurses to promote the drive for equality in career progression.
- The experiences of how some IENs successfully navigated the pathway of their careers and how IENs negotiate integration in UK healthcare requires closer study and implementation of the findings on a larger scale in the UK healthcare.

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documents that people of African descent experience issues of discrimination in promotion, training, and other forms of discrimination in UK healthcare more than any other groups (8,12,19).

Discrimination against BME group was still pervasive in the NHS, especially in promotion and recruitment to leadership and management positions despite several positive action projects (20,21). However, 3% of the Black/Black British nurses broke through the concrete ceiling in UK healthcare to achieve senior management and leadership positions and sustained those positions (18). There is a shortage of research about the lived experiences of these ethnic minority nurses in senior management and leadership positions and their interpretation of integration into UK healthcare services (21). There is an increasing number of BME in UK healthcare, and it is of relevance to have a clearer understanding how some of the BME nurses have successfully navigated their career pathway in UK healthcare and the best way 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 (8), these nurses constitute a significant force in the continuity of the function of UK healthcare. Therefore, the experiences of a group of African nurses might help us understand how some IENs successfully navigated the pathway of their careers and how IENs negotiate integration in UK healthcare. This study may also inform theory and practice in promoting knowledge and contribute to development of best practice in training, managerial and continuous professional development (CPD) 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 the UK healthcare.

In this study IEN includes overseas registered nurses (ORNs) and nationals of home country that had their primary, secondary and tertiary education in their home country before becoming registered nurses in their host country; and in this case UK.

ORNs trained as registered nurses in their home country before deciding to work as nurses in a host country. One of the processes through which ORNs become UK registered nurses include their employment by British NHS employers as unregistered nurses in nursing assistant roles until they satisfy credentialing assessment (22). However, some ORNs become UK registered nurses through the international student route in UK universities.

International recruitment of nurses in the UK is economically beneficial to the NHS. It offers a ready supply of migrant nurses in times of acute shortage of nurses in the UK (21). It takes three years to train a degree-educated 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. Still, employers can save £18,500 in agency nurse costs in the first year alone (23). Despite the economic benefits of IENs' recruitment to the NHS, institutionalised and systemic discrimination and everyday racial harassment, bullying and discrimination, racism, and intimidation towards migrant nurses are still evident in the 21st century NHS (23,24), and 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 (21,24-27).

The history of migrant nurses' exploitation by the social agencies of the NHS (16,22-24,28,29) is on the rise in the first quarter of the 21st century. Post-pandemic, healthcare employers seem to be facilitating and deeply involved in a combination of institutionalised and systematic discrimination and exploitation. This is demonstrated in the denial of migrants' rights and freedom of IENs working for UK healthcare becoming trapped in their jobs by contract clauses requiring them to pay thousands of pounds if they exercise their rights to change their position (23). This practice further manifests post-colonial exploitation and discrimination of migrant nurses from commonwealth countries (previous British colonies). Das 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*" (23).

The Nursing and Midwifery Council (NMC) has no control over the employing organisation on how they may enforce the employment contracts. Still, 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 (21). The NMC and the employers of labour do not promote long-term integration programmes for IENs but encourage programs that yield short-term immediate transitional needs so that international nurses can start work as soon as practicable and maintain the staffing level in the care setting (21).

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Methods

In this qualitative research, an interpretivist approach is in use. Sampling was consistent with the qualitative paradigm of interpretative phenomenological analysis (IPA) (30). Sampling was purposive and homogenous based on national heritage, and a snowballing approach was used to recruit participants for the study.

The primary data collection method was conducting and recording open-ended semi-structured interviews using interview prompts (30). Discussions were held in the participant's preferred venue and a conducive and relaxed atmosphere. The inclusion criteria were nurses of Nigerian descent who have been in UK healthcare for 5–30 years because the time frame is sufficient for a typical registered nurse to be promoted to the senior pay bands in UK healthcare (8). The subjects were senior nurses with diverse kinds of managerial responsibilities in UK healthcare. The recorded semi-structured interview lasted 60–90 minutes, and the data for the study was collected over between July and October 2019.

Participants were asked probing and follow-up questions from interview prompts for additional clarification, details, and a more in-depth understanding of the lived experience.

The research question for the study was: "What are the lived experiences of IENs with Nigerian heritage career progression on integration into UK healthcare services following registration with the NMC?".

Semi-structured interviews were conducted individually with nurses in each of the three categories of IEN with Nigeria heritage in UK healthcare in the London region:

(I) IENs with Nigerian heritage registered with the NMC who had primary, secondary and tertiary education with initial nurse training in Nigeria;
(II) IENs with Nigerian heritage registered with the NMC who had primary, secondary and tertiary education in Nigeria but nurse training in the UK;
(III) IENs with Nigerian heritage registered with the NMC born in the UK, who had primary, secondary and tertiary education in 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 5 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 Pay Band 7 in the UK healthcare service.

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

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 NMC. This group went through the Supervised Practice (Adaptation) Programme facilitated by UK universities to attain the NMC registration as UK 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 UK and have a subsisting UK NMC nurse registration.

Ethical approval

The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The Middlesex University Research Ethics Committee granted ethical approval (application number 2442) for the main study, and individuals participating in the study were not subjected to any physical or psychological harm. 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 (31). However, as this is an IPA 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 (32).

Informed consent and confidentiality

All participants in this study gave their voluntary consent to participate in the study. They were not subject to any

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implicit or explicit pressure. Participants were given written information about the study and offered the opportunity to clarify their understanding through a phone call or face-to-face discussion. 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.

The code specifies that nurses must respect people's right to confidentiality, pseudonyms were assigned to the participants to maintain confidentiality in line with the code requirement (33). I used encryption and 'PIN' code access to secure all electronic materials and the audio recording for the interview sessions.

Transcription

Each participant was assigned pseudonym to protect their identity in line with the NMC code of practice (33). Transcript from the verbatim recorded semi-structured interview was generated from direct transcription of the interviews. During the transcription, listening to the pauses and recollecting the non-verbal utterances brought alive empathetic feelings and deep reflection during initial interpretation of the statement or comment by the participant of their line of thought.

Participants' verification of transcripts

The transcript of the interviews was sent to the participants to confirm and give their approval of the transcription as a true reflection of the interview. They were also informed that they can clarify any point in the interview if they required or if they preferred another interview session. All the participants approved the transcript as a true and correct reflection of the interview session.

Reflexivity and positionality in this study

This study focus is on understanding the 'how' of workforce race equality' in the UK healthcare (17), and this explains in part why the study uses the IPA approach. IPA offers the best opportunity to the researcher to "*understand the innermost deliberation of the 'lived experiences' of research participants*" (34). The use of IPA positions the researcher to use reflexivity to define his positionality. It promotes honesty and openness in using double hermeneutics to offer interpretations of the phenomenon under 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*" (35). This provided me with an avenue for improving self-awareness in the study. IPA seeks to explore individuals' perceptions and experiences using a 'double hermeneutic' process of interpretation. In this sense it is impossible for the researcher to remove preconceptions but must become aware of preconceptions through reflexivity (36). Using 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 that involves acknowledging influences and possible bias at each stage of this study (37). In IPA, the researcher uses reflexivity to be fully aware of his meanings of the real world and his existence in the world of study (38,39). Finlay argues that the type of bracketing or reduction in IPA involves the researcher acknowledging his influences and possible bias in interpretative phenomenology (37). Self-critique and self-appraisal with an explanation of how 'own experience has or has not influenced the stages of the research process' (40) inform the use of reflexivity in this study, and I am aware of the new challenge posed by my membership of the 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.

The primary tool to encourage reflexivity in this IPA study included the use of a research journal (41). In addition to maintaining an e-journal, I engaged in the reflexive interview and data analysis, discussion and review of comments from my supervisory team made up of two senior professors and an associate professor, and discussions in conferences and with professional colleagues to ensure reflexivity in this study.

Results

The Smith *et al.*'s heuristic framework was employed to reflect on and analyse the lived experiences (30). I employed an analytical technique to manipulate the data for

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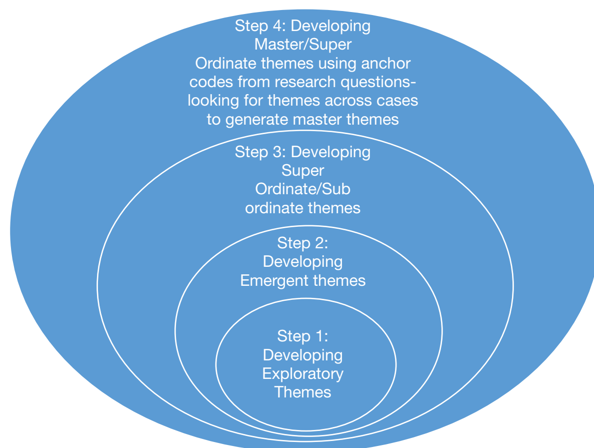

Figure 1 Summary of steps in data analysis (20).

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 (42,43). The steps in this IPA analysis comprises reading and rereading, initial noting, developing emergent themes, searching for connections across emergent themes, moving to the next case, and looking for patterns across cases. A summary of the steps in data analysis is in *Figure 1*.

In this study only one master theme and three sub-themes relevant to career progression are discussed below.

- Master theme 1: career progression:
  - Theme 1: education;
  - Theme 2: mentorship and coaching;
  - Theme 3: personal characteristic.

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 NMC. It explains the steps and factors they believed contributed to their career progression in the UK healthcare service. Three sub-themes are derived from the analysis: education, mentorship, coaching and personal characteristics or behavioural preferences. The logical and consistent story of this theme and analytical findings is that career progression in employment and education are significant components of the discrete domain markers and means of integration (20), and this is discussed further below.

Theme 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.

Osaro said, "*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 EU countries, where I did a master's degree in civil engineering; I came to the UK in 1991*".

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 was then called the Adaptation Programme*".

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 career pathway*".

Ede had a degree in English from Nigeria before transitioning to the UK, and her ability to communicate in English was fine. 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*".

Before becoming UK registered 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

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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 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 a half thousand pounds. I contributed half of it to do an MBA, but another colleague was given one hundred per cent; yes, …, I challenged it*".

Osuyi's previous educational background was a building block for her career progression. According to her:

"*It's been ups and downs regarding negotiating career progression. But one thing that worked in my favour was looking at my qualification from Nigeria. In my teaching experience, 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…, so 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….*".

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.

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, practiced, 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 and has now completed his PhD.

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

"*I practiced for about a year or a year plus; then I moved forward to do midwifery. So, I resigned and moved on to midwifery to have a broader experience within the care setting… And then, I practiced for about a year to two years plus. Then, I wanted to do my master's… I applied to 'Hospital' to maybe give me some support or time off to do my master's; … 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, 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… You see that this is sort of a summary of my journey*".

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 (bands). A number of the nurses progressed to positions in areas with greater adult and mental health nursing shortages in the London region, 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, 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', … 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*".

Ede, who had an English language degree before her nurse training, recounted her experiences: "*So when I went into university, I was a bit frustrated because sometimes you write essays and 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 expected more… to get an 'A'. But she said, 'I should be satisfied with what I had, and I do not need to get an 'A' really, it is not a big deal'… people 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 proved to myself and them that I could do it*".

Many nurses believed there were insurmountable obstacles to readily getting promotions in particular clinical areas. The solution to this challenge was to pursue higher education or specialised training to better position themselves for advancement.

Ehi said, "*No. I don't think so. Like becoming a district nurse*

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now and becoming Band 7, I knew I would never get a promotion to get there. I knew I had to do the training".

This sub-theme explains that all participants believed 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 cognate 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 academic performance in UK tertiary institutions.

Theme 2: access to mentorship and 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 or band.

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*".

According to Osaro, he had come to understand the three levels of knowledge that were relevant to his career progression. The three levels of knowledge were ['normal' intelligence, i.e., intelligence 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 these ethnic minorities from moving forward and to some degree, and I always categorise this into three perspectives that we may have… one is the normal intelligence (i.e., IQ) [education] And people with that will go as far as where that level of education will take them, … 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 [Band 7/8] just over six years post-qualification. But after that, I agreed, it was more or less stagnant for a very long period".

Osaro's moment of eureka came when he had a period of self-reflection. Osaro states:

"*What 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, some of the people I trained, I managed, and some of them were directors of nursing, some Directors of services all around. I realised then that the culture, the way people were in the society, is 'keeping quiet, not saying much, and doing 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...".

This self-reflection facilitated by a coach allowed 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 privately funded 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: "*Before qualifying, I had a mentor who was also a Nigerian but an Anaesthetic Consultant who was always challenging me and would set me a 5-year goal. So, by the time I qualified as a nurse, I had a 5-year goal to be able to go into health visiting or district nursing*".

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 going to work for a few years in an environment with predominantly white people helped me learn and listen. So,*

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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 learn how they speak and listen.

And I have shown that I use all that because now, as a manager, I manage people from different cultures, and certain behaviours are unacceptable at work. So, I learnt all that in that 9 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".

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

"*I think… 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…*".

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.

Theme 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 or bands. Personal factors also help the ethnic minority nurse utilise or take on the available opportunity and successfully gain higher grades (bands) and sustain the position. This sub-theme of unique characteristics revolves around resilience, intrinsic motivation, and the ability to use different types of intelligence, including EQ, 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.

Sub-theme 1: 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 or bands. 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. … If you want to move forward, you must do something different. You can be doing training to improve yourself. It was a land of opportunity for me and what I wanted to achieve*".

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. He continues to deal with the problems affecting his career progression with the same spirit. According to Osaro:

"*I think there were two things that impacted me before I started nursing… I am a qualified civil engineer! 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 to drink and sleep.*

And 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 depressing time of my life. My health was affected; my confidence went down. And you see that, for example, most people who came from abroad and are in poorly paid jobs have borrowed some money to come here. And to go back is not an option".

From the above experiences, it is clear that the individual nurse must be motivated, resilient and dedicated to overcoming challenges and succeeding in the new environment.

Sub-theme 2: 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 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

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clinical areas. The central motivation was that having the requisite qualification for a role was a set towards getting the job.

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 could tell me you don't qualify… No, I did not wait for sponsorship*".

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 wouldn't sit down and work in the wards. That was why I changed my jobs for the first six months... People should not think they should sit in one place without enriching themselves, trying to develop themselves, and moving on. People think it is all about just sitting*".

Sub-theme 3: levels of intelligence

All the participants believed that a good level of intelligence [education] was necessary to attain higher positions or grades (bands) in the clinical area. The participants essentially referred to having 'intelligence' as having the ability to succeed in formal education and having a good level of education. This general belief is evident in the respondents' interest in further education, engaging in 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 (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 excellent 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 (bands).

Many respondents believe that in addition to a high IQ [education], an additional level of intelligence was required to attain higher grades or bands. 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', 'EQ' and political intelligence or political assuteness. Osaro explains that the 'Guinness effect' sustained in the healthcare setting may partly be attributable to a culturally preferential lack of knowledge and practical application of EQ and political intelligence or political astuteness by ethnic minority staff in a management position. Osaro states:

"*This brings me to the issue of political intelligence. And I think we need political intelligence; we lack it. And I will tell you how that act. And … I want to say that is one thing most ethnic minorities lack. IQ will take us to a good level. Our emotional intelligence and conducting self, where we are not affected by the feeling of 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 that my experience and knowledge are enough to take me to whatever level; No, it doesn't".

Osaro explains that his access to a coach and the teaching on combining EQ with political intelligence gave him the key to unlocking 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, so my name came forward when this job came in terms of who could do this. 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*".

Discussion

The three themes derived from the human and social capital analysis are 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 define immigrants with a foreign university education who

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have moved permanently to reside and work in countries other than their own as qualified immigrants, and they have common attributes, such as agency in their international migration and a desire to enhance their career (44).

Skilled or qualified migrant 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*" (44). 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 the UK (45). 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 (46) and maybe deliberate decisions driven by personal, career and financial reasons (7). The motive to migrate is often explained by either the equilibrium or structural standpoint (47). 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.

A number of the nurses progressed to more elevated positions where nurse shortages in London area, such as care of older people, health visiting, district nursing, practice education and forensics (2), were recurring. 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 (48) 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*' (49). In an earlier study on how some Ghanaian nurses and midwives have experienced a system of processes and practices related to career progression, Henry found that the nurses had difficulties ascending into managerial positions in the NHS (50). 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 also found that the lack of upgrades to higher grades or bands 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 commitment to resolving the challenges (50).

Brathwaite argues that because Black, Asian, Minority Ethnic (BAME) women are both female and are a non-white ethnic group, they are subject to 'double colonialism' (28). 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" (28). However, in 'Race in the Workplace: The McGregor-Smith review' (51), 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%) (52).

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 organisational 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 with access to career mentors/preceptors or coaches could plan their career pathways and experienced progress relatively quickly.

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From this study, the most significant benefit to the nurses at the Agenda for Change Band 8 level is the need for coaching. This specialist's support, input and coaching enable a senior nurse to understand how to constructively use emotional and political intelligence to break the glass ceiling that had kept him at the same grade for over fifteen years.

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 or bands. Personal factors also help utilise or maximise opportunities to gain higher grades or bands and sustain the achieved position.

Hope, self-efficacy, coping, control, competence, flexibility, adaptability, hardiness, sense of coherence, skill recognition, and non-deficiency focusing (53-55) 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 (56). Resilience is inherent in individuals and describes when a person recovers easily and quickly from setbacks in life (57).

According to Hart *et al.*, 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 (56). Hope and optimism were vital factors in dealing with organisational challenges and maintaining resilience.

Despite living in harsh and challenging circumstances, some respondents' lived experience supports the importance of hope and coping mechanisms to overcome 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 could consider this period a 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 borrowed some money to come here. [And to go back is not an option]*".

According to Glass, flexibility, adaptability, and EQ are essential to resilience (58). All the respondents in this study were adaptable and flexible to the challenging clinical environment and developed their EQ to advance their careers. However, one of the respondents argued that in addition to these qualities, ethnic minority nurses needed to apply 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.

Conclusions

In this study, IEN includes ORNs and nationals of home country that had their primary, secondary and tertiary education in their home country before becoming registered nurses in their host country; and in this case UK. 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 because IENs eventually become part of the BME group and are often difficult to distinguish from UK born BME nurses.

Education, mentorship, coaching and personal characteristics or behavioural preferences are the themes and analytical findings that are significant markers and means of integration and career progression in employment. A working hypothesis seems to be emerging from the study that suggests that highly successful nurses of Nigerian heritage in the London region tend to be those who had received tertiary education in Nigeria prior to becoming a registered nurse in the UK. The individual nurse's characteristics and personal factors concerning professional practice help to utilise and maximise opportunities to break through professional barriers to gain higher grades or bands and sustain the achieved position. The current structure and practices ensure that for BME to reach the senior levels of healthcare careers, IENs often possess one or more educational degrees and develop higher levels of knowledge that domestic or "White" nurses do not need to attain or sustain similar position. Healthcare organizations and statutory bodies require to have essential and unbiased processes in place to give access to IENs growth and fulfilment and form a solid basis for developing long term policies and plans for IEN recruitment and retention rather than the current methods that is influenced heavily by the political philosophy and practices of the time.

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