University Hospitals Birmingham
NHS Foundation Trust

Annual Report and Accounts 2020/21

This annual report covers the period 1 April 2020 to 31 March 2021

University Hospitals Birmingham NHS Foundation Trust
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Section 1

Annual Report 2020/21

This annual report covers the period 1 April 2020 to 31 March 2021

Operational 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 over the last 12 months. It needs to be considered in the context of its response to the coronavirus pandemic that has now spanned two annual reports.

Since Covid-19 was first identified in December 2019, it has been an extraordinary journey for University Hospitals Birmingham NHS Foundation Trust (UHB), the UK and the world at large.

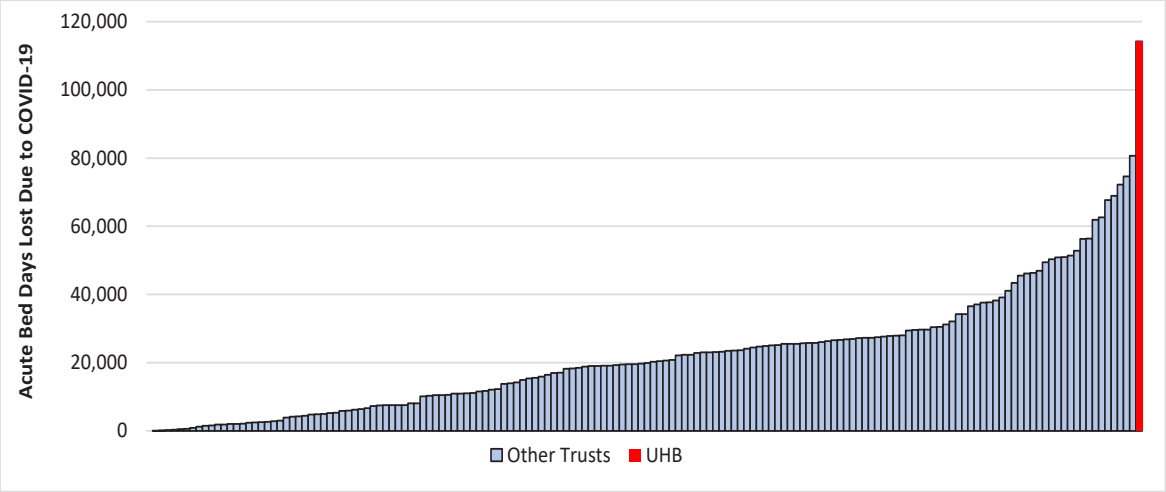
During this period UHB has faced unprecedented challenges, being the hardest-hit Trust in the country, treating over 14,000 covid-positive inpatients.

Despite the monumental efforts of its staff, 1,500 of whom were redeployed to help care for the sickest patients, the significant and enduring impact of Covid-19 on its hospitals has significantly impacted UHB's ability to provide routine care over the past year.

The table below shows the highest number that UHB recorded for a number of the key metrics over each of the waves.

		1st Wave	2nd Wave	3rd Wave
Daily inpatients Covid-19	Number	**708**	**469**	**1,067**
	Date	10 Apr 2020	24 Nov 2020	24 Jan 2021
Daily deaths Covid-19	Number	**37**	**16**	**27**
	Date	5 Apr 2020	7 Nov 2020	3 Feb 2021
Daily positives Covid-19	Number	**145**	**103**	**197**
	Date	31 Mar 2020	11 Nov 2020	18 Jan 2021
Total patients on ITU	Number	**171**	**133**	**211**
	Date	17 Apr 2020	26 Nov 2020	21 Jan 2021

When comparing the number of acute bed days lost to Covid-19 (table below) the impact on UHB was greater than any other Trust. The Trust lost 41% more bed days than the next most affected trust.



Despite the pressures, UHB has overcome many of these challenges, although its legacy will continue to present difficulties for some time to come yet and any future increase in cases will only exacerbate these.

NHS organisations in Birmingham and Solihull have agreed to work together, at pace, to reduce elective waiting lists and ensure that patients who need a procedure are seen as quickly as possible, in order of clinical need and urgency.

System-wide governance is in place to support this to ensure that theatres are operating at capacities that are in-line with our available resources, with single waiting lists and a clinical prioritisation process, and all patients on inpatient adult and paediatric waiting lists being reviewed and prioritised in order of clinical need.

Nightingale Hospital Birmingham

UHB was appointed as the host Trust for Nightingale Hospital Birmingham (NHB) in March 2020, at the start of the Covid-19 pandemic.

Nightingale Hospitals were established by NHSE&I as temporary, large-scale field hospitals, intended to treat or provide care for patients diagnosed with Covid-19. NHB, located at the NEC Birmingham, was the second Nightingale Hospital to be established in England; after a momentous effort from UHB colleagues, it was formally opened on 16 April 2020 by the Duke of Cambridge. NHB originally had a maximum capacity of 1,188 beds. The clinical model for NHB was a step down facility for patients recovering from Covid-19, or those not suitable for ventilation.

Whilst the first wave of the pandemic proved extremely challenging for the West Midlands region, thankfully there was sufficient hospital capacity to meet demand and NHB entered hibernation on 7 May 2020. During summer 2020, NHB capacity was reduced to 384 beds within a smaller footprint at the NEC. The facility remained on standby until the end of March 2021. It was subsequently decommissioned and handed back to the NEC on 12 April 2021.

Covid-19 vaccination programme

The Birmingham and Solihull Covid-19 vaccination service went live on 12 December 2020. The service is being delivered collaboratively across the Integrated Care System (ICS) through vaccination centres, hospital hubs and local vaccination services (GPs and community pharmacies). UHB has been designated lead provider for the system and has responsibility for vaccination centres and the hospital hubs located on UHB sites. To date, the programme has administered 1.3 million vaccinations.

Throughout the programme to date, responsive interventions have been taken to ensure that the vaccine is available in local communities that need it the most. Good practice examples of vaccination delivery include the roving vaccination model, which takes vaccine to where it is needed most e.g. the housebound, places of worship, the homeless and other vulnerable people. A pop-up vaccination service at Jaguar Land Rover in Solihull reached over 4,500 employees. The service has also led the development of multi-generational household vaccination, which was subsequently adopted nationally.

The programme is being supported by a robust and effective evidence-based communications and engagement approach, which has included deliverables to reach all external and internal audiences, including: a dedicated website; outdoor advertising; household leaflet drops; social media and digital messaging; and tailored communication and engagement for staff.

There has also been a system-wide focus on engagement and health inequalities, which has been facilitated by close partnership working. Several multi-agency initiatives have been implemented to increase uptake in seldom heard communities, communities where there is vaccine hesitancy, and areas where there have been repeated outbreaks, including on-going work with grass-roots organisations, such as food banks. There has been extensive and on-going engagement with community leaders, faith leaders, Covid Champions, third sector organisations and local people, using local GPs and clinical spokespeople. In addition, a series of five well attended locality-based public webinars were co-hosted with the local NHS and Birmingham City Council's Cabinet Member for Heath.

The Birmingham and Solihull Covid vaccination communications and engagement approach has been heralded as best practice nationally by NHSE&I, as well as the Government's Race Disparity Unit.

On behalf of the system, UHB's workforce team led on the recruitment of 4,600 staff, who were rapidly made roster-ready, with a focus on employing those individuals in Birmingham and Solihull who were furloughed or made redundant during the Covid pandemic. The programme has worked closely with St John Ambulance to incorporate volunteers within local vaccination

services and the vaccination centres, and has the highest uptake of St John Ambulance volunteers in the Midlands; the volunteers have proven to be valuable vaccination team members.

Whole system collaboration has been evident throughout the programme.

Mutual aid and collaborative working

The pandemic saw collaborative working in paediatrics across the ICS. During the first wave, the Children's Emergency Department was located on Ward 14 at Heartlands Hospital, to support the flow of adult emergency patients in main ED and allocate dedicated space for paediatric patients, in conjunction with an ambulance divert for paediatrics. In the second wave, a full paediatric divert for all ambulances was put in place from Heartlands and Good Hope hospitals, to Birmingham Children's Hospital (BCH), from December 2020 to support capacity for adult pathways at UHB. This included the paediatric wards being closed at UHB during January and February 2021, with children's inpatient care being clinically managed at BCH.

Birmingham Women's Hospital (BW) supported gynaecology elective surgery from November 2020 until March 2021, due to the closure of operating theatres in October 2020 at Good Hope Hospital, to support ITU staffing and the use of day surgery beds for medical emergencies.

Ambulatory and hand trauma activity was carried out at the Royal Orthopaedic Hospital (ROH), along with some non-ambulatory trauma during the first wave. In neurosurgery, revised spinal pathways were established; Birmingham Community Health Care FT and ROH partnered with the Trust to provide spinal theatre access and emergency triage. Cranial neurosurgery/oncology patients received support from hospitals in Stoke, Cambridge and Bristol.

During the height of the pandemic, the Trust was supported by numerous regional manufacturers including Jaguar Land Rover. The Trust also developed a Midlands PPE Collective with five regional manufacturers who supported the Trust in the manufacturer of surgical gowns and clear face masks. This created over 120 new jobs, deferring 200 staff from furlough.

In the last 12 months, UHB has supported over 111 mutual aid requests, providing over 3 million pieces of PPE to 40 separate organisations that included hospices, care homes, GP practices, dental services and homeless shelters (including soup kitchens). A further 500,000 pieces of PPE that were unable to be used within a hospital setting were provided to schools and other third sector organisations, to support the continuation of their services.

1.1 Context: University Hospitals Birmingham NHS Foundation Trust (UHB)

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 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 – most recently being asked to form an Improvement Alliance with Shrewsbury and Telford NHS Trust.

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

The Queen Elizabeth Hospital Birmingham, Birmingham Chest Clinic, Heartlands Hospital, Good Hope Hospital and Solihull Hospital are part of UHB along with various community services across the region. UHB treats more patients than any other Trust in England and employs more than 20,000 members of staff.

The Trust runs Umbrella, the sexual health service for Birmingham and Solihull, and has regional centres for trauma, burns, plastics, neurosciences, dermatology, cystic fibrosis, and cancer. It also has centres of excellence for vascular, bariatric and pathology services, and expertise in premature baby care, bone marrow transplants and thoracic surgery.

One in seven babies born in the UK are admitted to neonatal care in the UK and of the 10,000 babies born at our hospitals each year, over 1,000 of these babies are cared for in the units at Good Hope and Heartlands Hospitals.

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 is the lead organisation for two Health Data Research Hubs as well as the NHS lead for five National Institute for Health Research centres.

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.

The Trust is a Stonewall Diversity Champion and aims to create an inclusive, inspiring and equal environment for staff and service users.

1.2 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 postgraduate medical training and fellowship programmes with international partners
- Developing opportunities to share its expertise in new hospital developments overseas
- Exploring the potential of providing education with international partners

The Trust has taken the decision to close down its work in relation to healthcare improvement and development programmes in China, and accordingly has decided to cease Innovating Global Health China Limited, a Hong Kong registered company established as a Joint Venture between the Trust and Innovating Global Health SA (IGH).

1.3 Royal Centre for Defence Medicine

UHB 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 within the Joint Hospital Group (JHG). JHG's role is to provide highly capable secondary healthcare personnel for operations and deliver the patient pathway. JHG sits under the command of Director Medical Personnel and Training, part of Defence Medical Services.

RCDM is made up of approximately 425 uniformed personnel embedded with 18 separate NHS Host Trusts or Health Boards across the UK. The majority of personnel (approximately 300) fulfil a clinical role within the QEHB, with an additional 60 personnel providing command and support functions for the unit, military patients and their families.

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 most appropriate ward for their recovery. Families can also stay on-site 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 military patients and their families admitted from operations. This 'military patient group' concept is necessary for the wellbeing of the operational casualty and is an integral part of the moral component of fighting power.

1.4 Integrated Care System (ICS)

As part of the NHS Long Term Plan (LTP), it was confirmed that all parts of England would be served by an Integrated Care System (ICS). The ICS builds on the lessons and achievements of the earlier work which was undertaken through the Sustainability and Transformation Partnership (STP).

UHB played an integral part in the Birmingham and Solihull (BSol) STP and continues to play an integral role in the development of the BSol ICS. The ICS is a collaboration of Public NHS and Local Authority social care providers working in partnership to meet the health and care needs across BSol, to co-ordinate services, and to plan in a way that improves the health of the population and reduces inequalities between different groups.

The BSol ICS vision is to help everyone in Birmingham and Solihull to live the happiest and healthiest lives possible and a number of delivery priorities have been identified with an associated development plan. As part of the ICS, UHB has been engaged with the development of a provider collaborative with other NHS organisations within BSol.

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 2020/21 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 2021 and appropriate to NHS foundation trusts.

There have been no changes to accounting standards during 2020/21 that have had a material impact upon the Trust's Financial Statements. Due to the Covid-19 pandemic, HM Treasury postponed until 1 April 2022 the implementation of IFRS 16 'Leases' across the Department of Health accounting boundary.

The government response to the pandemic has created unique entries in the 2020/21 financial statements, including those of the Birmingham Nightingale facility, the Birmingham and Solihull vaccination programme and supplies of consumables and equipment from central DHSC inventories, in addition to funding specific for the pandemic's consequences. All these give rise to new accounting disclosures which are detailed in the financial statements.

2.2 Financial performance

The Trust's total annual revenue increased to £2,050.5 million (from £1,758.4 million in 2019/20), with this increase predominantly driven by the response to the Covid-19 pandemic. The DHSC and NHSI&E changed the funding regime of NHS Providers at the start of the financial year by replacing the activity pricing (tariff) mechanism with a block contract to ensure the continued provision of healthcare services, as elective activity decreased and Covid-19 emergencies increased substantially. During the financial year, this funding mechanism was adjusted and added to by specific new funding streams:

- Funding specifically to cover the costs of the Birmingham Nightingale Hospital, via NHSE
- Funding specifically to cover the costs of the Birmingham and Solihull vaccination programme, via NHSE
- Funding flows to cover both lost sources of other revenue and increased Covid-19 pandemic related expenditure. During the first half of the financial year, NHSE funded top-up revenue, during the second half of the year this was managed through NHS Birmingham and Solihull Clinical Commissioning Group (CCG)

Like many NHS acute service providers, the Trust's 2020/21 financial position is a small surplus (as a percentage of turnover), supported by the above mentioned Covid-19 pandemic related funding regime. The Trust delivered an overall retained surplus of £13.7m which is 0.7% of total revenue. The NHSI adjusted control surplus is £12.8m; this is after taking into account the following exclusions that are made removing the £8.8m of estates impairments, (£6.1m) of donated asset adjustments and (£3.6m) representing the net impact of DHSC centrally procured inventories.

The £8.8m 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 is the actual income and expenditure position for 2020/21, with an additional disclosure of how the NHSI adjusted control surplus of £12.7m is derived.

Summary income and expenditure – plan v. outturn

Consolidated Summarised Income and Expenditure - Group	YTD Plan Mar 21 £m	YTD Actual Mar 21 £m	YTD Variance Mar 21 £m
Operating income from patient care activities	1,641.7	1,709.7	68.0
Other operating income	261.1	340.8	79.7
Employee expenses	(1,064.5)	(1,126.8)	(62.3)
Operating expenses excluding employee expenses	(831.8)	(886.2)	(54.4)
Operating surplus	**6.5**	**37.5**	**31.0**
Finance costs			
Finance income	0.3	0.0	(0.3)
Finance expense	(23.7)	(23.7)	0.0
PDC dividend expense	(3.6)	0.0	3.6
Net finance costs	**(27.0)**	**(23.7)**	**3.3**
Other gains/(losses) including disposal of assets	0.0	0.0	0.0
Corporation tax expense	(0.2)	(0.1)	0.1
Surplus for the year	(20.7)	13.7	34.4
Adjusted financial performance			
Surplus for the year	(20.7)	13.7	34.4
Add back impairments	0.0	8.8	8.8
Remove capital donations impact	0.2	(6.1)	(6.3)
Remove net impact of DHSC donated PPE	0.0	(3.6)	(3.6)
Adjusted financial performance	(20.5)	12.8	33.3

The largest component of the Trust's income comes from the provision of NHS patient care services funded by NHS commissioners in England. This accounted for £1,694.5m (82.6%) of total income. This figure includes £70.6m of funding from NHS Birmingham and Solihull CCG, received in the second half of the year directly due to the Covid-19 pandemic and in addition to the block contract. Other patient care revenues contributed a further £15.2m (0.7%), 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 met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

The Trust has a range of income streams which are not linked directly to patient care. These include education levies, which account for £59.2m (2.9%) 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 £24.8m (1.2% of total income). This includes grants from the National Institute of Healthcare Research (NIHR) to support for the Wellcome Trust Clinical Research Facility and other research infrastructure.

As highlighted above, the Top-Up Funding (additional funding covering the increased costs

and reduced revenues arising from the Covid-19 pandemic), totalled £174.9m during the year. All funding was received from NHSE, including £20.2m received in the first half of the year in addition to the block contract, £47.4m for the Birmingham Nightingale Hospital costs, £70.7m for Covid-19 direct costs and £4.7m for the on-going vaccination programme. The remainder is £9.8m for digital healthcare developments and £22.1m for other revenue sources lost to the pandemic in the second half of the year.

Within Trust expenditure, the largest category is salaries and wages totalling £1,127.1m (including Directors and Non-executive Directors) which is equivalent to 56.0% of total operating expenditure. Other significant components include £464.5m on drugs and clinical supplies (23.1%), estates and premises costs of £143.7m (7.1%) and depreciation and amortisation of £40.4m (2.0%).

2.4 Capital Expenditure Plan

During 2020/21, the Trust invested £89.1m of capital expenditure on medical equipment, ICT infrastructure and improvements to existing buildings:

TYPE	Actual £m
Medical equipment replacement	16.5
Estates and facilities works	11.9
ICT infrastructure	3.5
ICT GDE, HSLI schemes and cyber security (PDC)	3.2
ACAD (PDC)	15.3
QEHB PFI lifecycle	4.9
Critical infrastructure (PDC)	7.8
Pandemic: Emergency Departments, equipment and critical care beds (PDC)	12.5
Diagnostic and endoscopy (PDC)	3.1
Grants and charitable	2.1
Equipment supplied free via DHSC for the Covid-19 pandemic	6.1
Subsidiaries	0.5
ICT workforce records (PDC)	1.7
TOTAL	**89.1**

This investment was £14.9m above the original planned capital programme for the year, predominantly as a result of Covid-19 pandemic related requirements to estates, equipment and IT. Those schemes funded by public dividend capital (PDC) are noted, including the requirements of the pandemic. Additional equipment was distributed for free directly to providers from the Department of Health and Social Care (DHSC) due to the nature of the emergency.

Planned capital investment for 2021/22 is currently estimated at £113.3 million and includes plans for:

- Proactive replacement of medical equipment - £6.2m
- On-going investment into IT infrastructure - £5.8m
- Statutory maintenance works within Trust buildings - £11.1m
- Major medical equipment - £9.0m
- Contracted lifecycle works within the Queen Elizabeth Hospital Birmingham - £4.9m
- Salix (grant funded) de-carbonisation (reduced emissions) works on the estate - £14.4m
- Ambulatory Care and Diagnostics (ACAD) Centre building at the Heartlands Hospital site - £61.3m (PDC)

2.5 Value for Money

During the financial year the revised NHS funding regime, due to the pandemic, did not require any formal cost improvement programme.

Value for Money (VFM) requirements: the work of the external auditor includes consideration of the arrangements that the Trust has made securing financial resilience and economy, efficiency and effectiveness in its use of resources. This forms part of the audit opinion and is the subject of a separate detailed VFM auditor report.

The auditors have not identified any risks of significant weakness in arrangements to secure economy, efficiency and effectiveness in the use of resources. There are no matters reported by exception in the external auditors' opinion.

2.6 Covid-19 Pandemic

During the financial year, the NHS response to the Covid-19 pandemic directed the financing regime in support of the costs incurred, as noted above, including the additional Nightingale and vaccination programmes. The Trust was fully funded for the 2020/21 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 2020/21, the Trust received grants of £2.1m and donated assets worth £1.2m from the UHB Charity.

2.8 External Auditor

The Trust's external auditor is Deloitte LLP; the audit cost for the year was £249,600 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 £90,000 for the Trust's local counter fraud work.

The appointment of external audit services for 2020/21 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 2021 and appropriate to NHS Foundation Trusts.

2.10 Going Concern

During the reporting year and due to the Covid-19 pandemic, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSE&I) announced reforms to the NHS cash regime that will continue into the 2021/22 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 new financial regime for NHS Providers. NHSE announced that during the reporting year contract income from commissioners was 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 was a retrospective top-up available to ensure providers were fully funded for increased expenditure or losses of other types of income as a result of Covid-19. This includes the running costs of the on-going Vaccination Programme for Birmingham and Solihull which continues into 2021/22.

The DHSC and NHSE&I announced in March 2021 that this agreed level of funding will continue into 2021/22 - for the first half of the new financial year and then to be reviewed again. This is detailed in their publication 'Supplementary guidance on H1 2021/22 finance and payments arrangements'.

There is not yet any formal guidance or detail as to what the financial regime might look like post September 2021, 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 2021/22 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.

3 Operational Performance

In 2020/21, the Trust, along with every healthcare provider, was massively impacted by the Coronavirus (Covid-19) outbreak.

As part of the Trust's response to the Covid-19 pandemic, the Trust needed to significantly reduce its activity, including suspending elective surgery and some cancer surgery, for extended periods when there were high numbers of patients admitted with Covid-19. Meanwhile, emergency performance continued to be affected by the necessary additional infection prevention and control (IPC) measures and the requirement for separate Covid-19 and non Covid-19 areas whilst diagnostic performance was also impacted by IPC and social distancing measures. This had an impact on the Trust's performance against the national targets and indicators of the NHS Oversight Framework, including the A&E four hour target, 18 week Referred To Treatment (RTT), six week diagnostic and cancer targets.

As the Trust implements its plans to reduce the backlog, including implementing the actions set out by NHS England and Improvement (NHSE&I), the focus remains on treating patients dependent on their clinical urgency, according to guidance from the Federation of Specialty Surgical Associations, as endorsed by NHSE&I. The Trust monitors its response against current guidance available from NHSE&I at all times.

Due to these and numerous other contingencies, measuring performance against key health care targets for the 2020/21 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 be 'building healthier lives' with the aim of both providing high quality care for the patients who come through our doors because that remains part of our core purpose and we will be increasingly concerned with the mental and physical health of our population before and after they come through our doors.

To support the implementation of these objectives, the Trust Strategy sets 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 ICS.

At the joint meeting of the Board of Directors and Council of Governors in December 2020, a draft of the plan for 2021/22 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 which have been brought together in the 2020/21 Strategy Implementation Plan which was approved by the joint meeting of the Board of Directors and Council of Governors in March 2021.

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 cyber security
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. This will include 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 brought forward to mitigate the effects.

Principal Risks

The key risks on the BAF at the end of March 2021 were:

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

Additional information is set out in the Annual Governance Statement on pages 79-86

3.2 Policies in relation to disabled employees and equal opportunities

Over the past 12 months, there has been a renewed focus on intolerance, racism, discrimination and the associated harassment and violence which persists, in this country and globally.

Situations like these compel us to reflect on our individual and collective responsibilities to stand united against racism and, indeed, all forms of discrimination.

UHB has and continues to be committed to stamping out all forms of discrimination.

The Trust will work as an organisation to pro-actively deliver equality for all, to ensure that all staff, patients and their families are treated in a more equal and equitable way.

We will use our voice, lived experiences and the documented data available, to drive our actions in reducing inequality, both within our Trust and across the new Integrated Care System (ICS), and affect cultural and structural change.

We know inequality can stem from a wide range of social, cultural, economic and physical circumstances. And we know from the many readily available sources that there remains a consistent evidence base of variation and unwarranted disparity for individuals - many from an ethnic minority background.

This is understood as a Board and our Chief Executive has chosen, personally, to lead this agenda. The Trust is initially focussing on supporting those of our workforce from underrepresented groups. But we recognise that if we get this right, it will help us to reduce the health inequalities for our patients and their families:

- The Chief Executive has established a Fairness Taskforce. It is chaired by him and comprises representation from our staff networks, senior managers, executive directors and the Trust's dedicated inclusion team, as well as those passionate about stamping out discrimination
- We have held and will continue to hold listening events, to ensure the voices of staff are heard
- We have launched a Reciprocal Mentoring (mentoring that works both ways) Programme to enable us to have honest conversations about our lived experiences and those of our colleagues
- We have started a Root Cause Analysis process, based on that used in clinical quality management for many years, to learn from fairness issues
- We have increased the ways in which colleagues can speak out
- We have increased the diversity at senior levels within our organisation, through improved recruitment, retention and progression. But there is much more to do

We will now start to focus on these actions, with other initiatives to follow:

- Senior leaders will use their voice to drive change
- We will ensure we drive our agenda of stamping out discrimination in the Trust by improving co-production with our underrepresented staff groups and patient populations
- We will use the Workforce Race Equality Standard, the Workforce Disability Equality Standard, the NHS Staff Survey measures for our organisation, and other local assessments as key public measures of our progress
- We will strive for a better understanding of the systems and structures that we work in and the way in which they may perpetuate discrimination to the disadvantage of the population we serve
- We will support our staff to speak out and engage as active citizens on issues that they care about around discrimination

Disabled employees

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. For staff that become disabled whilst in employment, they 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, the Business Disability Forum and the Disability Confident Scheme for specialist advice to enable disabled staff to continue working at the Trust where possible.

The Trust ensures that reasonable adjustments are made so that staff with disabilities can access all training opportunities. When booking onto 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 British Sigh Language (BSL) interpreters.

A number of courses are also provided which focus on equality, diversity and inclusion, disability awareness training, equality impact assessment training, cultural awareness workshops, recruitment and selection. All new staff have

inclusion training as part of their induction. In addition, a facility is provided for staff wishing to improve literacy and numeracy skills is provided by the Learning Hub at the Trust.

In 2020, the Trust submitted to the Workforce Disability Equality Standard (WDES): https://www.uhb.nhs.uk/Downloads/pdf/WorkforceDisabilityEqualityStandard2020.pdf and has committed to the following actions 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 Electronic Staff Records (ESR) in relation to staff with a disability. This is highlighted by the 17% of those staff who completed the 2019 National Staff Survey declaring they have a disability compared to 3% of staff on ESR.

The Trust aims to improve the declaration rates of staff with a disability on ESR from 3% 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 involves 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 has been forging 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/83% 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 (33% disabled staff/22% non-disabled staff); the percentage of staff saying they are satisfied with the extent to which their organisation values their work (34% disabled staff /47% non-disabled staff).

A Task and Finish Group has been 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 has developed a portfolio of internal leadership programmes which are available to all staff and provide them with the knowledge, skills and confidence to advance in their careers. The Trust has also developed 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 Development of Disability Champions to support staff with a disability or long-term health condition

The inclusion team has worked in partnership with HR to upskill HR managers to be champions for disability, to act as points of contact for staff in relation to disability case work where the member of staff believes they may have experienced harassment, and that this may have been associated to their disability or long-term health condition.

Disability Confident Scheme

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 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 monthly online 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 Neuro Diversity so that the voices of those staff could be heard.

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. Members of 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 a result of Covid-19, this was paused in 2020, however plans are in place to continue this work in 2021.

As part of the inclusion strategy, the Trust continues to increase 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 email inbox for staff to confidentially get in touch with the inclusion team; continuation of the inclusion newsletter to share relevant information and celebrate the stories of our staff; growth of the inclusion team who will provide advice, advocacy and support, and establishment of the CEO Fairness Taskforce.

In December 2020, the Trust held its first online conference to celebrate people with a disability. The conference was open to all staff and heard from experts on living with a physical disability; living with Neuro Diversities; mental health awareness; plus staff shared their personal stories of living with a disability or long term health condition. The conference was 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
- Carers
- LGBTQ+
- Mental Health and Wellbeing
- Neuro Diversity
- Women's
- Young Person's

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 upskilling managers to facilitate conversations about race with BAME colleagues to support them to have their voices heard.
- We are working in partnership with our BSol ICS NHS Trusts to develop a BAME Leadership Programme to build capacity and pathways for senior leadership opportunities for BAME staff in Band 6 roles and above. We are also increasing diversity in leadership roles through the introduction of talent management initiatives, specifically for staff in under representated groups, such as disabled staff from minority groups
- In 2020, we established a BAME Action Steering Group to support BAME staff impacted by the Covid-19 pandemic, with advice and guidance on the disproportional numbers of BAME staff affected by Covid-19, risk assessments, and the vaccination programme
- We will develop an employee voice strategy that straddles disability, race equality and other protected characteristics, to cultivate inclusive relationships and respect for social justice through;
  - BAME Staff Survey – deep dive
  - Brand identity
  - Communications – inclusive messaging and images across Trust communication platforms
  - Cultural Ambassadors/Leads
  - Hearts & Minds – Conversations
  - Implementation plan/Divisional/networks
  - Leadership Lectures - Race Equality and Disability - Intersectionality
  - Senior managers' survey

In the 2020 Workforce Race Equality Standard WRES report: (https://www.uhb.nhs.uk/Downloads/pdf/WorkforceRaceEqualityStandardReport2020.pdf), we have seen a substantial development in the positive decrease in the number of BAME staff entering the disciplinary process. This reduction of 21.87% demonstrates a Trust-wide shift for 2020. This equates to 54 fewer disciplinary actions taken - 19 of these were BAME staff.

The 2020 WRES report shows that the average percentage of BAME staff per band is below the Trust representation and the demographics of Birmingham, (32.5% and 42.07% respectively). We have seen positive gains in BAME applicants wanting to work for the Trust, and application figures show that we are rated highly as an organisation, with consistently more BAME applicants than white applicants.

3.3 Social and Community Issues

The Healthcare Careers and Development Department is responsible for the promotion and delivery of programmes aimed at attracting members of our local community into NHS careers. Within our portfolio we manage:

- Apprenticeships – which include the development and promotion of entry level apprenticeships
- Work Experience – which includes liaising with local schools and further education organisations in the development and co-ordination of both virtual and physical work experience opportunities
- Employability Skills – which includes delivery of a range of programmes from both our Learning Hub facility on the Queen Elizabeth Hospital Birmingham site, and recently extending the offer to our Heartlands Hospital site to ensure our offer is equitable and inclusive to all community groups across the city.

Employability Updates

In March 2020, due to the Covid-19 pandemic, we were required to halt all classroom delivery with immediate effect. This meant that the clinical and non-clinical pathways and the fast track programme needed to be re-worked so that it would be fit-for-purpose and accessible to as many people as possible. Initially, classroom-based programmes changed to bite-sized virtual sessions delivered over a 12-week period via MS Teams. Enrolled clients received support for their health and wellbeing from a pastoral worker. This was essential during these unprecedented times.

In January 2021, the delivery team split into two teams with one based at Queen Elizabeth offering coverage to the south side of the city and the other working from the Heartlands site offering support to the east side (an area which has been highlighted as one of high disadvantage and deprivation). The offer remained as a virtual 12-week structured programme of support as well as continued work with the Prince's Trust in the delivery of 'Get Into Hospitals' and 'Get Started' programmes. Since the March 2020 lockdown, 140 "Young People and 134 "30+" clients have enrolled onto our programmes.

Engagement

In January 2021, an engagement team was set up to develop partnerships with external stakeholders such as Department of Working Pensions, Birmingham and Solihull local authorities, Anchor Network, local schools, further education organisations, training providers and community groups to promote NHS careers and provide entry pathways via the services and programmes we offer. Although in its infancy, we see this function as a priority in the year ahead.

3.4 Further reducing disadvantage

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 was put on hold in 2020 as a result of the Covid-19 pandemic with a view to restarting both food and clothing donations in 2021.

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

3.5 Modern Slavery and Human Trafficking

In May 2021, 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

Following the ratification of the Trust-wide Sustainable Development Management Plan, a sustainability group has been brought together which meet on a regular basis to monitor progress and identify new objectives and to ensure co-ordination across the Trust.

Key points supporting the Trust's Sustainability Plan are;

Energy
An Energy Performance Contract based at Birmingham Heartlands Hospital has been successfully tendered. Decarbonisation of the site has been a major target and a £14.1m grant to support the project has been successfully approved. This scheme, albeit a challenging one, has adopted the approach of totally de-steaming the site and introducing innovating technology that not only reduces the carbon footprint, but provides guaranteed savings.

Waste
The moving of clinical waste is being facilitated, which will ensure all waste is 100% recyclable, supporting the Trust's Decarbonisation Plan. More detail is provided in further sections of this repor.t

Environment
Air monitoring is currently taking place at the Queen Elizabeth and Heartlands sites.

Printing IT
A new print strategy is being finalised with a view to reducing printing.

3.7 Energy

Energy consumption across UHB remains similar to previous reporting years. QEHB continued to operate within the Department of Health and Social Care's energy efficiency upper limit, consuming 51.88 GJ/100m^3 against a target range of 35-55GJ/100m^3. Within the last 12 months an improvement has been made to the energy performance, however, two of the four sites still remain outside the efficiency target of 55-65 GJ/100 m^3.

The Trust is currently reviewing, with the energy performance contract provider, both the Solihull site and Good Hope site options that may benefit the Trust in achieving the efficiency target of 55-65 GJ/100 m^3.

The energy performance contracts within the Trust continue to be a major contributor for reduction of energy costs and providing efficient electric, heat and hot water.

3.8 The Trust's Carbon Footprint

UHB's future carbon reduction targets are aligned with NHS aspirations of net zero carbon (generally reported as a reduction in grams of carbon dioxide per kilowatt hour), of 80% reduction by 2028-2032 and net zero carbon emissions by 2040. The most significant drivers behind these carbon reductions have been the on-going decarbonisation of the national grid, in addition, the replacement energy performance contract at

Heartlands Hospital and the review of existing energy performance contracts, which will provide a significant means of moving towards the target of net zero carbon within the NHS, whilst continuing to provide guaranteed savings.

3.9 Waste Recycling

The Trust was awarded a contract for commercial waste services across all UHB sites designed to both enhance the existing recycling services in place and to develop and improve existing commercial and waste recycling services.

This service incorporates a fully integrated waste minimisation and recycling programme across all sites with an emphasis on zero waste to landfill as the key objective underpinning previous and current good practice.

For all UHB sites, the volume of recyclable waste has remained comparable with previous years. Final phases of installing mixed recycling across the main Queen Elizabeth Birmingham Hospital and the off-site locations has been completed in full further supporting the on-going promotion of waste recycling.

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.

3.10 Sustainable Transport

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.

Bus and train operators ran reduced services during the Covid-19 pandemic; this, compounded with staff choosing alternatives to public transport and the temporary suspension of staff parking charges, resulted in significantly more staff travelling to work by car. In addition the proportion of single occupancy car journeys increased accordingly.

There has been an increase of staff cycling to work throughout 2020/21. The Trust has responded by seeking options to provide additional secure cycle storage across UHB sites to accommodate this increased demand and encourage more staff to adopt this mode of transport.

3.11 Major Capital Developments

3.11.1 Ambulatory Care and Diagnostic Centre (ACAD)

ACAD is a £97.1m investment in construction of a new 18,000m² four-storey building that upon completion will provide first-class facilities at Heartlands Hospital.

It will be a 'one-stop shop' for diagnostics, providing capacity in a range of services including outpatients, ambulatory imaging, day surgery, endoscopy, therapies and others. The centre will have 120 consultation rooms, 26 specialist audiology and ear nose and throat rooms, ultrasound and X-ray rooms, as well as CT and MRI scanners.

Main construction started in March 2020 with the completion due to be completed in September 2022. The ACAD Project Team are working in collaboration with partners, Kier on construction of the new building and with Value Engineering on design reviews to ensure value for money and that the building remains fit for purpose for the delivery of patient care. The project has been procured through the P22 framework.

In-line with the Trust's sustainability agenda and NHS guidance, the proposed building design and construction is currently achieving the Building Research Establishment Environmental Assessment Method (BREEAM) of 'Excellent'.

3.11.2 Solihull Hospital

- High voltage and low voltage electrical switch gear has been replaced to ensure resilience in maintaining a power supply by utilising the building management system and providing alternative supplies in the event of power loss.
- Existing wards/areas of the hospital have been adapted in order to respond to the Covid-19 pandemic

3.11.3 Heartlands Hospital

- Forming part of the ACAD project, a new bulk oxygen provision will be installed. As a consequence of the Covid-19 pandemic, the Trust has increased the scope of these works so as to ensure that the site has a sufficient supply of oxygen along with an adequate flow in key areas of the site
- Installation of a new high voltage network and associated transformers, that not only support the ACAD project but, offer reliance to the whole site have been completed
- A new generator set to the Princess of Wales

Maternity Unit has been installed
- The Emergency Department has been adapted to support the Trust pressures during the Covid-19 pandemic
- The Trust's in-house team delivered extensive enabling works so as to ensure the ACAD construction programme start date was achieved
- Adaptation of common areas so as to ensure a safe environment for both patients and staff during the Covid-19 pandemic
- A new car park to support the loss of car parking as a consequence of the ACAD development has been completed

3.11.4 Good Hope Hospital

The refurbishment/adaptation of a new Midwifery Led Unit has now been completed.

The makeover of the Richard Salt Unit main entrance commenced in November 2020 and is on programme for completion in July 2021. The scheme includes;
- Replacement/construction of a new entrance to the unit with rotating doors and heat curtain
- Refurbishment and adaption of existing toilets to provide suitable disabled access and Changing Places facilities
- New coffee shop facilities
- New reception desk services
- New lighting
- Replacement ceilings and floor finishes
- Decorations throughout

An extension to the current Emergency Department will see a new Children's Emergency Department open in June 2021.

Work began in December 2020 and the new space will have eight treatment cubicles, a new reception space, as well as a quiet room and wellbeing room. There will be a dedicated children's waiting room and ambulance entrance.

The new area will facilitate a more efficient patient flow through the department and supports the Trust's Covid-19 pandemic recovery plans.

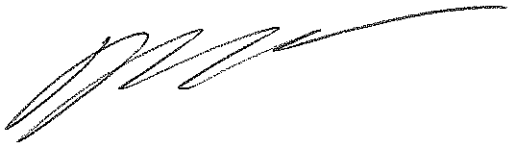
3.11.5 Queen Elizabeth Hospital Birmingham

A new Specialist Hospital Facility is being developed in collaboration with private healthcare provider HCA. The enabling works have been completed, including diverting major electrical and mechanical services and providing support to the developer through isolating services during the construction. Completion is programmed for September 2022.

Adaptation works in key areas were carried out to support the Trust during the Covid-19 pandemic:
- Significant refurbishment works of the Wellcome Theatre suite
- Modification to the existing oxygen infrastructure.
- Screening in common areas to ensure a safe environment

3.12 Procurement

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 on-going improvements to suppliers' sustainability performance and that of their supply chains; and
- Encouraging the appropriate uptake of sustainable products and services
- Furthermore, goods and services are reviewed at the Trust Sustainability Group to identify to identify new routes to source and/or utilise
- The Trust is also working with the BSol acute trusts, local Government and educational bodies regionally to create a sustainability tender questionnaire for all future procured projects



Dr David Rosser, Chief Executive
24 June 2021

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 so that they are 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 Operational 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	115,832	547,208
Total bills paid within target	113,258	541,724
Percentage of bills paid within target	97.8%	99.0%

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 and Social Care'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
- Deputy Chief Executive: Mike Sexton
- Chief Financial Officer: Julian Miller
- Chief Medical Officer: 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
- Dr Catriona McMahon
- Dr Jason Wouhra (until November 2020)
- Professor Michael Sheppard
- Professor Jon Glasby
- Jackie Hendley
- Karen Kneller
- Mehrunnisa Lalani
- Debu Purkayastha (from December 2020)

1.10.1 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 Chief Nurse and include Governors within their membership. Plans are in place to implement Divisional Patient Experience Groups in 2021/22.

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. When safe to do so, 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. Such activity was not possible during 2020/21, however site-based PCCCs and Trust-wide user groups have met virtually in-line with the regular meeting schedule. Members have continued to contribute to Trust activity virtually, despite the restrictions imposed.

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 when safe to do so. 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. It should be noted that some local surveys were paused during the early part of the Covid-19 pandemic although were resumed when safe and appropriate, while ward visits remain paused.

All of our volunteers, PCCC 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.

1.10.2 Infection prevention and control

For the majority of the year the Trust has been adapting to the Covid-19 pandemic. As of the 6 April 2021, the Trust position had 13,688 total cases of Covid-19. UHB, as a trust, has seen the largest number of Covid-19 cases in the country. The Trust has tackled this challenge with novel ways of working and repurposing of staff groups. Multiple initiatives have been undertaken with key measures including increasing screening capacity within the main microbiology laboratories and decreased turnaround times for results achieved via the main microbiology laboratories within the Emergency Departments and Acute Medical Units on the different sites.

Whole genome sequencing of Covid-19 variants, in conjunction with the University of Birmingham, has enabled early identification of new variants of concern, clusters and transmission routes, facilitating interventions to prevent reoccurrence of transmission events.

UHB has led Birmingham and Solihull's response for the Covid-19 vaccination programme, one of the single most important interventions to protect the patients we serve. Multiple staff interventions have included education around PPE, provision of appropriate PPE ensuring staff can deliver patient care safely, as well as support for our staff health and well-being. Adequate PPE stock has been maintained throughout and support has been provided to other organisations. The Trust has implemented a strategic PPE group to manage all PPE issues and has created a novel FIT testing team, incorporating Healthcare Assistant roles within infection prevention and control to deliver FIT testing to our staff.

The Trust has employed Covid marshals to help staff and visitors understand the importance of PPE in the prevention of Covid-19 and reinforce Covid-19 safety measures in general.

Cleaning interventions to lower the environmental burden of Covid-19 has been implemented using new cleaning technologies such as UV for terminal cleans.

The Trust Health and Safety team have been pivotal in managing staff outbreaks, and all wards have had health and safety reviews to ensure staff and ward compliance with the national 'hands, face, space' campaign.

The Occupational Health team have managed all our Covid-19 positive staff and been integral in implementing our staff screening programmes and supported during Covid-19 outbreaks.

Numerous estates works have been undertaken across the sites, including increasing the number of side rooms within the Emergency Departments and optimising ventilation.

A host of informatics solutions, such as a Trust-wide dashboard and electronic systems within our Patient Information System have been put into place to help manage Covid-19 patients.

Leadership, assurance and accountability has been driven by the Chief Executive and cascaded down, through daily strategic and tactical meetings. All sites have appointed Senior Responsible Clinicians (Medical Consultants) and Senior Responsible Officers (Directors of Nursing) to manage the sites' Covid-19 response. Daily outbreak meetings have been held with reporting through daily sitreps to the strategic group, which has maintained oversight of the Covid-19 hospital onset cases with learning being shared across the Trust's usual governance processes. The Trust has been at the forefront of innovation and research into Covid-19 nationally, recruiting large proportions of its patients and staff in various national projects.

For the financial year 2020/21 UHB had two Trust apportioned MRSA bacteraemias, which is a decrease on the previous year. The decrease could be due to the multiple interventions put in place for Covid-19.

The annual objective for Clostridioides difficile infection (CDI) for 2020/21 at UHB is 250 Trust apportioned cases. For the financial year 2020/21, UHB has had 223 Trust apportioned cases of *C. difficile*. Antimicrobial stewardship remains the biggest challenge in *C. difficile* prevention. The Trust-wide Antimicrobial Stewardship Group has developed 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 Chief Nurse.

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

Moving quickly to address concerns raised by patients, relatives and carers at the beginning of the Covid-19 pandemic, a number of initiatives were implemented and have continued throughout the year:

- The 'Letters for Loved Ones' service was introduced to bridge the gap in communication between the patient and their friends/relatives or carers unable to visit. Immediately successful, this service has made a significant difference to all involved helping to maintain important connections. In 2020/21, 6,134 letters were delivered to patients at the bedside, some were for patients fighting for life in Critical Care, some were last messages to patients at the end of their life, and other letters were full of news from home and were a real morale boost to patients in hospital. Where patients were too ill or unable to read the letters themselves, hospital staff read them out to the patient
- Activity packs were produced to give patients something to do whilst in hospital and unable to receive visitors. The packs contained a variety of puzzles, jokes and colouring in pictures. The festive fun pack, in particular, was very well received. A festive newsletter also kept patients informed in relation to television and radio highlights, Christmas food menus, religious services and useful information during the festive period
- UHB Charities kindly funded a patient and carer activity box for each ward on all four sites (and off-site inpatient areas). The box contained a selection of crossword and word search books, mindfulness colouring books and pencil crayons as well as colourful postcards to enable patients to write a message home to their family
- UHB Charities also funded mobile phones and computer tablets to assist patients with keeping in touch with loved ones. In addition, the tablets gave access to a number of entertainment options, including TV and radio channels, social media and games
- Identification of carers at the bedside became challenging due to visiting restrictions and the Carer Co-ordinator service adapted accordingly. Initiatives have been built into the service model going forward
- Support provided to carers of long-term or frequently admitted patients has significantly increased. Carer Co-ordinator input has not only reduced pressure on clinical staff but has also provided consistent, accessible support for carers, particularly in areas such as Critical Care

- Feedback received from an anxious patient about an experience in Nuclear Medicine prompted a walk-through of the department by the Patient Experience Manager and Senior Department Manager. The leaflet sent out to patients prior to attendance is being updated to include clearer advice regarding what to do if the patient feels anxious about their procedure
- A patient activity box was provided to enhance experience/reduce anxiety whilst waiting (around two hours) for dye to circulate around their system
- Camomile teabags were ordered to enhance refreshment provision in the waiting area. Staff awareness has been raised around supporting patients with additional needs relating to anxiety; and some minor changes made to the process in the procedure room
- National Cancer Patient Experience Survey results showed that not all patients were offered a care plan. As part of a National Cancer Collaborative project (focusing specifically on post surgical prostate cancer patients), this is being addressed by the development and implementation of a personalised care plan. Once finalised, this will be replicated across other prostate cancer treatment modalities and then other cancer sites
- A relative communication tool was developed for all Good Hope Hospital Acute Medical Unit (AMU) staff to document conversations with relatives. This was included in every patient's notes. Patients with the communication document in their notes increased the amount of documented communication per day by 300%.
- To reduce the amount of lost patient property, a Heartlands Hospital ward included property indemnity forms in the ward admission pack and commenced a weekly audit of patients' valuables. The Heartlands Emergency Department (ED) has also placed notices around the department regarding the safekeeping of patient property. New recording systems have been put in place to keep track of patient property and to ensure that items are returned to patients when they are discharged
- Feedback highlighted differences in consistency of information provided on a postnatal ward prior to new mothers' discharge home. A postnatal information video has been produced that all women view prior to going home. This ensures that all women are given the same level of information, in the same way and reduces any miscommunication issues from staff
- Following a delayed discharge in maternity services, a designated 'Discharge Midwife' is now allocated during night shifts who is responsible for ensuring any discharges are addressed immediately at the start of the shift. This Midwife will not be allocated any other workload until women are discharged home

1.11 Public and Patient Involvement

1.11.1 Patient, Carer and Community Councils (PCCCs)

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.

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.

Due to the Covid-19 pandemic, meetings with PCCC members and members of the Young Persons' Council were initially ceased, but were subsequently restarted via a virtual platform.

Unfortunately, due to the Covid-19 pandemic, members were not permitted on-site to carry out their usual ward visits in order to seek patients' views. As soon as visiting restrictions are lifted, members will recommence ward, outpatient and Saturday social visits in-line with a phased plan.

There are currently 104 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.

Council members have traditionally had 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. Due to the Covid-19 pandemic, PLACE and PLACE Lite visits did not take place during 2020.

The Trainee Nursing Associate programme continues to utilise the expertise of PCCC members, who are invited to provide regular advice and guidance to trainees on the programme, through regular meetings and discussions 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.

Some examples of specific changes as a result of the feedback from PCCC members are:

- Drop kerbs fitted at Solihull Hospital near the Renal Dialysis Unit following a concern raised by a member of the Solihull PCCC that their relative, who is a wheelchair user, had difficulty due to the absence of drop kerbs
- Laundry trollies being stored in a theatre area corridor – a new area to house the trollies was identified and shelving erected on which to put the laundry. This ensured the area was tidy and did not pose a fire hazard
- Members of the Solihull PCCC reported that the no-smoking signs at the north entrance of Solihull Hospital had faded which had resulted in people smoking in the area. The signs were re-painted

1.11.2 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 the Trust hospitals and for those transitioning to our hospitals. There are currently 29 young people who are members of the YPC.

Unfortunately, due to the Covid-19 pandemic, Saturday social meetings, provided through a scheme developed by the Young Persons' Council members where members visit our younger patients across the Trust, have not been undertaken during 2020/2021. Members will be able to recommence visits across the Trust once restrictions are lifted.

During 2020/2021, the Young Persons' Council have met virtually and are involved in the redevelopment of the Young Persons' Council information pages for the Trust's website. Members have also provided feedback on two patient information leaflets relating to keeping children safe in hospital during the Covid-19 pandemic, a leaflet relating to the paediatric swabbing process for Covid-19; a mystery patient leaflet for the Trust, and a recruitment video for children's services. Members of the YPC have also been involved in the analysis of feedback received from patients aged between 16-24 years following their in-patient stay at the Trust.

In addition, plans have been developed to run a series of virtual feedback sessions with young people who have been treated in specific services. The first of these sessions planned is with Emergency Department (ED)/trauma patients in conjunction with young people who were supported by the Redthread youth charity.

1.11.3 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 paused due to pressures on stakeholders due to the Covid-19 pandemic and the restrictions on face-to-face engagement.

Carers have been engaged with through other means; specifically through participation in the PCCC meetings and the Carers' Staff Network, all of which have met virtually during the last year.

The Carer Co-ordinators have participated in virtual networking and engagement events organised by external partners as well as the 'Carer Friendly Brum' Business Awards organised by Forward Carers.

1.11.4 Healthwatch Birmingham

Whilst on-site visits by Healthwatch could not be accommodated during 2020/21, the Trust maintains good relationships with Healthwatch in Birmingham, Solihull and South Staffordshire, with regular discussions throughout the year to ensure good partnership working to the benefit of our patients.

Enhancements to the Solihull phlebotomy service were implemented and monitored during 2020/21 following feedback provided by Healthwatch during the previous year.

Healthwatch Birmingham released a report about the healthcare experiences of the Somali community. The Trust has since had conversations with Healthwatch about repeating this piece of work to support the Trust's Task and Finish Group investigating ways of improving patients' health literacy.

1.11.5 Patient and Carer Consultations

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

- Healthcare Evaluation Data (HED) – Your Right to Choose
- Health Information Exchange
- DrDoctor digital system
- Digital transformation Breast Cancer patient pathway
- Patient Experience Strategy for 2021-2024
- Matron assessments (PCCC members were invited to sit on the interview panel for various Matron assessments throughout the year)
- Discharge process (Task and Finish Group)

- Covid-19: Visiting Monitoring Group (Task and Finish Group)
- Covid-19: Phased reintroduction of volunteering (PCCC and Patient Experience Group)
- NHSI Patient Experience Framework Self Assessment (Patient Experience Group)
- NICE Guidance Patient Experience in adult NHS Services: Improving the experience of care for people using adult NHS Services (CG138) (Patient Experience Group)
- Covid-19: Quality Impact Assessments and Equality Impact Assessments (Patient Experience Group)
- Ward communication with relatives/carers (Patient Experience Group)
- Transformation of the Breast Clinic (PCCC and Patient Experience Group)
- Phased reintroduction of visiting (Patient Experience Group)
- External food brought into hospital (Patient Experience Group and Visiting Monitoring Group)
- Birmingham Children's Partnership: UHB Youth Forum looking at services and support available to families within Birmingham (Young Persons' Council)
- Youth City Board: Birmingham City Council (Young Persons' Council)
- Feedback from the Demographic Task and Finish Group (Young Persons' Council)
- A total of 16 patient information leaflets were sent to members of the Readership Panel to review during 2020-2021

1.11.6 Volunteers from the local community

The number of volunteers at the Trust now stands at 1,291 registered volunteers across all four hospitals. Of these volunteers, 160 are currently active, 249 pending completion of recruitment or replacement, some in anticipation of the need to support all hospitals, including The Birmingham Nightingale and 882 are inactive due to the pandemic.

The demographic profile of our volunteers as at 31 March 2021 is:

Volunteer demographic profile	2019/20	2020/21
GENDER		
Male	29%	31%
Female	71%	69%
AGE		
16-17 years old	0.6%	0.5%
18-30 years old	11.0%	16.6%
31-50 years old	12.7%	14.3%
51-65 years old	18.8%	20.0%
66-74 years old	34.6%	27.0%
75+ years old	21.9%	20.5%
ETHNICITY		
White British	68.6%	70.9%
Asian / Asian mixed	11.3%	11.9%
Black / Black mixed	3.9%	4.3%
Other white	2.9%	5.5%
Other/undisclosed	13.1%	7.3%
EMPLOYMENT		
Employed	13.3%	18.7%
Unemployed	6.8%	6.0%
Student	4.0%	6.0%
Retired	35.1%	31.1%
Other/undisclosed	40.5%	37.9%
DISABILITY		
Disability		16.8%
Unemployed	6.8%	83.2%

Changes in the demographic profile of the volunteers are largely due to a focus on recruiting younger volunteers during the pandemic.

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

At the start of the pandemic, UHB voluntary services led a regional programme of volunteer recruitment to support all NHS organisations across Birmingham and Solihull, reporting to the Birmingham and Solihull STP. As the pandemic progressed and more information became available, the anticipated need for volunteers did not materialise as significant numbers of staff were temporarily redeployed to support front-line teams.

The voluntary services team did, however, set up a volunteer-led service to meet the needs of relatives delivering essential items to patients. 'Parcels for Patients' was launched on 8 June 2020 at Good Hope, Heartlands and Queen Elizabeth Hospitals, and up to 31 March 2021, in excess of 45,000 parcels had been delivered with the volunteers also offering support to the relatives who used the service. The service has been greatly appreciated by patients, relatives and staff, and has supported the Trust's objective of reducing footfall throughout the hospitals.

Voluntary services has supported the placement of volunteers under a Memorandum of Understanding between the Trust and St John Ambulance to assist the Emergency Departments in an enhanced volunteer role utilising the additional clinical skills these volunteers have.

During the second wave of infections and hospitalisations, the volunteer service collaborated with the chaplaincy service to safely recruit volunteers from the local faith communities to assist with the pastoral care of staff and patients.

1.12 Complaints and Compliments

UHB welcomes patients and families contacting the Trust where they have any concerns about our services to help us to learn and continuously improve. The number of complaints recorded in 2020/21 was 1,353, which represents a 24.6% decrease on the total number of complaints received in the previous year. This reflects periods where significantly reduced numbers of complaints were received due to the pandemic.

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.

The Trust's complaints team continues to develop regular reporting to Trust-wide and divisional groups. Additionally, regular reporting is provided to senior divisional colleagues, along with regular meetings, to ensure cases are being appropriately progressed.

Trust performance against its local challenging KPI of responding to 85% of complaints within the agreed target, based on complexity, has been under pressure for much of the year, reflecting the impact of the pandemic on colleagues' capacity to respond to complaints in a timely manner.

During the first wave of the pandemic, there was a national pause in the complaints process by NHS England, though this pause was not continued during the subsequent waves of pandemic activity. Consequently, agreement was reached at the end of January for all complaints to be placed on a 65 working days timeline for responding to help manage the expectations of patients and allow staff more time to respond.

Throughout the year, the Trust continued to receive, acknowledge, record and review cases received and resolve these in a timely manner where possible. The PALS office remained fully operational to deal with concerns as they arose. Record numbers of incoming calls were experienced by the PALS team at times during the last year, partly reflecting significant levels of contact from family members due to the impact of the pandemic related restrictions on visiting as well as due to cancelled activity.

We continuously monitor and seek to improve the complaints handling process. During the last year, a weekly Patient Relations compliance meeting has been initiated to review overall case activity, progress with individual cases and review current trends in new cases received. Additionally a Patient Relations Task and Finish Group was introduced to review and improve underlying processes, whilst also identifying ways of improving departmental staff's training and support. New initiatives in this respect have included supporting staff to complete an external complaints qualification, as well as training around mediation, safeguarding and mental health.

A rolling programme of complaints masterclasses has continued to be delivered across multidisciplinary teams, where pandemic related restrictions have allowed. Feedback from delegates has continued to be 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 2020/21, the Ombudsman upheld or partly upheld seven complaints, compared to eight in the previous year.

Positive feedback is also important in highlighting success and providing opportunities to replicate successful initiatives wherever possible. In 2020/21 the Trust formally recorded receipt of 1,667 compliments, compared to the 1,353 complaints received.

Below are a few examples of the compliments we receive:

Heartlands Hospital	"I would, on behalf of all of the family, wish to thank the doctors and staff who looked after our dad, granddad and husband. Held his hand, and reassured him when the family were not able to be there till he passed away. I'm sure he is one of many that the wonderful nursing staff had to comfort and we will be eternally grateful to you all. Thank you."
Good Hope Hospital	"I want to thank you all for the care you gave to my mum. You treated her with great care, compassion, dignity and respect. Everyone from the ward was fantastic."
Queen Elizabeth Hospital Birmingham	"Thank you very much for all the wonderful care I have received, for being so kind, friendly and supportive, and for being my home away from home these past few months. I will always be very grateful."
Solihull Hospital	"I would like to say a great big thank you for always going the extra mile to make me feel happy and comfortable. For making me smile when I was feeling down. For putting your own lives at risk to prolong mine. Words cannot express how grateful I am to each and every one of you. You really are all ANGELS. I hope that one day you are all rewarded with the kindness and goodness you have shown to me."

1.13 Research and Development

1.13.1 Infrastructure and Estate

The Research Development and Innovation estate spans all sites at UHB, providing facilities for patients and the Trust research staff generating, supporting and delivering a broad range of research and innovation activities. These facilities include the Medical Innovation Development and Research Unit (MIDRU), the Centre for Rare Diseases (CfRD), NIHR Clinical Research Facility (CRF) and the Institute of Translational Medicine (ITM).

The **Medical Innovation Development and Research Unit (MIDRU)** on the Heartlands Hospital site is a purpose-built research facility and is the main base for the research teams who work across the Heartlands site. The facility houses a clinical trials pharmacy and additional laboratory space to support the processing of research samples. The research focus is patient-centred research and late stage trials, both commercial and academic.

The **Centre for Rare Diseases** is a purpose-built outpatient facility supporting a range of specialities that provide highly specialist multi-disciplinary care to patients with rare diseases or rare syndromes. As with other Trust outpatient facilities, this area was affected by response to the Covid-19 pandemic, seeing a reduction in the number of outpatient appointments (down by 25%). CfRD put in place a mixture of virtual and face-to-face clinics to support patients.

CfRD has been able to restore clinic activity levels in tandem with staff returning from re-deployment. The Trust continues to engage with external bodies to leverage additional benefit for CfRD patients through collaborations and new funding for research into inherited disorders and innovative infrastructure growth.

In October 2020, the first person in the world to take part in a gene therapy study (commercially sponsored) for Phenylketonuria (PKU) was recruited at UHB. The PHEARLESS study aims to investigate how gene therapy could help people with PKU, a rare genetic disease that makes it difficult for individuals to break down enzymes.

In 2020/21, UHB was awarded NIHR funding to run a single patient CTIMP for use of the drug Miglustat in the ultra-rare metabolic disease, Tangier Disease in collaboration with Southampton and Oxford Universities. Data from this trial will directly inform NHSE's commissioning decisions for Miglustat.

The **NIHR Clinical Research Facility** supports experimental and early phase clinical trials. While the Covid-19 pandemic had an impact on the portfolio of work conducted in the CRF, the facility and its staff provided significant support to delivery of the broad portfolio of Covid-19 research trials, including vaccine studies during 2020/21. The NIHR funded the 'long covid' research study, Phosp-Covid, hosted at the NIHR CRF, achieving the highest recruitment numbers of any recruiting centre across the country in January and February 2021.

Overall, research appointment activity within the CRF increased by 44% with 861 research visits in total taking place.

The **Institute of Translational Medicine** hosts a broad range of externally funded research and innovation infrastructure and programmes. These include:

The **Midlands and Wales Advanced Therapy Treatment Centre** (MW-ATTC) is one of three national 'Innovate UK' funded centres with the goal of accelerating 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 MW-ATTC has been granted a 13-month extension of £3.2m to complete the original work as well as several new projects.

"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, cancer and diabetic ulcers. According to a report published in December 2020 by the Catapult, an umbrella organisation for the three advanced therapy treatment centres across the UK, the MW-ATTC hosted by UHB are currently delivering 33% of cell or gene therapy clinical trials in the UK, and 2% of cell and gene therapy trials across the world.

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. Supported by the Vocational Training Charitable Trust (VTCT), the centre received £1.5m funding from the Healing Foundation for five years. It also received £4.5m funding from other partner organisations.

The **Medical Devices Testing and Evaluation Centre (MD-TEC)**, supports accelerated translation of novel innovations in the laboratory through to the clinic and commercialisation. 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.

The **NIHR Trauma MIC (MedTech and In Vitro Diagnostic Co-operatives)** aims 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 offer patients the latest 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; with three projects granted funding.

The **NIHR Biomedical Research Centre (BRC)**. The BRC focusses on immune-mediated inflammatory diseases. There are three research themes: arthritis, gastroenterology and sarcopenia, and three cross cutting themes: diagnostics and biomarkers, entrepreneurship and commercialisation and trials design and delivery.

The centre drives discoveries in experimental medicine in order to reduce the time taken to translate scientific discoveries into clinical benefits for patients.

In-line with all NIHR infrastructure, the centre has received a pro-rata extension until November 2022 due to the Covid-19 pandemic.

The **NIHR BioResource** is at the heart of efforts to improve healthcare and the long-term prevention, diagnosis and treatment of disease. The Trust hosts one of 13 BioResource centres across the country. These actively contribute to national efforts to recruit patients into three areas (rare diseases, common diseases and healthy population).

The Trust has been awarded £1.1m to lead one of the common disease programmes - Non-Alcoholic Fatty Liver Disease (NAFLD). The NAFLD BioResource is co-ordinated by Chief Investigator Professor Philip Newsome, and is a partnership between the Birmingham, Nottingham and Newcastle Biomedical Research Centres. The project aims to recruit up to 7,500 patients across 80 recruiting sites to help catalyse future research.

UHB hosted the **West Midlands Genomic Medicine Centre (WM GMC)**, one of thirteen national centres in England, established to deliver the 100,000 Genomes Project. The WM GMC extension to contract ceased on the 31 March 2020 in anticipation of the creation of seven new NHS England/Improvement designated Genomic Medicine Service Alliances (GMSA). The provider selection process for the GMSAs was paused due to the emerging Covid-19 situation in March 2020, recommencing in August 2020.

UHB led a successful provider selection process for the Central and South (CAS) geography, and the **CAS Genomic Medicine Service Alliance (GMSA)** was confirmed as one of seven super-regional partnerships covering an area from the West Midlands, through Oxford and the Thames Valley to Southampton and the south coast and serving a population of around 12 million.

CAS GMSA received over £115,000 for Q4 20/21 infrastructure costs, and recurrent £1.2m infrastructure costs for three years.

NHS England supported nine of eleven business cases for 20/21 totalling over £213,000, with a further portfolio of business cases submitted in February 2021. This recent submission categorises a wide range of business case proposals into CAS GMSA prioritised projects, those that align to national priorities, and those that the GMSA would seek to leverage funds to support from alternative sources.

NHS England/Improvement has set seven national priorities, Lynch Syndrome, Monogenic Diabetes, Nursing and Midwifery, Sudden Cardiac Death, DPYD, Familial Hypercholesterolemia and Pathology.

Complementing these national priorities, the CAS GMSA has prioritised a Primary Care Development Programme, which prioritises equity of access and accessing poorly served groups by moving aspects of genetic diagnosis and care into the community. A somatic Cancer Development Programme utilises the Genomic Tumour Advisory Boards (GTABs). Negotiation on the provision of resources to support these programmes is ongoing with NHS England/Improvement and Health Education England.

1.13.2 Trials Activity

A team of lead research nurses and clinical managers oversee delivery of research across the Trust sites. A number of research delivery teams now operate their portfolios across UHB sites with combined portfolio and new study review process enabling research opportunities for patients regardless of where their standard care pathway takes place. During the last 12 months, this has been the key to successful recruitment into Covid-19 trials.

The Trust's Research, Development and Innovation portfolio was largely paused during the Covid-19 pandemic. The Trust followed the NIHR prioritisation scheme for trials, which was as follows:

1a. Covid-19 vaccine and prophylactic studies and platform therapeutic interventional trials (Recovery, Remap-CAP, Catalyst)

1b. Other Covid-19 urgent Public Health studies

2. Studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm, for example, studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient

3. All other studies

Level 3 studies closed during both waves of the pandemic, with all Level 1a and 1b and most Level 2 studies open.

Over the course of the Covid-19 pandemic, more than 17,000 patients at the Trust took part in Covid-19 research. Over 15,000 staff also took part in a range of Covid-19 studies.

The total number of UHB patients recruited into all studies open, (including Covid-19 and non-Covid-19 studies) at the Trust during 2020/21 was:

NIHR portfolio recruitment 01/04/2020 – 31/03/2021	12,908
Non-NIHR portfolio recruitment 01/04/2020 – 31/03/2021	2,151
Total patient recruitment 01/04/2020 – 31/03/2021	15,059

UHB's total recruitment, from March 2020 to date, combining patients, healthy volunteers and vaccine studies to Covid-19 only studies is 17,588.

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 sponsored by UHB. Eight of these 60 studies are Clinical Trials involving Investigational Medicinal Products (CTIMPs).

New research grant funding awards in 2020/21 numbered 37, a small increase from 34 in 2019/20. These awards include 20 NIHR funded trials, five charity funded, seven Research Council funded, three researcher led company funded studies, and two funded by the European Union Regional Development Fund (EDRF) and the Newton Fund respectively.

UHB's RD&I maintained non-Covid-19 grant activity whilst supporting NIHR/UKRI Covid-19 rapid response calls. Of the NIHR funded trials, three were NIHR-UKRI Covid-19 rapid responsive awards.

Five UHB-led studies received urgent Public Health status, including Recovery-Respiratory Support (Recovery-RS), REALIST and CATALYST. UHB was the highest recruiting site for the UHP Phase 2 platform trial, CATALYST.

1.13.3 Covid-19 Activity

In March 2020, during the Covid-19 pandemic, MDTEC, supported by the NIHR Trauma Med Tech Team, became the dedicated testing centre for the Government's National Ventilator Challenge. Over 50 prototypes of 12 different ventilators, CPAP systems and non-invasive ventilation systems underwent multiple rounds of safety and usability testing in the MDTEC Simulation Suite.

The testing was live-streamed to the company, providing instant feedback and recommendations to be included in the next iteration of the prototype. Formal written reports outlining findings and recommendations of the devices were also produced for the developers/manufacturers, Cabinet Office and Medicines Health and Regulatory Agency within 24 hours to support the accelerated development process.

This testing fed into the review process to decide which ventilators went into production for patient care. Through this process, the UK made over 11,000 mechanical invasive ventilators available in total for use, with capacity to increase this number in anticipation of a third wave of Covid-19.

The team's support of the challenge and the further national signposting from Cabinet Office has also resulted in new collaborations; a number of grant applications has been submitted and in progress continuing this work. For example, the Universities of Birmingham, Liverpool and Rio de Janeiro have collaborated and received UKRI funding to develop a high performance, low cost ventilator for use in low and middle-income countries where access to reliable power supplies and oxygen may be limited. The system will offer a web interface, accessible at local healthcare stations or via a mobile device to open up the potential for remote consulting and clinical training.

Following NIHR guidance stating that all research activity should pause to enable the delivery of Urgent Public Health Covid-19 studies, an immediate review of the research portfolio took place and activity paused where appropriate. Any research activity which delivered no other treatment options or where pausing the study would cause harm to patients was continued.

To enable a refocus of the entire RD&I portfolio, a workforce review took place. Research and Development employs 187 clinical and non-clinical delivery staff. Following the review, 19 staff shielded as per government guidelines, 110 redeployed to frontline clinical care, and 58 staff worked on the Covid-19 research portfolio.

Initially staff worked on two key studies, ISARIC and RECOVERY. ISARIC is an observational study, with the data shared with the Department of Health and Social Care to improve national and international knowledge about the disease. RECOVERY, a randomised evaluation of Covid-19 treatment therapies, quickly demonstrated the invaluable role of Dexamethasone in preventing mortality of Covid-19 patients, and introduced as the standard of care across the UK in June 2020. It also established the benefit of Tocilizumab in critically ill patients, which became a standard care treatment in January 2021.

The Covid-19 portfolio rapidly expanded and by the end of the first wave in June 2020, 23 studies were actively recruiting acute Covid-19 patients. Due to the urgent nature of the Covid-19 research, collaborative working across the Trust, sponsors and trial centres, ensured the safe opening of Covid-19 trials in a timely manner.

To date, 39 Covid-19 studies have opened, with 17,588 people taking part in Covid-19 research. This total includes UHB patients, healthy volunteers and participants in Covid-19 vaccine research. Many Covid-19 trials remain open, including studies looking at the effects of 'long Covid' and Covid immunology studies.

In May 2020, the expedited recruitment of healthy volunteers to the MHRA approved Oxford/AstraZeneca vaccine trial started. The success of this vaccine trial has led on to the delivery of four Covid-19 vaccine trials within the Clinical Research Facility, and has led to the development of a hugely successful vaccine rollout across the nation and world. To date, 921 healthy volunteers have participated in phase 1-3 vaccine trials at the Trust.

Despite the challenges of putting on hold a large, well-established, successful portfolio of research, the research teams significantly contributed to the treatment and prevention of Covid-19 whilst supporting clinical services. Staff demonstrated adaptability and resilience and developed new clinical skills during this time.

Following the second wave of the pandemic, where again many staff were redeployed to clinical service, we have now recommenced the recruitment into previously paused studies, whilst continuing recruitment to Covid-19 research trials.

1.13.4 Health Data Research (HDR) Activity

UHB supports an expanding portfolio of health data research infrastructure and activity. This includes:

HDR UK INSIGHT, led by UHB, in partnership with Moorfields Eye Hospital NHS Foundation Trust, the University of Birmingham, Action Against AMD, Roche, and Google. INSIGHT is a 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 data to enable discovery into systemic disease.

HDR UK PIONEER, is the health data research hub for Acute Care, led by the University of Birmingham and University Hospitals Birmingham NHS Foundation Trust, in partnership with West Midlands Ambulance Service (WMAS), the University of Warwick, and Insignia Medical Systems. PIONEER's core objective is to collect and curate acute care data from across the health economy, including primary, secondary, social care, and ambulance service data.

The datasets generated in 2020/21 by both INSIGHT and PIONEER and submitted to HDR UK for quality assessment received the highest rating possible.

DaRe2THINK
DaRe2THINK is a data-enabled randomised controlled trial that is fully embedded within NHS Primary Care in partnership with UHB, the University of Birmingham, and Clinical Practice Research Datalink (CPRD).

Through automatically screening over 10 million health records so that through the study, we can target site selection to maximise patient enrolment. The same system will enable automated 'no visit' follow-up, with e-consent, access to participants' electronic health records combined with patient reported outcomes via their personal electronic device.

This innovative trial design has the potential to completely change the clinical research landscape and is rightly being recognised as a leader in its field, including in the Department of Health and Social Care's Saving and Improving Lives: the future of UK Clinical Research Delivery.

DEMAND Hub
The Data-Enabled Medical technologies And Devices (DEMAND) Hub is a European Regional Development funded collaboration between the University of Birmingham and UHB. It offers a range of commercial services and support to small and medium sized enterprises (SMEs) and will run from July 2020 until June 2023.

DECOVID
DECOVID is funded through an EPSRC health data research collaboration between UHB, University College Hospital London, University of Birmingham, University College London, and the Alan Turing Institute.

This research was set up at pace in response to the Covid-19 pandemic to collect in-depth, longitudinal data from patients with a confirmed, suspected or at risk of a diagnosis of Covid-19. It comprises electronic health records for patients diagnosed with Covid-19, suspected of having or at risk of Covid-19, including for example data of: acuity, physiological bio-markers, prescriptions, and investigations. These electronic health records were drawn from UHB and University College London Hospitals NHS Foundation Trust (UCLH). Data from both the first and second wave of Covid-19 was analysed by cross-discipline/cross-institution clinical, health informatics, data science and analytics teams.

Understanding the journey of Covid-19 positive patients and those at risk of Covid-19, their disease burden and outcomes will provide critical insights into where we can change practice through research using health data.

Trauma MIC/MD-TEC data related projects/ grant applications

The Trauma MIC/MD-TEC team have supported an SME with their application to NIHR/NHSX AI in Health and Care funding scheme. They have developed a Smart Check application that confirms the safety checks in the operating room and alerts the perioperative team of any issues. Smart Check constitutes a combination of a digital application, physical sensors and a dashboard that can be displayed in the operating room. The digital application is aimed to be used by the perioperative team before surgery to enter patient-specific information. MIC and MD-TEC are advising on regulations and delivering human factors usability testing of the device/software.

In October 2020, the Trauma MIC/MD-TEC team successfully completed a VR controlled robotic arm case demonstration for Extend Robotics. To explore its potential use within the healthcare market a closed suction tracheal tube change was demonstrated. This is a high infection risk aerosol generating procedure in which removing the physical presence of a healthcare professional would be highly beneficial, particularly when treating patients with infectious respiratory diseases such as coronaviruses. Following this demonstration, a grant application was submitted to Innovate UK with partners across a diverse range of research/industrial areas to develop the technology further.

1.13.5 Research Highlights

- The NIHR SMRC published their findings into the use of diagnostic test for concussion. The results of the **SCRUM** (Study of Concussion in Rugby Union through MicroRNAs) study demonstrated for the first time that specific salivary biomarkers can be used to indicate if a player has been concussed. This new laboratory-based non-invasive salivary biological concussion test could have wide-reaching use and has the potential to reduce the risk of missing concussions not only in sport (from grassroots to professional levels), but also in wider settings such as military and healthcare. The publication attracted a great deal of media attention within the first week with more than 500 items of media coverage across the UK and Europe.

- A major study found that using a liver perfusion machine improved the function of donor livers that would have otherwise been rejected, with results showing that up to seven in every 10 could be used after just four to six hours of the assessment.

  The study, 'Transplantation of discarded livers following viability testing with normothermic machine perfusion', was published in Nature Communications in June 2020 and could have significant implications for the liver transplant waiting list and the commissioning of local transplant services.

- Patients could benefit from faster and more effective introduction of artificial intelligence (AI) innovations to diagnose and treat disease – thanks to the first international standards for reporting of clinical trials for AI.

  As evaluation of health interventions involving machine learning or other AI systems moves into clinical trials, an international group, led by Prof. Denniston at UHB, has developed guidelines aiming to improve the quality of these studies and ensure that they are reported transparently. These guidelines were published in Nature Medicine, British Medical Journal and Lancet Digital Health. The use of these international guidelines will enable patients, health care professionals and policy-makers to be more confident on whether an AI intervention is safe and effective. This is a key step towards trustworthy AI in health.

  Development of new reporting guidelines which expand on the current SPIRIT 2013 and CONSORT 2010 reporting frameworks will boost transparency and robustness for clinical trials evaluating AI health solutions.

  Future clinical trials evaluating an AI intervention will be expected - and often required - to report their publications to the new standards. The guidelines will also help medical professionals, regulators, funders and other decision-makers assess the quality of planned clinical trials and assess whether the algorithm is safe and likely to bring about patient benefit.

  Working with Health Data Research UK, UHB researchers also published analysis into datasets, and the risk of reinforcing healthcare inequalities if new AI health technologies are based on unrepresentative datasets – a situation described as 'health data poverty'. Dozens of datasets containing more than 500,000 clinical images were analysed, with results showing that most images coming from populations in Asia and Europe, with one in five datasets also missing basic demographic information such as age, sex and ethnicity.

- Covid-19 publication highlights include a study looking at differences in the occupational risk of exposure to the virus between hospital departments and job roles (https://thorax.bmj.com/content/75/12/1089); a study into NHS staff with Vitamin D deficiency, and the increased likelihood of developing severe Covid-19

Vitamin D deficiency potentially caused (https://erj.ersjournals.com/content/57/4/2004234). A study that looked at socioeconomic and other demographic factors that could explain differences in Covid-19 infection, severity and mortality (https://bmjopenrespres.bmj.com/content/7/1/e000644)

1.13.6 Building 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.

UHB has continued to grow the number of staff holding NIHR Senior Investigator designation. There was eight staff with NIHR Senior Investigator awards in 2020/2021. 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 Patient and Public Engagement

UHB and UoB have strong infrastructures and dedicated resources to support meaningful Patient and Public Involvement and Engagement in research (PPIE). UHB has a Trust lead for PPIE, hosts a number of patient groups, and adheres to the National Institute for Health Research's Standards for Involvement. UHB hosts several NIHR Research Centres including the Applied Research Collaboration West Midlands, Birmingham Biomedical Research Centre, Global Surgery Unit and Surgical Reconstruction and Microbiology Research Centre. Each NIHR Centre has its own PPIE Lead and is committed to patient and public involvement and engagement.

PPIE during Covid-19: Birmingham's Response: Research communities in Birmingham have responded to the rapidly changing needs and priorities of health and care services, adapting ways of working. Effective, creative, and timely collaboration between our NIHR Infrastructures in Birmingham has ensured that Covid-19 research projects have benefitted from the unique insights and perspectives of patients, carers and the public throughout the pandemic.

The Birmingham BRC and ARC WM public involvement communities worked together to support research from Public Health England, facilitated by the Health Research Authority, on a project evaluating home antibody tests for Covid-19. Thirteen public contributors reviewed and provided feedback on the research design and documents that would be given to participants in the study. PPIE Leads collated and sent feedback to PHE within 48 hours. PHE's Professor David Wyllie stated that feedback from public contributors was valued greatly and that the contributions, "turned something slightly viable into massively viable."

To ensure researchers are able to incorporate meaningful public involvement into projects, PPIE Leads from ARC WM and SRMRC set-up a Covid-19 Rapid Response PPI Panel. Twenty experienced public contributors from established public involvement/patient groups and networks in Birmingham were recruited to respond to fast developing Covid-19 projects and urgent funding calls. Panel members work virtually and PPIE Leads provided dedicated support to them.

The CATALYST Trial was a Birmingham-led trial to evaluate existing drugs for the treatment of Covid-19, with the hope of decreasing the number of patients requiring intensive care admission. Seventeen members of the SRMRC TrABC PPI Group, including patients/carers with experience of critical care, worked with researchers to provide a fast-track PPI review of the study. Contributors provided feedback on the study design (study recruitment), ethical considerations (patients in intensive care), and patient-facing documentation (accessibility/clarity of patient information sheets). Public contributors were supported throughout this 24-hour review by a PPIE Lead and researchers received valuable insights/feedback which shaped the project.

PPIE Leads in Birmingham have supported research teams on all aspects of PPIE during Covid-19 via regular online drop-in sessions. This has included providing advice, grant application support and signposting to resources to continue ensuring the public are involved throughout the research process.

The Global Surgery Community Engagement (CEI) and Involvement Lead collaborated with the NIHR to undertake a global health survey mapping CEI activity during Covid-19 highlighting challenges/solutions. Further CEI work has involved working with a patient advisory group to generate accessible patient information booklets. This project is part of CovidSurg - a global collaborative capturing real-world data on patients undergoing surgery during Covid-19.

During the pandemic, many research organisations contributed to the HRA's report "Public Involvement in a Pandemic". This identified gaps in many organisations strategy to involve patients in research and proposed means to bridge those gaps.

Across UHB, a number of Patient and Public Involvement groups support researchers to help 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 Hospital, 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 and GI Patient Involvement Reference Group.

1.15 Enhanced quality governance reporting

The Board of Directors takes direct responsibility for service quality. The Board receives regular reports regarding clinical quality and care quality. The Board of Directors has established a Committee for clinical quality 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 these requirements. 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 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 scheduled to resume in June 2021), and work is on-going 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 111.

2 Governance

2.1 NHS Foundation Trust Code of Governance

UHB 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 2020/21. 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 annually.

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 62, 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 56 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/patient 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 101 of the Annual Report. Details of terms of office of the Directors are set out in Board of Directors, page 61, 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 was extended by a further year to cover the period 2019/20. Following a formal tender in early 2021 and approval by the Council of Governors at the February meeting, Deloitte were re-appointed as external auditors for a period of three years with the option to extend by a further two 12 month periods up to a maximum contract term of five years.

The Trust's internal audit function is provided through a contract with an independent provider of internal audit services, KPMG LLP. Due to Covid-19, the contract with KPMG for the internal audit service was extended by a further year to cover 2020/21. A formal tender was conducted in early 2021 which resulted in the re-appointment of KPMG as internal auditors for an initial period of three years with the option to extend by a further two 12 month periods up to a maximum contract term of five years. 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 53.

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:

D.2.3 The Council of Governors should consult external professional advisers to market-test the remuneration levels of the Chair 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 2019/20 was benchmarked against other similar Trusts through information from NHS providers and Shelford Trusts. The Council of Governors' Nomination and Remuneration Committee further reviewed remuneration levels having regard to the latest guidance published by NHSI. Based on this assessment, the Committee recommended to the Council of Governors approval of the remuneration levels previously set in April 2019.

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
- Three public Governors elected from the Rest of England area (with two positions being vacant)
- Six staff Governors elected by the following staff groups:
  - Medical
  - Nursing (2)
  - Clinical Scientist and Professions Allied to Healthcare
  - Corporate and Support Services (2)
- Seven Stakeholder Governors appointed by seven of its key stakeholders

3.2 Governors

Elections for 10 Public Governors were held in September 2020, following a delay from June 2020 due to Covid-19. Governors elected at these elections were appointed commencing on 18 September 2020 until 30 June 2023.

During this year, the Governors have been:

3.2.1 Public (by Trust Constituency)

Birmingham Central
Ms Attiqa Khan (up to 17 September 2020)
Ms Aisha Abdul Latif (from 18 September 2020)

Birmingham East
Mr Keith Fielding (re-elected 17 September 2020 unopposed)

Birmingham Heartlands
Mr Gerry Moynihan (resigned 26/10/2020)
(Seat vacant until June 2021 elections)

Birmingham North
Mr Albert Fletcher (up to 17 September 2020)
Mr John Hope (from 18 September 2020)

Birmingham Reservoirs
Mr Adam Layland

Birmingham South
Mrs Bernadette Aucott (re-elected 17 September 2020)

Birmingham South East
Dr Elizabeth Hensel (re-elected 17 September 2020)

Birmingham South West
Mrs Sandra Haynes MBE

Birmingham West
Dr Elspeth Insch OBE

Lichfield, Northwest & Northeast
Mrs Phyl Higgins (up to 17 September 2020)
Mrs Deborah Porter (from 18 September 2020)

Quinton, Halesowen & Southwest
Mrs Maureen Haycock

Rest of England & Wales (3 seats)
Mrs Kath Bell
Mr Robert Jasper (from 18 September 2020)
Ms Veronica Kumeta (from 18 September 2020)

Solihull & Meriden (3 seats)
Mr Stan Baldwin
Dr Sue Balmer (up to 17 September 2020)
Mrs Anne Devrell (from 18 September 2020)
Ms Anne McGeever

Sutton Coldfield North
Mr Tony Cannon

Sutton Coldfield South
Ms Elizabeth Parry (re-elected 17 September 2020 unopposed)

Tamworth
Mr Derek Hoey

3.2.2 Staff

Medical and Dental
Dr Jattinder Khaira

Nursing and Midwifery (2 seats)
Ms Veronica Morgan
Ms Yvonne Murphy

Clinical Scientist & Allied Health Professional
Ms Jayne Robbie

Corporate & Support Services (2 seats)
Mr Richard Baker
Mr Lee Williams

3.2.3 Stakeholders

Birmingham City University
Prof Carol Doyle

Birmingham City Council
Cllr Jayne Francis

Faith Leaders
Rabbi Yossi Jacobs (up to 17 November 2020)
Amrick Singh Ubhi (from 18 November 2020)

RCDM
Colonel Timothy Steele

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 five meetings in total, including one joint meeting with the Board of Directors. The Chair (the Rt Hon Jacqui Smith) attended all meetings.

Name of Governor Public	No. of meetings attended out of five unless stated)
Mrs Bernadette Aucott	5
Mr Stan Baldwin	5
Dr Sue Balmer	2 out of 2
Mrs Kath Bell	5
Mr Tony Cannon	5
Mrs Anne Devrell	2 out of 3
Mr Keith Fielding	4
Mr Albert Fletcher	2 out of 2
Mrs Maureen Haycock	3
Mrs Sandra Haynes MBE	5
Dr Elizabeth Hensel	5

Name of Governor Public	No. of meetings attended out of five unless stated)
Mrs Phyl Higgins	2 out of 2
Mr Derek Hoey	5
Mr John Hope	3 out of 3
Dr Elspeth Insch OBE	5
Mr Robert Jasper	3 out of 3
Ms Attiqa Khan	0 out of 2
Ms Veronica Kumeta	1 out of 3
Ms Aisha Abdul Latif	0 out of 3
Mr Adam Layland	4
Ms Anne McGeever	5
Mr Gerry Moynihan	3
Ms Elizabeth Parry	5
Mrs Deborah Porter	3 out of 3

Name of Governor Staff	No. of meetings attended (out of five unless stated)
Mr Richard Baker	2
Dr Jattinder Khaira	3
Ms Veronica Morgan	5
Ms Yvonne Murphy	2
Ms Jayne Robbie	4
Mr Lee Williams	5

Name of Governor Stakeholder	No. of meetings attended (out of five unless stated)
Colonel Timothy Steele	4
Cllr Carol Doyle	4
Cllr Jayne Francis	3
Rabbi Yossi Jacobs	0 out of 2
Prof Isabelle Szmigin	3
Mr Amrick Singh Ubhi	3 out of 3
Cllr Kate Wild	0
Cllr Ashley Yeates	1
Cllr Carol Doyle	4
Cllr Jayne Francis	3
Rabbi Yossi Jacobs	0 out of 2
Prof Isabelle Szmigin	3
Mr Amrick Singh Ubhi	3 out of 3
Cllr Kate Wild	0
Cllr Ashley Yeates	1

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 24 September 2020 and 25 February 2021, 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 Chief Legal Officer, 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, nine Executive and nine Non-executive Directors.

Harry Reilly has held the appointment of Deputy Chair since 1 July 2016. Dr Catriona McMahon was Senior Independent Director until Jon Glasby was appointed from 24 September 2020. 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
- Deputy Chief Executive: Mike Sexton
- Chief Financial Officer: Julian Miller
- Chief Medical Officer: 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
- Professor Jon Glasby
- Jackie Hendley
- Karen Kneller
- Mehrunnisa Lalani
- Dr Catriona McMahon
- Debu Purkayastha (from December 2020)
- Harry Reilly
- Professor Michael Sheppard
- Dr Jason Wouhra (until November 2020)

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
Rt Hon Jacqui Smith	1 December 2019	3 years	30 November 2022
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
Debu Pukayastha	1 December 2020	3 years	30 November 2023
Jon Glasby	1 May 2021	3 years	30 April 2024
Jackie Hendley	1 May 2021	3 years	30 April 2024
Karen Kneller	1 May 2021	3 years	30 April 2024
Mehrunnisa Lalani	1 May 2021	3 years	30 April 2024
Michael Sheppard	1 May 2021	3 years	30 April 2024

The Board of Directors considers Jane Garvey, Harry Reilly, Catriona McMahon, Dr Jason Wouhra, Prof Jon Glasby, Jackie Hendley, Karen Kneller, Mehrunnisa Lalani, Debu Pukayastha 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 12 meetings in total. Attendance was as follows:

Directors	No. of meetings attended (out of 12, unless stated)
Rt Hon Jacqui Smith	11
Dr David Rosser	11
Mike Sexton	11
Tim Jones	11
Lisa Stalley-Green	11
Kevin Bolger	11
Jane Garvey	10
Harry Reilly	All
Cherry West	All
Dr Catriona McMahon	All
Dr Jason Wouhra	4 out of 8
Jonathan Brotherton	10
Prof Michael Sheppard	All
Prof Simon Ball	11
Prof Jon Glasby	All
Jackie Hendley	All
Karen Kneller	All
Mehrunnisa Lalani	All
Debu Purkayastha	4 out of 8

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, Chief Medical Officer

Simon was appointed as Chief Medical Officer 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 Department of Biology at Imperial College.

Appointed as a consultant nephrologist at 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 remain an important part of his role as Chief Medical Officer.

Kevin Bolger, Chief Workforce and 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 two 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 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, and Education. In 2019, Tim took on the role of Chief Innovation Officer which included responsibility for Research and Innovation, Education and Patient Services.

Tim is an Executive Director of Birmingham Health Partners, Senior Responsible Officer (SRO) for the NIHR West Midlands Applied Health Research Centre, SRO for the West Midlands Academic Health Science Network, SRO for the Midlands and Wales Advanced Therapy and Treatment Centre and a Director of the West Midlands Health Technologies Cluster. 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 apprenticeship programme.

Julian Miller, Chief Financial Officer

Julian graduated with a BA (Hons) in Business Studies in 1995 and became an Associate member of the Chartered Institute of Management Accountants when he qualified in 1999. He has over 25 years' experience in NHS Finance and joined the Trust for a second time in May 2000, since when he has held a variety of posts up to October 2015 including Divisional Finance Manager, Head of Financial Management and Planning, Deputy Director of Finance and Director of Finance (non-Board attending).

From November 2015 until March 2018 Julian was seconded to the former Heart of England NHS Foundation Trust (HEFT) as Interim Executive Director of Finance. Following the merger, Julian joined the Board of Directors of University Hospitals Birmingham NHS Foundation Trust and was appointed Chief Financial Officer in March 2020. He is also responsible for Estates and Capital Development.

Julian is also the Vice Chair of Create Partnership Trust, a multi-school academy chain based in East Birmingham.

Mike Sexton, Deputy Chief Executive

Mike, who became Director of Finance in December 2006, spent five years in the private sector working for the accountancy firm KPMG and worked 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 is an experienced Chief Nurse having worked in a broad range of roles in the NHS and prior to this in the criminal justice sector. Her experience includes leading and developing community services, offender health services, commissioning and acute services; holding roles in professional nurse leadership and as a Chief Operating Officer. Lisa has been at University Hospitals Birmingham NHS Foundation Trust for three years and leads on Infection Prevention and Control, Safeguarding, Care Quality and the patient experience.

An advocate of lifelong learning, Lisa graduated from Brunel University in 1990 with a BSc in Modern History and Politics after gaining management experience and achieved a Masters in Business Administration from Hull University in 1999.

With a desire to make a difference and add more value as a public servant, Lisa trained as a Nurse on rotation between St Bartholomew's, The Royal London and Homerton University Hospital, becoming a Nurse Professional in 2002. She continued her professional development through a Post-graduate Certificate in Primary Care, Diploma in Advanced Practice, and completion of the top leader programme at the Kings Fund.

A values driven leader, Lisa is the Trust lead for equality and staff health and wellbeing and is a Board level maternity safety champion.

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 UHB 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 and 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 at 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 grew 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 was Head of the School of Social Policy at the University of Birmingham until August 2020. 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 auditing developed in the public, not for profit/ social business, and third sectors.

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 the HM Prison Service. She started her career working with older people and BAME 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 and Social Care) 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.

Debu Purkayastha

Debu is Managing Partner at 3rd Eye, a Venture Capital and Private Equity firm investing in the technology, media and telecoms (TMT) sectors.

Debu is also Senior Advisor to EQT (global private equity fund, AUM $30B+) advising on late stage, big-ticket TMT private equity investments. Until 2017, Debu was Entrepreneur-in-Residence at Octopus Investments (global investment firm, AUM $8B+) doing early-stage technology venture capital investments.

Debu has significant Investment/M&A and operating experience - in US, Europe, Asia and Africa. Debu spent almost six years at Google, spearheading its mergers and acquisitions (M&A) and investment efforts including landmark acquisitions and investments globally. Debu also spearheaded Google's New Business Development team and was instrumental in launching several of Google's iconic products globally spanning multiple key strategic focus areas. Debu is a founding member of Google "Campus", the pre-eminent co-working space for start-ups in London's Tech City, which led to the "Google for Entrepreneurs" program.

Prior to Google, Debu headed Sabre's Corporate Development/M&A team (sold to TPG/Silverlake in a $5B transaction), and in a past life was a Technology/Media/Telecoms M&A Banker with Salomon Smith Barney/Citigroup in Wall Street, Silicon Valley and London.

Debu sits on the Boards of Cambridge University/ Cambridge Enterprise, MercyCorps (global NGO) and Tadaweb (Cyber) - in addition to the Advisory Boards of Unilever, Sadara Ventures and Global Tech Advocates/Tech London Advocates. He also sat on the Technology Pioneers Selection Committee at the World Economic Forum (WEF) and the Curriculum Committee at London Business School.

Debu used to be the Chair of the Advisory Board of Veon (global mobile telco) and on the Boards of HTL/Scandic (largest hotel chain in Scandinavia), DataFlow (data verification), Fon (wireless) and Mobile Planet (mobile apps) amongst others.

Debu has a MBA from London Business School and is a qualified Chartered Accountant.

Debu spends his personal time working with leading NGOs and governmental institutions in several politically sensitive and conflict zones focusing on economic development initiatives (primarily helping fund and build small businesses). A certified cricket nut and film fanatic, Debu is also passionate about white-water rafting and hiking.

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-executive Directorship at UHB, Jason holds the position of Chai of the West Midlands India Partnership and is a Patron of Acorns Hospice. He has previously held the position of Chair of the Institute of Directors West Midlands, Child Poverty Commission, Aston University Development Board (WM), Library of Birmingham Advisory Board and 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 Chief Legal Officer, 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 2020/21 were as follows:

- Karen Kneller
- Jane Garvey
- Jackie Hendley
- Harry Reilly
- Catriona McMahon

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; Chair – British American Business Council Midlands; Chair – Ashwell Corporation Limited; Chairman – Biotronics Limited.
- **Jackie Hendley** - Director - W. Wing Yip Plc; Director - W. Wing Yip (International Trading) Limited; Director - WWY (Holdings) Limited; Director - W. Wing Yip & Brothers (Holdings) Limited; Director - W. Wing Yip (London) Limited; Director - W. Wing Yip & Brothers Property and Investments Limited; Director - W. Wing Yip (Mail Order) Limited; Director - W. Wing Yip (Manchester) Limited; Director - W. Wing Yip & Brothers Trading Group Limited; Director - WWYC Limited; Director - WWYC (Holdings) Limited; Non-Executive Director – Word360; Member – Executive Committee, Sutton Coldfield Chamber of Industry & Commerce; Council Member – Greater Birmingham Chamber of Commerce
- **Catriona McMahon** - (Non-executive Director) Owner and Director – CMMK Ltd , Owner and Director – Te Are Coaching Ltd, Lead Industry Member of Scottish Medicines Consortium (contracted by Association of British Pharmaceutical Industries), Chair - The Shrewsbury and Telford Hospital NHS Trust, Agent - The Shrewsbury and Telford Hospital Trust Charity, Shareholder – AstraZeneca.

The Committee's principal support officer throughout the year was the Chief Legal Officer. 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 2020/21 and were attended as follows:

Director	No. of meetings attended (out of six unless otherwise stated)
Karen Kneller	6
Jane Garvey	5
Harry Reilly	6
Jackie Hendley	6
Dr Jason Wouhra	2 out of 4
Catriona McMahon	1 out of 1

The annual self-assessment for 2020/21 was undertaken based on the self-assessment form for Audit Committees recommended by the Trust's Internal Auditors. The outcome of the self-assessment was reported to the Council of Governors' meeting.

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 2020/21, 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 and 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 2020/21, 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 2020/21 external audit was £249,600; in addition, Deloitte LLP provided the following services during 2020/21:

Counter Fraud Service: £90,000

Statutory and audit-related work: £20,240 (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.

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 five 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 Resources 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 and Remuneration Committee for Non-executive Directors

The Council of Governors' Nomination and 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 and 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)
Mr Stan Baldwin
Prof Carol Doyle
Ms Yvonne Murphy (up to 26 November 2020)
Mrs Veronica Morgan (from 27 November 2020)

The Nomination and Remuneration Committee met three times during the year.

Members	No. of meetings attended
Rt Hon Jacqui Smith	3 of 3
Mr Stan Baldwin	3 of 3
Mrs Sandra Haynes MBE	2 of 3
Prof Carol Doyle	2 of 3
Ms Yvonne Murphy	0 of 1
Mrs Veronica Morgan	2 of 2

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

- Recommendations to the Council of Governors that Prof Michael Sheppard, Ms Karen Kneller, Ms Jackie Hendley, Prof Jon Glasby and Ms Mehrunnisa Lalani should each be re-appointed as Non-executive Directors for a further term of three years.[4]
- The Senior Independent Director who reports on the Chair's appraisals to this Committee changed from Dr Catriona McMahon to Professor Jon Glasby on 24 September 2020.
- A review of the remuneration levels for the Trust's Non-executive Directors and Chair, having regard to the guidance published by NHSI regarding the structure of Chair and NXD remuneration. The guidance recognises that there may be circumstances where special consideration of particular terms and conditions for Chairs or Non-executive Directors is required. In such circumstances, Foundation Trusts are expected to explain their rationale for divergence from the structure and to explain any decision not to comply with that guidance. Following this review, the Council of Governors accepted the Nomination and Remuneration Committee recommendations that the present structure of remuneration for the Chair and Non-executive Directors (approved in 2019) be maintained, the rationale being that:
  - Any remuneration of NEDs in-line with the guidance was likely to hamper the ability of the Trust to maintain a remuneration structure that takes full account of both market forces and the increased size and complexity of the Trust, which requires a highly-motivated, skilled and experienced set of Non-executive Directors;
  - Application of the guidance would result in a situation where recently re-appointed Non-executive Directors would be paid substantially less than their peers even though they equally share the additional responsibilities associated with a large, multi-site Foundation Trust; and
  - In order to attract exceptional skills in leading and influencing, combined with relevant professional experience requires a level of remuneration which is comparable to those occupying similar positions in the private sector

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. Debu Purkayastha's appointment as a Non-executive Director, which commenced during the reporting period, had been made by the Council of Governors in the preceding reporting period, following a recruitment process undertaken by a Nominations Sub-Committee involving open advertisement, short-listing and interview by the Sub-Committee.

[4] Because the merger in 2018 with Heart of England NHS Foundation Trust (HEFT) 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.

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 (2020/21)	Next year (estimated) (2021/22) NB: have used same figures as the Trust is not looking to grow membership numbers but rather maintain them
At year start (April 1)	28,964	28,964
New members	61	61
Members leaving	1,234	1,234
At year end (March 31)	27,791	27,791
Staff constituency	**Last year (2020/21)**	**Next year (estimated) (2021/22)**
At year start (April 1)	21,436	N/A
New members	15,411	N/A
Members leaving	4,454	N/A
At year end (March 31)	32,393	N/A

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	0	430,411
17-21	90	129,736
22+	25,064	1,323,979
Ethnicity:		
White	16,121	1,221,751
Mixed	194	62,344
Asian or Asian British	2,993	347,954
Black or Black British	750	113,445
Other	74	27,796
Socio-economic groupings*:		
AB	7,467	148,878
C1	7,860	222,981
C2	5,792	144,527
DE	6,621	222,724
Gender analysis		
Male	12,002	929,776
Female	15,074	954,346

The analysis section of this report excludes:

- 2,644 public members with no dates of birth, 1,540 members with no stated ethnicity and 715 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 2020/21

During 2020/21 the overall membership increased from 57,546 to 60,184.

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 aim of 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 when Covid-19 restrictions have allowed
- 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 the UHB Charity to increase membership opportunities amongst fundraisers

7.3.3 Governors' Development 2020/21

Meetings of the Membership, Engagement and Governors' Development Committee are held approximately two to three times a year. This committee is made up of Governors from across all the constituencies and is also attended by the Chief Legal Officer/Foundation Secretary and Director of Communications and Engagement. The content of seminars is agreed across the year. During 2020/21 topics covered the following:

- Proposed 2020/21 Annual Plan
- Patient Experience Strategy
- Annual Reports and Accounts
- Finance for Non-Financial People – how to understand financial reports
- Safeguarding/Maternity Mortality
- End of Life Care

Three other seminars had to be postponed due to the impact of Covid-19.

For 2021/22 topics are set to include:

- Sustainability Strategy – how to spread the word to the wider organisation
- Overview of PICS including links to dashboards and how data is used to change behaviours
- Integrated Care Systems – including accountability and reporting
- Trust School of Nursing
- How to represent and engage with members
- Service Integration – follow up

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

- Core Skills
- Accountability and Holding to Account
- NHS Finance and Business Skills
- Effective Questioning and Challenging (in holding the NEDs to account)

In addition, regional workshops and Governor focus groups are also held to enable Governors to network with Governors at other Trusts.

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
- news@UHB – Trust newspaper distributed through the hospital sites
- Social media tools – Twitter, Facebook, Instagram and YouTube

In addition the following activities have been held when Covid-19 restrictions have allowed:

- 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
- Annual membership week – activities held over three 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 2021

	Female	Male
All Staff	16,739	5,258
Executive Directors	3	6
Directors	1	5
Total Staff	**16,743**	**5,269**

*Definition of Executive: 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 as Healthcare assistants and other support staff, with the next highest groups of staff employed in Nursing, Administration and Estates and other support to clinical roles. The fewest number of staff are employed as Healthcare Scientists. Fixed-term working largely supports Medical and Dental roles, whilst bank working underpins workforce needs mostly for Allied Health Professionals, Nursing, Administration and Estates.

Average 2020-21

Staff Groups	Permanent	Bank
Medical and dental	2,465	182
Ambulance staff	0	0
Administration and estates (Including Ancillary)	3,447	333
Healthcare assistants and other support staff	5,393	1,014
Nursing, midwifery and health visiting staff	5,370	608
Nursing, midwifery and health visiting learners	0	0
Scientific, therapeutic and technical staff	1,859	171
Healthcare science staff	666	0
Social care staff	0	0
Other	0	0
Total average numbers	**19,200**	**2,308**
	21,508	

Average 2019-20

Staff Groups	Permanent	Bank
Medical and dental	2,313	145
Ambulance staff	0	0
Administration and estates (Including Ancillary)	3,432	214
Healthcare assistants and other support staff	5,139	923
Nursing, midwifery and health visiting staff	5,324	571
Nursing, midwifery and health visiting learners	0	0
Scientific, therapeutic and technical staff	1,800	99
Healthcare science staff	699	0
Social care staff	0	0
Other	0	0
Total average numbers	**18,707**	**1,952**
	20,659	

* UHB's Bank are NHS staff who are assigned on an ad-hoc basis to deliver work through UHB plus, to cover vacancies. They could be UHB substantive post holders or those of other local NHS providers.** The increase in bank staff during 2020/21 is due to the Birmingham and Solihull STP Covid-19 vaccination programme, which is being delivered through UHB.
*** The prior year data of 2019/20 has been restated to include the annual average bank staff to enable a full comparison with the 2020/21 table of staff numbers. Previously only permanent staff were disclosed.

8.3 Staff Turnover

In 2020/21, the Trust's annual turnover rate across all clinical and corporate divisions as at 31 March 2021 was 9.30%, against an internal target of 9%.

The staff groups with the highest rate of turnover were:

- Additional Scientific Professional and Technical 16.32%
- Allied Health Professionals 10.92%
- Additional Clinical Services 10.10%

There is an expectation that turnover may have increased in 2021/22 due to deferred leavers who would otherwise have left in 2020, in particular those who deferred their retirement.

The top three reasons for leaving in 2020/21, excluding "other not known" were:

- Work-life balance, 15% of all leavers
- Retirement, 13% of all leavers
- Relocation, 10% of all leavers

The top three staff groups affected were Nursing and Midwifery Registered, Administrative and Clerical and Additional Clinical Services.

There are a number of retention strategies being planned in 2021/22 to control the flow of leavers, including enhanced flexible working arrangements and creation of a reservist workforce to support surges.

8.4 Staff Exit Packages - audited

Termination benefit by band - Year Ended 31 March 2021	Compulsory Redundancies		Other Agreed Departures *		Total Number	Total Termination Cost £'000
	Number	Cost £'000	Number	Cost £'000		
<£10,000	1	7	2	13	3	20
£10,000 - £25,000	1	13	0	0	1	13
£25,000 - £50,000	1	47	0	0	1	47
£50,000 - £100,000	2	124	0	0	2	124
£100,000 - £150,000	0	0	0	0	0	0
>£150,000	0	0	0	0	0	0
Grand Total	**5**	**191**	**2**	**13**	**7**	**204**

Termination benefit by band - Year Ended 31 March 2020	Compulsory Redundancies		Other Agreed Departures *		Total Number	Total Termination Cost £'000
	Number	Cost £'000	Number	Cost £'000		
<£10,000	1	9	2	16	3	25
£10,000 - £25,000	1	16	1	17	2	33
£25,000 - £50,000	0	0	0	0	0	0
£50,000 - £100,000	3	233	1	88	4	321
£100,000 - £150,000	2	268	0	0	2	268
>£150,000	0	0	0	0	0	0
Grand Total	**7**	**526**	**4**	**121**	**11**	**647**

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

8.5 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 experiences, views and needs. 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 are invited to a monthly briefing with the Executive Team
- news@UHB – 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

8.5.1 NHS Staff Survey

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

The response rate to the 2020 survey among Trust staff was 38% (2019: 37%) Scores for each indicator together with that of the survey benchmarking group (Acute and Acute and Community Trusts) are presented below.

Indicator	2019/20	2020/21		
	Trust	Trust	Benchmarking group	Significant change
1. Equality, Diversity and Inclusion	8.9	8.9	9.1	No
2. Health and Wellbeing	5.6	5.8	6.1	Yes
3. Immediate managers	6.6	6.6	6.8	No
4. Morale	5.9	6.0	6.2	No
5. Quality of care	7.4	7.5	7.5	No
6. Safe environment – bullying & harassment	8.0	8.1	8.1	Yes
7. Safe environment – violence	9.5	9.4	9.5	No
8. Safety culture	6.5	6.6	6.8	Yes
9. Staff engagement	6.9	6.8	7.0	No
10. Team working	6.3	6.2	6.5	No

Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Comparing our 2019 and 2020 scores across the key themes, three of the ten indicators significantly improved. The improved indicators are health and wellbeing, safe environment – bullying and harassment, and safety culture.

Overall, the results are more positive than expected, in this exceptionally challenging year due to Covid-19. It is reassuring to see the improvement in health and wellbeing indicators, reflecting the significant action taken during the last year.

8.5.2 Future priorities and targets

The recovery of our services and our people, remain our key priorities, alongside implementing a range of initiatives to recognise the incredible efforts of our staff during the pandemic.

We have a number of actions in progress to support this:

- Support and develop our first-line leaders via the Building Healthier Teams engagement and development programme
- Support and develop leaders at all levels by continuing to embed and expand our leadership development support offer
- Support the recovery of our people with a range of high impact staff health and wellbeing actions, including site wellbeing hubs and access to psychological support
- Recognise the efforts and achievements of staff during the Covid-19 pandemic via a range of initiatives to continue to say thank you, and recognise and celebrate the achievements of the last 12 months

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

8.6 Sickness Absence

Staff absence information is published by NHS Digital: https://digital.nhs.uk/dataand-information/publications/statistical/nhs-sickness-absence-rates

In 2020/21, the Trust recorded an annual average sickness absence across all clinical and corporate divisions of 5.80%.

The increased levels of staff sickness absence in 2020/21 were associated with the Covid-19 pandemic. At the height of the first peak in April 2020, 2,622 staff were absent due to Covid-19 and a further 720 staff were unavailable as they were shielding due to age, pregnancy or due to being clinically vulnerable.

As at the 31 March 2021, we had 196 staff absent due to Covid-19 and 263 staff who were shielding due to age, pregnancy or due to being clinically vulnerable.

The reduction of absence during this time was as a result of a number of factors including:

- Social distancing measures
- Wearing of masks in all areas
- PPE
- Collaborative working with occupational health, infection control and health and safety teams
- Management of risk assessment processes, both environmental risk management and individual risk management
- Introduction of staff testing and household testing
- Homeworking and flexible working
- Introduction of wellbeing hubs
- Psychological support for staff
- Issuing of 160 key worker letters to support childcare provisions and exemption from quarantine requirements

In addition to the above, the employee relations team in conjunction with Occupational Health (OH) and other key network groups developed a suite of covid-19 guidance and frequently asked questions to support staff and managers including:

- Flexible working
- Self-isolation/absence
- Underlying health conditions/shielding and returning to work
- Risk Assessments
- Childcare, special leave
- Use of annual leave and public holidays during the pandemic
- Managing mental health and wellbeing
- Guidance on recruitment, training and appraisals during the pandemic
- Repurposing of staff
- Working time directive
- Quarantine

The above measures vastly reduced the number of staff that were absent during the second and third waves.

Daily reporting of Covid-19 and non Covid-19 absences commenced in March 2020 and continues.

Trust management continues to work in partnership with Trade Union colleagues to explore opportunities to reduce sickness absence rates to a target of 4%. However it is acknowledged that the pressures of managing the Covid-19 pandemic and the infection rate itself has understandably increased the 12-month-rolling figure.

Long-term sickness continues to be the main cause of absence from work, and has accounted for 3.53% of the total sickness absence for 2020/21. The total number of days lost due to sickness for the year is 514,212. The past 12 months has been a difficult time with an increase in staff absence due to psychological related effects as a result of the Covid-19 pandemic.

As at March 2021, psychological absence represented 29% of total sickness absence (circa 9,000 WTE days lost). Nursing and Midwifery and Additional Clinical Services account for the highest staff group affected.

Absence Reason	
1	Anxiety/stress/depression/other psychiatric illnesses
2	Infectious diseases
3	Other musculoskeletal problems
4	Other known causes - not elsewhere classified
5	Back problems

The employee relations team continue to undertake monthly analysis of sickness absence. Regular 'confirm and challenge' meetings continue to take 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 improved health and wellbeing of staff through individualised support and aid their return. 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.

Staff groups with absence consistently above the Trust Key Performance Indicator include Additional Clinical Services (9.93%), Estates and Ancillary (8.64%) and Nursing and Midwifery (6.46%).

Over the last 12 months, the employee relations team have supported a total of 434 long term absence management cases. Out of 434 staff, approximately 83% were supported with returning to work, either through redeployment, phased return following a long-term period of absence or through active management interventions, such as reasonable adjustments, regular wellbeing meetings and Occupational Health assessments.

There has also been a total of 24 mutually agreed termination meetings held. This process is followed where staff members have made a decision to reach a mutual agreement with their manager on ending their employment for health reasons. This process is beneficial to a member of staff where they believe there is no prospect of them returning to work and ending their employment is by mutual consent on the grounds of ill health.

A comprehensive training and education package is in place to develop managers' confidence and skills in supporting staff who are unwell. Bespoke sickness absence management training is targeted at identified hot-spot areas to ensure tailored support is provided where required.

The employee relations team have recently restructured to provide a dedicated HR Manager to each of the Divisional and Corporate areas. This change will bring more prominence and support to managers. It will enable the HR Managers to undertake deep dives into areas where hot spots are identified and use bespoke data to help identify trends and strategies to resolve issues.

For those staff affected by Long Covid, the Occupational Health service supports individuals through its own clinics or through referral to specialist support.

In addition, there has been an increased focus on the impact of domestic abuse on attendance and sickness absence. The HR and Occupational Health teams have received specialist training to help 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 which include:

- Staff support
- Staff well clinic
- Staff physiotherapy
- Occupational Health
- Mindfulness
- Chaplaincy support
- Wellbeing hubs
- Psychological First Aid Training

The Employee Relations Advisors maintained weekly contact with Divisional Managers, which has enabled early identification of staff who remain absent due to Covid-19. They have facilitated appropriate treatment plans or referrals, and safe and successful returns to work.

8.6.1 Shielding

Over the past year the Trust has supported members of staff who have been required to shield at home. Guidance has been developed for line managers to have supportive and compassionate discussions to enable staff to return to work safely and with support. Line managers were encouraged to maintain regular contact and to provide regular updates on team developments and Trust initiatives. As of the 31 March 2021, out of the 251 staff reported to be shielding, the HR team have supported proactive discussions with Divisional Managers to establish the return of 249 staff.

The Trust completed the merge of the two Electronic Staff Record systems in February 2021. This has removed the manual intervention required to join separate reports and has streamlined the production of sickness absence data per division, by staff group and specialty.

8.6.2 Disability

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

The HR team regularly discuss and undertake peer review of employee relations casework where disability is identified. This is so members of staff with a disability are not disproportionately represented in formal disciplinary outcomes and capability cases. Where staff 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 team have strengthened relationships with the inclusion team and share information, learning and best practice. In addition,

the team work with the Business Disability Forum, which provides external and expert advice on the management of staff with a disability.

'Disability Leave Guidance for Staff and Managers' has been developed which covers special leave for planned treatment and appointments. This guidance has been developed in conjunction with Occupational Health, Trust staff network leads and the Inclusion team.

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 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, along with 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. These sessions are interactive and experiential to better equip managers with the practical skills and knowledge to undertake recruitment effectively.

8.6.3 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.

8.6.4 Occupational Health

The Occupational Health (OH) service provides surveillance and support for new starters and for all staff where conditions are impacting on fitness at work. The service supports staff with work-based health assessments, referrals to specialists for treatment, self-care advice, and reasonable adjustment recommendations. During the pandemic, the OH service has led delivery of Covid-19 staff test and tracing along with risk assessments, and an advisory service to staff and managers on Covid-related health issues. The lead OH Consultant produced Occupational Health guidance on health conditions and remaining at work during the covid-19 pandemic.

A four-tier risk assessment framework was developed, and any complex cases were referred to a multi-disciplinary panel, and panel risk assessments applied to all staff identified for shielding so that the return to work was safe even when shielding was lifted. This included risk reduction recommendations and redeployment advice. All of those staff were risk assessed, and this remains on-going for new starters as well as revisiting staff where their health status changes. We have a fast track physiotherapy service for staff, and the Occupational Health service runs in-house counselling and fast track referrals to an in-house psychiatrist. High risk staff were among those prioritised for the Covid-19 vaccine.

Our staff Covid-19 risk assessment framework was designed based on medical and scientific evidence and was developed with involvement from BAME and Disability networks. The risk assessment matrix takes account of the disproportionate impact of Covid-19 on specific groups such as ethnic minorities, pregnant and older workers, and staff with long-term conditions and disabilities. Occupational Health and a multi-disciplinary panel including medical, nursing and HR representatives advised on work locations or duties including redeployment of frontline staff to safer environments.

The tables below detail the Occupational Health activity for 2020/21

Occupational Health and Counselling service activity 2020/2021	
Management referrals	1,073
Self-referrals	45
Review appointments	1,211
Pre-employment questionnaires	7,233
(2,013 temp staffing)	
Skin assessments	380
Inoculation injuries	526
Covid-19 Related	
Covid-19 queries/assessments	4,350
Covid-19 swabs for staff	7,215
Covid-19 swab for home contact	2,465
Counselling	
New referrals	360
Review appointments	617

Trust Flu campaign (frontline staff)	78.44%

The Occupational Health Service supported the Covid-19 response from February 2020, and the service adapted to the needs of staff.

Staff swabbing started in April 2020 including home contacts to enable staff to return to work at the appropriate time depending on the results of the swab/s.

The numbers of staff recruited to the Trust was higher than previously, including high volumes recruited on a temporary basis.

The counselling service was enhanced to meet the needs of staff, with an increase in numbers of individuals accessing the service in the last quarter.

8.7 Trade Union Facility Time Reporting Regulations

The Trade Union (Facility Time Publication Requirements) Regulations 2017 require the Trust 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 the 2020/21 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 – 70	Full-time equivalent employee number – 60.64

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%	65
51%-99%	1
100%	4

Table 3
Percentage of pay bill spent on facility time

Total cost of facility time	£141,239
Total pay bill	£1,126,314,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.013%

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: 22.9% (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

8.8 Gender Pay Gap

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

8.9 Reporting high paid off-payroll arrangements

There were no high paid off-payroll arrangements in 2020/21.

8.10 Expenditure on consultancy

The expenditure on consultancy is £13,672,000 for the year. See note 5 'operating expenditure' in the financial statements.

8.11 Analysis of staff costs

Employee costs	Year Ended 31 March 2021			Year Ended 31 March 2020		
	Permanently		Other	Permanently		Other
	Total	Employed		Total	Employed	
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	868,021	801,162	66,859	786,318	727,274	59,044
Short term employee benefits - social security costs	81,780	81,780	-	70,321	70,321	-
Post employment benefits - employer contributions to NHS pension scheme	92,561	92,561	-	87,205	87,205	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	40,397	40,397	-	38,160	38,160	-
Pension cost - other contributions (NEST)	241	241	-	214	214	-
Apprentice Levy	4,176	4,176	-	3,889	3,889	-
Termination benefits	758	758	-	663	663	-
Temporary staff - external bank	-	-	-	-	-	-
Temporary staff - agency/contract staff	39,461	-	39,461	36,782	-	36,782
Pay costs capitalised as part of assets	(568)	(568)	-	(3,872)	(3,872)	-
	1,126,827	**1,020,507**	**106,320**	1,019,680	923,854	95,826

Employee costs include those of staff and Directors, but exclude Non-executive Director costs.

9 NHS Improvement's Single Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

UHB is currently in segment 2: Targeted support: support needs identified in finance and use of resources and operational performance.

This segmentation information is the Trust's position as at 29 April 2021. Current segmentation information for NHS trusts and Foundation Trusts is published on the NHS Improvement website.

Dr David Rosser, Chief Executive
24 June 2021

10 Remuneration Report

10.1 Annual Statement on Remuneration

During the year ending 31 March 2021, the Committee has become even further convinced of the need to ensure 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 has supported steps taken to ensure that the Executive Team has the capacity and capability to deal with the extremely challenging issues of responding to the Covid-19 pandemic, 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 remains 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 regard to the Trust's equality and diversity strategy.

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 2.8% pay increase for all senior managers with effect from 1 April 2020, in line with that agreed at national level with NHS Consultants. Additionally, the Committee approved increases in remuneration for one Executive Team member.

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 by the Council of Governors' Committee for the Nomination and Remuneration of Non-executive Directors, with advice taken from independent consultants where appropriate. Details of the work undertaken by the Committee during the reporting period are set out at page 56.

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
24 June 2021
Chair of the Executive Appointments & Remuneration Committee

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 2020/21:

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 94 Salaries are determined by the Trust's Executive Appointments and Remuneration Committee Salaries will be reviewed during the year ending 31 March 2022. 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 30/09/2017 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 2020/21:

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 2022. 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 (2020/21 - £nil) paid to any Executive or Non-executive Director. There are no payments to any past senior managers that relate to the function of the Board of Directors (2020/21 - £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 98, 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 2020/21.

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 98.

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 David 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
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 four occasions during the year. Attendance was as follows:

Directors	No. of meetings attended
Rt Hon Jacqui Smith	4 out of 4
Dr David Rosser	4 out of 4
Prof Michael Sheppard	4 out of 4
Prof Jon Glasby	4 out of 4
Jane Garvey	1 out of 4
Harry Reilly	4 out of 4
Dr Catriona McMahon	4 out of 4
Dr Jason Wouhra	0 out of 2
Jackie Hendley	4 out of 4
Karen Kneller	3 out of 4
Mehrunnisa Lalani	2 out of 4
Debu Purkayastha	2 out of 2

During the reporting period, the Committee approved an annual inflationary pay increase of 2.8% with effect from April 2020 for senior managers, which reflects the increase provided to NHS Consultants as a result of national negotiations.

The Committee approved increases in remuneration for one Executive Team member. 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 and 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 and 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 and Remuneration Committee for Non-executive Directors are set out on page 101.

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 2021			
	Number in Office	Number receiving expenses	Total £00
Directors	23	2	2
Governors	33	5	2

Year Ended 31 March 2020			
	Number in Office	Number receiving expenses	Total £00
Directors	24	3	36
Governors	33	17	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 2020/21 - audited

Name and Title	Year Ended 31 March 2021					
	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				202.5 - 205.0	465-470
Mike Sexton Deputy Chief Executive, with effect from 1 Apr 2020	220-225				215.0 - 217.5	435-440
Professor Simon Ball Chief Medical Officer	230-235				50.0 - 52.5	280-285
Kevin Bolger Chief Workforce and International Officer	210-215				-	210-215
Jonathan Brotherton Chief Operating Officer	190-195				60.0 - 62.5	255-260
Cherry West Chief Transformation Officer	190-195				45.0 - 47.5	240-245
Tim Jones Chief Innovation Officer	210-215				-	210-215
Lisa Stalley-Green Executive Chief Nurse	190-195				55.0 - 57.5	245-250
Julian Miller Chief Financial Officer, with effect from 1 Apr 2020	210-215				-	210-215
Fiona Alexander Director of Communications	165-170				72.5 - 75.0	240-245
David Burbridge Chief Legal Officer	195-200				247.5 - 250.0	440-445
Andrew McKirgan Chief Officer for Out of Hospital Services	195-200				175.0 - 177.5	370-375
Mark Garrick Director of Quality and Development	160-165				120.0 - 122.5	285-290

Name and Title	Year Ended 31 March 2021					
	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 Jaqui 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, left office 30 Nov 2020	10-15					10-15
Debapriya Purkayastha Non-executive Director, with effect from 1 Jun 2020	10-15					10-15
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 2019/20 - audited

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

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 Chief Medical Officer 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	
Chief Medical Officer	Medical Consultant	Director
Professor Simon Ball	190-195	40-45

The only changes to the Board of Directors were to Mike Sexton becoming Deputy Chief Executive on 1 April 2020 (a new role) and Julian Miller becoming Chief Finance Officer on the same date (the role of Finance Director being discontinued). There was one change to the Non-executive Directors on the Trust Board: Jason Wouhra left office to be replaced by Debu Purkayastha.

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. The information below has been subject to audit.

	Year Ended 31 March 2021	Year Ended 31 March 2020
Band of Highest Paid Director's Total Remuneration (£'000)	260-265	260-265
Median Total Remuneration	27,416	26,220
Ratio	**9.5**	**9.9**

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 - audited

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.

Name and title	Real increase in pension at pension age	Real increase in pension related lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Total accrued pension related lump sum at pension age at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2021	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	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	10.0-12.5	17.5-20.0	105-110	295-300	2,111	224	2,409	N/A
Lisa Stalley-Green, Executive Chief Nurse	2.5-5.0	0-2.5	50-55	40-45	725	44	810	N/A
Mike Sexton, Deputy Chief Executive	10.0-12.5	30.0-32.5	90-95	275-280	-	-	-	N/A
Jonathan Brotherton, Chief Operating Officer	2.5-5.0	0-2.5	60-65	125-130	891	48	982	N/A
David Burbridge, Chief Legal Officer	10-12.5	25.0-27.5	55-60	155-160	994	263	1,303	N/A
Simon Ball, Chief Medical Officer	2.5-5.0	0-2.5	70-75	170-175	1,394	62	1,503	N/A
Mark Garrick, Director of Quality and Development	5.0-7.5	10.0-12.5	30-35	60-65	365	74	469	N/A
Fiona Alexander, Director of Communications	2.5-5.0	2.5-5.0	35-40	55-60	551	66	650	N/A
Cherry West, Chief Transformation Officer	2.5-5.0	7.5-10.0	75-80	235-240	1,814	95	1,968	N/A
Andrew McKirgan, Chief Officer for Out of Hospital Services	7.5-10.0	15.0-17.5	70-75	155-160	1,122	193	1,362	N/A

Dr David Rosser, Chief Executive
24 June 2021

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.

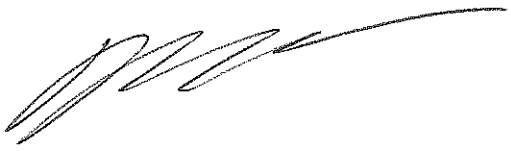
The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The purpose of the system of internal control

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
24 June 2021

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 policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, 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 2021 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 maps 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 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 strategic and operational risks is detailed in the 'Risk Management Policy and Associated Procedure', and the management of risks related to staff at work is detailed in the 'Health and 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 and then their learning is cascaded to other staff in the speciality/division.

Nominated managers (as defined in the Health and 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. The Audit Committee provides assurance to the Board of Directors on risk management as identified in the Internal Audit Programme. 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 2020. The Board Assurance Framework (BAF) identifies key risks to the Trust's aims and objectives and is reviewed on a quarterly basis by Executive Directors and the Board of Directors.

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 may include the following:

- Complaints and Care Quality Commission reports and recommendations
- Inquest findings and recommendations from HM Coroners
- Medico-legal claims and litigation
- Ad hoc risk issues taken to either the specialty meetings/departmental meetings, the divisional governance meetings, the Health, Safety and Environment Committee, the Clinical Quality Monitoring Group, the Care Quality Group (CQG) or the 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. In-line with national standards and guidance a five by five 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 these categories are 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 resources
- 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 may include transferring the risk, terminating the risk, tolerating the risk or 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, these operational risks also inform the Board Assurance Framework (BAF) process.

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. The internal audit of the risk management process and BAF for 2020/21 culminated in a finding of 'substantial assurance with minor improvement opportunities'.

During the financial year 2019/20, the Trust's processes for managing risks were reviewed by the Good Governance Institute (GGI) as part of its Well-Led Review. During the same reporting year, the Trust's internal auditors (KPMG) conducted a governance review. The outcomes of both reviews were subject of a Board seminar on governance in March 2021, where the respective GGI and KPMG recommendations were discussed in more detail.

Trust's response to the Covid-19 pandemic

The Trust was able to respond rapidly to the challenges caused by the pandemic owing to its flexible workforce and adjustments to governance arrangements. Pressure on the clinical workforce was mitigated by corporate staff assisting in administrative functions in clinical areas, freeing up time for clinical staff to work solely in a clinical

capacity. Traditional corporate activities, which were considered non-essential, were temporarily paused, whilst activities supporting the key control framework continued. The essential corporate work continued including risk management and control, with particular focus on Covid-19 related risks, as well as on-going compliance monitoring where possible.

The BAF and risk management reports received by the Board at the height of the pandemic reflected an increase in risk to staffing levels, compounded by increased sickness levels, shielding requirements, and the impact of a third wave on the health and well-being of the Trust's workforce. In addition to corporate staff supporting the clinical workforce, this risk was mitigated by the Trust making available additional health and wellbeing support to staff (e.g. Wellbeing hubs, psychological first aid).

Other strategic risks (for a full list please see the 'strategic risks' section below) which increased as a result of the pandemic include the risk of prolonged and/or substantial failure to meet operational performance targets. This risk was addressed by the development of a Trust strategy on performance recovery which is undergoing further refinement. In order to enable a collaborative, system wide response, a Birmingham and Solihull Operational Delivery Group (ODG) was established which leads on an effective approach to tackling reducing of the elective backlog.

The roll out of the Early Intervention Community Teams (EICT) across the five Birmingham localities during spring 2020/21 resulted in a significant increase in patients being able to be discharged home from hospital for their rehabilitation rather than waiting to access an inpatient community rehabilitation bed.

The Trust widely adopted the use of video and telephone remote clinics to keep patients as safe as possible whilst managing the backlog.

The increase in harm reviews and mental health referrals were addressed by making adjustments to existing processes and recruitment to additional roles.

Oversight of these adjustments to governance arrangements was provided by the Chair, the Deputy Chair, the Chief Legal Officer and the Covid-19 Strategic Group.

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 the Executive Directors.

Based on the discussions at CQMG, the Chief Medical Officer provides a regular exception report to the Board of Directors.

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, the 2020/21 quality report is not required to be included in the 2020/21 annual report, and the national deadline for publishing the 2020/21 quality report is yet to be specified.

The Care Quality Group, chaired by the Chief Nurse, receives monthly assurance reports from steering groups responsible for the following areas: Safeguarding; patient falls prevention and management; infection prevention and control; tissue viability; nutrition and hydration; patient experience; end of life care; and for 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, escalating concerns if required, and ensuring the contractual requirements in relation to reports to the Commissioners are met.

The Clinical Dashboard Review Group, which is chaired by the Director of Strategy and Quality Development and the Deputy Divisional Directors of Nursing, review the 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 Chief Legal Officer (CLO) provides a six-monthly emergency preparedness update report to the Board. The Policy Review Group, chaired by the CLO, 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 CLO via the CLO Governance

Group (CLOGG). The Chief Nurse and the CLO 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 CLO.

The Board of Directors receives performance indicator reports every quarter and the Clinical Quality Committee receives these reports each time it meets.

Cyber security risks are 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, the IG team and the Business Continuity team who review relevant DSPT assertions and general areas of concern regarding IT security.

The Audit Committee receives a report on compliance with the FT provider licence conditions. The Provider Licence requires Trusts to self-assess and declare 'compliance or 'non-compliance' with certain Provider Licence conditions, namely:

Condition G6 (3): Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution.

Condition FT4 (8): Providers must certify compliance with required governance standards and objectives.

Condition CoS7 (3): Providers providing commissioner requested services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver the designated service.

The FT Provider Licence compliance report provided assurance that each of the Provider Licence conditions was met during 2020/21. The Corporate Governance Statement, based on this report and the NHSI template, was signed off by the Board at the Special Purpose Meeting in June.

As part of the response to the Covid-19 pandemic, the Trust has continued to suspend significant proportions of its activity, including elective surgery and some cancer surgery, for extended periods when there have been high numbers of patients admitted with Covid-19. This has continued to affect 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 to reduce the backlog, including implementing the actions set out by NHS England and Improvement, although additional capacity will be available, this will not be sufficient to recover performance in the short-term. The focus therefore remains on treating patients dependent on their clinical urgency, according to guidance from the Federation of Specialty Surgical Associations, as endorsed by NHSE&I. 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 six 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 the 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 and they also take part in the national PLACE assessment as well as our own PLACE-Lite programme.

At a Committee level, elected Governors from each sites PCCC represent the group at the Patient Experience Group and also the Care Quality Group where they receive regular reports on care quality, including infection prevention and control, tissue viability, falls prevention and management, and nursing performance, to provide a patient perspective.

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 (IG)

Risks to information are managed and controlled in accordance with the Trust's 'Data Protection Confidentiality and Disclosure Policy' and the 'Policy for the Reporting and Management of Incidents', and reviewed during the Information Governance Group (IGG) and Information Governance Assurance Group meetings. The IGG meetings are chaired by the CLO, who has been appointed as the Senior Information Risk Officer (SIRO). The IGAG meetings are chaired by the Deputy Medical Director, who has been appointed as the Caldicott Guardian and is responsible for the protection of patient information. All IG issues are integrated through the Information

Governance Group. The Board of Directors receives a report regarding its systems of control for IG. These include satisfactory completion of its annual self-assessment against the Data Security and Protection Toolkit (DSPT), mapping of data flows, monitoring of access to data and reviews of incidents.

The Trust submitted the DSPT assessment for 2019/20 in September 2020 and achieved the status of: 'Standards Met'. The Trust is completing the DSPT assessment for 2020/21 in readiness for submission by 30 June given the extension owing to Covid-19. The Trust expects to submit at a level which will require further work to maintain its fully compliant status with all requirements. This is due to significant changes to the DSPT mandatory requirements, specifically in the area of cyber security. The internal audit of the DSPT submission resulted in 'significant assurance with minor improvement opportunities'.

For the reporting period, one incident has been reported to the Information Commissioner's Office (ICO) via the incident reporting tool. The incident relates to a staff member accidentally uploading an image they had taken of a clinical document to the social media platform, 'Facebook'. Once the Trust's IG department was alerted of the incident, the image was immediately removed. The ICO has taken no further action for the following reasons:

-The breach affected one data subject and the risk was assessed as minor adverse effects only

-The mistake was identified quickly and the document was only available for 15 minutes before being removed

-The Trust has data protection procedures in place and these were not followed on this occasion

-The Trust has instigated a full investigation into the incident and identified that further governance training is required

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 2020/2021. These are linked to the Annual Plan. 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 2021 were:

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

The overall financial risk will be managed and mitigated through on-going 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 on-going 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 CLO Governance Group meetings. The meetings are chaired by the CLO 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. Line managers are responsible for the provision of primary support for staff involved in an incident and this is made available to staff. 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 Chief Medical Officer 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 twelve 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

As a result of the Covid-19 pandemic, the usual planning process was suspended for 2020/21. Instead an emergency financial regime was introduced for the first six months of the year (H1) which guaranteed a breakeven position for all providers. Trusts were allocated a block payment based on 90% of the outturn expenditure in the periods eight to ten of 2019/20 with a retrospective claim for funding for costs incurred in excess of this. This retrospective claim process included the costs incurred by the Trust in commissioning the NHS Nightingale Birmingham at the National Exhibition Centre. The Trust claimed retrospective top-up funding of £112.9m in H1 (£45.0m of which related to NHS Nightingale Birmingham), with all claims having been validated and funding received. As such the Trust reported the anticipated breakeven position for H1.

For the second six months of the year (H2), the financial regime continued to be based primarily around the same block payments but with a fixed funding envelope to cover the additional costs incurred as a result of the Covid-19pandemic. The retrospective claim process largely ceased. A few distinct areas continued to be funded outside of these block envelopes including NHS Nightingale

Birmingham, Covid-19 testing and the Covid-19 Vaccination Programme roll-out. In light of the fixed block payments and the expenditure that the Trust considered it would incur, a planned deficit of (£11.4m) was expected for H2. Within this planned deficit was an efficiency requirement, which the Trust has delivered on in full and exceeded. The costs incurred increased from this plan, in particular around the increased annual leave accrued as a result of the pandemic. However, funding has been awarded to offset these increases.

In addition, funding has been allocated to offset the loss of variable income to the Trust, for example around reduced Research and Development activities, reduced footfall in catering facilities and reduced visitor car parking charges. As a result of these additional funding streams, the Trust was expected to deliver a surplus position of circa £12.6m against which the Trust are reporting a £12.8m surplus on a comparable basis. There are some further technical accounting adjustments which then takes the overall reported surplus of the Trust to £13.7m.

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. For the 2020/21 financial year, the Trust has delivered the anticipated financial position in full with all claims for additional funding having been validated and paid. The cost improvement target of 1% for H2 has been delivered and exceeded.

The Trust would normally benchmark in a variety of ways including through the national Reference Cost Index and by use of the national benchmarking data including Getting It Right First Time (GIRFT) and use of the Model Hospital data sets. However, as a result of the Covid-19 pandemic some of these programmes have been suspended. The Trust has submitted the reference cost information, but they are significantly different to the previous years as a result of redeployment of staff and reduced non-Covid activity. As part of the retrospective claim validation though, the Trusts claims/costs have been benchmarked against other organisations and are considered to be comparable or more efficient resulting in full payment of the Trust claims.

The emphasis on 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 process, 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 with HEFT 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.

As part of its response to the Covid-19 pandemic response, the Trust has continued to suspend a high proportion of its activity including elective surgery and some cancer surgery. Meanwhile, emergency performance has been affected by infection prevention and control measures and the requirement for separate Covid ("hot") and non-Covid ("cold") capacity whilst diagnostic performance has been significantly affected by IPC and social distancing measures. This affected the Trust's performance against the national targets and indicators of the NHS Oversight Framework including the A&E 4 hour, 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 cancer symptoms metrics.

As the Trust implements its plans to reduce the backlog, including implementing the actions set out by NHSE&I, additional capacity will be available in the longer-term. The short-term focus therefore remains on treating patients dependent on their clinical priority according to guidance from the Federation of Specialty Surgical Associations, as endorsed by NHSE&I. The Trust is monitoring its

response against current guidance available from NHSE&I at all times.

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.

The effectiveness of the Board Sub-Committees, notably the Audit Committee, Investment Committee and Executive Appointment and Remuneration Committee, are discussed in more detail in the Governance section of the Annual Report.

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 2020/21 are now in force, which means 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.

As of the reporting year, the national guidance for preparation of the quality accounts 2020/21 has not yet been confirmed by NHS Improvement.

NHS providers are not expected to obtain assurance from their external auditor on their quality report or associated indicators for 2020/21.

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 2020/21 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.

Signed

Dr David Rosser, Chief Executive
24 June 2021

NHS

University Hospitals Birmingham

NHS Foundation Trust

Section 2

Consolidated Financial Statements 2020/21

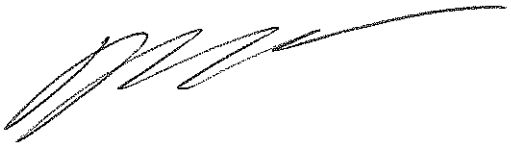
This annual report covers the period 1 April 2020 to 31 March 2021

University Hospitals Birmingham NHS Foundation Trust – Consolidated Financial Statements 2020/21

Foreword to the Financial Statements

University Hospitals Birmingham NHS Foundation Trust

These financial statements for the year ended 31 March 2021 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 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



Dr David Rosser, Chief Executive
24 June 2021

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

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 the Foundation Trust's affairs as at 31 March 2021 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 Statement of Financial Position
- The Consolidated and Foundation Trust Statement of Changes in Taxpayers' Equity
- The Consolidated and Foundation Trust Statement of Cash Flows and
- The related notes 1 to 34

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- The salary entitlements of senior managers 2020/21 on page 103
- The table of pension benefits of senior managers on page 107
- Analysis of staff numbers and costs on page 83 and 93
- The pay multiples disclosure on page 105 to 106and
- The table of exit packages on page 85

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.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice 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.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Foundation Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the Group and the Foundation Trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

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

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 course of 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 this gives rise to a material misstatement in the financial statements themselves. 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 this regard.

Responsibilities of accounting officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer of University Hospitals Birmingham NHS Foundation Trust, 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 they have been informed by the relevant national body of the intention to dissolve the Foundation Trust without the transfer of the Foundation Trust's services to another public sector entity.

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.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in-line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud, is detailed below.

We considered the nature of the Group and its control environment, and reviewed the Group's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management and Internal Audit about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the Group operates in, and identified the key laws and regulations that:

- Had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006
- Do not have a direct effect on the financial statements but compliance with which may be fundamental to the Group's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following area, and our specific procedures performed to address it are described below:

- Accruals, provisions and deferred income recorded at 31 March 2021 and the timing of their recognition at year-end is subject to potential management bias
- We tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2021
- We tested a sample of provisions to supporting documentation to understand the rationale for the inclusion of a provision, checking that it is a valid liability and that there was an event during 2020/21 that meant it was appropriate for the provision to be disclosed and
- We tested a sample of deferred income items to supporting documentation and evaluated management's assessment as to whether the criteria for revenue recognition had been met as at 31 March 2021

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- Reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements
- Performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud
- Enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations and
- Reading minutes of meetings of those charged with governance and reviewing internal audit reports

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- The parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- The information given in the Operational Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice, we are required to report to you if we have not been able to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the Trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the Trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Annual Governance Statement 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; 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.

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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report), and the work necessary to issue our statement on consolidation schedules. We are satisfied that our remaining work in these areas is unlikely to have a material impact on the financial statements or on our value for money conclusion.

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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Ian Howse CA, CPFA (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Birmingham
29 June 2021

Independent auditor's certificate of completion of the audit to the Council of Governors and Board of Directors of University Hospitals Birmingham NHS Foundation Trust

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 29 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the Group's and the Foundation Trust's affairs as at 31 March 2021 and of the Group's and the Foundation Trust's income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 29 June 2021, we had not completed our work on the Foundation Trust's arrangements and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 29 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources and the work necessary to issue our statement on consolidation schedules. We have now completed our work in these areas.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of University Hospitals Birmingham NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Ian Howse CPFA, CA (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
Cardiff
14 September 2021

Consolidated statement of comprehensive income

	Notes	Year Ended 31 March 2021 Total	Year Ended 31 March 2020 Total
Revenue from patient care activities	3	**1,709,682**	1,541,578
Other operating revenue	4	**340,863**	216,840
Total revenue		**2,050,545**	1,758,418
Operating expenses	5	**(2,004,172)**	(1,730,106)
Impairment charged to operating expenses	5	**(8,857)**	(2,500)
Total operating expenses		**(2,013,029)**	(1,732,606)
Operating surplus		**37,516**	25,812
Finance income	8	**15**	518
Finance expense	8	**(23,678)**	(24,032)
PDC Dividends payable	10	**-**	(1,347)
Net finance expense		**(23,663)**	(24,861)
Net loss on disposal	9	**(22)**	(271)
Taxation	11	**(109)**	(299)
Surplus for the year		**13,722**	381
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairment losses on property, plant and equipment	13.2	**(8,099)**	(17,991)
Revaluation increase on property, plant and equipment	13.2	**9,990**	5,654
Other comprehensive income / (loss)		**1,891**	(12,337)
Total comprehensive income / (loss) income for the year		**15,613**	(11,956)
Adjusted financial performance (control total basis):			
Retained surplus for the year		**13,722**	381
Remove net impairments not scoring to the Departmental expenditure limit		**8,857**	2,500
Remove (gains) / losses on transfers by absorption		**-**	-
Remove I&E impact of capital grants and donations		**(6,142)**	749
Remove net impact of DHSC centrally procured inventories		**(3,617)**	
Remove impact of prior year PSF post accounts reallocation		**-**	(943)
Adjusted financial performance surplus		**12,820**	2,687

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's Statement of Comprehensive Income and related notes, the Trust retained surplus for the reporting year was £13,417,000 (2019/20 - £39,000).

The notes on pages XVI to LXVIII are an integral part of these financial statements.

Consolidated statement of financial position

		Group		Foundation Trust	
		31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Notes	**£000**	£000	**£000**	£000
Assets					
Non-current assets					
Intangible assets	12	**18,515**	17,571	**18,515**	17,571
Property, plant and equipment	13	**767,409**	726,608	**764,911**	724,263
Trade and other receivables	19	**4,991**	10,057	**4,991**	10,057
		790,915	754,236	**788,417**	751,891
Current assets					
Inventories	18	**30,960**	37,933	**25,596**	32,562
Trade and other receivables	19	**96,538**	128,460	**103,595**	133,157
Cash and cash equivalents	20	**210,754**	60,970	**207,888**	58,295
		338,252	227,363	**337,079**	224,014
Total assets		**1,129,167**	981,599	**1,125,496**	975,905
Liabilities					
Current liabilities					
Borrowings	24	**(14,009)**	(48,373)	**(14,009)**	(48,373)
Trade and other payables	21	**(355,218)**	(275,458)	**(354,501)**	(272,459)
Current tax liabilities	11	**(81)**	(107)	**-**	-
Provisions	27	**(5,849)**	(5,018)	**(5,849)**	(5,018)
Other liabilities	22	**(51,805)**	(36,398)	**(51,781)**	(36,374)
		(426,962)	(365,354)	**(426,140)**	(362,224)
Total assets less current liabilities		**702,205**	616,245	**699,356**	613,681
Non-current liabilities					
Borrowings	24	**(434,813)**	(448,804)	**(434,813)**	(448,804)
Provisions	27	**(14,958)**	(9,020)	**(14,674)**	(8,740)
Deferred tax liabilities	23	**(47)**	(47)	**-**	-
Other liabilities	22	**(390)**	(414)	**(213)**	(213)
		(450,208)	(458,285)	**(449,700)**	(457,757)
Total liabilities		**(877,170)**	(823,639)	**(875,840)**	(819,981)
Net assets		**251,997**	157,960	**249,656**	155,924
Taxpayers' equity					
Public dividend capital		**453,411**	374,987	**453,411**	374,987
Revaluation reserve		**137,427**	137,837	**137,427**	137,837
Income and expenditure reserve		**(338,841)**	(354,864)	**(341,182)**	(356,900)
Total taxpayers' equity		**251,997**	157,960	**249,656**	155,924

The financial statements on pages XII to LXVIII were approved by the Board of Directors on 24 June 2021 and were signed on its behalf by:

Dr David Rosser, Chief Executive

Consolidated and Foundation Trust 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 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		-	(17,991)	-	**(17,991)**
Revaluations - property, plant and equipment		-	5,654	-	**5,654**
Balance at 31 March 2020		374,987	137,837	(354,864)	**157,960**
Surplus for the year		-	-	13,722	**13,722**
Public dividend capital received		78,424	-	-	**78,424**
Transfers between reserves			(2,301)	2,301	-
Net impairments	13.2	-	(8,099)	-	**(8,099)**
Revaluations - property, plant and equipment	13.2	-	9,990	-	**9,990**
Balance at 31 March 2021		**453,411**	**137,427**	**(338,841)**	**251,997**

Foundation Trust	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	**Total £000**
Balance at 1 April 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	-	(17,991)	-	**(17,991)**
Revaluations - property, plant and equipment	-	5,654	-	**5,654**
Balance at 31 March 2020	374,987	137,837	(356,900)	**155,924**
Surplus for the year	-	-	13,417	**13,417**
Public dividend capital received	78,424	-	-	**78,424**
Transfers between reserves		(2,301)	2,301	-
Net impairments	-	(8,099)	-	**(8,099)**
Revaluations - property, plant and equipment	-	9,990	-	**9,990**
Balance at 31 March 2021	**453,411**	**137,427**	**(341,182)**	**249,656**

Consolidated and Foundation Trust Statement of Cash Flows for the year ended 31 March 2021

		Group		Foundation Trust	
		31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
		Total	Total	**Total**	Total
	Notes	**£000**	£000	**£000**	£000
Cash flows from operating activities					
Operating surplus for the year		**37,516**	25,812	**36,891**	24,933
Depreciation and amortisation		**40,410**	36,913	**40,110**	36,574
Net impairment charged to operating expenses		**8,857**	2,500	**8,857**	2,500
Income recognised in respect of capital donations		**(8,183)**	(979)	**(8,183)**	(979)
Amortisation of PFI deferred income		**(448)**	(2,448)	**(448)**	(2,448)
Decrease / (increase) in inventories		**6,973**	(2,457)	**6,966**	(2,051)
Decrease / (increase) in trade and other receivables		**37,943**	(8,809)	**35,583**	(8,038)
Increase in trade and other payables		**68,103**	10,480	**70,452**	8,389
Increase in other liabilities		**15,831**	3,342	**15,855**	3,334
Increase in provisions		**6,767**	3,221	**6,765**	3,222
Tax paid		**(135)**	(158)	**-**	-
Net cash generated from operating activities		**213,634**	67,417	**212,848**	65,436
Cash flows from investing activities					
Interest received		**15**	521	**224**	751
Payments to acquire property, plant and equipment		**(69,305)**	(41,972)	**(68,919)**	(41,893)
Receipts from sale of property, plant and equipment		**1**	34	**1**	34
Receipt of cash donations to purchase capital assets		**1,201**	800	**1,201**	800
Payments to acquire intangible assets		**(2,107)**	(838)	**(2,107)**	(838)
Net cash used in investing activities		**(70,195)**	(41,455)	**(69,600)**	(41,146)
Cash flows from financing activities					
Public dividend capital received		**78,424**	7,487	**78,424**	7,487
Movement in loans from the Department of Health and Social Care		**(34,634)**	(129)	**(34,634)**	(129)
Capital element of finance lease obligations		**(204)**	(217)	**(204)**	(217)
Interest element of finance lease obligations		**(66)**	(85)	**(66)**	(85)
Capital element of PFI obligations		**(13,411)**	(12,711)	**(13,411)**	(12,711)
Interest element of PFI obligations		**(23,610)**	(23,407)	**(23,610)**	(23,407)
Interest on loans from the Department of Health and Social Care		**(106)**	(532)	**(106)**	(532)
PDC dividend (paid) / received		**(48)**	1,661	**(48)**	1,661
Net cash generated / (used) in financing activities		**6,345**	(27,933)	**6,345**	(27,933)
Net increase / (decrease) in cash and cash equivalents		**149,784**	(1,971)	**149,593**	(3,643)
Cash and cash equivalents at 1 April		**60,970**	62,941	**58,295**	61,938
Cash and cash equivalents at 31 March	20	**210,754**	60,970	**207,888**	58,295

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 2020/21 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 land and property, inventories 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. The Trust is not aware, as at the date of signing these financial statements, of any proposed transfers of NHS services between this Trust and another NHS Provider.

During the reporting year and due to the Covid-19 pandemic, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSE&I) announced reforms to the NHS cash regime, that will continue into the 2021/22 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 new financial regime for NHS Providers. NHSE announced that during the reporting year contract income from commissioners was 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 was a retrospective top-up available to ensure providers are fully funded for increased expenditure or losses of other types of income as a result of Covid-19. This includes the running costs of the ongoing Vaccination Programme for Birmingham and Solihull which continues into 2021/22. The Birmingham Nightingale Hospital commenced a decommissioning process in the period up to the reporting date.

The DHSC and NHSE&I announced in March 2021 that this agreed level of funding will continue into 2021/22 - for the first half of the new financial year and then to be reviewed again. This is detailed in their publication 'Supplementary guidance on H1 2021/22 finance and payments arrangements'. There is not yet any formal guidance or detail as to what the financial regime might look like post September 2021, 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 2021/22 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.

The Group has £210,754,000 of cash at the reporting date (of which the Trust has £207,888,000).

These financial statements were authorised for issue on the 24 June 2021. There is no event arising after the end of the reporting date requiring disclosure, as for the continuing Covid-19 pandemic; there is further detail disclosed in note 30 on page LXI 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 2021. 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 2020/21 paragraph 5.9, a separate Statement of Comprehensive Income for the parent (the Trust) has not been presented, an exemption afforded by the Companies Act 2006.

The GAM 2020/21 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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were

substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled 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.

1.2.2 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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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 donations

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.

1.2.5 Apprentice service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. 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 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% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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 three subsequent reporting dates, including 31 March 2021, 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 on a modern equivalent asset basis

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 the criteria in IFRS 5 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 and the assets are no longer subject to revaluation. 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 five to 25 years
- Land and assets under construction are not depreciated
- Plant and machinery is depreciated over five to 15 years
- Information technology is depreciated over two to 10 years
- Furniture and fittings are depreciated over five to 10 years
- Intangible software and licences / trademarks are depreciated over two to five years; and
- Finance lease assets are depreciated over the life of the lease.

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.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the DHSC GAM, the Trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

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 26.1 to the financial statements on page LVI. 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 Cost') 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 DHSC 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 26.1 to the financial statements on page LVI.

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 8 to the financial statements on page XXXIX.

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 19 to the financial statements on page LI.

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 three 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.

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 and until such terms and conditions of the contract in place are met, restrict the disclosure as revenue. 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 is then disclosed in non-current liabilities.

1.18 Borrowings

The Trust, during the reporting year, repaid the two DHSC loans inherited via the acquisition of the former Heart of England NHS Foundation Trust. Borrowings as at the reporting date 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 +0.18% (2019/20: +0.55%) in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of -0.95% (2019/20: -0.5%) 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 27.1 to the financial statements on page LXI, 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 28 to the financial statements on page LXI, 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

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 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 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 s987 ICTA 2010, 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 11 to the financial statements on page XL. 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 2021. 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 2020/21, disclosed in note 33 to the financial statements on page LXVII.

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 13.2 to the financial statements on page XLVII. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

During the prior 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. No further review occurred in the reporting year. The land and property values at the reporting date generally increased due to the application of the relevant indices of 31 March 2021.

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 healthcare and in provisioning for disputes with commissioners and customers. This arises from the complexity of the NHS funding regime (especially regards specialised services and its associated 'high cost' expenditure: drugs and devices), the 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 27 to the financial statements on page LIX.

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 2020/21:

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 2022. 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 2022, 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 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

IFRS 14 Regulatory Deferral Accounts and IFRS 17 Insurance Contracts
IFRS 14 is not applicable to DHSC group bodies and IFRS 17 which is expected to be adopted from April 2023 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 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 that sit outside this provision are noted below:

During the reporting year and due to the Covid-19 pandemic, the Trust hosted two arrangements outside of the healthcare services it normally provides. The first was the Birmingham Nightingale Hospital facility, based at the National Exhibition Centre, which at the reporting date was in the process of being decommissioned. The second was the Vaccination Programme which is ongoing at the reporting date and based at various locations across Birmingham and Solihull - vaccination is considered a 'primary care' activity and not one usually undertaken by secondary care providers. These two activities are considered to be distinctly separate from the core healthcare activity of the Trust - and arose from emergency Government directives as part of the national policy response to the pandemic. Therefore, both are considered separate segments reporting to the Trust board (the 'CODM'). In addition, the funded Covid-19 pandemic expenditure is also shown separately given its unique circumstance.

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 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.

Segmental analysis (cont)

Year ended 31 March 2021	Integrated Healthcare services	Covid-19 Pandemic	Nightingale Hospital	Vaccination Programme	Commercial subsidiaries	Inter-Group Eliminations	Total
	£000	£000	£000	£000	£000	£000	£000
Total segment revenue	1,919,416	70,728	47,354	4,718	61,694	(53,365)	2,050,545
Total segment expenditure	(1,891,385)	(70,728)	(47,354)	(4,718)	(61,066)	53,365	(2,021,886)
Net impairments	8,857		-	-	-	-	8,857
Operating surplus	**36,888**	**-**	**-**	**-**	**628**	**-**	**37,516**
Net financing	(23,449)	-	-	-	(214)	-	(23,663)
PDC dividends payable	-	-	-	-	-	-	-
Gains on disposal of assets	(22)	-	-	-	-	-	(22)
Taxation	-	-	-	-	(109)	-	(109)
Retained surplus	**13,417**	**-**	**-**	**-**	**305**	**-**	**13,722**
Reportable segment assets	1,125,496		-	-	20,174	-	1,142,660
Eliminations	-					(13,493)	(13,493)
Total assets	**1,125,496**		**-**	**-**	**20,174**	**(13,493)**	**1,129,167**
Reportable segment liabilities	(875,840)		-	-	(17,833)		(890,663)
Eliminations	-					13,493	13,493
Total liabilities	**(875,840)**		**-**	**-**	**(17,833)**	**13,493**	**(877,170)**
Net assets	**249,656**		**-**	**-**	**2,341**	**-**	**251,997**

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 (liabilities) / assets	**155,924**	**2,036**	**-**	**157,960**

All activities are based in the UK.

3 Revenue from contracted patient care activities

	Year Ended 31 March 2021	Year Ended 31 March 2020
	£000	£000
By commissioner		
Foundation Trusts	**1,678**	1,678
NHS Trusts	**2,128**	2,560
NHS England	**688,424**	638,277
NHS England - pension cost - employer contributions funding (6.3%)	**40,397**	38,160
NHS England - Covid-19 revenue	**-**	7,014
NHS England - annual leave and overtime corrective funding	**16,051**	-
Clinical Commissioning Groups (CCGs)	**859,040**	809,650
Clinical Commissioning Groups (CCGs) - top-up funding	**25,720**	-
Clinical Commissioning Groups (CCGs) - Covid-19 funding	**44,898**	-
Department of Health and Social Care	**-**	1,112
Local Authorities	**16,119**	17,872
NHS Other	**-**	2,171
Private patients	**2,381**	5,100
Overseas patients	**812**	1,269
NHS Injury Cost Recovery scheme	**2,420**	7,769
Non NHS other	**9,614**	8,946
	1,709,682	1,541,578

The responsibility for commissioning nationally funded NHS healthcare 'specialist healthcare activity' lies with NHS England which is the parent body of the CCGs.

As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements, but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

The revenue from NHS England and the CCGs disclosed in the reporting year are the block contract payments, the comparative year was disclosed under the activity based 'payments by results' methodology. The separate top-up and Covid-19 funding streams are additional sums paid to the Trust by Birmingham and Solihull CCG in the second half of the reporting year, to cover lost sources of revenue and increased costs of arising from the pandemic. In the first half of the reporting year, additional funding above the blocks was sourced directly from NHS England and is noted in other operating revenue - note 4 to the financial statements on page XXXIII.

The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. In the reporting year only another funding stream covers additional Agenda for Change related pay costs - increased annual leave entitlements not taken due to the pandemic and changes to overtime payments. The full cost and related funding of these pay costs have been recognised in these accounts. The equivalent pay costs are disclosed in employee expenses - note 7.1 to the financial statements on page XXXVII.

NHS Injury Cost Recovery scheme income, received from commercial insurance providers, is subject to a provision for expected credit losses of 22.43% (current), increasing with age: 40% (two years old), 60% (three years old), and up to 80% (four years old or more). Comparative year (2019/20 - all at 21.79%) - this increase reflects expected rates of collection versus withdrawn claims.

Non NHS other patient care revenue includes income from NHS Wales, NHS Scotland and NHS Northern Ireland.

Revenue from contracted patient care activities (cont)

	Year Ended 31 March 2021 £000	Restated Year Ended 31 March 2020 £000
By activity		
Acute Services:		
Block contract / system envelope income	**1,601,662**	1,181,731
Other NHS clinical	**3,806**	4,238
High cost drugs income from specialised commissioning	**16,420**	253,637
Community Services:		
Block contract / system envelope income	**-**	19,625
Income from other sources (e.g. local authorities)	**16,119**	17,686
All providers:		
NHS England - additional pension funding	**40,397**	38,160
NHS England - Covid 19 revenue support	**-**	7,014
Private patients	**2,381**	5,100
Other non-NHS clinical	**28,897**	14,387
	1,709,682	1,541,578

As noted on the previous page, the revenue from NHS England and the CCGs disclosed in the reporting year are block contract payments with additional top-ups, the comparative year was disclosed under the activity based 'payments by results' methodology. There is no longer any differentiation by activity type.

3.1 Overseas visitors (patients charged directly by the Trust)

	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Income recognised this year	**812**	1,269
Cash payments received in-year	**287**	520
Amounts added to provision for expected credit losses	**(1,788)**	(2,839)
Amounts written off in-year	**(1,701)**	(595)

3.2 Commissioner requested services

	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Commissioner requested services		
Revenue derived from NHS clinical activity in England	**1,694,455**	1,516,323
Non-commissioner requested services		
Revenue not derived from NHS clinical activity in England	**15,227**	25,255
	1,709,682	1,541,578
Commissioner requested services as a percentage of revenue	**99.11%**	98.36%

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure.

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.

4 Other operating revenue

	Year Ended 31 March 2021	Year Ended 31 March 2020
	£000	£000
Other operating income recognised in accordance with IFRS 15:		
Research and development	**24,803**	36,494
Education and training	**59,170**	53,691
Top up funding - NHS England	**174,908**	-
PSF, FRF and MRET funding	**-**	37,098
Non-patient care services to other bodies	**16,041**	22,681
Other revenue	**32,826**	59,646
	307,748	209,610
Other operating income recognised in accordance with other standards:		
Donations / grants of physical assets (non-cash)	**935**	679
Donated equipment from DHSC / NHSE for Covid response (non-cash)	**6,047**	-
Cash grants for the purchase of capital assets	**1,201**	300
Charitable and other contributions to expenditure	**2,187**	1,340
Contributions to expenditure - receipt of equipment donated from DHSC / NHSE for Covid response below capitalisation threshold	**6**	-
Contributions to expenditure - receipt of centrally procured inventories from DHSC	**20,116**	-
Apprenticeship fund	**45**	137
Rental revenue from operating leases	**2,130**	2,326
Amortisation of PFI deferred income / credits	**448**	2,448
	33,115	7,230
Other operating income	**340,863**	216,840

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.

In the comparative year the Provider Sustainability Funding (PSF) revenue was allocated to individual NHS Trusts, conditional upon their meeting certain financial targets. In the reporting year the revised NHS funding regime, due to the Covid-19 pandemic, has rendered that process invalid and it has been replaced by the top up and retrospective funding mechanisms. A breakdown of the top up funding disclosed above is as follows:

Other operating revenue (cont)

Breakdown of top up funding - by NHS England	£000	Year Ended 31 March 2021 £000
Block projected top up (M1 - M6)		**20,243**
Retrospective top up (M1 - M6) - validated	112,885	
Retrospective top up (M1 - M6) - unvalidated	-	
Reimbursement top up (M7 - M12) - validated	13,056	
Reimbursement top up (M7 - M12) - unvalidated	(3,141)	
		122,800
Specific scheme funding - NHSE		**9,790**
Specific scheme funding - DHSC	**-**	**-**
M7-M12 financial regime additional income		**22,075**
		174,908

The block top up (£20,243,000) in the first half of the reporting year reimbursed the Trust for the reduction in other operating income types (eg car parking and catering) due to the pandemic. The retrospective top up for the first half of the year and reimbursement top up for the second half of the year, includes all the costs incurred operating the Nightingale facility at the Birmingham NEC (£47,354,000), the vaccination programme (£4,718,000) and the additional costs incurred on specific Covid-19 related expenditure (£70,728,000). For months 7 to 12, the block top up was not reimbursed by NHS England, it was funded by Birmingham and Solihull CCG and was contained within the monthly block mandate payments, so is disclosed in healthcare revenue - see note 3 to the financial statements on page XXXI. The unvalidated deduction (-£3,141,000) is part of the disclosed retrospective and reimbursement top-up revenue sub-total (£122,800,000). The Trust believes it has been over funded for these activities and is disclosing a clawback of funding owing back to NHS England.

The specific scheme funding (£9,790,000) is largely made up IT digital technology funding.

The financial regime additional income represents the final calculation of lost revenue due to the pandemic by NHSE&I. This sum has been calculated by NHSE&I and is reflected with NHS receivables and the agreement of balances with NHS England (central body).

Other IFRS 15 revenue includes £1,238,000 from Clinical Excellence Awards (2019/20 - £2,730,000); recharges of £5,158,000 to the Ministry of Defence to fund the training expenditure of nurses, along with catering and car parking costs associated with the military contract (2019/20 - £2,849,000); £2,983,000 from Clinical Testing (2019/20 - £2,894,000); and funding of £1,862,000 (2019/20 - £2,090,000) 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 £34,398,000 (2019/20 - £31,034,000). As at the reporting date, there is contract liability - deferred income of £49,771,000 that is expected to be recognised as revenue in the 2021/22 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 2021	Year Ended 31 March 2020
	£000	£000
Recurring		
Purchase of healthcare from NHS and DHSC bodies	**15,390**	8,063
Purchase of healthcare from non-NHS and non-DHSC bodies	**27,954**	27,531
Directors' costs	**3,264**	3,267
Staff costs	**1,122,805**	1,015,750
Redundancy costs	**758**	663
Non executive Directors' costs	**245**	235
Drugs costs	**256,805**	241,943
Supplies and services - clinical	**191,189**	186,293
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for Covid response	**16,499**	
Supplies and services - general	**38,409**	23,980
Supplies and services - general: notional cost of equipment donated from DHSC / NHSE for Covid response below capitalisation threshold	**6**	
Consultancy services	**13,672**	1,988
Establishment	**13,353**	9,639
Research and development (non staff)	**16,531**	15,460
Education and training (non staff)	**12,642**	8,285
Transport	**5,968**	7,118
Operating lease expenditure	**2,000**	2,338
Premises	**143,709**	72,536
Movement in credit loss allowance: contract receivables	**4,280**	121
Depreciation on property, plant and equipment	**37,662**	34,659
Amortisation on intangible assets	**2,748**	2,254
Audit services - statutory audit	**250**	230
Other auditor remuneration - audit of subsidiaries	**20**	20
Other auditor remuneration - other assurance services	**90**	75
Internal audit services	**199**	150
Clinical negligence	**46,172**	38,847
Legal fees	**14**	2,237
Other	**31,538**	26,424
	2,004,172	1,730,106
Non-recurring		
Net impairments of property, plant and equipment	**8,857**	2,500
	8,857	2,500
Total operating expenses	**2,013,029**	1,732,606

Other expenditure includes £18,746,000 (2019/20 - £18,386,000) 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 auditor's liability of two million pounds sterling. Other auditors remuneration is £90,000 (2019/20 - £75,000) due to Local Counter Fraud Services. The engagement letter between the Trust and the external auditors was signed 16 March 2021.

An element of operating expenses arises from the charge of £8,857,000 (2019/20 - £2,500,000 charge) due to net impairments. See note 13.2 to the financial statements on page XLVII for details of the reporting year and prior year impairments.

During 2020/21 the Trust was a host Trust for the Birmingham Nightingale facility, based at the National Exhibition Centre, created as part of the regional coronavirus pandemic response. The lease with the NEC was arranged and held by NHS England; the Trust has paid for the actual setup, running and decommissioning costs; the Trust in turn was reimbursed by NHS England as part of the top-up process.

The costs incurred by the Trust in operating the facility have been included within the operating expenses note in these accounts. The total costs associated with the facility are disclosed below for information; This includes where existing resources were redeployed so the note below does not represent just the additional cost to the Trust of operating the facility. The gross costs (equal to the reimbursement from NHS England) are the total costs for the first half of the reporting year, and the incremental costs of the second half of the year, including all decommissioning costs, this reflects the changes in the NHS funding regime during the year.

Birmingham Nightingale hospital expenditure	**£000**
Set up costs:	
Staff costs	**37**
Other operating costs	**35,632**
Running costs:	
Staff costs	**1,371**
Other operating costs	**8,502**
Decommissioning costs:	
Staff costs	**-**
Other operating costs	**1,812**
Total gross costs	**47,354**

In addition to the operation of the Birmingham Nightingale facility, the Trust is also the host for the Birmingham and Solihull STP vaccination programme. As at the reporting date, the costs incurred for the on going vaccination programme are £4,718,000 - reimbursed by NHS England, see other operating revenue - note 4 to the financial statements on page XXXIII. Additional Covid-19 pandemic related expenditure (£70,728,000) included with the main operating expenditure note above has also been reimbursed by NHS England via the top up funding mechanism.

6 Operating leases

6.1 As lessee

Payments recognised as an expense	**Year Ended 31 March 2021**	Year Ended 31 March 2020
	£000	£000
Minimum lease payments - charged to operating expenses	**2,000**	2,338

Total future minimum lease payments	**Year Ended 31 March 2021**	Year Ended 31 March 2020
	£000	£000
Payable		
Not later than one year	**2,185**	2,464
Between one and five years	**4,608**	4,772
After five years	**1,253**	1,525
Total	**8,046**	8,761

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 2021	Year Ended 31 March 2020
	£000	£000
Rents recognised as income in the period	**2,130**	2,326

Total future minimum lease payments	Year Ended 31 March 2021	Year Ended 31 March 2020
	£000	£000
Receivable		
Not later than one year	**2,130**	2,326
Between one and five years	**8,519**	9,303
After five years	**29,412**	33,255
Total	**40,061**	44,884

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 2021			Year Ended 31 March 2020		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Short term employee benefits - salaries and wages	**868,021**	**801,162**	**66,859**	786,318	727,274	59,044
Short term employee benefits - social security costs	**81,780**	**81,780**	**-**	70,321	70,321	-
Post employment benefits - employer contributions to NHS pension scheme	**92,561**	**92,561**	**-**	87,205	87,205	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**40,397**	**40,397**	**-**	38,160	38,160	-
Pension cost - other contributions (NEST)	**241**	**241**	**-**	214	214	-
Apprentice Levy	**4,176**	**4,176**	**-**	3,889	3,889	-
Termination benefits	**758**	**758**	**-**	663	663	-
Temporary staff - agency/contract staff	**39,461**	**-**	**39,461**	36,782	-	36,782
Pay costs capitalised as part of assets	**(568)**	**(568)**	**-**	(3,872)	(3,872)	-
	1,126,827	**1,020,507**	**106,320**	1,019,680	923,854	95,826

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 2021	Year Ended 31 March 2020	**Year Ended 31 March 2021**	Year Ended 31 March 2020
	£000	£000	**£000**	£000
Salaries and short term benefits	**2,628**	2,556	**226**	217
Social Security Costs	**356**	335	**19**	18
Employer contributions to NHS Pensions Agency	**280**	376	**-**	-
	3,264	3,267	**245**	235

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 2021 there were nine early retirements from the Trust agreed on the grounds of ill-health (2019/20 - 7). The estimated additional pension liabilities of these ill-health retirements will be £318,000 (2019/20 - £430,000). The cost of these ill-health retirements will be borne by the NHS Pensions Scheme.

7.4 Staff exit packages

	Compulsory redundancies		Other agreed departures		Total termination packages	
	Number	**Cost £'000**	**Number**	**Cost £'000**	**Number**	**Cost £'000**
Termination benefit by band - Year Ended 31 March 2021						
< £10,000	8	45	-	-	8	45
£10,000 - £25,000	9	145	-	-	9	145
£25,000 - £50,000	5	161	-	-	5	161
£50,000 - £100,000	2	123	-	-	2	123
> £100,000	2	284	-	-	2	284
	26	**758**	**-**	**-**	**26**	**758**
Termination benefit by band - Year Ended 31 March 2020						
< £10,000	3	25	-	-	3	25
£10,000 - £25,000	2	33	-	-	2	33
£50,000 - £100,000	4	338	-	-	4	338
£100,001 - £150,000	2	267	-	-	2	267
	11	**663**	-	-	**11**	**663**

The termination benefits disclosed all relate to compulsory redundancies. Of the disclosed termination payments none (2019/20 - none) were non-contractual payments requiring HMT approval.

There were no termination benefits paid or due in the reporting year to key management personnel, who are defined to be the Board of Directors of the Trust (2019/20 - £nil).

8 Finance income and costs

	Year Ended 31 March 2021	Year Ended 31 March 2018
	£000	£000
Financing income		
Interest receivable	**15**	518
	15	518
Finance Expense		
Interest on loans from the DHSC - Capital	**-**	(54)
Interest on loans from the DHSC - Revenue support	**-**	(478)
Interest on obligations under PFI contracts	**(23,610)**	(23,407)
Interest on obligations under finance leases	**(66)**	(85)
Other financing charges	**(2)**	(8)
	(23,678)	(24,032)
Net finance expense	**(23,663)**	(23,514)

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 the reporting year (September 2020) all existing DHSC interim revenue and capital loans were extinguished and replaced by the issue of Public Dividend Capital (PDC) of equal amount, see the Borrowings note 25 on page 59 to these financial statements for further detail.

9 Gains on disposal of non-current assets

	Year Ended 31 March 2021	Year Ended 31 March 2020
	£000	£000
Profit on disposal of non-current assets	**1**	34
Loss on disposal of non-current assets	**(23)**	(305)
	(22)	(271)

10 Public dividend capital dividends

Public dividend capital ('PDC') dividends paid and due to the Department of Health and Social Care amounted to £nil (2019/20 - £1,347,000). PDC dividends are calculated as a percentage (3.5%) of average net relevant assets.

11 Tax recognised in Statement of Comprehensive Income

Recognised in the income statement	Year Ended 31 March 2021	Year Ended 31 March 2020
	£000	£000
Current tax expense		
Current year	**81**	107
Adjustments in respect of prior years	**28**	78
	109	185
Deferred tax expense		
Origination and reversal of temporary differences	**-**	113
Adjustments in respect of prior years	**-**	1
	-	114
Total tax expense recognised in income statement	**109**	299

Tax recognised in other comprehensive income is £nil (2019/20 - £nil).

Tax recognised directly in equity is £nil (2019/20 - £nil).

Reconciliation of effective tax rate	Year Ended 31 March 2021	Year Ended 31 March 2020
	£000	£000
Operating surplus before taxation – subsidiaries only *	**414**	641
Tax at the standard rate of corporation tax in the UK 19% (2018/19 - 19%)	**79**	122
Other	**2**	98
Adjustments in respect of prior years	**28**	79
Total tax expense / (credit)	**109**	299

* 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 XXVIII. 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% (2019/20: 19%). The government has announced that the UK corporation tax rate will remain at 19% until 1 April 2023 when it will increase to 25%."

12 Intangible assets

Group	Computer software – purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost				
At 1 April 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
Disposals	-	-	-	-
At 31 March 2020	**32,908**	**2,475**	**-**	**35,383**
Additions purchased / leased	1,981	126	-	2,107
Reclassifications	1,502	83	-	1,585
Disposals	(532)	(99)	-	(631)
At 31 March 2021	**35,859**	**2,585**	**-**	**38,444**
Amortisation				
At 1 April 2019	15,036	522	-	15,558
Charged for the year	1,922	332	-	2,254
At 31 March 2020	**16,958**	**854**	**-**	**17,812**
Charged for the year	2,355	393	-	2,748
Disposals	(532)	(99)	-	(631)
At 31 March 2021	**18,781**	**1,148**	**-**	**19,929**
Net book value				
At 31 March 2021	**17,078**	**1,437**	**-**	**18,515**
At 31 March 2020	15,950	1,621	-	17,571
At 1 April 2019	11,494	1,155	151	12,800

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.

Intangible assets (cont)

Trust	Computer software – purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost				
At 1 April 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**
Additions purchased / leased	1,981	126	-	2,107
Reclassifications	1,502	83	-	1,585
Disposals	(532)	(99)	-	(631)
At 31 March 2021	**35,859**	**2,585**	**-**	**38,444**
Amortisation				
At 1 April 2019	15,036	522	-	15,558
Charged for the year	1,922	332	-	2,254
At 31 March 2020	**16,958**	**854**	**-**	**17,812**
Charged for the year	2,355	393	-	2,748
Disposals	(532)	(99)	-	(631)
At 31 March 2021	**18,781**	**1,148**	**-**	**19,929**
Net book value				
At 31 March 2021	**17,078**	**1,437**	**-**	**18,515**
At 31 March 2020	15,950	1,621	-	17,571
At 1 April 2019	11,494	1,155	-	12,649

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.

13 Property, plant and equipment - 2020/21

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 2020	39,861	596,848	1,800	8,096	219,574	112	55,344	9,030	930,665
Additions purchased / leased	-	30,217	-	19,840	21,242	-	7,541	14	78,854
Additions donated / granted	-	1,232	-	-	802	-	-	102	2,136
Additions - equipment donated from DHSC for Covid response (non-cash)	-	-	-	-	6,047	-	-	-	6,047
Reclassifications	-	(739)	-	(1,294)	2,565	53	(1,284)	105	(594)
Impairments charged to the revaluation reserve	-	(8,099)	-	-	-	-	-	-	(8,099)
Reversal of impairments credited to operating expenses	-	4,951	57	-	-	-	-	-	5,008
Impairments charged to operating expenses	-	(13,865)	-	-	-	-	-	-	(13,865)
Revaluations	8	(7,427)	(30)	-	-	-	-	-	(7,449)
Disposals / derecognition	-	-	-	-	(4,155)	-	(6,711)	(966)	(11,832)
At 31 March 2021	**39,869**	**603,118**	**1,827**	**26,642**	**246,075**	**165**	**54,890**	**8,285**	**980,871**
Depreciation									
At 31 March 2020	-	3,069	-	-	150,165	112	42,354	8,357	204,057
Provided during the year	-	17,700	123	-	15,612	5	4,084	138	37,662
Reclassifications	-	30	-	-	961	-	-	-	991
Revaluations	-	(17,316)	(123)	-	-	-	-	-	(17,439)
Disposals / derecognition	-	-	-	-	(4,132)	-	(6,711)	(966)	(11,809)
At 31 March 2021	**-**	**3,483**	**-**	**-**	**162,606**	**117**	**39,727**	**7,529**	**213,462**
Net book value									
Owned	20,331	253,831	1,816	26,642	73,381	48	15,132	577	391,758
Finance leased	19,538	9,765	-	-	45	-	-	-	29,348
On-SoFP PFI contracts and other service concession arrangements	-	318,172	-	-	-	-	-	-	318,172
Owned - donated / granted	-	17,867	11	-	3,996	-	31	179	22,084
Owned - equipment donated from DHSC and NHSE for Covid response	-	-	-	-	6,047	-	-	-	6,047
At 31 March 2021	**39,869**	**599,635**	**1,827**	**26,642**	**83,469**	**48**	**15,163**	**756**	**767,409**

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 – 2020/21

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 2020	39,861	594,461	1,800	8,089	218,131	112	55,279	8,802	926,535
Additions purchased / leased	-	30,217	-	19,443	21,186	-	7,541	14	78,401
Additions donated	-	1,232	-	-	802	-	-	102	2,136
Additions - equipment donated from DHSC for Covid response (non-cash)					6,047				6,047
Reclassifications	-	(739)	-	(1,294)	2,565	53	(1,284)	105	(594)
Impairments charged to the revaluation reserve	-	(8,099)	-	-	-	-	-	-	(8,099)
Reversal of impairments credited to operating expenses	-	4,951	57	-	-	-	-	-	5,008
Impairments charged to operating expenses	-	(13,865)	-	-	-	-	-	-	(13,865)
Revaluations	8	(7,427)	(30)	-	-	-	-	-	(7,449)
Disposals / derecognition	-	-	-	-	(4,155)	-	(6,711)	(966)	(11,832)
At 31 March 2021	**39,869**	**600,731**	**1,827**	**26,238**	**244,576**	**165**	**54,825**	**8,057**	**976,288**
Depreciation									
At 31 March 2020	-	2,287	-	-	149,452	112	42,291	8,130	202,272
Provided during the year	-	17,538	123	-	15,476	5	4,082	138	37,362
Reclassifications	-	30	-	-	961	-	-	-	991
Revaluations	-	(17,316)	(123)	-	-	-	-	-	(17,439)
Disposals / derecognition	-	-	-	-	(4,132)	-	(6,711)	(966)	(11,809)
At 31 March 2021	**-**	**2,539**	**-**	**-**	**161,757**	**117**	**39,662**	**7,302**	**211,377**
Net book value									
Owned	20,331	252,388	1,816	26,238	72,731	48	15,132	576	389,260
Finance leased	19,538	9,765	-	-	45	-	-	-	29,348
On-SoFP PFI contracts and other service concession arrangements	-	318,172	-	-	-	-	-	-	318,172
Owned - donated / granted	-	17,867	11	-	3,996	-	31	179	22,084
Owned - equipment donated from DHSC and NHSE for Covid response	-	-	-	-	6,047	-	-	-	6,047
At 31 March 2021	**39,869**	**598,192**	**1,827**	**26,238**	**82,819**	**48**	**15,163**	**755**	**764,911**

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**

13.1 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

13.2 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 three subsequent reporting dates, including 31 March 2021, 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 2021**	Year Ended 31 March 2020
		£000	£000
Impairments			
Heartlands, Good Hope and Solihull land	4	**-**	(848)
Queen Elizabeth Hospital - non PFI estate	2	**(2,863)**	-
Heartlands, Good Hope and Solihull estate	3	**(11,002)**	(11,061)
		(13,865)	(11,909)
Reversals of impairments			
Queen Elizabeth Hospital - PFI facility	1	**1,401**	2,462
Queen Elizabeth Hospital - non PFI estate	2	**372**	1,325
Heartlands, Good Hope and Solihull estate	3	**3,235**	5,622
		5,008	9,409
Net (impairment)		**(8,857)**	(2,500)

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 2021 compared to 31 March 2020 of £1,401k. 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, Within the non PFI buildings of the Edgbaston estate, there are both impairments and reversals of impairments. The £372k reversal of previous impairments is largely due to the valuation of the Institute of Translational Medicine building. The -£2,763k of impairments is largely due to the difference between the expenditure on the

Wellcome building (theatres) and its MEA valuation, that exceeded the available revaluation reserve; therefore, the -£5,886k impairment to the revaluation reserve disclosed below, is also largely due to the decrease in MEA of the Wellcome building. The £4,040k increase in the revaluation reserve of the non PFI buildings at Edgbaston is largely due to the Pharmacy building increasing its MEA valuation as a result of the same improvement works noted above (Wellcome and Pharmacy are adjacent buildings).

3, Within the estate of the former Heart of England NHS Foundation Trust - the Heartlands, Good Hope and Solihull sites, there are both impairments and reversals of impairments. The £3,235k of reversals are due to additions at Heartlands (Ward 20 and 26) and Good Hope (Outpatients); while the -£11,002k of impairments are spread across the Emergency Departments and other critical infrastructure assets of all three sites - this being due to the difference between Covid-19 centrally funded expenditure (essential to the pandemic response) versus their respective MEA valuations.

4, In the prior reporting year the impairment of land charged to operating expenses and the revaluation reserve was due to the decrease in the land valuation determined by a revised revaluation methodology, there is no variation in the current reporting year as the valuation process was unchanged. The reporting year increase to the revaluation reserve of +£5,942k is largely due to the Cedarwood ward at Good hope and other ward improvements at Heartlands. The -£2,213k impairment to the revaluation reserve is largely due to the Oncology Unit at Good Hope and again a difference of expenditure versus MEA valuation.

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 XIV.

Revaluation gains/(losses) on property, plant and equipment Group		**Year Ended 31 March 2021**	Year Ended 31 March 2020
		£000	£000
Revaluation gains recognised in other comprehensive income			
Queen Elizabeth Hospital - land		**8**	-
Queen Elizabeth Hospital - non PFI estate	2	**4,040**	85
Heartlands, Good Hope and Solihull estate	4	**5,942**	5,569
		9,990	5,654
Impairments charged to the revaluation reserve and recognised in other comprehensive income			
Queen Elizabeth Hospital - non PFI estate	2	**(5,886)**	(470)
Queen Elizabeth Hospital - land	4	**-**	(8,236)
Heartlands, Good Hope and Solihull land	4	**-**	(6,115)
Heartlands, Good Hope and Solihull estate	4	**(2,213)**	(3,170)
		(8,099)	(17,991)
Net decrease to revaluation reserve		**1,891**	(12,337)

The revaluation gains and losses on property, plant and equipment for the Group are the same as for the Trust.

13.3 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 2019	326,472	38,440	364,912
Additions	4,041	-	4,041
Reclassifications	32	-	32
Revaluations	(15)	325	310
Reversal of impairments credited to operating expenses	2,470	-	2,470
Impairments charged to operating expenses	-	(8,236)	(8,236)
At 31 March 2020	**333,000**	**30,529**	**363,529**
Additions	5,345	-	5,345
Reclassifications	7,012	-	7,012
Revaluations	-	300	300
Impairments charged to the revaluation reserve	(23)	-	(23)
Reversal of impairments credited to operating expenses	1,418	-	1,418
At 31 March 2021	**346,752**	**30,829**	**377,581**
Depreciation			
At 1 April 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**
Charged for the year	7,373	333	7,706
At 31 March 2021	**28,580**	**1,481**	**30,061**
Net book value			
At 31 March 2021	**318,172**	**29,348**	**347,520**
At 31 March 2020	311,793	29,381	341,174
At 1 April 2019	312,472	37,618	350,090

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 26.1 to the financial statements on page LVI.

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 £19,538,000 (31 March 2020: £19,530,000), this is the Edgbaston site land leased from the Calthorpe Estate over a 999 year term.

13.4 Capital commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements, were £61,569,000 (31 March 2020: £11,462,000) for both Group and Trust. This amount relates entirely to property, plant and equipment, there are nil contracted capital commitments for intangible assets.

14 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 2021. 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.

15 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.

16 Joint Venture - Innovating Global Health China Limited

The Trust had 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 was a private company limited by shares, with the Trust and IGH each owning a 50% shareholdings. The partner company (IGH) was registered / organised under the laws of Switzerland. However, this joint venture is in the process of being closed down with the agreement of the partner company.

17 Non-current assets held for sale

The Trust has no non-current assets held for sale at the reporting date (31 March 2020: £nil).

18 Inventories

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Drugs	**17,674**	18,639	**12,391**	13,386
Consumables	**9,666**	19,112	**9,585**	18,994
DHSC centrally procured consumables	**3,617**		**3,617**	
Other	**3**	182	**3**	182
	30,960	37,933	**25,596**	32,562

The decrease across the reporting period is due to the reorganisation / centralisation into warehouses of stock holdings across the Trust, due in part to the pandemic.

The Group expensed £461,710,000 of inventories during the year (2019/20 - £427,619,000). The Group charged £2,783,000 to operating expenses in the year due to write-downs of obsolete inventories (2019/20 - £617,000).

19 Trade and other receivables

Current	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Contract receivables (IFRS 15): invoiced	**41,114**	72,488	**52,580**	73,181
Contract receivables (IFRS 15): not yet invoiced	**35,071**	36,748	**26,814**	36,856
Allowance for impaired contract receivables	**(11,777)**	(13,045)	**(11,692)**	(13,002)
PFI prepayments - lifecycle (capital)	**17,834**	16,927	**17,834**	16,927
Prepayments	**8,093**	10,571	**7,956**	10,459
PDC receivable	**201**	153	**201**	153
VAT receivable	**5,519**	4,106	**5,519**	4,106
Other receivables - revenue	**483**	512	**4,383**	4,477
Other receivables - capital	**-**	-	**-**	-
	96,538	128,460	**103,595**	133,157

Non-current	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Allowance for impaired contract receivables	**(4,942)**	(2,497)	**(4,942)**	(2,497)
Contract receivables (IFRS 15): not yet invoiced	**9,610**	11,458	**9,610**	11,458
Other receivables - revenue	**323**	1,096	**323**	1,096
	4,991	10,057	**4,991**	10,057
Of which receivable from NHS and DHSC group bodies:				
Current	**48,029**	76,487	**48,029**	76,487
Non current	**323**	1,096	**323**	1,096

Included within other receivables - revenue are amounts owing by NHS England for reimbursement of the Clinician pension tax provision, £38,000 current and £323,000 non-current; this being new in the reporting year. The corresponding liability (owed to NHS Pensions agency) is detailed in provisions, see note 27 to the financial statements on page LIX. Within the remainder of current other receivables - revenue is VAT owed by HMRC of £5,519,000 (31 March 2020: £4,106,000).

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 LXI.

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £18,508,000 (31 March 2020 £17,735,000) 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 2020/21	Group Contract receivables	Trust Contract receivables
	£000	£000
Balance at 1 April	15,542	15,499
New allowances arising	7,714	7,672
Reversals of allowances (collected in-year)	(3,434)	(3,434)
Utilisation of allowances (written off)	(3,103)	(3,103)
Balance at 31 March	16,719	16,634

Allowances for credit losses - 2019/20	Group Contract receivables	Trust Contract receivables
	£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)
Balance at 31 March	15,542	15,499

The transfer by absorption is the allowance for credit losses (both contract and other) of the former Heart of England NHS FT on 1 April 2018.

20 Cash and cash equivalents

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
At 1 April	**60,970**	62,941	**58,295**	61,938
Net change in year	**149,784**	(1,971)	**149,593**	(3,643)
At 31 March	**210,754**	60,970	**207,888**	58,295
Made up of				
Cash with Government Banking Service	**206,559**	57,437	**206,559**	57,437
Commercial banks and cash in hand	**4,195**	3,533	**1,329**	858
Cash and cash equivalents as in Statement of Financial Position	**210,754**	60,970	**207,888**	58,295
Cash and cash equivalents as in Statement of Cash Flows	**210,754**	60,970	**207,888**	58,295

21 Trade and other payables

Current	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
NHS payables	**10,756**	22,512	**10,745**	22,502
Amounts due to other related parties	**13,660**	13,075	**13,660**	13,075
Commercial trade payables	**108,556**	86,520	**103,569**	77,599
Trade payables - capital	**19,240**	7,583	**19,255**	7,665
Taxes payable	**22,869**	20,386	**22,799**	20,324
Other payables	**9,315**	4,305	**14,134**	9,984
Accruals	**133,619**	110,419	**133,136**	110,652
Annual leave accrual	**19,488**	4,382	**19,488**	4,382
Receipts in advance	**17,715**	6,276	**17,715**	6,276
	355,218	275,458	**354,501**	272,459

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 £13,035,000 (31 March 2020: £12,112,000).

Non current trade and other payables are nil (31 March 2020: £nil).

22 Other liabilities

Current	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Deferred income	**51,805**	36,398	**51,781**	36,374

Non-current	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Deferred income	**390**	414	**213**	213

Deferred income is due to the timing of contract liabilities arising from research and education activies.

23 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 2019	46	(113)	(67)
Charge to the income statement	1	113	114
At 31 March 2020	**47**	**-**	**47**
Charge to the income statement	-	-	-
At 31 March 2021	**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 2021	Year Ended 31 March 2020
	£000	£000
Deferred tax assets	**-**	**-**
Deferred tax liabilities	**47**	**47**
Net non current deferred tax asset	**47**	**47**

24 Borrowings

Group and Trust	Current		Non-Current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	Total	Total	**Total**	Total
	£000	£000	**£000**	£000
Loans from the DHSC - Capital	**-**	2,848	**-**	-
Loans from the DHSC - Revenue support	**-**	31,892	**-**	-
Obligations under finance leases	**210**	204	**806**	1,016
Obligations under Private Finance Initiative contracts	**13,799**	13,429	**434,007**	447,788
	14,009	48,373	**434,813**	448,804

The Private Finance Initiative obligation relates to the schemes as detailed in note 26.1 to the financial statements on page LVI.

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 five 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 were repaid in September 2020 and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £34,634,000 were thus converted to PDC at this time.

24.1 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 2020	34,740	1,220	461,217	**497,177**
Cash movements:				
Financing cash flows - principal	(34,634)	(204)	(13,411)	**(48,249)**
Financing cash flows - interest	(106)	(66)	(14,391)	**(14,563)**
Non cash movements:				
Interest charge arising in year	-	66	14,391	**14,457**
At 31 March 2021	**-**	**1,016**	**447,806**	**448,822**

25 Finance lease obligations (other than PFI)

Group and Trust	Minimum lease payments		Present value of minimum lease payments	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Gross lease liabilities	**1,171**	1,441	**1,171**	1,441
Of which liabilities are due:				
Not later than one year	**261**	273	**261**	273
Later than one year, not later than five years	**639**	884	**639**	884
Later than five years	**271**	284	**271**	284
Net finance charges allocated to future periods	**(155)**	(221)	**(155)**	(221)
Net lease liabilities	**1,016**	**1,220**	**1,016**	**1,220**
Not later than one year	**210**	204	**210**	204
Later than one year, not later than five years	**578**	779	**578**	779
Later than five years	**228**	237	**228**	237

The finance lease obligations disclosed relate to medical equipment and buildings. The Edgbaston site land is a long term finance lease, detailed in note 13.3 to the financial statements on page XLIX, this has a nominal charge as the land is covenanted for the 'provision of healthcare and education' to the city of Birmingham.

26 Private finance initiative contracts

26.1 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: Group and Trust	**Year Ended 31 March 2021**	Year Ended 31 March 2020
	£000	£000
Gross PFI lease liabilities	**662,874**	690,676
Of which liabilities are due:		
Not later than one year	**27,764**	27,803
Later than one year, not later than five years	**104,425**	107,761
Later than five years	**530,685**	555,112
Net finance charges allocated to future periods	**(215,068)**	(229,459)
Net PFI lease liabilities	**447,806**	461,217
Not later than one year	**13,799**	13,429
Later than one year, not later than five years	**52,857**	54,485
Later than five years	**381,150**	393,303
Net PFI lease liabilities by scheme:		
The Queen Elizabeth Hospital Birmingham	**446,388**	459,602
The main entrance and retail facility at Heartlands Hospital	**244**	278
The provision of energy management services at Heartlands Hospital	**1,174**	1,337
	447,806	461,217

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 and 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
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 2021**	Year Ended 31 March 2020
	£000	£000
Consisting of:		
Interest charge	**14,391**	**14,799**
Repayment of finance lease liability	**13,411**	**12,711**
Service element and other charges to operating expenditure	**18,746**	**18,386**
Capital lifecycle maintenance	**4,917**	**3,712**
Contingent rent	**9,219**	**8,608**
Addition to lifecycle prepayment - capital	**907**	**2,010**
Total amounts paid to service concession operators	**61,591**	**60,226**

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 2021			
	PFI 1	**PFI 2**	**PFI 3**	**Total**
	£000	**£000**		**£000**
2nd to 5th years (inclusive)	-	-	1,109	1,109
11th to 15th years (inclusive)	-	532	-	532
26th to 30th years (inclusive)	60,809	-	-	60,809

	31 March 2020			
	PFI 1	**PFI 2**	**PFI 3**	**Total**
	£000	**£000**		**£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

26.2 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 £863,000 was paid in the reporting year (£842,000 in 2019/20). 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 2021**	Year Ended 31 March 2020
	£000	£000
Payable:		
Not later than one year	**886**	865
Later than one year, not later than five years	**2,802**	3,697
Later than five years	**-**	-

27 Provisions

Group	Current		Non current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Pensions - early departure costs	**106**	108	**848**	884
Pensions - injury benefits	**292**	286	**4,964**	4,842
Legal claims	**2,825**	3,598	**284**	280
Redundancy	**323**	-	**-**	-
Clinician pension tax obligation	**38**	125	**323**	1,096
Other	**2,265**	901	**8,539**	1,918
	5,849	5,018	**14,958**	9,020

	Pensions - early departures	**Pensions - injury benefits**	**Legal claims**	**Redun-dancy**	**Clinician Pension tax Obligation**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2020	992	5,128	3,878	-	1,221	2,819	**14,038**
Change in the discount rate (rebasing)	15	207	-				**222**
Arising during the year	71	212	957	323	361	8,542	**10,466**
Used during the year	(105)	(289)	(411)	-	-	(431)	**(1,236)**
Reversed unused	(19)	-	(1,319)	-	(1,221)	(126)	(2,685)
Unwinding of discount	-	(2)	4	-	-	-	**2**
At 31 March 2021	**954**	**5,256**	**3,109**	**323**	**361**	**10,804**	**20,807**
Expected timing of cash flows:							
Within one year	106	292	2,825	323	38	2,265	**5,849**
Between one and five years	432	1,196	-	-	147	8,539	**10,314**
After five years	416	3,768	284	-	176	-	**4,644**

Trust	Current		Non current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Pensions - early departure costs	**106**	108	**848**	884
Pensions - injury benefits	**292**	286	**4,964**	4,842
Legal claims	**2,825**	3,598	**-**	-
Redundancy	**323**	-	**-**	-
Clinician pension tax obligation	**38**	125	**323**	1,096
Other	**2,265**	901	**8,539**	1,918
	5,849	5,018	**14,674**	8,740

	Pensions - early departures	**Pensions - injury benefits**	**Legal claims**	**Redundancy**	**Clinician Pension tax Obligation**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2020	992	5,128	3,598	-	1,221	2,819	**13,758**
Change in the discount rate (rebasing)	15	207	-	-	-	-	**222**
Arising during the year	71	212	957	323	361	8,542	**10,466**
Used during the year	(105)	(289)	(411)	-	-	(431)	(1,236)
Reversed unused	(19)	-	(1,319)	-	(1,221)	(126)	**(2,685)**
Unwinding of discount	-	(2)	-	-	-	-	**(2)**
At 31 March 2021	**954**	**5,256**	**2,825**	**323**	**361**	**10,804**	**20,523**
Expected timing of cash flows:							
Within one year	106	292	2,825	323	38	2,265	**5,849**
Between one and five years	432	1,196	-	-	147	8,539	**10,314**
After five years	416	3,768	-	-	176	-	**4,360**

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 provision arising - 'clinicians pension tax' - is an estimate of future obligations if in the current reporting year, clinicians either have already or will sign up to the NHS Pensions 'scheme pays' option for 2019/20 only (applications are still open). 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 LII.

The provisions included under 'legal claims' consist of employers and public liability £977,000 (31 March 2020: £961,000), employment tribunals £1,848,000 (31 March 2020: £2,637,000) and in respect of UHB Facilities Ltd a tenant's dilapidations contractual commitment for the Rabone Lane site £284,000 (31 March 2020: £280,000). There is £323,000 redundancy provision at the reporting date (31 March 2020: £nil).

The provisions included under 'other' include an amount of £10,804,000 (31 March 2020: £2,518,000) at the reporting date in respect of environmental corrections required within the both the estates of the Heritage buildings at Edgbaston (non-PFI) and of the former Heart of England NHS FT (Heartlands, Sutton Coldfield and Solihull), which was transferred to the Trust on 1 April 2018.

27.1 Provisions disclosed elsewhere in the DHSC group - the clinical negligence liability

Provisions within the annual accounts of NHS Resolution at 31 March 2021 include £339,817,000 in respect of clinical negligence liabilities of the Trust (31 March 2020: £276,889,000). Per the DHSC-GAM (paragraph 5.114), NHS Resolution has assumed responsibility for the settlement of clinical negligence claims, on behalf of NHS Providers.

28 Contingencies

There are £23,000 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 27 to the financial statements on page LIX (31 March 2020: £69,000). There are no contingent assets at the reporting date (31 March 2020: £nil).

29 Events after the reporting period

These financial statements were authorised for issue on the 24 June 2021, there were no events arising after the end of the reporting period up to which this date qualifies for disclosure.

30 The ongoing Covid-19 pandemic and the NHS response

The Covid-19 pandemic - this has impacted financially the way the Trust is funded from the DHSC (via NHS England) - for both the reporting year and now the following financial year 2021/22.

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, this continues into the next financial year 2021/22. To date, NHSE&I has announced a block contract funding regime for the first half of the year to September 2021.

1, Revenue
Due to the nature of the pandemic and its affect upon elective healthcare activity, the block contract arrangements will continue at least until September 2021 for all NHS Providers. In addition, the ongoing vaccination programme will continue to the funded by NHSE as this is outside the normal secondary healthcare provision the Trust is contractually obliged to provide, vaccination programmes (in this case for the population of Birmingham and Solihull) are traditionally considered primary healthcare services.

Post September 2021, there is not yet any formal guidance or detail as to what the financial regime might look like. It is expected to remain a block contract arrangement, with some elective activity incentive, 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.

2, Capital Funding

Where there is a requirement for capital expenditure over and above that supported by the Trust's internally generated funds, PDC capital is available for centrally approved projects, such as the new Ambulatory Care and Diagnostic (ACAD) building being constructed at the Heartlands site.

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 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 and Social Care 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	2,096	1	744,720	313
NHS Herefordshire and Worcestershire CCG	227	71	24,992	191
NHS Dudley CCG	75	-	9,384	-
NHS South Warwickshire CCG	30	-	5,500	-
NHS Sandwell And West Birmingham CCG	345	47	41,292	104
NHS South East Staffs and Seisdon Peninsula CCG	303	-	47,163	-
NHS Warwickshire North CCG	63	-	9,165	-
NHS Walsall CCG	-	-	12,395	-
NHS Cannock Chase CCG	-	-	2,101	-
NHS Coventry and Rugby CCG	17	-	2,218	-
NHS Shropshire CCG	23	-	2,139	-
NHS Wolverhampton CCG	-	-	2,862	-
NHS England (specialised commissioning)	5,886	-	18,375	-
NHS England (West Midlands)	1,171	-	667,190	-
Health Education England	965	93	52,605	-
Public Health England	347	847	1,063	4,371
Birmingham and Solihull Mental Health NHS Foundation Trust	-	-	1,017	3,288
The Royal Orthopaedic Hospital NHS Foundation Trust	9	167	4,494	1,877
Birmingham Women's and Children's Hospital NHS FT	414	718	10,243	4,428
Birmingham Community Healthcare NHS Foundation Trust	70	287	2,029	596
Sandwell and West Birmingham Hospitals NHS Trust	14	5	3,412	2,991
The Royal Wolverhampton NHS Trust	293	60	5,341	234
Department of Health and Social Care	1,566	55	15,700	-
NHS Litigation Authority	-	20	-	47,220
NHS Property Services	-	2,490	-	1,482
NHS England - Core (inc. Top-Ups)	27,857	3,512	192,985	-
Other	5,917	2,383	26,744	7,734
	47,688	**10,756**	**1,905,129**	**74,829**
Other related parties – Whole of Government Accounts				
Ministry of Defence	4,221	5	7,583	2,428
NHS Pension Scheme	69	13,035	-	132,958
Birmingham City Council	1,362	31	14,794	346
NHS Wales	123	177	8,951	64
NHS Blood and Transport	102	323	2,125	10,481
HMRC	5,519	22,997	-	86,065
West Midlands Combined Authority	-	-	-	6,000
Other	1,287	89	2,978	679
	12,683	**36,657**	**36,431**	**239,021**

The Trust has also received revenue and capital payments from the University Hospital Birmingham Charities totalling £1,997,000 (2019/20 - £2,019,000).

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 £3,266,000 (31 March 2020 - £710,000) owed by and payables include £2,021,000 (31 March 2020 - £10,000) owed to Pharmacy@QEHB Ltd. The Trust's revenue includes £1,259,000 (31 March 2020 - £1,059,000) received from and expenditure includes £57,418,000 (31 March 2020 - £58,365,000) paid to Pharmacy@QEHB Ltd.

The Trust's receivables include £110,000 (31 March 2020 - £38,000) owed by and payables includes £102,000 (31 March 2020 - £210,000) owed to UHB Facilities Ltd. The Trust's revenue includes £77,000 (31 March 2020 - £81,000) received from and expenditure includes £2,636,000 (31 March 2020 - £2,372,000) paid to UHB Facilities Ltd.

The Trust's receivables include £18,000 (31 March 2020 - £39,000) owed by and payables includes £nil (31 March 2020 - £nil) owed to Assure Dialysis Services Ltd. The Trust's revenue includes £31,000 (31 March 2020 - £31,000) received from and expenditure includes £993,000 (31 March 2020 - £902,000) 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 2019/20).

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 2021 under IFRS 9					
Trade and other receivables excluding non financial assets - non current	1	4,991	**4,991**	4,991	**4,991**
Trade and other receivables excluding non financial assets - current	1	64,891	**64,891**	72,085	**72,085**
Cash and cash equivalents	1	210,754	**210,754**	207,888	**207,888**
As at 31 March 2021		**280,636**	**280,636**	**284,964**	**284,964**

	Notes	Group		Trust	
		Loans and receivables cost	Total book value	Loans and receivables 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	**10,057**	8,961	**10,057**
Trade and other receivables excluding non financial assets - current	1	96,391	**96,703**	102,360	**101,512**
Cash and cash equivalents	1	60,970	**60,970**	58,295	**58,295**
As at 31 March 2020		**166,322**	**167,730**	**169,616**	**169,864**

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 2021 under IFRS 9					
Loans from the DHSC	2	-	**-**	-	**-**
Obligations under finance leases	2	1,016	**1,016**	1,016	**1,016**
Obligations under PFI service concession contracts	2	447,806	**447,806**	447,806	**447,806**
Trade and other payables excluding non financial liabilities	1	301,549	**301,549**	300,913	**300,913**
Provisions under contract	1	14,235	**14,235**	13,951	**13,951**
As at 31 March 2021		**764,606**	**764,606**	**763,686**	**763,686**

		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**

The fair value on all these financial assets and financial liabilities equates to their carrying value.

Maturity of financial liabilities

		Group		Trust	
	Notes	31 March 2021	31 March 2020	31 March 2021	31 March 2020
		£000	£000	£000	£000
In one year or less	3	**343,809**	303,957	**343,173**	301,030
In more than one years but not more than five years	3	**105,064**	110,563	**105,064**	110,563
In more than five years	3	**530,956**	555,676	**530,672**	555,396
		979,829	970,196	**978,909**	966,989

The maturity profile of financial liabilities is based on the contractual undiscounted cash flows (therefore, is shown gross including future interest on the finance leases and PFI obligations). This differs to the amounts recognised in the statement of financial position which are discounted to present value (eg net, as in the first two notes above - the carrying values of financial liabilities).

(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 25 and 26.1 to the financial statements on pages LV and LVI respectively.

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, VAT and PDC dividend receivable which are not financial instruments, see note 19 to the financial statements on page LI.
- Trade payables includes receipts in advance, social security and corporation taxation which are not financial instruments, see note 21 to the financial statements on page LIII.
- 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 27 to the financial statements on page LIX.

(3) Maturity of financial liabilities - this disclosure now based on the contractual undiscounted cash flows, was previously prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

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 XXVIII, 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 LII, 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 26.1 to the financial statements on page LVI. For the reporting year the relevant RPI index was 292.0 (annualised rate of 2.46%) fixed at February 2021. 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 2021**		Year Ended 31 March 2020	
	£000	**£000**	£000	£000
	+1.0%	**-1.0%**	+1.0%	-1.0%
Retained surplus/(deficit)	**(585)**	**585**	(576)	576
Taxpayers' equity	**(585)**	**585**	(576)	576

(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 10 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 £9,897 of cash at the reporting date (31 March 2019: £7,616) 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 2021		Year Ended 31 March 2020	
	Number	**£000**	Number	£000
Losses				
Cash losses	**89**	86	65	45
Bad debts and claims abandoned	**561**	1,943	412	730
Damage to property and stores losses	**5**	1,070	5	969
	655	3,099	482	1,744
Special payments				
Ex gratia payments	**114**	93	232	71
	114	93	232	71
Total losses and special payments	**769**	3,192	714	1,815

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: February 2021

National Health Service Act 2006

Direction by NHS Improvement Monitor, in Respect Of Foundation Trusts' Annual Reports and the Preparation Of Annual Reports

NHS Improvement 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 NHS Improvement Monitor

Signed:

Name: **Amanda Pritchard (Chief Executive)**

Dated: February 2021