NHS Providers

GOVERNWELL
INDUCTION TOOLKIT

2

CHAPTER TWO
WHAT DOES MY TRUST LOOK LIKE?

March 2020

GLOSSARY

Accountable Officer	An accountable officer for an NHS trust is responsible for ensuring that the trust carries out its functions in a way which ensures the proper stewardship of public money and assets.
CCG	Clinical commissioning groups were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local geographical area.
CEO	Chief executive officer, the highest-ranking person in the trust, ultimately responsible for taking managerial decisions
CoG	Council of governors is chaired by the trust's chairman, is made up of elected governors and appointed governors from partner organisations representing key stakeholders. The council of governors advises the trust on issues that are important to patients and the wider community to ensure it provides the best possible service to its patients. The council of governors is not responsible for the day-to-day running of the trust, but works with the board of directors to produce the trust's future plans; it ensures that the voice of members and partners are used to inform the trust's decisions.
Constituency	A group of voters in a specified geographic area or particular characteristic (carers or patients) which makes them eligible to elect a representative to the council of governors.
Constitution	The document setting out how an individual trust will be governed.
CQC	The Care Quality Commission is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom which monitor, inspect and regulate health and social care services. They publish what they find, including ratings to help people choose care.
DHSC/DH	The Department of Health and Social Care (formerly Department of Health) is a department of Her Majesty's Government, responsible for government policy on health and adult social care matters in England. It oversees the English National Health Service (NHS).
DN	The executive director who has professional responsibility for services provided by nursing personnel in a trust
ED	An executive director is a senior management employee who sits on the trust board.
FD	Finance directors are members of a senior executive team with responsibility for their trust's financial health.

GLOSSARY continued

FT or NHSFT	NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. Foundation trusts are still part of the NHS but are not directed by the Government, so have greater freedom to decide, with their own governors and members, their strategy and the way services are delivered. NHSFT have greater financial independence and are able to retain surpluses and invest in service improvements for patients and service users. Foundation trusts are regulated and monitored by both the Care Quality Commission (as are all NHS trusts) and NHS Improvement. As a foundation trust, they have a council of governors and a board of directors who work with each other to make decisions about the future of services and organisational priorities for the future.
GP	A general practitioner is a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients, generally in the community.
HR	The department which focuses on the workforce of an organisation including pay, recruitment and conduct.
IT	Information technology, the use of systems (especially computers and telecommunications) for storing, retrieving, and sending information.
NED	A non-executive director is a member of the trusts board of directors who is not part of the executive team. A non-executive director typically does not engage in the day-to-day management of the organisation, but is responsible for vetting strategy, providing challenge and holding the executive directors to account.
NHS/NHS England	The National Health Service is the publicly funded healthcare system of the UK. NHS England work with NHS staff, patients, stakeholders and the public to improve health outcomes for people in England.
NHSI	NHS Improvement is a body that provides strategic leadership and practical help to the health sector, supporting and holding all providers to account to achieve a 'single definition of success' across their five themes.
SID	The senior independent director is a non-executive director appointed by the board of directors in consultation with the council of governors. The SID supports the chairperson and serves as an intermediary for the other directors when necessary. The SID is also available to members of the FT and to governors if they have concerns.

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TOOLKIT OVERVIEW

CHAPTER OBJECTIVES

The aim of this chapter is to help you understand:

- what makes foundation trusts different
- what your foundation trust looks like
- the people at the trust with whom you will interact and an overview of their role
- how your trust fits into the wider NHS structure
- some of the other NHS organisations you will hear about and how you will come across them in your role as governor

CHAPTER CONTENTS

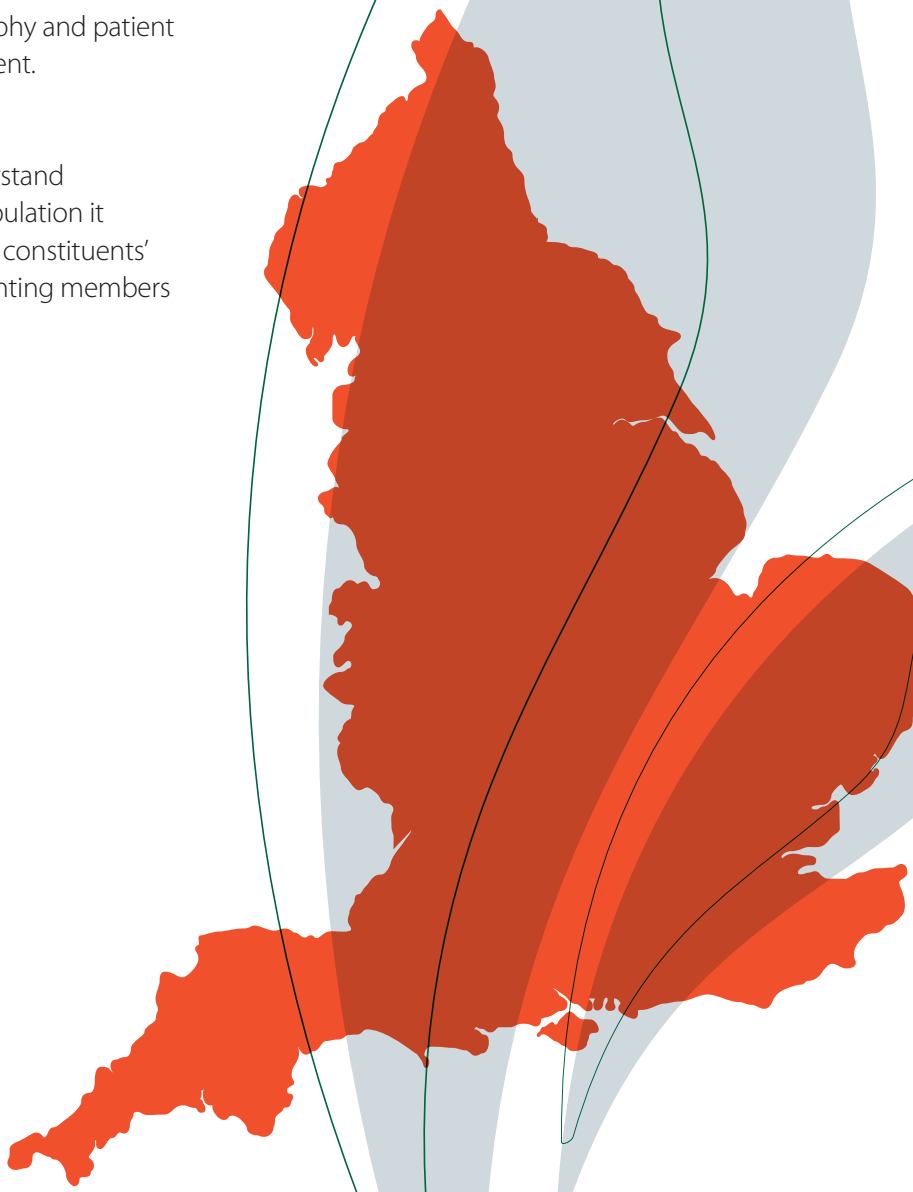
2.1 FACTS AND FIGURES

KEY POINTS

- **Every foundation trust is different in shape and size.**
- **Understanding the shape and size of your own foundation trust will help you make informed decisions about what is best for your constituency.**

The creation of a patient-led NHS means services should be more aligned to the needs of local communities, rather than set nationally. Unlike NHS trusts, foundation trusts are less directly accountable to government and more accountable to their local community, primarily via you, their governors. They also have greater freedom with regard to how they are organised and how they manage their finances. This means that the geography, demography and patient population of each trust will be different.

As a governor it is important to understand what your trust looks like and the population it serves so that you can represent your constituents' interests. We talk more about representing members in section 2.9.



WHAT DOES MY TRUST LOOK LIKE?

Try to find the answers to the following questions about your trust.
You might find it helpful to talk to your governor coordinator at the trust or to look at your trust website.

What size is the population that your foundation trust serves?

Where do the patients/service users come from (geographically speaking)?

How many trust sites are there?

How many staff does it employ?

What is the annual trust budget?

On average, how many patients/service users does it reach each day?

Are there any other facts and figures you think it would be helpful to know about the size and shape of your trust?

2.2 TYPES OF SERVICE

KEY POINTS

- **Different foundation trusts provide a range of different services.**
- **Foundation trusts and other types of NHS organisations work together to provide the full range of services that patients need.**

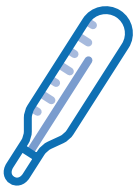
Across the NHS there are four main types of service providers. Your trust might specialise in just one area, or offer a combination of these services.

ACUTE SERVICE PROVIDERS

provide healthcare for a patient who has a brief but severe episode of illness, e.g. following an accident or other trauma, and it may involve intensive or emergency care. Acute service providers offer emergency services and general medical and surgical treatment rather than long-term residential care for chronic illness.

MENTAL HEALTHCARE PROVIDERS

promote recovery and quality of life through effective, innovative, and caring mental health, social care and specialist community services.



COMMUNITY SERVICE PROVIDERS

provide nursing and therapy services through a range of community teams comprised of different professional disciplines, who work in clinics, day services and in visiting people's own homes. Types of community services may include physiotherapy, speech therapy, falls prevention practitioners, audiology, phlebotomy, podiatry, district nursing, community midwifery and long term condition support.

AMBULANCE SERVICE PROVIDERS

help many people with serious or life-threatening conditions. They also provide a range of other urgent and planned healthcare and transport services. Ambulance crews can include a range of staff, such as emergency care assistants and paramedics. Patients will always be taken to hospital when there is a medical need for this. However, ambulance staff now carry out more diagnostic tests and do basic procedures at the scene. Many crews also refer patients to social services, directly admit patients to specialist units and administer a range of drugs to deal with conditions such as diabetes, asthma, allergic reactions, overdoses and heart failure.

2.3 OUR TRUST

KEY POINTS

- **The services that your trust provides and the communities it delivers them to will influence its nature, scale and public profile.**
- **Foundation trusts are often one of the biggest employers in an area, meaning that local people are connected to the trust in many different ways.**

NOTES

WHAT DOES MY TRUST DO?

Which services are provided by your foundation trust?

Who does your trust work with for services you don't provide? E.g. if you are from an acute trust who brings in your emergency patients, and to whom do you discharge people if they can't go straight home?

What are your trust's priorities for this year?

2.4 OUR MISSION

KEY POINTS

- **Governors are a critical route for feedback from patients and the public.**
- **Governors use their local knowledge and insight to help form the trust plans and strategies.**
- **Governors help their electorate to get the best out of trust services.**

The mission is the core purpose and focus of your trust, often written down in a mission statement.

WHAT IS YOUR TRUST'S MISSION?

Use this space to note down your trust's overarching mission statement.

NOTES

2.5 OUR VALUES

KEY POINTS

- **NHS and public sector values will govern everything an FT does, but other organisation specific values (e.g. compassion, innovation) can be just as important.**
- **Working in accordance with trust values should make a significant impact on the quality of services delivered to patients and carers.**
- **The trust's values should guide staff and governors in all their decision making interactions with each other.**

WHAT ARE YOUR TRUST'S VALUES?

Use this space to note down your trust's values.

NOTES

2.6 ORGANISATIONAL STRUCTURE

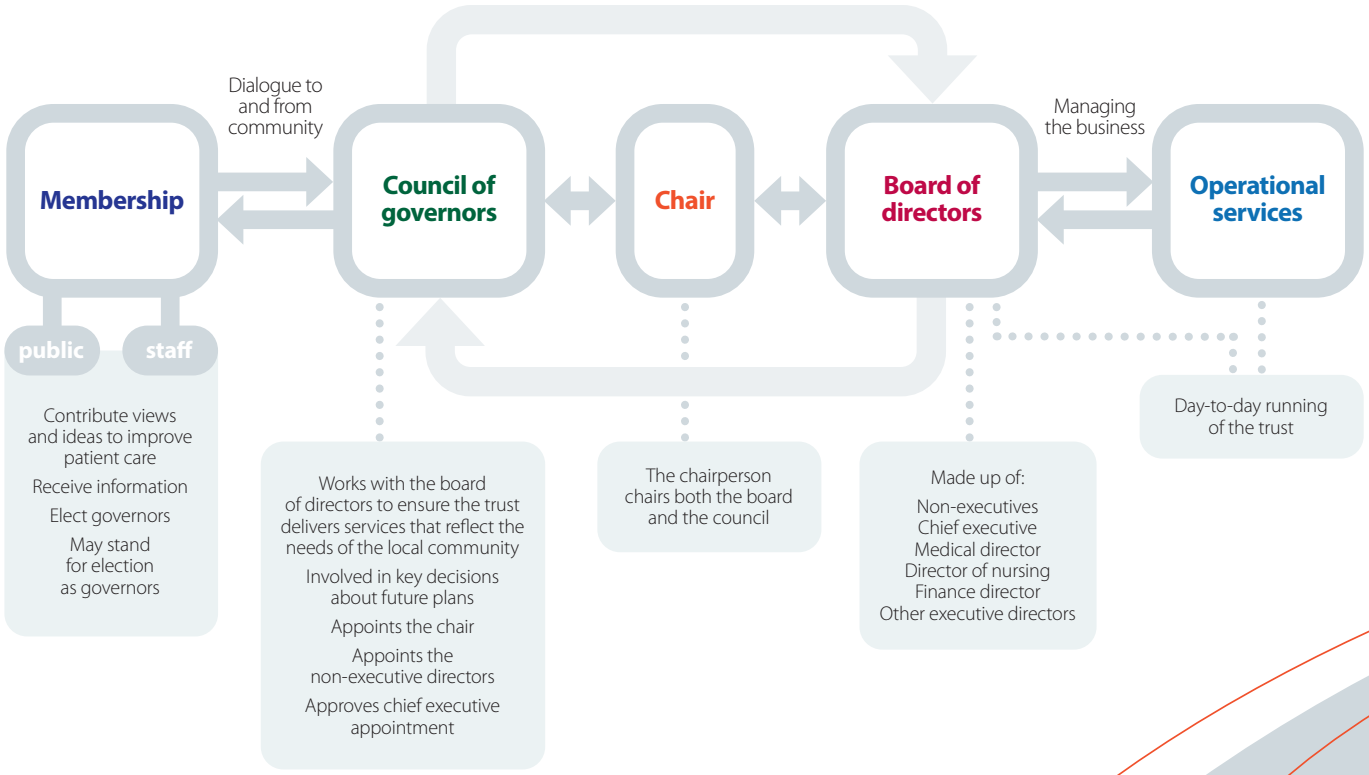
KEY POINTS

- **Different foundation trusts provide a range of different services.**
- **Foundation trusts and other types of NHS organisations work together to provide the full range of services that patients need.**

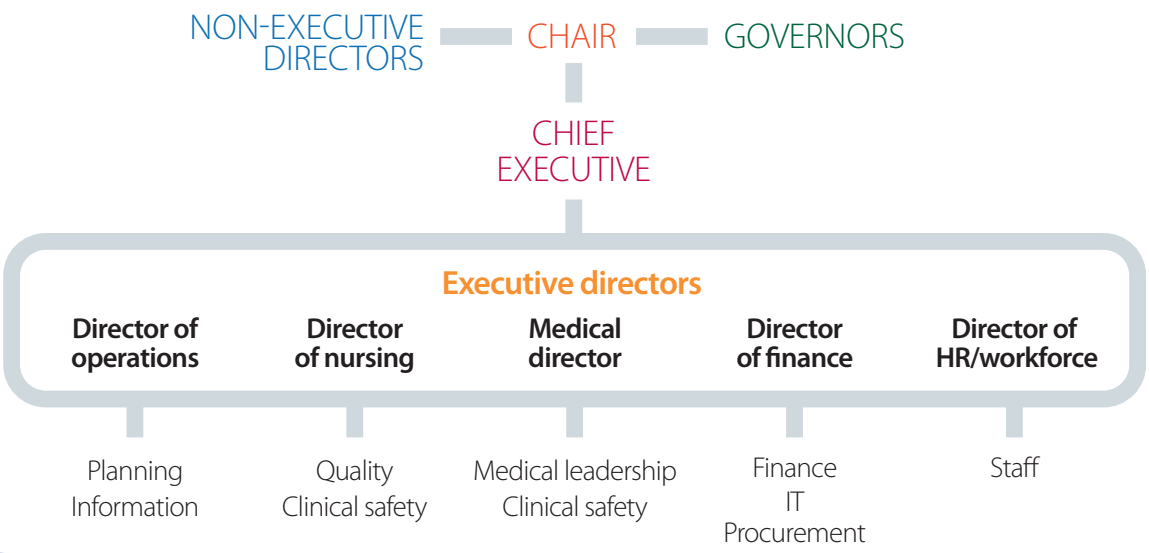
Foundation trusts are complex organisations with a large number of people; they also have the freedom to choose how they want to structure the management of the trust to achieve the most efficient way of working for them. The exact make up of your trust will be specified in your trust constitution.

As a governor, it is important to understand who's who in the trust and what their role is (see section 2.7 for more detail on each role).

FOUNDATION TRUST GOVERNANCE ARRANGEMENTS



The organisational structure of a trust can be shown in an organogram.
Here is an example:



HOW IS MY TRUST STRUCTURED?

Using the space below draw your trust's structure but this time try to add in as many names as possible rather than just job titles.

2.7 WITH WHOM WILL I INTERACT?

KEY POINTS

- **Governors do not work in isolation; there are a number of people in your trust you will interact with on a regular basis.**
- **Understanding their roles will help you work with them efficiently and direct questions to the right people.**

There are a number of people/groups within your foundation trust that you will meet on a regular basis. Below is a short explanation of some of their roles (as every trust is different some of the job titles may be slightly different in your trust):

The **board of directors** is responsible for setting the corporate strategy and organisational culture, taking those decisions reserved for the board, and being accountable to stakeholders for those decisions. All members of the board of directors have collective responsibility as a unitary board for every decision of the board, regardless of their individual skills or status.

The **chair** is a non-executive director who chairs both the board of directors and the council of governors meetings. In conjunction with other board members, the chair sets the items for review and discussion (the agenda) and ensures relevant information is provided. The role of the chair is expanded on in chapter 2.8.

The **chief executive** leads the management of the trust, is the accountable officer and is responsible for the overall running of the trust. He/she is employed by the trust and leads the executive directors (also known as the executive team).

Executive directors have a dual role to manage the service for which they are responsible and to form part of the board of directors. They are responsible for the day to day running of the trust and are usually in charge of clinical or other services, as well as being a member of the board. The law states that the board must include the chief executive, finance director, a qualified doctor and a qualified nurse. Executive directors may give reports to the council of governors and be involved in some of the sub-committees governors sit on (see chapter 4.2 for more on sub-committees).

The **non-executive directors (NEDs)** provide an independent perspective on the board and have a particular duty to hold the executives to account for the performance of the trust. Although they are remunerated, they are not employees of the trust. NEDs must form the majority on the board. It is a key duty of the council of governors to hold the NEDs to account for the performance of the board. NEDs should give reports to CoG on their areas of responsibility in sub-committees.

The board of directors may appoint one of the NEDs to be the **senior independent director (SID)**, in consultation with the council of governors. The SID is available to board members and governors if they have concerns which have not been resolved by contact through the normal channels of chair, chief executive or finance director, or for which such contact is inappropriate. The SID may also be the deputy chair.

The **company secretary** or **trust secretary** is responsible for supporting the board and council of governors in meeting their obligations to ensure that the foundation trust complies with the legislative and regulatory framework. He/she will play a leading role in the good governance of the foundation trust by supporting the chair and advising the board and council of governors via the chair, chief executive and directly.

Within your trust there is likely to be a designated **membership** or **governor coordinator** who will be your contact person. He/she may help with arrangements for meetings or training days and be your first port of call for many questions.

One of the key duties of being a governor is to represent the interests of **members** and **the public**. Working with your trust CoG members you will need to find ways of engaging with members and the public so you can understand their views. We talk more about members in chapter 3.7.

WHO WOULD YOU TALK TO ABOUT...?

Who would you talk to if you have a question about:

1
The time of the next
CoG meeting:

2
Something you would like to raise
at a CoG meeting:

3
One of the papers presented
at a previous CoG meeting:

4
A follow up issue you did not feel
had sufficient time to discuss within
a CoG meeting:

2.8 THE ROLE OF THE CHAIR

KEY POINTS

- **The chair is a non-executive director.**
- **They are the chair of both the board of directors and the council of governors.**
- **The chair sets the agenda for the meetings and ensures relevant information is provided to the council to help with discussion and decision making.**

Whereas the chief executive is responsible for the executive management of the trust, the chair's responsibilities relate primarily to chairing the board of directors and the council of governors, and ensuring that the board and council perform their duties effectively.

As chair of the board, the chair needs to ensure that the board discusses relevant issues in sufficient depth, with access to all the information needed to reach a decision, and with all the directors contributing to the discussions and decision-making.

As chair of the council of governors, the chair needs to ensure that the council is made aware of the relevant issues in sufficient depth to enable them to fulfil the needs of public accountability, with all the information needed, to invite contributions from governors, to hold the NEDs to account, and/or to reach a decision where appropriate.

Key roles of a chair are therefore to:

- set an appropriate agenda for board/council meetings, in conjunction with other board members and/or council
- ensure that relevant information is provided to the directors/governors, in advance of the meeting, with sufficient reading time
- manage the public board and council of governor meetings
- encourage open discussions with constructive debate in board/council meetings
- encourage all directors/governors to contribute to discussions and decision-making appropriately
- represent the trust with partner organisations.

EXAMPLES OF INTERACTION WITH THE CHAIR

Chairs often arrange to meet with a sub-group of governors and the trust secretary to plan a governor development programme or informal seminars to explore key topics.

One chair has a 'no-surprises' agreement with the governors, granting them the freedom to call or drop in on the chair and directors at any time on the understanding that they use this time to ask questions and share any concerns in private prior to raising them in a public forum.

Some chairs schedule informal meetings with their lead governor (see chapter 3.2 for more information) in between formal council meetings. One model is for the chair to meet the lead governor shortly after the formal council meeting to confirm actions from the meeting and clarify how best to complete them. The chair and lead governor then meet again midway between council meetings to update on progress enabling the chair to intervene and offer support if there are any challenges or blockages and to discuss the agenda for the next meeting.

A number of chairs schedule meetings (one-to-one or in small groups) with new governors to give them the opportunity to clarify their expectations and express their key interests.

WORKING WITH YOUR CHAIR

Talk to your existing governors or governor coordinator about how your council of governors works with your chair.

Think about the type of relationship you personally should establish with your chair and how you can achieve it.

Please be mindful of the time they will have and the breadth of issues they will need to be tackling.

2.9 MEMBERS AND CONSTITUENCIES

KEY POINTS

- **Foundation trusts have members from different constituencies to play a part in shaping local health services. Constituencies include patients/service users, carers, staff and the public. These are often subdivided into more specific classes and geographical areas.**
- **Governors are elected by members to represent the views of the local population and other service users/stakeholders and to act as a conduit for information between them and the board.**
- **Foundation trusts have systems and processes in place for recruiting and involving members, which governors should have a role in.**

NHS foundation trusts are organisations with members who can actively participate in the governance structure. All members can participate in electing their representatives (the governors) and all members have equal voting rights (one member, one vote). By giving staff, patients, the public and partners a stake in the organisation, foundation trusts have been set the challenge of transforming their organisation into outward facing, locally 'owned' organisations that use their members as a valuable resource to improve performance.

Your trust will want its members to play an active part in helping shape the future of the organisation by providing feedback, responding to surveys and consultations and voting in elections to the council of governors. Moreover, it is hoped that some members will want to be more involved by standing for election to the council of governors.

Governors have a responsibility for collecting feedback about the trust, its vision and performance to the constituencies, stakeholder organisations and to members. Furthermore it is the governors' responsibility to engage with the membership; ensuring that the voice of the membership is heard in the trust and used to inform decision making processes. Your trust will have plans about how to do this and work with the governors to develop and implement the plan.

A trust's aims in respect of membership are to ensure that:

- the membership is representative of the diversity of the population served in terms of, ethnic origin, age, social background, geographical spread and social deprivation
- the membership is representative of users of all the trust services/activities and all of its staff
- members can get involved at different levels depending on their interests and other commitments
- processes are in place to seek views of patients on a continual and regular basis about the quality of services they receive and make improvements based on those responses
- patients', carers' and the public's knowledge and experience can be used to benefit others
- proper time and thought can be given to patients, carers and public views on proposals
- there is a continuous review of membership numbers based on ensuring active engagement with current members and the recruitment of new members
- the membership recruited is realistic for the trust's size, population served and nature and that it reflects the diversity of the population. It will also be of sufficient size to deliver credible elections to the council of governors.

WHAT DOES OUR MEMBERSHIP LOOK LIKE?

Find out about your trust's membership...

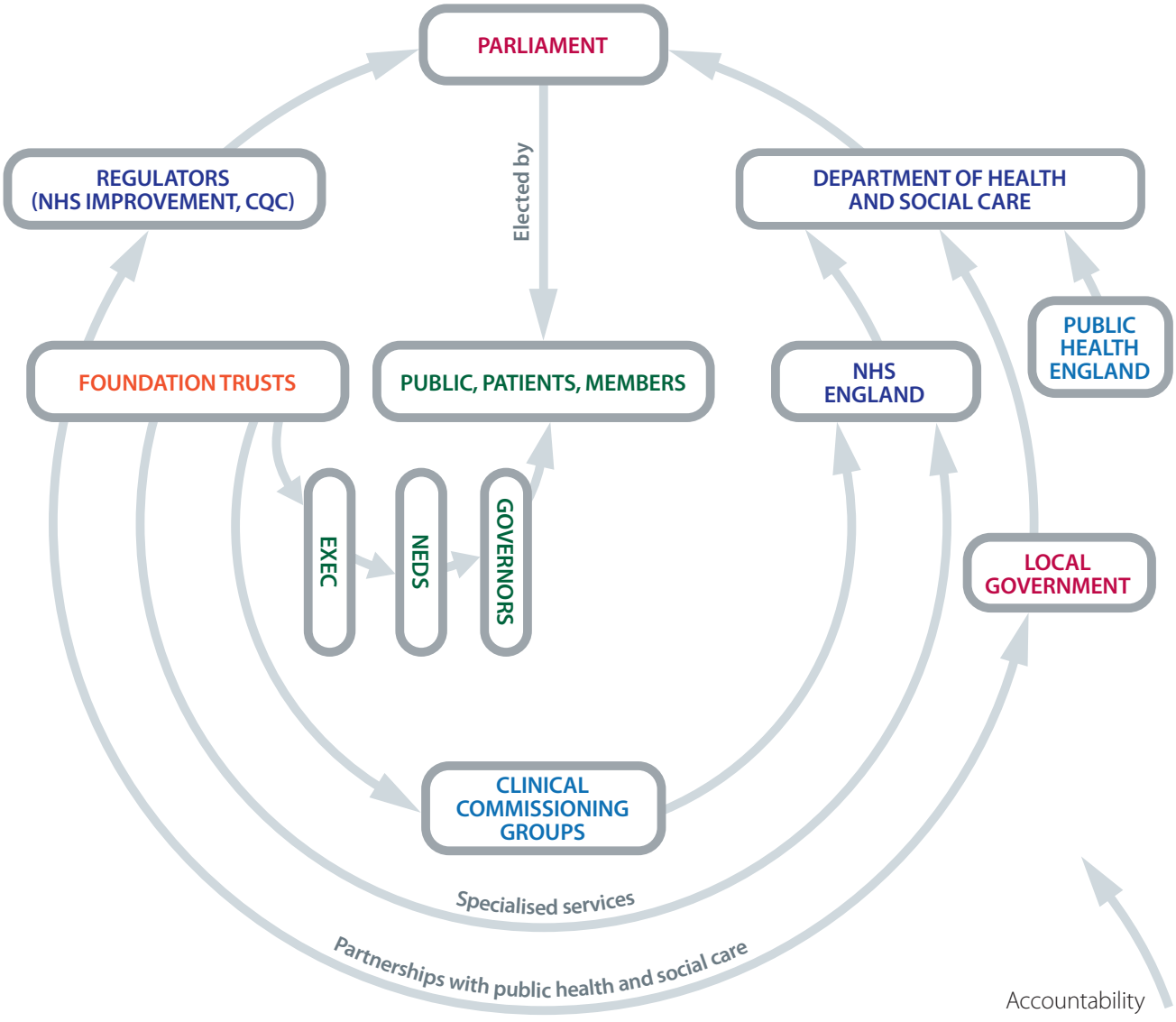
How many members does your trust currently have?	
How many members does your trust have in each category?	Public
	Staff
	Patient / service user / carer (if you have these constituencies)
Does your trust have an opt-in or an opt-out policy for recruitment?	
What is the minimum age for someone to become a member / governor in your trust?	
How many constituency areas do you have and what are they?	

2.10 THE STRUCTURE OF THE NHS

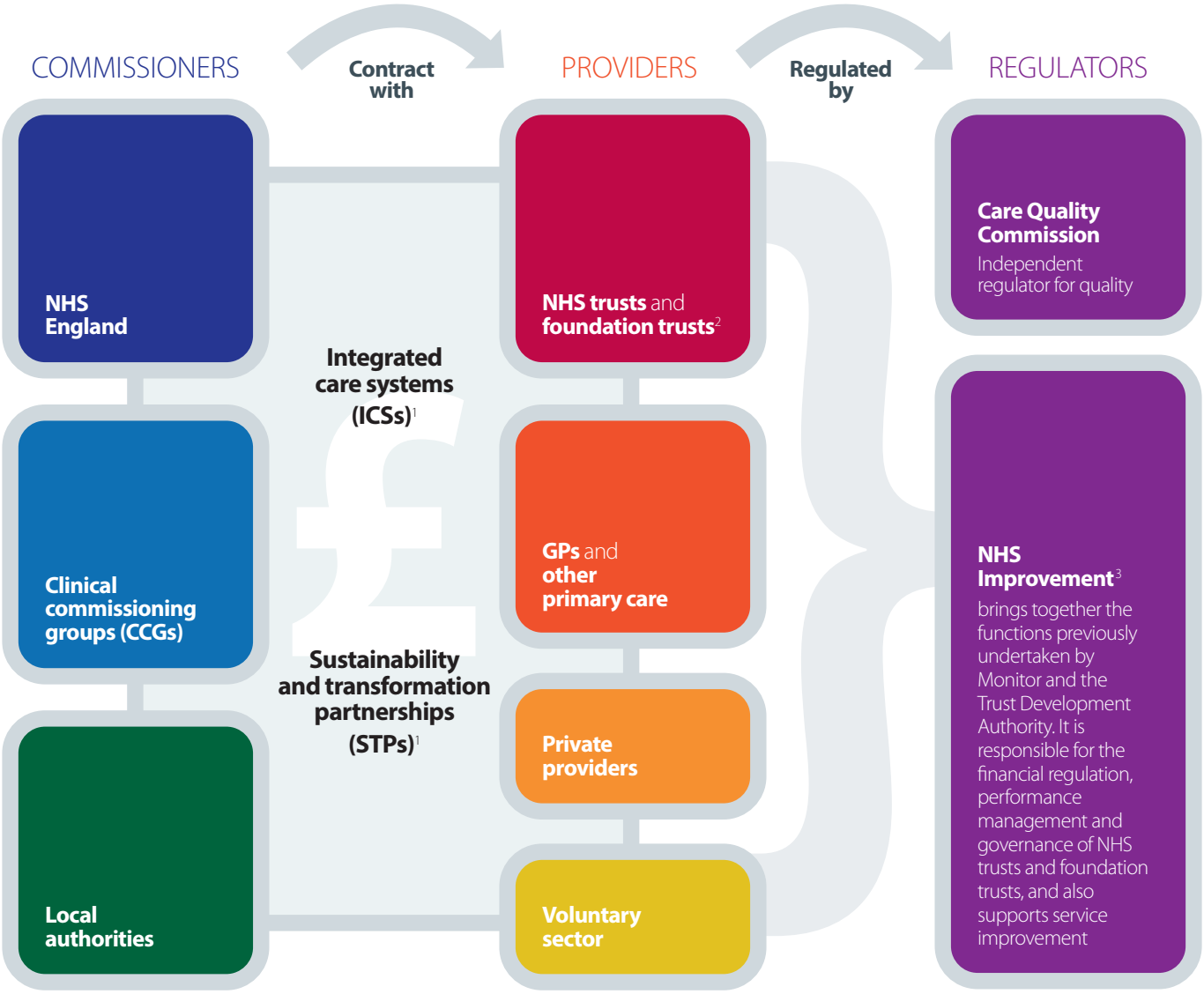
KEY POINTS

- **The Health and Social Care Act 2012 changed the structure and working relationships of the many organisations that constitute the NHS in England.**
- **Understanding the wider context in which your trust sits will help you understand why your trust is making certain decisions.**

As well as understanding how your own trust works, understanding where your trust fits into the wider NHS structure and the other organisations will help you understand why your trust is making certain decisions, where some information comes from, and how to compare how your trust is doing against others. As a governor, you are likely to hear about these organisations in your regular communications from the trust, in presentations and reports. Part of the Health and Social Care Act 2012 involved a restructuring of the NHS; it now looks like this:



HOW PROVIDERS TO THE NHS ARE COMMISSIONED AND REGULATED



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From December 2015 NHS providers, CCGs, local authorities and other healthcare services came together to form 42 STP 'footprints'. These are geographic areas that are coordinating healthcare planning and delivery, covering all areas of NHS spending.

A number of STPs have now evolved into integrated care systems (ICSs) and the *NHS long term plan* set out the intention for all STPs to become ICSs by 2021.

2

In early 2020 the NHS provider sector consists of 150 foundation trusts and 73 NHS trusts. The principal difference between them is that only foundation trusts have governors.

3

From April 2019, joint NHS England and NHS Improvement national directors and regional directors have taken on responsibility for overseeing and supporting both providers and commissioners.

OVERVIEW OF THE NHS

Which of these statements are true? (answers on pages 24-25)	?
1 The NHS provides a comprehensive service, available to those entitled to the service irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights.	
2 Access to NHS services is based on the level of national insurance paid by each individual and GPs assess this before making a referral for treatment.	
3 NHS services must reflect the needs and preferences of patients, their families and their carers.	
4 The NHS works solely in the area of healthcare and is restricted in its abilities to work in partnership with other organisations.	
5 Most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are taken by the local NHS and by patients with their clinicians.	
6 Primary care is essentially the provision of healthcare for children and young people.	

2.11 REGULATING FOUNDATION TRUSTS

KEY POINTS

- **NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.**
- **The Care Quality Commission (CQC) regulates all health and social care services in England. The commission ensures the quality and safety of care in hospitals, ambulances, care homes, dentists and the care given in people's own homes.**

NHS IMPROVEMENT

NHS Improvement (NHSI) is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHSI help the NHS to meet its short-term challenges and secure its future.

NHS Improvement uses a single oversight framework, which sets out how the regulator oversees NHS foundation trusts and trusts to help determine the level of support they need.

The framework is designed to help NHS providers attain, and maintain the Care Quality Commission ratings of 'good' or 'outstanding', but doesn't give a performance assessment in its own right.

The framework will help NHS Improvement identify NHS providers' potential support needs across five themes:

1. Quality of care
2. Finance and use of resources
3. Operational performance
4. Strategic change
5. Leadership and improvement capability (well-led).

Providers are placed in one of four segments which will help determine the level of support required:

- Providers with maximum autonomy
- Providers offered targeted support
- Providers receiving mandated support for significant concerns
- Providers placed in special measures

Your trust is required to send regular reports to NHSI and they may share some of that information with you as governors to help you understand how your trust is performing.

Since 2019, NHS Improvement and NHS England have come together to act as a single organisation with an overall aim to provide better support for the NHS and to work more efficiently and effectively.

CARE QUALITY COMMISSION (CQC)

The Care Quality Commission (CQC) monitors, inspects and independently regulates services to make sure they meet fundamental standards of quality and safety. They publish what they find, including inspection reports of NHS providers on their website, though your trust is likely to share this with you directly. In most cases, their inspection reports include ratings: outstanding, good, requires improvement and inadequate.

There are five questions CQC ask of all care services as part of the way they regulate and they help to make sure they focus on the things that matter to people:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

Each of the five key questions is broken down into a further set of questions called key lines of enquiry (KLOEs). When CQC carry out inspections, they use these to decide what they need to focus on. For example, the inspection team might look at how risks are identified and managed to help them understand whether a service is safe.

During an inspection the CQC will meet with the council of governors as part of their information gathering process, to get their perspective on the trust.

The CQCs ambition, within their current strategy (2016-2021), is a more targeted, responsive and collaborative approach to regulation, so more people get high-quality care. They will achieve this by focusing on four priorities:

- Encouraging improvement, innovation and sustainability in care
- Delivering an intelligence-driven approach to regulation
- Promoting a single, shared view of quality
- Improving efficiency and effectiveness.

FIND OUT MORE

You can learn more about NHS Improvement and the Care Quality Commission on their websites

NHSI improvement.nhs.uk
CQC www.cqc.org.uk

ANSWERS

OVERVIEW OF THE NHS

Which of these statements are true? (questions on page 21)	?
1 *The NHS provides a comprehensive service, available to those entitled to the service irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights.* At the same time, it has a wider legal duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.	TRUE
2 *Access to NHS services is based on the level of national insurance paid by each individual and GPs assess this before making a referral for treatment.* Once eligibility has been established access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by parliament.	FALSE
3 *NHS services must reflect the needs and preferences of patients, their families and their carers.* Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.	TRUE
4 *The NHS works solely in the area of healthcare and is restricted in its abilities to work in partnership with other organisations.* The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and wellbeing.	FALSE

ANSWERS continued

OVERVIEW OF THE NHS

Which of these statements are true? (questions on page 21)	?
5 *Most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are taken by the local NHS and by patients with their clinicians.* The NHS is a national service funded through national taxation, and it is the government which sets the framework for the NHS and which is accountable to parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff.	TRUE
6 *Primary care is essentially the provision of healthcare for children and young people.* Essentially the provision of healthcare by NHS is divided into three sections: primary, secondary and tertiary care. Primary care is the first point of contact for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists. Secondary care is known as acute healthcare and can be either elective care or emergency care. Elective care means planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP. Most of these services are provided by NHS bodies, which are part of the public sector. Tertiary providers deliver highly specialist care such as organ transplants, cancer services, specialist children's services and specialist mental health services.	FALSE

CHAPTER TWO REFLECTION

REFLECTION QUESTIONS

1
What have you learned about your foundation trust?

2
How do you plan to work with the different people in your foundation trust?

3
Do you know how your trust works with partners in the local health economy?

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

Thank you to Kathryn Stuart, Lois Howell, Claire Lea and members of the governor advisory committee for their support in developing this resource.

GOVERNWELL
INDUCTION TOOLKIT

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CHAPTER TWO
WHAT DOES MY TRUST LOOK LIKE?

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NHS Providers is the operating name of the Foundation Trust Network
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