Healthcare organisations succeed or fail in the middle

Clinical directors, the triumvirate and what it takes to make an NHS provider genuinely clinically led

Professor Andrew Corbett-Nolan
Chief executive and senior partner, GGi
November 2026

GGi exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

www.good-governance.org.uk

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Summary

Every NHS trust and health board will tell you that it is clinically led, and most of them believe it. In my experience rather fewer actually are, and the difference between the two is not usually to be found at the board, nor in the executive team on its own, but in the middle of the organisation. It is in the clinical divisions, care groups and service groups where strategy is actually put into practice. This paper is about that tier and about the particular design of leadership that I believe makes it work. In outline, a Clinical Director, usually a senior doctor but in some services a senior nurse, midwife or allied health professional, leads a team of three with the nursing or allied health lead and the operational manager as a triumvirate. He or she owns the whole of the service's agenda rather than only the clinical part of it, reports, for the running of the service, to the chief operating officer and sits alongside the executive directors in the forum where the organisation is actually run.

I have written this paper for chairs, chief executives, chief operating officers, medical directors, chief nurses, non-executive directors and Clinical Directors in England, Wales and Scotland. Although it has the NHS in mind, much of what it says will apply to any healthcare organisation in which doctors, nurses and managers have to run a service together, in the independent sector and overseas as much as here. I have written it now because the NHS is asking more of its middle tier than at any point in my career. Advanced Foundation Trust status, integrated health organisation contracts and system working all take for granted a layer of leadership that can own quality, performance and money together. That layer does not come into being simply because a strategy says it should. Throughout, I have tried to be clear about which parts of the argument rest on research, which rest on my own judgement formed over nearly forty years of watching the NHS at close quarters and which are simply my view of what boards ought now to do. The paper ends with a checklist that a board can use to test its own arrangements, and with answers to the questions that boards most often put to me on this subject.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Key messages for NHS trust boards and health boards

- Healthcare providers succeed or fail in the middle. However much attention is paid to the board and however carefully the regulator's 'well-led' framework is applied, the tier that decides whether an NHS provider succeeds is the clinical division, care group or service group, because that is where strategy becomes the daily management of quality, access, workforce and money. It is in the middle that organisations most often fail without quite noticing why.
- The first task of the executive is therefore to create the conditions in which the middle can succeed, and in particular to persuade capable clinicians that leading at this tier is worthwhile, valued and properly supported. If they cannot be persuaded of that, the organisation will not succeed.
- The three people who lead a care group have to meet and work as a single team, led by the Clinical Director as *primus inter pares* (first among equals), a senior doctor in most acute services and a senior nurse, midwife or allied health professional where theirs is the profession that carries the service, with the nursing or allied health lead and the operational manager as full principals rather than advisers.
- Accountability for quality, performance, workforce and resources is shared among the three, but it is the Clinical Director who is held to account for the whole of it. If the design leaves the medical member free to stand aside from money, waiting times or operational performance then the care group and the organisation it is part of will not succeed.
- Within the care group the nursing or allied health lead and the operational manager report managerially to the Clinical Director, rather than separately to the chief nurse and the chief operating officer.
- The Clinical Director's principal managerial line runs to whichever executive holds operational accountability for the organisation, which will normally be the chief operating officer. Professional lines to the medical director and the chief nurse remain essential, but they should not be allowed to become a second operational hierarchy.
- One tier up, the Clinical Directors sit with the executive directors as members of a single management team for the NHS provider, chaired by the chief executive. That forum is the true executive. The unitary board then holds this group to account for the performance of the organisation.
- The evidence points consistently in one direction. A critical mass of clinicians, and of doctors in particular, on boards, executives and in senior management teams is associated with better quality ratings, lower mortality, better patient experience and lower infection rates. Authentic medical engagement is associated with stronger organisational performance. Where the model fails, as it sometimes does, it fails in practice rather than in design.
- Structure is necessary but it is not sufficient. Cardiff and Vale University Health Board has had the right architecture on paper since 2013 and was nonetheless placed in targeted intervention in 2025; the lesson of that episode concerns function rather than form.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

- The consultant body also has a collective voice, expressed through the medical staff committee, and that voice is part of the architecture of a clinically led organisation rather than an obstacle to it. A well-governed committee gives Clinical Directors a forum in which to test their proposals with their peers and gives the board a critical friend.
- Boards should test their own arrangements against the checklist at the end of this paper.

Introduction: my front-row seat and my two dogmas

I am in the last few years of a career in UK healthcare that began in 1987 and for most of that time I have been lucky enough to have an unusually good view of the question this paper addresses. Each decade has shown me the same problem from a different angle. In the 1980s I was an NHS strategic planner and spent my time writing plans whose effect depended on people I did not manage. In the 1990s I worked with clinicians nationally to set and promote better clinical service standards, running for seven years Health Services Accreditation, which was the national clinical service peer review programme that served as the NHS's own in-house accreditation system. That work meant seeing services as their peers saw them rather than as their boards described them and it showed me early on how wide the gap between the two can be. I then became a director at the King's Fund in the Health Quality Service, which was the main independent national healthcare accreditation service. In the 2000s I directed quality improvement programmes in both the UK and South Africa and learned, often the hard way, that improvement lasts only where clinicians in the middle of the organisation are willing to take ownership of service delivery. Since the 2010s my work has been the governance and board leadership of major NHS organisations, through GGi, which I founded in 2009 and which now undertakes well over a hundred governance reviews, board development programmes and investigations a year, more than half of them for NHS trusts and health boards in England, Wales and Scotland. Along the way I have worked in the NHS at local, regional and national levels, sat on public and third sector boards for more than 35 years (from the largest NHS trust in England to small community organisations) and held university posts in health and governance since 2004.

This career experience is not research, and I do not pretend that it is. What it has given me is the chance to watch, year after year and in one organisation after another, how the disciplines of quality and governance have been used to improve patient care, and how often they have not been, and to notice the same patterns of success and failure recurring in organisations each of which was convinced that its circumstances were unique.

There is a good deal about all this of which I remain uncertain. On two matters, however, my views have hardened over the years to the point of being dogmatic.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

The first is that, important though leadership at the top undoubtedly is, healthcare organisations actually succeed or fail in the middle. It is the people leading clinical divisions, care groups, specialties and sites who make the difference to the quality and humanity of patient care, who drive better performance and who see that resources are used well, and the job of the board and the executive is to create the conditions in which they can do so.

The second is that none of this will happen unless clinicians can be persuaded that stepping up to lead at this tier is worthwhile, that the job of Clinical Director is valued and professionally rewarding and makes a difference to patients. Authentic, credible clinical leadership is what makes the difference and it has to be designed for rather than simply hoped for.

I should be clear at the outset about the kind of argument this is. The research evidence, which I set out later, supports the general proposition that clinicians in senior leadership, and doctors in particular, are associated with better organisational performance, and that medical engagement is associated with better outcomes. The particular design I recommend, a triumvirate chaired by a Clinical Director who is accountable to the chief operating officer and who sits in the organisation's management team, is a matter of professional experience. That judgement rests on the evidence, on the practice of trusts and health boards that have adopted the design, and on a long acquaintance with the various ways in which the alternatives go wrong. Where I am describing what I think should happen rather than what does, I have tried to say so.

A note on terms: the care group, the Clinical Director and the triumvirate

The NHS has never settled on a single word for this tier of the organisation. English trusts talk of divisions, care groups, clinical groups, directorates and service groups; Welsh health boards of clinical boards and clinical care groups; Scottish boards of directorates and of services within an acute or a community division. Throughout this paper I use 'care group' to stand for all of them, meaning the unit of leadership, at whatever level the organisation has chosen to draw it, that carries a whole service together with its budget. The argument applies wherever that unit happens to sit.

Titles change with the tier as well. In many trusts the clinician who leads a clinical service unit, a single specialty or a small group of specialties is called a clinical director, while the clinician who leads the division or clinical group above it, which may contain several such units, is a divisional director or a chief of service, and may work alongside a managing director. In this paper 'Clinical Director', with capitals, means the clinician who leads the unit that carries a whole service and its budget, whichever tier that happens to be in a particular trust, and nothing in the argument turns on the title. I also use 'the care-group executive' for the small leadership team that runs the care group, and 'the executive' or 'the executive directors' for the directors who sit on the unitary board. The two are different things and I have tried to keep them distinct.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Two further points about words are needed before I begin. The first concerns the profession of the clinician in charge. In most acute services the Clinical Director will be a senior doctor, and much of this paper is written with that in mind, but the principle at stake is professional primacy over the work of the service rather than a medical monopoly of leadership. In community services, in therapies and in some mental health and children's services the profession that carries the service is nursing, midwifery or one of the allied health professions, and the same logic puts a senior nurse, midwife or allied health professional in the chair. Where I write 'doctor' or 'consultant' in what follows, the reader should take the argument to apply to whichever profession leads the service.

The second concerns the word 'triumvirate' itself. It has been pointed out to me, and I agree with this view, that it is an imperfect term. The team is not always three: obstetrics and gynaecology services, for instance, often have four, including a head or director of midwifery, and the word 'quadrumvirate' is occasionally heard. The label is also used loosely, for teams that do not in fact work as one. I have kept it because it is the term the NHS actually uses and the one most readers will recognise, but nothing in the argument depends on the number being three, and everything in it depends on the team working as one.

Why the middle is the decisive layer

A large NHS trust or a territorial health board is a multi-professional, multi-site organisation of a kind found almost nowhere else, and its strategy only becomes care, cost and culture when it is translated at the scale of a medicine care group, a surgery and cancer group, a women's and children's service or a local care organisation. That is the scale at which success or failure is decided in practice and there are three reasons why. The first is that the care group is the point at which professional and corporate authority have to be reconciled. Consultants, senior nurses, allied health professionals and general managers each have a legitimate claim on the service and unless they are bound together in a single executive arrangement they fall back, quite naturally, into parallel hierarchies, with medicine speaking to the medical director, nursing to the chief nurse and operations to the chief operating officer. It is patients who experience the gaps between them.

Consider a patient who is fit for discharge on a Friday afternoon. The consultant's job plan contains no ward round before Monday, the ward sister cannot release the bed without one, and the site manager, under pressure from the emergency department, escalates to the chief operating officer, who escalates to the medical director, who telephones the consultant. Three professional lines, each falling back on escalation because the processes that should have made escalation unnecessary were never put in place, have between them added three bed days, one avoidable complaint and a weekend of risk.

Had the care group been run as a single executive, the pattern of ward rounds would have been settled months earlier, because the three people with the authority to settle it would have been sitting in the same room looking at the same figures. Better still, the Clinical Director of the service concerned, with some support and coaching, would have settled it without the matter ever reaching the care-group executive, and that is the level at which a well-run organisation aims to resolve such things.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

The second reason is that the care group is where performance is actually generated. Waiting lists, agency spending, theatre utilisation, length of stay, complaints and patterns of serious incident rarely start as trust-wide problems; they start as care-group problems, which the board inherits later. A board that scrutinises its integrated performance report before the three people who run the relevant service have scrutinised it themselves, week in and week out, will struggle to understand what it is looking at.

The third is that the care group is the only level at which improvement can be owned rather than administered. Pathway redesign, disinvestment and the engagement of medical colleagues cannot be done to a care group from outside. They have to be led by people who understand how to make the service work better for patients and what the change will mean for their colleagues, and whose clinical credibility is enough to carry the consultant body with them.

Readers from outside the NHS may wonder why the consultant body keeps appearing in this argument. The reason is that hospital consultants are not line-managed in the way that senior staff in most organisations are. Each consultant carries a personal professional accountability for his or her own patients, works to a job plan that is agreed rather than imposed, and belongs to a profession whose internal hierarchy is flat and whose influence over what the organisation actually does is very large. Doctors cannot simply be instructed to redesign a pathway or to change the way they work. They have to be persuaded, and they are persuaded most readily by colleagues whose clinical judgement they respect. That is why clinical credibility matters so much in the leadership of the middle, and why the collective voice of the consultant body, which I come to later, has to be taken seriously by any board.

Leadership and management are both needed here and although they are often run together they are not the same thing. The Health Foundation's definitions serve well enough: management is the control, monitoring and organisation of people, processes and systems in order to achieve particular goals, while leadership is the business of influencing and inspiring others towards common goals and of setting direction. The Clinical Director's post demands both, the leadership that only clinical standing can supply and the management of a service costing many millions of pounds a year, and the organisation must equip the postholder to do the second as well as the first. Much of what follows is concerned with keeping the two distinct, and with the unfairness of asking a clinician to provide the first while withholding the means of doing the second.

None of this should come as a surprise to anyone familiar with the research on NHS middle management. The study led by David Buchanan for the National Institute for Health and Care Research (NIHR) showed that the official count of NHS 'managers and senior managers', at around 3% of employees, greatly understates the management task in hospitals. Once full-time managers were counted alongside staff in hybrid clinical and managerial roles, from ward sister to Clinical Director, more than 30% of the hospital workforce turned out to carry some managerial responsibility, and the hybrids outnumbered the full-time managers by about four to one. Most of them had received little or no management training, many rejected the description 'manager' altogether, and more than half of those surveyed considered their jobs unmanageable.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Yet it is with these people, and not with the 3%, that an organisation's capacity to implement change actually rests.

Mary Dixon-Woods and her colleagues, in the largest study yet made of culture and behaviour in the English NHS, found the same gap from the other side. They identified unclear goals, overlapping priorities that scattered attention, management that was bureaucratic and oriented towards compliance, and organisations that found it genuinely difficult to obtain any valid insight into the quality of the care they were providing, preferring, in the authors' phrase, comfort-seeking to problem-sensing. Robert Francis described the end of that road at Mid Staffordshire as a 'disengagement from managerial and leadership responsibilities', and that, in the end, is how an organisation comes to fail in the middle without noticing until it is too late.

The implication for governance is simple enough, although it is frequently missed. If the middle is badly designed or not bought in, no amount of initiative at board or programme level will rescue the organisation, whereas if it is well designed and clinicians step forward to take the lead then the board is freed to do what only a board can do, which is to settle purpose and risk appetite, to seek assurance and to hold a coherent executive to account.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

The model in outline

What follows is a description of what ought to be rather than an account of what often is. The arrangement is a demanding one, and the various imitations of it are easy enough to recognise once one knows what to look for. The table summarises the design, and the sections that follow explain and defend each part of it.

Who	Leads on	Accountable for	Reporting lines
Clinical Director (usually a senior doctor), leading the triumvirate as *primus inter pares*	Clinical priorities and medical engagement; pathway redesign; job planning; decisions to invest and to withdraw; the medical workforce of the care group	The whole care-group scorecard: quality, performance, workforce, finance and improvement.The named executive of the care group	Managerial: the chief operating officer, or the executive who holds operational accountability. Professional: the medical director
Nursing, midwifery or allied health lead	Fundamentals of care; staffing models; patient experience; safeguarding; infection prevention; improvement at the point of care	Shares the whole scorecard as a full principal	Managerial: the Clinical Director. Professional: the chief nurse or director of allied health professions
Operational (general) manager	Planning and the performance system; construction and tracking of the budget; capacity, flow and estate; the interface with corporate functions	Shares the whole scorecard as a full principal	Managerial: the Clinical Director. Finance, people and governance partners support the team; they are not a line

Some of the responsibilities in the table overlap, and deliberately so. Pathway redesign and improvement at the point of care, for instance, are things that either clinical leader has to be able to do, and the examples later in the paper show the roles being drawn differently in different organisations. The table describes the centre of gravity of each role rather than a strict division of labour.

Two further features complete the picture. The three leads meet as a standing care-group executive with a single scorecard and that meeting is the normal place in which the care group's decisions are taken. One tier up, the Clinical Directors sit with the executive directors in a single management team chaired by the chief executive. Where all of this is done in earnest, the character of the organisation's conversations changes and the provider becomes clinically led in the way it works in practice rather than just in the way it describes itself.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

This is, I should add, an argument about governance quite as much as about leadership. It considers what the published evidence will and will not support, looks at trusts and health boards that have already written some version of the design into their operating models, and sets out the questions that boards might reasonably put to themselves.

The clinician as *primus inter pares*

Good practice at care-group level places the Clinical Director as *primus inter pares* within a leadership team of three. I use the phrase to describe a post rather than a role played at a particular meeting: the Clinical Director is accountable for the care group and, when the trust or health board is directed as a whole, takes his or her place among its executives.

Within the care group the three leads share executive responsibility for quality, performance, workforce, finance and improvement and none of them is just an adviser to the others. A cabinet nevertheless needs a chair, someone to set the agenda, to keep the discussion to the point and to prevent three leaders from each delivering a separate monologue, and that is how collective responsibility is achieved in practice rather than in theory.

The line of sight that matters most, however, runs beyond the care-group meeting. The nursing or allied health lead and the operational manager report to the Clinical Director; the Clinical Director reports, as the manager of the care group, to the chief operating officer, and professionally to the medical director. When the organisation's senior team meets, with the executive directors joined at agreed intervals by the Clinical Directors, the Clinical Director is there as the person who holds accountability for that part of the organisation. The job, in other words, is to lead a care group within a clinically led organisation and not to chair a local trio that reports upwards when it is invited to.

A long pedigree

There is nothing novel in any of this. The decentralised clinical directorate was pioneered at Johns Hopkins in the 1970s, where clinical departments were run as accountable units with their own budgets under a physician head. It arrived in the NHS at Guy's Hospital in the mid-1980s in the wake of the Griffiths report of 1983, which brought consensus management to an end and asked, in its most quoted passage, who was actually in charge. From the early 1990s clinical directorates spread across the NHS, grouping specialties under a doctor who coordinated colleagues as first among equals rather than managing them in the way an industrial line manager would.

Primary care has worked to a version of the same design for longer still. The general practice partnership, and now the clinical director of a primary care network, rests on a working triumvirate of general practitioner, nurse and practice manager, and the former Health Education England programmes in the West Midlands were built on the premise that the three professions should be developed as one team, around one project, with a visible return.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Secondary care has been slow to learn a lesson that primary care has been teaching for some time.

Marie Thorne's 1997 study, Being a clinical director: first among equals or just a go-between?, remains the most precise account of the strain built into the role. The Clinical Director, she observed, occupies a 'clinical diamond' of competing loyalties, to patients, to consultant colleagues, to the executive and to the directorate as a managed entity.

Where the postholder is no more than a postman carrying messages between these constituencies, professional identity and collegiality both suffer and nobody owns the outcome; where the role is properly constituted and supported, the influence of medicine within the organisation grows, to the appreciable benefit of patients and of the organisation's effectiveness.

That is why the design of the system in which the role sits is something the board itself must sign up to. To appoint Clinical Directors without redrawing the reporting lines is to ask individuals to absorb a contradiction that the organisation has declined to resolve for itself.

The contribution of each member of the triumvirate

The Clinical Director chairs the team and provides its overall leadership. The post carries medical engagement, the setting of clinical priorities, pathway redesign, decisions to invest and to withdraw, professional standards and job planning, and it also carries professional accountability for the medical workforce of the care group, exercised with and through the medical director. The Clinical Director chairs the care-group management board, shares with colleagues responsibility for the whole of the service's scorecard, and is the named executive of the care group in its dealings with the chief operating officer.

The nursing, midwifery or allied health lead provides professional leadership for nursing and allied staff and for the fundamentals of care, staffing models, patient experience, safeguarding and infection prevention, as well as for improvement at the point of care; in many services this colleague is also the one who provides continuity when others move on. Where nursing, midwifery or allied health is the dominant profession, as it is in much of community services, in therapies and in some mental health and children's services, the same logic may well put that professional in the chair. The principle is one of professional primacy over the work of the service, not a medical monopoly of leadership.

The operational or general manager is responsible for the day-to-day running of the service: for planning and the performance system, for the construction and tracking of the budget, for estate, capacity and flow, and for the interface with the corporate functions. The task is to make execution possible once the clinical decisions have been taken. I should say plainly that this is not a judgement about competence. Many operational managers understand their services, and their patients, quite as well as anyone who works in them, and the Health Foundation is right to insist that a call for more clinical leadership is not a call for fewer or lesser managers.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

It is a judgement about where knowledge and authority sit. The decisions that drive cost and waiting times are clinical decisions, and the evidence set out later in this paper suggests that they are made better by people who are close to the detail of the service and its patients and who carry the authority to change clinical practice. The Clinical Director has both; the manager, however able, has neither in the same measure. That is why the design should not allow the manager to become, by default, the executive of the care group while the Clinical Director confines himself or herself to questions of quality. Confining senior doctors to quality is not a courtesy to them. It is damaging, because it tells them that the decisions that shape their service are taken elsewhere, and it is one of the surest ways of producing the disengagement that this paper is about.

The Health Foundation has observed that the leading academic medical centres in the United States run a similar triad at service level, though with a sharper division of labour, the non-clinical lead being tightly focused on finance and human resources while operational decisions about care rest almost wholly with clinicians who, for the most part, continue to practise. An NHS version of the model should be more professionally plural than that, for two reasons. The NHS relies on nursing, midwifery and the allied health professions to carry far more of the clinical work, and of the clinical leadership, than the American centres do, and in community, mental health and therapy services those professions rather than medicine are the backbone of the service. The professional accountability of nurses and allied health professionals to their own regulators and executive leads is also as real as that of doctors, so that a care group cannot own the whole of its scorecard unless those professions are full principals in its leadership. None of this makes it any less clear that the clinical chair, from whichever profession he or she comes, is the executive of the service.

Accountability for quality, performance and resources

We come now to the heart of my argument and to the point on which everything else depends.

It is worth saying first why quality, performance and money belong together rather than in separate hands. They are commonly spoken of as if they were in tension, and the structures of many trusts, with quality reporting through one executive and performance and money through another, assume that they are. In practice the tension is far smaller than it looks. Poor quality is expensive: harm, infection, delayed discharge, readmission, complaints and litigation all cost money as well as suffering, and most of the things that improve flow and reduce waiting also improve the experience and the outcomes of care. Where real trade-offs exist, and they do, they can only be made well by people who understand the clinical consequences of each option, which is to say by clinical leaders who are also accountable for the resources. Separating the three does not resolve the tension; it simply hands each part of it to someone who can see only one side.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Doctors retain a distinctive authority over the activity that drives cost and waiting times: over who is added to a list, in what order, along which pathway and for which procedure; over how job plans are used and over whether a particular service remains viable at all. If the Clinical Director is only permitted to chair the clinical discussion while leaving finance and performance to the general manager, two things follow at once. The manager is required to deliver figures over which he or she has no adequate control and the consultant body is, in effect, invited to regard corporate constraint as somebody else's difficulty. That division of labour is among the oldest structural failure modes in the NHS and it is the reason why the phrase 'clinically led' so often describes an organisation that is in truth merely clinically advised.

Thorne's 'go-between' is the postholder who carries the executive's requirements downwards and the consultants' objections upwards and is accountable for neither, and the distinction drawn by Gerry McGivern and colleagues, and taken up by the Health Foundation, between 'willing' and 'incidental' hybrids makes the same point in today's vocabulary. The willing hybrid uses the corporate machinery in the interests of all patients and not only of those in his or her own clinic, whereas the incidental hybrid takes on the role in order to defend a professional group. A structure that allows the medical member to step back from resources will inevitably produce incidental hybrids.

A question the King's Fund has posed in its work on medical leadership is useful here: after patients, whom does the clinical leader serve, colleagues or the wider system? A Clinical Director who does not own the budget will almost invariably serve colleagues, and one who owns only the budget is liable to be captured by the system. A Clinical Director who chairs and indeed leads a joint executive, to whom the nurse and the manager report, and who in turn reports to the chief operating officer, is obliged by the design itself to serve the service and, through it, the patients.

What this means in practice is that the Clinical Director's name sits on the quality account, on the care-group budget and on the performance trajectory. Job planning, premium pay, theatre utilisation and the transfer of activity to the independent sector become matters the Clinical Director leads rather than papers the general manager brings for 'clinical comment', and disinvestment becomes a conversation the Clinical Director has with the consultant body rather than a cost-improvement instruction issued by the finance department. When the care group is off course it is the chief operating officer who holds the Clinical Director to account, rather than a committee in which no one is individually responsible.

Two lines of accountability, not one confused line

Even good organisations confuse themselves when they fail to distinguish managerial from professional accountability and the distinction is worth setting out carefully.

The managerial line ought to be simple. For the running of the care group, the nursing or allied health lead and the operational manager report to the Clinical Director, the Clinical

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Director reports to the chief operating officer and the chief operating officer reports to the chief executive. That is the line of delivery for quality in the round, for access and flow, for the deployment of the workforce, for money and for improvement and it is the line that should appear in the scheme of delegation and on the accountability organogram.

This asks something of the chief operating officer, who has to be willing and able to hold Clinical Directors to account for quality as rigorously as for performance, and not every chief operating officer is naturally so inclined. Boards will rightly continue to look to the chief medical officer and the chief nurse for professional assurance on quality. The point is that assurance and management are different things: the professional executives assure the board that the professions and their standards are safe, while the chief operating officer's line is the one through which the service is actually managed.

The professional line is a different thing altogether, and it must be preserved at all costs. The Clinical Director has a professional relationship with the medical director in respect of General Medical Council standards, revalidation, medical education, consultant conduct and the consultant body as a profession. The care group's nurse, midwife or allied health lead has a corresponding relationship with the chief nurse or the director of allied health professions in respect of the standards of the Nursing and Midwifery Council and the Health and Care Professions Council, of safer staffing methodology and of the professional voice. The professional line is how the board is assured that the professions themselves are safe; it is not the means by which the care group is managed.
Leeds Teaching Hospitals has been unusually explicit about this distinction one tier further down. Its Head of Nursing is managerially accountable to the Clinical Director and professionally accountable to the Nurse Director (Operations), sits within the clinical service unit triumvirate and deputises for the Clinical Director, and the pattern deserves to be copied one level up. Work in NHS Scotland on professional assurance for nursing draws the same distinction at board level, with operational management running through the general management structure and professional accountability running to the executive nurse director. The mistake, in both cases, is to treat the professional line as though it were a second operational hierarchy.

Why the principal line should run to the chief operating officer

When Clinical Directors report to the medical director for the running of their care groups, three distortions tend to follow. The medical director becomes in effect a second chief operating officer, a role for which few medical directors have the time, the supporting systems or, in many cases, the inclination. Performance and money are drawn into a professional silo, leaving the chief operating officer to manage the consequences without authority over the people who produce them. And the medical Clinical Director is given a comfortable setting in which quality can be discussed without reference to operational or financial pressure.

A line to the chief operating officer has the opposite effect, because it places the Clinical Director in the forum where flow, capacity, winter pressures, money and system commitments are treated as real constraints that have to be managed, and in doing so it removes the opportunity to stand aside that I have just described.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

None of this diminishes the medical director or the chief nurse, whose professional authority is if anything clearer when it is not diluted by a second operational hierarchy. The medical director should be in a position to judge that a Clinical Director is not a safe professional leader and the chief operating officer should be in a position to judge that a Clinical Director is not running the service. Those are different judgements, and a board that runs them together is likely to end up with neither.

Objections and alternatives

Colleagues with whom I have debated this design raise two objections which both deserve a straight answer.

The first concerns span of control. If every Clinical Director reports to the chief operating officer, does the chief operating officer not end up with an impossible number of direct reports? In practice the reverse is true, because the chief operating officer holds the Clinical Directors and only the Clinical Directors; the directors of operations and the heads of nursing report within the care group rather than upwards. A trust with five or six care groups therefore gives its chief operating officer five or six accountable people, each carrying a whole service, instead of twelve or eighteen people each carrying a part of one. The number of care groups is itself a design decision, and the test is whether the chief operating officer can hold each Clinical Director to a serious monthly account. My own rule of thumb is that more than seven is a warning sign, since it usually means that the organisation has drawn its care groups too small or has not yet decided which of them are real.

The second is whether, in a clinically led organisation, the line ought instead to run to the chief medical officer, the chief nurse or the chief executive. The chief executive is the right answer in a small organisation and the wrong one in a large one, since a chief executive who personally holds six care groups, the executive directors and the system cannot also do the job of a chief executive. A deputy chief executive who carries operational accountability is a perfectly acceptable answer, and Barking, Havering and Redbridge, whose Clinical Directors report to a combined deputy chief executive and chief operating officer, shows the arrangement working. Some trusts are now trying something different again, routing the managerial line for their clinical groups through a clinical executive such as the chief nurse. That is a legitimate choice, provided the executive concerned is given the operational machinery and the time to hold the groups properly to account, and provided the board understands the risk it is running, which is that the professional line and the operational line become one and the same, so that the professional assurance the board needs on quality is given by the person who is also managing the service. The principle lies not in the title but in the requirement that the clinician who leads the service reports, for the running of that service, to the executive who is accountable for operations, and that this should be one person. The chief medical officer and the chief nurse are the professional line, and that is exactly why they should not also be the operational one; to make them so would simply recreate, one tier up, the parallel hierarchies that the design is intended to remove.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

One management team: Clinical Directors as full members, not attendees

If reporting lines put the care group in order, it is membership of the executive management team that puts the NHS provider itself in order.

A provider that is clinically led in more than name is one where the Clinical Directors sit with the executive directors in a single leadership forum chaired by the chief executive. Whether that forum is called the trust management executive, the health board management team or something else matters very little; what matters is that the Clinical Directors are full members of it, rather than being invited to attend for particular items.

Where the management group consists of the executive directors alone, the conversation can become dominated by corporate business: the forthcoming board agenda, the regulator, the latest letter from the system and the financial position. Care groups appear as items of performance, Clinical Directors are summoned to explain them, and the relationship is that of principal and agent, which is how everyone present understands it.

Where the same forum comprises both the executive directors and the Clinical Directors, the discussion changes in three ways. The unit of management becomes the service rather than the corporate function, so that winter pressure is no longer an operational problem with a clinical commentary attached but a discussion among the medicine Clinical Director, the urgent-care Clinical Director and the chief operating officer. The allocation of resources becomes a negotiation conducted in the open and grounded in clinical need, with decisions to invest and to withdraw taken among peers each of whom carries a service budget, rather than handed down to a care group that was not in the room when the choice was made. And the scope for professional veto by absence shrinks, because a doctor who is a member of the management team cannot reasonably describe its decisions afterwards as 'management's'. That still happens, of course, but it should not, and the organisation is entitled to say so; it is this, quite as much as any job description, that binds the Clinical Director to the whole of the agenda.

One caution is needed, because this is the point at which well-intentioned organisations confuse two different kinds of forum. The group I am describing is an executive management group; it is not the board, and non-executive directors do not sit on it.

NHS England's *Code of governance for NHS provider trusts* continues to require a unitary board that holds the executive to account, and bringing Clinical Directors into the management team strengthens that executive without replacing independent scrutiny or giving any Clinical Director a vote at the board table. A board that blurs the distinction will rightly be criticised for drawing those who are managed into the circle of those who hold them to account.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

The consultant body and medical staffing committees

The triumvirate and the management team are the executive architecture of a clinically led organisation, but they are not the whole of it, because doctors also have a collective voice that is quite separate from the line of management and a board that ignores this does so at its peril. In most trusts that voice is expressed through the medical staff committee, known variously as the medical advisory committee, the senior medical staff committee or the consultants' committee. Whatever it is called, it represents the consultant body as a whole, it is independent of management, and in many trusts it is also the body consulted on consultant appointments under the National Health Service (Appointment of Consultants) Regulations 1996, which apply to NHS trusts and which most foundation trusts follow as a matter of good practice. The medical director normally attends as an observer rather than as a member, which is what preserves the committee's independence. I set out the case for well-governed medical staff committees at more length in an earlier GGi paper and will not repeat it all here, but three points bear directly on the argument of this one.

The first is that the committee is not a management forum and must not be confused with one, nor with the local negotiating committee, which is a different body with a different purpose. The local negotiating committee is a formal negotiating forum between management and the recognised trade unions, principally the British Medical Association, on pay, terms and conditions, job plans and rotas, and what it agrees can bind the trust locally. The medical staff committee is a professional body whose advice is not binding and whose subject matter is clinical strategy, quality, safety and professional standards. Executives who expect it to behave like a negotiating committee, and consultants who try to use it as one, both damage it, and where the two are confused relationships sour quickly.

The second is that the committee is where the Clinical Director's leadership of the consultant body is tested in the open. The triumvirate takes its hard decisions into the consultant meeting of its own care group, and the medical staff committee is the organisation-wide counterpart of that meeting. A Clinical Director who has carried his or her colleagues through a difficult reconfiguration will find the committee supportive; one who has merely announced it will find the committee an obstacle, and that is as it should be. The committee is one of the few places in which the consent on which clinical leadership depends can be given or withheld collectively, and a board that wants its Clinical Directors to lead by consent should want the committee to be strong.

The third is that a well-governed committee is a critical friend to the board, while a poorly governed one becomes the focal point for organised dissent. Senior doctors are usually the first to notice unsustainable on-call patterns, delays in decision-making and the slow erosion of clinical standards under financial pressure, and a committee that is properly resourced, with protected time in job plans, administrative support and terms of reference that go beyond appointments, will bring those matters to the board early and in a form it can act on.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Where instead the committee is treated as a formality, its meetings poorly supported, its agenda consisting of little but appointments and its minutes never reaching the board, the result is predictable: disengagement among senior clinicians, late recognition of problems and, in the worst cases, open conflict between the consultant body and the executive of the kind seen at University Hospitals Birmingham in 2024 and at Barking, Havering and Redbridge in 2017. Those episodes were symptoms rather than the disease. The disease is often a failure to treat the consultant body as a mature partner in governance.

What follows for the model in this paper is simple enough. The Clinical Directors lead the consultant body within their care groups and the chief operating officer holds them to account for doing so; the medical staff committee gives that same body a collective and independent voice at the level of the organisation; and the board should expect to hear from the committee regularly, through a standing report from its chair, and should expect its Clinical Directors to be able to speak to that committee with an authority they have earned. The two reinforce each other. An organisation with strong Clinical Directors and a weak medical staff committee has clinical leadership without clinical consent, and an organisation with a strong committee and weak Clinical Directors has consent without leadership. Neither is clinically led.

Creating the conditions for success: the executive's job

By 'the executive' I mean the executive directors, most of whom also sit as full members of the unitary board. In most effective organisations they meet weekly, as a small group, with the chief executive, and in the model described here they are joined, ideally every other week and at least monthly, by the Clinical Directors as the NHS provider's main executive management forum. That larger meeting is where the organisation is steered, while the smaller weekly meeting remains the place in which the executive directors prepare for the board, deal with corporate business and hold one another to account.

A familiar difficulty arises when the Clinical Director role is weak. The executive directors inherit too wide a span of control, become absorbed in the day-to-day running of services that the middle of the organisation ought to be running, and end up managing downwards, at the cost of being insufficiently forward-looking, insufficiently outward-looking and insufficiently strategic. In a high-performing provider the executive understands that the organisation succeeds only if its middle succeeds, a point Lord Darzi's 2024 investigation into the NHS in England made at national scale when it called for investment in developing managerial talent and in 'creating the conditions for success'.

The executive's preoccupation, then, should be to create the strategic space in which care groups can do their work and to make the organisation a place in which triumvirates can be effective, which is quite a different job from running the wards by proxy, and one that applies whatever the organisation chooses to call its middle tier.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

The hardest part of that job is to make the Clinical Director post one that the most capable clinicians will actually accept. Doctors already have standing, income and a career that can be pursued almost entirely in practice, in research or in a specialty society. It is a simple fact of life that the organisation needs capable clinicians to take on the Clinical Director role a great deal more than those clinicians need that role. Most doctors who take the post also know that they will return to the ranks of their colleagues when it ends, and that knowledge deters them from decisions that would alienate the people they will shortly rejoin. The executive's task, therefore, is to make the post one that the best people will say yes to, confident that they will not come to regret it and knowing that they will be supported to succeed.

The Health Foundation's 2024 briefing is unambiguous on this point. Clinical leadership is associated with better quality, productivity and decision-making, and yet in some services leadership posts are 'poisoned chalices', taken on reluctantly and given up with relief, and filled because it is someone's turn rather than because anyone has shown an aptitude for the work. Helen Dickinson, Chris Ham and their colleagues had reached a similar conclusion a decade earlier, finding that structure did not of itself explain differences in performance but that medical engagement did. Engagement of that kind is not a sentiment; it is a judgement, made by people who could perfectly well walk away, that the organisation will actively support the work of leadership, and it is formed by circumstances within the executive's control. Five of those circumstances matter most.

- **Time:** two programmed activities (PAs) a week is a common allocation for a Clinical Director, and it is not enough. Set against a full clinical workload and with no deputy it produces not a part-time executive post but a correspondence job with a title. At least four PAs are needed, and six are better, together with a named deputy and a clinical job plan adjusted to match. The leading American centres treat service leadership as a career with parity of esteem alongside clinical practice and research, whereas the NHS still too often treats it as an adjunct to a clinical job.
- **Support:** a finance partner and a people partner need to be consistently involved in care-group meetings, and increasingly I see a governance partner as well, in place of each care group keeping its own governance resource; analytical support, protected development time and proper management training are not luxuries either. The NHS Leadership and Management Framework launched in July 2026, with its code of practice and its standards and competencies for clinical and non-clinical managers at every level, gives trusts for the first time a common professional architecture for the hybrid roles described here. It sets out what a manager should know and be, but it does not, and cannot, say where a manager's accountability should sit, and that remains a decision for each board.
- **Authority:** the authority of the role must match its title. A leadership team that cannot appoint to senior posts, move resources within the care group, discontinue a low-value pathway or take a concern about a consultant into the proper process is not an executive at all but a commenting group, and capable clinicians see this at once. They will not exchange the standing they already have at the bedside for a post that is leadership in name only. Thorne's go-between remains the warning here, for loyalties to patients, colleagues, the executive and the directorate cannot be carried by someone to whom the organisation has given none of the corresponding rights.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

- **Culture:** the culture around the post matters quite as much as the authority delegated to it. If consultant colleagues regard the Clinical Director as having gone over to 'the management', or to 'the dark side' in the phrase the King's Fund set out to retire in 2011, while the executive uses the postholder merely to relay unwelcome messages, the role will attract people who want to defend a specialty or to advance a career rather than people who want to lead the service for its patients. The willing hybrid, the clinician who uses the corporate machinery for the benefit of the service and those it treats, appears only where the executive is seen to back the difficult conversation and not to disappear when it becomes costly.
- **Career:** if the post is filled by rotation among the least unwilling, if tenure is too short to allow anyone to lead, and if there is no visible route from care-group leadership into a medical director or other senior role that values clinical credibility, then able people will not apply a second time. An executive that wants Clinical Directors of quality must treat the pipeline as part of its workforce planning rather than as a local matter for each care group to sort out for itself. The American centres studied by the Health Foundation recruit for character as well as for clinical standing, place new clinician managers on long-term development programmes with mentoring and coaching and protect the time this takes; to measure the success of clinical leadership by the number of clinicians who have been on a course is to mistake activity for effect.

None of this is an argument for executive directors doing the middle's work for it. It is, if anything, an argument against, since their span of control is too wide for that and the cost of managing downwards is the loss of strategy. What they should do, and what only they can do, is to construct an environment in which a clinician of standing can accept the post without abandoning his or her professionalism and can then be held to account for the whole of the service rather than for whichever part of it happens to be comfortable. The executive team's whole approach should be to give the middle of the organisation the best possible chance of succeeding.

What the evidence will support, and where more is needed

Boards are entitled to ask whether the argument of this paper rests on evidence or on preference informed by experience. The answer is that the evidence is convergent and sufficient to justify action, but that it does not take the form of a randomised comparison of one model against another, and I have tried below to be candid about where it is strong and where it is weaker.

The stronger findings

Clinicians in leadership roles are associated with better organisational performance. The association is strongest for doctors and it strengthens where they are present as a critical mass.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Gianluca Veronesi, Ian Kirkpatrick and Francesco Vallascas, drawing on three years of data from English acute trusts between 2006/7 and 2008/9, found that a higher proportion of clinicians on trust boards, and of doctors in particular, was associated with better regulatory quality ratings and with lower hospital standardised mortality ratios. At the time clinicians made up about a quarter of board members and doctors about 14%. Moving from the lower to the upper quartile in the share of doctors on the board, a rise of roughly ten percentage points, raised the predicted probability of a top quality rating by about seven percentage points, from 23% to 30%, and reduced the likelihood of the lowest ratings. The tests the authors ran to rule out reverse causation, the possibility that successful trusts simply recruit more doctors, held up. The same group has since reported positive associations with efficiency in the use of resources and with patient experience.

In 2023 Kirkpatrick, Ali Altanlar and Veronesi, using data from 2013 to 2017 and a quasi-experimental design, showed that a critical mass of medical leaders on the senior management teams of acute trusts was associated with better patient experience and lower rates of infection. That study looked at trusts' senior management teams rather than their boards, which is why it matters for this paper. A management team that includes the Clinical Directors is one way of creating the critical mass of medical leaders that the study describes, without changing the membership of the unitary board.

The international evidence points the same way. Amanda Goodall found that the highest-ranked hospitals in the United States were disproportionately led by physicians, and Thomas Tsai, Nicholas Bloom and their colleagues found that hospital board and management practices were strongly related to performance on clinical quality measures.

Tsai and his colleagues were looking at the quality of board and management practice in general rather than at doctors in particular, but their finding matters here because it shows that how a hospital is managed, and not only how it is resourced, is strongly related to its clinical results. Bloom's wider studies of management practice in healthcare found that organisations with more clinically trained managers recorded stronger management scores, that higher-performing hospitals gave those managers more autonomy, and that the NHS lagged other systems in the proportion of clinicians in management. Fabrizia Sarto and Veronesi, reviewing the literature in 2016, reached the same broad conclusion while noting how little work has examined why the association holds.

Medical engagement, as distinct from medical leadership, has an evidence base of its own, and the term needs defining because it is used loosely. Peter Spurgeon and his colleagues, who developed the Medical Engagement Scale, define it as the active and positive contribution of doctors, within their normal working roles, to maintaining and improving the performance of the organisation, which in turn recognises that contribution by supporting and encouraging high-quality care. It is a two-way relationship rather than a mood among doctors, and the scale measures it in three dimensions: whether doctors feel they work in an open culture, whether they have a sense of purpose and direction, and whether they feel valued and empowered. Spurgeon and colleagues, applying the scale across NHS secondary care organisations, found consistent and relatively strong associations between levels of medical engagement and independently gathered measures of organisational performance, a finding later extended to Care

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Quality Commission ratings and to Australian data. Dickinson, Ham, Iain Snelling and Spurgeon, in the NIHR study *Are we there yet?*, found that trusts with higher medical engagement performed better on the available organisational indicators than trusts with lower engagement, and that it was engagement rather than structure that explained the difference.

Justin Waring and colleagues, writing in *BMJ Leader* in 2023, examined what clinical leaders contribute to the governance of integrated care systems, and their answer deserves more space than a list. They found four distinct contributions. Clinical leaders bring analytical insight, which keeps strategy clinically intelligible and stops it drifting into abstraction. They bring representation, because a change that clinicians have visibly shaped carries a legitimacy with other clinicians that no amount of corporate communication can supply. They act as translators, turning the intentions of the system into the language and the priorities of clinical communities, and turning clinical concerns back into terms the system can act on. And they broker relationships across organisational boundaries, which in a system built on cooperation between organisations is a large part of what makes anything happen. Although the study was about systems, those four contributions describe rather well what a Clinical Director does inside a management team that treats him or her as a valued member rather than as an adviser.

Where the evidence is thinner

The evidence at board and senior management level is stronger than the evidence at care-group level, largely because clinical divisions have been studied much less and there is no large, clean trial of a collective triumvirate chaired by a Clinical Director against a directorate led by a general manager. Nor, it should be said, is there any evidence pointing the other way beyond custom and practice. The support for the model proposed here comes instead from four directions, and the point is that they converge.

The first is the evidence on engagement and critical mass set out above, which establishes that clinical authority exercised collectively within the management of the organisation is associated with better outcomes. The second is process evidence from case research, discussed in the next section, which shows that where the model fails it fails in practice rather than in design. The third is the logic of service-line management, where Monitor's guidance for foundation trusts and the King's Fund's 2012 evaluation both found that it delivers where clinicians own the service line's decisions and its data and stalls where they are kept at arm's length from either. The fourth is the practice of the high-performing academic medical centres in the United States, where the Health Foundation found clinicians holding almost all the operational decisions about care and a non-clinical lead with a deliberately narrow brief.

The claim this paper makes is accordingly a measured one. The weight of NHS practice and of independent evaluation points to this arrangement as the one most likely to produce clinical ownership of the whole agenda, provided that it is operated as a joint executive and not merely described as one, and in my judgement it is the best design currently available.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

A board that wants more certainty than that should add to the evidence, by running the model properly, measuring medical engagement and care-group performance before and after, and publishing the results. That is an invitation rather than a rhetorical flourish. There is a real opportunity for a longitudinal study in a trust that is implementing the model now, following medical engagement, care-group performance and the experience of the leadership teams over several years, and GGi would be glad to work with a trust and its clinical leaders to design and carry one out.

Where the model has already been developed

The examples that follow are not a list of exemplary trusts, and none of them is held up as having solved everything. Their purpose is more modest. Each element of the design described in this paper is already in use somewhere in the NHS, in England and in Wales, and in one case the design has been in place for more than a decade while the practice has fallen a long way short of it. Taken together they show that the model is not a theoretical construct, and they also show where its weak points lie.

The clinician as the executive of the service, with a line to the chief operating officer

Maidstone and Tunbridge Wells remains one of the clearest English examples of a clinically led provider. In 2018 its newly appointed chief executive, Miles Scott, who had come to Kent from St George's, led the trust to adopt a structure of divisions and directorates that was expressly described as clinically led. The Divisional Chief of Service reports to the chief operating officer and is accountable to the chief executive; Chiefs of Service carry overall responsibility for leadership and management within their division, including its annual plan and budget. Clinical Directors carry the same responsibility within their directorates, chair the directorate board of the triumvirate and report to the Chief of Service, typically with dedicated programmed activities and the support of a full-time general manager and a senior matron. The 2018 paper is explicit about two further points that boards usually leave unsaid. The executive 'engages with the triumvirate together as much as possible, reinforcing their shared responsibility for the Division as a whole', and the Chiefs of Service were to join the executive team's meetings routinely, with the agenda shortened and sharpened accordingly. Later public material states simply that the Chiefs of Service are members of the executive team.

Barking, Havering and Redbridge University Hospitals NHS Trust states the reporting line without ambiguity. Clinical Directors lead six clinical groups, each supported by a director of nursing or midwifery and a director of operations, and 'our Clinical Directors report into the Deputy CEO/COO'. A board looking for a sentence to put in its scheme of delegation could do a great deal worse than start there. Imperial College Healthcare NHS Trust takes the same approach in a large teaching trust: the directors of its three clinical divisions (medicine and integrated care; surgery and cancer; and women's, cardiac, clinical support and sexual health services) report to the chief operating officer and sit on the executive team itself.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Cardiff and Vale University Health Board is the most fully developed Welsh example, and the reason this paper is not an argument about English trusts alone. Seven Clinical Boards were established in 2013, each led by a Clinical Board Director with a director of operations and a director of nursing. The internal audit of the Surgery Clinical Board is explicit about how they are meant to work: the Clinical Board Director chairs, the directors of operations and nursing manage the business of the Clinical Board day to day, and the Clinical Board reports upwards to the health board through the chief operating officer, using the business assurance framework and monthly executive performance reviews.

The health board's own earlier account was that the Clinical Boards had provided strong leadership in clinical areas, had speeded up operational decision-making and were held to account by the executive directors. What has happened at Cardiff and Vale since is the subject of the next section, and it is a warning against mistaking design for delivery.

One management team

The same trusts show the second element of the design, the single management team. At Maidstone and Tunbridge Wells the Trust Management Executive was built from the five divisional triumvirates, the Clinical Directors and a number of trust-wide lead roles. In September 2024 Manchester University NHS Foundation Trust introduced six Clinical Groups in pursuit of a more consistent operating model across its hospitals, managed clinical services and local care organisations, and from that date the chief executives of the Clinical Groups joined the trust's executive directors on a Trust Leadership Team. The Trust Management Executive at the Royal United Hospitals Bath is constituted as the trust's most senior operational group, accountable to the board through the chief executive, and its membership comprises the executive directors together with the divisional directors, the divisional directors of operations and the divisional directors of nursing: one leadership forum, rather than an executive meeting followed by a briefing for the divisions. Sandwell and West Birmingham reconstituted its Clinical Leadership Executive as the Trust Management Committee, which it describes as a formal platform for major decision-making on clinical and non-clinical operations in support of the chief executive and the chief officers. I cite Sandwell for the way it has constituted the committee rather than as a judgement on its performance, which I have not examined; a trust that has chosen to build its management committee out of its clinical leadership executive has, at least on paper, understood the point.

Accountability for resources written into the role

The third element, that the clinical lead cannot stand aside from money, is written into the contract at Manchester. The operating model developed through 2024–25 treats a lead clinician as the single point of accountability for a care division or clinical service, leadership teams are generally structured as triumvirates, and the job descriptions for Clinical Directors record accountability for quality and safety, workforce, finance, and operational performance and activity. In Wales, Hywel Dda University Health Board issues budget accountability letters that run from the chief executive to the executive directors and on to the Clinical Care Group leads, who are required to sub-delegate in writing,

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

so that accountability for resources rests on a clinical group and not only on a corporate director. Aneurin Bevan University Health Board runs its services through divisional triumvirates that work to the chief operating officer and the executive committee.

Scotland

Scotland's territorial health boards combine acute and community services and, through their integration joint boards, a great deal of partnership activity. Acute services commonly sit under a chief officer for acute, with a medical director for acute alongside, and the distinction between professional and managerial accountability is already well established there for nursing and allied health. The opportunity is to apply the same reasoning to the clinical directors of services, with managerial reporting through the acute chief officer or the nearest equivalent of a chief operating officer, membership of the board's management team alongside the executive directors, and no lodging of operational accountability solely with the medical director. NHS Scotland's national architecture now includes a chief operating officer distinct from the chief executive and director general, so that delivery has a named operational line at national level, and the same instinct belongs inside each board.

The formulation that holds good in England, Wales and Scotland alike is therefore a simple one: the clinician who leads the service reports, for the running of that service, to the person accountable for operations, and sits with those who run the organisation.

Why implementation fails

Cardiff and Vale: the form was right and the function was not

In July 2025 the Welsh Government escalated Cardiff and Vale University Health Board to Level 4, targeted intervention, for the whole organisation, citing a growing financial deficit, concerns about quality, waiting times for planned care, and cultural and leadership problems. An independent assessment, commissioned by the Welsh Government through NHS Wales Performance and Improvement, led by two independent advisers, Dr Pamela Johnston and Professor Em Wilkinson-Brice, and published in August 2026, examined leadership, culture, governance, planning and organisational capacity. Significantly, the assessment did not recommend that the Clinical Board architecture be dismantled, nor did it suggest that a clinician should stop chairing or that the line of account through the chief operating officer was misconceived. Its criticism was of practice. Clinical governance at Clinical Board level was found to be poorly developed, risk management was inadequate and the Clinical Boards were not being held effectively to account; the boards were dominated by the financial narrative and had a weak grip on quality and safety, and not every board even had a quality lead. The organisation had recorded a run of never events, and the assessors described a culture of 'learned helplessness' in which staff were afraid to speak openly. The executive expected the Clinical Boards to hold their budgets, redesign their services and provide assurance, while the Clinical Boards felt that they lacked the autonomy to take decisions that crossed board boundaries or affected the organisation as a whole, and each, it seems, blamed the other.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

The episode is instructive precisely because the form was right and the function was not. A Clinical Board that exists on the organogram but does not meet as a joint executive with equal ownership of quality, performance and resources will reproduce the oldest split in the service, with medicine talking upwards through a professional channel, operations talking through money and nobody carrying the whole. Structure is a necessary condition, but it is not a sufficient one. Unless the three leads work as one team, unless the clinician in the chair is answerable for the whole scorecard, and unless the executive and the Clinical Boards behave as a single leadership system rather than as principal and agent, the model will continue to be described far more often than it is actually practised.

What the research says about failure

The research arrives at the same conclusion by another route. Dickinson, Ham and colleagues found that most of their case-study trusts had a doctor, a nurse and a general manager in each principal unit, yet many of the people they interviewed did not recognise the term 'triumvirate'. Those who did often reported that the arrangement existed formally while the relationship that actually ran the service was the pairing of medical leader and general manager. One exception convened a genuine weekly care-group triumvirate and used it as the ordinary place for resolving difficulty. Medical leaders, the authors concluded, continue to occupy a precarious middle ground between the executive and the consultant body, gaps in engagement with colleagues remain common, and the journey that began with the Griffiths report in 1983 is not yet complete.

The roles themselves are often poorly supported. The Health Foundation records clinical leadership posts taken on with reluctance and relinquished with relief, and the Messenger Review of 2022 was candid about the thinness of the training available to those moving into hybrid roles, a deficiency to which the new Leadership and Management Framework is in part a response. None of this counts as evidence against the model; what it explains is why the model fails, which is that a genuinely effective, collectively responsible team is a good deal rarer than the organogram suggests, and that it has to be built; it cannot simply be declared.

Nine deadly sins

I have observed over the years that the model fails in nine recognisable ways, most of them failures of design rather than of character.

1. The triumvirate exists in name but not in practice. The Clinical Director and the general manager hold the real authority, while nursing is treated as an adviser rather than as an equal leader.
2. Three dotted lines and no executive. The nurse reports to the chief nurse, the manager to the chief operating officer and the Clinical Director to the medical director, so that nobody is the executive of the service. The organogram looks mature, but accountability has been distributed to the point of disappearance.
3. Clinical Directors reporting to the medical director for operational purposes. The arrangement is professionally coherent and, in operational terms, a mistake.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

4. Clinical membership of the management team by invitation only. The conversation does not change, and the Clinical Directors remain in the position of having to explain themselves.
5. Accountability without the budget, which makes *primus inter pares* a matter of courtesy rather than of substance.
6. The incidental hybrid, who takes the role in order to protect a professional group. Cost improvement is resisted as a matter of principle, and improvement is then imposed from above.
7. Inadequate time and no deputy. Two programmed activities, a full clinic and no analytical support reduce the role to correspondence and escalation.
8. The insertion of a further layer, a hospital medical director or a group clinical director, without any rewriting of whom the chief operating officer holds to account. Accountability drifts upwards, and this is increasingly visible in group and multi-site structures.
9. The drawing of Clinical Directors into strategic and system meetings while the care group itself is left unmanaged. Contribution at system level that hollows out the care group is not system leadership; it is neglect under another description.

How the care-group triumvirate works in ordinary practice

The three leaders who run a care group keep one scorecard, an integrated performance report, rather than three. Quality, operations, workforce, finance and improvement appear on the same page and are owned by all three, and it is the Clinical Director who answers for them to the chief operating officer. Separate nursing, medical and performance packs that meet only in a slide prepared for the board are a reliable sign that this care-group executive has not yet formed.

The three meet as a standing triumvirate, and that meeting is the ordinary place in which the care group's decisions are taken; issues are brought there rather than settled in conversations between two of the three. The Clinical Director leads and chairs, the operational manager runs the performance system and the nursing or allied health lead runs standards of care and staffing, but all three own the resulting actions and when a difficult trade-off has to be made they take it together into the consultant meeting.

Decision rights match the description of the role so that the three can appoint to senior posts within the care group, move resources between its services, discontinue a low-value pathway and escalate a concern about a consultant's performance. A finance partner and a people partner sit with them and increasingly a governance partner too.

Above and separate from all this, the line from ward to board runs through four steps: specialty governance; the care-group governance just described; the trust or health board management team, in which the Clinical Directors sit with the executive directors; and the unitary board, with the committee structure that supports its more detailed assurance. GGi's guidance on clinical governance already describes that stack, and what it should now say plainly is that within the care group the Clinical Director is the managerial head of the three.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Seven questions that show whether the model is working

- Can the Clinical Director explain, in his or her own words, the care group's run-rate, agency spend and cost-improvement programme?
- Can the operational manager explain the last three serious incidents and the clinical standard that was missed?
- Can the nursing or allied health lead change a medical pathway, and not only a nursing rota?
- When the chief operating officer requires an account of the care group, is it the Clinical Director who is asked?
- When the management team meets with the chief executive, are the Clinical Directors members of the meeting or simply in attendance?
- When a difficult trade-off is required, do the three walk into the consultant meeting together?
- After that trade-off, can any of the three describe the decision as someone else's?

Each of these questions points to a different failure. If the first two cannot be answered, the scorecard is not shared and the triumvirate has divided the agenda between its members. If the nursing or allied health lead cannot change a medical pathway, nursing is an adviser rather than a principal. If the chief operating officer asks the general manager rather than the Clinical Director, the managerial line runs to the wrong person. If the Clinical Directors are only in attendance when the chief executive meets the management team, the organisation is clinically advised rather than clinically led. And if the three do not go into the consultant meeting together, or if any of them can afterwards describe the decision as someone else's, the medical member has been allowed to stand aside.

Integrated care systems, provider groups and professional plurality

It is no longer possible to describe the care group as though the free-standing trust of 2010 were the only relevant unit, and three developments bear on the argument. Integrated care systems need clinical leaders who can interpret and broker across a place, and the contributions identified by Waring and colleagues are real ones. The principle of subsidiarity still holds, however: the place at which the budget and the harm sit should be the place at which the joint executive sits, and system work that empties the care group of its leadership is no contribution to the system at all. The sharp reductions in integrated care board running costs since 2025 have thinned clinical leadership at system level, which makes the clinical leadership of providers' care groups more important rather than less.

Provider groups and shared boards need a care-group model that works within sites as well as across them. Shared chairs and shared chief executives are now common, but they do not relieve any board of the need to know whether, on this site, medicine has a Clinical Director who owns the whole agenda and reports to a chief operating officer able to hold that person to account.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

The same applies, with if anything more force, to the large multi-site trusts that run several hospitals and community services under a single board and executive. There the care groups are often large enough to be organisations in their own right, led by a clinician and run day to day by a managing director, and the question for the board is whether the clinical lead of each group is its executive or its figurehead, and whether the chief executive's management team is built from those groups or merely informed by them. As trusts seek Advanced Foundation Trust status and prepare for integrated health organisation contracts, the importance of a middle tier that can own quality, performance and money together will grow rather than diminish.

Professional plurality, finally, remains unfinished business. NHS England's *Clinical leadership: a framework for action* was written because allied health professionals, scientists, midwives, pharmacists and psychologists remain structurally disadvantaged on the path to strategic roles. The nursing and allied health seat in the triumvirate has to be a real one, and in some services the clinical chair need not be a doctor. The argument survives that variation perfectly well; what it will not survive is a doctor who chairs the clinical conversation and leaves its consequences to others.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Conclusion

I strongly believe that healthcare organisations succeed or fail in the middle and the case I have made in this paper comes down to a few propositions. Three leaders who do not meet and decide together are not a triumvirate, whatever their job titles may say. A structure that allows the medical member to leave the hard decisions about quality, performance and resources to others will, in the end, recreate the oldest division in the service, the one between doctors and managers. The professional lines to the medical director and the chief nurse are there to keep the professions safe and should be kept for that purpose, but it is the managerial line to the chief operating officer that makes the service properly accountable. Finally, a Clinical Director who attends the executive team only when invited is not part of it and cannot be expected to own its decisions, whereas one who is a full member cannot afterwards claim that a decision was somebody else's.

When the management team is made up of the executive directors and the Clinical Directors meeting with the chief executive as one group, the conversation at the centre of the organisation changes in character. Within the care group the Clinical Director is first among equals; in relation to the chief operating officer he or she is the named executive of the care group; and around the chief executive's table he or she is a colleague of the executive directors, with everything that implies.

I do not believe that clinical ownership of money and operations is a threat to professionalism. On the contrary, it is what makes professionalism effective in a system whose resources are limited. Clinical judgement about what patients need can only shape what the organisation does if the people exercising it also understand, and share responsibility for, the limits within which the organisation works; otherwise clinical judgement becomes a demand on others rather than a decision. Clinical ownership also gives doctors a real part in the difficult and important decisions that trust and health board leaderships take every day, instead of leaving them close enough to those decisions to influence them and far enough away to disown them. The board's part in all this is to design for it, to pay for it, and then to ask, in public, whether it has actually happened.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

A checklist for boards and health boards

Boards and health boards ought to be able to answer the following questions in public. If they cannot, the organisation is not clinically led, whatever its strategy may say.

Purpose and design

- Have we named the clinical division, care group or service group as the unit that succeeds or fails, rather than as a layer on an organogram?
- Does each such unit have a triumvirate of Clinical Director, nursing or allied health lead, and operational manager?
- Is the Clinical Director (in most acute services, a senior doctor) explicitly *primus inter pares* and chair of that team?

Accountability that cannot be set aside

- Is the Clinical Director named in the scheme of delegation as accountable for quality, performance, workforce, finance and improvement in that unit?
- Can we identify a recent decision on disinvestment, job planning or theatre utilisation that the Clinical Director led rather than annotated?
- When the unit is off course, does the chief operating officer hold the Clinical Director to account, or is it left to a committee in which no one is individually responsible?

Reporting lines

- Do the nursing or allied health lead and the operational manager report managerially to the Clinical Director?
- Does the Clinical Director's principal managerial line run to the chief operating officer, or to the executive who holds operational accountability, and from there to the chief executive?
- Are professional lines to the medical director and the chief nurse written separately, used for professional standards, and kept out of day-to-day operational command?
- Have we avoided placing operational Clinical Directors under the medical director?

One management team

- Do Clinical Directors sit as full members of the trust or health board management team alongside the executive directors, rather than attending only when invited?
- Does the chief executive chair that forum as one leadership team, rather than as an executive meeting that later briefs the care groups?
- Has the agenda of that forum been rebuilt around services, choices about resources and clinical risk, and not only around corporate reports?
- Are we clear that this forum is the executive management of the organisation, and that the unitary board remains the place of independent challenge?

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Time, support and appointment

- Is the Clinical Director given sufficient time (at least four programmed activities), a deputy, and finance and people partners?
- Are Clinical Directors appointed for clinical standing and for a willingness to work as hybrids, rather than by rotation among the least unwilling?
- Do we develop the three members of the team together, rather than as three individuals on three separate programmes?
- Are tenures long enough to lead and short enough to permit succession, typically around three years, with a visible pipeline?

Assurance and culture

- Do we measure medical engagement, and not only vacancy rates and friends-and-family scores?
- Can a non-executive director, in a deep-dive review, hear the three members of a triumvirate give a consistent account of money, harm and waits?
- When a hard choice is made, do the three take it together into the consultant meeting?
- In group, multi-site or health-board structures, is it still obvious which Clinical Director the chief operating officer holds to account for this service on this site?
- Does the medical staff committee, or its equivalent, have terms of reference that go beyond appointments, protected time for its officers and a standing route to the board, and is it treated as a critical friend rather than as a formality?

A board that cannot answer the questions on the scheme of delegation, on managerial reporting lines, on membership of the management team and on time in the affirmative does not yet have the model, however much it may have the language.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Questions boards and leadership teams commonly ask

The questions below are framed so that colleagues, and retrieval tools such as Ask GGi, can find a direct answer.

What is a clinical leadership triumvirate in the NHS?

A clinical leadership triumvirate, sometimes called a triad or a tripartite team, is the three-person executive of a clinical division, care group, directorate or service group (occasionally four, as in obstetrics and gynaecology, where a head or director of midwifery joins the team). It comprises a Clinical Director (or chief of service), a senior nursing, midwifery or allied health lead, and an operational or general manager. In the model described here the three share collective accountability for quality, performance, workforce, finance and improvement, and the Clinical Director chairs as *primus inter pares*.

What does *primus* inter pares mean for a Clinical Director?

Primus inter pares means first among equals. The Clinical Director is neither a medical monarch nor a professional adviser to a general manager. He or she chairs the triumvirate, sets the clinical frame, leads medical engagement, strategy, pathway redesign and disinvestment, and carries the same executive accountability as the two colleagues, and in relation to the rest of the organisation the Clinical Director is the named executive of the care group.

To whom should a Clinical Director report?

The Clinical Director's principal managerial line should run to the chief operating officer, or to whichever single executive holds operational accountability for the organisation, and through that executive to the chief executive. There should be a separate professional line to the medical director for professional standards, revalidation and the consultant body. Confusing the two lines is how organisations come to allow their medical leaders to stand aside from performance and resources.

Why not the medical director, or the chief executive?

Reporting to the medical director for operational purposes turns the medical director into a second chief operating officer, draws performance and money into a professional silo, and gives the Clinical Director a comfortable home in which quality is discussed without reference to operational or financial pressure. Reporting to the chief executive works in a small organisation but not in a large one, where the chief executive cannot personally hold six care groups and still do the job of a chief executive. A deputy chief executive with operational accountability is a sound alternative. The principle is that the line runs to one executive who is accountable for operations.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Does this give the chief operating officer too many direct reports?

No. Because the director of operations and the head of nursing report to the Clinical Director within the care group, the chief operating officer holds only the Clinical Directors, typically five to seven people each carrying a whole service, which is fewer accountable relationships than a structure in which every divisional director of operations and every head of nursing reports upwards separately.

Should the care-group nurse and the operational manager report to the Clinical Director?

For the running of the care group, yes. Managerial reporting of the nursing or allied health lead and the operational manager to the Clinical Director is what makes the Clinical Director the executive of the service. Professional reporting of the nurse to the chief nurse must remain, but it is not a substitute for the managerial line.

Why should Clinical Directors sit on the trust or health board management team?

Because that is how the organisation comes to be steered as one clinically led team rather than as an executive that summons care groups to explain themselves. When executive directors and Clinical Directors meet with the chief executive as members of one forum, choices about resources, winter, harm and money are argued out as service problems among peers. Clinical Directors who attend only by invitation are not members of the forum, and cannot be expected to own its decisions.

What is the role of the medical staff committee in a clinically led organisation?

The medical staff committee, also called the medical advisory committee, the senior medical staff committee or the consultants' committee, is the independent collective voice of the consultant body. It is distinct from the management line and from the local negotiating committee, which negotiates terms and conditions with the trade unions. In a clinically led organisation it is the organisation-wide counterpart of the care group's consultant meeting: the place where Clinical Directors' proposals are tested by their peers and where the board hears, through a standing report from the chair, what senior doctors are seeing. It should be properly resourced, with protected time and clear terms of reference, and treated as a critical friend rather than as a formality.

How much time does a Clinical Director need?

Two programmed activities a week is common and it is not sufficient. At least four are needed and six are better, with a named deputy, a finance partner, a people partner and analytical support. Leading American medical centres treat service leadership as a career with parity of esteem, and the NHS should stop treating it as an addition to a clinical job.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Is there evidence that clinically led care groups perform better?

There is substantial evidence that clinicians in senior leadership, and in particular a critical mass of doctors on boards and in senior management teams, are associated with better quality ratings, lower mortality, better patient experience and lower infection rates. There is good evidence that medical engagement is associated with stronger organisational performance, and case research showing that formal triumvirates fail where they are not operated as a joint executive. There is no trial that isolates this precise organogram, and no evidence to the contrary beyond custom and practice, so the case for action is convergent rather than experimental.

Does the model apply in Wales and Scotland as well as in English NHS trusts?

Yes. The titles change but the reasoning does not. Welsh health boards such as Cardiff and Vale already operate Clinical Boards chaired by a clinician, with operations and nursing managing daily business and an upward account through the chief operating officer. Scottish territorial boards can apply the same managerial line through the acute chief officer or the nearest equivalent of a chief operating officer while retaining professional lines to the medical director and the executive nurse director.

How does this sit with the unitary board?

The two are compatible provided the distinction is observed. The trust or health board management team is the executive running of the organisation, while the board remains a unitary board of executives and non-executives. Clinical Directors on the management team strengthen the executive that the board holds to account; they do not replace non-executive challenge.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

Sources and further reading

- Bohmer RMJ. Leading clinicians and clinicians leading. New England Journal of Medicine 2013; 368: 1468–1470.
- Buchanan DA, Denyer D, Jaina J, Kelliher C, Moore C, Parry E, Pilbeam C. How do they manage? A qualitative study of the realities of middle and front-line management work in health care. Health Services and Delivery Research 2013; 1(4). doi: 10.3310/hsdr01040.
- Cardiff and Vale University Health Board. Clinical Board structure; internal audit of Surgery Clinical Board governance arrangements; response to the Level 4 independent assessment report, August 2026. cavuhb.nhs.wales.
- Corbett-Nolan A. The case for well-governed medical staffing committees. GGi, November 2025. good-governance.org.uk.
- Darzi A. Independent investigation of the National Health Service in England. Department of Health and Social Care, September 2024.
- Department of Health and Social Care. Fit for the future: 10 Year Health Plan for England. July 2025.
- Dickinson H, Ham C, Snelling I, Spurgeon P. Are we there yet? Models of medical leadership and their effectiveness: an exploratory study. NIHR Service Delivery and Organisation programme, 2013.
- Dixon-Woods M, Baker R, Charles K, et al. Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. BMJ Quality & Safety 2014; 23(2): 106–115. doi: 10.1136/bmjqs-2013-001947.
- Dorgan S, Layton D, Bloom N, Homkes R, Sadun R, Van Reenen J. Management in healthcare: why good practice really matters. McKinsey & Company and LSE Centre for Economic Performance, 2010.
- Foot C, Sonola L, Maybin J, Naylor C. Service-line management: can it improve quality and efficiency? The King's Fund, 2012.
- Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Stationery Office, 2013.
- GGi. Clinical governance good practice; clinical governance committees and outcome-driven assurance; clinical and quality governance maturity matrices. good-governance.org.uk.
- Goodall AH. Physician-leaders and hospital performance: is there an association? Social Science & Medicine 2011; 73(4): 535–539.
- Griffiths R. NHS management inquiry. Department of Health and Social Security, 1983.
- Ham C, Clark J, Spurgeon P. Medical leadership: from dark side to centre stage. The King's Fund, 2011.
- Heyssel RM, Gaintner JR, Kues IW, Jones AA, Lipstein SH. Decentralized management in a teaching hospital. New England Journal of Medicine 1984; 310: 1477–1480.
- Jones B, Home J, Jones D. Strengthening clinical leadership and management: lessons from our research in the UK and US. The Health Foundation, September 2024. health.org.uk.
- Kirkpatrick I, Altanlar A, Veronesi G. Doctors in leadership roles: consequences for quality and safety. Public Money & Management 2024; 44(6): 515–522 (published online June 2023). doi: 10.1080/09540962.2023.2217344.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

- Leeds Teaching Hospitals NHS Trust. Head of Nursing job descriptions, clinical service unit triumvirate accountabilities.
- Maidstone and Tunbridge Wells NHS Trust. Developing a more clinically led organisation, 2018; subsequent public descriptions of Chiefs of Service as members of the executive team.
- McGivern G, Currie G, Ferlie E, Fitzgerald L, Waring J. Hybrid manager–professionals' identity work: the maintenance and hybridization of medical professionalism in managerial contexts. Public Administration 2015; 93(2): 412–432.
- Messenger G, Pollard L. Leadership for a collaborative and inclusive future: health and social care review. Department of Health and Social Care, June 2022.
- Monitor. Service-line management: an introduction for NHS foundation trusts, and the accompanying how-to guides, 2009.
- National Health Service (Appointment of Consultants) Regulations 1996 (as amended).
- NHS England. Clinical leadership: a framework for action, 2019.
- NHS England. Code of governance for NHS provider trusts, 2022 (effective from April 2023).
- NHS England and NHS College of Leadership and Management. NHS Leadership and Management Framework: code of practice, standards and competencies. Launched 6 July 2026. lmframework.leadershipacademy.nhs.uk.
- NHS Wales Performance and Improvement. Independent assessment of Cardiff and Vale University Health Board, published 7 August 2026; Welsh Government written statements of 15 July 2025 and 7 August 2026 on escalation and intervention arrangements. gov.wales.
- Sarto F, Veronesi G. Clinical leadership and hospital performance: assessing the evidence base. BMC Health Services Research 2016; 16(Suppl 2): 169.
- Spurgeon P, Mazelan PM, Barwell F. Medical engagement: a crucial underpinning to organizational performance. Health Services Management Research 2011; 24(3): 114–120. doi: 10.1258/hsmr.2011.011006.
- Spurgeon P, Long P, Clark J, Daly F. Do we need medical leadership or medical engagement? Leadership in Health Services 2015; 28(3): 173–184.
- Thorne ML. Being a clinical director: first among equals or just a go-between? Health Services Management Research 1997; 10(4): 205–215.
- Tsai TC, Jha AK, Gawande AA, Huckman RS, Bloom N, Sadun R. Hospital board and management practices are strongly related to hospital performance on clinical quality metrics. Health Affairs 2015; 34(8): 1304–1311.
- Veronesi G, Kirkpatrick I, Vallascas F. Clinicians on the board: what difference does it make? Social Science & Medicine 2013; 77: 147–155. doi: 10.1016/j.socscimed.2012.11.019.
- Veronesi G, Kirkpatrick I, Vallascas F. Does clinical management improve efficiency? Evidence from the English National Health Service. Public Money & Management 2014; 34(1): 35–42.
- Veronesi G, Kirkpatrick I, Altanlar A. Clinical leadership and the changing governance of public hospitals: implications for patient experience. Public Administration 2015; 93(4): 1031–1048.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

- Waring J, Bishop S, Black G, Clarke J, Roe B. What can clinical leaders contribute to the governance of integrated care systems? BMJ Leader 2023; 7(4). doi: 10.1136/leader-2022-000709.
- Public descriptions of executive and clinical group structures: Imperial College Healthcare NHS Trust; Barking, Havering and Redbridge University Hospitals NHS Trust; Manchester University NHS Foundation Trust (Clinical Groups, September 2024); Royal United Hospitals Bath NHS Foundation Trust (Trust Management Executive); Sandwell and West Birmingham NHS Trust (Trust Management Committee); Aneurin Bevan University Health Board; Hywel Dda University Health Board.

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0

About this paper and the author

This paper is written for chairs, chief executives, chief operating officers, medical directors, chief nurses, Clinical Directors and non-executive directors who want the middle of their organisation to be governable. It is intended to stand on its own for readers and to be usable by GGi's Ask GGi retrieval system. Comments, and counter-examples from trusts and health boards that have made the model work or have watched it fail, are welcome. I am grateful to Dr Alistair Craig and to Dr Rafik Bedair, both of the Northern Care Alliance NHS Foundation Trust, for their close reading of earlier drafts and for their very helpful challenges and comments, which have improved the paper considerably. The opinions that remain, and any errors, are mine.

Professor Andrew Corbett-Nolan is Chief Executive and Senior Partner of GGi, which he founded in 2009, and a Visiting Professor at the Institute of Health, University of Cumbria. He has worked in UK healthcare since 1987 at local, regional and national levels: as a strategy planner in the 1980s; in the 1990s with clinicians nationally on clinical service standards, running for seven years Health Services Accreditation, the NHS's national clinical service peer review programme, before becoming a director at the King's Fund (Health Quality Service); in the 2000s directing quality improvement programmes; and since 2010, through GGi, on the governance and board leadership of major NHS organisations. He has sat on public and third sector boards for more than 35 years and is a Salzburg Global Fellow.

Professor Andrew Corbett-Nolan
Chief Executive and Senior Partner, GGi.

November 2026

© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0



© GGI Development and Research LLP 2026. All rights reserved.
ISBN 978-1-907610-79-0