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Research Paper

# *'You tried your best, but we suffered enormously': A decentred analysis of the contested narratives surrounding COVID-19 policy implementation in the British prison system*

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*Prison health is intricately connected to public health given the significant burden of poor health which the majority of people in prison experience. Prison healthcare suffers from chronic understaffing, mostly due to macroeconomic austerity. The COVID-19 pandemic inflicted extensive damage on this already fragile milieu. We employ decentred theory as a sensitising concept to articulate competing narratives about prison healthcare decision-making during the pandemic. We predominantly draw upon 44 interviews conducted in 2021. We found that non-urgent healthcare provision almost collapsed with exhausted healthcare staff trying to deliver a reduced service to patients who felt abandoned. Consequently, our analysis portrayed narratives of suffering, trauma and injustice that were experienced in markedly different ways. Many participants compared a muddled and un(der)funded prison healthcare COVID-19 strategy against that of well financed community healthcare. Decision makers implicitly competed with each other over lines of accountability and responsibility. The research process itself was distorted and resisted by various actors in both overt and covert ways. We argue that prison healthcare is emblematic of a devalued and underfunded public healthcare agenda where actors have been physically and emotionally harmed by habiting space within a struggling institution during the largest public health crisis of the past century.*

## Background

### *Prisoner Health, Public Health and Health Inequalities*

Prison healthcare in England sits within a complex institutional landscape which has undergone major system wide shifts in the past twenty years. In 2006, responsibility transferred from the Home Office to the National Health Service (NHS) via Primary Care Trusts (local commissioning organisations) and then in 2013 shifted again to become the responsibility of NHS England (centralised commissioning). Further potential change is on the horizon for prison healthcare to become the responsibility of newly formed Integrated Care Systems (regional commissioning). In addition to this shifting element of governance and commissioning, prison healthcare provision and delivery in England is fractured: a variety of private and non-profit healthcare providers compete for financially lucrative contenders in a four to five-year cycle. The National Partnership Agreement for Prison Healthcare in England 2022-2025 proposes strengthened collaboration and cross-working between five core organisations: Ministry of Justice, UK Health Security Agency, NHS England, Department of Health & Social Care and HM Prison & Probation Service. The relationship between commissioning, resource allocation, healthcare delivery and accountability is complicated, involving a disparate array of actors with competing interests, priorities and motivations.

There are 122 prisons in England and Wales and 96% of prisoners are male (House of Commons 2023). The proportion of people in prison aged over 50 rose from 7% to 17% between 2022 and 2020 and 27% of people in prison identify as being ethnic minority compared with 13% in the general population (Hutching & Davies 2021). As of March 2025, the prison population was almost 88,000 (Ministry of Justice 2025). The provision and delivery of healthcare differs by prison establishment, but all prisons in England and Wales have a minimum provision of primary care and mental health support services. All people arriving in prisons should receive an initial healthcare assessment from a healthcare professional within 24 hours, focusing on physical and mental health and any drug or alcohol treatment needs (Hutchings & Davies 2021)

People in prison represent possibly the most disadvantaged group in society in terms of their health profile. They have significantly higher levels of long-term health conditions, infectious diseases, mental illness and substance use problems than their peers in the community (Kinner & Young 2018). This takes the form of conditions such as diabetes, asthma, cardiovascular disease and infections like Hepatitis C, TB and HIV (Kinner & Young 2018). The prevalence of mental health conditions is noticeably high within prison populations, and this is often combined with substance misuse including opiate based drugs (Kinner & Young 2018).

Prison health is closely connected to public health, given the high prevalence of substance abuse and infectious diseases that people in prison may experience, the unequal burden of living in poor health that the majority of prisoners endure, and the fact that the majority of prisoners will be released and return to living in the community at some point in the future (Edge et al. 2021). Problematic drug and alcohol use has a significant relationship with re-offending behaviour, with alcohol estimated to be involved in almost half of all violent crime in the UK (UK Health Security Agency 2015). It is estimated that around 80% of prisoners regularly smoke cigarettes on arrival to prison compared to 15% of the general population, despite smoking being prohibited in all UK prisons from 2018 onwards (UK Health Security Agency 2018). The UK Health Security Agency (previously part of Public Health England) had a major focus on the containment and treatment of infectious diseases in British prisons, most noticeably the blood borne viruses Hepatitis B & C (UK Health Security Agency 2023). The mortality rate for prisoners in England is 50% higher than the general population with the average age of death of 56 compared to around 81 years in the community (McLintock et al. 2023).

### *Healthcare Delivery Under Conditions of Macroeconomic Austerity*

The prison estate is often viewed as a difficult environment for the delivery of health care and in which to be a patient. Challenges include old or dilapidated environments, overcrowding, security concerns and difficulty attracting and retaining healthcare staff (Hutchings & Davies 2021). UK prisons currently face levels of overcrowding so severe they have been described as a 'powder keg waiting to blow' (Dearden

2023). Overcrowding has significant negative implications for prisoners as they tend to be confined to their cells for longer (due to a lower prison officer to prisoner ratio) and consequently miss out on opportunities for education, religious worship, exercise and rehabilitation (HM Inspectorate of Prisons 2017). This increases tension and frustration, sometimes leading to violence between prisoners, exacerbates mental health problems (Kotecha 2024), and raises the risk of health conditions related to sedentary behaviour. It could be argued that overcrowding is a macro-level issue relating to centre-right political values, which deprioritise the spending of taxpayers' money on better living conditions for people who have been sentenced to imprisonment. Successive governments have chosen not to address the crisis in the prison sector and have instead cut prison budgets, despite an increasing prison population (Rowland 2024).

Intense difficulty recruiting and retaining healthcare staff is possibly the most influential factor in the provision of prison healthcare. Prison healthcare roles can be viewed as unattractive due to the complex multi-morbidity of patients, demanding working conditions and atypical career structure (McLintock & Sheard 2024). Private and third sector healthcare providers' terms and conditions (including pension provision, sick pay and holiday pay) are less favourable than within a clinical career with the NHS in the community or hospital sector (McLintock & Sheard 2024). A recent qualitative study found that chronic understaffing was the most significant organisational factor influencing the quality of and access to healthcare in prisons across the North of England. Understaffing and dependency on locum staff often led to healthcare provision in many prisons becoming reactive and crisis-led, and a situation of continual firefighting (Sheard et al. 2023). Moreover, a shortfall in prison officers has an indirect negative impact on patient access to healthcare appointments due to a lack of officer escorts for appointments within the prison (from cell to healthcare department) and for transfer outside the prison to hospital outpatient appointments or the Accident & Emergency department (Davies et al. 2020). Davies et al. (2020) found that 40% of hospital outpatient appointments made for people in prison are not attended.

The dilution of prison officer and healthcare staff workforce has happened gradually since 2010 under broad conditions of macroeconomic austerity imposed by the UK government (Ismail 2020a). Between 2010 and 2017, the state reduced funding for the prison service by 22% and the number of frontline prison officers dropped by 30%, whilst the number of people in prison remained high, leading to overcrowding, volatility and an unstable regime (Ismail 2020a). Healthcare staff numbers are difficult to quantify, due to the fractured nature of provision across disparate providers and unavailability of accurate records, but recent work suggests the workforce has been decimated (Sheard et al. 2023). Ismail (2020b) has characterised the decimation of prison healthcare (and the prison service more generally) as a process of deterioration, drift, distraction and denial related to the politics of austerity. His study with prison policy makers found that the exodus of staff and resulting loss of expertise significantly destabilised the prison regime nationally over the past decade. This in turn has had a demonstrably negative impact on prison healthcare services, which are dependent on regime stability regime to function.

### *COVID-19 Policies and Aftermath*

A swift and near-total national lockdown was implemented in early 2020 across all prisons in England and Wales in response to COVID-19. This included suspending external visitors, dramatically reducing movement across the prison estate, and severely limiting prisoner movement such that many people spent up to 23 hours a day locked inside their cell (Edge 2021). These conditions lasted significantly longer than the UK's first 'stay at home' eight-week community lockdown order imposed by central government on 20th March 2020. Some prisons remained in a state of near total lockdown some 18 months later. Although early release schemes were introduced in several countries to proactively save lives of prisoners (particularly at the start of the pandemic), England and Wales lagged, instead choosing to reinforce and prioritise penal policy over public health. By July 2020, only 80 people had been subject to early release despite almost 15,000 people near the end of their sentence being eligible (Edge et al. 2020).

A rapid review of the grey literature (Canvin & Sheard 2021) found high variability across the prison estate in terms of healthcare delivery and its governance arrangements in the first year of the pandemic. Research has uncovered some general but caveated patterns of COVID-19 related reconfiguration and disruption to prison healthcare. We found that urgent and emergency care continued in most areas, but routine clinics were often cancelled (Wainwright et al. 2023). Services provided by external agencies who needed to enter the prison from the community, such as physiotherapy, were universally halted. Access to dentistry was particularly disrupted due to dentistry being an aerosol generating procedure in a closed environment. Healthcare services in some prisons moved to a 'cell door' approach whereby the medical or nursing team conducted consultations with the physical barrier of the cell door between the clinician and the patient to prevent potential COVID-19 transmission. These consultations were described as rushed and lacking in confidentiality due to cell mates and others on the wing being able to overhear the conversation. Whilst the use of phone and video consultations increased in some areas, this was by no means utilised to its full potential due to interoperability problems between prison and community clinical systems.

### *Decentred Theory*

In this paper, we employ decentred theory as a sensitising concept in relation to formal and informal data both during and after the project's live timeframe. We draw upon Bevir's notion of policy as a negotiated outcome due to diverse beliefs and actions of situated agents which are shaped by tradition and evolve in response to changing situations and dilemmas (Bevir & Needham 2017, Bevir & Waring 2020). This approach emphasises the personal agency of actors expressed via their narratives and we utilise it in this paper to understand conflicting beliefs and outward resistance of actors against the agendas of others. In doing so, we explore both the implicit and explicit *differences* in the depth and scale of suffering and/or hardship which participants endured. Throughout, we adhere to Bevir & Needham's (2017) assertion that 'policies are sites of struggles' and use this idea to showcase multiplicities of narratives in relation to a system wide dilemma: how actors within the prison healthcare landscape navigated and contested what happened when COVID-19 hit the English prison estate. We take inspiration from previous qualitative research which has adopted a decentred approach to illuminate topics such as: priority setting in primary care (Kislov et al. 2023), co-production and public involvement in research (Williams et al. 2020) and collaboration in applied health research networks (Waring et al. 2022).

## Interviews, Artefacts and Analysis

### *Wider Study*

The findings presented in this paper are part of a large mixed methods study which aimed to understand the impact of COVID-19 on prison healthcare in England. Our research team was particularly interested in the ways in which healthcare in prisons *as a service and system* had been disrupted or changed due to the pandemic and what this meant for the health of prisoners. Specifically, we wanted to know what consequences service provision and infrastructure disruption had on relationships between key actors during this crisis including prison healthcare staff, those responsible for commissioning, policy and governance (decision makers) and prisoners themselves. In other stages of the project, we conducted a rapid environmental scan of the grey literature and policy literature (Canvin & Sheard 2021), an international scoping review of academic literature (Hearty et al. 2023) and an interrupted time series analysis of anonymised prison healthcare records during the height of the pandemic to understand healthcare activity across multiple domains. We also provided briefings and had meetings with national level policy makers and prison advocates. This paper draws upon the qualitative component of the study.

Descriptive thematic findings from the qualitative data have recently been published and are described in the Background section (Wainwright et al. 2023).

### *Data Collection*

Our core dataset of formal data is a corpus of 44 in-depth interviews conducted over video or phone call between July and December 2021 with key informants. This consisted of 15 people who had been a prisoner at some point during the pandemic, 15 prison healthcare staff who had worked on the frontline and 14 decision makers who had strategic level oversight for prison healthcare during the most acute COVID-19 period. We were interested in speaking to these groups of people across England to gain a nationally representative picture. People who had been released from prison were interviewed rather than people who were currently residing in prison. The reasons for this were multiple and pragmatic: it allowed interviewing across a wide geography and at a time selected by the participant alongside negating lengthy bureaucratic delays in applying for visitation rights to many different prisons. During the early months of fieldwork, there was a moratorium imposed on all research data collection in prisons across the entire estate.

We undertook progressive purposive sampling. At first, participants selected for interview were those which met the broad inclusion criteria of being a prisoner, healthcare professional or healthcare decision maker in England during the pandemic. As data collection progressed, the diversity of the sample was regularly monitored, and participants were sought out via snowball sampling to ensure that we spoke to, for example, women who had been in prison, and healthcare staff who worked a variety of roles and across a range of prisons. Of the 44 participants who took part in an interview, people who had left prison represented both males and females, a range of healthcare conditions, varying lengths of sentences and the collective experience of residing in 12 prisons during the pandemic. A wide range of professions and length of service were represented amongst frontline healthcare staff including medicine, nursing, dentistry, pharmacy, psychiatry, mental health and substance misuse. Staff participants were drawn from 14 prisons. The decision maker group comprised predominantly commissioners, directors and governors working at a regional and national level across England.

We also draw upon several sources of informal documents and artefacts to make sense of multiplicities and resistance. In doing so, we draw upon the importance of paying attention to 'power games, cultural practices, ideological differences, and taken-for-grantedness' outside of the direct verbal accounts of interview participants, as discussed by Mees-Buss et al. (2022). First, we incorporated in our analysis contextual data from two decision makers who agreed to speak to the researcher but did not consent for their data to be audio recorded or quoted verbatim. Second, we included content and reflections from meetings held with the Expert by Experience panel - a group of people who had been in prison and who agreed to act as critical friends to guide and steer the project from a patient representative viewpoint. Third, we used in person conversations, debriefing sessions, field notes, selected emails and meeting notes to inform interpretation not represented in the interview transcripts. The use of these artefacts as part of the analytic process most heavily influenced the interpretation of the third main finding "A fractious and knotty research process".

### *Analysis*

We employed Sheard's (2022) notion of 'telling a story rather than reporting the facts' whereby the analytical process is likened to a form of creative interpretative storytelling, rejecting positivist concerns such as replicability, impartiality and bias. This begins with understanding descriptive findings of qualitative research as a basis for further inquiry and then applying theories as sensitising concepts (Blumer 1954) to uncover high level, discursive findings that may not be apparent on a descriptive level. The sensitising concept we apply here is based on a decentred theoretical approach (Bevir & Needham 2017, Bevir & Waring 2020). To undertake the analysis, LS developed a broad coding framework based

on: re-reading interview transcripts, returning to various artefacts (as described above), her tacit knowledge of the project as a whole and her macro level understanding of the English prison healthcare landscape. This approach is aligned with the idea of an analyst drawing upon their broad disciplinary knowledge and subjectivities to be a resource rather than a threat or a source of 'bias' (Braun & Clarke 2019). LS sense checked her understanding of the headline interpretative findings with the researchers who had undertaken the interviews and then undertook further interpretative work to write up the findings into a coherent narrative. All quotation excerpts are taken directly from interview transcripts unless otherwise stated. Niche roles have been obscured to protect anonymity.

## Findings

Here, our main intention is to explore competing beliefs, narratives, struggles and elements of resistance between and amongst diverse actors who inhabited space within the prison healthcare system during the pandemic. We view the COVID-19 pandemic hitting the English prison estate as a macro-level dilemma and we then unpick its resultant impact on prison healthcare players. We do not view COVID-19 'policy' as a single entity but rather an ever-unfolding series of decisions and negotiated outcomes amongst and between national level elites, meso-level bureaucrats, frontline healthcare actors and patients.

### *An Emerging Conflict*

In the first few months of the pandemic, collective uncertainty reigned supreme with individuals within the prison system ascribing markedly variable meanings to the same situation dependent on their levels of power and agency. Decision makers spoke about the wide array of governing stakeholders involved in the provision of prison healthcare and how there was a lack of co-ordination or cohesive communication from 'the centre'. Understanding how COVID-19 policy decisions should be implemented in a healthcare context seemed to be a delicate and complicated negotiation between His Majesty's Prison and Probation Service (HMPPS), NHS England, UK Health Protection Agency and individual healthcare provider organisations. Some decision makers described feeling unsupported by governing agencies and were left to work things out locally on a prison-by-prison basis but within a challenging national context of rapidly – sometimes daily – changing information and circumstances.

> I don't think that we were particularly supported from the centre either from HMPPS or from NHS England particularly well at times. I certainly think it felt a lack of communication between gold [national level strategy], the command suite of gold with HMPPS and NHS commissioners. It felt sometimes a bit like a battle and the power struggle and I think that was ludicrous because health and well-being ought to have taken priority and it sometimes didn't (Prison Governor)

At the same time as decision makers grappled with confusing meso-level policy implementation, frontline healthcare staff were looking upwards to be guided by their area level commissioners and prison governors. Tension unfolded between the prioritisation of security which was informed from a non-clinical perspective and sometimes existed in opposition to the needs of healthcare.

> We've got quite an elderly population and sort of to be told by, not necessarily people ... well probably people who aren't nurses and haven't got healthcare backgrounds because, you know, they are managers. Like the Governor telling us that we can't see our patients. It was quite tough and when we had a telephone call saying, "so and so is wanting to know when he's going to have his bloods done" and to have to say, "I'm really sorry but that's not going to happen" It was quite tough (Senior nurse)

The stage of collective uncertainty for healthcare staff could be characterised by a 'flurry of activity' with essential healthcare services still needing to continue in addition to extensive and time-consuming COVID-19 specific activities. These activities - in addition to normal, everyday workload - included: infection prevention restrictions in a closed setting, personal protective equipment (PPE) donning and doffing, mass COVID-19 testing (sometimes entire wings of hundreds of people), attending COVID-19 specific healthcare meetings and updating risk registers. Adding to the burden of work for healthcare staff were disputed tasks, where confusion arose over lines of accountability. This included already pressurised healthcare teams in some prisons now becoming responsible for delivering food to the cells of COVID-19 positive patients whereas this has previously been a prison officer role prior to the pandemic.

The narratives of people in prison during the first few months of COVID-19 differed markedly with those of decision makers and frontline staff, concerning healthcare. Prisoners felt that 'everything stopped' as they saw all non-urgent care cancelled or postponed:

> Appointments became very, very difficult and rare. So dentistry was shut down, you know, you'd get check-up if it's an emergency, life or death and the most you would get is a paracetamol (Prison leaver)

Reinforcing the above was the physical and mental isolation which prisoners were enduring by being locked in their cells for almost the entire day and rushed healthcare encounters only being performed through the constraints of a cell door conversation. This contributed to prison leavers reported being uninformed and stressed by the rapid changes in healthcare provision.

> I don't think things were explained properly, you know, it was very matter of fact, "this is what is happening, it's happening for your safety and ours", which I understand. But I think it could have been more compassionately communicated… prisoners have already had their liberty taken from them, so you know, the tiniest bit of normality is really important (Prison leaver)

As the pandemic moved towards summer 2020, a brief moment occurred which we have typified as 'collective spirit', which various participants called 'all in it together' and a decision maker referred to as 'Dunkirk spirit'. This manifested in greater cohesive and collaborative working between departments within the same prison and between governing agencies and prisons. There were instances of mutual praise with prisoners commending healthcare staff for continuing to work under harsh conditions. Staff and decision makers applauded prisoners for being tolerant of the unusual conditions under which healthcare was being delivered and indeed under which prisoners were living. But this unity of collective positivity and reciprocity did not last and as the pandemic marched on with no end in sight, oppositional narratives began to take hold.

### *Collective but Compartmentalised Hurt*

The impact of the pandemic was intensely felt by everyone but in markedly different ways, with participants voicing their own emotional trauma and its relational effects on others around them. Further, a sense of inherent conflict across competing narratives emerged throughout the fieldwork period whereby participants tried to privilege their own sense of hurt and injustice over and above those who were perceived as different to them.

Healthcare staff reported feeling emotionally and physically exhausted due to a considerably increased COVID-19-specific workload in addition to their usual clinical duties.

> The people who were working on the ground didn't have a single day off (Pharmacist)

> I think there was a huge commitment from people who were here as well just to keep going really and deliver the service throughout and I think that changed throughout the, you know, the longevity of COVID to be honest (Allied health professional)

This was further compounded by depleted staffing levels due to healthcare services being reduced to essential or urgent provision only. Staffing was further (unintentionally) reduced by high rates of COVID-19 sickness amongst staff and by those who had been advised to stay at home for their own medical reasons to shield from the virus. The above factors applied to both healthcare staff and prison officers, with the prison officer workforce often being integral to the functioning of the healthcare department. As a consequence, staff who regularly went to work on site during the second half of 2020 and into 2021 became exhausted and frustrated at trying to work their hardest within a relentlessly unforgiving environment and system. For some, this culminated in a sense of bitterness and resentment towards staff who were isolating or working from home regularly and also towards their professional peers in the community (described in more detail below). Some prison leavers felt that staff exhaustion began to manifest as indifference towards patients in certain establishments:

> So there was a lot of people there and a lot of ailments and, you know, there wasn't enough hours in the day to care and look after everybody. So I think the pressure then sort of mounted on the staff and so when you turned up or whenever I seemed to turn up … I got that feedback from other people, they were slightly aggressive, slightly non-caring, slightly dismissive (Prison leaver)

Prison leavers expressed feeling abandoned and neglected with a sense of the pandemic and suspension of routine healthcare service having no end in sight. This took place within the aforementioned context of some people being locked in their cells for 23 hours a day for several consecutive months due to estate-wide lockdown conditions. Prison leavers sensed that the majority of healthcare provision not related to COVID-19 had been indefinitely cancelled, and that the excessive regime level emphasis on infection control came at the expense of routine healthcare needs and daily liberty. This was coupled with a severe lack of staff to consult with prisoners:

> I feel like when the pandemic came … I just feel like healthcare took advantage of it, they were barely there and I think at that stage a lot of people were becoming ill within the establishment. So whether it be mental illness or physical illness, there just wasn't enough nursing staff there or healthcare staff and when they was there because there was so many people wanting to see, there just wasn't enough time in one day to see the people (Prison leaver)

A distinct lack of face-to-face healthcare consultations contributed to worsening mental health of prisoners as psychological distress and self-harm/self-injury was obscured from clinical view.

> We had a huge increase in first line anti-depressant and anxiety medicines with men going to the GP with symptoms…normally, you know, they would engage in activities to manage their mental health, you know, go to the gym, have visits etc., etc., association. All that was removed, so there was nowhere for us to go other than medicine (Public health practitioner)

Within the interviews, it can be demonstrated that the two groups of participants did show compassion for each other and were attuned to each other's distress. However, the research team was left with an overwhelming sense of a dualism that we termed 'you tried your best but we still suffered enormously'. That is, prisoners acknowledged the role of individual healthcare staff putting themselves at risk (physically and emotionally) to deliver care. But, macro- and meso-system wide governance level

decisions led to a curtailment of healthcare provision for which the consequences were harm and suffering for prisoners.

> The monotony of day in day out on the same wing in lockdown has really taken its toll on people. You can see that staff are finding things difficult and the residents are finding things difficult as well to be honest and that manifests itself in some inappropriate behaviour. Some violence, self-harm, substance misuse (Allied health professional)

A feeling of grave injustice was held by those working in prison healthcare and decision making when comparing the COVID-19 specific processes, policies, resources and infrastructure in the community with those in the prison estate. That is, community healthcare was said to have been given all the additional resource, finance and planning it required to implement smooth policy and commissioning decisions for the national testing programme and vaccine drive, which began in early 2021[1]. The viewpoint held by many prison healthcare staff and decision makers was that the prison estate is an underfunded, poor relation in comparison with community/hospital healthcare. This tradition merely continued to play out and to be further reinforced in relation to the dilemma of COVID-19:

> She noted an important difference for nurses in the prison to nurses in the community - that they weren't part of the "clapping for carers" movement – or didn't feel part of it. They weren't intensive care workers, they didn't feel the public had their back. They were really very hidden. Felt it was a thankless task (Research field note following interview with decision maker)

Healthcare staff spoke of the additional workload they had encountered due to undertaking COVID-19 specific activities without any additional shop floor staffing resourcing for testing or vaccination. Excessive demands were said to be placed on frontline staff accordingly, with frontline participants recounting mass testing of hundreds of prisoners in addition to the daily workload of attending to prisoners' urgent medical needs. This also played out when differing elements of the COVID-19 response were implemented in competition with each other:

> We found out on Monday that they were cancelling the [vaccination] clinic today because they haven't got enough staff. The prison haven't got enough staff because they're doing mass testing of everybody on one day and it's today (Pharmacist)

Decision makers alluded in some of their interviews to nebulous offers of 'help' from community services which had been brokered at a national level. However, the onus was placed on the management of individual prisons to approach and partner with local healthcare teams in the community, which resulted in little success:

> I think there was some conversation about being able to access community support for that but I didn't see any prison actually manage that even when they approached the community. There wasn't that support of anybody coming in to support them (Decision-maker).

### *A Fractious and Knotty Research Process*

A particularly intriguing element of the research project were the differing ways in which participants sought to defy and potentially distort or resist the tradition of participation in a qualitative interview

[1] This took the form of routine community healthcare such as GP appointments and many outpatient clinics largely continuing to function as normal, albeit with a switch to digital means such as tele-consulting. Extra teams of healthcare staff attended to the vaccination programme and the NHS/public health teams paid for the public to receive PCR tests or rapid self-testing kits.

study, being associated with it and interacting with the study findings. We derive the following findings mostly from examination of artefacts and informal documents connected to the research process as described above

Some healthcare staff seemed to be afraid to speak out and some decision makers took active steps to disguise their identities, despite being reassured that they were taking part in an anonymous and confidential research interview, bound by professional and ethical frameworks. This is likely to be inherently connected to the dilemma of whether to speak out (or not) about distress and harm being experienced by prisoners and staff and the range of (potential) repercussions. During the recruitment phase of the project, there were two examples of this. First, a couple of potential participants in the healthcare staff group stated to the researchers that they would have to ask permission or approval first from authoritative sections of their employer in order to proceed. In one case, this was the legal department and in another it was a PR and communication department – both situated within third sector healthcare provider organisations. The second example pertains to two decision makers who wanted to tell the researchers their story but were extremely wary of it being 'on record' and only agreed to take part in an interview by declining for it to be audio recorded and not giving any form of consent. However, the two narratives within these interviews were intriguingly oppositional. One interview revealed an exhausted national level figure who was bereft at the ways in which the pandemic had psychologically and physically devastated the workforce. The other interview contained content that was not felt to be particularly controversial by the researcher. This calls into question the reason why this interviewee felt unable to speak to the researcher on record and highlights a political culture of being afraid to 'step out of line' regarding individual opinion conflicting with professional or organisational reputation.

The research team were advised throughout the study by an Experts by Experience panel. This was small group of people who had previously been in prison and could be considered akin to a patient and public advisory group. The panel met with the research team four times during the study live timeframe. At the second and third meetings, the panel delegates questioned the interim findings which the research team presented. In particular, they contested an early finding that all participant groups felt despair and exhaustion.

> They [panel delegates] said "how can you theme us and put us together with people that went home at the end of the day?" … That's when it started to ripple. I remember thinking: ok, what do we do? We have to make it explicitly clear that we're not trying to say that everyone felt it the same. At the third meeting, they didn't think I had gone far enough and that is where it all exploded … They were very angry that the struggles of 80,000 people had been reduced to three quotes (Researcher debriefing session)

As a consequence of the exasperation felt by the Experts by Experience group, the researchers reshaped the findings to pay more attention to the conflicting accounts resident in the data and to explicitly draw these out over and above identifying thematic commonality. Through this process, the initial funded research questions (regarding logistical changes to prison healthcare services) began to take a backseat to allow for a fuller explanation of the emotional impact of the pandemic and attempts to do 'justice' to everyone's pain and exasperation.

In late 2022, the descriptive study findings were under review with a peer reviewed journal but had simultaneously been delivered as an oral presentation at a national conference. Conversations following the presentation over several weeks led to a request for senior leaders in the prison service to view the presentation slides and then for the findings of the study to be circulated to teams and personnel working in healthcare commissioning prior to publication.

The research team complied with this request and, in response, organised an online event to disseminate the findings to commissioners. Implicit in this request was the suggestion that informal clearance needed to be gained from senior level healthcare commissioners before the study findings could be published or acted upon. It also represents a nervousness about where accountability lies for ensuring

that the findings had been rubber stamped by all interested parties and the findings would not come as a shock or embarrassment to senior figures upon publication. At the time, we perceived this process as contrary to the notion of academic freedom as the study had been funded by a UK research council and awarded to an independent academic. This should mean that publication of the findings were free from undue pressure or agendas of government departments or any other organisational standpoint which could untowardly influence them. As it transpired, the online event went relatively smoothly and commissioners seemed interested in the findings with a sense that the findings resonated with them. The research team was left with a sense of misappropriated apprehension that we had harboured prior to the online event as we were caught within a perceived tense agenda of elite organisational scrutiny.

## Discussion

Our study found that key decisions relating to COVID-19 prison healthcare policies in England were made and re-made at multiple levels by governing agencies (and elites within them) who implicitly competed with each other over lines of accountability and responsibility. As the pandemic progressed, excessive workload for too few healthcare staff led to an almost collapse of non-urgent healthcare provision with staff on the ground feeling exhausted whilst prisoners felt abandoned. Resultant oppositional narratives of suffering, trauma and injustice prevailed with a chasm developing between healthcare staff and people in prison that the research team has termed: 'you tried your best but we still suffered enormously'. Participants contrasted the underfunded and peripatetic COVID-19 policy response in prisons to the perceived abundant and strong COVID-19 response in the community. This served to reinforce the tradition of prison healthcare being a Cinderella area of healthcare that is always bottom of the pile. The potential for extra funding and resource for prison healthcare had become tangled in a web of meso-level brokering which failed to secure additional staffing at a moment of intense need. The research process itself was subject to resistance and distortion both top down and bottom up; national level senior figures declined to talk to the researchers 'on record' whilst patient representatives rejected preliminary findings, and an implicit scrutiny of the study findings by an authoritative agency took place before publication.

### *A Subversion of Normative Power Structures?*

Taking a decentred approach enabled an exploration and explication of local resistance(s) to public health policy narratives and directives regarding COVID-19 and prison healthcare. The findings point towards actors with markedly different levels of privilege constructing oppositional narratives to regain power in the face of their lack of autonomy within a failing system (more below). However, this is perhaps not exhibited in ways expected based on conventional notions of power and control in penal settings, where prisoners are assumed to have the least agency and power, and have the most to lose and least to gain from speaking out or whistleblowing about poor standards of healthcare delivery. Indeed, a qualitative study found that patients within prisons were often apprehensive or even frightened about complaining or making negative statements about their care (Hankins et al. 2022). This is largely related to a concern that future care, coupled with a lack of anonymity, will be denied. Yet in this study, it was two senior members of staff, at a national level, who declined to be recorded in presumed fear of organisational reprisal, with no such concerns among prison leavers during their interviews. Perhaps most vocal in local resistance narratives was the heated response of the Experts by Experience panel which led to a reshaping and reframing of the findings in the study's published descriptive paper (Wainwright et al. 2023).

Taking all the above in combination, it seemed like traditional hierarchies had been upended, subverted and reframed in response to this emotive topic of the COVID-19 pandemic hitting the English prison estate. Certainly, the reflection of the research team was that we had rarely researched a topic with

such acrimonious accounts. Indeed, some of our other prison healthcare research focussed on quality and access (Sheard et al. 2023) reported findings that were clearly derived across all participant groups with a uniformity of opinion about chronic understaffing. The research team was taken by surprise regarding the implicit and explicit power struggles between participants, wider actors and ourselves, which played out throughout fieldwork but also far beyond it.

### *Opaque Decision Making and Fruitless Brokering*

A plethora of government departments, agencies and arm's length bodies are responsible for governing and commissioning prison healthcare services. Five core national organisations[2] must work collaboratively and in partnership to ensure prison healthcare is delivered as intended, whilst each having their own priorities and parochial interests which often compete with each other. For instance, the Prison & Probation Service has security and public safety as its top concern, the Ministry of Justice focuses on justice policy and the UK Health Security focuses on public health. NHS England commission primary care (and mental, public, optical, dental health) within the prison gates but emergency and out-of-hours care is commissioned by the local clinical commissioning group within which each prison is located (Hutchings & Davies 2020). Further, provision of prison healthcare delivery is a fractured and complicated landscape of for-profit and non-profit sector companies existing within a competitively awarded medium term contracting cycle. At the local level of individual prisons, prison governors are said to simultaneously have too little involvement in healthcare commissioning choices and are held accountable for healthcare decisions that are not technically their responsibility (Commons Select Committee 2019).

All the above points to a confusing meso-level political terrain which helps to explain the findings of the paper in terms of a high-level *diffusion of responsibility* at a time of critical and intense need. Decisive action was taken in the form of a total lockdown in all prisons from March 2020 onwards but direction relating to how healthcare departments and their services should function was vague and left to localised decision making, which led to ambiguous implementation of COVID-19 related policies between individual prisons. Resource allocation and finance for additional COVID-19 specific staffing seems to be a key point of contention with tenuous offers of 'help' proposed at a national level, which then floundered locally without firm action and commitment. The reasons why this happened are obscured from view but perhaps relate to the perceived futility of recruiting extra healthcare staff in a system that has already collapsed and was demonstrably already understaffed pre pandemic. Most interesting to us is an inability throughout the analysis (and in this paper) to acknowledge or claim COVID-19 related prison healthcare policy as any one tangible 'thing'. This relates to the ever-shifting circumstances in which decision maker and healthcare staff participants were working and continually adapting alongside a lack of top-down direction and co-ordination.

## Conclusion

A decentred lens was applied to illuminate contested and competing narratives regarding policy decisions that were taken and not taken in response to the COVID-19 pandemic hitting prison healthcare across England in 2020 and 2021. Non-urgent healthcare provision collapsed with heavily overloaded and exhausted healthcare staff trying to deliver a reduced service to patients who felt abandoned. Our analysis found a disputed line of accountability between meso-level actors which led to a failure in securing additional staffing and resources. The research process itself was subject to intense resistance and scrutiny

[2] Ministry of Justice, UK Health Security Agency, NHS England, Department of Health & Social Care, HM Prison & Probation Service.

both top-down and bottom-up. We propose that the pandemic introduced a breaking point in the collective psyche of those living and working in prisons from 2020 onwards whereby macro-political and economic factors collided with healthcare professionals already struggling with pre-pandemic workload and patients who were routinely not having their clinical needs met. The invitation to take part in a qualitative interview for this study (and to comment on the interim findings, from the Experts by Experience panel) effectively lit a match which quickly became a bonfire of suffering, hurt and injustice narratives. Ultimately, we argue that prison healthcare has been pushed into an even further entrenched Cinderella area of medicine by inhabiting space within a struggling institution during the largest public health crisis of the past century.

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## Conflicts of interest

The authors declare they have no competing interests.

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