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Challenging NHS Corporate Mentality: Hospital-Management and Bureaucracy in London's Pandemic

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ABSTRACT

Whilst NHS Health Service management is usually characterized by hierarchized bureaucracy and profit-driven competitiveness, the COVID-19 pandemic drastically disrupted these ways of working and allowed London-based non-clinical management to experience their roles otherwise. This paper is based on 35 interviews with senior non-clinical management at a London-based NHS Trust during 'Alpha phase' of Britain's pandemic response (May-August 2020), an oft-overlooked group in the literature. I will draw upon Graeber's theory of "total bureaucratization" to argue that though the increasing neo-liberalization of the health-services has hitherto contributed toward a corporate mentality, the pandemic gave managers a chance to experience more collaboration and freedom than usual, which ultimately led to more effective realization of decision-making and change. The pandemic has shown NHS managers that there are alternatives to neoliberal logics of competition and hierarchy, and that those alternatives actually result in happier and effectively, more capable staff.

Much has been said about the experiences of clinical staff working at the forefront of the COVID-19 pandemic, but far less about the non-clinical managers making key decisions regarding the pandemic response of the British National Health Service (NHS) that would affect both clinical staff, patients, and ultimately the public during this critical time. Indeed, from social media to academic journals, the difficult circumstances faced by frontline medical staff have been, and continue to be, well documented. Reports suggest that those staff who were patient-facing and dealt with the initial, unexpected onslaught of COVID-19 cases at the start of the state of emergency have suffered not only extreme anxiety, stress, and exhaustion but also personal illness and death (Kursomovic 2020). In particular, the pandemic highlighted stark social disparities existent within the British health services themselves, when reports of disproportionate mortality statistics based on staff ethnicity began to surface (Siddique and Marsh 2020). As such, the NHS faced a significant and mounting problem not only when it came to coping with patient hospital admissions, but within their own ranks. However, the focus was overwhelmingly on frontline staff, even though it was not always or exclusively clinical staff who made the important decisions about how to run the health services in this difficult time. Alongside the public-facing frontline clinical staff, there is an entire network of non-clinical managers in the NHS whose choices and actions structure and influence the day-to-day running of health services. Often squirreled away in off-site office blocks physically removed from the patient-facing

hospitals and clinics within their respective trusts, non-clinical managers are certainly not the visible face of the NHS. Even so, they do pull operational strings and may have significant influence over the running of the health services, particularly for senior management. Yet, until now their voices and experiences have neither been recorded nor analyzed in depth within the wider anthropological literature addressing the COVID-19 pandemic in the UK. This is important because non-clinical management holds particular power when it comes to public health decision-making. In order to fully grasp the workings of the contemporary NHS, one needs to start paying attention beyond the clinical. The research on which this article is based took place during the initial stages of the COVID-19 pandemic's first wave in 2020, and as such, offers original insight into a unique moment of managerial experience within the NHS.

I argue that the exceptional circumstances provided by the national emergency highlighted fundamental disjunctures and concerns inherent within NHS management structure and functioning. Relieved of much of the usual operational bureaucracy, non-clinical management were able to exercise their roles with more fluidity and freedom than before, in the process perhaps contributing toward what Bear and Mathur have termed a "remaking of the public good" in anthropological studies of bureaucracy (Bear and Mathur 2015:18). Within this article, I follow Mathur's definition of bureaucracy as a "form of government that is predicated upon a desk" (Mathur 2017:1). Indeed, the ongoing decentralization of the NHS may be considered as one such new public good as it is meant to better serve the populace, and as Bear and Mathur argue, ethnographic insights are required to better understand these developments (Bear and Mathur 2015:18). In practical terms for NHS management, this often meant the realization of somewhat mundane decisions and plans that had long been held up by red tape, a not-uncommon management phenomenon as noted by Gupta (2012), and as I will later discuss in more depth. This change was recognized by the UK Government, who reported in November 2020 that "the COVID-19 pandemic has shown us that streamlining bureaucratic processes can release time for our workforce to prioritize care" (Department of Health and Social Care UK Government 2020) although whether or not this has resulted in any real change is yet to be seen. Additionally, an opportunity for greater collaboration and the breaking down of health care siloes was felt during the pandemic's initial phase, which non-clinical managers felt to be a positive enabler. The concept of management as a site of optimism is an important notion to hold onto, as Prince (2022) suggests, for managerial work is varied and complex.

These are important themes, as since the 1980s the NHS has increasingly begun to follow a neoliberal logic of competition and profit-seeking, which has contributed toward the expansion of bureaucracy and encouragement of competition over collaboration (Leys and Player 2011). As such, I take the notion of the pandemic as disruptor toward the functioning of NHS management, exploring the ways in which this unique disruption served to highlight the limitations highlighted within David Graeber's theory of the "total bureaucratization" of contemporary life (Graeber 2016:3), within health service management and managerialism and beyond. This builds upon Marilyn Strathern's earlier work on audit cultures (Strathern 2003) through understanding NHS corporate identity and hierarchy as a specific culture worthy of anthropological enquiry. In doing so, it will be possible to suggest that the total bureaucratization that comes with neoliberal market logic is not necessarily viewed as a positive or enabling factor even by those workers whose very roles are tightly tied to this administrative bureaucracy. There is therefore a case for suggesting that the multiple layers of bureaucracy within the NHS be flattened (Cowan 2021), as they apparently hinder effective decision-making and dampen the implementation of change, rather than support and encourage better working and outcomes. That said, Graeber's theory will not be taken uncritically, instead being used as a provocation. The idea of total bureaucratization may overlook nuances of day-to-day management functioning. In practice, "messy bureaucracies" (Gupta 2013:435) that may lack transparency (Bear and Mathur 2015) complicate Graeber's theory, as lived realities of managers operating within a bureaucracy do not follow set rules (Gupta 2013). Taking inspiration from Brown (2016), I will argue that to understand such nuances, anthropologists should study management seriously through ethnographic insight. Doing so will enable us to see that though it is possible that the NHS has begun

to follow a logic of total bureaucratization, the people working within the organization enact this bureaucracy in differential ways that are highly context dependent, as Heyman (2004) has previously noted.

This article comes at a key moment in the history of NHS bureaucracy. Until 2022, the UK Competition and Markets Authority (CMA) had the power to review (and in theory, challenge) NHS mergers. However, the government has decided that this should no longer be the case, with a specific aim to reduce bureaucracy around NHS governance (Department of Health and Social Care UK Government 2022). Though there is no specific mention of competition between departments within trusts, as I discuss, the overall panorama for market-based competition and the NHS looks set to change somewhat, making the insights from this article all the more valuable in understanding what this could mean for the future of NHS management.

COVID-19 and NHS managerialism

In early February 2020, British government declared a Level 4 National Incident in response to the novel virus COVID-19. This was a significant move for the NHS. Level 4 is the highest possible state of emergency, and triggering it resulted in the immediate implementation of a command-and-control structure of nationwide coordinated health response, controlled by NHS England and NHS Improvement (a centralized, nationwide unit that works to support local commissioners and NHS trusts). Although the NHS once worked as a national coordinated effort, this, under normal circumstances, is no longer the case. Instead, the NHS usually now operates through a system of trusts, each of which are commissioned to provide services for their geographic catchment and to an extent, operate according to a business model of income-generation whereby certain services and areas of focus are prioritized over others. In essence, this means that neighboring trusts do not necessarily work together as a united front, but may compete for resources and patients, and offer different and varying services and health specialties depending on management choices and patient demographics. Mindful of these operational specificities, critics have accused the NHS of undergoing "privatization by stealth" (Leys and Player 2011; Mulholland 2009:126) due to the policy of commissioning services to private providers. Either way, this has influenced the growth of the NHS management sector and the kinds of decisions that they are empowered to take, as managers are needed to oversee the logistical and operational aspects of day-to-day functioning of their respective trusts. Though it has been previously argued that the NHS is actually under-managed, rather than over-managed (Kings Fund 2012), more recent reports suggest that the pandemic changed this somewhat, acting as a catalyst for the "'astonishing' explosion in central bureaucracy," with the number of officials more than doubling in the period 2020–2022 (Donnelly 2022).

It has been suggested that the growth of the management sector has gone hand-in-hand with increased devolution of control and responsibility over public health from central government structures to individual trusts, and some view this as particularly negative. For example, public health academic Allyson Pollock makes the strong claim that "the permeation of NHS management [. . .] is penetrating and corroding the fabric of the NHS at every level" (Pollock 2004:1–2). She levels this accusation at management due to the increasing "blurred boundaries" (Pollock 2004:7) between the public and private and managers' roles in commissioning external private services to NHS patients. That said, it is also necessary to note that such polemical activist stances against NHS privatization may uncritically incorporate nationalistic sentiment about the institution, which could be problematic in its own right. Anthropologist Hannah Cowan (2021) argues that such notions of the NHS as a national treasure in need of saving serve to maintain the patriarchal nature of the healthcare system, and she argues for a different kind of activism that flattens hierarchy. Cowan says that this can be achieved by looking at how power is constructed across networks, which I will address in this article.

For example, under the Level 4 national emergency the usual hierarchical structure was disrupted. In practical terms, this meant that trusts shared resources between their own sites and others and were

not so focused on their individual goals and targets. It was a different structure than in "normal" times, and for those non-clinical managers who were used to working within a contained trust organizational model, it was a significant practical change in both ways of working and overall workplace culture. As will be seen later in this article, the structural change of hierarchy contributed positively toward collaborative working, which is arguably antithetical to market-based competition.

Within anthropology, managers and managerialism have received most attention in the context of the university. As Hyatt (2004) notes, anthropologists have taken a particular interest in this aspect of managerialism as they had previously been used to a higher degree of autonomy, "entrusted with the responsibility of policing ourselves" (Pollock 2004:25). As such, major anthropological works on managerialism have tended to focus on the question of management within anthropologists' immediate surroundings. For example, the chapters within Marilyn Strathern's (2003) edited collection *Audit Cultures*, one of the most significant anthropological works on managerialism and accountability, almost exclusively investigate these phenomena within university and research settings. Laura Bear and Nayanika Mathur's guest-edited "A New Anthropology of Bureaucracy" in the *Cambridge Journal of Anthropology* (Bear and Mathur 2015) developed such ideas further, with some specific focus on healthcare-related sites through Qureshi's (2015) analysis of HIV/AIDS governance in Pakistan, and John's (2015) discussion of the Scottish NHS. The following year, David Graeber's *Utopia of Rules* (Graeber 2016) also grappled with managerialism in higher education, though this work expands further into other questions including the casualization of labor and global neoliberal influence. This is not to discount the burgeoning field of business and management anthropology, however such works are relatively more targeted toward assisting managers with anthropological insights (such as Gillian Tett's 2021 *Anthro-vision*), as opposed to ethnographically exploring manager lived experiences. Organizational ethnography may offer such insights, but there has been limited focus on health system management within this subfield (see, for example, Brown 2016; Brown and Green 2017; Prince 2022).

As such, it could be argued that medical anthropologists in particular need to pay more attention to the role and relationships of management within health systems, and particularly the dynamic and societally influenced NHS (Jones et al. 2019). Though both management and patient-facing clinical work follow similarly vertical structures of hierarchy (Jenkins 2020), it has been argued that a significant disjuncture nevertheless exists between how the two spheres relate and pursue common goals. For example, Atun argues that the "highly codified tribal dialects" (Atun 2003:655) that distinguish the language of clinicians and non-clinical management are mutually very difficult to understand and result in a doctor-management divide. This, he argues, has intensified along with the shift of control from doctors to managers following the 1980s-onwards changes within the NHS, leading to an unhelpful "them and us" culture. Atun says that this situation results in doctors perceiving management as providing unnecessary work. However, as I will argue, non-clinical management may also be in agreement about this dimension of their roles (pre and post pandemic) as well. As such, anthropological enquiry into non-clinical hospital management can offer new insight into health service "wicked problems" (to borrow a term from management-speak) that could ultimately be used to reflect upon and suggest changes needed for a better-functioning NHS at different levels and spheres of operation.

Methodology

A qualitative approach was used for the present study. I undertook 35 semi-structured interviews with senior, non-clinical managers at one London-based NHS trust. Queen Catherine's (pseudonym) hospital was especially overstretched during the pandemic, impacted by the presence of an Intensive Care Unit offering a COVID-19 ward. The interviews explored questions of decision-making, ways of working, changes within the Trust during the pandemic response, and wider concerns relating to the strain placed on the NHS at that critical time. All quotations in the text are from interview transcripts, completed between May and August 2020, focusing on the initial "alpha phase" of pandemic response

that occurred during the period March–July 2020. Following this, the Trust entered a "beta phase" (July–December 2020; extended until April 2021), and subsequently a "cohabitation phase" whereby the Trust sought to cohabit with the virus (2021-present). The start of the pandemic saw a (necessary) boom in virtual ethnography and, as such, all interviews took place virtually over MS Teams, lasted around one hour each, and were voice recorded with permission and later transcribed by the researcher. Interview transcripts were then coded for recurring themes. All managers interviewed fell under NHS bands 7–9, indicating their level of varied seniority. (The NHS pays its staff based on their band, with 1 being the lowest with a corresponding salary and level of seniority, and 9 being the highest-paid band and level of seniority). Study participants worked in various roles such as general management, human resource (HR) management, estate management, finance management, project management, and operational management. Though the actual roles of the different managers focus on quite different aspects of running a hospital, they share a commonality of desk-based work and the overseeing of other members of hospital staff and practical, non-clinical day-to-day operations.

With the country's highest population density, London was one of the hardest hit areas of the United Kingdom, with a higher death toll and earlier arrival of COVID-19 compared to the rest of the country. As such, London was chosen as a case site because managers at Queen Catherine's were responding to significant challenges to their work that impacted their decision-making in a way never experienced before.

The project scope and interview questions were co-designed between a team of anthropologists at University College London, and members of senior management at Queen Catherine's. The project was commissioned by the Trust in order to learn more about the changing nature of decision-making during the pandemic, and the Trust charity funded the research. Initial questions were developed by the research team at UNIVERSITY with management approval and input. One researcher undertook the data collection, analysis, and research write-up. Ethical approval was given from UNIVERSITY Ethics Committee.

Unbinding bureaucracy

Bureaucracy and the challenges of its navigation are present in many institutions worldwide, the NHS being no exception. Decision-making is tightly tied to bureaucracy, and often managers are unable to push through changes or innovations as quickly as they would like (or is needed in a healthcare setting) due to the restraints imposed by bureaucratic mechanisms. For example, pre-pandemic managers needed sign-off from their own line managers and potentially very senior management before following through with fairly routine changes such as pre-planning staff rotas (see below). However, whilst institutional structure may rely on bureaucratic mechanisms of control during its normal functioning, during the pandemic this was disrupted with interesting consequences. Such changes made some managers begin to question the very necessity of the pre-pandemic bureaucracy itself, and ultimately, whether the audit culture (Strathern 2003) system of "total bureaucratization" (Graeber 2016): 3 truly contributed toward optimum functioning or not. That said, it will also be seen that systems of bureaucracy do not exactly follow "utopic" ideals (Heyman 2004:487) that they purport. As such, managers at Queen Catherine's are unlikely to be alone in their criticisms of, and frustrations with, the present system, lived realities of management do not necessarily correspond to bureaucratic expectations (Gupta 2013).

Significantly, every single manager interviewed mentioned that the speed and pace at which decisions were made during the alpha phase showed a substantial difference compared to what they saw as more normal, pre-pandemic times, in which it was noted that implementing change was tied up in red tape and hoop-jumping at every stage. Practically, this meant presenting written proposals or case reports about a new idea to one's line manager, and potentially at a board meeting (depending on one's level of seniority), and then waiting for multiple rounds of feedback and sign off before any steps toward implementation could be made. At Queen Catherine's, staff had been used to this arduous process of implementation, whereby decisions could take months to finalize, and even longer periods

of time would pass before any change could be observed. However, the pandemic necessitated a shift, and staff found themselves basking in the opportunity that this afforded them and their decision-making.

For example, estates manager Tim said that he "really liked the speed at which we were able to get things mobilized," and that "the speed of reaction and how this was set up was incredibly impressive." His estates colleague Sandra corroborated, stating that she also "enjoyed the pace of decision making on a personal level [as] an astounding amount of change had happened in a short period! [during alpha phase] The shackles were off, we had an ability to do things at pace. It was streamlined!." Estates managers are responsible for property management on behalf of the NHS. Pre-pandemic, it may have taken many months to confirm a purchase or sale, however the usual chain-of-command was removed in order to speed things along. However, it is important to note that the kind of changes and decisions that staff were referring to were not necessarily all about the COVID-19 response. Many of these were plans and ideas that had been waiting in the wings for an incredibly long time and had simply never received the necessary sign off that the pandemic provided.

Roger had been an operations manager for the last 10 years, though with the ongoing struggles over funding and the unmet need to update technology systems, had expressed pre-pandemic fatigue toward the restraints on his ability to have new information technology (IT) systems approved and up-and-running. Operations managers primarily address resource provision. Prior to the pandemic, Roger noted that it would take a number of years to have any kind of new IT system embedded within the hospital, if it was approved at all. Though he could try and make the decision, this kind of change would require the navigation of a long bureaucratic process, whereby senior staff would "keep plates spinning for too long," he told me. Yet, the "game changer" pandemic changed all this within the blink of an eye. Roger noted that within two short months, the hospital had gone from not using any video conferencing or remote communication services at all, to having Microsoft Teams not merely up and running, but servicing over 2,500 active users, for more than 3,500 meetings and 1,600 calls. This "premium placed on pace," as he called it, had made possible a two-month turnaround on a decision that would have previously taken years. Certainly, the pandemic change of pace seemed positive to some.

This was not only about individual projects finally being pushed through at pace. The change in decision-making was also closely linked to the sense of community and kinship that the pandemic produced. For example, finance manager Pam reflected on the speed and urgency needed, arguing that "there was a visceral sense of common purpose. We were all aligned around what to do so it was more likely to stick. Usually humans don't like change, but we had to be more flexible in our responses." Decisions that would have usually taken a long time, like Roger's new IT communication initiative, were suddenly supported by the whole team operating under the logic of "common purpose" and "alignment" as Pam noted, resulting in a team effort.

That said, it is also worth noting that not all decisions taken at pace necessarily had positive results. Take the decisions made by general manager Marcus, for example. As his main duties were no longer considered urgent in alpha phase, Marcus decided instead to campaign for the introduction of a free meal service in the hospital canteen. For all intents and purposes this seemed like a good decision and would serve the needs of the exhausted staff members toiling at the hospital's COVID-19 ward. However, as service staff increasingly began to need isolation periods as the virus spread, the canteen ran into staffing issues. Furthermore, the funding that had been used to supply the canteen began to dry up toward the end of alpha phase, yet staff were still expecting this complimentary service-especially those that were unable to go home to their families and were living out of hotels. Marcus reflected that he may have made this decision in a rush, and as such, did not have enough time to ensure the organizational structure necessary was fully in place. He noted that prior to the COVID-19 response, he "used to work with clear governance," and though he "still drew on those skills, [we] had to work in a fast-paced environment, and it was difficult to clarify how to work it out sometimes." Though Marcus may have yearned for more governance, his opinion was unusual few among the managers interviewed.

What made all of the above possible was the removal of the usually strict bureaucracy, enabling decisions to be made more quickly than before as they did not need to pass through layers of internal audit first. On this, finance manager Roy told me that "a lot of bureaucracy was taken away, and this influenced the quickness of decisions . . . the pre-covid bureaucracy was unnecessary. The freedom to make decisions with less bureaucracy was a blessing, I had more autonomy on a personal level." Despite this seeming freedom of instant decision implementation, it should be noted that Roy was already a very senior manager, and as such would have previously had more freedom and authority to make decisions even before the pandemic. On the other hand, the case of project manager Natasha was quite different. She said that she was "not sure I was freed to make decisions in my team, we talked a lot of about bureaucracy in general, not even just as a covid point . . . it was in a lot of discussions, but there was the perception that decisions in my team were all being made by the boss. There was always unnecessary layers of bureaucracy above me, that also have an extra layer that was bureaucratic." Her experience suggests that the reduction of bureaucracy would have been felt more keenly by those who already had less layers of bureaucracy to tackle anyway. Not all staff in Natasha's position felt the same, though. General manager Matt took advantage of the "chaos" he perceived, supported by his own manager who told him to "strike while the iron's hot," and implemented a change of his own accord. That change was to design rotas only one week in advance, instead of monthly as before. It may not be world-changing (and may indeed say more about the intense bureaucracy of normal-times if they restrict such a seemingly straightforward decision), but Matt still saw this as "freedom to be proactive and respond to the needs that I saw."

It is important to note that these decisions were also very much enabled by the relative lifting of constraints surrounding funding. Seven different people mentioned the idea of a blank check enabling them to make decisions with impunity, and of course the removal of budgeting concerns would clearly have influenced the scope and ambitions of managerial decision-making. Prior to the pandemic, budget requests would need to be justified and scrutinized before the hospital could agree to allocate the funds to a manager's initiative or project. While some of the pandemic-era changes may be more sustainable in the cohabitation phase, Finance manager Derek scoffed at his colleague's attitudes toward finance in alpha phase, telling me "You can't just re-design the financial regime to empower people to make decisions! This ties into the bureaucracy around finance, that doesn't necessarily question decisions but holds outcomes to account." Despite certain misgivings around potential errant spending without the bureaucracy of financial constraints, Derek did say that this was "easiest to do with blank cheques [in alpha phase] but would be difficult to recreate. People have been sensible, they haven't been irresponsible, though they have been seizing control and managing their own fate."

Alongside Derek, another austere voice came from HR manager Martha, who did not think that her colleagues were quite as restricted pre-pandemic, nor that bureaucracy was a bad thing. She told me:

> There is a danger of some analyses when people think that they did not have freedom before- they did, they just were not brave enough to use it. During alpha phase it [the freedom] was great because we were "all going to die" and so we cut through the bureaucracy. But decisions could have been made in peace time too; it's a cultural thing. You need to have some bureaucracy, or you will kill people! Process and control are in place to not kill people. I need some bureaucracy to pay them, to buy them things, to feed them!

Martha's thoughts are worthy of reflection here, as she suggests that the change was perceived as drastic, but people always could have made their decisions before except they did not feel brave enough to do so. Interestingly, Martha's comments seem to follow an individualistic, neoliberal logic, the kind of which is increasingly to be found in organizational structures for private corporations (Bal and Doci 2018) and which critics of NHS privatization may suggest is one of the more damaging concepts to sneak into NHS culture in recent decades. From this perspective, Martha's words actually reflect the wider corporate and market culture and logic within which she operates. The irony here, however, is that the extreme bureaucracy that results in healthcare managers being unable to make decisions at pace (in normal times) may be what ultimately kills people (patients), rather than the lack of bureaucracy to pay people, as Martha suggests. Yet furthermore, it is worth reflecting on Martha's

comments as she offers a different perspective when compared to some of her colleagues. Many managers saw the changes as a good thing, but Martha shows how there may be negative ramifications to reductions in bureaucracy. As a HR manager, Martha needed to be able to understand aspects of employee work schedules and realities in order to pay them, but also to undertake other tasks such as process sick-leave, which was particularly important during the pandemic. Some of the pandemic-bureaucratic changes would have interfered with this. For example, it has been noted that a manager was able to push through a decision to make staff rotas only one week in advance. Martha may consequently have experienced a harder time knowing who was working when. As such, she may not have been able to pay them, or process sick-leave, or book clinical staff into nearby hotels so that they could avoid contaminating their families after a day on the COVID-19 ward- all resulting in negative outcomes. Martha needs the bureaucracy to successfully undertake her role, pandemic or not.

It is of little doubt that the contemporary NHS is behest by increasing amounts of bureaucracy, a reality often found in contexts where the focus on the market is strong. Middle management contributes toward the layering of hierarchy, which, as many managers noted, was a pre-pandemic bureaucratic hurdle toward implementation of decisions. Based on such institutional changes, Talbot-Smith and Pollock suggest that the NHS has undergone a "transition to a market" (Talbot-Smith and Pollock 2006:5) as services have become outsourced, and Leys and Player (2011) argue that such changes constitute a plot to privatize the NHS. With the devolution of control over service provision from central government to NHS trusts in the early 2000s, the purchase of private health care services to be offered under NHS contracts added another layer to the market-oriented evolution of the health services (Talbot-Smith and Pollock 2006:36). With the advent of managerialism from 1983 onwards, the NHS has further increased its hire of managers (Tallis 2013:7), arguably leading to an increased number of bureaucratic hoops through which to jump within an ever-more hierarchical structure based on middle-management and free-market logic (Tallis 2013:8).

Non-clinical managers are arguably at the heart of bureaucracy within the NHS. These managerial staff, whose ranks swelled by 37% between 1997 and 2010 (Kings Fund 2012), undoubtedly contribute toward the "corporatization of the NHS" (Tallis 2013:8) which includes increased reliance on private-sector mechanisms of quantification and control. This extension of "corporate bureaucratic culture" that seeks to engulf "any location where any number of people gather to discuss the allocation of resources of any kind at all" (Graeber 2016:21) may also be present in Queen Catherine's. The comments and experiences of the managers in my study suggest that a corporate bureaucratic culture may have certainly existed prior to the alpha phase of pandemic response, but this was disrupted with the arrival of COVID-19 and the breakdown of bureaucratic processes.

At the initial outbreak, existing bureaucracy was necessarily reduced in order to facilitate actions that would otherwise be dangerously or unhelpfully delayed. It would therefore be wholly possible, and tempting, to discuss the apparent futility of processes that hinder actions in a context where they are literally life and death.

Tellingly, the managers interviewed reported that the usual level of bureaucracy was unnecessary, and that its removal gave them more freedom to make decisions. This in itself might seem an unsurprising revelation at first, however, one must remember that for non-clinical managers without physical presence on a hospital floor, bureaucracy is what allows them to govern through the imposition of rules and regulations imposed upon other staff and team members. As such, one might expect them to be the very champions of such processes of bureaucracy, as this is what ostensibly supports them in governing staff members. As Storey et al. (2011) argue, health service management is all about governance and therefore the means with which to govern should be significant for agents of that governance, like managers. However, they also acknowledge that a majority of regulatory intents within the NHS are short-lived and unsuccessful (Storey et al. 2011:41). This leads to an interesting paradox: over the years, the NHS has increasingly employed managerial staff to implement greater regulation and control through governance and bureaucracy, yet there is evidence to suggest that they are not often very successful at this, or that success was short-lived. It is only through the forced change of alpha phase that decisions could be made and

implemented, and this was largely down to bureaucracy reduction, not due to the existence of bureaucracy. It would appear that the bureaucracy associated with managerialism has been restricting the actions of decision makers, rather than helping them to organize.

In all, what can be said about the experiences and opinions on bureaucracy at Queen Catherine's is that it may restrict rather than support managerial decision-making. Though some voices recognized a use for bureaucracy, the majority of managers interpreted it as a negative that limited their ability to make any significant change in the Trust. In this view, bureaucracy is not a helpful tool as such, but a cultural artifact that exists to supposedly fulfill the needs of hierarchical governance. Importantly, Graeber (2016) argues that this process is accelerated by the fusion of the private and public spheres. I would suggest that the contemporary NHS is itself an excellent illustration of Graeber's thesis, given that it arguably represents such a fusion. Once a public, socialist institution designed to provide health services to all those in need regardless of income or social status (Mulholland 2009), nowadays the NHS is more market-oriented, and (some argue) has become a business (Leys and Player 2011). Graeber's total bureaucratization could be used to understand a case such as Queen Catherine's, whereby a senior staff member cannot even implement an IT systems update due to the myriad restrictions that internal bureaucracy places on his possibilities, despite the fact that this would help the hospital to function and communicate better in the long run. Bureaucracy is not working here; it is hindering. However, the fact that managers at Queen Catherine's noticed a positive shift when total bureaucratization was suspended may signal a positive outcome, as there could be scope to challenge this in the future. Prince (2022) introduces the idea of optimism in managerialism, and that notion holds relevance here. Though a critical eye is needed to understand the situation, it is not necessarily all bad news for the future of management in the NHS.

Common purpose among "tribes"

"Hospital teams are like tribes! There is definitely tribalism in the NHS," HR manager Kirsty reflected. What did she mean by this? Prior to the pandemic, Kirsty had perceived an unwritten rule that there were boundaries between teams at Queen Catherine's. One didn't necessarily interact with other teams unless there was a clear need to do so. Sometimes this boundary was due to geographic location, as non-clinical managers on different teams often worked in separate offices pre-pandemic. However, Kirsty thought that it was more about competition as resources were sometimes strained. With deadlines and goals to meet, this resulted in a disjointed workforce. At Queen Catherine's these tribes are often referred to as siloes and siloed working. And indeed, there was a shift in siloed thinking during alpha phase. I have already hinted at this by describing managers' comments about common purpose, and one person's community-spirited free canteen implementation. However, the feeling of commonality was greater than this among the managers, which highlights some of the potential flaws with the competitive, neoliberal mind-set in a world of human health. Here it is important to understand what siloes are and why they exist in order to see how they fit into the wider structure of the hospital and the NHS.

Healthcare silos refer to different departments within an institution and imply a dearth of communication and sharing of data and results between those groups (Kelly 2019). Within the NHS they have been criticized for inciting ineffectiveness and competition, with departments unnecessarily withholding information that could be of benefit to their own trust and indeed, ultimately the wellbeing of patients (McCartney 2016). The boundaries between silos have been called "artificial" (Storey et al. 2011:21), as there are no enforceable rules to oblige departments to act in this competitive way. Siloed working is a choice, but arguably it is a necessary business requirement if trusts are to compete in today's NHS. Pollock argues that contemporary NHS trusts oversee their own finances and are essentially run as income-generating businesses that are in competition with other hospitals (Pollock 2004:21). Competition is a fundamental basis of the neoliberal market, in which it could be said that the NHS now participates. NHS trusts and their different departments must compete because

this is the business model within which they are working. Whether or not this genuinely results in optimum care for patients is a question outside the scope of this article, however it is possible to ask whether or not this works for the managers of Queen Catherine's. The fact that they enjoyed the breakdown of siloes during alpha phase suggests that it does not, and that instead they may prefer working under a "messy bureaucracy" (Gupta 2013) where more freedom is granted.

Indeed, the idea of a common goal appeared throughout the interviews, as though everyone suddenly noticed that they all wanted the same outcomes as colleagues in other departments. Chris, an estates manager, said that "personal relationships and allegiances were put to one side for the common good, rather than individual rules. There was one common purpose – it was very easy. It was about, is it the right thing, yes, or no?" He went on to explain that "people's egos disappeared. How we usually function as a hospital, interacting across services, that normal day to day push and shove in a hospital . . . all that disappeared. The collective ego went, and it was helpful for everyone to be on the same team. Everyone came together and worked together." Other managers concurred with Chris' feelings, with Ophelia the HR manager noting how in alpha phase there was "genuine collaboration between teams" and a "breakdown of some of the boundaries."

In practical terms, this meant collaboration and cooperation between the various different sites comprising Queen Catherine's. Prior to the pandemic, staff would stick to their office. For example, HR manager Jordan used to work in an office space that was a 20 minute cycle ride away from the main hospital building. He never had reason to go there as he was not patient-facing and was unfamiliar with staff members who were not a part of his immediate team. However, alpha phase brought changes, as not only did people work from home (and so have more opportunities to communicate with other teams online), but some staff members also took on different duties to help out. For example, Jordan undertook some shifts in the makeshift hospital canteen, thereby bringing him into contact with colleagues at the hospital site as well as within his office-block. He said that now there was "more discipline to structure the talking between sites. This reinforced the fact that we are a group of sites, as there is a tendency for local leaders to focus on individual clinics. There isn't enough about group advantage . . . the competing departments between sites are unhelpful, hearing about each one more meant there was more discipline." Jordan's reflection that competition is unhelpful points to an underlying point about siloed working; when teams compete instead of collaborating, this may not necessarily produce the best result. This is especially the case when speaking about the pandemic response, and the managers recognized that. However, in a work environment with a culture of competition during normal times, the short-lived alpha response may not have been enough to change this way of working for good. Even so, there were those that considered that change could occur, and had occurred, even if it was hard to see. For example, project manager Lucy said of the structure of teams within the hospital, and the influence of alpha phase on them: "It's a bit like a scab, you pick a scab and its raw and hard, but you have networks growing over it and meshing . . . what's formed is a better network but it's messy." Whilst the metaphor of the new and better network forming is promising, Lucy also recognized that the new-found ways of collaborative working quickly dissipated as Queen Catherine's moved into beta phase:

> Covid gave everyone the same goal, and they don't have that now, it's back into silos . . . before it was the rapidity of change. The pace of it has all slowed down again—it's quicker than before but is still slow. We are going back to the new abnormal.

This return to competitive, siloed working was echoed by finance manager Sandra, who said that "during alpha phase, it felt like the hospital and groups pulled together, decisions were made at a group level, but in beta phase it feels like a siloed way of working has returned, something was lost with the emphasis coming on sites again. Cross-team working has gone, we are all back in little silos. The Dunkirk spirit won't last." The fact that managers had already begun to feel that the spirit of collaboration had faltered as the Trust entered beta phase suggests that the change was short-lived indeed. However, when staff had more feelings of freedom they collaborated and came out of their tribes to work toward the greater good. Perhaps, as the NHS is a public

institution that is meant to serve the British population, one might argue that this should have been the goal all along. The change during alpha phase not only suggests that this is possible for them, but that it was their default when optimum working was required to cope with the pandemic situation. As Queen Catherine's entered the beta phase, however, the pre-pandemic structures that produced siloed working in the first place began to re-appear, thereby hindering the collaborative work ethic of alpha phase and returning to a more competitive, market-oriented mind-set.

Managers mentioned the positivity felt by working toward a common purpose and breaking down the previously rigid tribes and fiefdoms experienced within their workplace. Suddenly, they noted, everyone started working together as a team, an observation also made by Vindrola Padros et al. (2020). This similar notion of a Dunkirk spirit, endlessly cited and now a cliché in regard to COVD-19 language (Boyle and Brandão 2022) was mentioned as a positive aspect of working during alpha phase, though the manager who mentioned it thought that it wouldn't last. She was correct, it seems, as responses did suggest that the collaborative spirit had very quickly dissipated at the onset of beta phase. As such, it could be argued that it is not necessarily the people themselves who encourage the competitive nature of siloed working, but the neoliberal system itself.

Though a return to siloes may seem unfortunate, this has not been the only outcome. Even if Queen Catherine's did not necessarily see its corporate culture totally changed, there may have been a wider shift in terms of attitude toward identity of the NHS. As Lawrence, a general manager, said, he saw the hospital's pandemic response as "putting the N back into NHS and promoting the idea of working together." The idea of national "working together" seems to refer to the collaboration between all NHS trusts as a nation. This is exactly what is meant to happen when a level 4 incidence is triggered by the government. Specifically, a level 4 incident occurs when there is a perceived national emergency, in this case a global pandemic. For the NHS, it implied that all trusts across the UK co-ordinate efforts in a command-and-control structure that takes the central government as its point of instruction. Usually, NHS trusts are self-contained and make their own decisions, which may influence some level of competition between trusts as they must financially manage themselves successfully in order to survive. However, under the level 4 incident, Queen Catherine's was obliged to coordinate efforts nationally. Practically, this could mean receiving and treating patients from other trusts, loaning staff and expertise, and generally collaborating with other hospitals.

To an extent, this approach is consistent with an earlier NHS structure that used a central command-and-control to move "towards the goal of universal and equal health care" (Pollock 2004:88) by using hospital planning for the nation as a whole. As Pollock (2004) notes, this country-wide standardized model was criticized for offering a lack of patient choice and thereby was slowly abandoned in favor of the business model that treated patients as customers who were free to compare and select their best option. What the pandemic uniquely necessitated, however, was a brief rupture in the business structure and a partial experience of the command-and-control model employed pre-privatization of the NHS. That is not to say that Queen Catherine's experienced a leadership model that looked exactly like the NHS used to be in its socialist heyday, however, the spirit of competition did change to one of a national goal of combatting the virus.

This theme of nationalist rhetoric is one that has arisen throughout the literature on COVID-19. In Britain, this was especially expressed through battle language, and references to war, and particularly the romanticization of the second world-war, but as Gamlin et al. (2021:12) argue, this is a "nostalgic nationalism" based upon memories of empire. Nationalisms and feelings of belonging can be exclusive, and as Yuval-Davis has observed (Yuval-Davis 2011), are based upon bordering and boundaries. Though staff at Queen Catherine's may have said that boundaries were broken down in alpha phase, it could instead be observed that they were simply redrawn around the country and the NHS remained as a hierarchical group run by managerial logic. This may suggest that staff are supportive of reduced competition within the NHS, and may favor and thrive on collaboration. At the onset of beta phase General manager Alison commented that "the NHS is forever changed, and for the better." However, it might be hard to agree. The pandemic caused a brief shift, but not a total rupture.

Conclusion

If managers thought that they were able to govern the contemporary NHS through systems of bureaucracy and the spirit of competition, the pandemic disrupted the fundamental basis of this notion by allowing managers the opportunity to work otherwise. Whilst it is true that not all of the managers at Queen Catherine's totally relished the sudden changes, overall, the freedom from restrictive bureaucracy and collaborative opportunities were seen as positive. The conclusions that can be drawn from this are threefold. Firstly, following Cowan (2021), I argue that management may not need such concretized hierarchies of bureaucracy in order to function, and though not all decisions were necessarily successful during the pandemic, people were nevertheless able to function effectively when given the freedom to do so. Further, it can be argued that the competitive nature of healthcare siloes is not a given nor seen as particularly positive by those working in a managerial role. Instead, collaboration is possible and could be effective as well. Ultimately, it can be argued that the conditions under which managers in the NHS work are largely dictated and influenced by the wider neoliberal context of market-logic that the health services are increasingly veering toward, a situation encompassed by Graeber's theory of the total bureaucratization of modern life (Graeber 2016). Competition (that does not necessarily benefit manager-employees nor perhaps patients), siloed working, bureaucratic red tape, and structures of hierarchy are not unique to NHS management. However, I have shown that in some cases, when those working within (and for) such systems are given the chance to experience a different way of working, a more messy system (Gupta 2013) and one that arguably reflects a more socialist-minded NHS, they enjoy their roles and continue to function effectively. This may give hope that there are other possibilities for managing the health services that take a different ideological framing, and do not encourage increased privatization and postcode-lottery competitiveness, but instead communality and prioritization of the patient over profit.

Notes on contributor

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