NHS

University Hospitals Birmingham

NHS Foundation Trust

Annual Report and Accounts 2019/20

This annual report covers the period 1 April 2019 to 31 March 2020

University Hospitals Birmingham NHS Foundation Trust
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Section 1

Annual Report 2019/20

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Performance report

1 Overview

The purpose of this section is to give a short summary that provides sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

University Hospitals Birmingham NHS Foundation Trust (UHB) is a high performing healthcare organisation with a proven international reputation for its quality of care, information technology, clinical education and training and research. The Trust was established in 1995 and was among the first to be awarded foundation trust status by Monitor (now NHS Improvement) in July 2004.

In recent years, the Trust has been increasingly acknowledged as one of the most successful NHS foundation trusts and has therefore been asked to provide management support to a number of other trusts.

From October and November 2015 respectively, UHB's then Chief Executive and Chair held Interim corresponding roles at Heart of England NHS Foundation Trust (HEFT), along with other senior managers, to improve its clinical, financial and operational position. The acquisition of HEFT by UHB was concluded successfully on 1 April 2018.

UHB runs the Queen Elizabeth Hospital Birmingham, Birmingham Chest Clinic, Heartlands Hospital, Good Hope Hospital, Solihull Hospital and various community services across the region.

As a foundation trust, UHB has approximately 57,500 members and employs more than 21,000 members of staff. It is one of the largest trusts in England treating over 2.8 million patients each year and has more than 2,700 beds across its sites.

The Trust has regional centres for trauma, burns, plastics, neurosciences, dermatology and cancer. It also has centres of excellence for vascular, bariatric and pathology services, as well as the treatment of MRSA and other infectious diseases.

It also has expertise in HIV/AIDS, premature baby care, bone marrow transplants and thoracic surgery.

The Trust delivers approximately 10,000 babies each year and provides around 20,000 days of neo-natal care.

UHB has the largest solid organ transplantation programme in Europe and runs Umbrella, the sexual health service for Birmingham and Solihull. It is also home to the West Midlands Adult Cystic Fibrosis Centre and a nationally-renowned weight management clinic and research centre.

The Queen Elizabeth Hospital Birmingham is a Major Trauma Centre treating the most severely injured casualties from across the region. The hospital's single site 100-bed critical care unit is the largest in Europe.

The Trust hosts the Institute of Translational Medicine (ITM) and led the West Midlands Genomics Medicine Centre as part of the national 100,000 Genomes Project.

UHB is proud to host the Royal Centre for Defence Medicine (RCDM). The RCDM provides dedicated training for defence personnel and is a focus for medical research.

UHB also holds the contract for providing medical services to military personnel evacuated from overseas via the aero medical service. UHB is one of only a small number of hospitals that can provide the full range of medical specialties – trauma, burns, plastics, orthopaedics, neurosurgery and critical care – needed to treat the complex nature of conflict injuries, all under one roof.

The pioneering techniques in surgery and pain control that have been developed whilst treating military patients are now being used for civilian surgery in the UK and elsewhere and are being progressed through the Surgical Reconstruction and Microbiology Research Centre (SRMRC).

The Trust's vision is 'to build healthier lives'. This is underpinned by the Trust's values: collaborative, honest, accountable, innovative and respectful and its core purposes of excellent clinical quality, patient experience, workforce, and research and innovation.

1.1 Details of overseas operations

The Trust has no permanent overseas operations but has continued its work to strengthen the Trust's international reputation and profile through:

- Delivering its international training and fellowship programmes with international partners
- Developing opportunities to share its expertise in new hospital commissioning overseas, particularly with Chinese partners (see below)
- Exploring the potential of providing education with international partners

Innovating Global Health China Limited is a Hong Kong registered company, established as a Joint Venture between the Trust and Innovating Global Health SA (IGH), for the identification, development and pursuit of healthcare opportunities in China. The Trust and IGH each own 50% shareholdings in Innovating Global Health China Limited. We have a number of proposals relating to improvement and development programmes but we do not expect progress on these for the foreseeable future given the obvious impact of COVID-19 and the resultant delays in business activity.

1.2 Royal Centre for Defence Medicine

University Hospitals Birmingham NHS Foundation Trust is the primary receiving hospital for military personnel injured overseas. The Royal Centre for Defence Medicine (RCDM), nested with the QEHB, works in partnership with UHB and a number of other NHS hospitals in the Birmingham area to support the operational patient pathway, with the majority of casualties receiving treatment at the QEHB.

Established in 2001, the RCDM's primary role is the focal point for the military reception of operational casualties. RCDM is one of the units commanded by the Defence Medical Group (DMG), which also includes the Defence Medical Rehabilitation Centre at Headley Court. DMG's role is to provide highly capable secondary healthcare personnel for operations and deliver the patient pathway. DMG sits under the command of Director Healthcare Delivery and Training, part of Headquarters Surgeon General.

RCDM is made up of approximately 380 uniformed personnel. Most fulfil a clinical role but around 50 personnel work in the Headquarters, with some working in academic positions throughout Birmingham.

The combined experience of the military and medical staff and the civilian doctors, nurses and allied health professionals working together means UHB strives to deliver the best clinical care in the country. The hospital is at the leading edge in the medical care of trauma injuries and the experience gained by the staff working in this busy acute care environment provides the ideal training required for operations.

Military patients are treated on the ward most appropriate to their recovery. Service personnel and their families have the opportunity to use a Day Room on one of the trauma wards, which features welfare facilities to maintain their morale during their hospital stay. Families of patients can also stay at Fisher House, an 18-bedroomed home from home for families of injured military personnel, during their recovery.

Whilst the NHS provides the treatment to meet the patient's immediate clinical needs, RCDM is uniquely enhanced to provide medical, administrative and welfare support to service patients (and their families) admitted from operations. This 'military bubble' concept is necessary for the wellbeing of the operational casualty and is an integral part of the morale component of fighting power.

1.3 Sustainability and Transformation Partnership

University Hospitals Birmingham continues to play an integral part in Birmingham and Solihull Sustainability and Transformation Partnership (STP). The STP, chaired by UHB's Chair Rt Hon Jacqui Smith, is a collaboration of public NHS and council social care providers across Birmingham and Solihull, working together with partners in the Community, Voluntary and Social Enterprise sector to find the most effective ways to manage the health and care needs of our population within the available resources and to provide high quality, sustainable care for the future.

The STP aims to do everything within its considerable, collective power to address inequality and contribute to its people's health and happiness, from local residents to staff at its numerous sites across the city.

Its vision is to help everyone in Birmingham and Solihull to live the healthiest and happiest lives possible.

Its mission is: Born well, grow well, live well, age well and die well. This ethos has been reflected in NHS England's (NHSE) Long Term Plan (LTP), which was launched in January 2019. The LTP is a new, ten year plan for the NHS to "improve the quality of patient care and health outcomes".

The Birmingham and Solihull STP's three priorities are focused on people's lives; not sectors, organisations or diseases. They are:

1. Maternity, Childhood and Adolescence
2. Adulthood and Work
3. Ageing and later life

They will be supported by 'enablers' based on new approaches to clean air, urgent care, digital innovation and the best use of public estates.

Each STP priority has a Portfolio Board which will drive forward delivery of the projects detailed within the Transformation and Sustainability strategy.

2 Financial Review

In 2004, the Trust achieved foundation trust status under the Health and Social Care (Community Health and Standards) Act 2003. As such, these annual accounts have been prepared under directions issued by the foundation trust regulator, NHS Improvement.

2.1 2019/20 changes in accounting policies

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2020 and appropriate to NHS foundation trusts.

There have been no changes to accounting standards during 2019/20 that have had a material impact upon the Trust's financial statements. Due to the COVID-19 pandemic, HM Treasury postponed until 2020/21 the implementation of IFRS 16 'Leases' across the Department of Health.

2.2 Financial performance

The Trust's total annual revenue increased to £1,758.4 million (£1,613.6 million in 2018/19), this increase predominantly driven by growth in emergency admissions and cost per case excluded drugs and devices. Like many NHS acute service providers, the Trust's 2019/20 financial position is a small surplus, supported by the Provider Sustainability and Financial Recovery Funding allocated via NHS Improvement. The Trust delivered an overall retained surplus of £0.4m; in order to compare to the breakeven (£nil) control total set by NHS Improvement. Exclusions are made removing the £2.5m of estates impairments, £0.7m of donated asset adjustments and (£0.9m) of 2018/19 bonus PSF resulting in a £2.7m favourable variance against the control total.

The £2.5m estates impairment is an accounting adjustment (non-cash) relating to the valuation of the Trust's land and properties; it is not an actual monetary loss.

2.3 Income and expenditure

The following table compares the revised planned income and expenditure with the outturn position for 2019/20.

Summary income and expenditure – plan v. outturn

Consolidated Summarised Income and Expenditure - Group	YTD Plan Mar 20 £m	YTD Actual Mar 20 £m	YTD Variance Mar 20 £m
Operating income from patient care activities	1,477.1	1,541.6	64.5
Other operating income	200.9	216.8	15.9
Employee expenses	(968.3)	(1,019.3)	(51.0)
Operating expenses excluding employee expenses	(684.8)	(713.3)	(28.5)
Operating surplus	**24.9**	**25.8**	**0.9**
Finance costs			
Finance income	0.6	0.5	(0.1)
Finance expense	(24.0)	(24.0)	0.0

Consolidated Summarised Income and Expenditure - Group	YTD Plan Mar 20 £m	YTD Actual Mar 20 £m	YTD Variance Mar 20 £m
PDC dividend expense	(1.5)	(1.3)	0.2
Net finance costs	**(24.9)**	**(24.8)**	**0.1**
Other gains/ (losses) including disposal of assets	0.0	(0.3)	(0.3)
Share of profit/ (loss) of associates/ joint ventures	0.0	0.0	0.0
Gains/(losses) from transfers by absorption	0.0	0.0	0.0
Movements in fair value of investments, investment property and financial liabilities	0.0	0.0	0.0
Corporation tax expense	0.0	(0.3)	(0.3)
Surplus for the year	0.0	0.4	0.4

The largest component of the Trust's income comes from the provision of NHS patient care services funded by NHS commissioners within England. This accounted for £1,518.5m (86.4%) of total income. Other patient care revenues contributed a further £23.1m (1.3%), which includes income for NHS patients treated from Scotland, Wales and Northern Ireland, private patients and costs recovered from insurers under the Injury Cost Recovery Scheme.

The Trust has a range of income streams which are not linked directly to patient care. These include education levies, which account for £53.7m (3.0% of the total income, such as the Service Increment for Teaching (SIFT), recognising the cost of training medical undergraduates from the University of Birmingham, the Medical and Dental Education Levy (MADEL), which supports the salary costs of post graduate doctors in training, and the Non-Medical Education and Training (NMET) levy.

Research and Development (R&D) activity funding totalled £36.5m (2.1% of total income). This includes grants from the National Institute for Health Research (NIHR) to support the Wellcome Trust Clinical Research Facility and other research infrastructure.

As highlighted elsewhere in this report, Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate Threshold (MRET) income totalled £37.1m during 2019/20 and a further £22.7m was generated from services provided by the Trust to other organisations. The balance of the Trust's income is attributable to trading activities and other miscellaneous items.

Within Trust expenditure, the largest category is salaries and wages totalling £1,019.7m (including Directors and Non Executives) which is equivalent to 58.9% of total operating expenditure. Other significant components include £428.2m on drugs and clinical supplies (24.7%), estates and premises costs of £72.5m (4.2%) and depreciation and amortisation of £36.9m (2.1%).

2.4 Capital Expenditure Plan

During 2019/20, the Trust invested £43.0m of capital expenditure on medical equipment, ICT infrastructure and improvements to existing buildings:

SITE	TYPE	Actual £m
All	Medical Equipment replacement	11.1
All	Estates & Facilities Works	9.4
All	ICT Infrastructure	4.9
All	ICT GDE, HSLI schemes & Cyber security	6.6
HGS	ACAD	0.6
QE	QEHB PFI Lifecycle	3.7
QE	Major Medical inc.	4.8
All	Winter Estates Schemes	0.3
All	Grants & Charitable	1.0
All	ICT workforce & healthcare records	0.6
	TOTAL	**43.0**

This investment was £2.9m below the original planned investments for the year, predominantly as a result of delays in replacement of some Major Medical Equipment.

Planned capital investment for 2020/21 is currently estimated at £68.8 million and includes plans for:

- Proactive replacement of medical equipment

- Ongoing investment into IT infrastructure
- Statutory maintenance works within Trust buildings
- Major medical equipment
- Contracted lifecycle works within the QEHB
- ICT Global Digital Exemplar systems investments (externally funded)
- ACAD building at the Heartlands site (PDC funded)

2.5 Value for Money

During 2019/20, the Trust delivered £43.1m of efficiency savings across all services against a plan of £42.0m. A formal cost improvement programme (CIP) target was set across all divisions and corporate functions. Divisions and corporate functions were supported in delivery of this target using benchmarking opportunities and review / improvement of patient pathways made possible by an organisational restructure to allow consistent management of services across all the Trust's sites.

A full database of all schemes being progressed was in place throughout the year for both expenditure reductions and income generation schemes and also included a full Quality Impact Assessment to ensure schemes did not have a detrimental impact on patient care.

Whilst some schemes did not deliver as anticipated at the start of the financial year, further efficiencies were identified and realised in year through initiatives such as ongoing tendering, contract renegotiation, product standardisation, bulk purchases and the use of local, regional and national purchasing frameworks. Weekly reviews of non-clinical recruitment requests are undertaken for new and existing posts (to ensure consistency of banding and sufficient funding streams), together with evaluation of short term agency requests, in the Establishment Review Group.

2.6 COVID-19 Pandemic

During the final month of the financial year, the COVID-19 pandemic began and the Trust incurred additional costs in responding to this. The Trust was fully funded for the 2019/20 impact of the pandemic and both the costs and additional income are included within the financial statements.

2.7 UHB Charity

The charitable funds for the Trust are administered by UHB Charity, a separate legal entity from the Trust and therefore are not consolidated with the Trust's accounts. In 2019/20, the Trust received grants of £1.4m and donated assets worth £1.0m from the UHB Charity.

2.8 External Auditor

The Trust's external auditor is Deloitte LLP; the audit cost for the year was £223,800 for the Trust's statutory audit and £5,400 for the quality report audit. Other work undertaken by Deloitte LLP in year included £20,240 for the statutory audit of the subsidiaries and £75,000 for the Trust's local counter fraud work.

The appointment of external audit services for 2019/20 was made by the Council of Governors. In addition, Deloitte also provide local counter fraud services to the Trust which is the non-audit work stated.

2.9 Basis for the Accounts

The Trust has four operational wholly-owned subsidiary companies:

- Pharmacy@QEHB Limited, which commenced trading in 2011, providing an outpatients pharmacy service in the Queen Elizabeth Hospital Birmingham
- UHB Facilities Ltd, which commenced trading in 2014, providing estate management services
- Assure Dialysis Services Ltd, which commenced trading in 2014, providing renal dialysis services to the Trust
- Professional Activity Ltd, purchased in 2017/18, which is not yet trading but developing software for the job scheduling of clinicians

The Trust also has a fifth wholly owned subsidiary, Birmingham Systems Ltd, which has not traded since it was acquired.

The financial results of the subsidiary companies are consolidated with those of the Trust to produce the group financial statements enclosed.

These group financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2020 and appropriate to NHS foundation trusts.

2.10 Going Concern

As a result of the COVID-19 pandemic the Department of Health and Social Care (DHSC) initiated an emergency financial regime initially for the first four months of 2020/21. This involves the Trust receiving a known block contract value on a monthly basis with a process to apply for retrospective top-up funding to ensure providers are fully funded for the requirements in responding to the pandemic.

The financial regime has not been finalised from August onwards but a clear commitment was published by NHSE/I that providers and commissioners will be adequately funded to continue to meet the healthcare needs of the population.

In addition, DHSC have announced the intention to repay all interim loans in September 2020.

As such the financial statements have been prepared on a going concern basis in light of the information available to the Board of Directors at this point.

3 Performance Review

In Q4, the Trust, along with every healthcare provider, was massively impacted by the Coronavirus (COVID-19) outbreak. By February 2020, the Trust had established cross-site working groups to oversee UHB's response to the pandemic.

The initial clinical focus of the Trust's preparedness was on patients presenting to emergency departments with concerns they may have Coronavirus or may have been in contact with someone suspected as having Coronavirus. As the situation quickly emerged the impact was felt throughout the organisation, with decisions made daily to create the safest possible environment for patients and staff.

With effect from 17 March, the Trust significantly reduced elective inpatient and day case surgery to repurpose capacity and train staff for dealing with the anticipated increase in very sick patients.

In order to remove footfall on site, the Trust also converted all outpatient appointments to telephone/video consultation, unless it was clinically necessary to attend hospital to have a procedure.

Due to these and numerous other contingencies, measuring performance against key health care targets for the 2019/20 period cannot be done in a meaningful way.

New guidance issued within the Foundation Trust Annual Reporting Manual, states that the Trust is therefore no longer required to include a Performance Analysis section within the Performance Review of this year's Annual Report.

3.1 The Trust strategy

The Trust's strategy remains broadly similar to that adopted in December 2018 with three headline strategic priorities running in parallel:

To maintain high quality care, through effective day-to-day operational and financial performance across our hospitals and services;

To integrate our clinical services and corporate functions across sites so that our patients can expect the same high standards and joined-up care wherever they are;

To transform the model of healthcare by using new technology to care for patients in the most appropriate settings and to manage demand.

As part of this agenda, the Trust vision continues to 'build healthier lives' with the aim of providing high quality care for the patients who come to us for treatment. We will also be increasingly concerned with the mental and physical health of our population before and after they come to us.

To support the implementation of these objectives, the Trust Strategy set out nine strategic themes, as shown here:

Clinical service planning across sites	**Standardise high quality patient care**	**Non-clinical support services**
Digital and technological transformation	**Make best use of all our resources**	**Develop and support our workforce**
Work with our partners	**Research and innovation**	**Emergency preparedness**

The Trust's strategy and plan is broadly congruent with that of the Birmingham and Solihull STP.

The planning process for 2020/21 has identified key deliverables for the delivery of the second full year of the new strategy. At the joint meeting of the Board of Directors and Council of Governors in December 2019, a draft of the plan for 2020/21 was shared with the Council of Governors which was given the opportunity to contribute in line with the Trust's constitution and the Foundation Trust Code of Governance.

Priorities were further discussed with the Governors' Strategy and Annual Plan Reference Group in February and that group will continue to undertake ongoing monitoring of the strategy and plan throughout the year ahead. Following further discussion with directors and leads across the Trust, the priorities have been developed into strategic objectives and have been brought together in the 2020/21 Strategy Implementation Plan which was approved by the Board of Directors in March 2020.

The Trust continues to have 20 strategic objectives for 2020/21 but these have been amended somewhat in response to both local and external developments. The agreed objectives are as follows:

Reference	Strategic objective
1	Increase alignment of corporate and clinical services across UHB
2	Eliminate unwarranted variation in services for patients through aligning and standardising pathways and service delivery
3	Provide the highest quality of care to patients through a comprehensive quality improvement programme
4	Meet regulatory requirements and operational performance standards, in line with agreed trajectories
5	Empower patients to have control over their care, data and referral pathways through a Digital First approach
6	Transition IT services to ensure all parts of UHB can access optimal clinical IT solutions
7	Achieve the highest standards in cybersecurity
8	Use our resources as efficiently as possible
9	Invest in our estates and capital infrastructure to provide high quality facilities for patients and minimise under-utilised clinical space
10	Transform the model of care to ensure patients are seen in the right settings and to move lower acuity care off acute/specialist sites
11	Optimise workforce supply to ensure sufficient staff and roles to meet patient demand
12	Provide high quality education and training to support a highly skilled and effective current and future workforce
13	Promote inclusion, health and wellbeing and diversity
14	Embed a comprehensive leadership development programme across the Trust
15	Align clinical and corporate service planning across other providers within the BSol STP to improve integration for patients
16	Work with international partners to develop health care services and forward UHB's reputation
17	Maximise the opportunities for research and innovation across the whole Trust
18	Standardise research and development processes across the Trust
19	Increase research and innovation activities associated with artificial intelligence
20	Align emergency preparedness and business continuity planning across our sites

As in previous years, the plan will continue to be reviewed in-year, in response to changes in the local and national environment including a full review at the end of each quarter when progress updates are presented to the Board of Directors.

In addition the implications of COVID-19 on delivery of the strategy are still being worked through. In some cases this may delay delivery but other objectives will see delivery earlier than planned as some key initiatives are being brought forward to mitigate the effects.

3.2 Policies in relation to disabled employees and equal opportunities

Disabled employees have regular access to the Trust's Occupational Health Services including ergonomic assessment of the workplace to ensure that access and the working environment is appropriate to their needs. Staff who become disabled whilst in employment have access to these services and are also supported in moving posts with appropriate adjustments, should it become inappropriate for them to continue in their original post. The Trust utilises organisations such as Access to Work, Autism West Midlands, Guide Dogs, RNIB, and Action for Hearing Loss for specialist advice to enable disabled staff to continue working at the Trust where possible.

The Trust also ensures that staff with disabilities are able to access training opportunities. When booking on to training courses staff are asked if they have any special needs or requirements. If this is the case, arrangements are made. This includes the use of hearing loop facilities and BSL interpreters.

A number of courses are also provided which focus on equality and diversity issues, including equality and diversity workshops, disability awareness training, equality impact assessment training, cultural awareness workshops, recruitment and selection. All new staff receive information on equality and diversity issues during their induction. In addition a facility is provided for staff who wish to improve upon their literacy and numeracy skills. Support can also be utilised via the Learning Hub at the Trust.

In 2019 the Trust submitted for the first time to the Workforce Disability Equality Standard (WDES) and has committed to the following actions in order to improve the experience of our staff with a disability:

3.2.1 Improve the declaration rates of staff with a disability

The workforce comparison against the local population suggests under-reporting of disabilities. Although the position has slightly improved through previous data cleanse exercises carried out, there is still work to be done to improve the data which is recorded on ESR in relation to staff with a disability. This is highlighted by the 16.5% (1,051) of those staff who completed the 2018 National Staff Survey declaring they have a disability compared to 2.6% of staff (539 employees) on ESR.

The Trust aims to improve the declaration rates of staff with a disability on ESR from 2.6% to 4% by the end of 2022. This will involve undertaking a further cleanse of the data which it holds. This will involve a communication campaign to raise awareness and improve understanding of the importance of recording disability as well as providing staff with the confidence to declare.

3.2.2 Changing the way we conduct recruitment and selection processes

Further investigation is required into the relatively low proportion of disabled recruits. The Trust has upgraded its Disability Confident Scheme status from 'Committed' to 'Employer' which will lead to innovative ways of attracting, recruiting and retaining people with a disability or long-term health condition. This will involve working with national and local partners to share best practice and implement new ways of conducting recruitment and selection in the Trust. In addition, to attract recruit and retain from a more diverse pool of talent, the Trust will forge links with key community stakeholders and showcase UHB as an inclusive employer of choice.

3.2.3 Changing the overall engagement and satisfaction of staff with a disability

There are some notable differences in the national staff survey results, in particular, the organisation acts fairly on career progression (72% Disabled Staff / 84% Non-Disabled Staff); the percentage of staff feeling pressure from their manager to come to work despite not feeling well enough to perform their duties (36% Disabled Staff / 25% Non-Disabled Staff); percentage of staff saying they are satisfied with the extent to which their organisation values their work (35% Disabled Staff / 48% Non-Disabled Staff). A task and finish group will be established to better understand the experiences of staff with a disability in the Trust and the cause of their low engagement score and overall satisfaction with the Trust.

3.2.4 Increase knowledge, skills and confidence for senior and middle management

The Trust will develop a portfolio of internal leadership programmes which will be available to all staff and will provide them with the knowledge, skills and confidence to advance in their careers. The Trust will also develop inclusion training for leaders in the Trust to increase confidence and the use of discretion. The Inclusion Leadership Programme for Managers will provide a better understanding of what inclusive leadership means and, amongst a range of inclusive subject matters, will cover supporting staff with a disability, workplace adjustments and Access to Work.

3.2.5 Consider the development of a Disability Case Manager for staff with a disability or long-term health condition

The Trust will consider the development of a Disability Case Manager who will advocate, advise and support staff with a disability or long-term health condition. Staff seeking support and guidance on matters relating to managing their disability, such as advice on workplace adjustments; the smooth process of Access to Work applications and implementing recommendations; and help with understanding Trust policy and procedures, will be able to speak to the Disability Case Manager. Staff will be able to approach this person for confidential advice where they feel they may have experienced harassment and that this may have been associated to their disability or long-term health condition. The Disability Case Manager will oversee the management of all related disability casework and will work with the individual and the Manager to reach a solution.

The Trust is committed to the Disability Confident Scheme which aims to attract, recruit and retain people with a disability or long-term health condition. The Disability Confident Scheme supports employers to make the most of the talents disabled people can bring to the workplace. Being Disability Confident is an opportunity for the Trust to lead the way for disability inclusion and to discover skills and talents we cannot do without. In 2019 the Trust upgraded its status from 'Committed' to 'Employer' status with the scheme which means the Trust is committed to inclusive and accessible recruitment; inclusive communication of vacancies; offering interviews to disabled people; providing reasonable adjustments; and supporting existing disabled employees. As part of the scheme the Trust is required to meet the following standards:

- ensure our recruitment process is inclusive and accessible
- ensure against discrimination
- make job adverts accessible
- provide information in accessible formats (e.g. large print)
- accept applications in alternative formats (e.g. electronically)
- communicate and promote vacancies
- advertise vacancies through a range of communication channels
- get advice from Jobcentre Plus, Work Programme providers and local disabled people's user-led organisations
- review current recruitment processes
- offer interviews to disabled people
- encourage applications from disabled people by offering them an interview if they meet the minimum criteria for the job (this is the description of the job set by the employer)
- anticipate and provide reasonable adjustments as required
- make sure disabled people aren't disadvantaged when applying for and doing their jobs
- support any existing employee who acquires a disability or long-term health condition to stay in work
- retaining an employee who has become disabled means keeping their valuable skills and experience and saves on the cost of recruiting a replacement

The Trust's commitment to candidates with disabilities is outlined in its Information for Applicants which is attached to all job advertisements.

Managers are required to promote the recruitment of all diverse groups.

All Trust policies and procedures are equality impact-assessed to ensure that they have no adverse impact due to disability (or any of the other protected characteristics as per the Equality Act 2010).

The Trust has a successful Staff with a Disability or Long-Term Health Condition network which continues to grow in size and influence. The network meets bi-monthly and provides an opportunity for the members to work in partnership with the Trust to enable change for staff and patients with a disability. The network has two dedicated Chairs who will often meet with disabled staff to listen to their experiences and offer advice and support. Recently, the network members requested for a separate sub group to be set up specifically for staff with neurodiversity so that the voices of those staff could be heard.

The staff network reports into the Inclusion Stakeholder Group chaired by the Executive Chief Nurse. These quarterly meetings offer the Chair of the staff network with the opportunity to share the experiences of the members with key stakeholders throughout the Trust. The Inclusion Stakeholder Group monitors the progress against the indicators in the WDES report and provides an update to the Trust Board.

In September 2019 the Trust held an engagement event with representatives from all staff groups in order to understand better the inclusion priorities for the Trust and to inform the new inclusion strategy. Staff with a disability were represented at this event and as a result it was recognised by the Trust that improving the overall engagement of disabled staff must be a key priority in the development of the new inclusion strategy.

As part of the new inclusion strategy the Trust will increase the engagement opportunities to hear the voices and listen to staff, including those with a disability, and use staff feedback to shape programmes of work to enable change. This will include a dedicated inclusion inbox for staff to confidentially get in touch with the inclusion team; the creation of an inclusion newsletter to share relevant information and celebrate the stories of our staff; a dedicated confidential contact for disability so that staff may have a person to contact who will understand their lived experiences; and a dedicated workforce inclusion team who will provide advice, advocacy and support.

In December 2020 the Trust will hold the first conference to celebrate people with a disability. The conference will be open to all staff and will hear from experts on living with a physical disability; living with neuro diversities; mental health awareness; plus six of our own staff will share their personal stories of living with a disability or long term health condition. The conference aims to be educational, informative as well as motivational and inspiring.

In addition to the Disability or Long-Term Health Condition Network the Trust has the following staff network groups that look to support our staff and provide a conduit for views and opinion on future developments and planning. Where possible Networks are run and chaired by their members:

- BAME
- LGBTQ+
- Women's
- Carers
- Young Person's
- Mental Health and Wellbeing
- Neuro Diversity

3.2.6 BAME

- The Trust will develop a comprehensive inclusion training offer to increase knowledge, skills and confidence and the use of discretion. This will include an Inclusion Leadership Programme for senior and middle managers which covers all aspects of inclusion and attends to the issues of intersectionality
- Work with all line managers to ensure that they understand the actions we are taking to support all our staff, particularly our BAME colleagues, who may be more susceptible to physical disabling factors and associated mental ill health due to the COVID-19 pandemic. We are skilling up managers to facilitate conversations with BAME colleagues as they would for all those within the vulnerable group
- Provide a BAME Leadership Programme to build capacity and pathways for senior leadership opportunities for BAME staff from Bands 5 and above. Increase diversity in leadership roles through the introduction of talent management initiatives, specific for staff in under representative groups such as disabled staff from minority groups
- The Trust will work with partners to improve its offer of inclusion training available to staff and expand on the inclusion training portfolio
- Develop an employee voice strategy that straddles disability, race equality and other protected characteristics – to cultivate inclusive relationships and respect for social justice through;
  - Communications – inclusive messaging and images across Trust communication platforms
  - Brand identity
  - Senior managers' survey
  - BAME Staff Survey – deep dive
  - Hearts & Minds – Conversations
  - Leadership Lectures - Race Equality and Disability - Intersectionality
  - Cultural Ambassadors/Leads
  - Engagement plan /Divisional / networks – Dialogue: Hearts and Minds extract

3.3 Social and Community Issues

The Learning Hub is a purpose-built training centre based on the QE site which promotes career opportunities within the healthcare sector. Having opened in September 2008 our aim is to continue to assist locally unemployed people within the local community who have a particular interest in working within the Healthcare Sector back into work. Within the last 12 months (April 19-March 20) The Learning Hub has supported 85 people into work with a majority being obtained through Youth Promise Plus (supporting 18-29 year old clients) and World of Work (supporting 30+ clients) both of which are Birmingham and Solihull Council initiatives funded via European Social Funds supporting those considered most at disadvantage.

Current Programme Delivery:

Once registered clients will be referred onto an appropriate pathway where they will receive 12 weeks of training and pastoral support. Pathways include:

Prince's Trust – Get into Hospitals

The Learning Hub works in partnership with the Prince's Trust in the delivery of their "Get Into" programme. Learners will receive a mixture of classroom (across both organisations) and work-based training (within the NHS) which is co-delivered by both the Learning Hub and Prince's

Trust staff. Enrolment for this programme is through the Prince's Trust directly.

Clinical and Non-Clinical Pathways

We currently offer two supported pathways for those that are further away from the job market. This will include classroom based training incorporating both employability and vocational based sessions. Where required learners will have the opportunity to upskill their English and Maths through the offer of functional skills support.

Clinical Pathway – this is designed for people who are interested in working within a clinical area e.g. health care assistants, theatre support workers, trainee nurse associate. Learners will complete a mixture of classroom and work based learning. Learners will gain an insight to the Care Certificate standards as well as employability skills.

Non-clinical – this is designed for non-clinical based roles, e.g. admin, porters, housekeeping, stores and logistics. Learners will complete a mixture of classroom and work-based learning. Learners will complete a digital skills qualification, as well as employability skills.

Fast track – for those that have maybe recently left employment or those that have that relevant qualifications or skills and experience, we will have a fast track pathway where they will be supported with NHS applications and interview techniques as well as a work placement in their chosen career.

3.4 Reducing Disadvantage

A key priority for the Trust has been to broaden access to the jobs and training healthcare has to offer to unemployed people, particularly those living in the most disadvantaged parts of the city.

As detailed in the last report, UHB commenced delivery on phase 2 of the "Youth Promise Plus" Birmingham City Council ESF initiative which will run until July 2021. To date in phase 2 we have registered 198 young people of which 104 have achieved a positive outcome including a conditional job offer, employment or an apprenticeship. In January we also embarked on a second Birmingham City Council ESF funded project "World of Work" which is due to run until October 2021 supporting the 30+ age group but with a priority group identified as 50+. To date we have registered 85 clients of which 33 have achieved a positive outcome including a conditional job offer, employment or an apprenticeship.

The focus for the next 12 months is to replicate the training delivered at the Learning Hub across our other hospital sites, in particular the Heartlands site which is in the heart of the West Midlands Combined Authority's priority ward areas. We have been working collaboratively with partner NHS trusts across Birmingham and Solihull looking at provisions available, with one of the key areas being how we support those disadvantaged. A recommendation is that the Learning Hub model will be replicated and so funding will need to be sourced. A community engagement plan is currently being compiled to ensure contact is made with all key community groups.

As detailed in the Workforce Disability Equality Standard (WDES), it reports the passage of disabled candidates from application, to shortlisted, to appointed. Analysis of the data taken from NHS Jobs shows the passage of disabled candidates from applied to shortlisted, to appointed. As at 31 March 2019 the number of shortlisted applicants with a disability was 1,238 compared to 29,276 without a disability. However despite the relative high number of people with a disability being shortlisted only 143 were successfully appointed compared to 4,625 people without a disability appointed. The report shows the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts 1.37 less likely. The Trust has upgraded its Disability Confident Scheme status from Committed to Employer which will lead to innovative ways of attracting, recruiting and retaining people with a disability or long term health condition. This will involve working with national and local partners to share best practice and implement new ways of conducting recruitment and selection in the Trust. In addition, to attract recruit and retain from a more diverse pool of talent the Trust will forge links with key community stakeholders and showcase UHB as an inclusive employer of choice.

In October 2015, the Trust launched three food collection points within the QEHB where members of staff, patients and visitors can donate food items to help those in real need, working in collaboration with Narthex (Sparkhill food and clothing bank). From May 2016 this was expanded to include clothing, which has enabled staff to 'draw down' clothes for patients who are assessed as being in need upon their discharge.

This year, 80 patients were provided with emergency clothing donations that have helped to support their discharge from hospital. Some 43 of these were between January and March 2020. In addition clothing has supported the Trust's 'Get up, Get dressed, Get moving' initiative. In total, in 2019/2020 1,401kg of clothes have been donated.

In 2019/20 UHB donated 1,414.9kg of food and issued 229 food parcels (compared to 40 food parcels in the previous year).

UHB remains the major contributor of clothes to the clothes bank.

3.5 Modern Slavery and Human Trafficking

In April 2020, the Chief Executive signed the Trust's Slavery and Human Trafficking Statement, pursuant to section 54(1) of the Modern Slavery Act 2015. The Statement is renewed on an annual basis. The Trust supports and respects the protection of human rights for all its employees and workers within its supply chain. It believes in treating people with respect and dignity and does not condone the use of its products or services which infringe the basic human rights of others. The Trust expects its suppliers and business partners to adhere to the same high standards and to take reasonable steps to combat slavery and human trafficking. It is committed to prohibiting corruption in all its forms, including extortion and bribery.

3.6 Sustainability

In October 2019, UHB's Board ratified a Trust-wide Sustainable Development Management Plan (SDMP). The SDMP supports UHB's vision of building healthier lives and seeks to ensure that UHB is adopting sustainable practices across the organisation.

In practical terms this will drive action including energy efficiency, waste minimisation, reducing the harmful effects of transport, reductions in the use of single use plastics and changes to procurement practice.

3.7 Energy

Energy consumption across UHB has remained similar to previous reporting years. QEHB continued to operate within the Department of Health's energy efficiency upper limit, consuming 51.88 GJ/100m^3 against a target range of 35-55GJ/100m^3. Despite improvements at Solihull and Good Hope, the three HGS sites are operating outside of the efficiency target of 55-65 GJ /100 m^3 for existing buildings.

Across Heartlands, Good Hope and Solihull hospitals, engagement with Energy Performance Contract partners remained a key focus for improving energy efficiency throughout the year. Alongside this, small scale upgrades to LED continued which should deliver energy and maintenance savings moving forward.

Working in collaboration with the ACAD project team, a range of opportunities for further heat utilisation from the Heartlands Energy Centre have begun to be explored and should be finalised within the coming financial year.

3.8 The Trust's Carbon Footprint

UHB's future carbon reduction targets are aligned with NHS England's aspirations of net zero carbon by 2050. Absolute emissions resulting from energy consumption (scope 1 and 2) for 2019/20 were estimated to be 45,460 CO_2e. This equates to an 18% reduction versus 2015/16. The most significant drivers behind these carbon reductions has been the ongoing decarbonisation of the national grid and efficiencies sought through initiatives such retrofitting LED lighting, variable speed drives, BMS upgrades and ongoing on-site solar PV generation.

3.9 Waste Recycling

The Trust currently has in place a comprehensive waste recycling programme across all UHB sites which continues to yield in excess of 1,300 tonnes of re-useable and recyclable material per year.

For all UHB sites the volume of recyclable waste has remained comparable with 2019/20. The introduction of additional mixed recycling bins into public areas on the Queen Elizabeth Hospital site was completed in autumn 2019 (Phase 3). A final Phase 4 programme is scheduled for 2020 for outlying off-site locations. This will further support the ongoing promotion of waste recycling.

A five-year waste strategy has been developed and is supported by an operational action plan with 12 key objectives that includes sustainable procurement and a waste prevention plan.

The Trust continues to recycle other material such as scrap metal, office/confidential paper, clothing, electrical and white goods, batteries and cardboard. Scheduled 'Dump the Junk' initiatives continue to take place throughout the year to support the recycling programme and promote good housekeeping.

The Trust is currently out to tender for commercial waste (domestic and recycling) with award scheduled for Autumn 2020. This service will incorporate a fully integrated waste minimisation and recycling programme across all UHB sites with an emphasis on zero waste to landfill as our key objective underpinning previous and current good practice linked to the five-year waste strategy.

3.10 Sustainable Transport

The Trust employs more than 21,000 staff and, last year, treated 2.8 million patients, with an estimated two million visitors. Consequently, our hospital sites are a major generator of traffic from across the city and beyond. Encouraging sustainable transport modes, specifically through a comprehensive Green Travel Plan, is a key part of the Trust's Sustainability Strategy and Action Plan.

Over the past year, the Trust has consolidated its Green Travel Plan, aimed at encouraging a further switch away from single occupancy car travel, by re-invigorating staff to travel sustainably and informing new staff of the travel package offers available to them. The strategy commits the Trust to developing and improving incentives for staff to minimise car use e.g. eligibility criteria, increase the use of sustainable transport modes and to continue to work with stakeholders to promote sustainable travel. The Trust launched FAXI, a car sharing facility at QEHB and intends to roll this out to all sites when circumstances permit.

A 2018 staff Travel Survey has highlighted a 7.6% reduction in single occupancy car journeys (38%) compared to 2016, as well as a 4% increase in bus (15%) and 6% increase in train (20%) patronage. A new Travel Survey is planned for October 2020 in conjunction with UoB, BSMHFT and the Women's Hospital.

3.11 Major Capital Development

3.11.1 Ambulatory Care and Diagnostic Centre (ACAD)

Kier Construction has been appointed by Trust to deliver the £97m Ambulatory Care and Diagnostics Centre.

The project has been procured through the P22 framework. It will include the construction of a new 18,000m² four-storey building that upon completion will provide a number of first-class facilities for the hospital, including 120 consultation rooms, 26 specialist audiology and ear nose and throat rooms, ultrasound and X-ray rooms, as well as CT and MRI scanners.

The new ACAD building will care for half a million patients per year and has been designed to provide a modern, spacious environment purpose-built to meet the needs of patients, with dementia friendly and accessible design features.

In line with the Trust's sustainability agenda and general NHS guidance, the proposed building design and construction is targeting a Building Research Establishment Environmental Assessment Method (BREEAM) of 'Excellent'. All the indications to date are that the target will be met.

Works are due to start on site in summer 2020, with the project due for completion in 2022.

3.11.2 Solihull Hospital

During the reporting year a new mobile MRI Vanguard unit was opened, with additional car parking spaces.

3.11.3 Heartlands Hospital

Replacement of low/high voltage switch gear and cables to the Radiology Department has taken place. This work was to provide / assure resilience to the service delivered from the Department.

Transfer of Gynaecology Assessment Unit from Ward 1 to Aspen Ward within the Princess of Wales maternity unit. This was to allow Ward 1 to be transformed into a 35 bed ward area.

There has been a refurbishment of seven additional negative pressure rooms on Ward 26, the ED Majors waiting room and the Ambulance admissions corridor. This was to improve patient flow and admissions of patients.

3.11.4 Good Hope Hospital

Ward 2 underwent a total refurbishment. This included a total replacement of all electrical infrastructure, nurse call system, lighting, floors and ceilings, bathrooms and decorations. All passenger lifts in the Richard Salt Unit have been replaced these new lifts have N+1 resilience technology.

The refurbishment / adaptation of a new midwifery led unit has been costed. This project is currently out to invitation to tender and is planned to commence this calendar year.

The make-over of the RSU Main Entrance is due to commence September 2020. The scheme includes;

- Replacement /construction of a new entrance to the unit having rotating doors and heat curtain.
- Refurbishment and adaption of existing toilets so as to provide suitable disabled access and "Changing Place facilities"
- New coffee shop facilities
- New reception desk services
- New lighting
- Replacement ceilings and floor finishes
- Decorations throughout

3.11.5 Queen Elizabeth Hospital Birmingham

The development of the Specialist Hospital Facility has been quite a focus. All the enabling works were completed to allow the scheme to commence. This entailed diverting major electrical and mechanical services, providing support to the developer in terms of isolating services during the construction.

3.11.6 Fire Compartmentation

It was reported within the 2018/19 report, that the Estates Department had completed Phase 1 of the works and planned to commence with Phase 2 at Heartlands, Good Hope and Solihull Hospitals. Phase two was planned to be completed by the end of 2019/20 financial year of which has been achieved.

3.12 Procurement

With regards to the procurement of goods and services, the Trust complies with all relevant UK Government policies on sustainable development and sustainable procurement, and all relevant legislation and regulations, ensuring that sustainability principles are given due consideration at each stage of the procurement process, including:

- Developing an in-depth understanding of the sustainability issues relevant to each category;
- Building a detailed appreciation of customer's sustainability requirements, and ensuring that customers have access to sustainable products and services to assist them in meeting these requirements
- Working with suppliers, including early market engagement, and working post-award to seek ongoing improvements to suppliers' sustainability performance and that of their supply chains; and
- Encouraging the appropriate uptake of sustainable products and services
- Furthermore, Goods & Services are reviewed at the Trust Sustainability Group to identify to identify new routes to source and/or utilise
- The Trust is also working alongside Local Government & Educational bodies regionally to create a sustainability tender questionnaire for all future procured projects

3.13 Physical Environment

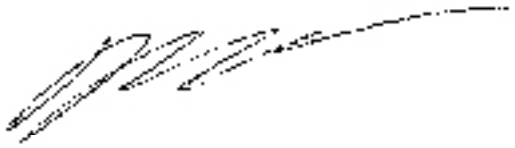
The design of QEHB was dictated by the large area of natural wildlife habitat surrounding the site. Careful management of this area protected it during the construction phase and provided sustainability for wildlife. Additionally, the site is the home of a Roman fort and the Trust has put considerable effort into its interpretation.

The configuration of the QEHB was developed to maximise light penetration. Extensive use of courtyards, together with the clinical plan arrangement, particularly within a deep plan podium, provides a natural light source. It is recognised that both natural ventilation and natural light are important to staff and patient wellbeing.

In recent years the Trust has developed in excess of 16,000m^2 of land on the site for food production or habitat enhancement and continues to make progress with its Community Orchards and Gardens project, with local community partner The Trust Conservation Volunteers (TCV).

Fruit and vegetable stall: As part of its sustainability and health and wellbeing strategies, the Trust wanted to make available to staff, patients, visitors and the wider community, fresh, competitively priced fruit and vegetables to give everyone healthier options both at work and at home. The Trust generates a small income from the stall which is re-invested into Trust-wide health and wellbeing programmes. The fruit and vegetable stall remains the most enquired about initiative at UHB with many other NHS organisations looking to emulate its success.

Farmers' Market: The Farmers' Market was started in November 2012 and trades twice a month. It has grown from eight stalls to more than 20. Key to the establishment of the market was the desire to provide staff, visitors, patients and local people with access to local produce as well as supporting local businesses. Many of the businesses are regulars at the region's farmers markets, but others are new to selling their produce. The Farmers Market closed at the beginning of the COVID-19 crisis and remains closed until further notice.



Dr David Rosser, Chief Executive
18 June 2020

Accountability report

1 Directors' Report

1.1 Overview

It is the responsibility of the Directors of the Trust to prepare the Annual Report and Accounts. The Board of Directors considers that that Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

1.2 Audit Information

So far as each of the Directors is aware, there is no relevant audit information of which the auditors are unaware. Each of the Directors has taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

1.3 Pensions

The accounting policy for pensions and other retirement benefits are set out in note 1.3 to the financial statements and details of senior employees' remuneration can be found in the Remuneration Report in Section 2.

1.4 Disclosures in accordance with Schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008

Disclosures regarding likely future developments, employment of disabled persons, and informing and engaging with staff are included within the Performance Report.

1.5 Other disclosures

Disclosures relating to NHS Improvement's well-led framework are included in the Annual Governance Statement.

Information on fees and charges are enclosed in the annual accounts.

1.6 Cost allocation

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information Guidance.

1.7 Better Payment Practice Code

	Number	£000
Total bills paid in the year	113,156	662,148
Total bills paid within target	110,868	658,587
Percentage of bills paid within target	98.0%	99.5%

The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

1.8 The Late Payment of Commercial Debts (Interest) Act 1998

Nil interest was charged to the Trust in the year for late payment of commercial debts.

1.9 Management costs/political donations

Management costs, calculated in accordance with the Department of Health's definitions, are 4%. There were no donations made to any political parties during the financial year.

1.10 Names of persons who were Directors of the Trust during the reporting period

During the reporting period, the Board was comprised as follows:

- Chair: Rt Hon Jacqui Smith
- Chief Executive: Dr David Rosser
- Chief Financial Officer: Mike Sexton
- Medical Director: Prof Simon Ball
- Chief Innovation Officer: Tim Jones
- Chief Nurse: Lisa Stalley Green
- Chief Workforce & International Officer: Kevin Bolger
- Chief Operating Officer: Jonathan Brotherton
- Chief Transformation Officer: Cherry West

Non-Executive Directors:
- Jane Garvey
- Harry Reilly
- Catriona McMahon
- Dr Jason Wouhra
- Professor Michael Sheppard
- Professor Jon Glasby
- Jackie Hendley
- Karen Kneller
- Mehrunnisa Lalani

1.11 Patient Care

The Trust continues to improve patient care through the work of the Care Quality and Patient Experience Groups, which are chaired by the Executive Chief Nurse and include Governors within their membership.

The Trust works closely with our Council of Governors to understand what matters most to patients, and welcomes Governors, members of the Trust, public and carers onto our site-based Patient, Carer and Community Councils (PCCCs) where we seek their involvement in consultations and service improvement projects. The PCCCs further contribute to improvements in patient care through visits to wards and departments both acting as a critical friend and during annual PLACE inspections and the Trust's own PLACE-Lite programme.

During the year the Trust has continued to monitor feedback through a variety of different methods including patient advice and liaison contacts (PALS), complaints, compliments, friends and family test, and local and national surveys to drive service improvement. Feedback is proactively sought from patients, visitors and carers via surveys and visits to wards and departments. These mechanisms are well established at the point of care and enable the Trust to prioritise issues that are important to patients, as well as assisting the Trust in benchmarking the success of its patient improvement measures against the results of its peers.

All of our volunteers, Patient, Carer and Community Council members and members of staff are members of our Foundation Trust and play a vital part in helping us to shape our services and make improvements for patients.

More information on how we involve our members in the Trust can be found in the Membership section of this report.

1.11.1 Infection prevention and control

The Trust has adapted to the COVID-19 pandemic with novel ways of working and repurposing of staff groups and so far has coped well with the challenges faced. There are multiple initiatives the Trust has undertaken in response to Coronavirus from increased laboratory testing, staff screening, multi-disciplinary COVID-19 outreach teams, specialist expert groups, a dedicated Trust micro-site, robust informatics dashboard, automated processes for alerting of results on PICS and the NEC Nightingale project ensuring appropriate IPC procedures are in place. The Trust is also supporting as many as staff as possible to work from home.

For the financial year 2019/20 UHB had 11 Trust apportioned bacteraemia, which is an increase on the previous year. The increase could be due to a large number of community associated MRSA bacteraemia being identified.

The annual objective for *Clostridioides difficile* infection (CDI) for 2019/20 at UHB is 250 Trust apportioned cases. For the financial year 2019/20, UHB has had 256 Trust apportioned cases of *C. difficile.* Antimicrobial stewardship remains the biggest challenge in *C.difficile* prevention. The Trust-wide Antimicrobial Stewardship Group is developing its strategic intentions to deliver effective antimicrobial stewardship across UHB.

Performance against, and monitoring of, improvements related to healthcare associated infections are monitored monthly at the Infection Prevention and Control Group and the wider care quality issues identified are monitored as part of the Care Quality Group chaired by the Executive Chief Nurse.

1.11.2 Service improvements following staff, patient or carer surveys/comments and Care Quality Commission reports

At the end of 2018/19 the Trust identified a number of themes from feedback where further improvement would be beneficial and these were selected as our patient experience quality priorities for 2019/20. More information about these can be found in the Quality Account which can be found on the Trust website.

A newly developed Carers Survey will be introduced during the forthcoming year along with a range of measures to monitor the quality of service being provided. This will help to build on the significant developments made to the Carer Coordinator service during 2019/20, following its implementation during the previous year.

The Carer Coordinator service continues to be supported by Birmingham Carers Hub, and both

the Carer Coordinators and health and social care professionals are able to easily refer carers to them (or relevant 'out of area' organisations) for a carer's assessment. During the year a carer identification card was developed in conjunction with Birmingham Carers Hub and distinguishes between visitors and those identified as recognised carers. Benefits include access to hot and cold drinks whilst on the ward, a guest bed and breakfast should a carer need to stay overnight on the ward, access to toilet and washing facilities, access to reading materials and open visiting. This card will be implemented during the forthcoming year.

'Tommy's Room', a designated room at Birmingham Heartlands hospital was re-launched for patients with dementia and their carers to relax, spend time together and have privacy when needed.

Around 200 carers were referred to the Carer Coordinators during 2019/20.

Partners in Care leaflets, designed to agree a level of carer involvement between the carer, patient and Trust staff, were relaunched during the year to recognise the relationship and knowledge of the cared for that could be beneficial from those persons with whom the cared for has a significant relationship or past relationship. This change was implemented following feedback from a previous carer of a patient.

During the year feedback was gathered from patients, carers and relatives to inform a review of visiting arrangements. Over 750 surveys were completed and a task and finish group used this feedback to develop a Trust-wide visitor charter and supporting materials. Unfortunately this new approach has not yet been implemented due to the onset of the COVID-19 pandemic which restricted visiting in line with national guidance.

The Trust inpatient survey asks patients whether rest or sleep was disturbed and if so, what the causes of this were. The feedback was previously used to introduce sleep kits at the QE site, which, during 2019/20, have been made available to offer to patients on all four main hospital sites. 'Helping patients to rest and sleep' guidelines have been shared with staff across the Trust and communication to raise awareness around promoting rest and sleep was distributed to staff in various formats including email, screensavers, communications bulletins and promotion through face to face discussion with staff.

Following feedback a Task and Finish Group was established on the use of chaperones. Awareness has been raised among staff and patients around the provision of a chaperone where intimate examinations and procedures are being performed. Staff training has focused on when a chaperone is required, how to ensure patients' wishes are respected, and the role of chaperones in maintaining privacy and dignity as well as supporting and safeguarding both patients and clinical staff. Promotional material has been produced to raise awareness amongst patients so they understand when and why they may need a chaperone, how to request one and how the chaperone will support them during their intimate examination and procedure.

The findings of the national children and young people's survey of 2018, published November 2019, showed that the Trust could improve upon how it communicates with, and caters for, the mental health of its youngest patients. To support children/young people's mental health in particular, a range of actions were agreed. Portable sensory equipment was placed in bed spaces and Red Thread, a youth work charity enabling young people to lead healthy, safe and happy lives are present in Emergency Departments. Red Thread also visit wards to support children/young people. SOLAR, a Solihull based organisation providing emotional wellbeing and mental health services for children/young people, contact ward staff daily and provide training days for Trust staff. Three mental health link nurses were identified, who undertook a period of shadowing with SOLAR colleagues. Learning Disability is also included in Mental Health Awareness sessions with staff and individualised care plans are produced. A two-day, in house training course has been developed for all staff in light of increased numbers of children requiring mental health support. A room for adolescents on the ward was developed to allow teenagers time and space away with computer games, a stereo, and comfortable seating. Further initiatives are planned into 2020/21.

Following a pilot of Pets in Hospital, glowing feedback from patients and staff alike has resulted in the roll-out of the scheme. Pets in Hospital, supported by the UHB Charity, has a positive impact on improving patient wellbeing by reducing anxiety, enhancing patient interaction and promoting a calm, positive environment for staff and patients.

"We love having the visits – it gives both staff and patients a lift in mood."

"I would like it [the visit] to happen on a regular basis – the highlight of the week – I'm sure it would benefit other patients too."

"Amazing!! Fantastic scheme, can't wait for it to be rolled out. This service is invaluable."

Laminated posters were created for each Emergency Department to show real-life patient, carer and relatives' comments of appreciation provided for staff in the department. The comments reflected the care, expertise and dedication shown by staff towards patients in the department and were hugely appreciated by the teams in the Emergency Departments.

1.12 Public and Patient Involvement

1.12.1 Patient, Carer and Community Councils

The Trust framework for Patient and Public Involvement continues to be facilitated through the Patient, Carer and Community Councils (PCCCs). There are four PCCC groups with one at Birmingham Heartlands Hospital, Good Hope Hospital, Queen Elizabeth Hospital Birmingham and Solihull Hospital. The framework also includes a Young Persons' Council and Carers' Forum, both of which operate on a Trust-wide basis. Community engagement visits have also taken place in the Heartlands Hospital area.

The PCCCs work in collaboration with staff and act as a critical friend to the Trust to influence improvements in the patient experience. PCCCs have particular focus on care and the environment.

All council members are also Foundation Trust members. Throughout 2019/20, the councils have been active in seeking patients' views to influence improvements in care. There are currently 107 patient and public representatives on the councils. All members undergo the volunteer recruitment process and induction enabling them to safely undertake visits to wards and departments.

Patient, Carer and Community Council members visit wards and departments to facilitate partnership working with staff to provide a patient perspective to improve the experience of patients and their relatives. From December 2019, visits previously only in place on the QE site, commenced across Heartlands, Good Hope and Solihull hospitals. During 2019/20, a total of 82 visits were undertaken by members of the PCCCs. Following their visits, feedback is given to the ward or department to enable action to be taken where necessary. Key themes are further discussed at the Patient Experience Group and by exception to the Care Quality Group which reports to Board.

Council members continue to be given the opportunity to sit on Trust committees where public representation is required and to participate in annual PLACE assessments and the Trust's own PLACE-Lite programme. Council members have also undertaken visits to diagnostic areas to provide a lay perspective as part of the Trust's application for United Kingdom Accreditation Service (UKAS) accreditation during the year. During 2019/20 this was at the Queen Elizabeth Hospital only and there are plans to incorporate Heartlands, Good Hope and Solihull hospital sites in the accreditation programme during 2020/21.

The Trainee Nursing Associate programme has also utilised the expertise of PCCC members, who were invited to provide regular advice and guidance to trainees on the programme, through regular meetings and discussions with their allocated trainee, about their experiences of healthcare as a patient or carer. This has supported trainees along their journey to achieving their status as a Nursing Associate and provides them with vital insight from a patient's perspective to assist them in their future career.

Council members have supported patients and the Trust with the level of information available about gluten-free products Trust-wide and with progress of the installation of an automatic door entrance at Good Hope Hospital, to be completed during 2020. Solihull PCCC members were also invited to a discharge learning event where a council member's personal experience of a family member's discharge from hospital was used to exemplify areas for improvement, which prompted much lively discussion. A series of similar events will be rolled out at all Trust sites, when possible during 2020, to inform the Trust's future approach to discharge planning.

Some examples of other specific changes as a result of the feedback from PCCC members provided either from pre-arranged visits or otherwise are (some pre-COVID initiatives):

- Changes to protect privacy and dignity when weighing patients within outpatient waiting areas
- Refreshments provided to all patients/relatives/carers waiting in the Emergency Department
- Unannounced inspection by the Trust Fire Officer
- Replacement of three extractor fans lowering the temperature to a suitable level in Maternity Assessment
- A ward's side rooms noted to require redecoration. One side room per day was made available to carry out remedial painting
- Security staff are in regular contact with a local school and police to minimise the Heartlands Hospital site being used as a short-cut
- Three drop-kerbs fitted to allow ease of access
- Intercom fitted to a ward to make relatives' access to a ward easier

1.12.2 Young Persons' Council

The Young Persons' Council (YPC) looks at ways to further improve the experience for young people aged 16-24 years, both under the care of Trust hospitals and for those transitioning to our hospitals. The YPC is involved in visits to wards to ask patients and staff for their views. There are currently 26 young people who are members of the YPC.

Saturday Social is a scheme developed by the Young Persons' Council members. During the year, 15 of our younger patients have received a social visit and gave their feedback about the hospital. Fewer visits took place than were planned, due to necessary cancellations towards the end of the year. Whilst YPC visits have taken place on Saturday morning, currently once per month, YPC members have discussed the possibility of expanding these visits to include weekday evenings.

During 2019/20, the children's wards at Birmingham Heartlands Hospital received a visit from YPC members, during which a survey was conducted and children and their families were asked their views about their experiences of care in the wards. The results of the survey were very positive and during the same visit 'Stella,' one of the 'Pets in Hospital' dogs accompanied by her owner, visited the children on the ward, which was received very warmly by both patients and staff. Children were also provided with gifts such as puzzles and colouring books.

1.12.3 Carers' Forum

The Carers' Forum brings together carers, service providers, staff, carer organisations and charities to work together on how we engage and listen to carers in improving our hospital services for them. During the year the forum has been instrumental in supporting the work of the Carer Coordinators.

As part of the Forum's work, representatives of local carers organisations have conducted drop-in sessions on Trust sites to offer support and advice to carers, they have also supported the Carer Coordinators with on-site activities during Carers Week in June 2019. The Coordinators have also supported forum members at events such as Carers Rights Day in November 2019.

1.12.4 Healthwatch Birmingham

The Trust maintains good relationships with both Healthwatch Birmingham and Healthwatch Solihull, with regular meetings throughout the year to ensure good partnership working to the benefit of our patients.

During 2019/20 the Trust has welcomed Healthwatch Solihull visits to the Phlebotomy Department at Solihull Hospital and improvement work has been undertaken, with more to follow. This has included improving the process of calling patients from the waiting room, moving the ticket machine to be more accessible to all patients and improving signage.

The Trust has also welcomed the Healthwatch Birmingham city-wide review of the Patient Advice and Liaison Service (PALS), highlighting that most patients, carers and families were satisfied with their experience overall and that the service is valued by those who use it.

In the study, service users felt it would be useful for PALS to provide clearer definitions of the issues of concern they deal with. Working as part of the Patient Relations team, PALS are often the first point of contact for patients or relatives who wish to raise a concern or who need quick information or support. Due to the nature of the Patient Relations team, service users can benefit from this single point of contact for all types of issues – some of which may be able to be dealt with swiftly by the PALS team, but others that may be dealt with by the complaints team. We will update our website and literature to make this clearer for service users.

The Trust recognises the report's observations regarding PALS' staff knowledge of different needs, including autism, and is currently organising autism awareness training and additional mental health awareness to help equip staff to have a better understanding of patients' needs and the difficulties they experience when accessing healthcare services. A Lead Nurse for Vulnerabilities has also been appointed.

The Trust acknowledged the report findings that there were further opportunities to improve the accessibility of the service and implemented a single Patient Relations Contact Centre with resource deployed to enable calls to be answered more promptly; while also maintaining face-to-face contact on the Heartlands, Good Hope and Queen Elizabeth hospital sites.

1.12.5 Patient and Carer Consultations

During the year Patient, Carer and Community Council members were consulted on:

- Ask A&E – Emergency Department symptom checker
- Gynaecology and Trauma and Orthopaedic – service reconfiguration
- 'Choose Wisely' – event to provide information to local families about which conditions are best treated through different healthcare settings

- Ambulatory Care and Diagnostics Centre
- Catering processes
- 'Support U Home' – discharge process
- Trust site maps
- Access and waiting – task and finish group
- The Nursing Associate Role
- Constitution for Patient and Carer Councils
- Healthcare Evaluation Data (HED) – Your Right to Choose
- Trust Annual Plan
- Trust Quality Priorities
- 'Eat, Drink, Dress, Move' – an initiative which supports patients to actively participate in their recovery in hospital
- Nutrition and Hydration
- Volunteer Procedure (Patient Experience Group)
- Patient Relations Policy (Patient Experience Group)
- New Specialist Hospital facility on the QE site
- Visitors' Charter (Patient Experience Group)
- Friends and Family Test – implementation of new guidelines
- UHB Website
- Smoking Policy – 'The Big Conversation'
- Carer Coordinator Service
- Patient Experience Nursing Priorities (Patient Experience Group)
- Non-emergency patient transport
- Survey questions for inpatients/day case patients and Emergency Department (Patient Experience Group)
- A public workshop for the PIONEER project, looking at how health data is being used and how it might be used in the future in the NHS
- Review of outpatient letters
- What a great patient experience looks like and what matters to patients?
- Discharge Learning event at Solihull Hospital (future events planned for other hospital sites)
- External food bought into hospital (Patient Experience Group)

1.12.6 Volunteers from the local community

The number of volunteers at the Trust now stands at 1,122 registered volunteers across all four hospitals who continue to provide an enhanced and quality experience for our patients and invaluable support to our staff.

The demographic profile of our volunteers as at 31 March 2020 is:

Volunteer demographic profile	2019/20
GENDER	
Male	29%
Female	71%

Volunteer demographic profile	2019/20
AGE	
16-17 years old	0.6%
18-30 years old	11.0%
31-50 years old	12.7%
51-65 years old	18.8%
66-74 years old	34.6%
75+ years old	21.9%
ETHNICITY	
White British	68.6%
Asian / Asian Mixed	11.3%
Black / Black Mixed	3.9%
Other white	2.9%
Other/undisclosed	13.1%
EMPLOYMENT	
Employed	13.3%
Unemployed	6.8%
Student	4.0%
Retired	35.1%
Other/undisclosed	40.5%

The Volunteer Service reports to the Patient Experience Group which provides oversight to the activity and contributes to the future strategy of the service.

During the last quarter of the year, Voluntary Services delivered a Winter Pressure project to fast-track volunteers through the recruitment process to support the Emergency Departments during a period of sustained pressure. Launched in early January 2020, the first volunteers were in place by the start of February and a total of 171 volunteers were recruited across the four sites. The support was very well received by the clinical teams and their patients and the placement was very popular with the volunteers. Hannah Johnston, Matron in the Emergency Department at Queen Elizabeth Hospital said: "The volunteers in the Emergency Department at the QE site have been fundamental in improving patient experience. With the increased demands on the department, the volunteers are allowing us to ensure patients receive food and drink in a timely manner, providing emotional support for patients and relatives and really helping the department run smoothly. The staff are finding a real benefit from the increased number of volunteers and they feel they are being fully supported in providing a better patient experience for all patients."

Unfortunately all the volunteers were stood down or redeployed as the COVID-19 pandemic developed but many have expressed a willingness to take part again next winter.

1.13 Complaints and Compliments

We welcome patients and families contacting us where they have any concerns about our services to help us to learn and continuously improve. The number of complaints received in 2019/20 was 1,795 which represent a 7.9% decrease on the total number of complaints received in the previous year.

The Trust has robust procedures in place to ensure that complaints are investigated and responded to in a timely manner to the satisfaction of the complainant. Senior divisional management oversight and ownership of complaints is used effectively to secure an early resolution of complaints wherever appropriate, for example issues around appointments can often be resolved quickly via a telephone call. Where a complaint requires a full investigation, the complaints team make early contact with the complainant, wherever possible, to agree the issues to be investigated, the preferred method of response and a realistic timescale for responding.

A new Patient Relations Policy and Procedure were introduced in 2019, which brought together the management of complaints and PALS cases into one policy and one procedure document and which governs activity across the Trust.

Trust performance against its local challenging KPI of responding to 85% of complaints within 30 working days has been under pressure for much of the year. This was heightened in June 2019 when performance dipped during a successful restructure of the clinical divisions. Performance subsequently recovered achieving 87.4% in August 2019 and experienced further fluctuation until January 2020 received cases, where performance was 84.2%. Following this, however, a national pause in the complaints process was initiated by NHS England/ NHS Improvement in March 2020 as a result of the COVID-19 pandemic to allow frontline staff to focus on their clinical commitments. This affected response performance for February and March 2020 cases. During this time the Trust continued to receive, acknowledge, record and review cases and resolved complaints where this was possible. The PALS office remained fully operational to deal with concerns as they arose.

We continuously monitor and seek to improve the complaints handling process. In 2019 a significant focus has been on alignment and streamlining of the process across the two historic trusts, culminating in a single database, improved reporting and new tiered response targets from 1 April 2020. Quality and clarity of responses continues to be at the forefront of our strategy for responding to complaints.

A rolling programme of complaints masterclasses has continued to be delivered across multidisciplinary teams and feedback has been very positive.

The Trust takes a number of steps to ensure that we learn from complaints. Agreed actions from individual complaints are shared with the complainant in the Trust's written response or at the local resolution meeting. This learning is further shared at divisional and departmental level. Reports on themes with individual learning examples are provided to the Patient Experience Group, Chief Executive's Advisory Group, the Executive Chief Nurse's Care Quality Group, Patient Experience Group and Divisional Clinical Quality Groups, to name but a few.

Whilst the Trust makes every effort to resolve complaints to the satisfaction of the complainant, this may not always be possible for a variety of reasons. Complainants are made aware of the option of approaching the Parliamentary and Health Service Ombudsman to assess their complaint independently. The level of complaints about this Trust reviewed by the Ombudsman remained relatively low. In 2019/20, the Ombudsman upheld or partly upheld eight complaints, compared to three in the previous year.

Positive feedback is also important in highlighting success and providing opportunities to replicate successful initiatives wherever possible. In 2019/20 the Trust formally recorded receipt of 2,602 compliments, compared to the 1,795 complaints received.

Below are a few examples of the compliments we received:

Heartlands Hospital

"I visited ward 19 today as an outpatient and I want to say how great all the staff were from reception to doctors to outpatient nurses. It is a pleasure to visit ward 19 they have been consistently great at their service to us always."

Good Hope Hospital

"Your team went over and above to help me, they each treated me with empathy, compassion and kindness, making me feel a person, not a number to be dealt with. Without their support, I would have found the procedure difficult. I wish to commend them to you. Please convey my sincere thanks to them for their invaluable service."

QEHB

"I wish to place on record my gratitude for the prompt and professional care I received from all staff, at every level of hierarchy and also for the excellent attention to personal well-being which I experienced. Aside from the excellent medical care, I was particularly impressed by the efficiency and calm atmosphere of the renal unit, the considerate and friendly engagement with consultants, doctors and nurses and also by the standard and range of food on offer. Attention to hygiene and cleanliness was very noticeable - which is reassuring! Subsequently, follow-up monitoring visits have been efficiently organised and interaction with consultants and other staff has been open, friendly and unhurried allowing for easy communication between medical staff and myself. I can only applaud enthusiastically the level of overall care which, on my experience, is provided by both Queen Elizabeth sites. I do not believe this happens by chance but must reflect the standards set by the managers and the quality of the staff employed."

Solihull

"I just wanted to say a huge thank you for looking after me during my treatment over the past year. When I first came for chemo I was terrified as I do not like medical stuff and also have anxiety. But your caring 'human' approach has made a difficult time easier for me and you were also great with my parents. I will not miss treatment but I will miss you all. I think you must all be very special people to be able to do that job. Thank you again and love to you all."

1.14 Research and Development

1.14.1 Infrastructure

The Centre for Rare Diseases (CfRD) forms part of the Institute of Translational Medicine (ITM) and will be celebrating its fifth anniversary in September 2020. There have been many developments, collaborations and achievements for the CfRD during this time including Biobanking, the 100K Genomes Project, NIHR Bioresource (both rare diseases and tissue banking) as well as continual staff training for fibroscans and spirometry in order for these to take place as part of the patient pathway.

Further, there has been the successful expansion of existing CfRD clinics to include different specialties to incorporate the "one stop" model, as well as clinics increasing in frequency.. The CfRD is the location for 86 clinics (two of which are virtual clinics) over 19 specialties. Patient attendance at the CfRD remains consistent, with an average of 1,000 appointments taking place each month with nearly 45,000 appointments having now taken place since the opening.

The ITM Clinical Research Facility (CRF) is operationally supported by a team of National Institute for Health Research (NIHR) CRF and R&D staff which enhances the collaboration between the NIHR CRF, ITM CRF and the Centre for Rare Diseases. There are a number of research clinics taking place in the ITM CRF across a range of specialities, including neurology, renal and inherited disorders.

The Trust continues to engage with external bodies to leverage additional benefit associated with the ITM through collaborations and new funding for research into inherited disorders and innovative infrastructure growth.

The Centre for Conflict Wound Research builds on previous collaborations with the Scar Free Foundation and the Centre for Burns Research. As well as improving understanding of how the body responds to burn injury in adults and children, the £6 million research centre also carries out translational clinical research to develop new treatments. The centre is supported by the Vocational Training Charitable Trust (VTCT) and funded for five years with £1.5m investment from the Healing Foundation and funds from partner organisations of £4.5m.

The Trust hosts the £9 million Midlands and Wales Advanced Therapy Treatment Centre (MW-ATTC) which is one of three national Innovate UK funded centres whose goal is to accelerate the delivery of advanced therapies. It is a regional network spanning the Midlands and Wales comprising a large consortium of industry, healthcare and university partners with expertise in advanced therapy manufacturing, including academic and commercial partners, logistics companies, specialists in clinical trial delivery and teams focussed on IT logistics, solutions and health economics.

"The aim of the MW-ATTC is to enable UK advanced therapy companies to reach the clinical market, whilst simultaneously building clinical capacity regionally to deliver these breakthrough therapies to patients"

Cell or gene therapies have recently shown great potential in treating patients with conditions that cannot be cured with current treatments. These include arthritis, liver disease, several types of cancer and diabetic ulcers.

The West Midlands Genomics Medicine Centre's reported performance at the end of the financial year included the successful return of whole genome sequence reports to 5,410 participants. This is a return in results of 98.7% of cancer participants and 60.7% rare disease

participants. Whilst national work has paused due to COVID-19, on additional findings and the re-consenting of young adults, the WM GMC has continued to monitor and update processes to ensure that these deliverables can be completed as part of the anticipated GMS Alliance priority activities. Progress beyond the primary findings has continued with discussions now extending to include the realignment of processes and pathways for participants with an actionable report that have, since recruitment, sadly passed away. It is anticipated that these reports will be triaged by clinical genetics for potential cascade pathways.

The WM GMC contract extension ceased on the 31 March in anticipation of a pronouncement of seven new NHS England/Improvement designated Genomic Medicine Service Alliances. As a consequence of the ongoing COVID-19 situation, the tender submission scheduled for 23 March 2020 was paused on 19 March 2020. NHSE/I requested that draft tender responses were still submitted and the Central and South GMS Alliance draft tender response was submitted for informal review on 23 March 2020.

Genomics education events have continued to be well received with five events being hosted by our Genomic Tumour Advisory Boards (GTABs) to support our cancer colleagues across the region, reaching in excess of 200 clinicians. Similarly, the Genomic Rare disease Advisory Boards (GRdABs) have held three events with excess of 100 attendees while in addition hosting 20 rare disease speciality teaching engagements in regional trusts, with engagement from 150 regional clinicians. Through extensive and well established relationships with colleagues at the West Midlands Cancer Alliance and in commissioning, the WM GMC has also secured funding for the Panel 500 project as well as the GTAB structures for another 12 months. This will further support the work of the GMC legacy activities, including identification of patients via the GTABs who can be offered an opportunity to participate in research which has identified targetable mutations and appropriate clinical trials.

UHB hosts the Medical Devices Testing and Evaluation Centre (MD-TEC), supporting the accelerated translation of novel innovations in the laboratory through to the clinic and commercial exploitation. In doing so, it aids the development of existing markets and stimulates new ones for companies within the Life Sciences market, enabling them to bring products to market quickly, at less cost and with reduced risk. Over the three year period of initial European Regional Development Fund (ERDF) funding, the team supported over 100 companies and their novel technologies.

MD-TEC collaborated with BT and West Midlands 5G and successfully carried out the UK's first demonstration of a remote-controlled ultrasound scan over a public 5G network. The demonstration simulates a paramedic in the field performing an ultrasound scan on a patient, under the remote guidance of a clinician who is able to interpret the ultrasound image in real-time. This was a real-world example of how 5G can support digital transformation in the delivery of public services. It is one example of how activities which can only be performed in static environments today can become mobile tomorrow and which will enable care delivery to be streamlined.

The NIHR Trauma MIC (MedTech and In Vitro Diagnostic Co-operatives) continues to build on the work commenced by the NIHR Trauma HTC (Healthcare Technology Co-operative) under the Clinical Directorship of Dr Tom Clutton-Brock. Its primary aim is to build expertise and capacity in the NHS to develop new medical technologies. Working with both commercial and academic sectors, it supports the development of interventions to improve the trauma care pathway, specifically focussing on the following themes: acute response to injury, reconstruction and regeneration, and re-enablement and rehabilitation.

Working closely with the MD-TEC using the fully equipped clinical simulation facilities, NIHR Trauma MIC is able to guide the development of novel devices and technologies through the regulatory processes to ultimately offer our patients the most cutting edge technological care. Over the past 12 months the team has contributed to the delivery of 17 active research projects and supported the submission of 13 grant applications, three of which were funded.

The Trust also hosts a £12 million NIHR Biomedical Research Centre focussed on immune-mediated inflammatory diseases and has three research themes: arthritis, gastroenterology and sarcopenia. There are three cross-cutting themes: diagnostics and biomarkers, entrepreneurship and commercialisation and trials design and delivery, in partnership with the University of Birmingham.

At the Medical Innovation Development and Research Unit (MIDRU), research is focused on patient-centred research and late-stage trials.

1.14.2 Clinical Trials Activity

The Trust's extensive Research, Development and Innovation portfolio allows us to work with a range of commercial and non-commercial partners across a range of specialties. Clinical trials give patients access to new medicines, devices or diagnostics which can provide treatment options

for patients for whom conventional treatments might have failed or where treatment options are limited. During 2019/20, UHB has been able to deliver benefits to patients on clinical trials including reduced symptoms, increased survival times and improved quality of life. The total number of patients recruited into all studies open in UHB from 01/04/2019 – 31/03/2020 was 13,299.

Portfolio Recruitment 01/04/2019 – 31/03/2020	11,754
Non-Portfolio Recruitment 01/04/2019 – 31/03/2020	1,545
Total Recruitment 01/04/2019 – 31/03/2020	13,299

The number of UHB consultants leading research studies as Principal Investigators and Chief Investigators has increased across UHB and is currently 366 with 60 studies being sponsored by UHB. Six of the 60 studies sponsored by UHB are Clinical Trials involving Investigational Medicinal Products (CTIMPs).

New research grant funding awarded in the year across UHB was 33. These include 15 NIHR funded trials, five charity funded, three Research Council funded, and five researcher led company funded studies, and four from 'other' funders to include the Association of Anaesthetics' (2), the Food Standards Agency and The Vascular Access Society. Of the awarded grants four were fellowships (MRC 2, NIHR 1 other 1).

681 patients have been recruited to rare disease studies in the time period April 2019 to March 2020.

RD&I workforce (80%) was redeployed in response to the COVID-19 pandemic in the last two weeks of March 2020. The retained RD&I workforce has delivered the entire COVID-19 trials portfolio, recruiting almost 3,500 patients (c2,000 in the first four weeks), 1,000 staff tests (PCR and antibody testing) and also held open a portfolio of no other treatment option clinical trials. RD&I and the CRF are currently positioning staff to deliver vaccine trial activities.

1.14.3 Health Data Research (HDR) Activity

The national lead for HDR UK's Better Care Programme is Professor Simon Ball, Medical Director at UHB, and Director of Research, HDR UK Midlands' substantive site.

UHB was successful in the national HDR UK/ MRC call and awarded two of the seven national HDR UK Health Data Research Hubs.

INSIGHT is the Health Data Research Hub for Eye Health led by University Hospitals Birmingham, in partnership with Moorfields Eye Hospital NHS FT, University of Birmingham, Action Against AMD, Roche and Google. The first-of-its-kind linkage of routinely collected, anonymised high-dimensional eye-imaging data with two key applications (enabling insights into sight-threatening diseases and using eye data to enable discovery into systemic disease) is a concept we describe as 'oculomics'. INSIGHT partners have expertise in curating and analysing high-dimensional imaging data, and have demonstrated the value of this previously in automated retinal triage and diagnosis through deep learning approaches. This provides the ability to not only analyse ophthalmic images in isolation but also link these images to other health data, supporting discovery into a wide range of diseases.

PIONEER is the Health Data Research Hub for Acute Care, led by the University of Birmingham and University Hospitals Birmingham, in partnership with West Midlands Ambulance Service, the University of Warwick, and Insignia Medical Systems. Acute care is the provision of unplanned medical care; from out-of-hours primary care, ambulance assessment, emergency medicine, surgery and intensive care. Demand for acute health services are currently unsustainable for our national healthcare resource. Despite this, there has been less innovation in acute care than in many others health sectors, in part due to siloed information about patients with acute illnesses. This has been clearly felt during the continuing COVID-19 pandemic.

PIONEER's core objective is to collect and curate acute care data from across the health economy, including primary, secondary, social care, and ambulance data. PIONEER will enable stakeholders to develop, test, and deliver new ways of caring for acutely unwell people, supported with expert patient, health care professional, and compute/ analytic services.

1.14.4 Research Highlights

The NIHR Surgical Reconstruction and Microbiology Research Centre (SRMRC) published a very topical paper on the impact of knife-related injuries on secondary healthcare resources at the QEHB. The paper recommended targeted interventions across the NHS, injury prevention agencies and police practice (Malik NS, Munoz B, de Courcey C, Imran R, Lee KC, Chernbumroong S, et al. Violence-related knife injuries in a UK city; epidemiology and impact on secondary care resources. EClinicalMedicine 2020) https://doi.org/10.1016/j.eclinm.2020.100296

The Scar Free Foundation Centre for Conflict

Wound Research (SFF CfCWR) hosted a "Conflict Wound Research Symposium" at the University of Birmingham Medical School on 16 and 17 May 2019. The aim of this event was to support a research agenda for conflict wound research over the next decade which has informed a national funding call by the Scar Free Foundation. The Symposium was attended by 84 researchers, clinicians, military veterans from the CASEVAC Club and senior armed forces personnel from the UK and the USA, along with representatives from military support charities.

UHB research was highlighted in news articles about CAR-T Infusion Therapy, and the first heart microchip implantation performed in the UK. Both stories featured on BBC Midlands Today, BBC WM, with the Telegraph, Daily Mail and Das Bild (Germany's biggest newspaper) also publishing the story.

The MiQuit study, looking at how effective text messages are at encouraging pregnant women to stop smoking, was highlighted at regional and national level.

1.14.5 Building our Academic Capability

The Trust continues to work closely with academic colleagues at the University of Birmingham and other local academic institutions, as part of Birmingham Health Partners.

Dr Rachel Cooney, Ms Ekta Punj, Mr Keith Roberts and Dr Zaki Hassan-Smith have been awarded NIHR WM CRN (Clinical Research Network) Research Scholar awards to develop Chief Investigator capacity across the West Midlands Clinical Research Network region.

UHB has continued to grow the number staff holding NIHR Senior Investigator designation. There are seven staff with NIHR Senior Investigator awards in 2019/2020. These are among the most prominent and prestigious researchers funded by the NIHR and the most outstanding leaders of patient and people-based research within the NIHR research community. Senior Investigators are appointed from NIHR Investigators through competition informed by the advice of an international panel of experts.

1.14.6 Patient and Public Engagement

The Trust's successful annual Research Showcase, held in May each year to coincide with International Clinical Trials Day, allows members of the public, patients and staff to see how their involvement in research can make a real difference to the healthcare of future generations.

In May 2019 there were more than 25 presentation stands. Patients and other members of the public were able to find out how they can get involved in research which offers cutting-edge treatments or expands understanding of how the human body works.

The Trust also celebrated Rare Disease Day on February 28, with stands providing information about the rare disease facilities across UHB, including the CfRD and WMGMC.

Across UHB, there are a number of Patient and Public Involvement groups, whose contributions include helping researchers decide what matters to patients, supporting the development of grant applications, and reviewing patient information leaflets and questionnaires.

Groups include the Clinical Research Ambassador Group (CRAG) at Heartlands, the SRMRC's Accident, Burns and Critical Care (ABC) group, and the Trauma Advisor Group (TAG) which works across the SRMRC and Trauma MIC. The BRC has a number of PPI groups, including the R2P2 (rheumatology research patient partners), Muscle Health Patient Involvement in Research Group (MHPIRG) and Liver & GI Patient Involvement Reference Group.

1.15 Enhanced quality governance reporting

The Board of Directors takes direct responsibility for service quality and has approved a Clinical Quality Strategy setting out the overarching principles underpinning the Trust's approach to Clinical Quality. The Board receives regular reports regarding clinical quality and care quality. The Board of Directors has established a Clinical Quality Committee to support, and provide continuity for, the Board of Directors in relation to the Board's responsibility for ensuring that the care provided by the Trust meets or exceeds the requirements of this strategy. Operationally, groups including the Clinical Quality Monitoring Group, the Care Quality Group and the Patient Safety Group, provide a framework for quality governance.

Comprehensive use of electronic decision-support and monitoring tools, developed within UHB and now being rolled out across the enlarged organisation, enables the Trust to monitor compliance with essential clinical protocols and to identify potential risk areas at an early stage. Additional investigations and audits can be undertaken following such triggers. The effectiveness of this monitoring system is backed up by regular unannounced governance inspections by board members (due to COVID-19, visits have been suspended since March 2020) and work is ongoing to ensure appropriate engagement with other relevant stakeholders.

Additional information regarding quality governance, well-led assurances and quality is set out in the Annual Governance Statement on page 71.

2 Governance

2.1 NHS Foundation Trust Code of Governance

University Hospitals Birmingham NHS Foundation Trust (the Trust) has applied the principles of the NHS Foundation Trust Code of Governance on a "comply or explain" basis. The NHS Foundation Trust Code of Governance (the Code), most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012 and was last updated in 2016.

The purpose of the Code is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice, but imposes some disclosure requirements. These are met by the Trust's Annual Report for 2019/20. In its Annual Report, the Trust is required to report on how it applies the Code. Whilst foundation trusts must always adhere to the main and supporting principles of the Code, they are allowed to deviate from the Code provisions provided the reasons for any such departure are explained and the alternative arrangements reflect the main principles of the Code.

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance. The Code is implemented through key governance documents and policies, including:

- The Constitution
- Standing Orders
- Standing Financial Instructions
- The Corporate Governance Policy, incorporating the Schedule Of Reserved Matters and Role Of Officers
- The Chief Executive's Scheme Of Delegation
- The Annual Plan
- Committee Structure

The Board of Directors has conducted a review of the effectiveness of the Trust's system on internal controls.

2.1.1 Application of Principles of the Code

A. The Board of Directors

The Board of Directors' role is to exercise the powers of the Trust, set the Trust's strategic aims and to be responsible for the operational management of the Trust's facilities, ensuring compliance by the Trust with its constitution, the Provider Licence, other mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.

The Trust has a formal Corporate Governance Policy which reserves certain matters to the Council of Governors or the Board of Directors and sets out the division of responsibilities between the Board of Directors and the Council of Governors. The Corporate Governance Policy is reviewed at least anually.

Annex 2 of the Trust's Constitution sets out a procedure for the resolution of any disagreements between the Board of Directors and the Council of Governors, through mediation.

The Board of Directors has reserved to itself matters concerning Constitution, Regulation and Governance; Values and Standards; Strategy, Business Plans and Budgets; Statutory Reporting Requirements; Policy Determination; Major Operational Decisions; Performance Management; Business Cases and Major Contracts; Finance and Activity; Risk Management Oversight; Audit Arrangements; External Relationships and any matter which may have a detrimental effect on the reputation of the Trust.

The Board of Directors remains accountable for all of its functions; even those delegated to the Chair, individual directors or officers, and therefore it expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. As members of a unitary board, non-executive directors are in the same way responsible and accountable as the executive directors.

All powers which are neither reserved to the Board of Directors or the Council of Governors nor directly delegated to an Executive Director, a committee or sub-committee, are exercisable by the Chief Executive or as delegated by her/him under the Scheme of Delegation or otherwise.

Details of the composition of the Board of Directors and the experience of individual Directors are set out in Board of Directors, page 41, of the Annual Report, together with information about the Committees of the Board, their membership and attendance by individual directors.

B. The Council of Governors

The Council of Governors is responsible for representing the interests of members and partner organisations in the local health economy, the governance of the Trust, as well as its forward plan, including its objectives, priorities and strategy. It regularly feeds back information about the Trust,

its vision and its performance to the constituencies and the stakeholder organisations.

The Council of Governors appoints and determines the remuneration and terms of office of the Chair and Non-Executive Directors and the external auditors. The Council of Governors approves any appointment of a Chief Executive made by the Non-Executive Directors. The Council of Governors has a duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. This includes ensuring the Board of Directors acts within the conditions of its licence. The Council of Governors also receives the annual report and annual accounts, and the outcome of the evaluation of the Chair and Non-Executive Directors.

The Chair is responsible for the leadership of both the Board of Directors and Council of Governors and plays a pivotal role in the performance evaluation of the Non-Executive Directors.

Details of the composition of the Council of Governors are set out on page 38 of the Annual Report, together with information about the activities of the Council of Governors and its committees.

Governors have canvassed the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the Trust's forward plan in a number of ways, including the following:

- Governors attendance at community presentations held in their constituency in relation to the hospital/patients issues; and
- Health Talks. Governors attend health talks which are held on a monthly basis for members and wider community

C. Appointments and terms of office

The balance, completeness and appropriateness of the membership of the Board of Directors was reviewed during the year by the Executive Appointments and Remuneration Committee.

Details of the composition of the Executive Appointments and Remuneration Committee and its activities are set out on page 63 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 41, of the Annual Report and in the Remuneration Report in Section 10.

D. Information

The Board of Directors and the Council of Governors are supplied in a timely manner with information in an appropriate form and of a quality to enable them to discharge their respective duties. The information needs of both the Board and the Council are agreed in the form of an annual cycle and are subject to periodic review.

E. Director Remuneration

Details of the Trust's processes for determining the levels of remuneration of its Directors and the levels and make-up of such remuneration are set out in the Remuneration Report in section 10.

F. Accountability and Audit

The Board of Directors undertakes a balanced and understandable assessment of the Trust's position and prospects, maintains a sound system of internal control and ensures effective scrutiny through regular reporting which comes directly to the Board itself or through the Audit Committee.

The Audit Committee is responsible for the relationship with the Trust's auditors, and its duties include providing an independent and objective review of the Trust's systems of internal control, including financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems. The Audit Committee receives instructions from the Board of Directors as to any areas where additional assurance is required and formally reports to the Board of Directors on how it has discharged its duty.

Deloitte LLP was appointed by the Council of Governors as the Trust's External Auditor with effect from 7 February 2014. In July 2018, the Council of Governors re-confirmed their appointment for the audit of the accounts for the financial year ending on 31 March 2019. Owing to COVID-19, the contract has been extended by a further year and a formal tender postponed to later in 2020/21.

The Trust's internal audit function is provided through a contract with an independent provider of internal audit services, KPMG LLP. Due to the COVID-19 major incident, the contract with KPMG for the internal audit service has extended

by a further year to cover 2020/21and a formal tender postponed to later in that year. The role of the internal auditors is to provide independent, objective assurance on the risk management, control, and governance processes within the Trust, through a systematic, disciplined approach to evaluation and improvement of the effectiveness of such processes. The internal audit team agrees a programme of work with the Audit Committee and provides reports during the year to the Committee.

Additional information regarding audit is set out in the Audit Committee Report on page 47.

G. Relations with Stakeholders

The Board of Directors recognises the importance of effective communication with a wide range of stakeholders, including Birmingham City Council's Health, Wellbeing and the Environment Overview and Scrutiny Committee, whose members make occasional visits to the Trust.

H. Development and evaluation

The Chair ensures all directors and governors receive a full and tailored induction on joining the Trust and their skills and knowledge are regularly updated and refreshed through seminars and individual development opportunities.

Both the Board of Directors and the Council of Governors regularly review their performance and that of their committees and, in the case of the Board of Directors, the individual members. Appraisals for all Executive and Non-Executive Directors (including the Chair) have been undertaken and the outcomes of these have been reported to the Council of Governors or the Executive Appointments and Remuneration Committee, as appropriate.

The Trust has engaged the Good Governance Institute in the conduct of an externally facilitated evaluation of the Board against the "well-led framework for governance reviews" this year. The evaluation consisted of Board seminars, focus groups and workshops, meetings with external stakeholders, shadowing of Board and Board Committee meetings as well as interviews with each of the Board directors, including Non-Executive Directors. The outcome of this review was reported to and discussed by the Board in November 2019. Other than as governance advisors and consultants, the Good Governance Institute does not have any other connection to the Trust.

2.1.2 Compliance with the Code

The Trust is compliant with the Code, save for the following exceptions:

B.7.1 *In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g, two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (eg, two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.*

During the reporting year, the Council of Governors re-appointed three non-executive directors, Jane Garvey, Harry Reilly and Catriona McMahon for further terms of three years, notwithstanding that they had each served six years, and without the need for annual re-appointment. The Council of Governors considered that the recent changes of key executives, the need for stability post-merger and in the context of former Heart of England FT NEDs' tenures having been reset as part of the acquisition[1] the circumstances of the Trust were sufficiently exceptional circumstances so as to justify these re-appointments for a further term of three years, without the need for annual reappointment.

C.3.6 *The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.*

The Trust had commenced a tender exercise for the appointment of an External Auditor, the present contract having come to the end of its five year term. However, for reasons associated with the COVID-19 major incident, the tender process was suspended and the present contract with Deloitte LLP has been extended for a further year.

D.2.3 *The Council of Governors should consult external professional advisers to market-test the remuneration levels of the Chairman and other Non-Executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.*

The Council of Governors has not appointed external professional advisors to market-test the remuneration levels of the Chair and other Non-Executive Directors. The material change to the remuneration of the Chair and the Non-Executive Directors made during the reporting year was benchmarked against other similar trusts through information from NHS providers and Shelford Trusts.

1 Because the merger in 2018 with Heart of England NHS Foundation Trust was undertaken as an acquisition, the non-executive directors who were appointed to UHB's board from the HEFT board have, in effect, had their "six-year clocks" reset. Had the merger been undertaken under section 56 of the NHS Act 2006 (as amended) as opposed to section 56A, i.e. through the formation of a new FT, all the non-executive directors (including the Chair) would be in this position.

3 Council of Governors

3.1 Overview

The Trust's Council of Governors continues to make a significant contribution to the success of the Trust and its commitment, support and energy is greatly valued. The Council currently has 33 places filled by 31 representatives.

The Trust opted to have elected Governors representing patients, staff and the wider public, in order to capture the views of those who have direct experience of the Trust's services, those who work for the Trust, and those that have no direct relationship with the Trust, but have an interest in contributing their skills and experience to help shape its future.

The Council of Governors is comprised as follows:

- 17 public Governors elected from the Trust's Constituencies in Birmingham, Solihull & Meriden and Lichfield & Tamworth
- 3 public Governors elected from the Rest of England area (with two positions being vacant)
- 6 staff Governors elected by the following staff groups:
  - Medical
  - Nursing (2)
  - Clinical Scientist and Professions Allied to Healthcare
  - Corporate and Support Services (2)
- 7 Stakeholder Governors appointed by seven of its key stakeholders

3.2 Governors

Elections were held for all Staff Governor constituencies with terms of office running for three years from 28 June 2019. In addition a by-election was held for the Sutton Coldfield South constituency where the term of office will run until 30 June 2020.

During this year, the Governors have been:

3.2.1 Public (by Trust Constituency)

Birmingham Central
Ms Attiqa Khan

Birmingham East
Mr Keith Fielding

Birmingham Heartlands
Mr Gerry Moynihan

Birmingham North
Mr Albert Fletcher

Birmingham Reservoirs
Mr Adam Layland

Birmingham South
Mrs Bernadette Aucott

Birmingham South East
Dr Elizabeth Hensel

Birmingham South West
Mrs Sandra Haynes MBE

Birmingham West
Dr Elspeth Insch OBE

Lichfield, Northwest & Northeast
Mrs Phyl Higgins

Quinton, Halesowen & Southwest
Dr John Cadle (up to 20 June 2019)
Mrs Maureen Haycock (from 9 August 2019)

Rest of England & Wales (3 seats)
Mrs Kath Bell
Mrs Beverley Martin (up to 19 June 2019)
Ms Keisha Pinnock (up to 9 October 2019)

Solihull & Meriden (3 seats)
Mr Stan Baldwin
Dr Sue Balmer
Ms Anne McGeever

Sutton Coldfield North
Mr Tony Cannon

Sutton Coldfield South
Vacant until 30 June 2019
Ms Elizabeth Parry (from 1 July 2019)

Tamworth
Mr Derek Hoey

Associate Governors
Mrs Susan Hutchings (up to 14 May 2019)
Ms Veronica Morgan (up to 30 June 2019)
Mr David Treadwell MBE (up to 12 August 2019)
Mr Tom Webster (up to 30 June 2019)

3.2.2 Staff

Medical and Dental
Dr Tom Gallacher (up to 30 June 2019)
Dr Jattinder Khaira (from 1 July 2019)

Nursing and Midwifery (2 seats)
Dr Kate Gee (up to 30 June 2019)
Ms Veronica Morgan (from 1 July 2019)
Ms Yvonne Murphy

Clinical Scientist & Allied Health Professional
Ms Jayne Robbie (from 1 July 2019)

Corporate & Support Services (2 seats)
Mr Patrick Moore (up to 30 June 2019)
Mr Richard Baker (from 1 July 2019)
Mr Lee Williams

3.2.3 Stakeholders

Birmingham City University
Prof Carol Doyle

Birmingham City Council
Cllr Jayne Francis

Faith Leaders
Rabbi Yossi Jacobs

RCDM
Acting Surgeon General AVM Alastair Reid (up to June 2019)
Also represented by Colonel Jo Palmer and Colonel Deborah Porter (up to March 2020)
Colonel Timothy Steele (from March 2020)

University of Birmingham
Prof Isabelle Szmigin

Solihull Council
Cllr Kate Wild

Lichfield & Tamworth Council
Cllr Ashley Yeates

3.3 Lead Governor

Mrs Sandra Haynes MBE has been appointed by the Council of Governors as Governor Vice-Chair and Lead Governor.

3.4 Meetings

The Council of Governors met regularly throughout the year, holding six meetings in total, including one joint meeting with the Board of Directors and a Special Purposes meeting. The Chair (the Rt Hon Jacqui Smith) attended all meetings.

Name of Governor Public	No. of meetings attended out of six unless stated)
Mrs Bernadette Aucott	5 out of 6
Mr Stan Baldwin	6 out of 8
Dr Sue Balmer	5 out of 6
Mrs Kath Bell	5 out of 6
Dr John Cadle	0 out of 1
Mr Tony Cannon	5 out of 6
Mr Keith Fielding	4 out of 6
Mr Albert Fletcher	4 out of 6
Mrs Maureen Haycock	3 out of 4
Mrs Sandra Haynes MBE	6 out of 6
Dr Elizabeth Hensel	1 out of 6
Mrs Phyl Higgins	4 out of 6
Mr Derek Hoey	3 out of 6
Mrs Susan Hutchings	0 out of 0
Dr Elspeth Insch OBE	5 out of 6
Ms Attiqa Khan	0 out of 6
Mr Adam Layland	3 out of 6
Ms Anne McGeever	3 out of 6
Ms Beverley Martin	0 out of 1
Mr Gerry Moynihan	3 out of 6
Ms Elizabeth Parry	5 out of 5
Ms Keisha Pinnock	2 out of 2
Mr David Treadwell	1 out of 2
Mr Tom Webster	1 out of 1

Name of Governor Staff	No. of meetings attended (out of six unless stated)
Mr Richard Baker	2 out of 4
Dr Tom Gallacher	0 out of 1
Dr Kate Gee	1 out of 1
Dr Jattinder Khaira	5 out of 5
Mr Patrick Moore	1 out of 1
Ms Veronica Morgan	5 out of 6
Ms Yvonne Murphy	3 out of 6
Ms Jayne Robbie	2 out of 5
Mr Lee Williams	4 out of 6

Name of Governor Stakeholder	No. of meetings attended (out of six unless stated)
Acting Surg Gen AVM Alastair Reid	1 out of 1
Colonel Jo Palmer	2 out of 2
Colonel Deborah Porter	2 out of 2
Colonel Timothy Steele	0 out of 1
Cllr Carol Doyle	3 out of 6
Cllr Jayne Francis	0 out of 6
Rabbi Yossi Jacobs	0 out of 6
Prof Isabelle Szmigin	4 out of 6
Cllr Kate Wild	2 out of 6
Cllr Ashley Yeates	0 out of 6

3.5 Steps the Board of Directors, in particular the Non-Executive Directors, have taken to understand the views of the Governors and members

- Attending, and participating in, Governor meetings and monthly Governor seminars
- Attending, and participating in, joint Council of Governor and Board of Director meetings to look forward and back on the achievements of the Trust
- Attendance and participation at the Trust's Annual General Meeting
- Governors and Non-Executive Directors are members of various working groups at the Trust e.g., Strategic Planning Group, Care Quality Group
- During the Reporting Period, two meetings, on 26 September 2019 and 20 February 2020, have been held between the Non-Executive Directors and Governors, specifically to facilitate the Governors in holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board.

3.6 Governors' Register of Interests

The Trust's Constitution and Standing Orders of the Council of Governors requires the Trust to maintain a Register of Interests for Governors. Governors are required to declare interests that are relevant and material to the Board. These details are kept up-to-date by an annual review of the Register, during which any changes to interests declared during the preceding 12 months are incorporated. The Register is available to the public on request to the Director of Corporate Affairs, University Hospitals Birmingham NHS Foundation Trust, Trust Headquarters, Mindelsohn Way, Edgbaston, Birmingham B15 2GW.

4 Board of Directors

4.1 Overview

During the reporting period, the Board of Directors comprised the Chair, eight Executive and nine Non-Executive Directors.

Harry Reilly has held the appointment of Deputy Chair since 1 July 2016. Dr Catriona McMahon holds the appointment of Senior Independent Director. The Senior Independent Director is available to meet stakeholders on request and to ensure that the Board is aware of member concerns not resolved through existing mechanisms for member communications.

During the reporting period, the Board was comprised as follows:

- Chair: Rt Hon Jacqui Smith
- Chief Executive: Dr David Rosser
- Chief Financial Officer: Mike Sexton
- Medical Director: Prof Simon Ball
- Chief Innovation Officer: Tim Jones
- Chief Nurse: Lisa Stalley-Green
- Chief Workforce & International Officer: Kevin Bolger
- Chief Operating Officer: Jonathan Brotherton
- Chief Transformation Officer: Cherry West

Non-Executive Directors:

- Jane Garvey
- Prof. Jon Glasby
- Jackie Hendley
- Karen Kneller
- Mehrunnisa Lalani
- Dr Catriona McMahon
- Harry Reilly
- Prof. Michael Sheppard
- Dr Jason Wouhra

The Non-Executive Directors have all been appointed or re-appointed for terms of three years.

Name	Date of Appoint-ment/ Latest Renewal	Term	Date of end of term
Jane Garvey	1 December 2019	3 years	30 November 2022
Harry Reilly	1 December 2019	3 years	30 November 2022
Catriona McMahon	1 June 2020	3 years	31 May 2023
Jason Wouhra	1 December 2017	3 years	30 November 2020
Jon Glasby	1 May 2018	3 years	30 April 2021
Jackie Hendley	1 May 2018	3 years	30 April 2021
Karen Kneller	1 May 2018	3 years	30 April 2021
Mehrunnisa Lalani	1 May 2018	3 years	30 April 2021
Michael Sheppard	1 May 2018	3 years	30 April 2021

The Board of Directors considers Jane Garvey, Harry Reilly, Catriona McMahon, Dr Jason Wouhra, Prof Jon Glasby, Jackie Hendley, Karen Kneller, Mehrunnisa Lalani and Prof. Michael Sheppard to be independent. In coming to this determination, the Board of Directors has taken into account the following: length of service (particularly in relation to Jane Garvey, Harry Reilly and Catriona McMahon who have served on the board of the NHS foundation trust for more than six years from the date of their first appointment), independence in character and judgement and any other relationships or circumstances which are likely to affect, or could appear to affect, their independent judgement and the need for continuity and leadership in the post-merger phase.

4.2 Board meetings

The Board met regularly throughout the year, holding 11 meetings in total. Attendance was as follows:

Directors	No. of meetings attended (out of 10, unless stated)
Rt Hon Jacqui Smith	All
Dr David Rosser	8 out of 10
Mike Sexton	8 out of 10
Tim Jones	9 out of 10
Lisa Stalley-Green	8 out of 10
Kevin Bolger	9 out of 10
Jane Garvey	All
Harry Reilly	All
Cherry West	All

Directors	No. of meetings attended (out of 10, unless stated)
Dr Catriona McMahon	All
Dr Jason Wouhra	3 out of 10
Jonathan Brotherton	9 out of 10
Prof Michael Sheppard	All
Prof Simon Ball	All
Prof Jon Glasby	8 out of 10
Jackie Hendley	8 out of 10
Karen Kneller	9 out of 10
Mehrunnisa Lalani	8 out of 10

4.3 The Board of Directors composition

Rt Hon Jacqui Smith, Chair

Jacqui Smith has been Chair of University Hospitals Birmingham NHS Foundation Trust since December 2013. She now chairs the enlarged Trust following the acquisition of Heart of England NHS Foundation Trust.

Jacqui grew up in Worcestershire and, after reading Philosophy, Politics and Economics at Hertford College, Oxford University, she returned to the county and had a successful teaching career for 11 years in Worcestershire schools.

In 1997, Jacqui was elected as the MP for Redditch and served for 13 years. After a period on the Treasury Select Committee, she was appointed as a Minister in 1999 and became one of the longest serving Ministers in the Labour government. In 2007, Jacqui was appointed as the UK's first female Home Secretary.

Jacqui is also Chair of the Sandwell Children's Trust and of the Precious Trust – a Birmingham based charity supporting girls at risk of violence or exploitation. She is a Trustee of the Kings Fund; an advisor to the Children's Commissioner of England and works in the Middle East supporting parliamentary and political development. She is a weekly contributor to Good Morning Britain and presents a podcast called For the Many.

Dr David Rosser, Chief Executive

David qualified from University College of Medicine, Cardiff in 1987, worked in general medicine and anaesthesia in South Wales, moving to London in 1993 as a research fellow in critical care and subsequently Lecturer in Clinical Pharmacology in UCLH. He was appointed to a Consultant post in Critical Care at University Hospitals Birmingham in 1996.

In 1998 he was appointed as Specialty Lead for Critical Care; as Group Director responsible for Critical Care, Theatres, CSSD and Anaesthesia in 1999; and as Divisional Director responsible for ten clinical services in 2002.

David was seconded two days per week to the NPfIT in 2004 and appointed as Senior Responsible Owner for e-prescribing in November 2005-April 2007.

In December 2006, David was appointed as Executive Medical Director of UHB, with responsibilities including Executive Lead for Information Technology. He has led the in-house development and implementation of the advanced decision supported electronic patient record into clinical practice across the organisation.

He took up the role of Deputy Chief Executive with responsibility for clinical quality at Heart of England NHS Foundation Trust (HEFT) in November 2015, in addition to the Medical Director role at UHB, and was appointed as Executive Medical Director of HEFT in March 2016. When the two trusts merged in April 2018, David continued in his role as Executive Medical Director and also became the Deputy Chief Executive for the combined Trust.

David was appointed as Chief Executive of UHB on 1 September 2018.

Executive Directors

Prof Simon Ball, Medical Director

Simon was appointed as Medical Director in 2019. He trained in medicine at Oxford University and University College London, underwent postgraduate training in nephrology, dialysis and transplantation in North West London and was an MRC doctoral fellow in the Dept of Biology at Imperial College.

Appointed as a consultant nephrologist to UHB in 2001, he has been Clinical Service Lead in Nephrology, an Associate Medical Director and Director of Digital Healthcare. He was President of the British Renal Society between 2013 and 2016. His contributions to research and innovation include collaborations with academic and industry partners seeking to understand and quantify immune response in transplantation. More recently his interest has pivoted toward the curation and analysis of high value health data assets, such that in 2018 he became Health Data Research UK Research Director in the Midlands. This is based on his longstanding contributions to UHB's development and implementation of electronic health care records, to improve the quality and effectiveness of patient care. This convergence of

technology and quality management will remain an important part of his role as Medical Director.

Kevin Bolger, Chief Workforce & International Officer

Kevin is proud that he started his career in the NHS as a Health Care Assistant at East Birmingham Hospital, he then trained to become a registered Nurse going on to work in a variety of clinical areas as well as moving into more senior clinical positions over the next 18 years.

His career moved away from purely clinical responsibilities into utilising his clinical experience in operational management, where he gained significant experience in all aspects of acute hospital services.

Kevin moved to University Hospitals NHS Foundation Trust in 2000 as a Group Manager and became a Director of Operations just twelve months later. In this role he successfully led a number of major change programmes and focused on developing acute and emergency services.

In 2006 he became Deputy Chief Operating Officer and just 2 years later in 2008 became Chief Operating Officer.

During his time as Chief Operating Officer he led, and was responsible for, the operational planning of the move to the new hospital in 2010 and redesigning the management structure pre- and post-move while maintaining successful existing operational performance of the trust.

Ready for a new challenge in September 2012 Kevin was appointed Executive Director of Strategic Operations and External Affairs leading regional service redesign, developing international opportunities and establishing a successful International Fellowship programme.

In 2013 he took his extensive clinical, managerial and leadership capabilities to support the wider health economy and was the lead Executive in supporting a number of trusts put into special measures following the 'Keogh Reviews'. He was appointed improvement Director for George Eliot Hospital by the National Trust Development Agency in 2015, while maintaining his post at UHB.

Kevin was appointed as Interim Deputy Chief Executive (Improvement) at Heart of England NHS Foundation Trust (HEFT) following the appointment of UHB's Chair and Chief Executive there to lead the turnaround in its clinical performance and finances while maintaining his role at UHB.

After the merger of UHB and HEFT, Kevin became the Director of Strategic Operations for the combined Trust leading the integration of all clinical Services.

In April 2019 Kevin became Chief Workforce and International Officer, a role which encompasses his previous responsibilities and expanded to include Human Resources and workforce.

Jonathan Brotherton, Chief Operating Officer

Jonathan joined Heart of England NHS Foundation Trust (HEFT) in September 2014 as Director of Operations and was appointed to the Board of Directors in March 2015. When UHB and HEFT merged in April 2018, Jonathan became the Chief Operating Officer (COO) for Heartlands, Good Hope and Solihull hospitals. On 1 April 2019 he was appointed COO for the whole Trust and is responsible for the day to day running of its four hospitals, Birmingham Chest Clinic, Solihull Community Services and a number of 'satellite' units.

He joined the NHS in 1992 as a trainee paramedic in Worcestershire working clinically for 12 years before moving into management full time. He graduated from the University of Worcester with a Masters' degree in management studies in 2007 and has worked in senior leadership roles in a number of acute hospital trusts, regional ambulance services and the National Intensive Support Team.

Tim Jones, Chief Innovation Officer

After graduating from University College Cardiff with a joint honours degree in History and Economics, Tim joined the District Management Training scheme at City and Hackney Health Authority based at St Bartholomew's Hospital in London.

Tim joined UHB in 1995 as an operational manager in General Medicine and Elderly Care. He continued to work in operations until 2002, when he undertook the role of Head of Service Improvement and led the New Hospital Clinical Redesign Programme, before being appointed to the role of Chief Operating Officer in June 2006. In September 2008, he was appointed to the newly-created role of Executive Director of Delivery which incorporated board level responsibility for Workforce, R&D, Education. In 2019 Tim took on the role of Chief Innovation Officer which included responsibility for Research & Innovation, Education and Patient Services

Tim is an Executive Director of Birmingham Health Partners, Senior Responsible Officer (SRO) for the West Midlands Genomic Medicine Centre, SRO for the NIHR West Midlands Applied Health Research

Centre and SRO for the West Midlands Academic Health Science Network, Tim is also a Steering Group member for "The Healthcare Improvement Studies Institute" based at the University of Cambridge and funded by the Health Foundation.

Tim holds an MSc in Health Care Policy and is a Senior Research Fellow at the University of Birmingham, Tim is also an Industrial Professor in the Warwick Manufacturing Group at the University of Warwick also acting as Course Director for their Master's Degree in Healthcare Operations Management and Digital Healthcare Scientist undergraduate and apprentice programme.

Mike Sexton, Chief Financial Officer

Mike, who became FD in December 2006, spent five years in the private sector working for the accountancy firm KPMG and had a spell in commissioning at the Regional Specialities Agency (RSA) before joining the Trust in 1995. Over the past 19 years, he has held numerous positions including Director of Operational Finance and Performance and Interim Director of Finance. Mike is also the executive lead for international affairs, commercial development, healthcare contracts, procurement, arts and charities.

Lisa Stalley-Green, Chief Nurse

Lisa graduated from Brunel University in 1990 with a BSc in Modern History & Politics. She spent nine years working in the Prison Service and private sector prisons in London, achieving a senior management post by the age of 25 and gaining a Masters in Business Administration from Hull University in 1999.

Lisa changed career and completed her nurse education on rotation between St Bartholomew's, The Royal London and Homerton University Hospital (1999 – 2002). She became A Nurse Professional in 2002 having achieved a Diploma in Nursing, (Distinction) from City University/St Bartholomew's.

Lisa gained six months' experience in orthopaedics, and specialising in A&E nursing, as a Senior Nurse in Accident & Emergency at Homerton University Hospital between 2002 and 2005, with ALS (Advanced Life Support) and trauma courses completed. She was Senior Matron for Prison Health in the East Midlands for three years (2005 – 2008) before being appointed Service Manager Specialist Services at Nottinghamshire Community Health Services (2008 – 2010).

Lisa held the post of Chief Operating Officer for Newark & Sherwood CCG (2010 – 2012) before moving to Lincolnshire Community Health Services. Here, she was Deputy Chief Nurse and then Director of Nursing & Operations of a Trust which has been rated as Outstanding by the Care Quality Commission, prior to her taking up the role of Executive Chief Nurse at UHB.

Lisa is a Registered Nurse and member of the Royal College of Nursing, having completed her revalidation in 2017, and a Kings Fund Alumna.

Cherry West, Chief Transformation Officer

Cherry began her NHS career as a Healthcare Scientist - Clinical Physiologist - before moving into Operational Management 20 years ago. She joined University Hospitals Birmingham as Chief Operating Officer in August 2014, and was the lead for delivery of patient services and operational performance through the Trust's Clinical Divisions at QEHB; Following nine years as Chief Operating Officer, in April 2019 Cherry was appointed to the role of Chief Transformation Officer across the newly merged organisation encompassing Healthcare Transformation, the digital agenda, long-term planning, Service Reconfiguration, Service Improvement & Quality Improvement Strategy, and Estates & Capital Developments incorporating off-site diagnostic hubs.

Cherry's aim is to deliver and maintain effective, high quality services, providing timely, evidenced based pathways and best possible outcomes to the patients we serve. She believes that in complex health systems this requires distributed leadership supported by digitally enabled services designed to ensure that patients receive the right care, in the right place, at the right time. Cherry is also the Executive Lead for the Cancer Pillar for Birmingham Health Partners, focusing on four key areas of work across primary and secondary care: How to achieve earlier cancer diagnosis; improving access to cancer diagnostics; use of AI to enable reporting opportunities; and translational research. In March 2020, following the COVID-19 pandemic, Cherry was also appointed Chief Operating Officer for the NHS Nightingale Hospital Birmingham.

Cherry completed undergraduate studies at UMDS, London; an MSc at University College London; an MBA at Henley Management College; Diploma in Health Planning and Management Birkbeck College, University of London and is undertaking a Masters in Executive Coaching through Ashridge Business School.

Non-Executive Directors

Jane Garvey

Presenter of Radio 4's 'Woman's Hour', Jane was brought up in Liverpool, moving to Birmingham in the early 1980s as a student to study English

Literature. Her early experience of the NHS came through her mother, who was a receptionist at the Royal Liverpool Hospital and, after leaving University, Jane's first job was as a Medical Records Clerk at the same hospital.

Jane then returned to the West Midlands and embarked upon her career in broadcasting. In 1994, Jane moved into national radio and after thirteen years at Five Live she moved to Radio 4 to present 'Woman's Hour'.

Jane, who has strong connections to the West Midlands, is keen to broaden her experience outside the 'BBC bubble'. She brings well-developed, high-level communications skills, developed over her very successful 30 year career in broadcasting. Jane's experience has given her valuable exposure to interacting with both high-profile figures and the public.

Jane joined the Board in December 2013.

Professor Jon Glasby

A qualified social worker by background, Professor Jon Glasby is Head of the School of Social Policy at the University of Birmingham. Prior to this, he was Director of the University's Health Services Management Centre for seven years, where he specialised in joint work between health and social care and was involved in regular policy analysis and advice.

He has previously served as a Non-Executive Director of Birmingham Children's Hospital and a trustee of the UK Social Care Institute for Excellence (SCIE). He is a Senior Fellow of the National Institute of Health Research (NIHR) School for Social Care Research, and a Fellow of the Academy of Social Sciences and the Royal Society of Arts.

Jon joined the Board at Heart of England NHS Foundation Trust in October 2015 and the UHB Board in May 2018. He is also a Non-Executive Director of the Birmingham Children's Trust.

Jackie Hendley

Jackie is a Chartered Accountant and Chartered Tax Adviser who offers the Trust over 30 years of professional services experience, 11 as a KPMG partner for both plcs and SME's across a varied range of sectors both in the private and public sector. She has advised a wide range of Boards on tax, structuring, strategy, risk management and governance including operational restructuring and dispute mitigation.

Combining a commercial, accounting, auditing and tax background with Boardroom experience to offer constructive challenge and strategic advice, her experience includes challenging what business will look like in the future and how to maximise potential.

Jackie has also advised clients and teams in many industries, including: retail, manufacturing, automotive, property, not-for-profit, public sector and transport. Jackie is passionate about supporting her local community and has been involved with a number of schools and charities in the area and is committed to bringing people together to build capacity and opportunity.

Jackie is currently a Board Adviser at Wing Yip Plc; a Non Executive Director at Word360 Limited and an independent Business and Tax Adviser. Prior to this she was Managing Partner of Smith Cooper in Birmingham and Head of Tax for the firm for seven years. She joined Smith Cooper following 23 years at KPMG. She is also Regional Vice Chair of the Institute of Directors; a Council Member of Greater Birmingham Chambers of Commerce and an Executive Committee Member of Sutton Coldfield Chamber of Commerce.

Jackie joined the UHB Board in May 2018 and was previously a Non-Executive Director at Heart of England NHS Foundation Trust from June 2016.

Karen Kneller

Karen brings over 20 years' experience as a barrister; in addition to her legal skills she also brings experience of strong leadership, finance and audit developed in the public, not for profit / social business, and third sector.

Based in Birmingham where Karen is a CEO, she has both a strong executive and non-executive background.

Karen is committed to diversity and inclusion and is Chair of BRAP, a national equalities charity based in Birmingham.

Karen joined the Board at Heart of England NHS Foundation Trust in October 2014 and joined the UHB Board in May 2018.

Mehrunnisa Lalani

Mehrunnisa has a diverse background having worked for a range of public sector organisations from local Government to HM Prison Service. She started her career working with older people and Black & Minority Ethnic (BME) communities experiencing mental health difficulties.

Mehrunnisa was Director of Inclusion for the Solicitors Regulation Authority (SRA) for 10 years leading on consumer affairs, corporate complaints

and equality, diversity and inclusion. Mehrunnisa transformed complaint handling leading to an improvement in customer satisfaction and reduction in complaints. She led the establishment of 'Legal Choices', an online interactive platform where consumers of legal services can access information about legal services, standards and regulation and participate in key areas of regulatory policy development.

She has also held a number of Non-Executive positions in the health and voluntary sector, serving as a Non-Executive Director on the Leicestershire, Northampton and Rutland Strategic Health Authority, an East Midlands ACCEA and as an Independent Lay Member of the Leicester City Clinical Commissioning Group (CCG). More recently, Mehrunnisa has been a member of the Doctors and Dentists Pay Review Body (DDRB).

Mehrunnisa is currently a Lay Adjudicator/Fitness to Practice panel member for the British Association of Counselling and Psychotherapists (BACP) and an Independent Member on the Leicestershire, Leicester and Rutland Police and Crime Commissioners Panel. She is also an Authorised Representative for Leicestershire Health Watch. She works as a consultant providing advisory and training services to public, voluntary and private sector organisations.

Mehrunnisa has a Postgraduate Diploma in Health Studies, a JNC Qualification in Youth and Community Work and an MA in Health and Community Studies. She was appointed as Non-Executive Director at the Heart of England NHS Foundation Trust in February 2017 and joined the Board at UHB in May 2018.

Dr Catriona McMahon

Catriona is a physician with over 16 years' experience in pharmaceutical medicine. Her NHS background is in anaesthetics and critical care medicine. She worked for AstraZeneca, a FTSE100 pharmaceutical company, as their Medical and Healthcare Affairs Director until December 2014. She has a wide experience of working as a national level board member in both the UK and Canada.

Catriona is passionate about the NHS, patient access to medicines and excellence in patient care. She is currently the Lead Industry Member of the Scottish Medicines Consortium and an Executive Coach with an interest in working with healthcare professionals. Prior to leaving the Industry, she was the Chair of the Medical Expert Network and member of the Innovation Strategy Board and Reputation Strategy Group of the Association of British Pharmaceutical Industries, and was the co-chair (with the Department of Health) of the MISG Clinical Research Working Group.

Catriona joined the Board in June 2014.

Harry Reilly

Harry, who trained as an accountant with Deloitte in the mid-1970s, joined British Leyland Plc in 1982. His career in the automotive sector took him via Leyland Trucks, DAF Holland, Rover Group and BMW.

During that time Harry has taken the opportunity to take on broader management positions and when he moved to the Rover Group and BMW he spent time in the Far East, Australia and South Africa, as well as some of the more developed markets in Europe and America.

In 1999 Harry was made Managing Director of Land Rover UK, immediately prior to its sale by BMW. He subsequently joined Brintons as Finance Director and later Managing Director, tasked with turning around and rebuilding the group. Since then Harry has taken on a variety of positions alongside his non-executive work. He supported a number of start-ups and since 2011 has been a NED and now an advisor of Quality Sterling Group based in Toronto. Harry continues as Honorary Chair of the British American Business Council in the Midlands and is Chair of Ashwell Corporation Limited and Biotronics Limited.

Harry is passionate about Birmingham and the West Midlands and feels that the Trust is a real beacon of excellence, deserving of its strong regional and national reputation.

Harry joined the Board in December 2013.

Professor Michael Sheppard

After an early career as a clinical academic in South Africa, Michael received MBChB (Honours) and PhD degrees from the University of Cape Town. He was elected Founder Fellow of the Academy of Medical Sciences in 1998.

Michael took up a lectureship at the University of Birmingham where he remained until 2013, becoming Professor of Medicine and then headed up the Division of Medical Sciences whilst also building his academic endocrine practice. Michael served most recently as Dean of Medicine and Provost and Vice Principal at the University of Birmingham.

Michael has been a member of, and chaired, a number of UK and international committees and endocrine societies as well as roles at The Royal College of Physicians, Medical Research Council and WHO. Michael was previously a Non-executive Director (NED) at Birmingham Children's Hospital and he is also Chair of the West Midlands Academic Health Science Network Board.

Michael joined the Board at Heart of England NHS Foundation Trust in June 2016 followed by the UHB Board in May 2018.

Dr Jason Wouhra OBE
Jason qualified with a BA (Hons) and LL.M Master of Laws in 1999. This was followed by an Institute of Directors Chartered Director qualification for which he was the youngest person ever to qualify.

Prior to the company's sale to Private Equity in late 2019, Jason was Director and Company Secretary of East End Foods Plc which is the UK'S foremost producer of ethnic food ingredients. Jason was responsible for the Company's wholesale division as well as for Group HR, Legal, Intellectual Property and Company Secretariat functions.

Jason is a highly experienced Company Director with entrepreneurial flair, strong work ethic and strong communication skills within a broad range of sectors including private, public and third sectors.

In addition to his Non-Exec Directorship at UHB, Jason currently holds the position of Chairman of the West Midlands India Partnership and is a Patron of Acorns Hospice. He has previously held the position of Chairman of the Institute of Directors West Midlands, Child Poverty Commission, Aston University Development Board (WM), Library of Birmingham Advisory Board and also Vice-Chairman of the Black-Country Local Enterprise Partnership. Jason has also acted as a Business Advisor to Prime Minister David Cameron through the Institute of Directors.

Jason was awarded an OBE in 2017 for services to Business and International Trade at the age of 39. He was also awarded an Honorary Doctorate by Aston University in 2014.

He has been involved in various charitable causes and has raised in excess of £250,000 for charity in the past few years.

Jason joined the Board in December 2014.

4.4 Directors' Register of Interests

The Trust's Constitution and Standing Orders of the Board of Directors requires the Trust to maintain a Register of Interests for Directors. Directors are required to declare interests that are relevant and material to the Board. These details are kept up-to-date by an annual review of the Register, during which any changes to interests declared during the preceding 12 months are incorporated. The Register is available to the public on request to the Director of Corporate Affairs, University Hospitals Birmingham NHS Foundation Trust, Trust Headquarters, Mindelsohn Way, Edgbaston, Birmingham B15 2GW.

5 Audit Committee

5.1 Overview

The Audit Committee is a committee of the Board of Directors whose principal purpose is to assist the Board in ensuring that it receives proper assurance as to the effective discharge of its full range of responsibilities. Its duties include providing an independent and objective review of the Trust's systems of internal control, including financial systems, financial information, governance arrangements, approach to risk management and compliance with legislation and other regulatory requirements, monitoring the integrity of the financial statements of the Trust and reviewing the probity of all Trust communications relating to these systems.

The Committee met regularly and was chaired by Karen Kneller. The Committee currently comprises five Non-Executive Directors of the Trust, with the external and internal auditors and other Executive Directors attending by invitation.

5.2 Membership of the Committee

The members of the Committee during 2019/20 were as follows:
- Karen Kneller
- Jane Garvey
- Jackie Hendley
- Harry Reilly
- Dr Jason Wouhra

The members of the Committee disclosed their interests, which included the following, in the Trust's Register of Interests:
- **Karen Kneller** - CEO, Criminal Case Review Commission, Tribunal Judge Social Entitlement Chamber, Fitness to Practice Member for General

Dental Council, Chair of BRAP (equalities think tank).

- **Jane Garvey** – nil declared
- **Harry Reilly** – Director – Galtons and Associates Limited; Chairman – British American Business Council Midlands; Chairman – Ashwell Corporation Limited; Chairman – Biotronics Limited
- **Dr Jason Wouhra** – Director & Company Secretary - East End Foods plc, Patron – Acorns Children's Hospice
- **Jackie Hendley** - Director - SC Advisory Services Ltd, Director – Smith Cooper Ltd, Director - Smith Cooper IT Services Ltd, Partner/Member – SHH 101 LLP, Member – Executive Committee, Sutton Coldfield Chamber of Industry & Commerce, Council Member – Greater Birmingham Chamber of Commerce; Regional Vice Chair – West Midlands Institute of Directors

The Committee's principal support officer throughout the year was the Director of Corporate Affairs. The Chief Financial Officer, Chief Operating Officer, Chief Nurse, Deputy Director of Corporate Affairs and Head of Clinical Risk and Compliance, together with representatives of both the External and Internal Auditors, attended the meetings of the Committee as a matter of course. Other directors and officers of the Trust attended meetings of the Committee as and when required.

5.3 Operation of the Committee

The Committee is required to meet at least four times a year. A total of six ordinary and extra-ordinary meetings took place during 2018/19 and were attended as follows:

Director	No. of meetings attended (out of six unless otherwise stated)
Karen Kneller	6
Jane Garvey	6
Harry Reilly	6
Jackie Hendley	6
Dr Jason Wouhra	3 out of 6

The action plan following the annual self-assessment of 2018/19 was addressed and all recommendations were implemented during the reporting year. The annual self-assessment for 2019/20 is under way and its findings will be reported to the Council of Governors' meeting in the summer of 2020. The self-assessment, based on the Good Governance Institute maturity matrix for Audit Committees, has been used in previous years, which allows the Trust to track any progress made.

The Committee has also maintained its practice of agreeing an annual cycle of business which is designed to facilitate forward planning and to assist the Committee in ensuring that all aspects of its terms of reference are being fulfilled.

The Audit Committee receives specific instructions from the Board of Directors as to the areas where additional assurance is required and has formally reported back to the Board of Directors on how it has discharged its duty. The Audit Committee has thus supported the Board of Directors in making its 'fair, balanced and understandable' statement. During 2019/20, the Audit Committee considered the following significant issues in relation to financial statements, operations and compliance:

Risks to the financial statements, including:

- Recognition of NHS revenue
- Capital programme and valuation
- Accruals and provisions
- Cost Improvement Plans (CIPs)
- Key Financial Controls, including:
  - Treasury management
  - Income and receivables
  - Expenditure & payables
  - PPE
  - General ledger
  - Budgetary Control
- UHB Payroll and Payroll Bureau

The Audit Committee further supported the Board by providing assurance on risk management and compliance with regulatory requirements by considering external and internal reports on the Trust's Board Assurance Framework (BAF) and risk management processes, compliance with the Data Security and Protection Toolkit, compliance with the FT Code of Governance, compliance with the CQC essential standards, and received several presentations during the year on the Use of Resources framework and patient level costing (PLICS) as well as cyber security.

Throughout the year, the Audit Committee was supported by the Internal Auditors, External Auditors and Local Counter Fraud Specialists who provided external assurance on general governance matters, financial reporting, as well as processes for fraud detection, investigation and prevention.

During the reporting period, the Audit Committee submitted formal reports to the Board of Directors' meetings following each Audit Committee meeting.

5.4 Auditors

During 2019/20, the Trust's External Auditor has been Deloitte LLP.

Owing to COVID-19 the previous contract for the appointment of External Auditors was extended by a further year with a view to resume the formal tender once the Trust has reverted to business as usual. The Audit Committee carries out a review of the effectiveness of the External Auditor following the completion of each annual audit, assessing the External Auditor's performance against an agreed framework and seeking the views of officers of the Trust, and reports the outcome of that review to the Council of Governors, together with a recommendation as to whether the External Auditor should be re-appointed for the following year.

The annual cost of the Trust's 2019/20 external audit was £223,800; in addition, Deloitte LLP provided the following services during 2019/20:

Counter Fraud Service: £75,000

Statutory and audit-related work: £25,640 (including audit of subsidiaries and the annual quality report

The Trust's contract with its external auditor, Deloitte LLP, provides for a limitation of the auditors liability of two million pounds sterling.

5.5 Independence of External Auditors

To ensure that the independence of the External Auditors is not compromised where work outside the audit code has been purchased from the Trust's external auditors, the Trust has a Policy for the Approval of Additional Services by the Trust's External Auditors. This policy arises from the 'Revised Ethical Standard of 2016 for Audit and Assurance services' issued by the Financial Reporting Council (FRC) and the supporting National Audit Office: 'Auditor Guidance note 1 (AGN 01).

The ethical standard places various duties upon the external audit firm with regard to both the external audit itself and other services (where they occur). These include:

- Rotation of audit partners after a maximum of 5 years
- Having a different partner (not the external audit partner) to lead any additional work
- No one from the external audit firm can have a key management position at the Trust or membership of the Audit Committee
- If any close family member of the engagement partner takes a role at the Trust this must be subject to review

Permitted non-audit services carried out by the external auditor are defined as work that is:

not relating to the financial statements and / or financial controls, is not integrated with the external audit work plan not performed by the existing audit team. The Trust views the provision of Local Counter Fraud Services (LCFS) as being permitted non-audit services.

In addition, certain projects where work is clearly audit-related and the external auditors are best-placed to do the work (e.g. regulatory work, e.g. acting as agents to NHS Improvement, the Audit Commission, the Care Quality Commission, for specified assignments). Statutory and audit-related work assignments do not require further approval from the Audit Committee or the Council of Governors. This includes the external audit of the subsidiaries and the Trust's Quality Report.

The external auditors are prohibited from providing the following non-audit services:

- Tax services and advice
- Any services that include taking part in the key management decision making process of the Trust
- Book keeping and preparation of accounting records
- Payroll services
- Designing or implementing internal controls
- Actuarial or litigation services
- The Trust's internal audit process
- Human resource activities

The Audit Committee must be informed of any non-audit work to be carried out by the external auditor in order for it to be reviewed for compliance with the above standard. This includes an upper limit ('cap') defined as: the total fees for non-audit services in a financial year cannot be greater than 70% of the external audit fee for the same year. Audit Committee must give prior approval for any non-audit service worth over £100,000.

5.6 Auditors' reporting responsibilities

Deloitte LLP, the Trust's independent auditors, report to the Council of Governors through the Audit Committee. Deloitte LLP's accompanying report on our financial statements is based on its examination conducted in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006, the Code of Audit Practice and the Financial Reporting Manual issued by the independent regulator Monitor. Their work, performed under International Standards on Auditing (UK and Ireland), includes a review of our internal control structure for the purposes of designing their audit procedures.

6 Nominations Committees

6.1 Council of Governors' Nomination & Remuneration Committee for Non-Executive Directors

The Council of Governors' Nomination & Remuneration Committee for Non-Executive Directors is a committee of the Council of Governors responsible, amongst other things, for advising the Council of Governors and making recommendations on the appointment of Non-Executive Directors, including the Chair of the Trust. Its terms of reference, role and delegated authority have all been agreed by the full Council of Governors. The committee meets on an as-required basis.

The Nomination & Remuneration Committee for Non-Executive Directors comprises the Chair and four Governors of the Trust. The Chair chairs the committee, save when the post/remuneration of the Chair is the subject of business, in which case the committee is chaired by the Governor Vice-Chair.

During the reporting year the membership of the Committee was as follows:
Council of Governors' Nomination and Remuneration Committee

- Rt Hon Jacqui Smith (Chair)
- Mrs Sandra Haynes MBE (Governor Vice-Chair)
- Dr Tom Gallacher (up to 30 June 2019)
- Mr Stan Baldwin
- Prof Carol Doyle
- Ms Yvonne Murphy (from 1 July 2019)

The Nomination & Remuneration Committee met six times during the year.

Members	No. of meetings attended
Dr Tom Gallacher	1 of 2
Mr Stan Baldwin	5 of 6
Mrs Sandra Haynes MBE	5 of 6
Prof Carol Doyle	5 of 6
Ms Yvonne Murphy	3 of 4

The business of the Nomination & Remuneration Committee during the Reporting Year included the following:

- A recommendation to the Council of Governors that the Rt. Hon. Jacqui Smith be re-appointed as Chair for a further term of three years without the need for annual reappointment;
- Recommendations to the Council of Governors that Ms Jane Garvey, Mr Harry Reilly and Dr Catriona McMahon be each re-appointed as non-executive directors for a further term of three years without the need for annual reappointment; and
- The commencement of the process to appoint a new non-executive director for a vacancy that will occur in the next financial year

6.2 Nominations Sub-Committee

When there is a vacant post in the Trust's Executive team, the Executive Appointments and Remuneration Committee (EARC) appoints a Nominations Sub-Committee to deal with this appointment. During the reporting period, there were no Nominations Sub-Committees appointed.

7 Membership

7.1 Overview

The Trust has two membership constituencies as follows:

- Public constituency (including the Rest of England constituency)
- Staff constituency

Public Constituency

The public constituencies correspond to the Parliamentary constituencies of Birmingham and a further constituency – the Rest of England constituency – which allows individuals who live outside the Public constituency, and are not Staff members, to become members of the Public constituency. Public members are drawn from those individuals who are aged 16 or over and:

- Who live in the area of the Trust; and
- Who are not eligible to become members of the staff constituency

Staff Constituency

The Staff Constituency is divided into four classes:

- Medical Staff;
- Nursing Staff;
- Clinical Professions Allied to Healthcare Staff; and
- Corporate and Support Services Staff

7.2 Membership size and movements

Public constituency	Last year (2019/20)	Next year (estimated) (2020/21) NB: have used same figures as the Trust is not looking to grow membership numbers but rather maintain them
At year start (April 1)	29,458	29,458
New members	251	251
Members leaving	745	745
At year end (March 31)	28,964	28,964
Staff constituency	**Last year (2019/20)**	**Next year (estimated) (2020/21)**
At year start (April 1)	20,874	N/A
New members	9,727	N/A
Members leaving	2019	N/A
At year end (March 31)	28,582	N/A
Analysis of current membership		
Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	0	430,411
17-21	113	129,736
22+	26,132	1,323,979
Ethnicity:		
White	16,891	1,221,751
Mixed	198	62,344
Asian or Asian British	3,072	347,957
Black or Black British	777	113,445
Other	76	27,796
Socio-economic groupings*:		
AB	7,741	148,878
C1	8,176	222,981
C2	6,034	144,527
DE	6,908	222,724
Gender analysis		
Male	12,585	929,776
Female	15,631	954,346

The analysis section of this report excludes:

- 2,726 public members with no dates of birth, 1,602 members with no stated ethnicity and 748 members with no gender

General exclusions

* Socio-economic data was completed using profiling techniques (eg: postcode) or other recognised methods.

7.3 Membership Strategy

7.3.1 Membership Development 2019/20

During 2019/20 the overall membership increased from 51,176 to 57,546. The main increase was in the Staff constituency due to the addition of bank staff whose status changed so that they became eligible for membership as employees.

The Trust's membership is largely representative of the populations it serves. The Trust has members from a broad range of backgrounds and the Trust publicises their contributions both internally and externally.

Although under-16s appear to be under-represented, this is due to them not being eligible for membership at UHB.

7.3.2 Membership Objectives

The Membership Engagement and Recruitment Strategy, approved by the Board of Directors, is to replace the annual churn and maintain existing membership numbers to no less than 50,000. Emphasis is placed on the retention of existing members and further engagement achieved through:

- Membership monthly e-bulletins
- Community-based presentations to community groups and involvement in constituency events
- The inclusion of members on appropriate patient groups
- Raising the profile and role of Foundation Members and Governors within the Trust via social media and the Trust website
- Working with QEHB Charity to increase membership opportunities amongst fundraisers

7.3.3 Governors' Development 2019/20

Meetings of the Membership, Engagement & Governors' Development Committee are held approximately 2-3 times a year. This committee is made up of Governors from across all the constituencies and is overseen by the Director of Corporate Affairs. The content of seminars is agreed across the year. Last year's topics covered the following:

- Proposed 2019/20 Annual Plan
- CQC visit outcomes
- Patient Experience/End of Life/Bereavement Services
- Service Integration
- The Use of Artificial Intelligence in Treatment/ Online Consultations
- Appointments Booking System, including appointment letter standardisation
- Inclusion, Wellbeing & Social Cohesion

For 2020/21 topics are set to include:

- Overview of PICS including links to dashboards and how data is used to change behaviours
- Sustainability Strategy – how to spread the word to the wider organisation
- Patient Experience Strategy
- Finance for Non-Financial People – how to understand financial reports
- How to represent and engage with members
- Safeguarding
- End of Life Care

Governors are able to attend update/training courses as part of the GovernWell programme run by NHS Providers. The themes covered each year are:

- Effective Questioning & Challenging (in holding the NEDs to account)
- Core Skills
- NHS Finance & Business Skills
- The Governor role in Non Exec Appointments

7.3.4 Member communication with governors and/ or directors

There are several ways for members to communicate with governors and/or directors. The principal ones are as follows:

- Telephone, written or electronic communications co-ordinated through the Membership Office which then steers members to the appropriate Governor/Director
- The Annual General Meeting
- Website. Each Governor has their profile and details of the constituency they serve, published on the Trust website including email address which is co-ordinated through the Corporate Affairs office
- Governors attend community presentations held in their constituency in relation to the hospital/ patients issues
- Health Talks. Governors attend health talks which are held on a monthly basis for members and wider community. Evening sessions are also held to provide greater access
- news@QEHB – Trust newspaper distributed through the hospital sites
- Social media tools – Twitter, Facebook, Instagram and YouTube
- Annual Membership Week – activities held over 3 days aimed at promoting membership; Recruitment stands in hospital atriums

7.3.5 Contacting the Membership Office

The Membership Office triages queries from members to the most appropriate Governor and or Director for action.

Contact: members@uhb.nhs.uk; 0121 371 4323; Membership Office, Third Floor, Nuffield House, University Hospitals Birmingham, Mindelsohn Way, Edgbaston, B15 2TH

8 Staff Report

8.1 Breakdown of the number of male and female staff at 31 March 2020

	Female	Male
All Staff	16,440	5,138
Executive Directors	*2	*6
Directors	**1	**4
Total Staff	**16,444**	**5,147**

*Definition of Executive Directors: Statutory Directors
**Definition of Directors: A person who (a) has responsibility for planning, directing or controlling the activities of the Trust, or a strategically significant part of the Trust, and (b) is an employee of the Trust.

8.2 Staffing Profile

The largest staff group at UHB are employed in Nursing, with the next highest groups of staff Healthcare Assistants and Other Support Staff and Administrative and Estates. The fewest number of staff are employed as Healthcare Scientists. The highest numbers of permanent staff are in Nursing, Healthcare Assistants and Other Support Staff and Administrative and Estates roles. Fixed-term working largely supports Medical and Dental roles, whilst bank working underpins workforce needs mostly in Nursing and Healthcare Assistants and other support staff.

Average 2019-20

Staff Groups	Permanent	Fixed Term	Bank
Medical and dental	1002	1310	247
Ambulance staff	0	0	0
Administration and estates (Including Ancillary)	3435	336	367
Healthcare assistants and other support staff	4662	137	826
Nursing, midwifery and health visiting staff	5217	106	1,646
Nursing, midwifery and health visiting learners	0	0	0
Scientific, therapeutic and technical staff	1761	40	154
Healthcare science staff	674	26	30
Social care staff	0	0	0
Other	0	0	0
Total average numbers	**18707**		

* Please note that the Bank numbers include those individuals available to deliver work through UHB's Bank who have been active within the past two years. It does not include staff who hold both a substantive and a bank contract.

8.3 Staff Exit Packages

Termination benefit by band - Year Ended 31 March 2020	Compulsory Redundancies		Other Agreed Departures *		Total Number	Total Termination Cost £
	Number	Cost £	Number	Cost £		
<£10,000	1	9,494.16	2	15,507.71	3	25,001.87
£10,000 - £25,000	1	16,169.75	1	17,063.48	2	33,233.23
£25,000 - £50,000	0	0.00	0	0.00	0	0.00
£50,000 - £100,000	3	233,327.56	1	87,641.52	4	320,969.08
£100,000 - £150,000	2	267,454.67	0	0.00	2	267,454.67
>£150,000	0	0.00	0	0.00	0	0.00
Grand Total	**7**	**526,446.14**	**4**	**120,212.71**	**11**	**646,658.85**

Other agreed departures Total termination

* These other agreed departures were due to fixed-term contracts ending and therefore incurring redundancy costs.

8.4 Staff engagement

UHB is committed to engaging its workforce and recognises that the quality of the services we deliver to patients is defined by our people. We strive to find ways to work with staff to improve their working lives, and feedback is crucial to understanding their needs and views. The Trust works in partnership with its trade unions to engage with staff; the strength of this partnership is demonstrated by the Trust in its responsiveness to this feedback.

The Trust runs a quarterly Staff Friends and Family Test to seek the views of staff on their experiences at work, and reasons for recommending as a place to work and recommending for care and treatment. In addition, all staff are invited to take part in the annual staff survey which provides detailed feedback on staff experience across a range of key themes.

The Trust uses other mechanisms throughout the year to actively seek the views and opinions of staff. These include hosting targeted focus groups, direct e-surveying on specific topics and engagement briefing sessions.

UHB is committed to keeping staff up-to-date with news and developments through an internal communications programme:

- Team Brief – staff receive the Chief Executive's core brief every two months
- news@ – the Trust's monthly staff magazine is available throughout the Trust
- The staff intranet is constantly updated with current news and important information
- In the Loop – staff receive weekly email updates on Trust news and developments
- Social Media – The Trust has active Twitter and Facebook accounts, sharing information and stories

8.4.1 NHS Staff Survey

The NHS staff survey is conducted annually. The results from questions are grouped to give scores on 11 indicators. The indicator scores are based on a score out of 10.

The response rate to the 2019 survey among Trust staff was 37% (2018: 36%) Scores for each indicator together with that of the survey benchmarking group (Acute Trusts) are presented below.

Indicator	2018/19	2019/20		
	Trust	Trust	Benchmarking group	Significant change
1. Equality, Diversity & Inclusion	8.9	8.9	9.0	No
2. Health & Wellbeing	5.7	5.6	5.9	Yes
3. Immediate Managers	6.7	6.7	6.8	No
4. Morale	6.0	5.9	6.1	No
5. Quality of appraisals	5.3	5.0	5.6	No
6. Quality of care	7.5	7.4	7.5	Yes
7. Safe environment – bullying & harassment	8.0	8.0	7.9	No
8. Safe environment – violence	9.4	9.5	9.4	No
9. Safety culture	6.6	6.5	6.7	No
10. Staff engagement	7.0	6.9	7.0	Yes
11. Team working	6.5	6.3	6.6	Yes

The 2019 scores are the second set of scores for the merged Trust. Comparing 2019 scores on individual questions with the 2018 scores, of the 90 questions, five were significantly better, 32 were significantly worse and 53 had no significant change.

Overall, the results reflect what we would expect to see in a challenging year with high levels of change, and therefore maintaining our scores on 59% of indicators is a relatively positive position.

8.4.2 Future priorities and targets

Our immediate focus in recent months has been supporting our staff during the COVID-19 pandemic. Specifically, we have been focusing on psychological and mental health support, establishing wellbeing hubs on each hospital site and distributing donated goods from the public to wards and departments to boost morale.

In addition, we will continue with our focus on strengthening positive behaviours and improving morale through a range of initiatives. We are supporting this work with a range of tools for teams to use locally, e.g. Values award cards, development platform, and a new behavioural framework. We are also continuing to progress our leadership development priorities, including a senior leaders development programme and staff mentoring programme.

The Trust will continue to provide with regular opportunities for staff to give their feedback via the quarterly Staff Friends & Family Test and full census of National Staff Survey, reviewing key themes and taking action in response.

8.5 Sickness Absence

In 2019/20, the Trust recorded an annual average sickness absence across all clinical and corporate divisions of 5.21%.

Long term sickness continues to be the main cause of absence from work, and has accounted for 3.41% of the total sickness absence for 2019/20. The total number of days lost due to sickness for the year is 414,813.

Not surprisingly sickness absence peaked in March 2020, and COVID-related absence accounted for an additional 2,741 staff being away from work by the end of that month. We have been tracking COVID and non-COVID absence on a daily basis since March, and have established mechanisms to support safe returns to work.

For the year-to-date the top five reasons for both long term and short term absence across the Trust are:

Absence Reason

1. Anxiety/stress/depression/other psychiatric illnesses
2. Other musculoskeletal problems
3. Cold, Cough, Flu - Influenza
4. Gastrointestinal problems
5. Other Known Causes – not elsewhere classified

The Trust continues to operate with two Electronic Staff Record systems which record sickness absence; however reporting is now completed on a Trust-wide basis for all sites and is no longer reported by site.

Trust management continues to work in partnership with Trade Union colleagues to explore opportunities to reduce sickness absence rates to a target of 4%.

Staff groups with absence consistently above the Trust Key Performance Indicator include Additional Clinical Services (8.68%), Estates and Ancillary (7.88%) and Nursing and Midwifery (5.21%). Sickness cases are led by managers with support from Human Resources Advisors, and high absence areas are focused on for targeted interventions to understand and address the root cause.

The Trust implemented a new Employee Relations Policy with effect from 1 October 2019 which incorporates a new procedure for managing sickness absence and attendance. As part of the implementation, a transition plan was agreed with Trade Union colleagues and rolled out across the Trust to ensure all staff who were previously being managed and supported under one of the Trust's two previous Sickness Absence procedures were transitioned across to the new procedure. This has ensured consistency across all cases and no staff have suffered a detriment as a result of this change in procedure.

The new procedure provides more clarity for managers and staff on timescales for each stage, provides staff with a degree of control for when they may want to reach a 'mutual agreement' with their manager on ending their employment for health reasons, and also focuses on the health and wellbeing of staff and prevention of issues which typically result in absence.

Regular Confirm and Challenge meetings for absence management are in place across the Trust, chaired by senior managers with support from HR. The purpose of these meetings is to review sickness cases, both short and long term, and facilitate the progression of cases. This has helped to resolve some complex long term cases and has offered line managers additional support in dealing with what are very often, challenging circumstances.

As part of the implementation plan for the new procedure, a comprehensive training and education package has been developed to support managers in understanding and applying the changes. In addition, bespoke sickness absence management training is targeted at identified hot-spot areas to ensure tailored support is provided where required.

More generally, the link between good people management and good attendance is recognised in the review of departmental performance, and more general people management and leadership training has been refreshed and delivered which we expect to develop work environments in which all staff can thrive and work well.

The Trust has rolled out a comprehensive training programme for managers in respect of 'Managing Mental Health at Work' which is delivered and facilitated by qualified facilitators from Mind, the national mental health charity. There has been a strong take-up of this as managers seek to support the mental health of their staff, as well as taking a proactive approach to looking after their own mental health. The feedback on this training has been excellent, and managers have valued the opportunity to take the time to focus on mental health and seek additional, specialist support from Mind. This training has also started to be rolled out across the Sustainability and Transformation Partnership (STP) in order that managers from neighbouring Trusts can also take up this opportunity.

UHB continues to actively promote health and wellbeing amongst its staff. National awareness days such as *World Mental Health* (October) and *Time to Talk* (February) have also been widely promoted with a series of activities to support awareness of key issues.

In addition, there has been an increased focus on the impact of domestic abuse on attendance and sickness absence. The HR team have received specialist training to help them identify where matters relating to domestic abuse may be at play, and have been encouraged to ensure that flexibility and discretion is applied where relevant to ensure that employees in a domestic abuse situation are well supported at work.

All staff are able to access or self-refer to a number of services and these include:

- Staff Support
- Staff Well Clinic
- Staff Physiotherapy
- Occupational Health
- Mindfulness
- Chaplaincy Support

The Staff Well Clinic has expanded and offers a complete health assessment for individuals with options to either refer back to the General Practitioner or refer within the Trust to the appropriate service. In conjunction with the onsite leisure centre The Morris Club, a 'passport' (worth up to £25) can be provided which allows the holder to use the gym, swimming pool or take classes (including pilates and yoga) at no cost.

Disability

The Trust takes a proactive approach to supporting staff with a disability, and staff are advised to make their managers aware of any disability in order that reasonable adjustments can be considered and appropriate support given.

The HR team also regularly review the outcomes of employee relations casework in conjunction with workforce data to ensure that staff with a disability are not disproportionately represented in formal disciplinary outcomes and capability cases. Where staff have raised complaints relating to their disability, such as disability discrimination claims, these are dealt with promptly and fully investigated in line with the Employee Relations Policy.

The Trust is a Disability Confident Employer and guarantees an interview for candidates where a disability is declared and the application meets the minimum requirements for the role. The Disability Confident logo is displayed on all job adverts and is reinforced with an additional paragraph in the advert 'footer' about the Trust's commitment to the programme and guaranteed interviews.

All candidates are asked to notify the recruitment team should they require adjustments to be made to the interview process and the opportunity to discuss these should the candidate wish to do so.

Recruitment and Selection training is in place which includes a dedicated section on unconscious bias, disability confident and reasonable adjustments. A Moodle package is also in the process of being developed to aid managers' understanding. These sessions are interactive and experiential to better equip managers with the practical skills and knowledge to undertake recruitment effectively. Senior Recruitment leads have also attended staff disability network meetings to talk through staff experiences and explore alternative ways to recruit.

The team are in the process of procuring an on boarding recruitment system which will offer a more effective way of recruiting and also provide a better candidate experience.

Counter Fraud

The HR team work closely with the Trust's Local Counter Fraud Specialist to seek advice on cases of potential fraud. Where appropriate, cases are investigated by the Local Counter Fraud Specialist as well as undertaking local investigation.

Occupational Health

The following table details the Occupational Health activity for 2019/20.

	Total all Trust
Management referrals	3,393
Self referrals	199
Review Appointments	1,893
Skin Assessments	401
Inoculation Injuries	763
Pre Employment Questionnaires	5,808
Total Trust Flu campaign	76.62% of frontline staff

The table below details the Trust's Staff Support/ Counselling activity for 2019/20. From the period 01/04/2019 to 30/09/2019 counselling services for staff at the Heartlands, Good Hope and Solihull sites was provided via an Employee Assistance Programme. From 1 October 2019 this provision moved to a face-to-face service provided in-house by the Trust.

Counselling Q1&2	
New	446
Reviews	262
Counselling Q3 &4	
New	269
Reviews	22

8.6 Trade Union Facility Time Reporting Regulations

The Trade Union (Facility Time Publication Requirements) Regulations 2017 took effect on 1 April 2017. This means that the Trust is required to publish certain information on trade union officials and facility time on the Trust website and Government portal.

The information contained in this report relates to University Hospitals Birmingham NHS Foundation Trust for the 2019/20 financial year.

The regulations require the following information to be published:

- table 1: the number of employees who were relevant union officials during the relevant period, and the number of full time equivalent employees
- table 2: the percentage of time spent on facility time for each relevant union official
- table 3: the percentage of pay bill spent on facility time
- table 4: the number of hours spent by relevant union officials on paid trade union activities as a percentage of total paid facility time hours.

Table 1
Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period - 57	Full-time equivalent employee number – 52.02

Table 2
Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	0
1-50%	52
51%-99%	2
100%	3

Table 3
Percentage of pay bill spent on facility time

Total cost of facility time	£146,210
Total pay bill	£1,019,300,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.014%

Table 4
Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 23.32%
(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

8.7 Gender Pay Gap

The Trust's Gender Pay Gap data can be found at: https://www.uhb.nhs.uk/gender-pay-gap.htm

8.8 Reporting high paid off-payroll arrangements

There were no high paid off-payroll arrangements in 2019/20.

8.9 Expenditure on consultancy

The expenditure on consultancy is £1,988,000 for the year. See note 7 in the accounts.

8.10 Analysis of staff costs

Employee costs include those of staff and directors, but exclude non-executive director costs.

Employee costs	Year Ended 31 March 2020			Year Ended 31 March 2019		
	Permanently		Other	Permanently		Other
	Total	Employed		Total	Employed	
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	786,318	727,274	59,044	739,900	700,297	39,603
Short term employee benefits - social security costs	70,321	70,321	-	70,179	70,179	-
Post employment benefits - employer contributions to NHS pension scheme	87,205	87,205	-	82,990	82,990	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	38,160	38,160	-	107	107	-
Pension cost - other contributions (NEST)	214	214	-	-	-	-
Apprentice Levy	3,889	3,889	-	3,640	3,640	-
Termination benefits	663	663	-	143	143	-
Temporary staff - external bank	-	-	-	-	-	-
Temporary staff - agency/contract staff	36,782	-	36,782	51,728	-	51,728
Pay costs capitalised as part of assets	(3,872)	(3,872)	-	(3,031)	(3,031)	-
	1,019,680	**923,854**	**95,826**	945,656	854,325	91,331

9 NHS Improvement's Single Oversight Framework

9.1 Explanation of the foundation trust's risk ratings

NHS England and NHS Improvement (NHSE/I) set out the approach taken to oversee organisational performance in the NHS Oversight Framework for 2019/20. This was an evolution of the existing Single Oversight Framework, however a greater emphasis is placed on system performance as NHSE/I has sought to identify the need for support across STPs and ICSs. The five existing themes of the framework remain:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

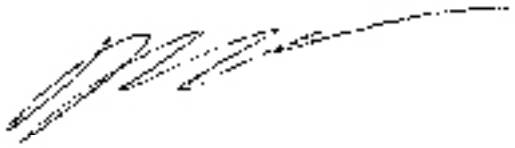
Despite the greater emphasis on system performance, the approach of segmenting individual providers remains with each provider being segmented into one of four categories:

Segment	Description
1	Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.
3	Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Oversight Committee has agreed to impose regulatory requirements.
4	Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Oversight Committee has agreed it meets the criteria to go into special measures.

For the whole year the Trust has been in Segment 2. This continues the Trust's performance under the Single Oversight Framework where it was consistently in segment 2 since the Framework's introduction on 1 October 2016. Consequently no enforcement action has been taken against the Trust over that period. This segmentation information is the Trust's position as at 31/03/2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website at https://improvement.nhs.uk/resources/nhs-oversight-framework-trust-segmentation/.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above is not the same as the overall finance score here.



Dr David Rosser, Chief Executive
18 June 2020

Area	Metric	Explanation	2019/20 Q4 score	2018/19 Q4 score	2017/18 Q4 score
Financial sustainability	Capital Service Cover	Can the Trust's income cover its longer term financial obligations	3	4	2
	Liquidity	Cash held to cover operating costs	4	4	2
Financial efficiency	I&E Margin	I&E surplus or (Deficit) as a proportion of total Income	2	4	1
Financial Controls	I&E Variance From Plan	Actual year to date surplus compared to plan	1	1	1
	Agency Spend	Distance of actual spend from the annual agency cap set by NHS Improvement	2	3	1
Overall scoring			**3**	**3**	**1**

10 Remuneration Report

10.1 Annual Statement on Remuneration

During the year ended 31 March 2020, the Committee remained focused on ensuring that the Trust has a strong, effective and motivated Board and Executive Team, whilst recognising that remuneration must reflect the public service ethos and be aligned with that of the staff of the Trust. In particular, it continues to focus on ensuring that the Executive Team has the capacity and capability to deal with the increasingly challenging issues of meeting greater demand for healthcare with limited resources, whilst supporting other NHS trusts and contributing to the health service in general.

Accordingly, the Committee recognises that, in order to ensure optimum performance, it is necessary to have a competitive pay and benefits structure. The objective of the Trust's policy for remuneration of senior managers[1] is to attract and retain suitably skilled and qualified individuals of high calibre, providing sufficient resources, strength and maintaining stability throughout the senior management team. Remuneration for such officers will be set and maintained at levels that remain competitive but affordable. The Committee considers that this is particularly so at present, when the demand for competent and effective senior leaders in the NHS is high, but the pool of suitable candidates is diminishing.

Remuneration levels of senior managers of the Trust will also reflect that the posts undertaken by some of the Executive Directors and senior managers at the Trust differ from those elsewhere in NHS organisations in combining several roles or in undertaking work not undertaken in other trusts.

The Committee has reviewed the remuneration policy and the responsibilities and remuneration of the senior managers of the Trust (not including the Non-Executive Directors). Minor amendments to the policy were approved.

During the reporting period, the Committee approved a 2.5% pay increase for all senior managers with effect from 1 April 2019, in line with that agreed at national level with Consultants. Additionally, the Committee approved increases in remuneration for certain Executive Team members, following adjustments to roles within the Executive Team.

Each Director has annual objectives which are agreed by the Chief Executive. Reviews on performance are quarterly. The Chair agrees the objectives of the CEO and associated performance measures. The Trust does not use performance-related pay mechanisms.

Non-Executive Directors' fees are reviewed regularly with advice taken from independent consultants where appropriate.

Overall, the Committee considers the remuneration policy and its application to be balanced and fair, fulfilling the aims of ensuring that the Trust retains the services of its senior managers, all of whom will have received tempting offers from other organisations, and is able to recruit when necessary.

Rt Hon Jacqui Smith
18 June 2020
Chair of the Executive Appointments & Remuneration Committee

[1]I.e.'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust'. The Chief Executive has confirmed that, in addition to the Chair, the Executive and Non-Executive Directors, this covers the Director of Finance, Director of Partnerships, the Director of Communications, the Director of Corporate Affairs and the Director of Strategic Planning.

10.2 Senior Managers' Remuneration Policy

10.2.1 Future policy table – Senior Managers (other than Non-Executive Directors)

The key goal of remuneration policy remains to recruit and retain competent and effective Senior Managers. This requires that the pay and benefits structure is competitive within the sector. The table below provides detail on each element of directors' remuneration packages for 2019/20:

Purpose and link to strategy	Operation (and changes if appropriate)	Maximum that could be paid in respect of that component
Salary		
Retains and motivates, takes account of complexity and scale of director's duties, and cognisance of market levels in the appropriate sector	Salary levels are set with reference to responsibilities and the need to retain and recruit. With regard to the latter, a comparison against similar roles in an appropriate comparator group is used (the comparator group comprises Shelford Group trusts and local trusts).	As set out in the remuneration table on page 65 Salaries are determined by the Trust's Executive Appointments & Remuneration Committee Salaries will be reviewed during the year ending 31 March 2021. Any increases will take into account salary increases awarded to the wider workforce as well as other factors.
Pension		
Provides post-retirement remuneration and ensures that the total package is competitive	Senior managers are eligible to become members of the NHS Pension Scheme. The benefits provided to Senior Managers through the NHS Pension Schemes are the same as for all other Trust employees. Where Senior Managers cease to accrue pensionable service in an NHS Pension Scheme due to reaching the lifetime allowance, they are entitled to a cash supplement equal to 10.5% of base salary. This policy remains unchanged from 2013/14.	The following Senior Managers withdrew from pensionable service on the dates shown: Tim Jones on 31/03/2018, Kevin Bolger on 01/04/2018 and Julian Miller on 10/11/2018 No pensionable service in any NHS Pension Scheme has been accrued by these directors since these dates. They receive a cash supplement of 10.5% of base salary in lieu of pension accrual.

10.2.2 Future policy table – Senior Managers (Non-Executive Directors)

The table below provides detail on each element of non-executive directors' (including the Chair) remuneration for 2019/20:

Purpose and link to strategy	Operation (and changes if appropriate)	Maximum that could be paid in respect of that component	
Non-Executive Director fees Attracts, retains and motivates non-executive directors with the required knowledge, experience and ability	Non-executive directors are paid a fee each year. Some non-executive directors with additional responsibilities may receive an additional fee, although none do at present.	**Chair**	£64,500
		Non-Executive Director	£17,000
		Fees are determined by the Council of Governors. Fees will be reviewed during the year ending 31 March 2021. Any increases will take into account salary increases awarded to the wider workforce as well as other factors.	

Notes:

There are no benefits in kind, performance related pay, nor severance payments (2019/20 - £nil) paid to any executive or non-executive. There are no payments to any past senior managers that relate to the function of the Board of Directors (2019/20 - £nil).

The Trust's governors and directors incur non-taxable expenses in association with activities that they undertake that support the objectives of the Trust. Information about expenses is set out below.

No new components of the remuneration package have been introduced.

Changes made to existing components of the remuneration package are set out above.

The Trust's general policy on remuneration is closely aligned to the Agenda for Change, NHS doctors' pay scales and national pay negotiations. The Trust does not operate any performance pay schemes or provide benefits in kind for any of its employees. Inflationary pay increases, if any, for senior managers will generally reflect the increases provided to other employees as a result of national negotiations. Thus the only differences between the Trust's policy on senior managers' remuneration and its general policy on employees' remuneration is that senior managers do not receive any form of automatic incremental increases such as are included within Agenda for Change.

As shown in the table on page 65, a number of the Trust's Senior Managers are paid more than £150,000. The Trust has, through the Executive Appointments and Remuneration Committee, satisfied itself that this remuneration is reasonable for the reasons set out in the annual statement on remuneration above and taking into account that competition for suitably qualified and able individuals to serve as Senior Managers will come not only from within the NHS sector, but from other organisations, both public and private sector and in the UK and abroad.

10.2.3 Service contracts obligations

There are no obligations on the Trust contained or proposed to be contained in any senior managers' service contracts which could give rise to, or impact on, remuneration payments or payments for loss of office but which are not disclosed elsewhere in this remuneration report.

10.2.4 Policy on payment for loss of office

Senior managers (other than Non-Executive Directors) are on substantive contracts with a notice period of six months. Non-Executive Directors are engaged on fixed term contracts of three years. The contracts do not stipulate that there is any entitlement to compensation for loss of office.

There were neither termination payments nor compensation for loss of office made to senior managers during 2019/20.

10.2.5 Statement of consideration of employment conditions elsewhere in the foundation trust

When determining Executive Directors' and senior managers' pay and conditions, the Committee has had regard to the pay and conditions of other staff on Agenda for Change and professional pay scales.

10.3 Pensions

All the Executive Directors and senior managers are members of the NHS Pensions Scheme, with the exception of Tim Jones, Kevin Bolger and Julian Miller. Under this scheme, members are entitled to

a pension based on their service and final pensionable salary subject to HM Revenue and Customs' limits. The scheme also provides life assurance cover of twice the annual salary. The normal pension age for directors is 60. None of the Non-Executive Directors are members of the schemes. Details of the benefits for Executive Directors are given in the tables provided on page 69.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

10.4 Annual Report on Remuneration

10.4.1 Service Contracts

Senior Managers (other than Non-Executive Directors) are on substantive contracts with a notice period of six months.

Name of Senior Manager	Date of Service Contract	Unexpired term	Details of Notice Period
Dr Dave Rosser	01/12/2006	N/A	Six months
Mike Sexton	26/10/2006	N/A	Six months
Tim Jones	13/06/2007	N/A	Six months
Kevin Bolger	15/06/2009	N/A	Six months
Lisa Stalley Green	01/09/2018	N/A	Six months
Prof Simon Ball	01/09/2018	N/A	Six months
Jonathan Brotherton	01/04/2018	N/A	Six months
Cherry West	01/09/2014	N/A	Six months
Fiona Alexander	01/02/2006	N/A	Six months
David Burbridge	07/05/2007	N/A	Six months
Andrew McKirgan	01/09/2014	N/A	Six months
Lawrence Tallon (left 28/02/2020)	02/10/2017	N/A	Six months
Julian Miller	22/10/2018	N/A	Six Months
Mark Garrick	22/10/2018	N/A	Six months

10.4.2 Executive Appointments and Remuneration Committee

The Executive Appointments and Remuneration Committee is a sub-committee of the Board of Directors responsible for reviewing and advising the Board of Directors on the composition of the Board of Directors and appointing and setting the remuneration of Executive Directors. Its terms of reference, role and delegated authority have all been agreed by the full Board of Directors. The committee meets on an 'as-required' basis.

The Executive Appointments and Remuneration Committee's terms of reference empower it to constitute a sub-committee to act as a Nominations Committee to undertake the recruitment and selection process, including the preparation of a description of the role and capabilities required and appropriate remuneration packages, for the appointment of the Executive Director posts on the Board of Directors.

The Executive Appointments and Remuneration Committee comprises the Chair, all other Non-Executive Directors and, for appointments of Executive Directors other than the Chief Executive, the Chief Executive. The Chair of the Committee is the Chair of the Trust.

The Executive Appointments and Remuneration Committee met on five occasions during the year. Attendance was as follows:

Directors	No. of meetings attended
Rt Hon Jacqui Smith	5 out of 5
David Rosser	5 out of 5
Prof Michael Sheppard	5 out of 5

Directors	No. of meetings attended
Prof Jon Glasby	4 out of 5
Jane Garvey	5 out of 5
Harry Reilly	5 out of 5
Dr Catriona McMahon	5 out of 5
Dr Jason Wouhra	2 out of 5
Jackie Hendley	4 out of 5
Karen Kneller	3 out of 5
Mehrunnisa Lalani	4 out of 5

During the reporting period, the Committee approved a 2.5% pay increase for all senior managers with effect from 1 April 2019. When reaching its decision, the Committee took into account the pay increase awarded under national negotiations with the Department of Health regarding the pay awards for consultant medical and dental staff.

The Committee approved increases in remuneration for certain Executive Team members, following adjustments to roles within the Executive Team. In determining the appropriate levels of remuneration, the Committee had regard to the size and complexity of the Trust, the scope and significance of the roles (reflecting that the posts undertaken by some of the Executive Directors and senior managers at the Trust differ from those elsewhere in NHS organisations in combining several roles or in undertaking work not undertaken in other trusts), comparative data obtained from Shelford Group trusts, and other local trusts, and salary comparison information published by NHSI.

The Committee has not received advice or services from any person that materially assisted the Committee in their consideration of any matter relating to remuneration during the reporting period.

10.4.3 Council of Governors' Nomination & Remuneration Committee for Non-Executive Directors

Non-Executive Directors' remuneration consists of fees which are set by the Council of Governors. The Council of Governors has established a committee, the Council of Governors' Nomination & Remuneration Committee for Non-Executive Directors. The role of the Committee is, among other things, to advise the Council of Governors as to the levels of remuneration for the Non-Executive Directors. (The Chair does not attend when the committee considers matters relating to her own remuneration.)

Details of membership and attendance of the Governors' Nomination & Remuneration Committee for Non-Executive Directors are set out on page 50.

During the reporting period, the Governors' Nomination & Remuneration Committee for Non-Executive Directors reviewed the fees paid to the Chair and the Non-Executive Directors and recommended to the Council of Governors that these be increased to £64,500 and £17,000 respectively. The recommendations were approved by the Council of Governors. The last substantial review of remuneration took place in November 2009. Since then, remuneration levels have been reviewed on two occasions, in 2013 and 2016, when both Chair and NEDS received an inflationary uplift.

10.4.4 Disclosures required by Health and Social Care Act

Information on the Trust's policy on pay and on the work of the Executive Appointments and Remuneration Committee are set out above and in Section 10.

Information on the remuneration of the directors is set out at Section 10.

Expenses

In addition, the Trust's governors and directors incur non-taxable expenses in association with activities that they undertake that support the objectives of the Trust, a summary of which is set out in the table below:

Year Ended 31 March 2020			
	Number in Office	Number receiving expenses	Total £00
Directors	24	3	36
Governors	33	17	30

Year Ended 31 March 2019			
	Number in Office	Number receiving expenses	Total £00
Directors	24	4	57
Governors	32	20	30

10.4.5 Salary and Pension Entitlements of Senior Managers

The following is subject to audit: senior manager remuneration table, senior manager pension benefit table and the ratio of the highest paid director compared to the staff pay median. The remainder of the remuneration report is not subject to audit.

A. Remuneration

Salary entitlements of senior managers 2019/20

Name and Title	Year Ended 31 March 2020					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
	(bands of £5000)	total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£000	£000	£000	£000	£000
Senior managers						
Dr David Rosser Chief Executive	260-265				347.5 - 340.0	605-610
Professor Simon Ball Medical Director	230-235				202.5-205.0	435-440
Kevin Bolger Chief Workforce and International Officer	205-210				-	205-210
Jonathan Brotherton Chief Operating Officer	155-160				62.5-65.0	220-225
Cherry West Chief Transformation Officer	185-190				37.5-40.0	225-230
Tim Jones Chief Innovation Officer	205-210				-	205-210
Lisa Stalley-Green Chief Nurse	185-190				187.5-190.0	375-380
Mike Sexton Chief Financial Officer	185-190				32.5-35.0	220-225
Fiona Alexander Director of Communications	155-160				37.5-40.0	195-200
David Burbridge Director of Corporate Affairs	155-160				22.5-25.0	180-185
Andrew McKirgan Director of Partnerships	155-160				32.5-35.0	185-190
Julian Miller Director of Finance	175-180				-	175-180
Lawrence Tallon Director of Corporate Strategy, Planning and Performance, left 29 February 2020	140-145				-	140-145
Mark Garrick Director of Strategy and Quality Development	130-135				95.0-97.5	225-230

Name and Title	Year Ended 31 March 2020					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
	(bands of £5000)	total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£000	£000	£000	£000	£000
Non-executive directors						
Rt Hon Jacqui Smith Chair	60-65					60-65
Catriona McMahon Non-executive Director	15-20					15-20
Harry Reilly Non-executive Director	15-20					15-20
Jackie Hendley Non-executive Director	15-20					15-20
Jane Garvey Non-executive Director	15-20					15-20
Jason Wouhra Non-executive Director	15-20					15-20
Professor Jon Glasby Non-executive Director	15-20					15-20
Karen Kneller Non-executive Director	15-20					15-20
Mehrunnisa Lalani Non-executive Director	15-20					15-20
Prof Michael Sheppard Non-executive Director	15-20					15-20

Salary entitlements of senior managers 2018/19

Name and title	Year Ended 31 March 2019					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
	(bands of £5000)	total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£000	£000	£000	£000	£000
Senior managers						
Dr David Rosser Chief Executive (commenced 01 Sep 2018)	155-160				-	155-160
Dame Julie Moore Chief Executive (resigned 31 Aug 2018)	105-110				-	105-110
Professor Simon Ball Medical Director (commenced 01 Jan 2019)	30-35				5.0-7.5	35-40
Mike Hallissey Interim Medical Director (commenced 01 Sep 2018, resigned 31 Dec 2018)	30-35				-	30-35

Name and title	Year Ended 31 March 2019					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
	(bands of £5000)	total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£000	£000	£000	£000	£000
Dr David Rosser Medical Director (resigned 31 Aug 2018)	55-60				-	55-60
Kevin Bolger Director of Strategic Operations	200-205				-	200-205
Jonathan Brotherton Chief Operating Officer	175-180				312.5-315.0	490-495
Cherry West Chief Transformation Officer	180-185				250.0-252.5	430-435
Tim Jones Director of Innovation	200-205				112.5-115.0	315-320
Lisa Stalley-Green Chief Nurse (commenced 01 Sep 2018)	105-110				92.5-95.0	200-205
Michele Owen Interim Chief Nurse (resigned 31 Aug 2018)	70-75				-	70-75
Mike Sexton Chief Financial Officer	185-190				312.5-315.0	500-505
Fiona Alexander Director of Communications	150-155				92.5-95.0	245-250
David Burbridge Director of Corporate Affairs	150-155				145.0-147.5	295-300
Andrew McKirgan Director of Partnerships	150-155				195.0-197.5	345-350
Julian Miller Director of Finance (commenced 22 Oct 2018)	85-90				140.0-142.5	225-230
Lawrence Tallon Director of Corporate Strategy, Planning and Performance	150-155				35.0-37.5	185-190
Mark Garrick Director of Quality and Development (commenced 22 Oct 2018)	65-70				5.0-7.5	70-75
Non-executive directors						
Rt Hon Jacqui Smith Chair	50-55					50-55
Catriona McMahon Non-executive Director	10-15					10-15
Harry Reilly Non-executive Director	10-15					10-15
Jackie Hendley Non-executive Director	10-15					10-15

Name and title	Year Ended 31 March 2019					
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
	(bands of £5000)	total to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2500)	(bands of £5000)
	£000	£000	£000	£000	£000	£000
Jane Garvey Non-executive Director	10-15					10-15
Jason Wouhra Non-executive Director	10-15					10-15
Professor Jon Glasby Non-executive Director	10-15					10-15
Karen Kneller Non-executive Director	10-15					10-15
Mehrunnisa Lalani Non-executive Director	10-15					10-15
Prof Michael Sheppard Non-executive Director	10-15					10-15
Angela Maxwell Non-executive Director (resigned 30 Apr 2018)	0-5					0-5
David Waller Non-executive Director (resigned 30 Apr 2018)	0-5					0-5

The 'all pension related benefits' disclosed arise from membership of the NHS Pensions Agency defined benefit scheme. They are not remuneration paid, but the increase in pension benefit net of inflation for the current year and applying the HMRC methodology multiplier of 20. Further details of the Board's pension benefits are disclosed in the Pension Benefits table below.

The Medical Director receives remuneration in both capacities of board director and medical consultant; the remuneration received for the role of board director only is disclosed in the tables above. The banding disclosure of the respective clinical role is as follows:

	Year Ended 31 March 2020	
Medical Director	Medical	Director
Professor Simon Ball	185-190	40-45

Lawrence Tallon left the Trust on 29 February 2020 and there are no further changes to the Board of Directors in the reporting year. There are no changes either to the non-executives on the board.

There are no benefits in kind, performance related pay, nor severance payments (2019/20 - £nil) paid to any executive or non-executive. There are no payments to any past senior managers that relate to the function of the Board of Directors (2019/20 - £nil).

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

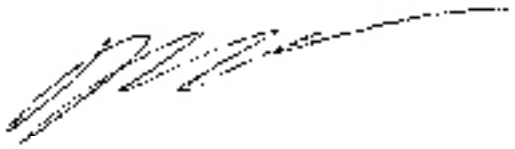
	Year Ended 31 March 2020	Year Ended 31 March 2019
Band of Highest Paid Director's Total Remuneration (£'000)	260-265	270-275
Median Total Remuneration	26,220	26,226
Ratio	**9.9**	**10.4**

Total remuneration includes salary, performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions, the cash equivalent transfer value of pensions nor any other accrued pension benefits not yet taken.

B. **Pension Benefits**

Name and title	Real increase in pension at age 60	Real increase in pension related lump sum at age 60	Total accrued pension at age 60 at 31 March 2020	Total accrued pension related lump sum at age 60 at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equiva- lent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Dr David Rosser Chief Executive	15.0-17.5	37.5-40.0	95-100	270-275	2,111	1,684	359	N/A
Lisa Stalley-Green Chief Nurse	10-12.5	7.5-10.0	45-50	40-45	725	550	135	N/A
Mike Sexton Chief Financial Officer	2.5-5.0	7.5-10.0	80-85	240-245	-	-	-	N/A
Jonathan Brotherton Chief Operating Officer	2.5-5.0	0-2.5	55-60	125-130	891	801	48	N/A
David Burbridge Director of Corporate Affairs	0-2.5	5.0-7.5	40-45	125-130	994	902	47	N/A
Simon Ball Medical Director	10.0-12.5	20.0-22.5	65-70	165-170	1,394	1,143	200	N/A
Mark Garrick Director of Strategy and Quality Development	5.0-7.5	7.5-10.0	25-30	50-55	365	283	56	N/A
Fiona Alexander Director of Communications	2.5-5.0	0-2.5	30-35	50-55	551	488	28	N/A
Cherry West Chief Transformation Officer	0-2.5	5.0-7.5	75-80	225-230	1,814	1,673	85	N/A
Andrew McKirgan Director of Partnerships	2.5-5.0	-	55-60	135-140	1,122	1,039	36	N/A

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members. Details above are provided by the NHS Pensions Agency.



Dr David Rosser, Chief Executive
18 June 2020

11 Statement of the chief executive's responsibilities as the accounting officer of University Hospitals Birmingham NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospitals Birmingham NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospitals Birmingham NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

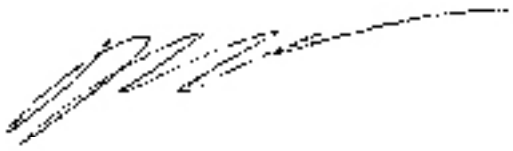
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*



Dr David Rosser, Chief Executive
18 June 2020

12 Annual Governance Statement

12.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of University Hospitals Birmingham NHS Foundation Trust's (the "Trust") policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

12.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk to the achievement of aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

12.3 Capacity to handle risk

Overall responsibility for the management of risk within the Trust rests with the Board of Directors. Reporting mechanisms are in place to ensure that the Board of Directors receives timely, accurate and relevant information regarding the management of risks.

The Annual Plan sets out the Trust's strategic objectives for the year ahead. Each Executive Director has responsibility for identifying any risks that could compromise the Trust from achieving these objectives. These strategic risks are contained in the Board Assurance Framework (BAF). The BAF is composed of the 'Strategic Risk Register' that are mapped against the key controls employed to manage the strategic risks and provides the Board of Directors with assurance about the effectiveness of the controls and any remaining gaps. The BAF is reviewed on a quarterly basis by Executive Directors and the Board of Directors.

The Audit Committee monitors and oversees both internal control issues and the process for risk management. Both the Internal Auditors and External Auditors attend the Audit Committee meetings.

Both the Board of Directors and the Committee for Clinical Quality (CCQ) receive reports that relate to clinical risks.

The management of risks is detailed in the 'Risk Management Policy and associated Procedure', as well as the 'Health & Safety Policy and associated Procedures'. All Policies and Procedures documents are available to all staff via the Trust's intranet and undergo an equality impact assessment which includes stakeholder consultation as part of the approval process.

All risk assessments and risk registers are recorded in the Risk Management module within 'Datix'. General risk management training (including the Risk Management Module in Datix) is provided to nominated Risk Leads within the (corporate and clinical) specialties/divisions who cascade their learning to other staff in the speciality/division. The (clinical and corporate) Risk Teams meet on a quarterly basis as part of the Risk Forum to facilitate shared learning and improve the quality of risk registers.

Nominated Managers (as defined in the Health & Safety Policy) attend the 'Managing Risks' course that covers the principles of risk assessment and the management of risk registers.

Learning from incidents, RCA and good practice is discussed at the Clinical Quality Monitoring Group (CQMG) and the Chief Executive's RCA Meeting that reports to the Board of Directors. Learning is fed back to the Divisions via the Divisional Governance Framework.

12.4 The risk and control framework

The Board of Directors is responsible for the strategic direction of the Trust in relation to Risk Management. It is supported by the Audit Committee which provides assurance to the Board of Directors on risk management as identified in the Internal Audit Programme. In addition, the Trust Executive and Non-Executive Directors carry out unannounced Board of Directors Governance visits. These are reported to the Board of Directors

and Clinical Quality Committee by the Director of Strategy and Quality Development. The Trust's Risk Management Policy defines risk management structures, accountability and responsibilities and the Board of Directors' Risk Appetite Statement defines levels of acceptable risk for the Trust. The Board of Directors' Risk Appetite Statement is reviewed annually by the Board and was last reviewed in October 2019.

The Trust's Risk Management Policy contains more detail on risk identification, evaluation, management, monitoring and reporting which can be summarised as follows:

Risk Identification

In applying an enterprise risk management approach, the Trust makes the distinction between strategic and operational risks. Whilst strategic risks are owned by a member of the Executive Team and aligned directly to their potential impact on the strategic objectives of the Trust, operational risks are owned at a lower level of the organisation and more readily reflect the day to day (shorter term) concerns of the individual specialties and divisions in meeting their quality and operational objectives.

Risks are identified via a variety of mechanisms, which are briefly described below:

Risk Assessments and audits (e.g. Health and Safety and Infection Control) are undertaken throughout the Trust. Identified risks at all levels are evaluated using a common methodology based on national standards and guidance.

Other methods of identifying risks are:

- Complaints and Care Quality Commission reports and recommendations
- Inquest findings and recommendations from HM Coroners
- Medico-legal claims and litigation
- Ad hoc risk issues brought to either the Specialty Meetings/departmental meetings, Divisional Governance meetings, Health, Safety and Environment Committee, Clinical Quality Monitoring Group, Care Quality Group (CQG) or Safeguarding Group
- Incident reports and trend analysis
- Internally generated reports from the Health Informatics Team
- Reviews by external regulators
- Internal and external audit reports

Risk Evaluation

All risks are evaluated in the same way to provide a consistent approach that allows management to make properly informed decisions. A standard 5 by 5 matrix is used to produce a risk score which is a combination of the likelihood of the risk occurring and the consequence if it happens. Higher graded risks require greater management attention with the highest risks with a score of 15 or above, classified as 'Red'. Together these high graded operational risks make up the Corporate Risk Register.

Risks are assigned a category based on the subject of their potential impact. For strategic risks this is linked directly to the strategic objectives of the Trust. For operational risks this is linked to one or more of the following categories:

- Quality
- Regulation and Compliance
- Reputation
- People and Resource
- Information and Communication Technology
- Finance and Efficiency
- Health and Safety

Managing, monitoring and reporting of risks

Once a risk has been properly evaluated, a decision is made about how to manage the risk which includes transferring the risk, terminating the risk, or tolerating the risk and treating the risk. Identified risks are added to departmental/specialty risk registers and reviewed on a quarterly or monthly basis, dependent on the level of risk, to ensure that action plans are being carried out and that risks are being managed, as appropriate. Any non-compliance is addressed with the appropriate Divisional and/or Corporate Management Team. Where required, Executive Directors escalate high level operational risks identified by the Divisional and Corporate Management Teams to the Board of Directors, in accordance with the agreed Board Risk Appetite Statement.

Strategic risks are reviewed on a quarterly basis by their Executive owner and reported to the Board of Directors through the Board Assurance Framework (BAF). The BAF contains details of the controls that have been implemented for each strategic risk and the source of monitoring and scrutiny that provides assurance that the control is effective. The BAF is the key source of evidence that links strategic objectives to risks and assurances, and the main tool that the Board uses in discharging its overall responsibility for internal Control.

The Board of Directors receives a quarterly BAF and Risk Management Report including the Strategic Risk Register and Corporate Risk Register, as described above. The Audit Committee receives an annual internal audit report on the risk management process, including the BAF, and has regard to the BAF when setting the priorities for the following financial year.

All of these papers are published on the Trust's

website to support transparency and allow scrutiny of the Trust's management of risk.

During the reporting year, the Trust's processes for managing risks were reviewed by the Good Governance Institute ("GGI") as part of its Well-Led Review. GGI found that:

- the Trust's technologically advanced risk management system ensured timely assessment, recording and reporting of risks, as well as escalation to appropriate levels;
- The Trust's BAF provides a detailed description of the key risks to the delivery of the Trust's strategic objectives;
- The Board had focussed on more global risks, such as Brexit, and more detailed risk information and actions were found in recent reports to the Board; and
- There was evidence of strong and robust escalation of risks at all levels within the Trust

GGI recommended that:

- an independent review of the effectiveness of the new risk management system and revised policy be carried out and that the opportunity be taken to refresh the Board Assurance Framework; and
- consideration be given to supplementing the Trust's Clinical Governance Annual Audit Programme with a stronger focus on impact assessment of improvements which result, for wider circulation and public reporting

Compliance Reporting

Compliance with the Care Quality Commission (CQC) Fundamental Standards of Quality and Safety, and other national requirements, is a natural by-product of the effective operations of the Trust's groups and committees which report to the Board of Directors through Executive Directors.

Based on the discussions at CQMG, the Medical Director provides a regular exception report to the Board of Directors. Usually, the Director of Strategy and Quality Development submits a draft Quality Report/Account to the Board in April and a final Quality Report/Account is provided in May. As a result of the COVID-19 pandemic, Trusts have been given to December 2020 to compile their 2019/20 Quality Report/Account. The Director of Strategy and Quality Development will submit a draft Quality Report/Account to the June 2020 CQMG and a final draft to the Board of Directors in July 2020.

The Care Quality Group, chaired by the Chief Nurse, receives monthly assurance reports from steering groups responsible for the following areas: Safeguarding; Patients Falls Prevention and Management; Infection Prevention and Control; Tissue Viability; Nutrition and Hydration; Patient Experience; End of Life Care; and Vulnerable Patients.

The Operational Quality Assurance Group, chaired by the Director of Nursing for Operations has been established to discuss and approve new initiatives, processes and policies before roll out. The group aims to ensure that discussions with clinical divisions take place at the early stages of improvement to support a more effective implementation of standards at operational levels. The specialist steering groups monitor compliance and performance with standards, ensure issues/incidents are recognised, acted upon, reported and lessons are learnt and shared.

The Nursing Incident Quality Assurance and Management Group (NIQAM) review all incidents that may result in severe (reportable) harm, quality assuring investigation reports, identifying and sharing lessons, escalation if required, ensuring the contractual requirements in relation to reports to the Commissioners are met.

The Clinical Dashboard Review Group, chaired by the Deputy Chief Nurse and Director of Strategy and Quality Development, reviews Clinical Dashboard performance. The purpose of the Clinical Dashboard Review Group is to provide a supportive learning environment for reviewing and improving ward level performance for a range of quality indicators.

The Director of Corporate Affairs (DCA) provides a six-monthly Emergency Preparedness Update Report to the Board. The Policy Review Group, chaired by the Director of Corporate Affairs, ensures that Trust policies implement statutory/regulatory requirements and national guidelines. Compliance with policy standards is monitored by the Corporate Governance Team which reports to the Director of Corporate Affairs via the DCA Governance Group.

The Chief Nurse and DCA report jointly on incidents, claims and complaints to the Board on a quarterly basis.

The Board of Directors receives an Audit Committee Activity Report from the chair of the Audit Committee following each Audit Committee meeting and a quarterly report on the Board Assurance Framework, from the Director of Corporate Affairs.

The Board of Directors receives Performance Indicators reports every quarter and the Clinical Quality Committee each time it meets.

Cyber security risks are being frequently reviewed by the Audit Committee as part of the IT security report. The Information Governance Group has established a sub-group, the Information Security Assurance Group (ISAG), which includes members of the IT security team, IG team and Business Continuity Team who review relevant DSPT assertions and general areas of concern regarding IT security.

In March 2020, the Audit Committee receives a report on compliance with the FT provider licence conditions. The Corporate Governance Statement was signed off by the Board at the special purpose meeting in June when it reviewed the completed FT governance statement based on the NHSI template. It was recognised that the Trust had to suspend a high proportion of its activity, including elective surgery which encompassed some cancer surgery, during phase one of the response to the COVID-19 pandemic. This had affected the Trust's performance against a number of the national targets and indicators included in the NHS Oversight Framework. As the Trust implements its plans for phase two of the response, including implementing the actions set out by NHS England and Improvement, additional capacity will be available thought it is expected that this remains very significantly below the baseline capacity and is not sufficient to recover performance. The focus therefore remains on treating patients dependent on their clinical urgency until such time that the Government decides to move into phase three ('recovery' period) when it should be possible to make further progress. The Trust is monitoring its response against current guidance available from NHSE&I at all times.

Safe staffing levels and short/medium/long term workforce strategies are reviewed by the Board under the Nurse Staffing 6 monthly Progress Report and the Annual Workforce Report.

Involvement of the public stakeholders

The Patient Carer and Community Council (PCCC) framework enables Governors, patients and the public to be involved in the governance of the organisation on a number of levels: site level, committee level and Board level. This includes a Council for each of our four main sites, plus a Young Persons Council, Carer Forum and Faith Advocacy Group.

At a site level public stakeholders are consulted with on proposed projects, as well as participating in site visits to talk to patients and staff. They also take part in the national PLACE assessment as well as our own programme of PLACE-Lite.

At a Committee level, a nominated Governor from each site PCCC represents the group at both the Patient Experience Group and also the Care Quality Group where they receive regular reports on care quality, including infection control, tissue viability, falls and nursing performance.

The work of the PCCC is reported to Board and Council of Governors via the Care Quality Group report by exception.

Further information can be found under the public and patient involvement section of this AGS.

Information Governance

Risks to information are managed and controlled in accordance with the Trust's 'Data Protection and Confidentiality Policy' and the 'Policy for the Reporting and Management of Incidents' and reviewed during the Information Governance Group (IGG) meetings. The IGG meetings are chaired by the Director of Corporate Affairs, who has been appointed as the Senior Information Risk Officer (SIRO). The Deputy Medical Director, as Caldicott Guardian, is responsible for the protection of patient information. All information governance issues are integrated through the Information Governance Group. The Board of Directors receives a report regarding its systems of control for information governance. These include satisfactory completion of its annual self-assessment against the Data Security and Protection Toolkit, mapping of data flows, monitoring of access to data and reviews of incidents.

The Trust is in the process of completing the Data Security and Protection Toolkit (DSPT) assessment for 2019/20 by 30 September given the extension owing to COVID-19 and expects to submit at a level which requires some further work by the Trust during 2020/21 to become fully compliant with all requirements. This is due to significant changes to the DSPT requirements and the introduction of cyber security standards. The internal audit of the DSPT submission resulted in partial assurance with minor improvement recommendations.

To date, one incident has been reported to the Information Commissioner's Office (ICO) via the incident reporting tool. The incident relates to a complaint from a member of the public, which was erroneously sent to another member of the public due to the auto-selection of recently used email addresses. Both members of the public have a similar name. The recipient of the email has advised that the email was deleted, but as the recipient is a member of the public and not a 'trusted recipient' (like a solicitor or medical professional who are under a professional duty of confidentiality), the incident was reportable to the ICO. As a result, internal processes were reviewed and staff reminded not to rely on auto-completion. The ICO has taken no further action.

Strategic Risks

The Board Assurance Framework (BAF) contains the organisation's strategic risks that may impact on the achievement of the Trust's Strategic Objectives for 2019/2020. These are linked to the Annual Plan and the Care Quality Commission's Fundamental Standards. This process ensures that the Board is informed about the most serious risks faced by the Trust.

All risks on the BAF have mitigation plans in place which are reviewed and updated every quarter by the relevant Executive Team Director and subsequently by the Board of Directors. Timeframes for completion of the proposed actions are also provided to ensure actions to mitigate the risk are implemented in a timely manner. The key risks on the BAF at the end of March 2020 were:

- Prolonged and/or substantial failure to meet operational performance targets
- Increased delays in transfer of care from UHB sites in excess of agreed targets
- Unable to recruit, manage and retain adequate staffing to meet the needs of patients
- Unable to maintain and improve quality and quantity of physical environment to support the required level of service
- Failure of IT systems to support clinical service and business functions
- Prolonged and/or substantial failure to deliver standards of nursing care
- Financial deficit in excess of planned levels
- Adverse impact of Brexit on Trust innovation agenda
- Cash flow affects day to day operations of Trust
- Material breach of clinical and other legal standards leading to regulatory action

The overall financial risk will be managed and mitigated through ongoing performance management and reporting along with effective engagement with commissioners. Oversight will continue to be provided by the Board of Directors and relevant committees.

The Trust continues to be involved in strategic discussions with a range of organisations regarding the long term funding of complex specialist patient activity where costs are not fully covered by national tariffs.

Whilst discussions are ongoing about long-term NHS provider sustainability and transformation, the Trust's existing cash balances mean the Trust can reasonably expect to continue meeting its working capital requirements during the next 12 months and beyond.

The Compliance Framework provides oversight of the responsibilities of the Trust's various Committees/ Groups and the effectiveness of the Trust's overall governance structure. The Groups/Committees are linked to the CQC standards and evidence of assurance is analysed quarterly for completeness and quality purposes. Where the Trust is exposed to new compliance standards or recommendations (e.g. new MHRA regulation regarding software as medical devices), these are cross-referenced to standards already logged on the framework and any gaps in assurance highlighted. This ensures the collection of timely, accurate and relevant assurance data on any compliance risks. Any anomalies, gaps in assurance or concerns about the quality of available assurance are reported on an exception basis to the relevant Executive Director and the DCA Governance Group meetings. The meetings are chaired by the Director of Corporate Affairs who decides whether further escalation to the Audit Committee or Board of Directors is required.

Incident management

The culture of the organisation aids the confident use of the incident reporting procedures throughout the Trust. The online reporting via the Trust's incident management system (Datix) has enabled a tighter management of incident reporting and has enabled more efficient and rapid reporting with the development of specific report forms for categories of incidents.

The Trust requires all clinical and non-clinical incidents, including near misses, to be formally reported. Members of staff involved or witnessing such an incident are responsible for ensuring that the incident is reported in compliance with this policy and associated procedural documents.

When an incident occurs and there is a remaining risk, all practical and reasonable steps are taken to prevent re-occurrence. The line manager is responsible for the provision of primary support for staff involved in the incident and this is made available immediately. Any incidents which are considered to be 'severe' (as defined by the National Patient Safety Agency (NPSA) definition) are escalated by the Clinical Governance and Patient Safety Team to the Clinical and Professional Review of Incidents Group, chaired by the Medical Director to decide whether the incident should be treated as a Serious Incident (SI).

All SIs must be investigated using the Root Cause Analysis (RCA) methodology. All SIs are reported and managed in accordance with the national framework.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined in the Gift, Hospitality and Sponsorship Policy) within the past 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that the deductions from salary, employer's contributions and payments into the Scheme are in accordance with Scheme rules, and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

12.5 Review of Economy, Efficiency and Effective Use of Resources

UHB ensures economy, efficiency and effectiveness in the use of resources through a variety of means, including:

- A robust financial control environment including recruitment and establishment controls and authorisation processes for non-pay expenditure
- Effective tendering procedures and procurement
- Regular financial reporting across the organisation from wards and departments through to Board level
- Continuous service modernisation and cost improvement including through the Transformation Programme at a macro level and through the Good Ideas Count initiative at a micro level
- Regular benchmarking and value for money testing
- Internal and External audit

Overall financial performance and progress against the delivery of the cost improvement programme is monitored throughout the year and reported to the Board of Directors via the monthly Finance and Activity report. The Trust has achieved a financial position slightly better than its planned performance in 2019/20, primarily as a result of delivering savings in excess of the £42.0m target for the year. Total efficiency was equivalent to 2.8% of healthcare income, more than double the deflator embedded within the national tariff, although a significant proportion of the schemes were non-recurrent.

The final month of the year saw the COVID-19 outbreak and additional direct costs incurred as a result. However, the Trust was successful in securing extra funding specifically for this purpose which offset the additional expenditure. The reported position benefitted indirectly with commissioners paying the normal level of monthly contract income for March despite reduced activity levels.

Overall delivery of the financial plan in line with the control total ensured full access to non-recurrent central funding including Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRF) made available to NHS providers who achieve their financial performance targets.

The Trust benchmarks efficiency in a variety of ways, including through the national Reference Cost Index and by use of national benchmarking data including Getting It Right First Time (GIRFT) and use of the Model Hospital data sets. This is shared with operational divisions and corporate departments for use in planning and to identify improvement opportunities. The emphasis of internal audit work is on governance and internal control processes. Where scope for improvement is identified during an internal audit review, appropriate recommendations are made for operational implementation.

As part of the annual audit, the Trust's external auditors are required to satisfy themselves that UHB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if, in their opinion, this is not the case.

The Trust has a comprehensive and well-established framework for performance management of national targets and other indicators of the quality of care we provide. This operates at multiple levels, but always with a clear line of sight from individual clinicians on the wards to the Board of Directors. Quality and performance are monitored regularly and at many levels, with clear routes of escalation and delegation The Board of Directors continues to receive a suite of reports at each of its meetings, including clinical quality,

experience of care, operational performance, and finance, which combine to give both a comprehensive overview of performance, and to highlight any exceptions that need to be escalated. The content and format of the performance report was significantly revised immediately following the merger to provide an overview of the whole Trust's performance and ensure that any exceptions that need to be escalated continue to be so. The Board is therefore able to triangulate performance across all domains and to assure areas of risk and approve mitigating actions. The content of these performance reports will continue to be reviewed regularly and changed if new risks or exceptions emerge.

Owing to the COVID-19 pandemic response (phase one) in the latter part of the financial year, the Trust suspended a high proportion of its activity including elective surgery, including some cancer surgery. This affected the Trust's performance against a number of the national targets and indicators of the NHS Oversight Framework which includes the A&E 4 hour target, 18 week RTT, 6 week diagnostic, cancer 62 day GP referral, 62 day referral from screening, 31 day first treatment, 31 day subsequent surgery, 2 week wait for suspected cancer and 2 week wait for breast symptoms metrics and the case finding element of the Dementia assessment and referral metric.

As the Trust implements its plans for phase two of the response, including implementing the actions set out by NHS England and Improvement, additional capacity will be available and performance against national targets and indicators is expected to improve.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all of the work-streams carried out. The findings of internal audit are reported to the Board through the Audit Committee.

Full details of the Trust's governance structure, together with membership and attendance numbers, can be found within the Accountability Report being in Section 2. Governance. These sections also include the Board's assessment of its compliance with the Corporate Governance Code together with key areas that have been considered by Board Committees throughout the year.

Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

Regulations making revisions to quality report deadlines for 2019/20 are now in force, which mean that, whilst the Trust is still required to prepare a quality report for the reporting year, there is no fixed deadline by which it must be published.

The Trust is aiming to publish its 2019/20 quality report by 30 September 2020.

NHS providers are no longer expected to obtain assurance from their external auditor on their quality report for 2019/20.

12.6 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Internal Audit, the Foundation Secretary and External Audit. The system of internal control is regularly reviewed and plans to address any identified weaknesses and ensure continuous improvement of the system are put in place.

The processes applied in maintaining and reviewing the effectiveness of the system of control include:

- the maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and review of the Board Assurance Framework
- The receipt of Internal and External Audit reports on the Trust's internal control processes by the Audit Committee
- personal input into the controls and risk management processes from all Executive Directors and Senior Managers and individual clinicians

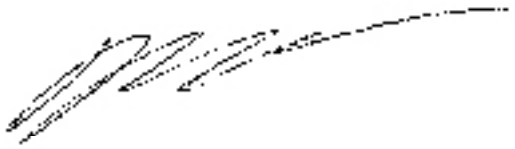
The Board's review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion. The opinion is based upon and limited to their work performed on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

KPMG's Head of Internal Audit Opinion is derived from the reviews of the key financial controls (treasury management; income and debtors; expenditure and creditors, fixed assets and general ledger), Payroll and the BAF and Risk Management, in addition to risk based reviews. The Head of Internal Audit Opinion for 2019/20 is one of 'significant assurance with minor improvements required' on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Conclusion

No significant internal control issues have been identified. I am satisfied that all internal control issues raised have been, or are being, addressed by the Trust through appropriate action plans and that the implementation of these action plans is monitored. The Audit Committee has agreed to prioritise the monitoring of the following risks during 2020/21:

- Monitoring the effects of changes in the general economic climate (including COVID-19 and Brexit) on the Trust's operations and financial position
- Monitoring the ongoing transformation following the acquisition of Heart of England NHS Foundation Trust and emergence of new digital services
- Monitoring the Trust's cyber security controls and assessing the Trust's security arrangements against cyber risks (including cloud) against the backdrop of increased digital services



Dr David Rosser, Chief Executive
18 June 2020

University Hospitals Birmingham
NHS Foundation Trust

Section 2
Consolidated Financial Statements 2019/20

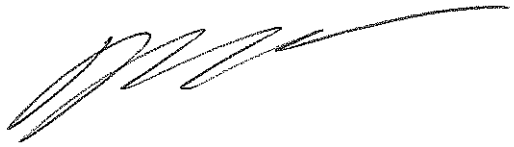
This annual report covers the period 1 April 2019 to 31 March 2020

University Hospitals Birmingham NHS Foundation Trust – Consolidated Financial Statements 2019/20

Foreword to the financial statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2020 have been prepared by the University Hospitals Birmingham NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.



Dr David Rosser, Chief Executive
18 June 2020

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

Report on the audit of the financial statements

1. Opinion

In our opinion the financial statements of University Hospitals Birmingham NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2020 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the consolidated and Foundation Trust statements of financial position;
- the consolidated and Foundation Trust statement of changes in taxpayer's equity;
- the group and Foundation Trust statements of cash flow; and
- the related notes 1 to 34.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

2. Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

3. Summary of our audit approach

Key audit matters

The key audit matters that we identified in the current year were:

- *Recognition of NHS clinical revenue;*
- *Property valuations; and*
- *Value for Money including financial performance and sustainability.*

	Within this report, key audit matters are identified as follows: Newly identified Increased level of risk Similar level of risk Decreased level of risk
Materiality	The materiality that we used for the group financial statements was £17.6m which was determined on the basis of revenue.
Scoping	The focus of audit work was on the Foundation Trust, with work performed directly by the audit engagement team, led by the audit partner. Our audit covered all of the entities within the group, including the Foundation Trust's subsidiaries.
Significant changes in our approach	There have been no changes in the audit scope during the year.

4. Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where: • the directors' use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or • the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Foundation Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.	We have nothing to report in respect of these matters.

5. Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

5.1. Recognition of NHS Clinical Revenue

Key audit matter description	As described in note 1, Accounting Policies and note 1.28, Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to:

- the complexity of the Payment by Results regime, in particular in determining the level of overperformance and revenue to recognise;
- the judgemental nature of accounting for disputes, including in respect of outstanding overperformance income for quarters 3 and 4; and
- the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts.

Details of the group's income, including £1,516.3m of Commissioner Requested Services (2019 £1,384.7m) are shown in note 3.2 to the financial statements. NHS receivables are shown in note 20 to the financial statements.

The group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position.

We have therefore concluded that there is a risk of fraud in recognition of NHS revenue due to the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future period contracts. This includes accrued income, over-performance and any other unconfirmed revenue or open areas of dispute/challenge at year end. This may include the Q3 and Q4 elements of PSF, FRF and MRET which are dependent on the Foundation Trust meeting certain financial targets, as well as outstanding debtor balances. These elements of unsettled revenue can involve management judgement and estimation, including management consideration of any unresolved commissioner challenges.

How the scope of our audit responded to the key audit matter	We obtained and understanding of relevant controls over recognition of NHS clinical revenue. We performed detailed substantive testing on a sample basis of the recoverability of over-performance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.
Key observations	Based on the audit evidence obtained, we concluded that NHS clinical revenue is appropriately recognised.

5.2. Property valuations

Key audit matter description	The group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £635.4m (2019: £649.3m). As described in note 1.28 Critical Accounting Judgements and Key Sources of Estimation Uncertainty the valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value. As detailed in note 14, the group has reassessed a number of valuation assumptions in the current year, including changes in market value and location and build cost index factors. The net valuation movement on the group's estate

shown in note 14 is an impairment of £14.8m (2019 £1.8m).

As detailed in note 30, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

How the scope of our audit responded to the key audit matter	We obtained an understanding of relevant controls over property valuations, and tested the accuracy and completeness of data provided by the group to the valuer. We worked with Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the group's properties. We challenged the foundation trust's assumption that an alternative, lower value, site could be used in calculating a Modern Equivalent Asset value by reviewing the foundation trust's Clinical Strategy, and critically evaluating whether the alternatives considered would be viable given the nature of the foundation trust's activities. We have reviewed the disclosures in notes 14 Property, plant and equipment and 1.28 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU and the COVID-19 pandemic upon property valuations in evaluating the property valuations and related disclosures including the adequacy of the disclosure of the material valuation uncertainty. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations	While we note the increased estimation uncertainty in relation to the property valuation as a result of COVID-19 as disclosed in note 30, based on the work performed, we found no other matters that were reportable to those charged with governance.

5.3. Value for Money including financial performance and sustainability

Key audit matter description	The Foundation Trust is required to consider whether the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. We identified financial performance and sustainability as a key audit matter on account of the significant ongoing cost pressures from the Foundation Trust's Cost Improvement Plan (CIP) target of £42m, reliance on Provider Sustainability Funding (PSF), Financial Recovery Fund (FRF) and Marginal Rate Emergency Tariff (MRET).The acquisition of Heart of England NHS Foundation Trust has had a significant impact on the financial performance of the combined Trust. For

	2019/20 the Trust's adjusted financial plan for the year was a deficit of £36.2m before additional funding. The Foundation Trust had a CIP target of £42.0m for the year to 31 March 2020 and has achieved savings of £43.1m. Of this 51% of savings were achieved on a non-recurrent basis including a stretch target of £14m which was phased into the final quarter of the year. The Foundation Trust's cash position at 31 March 2020 is £61.0m, in comparison to £62.9m at 31 March 2019. The Foundation Trust currently has a Use of Resources Rating (UOR) of 3, which is in line with the expected position.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of relevant controls in place around management's assessment and monitoring of the Foundation Trust's financial sustainability and going concern. We reviewed the Foundation Trust's financial performance during the year and outturn position as well as reviewing and challenging management's assessment of going concern. We reviewed the Foundation Trust's forecasts and Cost Improvement Plans set out within its 2019/20 operational plan. We have reviewed management's cashflow forecast over the next 12 months and understood management's progress in identifying a solution to ensure long term sustainability. We have reviewed the Foundation Trust's board minutes board assurance framework to assess whether risks in relation to sustainability are appropriately recognised and mitigating controls being implemented. We have considered the adequacy of disclosures made in note 1 to the financial statements concerning the foundation trust's ability to continue as a going concern.
Key observations	We have no matters to report by exception in regard to the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

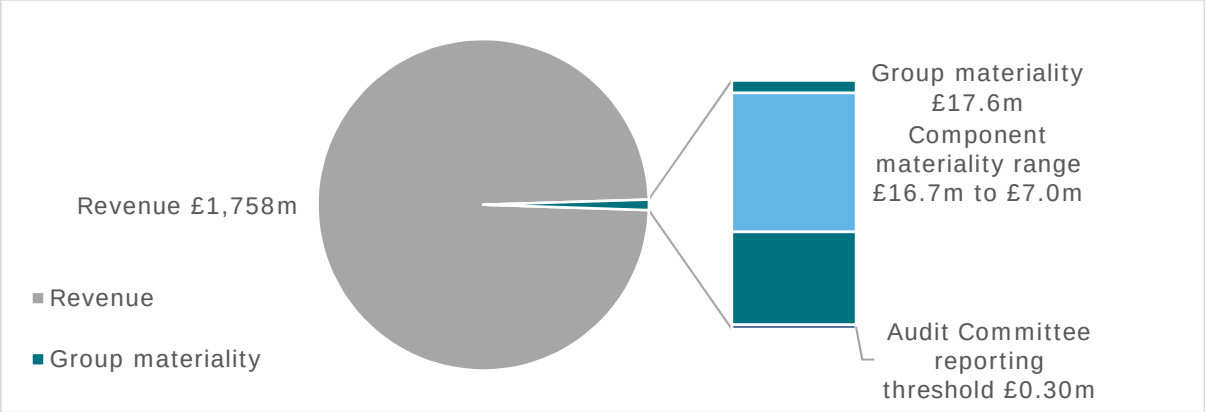
6. Our application of materiality

6.1. Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation Trust financial statements
Materiality	£17.6m (2019: £16.1m)	£16.7m (2019: £15.3m)
Basis for determining materiality	1% of revenue (2019: 1% of revenue)	1% of revenue (2019: 1% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark for both the group and the Foundation Trust, on the basis that the Foundation Trust a non-profit organisation, revenue is a key measure of financial performance for users of the financial statements, and the majority of the group's operations are carried out by the Foundation Trust.	



6.2. Performance materiality

We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Group performance materiality was set at 70% of group materiality for the 2020 audit (2019: 70%). In determining performance materiality, we considered the following factors:

a. the quality of the control environment; e.g. whether we were able to rely on controls, any significant control deficiencies identified; and
b. corrected and uncorrected misstatements identified in the previous audit; their nature, volume (low / high) and size (large / small).

6.3. Error reporting threshold

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.3m (2019: £0.3m), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

7. An overview of the scope of our audit

7.1. Identification and scoping of components

Our group audit was scoped by obtaining an understanding of the group and its environment, including group-wide controls, and assessing the risks of material misstatement at the group level. Our audit covered all of the entities within the group, including the Foundation Trust's subsidiaries which account for 100% of the group's net assets, revenue and surplus (2019: 100%). Review scope procedures were performed on the Foundation Trust subsidiaries.

Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality. The range of materiality used was £7.0m to £16.7m.

8. Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

9. Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the Foundation Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the Foundation Trust or to cease operations, or has no realistic alternative but to do so.

10. Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

11. Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

12. Matters on which we are required to report by exception

12.1. Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

12.2. Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

13. Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

14. Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of University Hospitals Birmingham NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10

of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Foundation Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Ian Howse, CPFA, CA (Senior statutory auditor)

For and on behalf of Deloitte LLP

Statutory Auditor

Cardiff, United Kingdom

24 June 2020

Consolidated statement of comprehensive income

	Notes	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Revenue from patient care activities	3	**1,541,578**	1,409,642
Other operating revenue	4	**216,840**	203,929
Total revenue		**1,758,418**	1,613,571
Operating expenses	5	**(1,730,106)**	(1,620,780)
Impairment / (reversal of impairment) charged / credited to operating expenses	5	**(2,500)**	(710)
Total operating expenses		**(1,732,606)**	(1,621,490)
Operating surplus / (deficit)		**25,812**	(7,919)
Finance income	9	**518**	766
Finance expense	9	**(24,032)**	(23,968)
PDC Dividends payable	11	**(1,347)**	(739)
Net finance expense		**(24,861)**	(23,941)
Net loss on disposal	10	**(271)**	(231)
Gain from the transfer by absorption		**-**	165,013
Taxation	12	**(299)**	(90)
Retained surplus for the year		**381**	132,832
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairment losses on property, plant and equipment	14.2	**(17,991)**	(4,384)
Revaluation increase on property, plant and equipment	14.2	**5,654**	3,278
Other comprehensive loss		**(12,337)**	(1,106)
Total comprehensive (loss) / income for the year		**(11,956)**	131,726
Adjusted financial performance (control total basis):			
Retained surplus for the year		**381**	132,832
Remove net impairments not scoring to the Departmental expenditure limit		**2,500**	710
Remove (gains) / losses on transfers by absorption		**-**	(165,013)
Remove I&E impact of capital grants and donations		**749**	(45)
Remove impact of prior year PSF post accounts reallocation		**(943)**	-
Adjusted financial performance surplus / (deficit)		**2,687**	(31,516)

All income and expenditure is derived from continuing operations.

All income and expenditure is attributable to the Group, there are no minority interests. The Group has taken advantage of the exemption afforded by the Companies Act 2006 to not disclose the parent Trust SoCI and related notes, the Trust retained surplus for the reporting year was £39,000 (2018/19 - £132,160,000).

The notes on pages XVIII to LXVI are an integral part of these financial statements.

Consolidated and foundation trust statement of financial position

		Group		Foundation Trust	
		31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Notes	**£000**	£000	**£000**	£000
Assets					
Non-current assets					
Intangible assets	13	**17,571**	12,800	**17,571**	12,649
Property, plant and equipment	14	**726,608**	740,462	**724,263**	737,878
Trade and other receivables	20	**10,057**	8,366	**10,057**	8,366
Investments	16	**-**	-	**-**	151
Deferred tax asset	24	**-**	113	**-**	-
		754,236	761,741	**751,891**	759,044
Current assets					
Inventories	19	**37,933**	35,476	**32,562**	30,511
Trade and other receivables	20	**128,460**	122,843	**133,157**	126,511
Cash and cash equivalents	21	**60,970**	62,941	**58,295**	61,938
		227,363	221,260	**224,014**	218,960
Total assets		**981,599**	983,001	**975,905**	978,004
Liabilities					
Current liabilities					
Borrowings	25	**(48,373)**	(13,184)	**(48,373)**	(13,184)
Trade and other payables	22	**(275,458)**	(263,485)	**(272,459)**	(260,798)
Current tax liabilities	12	**(107)**	(80)	**-**	-
Provisions	28	**(5,018)**	(3,353)	**(5,018)**	(3,353)
Other liabilities	23	**(36,398)**	(33,434)	**(36,374)**	(33,441)
		(365,354)	(313,536)	**(362,224)**	(310,776)
Total assets less current liabilities		**616,245**	669,465	**613,681**	667,228
Non-current liabilities					
Borrowings	25	**(448,804)**	(497,050)	**(448,804)**	(497,050)
Provisions	28	**(9,020)**	(7,456)	**(8,740)**	(7,183)
Deferred tax liabilities	24	**(47)**	(46)	**-**	-
Other liabilities	23	**(414)**	(2,484)	**(213)**	(2,260)
		(458,285)	(507,036)	**(457,757)**	(506,493)
Total liabilities		**(823,639)**	(820,572)	**(819,981)**	(817,269)
Net assets		**157,960**	162,429	**155,924**	160,735
Taxpayers' equity					
Public dividend capital		**374,987**	367,500	**374,987**	367,500
Revaluation reserve		**137,837**	151,428	**137,837**	151,428
Income and expenditure reserve		**(354,864)**	(356,499)	**(356,900)**	(358,193)
Total taxpayers' equity		**157,960**	162,429	**155,924**	160,735

The financial statements on pages XIV to LXVI were approved by the Board of Directors on 18 June 2020 and were signed on its behalf by:

Dr David Rosser, Chief Executive

Consolidated statement of changes in taxpayers' equity

Group	Notes	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	**Total £000**
Balance at 1 April 2018		193,305	93,705	(265,489)	**21,521**
Surplus for the year		-	-	132,832	**132,832**
Transfers by absorption: transfers between reserves		165,013	60,131	(225,144)	**-**
Public dividend capital received		9,182	-	-	**9,182**
Transfers between reserves			(1,302)	1,302	
Net impairments		-	(4,384)	-	**(4,384)**
Revaluations - property, plant and equipment		-	3,278	-	**3,278**
Balance at 31 March 2019		367,500	151,428	(356,499)	**162,429**
Surplus for the year		-	-	381	**381**
Public dividend capital received		7,487	-	-	**7,487**
Transfers between reserves			(1,254)	1,254	**-**
Net impairments	14.2	-	(17,991)	-	**(17,991)**
Revaluations - property, plant and equipment	14.2	-	5,654	-	**5,654**
Balance at 31 March 2020		374,987	137,837	(354,864)	**157,960**

Foundation Trust	Notes	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	**Total £000**
Balance at 1 April 2018		193,305	93,705	(266,511)	**20,499**
Surplus for the year		-	-	132,160	**132,160**
Transfers by absorption: transfers between reserves		165,013	60,131	(225,144)	**-**
Public dividend capital received		9,182	-	-	**9,182**
Transfers between reserves		-	(1,302)	1,302	**-**
Net impairments		-	(4,384)	-	**(4,384)**
Revaluations - property, plant and equipment		-	3,278	-	**3,278**
Balance at 31 March 2019		367,500	151,428	(358,193)	**160,735**
Surplus for the year		-	-	39	**39**
Public dividend capital received		7,487	-	-	**7,487**
Transfers between reserves		-	(1,254)	1,254	**-**
Net impairments	14.2	-	(17,991)	-	**(17,991)**
Revaluations - property, plant and equipment	14.2	-	5,654	-	**5,654**
Balance at 31 March 2020		374,987	137,837	(356,900)	**155,924**

Consolidated and foundation trust statement of cash flows for the year ended 31 March 2020

		Group		Foundation Trust	
		31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Notes	**£000**	£000	**£000**	£000
Cash flows from operating activities					
Operating surplus / (deficit) for the year		**25,812**	(7,919)	**24,933**	(8,872)
Depreciation and amortisation		**36,913**	36,386	**36,574**	35,995
Net impairment charged to operating expenses		**2,500**	710	**2,500**	710
Income recognised in respect of capital donations		**(979)**	(1,859)	**(979)**	(1,859)
Amortisation of PFI deferred income		**(2,448)**	(4,448)	**(2,448)**	(4,448)
(Increase) in inventories		**(2,457)**	(6,045)	**(2,051)**	(3,576)
(Increase) / decrease in trade and other receivables		**(8,809)**	5,819	**(8,038)**	13,826
Increase in trade and other payables		**10,480**	18,231	**8,389**	9,377
Increase in other liabilities		**3,342**	5,324	**3,334**	5,348
Increase / (decrease) in provisions		**3,221**	(1,488)	**3,222**	(1,489)
Tax paid		**(158)**	(37)	**-**	-
Net cash generated from operating activities		**67,417**	44,674	**65,436**	45,012
Cash flows from investing activities					
Interest received		**521**	827	**751**	1,012
Payments to acquire property, plant and equipment		**(41,972)**	(47,402)	**(41,893)**	(47,130)
Receipts from sale of property, plant and equipment		**34**	53	**34**	53
Receipt of cash donations to purchase capital assets		**800**	600	**800**	600
Payments to acquire intangible assets		**(838)**	(1,052)	**(838)**	(1,052)
Net cash used in investing activities		**(41,455)**	(46,974)	**(41,146)**	(46,517)
Cash flows from financing activities					
Public dividend capital received		**7,487**	9,182	**7,487**	9,182
Movement in loans from the Department of Health and Social Care		**(129)**	(129)	**(129)**	(129)
Capital element of finance lease obligations		**(217)**	(194)	**(217)**	(194)
Interest element of finance lease obligations		**(85)**	(94)	**(85)**	(94)
Capital element of PFI obligations		**(12,711)**	(12,324)	**(12,711)**	(12,324)
Interest element of PFI obligations		**(23,407)**	(23,325)	**(23,407)**	(23,325)
Interest on loans from the Department of Health and Social Care		**(532)**	(428)	**(532)**	(428)
PDC dividend received / (paid)		**1,661**	(4,242)	**1,661**	(4,242)
Net cash used in financing activities		**(27,933)**	(31,554)	**(27,933)**	(31,554)
Net (decrease) in cash and cash equivalents		**(1,971)**	(33,854)	**(3,643)**	(33,059)
Cash and cash equivalents at 1 April		**62,941**	85,490	**61,938**	83,692
Adjustments to cash in year					
Cash and cash equivalents transferred by absorption		**-**	11,305	**-**	11,305
Cash and cash equivalents at 31 March	21	**60,970**	62,941	**58,295**	61,938

Notes to the financial statements

1 Accounting policies

1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Group and Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Group and Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, and certain financial assets and financial liabilities.

1.1.2 Going concern

These accounts have been prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. Based on the financial performance detailed in these financial statements and the financial plans put in place by the Department of Health and Social Care due to the COVID-19 pandemic (see below for more detail) the Trust is forecasting that its cash balances will remain sufficient to continue meeting its working capital requirements for the immediate future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Due to the COVID-19 pandemic, on 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. Due to the specific expenditure incurred, loss of revenue streams and the consequent decrease in the elective NHS work, this announcement introduced a temporary new financial regime for NHS Providers. NHSE has announced that in the first four months of 2020/21 (April - July) contract income from commissioners is confirmed at an agreed level, to ensure the continuation of all contractual healthcare service provision. In addition to this agreed level of commissioning income there is a retrospective top-up available to ensure providers are fully funded for increased expenditure or losses of other types of income (such as car parking and catering) as a result of COVID-19. This includes the setting up and running costs of the Birmingham Nightingale Hospital (at the NEC). As a result, providers are expected to break even for the first 4 months of the financial year. PDC Capital funding will be available in 2020/21 for specific COVID-19 capital expenditure.

Post July 2020 there is not yet any formal guidance or detail as to what the financial regime might look like although it is expected to remain a block contract arrangement rather than national tariffs being re-introduced. As such there is uncertainty in accurately forecasting the cash position of the Trust through to the end of the 2020/21 financial year. However, there is a clear commitment from NHSI&E that providers and commissioners will be adequately funded to continue to meet the healthcare needs of the population, this is detailed in a statement published by DHSC, NHSE and NHSI on 27 May 2020.

The Trust has £60,790,000 of cash at the reporting date and the DHSC has also announced (as part of the COVID-19 response above) that all interim and capital loans will be replaced by an equal amount of PDC capital, see the Borrowings note 25 on page LIII to these financial statements for further detail.

These financial statements were authorised for issue on the 18 June 2020, the event arising after the end of the reporting date requiring disclosure (the COVID-19 pandemic) is detailed above and in the Events After the Reporting Date note 30 on page LIX to these financial statements.

1.1.3 Consolidation

The Group financial statements consolidate the financial statements of the Trust and all of its subsidiary undertakings made up to 31 March 2020. Under IFRS 10, an entity controls a subsidiary

when it is exposed to, or has rights to, variable returns from its involvement with the subsidiary and has the ability to affect those returns through its power over the subsidiary. The income, expenses, assets, liabilities, equity and reserves of the subsidiaries have been consolidated into the Trust's financial statements and group financial statements have been prepared.

All intra-group transactions, balances, income and expenses are eliminated on consolidation. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material, however there are no such differences at the reporting date. In accordance with the GAM 2019/20 a separate Statement of Comprehensive Income for the parent (the Trust) has not been presented.

The GAM 2019/20 requires the consolidation of any NHS charity that meets the criteria of control under IFRS 10. The Queen Elizabeth Hospital Birmingham Charity is not considered to be a subsidiary of the Trust under IFRS 10 and consequently is not consolidated within these financial statements. The charity is a separate legal entity with an independent Board of Trustees and the benefits from its activities are shared between the Trust, University of Birmingham and Royal Centre of Defence Medicine.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The joint venture is accounted for using the equity method. The Trust has no joint operations.

1.2 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

1.2.1 Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty. The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end and this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner which affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

1.2.2 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.2.3 NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.2.4 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants. The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.2.5 Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

1.2.6 COVID-19 revenue

In March NHS England has funded providers for additional COVID-19 related expenditure and loss of other types of income (such as car parking fees and catering). This special funding arrangement will continue into the subsequent financial year subject to HM Government review.

1.3 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following period.

Post employment benefits - pension costs

Past and present employees of the Trust are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The commercial subsidiaries operate a defined contribution scheme with Standard Life and the Government's NEST scheme, employees of these companies do not have access to the NHS Pension Schemes.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a. **Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of

the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b. **Full actuarial (funding) valuation**
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

Recognition
Property, plant and equipment assets are capitalised where:

- They are held for use in delivering services or for administration purposes
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- They are expected to be used for more than one financial year;
- The cost of the item can be measured reliably;
- Individually they have a cost of at least £5,000; or
- They form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- They form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own estimated useful economic lives.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
Valuation
All property, plant and equipment are stated initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. The last full valuation of the estate was 31 March 2018 and at the two subsequent reporting dates, including 31 March 2020, a desktop review was carried out by Avison Young LLP. Current values in existing use are determined as follows:

- Land and non specialised buildings - existing use value
- Specialised buildings - depreciated replacement cost

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

For all categories of non-property assets/ intangible assets, the Group and Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met; the sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and its economic life is adjusted.The asset is de-recognised when scrapping or demolition occurs.

1.6 Intangible assets

Expenditure on computer software which is deemed not to be integral to the computer hardware and will generate economic benefits beyond one year is capitalised as an intangible asset. Computer software for a computer-controlled machine tool that cannot operate without that specific software is an integral part of the related hardware and it is treated as property, plant and equipment. These intangible assets are stated at cost less accumulated amortisation and impairment losses. Amortisation is charged to the Statement of Comprehensive Income on a straight line basis.

1.7 Depreciation, amortisation and impairments

Depreciation and amortisation are charged on a straight line basis to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Depreciation of an asset commences in the calendar quarter following their purchase or acquisition, which is when the asset register is updated. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust

and may be shorter than the physical life of the asset itself. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful economic lives or, where shorter, the lease term.

The estimated useful economic lives of property, plant and equipment and intangible assets are as follows:

- Buildings are depreciated over 10 to 67 years;
- Dwellings are depreciated over 5 to 25 years;
- Land and assets under construction are not depreciated;
- Plant and machinery is depreciated over 5 to 15 years;
- Information technology is depreciated over 2 to 10 years;
- Furniture and fittings are depreciated over 5 to 10 years; and
- Intangible software and licences / trademarks are depreciated over 2 to 5 years.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

1.8 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to revenue. The revenue is recognised in full in the reporting year the asset is received, unless the donor imposes a condition that the future economic benefits embodied in the donation are to be consumed in a manner specified by the donor. In which case the donation would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Donated assets continue to be valued, depreciated and impaired as described for purchased assets.

1.9 Government grants

The revenue is recognised when the foundation trust becomes entitled to the grant, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grantor. In which case the grant would be deferred within liabilities carried forward to future years to the extent that the condition has not yet been met. Granted assets continue to be capitalised at their fair value upon receipt and are valued, depreciated and impaired as described for purchased assets.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an finance lease. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Private Finance Initiatives (PFI) transactions

Recognition
HM Treasury has determined that government bodies shall account for infrastructure PFI schemes following the principles of the requirements of IFRIC 12. Where the government body (the Grantor) meets the following conditions the PFI scheme falls within the scope of a 'service concession' under IFRIC 12:

- The grantor controls the use of the infrastructure and regulates the services to be provided to whom and at what price; and
- The grantor controls the residual interest in the infrastructure at the end of the arrangement as service concession arrangements.

The Trust therefore recognises the PFI asset as an item of property, plant and equipment on the Statement of Financial Position together with a liability to pay for it. The PFI assets recognised, including the Queen Elizabeth Hospital Birmingham, are detailed in note 27.1 to the financial statements on page LIV. The services received under the contract are recorded as operating expenses.

Valuation
The PFI assets are recognised as property, plant and equipment, when they come into use, in accordance with the HM Treasury interpretation of IFRIC 12. The assets are measured initially at fair value in accordance with the principles of IAS 17, HM Treasury guidance for PFI assets is the construction cost and capitalised fees incurred as at financial close, disclosed in the PFI contract.

Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16, as detailed in accounting policy note 1.5 'Property, plant and equipment - valuation'. For specialised buildings this is depreciated replacement cost.

The estimation technique of the Modern Equivalent Asset (the 'Depreciated Replacement Value') includes the assumption that any replacement PFI hospital would be VAT recoverable. VAT is recoverable on PFI builds under HMRC guidelines whereas traditional NHS estate construction is not recoverable and therefore valued gross of VAT. It is recognised that a modern equivalent asset, would be another PFI on the same Edgbaston site, hence VAT would be recoverable on any cost. The DH GAM states the circumstances where it is appropriate to value assets exclusive of VAT, detailed in Chapter 4 Annex 4 - Valuation issues, paragraph 8: provision of a fully managed and serviced building under a PFI agreement, where the service potential would be replaced by the PFI provider.

The PFI lease obligations due at the reporting date are detailed in note 27.1 to the financial statements on page LIV.

Subsequent expenditure
The annual contract payments are apportioned, using appropriate estimation techniques between the repayment of the liability, a finance cost, lifecycle replacement and the charge for services. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance expense and to repay the lease liability over the contract term. The annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is recognised under the relevant finance costs heading within note 9 to the financial statements on page XXXVIII.

The fair value of services received in the year is recognised under the relevant operating expenses headings within note 5 to the financial statements on page XXXV.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

The lifecycle prepayment recognised at the reporting date is detailed in note 20 to the financial statements on page L.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Other assets contributed by the Trust to the operator
Where existing Trust Buildings are to be retained as part of the PFI scheme, a deferred asset will be created at the point that the Trust transfers those buildings to the PFI partner. The deferred asset will be written off through the Statement of Comprehensive Income over the life of the concession.

Where current estate will be retained in use and maintained by the PFI provider but the risks and rewards will not pass to the provider, that part of the estate will remain on balance sheet and refurbishment costs which are included in the PFI will also be capitalised.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy and warehouse stocks are valued at weighted average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values. These balances exclude monies held in the Trust's bank accounts belonging to patients, see accounting policy note 1.26 for third party assets.

1.14 Finance income and costs

Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.15 Financial assets and financial liabilities

Recognition and de-recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expired.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost. Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy 1.10 for leases (IAS 17).

PDC Capital is not considered a financial instrument and the accounting treatment (historical cost) is described in accounting policy 1.21.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses. The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.16 Contract receivables

Contract receivables are recognised and carried at original invoice amount less expected credit losses for impairment. A credit loss for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The movement of the expected credit loss is recognised in the Statement of Comprehensive Income (operating expenses).

1.17 Deferred income

Deferred income represents grant monies received where the expenditure is expected to take place in a future period. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.18 Borrowings

The Trust has acquired two DHSC loans via the acquisition of the former Heart of England NHS Foundation Trust, borrowings as at the reporting date also include obligations under finance leases and the several PFI schemes, including the 'Queen Elizabeth Hospital Birmingham' Private Finance Initiative contract.

1.19 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the reporting date on the basis of the best estimate of the expenditure required to settle the probable obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of +0.55% (2018/19: +1.14%) in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of -0.5% (2018/19: +0.29%) in real terms.

Clinical Negligence Costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution which, in return, settles all clinical negligence

claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in note 28 to the financial statements on page LVII, but is not recognised in the Trust's financial statements.

Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises. The Trust has also taken out additional insurance to cover claims in excess of £1million.

1.20 Contingencies

Contingent liabilities are not recognised but are disclosed in note 29 to the financial statements on page LIX, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 to the financial statements on page LIX where an inflow of economic benefits is probable.

1.21 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated and grant funded assets,

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.22 Research and Development

Expenditure on research is not capitalised, it is treated as an operating cost in the year in which it is incurred.

Research and development activity cannot always be separated from patient care activity and is considered to be a part of the core NHS healthcare operating segment within the Trust. It is therefore not separately disclosed.

1.23 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.24 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non public sector source.

The tax expense on the surplus or deficit for the year comprises current and deferred tax due to the Trust's trading commercial subsidiaries, see note 12 to the financial statements on page XXXIX. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the balance sheet liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on taxable temporary differences arising on the initial recognition of goodwill or for temporary differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred tax asset is realised or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

1.25 Foreign exchange

The functional and presentational currency of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2020. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.26 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the financial statements in accordance with the requirements of GAM 2019/20, disclosed in note 33 to the financial statements on page LXV.

1.27 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.28 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The critical accounting judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

Modern equivalent asset valuation of property - key sources of estimation uncertainty

As detailed in accounting policy note 1.5 'Property, plant and equipment - valuation', Avison Young LLP provided the Trust with a valuation of the land and building assets (estimated fair value and remaining useful life). The significant estimation being the specialised building - depreciated replacement value, using modern equivalent asset methodology, of the new PFI hospital (the 'Queen Elizabeth Hospital Birmingham') and the acquired NHS estates of the former Heart of England NHS Foundation Trust. The result of this valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, is disclosed in note 14.2 to the financial statements on page XLVI. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

During the reporting year, management performed a review of the land area required to provide the contracted healthcare provision of the Trust, against the actual size of the sites owned. The conclusion of this exercise, allowed for a reduction in the land area required versus actual size, resulting in a £21,021,000 decrease to the Trust's land depreciated replacement value as at 1 April 2019; this included an alternative site valuation of the non-PFI Edgbaston healthcare provision utilising spare capacity at the existing Heartlands facility. The land and property values at the reporting date generally increased due to the application of the relevant indices of 31 March 2020. However, the ongoing COVID-19 pandemic and its economic impact, resulted in the external valuer (Avison Young LLP) inserting a 'material valuation uncertainty clause' in their valuation report.

Impairments and the estimated lives of assets - key sources of estimation uncertainty
As detailed in accounting policy note 1.7 'Depreciation, amortisation and impairments', the Trust is required to review property, plant and equipment for impairments and the accuracy of estimated useful lives. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

Provision for expected credit loss of contract receivables - critical accounting judgement
Management will use their judgement to decide when to write-off receivables or to provide against the probability of not being able to collect debt. There are significant judgements in recognition of revenue from care of patients and in provisioning for disputes with commissioners and customers. This arises from the complexity of the Payments by Results regime (NHS), the judgemental nature of over performance activity levels and partially completed spells not yet agreed with commissioners (NHS), commercial pricing regime (private patients) and overseas patients seeking NHS healthcare.

Provisions - critical accounting judgement
Management will use their judgement to decide when to make provisions for probable legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

The carrying amounts of the Group's and Trust's provisions are detailed in note 28 to the financial statements on page LVII.

1.29 Accounting standards, interpretations and amendments adopted in the year

All new, revised and amended standards and interpretations, which are mandatory as at the reporting date, have been adopted in the year. None have had a material impact on the Trust's financial statements.

1.30 Accounting standards, interpretations and amendments to published standards not yet adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2019/20:

IFRS 16 'Leases'
IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

IFRS 17 'Insurance Contracts'
IFRS 17 'Insurance Contracts' is applicable in the public sector for periods beginning 1 April 2021. It is not considered relevant to the financial statements of this Group and Trust as no insurance contracts are issued.

No other accounting standards, interpretations and amendments to published standards not yet adopted is predicted to have a material consequence on the Trust's financial statements.

2 Segmental analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker or 'CODM' as defined by IFRS 8), as follows:

Healthcare services - the Trust
NHS Healthcare is the core activity of the Trust - the 'mandatory services requirement' as set out in the Trust's Terms of Authorisation issued by Monitor and defined by legalisation. This activity is primarily the provision of NHS healthcare, either to patients and charged to the relevant NHS commissioning body, or where healthcare related services are provided to other organisations by contractual agreements. Healthcare services also includes the hosting of the Royal Centre for Defence Medicine (Ministry of Defence) and the treatment of private patients.

The acquisition of the former Heart of England NHS Foundation Trust on 1 April 2018 resulted initially in two separate healthcare segments being reported separately to the 'CODM', each with their own executive Chief Operating Officer on the Board in 2018/19. However, in the reporting year the Trust's clinical divisions were integrated into single cross site specialities on 1 April 2019, reporting to a single Chief Operating Officer and CODM. In addition, the regulator NHS Improvement set a single control total for the combined Trust in the reporting year - the Provider Sustainability Funding mechanism, see note 4 to the financial statements on page XXXIV. Therefore, the Trust considers there to be a single healthcare segment in the reporting year and in the future.

The healthcare and related support services as described are all provided directly by the Trust, which is a public benefit corporation. These services have been aggregated into a single operating segment, as noted above, as they have similar economic characteristics: the nature of the services they offer are the same (the provision of healthcare), they have similar customers (public and private sector healthcare organisations) and have the same regulators (NHS Improvement, Care Quality Commission and the Department of Health). The overlapping activities and interrelation between direct healthcare services and supporting medical research and education suggests that aggregation is applicable within this single reporting segment. However, other healthcare support services are provided by separate trading companies:

Commercial subsidiaries -
There are four trading companies that are all wholly owned subsidiaries of the Trust: (i) Pharmacy@QEHB Limited provides an Outpatient Dispensary service, (ii) UHB Facilities Ltd provides a fully managed healthcare facility, (iii) Assure Dialysis Services Ltd provides renal dialysis nursing healthcare services and (iv) Professional Activity Limited has been acquired to enable the Trust to develop and use its medical locum booking software. As trading companies, subject to additional legal and regulatory regimes (over and above that of the Trust), these activities are considered to be a third distinct business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker). A fifth subsidiary has been acquired by the Trust, Birmingham Systems Limited but remains dormant.

A significant proportion of these companies' revenues are inter group trading with the Trust which is eliminated upon the consolidation of these group financial statements. The monthly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table overleaf.

Year ended 31 March 2020	Integrated Healthcare services	Commercial subsidiaries	Inter-Group Eliminations	Total
	£000	£000	£000	£000
Total segment revenue	1,757,547	61,881	(62,810)	1,756,618
Total segment expenditure	(1,730,113)	(61,003)	62,810	(1,728,306)
Net impairments	(2,500)	-	-	(2,500)
Operating surplus	**24,934**	**878**	**-**	**25,812**
Net financing	(23,277)	(237)	-	(23,514)
PDC dividends payable	(1,347)	-	-	(1,347)
Gains on disposal of assets	(271)	-	-	(271)
Gain from the transfer by absorption	-	-	-	-
Taxation	-	(299)	-	(299)
Retained surplus	**39**	**342**	**-**	**381**
Reportable segment assets	975,905	18,383	-	994,288
Eliminations	-	-	(12,689)	(12,689)
Total assets	**975,905**	**18,383**	**(12,689)**	**981,599**
Reportable segment liabilities	(819,981)	(16,347)		(836,328)
Eliminations	-	-	12,689	12,689
Total liabilities	**(819,981)**	**(16,347)**	**12,689**	**(823,639)**
Net assets	**155,924**	**2,036**	**-**	**157,960**

Year ended 31 March 2019	QE Healthcare services	HGS Healthcare services	Commercial subsidiaries	Inter-Group Eliminations	Total
	£000	£000	£000	£000	£000
Total segment revenue	910,379	704,073	57,585	(58,466)	1,613,571
Total segment expenditure	(865,560)	(757,054)	(56,631)	58,465	(1,620,780)
Net impairments	8,252	(8,962)	-	-	(710)
Operating surplus	**53,071**	**(61,943)**	**954**	**(1)**	**(7,919)**
Net financing	(22,533)	(478)	(192)	1	(23,202)
PDC dividends payable	3,161	(3,900)	-	-	(739)
Gains on disposal of assets	(55)	(176)	-	-	(231)
Gain from the transfer by absorption	165,013	-	-	-	165,013
Taxation	-	-	(90)	-	(90)
Retained surplus	**198,657**	**(66,497)**	**672**	**-**	**132,832**
Reportable Segment assets	664,416	313,588	15,463	-	993,467
Eliminations	-	-	-	(10,466)	(10,466)
Total assets	**664,416**	**313,588**	**15,463**	**(10,466)**	**983,001**
Reportable Segment liabilities	(600,032)	(217,237)	(13,769)		(831,038)
Eliminations	-	-	-	10,466	10,466
Total (liabilities)	**(600,032)**	**(217,237)**	**(13,769)**	**10,466**	**(820,572)**
Net (liabilities) / assets	**64,384**	**96,351**	**1,694**	**-**	**162,429**

All activities are based in the UK.

3 Revenue from contracted patient care activities

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
By commissioner		
Foundation Trusts	**1,678**	1,791
NHS Trusts	**2,560**	2,604
NHS England	**638,277**	586,606
NHS England - pension cost - employer contributions funding (6.3%)	**38,160**	-
NHS England - COVID-19 revenue support	**7,014**	-
Clinical Commissioning Groups (CCGs)	**809,650**	762,192
Department of Health and Social Care	**1,112**	13,877
Local Authorities	**17,872**	17,633
NHS Other	**2,171**	849
Private patients	**5,100**	4,887
Overseas patients	**1,269**	2,267
NHS Injury Cost Recovery scheme	**7,769**	6,740
Non NHS other	**8,946**	10,196
	1,541,578	1,409,642

The responsibility for commissioning nationally funded NHS healthcare 'specialist healthcare activity' lies with NHS England which is the parent body of the CCGs. NHS England is the single largest commissioner of healthcare from the Trust under the Social Care Act of 2012.

In the reporting year there are two new revenue streams from NHS England. The first is due to the employer contribution rate for NHS pensions increasing by 6.3% (from 14.3% to 20.6% excluding administration charge) from 1 April 2018. NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. For 2019/20, the full cost and related funding have been recognised in these accounts for the first time, the cost is disclosed in employee expenses - note 7.1 to the financial statements on page XXXVII.

The second is due to the COVID-19 pandemic emergency. In March NHS England has funded providers for additional COVID-19 related expenditure and loss of other types of income (such as car parking fees and catering). This special funding arrangement will continue into the subsequent financial year subject to HM Government review.

The revenue from the Department of Health and Social Care in the prior year includes pay award funding - due to the NHS 2018/19 pay award being finalised after that prior reporting year's annual planning exercise. This revenue, therefore missed the 2018/19 tariff pricing and had to be funded separately, from 2019/20 this funding was incorporated into tariff for individual services.

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for expected credit losses of 21.79% (2018/19 - 21.89%) to reflect expected rates of collection.

Non NHS other patient care revenue includes income from NHS Wales, NHS Scotland and NHS Northern Ireland.

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
By activity		
Elective	**196,415**	195,268
Non elective	**406,462**	357,529
Outpatients	**180,195**	177,571
A & E	**57,090**	49,019
Other NHS clinical	**599,444**	565,815
Community Services	**37,311**	36,539
NHS England - additional pension funding	**38,160**	-
NHS England - Covid 19 revenue support	**7,014**	-
Private patients	**5,100**	4,887
Other non-NHS clinical	**14,387**	23,014
	1,541,578	1,409,642

3.1 Overseas visitors (patients charged directly by the Trust)

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Income recognised this year	**1,269**	2,267
Cash payments received in-year	**520**	486
Amounts added to provision for impairment of receivables	**(2,839)**	(2,500)
Amounts written off in-year	**(595)**	(1,353)

3.2 Commissioner requested services

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Commissioner requested services		
Revenue derived from NHS clinical activity in England	**1,516,323**	1,384,703
Non-commissioner requested services		
Revenue not derived from NHS clinical activity in England	**25,255**	24,939
	1,541,578	1,409,642
Commissioner requested services as a percentage of revenue	**98.36%**	98.23%

Non commissioner requested services consists of private and overseas patient, NHS injury cost recovery scheme, Ministry of Defence and clinical revenue from Wales, Scotland and Northern Ireland.

Following changes to the Health and Social Care Act 2012 (the 'Act'), Monitor (now part of NHSI&E) removed the requirement for foundation trusts to limit private patients revenue as a percentage of total revenue from activities. In its place, the Act requires that a foundation trust's principal activity is to deliver goods and services for the purposes of the National Health Service in England. These 'commissioner requested services' (as defined in the Trust's provider licence) are disclosed separately as a percentage of all healthcare revenue.

4 Other operating revenue

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Other operating income recognised in accordance with IFRS 15:		
Research and development	**36,494**	34,687
Education and training	**53,691**	51,997
PSF, FRF and MRET funding	**37,098**	29,872
Non-patient care services to other bodies	**22,681**	19,236
Other revenue	**59,646**	58,195
	209,610	193,987
Other operating income recognised in accordance with other standards:		
Donations / grants of physical assets (non-cash)	**679**	1,371
Cash grants for the purchase of capital assets	**300**	488
Charitable and other contributions to expenditure	**1,340**	1,493
Apprenticeship fund	**137**	-
Rental revenue from operating leases	**2,326**	2,142
Amortisation of PFI deferred income / credits	**2,448**	4,448
	7,230	9,942
Other operating income	**216,840**	203,929

The non-IFRS 15 revenue is limited to donations of and grant funding for property, plant and equipment (IAS 20); other charitable donations to support expenditure (IAS 20), rental income from property leases (IAS 17) and the amortisation of PFI deferred income.

The Provider Sustainability Funding (PSF) revenue is allocated to individual NHS Trusts, conditional upon their meeting certain financial targets. UHB was originally allocated a sum of £36,155,000 under the PSF scheme for the reporting year, consisting of £23,670,000 (core PSF), £2,255,000 Financial Recovery Fund (FRF) and £10,230,000 Marginal Rate Emergency Tariff (MRET). The Trust achieved the financial target in the reporting year and has been awarded these funds in full, in addition £943,000 of prior year bonus PSF was received in the reporting period.

Other IFRS 15 revenue includes £2,730,000 from Clinical Excellence Awards (2018/19 - £3,416,000); recharges of £2,849,000 to the Ministry of Defence to fund the training expenditure of Nurses along with catering and car parking costs associated with the military contract (2018/19 - £2,781,000); £2,894,000 from Clinical Testing (2018/19 - £3,343,000); and funding of £2,090,000 (2018/19 - £1,633,000) for the organ retrieval service. The remainder of other income is largely made up of service level agreements with other West Midlands NHS trusts (not commissioners) for the supply of clinical and other supporting services.

Revenue recognised in the reporting year under IFRS 15 that was previously included in the contract liability - deferred income balance is £31,034,000 (2018/19 - £21,744,000). As at the reporting date, there is contract liability - deferred income of £34,398,000 that is expected to be recognised as revenue in the 2020/21 financial year.

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

5 Operating expenses

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Recurring		
Purchase of healthcare from NHS and DHSC bodies	**8,063**	6,188
Purchase of healthcare from non-NHS and non-DHSC bodies	**27,531**	28,309
Directors' costs	**3,267**	2,788
Staff costs	**1,015,750**	942,725
Redundancy costs	**663**	143
Non executive directors' costs	**235**	189
Drugs costs	**241,943**	227,879
Supplies and services - clinical	**186,293**	178,289
Supplies and services - general	**23,980**	20,438
Consultancy services	**1,988**	1,484
Establishment	**9,639**	9,792
Research and development (non staff)	**15,460**	12,287
Education and training (non staff)	**8,285**	8,639
Transport	**7,118**	7,802
Operating lease expenditure	**2,338**	2,139
Premises	**72,536**	68,628
Movement in credit loss allowance: contract receivables	**121**	957
Depreciation on property, plant and equipment	**34,659**	34,697
Amortisation on intangible assets	**2,254**	1,689
Audit services - statutory audit	**230**	262
Other auditor remuneration - audit of subsidiaries	**20**	20
Other auditor remuneration - other assurance services	**75**	90
Internal audit services	**150**	200
Clinical negligence	**38,847**	38,733
Legal fees	**2,237**	1,054
Other	**26,424**	25,359
	1,730,106	1,620,780
Non-recurring		
Net impairments of property, plant and equipment	**2,500**	710
	2,500	710
Total operating expenses	**1,732,606**	1,621,490

Other expenditure includes £18,386,000 (2018/19 - £16,690,000) in relation to payments to the Trusts' PFI partners for services provided.

The Trust's contract with its external auditor, Deloitte LLP, provides for a limitation of the auditors liability of two million pounds sterling. Other audit remuneration - other services includes £6,000 (2018/19 - £24,000) due to audit assurance of the Quality Report and £75,000 (2018/19 - £90,000) due to Local Counter Fraud Services. The engagement letter between the Trust and the external auditors was signed 16 March 2020.

An element of operating expenses arises from the charge of £2,500,000 (2018/19 - £710,000 charge) due to net impairments. See note 14.2 to the financial statements on page XLVI for details of the reporting year and prior year impairments.

6 Operating leases

6.1 As lessee

Payments recognised as an expense	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Minimum lease payments - charged to operating expenses	**2,338**	2,139

Total future minimum lease payments	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Payable		
Not later than one year	**2,464**	2,260
Between one and five years	**4,772**	4,699
After 5 years	**1,525**	2,130
Total	**8,761**	9,089

The Group holds various non-cancellable operating lease agreements, covering leasehold buildings (warehousing and renal dialysis) plus transport vehicles and general office equipment.

6.2 As lessor

Rental revenue	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Rents recognised as income in the period	**2,326**	2,142

Total future minimum lease payments	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Receivable		
Not later than one year	**2,326**	2,142
Between one and five years	**8,059**	7,867
After 5 years	**15,820**	17,592
Total	**26,205**	27,601

The lease rental revenue is due from the Ministry of Defence and University of Birmingham for their occupation of facilities within the PFI hospital ('Queen Elizabeth Hospital Birmingham').

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2020			Year Ended 31 March 2019		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Short term employee benefits - salaries and wages	**786,318**	**727,274**	**59,044**	739,900	700,297	39,603
Short term employee benefits - social security costs	**70,321**	**70,321**	**-**	70,179	70,179	-
Post employment benefits - employer contributions to NHS pension scheme	**87,205**	**87,205**	**-**	82,990	82,990	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**38,160**	**38,160**	**-**	107	107	-
Pension cost - other contributions (NEST)	**214**	**214**	**-**	-	-	-
Apprentice Levy	**3,889**	**3,889**	**-**	3,640	3,640	-
Termination benefits	**663**	**663**	**-**	143	143	-
Temporary staff - agency/contract staff	**36,782**	**-**	**36,782**	51,728	-	51,728
Pay costs capitalised as part of assets	**(3,872)**	**(3,872)**	**-**	(3,031)	(3,031)	-
	1,019,680	**923,854**	**95,826**	945,656	854,325	91,331

Employee costs include those of staff and directors, but exclude non executive director costs. The latter are disclosed separately in operating expenses, see note 5 to the financial statements on page XXXV. The termination benefits included above are disclosed separately within 'other' operating expenses in note 5 to the financial statements on page XXXV.

7.2 Key management compensation

	Directors		Non-executives	
	Year Ended 31 March 2020	Year Ended 31 March 2019	**Year Ended 31 March 2020**	Year Ended 31 March 20198
	£000	£000	**£000**	£000
Salaries and short term benefits	**2,556**	2,291	**217**	176
Social Security Costs	**335**	302	**18**	13
Employer contributions to NHS Pensions Agency	**376**	195	**-**	-
	3,267	2,788	**235**	189

Key management compensation consists entirely of the emoluments of the Board of Directors of the Trust. Full details of Directors' and non-executives' remuneration and interests are set out in the Remuneration Report which is a part of the annual report and financial statements.

7.3 Retirements due to ill-health

During the year to 31 March 2020 there were 7 early retirements from the Trust agreed on the grounds of ill-health (2018/19 - 13). The estimated additional pension liabilities of these ill-health retirements will be £430,000 (2018/19 - £502,000). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

8 Better payment practice code

8.1 Measure of compliance

	Year Ended 31 March 2020		Year Ended 31 March 2019	
	Number	**£000**	£000	£000
Trade				
Total trade bills paid in the year	**106,618**	**437,524**	166,149	613,803
Total trade bills paid within target	**104,630**	**435,199**	160,460	606,065
Percentage of trade bills paid within target	**98.14%**	**99.47%**	96.58%	98.74%
NHS				
Total NHS bills paid in the year	**6,538**	**224,624**	8,562	216,251
Total NHS bills paid within target	**6,238**	**223,388**	7,753	212,070
Percentage of NHS bills paid within target	**95.41%**	**99.45%**	90.55%	98.07%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

8.2 The late payment of commercial debts (interest) Act 1998

£Nil interest (2018/19 - £nil) was charged to the Trust in the year for late payment of commercial debts.

9 Finance income and costs

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Financing income		
Interest receivable	**518**	766
	518	766
Financing costs		
Interest on loans from the DHSC - Capital	**(54)**	(56)
Interest on loans from the DHSC - Revenue support	**(478)**	(478)
Interest on obligations under PFI contracts	**(23,407)**	(23,325)
Interest on obligations under finance leases	**(85)**	(94)
Other financing charges	**(8)**	(15)
	(24,032)	(23,968)
Net finance expense	**(23,514)**	(23,202)

The acquisition of the former Heart of England NHS FT on 1 April 2018 transferred to the Trust two Department of Health and Social Care loans held by the provider - a capital loan of £3,100,000 and a revenue support loan of £31,792,000 - with respective interest rates of 1.84% and 1.5%.

During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment, see the Borrowings note 25 on page LIII to these financial statements for further detail.

10 Gains on disposal of non-current assets

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Profit on disposal of non-current assets	**34**	53
Loss on disposal of non-current assets	**(305)**	(284)
	(271)	(231)

11 Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health and Social Care amounted to £1,347,000 (2018/19 - £739,000). PDC dividends are calculated as a percentage (3.5%) of average net relevant assets.

12 Tax recognised in Statement of Comprehensive Income

Recognised in the income statement	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Current tax expense		
Current year	**107**	80
Adjustments in respect of prior years	**78**	(23)
	185	57
Deferred tax expense		
Origination and reversal of temporary differences	**113**	-
Adjustments in respect of prior years	**1**	33
	114	33
Total tax expense recognised in income statement	**299**	90

Tax recognised in other comprehensive income is £nil (2018/19 - £nil).

Tax recognised directly in equity is £nil (2018/19 - £nil).

Reconciliation of effective tax rate	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Operating surplus before taxation – subsidiaries only *	**641**	762
Tax at the standard rate of corporation tax in the UK 19% (2018/19 - 19%)	**122**	145
Other	**98**	(65)
Adjustments in respect of prior years	**79**	10
Total tax expense / (credit)	**299**	90

* Liability for corporation tax only arises from the activity of the commercial subsidiaries whose combined operating surplus before taxation is disclosed in the segmental analysis note 2 to the financial statements on page XXX. The activities of the Trust do not incur corporation tax, see accounting policy note 1.24 for detailed explanation.

The standard rate of tax applied to the reported profit on ordinary activities is 19% (2018/19: 19%). The government has announced that the UK corporation tax rate will remain at 19% for 2020/21."

13 Intangible assets

Group	Computer software – purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost				
At 1 April 2018	5,797	1,030	151	6,978
Transfers by absorption	14,253	-	192	14,445
Additions	1,067	-	-	1,067
Reclassifications	5,427	647	(192)	5,882
Disposals	(14)	-	-	(14)
At 31 March 2019	**26,530**	**1,677**	**151**	**28,358**
Additions purchased / leased	838	-	-	838
Additions donated / granted	33	-	-	33
Reclassifications	5,507	798	(151)	6,154
At 31 March 2020	**32,908**	**2,475**	**-**	**35,383**
Amortisation				
At 1 April 2018	1,341	342	-	1,683
Transfers by absorption	12,212	-	-	12,212
Charged for the year	1,509	180	-	1,689
Reclassifications	(12)	-	-	(12)
Disposals	(14)	-	-	(14)
At 31 March 2019	**15,036**	**522**	-	**15,558**
Charged for the year	1,922	332	-	2,254
At 31 March 2020	**16,958**	**854**	-	**17,812**
Net book value				
At 31 March 2020	**15,950**	**1,621**	**-**	**17,571**
At 31 March 2019	11,494	1,155	151	12,800
At 1 April 2018	4,456	688	151	5,295

The transfer by absorption is the intangible assets of the former Heart of England NHS FT on 1 April 2018.

The valuation basis is described in accounting policy note 1.6. There is no active market for the Group's intangible assets and there is no revaluation reserve.

The estimated useful economic lives of the Group's intangible assets range from two to five years and each asset is being amortised over this period, as described in accounting policy note 1.7.

Trust	Computer software – purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost				
At 1 April 2018	5,797	1,030	-	6,827
Transfers by absorption	14,253	-	192	14,445
Additions	1,067	-	-	1,067
Reclassifications	5,427	647	(192)	5,882
Disposals	(14)	-	-	(14)
At 31 March 2019	**26,530**	**1,677**	**-**	**28,207**
Additions purchased / leased	838	-	-	838
Additions donated / granted	33	-	-	33
Reclassifications	5,507	798	-	6,305
At 31 March 2020	**32,908**	**2,475**	**-**	**35,383**
Amortisation				
At 1 April 2018	1,341	342	-	1,683
Transfers by absorption	12,212	-	-	12,212
Charged for the year	1,509	180	-	1,689
Reclassifications	(12)	-	-	(12)
Disposals	(14)	-	-	(14)
At 31 March 2019	**15,036**	**522**	**-**	**15,558**
Charged for the year	1,922	332	-	2,254
At 31 March 2020	**16,958**	**854**	**-**	**17,812**
Net book value				
At 31 March 2020	**15,950**	**1,621**	**-**	**17,571**
At 31 March 2019	11,494	1,155	-	12,649
At 1 April 2018	4,456	688	-	5,144

The transfer by absorption is the intangible assets of the former Heart of England NHS FT on 1 April 2018.

The valuation basis is described in accounting policy note 1.6. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

The estimated useful economic lives of the Trust's intangible assets range from two to five years and each asset is being amortised over this period, as described in accounting policy note 1.7.

14 Property, plant and equipment - 2019/20

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2019	55,060	595,062	1,840	8,955	207,816	106	52,450	8,931	930,220
Additions purchased / leased	-	14,061	-	144	15,969	-	10,857	124	41,155
Additions donated / granted	-	460	-	-	486	-	-	-	946
Reclassifications	-	(13,049)	(88)	(1,003)	(159)	6	(7,963)	-	(22,256)
Impairments charged to the revaluation reserve	(14,351)	(3,640)	-	-	-	-	-	-	(17,991)
Reversal of impairments credited to operating expenses	-	9,386	23	-	-	-	-	-	9,409
Impairments charged to operating expenses	(848)	(11,061)	-	-	-	-	-	-	(11,909)
Revaluations	-	5,629	25	-	-	-	-	-	5,654
Disposals / derecognition	-	-	-	-	(4,538)	-	-	(25)	(4,563)
At 31 March 2020	**39,861**	**596,848**	**1,800**	**8,096**	**219,574**	**112**	**55,344**	**9,030**	**930,665**
Depreciation									
At 31 March 2019	-	2,706	-	-	140,159	106	38,560	8,227	189,758
Provided during the year	-	16,500	88	-	14,129	-	3,798	144	34,659
Reclassifications	-	(16,137)	(88)	-	122	6	(4)	(1)	(16,102)
Revaluations	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(4,245)	-	-	(13)	(4,258)
At 31 March 2020	**-**	**3,069**	**-**	**-**	**150,165**	**112**	**42,354**	**8,357**	**204,057**
Net book value									
Owned	20,331	254,554	1,788	8,096	64,538	-	12,990	579	362,876
Donated	-	4,716	12	-	4,780	-	-	94	9,602
Government granted	-	12,956	-	-	-	-	-	-	12,956
Private Finance Initiative	-	311,793	-	-	-	-	-	-	311,793
Finance Lease	19,530	9,760	-	-	91	-	-	-	29,381
At 31 March 2020	**39,861**	**593,779**	**1,800**	**8,096**	**69,409**	**-**	**12,990**	**673**	**726,608**

Property, plant and equipment – 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2018	30,399	415,075	1,158	182	108,931	11	14,185	1,800	571,741
Transfers by absorption	24,649	191,369	775	11,069	90,632	99	33,765	6,966	359,324
Additions purchased / leased	-	8,406	-	6,811	12,962	-	9,252	27	37,458
Additions donated / granted	-	1,054	-	-	714	-	6	70	1,844
Reclassifications	-	(18,928)	(179)	(9,107)	134	(4)	(4,728)	96	(32,716)
Impairments charged to the revaluation reserve	-	(4,384)	-	-	-	-	-	-	(4,384)
Reversal of impairments credited to operating expenses	-	9,650	51	-	-	-	-	-	9,701
Impairments charged to operating expenses	-	(10,411)	-	-	-	-	-	-	(10,411)
Revaluations	12	3,231	35	-	-	-	-	-	3,278
Disposals / derecognition	-	-	-	-	(5,557)	-	(30)	(28)	(5,615)
At 31 March 2019	**55,060**	**595,062**	**1,840**	**8,955**	**207,816**	**106**	**52,450**	**8,931**	**930,220**
Depreciation									
At 31 March 2018	-	13,265	94	-	75,123	10	9,719	1,443	99,654
Transfers by absorption	-	-	-	-	55,587	99	25,239	6,635	87,560
Provided during the year	-	16,092	85	-	14,710	2	3,619	189	34,697
Revaluations	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,276)	-	(30)	(25)	(5,331)
At 31 March 2019	**-**	**2,706**	**-**	**-**	**140,159**	**106**	**38,560**	**8,227**	**189,758**
Net book value									
Owned	27,294	252,225	1,828	8,955	62,020	-	13,890	596	366,808
Donated	-	4,596	12	-	5,500	-	-	108	10,216
Government granted	-	13,348	-	-	-	-	-	-	13,348
Private Finance Initiative	-	312,472	-	-	-	-	-	-	312,472
Finance Lease	27,766	9,715	-	-	137	-	-	-	37,618
At 31 March 2019	**55,060**	**592,356**	**1,840**	**8,955**	**67,657**	**-**	**13,890**	**704**	**740,462**

The significant increase across the reporting period is due transfer by absorption of the property, plant and equipment of the former Heart of England NHS FT on 1 April 2018.

Property, plant and equipment – 2019/20

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2019	55,060	592,675	1,840	8,955	206,466	106	52,385	8,703	926,190
Additions purchased / leased	-	14,061	-	137	15,876	-	10,857	124	41,055
Additions donated	-	460	-	-	486	-	-	-	946
Reclassifications	-	(13,049)	(88)	(1,003)	(159)	6	(7,963)	-	(22,256)
Impairments charged to the revaluation reserve	(14,351)	(3,640)	-	-	-	-	-	-	(17,991)
Reversal of impairments credited to operating expenses	-	9,386	23	-	-	-	-	-	9,409
Impairments charged to operating expenses	(848)	(11,061)	-	-	-	-	-	-	(11,909)
Revaluations	-	5,629	25	-	-	-	-	-	5,654
Disposals / derecognition	-	-	-	-	(4,538)	-	-	(25)	(4,563)
At 31 March 2020	**39,861**	**594,461**	**1,800**	**8,089**	**218,131**	**112**	**55,279**	**8,802**	**926,535**
Depreciation									
At 31 March 2019	-	2,086	-	-	139,601	106	38,510	8,009	188,312
Provided during the year	-	16,338	88	-	13,974	-	3,785	135	34,320
Reclassifications	-	(16,137)	(88)	-	122	6	(4)	(1)	(16,102)
Revaluations	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(4,245)	-	-	(13)	(4,258)
At 31 March 2020	**-**	**2,287**	**-**	**-**	**149,452**	**112**	**42,291**	**8,130**	**202,272**
Net book value									
Owned	20,331	252,949	1,788	8,089	63,808	-	12,988	578	360,531
Donated	-	4,716	12	-	4,780	-	-	94	9,602
Government granted	-	12,956	-	-	-	-	-	-	12,956
Private Finance Initiative	-	311,793	-	-	-	-	-	-	311,793
Finance Lease	19,530	9,760	-	-	91	-	-	-	29,381
At 31 March 2020	**39,861**	**592,174**	**1,800**	**8,089**	**68,679**	**-**	**12,988**	**672**	**724,263**

Property, plant and equipment – 2018/19

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost									
At 31 March 2018	30,399	412,689	1,158	8	107,981	11	14,120	1,572	567,938
Transfers by absorption	24,649	191,369	775	11,069	90,632	99	33,765	6,966	359,324
Additions purchased / leased	-	8,406	-	6,811	12,794	-	9,252	27	37,290
Additions donated	-	1,054	-	-	714	-	6	70	1,844
Reclassifications	-	(18,929)	(179)	(8,933)	(98)	(4)	(4,728)	96	(32,775)
Impairments charged to the revaluation reserve	-	(4,384)	-	-	-	-	-	-	(4,384)
Reversal of impairments credited to operating expenses	-	9,650	51	-	-	-	-	-	9,701
Impairments charged to operating expenses	-	(10,411)	-	-	-	-	-	-	(10,411)
Revaluations	12	3,231	35	-	-	-	-	-	3,278
Disposals / derecognition	-	-	-	-	(5,557)	-	(30)	(28)	(5,615)
At 31 March 2019	**55,060**	**592,675**	**1,840**	**8,955**	**206,466**	**106**	**52,385**	**8,703**	**926,190**
Depreciation									
At 31 March 2018	-	12,807	94	-	74,783	10	9,682	1,282	98,658
Transfers by absorption	-	-	-	-	55,587	99	25,239	6,635	87,560
Provided during the year	-	15,930	85	-	14,551	2	3,606	132	34,306
Reclassifications	-	(26,651)	(179)	-	(44)	(5)	13	(15)	(26,881)
Revaluations	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,276)	-	(30)	(25)	(5,331)
At 31 March 2019	**-**	**2,086**	**-**	**-**	**139,601**	**106**	**38,510**	**8,009**	**188,312**
Net book value									
Owned	27,294	250,458	1,828	8,955	61,228	-	13,875	586	364,224
Donated	-	4,596	12	-	5,500	-	-	108	10,216
Government granted	-	13,348	-	-	-	-	-	-	13,348
Private Finance Initiative	-	312,472	-	-	-	-	-	-	312,472
Finance Lease	27,766	9,715	-	-	137	-	-	-	37,618
At 31 March 2019	**55,060**	**590,589**	**1,840**	**8,955**	**66,865**	**-**	**13,875**	**694**	**737,878**

The significant increase across the reporting period is due transfer by absorption of the property, plant and equipment of the former Heart of England NHS FT on 1 April 2018.

14.1 Estimated useful economic lives

The estimated useful economic lives of the Group's property, plant and equipment are as follows with each asset being depreciated over this period, as described in accounting policy note 1.7.

	Minimum life Years	Maximum life Years
Buildings (excluding dwellings)	10	67
Dwellings	5	25
Plant and Machinery	5	15
Information technology	2	10
Furniture and fittings	5	10

14.2 Valuation at the reporting date – Group and Trust

The land, buildings and dwellings were valued at the reporting date by an independent valuer, Avison Young LLP. The purpose of this exercise was to determine a fair value for Trust property, as detailed in accounting policy notes 1.5 'Property, plant and equipment - valuation' and 1.28 'Critical accounting judgements and key sources of estimation uncertainty'.

The last full valuation of the estate was 31 March 2018 and at the two subsequent reporting dates, including 31 March 2020, a desktop review was carried out by Avison Young LLP. The valuation at the reporting date included an alternative site assessment of the land required for the non-PFI Edgbaston healthcare provision utilising spare capacity at the existing Heartlands facility.

The revaluation exercise resulted in both impairments and reversals of prior impairments being posted to operating expenses, inline with the Department of Health and Social Care Group Accounting Manual, within the consolidated statement of comprehensive income.

Impairments of property, plant and equipment charged to operating expenses		**Year Ended 31 March 2020**	Year Ended 31 March 2019
		£000	£000
Impairments			
Bordesley, Good Hope and Solihull land	4	**(848)**	-
Queen Elizabeth Hospital - non PFI estate	2	**-**	(21)
Bordesley, Good Hope and Solihull estate	3	**(11,061)**	(10,390)
		(11,909)	(10,411)
Reversals of impairments			
Queen Elizabeth Hospital - PFI facility	1	**2,462**	7,353
Queen Elizabeth Hospital - non PFI estate	2	**1,325**	920
Bordesley, Good Hope and Solihull estate	3	**5,622**	1,428
		9,409	9,701
Net (impairment)		**(2,500)**	(710)

There are no movements on revaluation for assets owned by the subsidiaries, only the Trust's estate is revalued as there are no land or buildings owned by the subsidiaries.

All impairments and reversals of impairments are due to changes in market prices only.

1 The valuation of the 'Queen Elizabeth Hospital Birmingham' PFI hospital gave rise to a reversal of a previous impairment resulting from the difference between the fair value in operational use (depreciated replacement cost), as measured at 31 March 2020 compared to 31 March 2019 of £2,462k. The estimation technique of the Modern Equivalent Asset incorporates the current cost of household and commercial property construction and is the main factor behind the valuation process.

2 The valuation of the non PFI estate at the Edgbaston site gave rise to reversals of previous impairments of £1,325k largely due to Regent Court, Yardley Court and the Institute of Translational Medicine buildings.

3 Within the estate acquired by the absorption of the former Heart of England NHS Foundation Trust - the Bordesley, Good Hope and Solihull sites, there are both impairments and reversals of

impairments. The £5,622k of reversals are due to the new buildings at Bordesley (A&E) and Good Hope (Cedarwood ward, pathology and theatres); while the (£11,061k) of impairments are due largely to the reduction in external works affected by the revised revaluation method across all Trust sites (£8,389k) and a (£700k) impairment to the Good Hope Education Centre.

4 The (£848k) impairment of land charged to operating expenses is due to the decrease in the land valuation determined by the revised revaluation methodology. The (£8,236k) and (£6,115k) impairments charged to the revaluation reserve (for QE and Heartlands land respectively, see below) is due to the same reason - the revised estimation technique of the land area required to provide the healthcare provision under the depreciated replacement cost methodology.

The surpluses and deficits upon the revaluation exercise resulted in the following gains and losses being charged to the revaluation reserve, see the Statement of Changes in Taxpayers' Equity on page XVI.

Revaluation gains/(losses) on property, plant and equipment Group		**Year Ended 31 March 2020**	Year Ended 31 March 2019
		£000	£000
Revaluation gains/(losses) recognised in other comprehensive income			
Queen Elizabeth Hospital - non PFI estate		**85**	1,425
Bordesley, Good Hope and Solihull estate		**5,569**	1,853
		5,654	3,278
Impairments charged to the revaluation reserve			
Queen Elizabeth Hospital - non PFI estate		**(470)**	(366)
Queen Elizabeth Hospital - land	4	**(8,236)**	-
Bordesley, Good Hope and Solihull land	4	**(6,115)**	-
Bordesley, Good Hope and Solihull estate		**(3,170)**	(4,018)
		(17,991)	(4,384)
Net decrease to revaluation reserve		**(12,337)**	(1,106)

The revaluation gains and losses on property, plant and equipment for the Group are the same as for the Trust.

14.3 Assets held under finance leases and PFI arrangements – Group and Trust

	PFI assets	Assets held under finance leases	Total
	£000	£000	£000
Cost			
At 1 April 2018	312,712	28,465	341,177
Transfer by absorption	3,768	9,300	13,068
Additions	2,785	-	2,785
Revaluations	-	675	675
Impairments charged to operating expenses	7,207	-	7,207
At 31 March 2019	**326,472**	**38,440**	**364,912**
Additions	4,041	-	4,041
Reclassifications	32	-	32
Impairments charged to operating expenses	-	(8,236)	(8,236)
Revaluations	(15)	325	310
Reversal of impairments credited to operating expenses	2,470	-	2,470
At 31 March 2020	**333,000**	**30,529**	**363,529**
Depreciation			
At 1 April 2018	7,000	516	7,516
Transfer by absorption	39	-	39
Charged for the year	6,961	306	7,267
At 31 March 2019	**14,000**	**822**	**14,822**
Charged for the year	7,207	326	7,533
At 31 March 2020	**21,207**	**1,148**	**22,355**
Net book value			
At 31 March 2020	**311,793**	**29,381**	**341,174**
At 31 March 2019	312,472	37,618	350,090
At 1 April 2018	305,712	27,949	333,661

The Private Finance Initiative assets are the Queen Elizabeth Hospital Birmingham and two smaller schemes acquired via the former Heart of England NHS Foundation Trust as detailed in note 27.1 to the financial statements on page LIV.

A separate schedule for the Trust's finance lease and PFI assets has not been produced as the subsidiaries have no assets classified as such. Within finance leased assets is land with a fair value of £19,530,000 (31 March 2019: £27,766,000), this is the Edgbaston site land leased from the Calthorpe Estate over a 999 year term.

14.4 Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £11,462,000 (31 March 2019: £9,537,000) for both Group and Trust. This amount relates entirely to property, plant and equipment, there are nil contracted capital commitments for intangible assets.

15 Subsidiaries

The Trust's subsidiary undertakings and investments as included in the consolidation as at the reporting date are set out below. The reporting date of the financial statements for the subsidiaries is the same as for these group financial statements - 31 March 2020. The registered office of the subsidiaries is the same as that of the Trust.

Pharmacy@QEHB Limited

The company is registered in the UK, company no. 07547768, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company provides an Outpatients Dispensary service to the Trust at the Queen Elizabeth and Heartlands hospital sites.

UHB Facilities Limited
The company is registered in the UK, company no. 08642236, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company provides a managed renal healthcare facility to the Trust.

Assure Dialysis Services Limited
The company is registered in the UK, company no. 08642238, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company provides of renal dialysis healthcare nursing service to the Trust.

Birmingham Systems Limited
The company is registered in the UK, company no. 07136767, with a share capital comprising one share of £1 which is 100% owned by the Trust. The company is dormant and has not yet traded, there are £nil assets and liabilities to consolidate into the Trust's financial statements.

Professional Activity Limited
The company is registered in the UK, company no. 08078932, with a share capital comprising £25,050 wholly owned by the Trust. The company has not yet traded, it is developing software to support the booking of locum shifts for the Trust's clinical work scheduling.

16 Investments

The Trust has one other investment comprising a 12% shareholding in a company 'Sapere Systems Limited', registered in the UK, company no. 7171338, the Trust's shareholding purchased for £12. This company is dormant and has not yet traded, therefore the investment is recognised in the Trust's statement of financial position at cost.

17 Joint Venture - Innovating Global Health China Limited

The Trust has established the following company as a joint venture between the Trust and Innovating Global Health SA (IGH): Innovating Global Health China Limited (IGHC) incorporated in Hong Kong. This was established for the identification, development and pursuit of healthcare opportunities in China. This is a private company limited by shares, with Trust and IGH each owning a 50% shareholdings. The partner company (IGH) is registered / organised under the laws of Switzerland. The joint venture is accounted for using the equity method and is now trading.

18 Non-current assets held for sale

The Trust has no non-current assets held for sale at the reporting date (31 March 2019: £nil).

19 Inventories

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Consumables	**18,639**	16,461	**13,386**	11,557
Drugs	**19,112**	18,780	**18,994**	18,719
Other	**182**	235	**182**	235
	37,933	35,476	**32,562**	30,511

The increase across the reporting period is due to additional stock holding of items relating to Brexit contingency planning and the COVID-19 pandemic emergency.

The Group expensed £427,619,000 of inventories during the year (2018/19 - £405,692,000). The Group charged £617,000 to operating expenses in the year due to write-downs of obsolete inventories (2018/19 - £476,000).

20 Trade and other receivables

Current	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Contract receivables (IFRS 15): invoiced	**72,488**	73,670	**73,181**	74,392
Contract receivables (IFRS 15): not yet invoiced	**36,748**	27,852	**36,856**	27,931
Allowance for impaired contract receivables	**(13,045)**	(13,211)	**(13,002)**	(13,211)
PFI prepayments - lifecycle (capital)	**16,927**	14,917	**16,927**	14,917
Prepayments	**10,571**	10,075	**10,459**	10,012
PDC Receivable	**153**	3,161	**153**	3,161
Other receivables - revenue	**4,618**	5,879	**8,583**	8,809
Other receivables - capital	**-**	500	**-**	500
	128,460	122,843	**133,157**	126,511

Non-current	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Allowance for impaired contract receivables	**(2,497)**	(2,423)	**(2,497)**	(2,423)
Contract receivables (IFRS 15): not yet invoiced	**11,458**	10,789	**11,458**	10,789
Other receivables - revenue	**1,096**	-	**1,096**	-
	10,057	8,366	**10,057**	8,366
Of which receivable from NHS and DHSC group bodies:				
Current	**76,487**	76,814	**76,487**	76,814
Non current	**1,096**	-	**1,096**	-

Included within other receivables - revenue are amounts owing by NHS England for reimbursement of the Clinician pension tax provision, £125,000 current and £1,096,000 non-current; this being new in the reporting year. The corresponding liability (owed to NHS Pensions agency) is detailed in provisions, see note 28 to the financial statements on page LVII. Within the remainder of current other receivables - revenue is VAT owed by HMRC of £4,106,000 (31 March 2019: £4,513,000).

IFRS 15 'Revenue from Contracts with Customers' was applied to these financial statements for the first time in the previous reporting period. Following an assessment of the adoption of IFRS 15 there is no material change to the receivables disclosed at the reporting date or prior year. The receivables and associated impairment provisions of previous years have now been split into two separate elements:

- IFRS 15 - where the receivable is defined by a contract with a customer. This receivable is disclosed as either invoiced at the reporting date (on the accounts receivable ledger) or not yet invoiced / non invoiced (example of the latter would be the Provider Sustainability Funding owed).
- Non-IFRS 15 receivables - revenue governed by other accounting standards. Examples includes capital amounts owed (an exclusion from IFRS 15), government grants owed (IAS 20) and VAT owed by HMRC (statutory, not contracted)

Within IFRS 15 receivables are balances owed by NHS bodies in England and other related parties of the HM Government 'Whole Government Accounts'. Related party transactions are detailed in note 31 to the financial statements on page LX.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £17,735,000 (31 March 2019: £13,479,000) which are past due at the reporting date but for which no specific provision has been made as they are considered to be recoverable based on previous trading history.

Allowance for credit losses 2019/20	Group		Trust	
	Contract receivables	Other receivables	Contract receivables	Other receivables
	£000	£000	£000	£000
Balance at 1 April	**15,634**		**15,634**	
New allowances arising	**2,359**	-	**2,316**	-
Reversals of allowances (collected in-year)	**(2,238)**	-	**(2,238)**	-
Utilisation of allowances (written off)	**(213)**	-	**(213)**	-
	15,542	**-**	**15,499**	**-**

Allowances for credit losses - 2018/19	Group		Trust	
	Contract receivables	Other receivables	Contract receivables	Other receivables
	£000	£000	£000	£000
Balance at 1 April	**-**	8,710	**-**	8,710
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2019	**8,710**	(8,710)	**8,710**	(8,710)
Transfers by absorption	**12,142**	-	**12,142**	-
New allowances arising	**2,975**	-	**2,975**	-
Reversals of allowances (collected in-year)	**(2,018)**		**(2,018)**	
Utilisation of allowances (written off)	**(6,175)**	-	**(6,175)**	-
	15,634	-	**15,634**	

21 Cash and cash equivalents

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
At 1 April	**62,941**	85,490	**61,938**	83,692
Transfers by absorption	**-**	11,305	**-**	11,305
Net change in year	**(1,971)**	(33,854)	**(3,643)**	(33,059)
At 31 March	**60,970**	62,941	**58,295**	61,938
Made up of				
Cash with Government Banking Service	**57,437**	60,297	**57,437**	60,297
Commercial banks and cash in hand	**3,533**	2,644	**858**	1,641
Cash and cash equivalents as in statement of financial position	**60,970**	62,941	**58,295**	61,938
Cash and cash equivalents as in statement of cash flows	**60,970**	62,941	**58,295**	61,938

22 Trade and other payables

Current	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
NHS payables	**22,512**	16,790	**22,502**	16,790
Amounts due to other related parties	**13,075**	12,241	**13,075**	12,234
Commercial trade payables	**86,520**	79,169	**77,599**	71,707
Trade payables - capital	**7,583**	6,090	**7,665**	6,193
Taxes payable	**20,386**	21,067	**20,324**	21,005
Other payables	**4,305**	3,959	**9,984**	8,420
Accruals	**114,801**	119,987	**115,034**	120,267
Receipts in advance	**6,276**	4,182	**6,276**	4,182
	275,458	263,485	**272,459**	260,798

NHS payables consist of balances owed to NHS bodies in England, amounts due to other related parties consist of balances owed to other HM Government organisations including pensions. Included within amounts due to other related parties are NHS pension contributions owed of £12,112,000 (31 March 2019: £11,419,000).

Non current trade and other payables are nil (31 March 2019: £nil).

23 Other liabilities

Current	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Deferred income	**36,398**	33,434	**36,374**	33,441

Non-current	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Deferred income	**414**	2,484	**213**	2,260

Deferred income is due to the timing of contract liabilities arising from research and education activies.

24 Deferred tax

An analysis of the movements in the deferred tax liabilities and assets recognised by the group is set out below:

Group only*	Capital allowances	Tax losses	Total
	£000	£000	£000
At 1 April 2018	25	(125)	(100)
Charge to the income statement	21	12	33
At 31 March 2019	**46**	**(113)**	**(67)**
Charge to the income statement	1	113	114
At 31 March 2020	**47**	**-**	**47**

* Liability for corporation tax only arises from the activity of the commercial subsidiaries, the activities of the Trust do not incur corporation tax, see accounting policy note 1.24 for detailed explanation.

Deferred tax assets and liabilities are to be recovered / settled after more twelve months. The amounts are as follows:

	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
Deferred tax assets	-	(113)
Deferred tax liabilities	**47**	46
Net non current deferred tax asset	**47**	(67)

25 Borrowings

Group and Trust	Current		Non-Current	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	Total	Total	Total	Total
	£000	£000	£000	£000
Loans from the DHSC - Capital	**2,848**	135	**-**	2,842
Loans from the DHSC - Revenue support	**31,892**	100	**-**	31,792
Obligations under finance leases	**204**	221	**1,016**	1,216
Obligations under Private Finance Initiative contracts	**13,429**	12,728	**447,788**	461,200
	48,373	13,184	**448,804**	497,050

The Private Finance Initiative obligation relates to the schemes as detailed in note 27.1 to the financial statements on page LIV.

The Trust had transferred by absorption from the former Heart of England NHS FT on 1 April 2018 two Department of Health and Social Care loans. Those loans were a £3,100,000 capital loan with an interest rate of 1.84% repayable over 24 years and a £31,792,000 working capital facility with an interest rate of 1.5% repayable over 5 years.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of

Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £34,634,000 of principal and £106,000 of interest accrued (at the reporting date) are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

25.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Finance leases	PFI schemes	Total
	£000	£000	£000	£000
At 1 April 2019	34,869	1,437	473,928	**510,234**
Cash movements:				
Financing cash flows - principal	(129)	(217)	(12,711)	**(13,057)**
Financing cash flows - interest	(532)	(85)	(14,799)	**(15,416)**
Non cash movements:				
Interest charge arising in year	532	85	14,799	**15,416**
At 31 March 2020	**34,740**	**1,220**	**461,217**	**497,177**

26 Finance lease obligations (other than PFI)

Group and Trust	Minimum lease payments		Present value of minimum lease payments	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£000	£000	**£000**	£000
Gross lease liabilities	**1,441**	1,739	**1,441**	1,739
Of which liabilities are due:				
Not later than one year	**273**	302	**273**	302
Later than one year, not later than five years	**884**	949	**884**	949
Later than five years	**284**	488	**284**	488
Net finance charges allocated to future periods	**(221)**	(302)	**(221)**	(302)
Net lease liabilities	**1,220**	**1,437**	**1,220**	**1,437**
Not later than one year	**204**	221	**204**	221
Later than one year, not later than five years	**779**	779	**779**	779
Later than five years	**237**	437	**237**	437

The finance lease obligations disclosed relate to medical equipment and buildings. The Edgbaston site land is a long term finance lease, detailed in note 14.3 to the financial statements on page XLVIII, this has a nominal charge as the land is covenanted for the 'provision of healthcare and education' to the city of Birmingham.

27 Private finance initiative contracts

27.1 PFI schemes on-statement of financial position – Group and Trust

The Trust has three on-statement of financial position PFI schemes:

- The Queen Elizabeth Hospital Birmingham (PFI 1)
- The main entrance and retail facility at Heartlands Hospital (PFI 2)
- The provision of energy management services at Heartlands Hospital (PFI 3)

Total finance lease obligations for on-statement of financial position PFI contracts due:

Total finance lease obligations for on-statement of financial position PFI contracts due: Group and Trust	**Year Ended 31 March 2020**	Year Ended 31 March 2019
	£000	£000
Gross PFI lease liabilities	**690,676**	717,981
Of which liabilities are due:		
Not later than one year	**27,803**	27,450
Later than one year, not later than five years	**107,761**	109,676
Later than five years	**555,112**	580,855
Net finance charges allocated to future periods	**(229,459)**	(244,053)
Net PFI lease liabilities	**461,217**	473,928
Not later than one year	**13,429**	12,728
Later than one year, not later than five years	**54,485**	54,752
Later than five years	**393,303**	406,448
Net PFI lease liabilities by scheme:		
The Queen Elizabeth Hospital Birmingham	**459,602**	472,116
The main entrance and retail facility at Heartlands Hospital	**278**	312
The provision of energy management services at Heartlands Hospital	**1,337**	1,500
	461,217	473,928

The Queen Elizabeth Hospital Birmingham
A contract for the development of the new hospital was signed by the Trust and its PFI partner on 14 June 2006. The purpose of the scheme was to deliver a modern, state of the art acute hospital facility on the QE site which is now fully operational as at the reporting date. This is part of a wider PFI deal between the Trust, Birmingham & Solihull Mental Health Trust and a consortium led by Consort Healthcare (Birmingham) Limited. The ownership of the consortium entity is as follows:

Balfour Beatty Infrastructure Investments Ltd (40%), InfraRed Infrastructure Yield Fund (30%) and Infrastructure Investments Holdings Limited, a subsidiary of HICL Infrastructure Company Limited (30%).

The contracted value of the new PFI hospital is £584,600,000 (of which £484,889,000 is capital and £99,711,000 are fees and finance costs incurred prior to 15 June 2010). The 'Queen Elizabeth Hospital Birmingham' was completed on 11 October 2011.

The Trust will be committed to the full unitary payment till the contract expires on 14 August 2046, at which time the building will revert to the ownership of the Trust. The unitary payment is subject to change based on movements in the Retail Prices Index.

The Trust has the rights to use the Queen Elizabeth Hospital Birmingham for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services, including facilities management and lifecycle maintenance. In addition, the Trust has the rights to possible deductions from the unitary payment due to the non availability of the infrastructure or under performance regarding the services provided. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

The main entrance and retail facility at Heartlands Hospital
This is a 25 year contract with BHE (Heartlands) Limited which commenced in August 2005. The contract states that the service provision must be made available for users of the Heartlands Hospital including patients, visitors and staff.

The contract contains a range of measures upon which deficiency points are allocated if pre-agreed levels are not achieved. The deficiency points are valued and deducted retrospectively from the Trust unitary payment at the end of the following quarter. At the end of the contract, ownership of the Main Entrance structure transfers to the Trust, at this point the Trust is not liable to provide any compensation payment and the contract is deemed to have reached its natural termination. The Trust is entitled to terminate the contract voluntarily with 12 months written notice and there are specific circumstances such as hospital closure or significant reconfiguration.

The provision of energy management services at Heartlands Hospital
This is a 15 year contract with Ener-G Combined Power Limited which commenced in August 2007.

The contract is for the provision of combined heat and power facilities at the Heartlands Hospital. If either party terminates the contract before the end of the agreement, there is provision for either party to be liable to pay compensation as detailed within the contract. The assets are transferred at the end of the agreement and become assets of the Trust. The service provision is implicitly for the patients, visitors and staff of Heartlands Hospital. There is a payment mechanism that allows for deductions to be made to the unitary payment where the quality standards set out in the contract are not met.

Unitary payments payable to service concession operators Group and Trust	**Year Ended 31 March 2020 £000**	Year Ended 31 March 2019 £000
Consisting of:		
Interest charge	**14,799**	**15,355**
Repayment of finance lease liability	**12,711**	**12,324**
Service element and other charges to operating expenditure	**18,386**	**16,690**
Capital lifecycle maintenance	**3,712**	**2,075**
Contingent rent	**8,608**	**7,970**
Addition to lifecycle prepayment - capital	**2,010**	**3,182**
Total amounts paid to service concession operators	**60,226**	**57,596**

The Trust is committed to making the following unitary payments for on-statement of financial position PFI commitments during the next reporting year and until the contract expires:

	31 March 2020			
	PFI 1 £000	**PFI 2 £000**	**PFI 3**	**Total £000**
2nd to 5th years (inclusive)	-	-	1,089	1,089
11th to 15th years (inclusive)	-	523	-	523
26th to 30th years (inclusive)	59,987	-	-	59,987

	31 March 2019			
	PFI 1 £000	**PFI 2 £000**	**PFI 3**	**Total £000**
2nd to 5th years (inclusive)	-	-	1,080	1,080
11th to 15th years (inclusive)	-	497	-	497
26th to 30th years (inclusive)	58,649	-	-	58,649

27.2 PFI schemes off-statement of financial position

The Trust did not have an off-statement of financial position PFI scheme until the transfer by absorption of such a scheme from the former Heart of England NHS Foundation Trust on 1 April 2018.

- The provision of energy management services at Solihull Hospital (PFI 4)

The Trust holds a second PFI agreement with EnerG Combined Power Limited for the provision of energy services at Solihull Hospital. The scheme commenced in April 2010 and a unitary payment of £842,000 was paid in the reporting year (£748,000 in 2018/19). This is a 15 year agreement.

The Trust is accounting for this scheme as an off Statement of Financial Position PFI contract using the NHS Finance, Performance and Operations Guidance on "Accounting for PFI under IFRS" and also has been classified as a non finance lease under IAS 17.

In accordance with SIC 29 (Service Concession Arrangements), the Trust is committed to make the following payments for the service charge element of off-SoFP service concessions:

Group and Trust	Year Ended 31 March 2020	Year Ended 31 March 2019
	£000	£000
payable:		
Not later than one year	**865**	748
Later than one year, not later than five years	**3,697**	3,222
Later than five years	**-**	867

28 Provisions

Group	Current		Non current	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Pensions - early departure costs	**108**	113	**884**	965
Pensions - injury benefits	**286**	278	**4,842**	4,508
Legal claims	**3,598**	817	**280**	273
Redundancy	**-**	745	**-**	-
Clinician pension tax obligation	**125**	-	**1,096**	-
Other	**901**	1,400	**1,918**	1,710
	5,018	3,353	**9,020**	7,456

	Pensions - early departures	Pensions - injury benefits	Legal claims	Redun-dancy	Pension tax	Other	Total
	£000	£000				£000	£000
At 1 April 2019	1,078	4,786	1,090	745	-	3,110	**10,809**
Change in the discount rate (rebasing)	43	404					**447**
Arising during the year	60	221	3,378	-	1,221	-	**4,880**
Used during the year	(111)	(284)	(172)	(663)	-	(291)	**(1,521)**
Reversed unused	(78)	-	(425)	(82)	-	-	(585)
Unwinding of discount	-	1	7	-	-	-	**8**
At 31 March 2020	**992**	**5,128**	**3,878**	**-**	**1,221**	**2,819**	**14,038**
Expected timing of cash flows:							
Within one year	108	286	3,598	-	125	901	**5,018**
Between one and five years	437	1,188	-	-	493	1,918	**4,036**
After five years	447	3,654	280	-	603	-	**4,984**

Trust	Current		Non current	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£000	£000	**£000**	£000
Pensions - early departure costs	**108**	113	**884**	965
Pensions - injury benefits	**286**	278	**4,842**	4,508
Legal claims	**3,598**	817	**-**	-
Redundancy	**-**	745	**-**	-
Clinician pension tax obligation	**125**	-	**1,096**	-
Other	**901**	1,400	**1,918**	1,710
	5,018	3,353	**8,740**	7,183

	Pensions - early departures	**Pensions - injury benefits**	**Legal claims**	**Redun-dancy**	**Pension tax**	**Other**	**Total**
	£000	**£000**				**£000**	**£000**
At 1 April 2019	1,078	4,786	817	745	-	3,110	**10,536**
Change in the discount rate (rebasing)	43	404	-	-	-	-	**447**
Arising during the year	60	221	3,378	-	1,221	-	**4,880**
Used during the year	(111)	(284)	(172)	(663)	-	(291)	**(1,521)**
Reversed unused	(78)	-	(425)	(82)	-	-	**(585)**
Unwinding of discount	-	1	-	-	-	-	**1**
At 31 March 2020	**992**	**5,128**	**3,598**	**-**	**1,221**	**2,819**	**13,758**
Expected timing of cash flows:							
Within one year	108	286	3,598	-	125	901	**5,018**
Between one and five years	437	1,188	-	-	493	1,918	**4,036**
After five years	447	3,654	-	-	603	-	**4,704**

The provisions for Pensions - early departure costs and injury benefits have been calculated on guidance received from the NHS Business Services Authority - Pensions Division. Employers and public liability have been calculated based on information received from NHS Resolution taking into account indications of uncertainty and timing of payments.

The new provision arising - 'clinicians pension tax' - is an estimate of future obligations if in the current reporting year, clinicians sign up to the NHS Pensions 'scheme pays' option. This is due to the Government's response to the consequences arising upon NHS employees of HMRC taxation rules related to the NHS Pension scheme. Due to personal taxation liabilities arising, linked to individual's pay and the value of their NHS pension, for clinicians only - the Government has created the option ('scheme pays') for this tax liability to be paid in the future, from the value of the individual's pension and recharged by NHS Pensions to the Trust. This future obligation upon the Trust is offset by an equal receivable (due from NHS England), disclosed in receivables, see note 20 to the financial statements on page L.

The provisions included under 'legal claims' consist of employers and public liability £961,000 (31 March 2019: £817,000), employment tribunals £2,637,000 (31 March 2019: £nil) and in respect of UHB Facilities Ltd a tenant's dilapidations contractual commitment for the Rabone Lane site £280,000 (31 March 2019: £273,000). There is £nil redundancy provision at the reporting date (31 March 2019: £745,000).

The provisions included under 'other' include an amount of £2,518,000 at the reporting date in respect of environmental corrections required within the estate of the former Heart of England NHS FT, which was transferred to the Trust on 1 April 2018. The values of all provisions transferred by absorption to the Trust on 1 April 2018 are disclosed in the 'transfers by absorption' line, prior year comparatives are not restated.

Provisions within the annual accounts of NHS Resolution at 31 March 2020 include £276,889,000 in respect of clinical negligence liabilities of the Trust (31 March 2019: £255,970,000).

29 Contingencies

There are £69,000 of contingent liabilities at the reporting date which relate to amounts notified by NHS Resolution for potential employer and public liability claims over and above the amounts provided for in note 28 to the financial statements on page LVII (31 March 2019: £72,000). There are no contingent assets at the reporting date (31 March 2019: £nil).

30 Events after the reporting period

These financial statements were authorised for issue on the 18 June 2020, there is an event arising after the end of the reporting period up to this date which qualifies for disclosure, with three separate distinct impacts upon the financial position:

The COVID-19 pandemic: this has impacted financially the way the Trust is funded from the DHSC (via NHS England) - for both revenue and capital funding, whilst also impacting upon the estates valuation as at the reporting date -

On 2 April 2020 the Department of Health and Social Care (DHSC), NHS England (NHSE) and NHS Improvement (NHSI) announced reforms to the NHS cash regime for the 2020/21 financial year as a result of the COVID-19 pandemic. The normal NHS funding regime (national tariff and specialised services contracts) was temporarily suspended.

1. Revenue

Due to the specific expenditure incurred, loss of revenue streams and the consequent decrease in the elective NHS work, this announcement introduced a temporary new financial regime for NHS Providers. NHSE has announced that in the first four months of 2020/21 (April - July) contract income from commissioners is confirmed at an agreed level, to ensure the continuation of all contractual healthcare service provision. In addition to this agreed level of commissioning income there is a retrospective top-up available to ensure providers are fully funded for increased expenditure or losses of other types of income (such as car parking and catering) as a result of COVID-19. This includes the treatment of the setting up and running costs of the Birmingham Nightingale Hospital (at the NEC). As a result, providers are expected to break even for the first 4 months of the financial year.

Post July 2020 there is not yet any formal guidance or detail as to what the financial regime might look like although it is expected to remain a block contract arrangement rather than national tariffs being re-introduced. As such there is uncertainty in accurately forecasting the cash position of the Trust through to the end of the 2020/21 financial year. However, there is a clear commitment from NHSI&E that providers and commissioners will be adequately funded to continue to meet the healthcare needs of the population, this is detailed in a statement published by DHSC, NHSE and NHSI on 27 May 2020.

2. Capital Funding

During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £34,634,000 of principal and £106,000 of interest accrued (at the reporting date) are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

3. Estates valuation

The valuation of the estate is based on property price and build indices issued by the Royal Institute of Chartered Surveyors (RICS), as at the reporting date. The economic uncertainty caused by the COVID-19 pandemic, on-going at the reporting date, could create uncertainty over these indices and hence the estates valuation of land and buildings. The Trust has a few buildings valued at commercial prices (non clinical facilities, such as offices) but whilst these assets are not material to the statement of financial position, the clinical facilities are material to the statement of financial position. The hospital assets are valued at their depreciated replacement cost and the relevant build indices are also affected by the current economic uncertainty. The chartered surveyors (Avison Young LLP) employed to value the Trust's estate have given this statement in their valuation report:

"Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Our valuation is therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Valuation – Global Standards effective from 31 January 2020. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of

this property under frequent review. For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. Rather, the phrase is used in order to be clear and transparent with all parties, in a professional manner that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case."

As a guide to the effect this uncertainty on construction build indices might have: the Trust's net book value of land, buildings and dwellings at the reporting date is £635,440k - a 1% change in valuation is a movement of +/- £6,354k on net assets.

31 Related party transactions

University Hospitals Birmingham NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Trust has taken advantage of the partial exemption provided by IAS 24 'Related Party Disclosures', where the Government of the United Kingdom is considered to have ultimate control over the Trust and all other related party entities in the public sector.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of NHS Improvement - part of the NHS in England. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services.

The Department of Health is also regarded as a related party. During the year University Hospitals Birmingham NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities of the NHS in England to which the Department is regarded as the parent organisation.

The Trust has had a number of material transactions with other Government Departments and local Government bodies.

These related parties are summarised below by Government Department, with disclosure of the total balances owed and owing as at the reporting date and total transactions for the reporting year with the Trust:

Group and Trust	Receivables	Payables	Revenue	Expenditure
	£000	£000	£000	£000
NHS in England				
NHS Birmingham and Solihull CCG	9,274	1,477	649,904	317
NHS South Worcestershire CCG	504	-	5,101	-
NHS Dudley CCG	126	-	9,183	-
NHS Redditch And Bromsgrove CCG	283	-	15,223	-
NHS Sandwell And West Birmingham CCG	23	884	39,058	-
NHS South East Staffs and Seisdon Peninsular CCG	1,760	-	47,026	-
NHS Warwickshire North CCG	946	-	9,486	-
NHS Walsall CCG	37	604	11,352	-
NHS England (specialised commissioning)	12,081	-	611,702	-
NHS England (Cancer Drugs Fund)	4,462	-	18,696	-
NHS England (West Midlands)	1,860	-	17,504	-
Health Education England	2,009	54	50,382	24
Public Health England	299	371	1,263	5,850
Birmingham and Solihull Mental Health NHS Foundation Trust	554	1,707	1,001	4,572
The Royal Orthopaedic Hospital NHS Foundation Trust	2,323	2,264	4,355	2,239
Birmingham Women's and Children's Hospital NHS FT	5,831	3,282	9,648	5,324
Birmingham Community Healthcare NHS Foundation Trust	753	1,126	1,941	631
Sandwell and West Birmingham Hospitals NHS Trust	2,617	2,895	3,187	2,927
The Royal Wolverhampton NHS Trust	1,171	174	5,384	248
Department of Health	149	-	15,210	-
NHS Litigation Authority	-	46	-	38,911
NHS England - Core (inc. sustainability & transformation fund)	16,294	691	49,081	-
Other	12,762	6,937	53,008	7,584
	76,118	**22,512**	**1,628,695**	**68,627**
Other related parties - Whole of Government Accounts				
Ministry of Defence	689	-	5,228	-
NHS Pension Scheme	6	12,112	34	125,365
Birmingham City Council	150	157	15,089	131
NHS Wales	749	80	10,648	-
NHS Blood and Transport	91	638	2,933	9,436
HMRC	4,106	20,540	4	74,509
Other	1,896	88	4,006	214
	7,687	**33,615**	**37,942**	**209,655**

The Trust has also received revenue and capital payments from the University Hospital Birmingham Charities totalling £2,019,000 (2018/19 - £2,864,000).

The financial statements of the parent (the Trust) are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation. The following directors of the Trust are also board members of the trading subsidiaries, roles as stated:

Trust director	Professional Activity Ltd	Pharmacy@QEHB Ltd	UHB Facilities Ltd	Assure Dialysis Ltd
Mike Sexton	-	chair	non-executive	-
Kevin Bolger	-	non-executive	-	-
David Burbridge	co. secretary	co. secretary	co. secretary	co. secretary
Mark Garrick	director	-	-	-

The four subsidiaries do not have any transactions with any NHS or other Government entity except those with its parent (the Trust) and HMRC (payroll and social security taxes). The Trust's receivables and payables includes the following:

The Trust's receivables include £710,000 (31 March 2019 - £382,000) owed by and payables include £10,000 (31 March 2019 - £3,215,000) owed to Pharmacy@QEHB Ltd. The Trust's revenue includes £1,059,000 (31 March 2019 - £1,020,000) received from and expenditure includes £58,365,000 (31 March 2019 - £53,913,000) paid to Pharmacy@QEHB Ltd.

The Trust's receivables include £38,000 (31 March 2019 - £3,654,000) owed by and payables includes £210,000 (31 March 2019 - £286,000) owed to UHB Facilities Ltd. The Trust's revenue includes £81,000 (31 March 2019 - £199,000) received from and expenditure includes £2,372,000 (31 March 2019 - £2,581,000) paid to UHB Facilities Ltd.

The Trust's receivables include £39,000 (31 March 2019 - £1,103,000) owed by and payables includes £nil (31 March 2019 - £nil) owed to Assure Dialysis Services Ltd. The Trust's revenue includes £31,000 (31 March 2019 - £86,000) received from and expenditure includes £902,000 (31 March 2019 - £852,000) paid to Assure Dialysis Services Ltd.

There are no transactions or balances in the reporting year between the Trust and Professional Activity Ltd (none in 2018/19).

32 Financial instruments and related disclosures

The fair value of a financial instrument is the price at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arms-length transaction. All the financial instruments of the Trust are initially measured at fair value on recognition and subsequently at amortised cost. IFRS 9 Financial Instruments was applied from 1 April 2018 onwards.

The following tables are a categorisation of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities:

Carrying values of financial assets:	Notes	Group		Trust	
		Held at amortised cost	Total book value	Held at amortised cost	Total book value
		£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2020 under IFRS 9					
Trade and other receivables excluding non financial assets - non current	1	8,961	8,961	8,961	8,961
Trade and other receivables excluding non financial assets - current	1	96,391	96,391	102,360	102,360
Cash and cash equivalents	1	60,970	60,970	58,295	58,295
As at 31 March 2020		166,322	166,322	169,616	169,616

		Group		Trust	
	Notes	Loans and receivables cost	Total book value	Held at amortised cost	Total book value
		£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9					
Trade and other receivables excluding non financial assets - non current	1	8,366	8,366	8,366	8,366
Trade and other receivables excluding non financial assets - current	1	89,243	89,243	85,980	85,980
Cash and cash equivalents	1	62,941	62,941	61,938	61,938
As at 31 March 2019		160,550	160,550	156,284	156,284

Carrying values of financial liabilities:

		Group		Trust	
	Notes	Held at amortised cost	Total book value	Held at amortised cost	Total book value
		£000	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2020 under IFRS 9					
Loans from the DHSC	2	34,740	34,740	34,740	34,740
Obligations under finance leases	2	1,220	1,220	1,220	1,220
Obligations under PFI service concession contracts	2	461,217	461,217	461,217	461,217
Trade and other payables excluding non financial liabilities	1	236,642	236,642	233,715	233,715
Provisions under contract	1	6,697	6,697	6,417	6,417
As at 31 March 2020		740,516	740,516	737,309	737,309

		Group		Trust	
	Notes	Held at amortised cost	Total book value	Held at amortised cost	Total book value
		£000	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9					
Loans from the DHSC	2	34,869	34,869	34,869	34,869
Obligations under finance leases	2	1,437	1,437	1,437	1,437
Obligations under PFI service concession contracts	2	473,928	473,928	473,928	473,928
Trade and other payables excluding non financial liabilities	1	226,793	226,793	224,176	224,176
Provisions under contract	1	4,945	4,945	4,672	4,672
As at 31 March 2019		741,972	741,972	739,082	739,082

The fair value on all these financial assets and financial liabilities equates to their carrying value.

Maturity of financial liabilities

	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£000	£000	**£000**	£000
In one year or less	**289,514**	242,939	**286,587**	240,322
In more than one year but not more than two years	**14,489**	21,026	**14,489**	21,026
In more than two years but not more than five years	**42,693**	68,523	**42,693**	68,523
In more than five years	**393,820**	409,484	**393,540**	409,211
	740,516	741,972	**737,309**	739,082

(1) Fair values of cash, trade receivables, trade payables and provisions under contract are assumed to approximate to cost due to the short-term maturity of the instruments.

(2) Fair values of borrowings - DHSC loans, finances leases and private finance initiative contracts, are carried at amortised cost. Fair values are estimated by discounting expected future contractual cash flows using interest rates implicit in the contracts. The maturity profile of both finance lease and private finance initiative contract liabilities are disclosed in notes 26 and 27.1 to the financial statements on page LIV.

The financial assets and financial liabilities of cash and cash equivalents, finance leases and private finance initiative contracts all equate to the amounts disclosed on the statement of financial position and supporting notes to the financial statements. Trade receivables, trade payables and provisions include non-financial assets and liabilities not disclosed in the table above. The reconciling amounts are as follows:

- Trade receivables includes prepayments which are not a financial instrument, see note 20 to the financial statements on page L.
- Trade payables includes receipts in advance and PDC payable which are not financial instruments, see note 22 to the financial statements on page LII.
- Provisions includes liabilities incurred under legislation, rather than by contract - early retirements due to ill health or injury. These are not considered by HM Treasury to fit the definition of a financial instrument, see note 28 to the financial statements on page LVII.

Risk management policies

The Trust's activities expose it to a variety of financial risks, though due to their nature the degree of the exposure to financial risk is substantially reduced in comparison to that faced by business entities. The financial risks are mainly credit and inflation risk, with limited exposure to market risks (currency and interest rates) and to liquidity risk.

Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Investment Committee. The main responsibilities of the Trust's treasury operation are to:

- ensure adequate liquidity for the Trust;
- invest surplus cash; and
- manage the clearing bank operations of the Trust.

(i) Credit risk

As a consequence of the continuing service provider relationship that the Trust has with NHS Commissioners and the way those organisations are financed, the Trust is exposed to a degree of customer credit risk, but substantially less than that faced by business entities. In the current financial environment where NHS Commissioners must manage increasing healthcare demand and affordability within fixed budgets, the Trust regularly reviews the level of actual and contracted activity with the NHS Commissioners to ensure that any income at risk is discussed and resolved at a high level at the earliest opportunity available.

As a majority of the Trust's income comes from contracts with other public sector bodies, see note 2 to the financial statements on page XXX, there is reduced exposure to credit risk from

individuals and commercial entities. The maximum exposures to trade and other receivables as at the reporting date, are disclosed in note 20 to the financial statements on page L, including details of the amounts owing on the sale of surplus land. The Trust mitigates its exposure to credit risk through regular review of receivables due and by calculating a bad debt provision.

In accordance with the Trust's treasury policy, the Trust's cash is held in current accounts at UK banks only. There are no cash or cash equivalent investments held, the result being to minimise the counter party credit risk associated with holding cash at financial institutions.

(ii) Inflation risk
The Trust has exposure to annual price increases of medical supplies and services (pharmaceuticals, medical equipment and agency staff) arising from its core healthcare activities. The Trust mitigates this risk through, for example, transferring the risk to suppliers by contract tendering and negotiating fixed purchase costs (including prices set by nationally agreed frameworks across the NHS) or reducing external agency staff costs via operation of the Trust's own employee 'staff bank'.

The unitary payment of the new 'Queen Elizabeth Hospital Birmingham' private finance initiative contract is subject to change based on movements in the Retail Prices Index (RPI), as disclosed in note 27.1 to the financial statements on page LIV. For the reporting year the relevant RPI index was 285.0 (annualised rate of 2.48%) fixed at February 2020. The sensitivity of the Trust's retained surplus and taxpayers equity to changes in this RPI inflation rate are set out in the following table:

RPI sensitivity analysis	**Year Ended 31 March 2020**		Year Ended 31 March 2019	
	£000	**£000**	£000	£000
	+1.0%	**-1.0%**	+1.0%	-1.0%
Retained surplus/(deficit)	**(576)**	**576**	(586)	586
Taxpayers' equity	**(576)**	**576**	(586)	586

(iii) Market risk
The Trust has limited exposure to market risk for both interest rate and currency risk:

Currency risk - the Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations nor investments and all Trust cash is held in Sterling at UK banks: Barclays bank and the Government Banking Service 'GBS'. The Trust therefore has minimal exposure to currency rate fluctuations.

Interest rate risk - other than cash balances, the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. Cash balances at UK banks earn interest linked to the Bank of England base rate. The Trust therefore has minimal exposure to interest rate fluctuations.

(iv) Liquidity risk
The Trust's net operating costs are incurred under annual service agreements with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash or committed loan facilities to meet all its commitments when they fall due. This is regulated by the Trust's compliance with the 'Continuity of Services Risk Rating' system created by NHSI, the Independent Regulator of NHS Foundation Trusts. The Trust is not, therefore, exposed to significant liquidity risks.

(v) Capital management risk
The Trust's capital is 'Public Dividend Capital' (PDC) wholly owned and controlled by the Department of Health, there is no other equity. The 3.5% cost of capital - the 'PDC dividend' is disclosed in note 11 to the financial statements on page XXXIX. Therefore, the Trust does not manage its own capital. Liquidity risk and the funding of the Trust's activities are described above.

33 Third party assets

The Trust and Group held £7,616 of cash at the reporting date (31 March 2019: £10,570) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

34 Losses and Special Payments

	Year Ended 31 March 2000		Year Ended 31 March 2019	
	Number	**£000**	Number	£000
Losses				
Cash losses	**65**	**45**	15	2
Bad debts and claims abandoned	**412**	**730**	884	1,530
Damage to property and stores losses	**5**	**969**	31	731
	482	**1,744**	930	2,263
Special payments				
Ex gratia payments	**232**	**71**	245	243
	232	**71**	245	243
Total losses and special payments	**714**	**1,815**	1,175	2,506

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £300,000.

The Trust losses and special payments disclosed are the same as the Group, there have been no equivalent payments made by the subsidiaries.

These amounts are stated on an accruals basis but exclude any provisions for future losses.

NATIONAL HEALTH SERVICE ACT 2006

DECISION BY MONITOR IN RESPECT OF NHS FOUNDATION TRUSTS' ANNUAL REPORTS

Monitor, in exercise of powers conferred on it by paragraph 26 of schedule 7 to the National Health Service Act 2006, hereby decides that:

1. The annual report of each NHS foundation trust shall be in the form and provide such information as laid down in the annual reporting guidance for NHS foundation trusts within the *NHS Foundation Trust Annual Reporting Manual (FT ARM)* that is in force for the relevant financial year.

2. The annual report of each NHS foundation trust shall be submitted in accordance with the requirements specified in the FT ARM of equivalent document as to when such reports must be sent to Monitor.

3. The following sections contained in each annual report shall be signed and dated by the chief executive of the NHS foundation trust to which it relates:
   - The performance report
   - The accountability report
   - The remuneration report
   - The annual governance statement

Signed by authority of Monitor

Signed:

Name: **Amanda Pritchard (Chief Executive)**

Dated: April 2020

National Health Service Act 2006

Direction by Monitor, in Respect Of Foundation Trusts' Annual Reports and the Preparation Of Annual Reports

Monitor, with the approval of the Secretary of State, in exercise of powers conferred on it by paragraphs 24(1A) and 25(1) of schedule 7 to the National Health Service Act 2006 (the '2006 Act'), hereby gives the following Directions:

1. **Application and Interpretation**

(1) These Directions apply to NHS foundation trusts in England.
(2) In these Directions:
a. references to "the accounts" and to the "the annual accounts" refer to:
- for an NHS foundation trust in its first operating period since being authorised as an NHS foundation trust, the accounts of an NHS foundation trust for the period from point of licence until 31 March
- for an NHS foundation trust in its second or subsequent operating period following initial authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March
- for an NHS foundation trust in its final period of operation and which ceased to exist as an entity during the year, the accounts of an NHS foundation trust for the period from 1 April until the end of the reporting period

b. "the NHS foundation trust" means the NHS foundation trust in question.

2. **Form of accounts**

(1) The accounts submitted under paragraph 24(1) of Schedule 7 to the 2006 Act must comply with the requirements of the Department of Health Group Accounting Manual (DH GAM) in force for the relevant financial year.

3. **Annual accounts**

(1) The annual accounts submitted under paragraph 25 of schedule 7 to the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial period.
(2) The annual accounts shall follow the requirements as to form and content set out in chapter 1 of this manual and meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) in force for the relevant financial year.
(3) The annual accounts shall comply with the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) as in force for the relevant financial year.
(4) The Statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation trust.

4. **Statement of accounting officer's responsibilities**

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

5. **Annual accounts: Foreword to accounts**

(1) The foreword to the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

Signed by the authority of Monitor

Signed:

Name: **Amanda Pritchard (Chief Executive)**

Dated: January 2020