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The multiplicity of BAME migrant nurses' vulnerabilities in South Wales

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Introduction

Since COVID-19 emerged in December 2019, it has had an unprecedented global social, behavioural and economic impact. Socio-cultural factors remained largely underappreciated in the pandemic measures that shaped the experiences of COVID-19 among migrant nurse populations. Dimensions that are part of this case study include different kinds of exposure to COVID-19, intersected with different forms of vulnerabilities and resilience that stem from, ethnicity and racialisation, gender, living conditions, daily activities, organisation of protective measures at work in healthcare setting and in public, legal allowances related to (a lack of) residency and citizenship for non-British nationals, and accessibility to various forms of care and support prior to, during, and after infection with COVID-19.

Vulnerability is the acknowledgement of the openness to the unchosen and unforeseen in human life (Harrison 2008). In the pandemic this concept has helped differentiate how for some social groups the consequences "increase the severity and mortality of COVID- 19" (Bambra et al. 2021: 8, Braidotti 2020). Whilst vulnerability to the effects of living in the pandemic has largely been understood and managed as a biological phenomenon that prioritised infection, illness, death, the effects of COVID-19 have gone far beyond physical health, impacting on "everyday life" and well-being, mental health, education, employment, and political stability. In addition to biological aspects, these other elements differentiated ways in which different social groups – ethnicity – and groups that are shaped by practice – healthcare workers.

This case study report focuses on the intersectional vulnerabilities of a social group that is both marginalised for being migrants from a minority ethnic background and working in healthcare during the pandemic. In particular, this report unearths the various ways in which predominantly qualified, but low-ranking[1] nurses from African countries have experienced the pandemic working in and around COVID wards in Swansea-based hospitals, and how their circumstances have rendered them vulnerable. Focussing on this group allows understanding better how the state-issued pandemic policies and protective measures in healthcare setting have had effects on Black Asian and Minority Ethnic (BAME)[2] migrant nurses.

The report is led by the following research questions:

1. What structural issues (mobility, opportunity, access) affect the pandemic experiences of BAME overseas qualified nurses who work in South Wales hospitals?
2. What organisational issues (management, spatial arrangements, institutional regulations) affect the pandemic experiences of BAME overseas qualified nurses who work in South Wales hospitals?
3. What can we learn about COVID-19 politics (containment, immunization and biopolitics) and the regulations of BAME overseas qualified nurses who work in South Wales hospitals?
4. What are the dominant rationalities (goals) in governing populations during the pandemic and techniques (means) of ensuring productivity, efficiency, and resilience of BAME overseas qualified nurses who work in South Wales hospitals?

[1] In the Welsh system, nurses are paid according to a hierarchy of 'Bandwidth', in which the lowest rank for qualified nurses is Bandwidth 5. Recruitment of overseas qualified nurses from Africa and Asia tends to focus on qualified nurses who are interested in working in these lower bandwidths.
[2] This report uses the acronym 'BAME' to indicate the differences between white Welsh or British and ethnic minority healthcare and medical staff, emphasizing Blackness as all interviewed nurses had a black African background.

5. How do government policies encourage beneficial forms of movement (money, goods) and limit harmful forms of circulation (disease) with reference to the Swansea region?

In Section 2, the report expands on the healthcare system in Wales and how foreign-born nurses are educated and employed in this system that has been adapted to cope with pandemic situations. Section 3 sets out the methodology, and Section 4 formulates answers to the research questions through themes emerging from the analysis. Following Section 5 which concludes the study, Section 6 offers recommendations.

Welsh healthcare and the COVID-19 pandemic

Set up of the healthcare system in Wales

The basic model of the Welsh healthcare system can be characterized as the so-called Beveridge or national healthcare model, based on universal health care coverage for all citizens provided by the Government (Kulesher & Forrestal, 2014). This national healthcare model is funded through taxation with a small proportion raised through national insurance contributions, and the Government has ownership of most of the delivery of health services (ibid.). Healthcare is therefore primarily provided through the publicly funded NHS Wales for all people in Wales, although the growing private sector also provides healthcare (Yar et al., 2006).

Since the devolution of Wales in 1999, the country is responsible for healthcare provision and the National Health Service Wales (NHS Wales) takes responsibility for healthcare in Wales. NHS Wales was reorganised in 2009 and seven local Health Boards are responsible for delivering all healthcare services within a geographical area. The Health Boards supported by three specialist NHS trusts: the Welsh Ambulance Services Trust offers emergency services, the Velindre NHS Trust offers specialist cancer care and a range of national support services, and Public Health Wales (PHW) is the national public health agency in Wales. One of PHW's roles is to protect the public from infection and to provide advice on epidemiology (the incidence and prevalence of disease). Although operationally independent of the Welsh Government, it acts at the Welsh Government's direction.

Statistically, the NHS in the UK employs 1.3 million staff in 2023, and staff with a Black, Asian, and Minority Ethnic (BAME) background amounts to 25.7% (UK Government 2023). Nonetheless, in 2020, 64% of staff who died from COVID-19 had BAME background (Chaudhry et al. 2020). In 2020, this group only represented 15% of people in managerial level positions, and only 11.3% in senior managerial positions (UK Government 2023).

Recruitment of BAME overseas qualified nurses

Many countries do not produce and retain enough midwife and nurse graduates to meet health service demands (WHO, 2021). Before and during the pandemic, BAME overseas qualified nurses had been recruited to make up for the shortage of nurses that have been educated in the United Kingdom. Also, the UK is committed to adhering to a WHO code of practice for international recruitment of health personnel (2023). NHS Wales recruits foreign born, overseas qualified nurses in particular countries in which the infrastructure has proven to be worth the investment. Besides Eastern European nurses, countries that nurses are successfully recruited from into NHS Wales are predominantly India and Nigeria. The seven health boards are responsible for their own organisation of the recruitment and facilitation of administrative, practical, and clinical quality level for integration in hospitals.

Upon passing an online interview with dedicated health board recruiters in their home country, nurses require a working visa, which the health boards assist with obtaining, they are provided with free travel to Wales, and are housed in shared accommodation with colleague overseas recruited nurses. Before being able to work as a nurse in a Welsh hospital, overseas qualified nurses need to successfully complete an Objective Structured Clinical Examination (OSCE). They receive special training to prepare them for passing the exam that is organised by the NHS across the UK. In adapted form, these trainings continued during the pandemic. In 2023 the Swansea Bay University Health Board that covers the Swansea region, is estimated to recruit 30-40 overseas qualified nurse according to a clinical educator interviewed for this study.

Methodology

This section explains the methodology and methods of the study. As the research seeks to uncover circumstances of BAME migrant nurses during the pandemic and as shaped by the pandemic measures, the methodology is rooted in experience and its contextualisation in broader terms of ethnicity in the Swansea region. Therefore, the answers to the research questions are based on a combination of qualitative and quantitative research. This methodology ensures that the insights and recommendations can be related to vulnerable groups (e.g. BAME people, migrants, and healthcare workers) in other European countries. Ethical approval has been obtained at the Swansea University College of Science and the NHS Health Research Authority (HRA).

Qualitative semi-structured interviews have been conducted with 8 Black, Asian, and Minority Ethnic overseas qualified nurses who have been working in a South Wales hospital during the COVID-19 pandemic. In addition, 7 healthcare managers were interviewed who have varied decision-making authority over different aspects of the Wales-based lives and careers of the nurses. These interviews provide a more specialised context about the nurses' recruitment, their training, their work circumstances, and the support they are offered. The interviews were audio recorded and conducted over the phone or videoconferencing platforms Zoom and Teams. The interviews were transcribed and coded in NVIVO v13. All transcripts were anonymised and provided with an individual code, and recognisable aspects of the interviewees and their background were omitted, with the exception of the job roles of some interviewees.

The interviews were combined with insights into the pandemic experiences of Swansea and Neath Port Talbot based BAME populations from a survey conducted online and offline between November 2021 and March 2022. It registered the opinions of 171 residents of different ethnic and national backgrounds in the Swansea region. Consisting of 50 open and closed questions, the themes included vulnerability, wellbeing, opinions about the pandemic measures, accessibility of healthcare, racism, and changes of life circumstances. 85% Of the respondents were ethnic minorities including mixed and multiple ethnicity and 15% are white (Welsh, British, and other white backgrounds). The minority groups include Black people (with African or Caribbean heritage), Bangladeshi, and/or Pakistani, Indian, and East Asian people (including Chinese and South-East Asian). All non-white ethnic group categories include mixed heritage; for example, a mixed Black and White background is counted towards the category of Black people. Although this survey is considered as a relatively large cohort, the survey results are not statistically representative of the areas. Therefore, as always in survey-based research, caution should be taken not to extrapolate and generalise the findings.

Results

"It was very hard for a lot of nurses, very hard. We all did it in our own ways, but it's not something I'd want to revisit." Clinical educator, Swansea hospital (Interviewee HMW36)

This section elucidates how public health policy that underpins the pandemic responses (at the Welsh national level and the local Swansea) and that informs healthcare organisation (Swansea Bay University Health Board) and policies in care institutions (hospitals in particular) (re)produces social and health inequalities with reference to ethnicity and working in healthcare. This results section uncovers aspects of life lived as a vulnerable person that have remained unconsidered in social policies, institutional organisation, and behavioural regulations. These emerge from the social, civic, and spatial organisation of the lives of BAME overseas qualified nurses onto which these policies and regulations do not map well compared to the lives of less vulnerable others.

Previous research has pointed out how BAME overseas qualified nurses in Wales have experienced a tremendous amount of stress during the pandemic both at the workplace and outside it (Public Health Wales 2020, Welsh Government 2020, Kabasinguzi et al. 2023). These studies' outcomes have been in line with the outcomes of the survey with people from largely minority ethnic background. The survey points out how minority ethnic groups tended to suffer a higher deterioration in mental health during the pandemic compared to British White groups (Beljaars & Shubin 2022). Survey responses highlighted not only the increased awareness of the inescapability and nearness of death and indicated that the pandemic produced a heightened sense of social responsibility towards close family members and other loved ones (Beljaars & Shubin 2023). It also suggested the persistence of a gender gap in mental health deterioration during the pandemic. Women and non-binary survey participants reported suffering a higher increase in mental distress than men taking part in the survey. Other studies from before and during the pandemic demonstrate that this is in part due to the inequalities they have been facing at the workplace (i.e. lower wages, more precarious work contracts, and fewer migrant nurses in managerial positions) and differences in workplace regulation per health board area and hospitals.

The Welsh pandemic in the hospital

BOX 1:

Research Question 1: What structural issues (mobility, opportunity, access) affect the pandemic experiences of BAME overseas qualified nurses who work in South Wales hospitals?

Research Question 2: What organisational issues (management, spatial arrangements, institutional regulations) affect the pandemic experiences of BAME overseas qualified nurses who work in South Wales hospitals?

> *"In a more general context, vulnerability is the ability of humans naturally to show our emotions and weaknesses by having no restriction to express how you feel."* - BAME overseas qualified nurse working on a COVID ward (Interviewee NN31)

Both nurses who had worked in Welsh hospitals before the pandemic and during the pandemic remark on differences in the way the provision of care in hospitals is organised. Such differences are important for these nurses' working in potentially dangerous virus-filled spaces, their wellbeing, and their career progression. Ultimately, these differences are important for the smooth running of the wards on which these nurses work, and how effective hospitals can respond to crises such as pandemics. The following subsections answer to Research Questions 1 and 2 (see Box 1).

The interviewed nurses were generally content with the choice to work in the Welsh NHS in Swansea hospitals. All mentioned that the wages are a large factor in their reasons, as many suffered poverty in their home country. An ITU nurse illustrated:

> *"The fact that my son [with cerebral palsy] is getting all these things that I dreamt of him getting and couldn't get, and he's now getting them, is far more important than me being well taken care of at work."* (Interviewee NZ36)

As such, on the one hand, all saw their work as a great opportunity and were very committed to their job. On the other hand, they felt that they had to be grateful for what they were granted and accept what was demanded of them. Their circumstances shaped by the pandemic had specific effects on the vulnerability of their situation.

During the pandemic, nurses felt largely vulnerable to the COVID-19 virus. These feelings were mostly based on them seeing so many different patients being so critically ill and so many colleagues being ill. That everyone was vulnerable to the virus seems to be the strongest held opinion amongst the nurses, immediately followed by the clinical hierarchy of vulnerability used in the pandemic measures. However, BAME overseas qualified nurses did generally not feel more vulnerable to COVID illness than their white British colleagues. Some argued that to work in a hospital, particularly in emergency care or ITU, or to work with patients with communicable diseases was just part of the job they accepted when they chose

the profession: in other words, to run the risk of catching COVID was no different than other dangers they were exposed to, and which rendered them no different than their non-black and non-brown colleagues. Aligned with biomedical – as opposed to epidemiological and sociological – approaches to the virus, which encouraged a more individualist consideration of risk – rather than a shared or collective consideration – the nurses agreed on the importance of 'keeping themselves safe'. They accepted that parts of the hospital were unsafe to be in, the COVID wards in particular, but that safety could mostly be granted if they adhered to the PPE rules and protocols. Ethnicity, living conditions, and other personal circumstances were considered of diminishable relevance.

Cultural differences in work and training

Particularly evident are differences in the usage of technology, the specialisation of nursing work, and documentation of illness progression and care provided. A nurse working on an emergency ward remarks that in the Welsh hospital that he works in "everything seems automated" (interviewee NN37). His experience of using technology in his African home country's hospital contexts is that computers are involved for particular tasks but not for everything. He was more used to relying on prior knowledge of patients' illnesses and making connections between clinical phenomena on their own. His experience is echoed by an ITU nurse who shared that she "realized that here you are more worried about litigation than anything. People would rather document than do the work" (Interviewee NZ36). The more intense focus on documenting and fear of litigation has an effect on the role nurses have in the organisation of care provision in hospitals. The ITU nurse explained:

> *"I realized that the way nurses are educated here and the way we are educated is totally different. Because we are taught to be having done ITU as well, you are taught to not to have blinkers on as a nurse and to be open-minded to deal with situations as they arise."* (Interviewee NZ36)

As such, the overseas qualified nurses thus considered having more capacity for thinking creatively about possibilities for care provision, being less afraid of being sued, and dealing with rapidly changing circumstances. In addition, in their home countries, the roles in wards, such an ITU, tend to be much less specialised as the roles they have been recruited for in Wales, which means that these nurses are experienced in more facets of delivering care. Overseas qualified ITU nurses therefore judged themselves more versatile acute care nurses than their Welsh counterparts. Nonetheless, they did not feel like their qualities were considered important, as demonstrated by an incident with the ITU nurse:

> *"I've done intensive care nursing, so when I got the job here, I was told about going to a surgical ward, which I wasn't really pleased with, because I was used to ITU. But anyway, I thought, 'Oh, well, it's alright. I will learn all the systems and all that'. So when we're doing OSCE, and then they say they're giving us temporary teams, I received a call now. They wanted me to work in ITU. And I refused. Not because I don't want to work in ITU, I want to work in ITU, but I felt like a means to an end. Like, I felt like 'oh, now that suits you because we are short staffed in ITU, now you need ICU nurses, now you want me to work in ITU. But you didn't trust that I could work in ITU before you had this need for ICU nurses', which I didn't really like, which for me was like a sign for the future, that it's not as rosy as I thought it would be."* (Interviewee NZ36)

Such treatment by management, in which their wishes were not taken into account despite clear arguments for the benefit of their wishes, contributed to feelings of being undervalued and not considered beyond their capacity to fill gaps in the hospital staffing organisation.

Another, pandemic related aspect of cultural difference to play a role in the pandemic was the alteration of the training for the OSCE exam. A clinical educator working with foreign nurses explained that the lack of face-to-face training had significant consequences:

> *"I speaking as a teacher, generally, I do not think [teaching via Microsoft] Teams works. (…) I've had to do extra teaching with these guys to make sure they're up to speed when they come under warranty, because they were extremely vulnerable, in respect and lacking in knowledge, because they hadn't had the teaching. (…) I realized that there is no substitute for face to face. (…) In nursing school, they would have had classes where you basically get around a dummy and do simulated training. And because that never happened, and if it didn't happen on the boards, because of both staff and etc, then they never got that experience."* (Interviewee HMW36)

Not only did the adapted training to prioritise COVID safety during the sessions deprive the BAME overseas qualified nurses of particular hand-on experiences, not having the patient interactions with actual people or patients in their training puts these nurses at a disadvantage for not learning cultural sensitivities around the provision of care for white Welsh patients and communications with white Welsh colleagues. Indeed, nurses working in Welsh hospitals with the pre-pandemic level of face-to-face contact with colleagues and patients spoke of this time in much more positive terms when recalling the early stages of their immigration:

> *"It was a good learning experience, you get to learn other people's culture. So for me, it was quite good. I enjoyed every bit of it. I wanted to learn more. And it helped me to adapted quickly so it was a good learning experience for me"* (Interviewee NN37).

Staffing

> *"It was very emotional, you will be crying all the time, because I have a lot of Filipinos I work with as well. And for some reason, in our hospital, the staff that were affected most were Filipinos. And these were ones that were in ICU. (…) And it's most of us. You got to it is 70%. Filipinos, Africans. I'm telling you, it is done. It is us."- Medical and theatre nurse* (Interviewee NG33)

Staffing was one of the elements that greatly contributed to BAME overseas qualified nurses' exposure to the COVID-19 and sense of safety and wellbeing in hospitals. Understaffing in the Welsh NHS has been a long-standing problem that the pandemic compounded in myriad ways, and which created particular issues for BAME overseas qualified nurses. This section discusses the various organisational aspects of staffing during the pandemic.

During the pandemic, the practice of hiring so-called 'agency nurses' to fill in gaps in staff schedules became normalised. Agency nurses are employed by agencies rather than hospitals and are hired by hospitals for their specialism through the agencies to cover gaps in the shift schedule for hospital contract nurses. The better pay, more flexible working opportunities, better access to training opportunities, and "less requirement to respond to managerial pressures" proved attractive to many nurses from Wales or other UK nations (RCN 2022, 2). Foreign nurses from African and Asian countries cannot switch to agency work as their working VISA is linked to their NHS contract and with the hospital. Nonetheless, agency nurse hire did increase, which meant that foreign nurses often worked with agency nurses. According to interviewee NN31, agency nurses "were being choosy" and would not accept being allocated to a COVID ward, as a nurse working on a medical and surgery ward argued: "they will come over and say, 'I'm not working with the COVID patients. And if you don't try to accommodate their ground, [these agency nurses] will tell you that they are going home". Therefore, she and other foreign nurses were more exposed to the virus as they covered COVID wards disproportionately often, and they had to work in severely understaffed conditions. This nurse recalled having 6 to 7 patients to care for on an ITU ward, where she should have 1-2 with a maximum of 3: a staffing level that was confirmed by other nurse interviewees. This risked not only the quality of care for patients on these wards, but also the welfare of these nurses. However, hospital management responded to take some pressures of these nurses. COVID patients on COVID wards could deteriorate severely rapidly, which required the nurses to do many time-consuming checks of oxygen saturation and blood pressure and diminished the reliability of the previous check. Supporting the nurses' clinical decision making around the kind of care such patients required, the hospital applied continuous monitoring. This was strongly welcomed by the nurses.

On non-COVID wards, the ratio of contract staff to agency staff was also sub-optimal because of some agency staff refusing to work on COVID wards. This led to extra work pressure for contract nurses on the non-COVID wards, because, as another medical ward nurse (interviewee NN35) attested, agency staff need constant help as they did not know their way around the ward. Helping these agency nurses organise themselves consequently fell on the shoulders of the contract nurses.

BAME overseas qualified nurses also recalled the considerations management had around staffing the newly set-up COVID wards. At the beginning, a medical and surgery ward nurse argued that management prioritised risks of understaffing over the health and safety of a small group of medical personnel. Instead of rotating the nurses so that the exposure to the virus was limited in time and spread out across the group to limit a potentially large group of staff going off sick and infecting patients on non-COVID wards, it was decided that a smaller group would have to work in the COVID wards for an extended period. She, as one of the nurses chosen to stay on the COVID ward, sets out the debate that followed when she and other nurses resisted:

"The fact that we want to curtail the spread doesn't mean [management] should expose us more, because the duration also influenced the risk of contractility. So the fact that [management] wants to manage staff, [management] wants to reduce the number of staff that might tend to go off sick due to COVID doesn't mean we need to always face it. So the argument came up. And at the end of the day, they do have to review this. I never knew whether it's like a formal policy then, or whether it was just something that was limited to my ward. I wasn't quite sure. But then it came up as a debate, because we started contesting it that 'Oh, no, I was there all last week, you can't put me back there: there are other people'" (Interviewee NN31).

The debate then changed to other ways of deciding who would have to work on the COVID wards, as medical and support staff would bring up living with children and elderly people. The nurse quoted above points out how what she called 'excuses' "put people who have kids in another country at a disadvantage". In response, the hospital management chose to more equally distribute the time staff spent on COVID and non-COVID wards, regardless of other potential effects. Doing so reduced the potential for BAME overseas qualified nurses to disproportionately run the risk of becoming ill with COVID-19.

Another aspect of working in a South Wales hospital during the pandemic as a BAME overseas nurse has been the difference in attitude to work that these nurses remarked on. The following quotation from a nurse who worked on theatre and A&E wards explains how knowledge of the system and being very familiar with cultural sensitivities around illness, vulnerability, and working in the NHS puts BAME overseas qualified nurses behind on their Welsh/British colleagues:

"What I find is that the British know how to play the games. So, for example, during the pandemic, they will say they're positive, and yet, they are not positive, they use that as, you know, to stay home. (…) I'm not saying they don't like to work, but they know how to play with the money: just to sort of give excuse not to be at work. And that is what we've had in pandemic, lots of people were ringing to say, in the morning. 'Oh, I've got COVID, I think I'm coughing, I think I have fever'. (…) Oh, 10 days don't come to work is a another: 'Oh, my sister has got it. Okay, isolate with my family for days'. So then that person is off work for how many (…) And that is where I find that managers, they know we will come to where they know, we the foreigners we will come, they know we do most of the work. That is everywhere, not only Wales, everywhere, we do most of the work. And they understand we're not here to play, we're here to work. You know, we're here to look after patients, so we're not going to complain so much, because I have come myself to work to look after the patient." (Interviewee NG33).

In 2022, when the Welsh government had lifted the legal necessity for people to stay at home when infected with COVID-19, the Swansea region-based hospital restarted with registering and counting COVID-19 illness as regular sick days that are limited within a year. Discussing the consequences, a medical ward nurse elaborated: "and then we realized. We were like, 'Oh, I said I can't take sick time off. I'm coughing, but yeah, it doesn't matter." This decision thus seemed to allow potentially infectious nurses to staff non-COVID hospital spaces and contaminate staff break room if they had already been off ill earlier in that year, regardless of people being able to get reinfected with the different strands of the COVID-19 virus within months, such as what happened with the different versions of Omicron.

Racialisation and racism

> *"When things are happening, it's all sugar-coated and nicely presented to you or in a way that you don't realize it in the moment. But when you reflect on certain events, you realize it's them"* - BAME overseas qualified ITU nurse (Interviewee NZ36)

The experiences of being racialised in the healthcare system differ amongst the nurses that were interviewed. Some shared that they had not had any instances in which their non-white ethnicity played a role in interactions with colleagues, patients, or the healthcare system at large. However, that is questioned by an emergency ward nurse who pointed out the forms of racism he had encountered:

> *"Maybe if I'm talking to you, somebody will tell me some racial slur, and I'll feel like okay, yes, this is racism. So I have not seen that. For me personally, I've never experienced that. (…) What I feel like what we can have now, I think the word has actually moved on, we have like always the same rights like everywhere. But now we have like maybe some subtle racism, in which maybe if people from black and an ethnic minority background demand an opportunity, they don't have the opportunities. Those reasons might be even, maybe a deep form of racism. And that one is actually difficult to fight, because you're not seeing it to your face, so you just like maybe like, we'll put it like, institutional racism lies embedded in a way."* (Interviewee NN37)

He continued to explain how it is impossible to tell if being denied opportunities is related to his ethnicity, but he and others have felt that it did play a role. His experience with racism thus seems to be the more insidious and institutionalised kind that strays from the obvious kind of racism that involves slurs and direct racist language. Racism as a lack or a negative is, as he argued, "difficult to fight".

In direct relation to the pandemic, nurses reported having been offered different possibilities for them to remain off COVID wards and working away from COVID-positive patients in the hospital, as it was clear that BAME people had a higher chance to fall severely ill or die. The former Chief Nursing Officer for Wales explained that this social inequity required more management through calculations of vulnerability:

> *"Lots of people went out of their way to do this public response. Yet, as we found with the evidence coming through over who was higher risk, we had to actually develop a tool to stop them dying by putting themselves at risk. (…) At the beginning, the only plan we had to work on was the Flu plan. This was a new bug, so we had to chuck the rules away."* (Interviewee HMW35)

Those who were offered to be treated with more caution on work placement for their higher potential to fall severely ill or die during the first wave felt that clinically it might be a correct solution. Nonetheless, the more dominant feeling was being singled out, where their ethnicity had not been a reason for different treatment from management before, and they felt that they would not be able to contribute to

the hospital's and their colleagues' handling of the patient deluge. That reason became the dominant response from many BAME overseas qualified nurses as they declined the offer to stay home or work in hospital-designated safe spaces.

Most nurses did report such openly and unbound kind of racism. When the racist incident was instigated by patients, they explained they deal with in different ways. Often nurses brushed off the incident as part of the illness which led patients to display delirious behaviour. Stated by a nurse who worked on a medical ward: "you can't really be angry at them" (Interviewee NN35). As such, she had found a way of coping with being racialised at work that worked in her mind to reduce the energy she had to spend on dealing with this. She has made complaints to management in the past. She elaborates on her disappointment:

> *"The managerial system, I don't think they're fully equipped to, like, undo racism, they just tell you to report, but that doesn't change how I'm feeling on the inside. And obviously, they ask you how you are, alright and all that. But there's never really a follow up on how you feel afterwards. And for me, I'm the kind of person that because I'm having a difficult time with you, I'm not going to avoid you. So for some people that would rather not work on that section, they'll choose to go to another section, but I'm like, 'Why should I run away from you? That kind of person'. So I'd rather stay there and just walk around, and we still interact until my shift is over. It's not easy on the inside, especially when you're trying to help someone when you are faced with this."* (Interviewee NN35)

Both nurses who have and nurses who have not made complaints to the managers responsible for the ward have learned to cope with it on their own as complaining, and learning how others had complained about it did not trigger an adequate response. A BAME nurse manager emphasized with more junior BAME overseas qualified nurses who she had worked with and noticed how her team BAME members dealt with the instances:

> *"I saw that people have different ways of dealing with people, even things that you normally wouldn't accept to be said or done to you. Sometimes we give them a blind eye and say, 'Oh, I'll decide not to focus on that. And focus on what I need to do and focus on the bigger picture'."* (Interviewee HMZ37)

Whilst the situation was found to be managed alright in the moment, there was often no sufficient follow up. For the foreign nurses it seemed to become clear rapidly that these instances were treated as unacceptable but also unavoidable. The nurse manager explains how she knew that them being racialised would not necessarily be best thought of as mistakes, but as reflections of deep-seated dispositions and ignorant misconceptions. She explores what leads to BAME nurses having to defend their knowledgeability and capabilities as coming from abroad; from African countries in particular:

> *"Different people have a perception of Africa that they want to believe. So coming in, and them knowing that I came from Africa they make you feel useless. Because in their minds when we are nursing patients in Africa, we will be nursing patients close to lions. And they're watching us when we are asking questions. (…) And all your years of experience are sort of thrown away, which is not true, because when push comes to shove, your experience just kicks in. You do what needs to be done. But in the moment, we are restricted to what we can do, because of being new. But students who were qualified like maybe last month are treated differently to you with all your years of experience, which I honestly didn't appreciate. (…) And they are not as knowledgeable as you would anticipate that they are. (…) You have to work with these students, and you ask them questions; they're in their final year. They don't know simple pharmacology, drug classes and things like that. Then I asked myself so 'how come someone who qualified last month is considered better than me, but they lack all this?' I fail to understand that."* (Interviewee HMZ37)

This manager, having had first-hand experience of having her capabilities questioned and being treated as underqualified at times, demonstrates how asking questions about processes that are taken for granted by Welsh or British nurse students and nurse colleagues can easily be construed at best as lacking skills and knowledge at a more advanced level, and at worst unreliable with correct care provision for patients. This can affect foreign nurses in major ways. Because of being racialised on many occasions, an acute medical ward nurse dreaded to go to work. She stated the following: *"I'll just say that 60% of people I've worked with kind of let me know that being black or not being white is a huge thing for [them] and make you feel less of yourself sometimes"* (Interviewee NN32). She stated that having been racialised had affected her mental health so profoundly that she was seriously considering returning to her home country. As the anticipation of coping with racialisation can take up significant 'mind space', the level of care that she and nurses like her can provide therefore comes into question.

In conclusion, whilst ethnicity and race are not categories that have a specific place in the organisation of Welsh hospitals are organised, including not during the pandemic, it seems like not being white British does put people at a disadvantage. Such disadvantages may not be clear in the severity of racial confrontation by patients or colleagues, the heaviness of the accumulation of being ignored in social situations or rejected in career prospects, nor in the betrayal of being left to work through the incidents themselves. However, they may lead to situations that render BAME overseas qualified nurses unsafe in the pandemic for social reasons in the hospital workplace.

Territorialisation of the virus

Hospital management employed an understanding of the virus response within the hospital on the basis of biomedical and life scientific understandings of viruses. These understandings are materialistic and sees bodies and viruses as distinct entities that can be separated. Based on these understandings hospitals employed spatial tactics to keep the virus as potentially attached to objects and residing in contagious bodies away from bodies that are not affected: i.e. through territorialisation. Territorialisation worked through differences of PPE required in hospital spaces, which was an extension of the system that had already been in place in parts of the hospital before the pandemic, as a theatre & A&E ward nurse explained:

> Interviewee NG33: *"We always had to do all different things, so we have the red, amber, and green. So when I'm back red, then that's the danger, so if we are going there, you definitely have to put your complete protective on. And for amber it depends on what case it is either complete, or it's up to individual, but then you've been advised. I even wear glasses, I make sure I clean my glasses before I come out, or I dropped my glasses in a case and somebody will pass it back to me. We try not to, you know, impact other places, so that was everywhere was red, green, red, yellow, green.*
>
> Interviewer: *Was it confusing to have all these different zones?*
>
> Interviewee NG33: *But because we had the training, the initial start, which I thought was very good, it helped all of us, because we were even taught how to take it up. We do it but because it's a different way of wearing it: how to take it up, so that you don't even shake the virus around you and others."*

As such, the hospital became a pattern of red, orange, and green spaces that medical staff had to navigate. The primary difference from other earlier practices around infection control was the practice of donning and doffing the PPE as the virus could be 'shaken' off clothes and onto bodies and other clothes, reflecting the fear for virus' airborne transmission. The amber category, as this nurse described allowed for individuals to make their own decisions about how to use protective equipment. Whilst this rule demonstrates sensitivity for difference in opinion around how to protect oneself around the virus, it also demonstrates the introduction of ambiguity in the hospital.

This territorial pattern had disadvantages for medical staff working in the red zones over staff working in orange and green zones aside from the increased exposure to the virus through bodily interactions with contagious patients. Red zones held patients with COVID, and whereas green-zoned nurses were allowed in and out of green and orange zones (when donning appropriately), red-zoned nurses were contained within their red zones. Movement of people and objects alike were curbed for fear of bringing COVID-19 into non-COVID zones. The strict boundaries put up between COVID and non-COVID wards challenged the normal way of working for the nurses on the COVID wards. As explained, the BAME overseas nurses had a higher chance to be working on these wards. On top of the understaffing, a medical and surgery nurse explained the disruption to her workflow as she had no longer access to a 'runner':

"A runner is somebody that will stay by the reception. Because when you are fully donned in your PPE and then you remember, 'oh, I need this pair of scissors'. You don't want to come out of the bay, remove all your gadgets, make excuses, come back again and don everything because at that point, you are even at risk of contaminating other things. So you don't want to keep popping in and out. If you have somebody like that, but the fact that we're never, like, we never had like good stuff, and it was difficult to keep up with that pace of not having a runner. (…) I would say, 1 in 10 times, you have a runner, the other nine times you would never." (Interviewee NN31)

As expressed by her and others, not having access to a runner to accommodate the care provision increased workload stress with the nurses and it increased chances of contamination of the nurse heaving to go in and out of their PPE and those around them on other wards. Whilst this did not single out BAME nurses, they may have had to deal with this lack more often, given that they seemed more likely to work on COVID wards.

Another way in which the virus created ambiguity in the hospital was the ill-recognition of the manifestation of the virus. As in Western medicine, disease, including COVID-19, is proclaimed and described from an objective, outside point of view, and as the illness has a varied presentation, healthcare workers equally struggled with recognising bodily phenomena as symptoms from their own experience. A nurse who worked on a critical care ward explained her confusion at an unknown moment in the pandemic, but during which they had access to lateral flow tests:

"I had to like hurry by running, so when I came, I was breathless. So I was trying to catch my breath in between I was coughing, so I thought it was because of that. But when COVID came, everybody had this paranoia going on. So if you cough, your colleagues would look at you a certain way. Because I kept coughing intermittently, I didn't think it was anything I thought it was just because I was trying to catch my breath. So when we went on break, my colleague said, they should just check my temperature that I never noticed, I was like 'No, I'm very sure I don't have COVID that I haven't lost my sense of taste. I don't feel this way'. So she was like 'you never know, just to be sure to protect yourself. Just check your temperature'. So I checked my temperature. My temperature was okay. But I started having chills after going home. And cough continued, though. And then headache was creeping in. So I decided to give the occupational department a call. They scheduled me to come and swap at one of their centres. So I was very sure I didn't have COVID. So I was very much taken aback when the results came out. I was I was positive COVID. I was like, 'Are you really sure this is my results? So after the results came in, that's when I started feeling the symptoms." (Interviewee NN35)

The virus' disguise as exertion symptoms was therefore brought into the different spaces in which this nurse worked, as the hospital regulations aimed at early detection of staff infection had not been sufficient in recognising her body as infectious. Hence, even in a space that was highly regulated, and in which highly trained clinical professionals who were familiar with the virus and its symptomatology, the virus could not be kept from spreading. As such, the territorialised approach to contain the virus as adopted in the hospital and as reflected in the Welsh government's regulations, seemed to have allowed for multiple kinds of ambiguity that permitted the healthcare workers and patients alike to be exposed to COVID illness.

Section conclusions

This section uncovered aspects of the life lived by a Swansea-based BAME overseas qualified nurse within the hospital and how they were rendered vulnerable through the circumstances they were put in. The organisation of healthcare provision, predominantly in hospitals was an important factor in the ways in which nurses were vulnerable during the pandemic. Lacking the development of cultural competencies in adapted trainings rendered the foreign nurses socially vulnerable after qualifying, which may have compounded anxieties around being racially accosted by patients of colleagues. Staffing issues also played an important role in the organisation of hospitals during the pandemic, which created challenging circumstances for the BAME overseas qualified nurses. Furthermore, the territorialised approach, and the partially inadequate scrutiny of bodies coming into the hospital through reliance on symptoms, to avoiding the spread of COVID-19 introduced new ambiguities into the hospital. As such, this rendered healthcare workers, and especially minority ethnic healthcare workers vulnerable.

BOX 2:

Research Question 4: What are the dominant rationalities (goals) in governing populations during the pandemic and techniques (means) of ensuring productivity, efficiency, and resilience of BAME overseas qualified nurses who work in South Wales hospitals?

Research Question 5: How do government policies encourage beneficial forms of movement (money, goods) and limit harmful forms of circulation (disease) with reference to the Swansea region?

Whilst the pandemic measures worldwide severely restricted the flow of travellers between countries, qualified nurses were actively made exceptions for. European countries, including the UK, restricted travel from African countries and other parts of the world that are considered to be developing regions from a Western point of view by categorising them as 'red countries' for large periods during the pandemic. A recruitment manager for the Swansea Bay University health board illustrated:

> *"Through the pandemic, we were obviously still keen to recruit overseas nurses, and the overseas nurses was still as keen to come for the opportunities and come to work for us in in, you know, in Wales, but to that led to, you know, obviously, significant delays in different processes, etc. And that was, I suppose, the biggest impact that we had from COVID, in terms of us actually getting the nurses to come, once the nurses were here, then, you know, we were able to support, etc, and care for them."* (Interviewee HMW31)

Once the nurses had arrived, many argued that family members who were due to reunite with them in Wales also faced significant delays; both in acquiring the right documentation to travel at the embassies in their home country, and in receiving the right documentation that proved their right to remain in the UK. This created many uncertainties as the dysregulated foreign document processing capacity of the UK government put their life on hold in their home country as one foreign nurse manager explained how a colleague nurse from India heard nothing from the UK embassy for months and was then expected to be on a flight two days later. Also, family reunions took much longer than had been expected and had the case prior to the pandemic with Biometric Residence Permit (BRP) provision being delayed for the husband of a medical and surgery ward nurse who then had to wait for his BRP, which had major consequences:

"He didn't get the card [until] after six weeks, but after four weeks of we go into the post office every week. They keep telling us 'Oh, it's not here yet. It's not here yet'. And at some point, it does become frustrating for him because without the BRP you can't open a [bank] account. Yeah, without the VRP, you can prove to employers that you are legal immigrants so you can get a job. So it was like a, like a pause for him. They've always justified the delay with COVID pandemic. That's due to the pandemic, they are having loads of backlog and began – they couldn't do anything about it done for us to just wait. But you when do we wait was an answer that they couldn't provide? So at some point, it had a strain on my marriage? Because my husband was very, very emotionally downcast then was like, no, because coming from an African perspective, the men always feel their pride and their ego lies in their ability to provide." (Interviewee NN31)

As such, the bureaucratic functions of the Welsh and UK governments during pandemic faltered, which created a series of problems at different aspects of the lives of BAME overseas qualified nurses.

Living arrangements and everyday life

Living arrangements are vital in the organisation and possibility for rest and deployment of other aspects of personality. If such arrangements are not in line with people's needs, this can create new vulnerabilities in pandemic lives. Higher levels of anxiety and mental distress as well as large households characterised the lives of other BAME people in the Swansea region. The survey outcomes suggest that BAME women particularly struggled, scoring a 52 on the happiness scale, which was 10% less than men. Thibaut and Van Wijngaarden-Cremers (2020: np) argue that the gender gap in mental health deterioration during the pandemic exists because of "the specific psychological and psychiatric risks faced by women both as patients and as workers in the health sector, the increased risk of violence against women at home and at workplace and, finally the risk run by children within their families." Recent research in the Welsh context by women's labour organisation Chwarea Teg (2020) found that during the pandemic women largely lost their support networks and saw alterations in childcare expectations, which negatively affected their mental health. The pandemic lives of the BAME overseas qualified nurses illustrates how mental pressures and living situations made them vulnerable.

When the BAME overseas qualified nurses first arrived in the UK they were not provided with accommodation somewhere in the Swansea region, but at the hospital. A recruitment manager explained:

"So the accommodation at that time during the pandemic, it's changed. Not because we've increased our numbers and they've got an external provider for accommodation, but they will go into our hospital accommodation that we've got for staff. So they would be met as soon as they arrived out of quarantine. Someone – I've met the nurses myself and taken them to the [surgical] theatre accommodation, whatever or, you know, different people within the team do that. Help them settle in, welcome them, give them information, etc." (Interviewee MHW31)

Hence, the nurses who arrived during the pandemic were immediately embedded into the hospital setting, whereas before they would have been living in shared accommodation in a residential area. This pre-pandemic placement would allow easier contact with Welsh people, which would have helped them settle in the country quicker. During the pandemic, in the beginning stages of their move to Wales their lives were entirely dominated by the hospital.

Many BAME overseas qualified nurses experienced anxieties around how to feel safe in working with the virus at such close proximity. Most nurses linked these anxieties to the waves in 2020 and 2021 through feelings of not having any control and until the vaccines were considered to reduce the number of hospitalisations. A theatre & A&E ward nurse attempted to keep her home as a virus-free space that felt safe:

> *"I didn't feel safe or the onset because there were some theories going on that the virus tends to stick to your uniform. So there was a lot of anxiety on my own part, where once I come back from work, I'd try to like, take my dirty clothes, right? Right at the entrance of the house if I can."* (Interviewee NN35)

Despite following all the rules precisely, she still caught the virus. She also lived with a friend who she had met during their shared OSCE training upon arrival. As they are both nurses, it became virtually impossible to keep the virus out of their home. However, whilst her feelings of safety were not helped by the insufficient measures that she adhered to, she felt better for living with a friend:

> *"Yeah I live with my friend. She's also a nurse, so we're able to relate our experiences and we have similar experiences, so it makes it easier. When you are having a difficult day, you have someone to share it with, and somehow laugh alright in the end."* (Interviewee NN35)

The comradery between nurses who share living arrangements was therefore of particular importance during the pandemic: not just to relay experiences with and consider challenges at work, but also to keep each other's mental health in check and have each other for emotional support. However, sharing accommodation, which is common for foreign nurses and medical staff in training (e.g. junior doctors on rotation) has also lead to an intensification of pandemic anxieties for BAME overseas qualified nurses. As a ITU nurse explained:

> *"It was made obvious that we were at risk. We [foreign nurses] were more at risk than the other groups. So just interacting with my colleagues and my housemates in the house who were working in COVID wards made me anxious because I thought 'I'm very much as exposed as they are, because they are going to work in a COVID ward and we are coming back to interact together'. And sometimes you tend to isolate yourself, but this is like the only family you have. And you want that social interaction and it made it so difficult. So yeah, I'll say there was a time I felt really vulnerable and at risk of just contracting COVID."* (Interviewee NZ36)

Whilst hospitals were so tightly regulated through the zoning and the many rules that aimed to prohibit the spread of COVID-19, the lives outside of the hospital did not offer a continuation, despite being organised by the institution. Living arrangements could thus increase the exposure to the virus outside the hospital.

As part of their lives in shared accommodation or as living with family, BAME overseas qualified people spent time in public places. A medical and surgical ward nurse explained how their job in healthcare created new anxieties in these spaces:

> *"I felt it was during the height of the of the pandemic, when everybody were using their mask, and all these restrictions were in place – I would say I feel safe, I felt more protected then. But over time, when they started opening up the places and the restrictions were been lifted, one after the other. At some point, I was like, 'oh, I hope we aren't going back to this awful time, I don't want it to be crazy again, okay. (...) At some point, I was finding it difficult to wear my mask. Despite the fact that they've taken it off the public places like the supermarkets and all that it became quiet. It was more of a suggestion than a law. So it was up to individuals. So at that point, I was still stuck to my mask that at some point, there was even my husband that will tell me 'you are home now, take that off'. I hadn't forgotten. I was quite used to it, because I felt more protected having it on. But over time, when I could see that nine in 10, people were not having the mask on. So gradually, I just felt it's I don't even think is quite reasonable. Because there are nine people surrounding me and I'm the only one using this mask."* (Interviewee NN31)

She raises feeling very uncomfortable noticing the juxtaposition between the call for civic liberties entailing not taking COVID precautions by not wearing masks, and still having fresh memories of the COVID patient deluge and the many people she saw dying from the illness. Also other nurses raised the awkwardness of seeing people actively putting themselves in jeopardy and the nurse having to care for people like this when they would be brought into the hospital days later.

Migration and the pandemic regulations

BAME overseas qualified nurses working in hospitals in South Wales were also rendered vulnerable by virtue of their migrant status in the UK-based and Welsh pandemic regulations. In addition to travel and work documents having been delayed in many cases, coming from red-listed countries, they also had to quarantine for 10 or 14 days. A respiratory ward nurse who did not see her VISA application and approval delayed, recalled her quarantine experience as such:

> *"That was fantastic. Brilliant, yeah. Two weeks of not doing anything getting your meals, right. Yeah. (…) It is the mind that was free, so I had my things working out; watched movies, called for food, eat, sleep."* (Interviewee NN34)

Whilst this nurse recounts it mainly as a positive time, the isolation of the quarantine can be a difficult period for a migrant who has just left their familiar life and has built no familiarity with the new country yet. However, the health board and hospital management seemed to have recognised the potential for nurses' mental health to decline. As a nurse later working on a medical ward explained, they had coping mechanisms:

> *"We had to do the isolation in the hotel. And we could not see each other. If I could remember correctly it was until the last day that we saw each other. But during the isolation we had like video calls together just to see each other like 'Oh, I'm fine. I'm okay'. Then also our coordinator then in Swansea, she called us every day as well to keep in touch, which was really helpful."* (Interviewee NN37)

As such, hospital management had very well anticipated the mental pressures of moving to another country on your own and the extra pressures the loneliness of quarantine could bring.

Migration and the pandemic regulations

Wales as a Western capitalist state governs at the population level through political strategies that interfere with the biological processes of this population to achieve a balance in economic growth stability that is measured in the life and death of its subjects (Foucault 1976). According to Deleuze and Guattari (2004: 260) states exert control over the population by mediating the stabilising and destabilising oscillations between the poles of rigidity and chaos. Adapting to the incessant changes in circumstances that threaten the balance these mediations attempt to introduce and maintain, the state continually introduces new regulations. As the pandemic was such an anomalous event that disrupted the balance to such a strong extent, the severe measures reflected this profound disruption. States can, however, only interfere with the biological processes that government officials find important, can measure, and that are embedded in its governance structures. Ethnic minorities with and without migration background in Wales are an historically disadvantaged group for whom services have not been set up as accessibly as for the white British majority group.

Provided with investment – as seen in 'Shared Prosperity Funds' from Swansea Council and the 'Strategic Equality Plan 2020-2024' from Neath Port Talbot Council – it became possible to create opportunities,

provide additional support, and offer special funding and project-based investment. However, as the terms suggest, the provisions for many ethnic minorities were additional elements; not aspects of the foundations of the governmental system that would suggest full integration of their lives. Nonetheless, a Chief Nursing Officer for Wales who was active during the pandemic ensured that all policies relevant to healthcare workers, and nurses in particular, went through equality impact assessment. She recalled being questioned about this in meetings with other CNOs and senior civic servant colleagues in other UK nations and of the UK government:

> *"They all went, "What's that? What have you done with that? Why? Why do we need it?' And as I said, 'because it has to be for the populations that we are serving, actually, it won't be the same, this mask won't work the same as it will for somebody who's very much further at risk based on ethnicity or genetic definition than someone else'. So we did that. But did it move enough? I don't think it has, I think they don't focus on this in all governments, but even my [Welsh] government now is very much on inequalities as the thread and the lens through which we write our all our policies. But it does need – it takes time and doesn't instigate a shift change. People don't do it just because the government says it, doesn't mean everyone's going to think that's the right thing to do."* (Interviewee HME33)

The BAME overseas qualified nurses included in this research did not recall their ethnicity to be of major importance in staffing decisions. A foreign medical ward nurse stated that her management served them a risk assessment to determine in what spaces they could be scheduled to work.

BAME overseas qualified nurses who are recruited into NHS Wales do so for a variety of reasons, but, as mentioned before, the primary reason is to be able to better support one's family financially. This is a known fact as this is what makes recruitment so successful for the Welsh health boards. However, this financial dependency of people in the nurses' home country on average disadvantages foreign nurses in comparison to Welsh or British nurses who are less likely to have many people depend on their salary. A nurse who worked on a medical ward explained the consequences for her:

> *"I haven't been in my country since I came here for 15 years, and I just went. I know! I put my whole life in the British and the Welsh. Yeah, I just went back in April. Yeah. So that's what I'm saying we work and work, work and it is all we do, most of us at least, you know. We work and send the money home. And then sometimes you go [check your account] and it's empty. There's nothing there for you."* (Interviewee NG33)

The statement demonstrates how the wages could not fully be enjoyed by the BAME overseas qualified nurses themselves as it funded their family and community in their home country or family brought over to Wales. Not only did having little access to money disallow doing activities and purchasing enjoyable items to relieve work stress and anxieties, it also kept these nurses living in shared accommodations. Whilst the latter had distinct advantages regarding emotional support and possibly some cultural familiarity, it also disallowed privacy and peacefulness and retained a high level of exposure to the virus from – or possibility to infect – nurse colleagues who (also) worked in COVID wards. These mechanisms keep these foreign nurses in their job and accept the unsafe conditions without complaining too much as they are too dependent on their job in the Welsh NHS. Consequently, this workforce becomes a cheap and reliable element in the management of the healthcare system in Wales.

Section conclusions

BAME overseas qualified nurses were rendered vulnerable outside the hospital and as part of Welsh society in several ways. Not only did the tightly regulated and relatively clear and equal management of the pandemic conditions for nurses in hospitals not necessarily extend to spaces outside the hospital. The foreign nurses also had little flexibility on shaping their living situation as line with their need to stay safe from the virus and benefit from community and care networks is the absence of (the majority of) their family in Wales. The first stages of the move towards integrating in the hospital training system during the pandemic was appreciated by the nurses. The dependency mechanisms that lock nurse into their hospital job keep these foreign nurses in front-line posts and accept the unsafe conditions without complaining too much. Consequently, this workforce becomes a cheap and reliable element in the management of the healthcare system in Wales.

Conclusions

This section provides new indications of pandemic policies and regulations in Wales (re)produced inequities between social groups with particular reference to healthcare workers, migrants, and ethnic minorities. It will also provide suggestions for pre-empting the formation of these inequities and reducing some of those that have pervaded and exist today.

From the beginning of the pandemic onward, there has been clear evidence that BAME people seemed to a higher chance for severe illness and death, which had been established already in April 2020 (Kirby 2020). The clinical indication of vulnerability in the pandemic context of not specifying ethnicity as a factor thus did little to structurally protect BAME overseas qualified nurses in their job. Therefore, this allowed an unequal situation for these nurses to go unnoticed in healthcare spaces. Vulnerabilities over BAME healthcare workers in Wales can be attributed to the following:

- The structural unequal embedding of BAME overseas qualified nurses in the Welsh healthcare system emerged as unrecognised vulnerability that could arise because of ill-recognition of compounding processes and exclusions that singled out BAME overseas qualified nurses.
- The Welsh government's responses to the pandemic operated on the basis of separation of the ill (contagious) and healthy, segregating individuals on the basis of risk and vulnerability in relation to specific territories (Toscano, 2020). The territorial approach to managing the virus in the pandemic measures added extra pressure on the BAME nurses, and limited their everyday contacts and support networks, which increased their vulnerability.
- The organisation of ward staffing and the eventual rotation-based schedule balanced the exposure to COVID-19 between nursing staff. However, the hospital's choice to hire agency nurses and their refusal to work on COVID wards did seem to disproportionately put the BAME overseas qualified nurses at risk of contracting COVID-19. The organisation of staffing combined with the zoning of the hospital according to the need for patients' treatment specifically for COVID-19 exacerbated the already challenging circumstances for foreign nurses. A perceived lack of opportunities for their career made it extra difficult to retain the motivation to put oneself in danger at the request of the hospital, all the while seeing how white nurses seemed to be offered more opportunities from earlier on in their career, got away with excuses to avoid working at points in the pandemic. As such, hospital management seemed unable to appropriately reconcile ethnic differences.
- Simultaneously, BAME overseas qualified nurses often faced continuing exposure in front line positions due to the financial dependability of their family and community.

Recommendations

BOX 3:

Research Question 3: What can we learn about COVID-19 politics (containment, immunization and biopolitics) and the regulations of BAME overseas qualified nurses who work in South Wales hospitals?

This section develops recommendations for the Welsh Government, the local Swansea and Neath Port Talbot councils, Public Health Wales, Swansea Bay University Health Board, Swansea-based hospitals, civic society organisations, and media. Answering to research question 3, the following recommendations can be made:

a. The structural organisation of the nurses' employment in hospitals, the Visa-related restrictions placed on foreigners, and state-issued pandemic measures locked them in a bounded and disadvantaged place in Wales.

b. Hospitals can improve the organisation of labour in which BAME overseas qualified nurses function to make better use of their creative and solution-based capacities – predominantly in emergency care – and their time providing care instead of managing agency nurses.

c. Acknowledgement of hospital management that hospitals could have run the risk of collapse if management had not been so effective in arguing that COVID safety was attainable through individual protective behaviour, rather than manage it as a collective responsibility.

d. Developing mindfulness of racism emerging as limitation in career development possibilities, by patronising behaviour from other staff and colleagues, abuse of grateful attitude and accepting the foreign nurses' tolerance of dismissive behaviour, and lacking insight and action on preventing the accumulation of circumstances that lead to disproportionate exposure to the virus and mental pressures through uncertainty.

e. Mental health support in pandemic and perhaps also other crisis and high-pressure situations, needs to be designed and organised to target ethnic groups differently and with great sensitivity to gender difference.

f. Living arrangements as shared between hospital staff need to be considered following similar scrutiny to infection as hospital spaces to avoid infections and the infection anxieties that these arrangements can create.

g. Better attention to the social structures and social pressures that minority ethnic people and healthcare workers function within in the institutions they work for.

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The COVINFORM project

Acronym	COVINFORM
Title	COronavirus Vulnerabilities and INFOrmation dynamics Research and Modelling
Coordinator	SYNYO GmbH
Reference	101016247
Type	Research and Innovation Action (RIA)
Programme	HORIZON 2020
Topic	SC1-PHE-CORONAVIRUS-2020-2C Behavioural, social and economic impacts of the outbreak response
Start	01 November 2020
Duration	36 months

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