BB Healthcare Trust

Monthly News
December 2020

Marketing document

As at 12/31/2020	Value	1 Month (December)	YTD	Since Launch (ITD)
Share	177.50	3.2%	28.5%	92.4%
NAV	175.11	1.5%	25.1%	93.4%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.12.2020, NAV and share price returns are adjusted for dividends paid during the period (but not assuming re-investment). Full performance data is on page 5.

Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed.

Welcome to our December update. Ordinarily, the artificer might choose this time to cast one eye to the outlook for the coming year, whilst wistfully reviewing that which has gone before. There are many dangers in this approach; a mawkish tendency to conflate previous good fortune with skilled decision making and that most instinctive of tendencies – to confer the future with an optimistic outlook. If only it were true that "things can only get better…"

Brexit is done; vaccines are here and the recovery mantra from Wall Street's panjandrums is so pervasive and seemingly infectious, that it too might soon be declared a pandemic. Alas, the near-term outlook suggests things could worsen significantly before they finally improve. None of this is unforeseen, but navigating between two opposing forces is seldom easy.

Summary

BB Healthcare Trust Ltd is a high conviction, unconstrained, long-only vehicle invested in global healthcare equities with a max of 35 stocks. The target annual dividend is 3.5% of NAV and the fund offers an annual redemption option. BB Healthcare is managed by the healthcare investment trust team at Bellevue Asset Management (UK) Ltd.

Britain finally leads the world…

One could devote countless pages to the many and various poor decisions that have typified the UK's response to COVID-19 and the money wasted along the way. No matter, for we shall eschew any retrospective considerations in this update. The key point is that, all the way through, the Government has elected to mark its own homework and describe its efforts as world-beating.

In one respect, we can claim leadership and that is in the genetic sequencing of pathogens. Britain seemingly gave the world "SARS-CoV-2 B.1.1.7" (pejoratively referred to as "mutant COVID" to the world's media), but was able to gift wrap it for other nations to track, thanks to our rapid sequencing capabilities.

It was inevitable that the virus would accumulate mutations that would ultimately improve human-to-human transmission. This has happened once already, with the D614G mutation that emerged in early spring 2020 rapidly superseding the original Wuhan strain as the dominant type, due to improved transmissibility. There have long been thousands of variants with random differences that do not confer any benefit, but what might the emergence of a further refined pathogen mean practically?

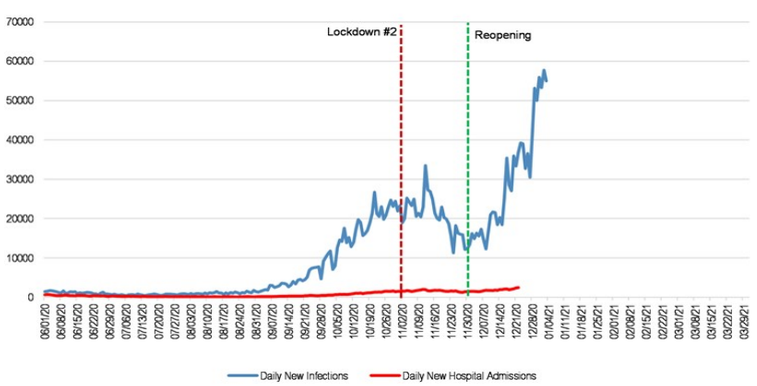
It now seems clear that this variant has increased transmissibility through higher viral loads being generated; its R0 ("basic reproduction number") is thus higher, perhaps 0.3-0.4 higher than the initial strain, where estimates of R0 vary from around 2.0 to almost 6.0. Estimating R0 is fraught with uncertainties, in part because you can only use data from early on in a pandemic when no infection control measures are in place and the absence of testing from these early days make it very difficult to ascertain the case number doubling time with any confidence. Based on the data that we have seen, we intuitively agree more with values ~2.0 than suggestions that it is 5+.

Returning to the practical: control measures are intended to keep RE ("the effective reproduction number" – the "R value" that the Government reports on weekly) below 1.0, which means cases are falling rather than rising. Clearly, a virus with an inherently higher R value will need more stringent measures in order to achieve this. We have seen this manifest in the failure of the four tier UK restriction system to contain case growth and another lockdown has seemed inevitable for several days now.

The emergence of the B.1.1.7 strain coincided with the run up to both the UK's departure from the European Union and Christmas, a busy time for international travel. Whilst the world is awash with movement restrictions, both of these events were independent drivers of international travel to and from the UK. Now that other countries know what to look for, this strain is turning up everywhere and it will doubtless become the dominant global strain over the coming months (although it has some competition from another variant called 501Y.V.2. This has similar important mutations but emerged independently in South Africa, which is less well connected globally than the UK, so we would expect this logistical leg up will help B.1.1.7 outcompete 501Y.V.2). We are thus the petri dish for what the rest of the world will soon experience: faster case growth and increased numbers of morbid patients.

Looking at the data so far (Figure 1 below), the increased case numbers are not translating into proportionately more severe disease but the higher denominator of more cases means a higher numerator of hospitalisations and we are now at the threshold of the NHS being able to cope; non-emergency surgical procedures (so called level 2 operations, which can include cancer resections and some cardiovascular procedures) are already being cancelled in a number of areas.

Readers will of course recall that "protecting the NHS" has been the primary trigger for previous lockdowns. Paradoxically, improved treatment for severe COVID-19 means longer in-patient stays, because the patients survive and then need time to recover, especially after ventilation. This exacerbates further the pressure on critical care infrastructure.



Source: WHO, Worldometer; J.P. Morgan estimates

Even before the Government finally moved toward another "national lockdown", the majority of people here are already constrained by onerous Tier 4 measures. From a consumer sentiment point of view, it is apparent that fear is once again on the ascendency. One need only go for a walk to see the return of COVID wariness in how people are giving each other a wide berth. Your managers can recount several first hand examples of renewed shielding, especially amongst those who perceive they will imminently receive the hallowed vaccine. This cannot be good for the forthcoming economic recovery, on which so much is already wagered.

It is this singular issue that weighs on our appetite for further capital deployment. If one delves into Wall Street's aforementioned prognostications for the coming year, there are generally some caveats to whatever base case scenario is proposed. These are many and varied, but many cite COVID resurgence or issues with vaccine deployment (be that logistics, reluctant uptake or emergent resistance) as key issues. It feels to us that the downside scenario is already upon us.

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"Following the Science" part 1 – vaccines

In our ongoing quest to lead the world, Britain was first to approve both the Pfizer/BioNTech and Astra/Oxford vaccines. We have also been first to dose non trial participants with each of these vaccines. In most respects, there nothing remarkable in the UK vaccination approach; focusing as it does on the groups with the highest risk of morbidity and then cascading down the risk profiles over time until open vaccination becomes an option for everyone. The same approach is being taken across the globe.

However, the desire for mass vaccination, allied to repeated (and scarcely credible) claims of "getting back to normal by Easter [2021]" seem to have become an embarrassment for the Government. Such a promise might have been realistic based on the orders placed for vaccines, but asking for something and receiving it are not the same thing.

For instance, it was initially stated that the UK would receive 10 million doses of the Pfizer vaccine during 2020, but less than one million were administered by the end of the year. We do not know how many more doses are on hand, but it seems to be in the hundreds of thousands rather than the millions (per the Prime Minister's comments on the Andrew Marr show on January 3rd 2021). The "tens of millions" of doses of the home grown Astra/Oxford vaccine has translated into around 500,000 doses being available on the first day of deployment.

None of this is remotely surprising. The complexities of manufacturing scale-up, allied to the rapidity of approval and significant pressure to distribute supplies equitably between countries means that demand will exceed supply for many months to come.

The UK vaccination plan (which covers around 22 million people being vaccinated before the end of 2021) is predicated on hiring around 40,000 additional staff and reports of the Kafkaesque absurdities of this process mean that only a fraction had been recruited and trained by the end of 2020. Incidentally, Scotland has said that it will take until May to have given the first dose of vaccine to the vulnerable plus the over 50s, with various supply-related caveats being made. Given the UK vaccine allocation pro-rates for Scotland, one does rather wonder how one devolved unit could have a vastly different view on this to another...

To our minds, the only surprising thing about this whole situation is why any politician would be foolish enough to repeat the notion that we will be sufficiently progressed in all of this by Easter to allow a rollback of restrictions. Nonetheless, the target is out there and the "optics" of its achievement seem to have jumped the (much maligned) shark of following the science.

In the dying days of 2020, it was announced that the UK would cease to follow the recommended 21 day gap between doses of the Pfizer/BioNTech vaccine and extend this to as much as 12 weeks. The Government claim that the Pfizer jab offers protective efficacy of up to 89% within a few weeks of the first dose, rising to 95% within two weeks of the second.

Self-evidently, the limited supplies of the vaccine can be stretched further in this scenario. However, it is not clear if this will have any deleterious impact on the duration of protection offered by the vaccine, or if the improvement from 89% to 95% will still be offered under the delayed administration since there is no evidence on the matter. Pfizer/BioNTech have (unsurprisingly) commented that they cannot support this approach due to a lack of evidence and the European Medicines Agency has said that the maximum 42 day window between doses must be respected, as has the US FDA.

There is some evidence relating to delayed administration of a second dose from the COV-002 cohort of the Astra/Oxford study (the same group where patients received a lower initial dose); roughly half of the patients in that study received their second dose at least 12 weeks after the first and the efficacy in this group was not impaired. However, this is not an mRNA vaccine, so comparing across trials is of limited value.

History may well show this to have been a master-stroke, allowing the UK to prevent more symptomatic cases more quickly; other countries may follow (Denmark and Germany are said to be evaluating a similar proposal, again driven largely by vaccine supply concerns). Conversely, history may also show that it is more challenging to follow-up when such a long timeline is used. Efficacy is impaired, albeit marginally, and we will probably see more cases of people developing symptomatic COVID-19 after initial vaccination as a consequence.

Infections in the vaccinated are an inevitable development and one already reported in the medical literature, but the non-medical general public may not see it like that; the public may associate correlation with causation and it may have the undesired effect of reducing public perception of the vaccine's efficacy. This is no risk-free trade.

Whatever the outcome, it cannot really be argued that the science is being followed, as this approach has not been assessed in a controlled trial; something its developers have been at pains to stress.

"Following the Science" part 2 – testing

We have commented before that mass surveillance testing of the outwardly asymptomatic is fraught with risks, not least the inevitably high number of false positive and false negative results that would arise when a low index of suspicion was attached to participant selection. This would apply if the tests being used were highly accurate and specific, but those risks would of course be magnified if the tests selected, or the process of sampling were not optimised.

Helpfully, the UK Government has evaluated such a scenario, via a mass testing pilot in the city of Liverpool, which took place in November 2020. The available data compared 'gold standard' PCR testing to the UK's only approved rapid test kit, the Innova lateral flow assay. In clinical studies, this assay demonstrated high levels of sensitivity, the basis of its approval (Innova is a US company and the test kit is manufactured in China).

However, the same kit has shown lower levels of sensitivity in studies conducted by the UK Government using research staff (73-79%) and lower rates still when used in a community setting (58% in Liverpool). In November, the British Medical Journal wrote the test was not fit for purpose in such a setting and could generate twice as many false positive readings as true positives if used in such a manner (the article was referring to its use for university students).

We were surprised to learn then in late December that the same testing kit has been selected for use in schools across the UK! Perhaps more worryingly, the swabbing may be done as a self-test under supervision. There is no data on how well children can swab themselves, but it seems reasonable to assume that they won't be overly aggressive in jamming a cotton bud up their nose (anyone who has had a COVID test performed by a healthcare professional will know it is an uncomfortable process).

It is easy for us to sit in our home offices and poke holes in the Government's strategy. One can of course counter that doing nothing is not an option. So how about this? If schools are a potential risk in the face of this new strain, surely the time and money being invested in inaccurate mass testing could instead be deployed to ensure those pupils so disadvantaged as to not have access to online learning resources could be provided with the requisite equipment, since another national lockdown has resulted in the closure of schools anyway. It will be interesting to see if the planned mass testing of school children survives the interregnum; it does not deserve to.

What happens now?

Variant B.1.1.7 accounted for >50% of new cases in the UK over the past week, from virtually nothing one month ago. With the UK having been forced into a lockdown to prevent the NHS from collapse, it seems inevitable that other nations will need to follow suit in the coming weeks as this more virulent strain takes hold.

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No timeline has yet been given on the likely easing of the measures just imposed, they could go on for as long as 12 weeks. We would observe that restrictions lasting less than 6-8 weeks have generally proven to be inadequate in terms of getting case numbers down. There will be some sort of case-related or hospitalisation related level that ministers have in mind to ease restrictions, but the Government is unlikely to disclose this.

So when will it all end? For now, the market seems to have accepted a premise that normality will begin to return in Q2 21. For this to occur, restrictions will need to be lifted and consumers will need to feel confident to venture out and confident enough in their own personal financial circumstances to spend rather than save.

If one assumes that the approved vaccines prevent transmission to the same degree that they prevent symptomatic COVID-19 (and, as we went to press, the evidence here was limited), the return to normality will depend on reaching a penetration of vaccination within the population that is sufficient to reduce hospitalisations and deaths to a level that society is willing to live with. That level is unknown, as is the cadence of the vaccine rollouts in reality. The only shots that count are the ones that are already in someone's arm, not how many you notionally have on order and no country is managing to stick to its lofty goals in the early phases of these programmes (save perhaps for Israel, but there are other questions with the approach there).

In conclusion: if you are investing in equities at this current moment, you are to a large extent playing this re-opening trade. This begs a number of beguilingly simple questions: how much 'normalisation' do you think the market is currently pricing in? Are you happy with that? Is the risk to that on the upside or the downside? This is a bedevilling macro conundrum to be sure and one that sits on ever-shifting sands. Right now, those sands are ebbing away.

As we have seen though, the situation can change very rapidly. Furthermore, it behoves us to note the market has thus far been more than willing to look past these known risks and focus on the opportunities that lie beyond, mainly (in our view at least) because investors believe the vaccine rollout will largely limit the ongoing malaise to Q1. Our conclusion is that further delays to vaccination programmes are the key risk to sentiment in the near term.

With this in mind, putting all one's cash under the mattress or in gold is probably not the right answer, but having some continued exposure to defensive growth areas like healthcare seems eminently sensible and, within that, to allocate one's capital in a manner consistent with COVID impacts on the functioning of the healthcare system continuing for many months to come.

Performance review

The wider market

The MSCI World Index continued to build on November's momentous advance, ending the month up 1.7% in sterling terms (4.1% in dollars) and making all-time highs on multiple occasions. Once again the performance was led by Technology (across software, hardware and those online/streaming focused companies included within the 'Media' sector). The laggards were classic defensives such as Telecoms, Food Retailing and Personal Care. With this new COVID variant now dominating the headlines, we wonder if this positive momentum can be sustained for much longer.

Healthcare

Once again, defensive healthcare was a source of funds during the continuing mind-set of the risk-on 'normalisation' and 're-opening' thematics driving the wider market to new highs, albeit to a lesser extent than last month. The sector rose only 0.8% in sterling terms (3.0% in dollars), underperforming the wider market. The sector performance was restrained by the underperformance of Biotech/Specialty Pharma (our Focused Therapeutics classification), which was very much driven by some material declines in a small number of stocks and Tools, which has been viewed as a safe haven throughout the pandemic.

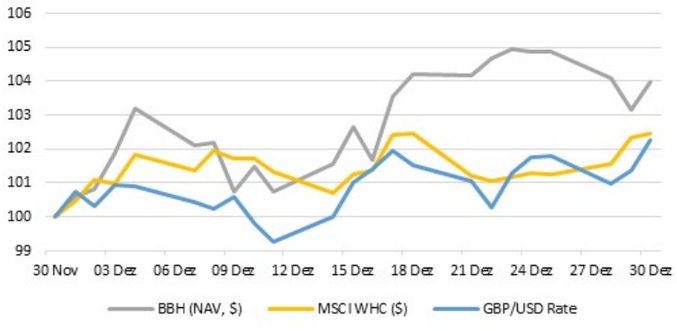
BENCHMARK SUB-SECTOR PERFORMANCE AND WEIGHTINGS

Sub-Sector	Weighting	Perf. (USD)	Perf. (GBP)
Focused Therapeutics	9.0%	-0.6%	-2.8%
Conglomerate	11.8%	5.3%	3.1%
Dental	0.7%	8.7%	6.4%
Diagnostics	2.2%	8.3%	6.0%
Distributors	1.2%	-2.8%	-4.8%
Facilities	1.1%	7.5%	5.1%
Generics	0.6%	6.6%	4.2%
Healthcare IT	1.9%	1.3%	-0.8%
Healthcare Technology	0.7%	9.7%	7.3%
Managed Care	9.0%	2.9%	0.6%
Med-Tech	15.7%	5.0%	3.0%
Other HC	1.4%	2.8%	0.5%
Diversified Therapeutics	34.2%	2.1%	0.0%
Services	2.5%	3.7%	1.6%
Tools	8.0%	0.9%	-1.3%
Index perf.		**3.0%**	**0.8%**

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 30-11-20. Performance to 31-12-20.

The Trust

The Trust's Net Asset Value rose 1.5% during the month in sterling terms to yield a month-end NAV of 175.11p, outperforming the MSCI World Healthcare comparator index by 0.9%. It was a volatile month, with some significant moves in the mid-cap end of our book as liquidity drained away in a typical fashion toward the year end. The continued strengthening of sterling reduced the month end NAV by around 2.6%. The evolution of the NAV over the month is illustrated below:



Source: Bloomberg and Bellevue Asset Management (UK) Ltd.

The 27 stock portfolio (plus the Alder CVR) was unchanged from November. The evolution of our sector weightings is illustrated in the table overleaf. The main change was further profit taking in the Diagnostics area. The capital was broadly redistributed across the other sub-sectors, but there was an active allocation toward Med-Tech, where we continue to focus on the more acute end of the acuity spectrum with respect to our investments.

We have made a number of changes to the stock-level weightings within our Focused Therapeutics holdings, significantly reducing the weightings of a couple of companies and adding across the remainder. This was driven by a combination of relative performance and risk management considerations as we head into January and the JP Morgan healthcare conference.

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EVOLUTION OF PORTFOLIO WEIGHTINGS

	Subsector end Nov	Subsector end Dec	Change
Diagnostics	10.6%	8.4%	Decreased
Diversified Therapeutics	15.9%	16.4%	Increased
Focused Therapeutics	37.0%	36.4%	Decreased
Healthcare IT	2.2%	2.4%	Increased
Managed Care	12.9%	12.9%	Unchanged
Med-Tech	12.6%	13.8%	Increased
Services	5.4%	6.1%	Increased
Tools	3.4%	3.5%	Increased
	100.0%	**100.0%**	

Source: Bloomberg/MSCI and Bellevue Asset Management (UK) Ltd. Weightings as of 30-11-20. Performance to 31-12-20.

The net cash position stood at 10.3% at the month end, versus 10.6% at the end of November. Now that the 'no deal' Brexit risk has passed, we have re-allocated around half of our sterling cash position back to dollars. We issued 5.3m shares via the tapping programme.

Regular readers will note that we have eschewed our usual form of commenting on our expectations for healthcare over the coming year at the sub-sector level in the first factsheet of the new year. We felt there were simply too many uncertainties at this time to make it a worthwhile exercise.

Much depends on the commentary at the forthcoming JP Morgan Conference, where many a bellwether will opine on the year ahead; expectations are muted and most companies likely to widely bracket any prognostications, portentous or otherwise.

Sentiment also rests on the outcome of the imminent Georgia run-off elections, which will quite literally determine the ambition of the Biden administration for the next two years. If the Republicans hold the State then Biden looks like a wounded waterfowl (which would be positive for sentiment toward the sector).

There are a number of issues on which we would like to get a better read and we hope to be in a position to deploy some of the cash on hand if the conference affords us the opportunity to resolve these. Any hope that 2021 would be an easy ride after the travails of 2018-2020 has already faded, and we aren't even through the first week!

We always appreciate the opportunity to interact with our investors directly and you can submit questions regarding the Trust at any time via: shareholder_questions@bbhealthcaretrust.co.uk

As ever, we will endeavour to respond in a timely fashion. We thank you for your support of BB Healthcare Trust.

Paul Major and Brett Darke

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Standardised discrete performance (%)

12-month total return	1 year Dec 19 - Dec 20	2 years Dec 18 - Dec 20	3 years Dec 17 - Dec 20	since inception
NAV return (inc. dividends)	25.1%	56.1%	67.7%	93.4%
Share price	25.0%	48.5%	51.1%	77.5%
Share price (inc. dividends)	28.5%	56.4%	62.2%	92.4%
MSCI WHC Total Net Return Index	10.3%	30.6%	42.1%	62.3%

Sources: Bloomberg & Bellevue Asset Management (UK) Ltd., 31.12.2020

NAV return and share price returns are adjusted for dividends paid during period where started (but not assuming reinvestment)

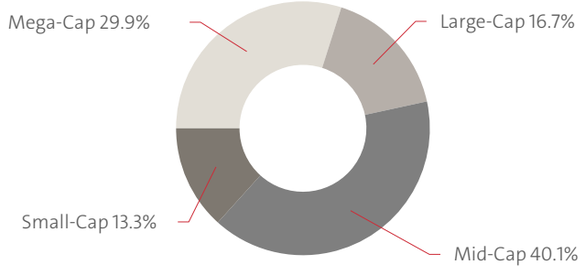
Note: Past performance is not a guide to future performance. The value of an investment and the income from it may fall as well as rise and is not guaranteed

TOP 10 HOLDINGS

Bristol Myers Squibb	7.1%
Hill-Rom Holding	6.0%
Vertex Pharmaceuticals	6.0%
Anthem	5.9%
Jazz Pharmaceuticals	5.4%
Insmed	5.1%
GW Pharmaceuticals	5.0%
Alnylam Pharmaceuticals	4.7%
Humana	4.1%
Amgen	3.7%
Total	**53.0%**

Source: Bellevue Asset Management, 31.12.2020

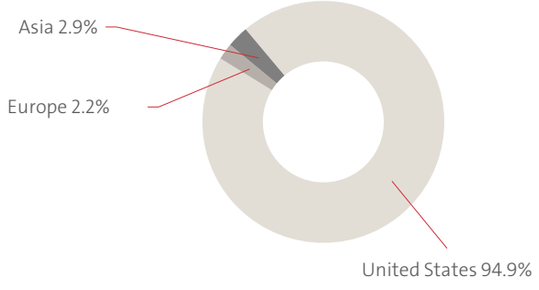
MARKET CAP BREAKDOWN



Source: Bellevue Asset Management, 31.12.2020

"Mega Cap >$50bn, Large Cap >$10bn, Mid-Cap $2-10bn, Small-Cap <$2bn."

GEOGRAPHICAL BREAKDOWN (OPERATIONAL HQ)



Source: Bellevue Asset Management, 31.12.2020

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INVESTMENT FOCUS

- The BB Healthcare Trust invests in a concentrated portfolio of listed equities in the global healthcare industry (maximum of 35 holdings)
- Managed by Bellevue group ("Bellevue"), who manage BB Biotech AG (ticker: BION SW), Europe's leading biotech investment trust
- The overall objective for the BB Healthcare Trust is to provide shareholders with capital growth and income over the long term
- The investable universe for BB Healthcare is the global healthcare industry including companies within industries such as pharmaceuticals, biotechnology, medical devices and equipment, healthcare insurers and facility operators, information technology (where the product or service supports, supplies or services the delivery of healthcare), drug retail, consumer healthcare and distribution
- There will be no restrictions on the constituents of BB Healthcare's portfolio by index benchmark, geography, market capitalisation or healthcare industry sub-sector. BB Healthcare will not seek to replicate the benchmark index in constructing its portfolio

DISCLAIMER

FIVE GOOD REASONS

- Healthcare has a strong, fundamental demographic-driven growth outlook
- The Fund has a global and unconstrained investment remit
- It is a concentrated high conviction portfolio
- The Trust offers a combination of high quality healthcare exposure and targets a dividend payout equal to 3.5% of the prior financial year-end NAV
- BB Healthcare has an experienced management team and strong board of directors

MANAGEMENT TEAM

Paul Major

Brett Darke

GENERAL INFORMATION

Issuer	BB Healthcare Trust (LSE main Market (Premium Segment, Offical List) UK Incorporated Investment Trust
Launch	December 2, 2016
Market capitalization	GBP 874.4 million
ISIN	GB00BZCNLL95
Investment Manager	Bellevue Asset Management (UK) Ltd.; external AIFM
Investment objective	Generate both capital growth and income by investing in a portfolio of global healthcare stocks
Benchmark	MSCI World Healthcare Index (in GBP) - BB Healthcare Trust will not follow any benchmark
Investment policy	Bottom up, multi-cap, best ideas approach (unconstrained w.r.t benchmark)
Number of ordinary shares	494 019 689
Number of holdings	Max. 35 ideas
Gearing policy	Max. 20% of NAV
Dividend policy	Target annual dividend set at 3.5% of preceding year end NAV, to be paid in two equal instalments
Fee structure	0.95% flat fee on market cap (no performance fee)
Discount management	Annual redemption option at/close to NAV

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