

BTHFT Self-certification - NHS Provider Licence						
Licence Condition	Summary Definition	Executive Lead	Response 2021/22	Evidence 2021/22	Response 2022/23	Evidence 2022/23
General Conditions						
G1 – Provision of information	This condition contains an obligation for all licensees to provide NHS I with any information we require for our licensing functions.	Chief Executive	The Trust complies with this condition as required. There are three established contacts with NHS Improvement – Chief Executive, Director of Finance and Chief Operating Officer. All information requested by NHS Improvement is supplied in a timely manner in the format requested.		The Trust complies with this condition as required. All information requested by NHS England is supplied in a timely manner in the format requested.	Information uploaded via the NHSE information portals.
G2 – Publication of information	This licence condition obliges licensees to publish such information as NHS I may require	Chief Executive	The Trust complies with this condition as required. Information is published as required in accordance with the Code of Governance and the Annual Reporting Manual.	Self-assessment against FT Code of Governance; Annual Report; Quality Account.	The Trust complies with this condition as required. Information is published as required in accordance with the FT Code of Governance and the Annual Reporting Manual.	Self-assessment against FT Code of Governance; Annual Report; Quality Account.
G3 – Payment of fees to Monitor	The Act gives NHS I the ability to charge fees and this condition obliges licence holders to pay fees to NHS I if requested.	Director of Finance	The Trust will comply with this condition as required.	Annual Accounts	The Trust will comply with this condition as required.	Annual Accounts
G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors (or those performing similar or equivalent functions).	Director of Human Resources/Director of Strategy and Integration	The Trust complies with this condition. It has robust pre-employment and employment processes in place to ensure that Executive and Non-Executive Directors meet the requirements of the FPPR regulations both on appointment and then annually in terms of reviewing the ongoing fitness of Directors. This is documented in an assurance process.	Pre-employment checks for new recruits and self-declarations and associated checks for existing directors. Trust Employment Checks Policy and Procedure updated March 2022 with reference to updated NHS Employment Check Standards.	The Trust complies with this condition. It has robust pre-employment and employment processes in place to ensure that Executive and Non-Executive Directors meet the requirements of the FPPR regulations both on appointment and then annually in terms of reviewing the ongoing fitness of Directors. This is documented in an assurance process. The Assurance process was updated February 2023. All Governors are subject to DBS checks on appointment and at least every three years.	Pre-employment checks for new recruits and self-declarations and associated checks for existing directors. Trust Employment Checks Policy and Procedure updated March 2022 with reference to updated NHS Employment Check Standards. Governors DBS checks and declarations of interest (for both Governors and NEDs).
G5 – Monitor guidance	This licence condition requires licensees to have regard to any guidance that NHS I issues.	Chief Executive	The Trust is compliant with this condition. Guidance is studied in detail by the relevant Executive Director and a lead assigned relevant to the subject matter. Discussion and approval at Executive Team Meeting/Board where required.	Self-assessment against Code of Governance, compliance with the Annual Reporting Manual, routine review and compliance with all directives issued by NHSI. ETM / Board meeting papers.	The Trust is compliant with this condition. Guidance is studied in detail by the relevant Executive Director and a lead assigned relevant to the subject matter where required. Discussion and approval at Executive Team Meetings / Academies / Board Committees / Board of Directors where required.	Self-assessment against FT Code of Governance; compliance with the Annual Reporting Manual; routine review and compliance with all directives issued by NHS England. Executive Team Meetings / Academies / Board Committees / Board of Directors meeting papers.
G6 – Systems for compliance with licence conditions and related obligations	This licence condition requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	<i>Refer to lines below for requirements 1, 2, 3 and 4.</i>				
G6 (1)	1. The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	(a) Chief Executive (b) Director of Finance (c) Chief Executive	The Trust complies with this condition. It has no conditions imposed upon it preventing it from discharging its statutory responsibilities.	Board Assurance Framework and High Level Risk Registers	The Trust complies with this condition. It has no conditions imposed upon it preventing it from discharging its statutory responsibilities.	Board Assurance Framework and High Level Risk Registers, Signed contracts for the provision of healthcare services
G6 (2)	2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) Regular review of whether those processes and systems have been implemented and of their effectiveness.	a)/(b) Chief Executive (a)/(b) Director of Finance	The Trust complies with this condition. It has an established system, including a risk escalation framework to identify risks (including financial risks) and their mitigation. The Foundation Trust uses a variety of mechanisms to test the effectiveness of the governance system, including Internal Audit, assurance reviews, gap analysis and root cause analysis when issues are identified.	Risk Management Strategy, Board Assurance Framework, Annual Governance Statement, Quality Account, Internal Investigations, Internal Audit Reports	The Trust complies with this condition. It has an established system, including a risk escalation framework to identify risks (including financial risks) and their mitigation. The Foundation Trust uses a variety of mechanisms to test the effectiveness of the governance system, including Internal Audit, assurance reviews, gap analysis and root cause analysis when issues are identified.	Risk Management Strategy, Board Assurance Framework, Annual Governance Statement, Quality Account, Internal Investigations, Internal Audit Reports, Academy and Board reports
G6 (3)	3. Not later than two months from the end of each Financial from the end of each Financial Year, the Licensee shall prepare and submit to NHS Improvement Board Secretary a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.	Chief Executive	The Trust will comply with this condition. This report, presented to the Trust Board in May 2022, will demonstrate how the Trust has taken all precautions necessary to comply with the license, NHS Acts and NHS Constitution along with required governance arrangements.	Agenda and Minutes from open and closed Board meetings and Academy and Committee meetings.	The Trust will comply with this condition. This report, presented to the Trust Board in May 2023, will demonstrate how the Trust has taken all precautions necessary to comply with the license, NHS Acts and NHS Constitution along with required governance arrangements. A self-certification will be completed following the Board Review in May 2023 as to whether the Trust's processes and systems were implemented in the previous financial year and were effective.	Agenda and Minutes from open and closed Board meetings, Academy and Committee meetings and, Audit Committee.
G6 (4)	4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHS I in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.	Chief Executive	The Trust will comply with this condition. Following approval by the Board, the required declarations to be published on the Trust's website prior to 30 June 2022.	Declaration to be published on the Trust's website prior to 30 June 2022.	The Trust will comply with this condition. Following approval by the Board in May 2023, the required self-certification will be published as required no later than 30 June 2023	Self-certification will be published on the Trust Website, as required, no later than 30 June 2023
G7 – Registration with the Care Quality Commission	This licence condition requires providers to be registered with the CQC (if required to do so by law) and to notify us if their registration is cancelled.	Chief Executive	The Trust complies with this condition. The Trust is fully registered with the CQC. All sites are registered.	CQC registration document.	The Trust complies with this condition. The Trust is fully registered with the CQC. All sites are registered.	CQC Registration information for BTHFT is available on the CQC website here - https://www.cqc.org.uk/provider/RAE/registration-info
G8 – Patient eligibility and selection criteria	The Licensee shall: a. set transparent eligibility and selection criteria, b. apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and c. publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.	Chief Operating Officer	The Trust complies with this condition. The ERS directory of services provides patients with easily accessible information by speciality on: • Choice of hospital • Choice of site • Wait times for appointment • Waiting time in relation to 18 week RTT Patient access and treatment is provided in line with national 18 week RTT standards, cancer waiting time standards and diagnostic waiting time standards. During 2021/22 the Trust has used guidelines from the national college of surgeons to clinically review and prioritise access for surgical procedures; patients have been kept informed throughout this process. From March 2022 the Trust's waiting time information has also been published in the MyPlannedCare app.	• Elective Care access policy • NHS ERS Directory of services • Clinical prioritisation guidelines for surgical procedures during COVID-19 • MyPlannedCare app	The Trust complies with this condition. The ERS directory of services provides patients with easily accessible information by speciality on: • Choice of hospital • Choice of site • Wait times for appointment • Waiting time in relation to 18 week RTT Patient access and treatment is provided in line with national 18 week RTT standards, cancer waiting time standards and diagnostic waiting time standards. During 2022/23 the Trust has used guidelines from the national college of surgeons to clinically review and prioritise access for surgical procedures; patients have been kept informed throughout this process. Since March 2022 the Trust's waiting time information has also been published in the MyPlannedCare app.	• Elective Care access policy • NHS ERS Directory of services • Clinical prioritisation guidelines for surgical procedures during COVID-19 • MyPlannedCare app

CoS1 - Continuing provision of Commissioner Requested Services	This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provide Commissioner Requested Services, without the agreement of relevant commissioners.	Chief Operating Officer	The Trust complies with this condition. No changes to provision were made during 2021/22 outside of those agreed in response to COVID-19 following national and local commissioner agreements.		The Trust complies with this condition. No changes to provision were made during 2022/23.	N/A
CoS2 - Restriction on the disposal of assets	This licence condition ensures that licensees keep an up-to-date register of relevant assets used in the provision of Commissioner disposal of assets Requested Services. It also creates a requirement for licensees to obtain NHS I's consent before disposing of these assets when NHS I is concerned about the ability of the licensee to carry on as a going concern.	Director of Finance	The Trust complies with this condition.	Asset Register. The Trust has not disposed of any applicable assets in year.	The Trust complies with this condition.	Asset Register. The Trust has not disposed of any applicable assets in year.
CoS3 - Standards of corporate governance and financial management	This condition requires licensees to have due regard to adequate standards of corporate governance and financial management.	Chief Executive/ Director of Finance	The Trust complies with this condition. It has a clearly defined corporate and financial governance structure supported by an established risk escalation framework.	Risk Register, Annual Report and Accounts 2021/22 and Quality Account, Annual Governance Statement, Self-Assessment against Code of Governance, Standing Financial Instructions, Scheme of Delegation, Financial Policies and Procedures, Budgetary Control Framework.	The Trust complies with this condition. It has an established system, including a risk escalation framework to identify risks (including financial risks) and their mitigation. The Foundation Trust uses a variety of mechanisms to test the effectiveness of the governance system, including Internal Audit, assurance reviews, gap analysis and root cause analysis when issues are identified.	Risk Management Strategy, Board Assurance Framework, Annual Governance Statement, Quality Account, Internal Investigations, Internal Audit Reports, Academy and Board reports
CoS4 - Undertaking from the ultimate controller	This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the licence conditions. This condition specifies who is considered to be an ultimate controller.	N/A			N/A	N/A
CoS5 - Risk pool levy	This licence condition obliges licensees to contribute, if required, towards the funding of the "risk pool" - akin to an insurance mechanism to pay for vital services if a provider fails.	Director of Finance	The regulatory Risk Pool levy has not come into effect to date. The Trust currently contributes to the NHS Litigation Authority risk pool for clinical negligence, property expenses and public liability schemes.		The regulatory Risk Pool levy has not come into effect to date. The Trust currently contributes to the NHS Litigation Authority risk pool for clinical negligence, property expenses and public liability schemes.	N/A
CoS6 - Cooperation in the event of financial stress	This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHS I in these circumstances.	Director of Finance	The Trust is not in financial special measures, but would cooperate fully with NHSI should this ever be the case		The Trust is not in financial special measures, but would cooperate fully with NHS England should this ever be the case	N/A
CoS7 - Availability of resources	This condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.	Director of Finance	The Trust complies with this condition and has agreements/contracts in place with Commissioners to continue to provide services. NHSE/I suspended the normal financial framework throughout 2021/22, with providers funded on a block arrangement with specific allocations to cover Covid costs. BTHFT has complied with the stipulations of the NHS funding regime during the pandemic.	Contracts and SLAs in place under business as usual circumstances. NHSE/I published funding arrangements during the COVID-19 pandemic.	The Trust complies with this condition and has agreements/contracts in place with Commissioners to continue to provide services.	Contracts and SLAs in place. The financial plan and monthly reports to F&P Academy and Board. Capital Programme papers, Treasury Mgt Papers
CoS7 (3)	3. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the three forms, (a), (b) or (c)	Director of Finance	The Trust will comply with this condition. In previous years the Trust has been required to complete a template to declare which of the following statements is 'confirmed' and which are not confirmed and submit the formally signed template to NHSI. Since March 2019, the requirement is no longer mandatory however a copy of the template previously provided by NHSI is available for the declarations to be made by Board. NHSI advise that these are not required to be returned to NHS Improvement "unless requested to do so". NHS Improvement will retain the option each year of contacting a select number of foundation trusts to "ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording "sign-off". The veracity of the statement that the Board will be asked to confirm in May 2022 is evidenced from and within a range of documents.	Internal Audit Reports, Annual Report and Accounts 2021/22, Quality Account 2021/22, A statement regarding self-certification will be added to the Trust website by 31 May 2022.	The Trust will comply with this condition. In previous years the Trust has been required to complete a template to declare which of the following statements is 'confirmed' and which are not confirmed and submit the formally signed template to NHSI. Since March 2019, the requirement is no longer mandatory however a copy of the template previously provided by NHSI is available for the declarations to be made by Board. NHSI advise that these are not required to be returned to NHS Improvement "unless requested to do so". NHS Improvement will retain the option each year of contacting a select number of foundation trusts to "ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording "sign-off". The veracity of the statement that the Board will be asked to confirm in May 2022 is evidenced from and within a range of documents.	Internal Audit Reports, Annual Report and Accounts 2021/22, Quality Account 2021/22, A statement regarding self-certification will be added to the Trust website by 31 May 2023.
NHS Foundation Trusts Conditions						
FT1 - Information to update the register of NHS foundation trusts	Monitor has written and electronic copies of: a) the Licensee's current constitution; b) the Licensee's most recent published audited accounts; c) the Licensee's most recently published annual report. Monitor has any document requested for the purpose of section 39 of the 2006 Act.	Chief Executive	The Trust complies with this condition. Annual Accounts, Annual Report, and Auditors opinion are submitted to NHSI annually in accordance with requirements. The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust.	Annual Report and Accounts 2021/22, BTHFT Constitution	The Trust complies with this condition. Annual Accounts, Annual Report, and Auditors opinion are submitted to NHSE annually in accordance with requirements. The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust.	Annual Report and Accounts 2021/22, BTHFT Constitution
FT2 - Payment to Monitor in respect of registration and related costs	NHS foundation trusts are to pay to Monitor any fees due in respect of section 39 and 39A of the 2006 Act.	Chief Executive	The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust.		The Trust has systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust.	N/A
FT3 - Provision of information to advisory panel	The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the 2006 Act.	Chief Executive	The 'panel for advising governors' has been stood down by NHSI. As such this condition is no longer applicable.		The 'panel for advising governors' has been stood down for a number of years. As such this condition is no longer applicable.	N/A
FT4 - NHS FT governance arrangements	<i>see below</i>					

FT4 (2)	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Chief Executive	The Trust complies with this condition. An Associate Director of Corporate Governance/Board Secretary was appointed in 2020 who reports to the Director of Strategy & Integration as the lead Executive for corporate governance. The Associate Director is responsible for ensuring that the Trust has robust corporate governance arrangements in place. The Trust established a new academy governance model in the latter half of 2020/21, which was informed by an independent review undertaken by governance specialists. In September 2021 the structure was revised. The Regulation and Assurance Committee was stood down and the Chair roles for the Academies were assigned to the Non-Executive Directors.	Job Description for Associate Director of Corporate Governance/Board Secretary, Risk management strategy, Internal Audit reports, Annual Governance Statement, self assessment against FT Code of Governance. Open Board meeting papers.	The Trust complies with this condition. An Associate Director of Corporate Governance/Board Secretary is in place and reports to the Director of Strategy & Integration as the lead Executive for corporate governance. The Associate Director is responsible for ensuring that the Trust has robust corporate governance arrangements in place.	Job Description for Associate Director of Corporate Governance/Board Secretary, Risk management strategy, Internal Audit reports, Annual Governance Statement, self assessment against FT Code of Governance. Board meeting papers.
FT4 (3)	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Chief Executive	The Trust complies with this condition. It uses a range of mechanisms to receive, consider and assure itself in relation to the 'Well Led' Standards described by the Care Quality Commission and any guidance issued by NHS Improvement in relation to good governance.	Minutes of the Academy meetings, Committee meetings and, Open and Closed Board.	The Trust complies with this condition. It uses a range of mechanisms to receive, consider and assure itself in relation to the 'Well Led' Standards described by the Care Quality Commission and any guidance issued by NHS England in relation to good governance.	Minutes of the Academy meetings, Committee meetings and, Open and Closed Board, self assessment against the FT Code of Governance, Internal Audit reports.
FT4 (4)	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Chief Executive	The Trust complies with this condition. Following a review of governance arrangements in 2020/21 the Trust has implemented an academy governance model which was developed with the support of external governance specialists. In September 2021 the Board reviewed its arrangements and made adjustments in standing down the Regulation and Assurance Committee, and the appointment of Non-Executive Director Chairs of the Academies. The Trust uses a range of mechanisms to assure the effectiveness of its governance arrangements including Internal Audit, external 'well led' reviews and internal assurance work in terms of the conduct of academies and committees. The Audit Committee provides assurance and challenge across the governance portfolio of the organisation. Terms of reference for the Board of Directors, its Committees, Academies and their Sub-Groups are reviewed at least annually to ensure alignment with the Foundation Trust's Strategic Objectives. The Risk Management Strategy describes accountabilities and reporting lines throughout the organisation. The Foundation Trust received a rating of 'good' for the CQC 'well led' domain following an inspection in November 2019.	CQC Well Led Review, NHS I Review of 'Use of Resources', Internal Audit Reports, Committee/Academy Terms of Reference, Agendas, Papers and Minutes of Board, Committees, and Academies, Internal assurance review reports, Board Assurance Framework, Constitution, Code of Governance, Register of Interests, Annual Governance Statement, CQC inspection outcome.	The Trust complies with this condition. The Trust has in place an academy governance model which was developed with the support of external governance specialists. The Trust uses a range of mechanisms to assure the effectiveness of its governance arrangements including Internal Audit, external 'well led' reviews and internal assurance work in terms of the conduct of academies and committees. The Audit Committee provides assurance and challenge across the governance portfolio of the organisation. Terms of reference for the Board of Directors, its Committees, Academies and their Sub-Groups are reviewed at least annually to ensure alignment with the Foundation Trust's Strategic Objectives. The Risk Management Strategy describes accountabilities and reporting lines throughout the organisation. The Foundation Trust received a rating of 'good' for the CQC 'well led' domain following an inspection in November 2019.	CQC Well Led Review, NHSE Review of 'Use of Resources', Internal Audit Reports, Committee/Academy Terms of Reference, Agendas, Papers and Minutes of Board, Committees, and Academies, Internal assurance review reports, Board Assurance Framework, Constitution, FT Code of Governance, Register of Interests, Annual Governance Statement, CQC inspection outcomes.
FT4 (5)	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	(a) Director of Finance/Chief Operating Officer (b) Chief Executive (c) Chief Executive (d) Director of Finance (e) Chief Digital and Information Officer (f) Chief Executive (g) Director of Finance/Chief Operating Officer (h) Chief Executive	(a) The Trust complies with this condition. The Foundation Trust has a range of co-ordinated systems and processes that are clearly described within its operational and governance infrastructure that ensures that it operates efficiently, effectively and economically. As part of its annual audit, it is expected that the Trust's external auditor will be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2021/22. (b) The Trust complies with this condition. The Board of Directors and its Academies receive a comprehensive suite of information in a timely fashion that enables Directors to oversee and scrutinise operations. The information is provided in a dashboard format, using SPC charts to provide contemporaneous performance oversight. This is supplemented by a range of scheduled and by exception papers and presentations. Assurance reports are provided by Academies to the Board. (c) The Trust is compliant with this condition. The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust was subject to an inspection by the CQC in December 2019 and received an overall 'Good' rating with a 'requires improvement' for Maternity. The Trust uses different methods to understand and evidence its compliance with health care standards, and, following a pause due to Covid, has now re-instated regular meetings to oversee the Trust's ambition to be an outstanding provider of healthcare. The Trust uses the NHS Standard contract for all material contracts with commissioners to ensure a consistent approach to contracting. Where possible all sub contracts and provider to provider agreements now utilise the non-mandatory NHS Standard Sub-Contract template. All contracts are subject to internal and external audit where required and actions all completed. The requirements placed upon providers to meet the NHS Operating Framework are all detailed within the standard contract. The Trust has complied with the national interim NHS governance /	Annual Report and Accounts 2021/22, Auditors Annual Report including Value for Money Arrangements, Annual Governance Statement, integrated dashboards, CQC inspection report, SFIs, scheme of delegation, budgetary control framework, Internal Audit reports, ISA260, Risk Management Strategy, R&A and Board papers and minutes, Annual audit reports, Governance structure, Board Assurance Framework.	(a) The Trust complies with this condition. The Trust has a range of co-ordinated systems and processes that are clearly described within its operational and governance infrastructure that ensures that it operates efficiently, effectively and economically. As part of its annual audit, it is expected that the Trust's external auditor will be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in 2022/23. (b) The Trust complies with this condition. The Board of Directors and its Academies receive a comprehensive suite of information in a timely fashion that enables Directors to oversee and scrutinise operations. The information is provided in a dashboard format, using SPC charts to provide contemporaneous performance oversight. This is supplemented by a range of scheduled and by exception papers and presentations. Assurance reports are provided by Academies to the Board. (c) The Trust is compliant with this condition. The Trust was (and continues to be) registered with the Care Quality Commission (CQC) with no conditions. The Trust was subject to an inspection by the CQC in December 2019 and received an overall 'Good' rating with a 'requires improvement' rating for Maternity. The Trust uses different methods to understand and evidence its compliance with health care standards, and, following the pause due to the Covid pandemic, has now re-instated regular meetings to oversee the Trust's ambition to be an outstanding provider of healthcare. The Trust uses the NHS Standard contract for all material contracts with commissioners to ensure a consistent approach to contracting. Where possible all sub contracts and provider to provider agreements now utilise the non-mandatory NHS Standard Sub-Contract template. All contracts are subject to internal and external audit where required and actions all completed. The requirements placed upon providers to meet the NHS Operating Framework are all detailed within the standard contract. (d) Financial decision making, management and control is governed through the SFIs, scheme of delegation and budgetary control framework. The Trust has a Finance & Performance Academy whose responsibilities include oversight of financial risks and management. The Academy reports to the Board. The Audit Committee is responsible for monitoring the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance. The Committee ensures that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided. The Committee reviews the Annual Report and Financial Statements before submission to the Board of Directors. (e) The Trust has systems and processes in place for the collection, recording, analysis and reporting of data. Robust controls are in place to continually evaluate data and ensure it remains accurate, valid, reliable, timely, relevant and complete on use. These controls are visible via a Trust-wide Data Quality Framework. The Trust has a range of governance mechanisms to ensure that data generated, collected and used, both internally and externally, is subject to an appropriate level of scrutiny, validation procedures and assurance processes. This includes; data quality 'kite marking' of all Board dashboard indicators, service sign off processes for mandatory reports, regular audits and an annual rolling improvement plan, monitored through a Data Governance Board. (f) The Trust has a clear risk management and escalation framework in place. High level risks are overseen by the Executive Management Team, Academies, and Board. (g) Financial and operational plans are developed in line with national planning guidance and are approved through the Board of Directors. (h) The Board of Directors is responsible for ensuring that the Trust complies with its statutory obligations.	Annual Report and Accounts 2021/22, Auditors Annual Report including Value for Money Arrangements, Annual Governance Statement, integrated dashboards, CQC inspection report, SFIs, scheme of delegation, Finance & Capital reports, Treasury Mgt reports, budgetary management framework, Internal Audit reports, ISA260, Risk Management Strategy, R&A and Board papers and minutes, Annual external audit reports including value for money, Governance structure, Board Assurance Framework. HFMA Financial Sustainability Self Assessment.
FT4 (6)	The Board is satisfied that the systems and/or processes referred to in paragraph FT4(5) (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Director of Strategy and Integration	The Trust complies with this condition. Recruitment and development processes ensure an appropriate capability across the Board. Board Assurance Framework displays timely information collated to capture quality of care across the Trust. The Quality and Patient Safety Academy, which is responsible to the Board has oversight of the quality governance arrangements within the Trust. The Academy provides assurance to the Board and Audit Committee and escalates issues where required. The Academy also ensures that opportunities for learning and improvement are identified and shared across the Trust as appropriate. Every Care Group, and in turn each component specialty, has a Quality and Safety Meeting where key individuals come together to discuss quality and safety issues as part of a standard agenda, ensuring the sharing of transferable lessons from incidents, complaints and claims and reviewing the risks being managed at both Clinical Business Unit and Specialty level, identifying the effectiveness of controls in place and ensuring appropriate application of the risk escalation framework.	Quality and Patient Safety Academy Minutes, Board minutes and papers, Board Assurance Framework, work plans.	The Trust complies with this condition. Recruitment and development processes ensure an appropriate capability across the Board. Board Assurance Framework displays timely information collated to capture quality of care across the Trust. The Quality and Patient Safety Academy, which is responsible to the Board has oversight of the quality governance arrangements within the Trust. The Academy provides assurance to the Board and Audit Committee and escalates issues where required. The Academy also ensures that opportunities for learning and improvement are identified and shared across the Trust as appropriate. Every CSU has a Quality and Safety Meeting where key individuals come together to discuss quality and safety issues as part of a standard agenda, ensuring the sharing of transferable lessons from incidents, complaints and claims and reviewing the risks being managed at both Clinical Service Unit and Specialty level, identifying the effectiveness of controls in place and ensuring appropriate application of the risk escalation framework.	Quality and Patient Safety Academy Minutes, Board minutes and papers, Board Assurance Framework, work plans, CSU quality and safety meeting minutes and papers.

FT4 (7)	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Chief Executive	The Trust complies with this condition. The Board regularly reviews requirements with regard to the skills and knowledge required to ensure the satisfaction of this requirement. As does the Council of Governors with regard to the appointments of the Chairperson and Non-Executive Directors. People arrangements within the Trust are overseen by the People Academy which reports to the Board.	Chair, Non-Executive, Executive and Director Job roles and person specifications. Implementation of the People Plan. Terms of reference, papers and minutes from the People Academy.	The Trust complies with this condition. The Board regularly reviews requirements with regard to the skills and knowledge required to ensure the satisfaction of this requirement. As does the Council of Governors with regard to the appointments of the Chairperson and Non-Executive Directors. People arrangements within the Trust are overseen by the People Academy which reports to the Board.	Chair, Non-Executive, Executive and Director Job roles and person specifications. Implementation of the People Plan. Terms of reference, papers and minutes from the People Academy.
FT4 (8)	8. The Licensee shall submit to Monitor within three months of the end of each financial year: a. a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and b. if required in writing by Monitor, a statement from its auditors either: i. confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or ii. setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.	Director of Strategy and Integration	It is expected that the Trust will be compliant with this condition. NHSI now no longer require the submission of a completed self-certification template to NHS I. The Trust is now required to publish a self-certification with regard to this condition by 30 June 2021.	The self-certification with regard to this condition will be published by the end of June 2021.	It is expected that the Trust will be compliant with this condition. NHSE now no longer require the submission of a completed self-certification template. The Trust is now required to publish a self-certification with regard to this condition by 30 June 2023.	The self-certification with regard to this condition will be published by the end of June 2023.

Good Governance and Collaboration					
Key collaboration function	Description	Executive Lead	Illustrative minimum behaviours (examples)	Response 2022/23	Evidence 2022/23
Providers will engage consistently in shared planning and decision making	Participating consistently and constructively with partners in system and place-based partnerships and provider collaboratives (this may include place based partnerships, provider collaboratives or other clinical networks), and ensuring open sharing of information and appropriate delegations are in place to develop shared plans and priorities and reach shared decisions.	Director of Strategy and Integration	Ensuring the participation of leaders with appropriate authority in system and place-based partnerships, and provider collaboratives to ensure shared or joined-up planning and effective decision-making arrangements, including in respect of capital plans. Committing sufficient resources to, and ensuring digital and data systems enable, system and place-based partnerships, and provider collaboratives to ensure shared planning and decision-making. Sharing sufficient information on a timely basis with partners to support shared planning and decision-making, and having regard to other sources of information such as joint strategic need assessments. Exploring the case for new service delivery models with partners, such as lead provider contracts, service reconfigurations, mergers or other arrangements.	The Trust is represented by senior members of staff at all appropriate system and place based meetings. A list of the Executive membership of these forums was presented to the Board in November 2022. In addition Mel Pickup is the Place Leader for Bradford District & Craven Health and Care Partnership. Members of BTHFT staff are involved in the Act as One strategic priorities e.g. Mel Pickup is lead for Access to Care, John Holden is SRO for Estates, Paul Rice is SRO for Digital & Information Intelligence, Karen Dawber is SRO for Complex Care pillar of Children, Young People & Families.	Minutes of system and place based meetings. List of executive membership of system and place based meetings, presented to Board in November 2022. Board Assurance Framework.
Providers will consistently take collective responsibility with partners for delivery of services across various footprints including system and place.	Helping enable a shared understanding of performance, supporting arrangements for working together to manage any risks to delivery and contributing to a culture that supports continuous system improvement.	Director of Strategy and Integration	Sharing demand and capacity information, including through system and place-based partnerships, or provider collaboratives, to allow partners to effectively manage risks to delivery of services. Engaging in mutual aid with other providers such as patient redirection, sharing of key workforce and sharing of scarce resources according to need. Seeking peer review and support in a timely manner if their organisation is at risk of failing to deliver its contribution to overall delivery of services. Working collaboratively with partners to improve care quality across pathways and services. Participating in clinical networks to raise standards of clinical practice and deliver benefits from collaborative working. Working with partners to deliver financial objectives in line with any system agreements of which a provider is part.	The Trust takes collective responsibility for delivery of services with partners across the ICS, Bradford District & Craven Place and WYAAT. One example of a WYAAT project is the West Yorkshire Vascular Service (WYVaS) which brings together two arterial centres in Leeds and Bradford Teaching Hospital Trusts, where vascular inpatient surgeries and vascular emergencies are located. Outpatient appointments will be undertaken at more local Trusts. By working together, we ensure that patients across West Yorkshire receive the same, high quality vascular care, no matter where they live. Another WYAAT programme has focused on elective care. In December 2021, the WYAAT hospitals came together and identified opportunities for patients to move between organisations (including the independent sector) and receive their treatment earlier. By October 2022, more than 300 patients were transferred and received treatment who otherwise may have remained on a waiting list at their local trust.	Minutes of system and place based meetings. WYAAT website and annual report.
Providers will consistently take responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider	Ensuring that: organisational plans are integrated with the five-year joint system plan; annual capital plan is agreed with the ICB and its partners; and that the organisation implements shared decisions and plans agreed through all relevant forums in a timely manner.	Director of Strategy and Integration	Clearly articulating how organisational plans integrate with the ICB five-year joint plan and annual capital plan, and other shared plans for delivery of agreed improvements. Active participation in system quality groups to support improvement in care quality. Timely and effective implementation of decisions agreed through system and place-based partnerships and provider collaboratives, or any other relevant forums. Working to deliver the financial duties and objectives for which the provider is collectively responsible with ICB partners. This includes the duty on local resource use not exceeding a limit set by NHS England. Sharing with partners the risks and benefits of agreed improvements or shared decisions. Committing sufficient workforce and resources to deliver agreed improvements.	The Trust published a new Corporate Strategy in 2022 which describes its alignment with ICB and Place level plans and strategies, including the WYHCP's '10 big ambitions'. The Strategy is focused around patients, people, partners and place and clearly describes how we will work with our partners across Bradford District & Craven and West Yorkshire; tackling problems together that cannot be resolved by individual organisations alone. There are established processes to support the development and delivery of financial plans at place and ICB and the Trust's Director of Finance and supporting staff are closely involved. The NED Chair of the Trust's Finance & Performance Academy is also chair of the BD&C System Finance & Performance Committee. The Trust's Finance & Performance Committee receives regular updates on financial performance for our Place and ICB.	Minutes of system and place based meetings. Corporate Strategy 2022-2027. BD&C and ICB financial updates to F&P Academy.
Characteristic	Description	Executive Lead	Key Lines of Enquiry (examples)	Response 2022/23	Evidence 2022/23
1. Developing and sustaining strong working relationships with partners	The manner of engagement must be consistently constructive and where appropriate proactive.	Director of Strategy and Integration	<ul style="list-style-type: none"> Do providers consistently engage with partners in a meaningful, effective and constructive way? Are providers contributing to building a culture of transparency, honesty, and constructive challenge where collective responsibility is taken for problems and conflicts are resolved quickly? Do providers communicate system vision, values and strategic goals to their staff and other stakeholders? 	The Trust has worked with its partners across Bradford District & Craven for a number of years. Our Corporate Strategy emphasises our commitment to working with our partners to deliver the best outcomes for patients. The Trust participates fully in place and ICS meetings with senior representation on all appropriate forums.	Corporate Strategy 22-27 Minutes of ICS forums, BD&C and WYAAT meetings
2. Ensuring decisions are taken at the right level	Decisions should be taken at the most appropriate level (eg ICP, ICB, place-based partnership, provider collaborative, provider board).	Director of Strategy and Integration	<ul style="list-style-type: none"> Do providers actively participate in all relevant and appropriate planning and decision- making forums? This may include system and place-based partnerships or provider collaboratives. Are decisions taken at the most appropriate level given the nature of the issue and are providers working with partners, including NHS bodies, local government and primary care, and engaging staff, patients and the wider public as necessary? Do providers engage with all relevant organisations and stakeholders on decisions that might affect them? 	See above regarding participation in relevant forums. There is a commitment across the ICB and BD&C place to the principle of subsidiarity - decisions are taken as close to communities as practical. Where we need to, we work at scale. Our three tests guide our choices on where work is undertaken and decisions taken. Is it necessary to work at a bigger scale in order to: <ul style="list-style-type: none"> achieve a critical mass in order to achieve the best outcomes for our population? share best practice and reduce variation? achieve better outcomes for people overall by tackling wicked issues (i.e. complex and / or intractable problems)? There are clear engagement processes in place - for example a public consultation exercise has been undertaken in relation to the review of Shipley Hospital and physiotherapy services.	Minutes of ICS forums, BD&C and WYAAT meetings Engage BDC website
3. Setting out clear and system-minded rationale for decisions	There should be clear consideration and articulation of why decisions have been made, having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for al, and sustainable use of NHS resources.	Director of Strategy and Integration	<ul style="list-style-type: none"> Are providers collaborating to develop the business case for any proposed system improvements, through a structured planning process, and working with patients, workforce and external partners? Do providers support an open and constructive dialogue regarding any risks or concerns? Has an equalities and health inequalities impact assessment been conducted where appropriate to inform decision-making? Have decisions been made with regard to the triple aim duty to support better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources, giving particular attention to reducing health inequalities between communities within the population? Are providers actively building business intelligence capacity to enable a single shared view of local challenges, performance and progress against delivery? 	The Trust works with its partners at place, ICS, and WYAAT to develop system improvements. For example the Director of Strategy & Integration is SRO for the Diabetes Programme across Bradford District & Craven and the Chief Medical and Chief Operating Officers are working with their counterparts at Airedale FT to develop service resilience plans, including in Haematology. Programmes of work are developed and delivered in a structured way with appropriate project management, engagement and involvement activity and impact assessments. The People First: Digital First programme plans to join up health and care records across Bradford District & Craven, so that health and care staff have access to the complete picture of a patient's health and social care. Beyond this, anonymised information will be securely linked together from across primary, secondary and community services. This 'big picture' perspective will allow services to be redesigned, offering more personalised and prevention-focused support to patients.	Minutes of ICS forums, BD&C and WYAAT meetings WYAAT Collaborative Programme Report, website and annual report People First: Digital First website
4. Establishing clear lines of accountability for decisions	There must be clear lines of accountability for decisions, taking into account providers' legal responsibilities and internal governance.	Director of Strategy and Integration	<ul style="list-style-type: none"> Have providers established clear reporting lines and accountabilities, with timely and effective oversight of their involvement in system and place-based partnerships, and provider collaboratives? Do providers empower system, place-based and at scale provider decision-making by appropriately delegating responsibility? Are there appropriate governance mechanisms within the organisation and joint working arrangements with partners, such as dispute resolution or escalation mechanisms, in place and are they well understood and effective? Are providers' strategic plans integrated with the ICB's five-year joint plan and annual capital plan, and the plans of place-based partnerships and provider collaboratives? Are providers actively involved in co-producing and driving programmes and plans? 	There are clear lines of accountability at all levels. The Bradford District & Craven Partnership Board is a committee of the ICB with delegated authority as set out in the ICB scheme of delegation and the Partnership Board's Terms of Reference. A Strategic Partnering Agreement is in place for the BD&C Health and Care Partnership which sets out the operating framework, values, principles and shared ambition of the Partners in supporting work towards the transformation of health and care and better health and wellbeing outcomes for the people who live in Bradford District and Craven through the Place Partnership model. WYAAT is overseen by a 'committee in common'. No authority has been formally delegated to the WYAAT CIC therefore decisions are referred to the individual Trust boards for approval, as required. The Trust receives regular updates and reports relating to its involvement in the ICS, BD&C Health and Care Partnership and WYAAT. Updates are provided through the Chief Executive's report to the Board, updates presented to Academy meetings and a regular update report on the WYAAT collaborative programmes. The Board also receives a partnership dashboard at each meeting and there are two risks included on the BAF relating to our strategic objective to collaborate effectively with local and regional partners.	ICB Constitution and Scheme of Delegation BD&C Health and Care Partnership Board Terms of Reference Strategic Partnering Agreement WYAAT CIC Terms of Reference and MOU
5. Ensuring delivery of improvements and decisions	There must be adequate systems and processes to ensure providers follow through on shared decisions so that system and place level improvements are delivered for the benefit of patients and the public.	Director of Strategy and Integration	Are providers committed to enabling the successful delivery of plans, including a willingness to share any risks or benefits that arise from collaboration? <ul style="list-style-type: none"> Do providers proactively and openly share high-quality information as appropriate to support planning and/or implementation of improvements for the benefit of patients? Do providers commit adequate resources and staff to participate in system planning and delivery, such as taking up system leadership roles, embedding or seconding staff to partner organisations, or contributing to funding a joint project management office? 	See above - senior leaders within the Trust participate in system meetings as appropriate, and staff across the Trust are supporting the delivery of collaborative programmes and initiatives. For example the Head of EDI and Head of OD are leading place workstreams on inclusion and leadership respectively.	Minutes of ICS forums, BD&C and WYAAT meetings