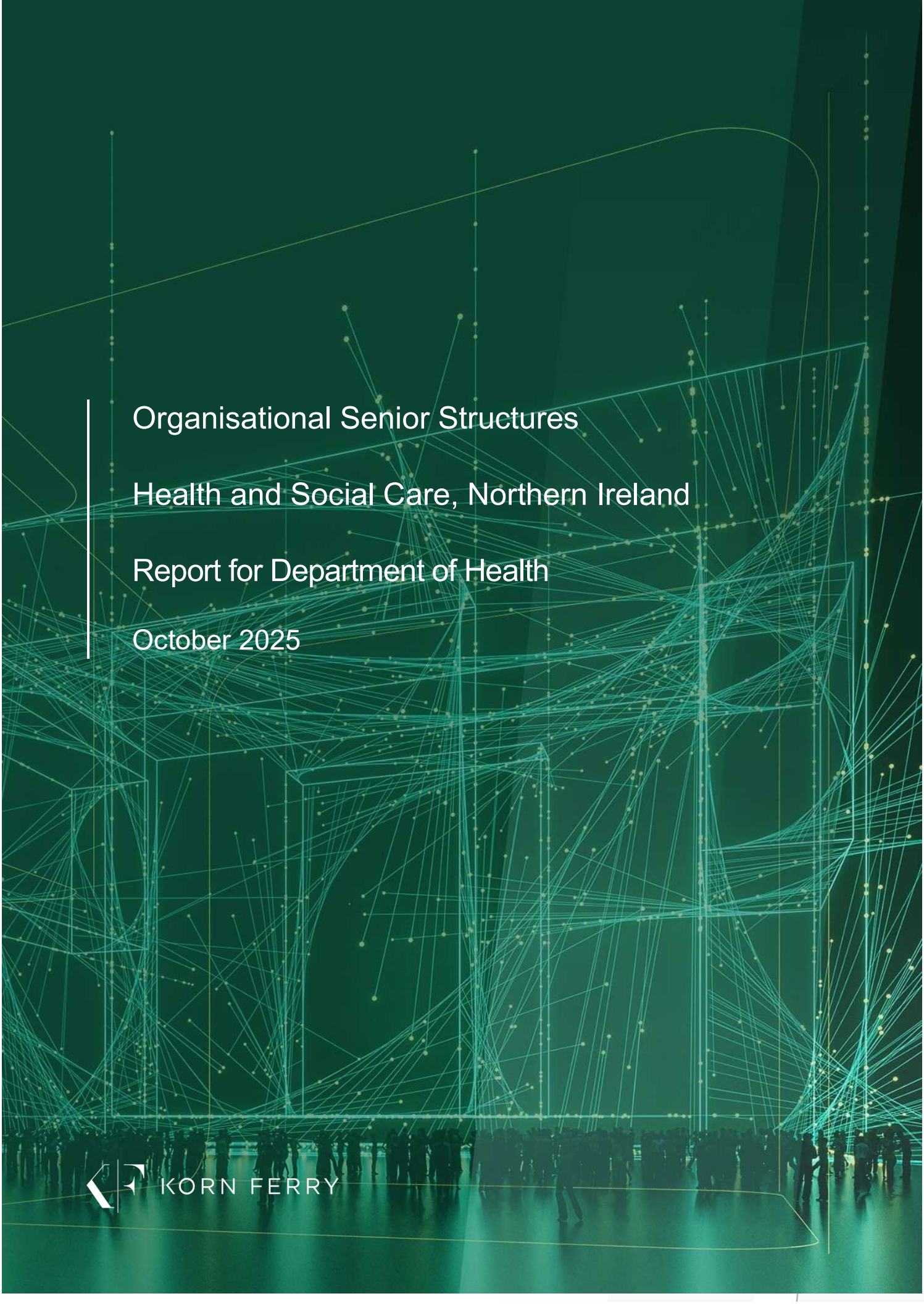

Organisational Senior Structures

Health and Social Care, Northern Ireland

Report for Department of Health

October 2025

KORN FERRY

Executive Summary

- This report is a companion report to the Job Evaluation review that Korn Ferry were asked to complete and it provides commentary on current/desired structures across Northern Ireland Health and Social Care organisations.
- This commentary is based upon our view of spans of control/job sizes and comparative data from the NHS and wider public sector across England, Wales and Scotland.
- This report provides advice and commentary and any decisions are a matter for the Department.
- The main source of understanding of the roles and structures is from the job evaluation exercise we undertook in 2025 as well as information gathered in context calls with Chief Executives and Chairs.
- The report initially looks at trust structures and spans of control. In the majority of the Trusts the Chief Executives have 10 or more direct reports. A span of control of more than 1 in 8 is ineffective and inefficient and will result in the Chief Executive being drawn into operational and implementation issues.
- The report also looks at Chief Executive succession. With the exception of Northern, the smaller trusts do not have obvious successors because responsibilities and accountabilities are heavily subdivided across a number of roles.
- The title of Deputy Chief Executive will typically only influence job size when they have a portfolio of accountabilities that are broad and weighty enough to bring the role closer to the Chief Executive in evaluation terms.
- Succession planning across the system is another matter for consideration and there may be an opportunity to manage careers between organisations.
- Korn Ferry observes that managing aspects of performance at regional and system levels would support the integration and collaboration agenda.
- The newly formed Committee in Common is an advisory group only currently and it is too early to comment on its impact. In England we have seen a range of collaboratives and a board in common aligns governance across the organisations to make sure they can work effectively.
- The report comments that there are multiple small arm’s length organisations where the Chief Executives are the only senior executive roles and consequently, they feel more exposed due to autonomous decision making. Korn Ferry observes that in Northern Ireland there are more agencies than in any of England, Wales and Scotland, However, it is beyond the scope of the study to suggest changes to the number and accountabilities of the organisations.
- Korn Ferry suggest that there is merit in considering whether a model that organises mental health regionally for all 1.9 million of the population could give great integration. However, this requires significant research and evidence if such a change was to be proposed and is beyond the scope of the study.
- The report shares examples and insights from across the UK. In the NHS in England, we typically see narrower spans of control, with a top structure of more like 1:8 to ensure that the Chief Executive and major board figures have time and space to look outward, to partners and the broader health and social care system. In local authorities and higher education, we have also seen a reduction in the size of executive teams as services and functions have become integrated.

- The Executive population is not static and will change to reflect the view of Chief Executive's and the demands/expectations on the system. There is a need for the Department to define an approach to future evaluations and consideration of relativities that recognises the dynamic nature of change, and the role of organisations and stakeholders in influencing and governing that.

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Introduction

This is a companion to the outputs of the Job Evaluation review Korn Ferry was asked to complete – where all current senior executive jobs (July 2025) were evaluated to confirm job sizes and relativities.

KF were also commissioned to provide external advice about senior organisational structures, drawing on a desk-based review of current arrangements. This report provides commentary on the current/desired structures and makes recommendations based on the information gathered in our job evaluation work across the system and the various calls, meetings and documents engaged with and reviewed. This commentary is based upon our view of spans of control/job sizes and comparative data from the NHS and wider public sector across England, Wales and Scotland.

There are significant changes coming across health and social care in the coming years/decades - not least the push to move from analogue to digital systems, hospital-based care to community based (supported by technology) and from a focus on sickness to greater prevention and early detection/diagnosis. This will undoubtedly impact the remit of Executive roles across the Northern Ireland system in ways that are not yet clear but may change the size and shape of the organisations and senior roles required to lead across the health and social care of the population. The Department will want to stay alert to the potential impacts of changes on evaluation of these roles, and to regularly review how this is showing up/impacting for this population and the need to maintain active consideration of relativities and evaluations at whole system level.

Trust Structures

Each of the Trusts are broad and wide-ranging organisations, and there have been different approaches over the years to creating a resilient senior structure with ‘do-able’ jobs. Even with the current focus on creating roles concentrated on functional groupings, this is challenging enough, and in our experience, this has been even messier in the Northern Ireland system because of the link to ongoing challenges around pay for senior roles.

This has resulted in three of the four smaller Health and Social Care Trusts (excluding Belfast) taking a similar design approach, leading to spans of control for the Chief Executive Officer of 1 to 10. In Belfast, the functional/clinical groupings are similar but with more roles, and the Chief Executive’s span of control is 1 to 16 (including one role that is not part of the senior executive population). The Northern Trust has adopted a different approach with the creation of a Chief Operating Officer (COO) role/model with Divisional Directors reporting here, resulting in a 1 to 6 span of control.

Korn Ferry’s experience and advice is that a span of control of 1 to 8 or beyond is ineffective and inefficient – resulting in significant challenges for the Chief Executive relating to less strategic focus and being drawn into operational and implementation issues. If there are too many direct reports, it will place a heavy demand on the Chief Executive and will reduce the amount of time they can spend engaging externally and working across the system.

Chief Executive Succession

Another consequence of the number of direct reports and a significant challenge in the current structures (both in the Trusts and more widely across the system) relates to succession.

One critical aspect of the operation of the Korn Ferry Hay Guide Chart and Profile Method of Job Evaluation is to allow evaluators to consider and reflect on the meaning and interpretation of size

differences between roles, NOT JUST the job size number or grade. This is reflected in the scoring system within the Method and relates to the ‘step difference’ principle and its interpretation. The ‘step difference’ principle describes the size of the gaps between jobs and how easy it is likely to be to bridge the gaps. Appendix 1 provides further information on the operation of the step difference principle in job evaluation and its implications for this senior population.

Based on the step difference principle, we observe that there is a clear route for succession to the Chief Executive Belfast role from Chief Executive in one of the smaller Trusts. We understand that this has indeed been the succession route of the newly appointed Chief Executive of Belfast. It is less clear what the succession routes to smaller Trust Chief Executive roles are because of the significant gap (step difference) between these Chief Executive roles and their direct reports because the responsibilities and accountabilities are more heavily subdivided across a number of roles.

With the exception of Northern, the other Trusts all have a three step (or more) gap between the Chief Executive and their direct reports. This suggests that none of the direct reports has the scope or breadth to be considered as easily promotable to the Chief Executive without significant training and development. A smaller gap of two steps (two grades) would be easier to bridge and is considered to be a fairly typical promotion. Therefore, the creation of the COO role in Northern (which is two steps below the Chief Executive) suggests that there is a more natural succession route/option to Chief Executive. COO roles are common across the English NHS system, and often have accountability for pulling together clinical expertise and delivery, and provide one pathway for career growth and create differentiation of job levels and opportunities for lateral and diagonal career moves.

Korn Ferry understand that there is a potential concern for the Northern Trust that their Divisional Director roles are becoming/could become a succession/feeder/training/development role to Director level roles at a higher grade across the smaller Trust system. This will be an issue for the incoming Chief Executive of Northern to consider, with a suggestion that if other Trusts remain with their structures as is, then Northern may move to revert to the Chief Executive having a larger span of control in order to ensure their approach is sustainable and doesn’t present such a risk to retaining talent within their senior structures. We have already commented the risks associated with having too many direct reports (more than 1:8) and the structures typically seen in the English NHS system have evolved to avoid this.

Deputy Chief Executive

In and of itself labelling a role as Deputy Chief Executive doesn't mean anything at all. Whilst there are very few roles currently in the system labelled that way, it was a point of discussion with some Chief Executives. The label Deputy might mean that this is the role that is ‘in charge’ when the Chief Executive is away – a ‘first among equals’ kind of responsibility. This alone rarely makes a difference to job size as we also assume that the Chief Executive would be likely to avoid absence when there are major decisions to be made.

But the term Deputy Chief Executive can mean much more where the accountabilities of that role are grouped together to create a portfolio of accountabilities that are broader and weighty enough to bring the role closer to the Chief Executive in evaluation terms. And in the English NHS system, we do see large roles leading collaborations and cross agency initiatives described as Deputy Chief Executive. Often where there is a COO role, this is automatically seen as the formal Deputy Chief Executive and a natural successor to the Chief Executive because the combination of accountabilities in that role that describe it as a weighty enough role to lead the work of the Chief Executive (if they are away for some time) without that interfering with the work of the wider senior team.

With spans of control of 1 to 10 or greater it is hard to see that the term Deputy can be used to add up to a weighty portfolio because of the subdivision of responsibilities across the direct reports to the Chief Executive.

The Department will need to take account of the impact of the current and changing pay and reward policies on creating incentives to shape structures in particular ways.

We have shared some examples and insights from across the UK later in this report (Page 9).

Succession Planning Across the System

In addition to the commentary above on succession within and across Trusts, Korn Ferry suggest that there are no clear routes of succession into, through and beyond the health and social care system. Where do senior leaders come from and what are the opportunities for Directors to move between Trusts and other health and social care organisations?

With some 90 roles in this senior population (of some 80+ thousand employees in health and social care) could this be an opportunity for the Department to work with the current and aspiring senior population to manage their careers across the system.

This would ensure that there are promotion opportunities for senior staff across all of the different types of organisation, and ensure that there is a pipeline of talent and workforce planning in support of this critical population of roles.

Performance Management

While Korn Ferry recognise that there are individual, team and organisational performance management approaches, it seems sensible to ensure that some aspects of the performance of health and social care for the 1.9 million population of Northern Ireland are arranged at a regional and system level – for example, waiting lists, hospital discharge, recruitment of specialist clinicians – as this would support the integration and collaboration agenda and ensure that agendas work in support of the greater system aims and objectives.

Committee in Common

Korn Ferry understand that the recently created Committee in Common consists of core members from the Trusts and Northern Ireland Ambulance Services (NIAS), with Business Services Organisation (BSO) and Public Health Agency (PHA) invited to attend. The Committee in Common will support a move towards regional/system level working. However, it is not yet clear what the arrangements and impact of this way of working will be. Currently it is an advisory group without decision making powers, which differs from the approach we typically seen in England.

In England collective decision making is often delegated to Committees in Common to support collaborative decision making and efficiency. Following the Health and Care Act in 2022, committees in common have been a preferred governance model for Integrated Care Systems and have enabled NHS trusts, foundation trusts and local authorities to jointly exercise statutory functions. We have seen a range of arrangements of multi-Trust efforts to bring services together to deliver improvement and integration. All trusts providing acute health services are required to be part of one or more provider collaboratives as part of new ways of working across health and care in England. Collaboratives may support the work of other collaborations including clinical networks, cancer alliances and clinical support service networks. Providers have an active and strong leadership role to play in system and place-based partnerships, provider collaboratives, and the wider health and care system, collaborating with both NHS partners and others such as local

authorities, to use resources in the best way for all patients, and develop consistently high-quality services.

In particular, acute provider collaboratives are intended to deliver: reductions in unwarranted variation in outcomes and access to services, reductions in health inequalities, greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures, better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans, consolidation of low-volume or specialised services, efficiencies and economies of scale. A board in common aligns governance across these organisations to make sure they work as effectively as they can – separately and collectively - for the population of a larger area. Korn Ferry are seeing a number of senior executive roles created which operate at the level of the provider collaborative with a matrix of direct and indirect leadership at the level of each Trust.

Arms Length Bodies/Ambulance Service/Other Organisations

The recent job evaluation exercise completed by Korn Ferry confirmed that there are a number of very small arm's length organisations with discrete functions. The Department will want to consider the ways in which these roles are engaged with the challenges and changes required across the system.

As highlighted above, the succession routes into and out of senior roles in these organisations is not clear to Korn Ferry – and in several cases the Chief Executive Officer is the only role in the organisation that is a member of the senior executive population. Korn Ferry recognise that in these situations the Chief Executive role can feel like they are making decisions more autonomously and it can feel like a more exposed role because of that. Statutory responsibilities reside solely with the Chief Executive and there is a feeling that they are subject to high public scrutiny. In most cases, the nature and scale of the organisation means that it is very unlikely that there would be room for any senior executive roles (being a part of this Department population) to report into these roles.

The Table below (Table 1) is a high-level and only partially complete comparison of the subdivision of responsibilities across different bodies in the systems in Northern Ireland, England, Wales and Scotland and shows that the leadership responsibilities subdivided across seven organisations in Northern Ireland are undertaken in potentially smaller numbers of organisations in England/ Wales and Scotland respectively. This may be part of the future and wider consideration of the Health and Social Care system for the 1.9m population of Northern Ireland that goes beyond the remit of this commission.

Table 1: Subdivision of responsibilities across different bodies in the systems across the UK

Organisation focus	Health & Social Care Northern Ireland	NHS Scotland	NHS England	NHS Wales
Blood Transfusion	NIBTS	Part of National Shared Services	NHS Blood & Transplant	Velindre University NHS Trust.
Medical & Dental Training and Education	NIMDTA	Part of NHS Education	Health Education England	Health Education & Improvement Wales
Regulation, Quality & Improvement	RQIA	HIS and regulation of social care by SSSC	Care Quality Commission, NHS England	Health Education & Improvement Wales
Public Health	PHA	Public Health Scotland	UK Health Security Agency/Department of Health & Social Care/ Local Government	Public Health Wales
Nursing & Midwifery professional education	NIPEC	Part of HIS	NHS England	Health Education & Improvement Wales
independently represent the interests of the Public in Health and Social Care	Patient and Client Council	Part of HIS and other advocacy initiatives	NHS England's Patient and Public Voice Assurance Group (PPV AG)	Citizen Voice Body (CVB)
regulating workforce standards and promoting continuous training and learning	Social Care Council	SSSC/NHS Education Scotland	Various	Social Care Wales

Suggesting changes to the number and accountabilities of organisations goes beyond the scope of this piece of work and the Department will want to reflect on how to most effectively ensure that the objectives and accountabilities of these organisations are integrated and aligned to the wider direction of change across the system – and that the potential impact of these 'smaller' organisations across the system is recognised.

Mental Health Strategy and Services

The locality focus model that Northern Ireland currently have where all mental health services are embraced through each Trust has been created to bring integration of these critical services for the population. Mental health requires distinct clinical expertise and governance and nuanced care for complex conditions. There are risks of too much segmentation and disconnection in the leadership across (at least) five organisations, and very strong mechanisms for lateral connection between individuals, services and organisations is needed. The locality focus can also make recruitment difficult in some locations due to limited scope for progression in each location.

Korn Ferry suggest that there is merit in considering whether a model that sees mental health organisation regionally for all 1.9 million of the population could give great integration. However, this requires significant research and evidence if such a change was to be proposed. We recognise that this goes beyond the scope of this piece of work.

Insights from wider UK Public Sector

These notes look briefly at common structures and models of organisation in the NHS, local government and higher education.

Hospital trusts in England

Clearly, the subject coverage of these differs from the model in Northern Ireland. Trusts deliver hospital services and sometimes community healthcare; mental health is mostly handled by separate trusts and social care is largely a matter for local government. They are nonetheless large organisations – at the top end, Guy's & St Thomas' and University Hospitals Manchester both have income in excess of £3 billion.

Hospital trusts must have a Chief Finance Officer, a Chief Medical Officer and a Chief Nurse on the board. Larger trusts, which are often also multi-site, commonly also have a Chief Operating Officer, responsible for all the clinical directorates/divisions. Any of these four – Finance, Medical, Nursing and Operations – might provide a route of succession to Chief Executive. In addition, there will always be a company secretary/governance role, with some accountability both to the Chief Executive and the Chair. This is a smaller job and not a stepping stone into general management.

Other functions – HR, Information & IT, estates, strategy, communications – may also be direct reports to the Chief Executive or might be clustered under some of the board roles. That might stretch what is at core a 1:5 top structure to more like 1:8.

One of the issues in the bigger trusts is how to ensure the Chief Executive and major board figures such as the Finance and Medical Directors have enough time and space to look outward, to partners and the broader health and social care system. There are many multi-agency roles to discharge, and big institutions are expected to provide support to smaller and less capable providers in their local and regional system. This influences not only the very top structure in a trust – creating a need to avoid too many direct reports to the Chief Executive – but also arrangements at the next tier, where the Chief Medical Officer or the CFO will want to be sure that there is internal resilience if they are focusing externally. This affects both reporting ratios and the design of jobs, particularly in big Group structures like Guy's, Barts, Manchester and Birmingham, as there need to be big jobs and clear routes of succession below the board directors.

The broader system responsibilities in major parts of Scotland show a not dissimilar pattern. Reports to the Chief Executive on the board of Greater Glasgow and Clyde, for example, are: a Deputy Chief Executive; Director of Finance; Director of Nursing; Medical Director; and Director of Public Health. This is replicated across all Scottish territorial health boards, with a separate group of special health boards providing a range of other critical enabling services. However, like Northern Ireland, the Scottish system is dealing with challenges of relative pay uncompetitiveness (particularly in relation to Agenda for Change and Local Authority relativities) with some related results in terms of larger numbers of roles reporting directly to Chief Executives.

Local government

Most local authorities have been through various phases of organisation in the past few decades, commonly starting with relatively large executive teams. However, as money has become tighter and the requirement to integrate rather than segmenting services and functions has become greater, councils have looked more and more to simple and broad directorate models, linked to their responsibilities for managing place, people and resources.

In England, this is reflected for example in:

- Lancashire County Council, which has executive directors for: Growth, Environment, Transport & Health; Education & Children's Services; Adult Services; and Resources. There are 14 Directors at the next tier, where the breakdown becomes more detailed, including the Director of Public Health.
- The London Borough of Camden, which has executive directors for: Homes & Communities; Investment & Place; Adults & Health Integration; Children & Learning; and Corporate Services. There are 19 Directors at the next tier, with Executive Directors having between 3 and 6 direct reports.
- More generally, structures in which two or three direct reports provide a potential toute of succession to Chief Executive

Reporting ratios are at a similar level in Scotland. For example, at Edinburgh City Council there are four Executive Directors below the Chief Executive: Children, Education & Prevention Services; the Health & Social Care Partnership; Place; and Corporate Services.

Higher education

Big universities have also been through phases of having large senior teams. Again, there are questions about allowing time and space for external and partnership working as well as developing and running the operation and trying to ensure that spans of management are realistic.

Universities have academic operations – let's call them faculties, though they have various titles in practice; they need thematic leadership of education, research and their other strategic priorities, which might be local, regional and/or international; they have middle office activities, including student support and services, recruitment and admissions, and libraries; and corporate functions – finance, IT, communications, HR etc.

In terms of structure, there are two ways of reducing reporting lines to the top job – Vice Chancellor. One approach is to combine all faculty operations, sometimes including thematic leadership of education, research etc, under one job, normally called a Provost. This is the equivalent of a Chief Operating Officer in the NHS. To illustrate, 16 of the 24 members of the Russell Group have Provosts. This limits the number of direct reports to the Vice Chancellor and provides some coherence to the academic offer, but to a degree compresses the accountability and autonomy of the heads of faculty below. Eight Russell Group universities do not have a Provost and have faculty representation on the top team.

Another approach is to corral all professional and support services under one role – which, confusingly, would in higher education be called a Chief Operating Officer, in this case a job which combines all non-academic services. Cambridge, Manchester, Birmingham and Exeter do this. At

Cambridge and Manchester, this sits alongside a structure in which faculty heads and thematic leaders for strategic issues also report to the Vice Chancellor. At Birmingham and Exeter, the result is that the Provost and the COO are the key direct reports to the Vice Chancellor – but the compromise is that a larger number attend the executive team.

A local illustration is Queen's University Belfast. QuB used to have all non-academic functions under a COO, with the faculties reporting to the Vice Chancellor. The current model is the other way round: all academic operations report through a Provost; whereas middle office and corporate services are divided across four executive directors, for students, people, governance and resources. In this case, the Provost role provides a possible route of succession to Vice Chancellor.

Appendix 1 - Step Differences

The Korn Ferry Job Evaluation method has several distinctive features, one of which is the concept of just noticeable difference between different jobs. This is reflected in a scoring system which enables simple comparison between jobs and creates clusters of job sizes, which are the building blocks for grades. This is summarised in the diagram below:

Steps of difference in Know-How	Interpreting differences	How much of the boss' remit is covered	OD Comments – gap between boss and direct reports	What that means for possible progression to the boss' role
<1	For evaluation purposes – identical	n/a	n/a	A sideways move
1	Just noticeable difference	≈80%	'Too close for comfort'. Suggests over layering. Not adding value	A logical progression or 'heir apparent'
2	Clear difference	≈40%	Most common gap in a classic functional pyramid	Comfortable, solid promotion. Possible successor
3	Big difference	≈20%	Likely in a lean structure, with a broad span of control and where direct reports are not in the same function	Risky, stretching promotion. An unlikely successor
4	A world of difference	≈ 10%		Not advisable

In the KF evaluation report on the Executive and Senior roles in Health and Social Care in Northern Ireland, this was summarised in relation to the hierarchies of suggested evaluation scores as:

- A difference of 3 grades/levels or more = the difference is immediately evident without consideration. It is unlikely that an individual would be able to successfully move up 3 steps to the higher level without significant training and a considerable period of development into role.
- A difference of 2 grades = clear difference is quite evident, some consideration required. A move between the two roles would be seen as a good promotion.
- A difference of 1 grade = a 'just noticeable difference' between the roles.

- Same grade = identical for evaluation purposes. After careful scrutiny there is no significant difference between size of the roles.