**Challenges of maintaining accountability in networks of health and care organisations: a study of developing Sustainability and Transformation Partnerships in the English National Health Service**

**Abstract**

The English National Health Service (NHS) constitutes a unique institutional context, which combines elements of hierarchy, markets and networks. This has always raised issues about competing forms of accountability. Recent policy has emphasized a move from quasi market competition towards collaboration in the form of new regional organizational arrangements known as Sustainability and Transformation Partnerships (STPs). We explore accountability relationships in STPs, focusing on the challenges of increasing horizontal accountability given existing vertical accountabilities, most notably to national regulators. We utilize a case study approach concentrated on three Clinical Commissioning Groups (CCGs) in urban and rural settings in England. We conducted in-person interviews with 22 managers from NHS organisations and local authorities and examined local documents to obtain information on governance and accountability structures. The fieldwork was undertaken between November 2017 and July 2018. We analysed results by considering which actors were accountable to what forums and the nature of the obligation (vertical or horizontal). We found that individual organisations still retained vertical accountabilities and were reluctant to be held accountable *for* the whole STP, given they were responsible for only part of the joint effort. Moreover, organisations did not feel accountable *to* STPs and instead highlighted vertical accountabilities upwards to their own boards and to national regulators; and downwards to the public. But while local commissioning organisations, CCGs engaged with their members and the public, STPs failed to engage adequately with the public. Nevertheless, there were indications that horizontal accountability was starting to develop. This could become complementary to vertical accountability by facilitating mutual learning and peer review to anticipate and defer regulatory intervention. While vertical accountability is necessary to provide oversight and apply sanctions, it is not sufficient and should be accompanied by horizontal accountability.

**Keywords:** accountability, hierarchy, networks, health policy, English NHS

**INTRODUCTION**

An accumulation of structural reforms in the National Health Service (NHS) in England has resulted in a unique institutional context in which different modes of coordination of organisational activity coexist, namely hierarchy, markets and networks, which give rise to distinct accountability obligations. Recent policy has encouraged commissioners (responsible for planning and purchasing) and providers of healthcare to work together in collaborative arrangements such as ‘new care models’, Integrated Care Providers (formerly Accountable Care Organisations (ACOs)), Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) (see page 4). These novel arrangements enable organisations in a defined geographical area to work more closely together without creating a new organisational form in order to improve health care delivery and outcomes and promote sustainable finances. This paper explores accountability relationships in STPs in the English NHS. These novel horizontal cooperative working arrangements raise concerns about accountability due to complex and non-legally sanctioned organisational structures, which suggests that horizontal accountability needs to be developed and implemented alongside existing vertical accountabilities. A key question arises of how to balance formalised vertical accountability structures with horizontal accountability in non-statutory networks and, given this challenge, if traditional vertical accountability arrangements are sufficient by themselves.

This paper proceeds as follows: first, we present an overview of the recent policy context, followed by the definition of accountability used throughout the paper; we then describe the organisational theory underpinning the institutional context of the English NHS to provide insight into the different accountability obligations that arise within this context; next we consider the challenges to accountability posed by one organisational form – networks; the subsequent section describes the study design and methods while the penultimate section presents the results, where we explore vertical and horizontal accountability through the lens of who is accountable to whom; we conclude with a discussion of our findings and their implications.

***Policy context***

A recent international health policy trend has been a move towards increasing cooperation between healthcare providers as seen in initiatives such as the Gesundes Kinzigtal in Germany, Ribera Salud in Spain and ACOs in the United States (Barnes et al., 2014; Pimperl et al., 2017; Thoumi et al., 2015). The organization of these initiatives differs across countries, in part reflecting the institutional structure of the health system. However, they share a common objective of improving efficiency and patient care and outcomes through better care coordination between providers.

In England, recent health policy has promoted increased inter-organisational co-operation and downplayed the role of competition in the NHS, which was emphasised in the Health and Social Care Act 2012 (HSCA 2012). This legislation introduced major changes into the English NHS and encouraged the use of competition to procure and deliver clinical services to improve quality and efficiency. The HSCA 2012 introduced a new economic regulator – Monitor (now NHS Improvement) with powers to enforce competition law to prevent anticompetitive behaviour. Monitor was also responsible for promoting cooperation. The role of the Care Quality Commission (CQC), the independent regulator of health and social care was strengthened. Together with Monitor, the CQC was responsible for issuing and overseeing the licensing of public and private providers (Anonymous, 2020). Arguably, these regulators represented additional channels of upward accountability for providers.

The Act also introduced Clinical Commissioning Groups (CCGs), clinically-led statutory bodies responsible for the planning and commissioning (purchasing) of health care services for their local area. CCGs are membership organisations comprised of GP practices. A new arms-length body, NHS England (NHSE), was established with responsibility for overseeing the work of CCGs. Commissioning responsibilities for local populations are now divided between CCGs, local authorities and NHSE. Nevertheless, the HSCA 2012 also required organisations to co-operate and since this legislation has taken effect, there have been several important policy developments. In 2014, *The Five Year Forward View* (FYFV) (NHS England, 2014) focussed on how organisations in the NHS need to cooperate with each other, and form new configurations known as ‘new care models’. In 2015, the concept of local cooperative, place-based planning was introduced, initially known as Sustainability and Transformation Plans and from March 2017 Sustainability and Transformation Partnerships(STPs). There are currently 44 STPs, each with a lead from an NHS organisation or local authority (NHS England et al., 2016). The introduction of STPs brought an expectation of increased efficiency savings leading to a fear that they would become a vehicle for cuts to services (Gillam, 2017).

ICSs (formerly Accountable Care Systems) were originally envisioned as an ‘evolved’ version of an STP, whereby NHS organisations would work together (often in partnership with LAs) as a locally integrated health system (NHS England, 2017; NHS England and NHS Improvement, 2018). ICSs would achieve joint working without concomitant changes to organisational arrangements. The ICS would take on collective responsibility for resources and population health and provide more coordinated care. They would gain more control and freedom over the local health system and receive financial and regulatory support (NHS England, 2017). While it is expected that ICSs will continue to develop from STPs and cover all of England, recent policy also stipulates that ICSs will work with local authorities at ‘place’ level and streamlined commissioning arrangements will entail a single CCG in an ICS area (NHS England and NHS Improvement, 2019). This implies that an ICS could be developed at the CCG level, co-terminous with a local authority.

Despite these developments, there have been no relevant legislative changes, so the HSCA 2012 provisions remain in force. Policy guidance indicated that “STPs are not new statutory bodies. They supplement rather than replace the accountabilities of individual organisations.” (NHS England, 2017: page 32). STPs were required to form an STP Board with representatives from partner organisations and “appropriate non-executive participation” (NHS England, 2017). Similarly, ICSs were asked to “create an effective collective decision making and governance structure, aligning the ongoing and continuing individual statutory accountabilities of their constituent bodies.” (NHS England, 2017: 36). As ICSs develop, it is expected that they will all have a Partnership Board with representatives from each constituent organisation (NHS England and NHS Improvement, 2019). As STPs and ICSs have no statutory basis, legal decision-making powers rest with individual organisations. The lack of legal status means it is difficult to hold STPs and ICSs accountable for their joint actions or outcomes to regulators, patients and the public (Hempsons et al., 2017). Several authors (Boyle et al., 2017; Centre for Public Scrutiny, 2017; Buckingham and Curry, 2018) have raised concerns about their accountability. Pollock and Roderick (2018) maintained that ACOs would receive large amounts of public funds in the absence of statutory accountability and governance obligations including adequate public involvement and oversight. Concern over the transferral of resources and decision-making power to new non-statutory entities prompted two high-profile judicial reviews of proposals to introduce ACOs (Dyer, 2018) in an attempt to increase accountability. It should also be noted that the STP process included an explicit requirement for patient and public involvement (NHS England et al., 2015).

Research has highlighted the increasing complexity of accountability relationships in the English NHS since the HSCA 12. Anonymous (2013) found that CCGs had both external and internal accountability relationships. The most important external accountability was to the national regulator NHSE, which was sanction based. Other important accountabilities were to the public and CCG members. Anonymous (2018) focused on accountability relationships between accountability *actors* and their accountability *forums.* They found that the nature of obligation underpinning these relationships was both formal-informal and vertical-horizontal concurrently. This resulted from vertical formal accountability obligations becoming informalised and horizontal informal obligations becoming formalised. Anonymous (2019) argued that NHSE increasingly acted over and above its original remit by guiding national policy and restructuring NHS organisation and governance, leading to increased ambiguity around accountability.

***Definition of accountability***

This section explores the meaning of accountability and how it can be measured. We use the definition of accountability put forward by (Bovens, 2007: p. 467): “Accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences.” This definition can be interrogated to identify different types of accountability based on the nature of the actor, forum, conduct and obligation. If the actor is a public organisation, then the following types of accountability arise: *corporate* arising from independent legal status, *hierarchical* whereby the head of the organisation is held responsible, *collective* where any individual within the organisation can be held accountable for the entire organisation or *individual* whereby accountability is proportional to each person’s contribution to the conduct of the organisation. Bovens (2007) identifies five different *forums*: Political, Legal, Administrative, Professional and Social.

The nature of the *obligation* can be *vertical* or *horizontal* (Bovens, 2007). *Vertical* accountability refers to a hierarchical relationship between the actor and the forum, which allows the latter to formally wield power over the former. In contrast, with *horizontal* accountability, a hierarchical relationship and formal accountability obligations are absent, and the concern is with accountability between stakeholders in a network (Bovens, 2007; Bovens et al., 2014). More precisely, we are interested in the challenges posed by horizontal accountability and whether there are adequate mechanisms in place to hold NHS organisations to account for their collective endeavours. This research question stems from the institutional context of the English NHS where different modes of co-ordination, namely hierarchy, markets and networks coincide, each creating different forms of accountability. These modes of co-ordination are discussed in the following section.

***Hierarchies, Markets and Networks***

This section outlines theories relating to the co-ordination of organisational activity and behaviour in the form of hierarchies, markets and networks. Accountability differs according to each mode of co-ordination. Moreover, the three modes of co-ordination can and often do, co-exist, meaning that different forms of accountability will need to be reconciled.

The NHS is fundamentally a hierarchy in which the allocation of resources and delivery of services is co-ordinated by centrally led decision-making. Hierarchies achieve co-ordination through the conscious control of tasks to achieve a predefined objective within a vertical tiered arrangement of sub-units (Weber, 1968). Therefore, accountability is achieved through control whereby an actor is obliged to render account to a forum. Hierarchies purposively construct their own incentives and sanctions, which are used to achieve the co-ordination of activities.

In contrast to the conscious and carefully controlled co-ordination of activity within a hierarchy, co-ordination in the market occurs spontaneously and is driven by the exchange of goods and services between parties for an agreed price (Levacic, 1991). Accordingly, contracts are the means through which accountability is exercised as they outline the terms of the relationship between an actor and forum. Co-operation can sometimes also occur in the market spontaneously when organisations’ self-interest coincides (Bengtsson and Kock, 1999; Brandenburger and Nalebuff, 1996).

Definitions of networks vary, but they can be characterised as informal modes of co-ordination (Thompson, 2003) between organisations (Thompson, 2003; 6 et al., 2006), or between organisations and individuals (6 et al., 2006). Networks can be conceptualised as a third mode of governance, with co-ordination mechanisms which differ from the mechanisms of the market (price, transactions, exit) and those of the hierarchy (rules, commands, authority). A key mechanism of co-ordination in networks is trust and co-operation (Thompson et al., 1991). (Uzzi, 1997) suggests that long term relationships between organisations in networks can lead to co-operative relationships, even between competitors with these relationships being characterised by norms of reciprocity. Hence, in networks accountability is realised through relationships, with individual organisations behaving as both actor and forum in order to hold each other to account. Even in the absence of formal structures, other mechanisms such as reciprocity, professional credibility and long-term dependency will help to sustain accountability in networks.

Networks can exist between individuals within a single profession (professional networks), which can be both formally mandated by the NHS hierarchy or can be based on personal relationships or can exist across organisational boundaries between individuals involved in the co-ordination of a particular service. Networks can also exist at an organisational level, such as formal risk sharing agreements, or agreements to work together to provide a particular service. Clans are particular forms of networks that are formed within occupational groups. Clans are defined as groups with ‘organic solidity’, which is based on shared objectives due to dependence on each other (Ouchi, 1980). Clans operate where there is high performance ambiguity, but where individuals share similar goals. Clan members co-operate because they believe their interests are best served by the interests of the clan, rather than due to contractual obligations or monitoring. The interdependence of clan members on each other may also induce cooperation as network organisations rely on each other to succeed (Sanderson et al., 2018).

Hierarchies, markets and networks are ideal types of co-ordination, and in reality, these control mechanisms may be combined resulting in a structurally hybrid system (DENIS et al., 2015; Anonymous, 2016). Exworthy et al. (1999) found that the notion of a continuum of hierarchy through to market, with network in between was not borne out empirically in the NHS. This means that in many circumstances NHS organisations are likely to have both vertical and horizontal accountabilities and will need to find ways to balance the two. A common belief in relation to these three modes of co-ordination is that organisations will self-organise to find the most efficient way of conducting business (Williamson, 1996). Clearly this is not always possible within the NHS policy environment in England, where organisations are subject to a mixed environment in which elements of the market have been introduced to the hierarchical structure.

Advocates of New Public Governance such as (Osborne, 2006) contend that network systems operate in the ‘shadow’ of the hierarchy and that the hierarchy fulfils an important role in the mandating and leadership of the network approach (van der Elst and de Rynck, 2013).

***Networks and accountability***

Networks can raise numerous challenges for accountability (Bovens et al., 2014; Newman, 2004). Networks may lack formal accountability arrangements and associated performance goals or targets and sanctioning powers if these are not met (Bovens et al., 2014; Provan and Kenis, 2007). Moreover, adherence to network rules and procedures is often on a voluntary basis by partners (Provan and Kenis, 2007) and it is not possible to impose a solution or mandate from the top as in a hierarchy (Bovens et al., 2014). Outcomes cannot be easily attributed to individual network participants, so responsibility becomes fragmented and nebulous (Newman, 2004). This may lead to less effective vertical accountability or even an accountability vacuum as an individual organisation may not want to take responsibility for outcomes resulting from joint working (Bovens et al., 2014; Newman, 2004). Nevertheless, individuals in organisations participating in networks will still retain vertical accountabilities through organisational hierarchies to boards (Bovens et al., 2014; Newman, 2004). This means that networks will have multiple forms of accountability, which may be incompatible or undermine each other (Bovens et al., 2014). Additional challenges arise from differences between organisations, for example in terms of attitudes and cultures and a lack of accountability to external stakeholders (Bovens et al., 2014).

In this paper, we will explore accountability relationships in STPs, by asking *who* is accountable *to whom* and *for what*. We will focus on the challenges of horizontal accountability because these are the new issues raised by the focus on cooperative arrangements between organisations in these groupings. We will examine the challenges posed by the non-statutory nature of such arrangements when these are being introduced in conjunction with existing vertical accountabilities. We will consider if existing vertical accountabilities are sufficient or whether it is worth pursuing horizontal accountability, despite the challenges.

**STUDY DESIGN AND METHODS**

The study consisted of three in-depth case studies of how CCGs are dealing with the foregoing challenges in respect of accountability. The case study method was used to capture the complexity associated with organisations that were developing throughout the study (Stake, 1995). This approach allows in-depth and contextual exploration of phenomena, which is important in gaining a clear understanding of change processes (Yin, 2003). We conducted in-depth face-to-face interviews with chief executives and senior managers and analysis of documents, which provided information on accountability and governance structures such as planning documents, alliance agreements, Memoranda of Understanding, and STP consultation documents.

Ethical approval for the study was granted by the Anonymous internal ethics committee in July 2017. The fieldwork was undertaken between November 2017 and July 2018. During the fieldwork we interviewed 22 people from CCGs, NHS providers and local authorities across the three case study sites (see Table 1).

**Table 1. Number of interviews by case study site and organisation**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **CCG1****Midlands** | **CCG2****London** | **CCG3****North** |
| **Commissioners** |
| CCG | 2  | 3 | 4 |
| Local Authorities | 0 | 1 | 1 |
| **Providers: NHS** |
| Integrated Acute and Community | 4 | 1 | 1 |
| Community and/or Mental Health | 2 | 1 | 1 |
| **Total** | 8 | 6 | 8 |

Case study sites comprised a mix of rural and urban settings and were located in the North, Midlands and London (Table 1) in order to obtain geographical variation.

CCG1 was located in the middle of England and crossed the boundaries of two local authorities, covering all of one and part of another. This meant that the CCG comprised two distinct geographical footprints. In both local authority (LA) areas served by the CCG, the health outcomes were relatively poor, with high levels of deprivation compared with the England average and significant numbers of minority ethnic groups. An integrated acute and community Trust covered the whole catchment area of the CCG. This provider delivered acute services for the whole of the CCG catchment area and provided community services to one of the LA footprints. A community Trust provided community services to the other LA footprint. Two mental health Trusts provided the majority of mental health services, one for each LA footprint. CCG1 was a partner in a new care model. The Accountable Officer (AO) of CCG1 became the STP Lead when the STP was established. As the CCG covered part of an LA and this LA was a partner in a neighbouring STP, CCG1 had contracts with a mental health Trust and a community Trust that were partners in the neighbouring STP.

CCG2 was co-terminous with a London Borough. The CCG served a local community that was very ethnically diverse, with approximately two-thirds of the population comprising Black, Asian and minority (BME) ethnic groups and high levels of deprivation. The main provider of acute services was an integrated acute and community Trust that also served CCGs in two neighbouring Boroughs. Mental health services were provided by a community and mental health Trust that served other CCGs in London as well as CCGs outside London. Community services were provided by the integrated acute and community Trust, the community and mental health Trust and a GP Federation (a group of GP practices working together within their local area, in some sort of collective legal or organisational entity) working together in partnership. CCG2 was a partner in a new care model. The STP Lead was formerly the AO of CCG2 and became AO of all the CCGs in the STP.

CCG3 was located in the North of England. The CCG had a small ethnic minority population and ranked poorly for life expectancy compared to other districts across England. There was one integrated provider of acute and community services and one provider of mental health services. Both Trusts provided services to other geographical footprints. The CCG was a partner in a new care model. The STP Lead was from a provider Trust. The STP also had a Director, who was an employee of CCG3.

Within the three case study sites, participants were purposively selected to include those managers most knowledgeable about recent developments in commissioning and who were involved in integrated working at CCG and STP levels. Table 2 shows the number of interviewees by case study site and interviewee role. Two CCG AOs and one provider Chief Executive were also the STP Lead while other CCG interviewees also had senior roles in the STP.

**Table 2. Interviewees by case study site and role**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **CCG1** | **CCG2** | **CCG3** |
| **Commissioners** |
| CCG AO/Managing Director | 1 | 2 | 1 |
| CCG Clinical Chair/Lead | 1 | 1 | 0 |
| CCG Director of Integrated Care/STP | 0 | 0 | 2 |
| Local Authority Director of Integrated Commissioning/Public Health | 0 | 1 | 1 |
| **Providers: NHS** |
| Chief Executive | 2 | 0 | 2 |
| Director of Finance | 2 | 0 | 0 |
| Director of Strategy/Partnerships/Integrated Care | 1 | 2 | 0 |
| Manager | 1 | 0 | 2 |
| **Total** | 8 | 6 | 8 |

A team of experienced qualitative researchers conducted the interviews. The interviews were transcribed and coded. Coding criteria were developed based on the interview questions, accountability theory and the data. The coding criteria were used to analyse sections of text to identify themes. We selected data extracts that illustrated the concepts of accountability outlined in the Introduction. We systematically searched documents for references to accountability and governance arrangements. The STP plans were developed within a short timescale just prior to our fieldwork and were labelled ‘draft’ documents. Therefore, the plans were largely aspirational with references as to how accountability arrangements would or should be developed as opposed to a clear roadmap or framework for how they would be implemented in practice. Similarly, alliance agreements were still in draft form and under development and negotiation. Therefore, there was insufficient detail in the documents, either to analyse and include in the results or to inform the analysis of the interview data.

**RESULTS**

We return to the definition and types of accountability from (Bovens, 2007) outlined in the Introduction to analyse our results. We start by considering the actor (who is accountable) followed by the forum (to whom they are accountable). With respect to the obligation, we first consider vertical accountability, followed by horizontal accountability.

1. **Who is accountable (Actor)?**

There was a lack of clarity about who was ultimately accountable for outcomes produced under STPs. Although individual organisations had clear accountabilities, spontaneous forms of extra legal accountability were starting to develop as we describe below.

***The organisation as actor (corporate accountability)***

CCGs and other statutory organisations still had legal accountability to the national regulators and the introduction of STPs did not change these statutory responsibilities and accountabilities:

*So I might have an obligation to partners, but my accountability in law is defined under the Health Act and by my signature as an accountable officer. And all of the other accounting officers, whether they are chief execs of councils or Health Authorities are very clear that there is a legal accountability defined in law.”* (CCG1, Commissioner 1: CCG, AO and STP Lead)

All respondents emphasised that STPs or ICSs were not statutory bodies and did not have any legal accountability.

***One for all (hierarchical accountability)***

In a hierarchy, central control of decision-making about the allocation of resources and delivery of services is exerted throughout a vertical layer of sub-units. While the boards of NHS or other statutory organisations were traditionally the focal point for hierarchical accountability, it was not always clear what the equivalent was in a system with joint arrangements nor was it clear how this could be created. For STPs it would seem natural that the STP Lead would be held accountable by national regulators. Indeed, one STP Lead, the AO of CCG1, believed that the regulators treated him/her as being accountable for the performance of the STP. This interviewee cited a hypothetical example of a problem with quality performance at an acute provider in the STP footprint. Although the AO was not directly responsible for this issue as their CCG did not commission the provider, the AO as STP Lead was the person who would be contacted by the regulators and expected to deal with the problem. The STP Lead believed that the regulators behaved in this way to induce the same behaviour throughout the system to circumvent the current legislation:

*“I think what NHS England and NHS Improvement are doing effectively is inducing a behaviour by behaving a certain way themselves.*

*So it’s quite an interesting … I call it Tinkerbell management. If you wish for it enough, it will happen. I think that’s what they’re doing”* (CCG1, Commissioner 1: CCG, AO and STP Lead)

This demonstrates that actors will behave in ways they are asked or expected to by the centre even if it is not part of the legal framework, thereby constructing a quasi-legal accountability. The existence of this behaviour by commissioners and providers in relation to competition and cooperation was also documented by (Anonymous, 2017). These empirical findings are underpinned by an established body of theoretical work (see, for example, Macneil (1981)).

The AO of CCG2, who was also the STP Lead felt that s/he was accountable in terms of delivering the STP plan and approving access to transformation funds. The STP Lead needed to ensure the STP had a clear vision, sufficient resources and the right approach to carry out its activities.

However, this interviewee noted that the only direct control came from being a commissioner and that, in the absence of statutory changes the role of STP Lead would always be a challenge. This underlines a key problem with holding the STP Lead to account for the whole STP: STP Leads had no statutory powers that they could exercise in this capacity.

***All for one (collective accountability)***

As there was no one organisation or individual that was accountable, an alternative was collective accountability; that any of the partner organisations could be held accountable for each other’s performance. However, this could potentially pose a problem for providers who might be responsible for only one part of the care pathway. An additional anxiety was that if the acute hospital was held ultimately responsible, a question arose as to how this would encourage good quality care, given that most of the care was delivered outside the hospital.

In summary, the answer to the question of *who* was accountable for the performance of the STP was unclear, and the lack of clarity was underpinned by the fact that these new arrangements had no statutory footing. This was a key challenge to holding these networks to account. Constituent organisations retained statutory responsibility and had clear vertical accountabilities to regulators. However, there appeared to be a reluctance on the part of individual organisations to be held accountable for the activity or outcomes of the partnership.

1. **To whom are they accountable (Forum)?**

We explicitly asked interviewees if they felt accountable to the STP. The responses were unequivocal: interviewees did not feel directly accountable to the STP but reverted to the traditional hierarchical or vertical lines of accountability upwards, such as regulators and boards and downwards to members or shareholders and the public. However, there were indications of horizontal accountability to partners arising from a professional accountability stemming from professional relationships between peers and there were moves to operationalise these.

***Accountability to the STP***

Overall, STP partners did not see themselves as primarily accountable to STPs as STPs did not hold a legal accountability. Statutory organisations could not be accountable to a non-statutory entity:

*But, we don’t have an accountability to the STP, yet. I couldn’t quite make sense of how the statutory body can be accountable to a non-statutory body, in the sense of what I understand accountability to mean.”* (CCG2, Provider 2: Integrated Acute and Community, Director)

Instead, STP partners viewed their primary accountabilities were to the regulators (administrative accountability), organisation Boards (legal accountability) and local populations (political and social accountability).

One interviewee perceived STPs as bottom-up arrangements in the sense that they were comprised of organisations working in partnership and not an external entity that organisations were subservient or accountable to:

*“I think is a fundamental misunderstanding often of STPs. They are a servant of the organisations that are in the partnership, they’re not the master, because they can only get authority that’s delegated from the organisations.”* (CCG3, Provider 1: Community and/or Mental Health, Chief Executive and STP Lead)

This implies that it was more appropriate to view the STP in terms of horizontal accountability between partners rather than in terms of an upwards vertical accountability to the STP Lead or STP Board.

While there was no ambiguity among partners, an interviewee felt that NHSE behaved as if partner organisations did have some vertical accountability upwards to the STP Lead:

*“I don’t think there’s any ambiguity, other than by the regulator. I don't think any of the partners have any ambiguity about that. I am very clear I’m not the boss of anybody as the STP Lead.”* (CCG1, Commissioner 1: CCG, AO and STP Lead)

Nevertheless, one provider recognised that while there was no direct legal accountability to the STP, there was a sense of accountability arising from CCGs, who held providers’ contracts and sat on the STP Board: “*So, from a straight commercial local perspective, there’s still a black and white relationship there*.” (CCG1, Provider 2: Community and/or Mental Health, Director of Finance)

In CCG3, NHSE was keen to work with the STP leadership in exercising its regulatory function. In practice, this meant that the STP Lead and Director were more closely involved in conversations about CCG performance. This would potentially be welcomed by CCGs as the view of the STP Director was that the relationship between NHSE and CCGs tended to be risk related with NHSE exercising greater control where they perceived higher risk.

***Accountability to GP members and the public***

At the same time as their upwards accountability. CCGs had vertical accountability downwards to GP members and the public. The accountability to GP members was a form of political accountability as members elected the CCG Board, while accountability to the public was a political and social accountability. STPs had not affected these accountabilities and CCGs continued to undertake various activities to engage with their members and the public.

In CCG3, the importance of a strong relationship with the Local Medical Committee (LMC) (a statutory professional body representing GPs) was recognised as it was not always possible to have the involvement of every practice in every decision. The credibility of the CCGs’ clinical leadership and CCG Board were central to engagement of members.

A GP Commissioner in CCG2 did not believe the STP would change the way the CCG was accountable to the public. In contrast, a GP Commissioner in CCG1 felt that the lack of initial public consultation in the STP process meant the CCG had to increase their public engagement to provide reassurance about the STP process:

“So, the STPs came out, and because of the lack of consultation with the public around them we had to basically do consultations to say it's okay, it’ll be alright moving forward. So we ended up doing more consultations to solve the STP’s problem than our problem before.” (CCG1, Commissioner 1: CCG, GP)

Interviewees from both the NHS and LAs perceived a difference in vertical accountability between the organisations. The democratic nature of LAs meant that accountability was derived bottom-up from the electoral process, implying a political accountability:

*“so it’s interesting when you start working with local authority colleagues because the fact that they’re elected they feel that they have a sort of much more … they feel that they are more accountable than we are because of that electoral process.”* (CCG2, Commissioner 1: CCG, GP)

A Commissioner from the LA in CCG3 also highlighted this political accountability deriving from the electoral process. This resulted in LAs having more local accountability whereas in the NHS, accountability was upwards and represented an administrative accountability. The perception of this interviewee was that the “*top down control”* (CCG3, Commissioner 2: LA, Director) of the NHS meant that CCG colleagues had to implement directives from NHSE that might not necessarily fit with the local context. LAs had greater ability to fulfil accountability obligations relating to local priorities.

*“Because we’re accountable to the population, we’re accountable to our elected members. I’m not saying it’s perfect and I think [place] is a really good local authority, but it is just brilliant not to be constantly jumping to a sort of national, very disconnected agenda. I really like that about local authority.”* (CCG3, Commissioner 2: LA, Director)

These differing vertical accountabilities would seem to pose a challenge to the development of horizontal accountability between the two organisations along with other partners.

***Mutual accountability***

Networks are a more informal means of co-ordination between organisations, fostered by trust and co-operation, often stemming from long term relationships. In all three case study sites, the CCG had worked with other organisations at both local and STP levels. Collaboration changed over time in sites, responding to different policy initiatives. The history of working together helped build relationships and the foundation for current initiatives.

While upward and downward vertical accountabilities were predominant, there was also a growing recognition of a horizontal accountability between partners working together. This stemmed from a professional accountability whereby partners would give account to one another on a peer-to-peer basis, despite a lack of any formal obligation to do so. This behaviour is reminiscent of the ‘clan’ (Ouchi, 1980) whereby members of occupational groups with similar goals co-operate in order to further their common interest.

The AO of CCG1 felt that the STP partners had a professional accountability to one another, represented by the STP. While this was different from a legal accountability, it was just as important. This indicates that there was a sense of horizontal accountability to the other partners, in addition to the vertical accountabilities upwards to the regulator and downwards to CCG members and the public. Despite this awareness of the need for horizontal accountability, operationalising this was challenging due to the existing vertical accountabilities.

In CCG3, there was a desire to move towards a mutual accountability arrangement in respect of performance. This would entail a system whereby providers were expected to deliver against a set of standards and outcomes and performance was peer reviewed by other partners. The STP Director in CCG3 felt that peer review would drive clinical motivation to improve and improve standards.

*“rather than accounting for your performance to a regulator, you're accounting for your performance to your peers, and I think that brings two things. Firstly people are more likely to listen to their peers than they are to a regulator because they've walked in their shoes, they understand the ins and outs of it. Second, it means that the peer is often better placed to diagnose the problems and offer solutions because they've done that job, they've walked in those shoes, etc.”* (CCG3, Commissioner 1: CCG, STP Director)

The partners were working towards a situation where mutual accountability was as much about driving improvement through peer learning as opposed to just managing failure. The Director of Finance of the Community Trust in CCG1 saw a similar role for the STP in terms of setting standards and peer review of performance. This interviewee felt that the STP was not very helpful in terms of holding providers jointly to account and this was better managed through conversations between executives and clinicians across organisations. The STP would be best placed to set system wide targets and allocate corresponding roles and responsibilities, such as task and finish groups.

While individual partners were still accountable to the regulators, joint working and horizontal accountability could help to address system challenges with regulatory intervention viewed as a last resort.

*“The philosophy behind this is that fragmentation of accountability that currently exists in the system is detrimental to improved care and financial efficiency. So what we’re trying to do is you've got this regulatory accountability as a backstop and NHS England can step in, CQC can step in and NHS Improvement can say this isn’t working, we need you to do X, Y and Z otherwise there are going to be significant issues.*

*That all stands. I think what we’re trying to do is put something between that backstop position. What we’re trying to do is create a network of organisations that work together, create shared plans, create shared ambitions so that we’ve got a better chance of getting after some of the challenges that we face before it gets to that point.”* (CCG3, Commissioner 1: CCG, STP Director)

The STP Programme Manager in CCG3 felt that the goal of achieving ICS status would provide a strong incentive for mutual accountability. In order to gain ICS status and the associated benefits, the system as a whole, and not just individual partners would need to perform well.

In summary, while interviewees primarily viewed their accountabilities in vertical terms upwards to regulators and boards as well as downwards to members or shareholders and the public, horizontal accountabilities to partners were gaining traction. A key challenge to horizontal accountability was developing appropriate structures and these were very much in their infancy and not widespread. Another key challenge was how to reconcile horizontal accountability with the different vertical accountabilities of individual organisations.

**Discussion and Conclusions**

In this paper we have analysed accountability relationships in new forms of collaboration in the English NHS. The NHS presents a distinctive institutional context, which combines elements of hierarchy, markets and networks. Following decades of reforms that introduced and consolidated market elements into the NHS, recent policy has encouraged organisations to cooperate more closely, based on a belief that this would lead to costs savings and quality improvements, which the quasi market had failed to deliver. However, there is no evidence to suggest that closer working between organisations will reduce costs (Anonymous, 2003; Improvement Analytics Unit, 2018; Stokes et al., 2016). Despite reforms introducing elements of markets and networks, the English NHS retains a strong hierarchical structure. The dominance of hierarchy in the NHS means that vertical accountability arrangements are entrenched. Our research provides an insight into attempts to develop horizontal accountability arrangements in an institutional context where vertical accountability prevails.

The challenge of reconciling horizontal and vertical accountabilities in the English NHS is not new. In the context of decentralisation in the NHS, Peckham et al. (2008) note that organisations such as Primary Care Trusts (the predecessors of CCGs) and provider Trusts were accountable not only to central government but also to various central and local agencies. They highlight that while organisations were granted decision-making powers at the vertical level, their autonomy or ability to act was dependent upon networks of relationships, including partnership working, at the horizontal level.

The challenge of creating accountability and governance arrangements for joint working arrangements is not unique to England. Although ACOs in the US have different organisational and accountability structures compared to STPs, a key challenge to the success of ACOs was the creation of effective governance structures (Barnes et al., 2014; Burns and Pauly, 2012). Addicott and Shortell (2014) explored attempts to create collaborative accountability and governance arrangements in ACOs and found limited evidence of collective accountability. They recommended that accountability structures and processes were tailored to local circumstances. Lewis et al. (2017) identified two types of accountability mechanisms used by ACOs: formal legal mechanisms and informal-social mechanisms. The former included legal contracts, mandatory contributions and pre-requirements to join the ACO while the latter consisted of pacts and group norms.

The study has certain limitations. *First*, as the study design consisted of three in depth case studies, it is not possible to make statistically based generalisations to the whole NHS. *Secondly,* in order to maintain depth of focus we limited our data collection to the local CCG, not a whole STP area. *Thirdly*, our case study CCGs were partners in STPs being led by individuals from NHS organisations. LAs lead a small number of STPs and while we approached a CCG in one of these STPs, they did not have capacity to participate in this study. There might have been a different approach in these STPs.

The endurance of the hierarchy is not necessarily a bad thing. Vertical accountability is necessary to provide adequate oversight of the use of public funds for healthcare and to apply sanctions if necessary. The governance arrangements for STPs have several weaknesses. Lay member committees lack powers and do not provide the necessary challenge and oversight akin to non-executive directors of NHS providers (Hempsons et al., 2017). However, as ICSs develop, it has been suggested that they should have a non-executive chair and involve non-executive members of commissioning and provider organisations (NHS England and NHS Improvement, 2019). As STPs and ICSs derive their decision-making powers from their constituent organisations, there is a potential for conflicts of interest if STPs or ICSs are responsible for holding these organisations to account (NHS Providers, 2018). Some STPs have appointed independent Chairs (Illman, 2017; Healther, 2017; Heather, 2017), who could help to overcome any potential conflict of interest. Future legislation could enable CCGs and providers to make decisions through a joint committee, which would be publicly accountable (NHS England and NHS Improvement, 2019). Another important reason for continued hierarchical oversight of NHS organisations is the lack of local or public accountability. This is a key discrepancy between the NHS and local authorities highlighted by our data. Insufficient public accountability has been a leading criticism of STPs since their inception (Reynolds, 2016) and has led to local authorities threatening to quit their participation in STPs (Brennan, 2018). The disparities between the NHS and local authorities in public accountability could present an impediment to the development of horizontal accountability in STPs and ICSs.

Nevertheless, vertical accountability is insufficient by itself (Schillemans, 2011) and given the policy goal of ICS coverage across all of England (NHS England and NHS Improvement, 2019), there is a need to continue to develop structures for horizontal accountability. Our results show that representatives of partner organisations did not feel accountable to the STP. This finding, together with the potential for conflict of interest suggests it is more suitable to consider the STP with respect to horizontal accountability between partners rather than an upwards vertical accountability to the STP Lead or STP Board. The unwillingness of constituent organisations to be held accountable for the activity or outcomes of the partnership suggests a need to construct an accountability mechanism unique to the partnership that is independent of the partners as traditional vertical accountabilities are inadequate. Horizontal accountability can enhance the legitimacy of networks and partnerships (Bovens et al., 2014) and help to prevent failures symptomatic of weak accountability such as ambiguity over responsibilities, failure to address poor performance and a lack of transparency (Guerin et al., 2018). Horizontal accountability mechanisms stimulate mutual learning as they employ the experience and knowledge of peers (Schillemans, 2008; Schillemans, 2011) who are more concerned with the long-term quality of services rather than short time political objectives (Schillemans, 2008). This means that horizontal and vertical accountability can complement and support each other (Schillemans, 2008; Schillemans, 2011; Levasseur, 2018).

Schillemans (2008) posits that the learning process facilitated by horizontal accountability occurs in the ‘shadow of hierarchy’. Network partners are aware that performance will be subject to regulatory appraisal and will attempt to anticipate the regulator’s response. This means that the hierarchy indirectly influences the processes and outcomes of networks. Indeed, this phenomenon was evident in our data where horizontal accountability arrangements were starting to develop – a clear objective was that they would help to defer regulatory intervention. Schillemans (2008) maintains that the ‘shadow of hierarchy’ simultaneously supports and limits horizontal accountability arrangements. On one hand, relatively weak mechanisms are strengthened by their relationship with the hierarchy, but on the other hand the hierarchy can exert more power, for example by applying sanctions meaning that vertical accountability will always outweigh horizontal accountability. A key issue to resolve is how to design accountability arrangements to create an optimal blend of vertical and horizontal imperatives (Considine, 2002).

In England, the policy context continues to evolve. On one hand, the integration of the separate regulators for commissioners and providers at a regional level reinforces hierarchical control and vertical accountability. On the other hand, there is potential for ICSs to operate under a more autonomous regulatory regime (NHS England and NHS Improvement, 2018), underlining the need to continue to develop horizontal accountability arrangements. A new ICS accountability and performance framework is envisioned, and ICSs will have an opportunity to earn more authority according to their performance against system-wide objectives (NHS England and NHS Improvement, 2019). This should provide an incentive for partners to develop mutual accountability arrangements. In the US, ACOs use legal contracts to enforce accountability (Lewis et al., 2017). Alliance contracts are gaining traction in the NHS and these may provide a means to improve horizontal accountability. There have been calls for STPs and ICSs to gain statutory status (House of Commons Health and Social Care Committee, 2018; Charles et al., 2018) and this may also help to strengthen horizontal accountability. Future research should continue to track the progress of accountability structures in STPs and ICSs in England.

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