Putting quality at the heart of everything we do.

Annual Report and Accounts 2018

Spire Healthcare

Spire Healthcare is the largest private hospital group by turnover in the United Kingdom. We deliver high standards of care, with integrity and compassion and from high-quality facilities to our insured, self-pay and NHS patients.

We provide diagnostics, in-patient, daycase and outpatient care from our 39 hospitals, eight clinics and one oncology centre across England, Wales and Scotland. We also own and operate the sports medicine, physiotherapy and rehabilitation brand, Perform.

Working in partnership with over 7,500 experienced consultants, our hospitals delivered nearly 777,000 tailored patient treatments in 2018.


Richard Sabino
Spire Healthcare
2018
AUG

Why Spire Healthcare has a strong proposition.

Who we are

Our vision is to be the 'go-to' healthcare brand, famous for clinical quality and care.

Our mission is to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care.

A growing need

Demand continues to be driven by the care needs of a growing and ageing population, and we have invested in higher acuity services, which account for 23.8% of revenue (2017: 22.8%).

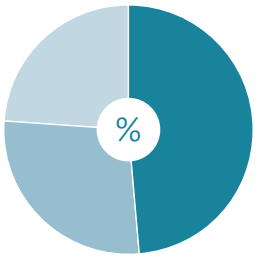
The NHS has to manage competing demands in the face of funding and capacity constraints. We are a partner to the NHS, providing access to treatments and choice for patients.

Spire Healthcare – five key strengths

1. **Attractive UK healthcare fundamentals**
   - The UK's leading private provider, by volume of knee and hip operations
   - Long-term relationships with the top five PMI providers
   - Self-pay demand accelerating
   - Trusted partner to the NHS
2. **Well-invested, geographically diverse profile**
   - 39 private hospitals, eight clinics and one oncology centre
   - Highest postcode coverage of any private provider in the UK, not centred around single cities or areas
   - Significant existing capacity offering potential for growth
3. **Solid financial position**
   - Consistent EBITDA conversion to cash (2018: 105%)
   - Balanced payor mix (NHS 29.2%, PMI 46.5%, self-pay 18.7%)
   - Strong asset base, 20 freehold hospital assets, valued at around £1.138 billion
   - EBITDA £119.4 million (down from £150.0 million in 2017), but cash generative
4. **Focus on quality and clinical excellence aligned to demand**
   - 76% rated 'Good' or 'Outstanding' by CQC (2017: 67%)
   - Strong ward-to-Board governance
   - Increasing our private pay mix will require quality to continue improving, putting Spire Healthcare ahead of its competitors
5. **Strong, new management team**
   - Diverse, proven experience
   - Entire C-Suite focused on the same outcomes, driving for improved financial performance

A well diversified business

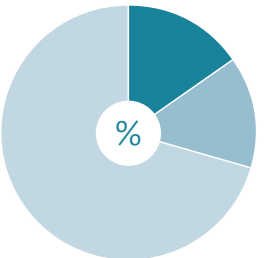
2018 Percentage of revenue*



- Orthopaedics **48.8%**
- Gynaecology, plastic surgery, urology and others **27.4%**
- High acuity services, including cardiology, cardiothoracic, neurosurgery, oncology and general surgery **23.8%**

* In-patient and daycase revenue.
Source: Company information.

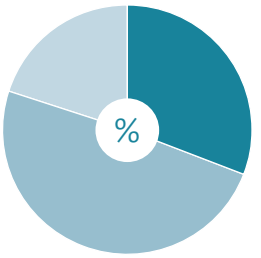
2018 Key activities (%)*



- Diagnostic **15.3%**
- Outpatient services **14.3%**
- In-patient and daycase procedures **70.4%**

* Excludes other revenue.
Further details can be found on page 65.

2018 Revenue sources*



- NHS **29.2%**
- PMI **46.5%**
- Self-pay **18.7%**

* Self-pay no longer includes Partnership related business, this segment is now reported separately and the 2017 figures have been restated to this effect.

Why be a patient with Spire Healthcare.

Quality healthcare

For us, quality of care and patient safety are non-negotiable. They are the bedrock of Spire's philosophy and are at the heart of our strategy. We consistently invest in our facilities, services and colleagues to provide excellent quality of care and customer experience at each stage of the care pathway: from initial GP referral or self-referral, through consultation, diagnosis and treatment, to recovery and rehabilitation.

Our services

Clinical care
Our clinical team ensures we have comprehensive clinical governance at our hospitals – from ward to Board. We work with consultants throughout their careers. This includes the biannual review process, business development reviews, providing access to connected doctors for mandatory training and offering Human Factors training. We invest in the quality of our facilities. All this ensures our clinicians can deliver outstanding healthcare across a wide range of services.

Primary care
We build good relationships with GPs and are investing in hospital-based private GP services to give patients rapid access to diagnosis. This helps patients make considered choices about their care and take control of their health sooner.

Diagnostics
Our skilled clinicians, scanning technology and comprehensive pathology services provide prompt and accurate diagnoses, giving patients the reassurance that comes from a clear treatment plan.

Treatment and surgery
At our hospitals, we offer a wide range of treatment and surgery when you need it – from routine procedures such as knee and hip replacements, to more specialist procedures.

Recovery and rehabilitation
We're here to look after people and get them back on their feet as fast as possible. Our high dependency and intensive care units offer tailored individual care through early recovery, while our rehabilitation facilities help with longer-term strength, health and fitness.

Service coverage where it's needed

Our network of hospitals covers major population centres across the country.

“Spire Healthcare continues to push for quality, reinforcing not just our leading role in the private sector but in UK healthcare as a whole.

Despite this year’s disappointing financial results, I believe our strategy is absolutely right for the patients we serve, our investors and us.”

Justin Ash
Chief Executive Officer

Investing in quality

Despite disappointing financial results in 2018, we built on our quality, improved our processes, invested in our teams and moved the business forward.

Revenue (-0.1%)

£931.1m

2017: £931.7m

Self-pay revenue growth (+8.7%)

£174.1m

2017: £160.2m

Conversion of EBITDA to cash

105%

2017: 106%

Profit before tax (-63.9%)

£8.2m

2017: £22.7m

EBITDA* (-20.4%)

£119.4m

2017: £150.0m

Proposed final dividend per share (0%)

2.5p

2017: 2.5p

Operating profit before exceptional items (-41.2%)

£54.2m

2017: £92.1m

Adjusted basic earnings per share (-52.1%)**

6.9p

2017: 14.4p

Operating profit (-33.3%)

£28.6m

2017: £42.9m

Basic earnings per share (-33.3%)

2.8p

2017: 4.2p

Hospitals rated as 'Good' or 'Outstanding' by the Care Quality Commission

76%

2017: 67%

Online enquiries

150,195

2017: 84,306

Please see pages 44 and 45 for our KPIs, and page 161 for Alternative Performance Measure ('APMs') definitions.

* Operating profit, adjusted to add back depreciation, profit or loss arising from the disposal of fixed assets and exceptional items, referred to hereafter as 'EBITDA'.

** Calculated as adjusted profit after tax divided by the weighted average number of ordinary shares in issue. Adjusted profit is calculated as earnings after tax adjusted for exceptional and other items and related tax.

39

hospitals

We work hard to make sure our hospitals are of the highest quality.

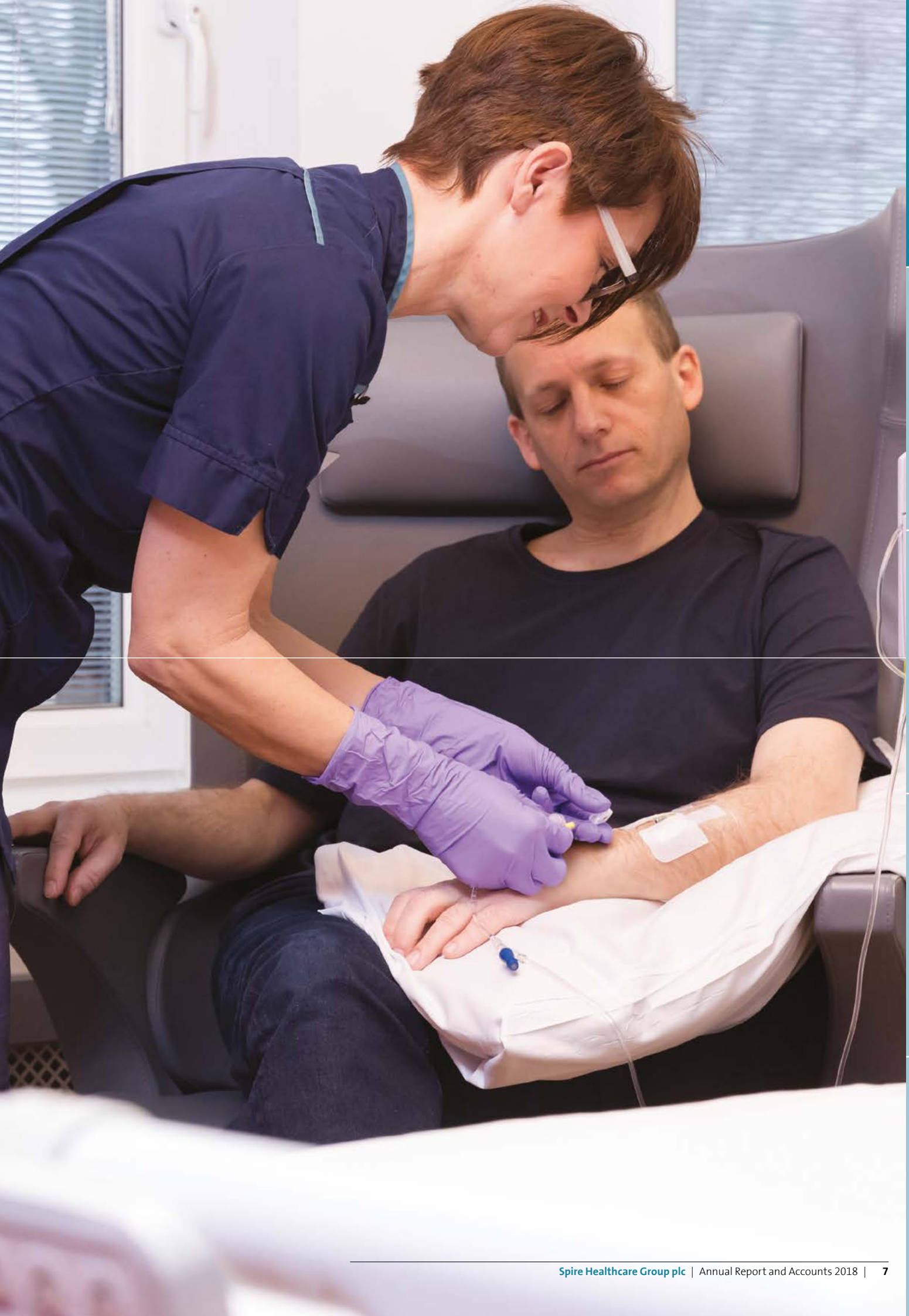
We continually invest in our facilities to provide great environments where our patients benefit from calm, hotel-style rooms and check-in areas. This is backed up by the way our people take accountability for quality in every aspect of our hospitals, assessing them regularly and maintaining strong oversight processes – all of which ensure our patients can depend on brilliant service and excellent personalised care.

77,000

patient treatments

Our patients can be assured of the best healthcare every day.

Our primary focus is on the highest standard of clinical quality. That's fundamental at Spire Healthcare, whenever we see our patients – from initial consultation and diagnosis to their treatment and the aftercare we provide. We aim to understand our patients' needs and make their experience with us as stress-free and comfortable as possible.



7,700+

dedicated clinicians and clinical support staff

Our clinicians strive to provide the highest standard of personal care.

Our clinicians and clinical support staff include our employed and bank nurses, healthcare assistants and allied health professionals. We train and support our clinicians, so they are always ready with the advice and practical assistance people who visit us need, whether they are undergoing treatment themselves or supporting their friends and family. All of our dedicated clinicians, support staff and the consultants we work with are there for our patients every step of the way.

Q&A

Following a year of sector turbulence and challenge, Chief Executive Officer, Justin Ash, explains why quality will be the key to our success.

"I expect 2019 to be a year of consolidation for Spire Healthcare. We are responding to the challenges in our markets by redefining how the business operates."

Justin Ash
Chief Executive Officer

Q.

Your 2018 results have been disappointing – what confidence can you give investors that your strategy is working?

A.

We haven't met all the targets we set ourselves at the start of the year and our EBITDA fell sharply. That is disappointing and we are determined to bring Spire Healthcare back into profitable growth.

However our performance did show underlying positive features. Our revenue was broadly flat which was a resilient performance in a challenging year, and we created positive cash flow by controlling capital costs well. The business achieved private revenue growth that almost offset the decline in our NHS business, which is a healthy sign for the future, and this was achieved in part through the investments we made in 2018. We also re-doubled our focus on quality across the business that showed clear positive results.

Throughout the year we listened to our people, our patients and our investors, as well as internal and external clinical and medical experts, and informed our strategy through this. That's why I'm confident we have the right strategy. We know where we're going, and we understand how to run a safe and effective healthcare business.

Q.

But in light of your tough year, will your strategy need to change?

A.

The decline in NHS business made 2018 a difficult year, not just for us but across the sector. We have seen fewer NHS admissions in 2018, particularly to our orthopaedics care, as NHS commissioners deal with ongoing financial pressures and the implications of rising health demands through triage and changes to referral processes. This affected our volumes.

We are proud to partner with the NHS, but the volatility of NHS demand we experienced in 2018 is one reason we have a strategy of increasing the private pay part of our business. It also reflects our commitment to offering choice in hospital care. I believe this remains the right strategy, we saw pleasing progress from a private perspective. Our revenue from the private medical insurance sector has grown by 1.5% and by 8.7% from self-paying patients. In both of these markets we believe we grew market share.

In the insurance market, our strategy of focusing on quality is paying off as insurers increasingly recognise that their referral directing strategies should concentrate on high-quality providers. Having a high-quality reputation is especially important in the self-pay sector, where we have performed well, but so is being easy to access. We have invested in sophisticated targeted marketing – both online and offline – so we can better reach our key potential customers, have made online booking simpler and have improved the customer experience for those who call us. Our aim is to increase the private share of our business in the short to medium term.

I feel we are working harder and faster than our competitors in these areas, and our investments are paying off. We have the right strategy and will work at pace in 2019 to build on the platform laid down in 2018.

Q.

You talk about investing in quality – what will this deliver for the business?

A.

Ultimately I believe investing in quality will make us more successful – more successful in terms of patient satisfaction, our relationships with key stakeholders and financially.

We've been in an investment phase this year. Quality takes time and, in the most part, investment. What do I mean by quality? It's patient safety, ensuring the right treatment for the right patient in a safe environment with appropriate and skilled staffing. It's a caring environment, which is well led, by well trained and capable teams. It's strong governance from our wards to our Board, to assure ourselves that our service meets these tests, and that we have good oversight of the credentials and conduct of our consultant partners. It is also about a culture of openness and candour.

All this supports our efforts to become the go-to UK private healthcare brand, and much of our cost increases in 2018 were due to investment in our clinical quality and customer care, as well as our people, real estate and technology, to help us meet this goal. We also spent a lot of time discussing openness and how to raise concerns, and have rolled out Freedom to Speak Up Guardians – a recommendation of the Francis report. This supports our commitment to quality and governance.

I am also excited to see the potential for a focus on the digitalisation of our processes and how it can improve access to our world-class facilities and clinical services. And, while some of our larger-scale capital expenditure is now complete, I would expect to see continued investment of around £60–£70 million per annum. Future investments will target quality initiatives, improve customer experience and support our frontline employees, in particular the Hospital Directors and Matrons who are fundamental to making our hospitals work. This will include digital access to our services, advanced imaging technology, and even robots, like the Mako and NAVIO knee robotics we invested in at several sites last year.

All this focus on quality is at the heart of our strategy and we believe it will distinguish us as a safe and caring environment for all payors.

Q.

With all this investment, how are you addressing costs?

A.

Hand in hand with this strategic investment, we are identifying ways to reduce complexity and costs, and I expect this to make a real difference to the business in 2019. We are improving our team structures to make ourselves more efficient and leveraging our scale to improve outcomes. By streamlining our processes, we can work more effectively as 'One Spire' across each of our locations. In 2019 we will start trialling some digital processes, which support quality and ease of access, whilst at the same time reduce the currently high administrative costs in our business.

Q.

How is the current political and economic uncertainty affecting your business?

A.

For all the work we have done this year to build the foundations for a sustainable future and to enhance the quality of our operations, there is still risk in our business model. The difficulties of the NHS and the wider economy undoubtedly continue to present uncertainties as we look forward. We're certainly not complacent. As with many other UK businesses, the prospect of a no-deal Brexit makes the short term hard to predict for our market and the economy. This is not helpful for us, our suppliers or partners, and could affect consumer confidence. We have however, been planning for some months to mitigate any supply, employee or demand issues that arise from a no-deal Brexit. We believe we are taking all reasonable steps to ensure that disruption to our patients and other stakeholders is kept to a minimum. However, given the uncertainties around the impact of a no-deal Brexit we cannot rule out disruption to the business as there maybe some circumstances outside of our reasonable control.

We also recognise that there is political debate about the role of companies like Spire Healthcare in providing NHS services. The new NHS 10-year plan recognises the critical role of choice in NHS care and the importance of including all providers in planning for the future, which we welcome. It is our view that whatever the political debate at the time, the compelling role of Spire Healthcare and others in the independent sector in bringing down waiting lists in a high-quality environment is a well established and durable part of UK healthcare.

Q.

What are your priorities for 2019?

A.

I expect 2019 to be a year of consolidation for Spire Healthcare. We are responding to the challenges in our markets by redefining the way the business operates – improving engagement, digitalisation and clinical governance. We are strengthening our self-pay proposition, working more efficiently and making more use of our call centres. Our managed investments in quality will continue, we will improve our diagnostics, and we will introduce new digital processes such as electronic pre-assessment to reduce both our clinical and administration costs. NHS waiting lists are getting longer and Spire Healthcare is part of the solution, so we will pursue many opportunities to partner with the NHS.

Given the external factors, I think we can be sure it won't be an easy year, but we believe we will navigate it soundly and end 2019 in a strong position. Spire Healthcare has a unique asset – its highly-skilled and capable people who really care about the support they give – from our porters who greet our patients, to our caring nurses, world-class consultants and the newly-appointed Executive Committee. Our job is to ensure we do the right thing for the people we care for, guiding them through from diagnosis to treatment and successful recovery, and to create a culture in which our employees can thrive and focus on what's most important – making people better. If we get that right, our commercial future and a growing business is assured in our view.

"We are improving our technology, processes and outcomes, and I am confident this will lead to further increases in patient satisfaction and better clinical scores."

Garry Watts
Chairman

Dear shareholder,

It has been a difficult year for your Company, in which the share price has fallen significantly, reflecting some disappointing outcomes in a turbulent market. The Executive Committee has worked hard, with full support from your Board, to respond to this challenging market and has raised the bar on patient safety and governance, while investing in our infrastructure, people and systems.

Performance

NHS revenues fell by 7.2% this year, while our business from private medical insurance sources was up 1.5% and we achieved 8.7% revenue growth from self-pay patients. Overall, Group revenue was broadly flat in 2018, alongside a decline in profit before tax of 63.9% and EBITDA of 20.4%, which I appreciate was disappointing. These results are below expectations, but I believe they represent a solid outcome given the challenging market, and I am reassured by the strength and commitment of our Executive Committee. The early signs are that our focus on quality is making a real difference to the business.

Clinical standards and patient safety

We have already seen a significant improvement in quality and clinical governance – which is all part of putting the right pieces in place for the future. I am encouraged by the progress we are making through our investments in clinical teams, central resources and governance, which is driving improvements in the external assessments of our facilities.

We are improving our record through the Care Quality Commission's ('CQC') inspections and have invested time and resources in our existing hospitals and the people who work there. Four of our hospitals are now rated 'Outstanding', 22 hospitals and two clinics rated as 'Good', and nine as 'Requires Improvement'. Our overall quality of care rating continues to outperform the private acute sector average – which is important to delivering on our strategy.

Dividend

The Company was cash-generative, and the Board has proposed the payment, subject to shareholder approval, of a final dividend of 2.5 pence per ordinary share for the year. Together with the interim dividend of 1.3 pence per ordinary share, this amounts to a total annual dividend of 3.8 pence per ordinary share. This is consistent with 2017.

Our people

We ended the year with a full management team, which is a very positive outcome for the Company. Jitesh Sodha and John Forrest joined us in October 2018, as Chief Financial Officer and Chief Operating Officer respectively.

I would very much like to extend my thanks to Justin Ash, our Chief Executive Officer, our Hospital Directors and all our people who have operated in challenging circumstances this year, and yet have continued to focus on positive patient outcomes while driving a change agenda. I would also like to thank Dame Janet Husband, whose regular hospital visits provide a vital link between the Board and our frontline employees and patients.

Board changes and focus

In addition to Jitesh Sodha, who joined the Board in his capacity as Chief Financial Officer, Dr Ronnie van der Merwe, chief executive officer of Mediclinic International PLC – our largest shareholder – was appointed as a Non-Executive Director in May 2018, replacing Danie Meintjes his predecessor in that role. Ronnie brings a wealth of medical and commercial experience to the Board.

With these changes, we now have a full strength and fully engaged Board and Executive Committee. Unsurprisingly, the Board's main focus this year has been to support our Chief Executive Officer and management through a challenging period. The Independent Inquiry into the issues raised by Ian Paterson is ongoing. We have co-operated fully with the Inquiry and await the report it will produce with interest. I would like, however, to apologise, once again, for the pain and suffering caused by Ian Paterson to patients in our care. As we outlined when giving evidence to the Inquiry earlier this year, since 2011, Spire Healthcare has taken significant steps to improve our clinical governance in order to prevent any future incidents such as this.

Subsequent to the year end, on 27 February 2019, Peter Bamford gave notice that he intended to step down as our Senior Independent Director on 16 May 2018. I thank Peter for his contribution to Spire Healthcare's Board and for the support he has given me personally. A search is underway for his replacement.

Governance

The new UK Corporate Governance Code ('the Code') updates standards of good practice in relation to board leadership and effectiveness, remuneration, accountability and relations with shareholders. One of the key implications this year relates to employee engagement and we welcome this focus. For us, engaging with our people is critical, as they are central to the way we deliver for our patients.

We have continued to strengthen our Internal Audit function this year to enhance our governance and improve controls. They are responsible for both financial and operational audits. You can read more about our governance and the activities of the Board and its committees on pages 74 to 109.

Outlook

In common with the majority of UK businesses, Spire Healthcare is concerned at the continuing uncertainty surrounding the UK's exit from the European Union. The protracted discussions are, in our view, impacting consumer confidence and, at least at the margin, are adversely affecting the prospects for our business. In particular a no-deal Brexit has the potential to restrict supply and increase the cost of goods from the European Union. We have been working closely with our key suppliers to understand their Brexit plans and explore mitigations in a no-deal scenario. Whilst we cannot provide an absolute assurance, we believe we are taking all reasonable steps to ensure that disruption to our patients and other stakeholders is kept to a minimum.

Within healthcare there will be further challenges ahead, with continuing constraints on NHS spending and political uncertainty. The short term remains highly unpredictable, but the longer-term dynamics in our market are unchanged – with an aging population in need of better clinical care.

We are responding by redefining the way the business operates – improving engagement, digitalisation and clinical governance. We have been through a period of heavy capital expenditure, but we are now making investments that are more focused, with an increased emphasis on clinical quality and enhancing our capabilities.

We are improving our technology, processes and outcomes, and I am confident this will lead to further increases in patient satisfaction and better clinical scores. We have the leadership and the scale to drive efficiency, by setting new standards centrally, and maintain our leading position in the UK's private healthcare market.

Garry Watts
Chairman
27 February 2019

We aim to be the most recognised and respected healthcare provider brand in the UK.

Introducing the Executive Committee

1. Justin Ash
Chief Executive Officer
C D E

2. Jitesh Sodha
Chief Financial Officer
D E

3. John Forrest
Chief Operating Officer
E

4. Dr Jean-Jacques de Gorter
Chief Medical Officer
E

5. Peter Corfield
Chief Commercial Officer
E

6. Alison Dickinson
Group Clinical Director
E

7. Daniel Toner
General Counsel and Group Company Secretary
D E

8. Antony Mannion
Director, Strategy and Investor Relations
D E

Board committee membership:	
C	Clinical Governance and Safety Committee
D	Disclosure Committee
●	Committee Chair
Management committee membership:	
E	Executive Committee
●	Committee Chair

Biographies of our Executive Committee can be found at www.spirehealthcare.com

In February 2019, Shelley Thomas joined as Group Human Resources Director (not pictured).

A year of challenge but also progress

2018 has been a challenging year for our shareholders, and we recognise that the decline in profitability is a setback for the business's short-term growth ambitions. Shareholders should be assured however, that we have made good progress on building on the quality and service that underpins the business despite the disappointing financial outturn. We are working at pace to build the leading platform for independent healthcare in the UK, one which serves its patients' needs and achieves exceptional standards, and so drives growth in private self-pay and with medical insurers, as well as being a key partner for the NHS.

During the year we made several key appointments to our Executive Committee, with our new Chief Financial Officer, Jitesh Sodha and Chief Operating Officer, John Forrest joining in October, the internal promotion of Alison Dickinson to Group Clinical Director in November and the appointment of Shelley Thomas as Group Human Resources Director shortly after year end. Alison's promotion reflects our commitment to patient safety and clinical quality, and I believe having a full strength Executive Committee will improve our leadership and stability in 2019.

Becoming the go-to UK independent healthcare brand

At Spire Healthcare we believe in putting patients first and, to support that, in 2018 we invested in our clinical network, clinical teams, pre-operative assessment capability and clinical reviews. This is consistent with our commitment to ensuring that all Spire Healthcare hospitals are rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC).

As NHS income becomes less predictable, we have put a stronger focus on self-pay private patients, are engaging digitally with customers using newly-developed electronic systems and employing more targeted marketing initiatives. Other investments we have made this year – such as the delivery of the new Spire Manchester Pathology Centre, and major upgrades to the facilities at Spire Bushey, Spire Cheshire and Spire Cambridge Lea hospitals – will help to make all this possible. We have also made good progress in developing our newer sites at Manchester, Nottingham and St Anthony's, all of whom made good financial progress in 2018.

Our values:

1. Driving clinical excellence

We stretch ourselves to achieve excellent results.

2. Doing the right thing

We make sound and considered judgements.

3. Caring is our passion

We put patients at the heart of everything we do.

4. Keeping it simple

We make complex things easier.

5. Delivering on our promises

People can trust us to do what we say we'll do.

6. Succeeding and celebrating together

We work together, learn from each other and celebrate success.

Famous for quality and clinical care

I am delighted that in 2018 we launched our new Quality Governance Report, with our second to follow in April. This is part of our commitment to transparency within the UK health sector. Our rising CQC ratings in 2018 demonstrate the high standards of care our patients receive. I was delighted when Spire Nottingham achieved a CQC rating of 'Outstanding' this year, which means that four of the 14 'Outstanding' acute hospitals in the entire private hospital sector in England are now Spire Healthcare hospitals. Services at Spire St Anthony's, Spire Wellesley, Spire Clare Park and Spire Hull and East Riding hospitals and Spire Hesslewood Clinic were also rated 'Good' by the CQC during the year. This improved our percentage of 'Good' and 'Outstanding' sites from 67% to 76% in one year.

Other areas of clinical quality continued to improve, with good Patient Reported Outcome Measures (PROMS) and only four incidents of MRSA or MSSA. Our Chief Medical Officer and Group Clinical Director detail our progress on patient safety, governance, clinical matters and medical outcomes during the year in our Clinical review on pages 26 to 31.

First choice for private patients

This push for quality is critical to our future – and we are confident it will help us to win new business across all the sectors we operate in. The business faced a continuing decline in NHS-funded care due to constraints on NHS budgets, with NHS income down 7.2%. This had a material impact on hospital profitability. However, income from private medical insurance-funded patients grew by 1.5% and revenue from the care of patients who chose to self-pay increased by 8.7%, which combined, compensated the NHS decline. We were delighted to be entered into Aviva's open referral network in Q4 2018 – in part because of our proven high-quality standards – and this contributed to a strong end to the year for our insurance-based activity. The growth in private income also saw a broadening of Spire Healthcare's treatment mix. While we saw a decline in orthopaedic patients (largely NHS), there was overall growth in oncology, acuity and children and young people services. We will continue to diversify our mix and strengthen our service range in 2019. Significant enhancements were made to our website in 2018 based on extensive user research, which now makes it easier to research and book a consultant or Spire GP appointment online.

Becoming more efficient

Overall therefore, revenue was broadly flat, but higher depreciation and an increase in other costs affected the Group's profitability during the year, driven by the investments I have mentioned above and the loss of NHS volume. Our new Chief Financial Officer, Jitesh Sodha, reviews all the numbers in detail on pages 62 to 73.

This calls on the business to find efficiencies to fund these investments, and we have been targeting these savings across our operations, supported by improved planning, project management and delivery. Our cost savings programme during 2018 was the start of a multi-year programme, and this will reduce the rate and impact of future cost increases. We are now accelerating our cost savings programme, leveraging our scale in procurement and using technology to drive consistency across the business. We believe that these programmes will also improve our customer experience and indeed, quality of care over time. Our new Chief Operating Officer, John Forrest, reviews these activities in detail on pages 46 to 47. We have been through a period of significant capital expenditure, but we are now making investments that are more focused – with an increasing emphasis on clinical quality and enhancing our capabilities. This is leading to improved net cash flow for the business.

Most recommended customer experience

We continually strive to set new standards in our patient care. Spire Healthcare cared for 260,100 in-patient and daycase patients during the year (2017: 269,300). In April we launched a new, online patient feedback system to capture feedback from all admitted patients. Since the launch, 96% of patients have said that they would be 'Extremely Likely' or 'Likely' to recommend Spire Healthcare to others in need of similar care, with 80% saying they would be 'Extremely Likely' to recommend us. The standard of our nursing care was rated particularly highly with 96% of patients agreeing that they received excellent care from our nursing staff. This survey is part of a wider programme of gathering customer feedback which we use to target investment, training or service development requirements at specific hospitals.

I thank all our patients and their families for choosing Spire Healthcare in 2018 and we are all committed to an ever-improving experience for those who choose us in 2019 and beyond.

Best place to work and to practise

At the heart of Spire Healthcare are our teams. From the Hospital Directors and Matrons who have such key roles in making our hospitals run safely and effectively, to our nurses and laboratory technicians, our support staff and the consultants we engage – everyone has a key role to play. We started the year with a refresh of our values and a company-wide communication process. I enjoyed 54 hospital visits in the year, and was able to hold staff forums on many occasions to listen to ideas and share views about our progress. I was delighted to see an overall engagement score of 79% with an 81% response rate, in our recent employee survey despite the challenges of 2018 for our staff. The results show that our teams are proud to work for Spire Healthcare (77%) and believe that they really fit in with and work well with their team (86%). We are committed to ensuring Spire Healthcare is an inclusive environment for all our colleagues where they are treated equally and fairly. In our most recent employee survey 75% of colleagues responded that Spire Healthcare treats all people as equals regardless of individual differences. This is the first time we have asked the question so we will use this as a benchmark to make further improvements. In 2018 we introduced our first 'temperature check' employee survey and have been focusing on action planning after our biannual surveys to ensure we respond to the needs of our colleagues.

There is still a degree of employee churn at our sites and vacancies are a problem in some hospitals. We moved to central recruitment in February 2018 to help address this. This posed some challenges early on, but we are now making real progress in reducing vacancies, especially in clinical roles. We have worked on our pay comparators, offer a competitive benefits package and have replaced our bonus scheme with a new Spire for You 'recognition pot' that enables colleagues to recognise each other's contribution and performance. We were also very pleased to be commended by the Right Honourable Anne Milton MP, Minister of State for Apprenticeships and Skills, for Spire Healthcare's strong apprenticeship programme, as we train the Spire Healthcare professionals of the future.

Consultants are our key partners in the delivery of care and business development at Spire Healthcare. We survey our consultants annually to help understand their levels of satisfaction and their needs. In 2018, their overall level of satisfaction was 68% 'Satisfied' or 'Very Satisfied', with particular support for the excellence of our nursing staff. We worked closely with our Medical Advisory Committees in 2018 to ensure we selected the right consultants to join our hospital communities and to ensure Spire Healthcare discharges its responsibilities for consultant oversight with input from respected local clinicians.

I thank everyone who works for Spire Healthcare and in our extended teams, for their hard work and enormous commitment and contribution in 2018.

Looking ahead

We expect the market to remain challenging in 2019. NHS volumes may remain suppressed and the private market is competitive. However, the self-pay private market is expected to grow and we have already shown the potential for growth in our private medical insured market share. We are confident we have the right foundations, plans and above all people, to do things right and build a healthy future for our business, our shareholders and our patients. We are using our scale to improve our position and reputation in the market and are conscious of the need to balance investment with efficiencies. Our prospects for the next five years remain good, our commitment to putting patients first is firm and we see this as both consistent with, and supportive of improving margins, stronger free cash flows and a reduction in net debt – creating value for our shareholders and other stakeholders in the medium term.

Justin Ash
Chief Executive Officer
27 February 2019

Our strategic priorities:

1. Famous for quality and clinical care

We aim to lead our sector in quality and clinical care.

2. First choice for private patients

We want to become the 'go-to' private healthcare brand.

3. Most recommended customer experience

We aim to lead our sector in customer care.

4. Best place to practise

We aim to become the place where consultants most want to work.

5. Best place to work

We want to be recognised as a Top 100 employer.

For more information, see pages 21 to 25.

1. Famous for quality and clinical care

We aim to lead our sector in quality and clinical care by setting new standards in the industry.

By embedding a 'quality first' culture, we continue to improve our CQC ratings and to achieve other external accreditations from specialist organisations. We are building on the systems we already have in place to develop even more robust standards of patient care.

We put patient safety first and have increased our clinical resources to continually assess and support quality improvements. By enhancing the ongoing clinical reviews we conduct, we can be assured of providing the highest standards and quality care at our hospitals.

Measuring success:

28

Sites rated 'Good' or 'Outstanding' by the CQC, (out of 37 sites covered by CQC inspections), up from 24/36 sites in 2017.

0.14%

Infection rates per 10,000 beds in 2018 (2017: 0.13%)

Using risk to help make the right strategic decisions:

Principal risk 1, 2, 6 and 9

Further information:

Further information is available in our Clinical review on pages 26 to 31.

2. First choice for private patients

We want to be the 'go-to' private healthcare brand – offering rapid diagnosis and first-class treatment.

We are committed to providing access to diagnosis and treatment on our patients' terms. That's why we have aligned our sales and marketing functions to better understand our customers and meet their needs – especially those within the self-pay sector.

We have invested in our sites to provide the most welcoming environments for patients, and we are developing advanced clinical services to meet emerging needs.

Measuring success:

8.7%

Self-pay revenue growth 2018 vs 2017

£65.2m

Invested in our sites in 2018 (2017: £119.9m*)

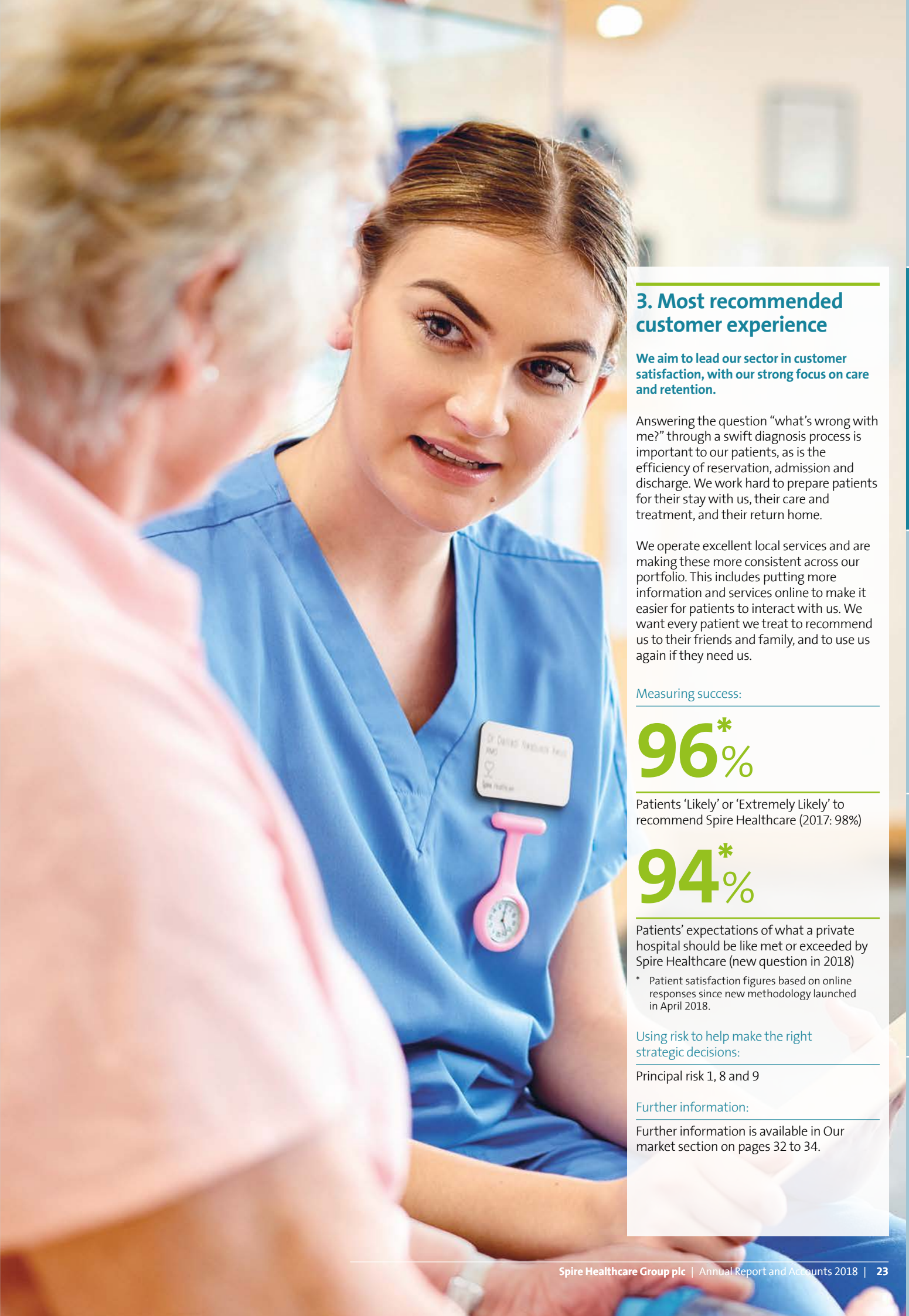
* CAPEX in 2017 included investment relating to the completion of the new Spire Manchester and Spire Nottingham hospitals and the redevelopment of Spire St Anthony's Hospital.

Using risk to help make the right strategic decisions:

Principal risk 5, 7 and 8

Further information:

Further information is available in Our market section on pages 32 to 34.



3. Most recommended customer experience

We aim to lead our sector in customer satisfaction, with our strong focus on care and retention.

Answering the question "what's wrong with me?" through a swift diagnosis process is important to our patients, as is the efficiency of reservation, admission and discharge. We work hard to prepare patients for their stay with us, their care and treatment, and their return home.

We operate excellent local services and are making these more consistent across our portfolio. This includes putting more information and services online to make it easier for patients to interact with us. We want every patient we treat to recommend us to their friends and family, and to use us again if they need us.

Measuring success:

96*%

Patients 'Likely' or 'Extremely Likely' to recommend Spire Healthcare (2017: 98%)

94*%

Patients' expectations of what a private hospital should be like met or exceeded by Spire Healthcare (new question in 2018)

* Patient satisfaction figures based on online responses since new methodology launched in April 2018.

Using risk to help make the right strategic decisions:

Principal risk 1, 8 and 9

Further information:

Further information is available in Our market section on pages 32 to 34.

4. Best place to practise

We work closely with consultants and want to be the place where they most want to work.

The relationship we have with our consultants begins with strong local engagement. We understand their needs and work hard to meet them, using findings from our annual consultant survey. We have also strengthened the biennial review process to ensure high standards.

We use technology to make patient and theatre bookings easier and more flexible, and support our consultants by providing them with modern equipment. They also have access to our dedicated consultant app, which has been further enhanced this year.

Measuring success:

68%

Consultant satisfaction following 2018 consultant survey (2017: 67%)

7,500

Consultants engaged by the Group

Using risk to help make the right strategic decisions:

Principal risk 3, 4, 6 and 9

Further information:

Further information is available in our Clinical review on pages 26 to 31.

5. Best place to work

Our aim is to be the employer of choice for the best people in our industry.

With a strong focus on employee communications and engagement, we are building our culture and values, and driving performance across a more aligned organisation. We have strengthened our HR function and our central recruitment capability to support our teams.

We're developing transparent, easy to understand reward frameworks to recognise excellent performance and celebrate the contributions of our people. This has included the launch of 'Spire for You', an online portal that supports our employee reward, benefits and engagement.

Measuring success:

79%

Employee engagement following January 2019 survey (2017: 81%; 2018 temperature check: 79%)

81%

Participation rate in the January 2019 employee survey (2017: 70%; 2018 temperature check: 67%)

Using risk to help make the right strategic decisions:

Principal risk 6 and 8

Further information:

Further information is available in our Resources and responsibilities section on pages 38 to 42.

Patient safety and high quality clinical care must be our foremost priorities.

"During the year we have invested in strengthening our systems for medical governance and oversight."

Dr Jean-Jacques de Gorter
Chief Medical Officer

Firstly I would like to congratulate Alison Dickinson on her promotion last year from Chief Nursing Officer to Group Clinical Director.

As our Chief Executive Officer pointed out, this reinforces our strategic commitment to patient safety and our emphasis on clinical quality at the most senior levels within Spire Healthcare. Alison and I are working closely together to drive improvements in relation to patient safety, clinical effectiveness and patient experience.

Dedicated to safe, high-quality care

In 2018, Spire Healthcare delivered on the commitment we made at the start of the year to achieve ratings of either 'Good' or 'Outstanding' for every hospital inspected by the Care Quality Commission ('CQC'). This means that every site inspected since 2016 received a published rating of at least 'Good' by the CQC, with four hospitals rated 'Outstanding'. This reflects the dedication of our people to deliver safe, high-quality care which we have achieved by working in partnership with doctors through our Medical Advisory Committees (MAC) who believe, as we do, that patient safety and high-quality clinical care must be our foremost priorities.

We are also committed to greater transparency because this helps patients make more informed choices and it makes us more accountable for driving up standards. In June 2018, we published online our Quality Governance Report to demonstrate our performance and progress against 10 key indicators including Serious Incidents Requiring Investigation (SIRIs), never events, learning from deaths and complaints. We believe that by openly sharing this information, along with details of our CQC inspection results, general governance developments and our commitments to Freedom to Speak Up initiative and whistleblowing, will better inform our patients and help drive us to be the best.

Strengthening our medical governance and oversight

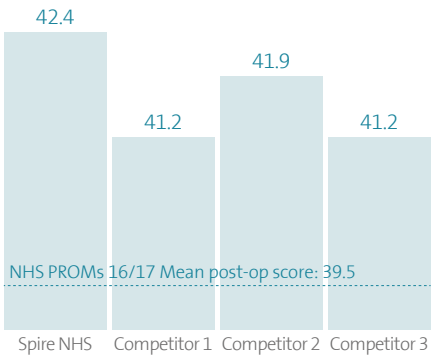
During the year, we have invested in strengthening our systems for medical governance and oversight. I appointed Mr David Macdonald – an experienced orthopaedic surgeon and MAC Chair – as Spire Healthcare's new Responsible Officer to work alongside me. Together we have worked on revising the process for appointing and appraising our MAC Chairs. We already hold twice-yearly conferences with our MAC Chairs from 39 hospitals. In 2018, we held a third meeting dedicated to consulting with them on our plans for enhancing their critical role and that of the hospital MAC, in advising our hospital Registered Managers on medical matters.

We followed this up by appointing two General Practitioner advisors – for our Spire GP Clinics and our BUPA Health Clinic franchises – who we invited onto our new national Specialist Advisory Panel (listed on page 29). Also, in October, NHS England inspected Spire Healthcare's systems and processes for medical governance and compliance with the Responsible Officer regulations. The result was a very positive report with zero improvement recommendations and some development recommendations which we are reviewing.

In 2019 we will be increasing our focus on medical governance and oversight in a number of ways including, releasing a new Medical Governance and Oversight policy, updating and enhancing the role of the MAC Chair, and strengthening our assurance where a doctor's practising privileges are restricted or suspended.

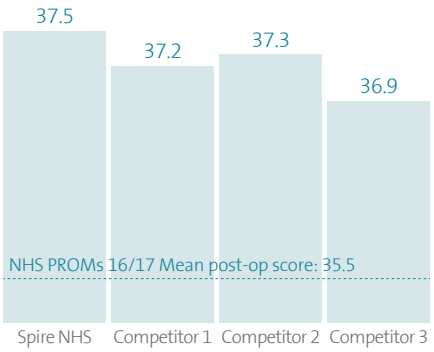
Patient reported Outcome Scores – NHS funded Hip Replacement

Mean Oxford Hip Scores



Patient reported Outcome Scores – NHS funded Knee Replacement

Mean Oxford Knee Scores



Indicative analysis based on small initial dataset; no case mix adjustment or statistical tests applied.
Sources: My Clinical Outcome database August 16–January 19. NHS Digital April 16–March 17 national PROMs dataset.

Monitoring patient outcomes

We have taken great strides in our systems for medical oversight, especially in relation to the monitoring of Patient Reported Outcome Measures (PROMs) in partnership with 'My Clinical Outcomes'. We have monitored health improvements for patients undergoing hip and knee replacements as well as cataract surgery for many years. We also began monitoring outcomes for patients undergoing breast enlargement, facelift and eyelid cosmetic surgery in 2018 using the Q-PROMs tool.

The volume of responses from patients has grown considerably and is now providing meaningful insights to share with hospitals and consultants alike. More than 13,000 patients have completed the Baseline Hip PROMs questionnaire (with almost 4,000 completing the follow-up questionnaire at six months). Similarly, more than 14,000 have completed the Baseline Knee PROMs questionnaire (with over 3,000 completing the follow-up questionnaire at six months). Where comparable external published benchmarks exist, Spire Healthcare patients funded by the NHS report superior average follow-up scores compared with NHS and larger independent sector providers (as shown in the charts above).

In 2019 we will further improve by making available hospital-specific Patient Reported Outcome Measure (PROM) reports incorporating data on individual consultant performance.

Demonstrating our quality

A critical element of our journey to becoming famous for quality is transparency. To this end, we believe that submission of data to national registries is an important part of what we do. Spire Healthcare submits data to several national registries, including: the National Joint Registry (NJR) for orthopaedic joint replacements; the National Adult Cardiac Surgery Audit managed by the Institute for Cardiovascular Outcomes Research (NICOR) and the Breast Implant Registry. In 2019, we plan to extend our submissions to include national Cancer Audits and the National Audit Project run by the Royal College of Anaesthetists.

We also submit activity and quality data to the Private Healthcare Information Network (PHIN). The volume and quality of our data has improved considerably throughout 2018 and now includes clinical coding for privately-funded episodes. We also supported our consultants to provide written information to patients on their consultation and treatment fees. These are important steps in demonstrating our quality credentials to prospective patients, as well as supporting their informed decision-making and choice of provider and consultant.

Investing in our diagnostic capability

We believe that rapid diagnostics including pathology services, are integral to high-quality care, are core to our proposition to patients and are not a service to be outsourced. That's why Spire Healthcare operates a network of pathology laboratories and, in 2018, we invested further in our diagnostic capability, including the opening of our new dedicated Pathology Centre in Manchester, which is expected to process over 200,000 samples over the next five years.

During the year, we rolled out a new Laboratory Information Management System (Winpath), started a pilot for the electronic and remote issue of blood, and achieved United Kingdom Accreditation Service (UKAS) accreditation of every Spire Healthcare laboratory ahead of schedule. We also consolidated some of our existing pathology services, specifically in relation to microbiology.

Looking ahead

We have achieved a lot over the past 12 months, but there is more for us to do on medical governance and oversight. Working alongside Alison Dickinson and her team, my team and I are committed to delivering an ambitious programme of improvements in 2019.

We will enhance our medical governance by investing in, and developing our hospital governance systems, specifically our hospital MACs and our national Specialist Advisory Panel. The role of the Panel is to advise us in relation to medical standards, governance, oversight and ethics. It met for the first time in October, with a strong representation of leaders in key medical disciplines. The Panel plans to meet twice a year in addition to our biannual MAC Chair conferences.

Whilst most of our MACs already include GPs, we are working to strengthen GP representation at all hospital MACs going forward. We are updating our medical policies to make clear the standards expected of those to whom we grant practising privileges, and the sanctions for failing to meet them.

We will contribute to, and respond to the recommendations from the review by Sir Bruce Keogh commissioned by the Independent Hospitals Partners Network, which is looking at developing a new Consultant Oversight Framework. We are also investing in our systems for medical oversight, so we can be certain we always act promptly and fairly in our patients' best interests where we believe our clinical standards are not being met.

We are piloting the 'Getting It Right First Time' inspection programme for the independent sector, building on work by NHS Improvement, to ensure every one of our 39 hospitals undergoes an inspection in the coming year. Working with the Royal College of Surgeons, we are also planning to hold a masterclass as part of their cosmetic surgery certification scheme for students undertaking this surgery at Spire Healthcare.

Achieving Level 8 data maturity to enable PHIN to publish data in relation to treatment fees and quality will be needed to comply with the Competition and Mergers Authority Order in 2019.

Finally, we will complete our rollout of the new Pathology Laboratory Information Management System (LIMS) and develop a plan to ensure our network of laboratories is best able to support our future growth and quality aspirations. Working alongside dedicated colleagues, and in partnership with skilled consultants and general practitioners across the country, I am committed to driving up medical standards for the benefit of those who matter to us most, our patients.

Specialist Advisory Panel

Mr Barry Auld
Medical Lead
Gynaecology

Professor Peter Lodge
Medical Lead
General Surgery

Dr Paul Crowe
Medical Lead
Radiology

Professor Amit Dahl
Medical Lead
Oncology

Dr Ian Doughty
Medical Lead
Paediatrics

Dr Hilary Luscombe
Medical Lead
Primary Care

Dr Sass Levi
Medical Lead
Endoscopy

Dr Christopher Bouch
Medical Lead
Anaesthetics/Critical Care

Dr Andrew Li
Medical Lead
Health Clinics

"We invested significantly in clinical governance in 2018."

Alison Dickinson
Group Clinical Director

Having spent considerable time during 2018 strengthening our resources and building on Spire's commitment to clinical governance, patient safety and regulatory compliance, I was delighted to accept the position of Group Clinical Director towards the end of the year.

In my new role I am directly accountable for our clinical standards and quality, and provide clinical guidance for our commercial and operational initiatives. I spend a large proportion of my time in our hospitals and use feedback from my site visits to reflect the clinical voice at the most senior level of the business. I also have a wider view of the sector as vice chair of the Department of Health's Independent Sector Nursing Advisory Forum.

Working closely with Dr Jean-Jacques de Gorter and Dame Janet Husband, I have overseen significant investment in our clinical governance during the year. I value Dame Janet Husband's support, critical and constructive oversight and input from a Board perspective. One very important governance initiative has been the introduction of Freedom to Speak Up Guardians at all our sites. It is vital that our colleagues are free to raise any concerns about safety or wrongdoing, so that they can be properly investigated without repercussions. The aim of the initiative is to make speaking up business as usual and is in line with the National Guardian's Office, which is sponsored by the CQC, NHS England and NHS Improvement.

In 2018, we have also appointed Surgical Safety Guardians in every hospital to lead on safety checks and compliance with our standards. This group has already held two conferences to share ideas and good practice. A further Patient Safety Guardian programme will be introduced in 2019.

I am committed to embedding an open and learning culture across the business. We continue to learn from when things go wrong, including compliance with the learning from deaths programme, independent scrutiny of significant incidents, and sharing of learning across the Group, as well as sharing good practice through national communication alerts and specialist conferences and events – many with expert speakers.

Of course, a particular focus of my work is to ensure every hospital and clinic is rated 'Good' or 'Outstanding'. During the year, the CQC completed a number of second inspections of our hospitals, including some focused reviews of core services. Most results have been published, though some are awaited. Of the reports issued, all were rated 'Good' or 'Outstanding' for all core services and all key questions, some with improved ratings on initial reviews.

This performance remains in line with the rest of the private sector and continues to far exceed the NHS average. Within domains, 100% of our hospitals are rated 'Good' or 'Outstanding' for Caring and our performance in the Safe, Effective, Responsive and Well-led domains remains in line with or better than the rest of the sector average for each.

Four of our hospitals are rated 'Outstanding' overall, with others having 'Outstanding' ratings for individual domains or services. Both of our hospitals in Scotland were inspected in 2018 and continue to demonstrate high-quality standards under HIS's new ratings system. There are some areas for improvement that we continue to address as a matter of urgency. We look forward to the CQC returning to more of our hospitals in 2019/20 to enable us to demonstrate the improvements we have made and to showcase good practice.

We continue to deliver a rigorous annual programme of clinical reviews of all hospitals and clinics. These visits provide hospitals with an independent assessment of their services and any areas for improvement, as well as providing assurance to the Clinical Governance and Safety Committee and the Board that services are meeting or exceeding expected standards. To reward services assessed as being 'Outstanding' at these reviews, our Spire Exemplar awards were introduced in 2018, with plaques to display in their units that provide assurance to patients and visitors.

Significant investment has been made in improving patient safety and quality in 2018 with the recruitment of additional clinical specialists to provide expert onsite support, more strategic oversight and to drive best practice initiatives. This includes bringing together the best people to further support theatre services, pre-operative assessment, endoscopy, diagnostic imaging and infection control.

New service specific dashboards have also been introduced to the business using external targets and intelligence to inform improvement measures wherever possible. In the absence of national audit programmes for the independent sector to participate in, this means we can better evidence excellent patient outcomes and high standards across all sites, and tailor support where needed.

Our focus for 2019 continues to be the safety of our patients at every stage of their pathway. This includes a quality focus on pre-operative assessment to minimise any potential harm, and the introduction of national standards for new specialist areas. Investing in the training and competencies of our clinical staff, the focused development of our Matrons and other leaders, and the further enhancement of our Surgical Safety and Patient Safety Guardians will all assist us with the aim to be recognised as a world-class healthcare business.

"At Spire Healthcare, we aim to lead the way in marketing and retailing private healthcare, while keeping quality and patient care at the centre of everything we do."

Peter Corfield
Group Commercial Officer

Population of the UK

66.5m

in 2018

71.1m

by 2028 (forecast)

Ageing population

+19%

people 55+ by 2028 (forecast)

+37%

people 75+ by 2028 (forecast)

Increase in self-pay patients

+19.1%

2018 to 2021 (forecast)

While our market is subject to major long-term trends, there are also more immediate factors that we can influence to meet patient needs, such as the clinical quality we offer, the way we market and retail our services and the detailed market intelligence we can access. The major trends are unchanged – the UK's population continues to grow, and people are living longer, often with multiple co-morbidities – but it is important that we both understand and can identify people who are willing to consider private treatment.

Overall healthcare market

The ageing population and greater prevalence of long-term medical conditions will increase demand for healthcare services and significantly stretch the UK's resources. The NHS delivers comprehensive healthcare to the nation, but it is struggling to cope with growing demand and is subject to a severe and long-term budget squeeze.

Treatment and care for people with long-term conditions already accounts for an estimated 70% of total health and social care expenditure. People with long-term health conditions account for about 50% of all GP appointments, 64% of all outpatient appointments and more than 70% of all in-patient bed days. The number of people with three or more long-term conditions was estimated to be around 2.9 million in 2018 (up from 1.9 million in 2008).

Private healthcare can play an important role in helping to meet the UK's increasing healthcare needs – we are proud to work in partnership with the NHS and are also committed to providing easier access to quality care in the self-pay sector. We have invested in our core resources and the quality of care for our orthopaedic and other patients, as well as in the higher acuity services we offer, including cancer and cardiac. We are positioning the Company to ensure we can care for the growing number of mature patients with multiple and challenging co-morbidities.

Spire Healthcare's nationwide presence, modern facilities and capacity, mean we can provide services to NHS commissioners and providers, as well as private patients. Using targeted marketing and better research, we can also make more people aware of their options to go private and build on our brand that is recognised for quality and service.

The NHS – we are part of the solution

The NHS is widely considered to be both efficient and unique in offering care to all, free at the point of care. However, the service remains under strain, due to under-funding and rising demand. We are proud to play our part in helping the NHS meet the nation's health needs, while reducing the requirement for capital investment in the public sector.

As NHS decision-making is dispersed, the way in which our NHS contracts are managed is likely to require more resource, and our NHS revenue is vulnerable to priorities that can vary by geography. However, during 2018, the NHS was allocated additional funding to help reduce waiting times – some £20 billion that will be spread out over the five years to 2023/24. Some of this funding is expected to result in increased NHS spending in the independent sector, enabling Spire Healthcare to remain part of the solution by continuing to help the NHS deliver outstanding healthcare and providing choice to patients.

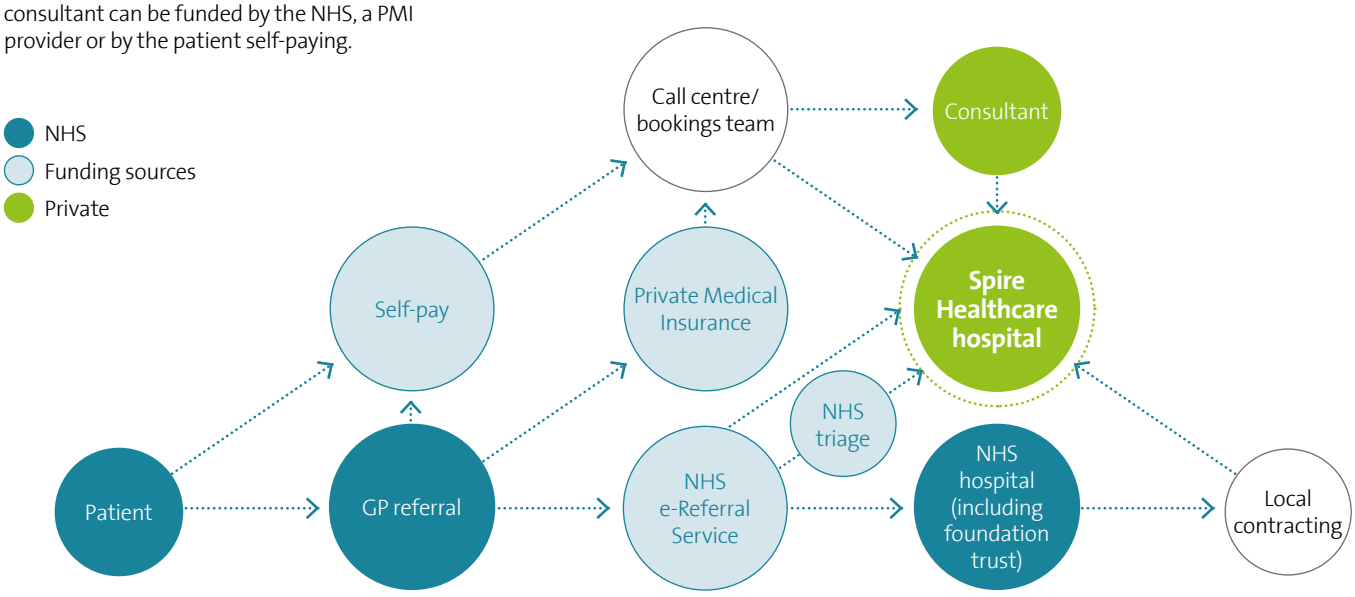
Private medical insurance (PMI) business – competing for value

The majority of private patients are funded by private medical insurers, with most PMI being funded by the corporate market. This makes PMI sensitive to economic downturn, as demonstrated by the fall in the proportion of the population covered by PMI in the UK from 12.3% in 2008 to 10.4% in 2017. At year end 2018, the sector has not recovered since this decline caused by the financial crisis.

PMI providers now market the end-benefits to corporates – highlighting increases in productivity and reductions in sickness absence as key selling points – but this has only offered limited growth potential. In the medium term, Spire Healthcare will need to differentiate on quality and compete hard to achieve growth in PMI, while insurance providers may seek to expand the sector by broadening their range of services to cover health and fitness, GP services and emergency care.

Who we serve

We receive patients through multiple routes. The patient's journey typically begins with a visit to their GP who will either treat the patient directly or provide a referral to a consultant. The procedure or treatment provided by the consultant can be funded by the NHS, a PMI provider or by the patient self-paying.



In 2018, we entered into a new contractual agreement with leading private medical insurer, Aviva who have confirmed that this was based on our transparency and quality: "Aviva are delighted to collaborate with Spire Healthcare, who share metrics such as hospital level treatment outcomes, experience ratings and feedback. This aligns with our own value-based commissioning strategy to recommend treatment providers to our customers based on quality of treatment as well as affordability."

Self-pay treatment – growing demand

Self-pay offers the potential for real growth in private patients and treatments, as demand appears largely unaffected by economic uncertainty. Indeed, we have seen good growth in self-pay volumes for several years. This suggests that people whose access to PMI has been restricted have continued to seek fast access to quality, paid-for healthcare.

Longer NHS waiting times are a key driver of demand, while thresholds for NHS surgery have been raised on several treatments and others of 'limited clinical value' have been restricted altogether. Convenience and flexibility are also key factors in choosing private healthcare, and more patients are now using the private sector for outpatient appointments and diagnostics before deciding whether to switch back to the NHS or continue with private treatment.

The proportion of the workforce who are self-employed has also risen, with most of the growth coming in management and professional occupations in the service sector. More of these people are looking to self-fund healthcare as they cannot afford to take too much time away from work without the security of sick-pay and other corporate benefits.

Leading the way in marketing and retailing private healthcare

The challenge for private healthcare providers is to improve their marketing capabilities and retail offerings to ensure that the public is better aware of the options to self-fund treatment. This will require greater price transparency and could lead to price deflation over the medium-to-long term, but this is likely to be offset by increased volumes of self-pay patients and treatments.

Understanding patient needs is vital to tapping this demand effectively. Our research shows that providing quick and easy access to diagnosis meets a fundamental need for our target market – when people have a health problem or notice a symptom, it is normal to want to quickly find out "what's wrong with me?" Quality of care, in the form of access to leading consultants, the latest and most advanced technology, a choice of treatments not always available on the NHS and flexibility in the choice of appointment times, is also important. The roll-out of Spire GP at our hospitals offers a more immediate way for patients to be referred for these treatments.

At Spire Healthcare, we aim to lead the way in marketing and retailing private healthcare, while keeping quality and patient care at the centre of everything we do. Having invested in our central marketing team and resources in 2018, we have access to better market insights and are able to leverage our scale and reach the right people.

We must enable patients to access our services quickly, efficiently and on a cost-assured basis. That's why, in 2018, we launched online booking for self-pay consultations, through which we are already taking a significant volume of bookings. Our patients can also now book private GP appointments directly, and we are running several trials and launching new initiatives, including tablet registration and online satisfaction surveys, as we move towards the ideal of paper-free 'electronic hospitals'.

Making all the right choices

Spire Healthcare not only offered the highest standard of clinical care but also a number of choices that helped Jane feel more involved with her treatment and eased the stress of having such a major operation.

Reverend Jane Proudfoot
Spire Healthcare patient

Reverend Jane Proudfoot has been the Rector at St Wilfrid's Church in Grappenhall near Warrington, since September 2012. She has a busy life with many obligations to the volunteers who help run the church and its many activities, as well as to her friends and parishioners in the community. That's why, when the arthritis in her right hip, which had been causing her pain for around eight years, became unbearable, Jane knew she would have to take action.

Alarmingly, what she discovered was that her hip joint and socket had all but crumbled away, meaning that a replacement was the only option that could offer her full mobility again. On a personal recommendation, Jane opted for our Spire Cheshire Hospital for the operation. Despite the pain she was experiencing, she was delighted to discover that Spire Healthcare not only offered the highest standard of clinical care but also a number of choices that helped her feel more involved with her treatment and eased the stress of having such a major operation.

First, she was able to choose her consultant. That was important for Jane: "I wanted to be sure everything was right and, after some online research, I decided on Consultant Orthopaedic Surgeon, Mr Nikhil Pradhan. He has a great track record and knowledge, and when I met him, he was very understanding. He really took the time to explain everything in detail. Everyone at Spire Cheshire Hospital helped to put me at ease."

With all the facts, Jane was even able to select the type of anaesthesia that suited her and to pick the exact hip replacement she wanted. At 52, she is young for this kind of procedure, so she opted for the best she could – or an "upgraded hip" as Jane puts it. Then there was Spire Healthcare's add-on 'premium package', which provided a door-to-door service with cars to the hospital and back home a few days later, family meals at the hospital and one-to-one aftercare.

This individual service helped Jane reduce the strain of what could have been a traumatic situation. And the opportunity to pick a date for the operation helped Jane manage the hip replacement and her recovery alongside her work commitments. "Being in control of my life, work, family and Christmas was so important for me," explains Jane, "especially for someone in my line of work."

Link to Strategy:

2. First choice for private patients

How we invest in and operate our business to generate value for our stakeholders.

Investment

Where we invest

The sustainability of our business model relies on several interconnected resources and relationships.

Financial strength
We benefit from financial strength and stability, supported by a cash-generative operating model and properties in commercially attractive locations across the UK.

Well-invested hospitals
Our portfolio of hospitals is equipped with modern technology and comfortable treatment facilities.

Highly-skilled employees
Our employees are highly skilled and our nursing and medical support employees have the expertise to provide an excellent standard of patient care.

NHS
Spire Healthcare offers the NHS capacity, capability and flexibility. At the same tariff (price) as an NHS Trust, we perform complex operations which help move thousands of patients off waiting lists across the country. The capital we invest in our sites is at no charge to the NHS but allows us to make clinical teams, theatre time and beds available quickly. Patients really appreciate the service with 97% of NHS patients saying they would recommend Spire Healthcare to friends and family.

Referrers
We work with GPs to facilitate speedy, convenient and fully informed referrals. We are investing in our own hospital-based primary care to offer patients convenience and facilitate speedier referrals.

Consultants
Consultants are integral to providing high levels of medical care to our patients and we offer them the facilities and support they need to deliver high-quality healthcare.

Private patients
We offer treatments for patients who have private health insurance or wish to pay for their own treatment. We offer them choice of when and where they are treated, in hospitals that combine excellent clinical outcomes and levels of infection control with 'hotel-style' levels of service.

PMI
We have long-term relationships with the top five private medical insurance providers.

How we leverage national scale

Our hospitals and clinics span the country, serving a diversified patient mix.

National scale:

19
Macmillan-accredited cancer centres

39
Hospitals

8
Clinics

7,500+
Consultants

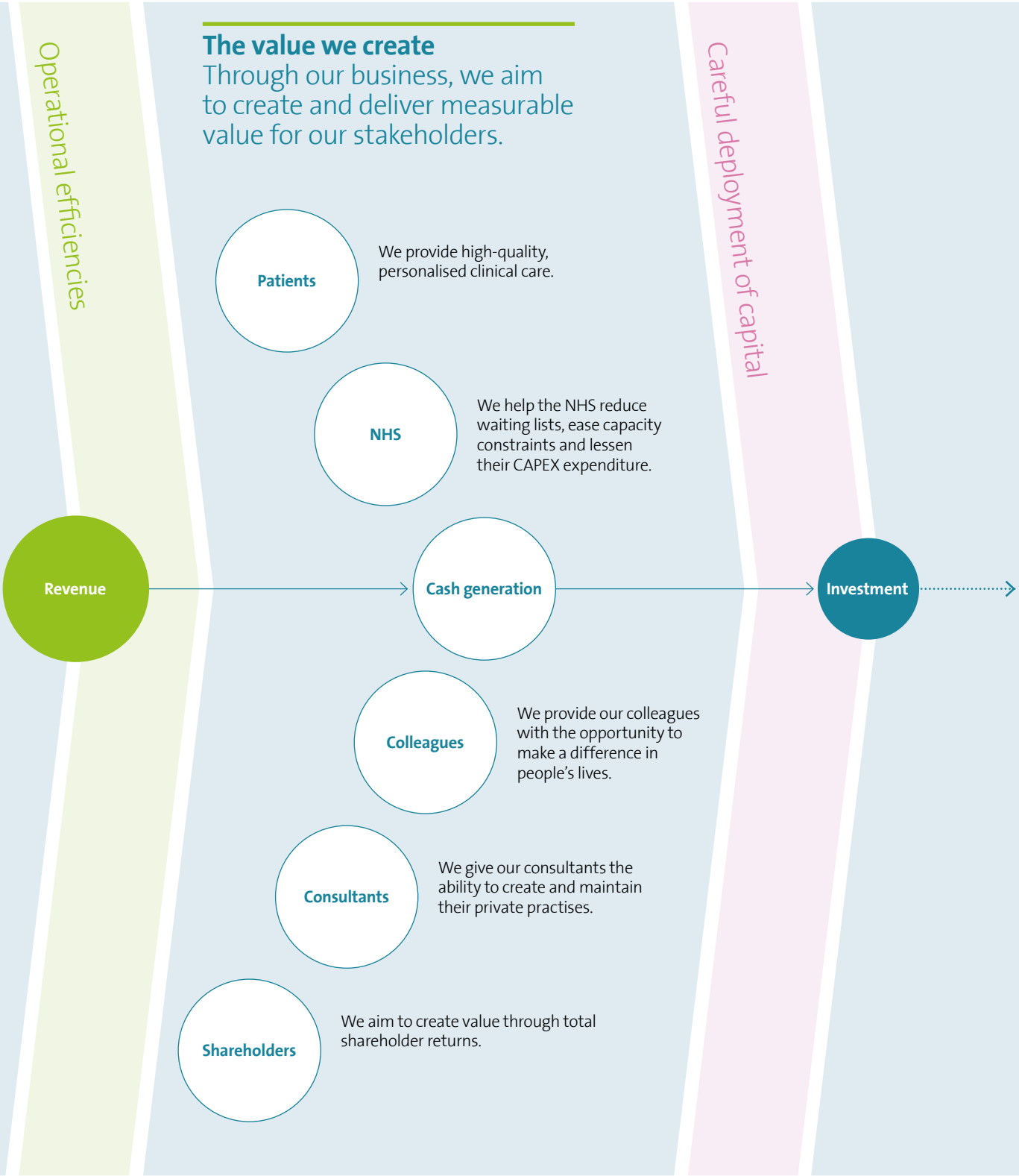
777,000
Patient treatments

Our critical success factors:

– Patient safety
– Quality of care
– Clinical governance

The value we create

Through our business, we aim to create and deliver measurable value for our stakeholders.



We can only put quality at the heart of everything we do if we have the right resources in place and have outstanding relationships both within and external to our business.

First and foremost, we depend on our people – our nurses, theatre staff, allied health professionals, non-clinical support colleagues and bank staff – to cement our internal and external relationships and help build on Spire Healthcare's strong reputation in the market. We work hard to create the right culture – ensuring that colleagues are fully engaged with our business strategy, live up to our values, support each other and are, of course, dedicated to clinical safety and patient care.

Our 'duty of care' also extends to the environment in and around our hospitals, as well as to the partners and suppliers we work with, and the communities we serve. We promote a low carbon culture across our sites and continually review how we operate our buildings and infrastructure to reduce energy use, improve carbon efficiencies and manage our operational risks more effectively.

Leadership development

The strength of our leadership is an important influence on our culture and is key to our future success. That's why the values-based leadership competencies we developed last year have been invaluable in reviewing the performance of our senior hospital management teams during 2018.

Alongside these reviews, our Operations Directors have started building structured succession plans for key roles at each hospital, including Hospital Director, Matron, Head of Clinical Governance, Business Development Manager, and Finance and Commercial Manager.

We also made a significant investment in training our senior leadership team in 2018. More than 70 senior leaders took part in our bespoke Leadership Development programme at Ashridge Business School over the summer. Each participant attended two three-day sessions, focused on their specific needs and how to overcome the challenges we face as a business. They also have access to an online portal – making tools from the Ashridge course available for use as they apply what they learnt during the training.

Making Spire Healthcare a 'destination employer'

Recruiting and retaining the best people remains a priority for Spire Healthcare. To enhance our status as a 'destination employer', we need to make sure colleagues feel valued and have clearly defined career paths. We must embrace diversity, especially when it comes to senior appointments; we have to offer competitive salaries and benefit packages; and we must improve recruitment to the business, including offering great apprenticeship opportunities and looking beyond the UK and EU in the search for the people we need when necessary.

We relaunched our performance review process for colleagues to use during 2018, which included redesigned paperwork to support it and user-friendly communications and videos to explain the changes. We have stripped the process back to cover the 'what' and 'how,' along with behaviours and objectives. Numerical ratings have also been scrapped in favour of descriptions that measure an employee's progress against expectations.

To further improve our recruitment processes both internally and for external candidates, we outsourced recruitment across every hospital in 2018. Moving from local recruitment to a central model was difficult and took time, as our outsourced provider had to transition the service and build a dedicated Spire Healthcare recruitment team. However, we are now leveraging our scale with clear visibility and filling vacancies effectively. The criteria from our leadership competencies have been used as a part of our recruitment processes this year, and we have seen improvements in the quality of candidate and the process. Candidates have also reported that their experience has been good, with a more hands-on approach from application through to appointment.

Employees' responses to our recent engagement survey:

79%
feel fully engaged at work

78%
believe our top priority is delivering the highest quality patient care

86%
believe what they do at work makes a positive difference

82%
would be happy with the standard of care provided by Spire Healthcare if a friend or relative needed treatment.

Developing the next generation of healthcare professionals

We are also developing apprenticeship programmes that cover a wide range of areas, including accountancy, business analyst and HR roles, but our primary focus is on clinical apprenticeships and leadership development. Existing employees are encouraged to apply and anyone joining us will be offered Healthcare Assistant (HCA) training as part of their interview process.

Five nurses started their apprenticeships in September 2018 with another six to start in April 2019. Our Level 3 Apprenticeship Standard is flexible and offers theatre and adult nursing pathways, making it possible for an apprentice to progress from HCA training to a higher-level programme. They can even qualify for our new three-year Operating Department Practitioner (ODP) Degree Apprenticeship scheme with Derby University, which will launch in May 2019.

We have a growing cohort of apprenticeships in pathology, with new and existing staff due to join our Medical Laboratory Assistant (MLA) scheme in 2019, bringing the numbers up to 12 colleagues over the last year and into next year. We are also trialling an apprenticeship for the new Nurse Associate role introduced by the NHS, with one nurse already working on her degree through Salford University.

We are soon to launch a clinically-focused course aimed at clinician and non-clinician line managers in the business, supported by South Teeside NHS Trust. It is a 12-month programme that provides leadership development but is specifically focused on managing in a clinical environment.

Engaging colleagues

Our colleagues interact with thousands of patients every day and play a crucial role in delivering the highest quality care and outcomes. We value what they do and engage closely with them, through a variety of two-way communication channels open to colleagues at all levels of the organisation. For example, we hold senior leadership meetings throughout the year, but also reach a wider audience through bimonthly 'town hall' meetings in our two main office sites that are normally led by Justin Ash, our Chief Executive Officer.

We have a People Forum that meets three times a year, which is a dedicated half-day meeting with the Executive Committee, Operations Directors and HR leadership, to discuss important topics, including quality and inclusivity. We have also seen excellent participation in our quarterly 'All hands' colleague conference calls, which update colleagues on what's happening in the business, and John Forrest, our Chief Operating Officer, produced a video message at the end of the year for our hospital-based employees.

Our recent engagement survey saw an overall engagement score of 79%, which exceeded external benchmark rates of 71% but was slightly lower than our last full survey (2017: 81%). We introduced a temperature check survey in the summer of 2018, and will survey all colleagues twice a year going forward. More people are responding online to the survey and we have increased the actions taken in response to employee feedback. We have a strong commitment from the Executive Committee to address any issues and to spend time on proper engagement with our people and hold good open discussions with them.

Reward and recognition

Having completed a detailed review of our reward and benefits at the end of 2017, we have now developed a simple, clear framework that can be used across all roles and functions to provide consistency and fairness. Instead of traditional performance-based bonuses, our people can be recognised within hospitals by management and colleagues, with more than 3,400 employees having received an award in 2018.

This is run on our 'Spire for You' platform that was launched in March 2018. As well as nominating colleagues for a cash award it allows people to send a 'thank you' e-card. The platform can also be used for wider recognition and other messages. It also provides a Reward Gateway, which includes a discount portal for employees, which 60% of our people registered to use within the first few months.

During the year, we held 'restart a heart' training at our Regents Gate office and 'know your numbers' (British Heart Foundation's campaign to monitor blood pressure) at Regents Gate and our head office. Flu jabs were also offered to all colleagues across the Group, with a high take-up.

Our Employee Assistance Programme has also been promoted this year, giving employees access to advice on difficult matters related to both work and domestic life. We are now planning a new Health and Wellbeing resource to be made available in 2019 covering advice and planning on mental, physical, financial and diet issues.

Pension scheme changes

Following a consultation, we have moved the Group pension scheme to a Master Trust. This is a multi-employer occupational scheme where each employer has its own division within the master arrangement. Master Trusts offer employers the benefit of a governance function but with generally lower operating costs and greater simplicity than a single employer scheme. They are usually better for individuals, offering better terms, more control and increased access to information.

Whistleblowing

We want colleagues to feel confident and empowered to raise any issues or concerns they may have; however, we also have a robust whistleblowing policy in place. Our whistleblowing helpline is managed by a third-party provider, enabling colleagues to raise any concerns they may have about issues of safety or wrongdoing, anonymously if necessary.

All such concerns received through the helpline are sent to the Group Company Secretary for review, and to ensure that they are appropriately investigated and concluded. Awareness of our whistleblowing policy amongst colleagues is high with 92% of colleagues responding positively as part of our recent employee survey.

Anti-bribery and corruption

Spire Healthcare's Anti-Bribery, Gifts and Hospitality policy extends to all its employees. We take a zero-tolerance approach to bribery and corruption and we are committed to conducting our activities free from any form of it. We expect the same from any third parties providing services for us or on our behalf. Employees who fail to comply with the requirements of our policies and standards may face disciplinary action, including dismissal.

Gender pay gap

Spire Healthcare's workforce across all our hospitals and clinics is 81% female and includes 24% temporary workers (predominantly bank staff comprising nurses and other clinical staff).

Employees	Male	Female
Overall employees	2,421	10,401
Senior managers	43	27
Board members	7	2

We are required to report gender pay gap figures for our main employing entity – Spire Healthcare Limited – covering 98% of all reportable employees of Spire Healthcare Group. We also have to report our gender pay gap figures for Montefiore House Limited, a joint venture hospital based in Brighton who had 250 relevant employees for gender pay gap purposes in April 2018. In the interests of full transparency, we have supplemented the statutory disclosure requirements with additional data that captures relevant employees across the Spire Healthcare Group.

The gender pay gap required by the Gender Pay Gap Regulations represents an average figure. This is distinct from 'Equal pay', which considers whether men and women are paid the same for carrying out the same work, or work of equal value.

Gender pay gap – reported data for 2018

Entity	Montefiore House Limited		Spire Healthcare Ltd		Spire Healthcare Group (including Spire Healthcare, Spire Healthcare Group Limited and Montefiore House Limited)	
Number of Employees (includes bank workers)	250		11,514		11,770	
Women's Hourly Rate is:						
Mean	3.7% higher		21.3% lower		23.5% lower	
Median	32.3% higher		10.3% lower		9.8% lower	
Pay Quartiles:	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
Top Quartile	24%	76%	26%	74%	26%	74%
Upper Middle Quartile	19%	81%	15%	85%	15%	85%
Lower Middle Quartile	21%	79%	17%	83%	17%	83%
Lower Quartile	38%	62%	19%	81%	19%	81%
Women's Bonus Pay is:						
Mean	No men received a bonus, therefore no reportable figures		64.8% lower		64.9% lower	
Median			3.3% lower		6.7% lower	
Who received a Bonus?						
Men	0.0%		2.2%		2.1%	
Women	0.5%		2.3%		2.3%	

Key findings
The overall median gender pay gap in both Spire Healthcare Limited and the Spire Healthcare Group (10.3% and 9.8% respectively) is considerably lower than the Office for National Statistics (ONS) provisional national average of 17.9% (as per their publication of 25th October 2018). The median gender pay gap in Montefiore House Limited is in favour of women at -32.3%.

In 2018 our numbers of female employees at the Executive level reduced and we had the addition of our Chief Executive Officer, Justin Ash. These changes have had a negative impact on our gender pay gap in 2018.

At the Montefiore House Hospital, they have a very small population size, with no central function support directly employed by this entity. The distribution of women's salaries is far more even than that of the men (who are outnumbered significantly), which is driving the positive position for the women.

The bonus gender pay gap set out in the table for 2018 should be treated with caution. Firstly, less than 3% of employees received a bonus in the period under review, as a number of internal and external factors impacted the business. This means that the data is based on a relatively small number of employees. Secondly, the data has been heavily skewed by a single legacy share award related to legacy arrangements which made up 18% of total bonuses paid.

How we are responding to the gender pay gap
Spire Healthcare is committed to diversity and inclusivity, and in particular supporting women to become leaders within the business.

We believe that the implementation of our Reward Framework will provide greater consistency between roles and locations, assist reducing pay anomalies and, in time, help our gender pay gap. The launch of the Competency Framework will also be used to drive consistency and assist their development as well as being used for talent and succession planning moving forward.

In addition, the Leadership Development programme was launched in 2018 to give our employees the support and training they need to develop their skills and experience. Almost half of the attendees were females. We will continue to monitor our gender pay gap and we are committed to taking steps and spotting opportunities to reduce it further.

Looking after our environment

At Spire Healthcare, the quality of care we provide extends beyond the way we look after our patients. We also have a 'duty of care' to the environment, which includes promoting a low carbon culture across our hospitals, with a focus on reducing carbon emissions associated with our use of electricity and natural gas. The way we purchase, monitor, target and report on our buildings' energy consumption is undertaken in partnership with our energy consultants Inenco.

Energy

Targets vs performance

In 2016, we published the five-year energy reduction targets set out in our Carbon and Environmental policy document to reduce CO_2e from electricity and natural gas by 15% per pound of revenue by 2020 from the baseline year of 2015.

We use the intensity metric of carbon emissions per pound revenue which increases in proportion to the growth in our business. The addition of Spire Manchester and Spire Nottingham hospitals to our portfolio for example added significant energy consumption overnight. Our values are based on providing excellence in clinical quality and innovation to our patients. As a consequence of continuing to meet these values we hope to continue to grow, to treat more patients, to provide more treatments and to offer the latest technology.

Legislation

Since becoming a publicly listed company in 2014, Spire Healthcare is registered for the Government's CRC Energy Efficiency Scheme and we report our carbon emissions to the Environment Agency accordingly.

Our mandatory Phase 1 Energy Savings Opportunity Scheme ('ESOS') audits were completed on schedule and concluded that due to the excellent work already undertaken in improving energy efficiencies across our estate, their recommendations would be unlikely to produce large energy savings. The recommendations will, however, be incorporated into our carbon reduction planning for the future. We are now working with our energy consultants to discharge our responsibilities under ESOS Phase 2 assessment and audit reporting obligations.

Spire Healthcare was invited to participate in the Carbon Disclosure Projects (CPD) again in 2018. We made our fourth submission to the CDP this year and have been upgraded to a 'B' grading which demonstrates our knowledge of our impact on climate change issues.

Energy Monitoring

Our hospitals receive monthly energy reports detailing utilities consumption and benchmarking them against similar sized hospitals across the Group. The reports include dashboards at site and group level detailing year on year performance. Our Regional Engineering team audit and monitor our hospitals' carbon reduction action plans as part of our annual compliance auditing programme.

Capital investment in low carbon infrastructure

We continue to invest in our engineering infrastructure to improve energy efficiencies. Key projects this year included investment in areas such as lighting, mechanical ventilation, building controls, heating and domestic hot water services. These projects are having a positive impact on relevant Energy Performance Certificates (EPC) for our buildings. After completion of boiler replacement and LED lighting installation at Spire Leicester Hospital for example, our EPC improved dramatically from an energy performance rating of 'F' to a much improved 'B' rating.

High-efficiency lighting – On the back of the measured energy and aesthetic benefits of upgrade to LED lighting, we have invested heavily in this area over recent years (£2.5 million). This investment has helped to reduce our carbon footprint and we also benefit from the much improved light quality that this technology brings. We have continued to install these systems as standard in 2018 as part of our national refurbishment programme, to ensure we continue to reduce our electricity consumption and ensure we meet our stated energy reduction targets in 2020.

High-efficiency heating and hot water services – Modular condensing heating and hot water boilers were installed at Spire Fylde Coast, Spire Hartswood and Spire Edinburgh (Shawfair Park) hospitals during 2018, which will deliver a reduction in gas consumption at these sites in future years.

High efficiency ventilation systems – Our theatre ventilation plant ensures rapid air exchange within our theatre suites to protect our patients from infection. By its nature, these systems are energy hungry. We have replaced ageing systems at Spire Hartswood Hospital in 2018. The new systems now include high-efficiency control systems that help deliver this critical air in the most efficient way.

Directors' report greenhouse emissions 2018

This section provides the emission data and supporting information required by The Companies Act 2006 (Strategic Report and Directors' Report) Regulations 2013.

Footprint boundary

An operational control approach has been used to define the greenhouse gas (GHG) emissions boundary, as defined in Defra's latest Environmental Reporting guidelines: "Your organisation has operational control over an operation if it, or one of its subsidiaries, has the full authority to introduce and implement its operating policies at the operation."

For Spire Healthcare this captures emissions associated with the operation of all our hospitals and other buildings such as clinics, offices and our distribution centre, plus company-owned and leased transport.
As Spire Healthcare has no overseas operations, all emissions refer to UK operations only.

Emission sources

All material scope one and two emissions are included, plus scope three electricity transmission and distribution losses. These include emissions associated with:

- fuel combustion: stationary (natural gas; and red diesel for backup generators); mobile (vehicle fuel)
- purchased electricity
- fugitive emissions (refrigerants, medical gases).

Methodology and emissions factors

This report was calculated using the methodology set out in Environmental Reporting Guidelines (ref. PB 13944), published by Defra in June 2013.

Emissions factors are taken from the Department for Business, Energy and Industrial Strategy (BEIS) emissions factors update published in 2018. There are no notable omissions from the mandatory scope one and two emissions. Approximately 11% of emissions are based on estimated data.

Greenhouse gas emissions

The greenhouse gas (GHG) emissions for Spire Healthcare for January to December 2018 were 38,350 tCO_2e, tabulated by emissions source below.

Engineering governance and compliance:

Our central engineering team has been expanded in 2018. We now employ three full-time Regional Engineers which has allowed dedicated engineering risk and compliance auditing support in this complex arena.

The identification, publication and management of risk associated with our engineering infrastructure and its operation is managed though annual audits alongside our clinical team. These audits are used to make this risk transparent, enabling a prioritised approach to risk mitigation. The resultant risk profile informs the business of future capital requirements, gives confidence this capital is managed on a true risk basis and is targeted in the most efficient and effective way. The central engineering team supplement the formal annual audits with regular routine visits which ensure the engineering governance system is dynamic with continual addition, closure and reassessment of risk which future proofs the business.

Emissions source	2014 (tCO_2e)	2015 (tCO_2e)	2016 (tCO_2e)	2017 (tCO_2e)	2018 (tCO_2e)	Share	Change YoY
Fuel combustion: stationary	10,360	11,150	10,488	10,842	12,917	34%	19%
Fuel combustion: mobile	1,124	1,112	952	1,314	1,347	4%	3%
Facility operation*	6,543	7,152	8,288	6,128	6,936	17%	13%
Purchased electricity	27,027	25,868	23,792	21,145	17,151	45%	-19%
Total emissions	**45,054**	**45,282**	**43,520**	**39,429**	**38,351**		**-3%**
Revenue (£m)	£856.0	£884.0	£926.4	£931.7	£931.1		
Intensity: tCO_2e per £m	52.6	51.2	47.0	42.3	41.1		

The 'facility operation' emissions are attributable to the use of medical gases; carbon dioxide and nitrous oxide (5,215 tCO_2e) and leakage of refrigerant gases (1,721 tCO_2e).

Making the difference for patients.

"You just want the hospital visits to be less traumatic. You want the nurses to make it as easy as possible – and that's what they did. Even the receptionists got to know my face and remembered my name."

Sara Liyanage
Spire Healthcare patient

When you are facing something that for most us is simply unthinkable, it is the quality of care and little personal touches that make such a difference. For Sara Liyanage, who had already undergone surgery to remove a 'suspicious lump' in her armpit, the prospect of coming into the oncology department at Spire Harpenden Hospital for chemotherapy was a daunting one.

"What really helped," says Sara, "was that I was invited to visit the chemo ward before my treatment started, so that I would know what to expect. Even before that, I had met Amber, the breast care nurse, and she gave me her number and the number for the chemo ward, so that I could talk through any questions or worries I had about the chemotherapy up front."

Sara met Vicki, a chemotherapy nurse, during this initial visit. Vicki showed her around the ward and talked Sara through the specific chemotherapy she would undergo. "Vicki talked me through everything and gave me a booklet explaining all the potential side effects," says Sara. "And by seeing where things would happen, it wasn't all new when I went for my first treatment."

What struck Sara was the kind and gentle way everyone at Spire Harpenden Hospital treated her. "You just want the hospital visits to be less traumatic," she explains. "You want them to make it as easy as possible – and that's what they did. Even the receptionists got to know my face and remembered my name. So, when I went up to the counter, they greeted me with 'Hi, Sara, where are you going to today?' It made such a difference to the whole experience."

With four chemotherapy nurses, one breast care nurse, and one breast care assistant taking Sara through the process, she underwent six cycles of treatment, each three weeks apart, allowing time for recovery from a harsh cocktail of drugs. 12 more cycles followed, each just a week apart, as the dosage was lower. Sara also had to go through a biological therapy course, which involved infusions of herceptin. She finally showed 'no evidence of disease' in May 2018 but will remain on medication for the next five to 10 years and is now monitored three times a year.

"I can't fault the nurses in any way," says Sara. "They were such a lifeline for me, because each of them helped me in a different way. I could even have a laugh with them. They were so approachable, I could ask them about anything, it was never any trouble. They were so welcoming every time and being on the receiving end of kindness makes the world of difference."

Link to Strategy:

3. Most recommended customer experience

Key performance indicators

We measure our strategic and operating progress using a range of financial and non-financial performance indicators, all of which are aligned to our strategy.

1. Famous for quality and clinical care

Unplanned returns
per 100 theatre visits (2017: 0.12)

0.11

Unplanned readmissions
per 100 discharges (2017: 0.18)

0.21

We continued a low level of unplanned returns and readmissions, reflecting our strong record of treatment effectiveness.

C.difficile
infection rate per 10,000 bed days*.

0.14

Infection rates continued to remain extremely low.

* 2 cases.

MRSA
infection rate per 10,000 bed days.

0.07

In 2018 we reported a single case of MRSA across all 39 hospitals.

2. First choice for private patients

Revenue by payor

£931.1m

Revenue declined in 2018, down by £0.6 million in the year (-0.1%). Self-pay growth was strong which mitigated NHS revenue pressure in the second half of 2018.

Self-pay revenue growth*

£174.1m

Self-pay revenue increased by 8.7% in the year to £174.1 million.

* Restated to exclude Partnerships revenue

3. Most recommended customer experience*

Patient satisfaction
Friends and Family Test

96%

When asked 'How likely would you be to recommend Spire Healthcare?' 96% of patients responded 'Likely' or 'Extremely Likely', with 80% responding 'Extremely Likely'.

Patient satisfaction

82%

When asked 'How likely would Spire Hospital be your first choice next time you needed to visit a hospital?' 82% responded positively. (New question in 2018).

* In April 2018 a new patient satisfaction survey was introduced. This online survey is offered to all discharged patients and is issued two to three days post-discharge to allow patients time to reflect on their experience.

Post-operative mortality*
per 10,000 theatre visits

105%

Post-operative mortality increased slightly in 2018.

* Within 31 days of surgery.

4. Best place to practise

Consultant satisfaction

68%

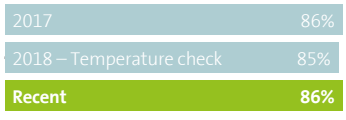
When asked, 'How would you rate the quality of service you receive from this hospital?', Consultant satisfaction rose to 68% in 2018.

5. Best place to work

Employee Engagement Survey

86%

Percentage of participants in the recent employee survey who said they believe what they do at work makes a positive difference, up 1% on 2018.

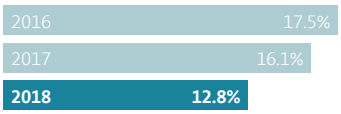


Financial and operating measures

EBITDA margin

12.8%

Including Spire St Anthony's, Spire Manchester and Spire Nottingham hospitals.



Conversion of EBITDA to cash

105%

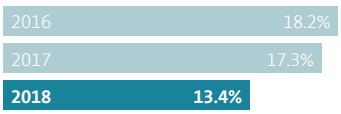
Conversion of EBITDA to operating cash flow before exceptional items and taxation decreased to 105%.

Underlying EBITDA margin

13.4%

Adjusted to exclude Spire St Anthony's, Spire Manchester and Spire Nottingham hospitals.

Factors affecting margin include inflationary cost increases, investments to extend training and development capabilities, clinical assurance functions and indexed property rental increases.



Other direct costs* as a percentage of revenue

32.9%

Including Spire St Anthony's, Spire Manchester and Spire Nottingham hospitals.

* Comprises direct costs and medical fees. For more information, see page 67.

Clinical staff costs as a percentage of revenue

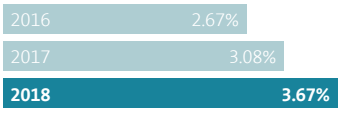
20.5%

Including Spire St Anthony's, Spire Manchester and Spire Nottingham hospitals.

Net debt/EBITDA

3.67

Net debt to EBITDA increased only marginally despite £65.2 million for capital expenditure in 2018, and the cash funding of Exceptional and other items of £7.7 million and additional 'one-offs' of £4.7million.



Total CAPEX*

£65.2m

Total CAPEX declined in 2018, down by £54.7 million in the year (-45.6%).

* CAPEX in 2017 included investment relating to the completion of the new Spire Manchester and Spire Nottingham hospitals, and the redevelopment of Spire St Anthony's Hospital.

Building on our solid foundation of quality will take the business forward.

Having joined Spire Healthcare in October 2018, my immediate priorities have been to get to know the sector in depth and to steady our business performance by putting a renewed focus on our strategy and delivering profits for the Group. I have been impressed by the investments in clinical quality Spire Healthcare has made, and by the quality of the people I have met around the business who, without fail, put patient safety and quality at the centre of everything they do. They are people who really care, they are passionate, talented and diligent, and I look forward to what we can achieve together in 2019.

Solid foundation of quality

We have been without a permanent Chief Operating Officer for some time and I would like to congratulate our Operations Directors across the country who have done a great job through what has been a tough year. They have had a crucial role in managing changes in clinical quality standards and across our teams – playing an important part in building a solid foundation of quality during 2018.

We must now take the business forward on these foundations and, as part of my efforts to really understand what's needed, I have already visited more than 20 hospitals and our shared service centre in Reading. I have attended Matron meetings and senior management meetings up and down the country, and there is much for us still to do to improve project management and delivery.

"I want to ensure our central and local teams work better together, sharing best practice and common processes, and are fully engaged in making the changes that will reinvigorate the business."

John Forrest
Chief Operating Officer

We are moving to shorter, more targeted 90-day plans and I am determined that we will continue our patient safety focus and do everything possible to improve our record of keeping promises and hitting targets. That means improving communications, getting a tighter grip on revenue, and clearer reporting of key data. We must also focus on team engagement. Our people are what makes Spire Healthcare what it is, so developing the right teams and attitudes is critical to our success. We have had a lot of people in interim roles during the last year or so. They have helped us navigate the ups and downs in 2018, but this is changing, as we need people who can be fully engaged and can build long-term relationships.

We are also improving our operational efficiency and commercial focus. Working closely with Peter Corfield, our Chief Commercial Officer, I want to ensure our central and local teams work better together, share best practice and common processes, and are fully engaged in making the changes that will reinvigorate the business. Making every day a 'sales day' is not a mantra that comes too easily in our sector, but we are dialling up the local focus on sales. We are also 'making every penny count', through better spending and more focus on the time and resources we need.

Investing in our business

Key investments in quality continued in 2018, including significant work at Spire Cambridge Lea Hospital, comprising the expansion and refurbishment of the daycase unit, a new Jag compliant endoscopy suite and the upgrade of the Level 1 critical care extended recovery area. Work was completed on a diagnostics centre in Elstree, Hertfordshire, which acts as a 'satellite centre' to Spire Bushey Hospital, increasing our capacity for diagnostic and outpatient appointments. We are also providing a sixth operating theatre at the hospital, as well a new larger recovery unit and Theatre Sterile Supply Unit, and 10 new patient bedrooms, with work due to complete in Q2 2019.

We have refurbished the administration areas and theatres at Spire Methley Park, and created a new day care suite and operating theatre, taking the Group's total of operating theatres to 134. At the same time, we are seeking to improve the use of spare operating theatre capacity to improve the recovery of fixed and semi-variable costs in the business.

Overall, we have invested more than £65 million during the year to enhance facilities and purchase new equipment. These investments have also included a new MRI scanner at Spire Norwich and Spire Edinburgh Murrayfield hospitals, the refurbishments at Spire Hartswood, Spire Bristol, Spire Parkway (Solihull) and Spire Hull and East Riding hospitals, a new mobile CT scanner and Group-wide telephony improvements. We have also delivered the new Spire Manchester Pathology Centre. We continue to focus on delivering economies of scale in procurement, distribution and logistics and other in-house support services such as pathology and sterilisation.

'One Spire' way of working

One thing that has been well understood in the business for some time, is that it does not pay to do the same task in 39 different ways at each of our hospitals across the Group. Changing this can be difficult, however, and our efforts to act as 'One Spire' have been challenged a little during the year.

We already have a major programme in place to review and simplify our end-to-end processes, which will help us to deliver a better customer experience and make us easier to do business with. However, we will redouble these efforts in the coming year – strengthening our central marketing and commercial functions, better engaging our people, reducing complexity and identifying cost savings.

This will provide additional headroom for local management, especially our Hospital Directors and their senior management teams, to focus on what really matters locally – clinical safety, their relationships with consultants and key suppliers, and doing everything they can to enable their people to provide the brilliant service to patients they are so committed to.

Making the most of an opportunity.

"It's great to be part of a team of apprentices from different hospitals around the country who support each other, helping each other and sharing experience."

Sally Harvey
Spire Hartswood Hospital apprentice

Link to Strategy:

5. Best place to work

It is never easy to balance the needs of a young family and the pressures of work, but it takes an extra special effort to add in the demands of an apprenticeship and the evening and weekend work that comes with it. When such an opportunity came up for Sally Harvey in January 2018, she grabbed it, but she knew it would be a real challenge.

Sally was working 17 hours a week as a Medical Laboratory Assistant at Spire Hartswood Hospital in Brentwood, which allowed her to fit school runs and other family commitments into her week. However, this new commitment would add another full working day to her schedule. "I wasn't sure how to juggle the apprenticeship around family life, but I was reassured that it was all up to me, and that I could quit any time if it didn't work out," Sally explains.

Spire Hartswood Hospital Director, Jo Dean, had to sign off the apprenticeship and has been very supportive during the year, as have Sally's colleagues in the laboratory. "They are always ready to answer my questions to help me achieve my Lab Technician Level 3 qualification," says Sally. "It's also great to be part of a team of apprentices from different hospitals around the country who support each other. We talk regularly on a WhatsApp group, helping each other and sharing experience, and we get to network and meet up at training events."

Jo Dean has been impressed by the dedication and hard work that saw Sally awarded runner-up at our training provider's internal Apprentice of the Year awards: "I have heard nothing but praise for Sally. She has been awarded the merit badge for her efforts, and her tutors have drawn attention to her outstanding commitment to her academic responsibilities. It's an amazing achievement."

"I'm not sure many people at Spire Hartswood Hospital even knew I was doing the apprenticeship until the award came up," says Sally. "And people don't realise that these apprenticeships are available to anyone, not just school leavers. Hopefully, this will encourage more people to apply."

Sally's current apprenticeship is a two-year programme, but she is on track to complete it around four months early, in August 2019 – and she has no plans to stop there. No stranger to academia, having previously earned a criminology degree at university, Sally's next goal is to train as a biomedical scientist, which would involve one day a week at university over three years.

Overall responsibility for the Group's risk management and internal control systems lies with the Board of Directors with delegated oversight to two committees.

The Board has a consolidated view of key risks from across the Group. The Group's strategy, risk management and internal control processes are managed through the Audit and Risk Committee in association with the Clinical Governance and Safety Committee (CGSC).

The risk management framework is designed to identify, evaluate and mitigate the risks that the Group faces at all levels, which is a core component of driving quality improvement across the Group in order to provide outstanding services. The underlying process aims to provide robust management information to enable conscious risk-based decision-making.

In 2018, the Group reviewed its Risk Management policy, in particular its methodology for all areas of its business whether clinical or non-clinical, and this is now in-line with the majority of the NHS and the private sector. The risk management software has been redesigned to reflect the new policy and to record all hospital, non-hospital and group corporate risks electronically and on one system. This will result in greater degrees of oversight and analysis across the Group, enhancing integrated governance i.e. with the central clinical and health and safety functions, as well as being open and transparent.

The Board recognises that it has limited control over many of the external risks it faces, such as macroeconomic events and the complex regulatory environment for example the UK's exit from the EU which is currently planned to occur on 29 March 2019 ('Brexit'). However, it is important to consider the potential impact of such ongoing risks to the business, and where possible develop contingency plans to minimise the impact of these external risks.

In 2019, Risk management will continue to be used to drive quality improvement across the organisation.

Risk Management

The Board recognises that the Group needs to comply with the UK Corporate Governance Code and with its increasing regulatory expectations for listed companies, and recognises the value of effective risk management in the business. The risk management framework was reviewed by the Board and its committees during 2018, and it will continue to evolve and develop as the level of risk maturity increases within the Group.

The process for reporting and managing risks is embedded across all of our sites and at Group level, with all having risk registers in place. In 2019 work will continue in fully embedding the new framework along with establishing an integrated governance framework where a cohesive way of working is promoted and adopted to ensure the best quality outcomes.

The risk register is used to manage all significant risks facing the Group and assessed in terms of consequence and likelihood. All risks have an identified risk lead in charge of monitoring and mitigating the risk. All risk registers are reviewed in-line with the Risk Management policy at intervals of one, three and six months or where there is imminent change in the risk environment such as legislation.

The principal risks facing the Group are drawn from the Group's risk framework and are linked to the Group's strategic drivers, as set out in the Chief Executive Officer's Strategic review on pages 16 to 25.

Clinical risks

During 2018, the CGSC continued to review clinical risks and trends, including all notifiable incidents and the outcome of both internal clinical reviews and external regulatory inspections.

In 2019, as work continues in embedding the risk framework in everyday clinical practise of our hospitals, the CGSC will continue to monitor risk closely and will endeavour to ensure that an aligned process of sharing and learning leads to ever-improving quality of patient care.

Brexit impact on Spire Healthcare

Spire Healthcare is monitoring closely the legal and political developments in the process towards Brexit. We have established a Brexit working group which reports to our Executive Brexit Preparation Committee. We have undertaken comprehensive planning to prepare the Group for the operational and economic arrangements that we can reasonably expect following a no-deal Brexit.

We take business continuity extremely seriously and our number one priority is to mitigate the risks to continuity and safety of patient care, alongside critical issues related to other stakeholders be they employees, customers or consultants.

However, the absence of an agreed and binding post-Brexit trade arrangement with the EU, this close to 29 March 2019, means that a no-deal Brexit remains a principal risk for the Group.

The Group has considered the impact in a number of areas:

Supply Chain

The Group buys directly from UK suppliers, but our due diligence indicates that around 80% of the goods (other than blood) that we use to operate our hospitals come into the UK, from or via the EU.

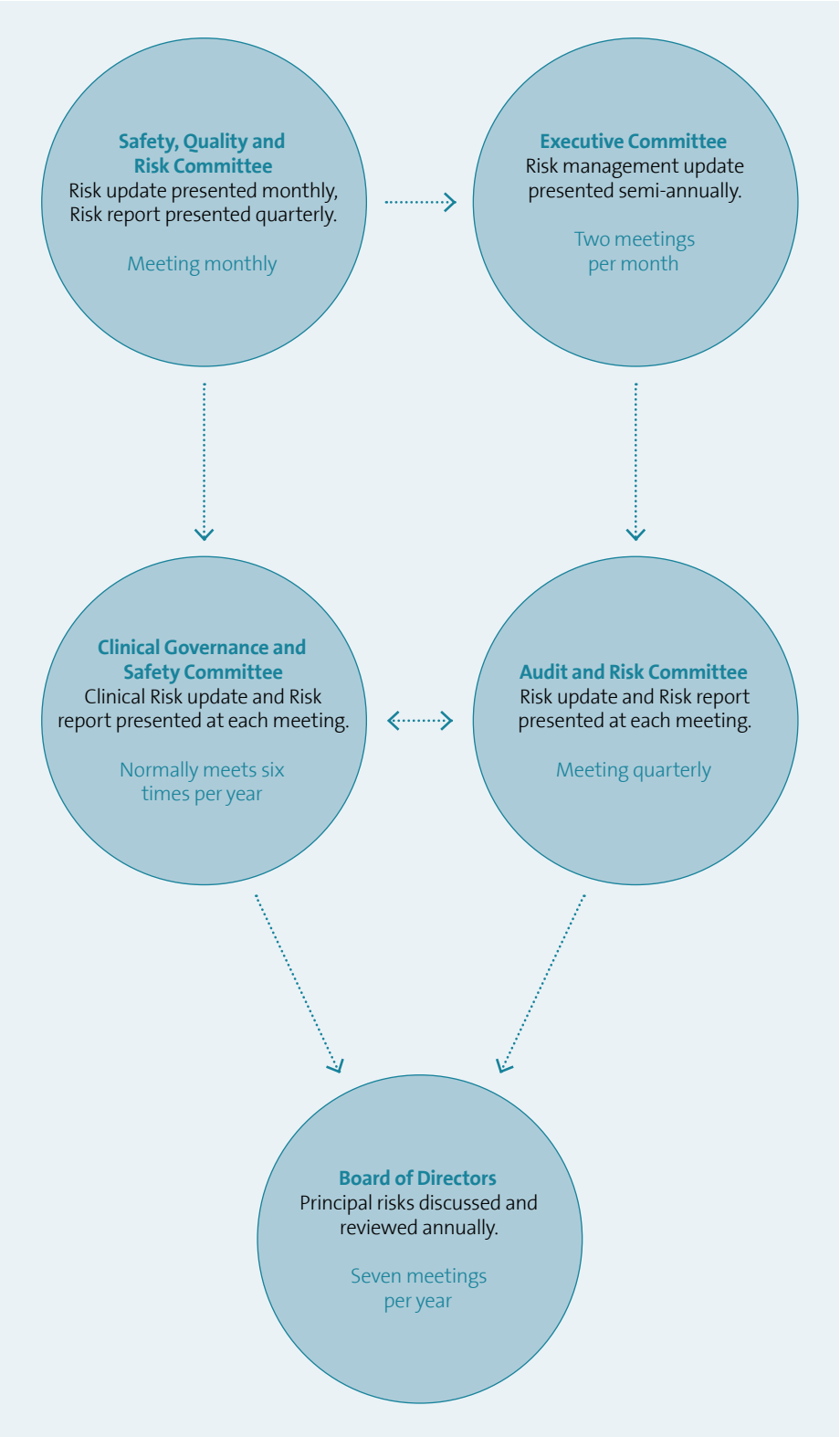
Our supply chain currently operates on short ordering times and low inventories. If a no-deal Brexit results in border checks causing delays or shortages due to other supply chain factors, then our supply chain may be disrupted.

After reviewing our operations and logistics network, the Group has taken precautions to ensure we will be holding sufficient supplies to allow the business to continue to operate in the weeks following a no-deal Brexit, while respecting Government guidance. We are also engaging with the Government as our long term operations are reliant on its plans to ensure that there are continued supplies of adequate medical supplies in the UK.

Employees

Each Spire Healthcare employee is a highly valued member of our organisation. While fewer than 6% of our employees are EU citizens, we are encouraging them to stay in the UK and will support them to register with the EU Settlement Scheme when it opens in March 2019. We will continue to recruit the highest calibre of candidates from the EU and elsewhere, in line with our current recruitment processes.

Spire Healthcare's 2019 Risk Management framework



Increased costs
After a no-deal Brexit, it's reasonable to anticipate that EU imports will be subject to customs charges and tariffs. We do not yet know what duties will be levied so cannot quantify the impact.

Mitigation
We have been working closely with our key suppliers over many months to understand their Brexit plans. We have also been undertaking detailed contingency planning for some time to mitigate the impact of a no-deal Brexit in accordance with Government guidance.

We believe we are taking all reasonable steps to ensure that disruption to our patients and other stakeholders is kept to a minimum. However, given the uncertainties around the impact of a no-deal Brexit, we cannot rule out disruption to the business as there may be some circumstances outside of our reasonable control.

Internal controls
The principal internal controls and assurance activity over the risks that are directly manageable by the Group are:

Standard policies and procedures
The Group has documented policies and standard procedures in place covering all significant activities and areas of risk, which are subject to regular review and update.

Assurance over clinical delivery and clinical regulatory compliance risks
As a provider of clinical services to patients, the Group faces a specific set of non-financial risks associated with such provision.

In relation to these risks:
- the corporate Clinical Services team, which is independent of our hospital operations and is led by the Group Clinical Director, oversees a national programme of clinical audits, in addition to conducting on-site clinical reviews of every hospital and non-hospital unit e.g. clinics, according to the approach taken at regulatory inspections. These form part of the overall framework for clinical governance and quality, to ensure that clinical risk and clinical regulatory compliance is managed effectively across all registered sites. The results of these activities are regularly reviewed by the corporate Clinical Services team, Operations Directors, Matrons, the Executive Committee and the CGSC;
- each hospital has a risk register through which risks are managed;
- comprehensive, non-financial management information on clinical performance including safety, clinical effectiveness and customer experience, is produced and reviewed quarterly against pre-agreed standards by the corporate Clinical Services team, Operations Directors, Matrons, the Executive Committee and the CGSC. Specific KPI measures drawn from this management information are given on pages 44 and 45;
- the Group is subject to substantial levels of external inspection and review, both by the range of national healthcare regulators (CQC/HIW/HIS) and through invited assurance inspections such as the rolling programme of health and safety inspections carried out by third-party specialists. The outcomes of these activities are reviewed by the Executive Committee and the CGSC; and
- the structures and processes for internal confirmation of clinical regulatory compliance and the level of evidence and assurance required to monitor this on an ongoing basis have been further strengthened and formalised in 2018.

Financial and operational controls
Financial control is established through:
- the annual process of preparing business plans and budgets, followed up by close monitoring of operational performance by the Executive Committee and the Board;
- monthly monitoring of actual results, compared to budgets, forecasts and the previous year;
- all material capital expenditure is subject to an investment evaluation and authorisation procedure;
- common accounting policies and procedures; and
- the Group's treasury position and forecast liquidity are kept under review to ensure that borrowings are aligned with the Group's growth and are in compliance with banking covenants.

Other non-financial operational risks are managed by means of the application of best practice, as defined by Group policies and standard procedures, in areas such as project management, human resources management and IT security and delivery, supported by detailed performance monitoring of outputs and issues.

Internal Audit/Internal control assurance
The Internal Audit function was established in 2017, and was fully resourced by the end of Q1, 2018, with a small team of experienced auditors.

A risk based approach, with input from the senior management team, was adopted for 2018 with a primary focus on hospital financial and operational audits, supplemented by corporate reviews.

In 2019, Internal Audit, Risk and Clinical Assurance will work more closely together in order to further align respective reviews, and will continue to work with other assurance functions, i.e. Health & Safety.

Continuous learning
Our process of continuous improvement through events, knowledge and awareness will help us to make progress. The Group unequivocally recognise this and its importance in driving outstanding quality. No matter how robust and reliable, internal control systems and risk management cannot guarantee to remove all error or loss. The Group takes all instances of incidents (including near misses), complaints, control failures, regulatory non-compliance or other risk events very seriously. As such, we have a detailed process in place to fully understand the cause and identify learning to minimise the chances of reoccurrence.

An open culture is actively promoted and monitored within the Group to positively encourage the reporting of all risk events and other issues arising. The number and nature of events arising and the operation of event management processes are closely monitored by hospital management, the Executive Committee, the Audit and Risk Committee and the CGSC.

The Group offers various channels through which colleagues can report any issues or concerns including an independent whistleblowing helpline to facilitate anonymous reporting of issues or concerns that they are unwilling to raise via any other channel. During 2018, Freedom to Speak Up Guardians were also introduced into every Spire Healthcare hospital.

Principal risks

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
1. Patient Safety						
(previously: Clinical Care) – Group Clinical Director – Group Medical Officer			Famous for quality and clinical care. Most recommended customer experience.	The Group's future growth depends upon its ability to maintain its reputation amongst patients, clinicians and referrers for high-quality services. Failure to have relevant and effective clinical and corporate governance systems that are complied with could result in unsafe patient services, regulatory enforcement and reputational damage.	Breaching healthcare and/or professional regulations will result in adverse regulatory inspection ratings, inadequate clinical quality and/or safety of patients, risk of over-servicing and increase in legal claims. This may also result in reputational damage and a consequent negative impact on patient referrals, a failure to attract and retain high quality staff and consultants and reduced future earnings.	Spire Healthcare continually monitors its clinical standards, policies and procedures and will further strengthen medical governance and oversight in 2019, reporting plans and progress via the Board's Clinical Governance and Safety Committee ('CGSC'). During 2018, regular reporting of management and clinical information has been scrutinised by the Executive Committee and Board. Management information is subject to continuous development to ensure relevance, leverage of underlying clinical insights and benchmarking. There is a schedule of robust and regular clinical reviews by the Clinical team according to the Care Quality Commission's ('CQC') key lines of enquiries planned for 2019. Hospitals are reviewed with a subsequent action plan for improvement that is monitored. The Group will engage on clinical outcomes with workforce and consultants including the Chairs of hospital Medical Advisory Committees with a view to driving up engagement and performance.

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
2. Government and NHS Policy						
(previously: Government) – Chief Commercial Officer			Famous for quality and clinical care	Change in the short to medium-term public funding of NHS services provision, and/or the prioritisation of this funding to particular service lines over time could adversely reduce the flow of NHS patients to Spire Healthcare. Changes in the service level requirements for providers of NHS services, and service level commitments to members of the public served by the NHS, could adversely impact the attractiveness of privately funded treatment. Changes in fiscal policy could increase the burden of welfare resulting in a reduction of NHS-funded options. A fundamental change in the tariff structure associated with the provision of services to the NHS could result in reduced access to patients, reduced tariffs, or reduced prices leading to reduced revenues and/or margins. Material change in NHS commissioning models could result in a material adverse change to commissioning behaviours impacting volumes.	Reduction of NHS patients and/or associated revenue and profit. Reduction in the operational efficiency of our existing hospital network.	The Group derives revenues from three primary payor groups (PMI, NHS and Self-pay) and this provides a natural 'hedge' against exposure to risks in each of these payors. The Group looks to optimise the mix of revenues across each of these payor groups dependent upon local market circumstances. For example, restricted access to NHS treatment can lead to increased numbers of patients electing to pay privately for their healthcare needs. The Group's service levels are confirmed by regular surveys of patients, GPs and consultants, which provide ongoing feedback to ensure NHS requirements (whether as providers or as commitments to its patients) are met. In addition, the Board regularly reviews the competitiveness of its patient offering (both NHS and private patients). The Group maintains direct engagement with Government via Department of Health, NHS England and NHS Improvement. The Board continually monitors Government policy, NHS requirements and associated tariff structures to consider the need for cost and/or investment reduction, whether in the short, medium or long term. The Group is an active member of the Independent Healthcare Providers Network, contributing across all associated specialist working groups.

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
3. Compliance and Regulation						
(previously: Compliance with laws, regulations and other applicable requirements) – General Counsel and Group Company Secretary – Group Clinical Director			Best place to practise.	The Group operates in a highly regulated environment, including complying with the requirements of, for example, the CQC, NHS Improvement and the CMA. Failure to comply with laws, regulations or regulatory standards e.g. CQC/HIS/HIW, GMC, HSE, CMA, NHS Improvement, NHS England, HMRC, DPA 2018 (GDPR) may expose the Group to patient claims, fines, penalties, damage to reputation, suspension from the treatment of NHS patients, loss of hospital licence and loss of private patients.	The Group may not be able to operate one or more of its hospitals, due to regulatory breaches which could lead to loss of licence to practise at one or more sites causing a significant reduction in profit.	The Group continues to strengthen its Group-wide risk management framework (and associated policies and procedures) to ensure that risks are mitigated as far as possible, with the Executive Committee having appropriate visibility to ensure robust decision-making. The Group has the ability to monitor and react to the changing regulatory framework of a listed company in the healthcare sector. The Group has a significant centralised clinical services team which assists hospitals in establishing and maintaining a high level of clinical performance. Emerging legal or regulatory changes are monitored by the Board, the Executive Committee, the Audit and Risk Committee and the CGSC, in addition to consultations with external advisers and industry briefings. Identification and reporting of Data protection and associated risks are managed by the Data Protection Officer and brought to the attention of the Board by the General Counsel.

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
4. Insurance						
(previously: no change) – General Counsel and Group Company Secretary			Best place to practise.	Spire Healthcare could be subject to litigation for actions by third parties or may be found liable for damages which may not be covered by its insurance policies, if the claims are in excess of cover or claims are not covered by the Group's insurance due to other policy limitations or exclusions or where it has failed to comply with the terms of the policy.	The Group's insurance premiums may increase and, if there is a significant deterioration in its claims experience, insurance may not be available on acceptable terms. There may also be costs relating to damages and defence costs.	The Group reviews and maintains insurance to mitigate the possibility of a major loss. Adequacy of cover is reviewed annually with the Group's brokers. Personal injury claims relating to: patient, third-party and employees are partially covered by third-party liability insurance and is partially self-insured up to predetermined levels, above which its third-party liability insurance applies.
5. Concentration of PMI market						
(previously: no change) – Chief Commercial Officer			First choice for private patients.	The PMI market is concentrated, with the top four companies (Bupa, AXA, Aviva and VitalityHealth having a market share estimated at over 85%. Loss of an existing contractual relationship with any of the key insurers could significantly reduce revenue and profit. Further consolidation of the PMI market could adversely impact Spire Healthcare's relative negotiating power in any ongoing commercial arrangements.	Reduction of PMI patients and/or associated revenue and profit. Reduction in the operational efficiency of our existing hospital network.	The Group works hard to maintain good relationships and a joint product/patient health offering with the PMI companies, which, in the opinion of the Directors, assists the healthcare sector as a whole in delivering high-quality patient care. The Board believes continuing to invest in its well-placed portfolio of hospitals provides a natural fit to the local requirements of all the PMI providers. The Group seeks to ensure we have long-term contracts in place with our PMI partners to avoid co-termination of contractual arrangements.

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
6. Availability of Key Clinical and Medical Professionals						
(previously: Availability of key medical staff) – Group Clinical Director – Chief Operating Officer			Famous for quality and clinical care. Best place to practice. Best place to work.	There is an increasing aging workforce amongst key medical staff. This coupled with a shortage of nursing staff, specific skill-set practitioners and legislative restrictions may lead to a shortage of medical staff.	Patient safety may be impacted as well as cause delays due to a lack of suitable clinical staff which could also see not only a decline in the Group's profits but affect the growth of complex surgical procedures and ongoing treatment of higher-risk patients. This may also result in a fall of referrals from key insurers. There is uncertainty regarding worker status post-Brexit. It is envisaged the length of time to hire staff from the EU will increase which will have an impact on costs due to flexibility of current workforce. The market may see salary rates rise as competition for staff increases, there may be compliance issues with IR35 and, as a result, the Group's costs may increase.	The Board focuses on staff retention, with trends and changes in our staff survey informing our strategy for engagement with a focus on incentives, staff development and training. The Board has a significant appetite to further improve staff engagement ensuring the people who run our services are at the fore front of the Group. Management deploys productivity tools and pursues opportunities to reduce clinical nursing time spent on non-clinical activities to optimise the effectiveness of its clinical staff base. The Group undertakes continuous investment in its equipment, facilities and services to retain high-quality consultants and also provides theatre capacity to new consultants. This is confirmed by good consultant satisfaction levels, which is consistent with last year. The Group has put in place a new, centralised recruitment processes and works with a range of partners to ensure we secure the best talent and closely monitors vacancy levels to ensure key roles are filled. The Group has developed an overseas recruitment capability to secure highly trained healthcare workers from outside the EU where local recruitment is unsuccessful.

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
7. Macroeconomics						
(previously: no change) – Chief Commercial Officer			First choice for private patients.	Approximately 65% of the Group's revenue is dependent on private patients having PMI, paid by their employer or paid by the individual, or being able to afford its services (Self-pay). In an economic downturn, the numbers of insured individual's falls with the level of employment and individuals have reduced real income to fund insurance or Self-pay for procedures. This would have an adverse effect on the Group's business, the results of its operations and prospects.	Reduction of Private patients and associated revenue and profit contributions. Reduction in the operational efficiency of our existing hospital network.	The Board manages this risk by regularly reviewing market conditions and economic indicators to assess whether actions are required. As successfully employed in the last economic downturn, if the private market contracts, the Group can try to reduce costs and future investment to improve profit and cash flow, and may be able to offer the released capacity to the NHS at its lower tariff, reducing the impact on profit. Macroeconomic conditions may put comparable finance strain on competitors, who may not be as well positioned to respond. Opportunities may arise from reduced competition or market consolidation.
8. Competitor Challenge						
(previously: no change) – Chief Commercial Officer			First choice for private patients. Most recommended customer experience. Best place to work.	Spire Healthcare operates in a highly competitive market. New or existing competitors may enter the market of one or more of our existing hospitals, or offer new services. This could lead to uncertainly if a new strategy materially changed the existing operating model. In turn this could potentially impact the way in which the NHS and PMI providers' commission work.	The potential impact would be the loss of market share due to a new competitor and reduced profitability and cash flow.	The market has seen increased pressure in 2018 and the Group maintains a watching brief on new and existing competitor activity and retains the ability to react quickly to changes in patient and market demand. The Group considers that a partial mitigation of the impact of competitor activity is ensured by providing patients with high-quality clinical care and by maintaining good working relationships with GPs and consultants.

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
9. Cyber Security						
(previously: no change) – Chief Financial Officer			Famous for quality and clinical care. Most recommended customer experience. Best place to practice.	The Group faces the challenges of a continually evolving external cyber threat landscape, and could become vulnerable to computer viruses, break-ins and similar disruption from unauthorised tampering. The level of risk to Spire Healthcare's IT architecture and systems continues to grow as the volume of cyber security threats are increasing and becoming more sophisticated.	The Group's business could be disrupted if its information systems fail or if its databases are breached, destroyed or damaged. This could cause financial and reputational impacts. The Group could also be subject to litigation by third-parties.	The Group's technical IT teams continually monitor these developments as a business as usual activity. Working with a number of specialist and industry leading technical partners, multiple layers of business protection have been created through the use of advanced intrusion detection and protection systems, web access firewalls and advanced content filtering to combat denial of service attacks. Business processes are also kept under review and user education regularly carried out to minimise the possibility of ransomware incidents. Regular third-party penetration testing is performed on Spire Healthcare's core IT systems. New IT system developments are subject to rigorous penetration testing prior to release. This approach allows the Group to keep pace with the increasing risk profile, ensuring the risk to Spire Healthcare remains stable.

Principal Risk and Executive Owner(s)	Risk movement in 2017	Risk movement in 2018	Link to Strategy	Risk Description	Risk Impact	Risk Mitigation
10. Liquidity and Covenant risk						
(previously: no change) – Chief Financial Officer			All five current strategic objectives.	The Group may not have sufficient liquid resources to meet its financial liabilities as they fall due, or breach financial covenants linked to its borrowings.	Failure to meet its obligations or covenants would have a substantial adverse effect on the Group's reputation and may lead to borrowings becoming repayable earlier than contracted for. This would have a direct impact on the delivery of strategy and site improvements as well as media attention.	The Group has a solid asset base with the ability to promptly leverage in a short timescale, if required. The Group actively monitors and manages its liquid asset position, its financial liabilities falling due and the cover against its loan covenants. The Group is also actively focused on cash management and capital expenditure, and continues to maintain close working relationships with a highly supportive banking group. The Board has considered the risk in detail as part of its assessment of the viability of the Company.
11. No-deal Brexit						

(previously: not listed)
 	
– General Counsel and Group Company Secretary
	NEW		Famous for quality and clinical care.
			
			Best place to practise.
			
			Best place to work.
				The Group potentially faces significant impacts if there is a no-deal Brexit.
				
				If the UK leaves the European Union without a post-Brexit trade agreement the Group may be impacted in a number of areas including:
				– Supply Chain
				  – Medicines
				  – Consumables
				  – Prostheses
				  – Food
				– Patient numbers
				– Workforce
				– Transport disruption
				– Cash-flow.
					The Group may experience major disruption in key function areas, increased costs, and see a significant reduction in patient numbers.
					
					The Group may experience increased difficulty in recruiting and retaining EEA employees.
					
					The Group may find supply of medicines, consumables; drugs (especially those with short-life spans) and other key items are not available or severely restricted, which may impact the Group's ability to operate.
						The Board is continually monitoring the implications and effects of Brexit through the Group's Brexit committee which is putting in place measures to ensure disruption is as minimal as reasonably possible.

Viability statement

Viability

In accordance with provision C.2.2 of the 2014 revision of the Corporate Governance Code, the Directors assessed the viability of the Group and have maintained a period of three years for their assessment. The assessment conducted considered the Group's revenue, EBITDA, operating profit, cash flows, risk management controls and loan covenants over the three-year period (which is consistent with the approach for prior years).

These metrics were subject to severe downside stress testing and sensitivity analyses over the assessment period, taking account of the Group's current position, the Group's experience of managing adverse conditions in the past and the impact of a number of severe yet plausible scenarios, based on the principal risks set out in the Strategic Report.

These scenarios included Brexit related risks which are covered in the Risk management and internal control section on page 50, as well as the following:

- Spire Healthcare is unable to access sufficient numbers of appropriately qualified clinical staff, restricting growth, driving up clinical staff costs and constraining the capacity of new hospital developments;
- A key hospital is subject to temporary suspension of trade, with a permanent adverse impact on revenues, for example, due to a major fire;
- The Group is subject to temporary suspension of trade, with a temporary adverse impact on revenue, for example, as a result of a successful cyber-attack on key business systems;
- The downside modelling of a number of risks which result in a decline in earnings, including lower NHS tariffs or referral rates or a general economic downturn; and
- The business is subject to significant uninsured losses arising from medical malpractice, negligence or similar claims.

This review included the following key assumptions:

- No change in capital structure given the Group extended its existing senior finance facility and revolving credit facility to mature in July 2022.
- The government will not change its existing policy towards utilising private provision of healthcare services to supplement the NHS.

Based on the results of this analysis, the Directors confirm that they have a reasonable expectation that the Group will be able to continue in operation and meet its liabilities as they fall due over the next three years.

Making the grade at Spire St Anthony's Hospital.

Bryan, Michele and Anne have always been highly visible to everyone at Spire St Anthony's Hospital – people can approach them, and they are seen to be listening and acting on what they have heard.

Link to Strategy:

1. Famous for quality and clinical care

Having acquired St Anthony's Hospital in Cheam, Surrey, in 2014, it was rated as 'Requires Improvement' by the Care Quality Commission (CQC) in early 2017. Since then we have improved quality and governance standards and Spire St Anthony's Hospital has not only been rated as 'Good' but has also been interviewed by the CQC for its Driving Improvements publication.

This is a tribute to the hard work of our employees at St Anthony's and to the leadership offered by the senior management team, including Bryan Harty (Hospital Director), Michele Millard (Matron) and Anne O'Connor (Head of Clinical Governance).

"We needed to review the Governance arrangements and help staff understand what good governance means and why we need it," explains Anne. "We simplified reporting and provided access to information for everyone, both clinical and non-clinical."

Although work had been done to close off actions for both CQC and clinical review requirements, we needed to put a real focus on evidence to support this. "Today, I hear colleagues using similar language and showing that they won't stand for any lowering of standards," says Anne. "The focus now is to really embed these changes."

"It has been a battle for hearts and minds – people have to want to achieve a goal and be part of the process" insists Michele. "We spent a lot of time explaining targets and encouraging people to respond to them. Simple things like more computers on the wards made life easier, gave people better access to learning, and helped them to engage with us. Encouraging a multidisciplinary approach to improvement is key, nothing can be achieved unless we all work together."

Bryan, Michele and Anne have always been highly visible to everyone at the hospital – people can approach them, and they listen and act on what they have heard. Better communications have helped too, with more face-to-face communications, weekly meetings and daily briefings for all colleagues in the hospital.

"My job was to put a new senior management team in place, and that team has made significant progress including a much-improved financial performance," says Bryan. Michele's and Anne's colleagues throughout the hospital have worked with the CQC to improve Spire St Anthony's quality rating to 'Good' and we have been interviewed by the CQC about the significant improvements we've made for the development of their Driving Improvements publication.

Revenue growth was flat with strong self-pay growth throughout the year mitigating NHS revenue pressure.

Highlights

Revenue (-0.1%)

£931.1m

Revenue decreased by 0.1% to £931.1 million (2017: £931.7 million)

Self-pay revenue growth* (+8.7%)

£174.1m

Self-pay revenue increased by 8.7% to £174.1 million (2017: £160.2 million)

* Restated to exclude Partnerships revenue.

EBITDA (-20.4%)

£119.4m

EBITDA down 20.4% to £119.4 million (2017: £150.0 million)

Adjusted basic earnings per share (-52.1%)

6.9p

Adjusted, basic earnings per share (2017: 14.4p)

EBITDA conversion to operating cash flows before exceptional items and income tax paid

105.0%

EBITDA conversion to operating cash flows above 100% for the fourth successive year

Capital investments

£65.2m

Investment in capital projects totalled £65.2 million (2017: £119.9 million)

Net debt

£453.8m

Net debt decreased to £453.8 million, with leverage at 3.67 times EBITDA (2017: £462.8 million and 3.09 times EBITDA)

Please see page 161 for full APM definitions.

Profit before tax (-63.9%)

£8.2m

(2017: £22.7 million)

"The drive for clinical quality remains our priority. This will continue to be the focus of our investments in the months and years ahead, along with the digitalisation of key processes."

Jitesh Sodha
Chief Financial Officer

Group revenue was flat in 2018 at £931.1 million (2017: £931.7 million), while EBITDA declined 20.4% to £119.4 million (2017: £150.0 million), after charging one-offs items of approximately £4.7 million. A decline in NHS revenues from 2017 £293.3 million to 2018 £272.2 million was compensated by increased private revenues in both PMI £2018: £432.6 million; (2017: £426.0 million) and self-pay 2018: £174.1 million; (2017: £160.2 million). Profit before tax decreased by 63.9% to £8.2 million in 2018.

The main drivers of the Group's lower operating profits of £28.6 million in 2018 (2017: £42.9 million) were increased costs as the business invested in clinical quality, and reduced NHS volumes. There was a mix effect with lower margins due to a shift to oncology and a further shift from in-patient to daycase. There were higher costs which were planned, from our investments in quality and safety, the increased full year effect of our new hospitals, additional marketing spend, as well as inflationary increases. NHS admissions were down 8.7% from 2017:101,531 to 2018: 92,674. This reduced NHS volume also resulted in theatre and ward inefficiencies.

We have seen a strong cash flow performance with EBITDA conversion to cash flow of 105.0% (2017: 105.6%) and the first year of positive net cash for three years. Year end net debt is broadly in line with 31 December 2017.

These results reflect continued good growth in our self-pay business, with an increase of 7.6% in underlying revenue. PMI underlying revenue grew by 0.5% to £396.8 million 2018 (2017: £394.9 million), while lower NHS volumes mentioned above resulted in a decline in underlying NHS revenues of 8.3% in the year to 2018: £262.7 million (2017: £286.6 million).

I anticipate that this will be the last year we will need to strip out our new hospitals to arrive at our underlying results. Our new-build hospitals are in full operation and capital expenditure will be lower in 2019. We are putting a real focus on cash, not just EBITDA, which means looking closely at every line of our cash flows.

Our robust operating cash flows have enabled us to invest in our estate and our systems, as well as maintain the dividend paid to shareholders. The Board is recommending a final dividend of 2.5p per share (2017: 2.5p per share). Together with the interim dividend paid in December 2018 of 1.3p per share, this will give a total dividend for the year of 3.8p per share (2017: 3.8p per share). Subject to approval by shareholders, the final dividend will be paid to shareholders on 25 June 2019.

We have a solid asset base. Our 20 freehold properties have been independently valued at £1.138 billion.

We have a very supportive banking group and have, during the year, extended the existing £425 million bank loan and £100 million revolving credit facility to July 2022. We have also changed an anomaly in the way that three of our 19 leased hospitals were treated under the banking covenant. The result of this change is that our net debt to EBITDA ratio, which was 3.67 as at 31 December 2018 would have been 3.27 under the new calculation. This revised calculation will be applied from 1 January 2019.

The drive for clinical quality remains our priority and this will continue to be the focus of our investments in the months and years ahead, along with the digitalisation of key processes.

Having joined Spire Healthcare in October 2018, I was struck by the quantity of paper in the business, so the delivery of digital initiatives and more efficient clinical processes are objectives that I am eager for us to progress in 2019.

Selected financial information

(£ million)	Year ended 31 December 2018 Total before exceptional and other items	2018 Exceptional and other items[5]	2018 Total	2017 Total before exceptional and other items	2017 Exceptional and other items[5]	2017 Total	Variance (on total after exceptional and other items) %	Underlying variance %[1]
Revenue	**931.1**	**–**	**931.1**	**931.7**	**–**	**931.7**	**(0.1%)**	**(1.3%)**
Cost of sales	**(497.6)**	**–**	**(497.6)**	(492.2)	–	(492.2)	1.1%	0.5%
Gross profit	**433.5**	**–**	**433.5**	**439.5**	**–**	**439.5**	**(1.4%)**	**(3.2%)**
Other operating costs	**(379.3)**	**(25.6)**	**(404.9)**	(347.4)	(49.2)	(396.6)	2.1%	0.4%
Operating profit	**54.2**	**(25.6)**	**28.6**	**92.1**	**(49.2)**	**42.9**	**(33.3%)**	**(30.9%)**
Net finance costs	**(20.4)**	**–**	**(20.4)**	(20.2)	–	(20.2)	1.0%	
Profit before taxation	**33.8**	**(25.6)**	**8.2**	**71.9**	**(49.2)**	**22.7**	**(63.9%)**	
Taxation	**(6.3)**	**9.4**	**3.1**	(14.0)	8.1	(5.9)	152.5%	
Profit for the year	**27.5**	**(16.2)**	**11.3**	**57.9**	**(41.1)**	**16.8**	**(32.7%)**	
EBITDA[2]			**119.4**			**150.0**	**(20.4%)**	**(23.3%)**
Basic earnings per share, pence	**6.9**	**(4.1)**	**2.8**	**14.4**	**(10.2)**	**4.2**	**(33.3%)**	
Total dividend paid/proposed per share, pence[3]			**3.8**			3.8	–	
Capital investments			**65.2**			119.9	(45.6%)	
Operating cash flows	**125.4**	**(9.1)**	**116.3**	158.4	(34.4)	124.0	(6.2%)	
Net debt at the year end[4]			**453.8**			**462.8**	**(1.9%)**	

1 Excludes the impact of Spire Manchester, Spire Nottingham and Spire St Anthony's hospitals (referred to as 'underlying'). See page 71.
2 Operating profit, adjusted to add back depreciation, loss on disposal of PPE and other exceptional and other items, referred to hereafter as 'EBITDA'.
3 A final dividend of 2.5 pence per ordinary share will be proposed at the Company's annual general meeting on 16 May 2019. If approved, it will be paid on 25 June 2019 to shareholders on the register of members as at 31 May 2019.
4 Net debt is calculated as total debt (comprising obligations under finance leases and borrowings), less cash and cash equivalents and excluding the £3.3 million gain recorded at the date of the extension. See note 20 to the consolidated financial statements.
5 Exceptional and other items includes the before and after taxation impact of exceptional operating expenditure in each year. See note 9 to the consolidated financial statements.

Analysis by payor

(£ million)	Year ended 31 December 2018	2017[3]	Variance %	Underlying variance %[1]
Total revenue	**931.1**	**931.7**	**(0.1%)**	**(1.3%)**
Of which:				
PMI	**432.6**	426.0	1.5%	0.5%
NHS	**272.2**	293.3	(7.2%)	(8.3%)
Self-pay	**174.1**	160.2	8.7%	7.6%
Partnerships	**27.0**	26.6	1.5%	0.8%
Other[2]	**25.2**	25.6	(1.6%)	(4.1%)
	931.1	**931.7**	**(0.1%)**	**(1.3%)**
Of which:				
In-patient/daycase	**637.5**	637.2	0.1%	(1.0%)
Out-patient	**268.4**	268.9	(0.2%)	(1.7%)
Other	**25.2**	25.6	(1.6%)	(4.1%)
	931.1	**931.7**	**(0.1%)**	**(1.3%)**
Number ('000s)				
Total in-patient/daycase admissions	**260.1**	269.3	(3.4%)	(4.6%)
Of which:				
PMI volumes	**116.8**	118.4	(1.3%)	(2.2%)
NHS volumes	**92.7**	101.5	(8.7%)	(9.9%)
Self-pay volumes	**47.5**	46.2	2.8%	1.5%
Partnerships volumes	**3.1**	**3.2**	**(2.2%)**	**(3.1%)**

1 Excludes the impact of Spire Manchester, Spire Nottingham and Spire St Anthony's hospitals (referred to as 'underlying').
2 Other revenue includes consultant revenue, third-party revenue streams (e.g. pathology services), secretarial services and commissioning for quality and innovation payments (earned for meeting quality targets on NHS work) ('CQUIN').
3 2017 numbers have been restated to separately present the Partnership revenue figures.

Revenue

(£ million)	2017	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	Other	2018	Growth
Underlying revenue	881.1	(27.4)	21.4	(4.5)	(0.9)	**869.7**	**(1.3%)**
Non underlying revenue	50.6	7.1	(0.6)	3.8	0.5	**61.4**	
Total revenue	931.7					**931.1**	**(0.1%)**

Revenue for the year ended 31 December 2018 decreased by £0.6 million, or 0.1%, to £931.1 million (2017: £931.7 million).

Underlying revenue reduced by £11.4 million, or 1.3%, to £869.7 million (2017: £881.1 million). Of the underlying revenue reduction of 1.3%:
- a decrease of 4.6% in the volume of underlying in-patient and daycase admissions accounted for a 3.1% decline in revenue in the year, with Self-pay admissions growth partially offsetting volume declines in other payors;
- a 3.7% increase in rate for underlying in-patient and daycase admissions (average revenue per case) drove an increase to total revenue of 2.4%. Private payors rate overall grew by 5.2%; partnerships 9.8%, self-pay 7.1%, PMI 3.9% and NHS payors saw a small increase of 0.8%;
- underlying outpatient revenues have declined by 1.7% overall with the biggest decline of 5.4% in NHS revenues. The impact of the NHS triage centres is a significant contributory factor as seen by a 1.1% decline in NHS outpatient activity. PMI volumes have declined by 4.2% however higher revenue per activity has resulted in an overall decline of only 1.5%. Self Pay outpatient revenues are up 3.9% driven by an increase in volumes of 6%;
- an increase in non-underlying revenues of £10.8 million, or 21.3% was driven by increases of in-patient and daycase volumes driving revenue growth across PMI of £2.6 million, NHS of £2.0 million and Self-pay of £2.0 million with increase in outpatient revenues of £3.8 million, primarily PMI of £2.3 million.

PMI

(£ million)	2017	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	2018	Growth
Underlying PMI revenue	394.9	(5.6)	9.6	(2.1)	**396.8**	**0.5%**
Non underlying revenue	31.1	2.6	(0.2)	2.3	**35.8**	
Total PMI revenue	426.0				**432.6**	**1.5%**

PMI revenue for the year ended 31 December 2018 increased by £6.6 million, or 1.5%, to £432.6 million (2017: £426.0 million). Underlying revenue increased by £1.9 million, or 0.5%, to £396.8 million (2017: £394.9 million). Of the underlying increase in PMI revenue of 0.5%:
- a decrease of 2.2% in the volume of in-patient and daycase admissions accounted for a 1.4% reduction in PMI revenue in the year;
- a 3.9% increase in rate for in-patient and daycase admissions (average revenue per case), resulted in an increase to PMI revenues overall of 2.4%. This rate increase was a combination of contractual increases to prices and a modest increase in the complexity of work undertaken in the year;
- outpatient revenues have declined 1.5%, outpatient activity has continued to decline, by 4.2% versus prior year compared to a decline of in-patient and daycase admissions of 2.2%. The impact of the decline in activity has been partially mitigated by the year on year increase in average revenue per activity of 2.7%.

NHS

(£ million)	2017	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	2018	Growth
Underlying NHS revenue	286.6	(22.4)	1.7	(3.2)	**262.7**	**(8.3%)**
Non underlying revenue	6.7	2.0	–	0.8	**9.5**	
Total NHS revenue	293.3				**272.2**	**(7.2%)**

NHS revenue for the year ended 31 December 2018 decreased by £21.1 million, or 7.2%, to £272.2 million (2017: £293.3 million). Underlying NHS revenue declined by £23.9 million, or 8.3%, to £262.7 million (2017: £286.6 million). Of the underlying decline in NHS revenue of 8.3%:
- a decrease of 9.9% in the volume of underlying in-patient and daycase admissions accounted for a 7.8% reduction in total underlying NHS revenue in the year;
- The average revenue per case for NHS admissions increased by 0.8% over 2017. Growth in in-patient and daycase rate (average revenue per case) contributed 0.6% to underlying NHS revenue growth in the year. Orthopaedic revenues have declined significantly year on year, 10.1%, accounting for 70.3% of the total underlying revenue decline; and
- outpatient revenue fell against 2017 primarily due to a combination of a decline in e-referral average rate per activity of 5.1% and a decline of 29.4% in NHS local activity.

The underlying revenue decline in NHS revenue of 8.3% is split as follows:
- NHS eReferral revenue declined by 5.2% in the year ended 31 December 2018;
- NHS local revenue declined by 28.0% in the same period. Management had expected NHS local contract revenue to continue the decline started in 2017 due to the relaxation of penalties linked to referral to treatment time key performance indicators. This reduced the appetite of NHS Trusts to outsource work; and
- NHS eReferrals revenue account for 89.3% of underlying NHS revenue in the year ended 31 December 2018, up from 86.3% in the prior year.

Self-pay

(£ million)	2017	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	2018	Growth
Underlying Self-pay revenue	151.1	1.7	8.4	1.3	**162.5**	**7.6%**
Non underlying revenue	9.1	2.0	–	0.5	**11.6**	
Total Self-pay revenue	160.2				**174.1**	**8.7%**

Self-pay revenue for the year ended 31 December 2018 increased by £13.9 million, or 8.7%, to £174.1 million (2017: £160.2 million). Underlying revenue grew by £11.4 million, or 7.6%, to £162.5 million (2017: £151.1 million). Of the underlying growth in Self-pay revenue of 7.6%:
- an increase of 1.5% in the volume of underlying in-patient and daycase admissions accounted for a 1.1% rise in Self-pay revenue in the year;
- the average revenue per case for Self-pay in-patient and daycase admissions grew by 7.1% over the prior year which drives an additional 5.6% of revenue; and
- outpatient activities grew by 6% against 2017 which resulted in an increase in self-pay outpatient revenue of 3.9%.

Partnerships

(£ million)	2017	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	2018	Growth
Underlying Partnerships revenue	24.3	(0.2)	0.7	(0.3)	**24.5**	**0.8%**
Non underlying revenue	2.3	–	–	0.2	**2.5**	
Total Partnerships revenue	26.6				**27.0**	**1.5%**

Partnerships revenue for the year ended 31 December 2018 increased by £0.4 million, or 1.5%, to £27.0 million (2017: £26.6 million). Underlying revenue grew by £0.2 million, or 0.8%, to £24.5 million (2017: £24.3 million). Of the underlying growth in Partnerships revenue of 0.8%:
- a decrease of 3.1% in the volume of underlying in-patient and daycase admissions accounted for a 0.8% fall in Partnerships revenue in the year;
- the average revenue per case for Partnerships in-patient and daycase admissions grew by 9.8% over the prior year, contributing 2.9% to the increase in Partnerships revenue in the year; and
- outpatient activities in 2018 declined 14.6% which was mitigated by an increase in average revenue per activity resulting in an annual decline in outpatient revenues of 1.5%.

Other revenue
Other revenue, which includes fees paid to the Group by consultants (e.g. for the use of Group facilities and services) and third-party revenue (e.g. pathology services to third-parties), decreased by £0.4 million, or 1.6%, in the year, to £25.2 million (2017: £25.6 million). This is due to the cessation of an external supply contract which ended mid-year.

Cost of sales and gross profit

Cost of sales increased in the year by £5.4 million, or 1.1%, to £497.6 million (2017: £492.2 million) on revenues that declined by 0.1% in the year. Underlying cost of sales increased in the year by £2.0 million, or 0.4%, on underlying revenues that decreased by 1.3% in the year. Underlying gross margin for the year of 2018 was 47.3%, compared with 48.2% in 2017.

On an underlying basis, and as a percentage of relevant revenue:

	Group		Underlying	
	Year ended 31 December		Year ended 31 December	
	2018	2017	**2018**	2017
Clinical staff	**20.5%**	19.6%	**19.8%**	18.8%
Direct costs	**22.4%**	22.1%	**22.3%**	21.9%
Medical fees and other	**10.5%**	11.1%	**10.6%**	11.1%
Cost of sales	**53.4%**	52.8%	**52.7%**	51.8%
Gross margin	**46.6%**	47.2%	**47.3%**	48.2%

Overall the underlying Group gross profit margin has reduced compared to 2017. There has been a significant impact in clinical staffing costs relating to achieving compliance against all necessary standards. Supply-side constraints to nursing resource continue to exist; clinical staff costs as a percentage of revenues have increased in 2018 compared to the prior year. Management has initiated changes to the recruitment process in the latter half of the year in order to limit use of agency staff in the future.

Continued initiatives in Procurement have resulted in savings in direct costs of drugs, prostheses and consumables. Conversely, an increase in oncology volumes this year incurred a higher drug spend (oncology revenue has increased by 23.2% year on year).

Management actions alongside case mix changes have continued to generate medical fee savings in the year. The mix shift in NHS work towards lower orthopaedic volumes has also impacted favourably.

Other operating costs

Other operating costs for the year ended 31 December 2018 increased by £8.3 million, or 2.1%, to £404.9 million (2017: £396.6 million). Excluding exceptional and other items, other operating costs for the year increased by £31.9 million, or 9.2%, to £379.3 million (2017: £347.4 million).

Underlying other operating costs decreased in the year by £1.5 million, or 0.4%, to £377.5 million (2017: £375.9 million). Excluding exceptional and other items, underlying other operating costs for the year increased by £25.1 million, or 7.7%, to £351.9 million. The composition of these costs are shown below:

	Group		Underlying	
	Year ended 31 December		Year ended 31 December	
Stated before exceptional and other items	**2018**	2017	**2018**	2017
Gross profit margin	**46.6%**	47.2%	**47.3%**	48.2%
Hospital and central overheads	**(26.6%)**	(24.2%)	**(26.2%)**	(23.6%)
Depreciation and amortisation	**(7.0%)**	(6.2%)	**(6.4%)**	(6.1%)
Rent	**(7.1%)**	(6.9%)	**(7.6%)**	(7.3%)
Loss on disposal of assets	**(0.1%)**	–	**–**	(0.1%)
Operating margin	**5.8%**	9.9%	**7.1%**	11.1%
EBITDA margin	**12.8%**	16.1%	**13.4%**	17.3%

EBITDA and underlying EBITDA

EBITDA for the year ended 31 December 2018 decreased by £30.6 million, or 20.4%, to £119.4 million (2017: £150.0 million). Underlying EBITDA decreased by £35.5 million, or 23.3%, from £152.2 million to £116.7 million.

The Group EBITDA margin of 12.8% compares to 16.1% in 2017 and was impacted by the costs associated with the start-up nature of new sites. The Group underlying EBITDA margin of 13.4% compares to 17.3% in 2017 and the movement is the result of hospital and central overhead and rent increases explained above.

Investments have been made in central overheads to support additional training and development of our people, clinical and non-clinical assurance functions and sales and marketing to support Self-pay growth. On an underlying basis, the increase in hospital and central overhead costs is substantially linked to those central investment initiatives referred to above.

Underlying depreciation charged in the year increased by £3.0 million, or 5.5%, to £57.5 million (2017: £54.5 million) as the Group continues to invest in capacity and capability across the existing network of hospitals.

Total depreciation charged in the year of £65.1 million includes that arising on the new hospital in Nottingham and higher charges on Spire Manchester and Spire St Anthony's hospitals as a consequence of the investment in new and extended facilities in these sites respectively.

Rent of land and buildings for the year increased by £2.2 million, or 3.4%, to £66.1 million (2017: £63.9 million). The increase is mainly due to inflationary uplifts in relation to annual rent indexation in line with RPI.

Share-based payments

During the year, grants were made to Executive Directors and members of the senior leadership team under the Company's Long Term Incentive Plan. For the year ended 31 December 2018, the charge to the income statement was £0.5 million (2017: £1.0 million), or £0.6 million inclusive of National Insurance (2017: £1.1 million). Further details are contained in note 25 on pages 146 to 148 of the Consolidated financial statements.

Exceptional and other items

(£ million)	2018	2017
Ian Paterson claims and related costs	**1.0**	28.7
Hospital set-up and closure costs	**0.8**	3.4
Executive medical leave and death in service	**–**	0.9
Business reorganisation and corporate restructuring	**4.7**	0.6
Hospital impairment on property, plant and equipment, write offs and aborted project costs	**17.9**	14.4
Other	**(0.3)**	0.7
Total exceptional costs	**24.1**	48.7
Income tax credit on exceptional items	**(9.1)**	(8.0)
Total post-tax exceptional items	**15.0**	40.7

Spire is continuing to pursue legal action against its insurers to seek recoveries of the Ian Paterson settlement and related costs. This may give rise to future exceptional income being recognised in the income statement. In 2018, a further £1.0 million expense has been incurred. No account has been taken of further recoveries in the results for the year ended 31 December 2018.

Hospital set-up and closure costs are mainly due to closure and decommissioning of the Spire Windsor Clinic. Business reorganisation costs include internal group reorganisation costs associated with the strategic review that commenced in Q4 2017 and a cost reduction project covering hospitals and central functions. Property impairment primarily relates to the Spire Alexandra Hospital, where a charge of £12.6 million was taken in the first half of 2018. Other property impairment costs in 2018 relate to the aborted development in 2017 of a hospital site in Central London and the write off of costs associated with a potential development in Milton Keynes.

In the year ended 31 December 2017, the completion of the criminal proceedings against Ian Paterson (a consultant who previously had practising privileges at Spire Healthcare) resulted in Spire Healthcare providing £28.7 million in relation to this settlement. In the final quarter of 2017, management undertook a strategic review of its current portfolio of sites and the future development options for the Group which resulted in write-offs and aborted project costs charged as exceptional items in the year of £14.4 million.

(£ million)	2018	2017
Other items:		
Compliance set-up costs	**1.5**	0.5
Total other items	**1.5**	0.5
Income tax credit on other items	**(0.3)**	(0.1)
Total post-tax other items	**1.2**	0.4

Compliance set up costs include amounts incurred in 2018 and 2017 to meet the requirements of GDPR regulations.

Full details of exceptional items are disclosed in note 9 on pages 135 to 136.

Net finance costs

Net finance costs increased by 1.0% to £20.4 million (2017: £20.2 million) as a result of an incremental increase in finance lease costs and higher margins on bank borrowings.

Taxation

The effective tax assessed for the year, all of which arises in the UK, differs from the standard weighted rate of corporation tax in the UK. The reconciliation of the actual tax charge to that at the domestic corporation tax rate is as follows:

(£ million)	2018	2017
Profit before taxation	**8.2**	22.7
Tax at the standard rate	**1.6**	4.4
Effects of:		
Expenses not deductible for tax purposes	**1.1**	0.5
Adjustments to prior year	**(1.0)**	0.2
Difference in tax rates	**(0.2)**	(0.5)
Increase from impairment of fixed assets	**0.7**	1.3
Disposal of fixed assets	**(5.3)**	–
Total tax expense	**(3.1)**	5.9

Expenses not deductible for tax purposes relate mostly to depreciation on non-qualifying fixed assets, disallowable entertaining and professional fees.

Profit after taxation

The profit after taxation for the year ended 31 December 2018 was £11.3 million (2017: £16.8 million).

Adjusted financial information

This statement was prepared for illustrative purposes only and does not represent the Group's actual earnings. The information was prepared as described in the notes set out below.

Non-GAAP financial measures

We have provided in this release financial information that has not been prepared in accordance with IFRS. We use these non-GAAP financial measures internally in analysing our financial results and believe they are useful to investors, as a supplement to IFRS measures, in evaluating our ongoing operational performance. We believe that the use of these non-GAAP financial measures provides an additional tool for investors to use in evaluating ongoing operating results and trends in comparing our financial results with other companies in our industry, many of which present similar non-GAAP financial measures to investors.

Non-GAAP financial measures should not be considered in isolation from, or as a substitute for, financial information prepared in accordance with IFRS. Investors are encouraged to review the reconciliation to these non-GAAP financial to their most directly comparable IFRS financial measures provided in the financial statement tables included in this press release.

Consistent with our approach for 2017, we have excluded the results of Spire Manchester, Spire Nottingham and Spire St Anthony hospitals in arriving at 'underlying' in this 2018 Annual Report. Our approach recognises that, whilst significant progress has continued to be made since the opening or redevelopment of these sites in 2017, their transition from what were effectively start-up operations flowed into 2018.

	Year ended 31 December	
(£ million)	**2018**	2017
Revenue	**931.1**	931.7
Adjustments:		
New hospital openings (Spire Nottingham and Spire Manchester hospitals)	**(34.6)**	(24.5)
Hospital redevelopment (Spire St Anthony's Hospital)	**(26.8)**	(26.1)
Underlying revenue	**869.7**	881.1
Operating profit before exceptional items	**54.2**	92.1
Adjustments:		
New hospital openings (Spire Nottingham and Spire Manchester hospitals)	**5.2**	3.5
Hospital redevelopment (Spire St Anthony's Hospital)	**(0.2)**	2.1
Underlying operating profit before exceptional and other items	**59.2**	97.7
Underlying depreciation and amortisation on underlying assets	**57.5**	54.5
Underlying EBITDA	**116.7**	152.2
EBITDA	**119.4**	150.0
Adjustments:		
New hospital openings (Spire Nottingham and Spire Manchester hospitals)	**(0.6)**	1.0
Hospital redevelopment (Spire St Anthony's Hospital)	**(2.1)**	1.2
Underlying EBITDA	**116.7**	152.2

Adjusted profit after tax and adjusted earnings per share

Adjustments have been made to remove the impact of a number of significant non-recurring items.

	Year ended 31 December	
(£ million)	**2018**	2017
Profit before taxation	**8.2**	22.7
Adjustment for:		
Exceptional items and other items	**25.6**	49.2
Adjusted profit before tax	**33.8**	71.9
Taxation[1]	**(6.3)**	(14.0)
Adjusted profit after tax	**27.5**	57.9
Weighted average number of ordinary shares in issue (No.)	**400,818,049**	400,614,357
Adjusted basic earnings per share (pence)	**6.9**	14.4

1 Reported tax charge for the period adjusted for the tax effect of exceptional items.
GAAP basic earnings per share can be found in note 11 of the financial statements on page 137.

Cash flows analysis for the year

	Year ended 31 December	
(£ million)	**2018**	2017
Opening cash balance	**39.2**	67.9
Operating cash flows before exceptional items and income tax paid	**125.4**	158.4
Exceptional items	**(7.7)**	(31.3)
Net income tax paid	**(1.4)**	(3.1)
Operating cash flows after exceptional items and income tax paid	**116.3**	124.0
Net cash used in investing activities	**(68.0)**	(118.3)
Net cash used in financing activities	**(39.8)**	(34.4)
Closing cash balance	**47.7**	39.2
Closing net indebtedness	**453.8**	462.8

Operating cash flows before exceptional items and income tax paid

The cash inflow from operating activities before exceptional items and income tax paid for the year was £125.4 million, which constitutes a cash conversion rate from EBITDA for the year of 105.0% (2017: £158.4 million or 105.6%). The net cash outflow from movements in working capital in the year was £7.7 million (2017: £15.1 million net cash inflow), a significant achievement given the working capital requirements associated with new hospital openings in 2017.

Investing and financing cash flows

Net cash used in investing activities for the prior year ended 31 December 2018 was £68.0 million (2017: £118.3 million). Cash outflow for the purchase of property, plant and equipment in the year totalled £73.7 million (2017: £119.2 million), which included the completion of the new Spire Manchester (opened in January 2017) and Spire Nottingham hospitals (opened in April 2017), and Spire Bushey Hospital medical centre (opened in November 2017).

Additional to the development scheme-led capital investment, the Group continued to invest significant amounts within the existing estate in engineering, plant upgrade and replacement, diagnostic equipment upgrade and replacement, theatre and bedroom refurbishment and other medical equipment replacement.

Net cash used in financing activities for the year ended 31 December 2018 was £39.8 million, including interest paid of £24.4 million and dividend paid to shareholders of £15.2 million.

Net cash used in financing activities for the year ended 31 December 2017 was £34.4 million, including interest paid of £18.8 million and dividend paid to shareholders of £15.2 million.

Borrowings

At 31 December 2018, the Group had bank debt of £423.8 million (2017: £425.1 million), drawn under facilities which mature in July 2022 and finance lease debt of £77.7 million (2017: £76.9 million). Additionally, the Group has a revolving loan facility of £100.0 million (2017: £100.0 million) available until July 2022, which was undrawn at 31 December 2018.

(£ million)	2018	2017
Cash	**(47.7)**	(39.2)
External debt (including finance leases)	**498.1**	502.0
	453.8	462.8

As at 31 December 2018, net debt was £453.8 excluding the gain of £3.3 million that was recorded at the date of the extension. Net debt for the purposes of the net debt/EBITDA covenant was £455.0 million and was 3.67 times EBITDA after adjusting for one-offs of £4.7million (2017: 3.09 times).

As of 1 January 2019 the Group will adopt a revised calculation methodology for its net debt/EBITDA covenant, this will deal with an inconsistency relating to how certain sites were treated within the overall portfolio of leasehold sites. At December 2018 our net debt/EBITDA for covenant purposes was 3.67, whereas it would have been 3.27 under the revised calculation.

Adoption of IFRS 16 – Leases

The Group will adopt IFRS 16 – leases, on a full retrospective basis from 1 January 2019. Under IAS 17 the Group had a significant portfolio of operating leases relating to various hospital properties. IFRS 16 will change the Group's accounting treatment for its operating leases, it will recognise a right-of-use asset relating to the leased asset and a liability for its obligation to make lease payments.

Rental costs will be replaced by a depreciation charge on the asset as well as an interest charge on the liability. Due to the size of the Group's property lease portfolio, the impact of adopting IFRS 16 will be significant. The impact arising from non-property operating leases is negligible, the Group will adopt the exemption for short-term leases (less than 12 months) or where the underlying asset value is low.

The Group expects a decrease in net assets of £29.6 million in its opening balance sheet on 1 January 2018. This comprises Right-of-Use assets of £557.6 million, Lease Liabilities of £633.0 million, a Deferred Tax asset of £45.8 million and a charge of £29.6 million to retained profits.

Risk management

The principal risks faced by the Group are identified in the Principal risks section on pages 52 to 59.

Treasury policies and objectives

The Group has established treasury policies aimed at reducing financial risk.

Further information about financial risk management (including interest rate, credit and liquidity risks) is provided in note 28 to the financial statements on pages 149 to 151.

The consolidated cash and cash equivalents as at 31 December 2018 was £47.7 million (2017: £39.2 million). Surplus cash balances are held with UK-based investment-grade banks.

Jitesh Sodha
Chief Financial Officer
27 February 2019

The Strategic Report, from pages 1 to 73, was reviewed, approved by the Board and signed on its behalf on 27 February 2019.

Garry Watts
Chairman
27 February 2019

"I am delighted with the Board appointments that the Company has been able to make during the year which has returned Spire Healthcare to a strong governance footing."

Garry Watts
Chairman
27 February 2019

Changes to your Board during 2018

Individual	Event	Date
Simon Gordon	Stepped down as Chief Financial Officer and an Executive Director	1 March 2018
Danie Meintjes	Ceased to act as Mediclinic International PLC's nominated Non-Executive Director	24 May 2018
Dr Ronnie van der Merwe	Appointed Mediclinic International PLC's nominated Non-Executive Director	24 May 2018
Jitesh Sodha	Appointed as Chief Financial Officer and an Executive Director	1 October 2018

Dear Shareholder,

Governance framework

The success of our business depends on us maintaining a strong governance framework in every aspect of what we do. This supports effective strategic and operational decision making and risk management. The Board continues to take its responsibilities for effective governance very seriously and our Non-Executive Directors all provide extensive challenge to management.

In this Annual Report we are reporting against the UK Corporate Governance Code 2016 (the '2016 Code'). As a Board we have taken the time to review the requirements of the new UK Corporate Governance Code 2018 (the '2018 Code') issued by the Financial Reporting Council and are preparing for its implementation. Whilst this Annual Report provides some additional information on engagement and other issues as required by the 2018 Code, we expect to report in more detail on these matters when the new reporting requirements apply to Spire Healthcare in the next financial year.

Executive management

I was delighted to welcome both Jitesh Sodha and John Forrest to Spire Healthcare, as Chief Financial Officer and Chief Operating Officer respectively, in October 2018. Jitesh was most recently chief financial officer of De La Rue plc, having previously held the same role at Greenergy International, and John joined us from Greene King plc, where he was managing director for their Pub Partners Business. I am certain that the skills and experience they bring to the Group will have a very positive influence on the business in the years ahead. I am equally pleased that Alison Dickinson was promoted during the year to Chief Medical Officer. She brings a wealth of clinical experience to the Executive Committee.

Board changes

Jitesh joined the Board as an Executive Director on 1 October 2018. We have also welcomed Dr Ronnie van der Merwe, who was appointed to our Board as a Non-Executive Director in May 2018 by our largest shareholder, Mediclinic International PLC. Ronnie is a specialist anaesthetist who worked in the medical insurance industry before joining Mediclinic Group in 1999. He has been chief executive officer of Mediclinic International PLC since June 2018 and previously served as its chief clinical officer. Ronnie's experience, both medical and commercial, greatly strengthens our Board, and underlines the close relationship between the two businesses.

Subsequent to the year end, on 27 February 2019, Peter Bamford gave notice that he intended to step down as our Senior Independent Director on 16 May 2018. I thank Peter for his contribution to Spire Healthcare's Board and for the support he has given me personally. A search for his replacement is underway.

2018 performance evaluation

The Board's evaluation in 2018 was led by Peter Bamford and facilitated internally by the Group Company Secretary. This year, the review was conducted using short open questions that produced very useful outputs. The principal conclusions of the review were shared with the Board in November. It was determined that the Company's Board continued to operate effectively, in an open and transparent manner, providing support and challenge to senior management. A fuller review of the results and our agreed action plan can be found on pages 78 and 79 as well as an update on the actions identified from last year's evaluation.

Peter Bamford also separately led the review of my performance as Chairman of the Board in conjunction with the other Non-Executive Directors.

Risk management and corporate culture

Our risk culture is centred on risk awareness, openness, continuous improvement and encouraging the right behaviours to ensure an appropriate outcome for both the Company and its customers. A review of our principal risks is set out on pages 52 to 59.

Annual general meeting

Finally, the Board looks forward to meeting as many shareholders as possible at our annual general meeting which will be held at 11.00am on Thursday, 16 May 2019 at the offices of Freshfields Bruckhaus Deringer LLP, 65 Fleet Street, London EC4Y 1HS.

Garry Watts
Chairman
27 February 2019

Compliance with the UK Corporate Governance Code in 2018

The 2016 UK Corporate Governance Code provides the standard for corporate governance in the UK. The Financial Conduct Authority requires listed companies to disclose whether they have complied with the provisions of the UK Code throughout the financial year under review.

The Company has complied with the principles (and code provisions) of the UK Corporate Governance Code issued in April 2016 (the '2016 Code'), throughout the year except as shown in the following table.

UK Code provision	How has the Company not complied with the provisions of the UK Code?	The Board's response
A.3.1	Garry Watts was not independent on appointment to the Board having previously served as Executive Chairman of the Company prior to IPO.	The Non-Executive Directors have determined that Garry Watts continues to lead the Board effectively.

Director independence

Independence is determined by ensuring that, apart from receiving their fees for acting as directors or owning shares, Non-Executive Directors do not have any other material relationship or additional remuneration from, or transactions with, the Group, its promoters, its management or its subsidiaries, which in the judgement of the Board may affect, or could appear to affect, their independence of judgement.

The Chairman did not satisfy the independence criteria on his appointment to the Board. In addition, the Company does not consider the following two Non-Executive Directors to be independent for the reasons given:

- Simon Rowlands previously held a senior position with the Company's former principal shareholder, Cinven; and
- Dr Ronnie van der Merve has been nominated to act as a Non-Executive Director by Mediclinic International PLC, the principal shareholder, whose subsidiary, Mediclinic Jersey Limited (formerly Remgro Jersey Limited), entered into a relationship agreement with the Company in June 2015 (the 'Relationship Agreement'). Under the terms of the Relationship Agreement, when Mediclinic International PLC controls 15% or more of the votes, it will be entitled to appoint one Non-Executive Director to the Board. It controls 29.9% of votes as at 27 February 2019. The Directors believe that the terms of the Relationship Agreement will enable the Group to carry on its business independently of Mediclinic International PLC.

The Board considers that, excluding the Chairman, half of the Board is independent of management and free from any business or other relationship that could affect the exercise of their independent judgement.

Conflicts of interest

Save as set out below, there are no actual or potential conflicts of interest between any duties owed by the Directors or senior management to the Company and their private interests or other duties. The Board will continue to monitor and review potential conflicts of interest on a regular basis.

Director	Conflict
Dr Ronnie van der Merve	Chief executive officer of Mediclinic International PLC, which controls 29.9% of the voting rights in the Company as at 27 February 2019

Key roles and responsibilities

Chairman, Senior Independent Director and the Chief Executive Officer
The Company has set out in writing a division of responsibilities between the Chairman, Senior Independent Director and the Chief Executive Officer.

Garry Watts
Chairman

The Chairman leads the Board and is responsible for:
- the leadership and overall effectiveness of the Board;
- a clear structure for the operation of the Board and its committees;
- setting the Board agenda in conjunction with the Group Company Secretary and Chief Executive Officer; and
- ensuring that the Board receives accurate, relevant and timely information about the Group's affairs.

Justin Ash
Chief Executive Officer

The Chief Executive Officer manages the Group and is responsible for:
- developing the Group's strategic direction for consideration and approval by the Board;
- day-to-day management of the Group's operations;
- the application of the Group's policies;
- the implementation of the agreed strategy; and
- being accountable to, and reporting to, the Board on the performance of the business.

Peter Bamford
Deputy Chairman and Senior Independent Director

The Board nominates one of the independent Non-Executive Directors to act as Senior Independent Director and is responsible for:
- being an alternative contact for shareholders at Board level other than the Chairman;
- acting as a sounding board for the Chairman;
- if required, being an intermediary for Non-Executive Directors' concerns;
- undertaking the annual Chairman's performance evaluation; and
- when required, leading the recruitment process for a new Chairman.

Daniel Toner
General Counsel and Group Company Secretary

The Group Company Secretary supports the Chairman on Board corporate governance matters and is responsible for:
- planning the annual cycle of Board and committee meetings and setting the meeting agendas;
- making appropriate information available to the Board in a timely manner;
- ensuring an appropriate level of communication between the Board and its committees;
- ensuring an appropriate level of communication between senior management and the Non-Executive Directors;
- keeping the Board apprised of developments in relevant legislative, regulatory and governance matters;
- facilitating a new Director's induction and assisting with professional development, as required.

Board and Committee structure

Ultimate responsibility for the management of the Group rests with the Board of Directors. The Board focuses primarily upon strategic and policy issues and is responsible for:

- leadership of the Group;
- implementing and monitoring effective controls to assess and manage risk;
- supporting the senior leadership team to formulate and execute the Group's strategy;
- monitoring the performance of the Group; and
- setting the Group's values and standards.

There is a specific schedule of matters reserved for the Board.

The Non-Executive Directors

The Non-Executive Directors bring a wide range of skills and experience to the Board. The independent Non-Executive Directors represent a strong, independent element on the Board and are well placed to constructively challenge and support management. They help to shape the Group's strategy, scrutinise the performance of management in meeting the Group's objectives and monitor the reporting of performance.

Their role is also to satisfy themselves with regard to the integrity of the Group's financial information and to ensure that the Group's internal controls and risk management systems are robust and defensible.

The independent Non-Executive Directors oversee the adequacy of the risk management and internal control systems (from their membership of the Audit and Risk Committee and Clinical Governance and Safety Committee ('CGSC')), as well as the remuneration for the Executive Directors (from their membership of the Remuneration Committee).

As members of the Nomination Committee, the Non-Executive Directors also play a pivotal role in Board succession planning and the appointment of new Executive Directors.

Your Board in 2018

During the year, the Board met for nine scheduled meetings but also convened on other occasions (normally by telephone) to discuss certain specific matters of business. Director attendance at scheduled meetings is shown on page 79.

The agenda at scheduled meetings in 2018 covered standing agenda items, including: a review of the Group's performance from the Chief Executive Officer, the current month's and year to date financial statistics by the Chief Financial Officer and a review of clinical performance by the Chief Medical Officer. In addition, the Board received a verbal report from committee chairs, where their committee met immediately in advance of the scheduled Board meeting, and the Board regularly received reports on legal and statutory matters.

Also in 2018, the Board focused on major elements of the Group's operations including:

- the implementation of Spire Healthcare's quality agenda; and
- reviewing and approving certain capital expenditure items.

The Board has a formal schedule of matters reserved to it and delegates certain matters to committees. Specific matters reserved for the Board considered during the year to 31 December 2018 included reviewing the Group's performance (monthly and year to date), approving capital expenditure, setting and approving the Group's strategy and annual budget.

The Board's plan for 2019

It is planned that the Board will convene on seven formal scheduled occasions during 2019, as well as holding any necessary ad hoc Board and committee meetings to consider non-routine business.

The Chairman and the other Non-Executive Directors will meet on their own without the Executive Directors present. In addition, the Senior Independent Director and other Non-Executive Directors will meet without the Chairman present to discuss matters such as the Chairman's performance.

The Board will maintain its focus on the Group's pursuit of its 2019 targets and also review succession planning during the year. Its activities will include:

- review and approve the 2018 Annual Report;
- review the proposed final dividend for 2018;
- review the revised five-year strategic plan and approve the 2019 Annual Operating Plan;
- consider specific major themes;
- embed the risk management framework;
- review the make up of the Board; and
- follow a rolling agenda, ensuring proper time for strategic debate.

Board evaluation

2018 Action plan update

The 2017 Board evaluation identified three principal areas of focus and associated actions to address them during 2018.

Area of focus	Actions	Progress
1) Leadership and succession planning	– Review future composition of the Board and succession plan having regard for the likely revisions to the UK Corporate Governance Code in 2018. – Support Justin Ash in building capability and succession in the executive team.	– The appointments of Jitesh Sodha to the Board and of John Forrest and Alison Dickinson to the Executive Committee has significantly strengthened the management team.
2) Risk management	– Maintain oversight and evaluation of risk management. – Continue to develop internal risk management capabilities and processes. – Oversee General Data Protection Regulation (GDPR) implementation project. – Ensure IT security remains robust.	– The Audit and Risk Committee and CGSC has continued to oversee the development and roll out of risk evaluation and reporting systems across the Group. – Requirements of GDPR have been successfully implemented across Group.
3) Board information	– Review information flows to/from Board.	– A significant redevelopment of reports to the Board and its committees was undertaken during the year, which the new Executive Committee will further refine during 2019. – Training on listed company obligations and CQC Well Led domain provided to the Board during the year.

2019 Action plan
The 2018 Board evaluation identified three principal areas of focus and associated actions to address them during 2019.

Area of focus	Actions
1) Board succession planning	– Look to appoint an additional Non-Executive Director with clinical or other healthcare experience. – Nomination Committee to lead longer term systematic succession plan for Non-Executive Directors.
2) The Board's agenda	– Continued training for Board members on healthcare issues. – Dedicated deep dives on critical topics such as technology in healthcare and the role of critical care in hospitals. – New Executive management team to continue its revised reporting to the Board.
3) Strategy and Risk	– Board to further develop strategic implementation and integration with risk appetite and control.

Furthermore, the Board will remain focused on continuous improvement of clinical quality and maintain overall responsibility for the Group's system of internal control and risk management processes via the relevant Board committees.

Disclosure Committee
With the implementation of the EU's Market Abuse Regulations in 2016, the Board established a Disclosure Committee to ensure, under delegated authority from the Board, that the Company complies with its disclosure obligations, specifically under the Market Abuse Regulation and related legislation. The Disclosure Committee also manages the Company's share dealing code, ensuring colleague compliance and provides training where required. The members of the Disclosure Committee are shown on page 80.

Share Schemes Committee
In addition, the Board delegates certain responsibilities in relation to the administration of the Company's share schemes on an ad hoc basis to the Share Schemes Committee. This committee operates in accordance with the delegation of authority agreed by the Board.

Executive Committee
The Executive Committee meets twice a month, splitting its time between project work and strategic matters. The Executive Committee delegates certain matters to the Safety, Quality and Risk Committee who have specific focus on safety, quality and risk matters respectively (see the Governance framework on page 80).

Board meetings
The attendance of the Directors who served during the year ended 31 December 2018, at meetings of the Board, is shown in the following table. The number of meetings a Director could attend in the year is shown in brackets.

Board meeting attendance

Non-Executive Chairman	
Garry Watts	9 (9)
Deputy Chairman and Senior Independent Director	
Peter Bamford[1]	8 (9)
Executive Directors	
Justin Ash	9 (9)
Simon Gordon[2]	2 (2)
Jitesh Sodha[3]	2 (2)
Non-Executive Directors	
Adèle Anderson	9 (9)
Tony Bourne	9 (9)
Dame Janet Husband	9 (9)
Danie Meintjes[4]	2 (3)
Simon Rowlands	7 (9)
Dr Ronnie van der Merwe[4]	6 (6)

1 Peter Bamford has indicated his intention to step down from the Board on 16 May 2019.
2 Simon Gordon stepped down as Chief Financial Officer and an Executive Director on 1 March 2018.
3 Jitesh Sodha was appointed as Chief Financial Officer and an Executive Director on 1 October 2018.
4 By letter dated 1 March 2018, Mediclinic International PLC gave notice that Danie Meintjes would cease to be its nominated Non-Executive Director on 24 May 2018 and that instead Dr Ronnie van der Merwe would be appointed from that date.

To the extent that Directors are unable to attend scheduled meetings, or additional meetings called on short notice, they will receive the papers in advance and relay their comments to the Chairman for communication at the meeting. The Chairman will follow up after the meeting in relation to both the discussions held and decisions taken.

Effectiveness
Board composition
The Board seeks to ensure that both it and its committees have the appropriate range of skills, experience, independence and knowledge of the Group to enable them to discharge their respective duties and responsibilities effectively; for example, the 2018 Board calendar included sessions on clinical and statutory regulations. The Board considers its size and composition to be appropriate for the current requirements of the business but will continue to keep this under review.

Committee composition is set out in the relevant committee reports and listed on page 80. No one other than committee chairs and members of the committees are entitled to participate in meetings of the Audit and Risk, CGSC, Disclosure, Nomination and Remuneration committees, unless by invitation of the respective committee chair.

Peter Bamford is the Deputy Chairman and Senior Independent Director. Biographical details of the Directors are set out on pages 86 and 87.

Appointments to the Board
Recommendations for appointments to the Board are made by the Nomination Committee. As part of the recruitment process the Nomination Committee follows a formal, rigorous and transparent procedure. Further information is set out in the Nomination Committee Report on pages 88 and 89.

Governance framework in 2018

Chairman
Garry Watts

Key objectives:
- ensure effectiveness of the Board;
- promote high standards of corporate governance;
- ensure clear structure for the operation of the Board and its committees; and
- encourage open communication between all Directors.

The Board of Spire Healthcare Group plc
The Board comprises nine Directors – the Non-Executive Chairman, two Executive Directors and six Non-Executive Directors, four of whom are deemed to be independent for the purposes of the 2016 UK Corporate Governance Code. Daniel Toner serves the Board as General Counsel and Group Company Secretary.

Key objectives:
- leads the Group;
- oversees the Group's system of risk management and internal controls;
- supports the Executive Committee to formulate and execute the Group's strategy;
- monitors the performance of the Group; and
- sets the Group's values and standards.

Audit and Risk Committee
Adèle Anderson (chair), Tony Bourne, Dame Janet Husband

Key objectives:
- monitors the integrity of financial reporting; and
- assists the Board in its review of the effectiveness of the Group's internal control and risk management systems.

Clinical Governance and Safety Committee
Dame Janet Husband (chair), Adèle Anderson, Justin Ash, Tony Bourne, Garry Watts

Key objectives:
- promotes, on behalf of the Board, a culture of high-quality and safe patient care; and
- monitors specific non-financial risks and their associated processes, policies and controls:
  (i) clinical and regulatory risks;
  (ii) health and safety; and
  (iii) facilities and plant.

Disclosure Committee
Garry Watts (chair), Justin Ash, Jitesh Sodha, Daniel Toner, Antony Mannion

Key objectives:
- ensures that the Company complies with its disclosure obligations, specifically under the Market Abuse Regulation and related legislation; and
- oversees the Company's Share Dealing Code including employee training.

Nomination Committee
Peter Bamford (chair), Dame Janet Husband, Garry Watts

Key objectives:
- advises the Board on appointments, retirements and resignations from the Board and its committees; and
- reviews succession planning for the Board.

Remuneration Committee
Tony Bourne (chair), Adèle Anderson, Peter Bamford

Key objectives:
- determines the appropriate framework and level for remuneration of the Chairman, Executive Directors, Group Company Secretary and other members of the Executive Committee; and
- reviews workforce remuneration and related policies.

Executive Committee
The Group also operates an Executive Committee (convened and chaired by the Chief Executive Officer). The team generally meets twice a month and its members are shown on page 16.

Key objectives:
- assists the Chief Executive Officer in discharging his responsibilities;
- ensures a direct line of authority from any member of staff to the Chief Executive Officer; and
- assists in making executive decisions affecting the Company.

Safety, Quality and Risk Committee
A committee of the Executive Committee that focuses on safety, quality and risk matters across the Group's operations.

Key objectives:
- reviews the Group's clinical performance;
- reviews evidence of compliance with statutory notification requirements; and
- scrutinises all unexpected deaths occurring at hospitals.

Time commitment of the Non-Executive Directors
The Non-Executive Directors each have a letter of appointment which sets out the terms and conditions of their directorship. An indication of the anticipated time commitment is provided in any recruitment role specification, and each Director's letter of appointment provides details of the meetings that they are expected to attend.

Non-Executive Directors are required to set aside sufficient time to prepare for meetings, and to regularly refresh and update their skills and knowledge. In signing their letters of appointment, all Directors have agreed to commit sufficient time for the proper performance of their responsibilities, acknowledging that this will vary from year to year, depending on the Group's activities.

Directors are expected to attend all Board and committee meetings, and any additional meetings, as required. Each Director's other significant commitments were disclosed to the Board at the time of their appointment and they are required to notify the Board of any subsequent changes. The Group has reviewed the availability of the Non-Executive Directors and considers that each of them is able to, and in practice does, devote the necessary amount of time to the Group's business.

Induction and training
Generally, reference materials are provided, including information about the Board, its committees, directors' duties, procedures for dealing in the Group's shares and other regulatory and governance matters, and Directors are advised of their legal and other duties, and obligations as directors of a listed company.

On joining the Board, it is the responsibility of the Chairman and Group Company Secretary to ensure that all newly appointed Directors receive a full and formal induction which is tailored to their individual needs. The induction programme includes a comprehensive overview of the Group, dedicated time with other Directors and senior management, as well as guidance on the duties, responsibilities and liabilities as a director of a listed company. Directors visit hospitals in order to gain an understanding of the business operations and culture. These activities formed part of the induction programme for both Dr Ronnie van der Merwe and Jitesh Sodha.

The Group Company Secretary ensures that any additional request for information is promptly supplied. The Chairman, through the Group Company Secretary, ensures that there is an ongoing process to review any internal or external training and development needs.

As already noted, in the event of a general training need, in-house training will be provided to the entire Board. Necessary and relevant regulatory updates are provided as a standing item at each Board meeting in the Group Company Secretary's report and Board briefing by external advisers, where appropriate.

Information and support
The Board ensures that it receives, in a timely manner, information of an appropriate quality to enable it to adequately discharge its responsibilities. This is aided by the use of an online portal. Papers are provided to the Directors in advance of the relevant Board or committee meeting to enable them to make further enquiries about any matters prior to the meeting, should they so wish. This also allows Directors who are unable to attend to submit views in advance of the meeting.

Outside the Board papers process, the Executive Directors provide written updates to the Non-Executive Directors on important business issues, including financial and commercial information. In addition, relevant updates on shareholder matters (including analysts' reports) are also provided to the Board.

All Directors have access to the advice and services of the Group Company Secretary. There is also an agreed procedure in place for Directors, in the furtherance of their duties, to take independent legal advice, if necessary, at the Group's expense.

Election of Directors
All the Directors, except Danie Meintjes who stepped down from the Board, offered themselves for election or re-election at the fourth annual general meeting in May 2018. Directors will in future be elected or re-elected in accordance with the requirements of the 2018 Code.

All Directors, with the exception of Peter Bamford, will stand for election or re-election at the annual general meeting in May 2019. The biographical details of each Director standing for election or re-election is included in the 2019 Notice of Meeting. The Board believes that each of the Directors standing for election is effective and demonstrates commitment to their respective roles. Accordingly, the Board recommends that shareholders approve the resolutions to be proposed at the 2019 annual general meeting relating to the election of the Directors.

The biographical details of all current Directors are set out on pages 86 and 87.

Directors' indemnities
The Directors of the Company have the benefit of a third-party indemnity provision, as defined by section 236 of the Companies Act 2006, in the Group's Articles of Association. In addition, Directors and officers of the Group are covered by directors' and officers' liability insurance.

Directors' conflicts of interest
The Companies Act 2006 provides that directors must avoid a situation where they have, or can have, a direct or indirect interest that conflicts, or possibly may conflict, with the Company's interests. Directors of public companies may authorise conflicts and potential conflicts, where appropriate, if a company's articles of association permit.

The Board has established formal procedures to authorise situations where a Director has an interest that conflicts, or may possibly conflict, with the interests of the Company – a Situational Conflicts. Directors declare Situational Conflicts, so that they can be considered for authorisation by the non-conflicted directors.

In considering a Situational Conflict, these Directors act in the way they consider would be most likely to promote the success of the Group, and may impose limits, or conditions, when giving authorisation or, subsequently, if they think this is appropriate.

The Group Company Secretary records the consideration of any conflict and any authorisations granted. The Board believes that the system it has in place for reporting Situational Conflicts continues to operate effectively.

Accountability

The Audit and Risk Committee

The Audit and Risk Committee Report is set out on pages 94 to 97 and identifies its members, whose biographies are set out on page 87.

The report describes the Audit and Risk Committee's work in discharging its responsibilities during the year ended 31 December 2018, and its terms of reference can be found on the Group's website at www.investors.spirehealthcare.com.

Risk management and internal control

The Board has overall responsibility for establishing and maintaining a sound system of risk management and internal control, and for reviewing its effectiveness. This system is designed to manage rather than eliminate, the risks facing the Group and safeguard its assets. No system of internal control can provide absolute assurance against material misstatement or loss. The Group's system is designed to provide the Directors with reasonable assurance that issues are identified on a timely basis and are dealt with appropriately.

The Audit and Risk Committee and the Clinical Governance and Safety Committee, whose reports are set out on pages 94 to 97 and pages 90 and 93, respectively, assist the Board in reviewing the effectiveness of the Group's risk management system and internal controls, including financial, clinical, operational and compliance controls.

Executive compensation and risk

Only independent Non-Executive Directors are allowed to serve on the Audit and Risk Committee and Remuneration Committee. The Non-Executive Directors are therefore able to bring their experience and knowledge of the activities of each committee to bear when considering the critical judgements of the other.

This means that the Directors are in a position to consider carefully the impact of incentive arrangements on the Group's risk profile and to ensure the Group's Remuneration Policy and programme are structured, so as to accord with the long-term objectives and risk appetite of the Group.

Financial and non-financial risk

The Clinical Governance and Safety Committee, with the Audit and Risk Committee, collectively ensure that the control and monitoring of both financial and non-financial risks is satisfactory.

In addition, both committees seek to ensure, as far as practicable, there are no elements omitted or unnecessarily duplicated, and that all critical judgements receive the correct level of challenge.

Relations with shareholders

The Board is committed to communicating with shareholders and stakeholders in a clear and open manner, and seeks to ensure effective engagement through the Group's regular communications, the annual general meeting and other investor relations activities.

The Group undertakes an ongoing programme of meetings with investors, which during 2018 was led by the Chief Executive Officer and the Director, Investor Relations and Strategy. During the year, there were in excess of 250 individual meetings, conference presentations, group lunches and telephone briefings with investors.

The Chairman, Senior Independent Director and committee chairs remain available for discussion with shareholders on matters under their areas of responsibility, either through contacting the Group Company Secretary or directly at the annual general meeting.

The Company reports its financial results to shareholders twice a year, with the publication of its annual and half yearly financial reports. In conjunction with these announcements, presentations or teleconference calls are held with institutional investors and analysts, and copies of any presentation materials issued are made available through the Company's website at www.investors.spirehealthcare.com.

All Directors are expected to attend the Company's annual general meeting, providing shareholders with the opportunity to question them about issues relating to the Group, either during the meeting, or informally afterwards.

Modern slavery

In line with our values, we are committed to acting ethically and with integrity in all our business dealings. This includes working to ensure that modern slavery and human trafficking does not touch our business or supply chain. Our approach to tackling this issue has evolved since our first transparency statement. An internal, multi-department working group was established to develop a plan of action to build on the work already done. This plan includes conducting in-depth due diligence on certain high-risk suppliers (already underway), repeating the high-level due diligence for the majority of Group suppliers (by spend) and rolling-out targeted training to a wider base of staff in accordance with their role (including registered managers and our network of Freedom to Speak Up Guardians). We have maintained mandatory contractual requirements on suppliers to comply with the provisions of the Modern Slavery Act and hold their own suppliers to the same standards.

A copy of our latest Modern Slavery Act statement can be found on our website at www.investors.spirehealthcare.com.

Annual general meeting

Shareholders are encouraged to participate at the Company's annual general meeting, ensuring that there is a high level of accountability and identification with the Group's strategy and goals. A summary of the proxy voting for the 2018 annual general meeting was made available via the London Stock Exchange and on the Company's website as soon as reasonably practicable on the same day as the meeting.

	Summary of resolution	Total votes for %	Total votes against %	Number of votes withheld
1	2017 Annual Report and Accounts	99.92	0.08	12,076
2	2017 Directors' Remuneration Report	84.56	15.44	792,196
3	Directors' Remuneration Policy	99.41	0.59	1,779
4	Final Dividend	100.00	0.00	0
5 to 11	Election or re-election of Directors	Between 83.45 and 99.76	Between 0.24 and 16.55	Maximum 2,719,086
12	Reappointment of Auditors	99.73	0.27	5,550
13	Auditors' remuneration	100.00	0.00	567
14	Political expenditure	96.76	3.24	4,662
15	Authority to allot shares	98.56	1.44	5,104
16	Disapplication of statutory pre-emption rights*	98.73	1.27	2,013
17	Disapplication of statutory pre-emption rights for an acquisition*	95.19	4.81	4,558
18	Authority to purchase own shares*	99.67	0.33	884
19	General meetings to be held on 14 clear days' notice*	98.04	1.96	884

* Special resolution.

The Corporate Governance Report has been approved by the Board and signed on its behalf by:

Daniel Toner
General Counsel and Group Company Secretary
27 February 2019

Board of Directors

1. Garry Watts
Non-Executive Chairman

2. Justin Ash
Chief Executive Officer

3. Jitesh Sodha
Chief Financial Officer

4. Peter Bamford
Deputy Chairman and Senior Independent Director

5. Dame Janet Husband
Independent Non-Executive Director

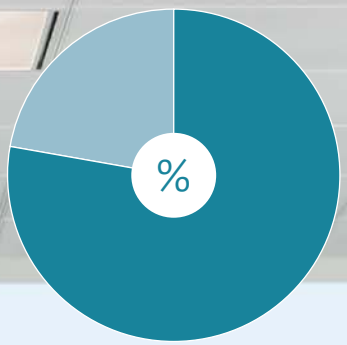
6. Tony Bourne
Independent Non-Executive Director

7. Adèle Anderson
Independent Non-Executive Director

8. Dr Ronnie van der Merwe
Non-Executive Director

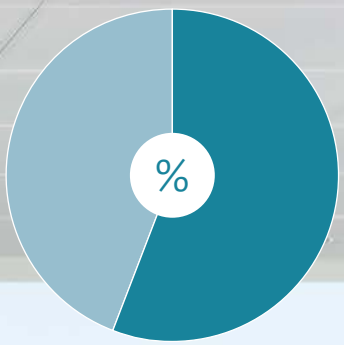
9. Simon Rowlands
Non-Executive Director

Board diversity



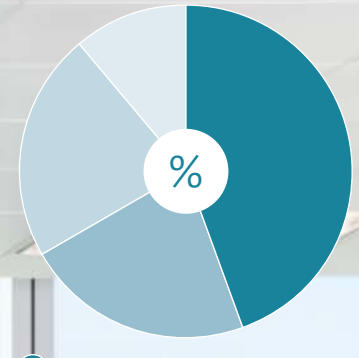
- Male **78%**
- Female **22%**

Board tenure



- 0–3 years **56%**
- 3–6 years **44%**
- 6–9 years **0%**

Board composition



- Independent NED **44%**
- Non-independent NED **22%**
- Executive **22%**
- Chairman **11%**

Board committee membership:

- (A) Audit and Risk Committee
- (C) Clinical Governance and Safety Committee
- (D) Disclosure Committee
- (N) Nomination Committee
- (R) Remuneration Committee
- Committee Chair

Management committee membership:

- (E) Executive Committee
- Committee Chair

1. Garry Watts
Non-Executive Chairman

(C) (D) (N)

Garry Watts joined the Group as Executive Chairman in 2011 before becoming Non-Executive Chairman between Admission and March 2016. He again served as Executive Chairman between March 2016 and June 2017 before resuming his Non-Executive Chairman role in July 2017. The Company does not consider Garry to be independent due to his previous executive role.

Current external appointments
- chairman of BTG plc*
- chairman of Foxtons Group plc
- non-executive director of Coca-Cola European Partners Ltd

Skills and previous experience
A chartered accountant by profession and former partner at KPMG, Garry's extensive business knowledge and leadership on other listed company boards, including SSL International plc and Celltech Group plc, has ensured a seamless transition from private to public for the Company. He has a deep understanding of the healthcare sector having served as a member of the UK Medicines and Healthcare Products Regulatory Agency Supervisory Board for 17 years. Garry was also previously an executive director of Medeva plc, deputy chairman of Stagecoach Group plc and a non-executive director of Protherics plc.

2. Justin Ash
Chief Executive Officer

(C) (D) (E)

Justin Ash was appointed Chief Executive Officer and an Executive Director at the end of October 2017.

Current external appointments
- non-executive chairman of The New World Trading Company Co.
- chair of Independent Healthcare Providers Network

Skills and previous experience
Justin was previously chief executive of Oasis Dental Care between 2008 and 2017 before leading its sale to Bupa. Prior to this, he was managing director of Lloyds Pharmacy and has held several other senior retail positions including general manager of KFC in the UK/Ireland, and commercial director of Allied Domecq Spirits and Wines (Europe). Justin was previously a senior consultant with Bain and Company in London and Paris, and a non-executive board member and chair of the audit and risk committee of Al Nadhi Medical Company.

3. Jitesh Sodha
Chief Financial Officer

(D) (E)

Jitesh Sodha was appointed Chief Financial Officer and an Executive Director at the start of October 2018.

Skills and previous experience
Jitesh graduated from New College, Oxford with a degree in Philosophy, Politics and Economics, and is a CIMA qualified accountant. He has worked in a range of businesses with an international footprint, most recently as Chief Financial Officer of De La Rue plc. He was previously Chief Financial Officer of Greenergy International, Mobilestreams Plc, where he led the IPO, and T-Mobile International UK.

4. Peter Bamford
Deputy Chairman and Senior Independent Director

(N) (R)

Peter Bamford was appointed as Deputy Chairman and Senior Independent Director in May 2017.

Current external appointments
- chairman of Superdry Plc
- chairman of B&M European Value Retail S.A.

Skills and previous experience
Peter was chairman of Six Degrees Holdings Limited from 2011 to 2015 and a non-executive director of Rentokil Initial plc from 2006 until 2016. He was also a director of Vodafone Group plc from 1998 to 2006 where he held senior executive roles including chief marketing officer, chief executive of Northern Europe, Middle East and Africa and chief executive of Vodafone UK.

Prior to this, Peter held senior positions with WH Smith plc (being a director between 1995 and 1997), Tesco plc and Kingfisher plc. He has served on the boards of public companies for the last 23 years and has extensive experience in developing and growing businesses and brands internationally. Peter was also a director of PRS for Music Limited between 2008 and 2014, including as chairman from 2010.

* Until mid-2019 when the sale of BTG plc to Boston Scientific is expected to complete.

On 27 February 2019, Peter Bamford gave notice that he intended to step down as a Director on 16 May 2019. A search is underway for his replacement.

5. Dame Janet Husband
Independent Non-Executive Director

A C N

Dame Janet Husband was appointed an independent Non-Executive Director in June 2014.

Current external appointments
- Emeritus Professor of Radiology at the Institute of Cancer Research
- senior adviser of Royal Marsden NHS Foundation Trust

Skills and previous experience
Having trained in medicine at Guy's Hospital Medical School, Dame Janet's extensive career in healthcare allows her to bring invaluable insight and knowledge of the healthcare industry.

She has previously served as a non-executive director of Royal Marsden NHS Foundation Trust, and was a specially appointed commissioner to the Royal Hospital Chelsea, was president of the Royal College of Radiologists, chaired the National Cancer Research Institute in the UK and was a non- executive director of Nuada Medical Group. Dame Janet was appointed as Professor of Diagnostic Radiology at the University of London, Institute of Cancer Research, in addition to more than 30 years as a practising consultant radiologist at the Royal Marsden Hospital.

6. Tony Bourne
Independent Non-Executive Director

A C R

Tony Bourne was appointed an independent Non-Executive Director in June 2014.

Current external appointments
- non-executive director of Barchester Healthcare Limited
- non-executive director of Totally plc

Skills and previous experience
Tony brings considerable knowledge of the healthcare industry to his role having been chief executive of the British Medical Association for nine years until 2013. Prior to this he was in investment banking for over 25 years, including as a partner at Hawkpoint and as global head of the equities division and a member of the managing board of Paribas.

Tony has also previously served as a non-executive director of Bioquell Plc, Southern Housing Group, and the charity, Scope.

7. Adèle Anderson
Independent Non-Executive Director

A C R

Adèle Anderson was appointed an independent Non-Executive Director in July 2016.

Current external appointments
- senior independent director and chair of the audit committee of intu properties plc
- member of the audit committee of the Wellcome Trust

Skills and previous experience
Adèle has gained extensive financial experience throughout her career and has significant knowledge of audit committees. Until July 2011, she was a partner in KPMG LLP and held a number of senior roles across their business including chief financial officer of KPMG UK, chief executive officer of KPMG's captive insurer and chief financial officer of KPMG Europe. Adèle was a non-executive director of easyJet plc until February 2019.

8. Dr Ronnie van der Merwe
Non-Executive Director

Dr Ronnie van der Merwe was appointed as a Non-Executive Director in May 2018. The Company does not consider Ronnie to be independent as he has been appointed to the Board by the Company's principal shareholder, Mediclinic International PLC, under the terms of the relationship agreement with them.

Current external appointments
- Chief executive officer of Mediclinic International PLC

Skills and previous experience
Ronnie is a specialist anaesthetist who worked in the medical insurance industry before joining the Mediclinic Group in 1999 as Clinical Manager. He established the Clinical Information, Advanced Analytics, Health Information Management and Clinical Services functions at Mediclinic, and subsequently served as the Mediclinic Group's Chief Clinical Officer. He was appointed as an executive director of Mediclinic International Limited in 2010 up to the combination of the businesses of the Company (then Al Noor Hospitals Group plc) and Mediclinic International Limited.

9. Simon Rowlands
Non-Executive Director

Simon Rowlands was appointed a Non-Executive Director in June 2014, although he served in a similar capacity prior to Admission having been an appointment of Cinven, the Company's former principal shareholder. The Company does not consider Simon to be independent due to the senior position he held with Cinven.

Current external appointments
- non-executive director of MD Medical Group Investment plc
- founding partner of Africa Platform Capital

Skills and previous experience
Simon's extensive knowledge of the Company and its markets, combined with his wise counsel over a number of years, were among the reasons he was asked to continue to serve as a member of the Board following Cinven's sale of their shareholding in 2015. He was a founding partner of the private equity firm Cinven until 2013, establishing and leading its healthcare team, and then served as a senior adviser until 2017. Simon founded a new private equity firm in 2016 focused on healthcare and consumer sectors of Sub-Saharan Africa. Prior to joining Cinven, he worked with an international consulting firm on multidisciplinary engineering projects in the UK and southern Africa.

Daniel Toner
General Counsel and Group Company Secretary (Photo shown on page 16)

Daniel Toner joined Bupa Hospitals as head of legal in 2006 before being appointed General Counsel and Group Company Secretary upon Spire Healthcare's formation in 2007 and is a solicitor by profession. He oversees all legal activity at Spire Healthcare, ensures compliance with statutory and regulatory requirements, and that decisions of the Board of Directors are realised. Daniel is also the Company's Whistleblowing Officer.

Skills and previous experience
Daniel is an award-winning lawyer who brings considerable legal, commercial and healthcare experience to Spire Healthcare, having previously worked in both law firms (most recently Freshfields Bruckhaus Deringer), in businesses across a range of sectors and for the commercial directorate of the UK Department of Health.

Nomination Committee at a glance

Committee membership and meeting attendance

The Nomination Committee members at the end of 2018 and the number of meetings they each attended during the year were as follows (the maximum number of meetings that the member could have attended is also shown):

Committee meetings

7

Member	Committee member since	Position in Company	Committee meetings attended in 2018
Peter Bamford (Committee Chair)	May 2017	Deputy Chairman and Senior Independent Director	7/7
Dame Janet Husband	July 2014	Independent Non-Executive Director	7/7
Garry Watts	July 2016	Non-Executive Chairman	7/7

Nomination Committee members' biographies are shown on pages 86 and 87.

The Nomination Committee's terms of reference can be found at www.investors.spirehealthcare.com

The majority of Nomination Committee members were independent Non-Executive Directors at all times during the year in line with the provisions of the UK Corporate Governance Code 2016. The Board appoints the Chair of the Committee, who must be either the Chairman of the Board or an independent Non-Executive Director. If members are unable to attend a meeting they have the opportunity beforehand to discuss any agenda items with the Chair of the Committee.

The Group Company Secretary, or their appointed nominee, acts as secretary to the Committee.

Role and responsibilities

The Nomination Committee's foremost priorities are to ensure that the Group has the best possible leadership and to plan for both Executive and Non-Executive Director succession. Its prime focus is therefore on composition of the Board, for which appointments will be made on merit against objective criteria. The Nomination Committee advises the Board on these appointments, oversees the recruitment processes, and also considers retirements and resignations from the Board and its other committees. The Nomination Committee regularly examines succession planning based on the Board's balance of experience, overall diversity and the leadership skills required to deliver the Company's strategy.

Process for Board appointments

When considering a Board appointment, the Nomination Committee draw up a specification for the Director, taking into consideration the specific role together with the balance of skills, knowledge and experience of its existing Board members, the diversity of the Board and the independence of continuing Board members, together with the ongoing requirements and strategic development of the Group. Care is taken to ensure that proposed appointees have sufficient time to devote to the role and do not have any conflicts of interest.

The Nomination Committee utilises the services of an executive search firm to identify appropriate candidates, ensuring that the search firm appointed does not have any other conflicts with the Group. In addition, the Nomination Committee will only use those firms that have adopted the Voluntary Code of Conduct addressing gender diversity and best practice in search assignments. A long list of potential appointees is reviewed, followed by the shortlisting of candidates for interview based upon the objective criteria identified in the specification. Committee members interview the shortlisted candidates together with other Directors as appropriate, and identify a preferred candidate. Following these meetings, and subject to satisfactory references, the Nomination Committee make a formal recommendation to the Board on the appointment.

"The Committee's principal activities in the year have been the development of the Executive Committee and reviewing Board composition."

Peter Bamford
Chair, Nomination Committee

Dear Shareholder,

As Chair of the Nomination Committee (the 'Committee'), I am pleased to present our report for the year ended 31 December 2018.

The Committee has played a key role in the identification and appointment of the right individuals to the Company's Board and senior leadership team during the year. It has also assisted in their ongoing evaluation and development.

In light of the requirements of the UK Corporate Governance Code 2018 and recognising that a number of Directors are approaching six years of service on the Board, we have begun a review of the Board's composition and succession plans.

Director and senior management changes

Following Simon Gordon's decision to step down from Spire Healthcare's Board from 1 March 2018, the Committee in conjunction with Justin Ash, commenced a focused search for a new Chief Financial Officer. The Committee was pleased to review a list of individuals for the role with Jitesh Sodha being the preferred candidate. Heidrick & Struggles assisted in the executive search.

The Committee has actively engaged with Justin Ash to support him in his plans to further strengthen the Company's senior management team. All members of the Committee met with candidates for the Chief Operating Officer role and John Forrest was selected as the lead candidate. Since the beginning of this year, the Committee has reviewed and agreed the appointment of Shelley Thomas as Spire Healthcare's new Group Human Resources Director.

I have today announced my intention to step down from the Board and will leave Spire Healthcare on 16 May 2019. A search for my replacement has commenced.

Performance evaluation

In November, the Committee completed its annual performance evaluation. In discussing the findings, it was agreed that the Committee would continue to focus on the development of skills and capabilities within the Executive Committee and other members of the senior leadership team, and on succession planning for the Board and Executive Committee.

Diversity and inclusion

We reviewed and considered the annual publication of the Hampton-Alexander review of gender leadership in FTSE companies, and in this year's Annual Report we again publish details of the Company's staff diversity and gender pay gap, in line with reporting requirements (see the Resources and responsibilities section on pages 38 and 42). The chart on page 85 also illustrates the diversity of the Board in terms of gender.

While Spire Healthcare employs a large majority of female staff and the Company's gender pay gap is lower than average, we recognise that there is further progress to be made towards better gender representation at Board and senior leadership levels. Our aim is to move to 33% female representation on the Board and Executive Committee as soon as practicable, commensurate with selection being on qualification and merit.

Re-election of Directors

The Committee met in early 2019 to review the continuation in office and potential reappointment of all members of the Board. Following this review, the Committee recommended to the Board that all Directors be reappointed, and hence all Directors, except for myself as I will be stepping down from the Board as mentioned, will seek election or re-election at the annual general meeting in May.

Peter Bamford
Chair, Nomination Committee
27 February 2019

Clinical Governance and Safety Committee at a glance

Committee membership and meeting attendance

The Clinical Governance and Safety Committee (CGSC) members at the end of 2018 and the number of meetings they each attended during the year were as follows (the maximum number of meetings is also shown):

Committee meetings

7

Member	Committee member since	Position in Company	Committee meetings attended/ held in 2018
Dame Janet Husband (Committee Chair)	July 2014	Independent Non-Executive Director	7/7
Adèle Anderson	February 2018	Independent Non-Executive Director	7/7
Justin Ash	October 2017	Chief Executive Officer	6/7
Tony Bourne	July 2014	Independent Non-Executive Director	6/7
Garry Watts	July 2014	Chairman	6/7

CGSC members' biographies are shown on pages 86 and 87.

The CGSC's terms of reference can be found at www.investors.spirehealthcare.com

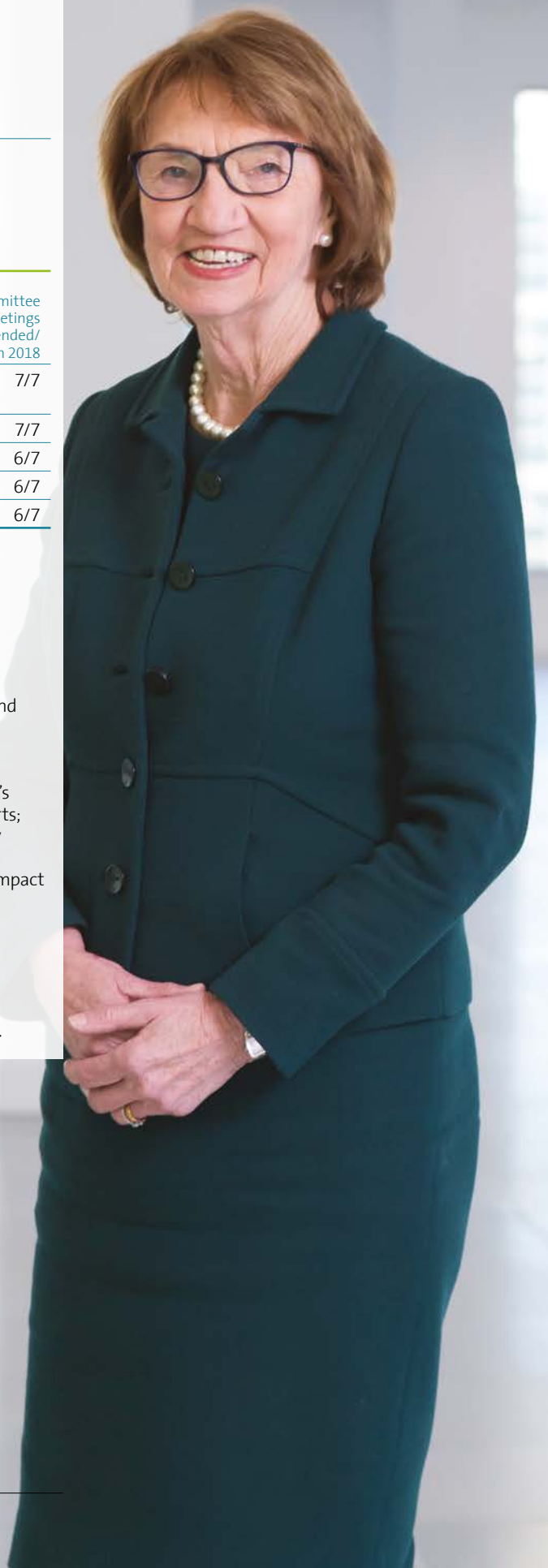
The CGSC must have at least two members, one of whom must be an independent Non-Executive Director. The Board appoints the Chair of the CGSC who must be an independent Non-Executive Director. Adèle Anderson joined the CGSC in February 2018, furthering the CGSC's close links to the Audit and Risk Committee. If members are unable to attend a meeting they have the opportunity beforehand to discuss any agenda items with the Chair of the Committee.

The Group Company Secretary, or their appointed nominee, acts as secretary to the CGSC.

Role and responsibilities

These include:

- promoting a culture of high quality and safe patient care and experience;
- reviewing the Chief Medical Officer's Report;
- reviewing the Group Clinical Director's Clinical Governance and Safety Reports;
- monitoring patient health and safety matters;
- reviewing governance matters that impact patient safety;
- reviewing the clinical matters on the Whistleblowing Register;
- promoting continuous clinical improvements; and
- holding the Executive Committee accountable for following-up actions.



"Robust and effective clinical governance is central to Spire Healthcare's focus on consistently delivering the highest quality healthcare for all our patients."

Professor Dame Janet Husband
Chair, Clinical Governance and Safety Committee

Dear Shareholder,

On behalf of the Clinical Governance and Safety Committee (the 'Committee' or the 'CGSC'), I am delighted to report that we have made excellent progress on the promotion of best practice and clinical governance in 2018. The Company has faced significant commercial pressures this year, but we have strong central leadership in place and a highly engaged workforce in our hospitals, who are committed to the highest standards of clinical quality, as well as robust and effective clinical governance.

It is a pleasure to work with our Chief Executive Officer, Justin Ash, whose focus on quality is supporting the delivery of excellence in every aspect of patient care. I would also like to welcome our new Chief Financial Officer, Jitesh Sodha, and Chief Operating Officer, John Forrest – both of whom have already joined me on hospital visits as they get to know the business in depth.

Care quality progress

We have a very committed central clinical team with whom I work closely, and during the year, I have held regular one-to-one meetings with both our Chief Medical Officer, Dr Jean-Jacques (JJ) de Gorter, and our Group Clinical Director, Alison Dickinson, to assess our progress. JJ and Alison have led a strong programme of quality improvement during 2018 and I would particularly like to commend Alison Dickinson who has revitalised her team this year. In so doing she has sought to draw on both internal and external expertise to make a further step change in our clinical governance, taking us further towards our goal of being the best-known healthcare group for quality.

On this journey, I am proud that every one of our hospitals rated by the Care Quality Commission (CQC) this year has achieved a rating of 'Good' or 'Outstanding'. With the rating of Spire Nottingham Hospital as 'Outstanding' we now have four hospitals at this level. It has been evident that the CQC programme has brought many of our hospital teams closer together, inspiring them to build a stronger 'Spire' brand across the group. Progress in our remaining hospitals which were rated 'Requires Improvement' by the CQC is also evident as services continue to be enhanced and good practice shared across the group. All our 'Requires Improvement' hospitals are carefully monitored as a standard item on our CGSC agenda.

Committee activities in 2018

The Committee held seven meetings during the year, located at our central London offices as well as various hospital sites including Liverpool, Norwich and Dunedin.

We recognise that 39 hospitals generate a huge amount of data, and a major challenge is to present it usefully so that clear performance measures can be compared across our hospitals. To that end, we have improved the information supplied to the Committee by introducing 'Quality on a page' – a snapshot of data at each hospital as a single point of reference for all the KPIs identified for easy review. This is proving to be a practical and workable tool which gives us a 'bird's-eye' view of each hospital and where it sits within our portfolio.

Another important task this year has been to continue to embed and maintain a robust and consistent risk management process in all our hospitals. The improved clarity of clinical reports from individual hospitals has improved our ability to assess and review clinical risk across the Group and to take action as required. We work closely with the Audit and Risk Committee on risk, as well as on other important initiatives such as whistleblowing. Adèle Anderson's appointment as a member of the CGSC strengthens the links between both committees, and I report highlights of CGSC activities to the Audit and Risk Committee. Clinical risk is a standing item on our committee agenda.

The Committee has overseen a full review of our clinical competencies and we have reassigned some key responsibilities – for example, pathology governance now goes through our Hospital Directors. We also looked again at the complaints process that was introduced in 2017, to ensure that the new process has been embedded effectively across the Company, and as a result we have noted significant improvement.

In line with national guidance, we have updated our process for learning from incidents, most of which are 'no harm', but also include the new approach of formally learning from deaths and 'never events'. The Committee already reviews every 'never event' or death in detail, with a focus on these learnings shared across our hospitals to help prevent any further occurrences.

Health and safety also comes under the Committee's remit, and we have improved our reporting this year, with better data coming into the CGSC from our hospitals.

New initiatives

The Committee oversaw the development of new standards and a plan across our hospitals to improve pre-operative assessment in 2018. The new assessments are accurate and detailed, reducing the potential for complications and avoiding cancellations. We have continued to focus on our quality of care for cancer patients and Spire Healthcare is now consistently compliant with Multidisciplinary Team (MDT) working standards, NHS England's 'gold standard' for cancer patient management.

We have introduced 'Freedom to Speak Up Guardians' this year, which makes the process easier for whistleblowing by ensuring that there are nominated people who colleagues can speak to in complete confidence to raise any concerns.

An important new initiative was the publication of Spire Healthcare's first Quality Governance Report. This publication provides the reader with detailed review and analysis of our services and of our performance. As a part of this report, the CGSC conducted a review of all our end-of-life care, as well as our critical care and high dependency unit standards and facilities, and their appropriateness in the context of the hospitals we operate.

Hospital engagement

As in previous years I have continued to develop my programme of personal hospital visits, with a total of 11 hospitals visited in 2018. It is very rewarding to see first-hand the progress made in the quality of care and the outcome of refurbishments and other investments. I make a point of having in-depth discussions with Hospital Directors and Matrons during these visits, exploring every aspect of life at the hospital.

I believe it is especially important to sit down with front-line hospital colleagues to hear peaks and pitfalls of their everyday working lives; the challenges and areas on which to improve are of particular interest to me. I often come away with the feeling that our hospitals are like families; working hard and supporting each other to best care for patients.

I am pleased to report that on several of my visits I have been joined by another Non-Executive Director of our Board. This broadens the scope of our visit and gives non-clinically based Board members a better understanding of some of the more complex and demanding aspects of healthcare, while at the same time giving me insight into issues that their particular expertise and experience brings to our discussions. These support the regular visits made by our Chief Executive Officer, Justin Ash.

This year, as in previous years, I attended the Medical Advisory Committee Chairs' Conference, which allows me to meet with consultants informally and to discuss individual hospital issues from a clinical perspective. These interactions are informative and helpful as we build a full picture of hospital performance, their governance and culture.

As the CGSC is a committee of the Board, I regularly report highlights of our activities to the Directors, including aspects of these hospital visits. I also talk with local consultants and patients on my visits to find out what really matters to them and discuss ideas for other services we could provide.

Focus for 2019

The patient mix is changing with less NHS patients, and we are developing services and processes in an uncertain environment, but we are committed to exemplary clinical governance and in this changing landscape, our priorities remain unchanged.

The Committee continued to function well amid a challenging year. Our approach and areas of focus will continue to be enhanced in 2019 including oversight of the work planned to strengthen medical governance., We will also be organising training for members of the CGSC linked to our annual evaluation of performance and the Company's needs.

As we look forward to 2019 our focus will be to ensure that our hospital teams are fully supported and empowered to deliver clinical excellence every single day of every week.

Professor Dame Janet Husband
DBE FMedSci, FRCP, FRCR
Chair, Clinical Governance and Safety Committee

Audit and Risk Committee at a glance

Committee membership and meeting attendance

The Audit and Risk Committee members at the end of 2018 and the number of meetings they each attended during the year were as follows (the maximum number of meetings that the member could have attended is also shown):

Committee meetings

5

Member	Committee member since	Position in Company	Committee meetings attended in 2018
Adèle Anderson (Committee Chair)	July 2016	Independent Non-Executive Director	5/5
Dame Janet Husband	July 2014	Independent Non-Executive Director	5/5
Tony Bourne	July 2014	Independent Non-Executive Director	4/5

The biographies of the Audit and Risk Committee members are shown on page 87.

The Audit and Risk Committee's terms of reference can be found at www.investors.spirehealthcare.com

The Audit and Risk Committee must have at least three members, all of whom must be independent Non-Executive Directors. If members are unable to attend a meeting, they have the opportunity beforehand to discuss any agenda items with the Chair of the Committee.

The Audit and Risk Committee invites the external auditor, the Chief Executive Officer, Chief Financial Officer and the Director of Internal Audit and Risk to attend each meeting, with other members of the management team attending as and when invited. Representatives of the Group's external auditor have a private session with the Audit and Risk Committee or its Chair whenever required.

The Group Company Secretary, or their appointed nominee, acts as secretary to the Committee.

Recent and relevant financial experience

At least one member of the Audit and Risk Committee must have been determined to have recent and relevant financial experience, and Adèle Anderson has been identified by the Board as meeting this requirement. Her extensive current and previous experience which included being a partner in KPMG until July 2011 holding roles including chief financial officer of KPMG UK and chief executive officer of KPMG's captive insurer. Adèle Anderson currently chairs the audit committee of intu properties plc, and previously chaired the audit committee of easyJet plc for six years until December 2018.

Role and responsibilities

The Audit and Risk Committee has responsibility for overseeing the financial reporting and internal financial controls of the Group, for reviewing the Group's internal control and risk management systems, and for maintaining an appropriate relationship with the external auditor of the Group, and for reporting its findings and recommendations to the Board.

These include:

- receiving and reviewing the Annual Report and Accounts of the Group and half yearly financial statements, and any public financial announcements, and advising the Board on whether the Annual Report and Accounts is fair, balanced and understandable;
- receiving and reviewing reports from the external auditor, monitoring its effectiveness and independence, and approving its appointment and terms of engagement;
- agreeing the annual internal audit programme, including the use of external consultants to support the internal resource, and reviewing the results;
- monitoring the effectiveness of the risk management system;
- reviewing the effectiveness of the Group's system of internal controls and assessing and advising the Board on the internal financial, operational and compliance controls; and
- overseeing the Group's procedures for detecting fraud and whistleblowing.

"Our priority is to deliver an effective governance and risk management framework that allows us to ensure the appropriateness of the Group's financial reporting."

Adèle Anderson
Chair, Audit and Risk Committee

Dear Shareholder,

As Chair of the Audit and Risk Committee (the 'Committee'), I am pleased to present our report for the year ended 31 December 2018.

Risk management and internal controls

Internal audit and risk management continue to be areas of particular focus and scrutiny for the Committee at each meeting, with papers presented and discussed in detail to understand key issues raised and identify emerging and significant risks to the business.

Internal Audit function

As detailed in our previous Annual Report, the Internal Audit function was set up during 2017 and is a small, professional team of internal auditors.

The 2018 audit plan was prepared on a risk focused basis with input from the senior leadership team and Non-Executive Directors, and was substantially completed in the year. The plan focussed on internal audit reviews of hospital sites (which commenced in Q2, as planned), supplemented by a number of corporate reviews at Head Office.

The Internal Audit Plan for 2019 has been approved by the Committee and continues to focus on areas of higher risk as well as completing internal audits of the 39 principal hospital sites on a three-year rotational basis.

Risk management function

The reporting line for Risk management was changed in Q4, 2017 and now reports to the Director of Internal Audit and Risk.

During 2018, a fundamental review of the risk policy, methodology and process was completed, resulting in changes to the way risks are assessed, recorded and reviewed bringing Spire Healthcare in line with the majority of the NHS and private hospital providers. Further details on Risk Management can be found on pages 49 to 51.

The overall risk management framework, including the Board's appetite for risk and the underlying process for capturing and reporting risk and control data, will continue to be reviewed and developed by the Board and its committees during 2019 to ensure that changes to reflect the new regulatory environment and best practice are incorporated.

Other activities in 2018

Prior to the release of the Company's 2018 interim results, the Committee completed a thorough review of management's reforecasting exercise. We also reviewed the Company's banking covenant compliance at year end.

We have strengthened the Committee's links to the Clinical Governance and Safety Committee and we now receive regular reports from Dame Janet Husband on clinical risk and assurance.

In addition to providing oversight of the Group's financial reporting, internal controls and risk framework, the Committee has had the opportunity to complete a number of deep dive sessions during the year. This included sessions on GDPR, taxation, cyber security and health and safety.

The Committee reviewed the nature of all items classified as 'exceptional and other items' in the year and management's justification thereof against relevant accounting guidance. Where costs spanned a reporting period, the Committee considered the significance of the total expected costs to be incurred across reporting periods (based on management's estimates), when determining the appropriateness of the accounting treatment.

External audit

The Committee has primary responsibility for the relationship with, and performance of, our external auditor. This includes making the recommendation on the appointment, reappointment and removal of the external auditor, assessing their independence on an ongoing basis and for negotiating the audit fee in conjunction with the Chief Financial Officer.

Auditor appointment

Ernst & Young LLP was appointed as the Company's external auditor in July 2014 on our Admission to the London Stock Exchange, although they have served the business since 2008. Our current audit partner appointed by Ernst & Young LLP is Debbie O'Hanlon who took on the role in 2015.

Significant issues and material judgements

The Audit and Risk Committee assesses whether suitable accounting policies have been adopted and whether management has made appropriate estimates and judgements. The table below summarises the matters where the most material judgements have been made in relation to reporting in 2018:

Matters	Judgement and estimation required	How the Committee gained comfort on the matter
Improper revenue recognition: Management manipulation	Pressure to achieve results and secure bonus payments could lead management to manipulate the financial reporting of revenue. This could include the: – manipulation of prices charged, in particular in relation to PMI and NHS revenue; – intentional miscoding of procedures by hospitals impacting revenue recorded; – misreporting of other income in the year; and – overstatement of deferred revenue at the year end.	Management carry out a detailed review of monthly hospital performance compared to forecast, in particular focusing on the cut-off of revenue reported at the balance sheet date. The Group maintains effective segregation of duties to safeguard the integrity of pricing masterfile data on which billing is dependent. Management routinely reconcile revenues and cash collections as part of monthly cash flow management procedures.
Complexity of PMI and NHS contracts	The complexity of the pricing structures and the high volume of procedures undertaken present a risk in relation to the accuracy of revenue recognition, in particular the use of incorrect codes or prices.	Billing to PMIs is subject to selective independent audit by representatives of the relevant PMI and issues arising are subject to timely review by management as appropriate. Independent internal reviews are regularly carried out to test the accuracy of the clinical coding process, which did not raise any issues of concern. The Committee noted the testing of revenue recognition in the year by the external auditors. This testing included the use of software-based assurance tools to check the accuracy of invoicing for services delivered to the NHS and to match pricing information to third-party reference information. This audit work covered over 90% of the NHS revenues recognised in the year. In addition the external auditors undertook sample-based substantive testing on private revenues, checking invoices back to procedure and price list information across a number of contracts. While considering the totality of revenues recognised in the year, external auditors also compared the total of revenues recorded in the year to cash collected to verify the recovery of revenue billed (after consideration of the movement in the year end debtors position). No significant differences were noted by the external auditors during the course of this work. This area continued to remain a focus of the risk-based internal audit plan of hospitals during 2018.
Property carrying values	Freehold property is held at depreciated cost and its carrying value is required to be assessed for indicators of impairment by management on an annual basis. For those properties with an indicator, an impairment test is performed by calculating a value in use, by means of a discounted cash flow model. As this process involves some degree of estimation there is a risk that properties are held in the financial statements at inappropriate carrying values.	The Committee reviewed: – the results of the independent valuation performed by an external party over the portfolio of freehold hospitals; and – the impairment tests performed by management and the appropriateness of the assumptions applied. The Committee noted that the work carried out by the external auditors, Ernst & Young LLP, supported its own findings in this area.

The Committee ensures that the external auditor adheres to The Auditing Practices Board's Ethical Standard 3, which requires the rotation of the audit partner for listed companies every five years. As a result, Debbie O'Hanlon is anticipated to serve until the fiscal year commencing on 1 January 2020.

Whilst recognising that the 10-year period of the external auditor's appointment technically began with the Company's Admission in 2014, rather than an earlier point, the Committee has agreed that a full external auditor tender should be linked to the end of Debbie O'Hanlon's term as lead audit partner. The external audit tender process to appointing a new audit firm, or re-appointing Ernst & Young LLP, will commence in Q2 2019. This appointment will be effective for the audit of the fiscal year commencing on 1 January 2020.

The Committee reviewed the independence and effectiveness of the external auditor. We did this by:

- reviewing its proposed plan for the 2018 audit;
- discussing the results of its audit, including its views about material accounting issues and key judgements and estimates, and its audit report;
- reviewing the quality of the people and service provided by Ernst & Young LLP; and
- evaluating all of the relationships between the external auditor and the Group, to determine whether these impair, or appear to impair, the auditor's independence.

The Committee recommended, and the Board subsequently agreed, that, for the year ended 31 December 2019, Ernst & Young LLP are reappointed under the current external audit contract, and the Directors will be proposing the reappointment of Ernst & Young LLP at the annual general meeting in May 2019.

UK Competition and Markets Authority (CMA) Order

During the year, the Company has complied with the CMA Order in relation to Statutory Audit Services for Large Companies.

Audit risk

The Committee received from Ernst & Young LLP a detailed plan identifying the scope of their audit for the year, planning materiality and their assessment of key risks. The audit risk identification process is considered a key factor in the overall effectiveness of the external audit process.

These risks were reviewed by the Committee during the reporting of the half year results to ensure the external auditor's areas of audit focus remain appropriate.

Working relationship with the external auditor

During the year, the Committee met with the external auditor without management present to provide additional opportunity for open dialogue and feedback between both parties. Matters typically discussed include the external auditor's assessment of business risks, the transparency and openness of interactions with management, confirmation that there has been no restriction in scope placed on them by management, the independence of their audit and how they have exercised professional scepticism. I also meet with the external lead audit partner ahead of each Committee meeting. Additionally, the Director of Internal Audit and Risk liaises with, and meets, the external auditors on a regular basis, and the external auditors also receive a copy of each internal audit report.

External financial reporting

The Committee is responsible for monitoring, reviewing and challenging the integrity of the financial statements, and ensuring compliance with legal, regulatory and statutory requirements, giving due consideration to the provisions of the UK Corporate Governance Code.

The external auditor provided reports for the half year and year end reporting, including all significant issues, with an assessment of their view of the appropriateness of management's judgements.

At the request of the Board, the Committee considered whether the Annual Report and Accounts for the year ended 2018 was fair, balanced and understandable, and whether it provided the necessary information for the shareholders to assess the Group's performance, business model and strategy. The Committee took into account its own knowledge of the Group, its strategy and performance in the year, internal verification of the factual content, comprehensive review undertaken at different levels in the Group to ensure consistency and overall balance, and detailed review by senior management and the external auditor. The Committee was satisfied that, taken as a whole, the Annual Report and Accounts for the year ended 2018 is fair, balanced and understandable, and has affirmed that view to the Board.

Recent accounting developments

During the year, the Committee has given particular focus to IFRS 16 Leases, including the implication for reported results, the methodology in which the standard would be adopted, and the implication for systems and process. The standard has been adopted retrospectively from the start of 2019.

The Committee also discussed the disclosures to be made in respect of IFRS 9 Financial Instruments and IFRS 15 Revenue from Contracts with Customers which were adopted in 2018. Please see note 2 of the financial statements on pages 127 to 133 for further information.

Our priorities for 2019

The Committee will continue to monitor and track the progress of fully embedding the Risk Management framework both at Hospitals and in the corporate functions, together with ensuring the findings from Internal Audit work are implemented effectively, and on a timely basis, to incrementally improve both operational and financial processes.

We will oversee the external audit tender process which is due to commence in Q2 2019.

We will also monitor how the new Group-wide Freedom to Speak Up process, enabling staff to raise any concerns is embedded.

Non-audit services and independence

Ernst & Young LLP provided no non-audit services to the Group during the year ended 31 December 2018 (2017: nil). All non-audit fees are approved by the Committee.

Viability

The Committee reviewed the process undertaken by management to support and allow the Directors to make the Group's viability statement. The Committee considered and provided input into the determination of which of the Group's principal risks and combinations thereof might have an impact on the Group's liquidity and solvency. The Committee reviewed the results of management's scenario modelling and the stress testing of these models. The viability statement can be found on page 60.

Whistleblowing

The Committee also continued its monitoring and oversight of the procedures for the receipt, retention and treatment of qualifying disclosures by staff. Further details can be found on Page 38 in Resources and relationships section.

Annual evaluation of the Committee's performance

The evaluation of the Committee's performance was carried out in early 2019 which confirmed that it continued to perform effectively.

Adèle Anderson
Chair, Audit and Risk Committee
27 February 2019

Remuneration Committee at a glance

Committee membership and meeting attendance

The Remuneration Committee members at the end of 2018 and the number of meetings they each attended during the year were as follows (the maximum number of meetings that the member could have attended is also shown):

Committee meetings

6

Member	Committee member since	Position in Company	Committee meetings attended in 2018
Tony Bourne (Committee Chair)	July 2014	Independent Non-Executive Director	6/6
Adèle Anderson	August 2016	Independent Non-Executive Director	5/6
Peter Bamford	May 2017	Independent Non-Executive Director	5/6

Remuneration Committee members' biographies are shown on pages 86 and 87.

The Remuneration Committee's terms of reference can be found at www.investors.spirehealthcare.com

The Remuneration Committee must have at least three members, all of whom must be independent Non-Executive Directors, and the Board appoints the Remuneration Committee's Chair. If a member is unable to attend a meeting, they have the opportunity beforehand to discuss any agenda items with the Committee's Chair.

The Group Company Secretary, or their appointed nominee, acts as secretary to the Remuneration Committee.

Role and responsibilities

The Remuneration Committee has authority from the Board to determine the framework and total remuneration arrangements of the Executive Directors and, in consultation with the Chief Executive Officer, senior management. It also oversees the Group's share-based incentive arrangements.

In practice, the Committee agrees the:

- policy for cash remuneration, executive share plans, service contracts and termination arrangements;
- reward packages of the Chairman, Executive Directors and the Executive Committee;
- termination arrangements for Executive Directors;
- recommendations to the Board concerning any new executive share plans or changes to existing schemes which require shareholders' approval;
- basis on which awards are granted and their amount to Executive Directors and senior management under the LTIP; and
- ensures a consistency of remuneration arrangements across all levels within Spire Healthcare.

"Overall the Remuneration Committee is focused on pay-for-performance."

Tony Bourne
Chair, Remuneration Committee

Dear Shareholder,

I am pleased to present the Directors' Remuneration Report for 2018. This report includes details of decisions taken by the Remuneration Committee in respect of 2018, as well as a summary of how we intend to structure executive director pay for the coming year.

Overall the Remuneration Committee is focused on pay-for-performance by ensuring that remuneration arrangements for Executive Directors support successful execution of the long-term strategy and align with the interests of our shareholders.

Outcomes for 2018

During 2018, the Company put forward its vision to become the go-to UK independent healthcare brand, famous for clinical quality and patient care. This vision was focussed on delivering clinical quality and to increase the private share of our business. The challenging market conditions faced in the past year have further confirmed the appropriateness of this strategy.

In 2018, there was an unprecedented decline in the scale of NHS admissions which had a disappointing impact on Group revenues. Despite the growth and opportunities in our private business, the net effect was that Group revenues were broadly flat year-on-year. While the business has sought to manage costs and delivered strong cash conversion, the prolonged decline in NHS volumes impacted overall Group profitability. The overall EBITDA outcome of £119.4 million fell below the objectives set at the start of the year.

This performance context is reflected in the incentive outcomes for Executive Directors. No bonuses will be paid to the Executive Directors for 2018. While neither of the current Executive Directors had an interest in the Long Term Incentive Plan (LTIP) awards granted in 2016 (based on performance to 31 December 2018), shareholders will note that these awards also lapsed without vesting.

While the performance context was disappointing, the incentive outcomes demonstrate the Company's ongoing commitment to pay only for performance.

Changes to the Board

The Board was pleased to announce the appointment of Jitesh Sodha as Chief Financial Officer. All remuneration terms for Jitesh Sodha are consistent with the Remuneration Policy approved by shareholders at the 2018 annual general meeting.

The Remuneration Committee gave careful consideration to the remuneration terms, and we believe that this package is fully reflective, not only of the quality of Jitesh as a candidate, but also the competitive market faced by the Company during the recruitment process. An LTIP award was granted at 200% of salary in October 2018 but was pro-rated to reflect the proportion of the three-year performance period (1 January 2018 to 31 December 2020) that he would work at Spire Healthcare. Further details of the remuneration terms on appointment are set out in the main body of the report.

In recruitment scenarios, the value of buyout arrangements required to secure candidates can represent a very significant cost to the Company and this was apparent during the recruitment process. Shareholders will note that no such buyout award was made to Jitesh Sodha.

Remuneration decisions for 2019

When making remuneration decisions in relation to the coming year, the Remuneration Committee has been mindful of both the performance challenges being faced by the industry and the shareholder experience.

The key decisions taken by the Remuneration Committee in respect of 2019 include:

Base Salary – no salary increase for either Executive Director.

Annual Bonus – the bonus maximum for executive directors remains unchanged at 150% of salary. The details of the targets for the annual bonus targets are commercially sensitive and will be disclosed on a retrospective basis. However, the Remuneration Committee has been thoughtful regarding the payout schedule and has set highly challenging performance targets for full payout.

The Committee has also reinforced the underpin applicable to the bonus, so that a minimum profit level and a hurdle linked to clinical quality have to be achieved before any bonus is payable.

A new introduction for the 2019 bonus is that, for any of the bonus which is deferred into shares, an additional underpin condition will be applied to these shares. The release of these shares will be conditional on the achievement of a continuing satisfactory improvement in leverage at year end 2020.

LTIP –the maximum opportunity under the 2019 LTIP will be reduced from 200% to 150% of salary. The Committee believes this reduction is appropriate in light of 2018 performance and reflects both the fall in share price over the past year and a recalibration of our adjusted EPS projections. Overall, the performance metrics for 2019 LTIP awards remain unchanged and will be subject to adjusted EPS, total shareholder return and Operational Excellence targets.

The EPS targets for the 2019-2021 period are reflective of our current business plan and external expectations. Threshold vesting for the EPS portion of the LTIP would require performance broadly aligned with current consensus forecasts, and full vesting (35% of the total LTIP) would require very significant outperformance of internal as well as external expectations and represents a twofold increase on 2018 performance. The range corresponds to highly stretching compound per annum growth rates – 9% at threshold up to 27% for full vesting. The Committee has also reduced the amount of the EPS portion which vests for threshold performance from 25% to 0%.

The target ranges for Operational Excellence (Regulatory Rating and Friends and Family) are unchanged from the 2018 LTIP award. For Friends and Family – a measure of patient satisfaction – we have implemented a market-leading method of collecting patient feedback online. We anticipate that this new method will make the scores more challenging to achieve and in doing so will make the targets more stretching.

The new UK Corporate Governance Code comes into effect for Spire Healthcare in 2019. We are well-placed to comply with many of the expanded requirements relating to remuneration under the new UK Code. In response to the new UK Code we have already formally expanded the remit of the Remuneration Committee to include consideration of pay below the main Board and have reviewed the documentation for future incentives to ensure that the provisions relating to discretion, malus and clawback align with best practice.

The Committee is also closely monitoring developments in areas covered by the new UK Code such as post-employment shareholding requirements and executive pension alignment with the wider workforce. This is in addition to the Remuneration Committee keeping abreast of broader best and market practices.

Looking ahead

Overall, the Remuneration Committee has sought to adopt a balanced approach to pay at a time when the industry is facing a number of headwinds. We are keen to ensure management remain motivated towards execution of the strategy and ultimately restore value for our shareholders.

I am committed to ensuring an open dialogue with all of our shareholders. If you have any questions about the content of this year's Directors' Remuneration Report please contact me via companysecretary@spirehealthcare.com.

We look forward to your continued support at our annual general meeting in May.

Tony Bourne
Chair, Remuneration Committee,
27 February 2019

Summary of remuneration policy and approach for 2019

The Directors' Remuneration Policy was approved by shareholders at the annual general meeting on 24 May 2018. This Remuneration Policy will continue to apply for 2019.

The table below summarises the key terms within the policy together with detail on how remuneration arrangements will be operated in the coming year. The full Remuneration Policy can be found in the 2017 Annual Report and Accounts.

Non-Executive Directors

Summary of policy

Fees are set at appropriate levels to ensure Non-Executive Directors are paid to reflect the individual responsibility taken, as well as the skills and experience of the individual. When setting fee levels, consideration is given to a number of factors, including responsibilities and market positioning. Where appropriate travel and other reasonable expenses incurred in the course of performing their duties may be paid by the Group or reimbursed.

Whilst there is no individual fee limit, the total fees paid to Non-Executive Directors will remain within the stated limit in the Articles of Association of the Company.

Implementation for 2019

No increase to fees for 2019.
The current fees payable to the Non-Executive Directors are shown in the following table.

Role	Fee per annum
Non-Executive Chairman	£295,000
Deputy Chairman and Senior Independent Director	£150,000
Basic fee for independent Non-Executive Directors	£55,000
Basic fee for non-independent Non-Executive Director	£50,000
Chairs of the Audit and Risk Committee and Remuneration Committee	£10,000
Chair of the Clinical Governance and Safety Committee	£15,000

Executive Directors – fixed pay

Salary

Summary of policy

Fixed remuneration appropriate to the role to secure and retain required talent. When setting the salary level the Remuneration Committee takes into account factors including: scope and responsibility of the role; salary levels for similar roles within comparators; and wider workforce remuneration.

Implementation for 2019

No salary increases for 2019. The Executive Directors salaries are:
- Justin Ash – £615,000
- Jitesh Sodha – £395,000

Benefits

Summary of policy

A range of role-appropriate benefits may be provided to Executive Directors, these include: private medical cover, income protection scheme, life assurance, annual health assessment and car allowance.

Implementation for 2019

The benefits paid to Executive Directors for 2019 are unchanged from 2018.

Retirement Benefits

Summary of policy

Retirement benefits assist with retirement planning and are provided to support retention.

Implementation for 2019

Executive Directors can opt to join the Company's defined contribution scheme; take a cash supplement; or a combination.

Retirement benefits for the Executive Directors' is unchanged in 2019 at a rate of 18% of base salary. This is below the maximum allowable under the Remuneration Policy and is consistent with levels offered to other senior executives in the business.

Executive Directors – performance related pay

Annual Bonus

Summary of policy

The annual bonus incentivises and rewards the achievement of annual financial, operational and individual objectives. Objectives are set annually, taking into account internal and external expectations of performance, targeted and focused on the delivery of strategic goals.

- At least 50% assessed against financial goals, the remainder will be based on performance against strategic and/or individual objectives.
- Awards are subject to malus and clawback.
- Policy maximum: 150% of salary.

Implementation for 2019

- 2019 Maximum: 150% of salary
- Deferral into shares for three years: Chief Executive Officer – one-half of any bonus; and Chief Financial Officer – one-third of any bonus. The release of these shares will be conditional on the achievement of continuing satisfactory improvement in leverage at year end 2020.
- 2019 metrics: EBITDA – 90%; and individual objectives – 10%.
- No bonus will be paid unless a minimum quality trigger and Group earnings targets are met.
- The details of targets for the coming year are commercially sensitive; however, the Remuneration Committee will look to provide disclosure regarding targets and bonus outcomes in next year's report.

Long Term Incentive Plan (LTIP)

Summary of policy

- The LTIP incentivises and rewards the achievement of long-term strategic objectives.
- Targets are set by the Remuneration Committee for a three year performance period. Award will normally be subject to a two-year holding period.
- Awards are subject to malus and clawback.
- Policy maximum: 200% of salary.

Implementation for 2019

- 2019 LTIP grants: 150% of salary (reduced from 200% of salary in 2018).
- Performance will be measured from 1 January 2019 to 31 December 2021.
- The Remuneration Committee have reviewed targets for the performance period to ensure they suitably reflect both internal and external expectations over the performance period. The Remuneration Committee are satisfied that the target ranges for the 2019 awards are suitably stretching in the context of current expectations and that the hurdles at the top-end of the range would suitably justify full vesting.

			25% vests	100% vests
TSR v FTSE 250 (excluding investment trusts) (35%)			Median[1]	Upper quartile
	0% vests	16.67% vests	50% vests	100% vests
Adjusted EPS – outcome for 2021 (35%)[2]	9p[1]	10p	12p	14p
Operational Excellence:	0% vests	25% vests	50% vests	100% vests
Regulatory Rating (15%)[3]	n/a	75% of hospitals to achieve 'Good' or above[1]	80% of hospitals to achieve 'Good' or above	90% of hospitals to achieve 'Good' or above
Friends and Family (15%)[4]	n/a	82%[1]	85%	87%

1 There is no vesting below the levels.
2 The EPS targets have been set relative to our current business plan and external expectations. The range shown above corresponds to a compound annual growth rate of 8% per annum for 0% vesting and 25% per annum for 100% vesting.
3 Vesting for this element would be scaled back (including to nil) if any site is rated as 'inadequate'. The target range has been adapted to reflect expected changes in the stringency of the external regulatory review process and the benchmarks required to achieve a 'Good' rating. The threshold hurdle would continue to require improvement from current levels.
4 The Friends and Family test is a measure of patient satisfaction. The target range is unchanged from 2018, notwithstanding the implementation of market-leading method of collecting patient feedback online. We anticipate that this new method will make the scores more challenging to achieve and in doing so will make the targets more stretching.
5 There is straight line vesting between the points shown.
6 The Remuneration Committee may adjust targets or outcomes in certain circumstances (e.g. for changes to accounting standard or material acquisitions). In line with good practice, the Remuneration Committee also retains the ability to exercise discretion so that overall vesting level remains appropriate (e.g. to reflect underlying performance).

Executive Directors – further details

Recovery provisions

The Remuneration Committee may cancel or reduce the number of shares in the following circumstances:

- A serious misstatement of the group's audited financial results;
- A serious miscalculation of any performance measure;
- A serious failure of risk management or regulatory compliance;
- Serious reputational damage to the Group; and
- A participants' material misconduct.

Shareholding

- Executive Directors are expected to build up and maintain, over a period of five years, a shareholding equivalent to twice their respective base salary.
- Following departure, departing directors will typically maintain a material interest in shares. For good leavers, bonuses deferred into shares will typically only be released at the end of the normal deferral period, and LTIP awards will typically only be released at the normal time after the end of any holding period.

Single total figure of remuneration – Executive Directors (audited)

The following table sets out the total remuneration for the Executive Directors for the year ended 31 December 2018. This comprises the total remuneration received over the full year from 1 January 2018 to 31 December 2018.

	Justin Ash		Jitesh Sodha[1]		Simon Gordon[2]	
(£000)	**2018**	2017	**2018**	2017	**2018**	2017
Salary	**615.0**	105.8	**98.8**	–	**54.8**	447.4
Benefits	**6.7**	3.4	**4.0**	–	**2.7**	17.3
Retirement benefits	**110.7**	19.0	**17.8**	–	**9.9**	80.5
Annual bonus (including deferred element)	**–**	–	**–**	–	**–**	–
Long-term incentives[3]	**–**	–	**–**	–	**–**	–
Total	**732.4**	128.2	**120.6**	–	**67.4**	545.2

1 Jitesh Sodha was appointed as Chief Financial Officer on 1 October 2018 on a salary of £395,000 per annum.
2 Simon Gordon stepped down as Chief Financial Officer and an Executive Director of the Company on 1 March 2018.
3 The 2016 LTIP award was based on performance to 31 December 2018, as noted below this award will lapse in full and therefore no value is shown for 2018.

Additional notes to the table

Salary

As disclosed in last year's Remuneration Report, Justin Ash's salary was set on appointment during 2017 at £615,000 per annum. No further salary increase was awarded in 2018.

During the year, Jitesh Sodha was appointed as Chief Financial Officer. His salary on appointment was set at £395,000 per annum. When determining the salary level, the Remuneration Committee took into account his experience and skills, including his track record in helping companies execute ambitious transformation plans, as well as his value in the talent market. Shareholders will also note that no buyout awards were made to Jitesh Sodha on his appointment.

Benefits

The benefits consist of private medical cover (for the Executive Directors and their families), life assurance and income protection cover. Jitesh Sodha also receives a car allowance.

Retirement benefits

The amount set out in the table represents the Group contribution to the Executive Directors' retirement planning at a rate of 18% of base salary. Amounts above the HMRC annual allowance are paid as taxable cash supplements. The level of retirement benefit is below the maximum allowable under the Remuneration Policy and is consistent with benefit levels offered to other senior executives in the business.

Annual bonus

For the 2018 financial year, the maximum bonus opportunity for Justin Ash was 150% of base salary. The annual bonus targets were set at the beginning of the financial year, with 85% of the award being assessed against EBITDA and 15% assessed against a balanced scorecard based on strategic targets. The EBITDA targets for 2018 were set at £152.0 million for threshold (25% of maximum bonus) and £156.0 million for on target performance (50% of maximum). The level at which a maximum bonus was payable was set at £174.0 million. No bonus would be payable if the threshold was not achieved.

For Justin Ash, the Balanced Scorecard of strategic objectives were based on productivity, customer quality and staff measures. The Strategic Report on pages 1 to 73 provides further details regarding the Company performance in each of these areas during the year. Despite progress made in a number of areas, the Remuneration Committee determined that as the threshold EBITDA threshold was not achieved, no bonus would be payable to Justin Ash.

Jitesh Sodha joined the business in October 2018. In light of the EBITDA outcome for the year, Jitesh Sodha informed the Remuneration Committee that he did not want to be considered for a pro-rated bonus for 2018, and therefore no bonus was payable.

Long Term Incentive Plan (LTIP)

The performance period for awards granted in 2016 ended on 31 December 2018. This award was based on targets linked to EPS and relative TSR performance. Justin Ash and Jitesh Sodha did not have any interests in this award cycle.

The performance targets for this award were disclosed on a prospective basis in the 2015 Directors' Remuneration Report. Half of the award was based on TSR performance measured against the constituents of the FTSE 250 (excluding investment trusts). Over the period to 31 December 2018, the Company delivered negative total shareholder return which was below the median position and therefore threshold vesting was not achieved. This meant that none of this element of the award would vest. The remaining half of the award was based on EPS targets. The 2018 EPS was below the threshold of 20.0 pence. Therefore this award will lapse in full.

Awards under the LTIP were granted to Justin Ash on 28 March 2018 and to Jitesh Sodha on 8 October 2018. These awards were granted in the form of nil-cost options over Spire Healthcare Group plc shares, with the number of shares that may vest conditional on performance over the three-year period to 31 December 2020. The maximum award granted to Executive Directors was equivalent to 200% of base salary, although Jitesh Sodha's award was pro-rated to reflect his start date of 1 October 2018.

As disclosed in last year's report, the Remuneration Committee determined that in addition to the value created for shareholders over the period, measured by EPS and relative TSR performance targets, 2018 awards should continue to include an element based on Operational Excellence. Further details of the performance conditions applying to the 2018 awards are set out below.

LTIP

- Conditional award over shares were made in 2018 equivalent to 200% of base salary in the form of nil-cost options.
- Performance will be measured over the period from 1 January 2018 to 31 December 2020.

			25% vests	100% vests
TSR v FTSE 250 (excluding investment trusts) (35%)			Median[1]	Upper quartile
	0% vests	25% vests	50% vests	100% vests
Adjusted EPS – outcome for 2020 (35%)	n/a	16.5p[1]	17.2p	18.3p
Operational Excellence:				
Regulatory Rating (15%)[2,3]	n/a	75% achieve 'Good' or above[1]	80% achieve 'Good' or above	90% achieve 'Good' or above
Friends and Family (15%)	n/a	82%[1]	85%	87%

1 There is no vesting for performance below these levels.
2 Vesting for this element would be scaled back (including to nil) if any site is rated as 'Inadequate'.
3 Due to a clerical error the Regulatory Rating targets were stated incorrectly in the 2017 Annual Report. The targets shown above are correct for this portion of the 2018 LTIP award.
4 There is straight line vesting between the points shown.
5 The Remuneration Committee may adjust targets or outcomes in certain circumstances (e.g. for changes to accounting standards or material acquisitions).
In line with good practice, the Committee also retains the ability to exercise discretion so that the overall vesting level remains appropriate (e.g. to reflect underlying performance).

Outstanding share awards

The following table provides details of all outstanding awards, as at 31 December 2018, made to Executive Directors under the LTIP:

	Type of award	Date of grant	Number of shares	Share price	Face value at grant[1]	End of performance period
Justin Ash	Conditional Share Award (in the form of nil-cost options)	28 March 2018	576,058	£2.1352	£1,230,000	31 December 2020
Jitesh Sodha	Conditional Share Award (in the form of nil-cost options)	8 October 2018	414,219	£1.4304	£592,500	31 December 2020

1 The share price used to determine the number of shares under each award is based on the average of the mid-market quotation at close of business over the last five dealing days prior to the date of grant. The face values at grant are equivalent to 200% of base salary but Jitesh Sodha's award has been pro-rated for the proportion of the three-year performance period he will be employed. The 2018 award is subject to EPS, relative TSR performance and Operational Excellence conditions.

Simon Gordon
Simon Gordon ceased to be an Executive Director of Spire Healthcare Group plc on 1 March 2018 and left the business on 31 March 2018. All arrangements on departure were consistent with the shareholder approved Remuneration Policy.

As previously disclosed, under Simon Gordon's contractual terms he was entitled to a payment in lieu of notice, which equated to 12 months' salary (£373,012.50), pension allowance (18% of salary) and benefits including car allowance and membership of Spire Healthcare's private medical cover (£17,000).

All payments were subject to deductions for tax and national insurance.

Simon Gordon was not eligible for a bonus in respect of 2018. Unvested LTIP awards granted to Simon Gordon in 2016 and 2017 were retained subject to time pro-rating and performance. As noted above, the 2016 LTIP award will lapse in full. The 2017 LTIP award (223,146) will be considered for vesting after the end of the 2019 financial year. Simon Gordon retained his interest in 10,922 shares under the Deferred Bonus Plan which was granted in 2015 and related to the annual bonus earned in respect of 2014. This award was released on 1 April 2018.

Single total figure of remuneration – Non-Executive Directors (audited)

The basic fee for independent Non-Executive Directors is £55,000 per annum. The fee for the chair of the Clinical Governance and Safety Committee is £15,000 per annum whilst the chairs of the Audit and Risk Committee and Remuneration Committee each receive £10,000 per annum.

The following table sets out the total remuneration for the Non-Executive Directors for the year ended 31 December 2018.

			Total remuneration	
(£000)	Fees	Benefits[4]	**2018**	2017
Adèle Anderson	65.0	1.2	**66.2**	65.1
Peter Bamford[1]	150.0	5.8	**155.8**	94.5
Tony Bourne	65.0	4.0	**69.0**	65.1
Dame Janet Husband	70.0	19.1	**89.1**	79.3
Danie Meintjes[2,3]	19.7	–	**19.7**	50.0
Simon Rowlands	50.0	–	**50.0**	50.0
Dr Ronnie van der Merwe[2,3]	30.3	–	**30.3**	–
Total	450.0	30.1	**480.1**	404.0

1 Peter Bamford has given notice that he intends not to stand for re-election at the 2019 annual general meeting and will step down from the Board on 16 May 2019.
2 Pursuant to the relationship agreement dated 22 June 2015 between the Company and Mediclinic Jersey Limited, under which Mediclinic Jersey Limited is entitled to nominate for appointment to the Board one Non-Executive Director, Dr Ronnie van der Merwe was appointed to the Board on 24 May 2018 in place of Danie Meintjes.
3 As a Non-Executive Director nominated by the principal shareholder, the fees for Dr Ronnie van der Merwe and, before him, Danie Meintjes are paid to a subsidiary company within the Mediclinic International PLC group.
4 Reasonable expenses incurred by any Non-Executive Director will be reimbursed by the Company but they have no other contractual entitlement to benefits. For Non-Executive Directors certain expenses relating to the performance of a Non-Executive Director's duties in carrying out activities, such as travel to and from Company meetings, are classified as taxable benefits by HMRC. In line with current regulations these taxable benefits have been disclosed and are shown in the taxable benefits column in the Directors' remuneration table above. The figures shown include the cost of the expenses grossed up for tax and national insurance.

Single total figure of remuneration – Chairman (audited)

(£000)	**Garry Watts (as Non-Executive Chairman) 2018**	Garry Watts[1] (as Non-Executive Chairman) Jun 17 – Dec 17	Garry Watts[1] (as Executive Chairman) Jan 17 – Jun 17
Salary/fees	**295.0**	223.8	300.0
Benefits	**5.8**	3.0	2.7
Retirement benefits	**–**	–	–
Annual bonus	**–**	–	–
Long-term incentives	**–**	–	–
Total	**300.8**	226.8	302.7

1 Garry Watts resumed his previous role of Non-Executive Chairman on 1 July 2017. Between 14 March 2016 and 30 June 2017 he acted in the capacity of Executive Chairman.

Notes to the table

On Admission, Garry Watts was appointed as Non-Executive Chairman and, in line with corporate governance guidelines, in that role he did not participate in any future incentive plans. On 14 March 2016, Garry Watts resumed the role of Executive Chairman, following Rob Roger's notification to leave the Company. Garry Watts received an annual salary of £600,000 for that role, but did not receive any pension allowance or LTIP awards.

On 1 July 2017, Garry Watts resumed the role of Non-Executive Chairman. Since 1 October 2017 he has received a fee of £295,000 per annum for this role.

Garry Watts has a contractual entitlement to benefits, which include: private medical cover for himself and his family; life cover for himself only; annual health assessment for himself and his spouse; and office facilities to enable him to perform his duties as Chairman. Reasonable expenses incurred will be reimbursed by the Company.

Statement of Directors' shareholding and share interests (audited)

The table below sets out the Directors' shareholdings in the Company. As noted above, Executive Directors are expected to build up and maintain a holding equivalent to twice their base salary. There is no requirement for Non-Executive Directors to hold shares in the Company.

	Shareholding		Guidelines
	As at 31 December 2018	As at 31 December 2017	Proportion of shareholding guideline achieved[1]
Non-Executive Chairman			
Garry Watts	**603,577**	503,577	
Executive Directors			
Justin Ash	**345,100**	173,600	30.55%
Jitesh Sodha[2]	**50,500**	–	6.96%
Non-Executive Directors			
Adèle Anderson	**9,582**	–	
Peter Bamford	**19,000**	5,000	
Tony Bourne	**11,904**	11,904	
Dame Janet Husband	**10,231**	10,231	
Danie Meintjes[3]	**–**	–	
Simon Rowlands	**528,516**	214,516	
Dr Ronnie van der Merwe[3]	**–**	–	

1 Calculated based upon the closing share price on 31 December 2018 of 108.9 pence.
2 Jitesh Sodha was appointed Chief Financial Officer on 1 October 2018 and he purchased 50,500 shares on this date.
3 Dr Ronnie van der Merwe did not hold any shares as at the date of his appointment on 24 May 2018.
4 As noted above, Mr Gordon ceased to be an Executive Director on 1 March 2018. On departure from the Board, Mr Gordon held 537,332 shares in the Company.

There have been no changes to Directors' shareholdings between 31 December 2018 and the date of this report.

The table below sets out the Directors' interests in shares of the Company which remain unvested or have vested but are unexercised as at 31 December 2018. Unvested awards are structured as nil-cost options.

	Shares		
	Unvested and subject to performance conditions[1]	Unvested and not subject to performance conditions[2]	Vested and not subject to performance conditions
Non-Executive Chairman			
Garry Watts	–	–	–
Executive Directors			
Justin Ash	576,058	–	–
Jitesh Sodha[3]	414,219	–	–
Simon Gordon[4]	n/a	n/a	
Non-Executive Directors			
Adèle Anderson	–	–	–
Peter Bamford	–	–	–
Tony Bourne	–	–	–
Dame Janet Husband	–	–	–
Danie Meintjes	–	–	–
Simon Rowlands	–	–	–
Dr Ronnie van der Merwe	–	–	–

1 Consists of awards granted under the LTIP.
2 Consists of shares held through the Deferred Bonus Plan awarded on 1 June 2015 in respect of the bonus paid for the 2014 financial year.
3 Jitesh Sodha was appointed Chief Financial Officer on 1 October 2018.
4 Simon Gordon ceased to be an Executive Director on 1 March 2018. As detailed on pages 104 and 105, on departure Mr Gordon retained an interest in Deferred Bonus shares which subsequently vested in April 2018, and unvested LTIP awards granted in 2016 (which has since lapsed) and 2017 subject to time pro-rating and performance.

Letters of appointment

Non-Executive Director	Date of appointment	Notice period	Date of expiry
Adèle Anderson	28 July 2016	2 months	No later than 30 June 2019
Peter Bamford	26 May 2017	3 months	No later than 30 June 2020
Tony Bourne	24 June 2014	2 months	26 May 2020
Dame Janet Husband	24 June 2014	2 months	26 May 2020
Simon Rowlands[1]	24 June 2014	2 months	23 July 2019
Dr Ronnie van der Merwe[2]	24 May 2018	n/a	24 May 2021

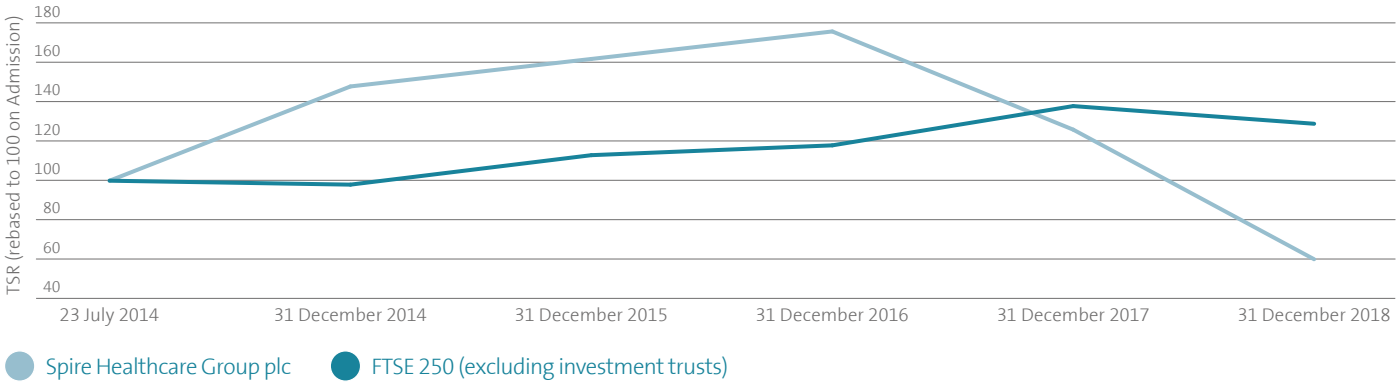
1 Simon Rowlands appointment was renewed for a further one-year period and a letter of appointment dated 23 July 2018 was issued to him. Due to the senior position Simon Rowlands previously held with Cinven Partners he is considered to be a non-independent Non-Executive Director.
2 Pursuant to the relationship agreement dated 22 June 2015 between the Company and Mediclinic Jersey Limited, under which Mediclinic Jersey Limited is entitled to nominate for appointment to the Board one Non-Executive Director, Dr Ronnie van der Merwe was appointed to the Board on 24 May 2018. Dr Ronnie van der Merwe is considered to be a non-independent Non-Executive Director.

Service contracts

Justin Ash and Jitesh Sodha will put themselves up for election at the annual general meeting to be held on 16 May 2019. Executive Directors are employed under ongoing service contracts with the Group. These contracts do not have a fixed term of appointment. Copies of their service contracts are available to shareholders at the registered office for inspection.

Performance graph

The graph below illustrates Spire Healthcare Group plc's TSR performance against the FTSE 250 (excluding investment trusts) since Admission on 23 July 2014.



The table below shows the total remuneration paid in respect of the Chief Executive Officer role.

	2018	2017	2016	2015	2014
Chief Executive's single figure remuneration (£000s)[1,2]	**732.4**	128.2	320.5	1,095.8	6,223.1
Annual bonus payout (% of maximum)	**0%**	0%	0%	0%	34%
LTIP vesting (% of maximum)[3]	**n/a**	n/a	n/a	n/a	n/a

1 2017: Justin Ash was appointed Chief Executive Officer on 30 October 2017. The value shown for 2017 therefore represents a part-year figure for his time in role. During 2017: (i) Garry Watts fulfilled the role of Chief Executive Officer from 14 March 2016 to 12 June 2017 for which he was paid £714.6k; and (ii) Simon Gordon undertook the role of Interim Chief Executive Officer between 13 June 2017 and 29 October 2017 for which he was paid c.£243k.
2 2016: Rob Roger stepped down from the Board on 30 June 2016. The value shown for 2016, therefore represents a part-year figure for his time in role. During 2016, Garry Watts fulfilled the role of Chief Executive Officer from 14 March 2016 to 12 June 2017 for which he was paid £714.6k.
3 Rob Roger and Garry Watts did not have any LTIP awards vesting in respect of 2016; for other participants the LTIP based on performance to 31 December 2016 vested at 50% of maximum. Similarly, Justin Ash and Garry Watts do not have any LTIP awards vesting in respect of 2017 or 2018; for other participants (including Simon Gordon) the LTIP based on performance to 31 December 2017 and 31 December 2018 lapsed in full.

Annual change in remuneration

The table below shows the percentage change in remuneration (based on salary, fees, benefits and annual bonus) between 2017 and 2018.

	Chief Executive Officer % change[1]	Other employees % change
Base salary	0	5.3%
Benefits	n/a	11.8%
Annual bonus	n/a	0%

1 As noted above, Justin Ash was appointed Chief Executive Officer on 30 October 2017.

Pay in the wider organisation

The Remuneration Committee spends considerable time reviewing pay matters across the wider Company. This helps to provide additional context for when determining remuneration for Executive Directors.

In line with the new UK Corporate Governance Code, the remit of the Remuneration Committee will be expanded from 2019 onwards to expand both the decision-making powers of the Committee and the extent to which the Committee engages on pay matters relating to the wider workforce. In many cases this will formalise existing practices.

The Remuneration Committee has also been kept informed regarding the expanding disclosure requirements on pay matters. Over the past two years, the Committee has provided input on the disclosures relating to the Gender Pay Gap, and the Committee is also aware of the current discussion on the disclosure of the CEO pay ratio and pay reporting based on ethnicity.

We remain committed to complying with new disclosure requirements as they come into effect, and over the coming year the Committee will be spending time to better understand how the metrics compare across the Group and how they may vary in different scenarios.

Relative importance of spend on pay

The table below illustrates the year-on-year change in the total remuneration costs for all employees and shareholder distributions.

(£ million)	2018	2017	% change
Total remuneration	**298.9**	282.1	5.96
Distributions to shareholders	**15.2**	15.2	0

Advice provided to the Remuneration Committee

During the course of the year, Deloitte LLP provided external advice to the Committee and its total fees were £56,300 (2017: £57,950). During 2018, Deloitte LLP also provided other consulting services to the Group. Deloitte LLP has voluntarily signed up to the Remuneration Consultants' Code of Conduct in relation to executive remuneration consulting during the year. The Committee is comfortable that the Deloitte LLP engagement partner and team that provides remuneration advice to the Committee do not have connections with the Company that may impair their independence.

The Chairman, Chief Executive Officer, interim Group Human Resources Director and Simon Rowlands attended Committee meetings by invitation in order to provide the Committee with additional context. No individual participates in decisions regarding their own remuneration.

Statement of voting at 2018 annual general meeting

The following table sets out the voting in respect of the resolutions to approve the Company's 2017 Directors' Remuneration Report and Directors' Remuneration Policy, put to shareholders at the Company's annual general meeting held on 24 May 2018:

Resolution	Votes for	% of vote	Votes against	% of vote	Votes withheld
Approve the 2017 Directors' Remuneration Report	254,155,475	84.56%	46,406,986	15.44%	792,196
Approve the Directors' Remuneration Policy	299,589,232	99.41%	1,763,647	0.59%	1,779

This report on Directors' remuneration will be put to an advisory vote at the annual general meeting on 16 May 2019. The Directors confirm that this report has been prepared in accordance with the Companies Act 2006 and reflects the provisions of the Large and Medium-sized Companies and Groups (Accounts & Reports) (Amendment) Regulations 2013 and was approved at a meeting of the Directors held on 27 February 2019. The Committee consulted with major shareholders around the time of the 2018 AGM. We welcomed the overwhelming support received for the forward looking Remuneration Policy which indicated very strong support for our overall approach to pay. In light of this support, we intend to maintain this policy for the coming year, subject to the changes in the approach to implementation described in the statement from the Chair of the Remuneration Committee and on pages 99 and 100.

While the majority of shareholders were supportive of the 2017 Directors' Remuneration Report, we are aware that some shareholders had concerns regarding certain decisions taken in 2017. As evidenced by incentive outcomes for 2018 and since IPO, the Remuneration Committee has consistently demonstrated a focus on pay-for-performance. We remain committed to a constructive dialogue with our investors in future years.

Details of all resolutions passed at the annual general meeting held on 24 May 2018 can be found on page 83.

Share prices

The market price of a Spire Healthcare Group plc ordinary share at 31 December 2018 was 108.9 pence and the range during the year was 99.5 pence to 258.0 pence.

Tony Bourne
Chair, Remuneration Committee
27 February 2019

Directors' report

The Directors submit their Annual Report together with the audited financial statements of Spire Healthcare Group plc (the 'Company') together with its subsidiaries (the 'Group') for the year ended 31 December 2018.

Certain disclosure requirements for inclusion in this Directors' Report have been incorporated by way of cross reference to the Strategic Report on pages 1 to 73 and the Directors' Remuneration Report on pages 101 to 109, and should be read in conjunction with this report. The following, included in the Strategic Report, also form part of this report:

- greenhouse gas emissions, which can be found under Resources and responsibilities on page 42;
- employees, which can be found in Resources and relationships on pages 38 to 41;
- the Corporate governance report, set out on pages 76 to 83; and
- Our strategy set out on pages 16 and 25.

A description of the Group's exposure and management of risks is provided in the Strategic Report on pages 49 to 59.

Information regarding the Company's Gender Pay Gap Reporting and charitable donations can be found in Resources and relationships on pages 40 to 41.

Registered office

The Company's registered office and principal place of business is 3 Dorset Rise, London EC4Y 8EN.

Annual general meeting

The annual general meeting of Spire Healthcare Group plc will be held at the offices of Freshfields Bruckhaus Deringer LLP, 65 Fleet Street, London EC4Y 1HS on Thursday, 16 May 2019 at 11.00am.

At the meeting, resolutions will be proposed to declare a final dividend, to receive the Annual Report and Financial Statements, approve the Directors' Remuneration Report, approve the Company's Remuneration Policy, elect or re-elect all of the Directors and to reappoint Ernst & Young LLP as auditor. Shareholders will also be asked to authorise the Directors to hold general meetings at 14 clear days' notice (where this flexibility is merited by the business of the meeting and is thought to be in the interests of shareholders as a whole). Further items of business to be proposed at the annual general meeting are described throughout this Directors' Report.

Dividends

The Directors recommend the payment of a final dividend in respect of the year ended 31 December 2018 of 2.5 pence (2017: 2.5 pence) per ordinary share making a proposed total dividend for the year of 3.8 pence per share (2017: 3.8 pence). Subject to shareholders approving the recommendation at the annual general meeting, the final dividend will be paid on 25 June 2019 to shareholders on the register as at 31 May 2019.

The Company paid an interim dividend in respect of the year ended 31 December 2018 of 1.3 pence per ordinary share on 11 December 2018.

Board of Directors

The following changes were made to the Board of Directors during the year:

- Simon Gordon resigned as Chief Financial Officer and an Executive Director on 1 March 2018. Simon left the Company on 31 March 2018;
- by letter dated 1 March 2018, Mediclinic International PLC gave notice that Danie Meintjes would cease to be its nominated Non-Executive Director on the Board on 24 May 2018 and that Dr Ronnie van der Merwe would be appointed from this date; and
- Jitesh Sodha was appointed Chief Financial Officer and an Executive Director on 1 October 2018.

Subsequent to the year end, on 27 February 2019, Peter Bamford gave notice that he intended to step down as our Senior Independent Director on 16 May 2018. A search is underway for his replacement.

The UK Corporate Governance Code provides for all directors of FTSE companies to stand for election or re-election by shareholders every year. Accordingly, all members of the Board will retire and seek election or re-election at this year's annual general meeting. Full biographical details of all of the Directors can be found on pages 86 and 87.

Further information on the contractual arrangements of the Executive Directors is given on pages 101 and 102. The Non-Executive Directors do not have service agreement.

Powers of the Directors

The business of the Company is managed by the Directors who may exercise all the powers of the Company, subject to any relevant legislation, any directions given by the Company by passing a special resolution and to the Company's Articles of Association. The Articles, for example, contain specific provisions concerning the Company's power to borrow money and issue shares.

Appointment and removal of Directors

Rules relating to the appointment and removal of the Directors are contained within the Company's Articles of Association.

Director's indemnities

See page 81 in the Corporate Governance section.

Amendment of articles of association

The Company may only make amendments to the Articles of Association of the Company by way of special resolution of the shareholders, in accordance with the Companies Act 2006.

Employees

The Group is an equal opportunities employer and is committed to creating an environment which will attract, retain and motivate its people, by creating a working environment in which individuals are able to make best use of their skills, free from discrimination or harassment, and in which all decisions are based on merit. Spire Healthcare employs people who consider themselves to have a disability (a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities). Employees who consider themselves to have a disability are under no obligation to inform their employer of this, however, we are fully aware of, and comply with, our obligations in accordance with the relevant provisions of the Equality Act 2010.

We remain committed to colleague involvement throughout the business. Colleagues are kept well informed of the clinical and financial performance of the hospital that they work in as well as the Group more widely. Examples of colleague involvement and engagement are highlighted throughout this Annual Report. When appropriate, consultations with employee and union representatives take place.

The Group gives full and fair consideration to applications for employment from disabled persons. Should an employee become disabled during their employment with Spire Healthcare, every effort is made to enable them to continue their service with the Group.

Further information on our employees can be found under Resources and relationships on pages 38 to 42.

Political donations and expenditure

The Group made no political donations during the year. Although the Company does not make, and does not intend to make, donations to political parties, within the normal meaning of that expression, the definition of political donations under the Companies Act 2006 is very broad and includes expenses legitimately incurred as part of the process of talking to members of Parliament and opinion formers to ensure that the issues and concerns of the Group are considered and addressed. These activities are not intended to support any political party and the Group's policy is not to make any donations for political purposes in the normally accepted sense.

A resolution will therefore be proposed at the annual general meeting seeking shareholder approval for the Directors to be given authority to make donations and incur expenditure which might otherwise be caught by the terms of the Companies Act 2006. The authority sought will be limited to a maximum amount of £100,000.

Share capital

As at the date of this report, Spire Healthcare Group plc had an issued share capital of 401,081,391 ordinary shares of 1 pence each, being the total number of shares with voting rights.

Equiniti Trust (Jersey) Limited, as trustee of the Company's Employee Benefit Trust, holds 252,652 ordinary shares of 1 pence each (2017: 281,631). Further details can be found in note 19 on pages 142 and 143.

The rights attaching to the shares are set out in the Articles of Association. There are no restrictions on the transfer of ordinary shares in the capital of the Company other than those which may be imposed by law from time-to-time. There are no special control rights in relation to the Company's shares and the Company is not aware of any agreements between holders of securities that may result in restrictions on the transfer of securities or on voting rights. In accordance with the Disclosure and Transparency Rules, certain employees are required to seek approval prior to dealing in the Company's shares. The Company's entire issued ordinary share capital is listed on the premium segment of the Official List of the Financial Conduct Authority and to unconditional trading on the London Stock Exchange plc's main market for listed securities.

Further information relating to the Company's issued share capital can be found in note 19 to the Company's financial statements on pages 142 and 143.

The Company has made no purchases of its own shares during the year and no shares were acquired by forfeiture or surrender or made subject to a lien or charge. Details of the shares purchased by the Company's Employee Benefit Trust are shown in note 19 on pages 142 and 143.

Allot shares and pre-emption rights

Shareholders will be asked to renew both the general authority of the Directors to issue shares and to authorise the Directors to issue shares without applying the statutory pre-emption rights. In this regard, the Company will continue to adhere to the provisions in the Pre-emption Group's Statement of Principles.

Further details on these matters can be found in the 2019 Notice of annual general meeting.

Voting rights

In a general meeting of the Company, on a show of hands, every member who is present in person or by proxy and entitled to vote shall have one vote. On a poll, every member who is present in person or by proxy shall have one vote for every share of which they are the holder.

Restrictions on voting

Unless the Directors otherwise determine, a shareholder shall not be entitled to vote either personally or by proxy:

- if any call or other sum presently payable to the Company in respect of that share remains unpaid; or
- having been duly served with a notice to provide the Company with information under Section 793 of the Companies Act 2006, and has failed to do so within 14 days, for so long as the default continues.

Directors' interests in shares

The beneficial interests of the Directors' and their families in the shares of the Company are detailed on page 106.

During the year, no Director had any material interest in any contract of significance to the Group's business.

Material interests in shares

As of 27 February 2019, the Company has been notified by the following investors of their interests in 3% or more of the Company's issued share capital. These interests were notified to the Company pursuant to Disclosure and Transparency Rule 5:

Shareholder	Current %
Mediclinic International PLC	29.90
Norges Bank	5.47
Highclere International Investors LLP	5.03
M&G Investment Management	5.01
Woodford Investment Management LLP	5.00
The Capital Group Companies, Inc	4.83

Significant agreements

The following agreements are considered to be significant in terms of their potential impact on the business of the Group as a whole and could alter or terminate on a change of control of the Group:

- the Group's bank facility agreement contains provisions entitling the counterparties to exercise termination or other rights in the event of a change of control;
- there are a number of contracts which allow the counterparties to alter or terminate those arrangements in the event of a change of control of the Company. These arrangements are commercially sensitive and confidential and their disclosure could be seriously prejudicial to the Group; and
- the Company's share incentive plans contain provisions relating to a change of control and full details of these plans are provided in the Directors' Remuneration Report on pages 101 to 109. Outstanding options and awards would normally vest and become exercisable on a change of control, subject to the satisfaction of performance conditions, if applicable, at that time.

The relationship agreement entered into with Mediclinic Jersey Limited (formerly called Remgro Jersey Limited), a subsidiary of Mediclinic International PLC, in June 2015 is deemed a material agreement between the Company and its principal shareholder. The agreement does not include a change of control provision but does terminate upon the earlier of the Company's ordinary shares ceasing to be listed and traded on the London Stock Exchange's main market for listed securities and the principal shareholder's ceasing to be entitled, in aggregate, to exercise or to control the exercise of 15% or more of the votes to be cast on all or substantially all matters of a general meeting of the Company.

Compensation for loss of office

There are no agreements between the Group and its Directors or employees providing for compensation for loss of office or employment that occurs as a result of a change of control.

Disclosures required under listing rule 9.8.4R

The above table is included to meet the requirements of Listing Rule section 9.8.4R. The information required to be disclosed by that section, where applicable to the Company, can be located in the Annual Report 2018 at the references set out above.

Events after the reporting period

There have been no material events affecting the Group or Company since 31 December 2018.

Going concern

The Group is financed by a bank loan facility that matures in July 2022. The Directors have considered the Group's forecasts and projections, and the risks associated with their delivery and are satisfied that the Group will be able to operate within the covenants imposed by the bank loan facility for at least twelve months from the date of approval of these financial statements. In relation to available cash resources, the Directors have had regard to both cash at bank and a £100 million committed undrawn revolving credit facility.

The Group has undertaken extensive activity to identify and mitigate its exposure to plausible risks which may arise from Brexit. Further information on this is provided in the Risk management and internal control section on pages 49 to 51. Based on the Directors' current assessment of the likelihood of the Brexit risks arising together with their assessment of the planned mitigating actions being successful, the Directors have concluded it is appropriate to prepare the accounts on a going concern basis.

Information required	Location in Annual Report 2018
Amount of interest capitalised	Note 7 on page 135
Long-term incentive schemes	Directors' Remuneration Report pages 98 to 109
Equity securities allotted for cash	Note 19 on pages 142 and 143
Parent and subsidiary undertakings	Note 14 on page 140
Subsisting significant agreements	Page 112
Controlling shareholder relationships	Page 112

Disclosure of information to auditor

Having made enquiries of fellow Directors and of the Company's auditor, each of the Directors confirms that:

- to the best of their knowledge and belief, there is no relevant audit information of which the Company's auditor is unaware; and
- they have taken all the steps a Director might reasonably be expected to have taken to be aware of relevant audit information and to establish that the Company's auditor is aware of that information.

Reappointment of auditor

Resolutions for the reappointment of Ernst & Young LLP as the auditor of the Company and to authorise the Directors to determine its remuneration will be proposed at the annual general meeting. Ernst & Young LLP has expressed its willingness to be reappointed.

The Directors' Report has been approved by the Board and is signed on its behalf by:

Daniel Toner
General Counsel and Group Company Secretary
27 February 2019

Statement of Directors' responsibilities

The Directors are responsible for preparing the Annual Report and Accounts for the year ended 31 December 2018, including the Consolidated financial statements and the Parent Company financial statements, Directors' Report, including the Directors' Remuneration Report and the Strategic Report in accordance with applicable law and regulations. Under that law, the Directors are required to prepare the Group financial statements in accordance with International Financial Reporting Standards ('IFRS') as adopted by the European Union and Article 4 of the IAS Regulation and have elected to prepare the Parent Company financial statements in accordance with IFRS, as adopted by the EU.

Company law requires the Directors to prepare such financial statements for each financial year. Under company law, the Directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the Company on a consolidated and individual basis, and of the profit or loss of the Company on a consolidated basis for that period.

In preparing these financial statements, the Directors are required to:

- select suitable accounting policies in accordance with IAS 8: Accounting Policies, Changes in Accounting Estimates and Errors and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- present information, including accounting policies, in a manner that provides relevant, reliable, comparable and understandable information;
- provide additional disclosures when compliance with the specific requirements in IFRS as adopted by the EU is insufficient to enable users to understand the impact of particular transactions, other events and conditions on the Group's and Company's financial position and financial performance;
- state that the Group's and Company's financial statements have complied with IFRS as adopted by the EU, subject to any material departures disclosed and explained in the financial statements; and
- prepare the financial statements on a going concern basis, unless it is not appropriate to presume that the Company will continue in business.

The Directors are responsible for keeping adequate accounting records that are sufficient to show and explain the Company's transactions, and disclose, with reasonable accuracy at any time, the Company's financial position and enable them to ensure compliance with the Companies Act 2006. They are also responsible for safeguarding the Company's assets and for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Each of the Directors, whose names and functions are listed on pages 86 and 87, confirms that:

- to the best of their knowledge, the Consolidated financial statements and the Parent Company financial statements, which have been prepared in accordance with IFRS as adopted by the EU, give a true and fair view of the assets, liabilities, financial position and profit of the Company on a consolidated and individual basis;
- to the best of their knowledge, the Strategic Report and the Directors' Report include a fair review of the development and performance of the business and the position of the Company on a consolidated and individual basis, together with a description of the principal risks and uncertainties that it faces; and
- they consider that the Annual Report and Accounts for the year ended 31 December 2018, taken as a whole, is fair, balanced and understandable, and provides the information necessary for shareholders to assess the Company's performance, business model and strategy.

By order of the Board.

Garry Watts
Chairman
27 February 2019

Jitesh Sodha
Chief Financial Officer
27 February 2019

Independent Auditor's report

To the members of Spire Healthcare Group plc

Our opinion on the Group financial statements and parent company financial statements

In our opinion:

- Spire Healthcare Group plc's group financial statements and parent company financial statements (the "financial statements") give a true and fair view of the state of the Group's and of the parent company's affairs as at 31 December 2018 and of the Group's profit for the year then ended;
- The Group's financial statements have been properly prepared in accordance with IFRSs as adopted by the European Union;
- the parent company financial statements have been properly prepared in accordance with IFRSs as adopted by the European Union as applied in accordance with the provisions of the Companies Act 2006; and
- the financial statements have been prepared in accordance with the requirements of the Companies Act 2006, and, as regards the group financial statements, Article 4 of the IAS Regulation.

We have audited the financial statements of Spire Healthcare Group plc which comprise:

	Group	Parent Company
Balance sheet as at 31 December 2018	✓	✓
Income statement for the year then ended	✓	
Statement of comprehensive income for the year then ended	✓	
Statement of changes in equity for the year then ended	✓	✓
Statement of cash flows for the year then ended	✓	✓
Related notes to the financial statements	✓	✓

The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and, as regards the parent company financial statements, as applied in accordance with the provisions of the Companies Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the Group and parent company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard as applied to listed public interest entities, 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 principal risks, going concern and viability statement

We have nothing to report in respect of the following information in the annual report, in relation to which the ISAs (UK) require us to report to you whether we have anything material to add or draw attention to:

- the disclosures in the annual report set out on pages 52 to 59 that describe the principal risks and explain how they are being managed or mitigated;
- the directors' confirmation set out on page 113 in the annual report that they have carried out a robust assessment of the principal risks facing the Group and the parent company, including those that would threaten its business model, future performance, solvency or liquidity;
- the directors' statement set out on page 113 in the financial statements about whether they considered it appropriate to adopt the going concern basis of accounting in preparing them, and their identification of any material uncertainties to the entity's ability to continue to do so over a period of at least twelve months from the date of approval of the financial statements;
- whether the directors' statement in relation to going concern required under the Listing Rules in accordance with Listing Rule 9.8.6R(3) is materially inconsistent with our knowledge obtained in the audit; or
- the directors' explanation set out on page 60 in the annual report as to how they have assessed the prospects of the Group and the parent company, over what period they have done so and why they consider that period to be appropriate, and their statement as to whether they have a reasonable expectation that the entity will be able to continue in operation and meet its liabilities as they fall due over the period of their assessment, including any related disclosures drawing attention to any necessary qualifications or assumptions.

Overview of our audit approach

Key audit matters	– Manipulation of NHS revenue by changes to the pricing master file. – Misstatement of revenue due to management posting fraudulent manual journal entries to revenue. – Inappropriate capitalisation of costs to property, plant and equipment. – Risk of impairment to property carrying values
Audit scope	– We performed an audit of the complete financial information of 2 components and audit procedures on specific balances for a further 26 components. – The components where we performed full or specific audit procedures accounted for 98% of Profit before tax, 100% of Revenue and 100% of Total assets.
Materiality	– Overall group materiality of £1.6 million which represents 5% of profit before tax adjusted for certain exceptional items.

Key audit matters

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

Risk	Our response to the risk	Key observations communicated to the Audit and Risk Committee
Manipulation of NHS revenue by changes to the pricing master file NHS Revenue 2018 YE: £272.2m (2017 YE): £293.3m. *Refer to the Audit and Risk Committee Report (pages 94 to 97); Accounting policies (page 127); and Note 5 of the Consolidated Financial Statements (page 134)* Inappropriate revenue recognition by way of management manipulation of NHS prices within the pricing master file, resulting in inaccurate patient invoicing in respect of NHS revenue. The high volume of patient transactions, for which pricing is contractually agreed by a comparatively small number of NHS trusts, leads to a higher likelihood of material misstatement through intentional changes to individual procedural pricing on the pricing master file. We consider that the pressure to achieve forecast results or targets increases the risk of financial reporting manipulation by management.	To gain assurance over the NHS revenue recognised during the period, we have performed the following procedures: – We used data analytics to assess the accuracy of all FY18 NHS billing data to publicly available NHS national tariff base prices, adjusted by Market Force factors. – For any material revenue portion of the population for which we were unable to agree the price billed to NHS national tariff base prices, e.g. for local plans where we would already have the expectation of a possible price deviation, we have agreed a sample of this billing data to appropriate audit support. Specifically, we have agreed a sample of this billing data to the underlying signed agreement (local plan) or, in instances where no current contract or correspondence was available, we traced the settlement of the invoice directly to cash. – We used data analytics, covering all NHS revenue transactions in the year, to test the correlation between revenue, accrued revenue, accounts receivable and cash. – We investigated whether there were any pricing disputes with the NHS during the year through discussions with legal counsel, review of minutes and verifying any matter noted to correspondence, where available. – We obtained a summary of aged NHS receivables and verified that the ageing is appropriate by testing a sample across the different ageing categories. We have performed a search for any large or unusually long outstanding receivables that are outside expected credit terms that may indicate that pricing disagreements exist. – Whilst we have not relied on any of the work performed by internal audit, we reviewed the results from their individual site audits completed during FY18, to understand if there were any revenue findings specific to NHS pricing which require further enquiry and corroboration.	We did not identify material errors in the pricing master file, nor evidence of management manipulation of revenue through this means. Furthermore, we did not identify any indicators of pricing disputes with the NHS. Based on our audit procedures performed, we concluded that revenue for the year is appropriately recognised and free from material misstatement.

Risk	Our response to the risk	Key observations communicated to the Audit and Risk Committee
Misstatement due to management posting fraudulent manual journal entries to revenue NHS Revenue 2018 YE: £272.2m (2017 YE: £293.3m). PMI Revenue 2018 YE: £432.6m (2017 YE: £426.0m). Self-pay Revenue 2018 YE: £174.1m (2017 YE: £160.2m). Partnership Revenue 2018 YE: £27.0m (2017 YE: £26.6m). Other Income 2018 YE: £25.2m (2017 YE: £25.6m). *Refer to the Audit and Risk Committee Report (pages 94 to 97); Accounting policies (page 127); and Note 5 of the Consolidated Financial Statements (page 134)* We consider that the pressure to achieve forecast results and analysts' expectations increases the risk of financial reporting manipulation by management. Given management's bonus structure and the pressure to achieve the agreed performance target, we consider there to be a risk of financial reporting manipulation by management. Based on the key performance indicators that are analysed by both external and internal parties, we consider revenue to be susceptible to management override of control as this forms the foundation for the key performance indicators. We understand that the high volume of system generated, low value revenue transactions, results in limited opportunity for management to fraudulently misstate revenue, (other than through manipulation of changes to the pricing master file for NHS billing data as considered above). For management to fraudulently misstate, we consider there to be a greater incentive to override controls by posting manual journal entries to revenue.	We performed a walkthrough of the financial statement close process and obtained an understanding over the journal entry process, consolidation journal entry process and adjusting journals posted directly to the financial statements. Utilising our analytics-based revenue programme, we have understood revenue trends through the use of analytics as follows: – analysis of double-entry postings to the related accounts and how these accounts are aligned with our understanding of the revenue process, activity and source; and – identifying revenue trends which do not correlate with our expectation, and investigating and corroborating these uncorrelated trends. We performed mandatory journal testing by focusing on specific criteria designed to identify journals through which we believe management can/may post fraudulent manual entries to revenue.	We have not identified any misstatements due to management posting fraudulent manual journal entries to revenue. We have not found any instances of management override.

Risk	Our response to the risk	Key observations communicated to the Audit and Risk Committee
Inappropriate capitalisation of costs to property, plant and equipment Costs capitalised for YE 2018: £65.2m (2017 YE: £119.9m). *Refer to the Audit and Risk Committee Report (pages 94 to 97); Accounting policies (page 128); and Note 12 of the Consolidated Financial Statements (page 138)* Given management's bonus structure and analysts' expectations of the Group's performance, for example underlying EBITDA and adjusted EPS, we consider the risk of inappropriate capitalisation to be a fraud risk. As a result of the scale of capital expenditure in the current year, relating to both development projects and general capital spend, we consider there is increased opportunity for management to inappropriately capitalise costs to manipulate the Group's profits. The high volume of costs being capitalised over all property, plant and equipment categories means that it is harder for management to detect material inappropriate items.	– We obtained an understanding of the capital budgeting process through our walkthrough; specifically, how management monitors the actual spend versus budget and how this is reported through the business and to the board and executive committee. – As part of our detailed testing, we compared actual expenditure to approved budgets for the selected projects, where applicable, and investigated any material variances. – We tested a sample of capital additions to property, plant and equipment. We obtained the invoice to verify the existence and valuation of each item. We also obtained evidence that the expenditure has been authorised by an appropriate individual. We verified that the expenditure was capital in nature by reading the description and detail on the invoices, and supporting documentation. – Our sample selected included both low and high value items. We focused our attention on accrued spend and 'internal' costs such as staff costs for the Group's employees, as we considered there to be higher risk of manipulation in this area. Where internal costs were capitalised, we verified that the costs were directly attributable to the relevant project. – We performed mandatory testing of journal entries. Our journal testing approach considered appropriate criteria to identify a journal testing sample which addressed the risk of inappropriate capitalisation of costs to property, plant, and equipment.	Our audit procedures found no instances of expenditure which had been inappropriately capitalised to property, plant and equipment. Based on our audit procedures performed, we concluded that costs have been appropriately capitalised to property, plant, and equipment.

Risk	Our response to the risk	Key observations communicated to the Audit and Risk Committee
Risk of impairment to property carrying values Freehold property carrying value for 2018: £687.0m (2017 YE: £725.5m). *Refer to the Audit and Risk Committee Report (pages 94 to 97); Accounting policies (page 128); and Notes 6 and 12 of the Consolidated Financial Statements (pages 134 and 138 respectively).* Management look for indicators of impairment based on various factors, such as how hospitals are performing compared to budget. Where there is an indicator of impairment, management perform an impairment test in accordance with IAS 36, by calculating a value in use for these properties. The value in use is calculated using a discounted cash flow model based on the Group's forecasts through to 2022. Given the shortfall in actual EBITDA experienced during FY18, we consider that the risk of property impairment is increased. The uncertainty over current forecasting assumptions, leads us to consider that the risk of a material misstatement in management's value in use calculation is increased for those properties where an indicator of impairment exists. Management continue to review for impairment all other properties where indicators of impairment exist and where headroom between cost and VIU based on current forecasts is considered insignificant.	– We obtained a comparison of each hospital's EBITDA for FY18 to its budget. From this comparison, we selected certain freehold and long leasehold hospital properties to focus our impairment testing on, specifically those which show underperformance compared to budget of 10% or more. – We obtained management's value in use calculation for the selected hospitals. We made enquiries to understand the process and controls behind the preparation of management's underlying five-year forecast, given the reliance on this plan for the value in use model. – We compared the actual results achieved in the prior periods to the forecasts prepared for those periods, to judge the historical accuracy of management's forecasts. – We assessed the reasonableness of management's cash flow forecasts by comparing to prior year actuals. We obtained external views of the market, and had discussions with EY health sector specialists on market dynamics and expected market performance. We used this information to challenge the forecasts and assumptions made by management. – We engaged EY specialists to assist us in verifying the appropriateness of key inputs to the discounted cash flow model, such as the discount rate and the terminal growth rate. – We performed sensitivity analyses over the assumptions used by management, incorporating the above-mentioned healthcare market data and inputs, as appropriate.	Having sensitised management's value in use calculations for the hospitals we focused on, we conclude that the risk of material misstatement is low. The carrying value was supported, suggesting no need to recognise impairment on these properties. We therefore agree with management's conclusion that the carrying value of the Group's properties is appropriate.

In the prior year, our auditor's report included a key audit matter in relation to the risk of manipulation of revenue by changes to both the NHS and PMI pricing master files. In the current year, we have re-evaluated our risk assessment and concluded that the key audit matter is only considered relevant to NHS revenue. This is based on our assessment that the risk of manipulation of PMI revenue resulting in a material misstatement is low.

Specifically, as part of our continued increase in the use of data analytics in our audit, we have utilised a custom-built pricing analyser in our significant risk assessment for the first time in our FY18 audit. As a result, we have evaluated that, although there still exists a higher likelihood that the pricing of PMI revenue may be manipulated, there is a lower magnitude of effect of such manipulation, should it occur, than previously assessed. This is primarily due to the level of disaggregation in the structure of PMI pricing data, which we have been able to analytically examine as part of our risk assessment for the first time. Consequently, we have concluded that there is a lower opportunity for management to materially misstate PMI revenue through this method, and we no longer consider this to be a significant risk to the financial statements.

An overview of the scope of our audit

Tailoring the scope

Our assessment of audit risk, our evaluation of materiality and our allocation of performance materiality determine our audit scope for each entity within the Group. Taken together, this enables us to form an opinion on the consolidated financial statements. We take into account size, risk profile, the organisation of the Group and effectiveness of group-wide controls and changes in the business environment when assessing the level of work to be performed at each entity.

In assessing the risk of material misstatement to the group financial statements, and to ensure we had adequate quantitative coverage of significant accounts in the financial statements, we identify the subsidiaries, which represent the principal business units within the Group. The Group continues to operate solely in the UK.

We performed an audit of the complete financial information of two components (2017: four) ("full scope components") which were selected based on their size or risk characteristics. For a further 26 (2017: 14) components ("specific scope components"), we performed audit procedures on specific accounts within that entity that we considered had the potential for the greatest impact on the significant accounts in the group financial statements either because of the size of these accounts or their risk profile.

The entities for which we performed audit procedures accounted for 100% (2017: 100%) of the Group's Revenue and 100% (2017: 100%) of the Group's Total assets. For the current year, the full scope components contributed 93% (2017: 92%) of the Group's Revenue and 69% (2017: 68%) of the Group's Total assets. The specific scope components contributed 7% (2017: 8%) of the Group's Revenue and 32% (2017: 32%) of the Group's Total assets. The audit scope of these components may not have included testing of all significant accounts of the component but has contributed to the coverage of significant accounts tested for the Group. It is not possible to present the split between full and specific scope components on a profit before tax basis in a meaningful way. This is due to intra-group profits earned in certain specific scope components which result in the aggregated profit before tax amounting to more than 100%.

Of the remaining 12 entities (2017:17), we performed other procedures, including analytical review and testing the clerical accuracy of consolidation journals to respond to any potential risks of material misstatement of the group financial statements.

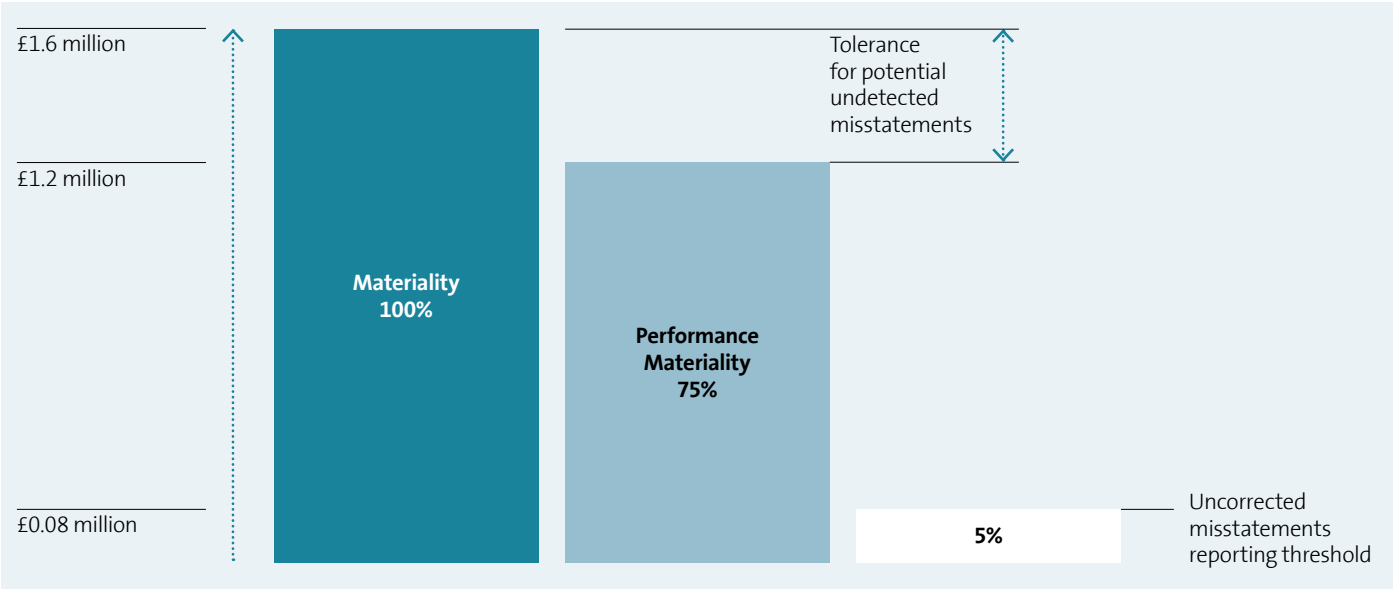
Changes from the prior year

We note the following changes in our scoping from the prior year:

Entity Name	Scoping in FY18	Scoping FY17	Rationale for change
Spire Healthcare Property Development Limited	Specific scope	Full scope	Contributing percentage to total assets (scoping parameter) has decreased due to decrease in hospital builds and assets under construction.
Spire Healthcare Finance Limited	Specific scope	Full scope	No significant contribution to any other scoping parameters other than external debt held.

Our application of materiality

We apply the concept of materiality in planning and performing the audit, in evaluating the effect of identified misstatements on the audit and in forming our audit opinion.



Materiality

The magnitude of an omission or misstatement that, individually or in the aggregate, could reasonably be expected to influence the economic decisions of the users of the financial statements. Materiality provides a basis for determining the nature and extent of our audit procedures.

We determined materiality for the Group to be £1.6 million (2017 YE: £3.5 million), which is 5% of adjusted profit before tax (2017: 5% of adjusted profit before tax). We have adjusted profit before tax for certain exceptional items amounting to £ 24.4 million (2017: £47.7 million), in order to calculate materiality on a basis which reflects the underlying performance of the Group. We believe this provides us with the most applicable measurement basis for the users of the financial statements and is in line with the adjusted performance measures the Group uses. We have not adjusted for 'other' exceptionals being a credit of £0.3 million (2017: £1.6 million charge).

We determined materiality for the Parent Company to be 75% of Group materiality.

Performance materiality

The application of materiality at the individual account or balance level. It is set at an amount to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality.

On the basis of our risk assessments, together with our assessment of the Group's overall control environment, our judgement was that performance materiality was 75% (2017: 75%) of our planning materiality, namely £1.2 million (2017 YE: £2.5 million). We have set performance materiality at this percentage due to our assessment of the overall control environment and the history of no or very few audit adjustments.

Audit work on subsidiaries for the purpose of obtaining audit coverage over significant financial statement accounts is undertaken based on a percentage of total performance materiality. The performance materiality set for each entity is based on the relative size and risk of the entity in relation to the Group as a whole and our assessment of the risk of misstatement arising in that entity. In the current year, the range of performance materiality allocated to components was £0.2 million to £1.2 million (2017: £2.5 million to £0.5 million).

Reporting threshold

An amount below which identified misstatements are considered as being clearly trivial.

We agreed with the Audit and Risk Committee that we would report to them all uncorrected audit differences in excess of £0.08 million (2017: £0.2 million), which is set at 5% of planning materiality, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations in forming our opinion.

Other information

The other information comprises the information included in the annual report set out on pages 2 to 113, including the Strategic Report set out on pages 2 to 73 and the Governance Report set out on pages 74 to 113, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- **Fair, balanced and understandable** set out on page 113 – Statement of Directors' responsibility – the statement given by the directors that they consider the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for shareholders to assess the group's performance, business model and strategy, is materially inconsistent with our knowledge obtained in the audit; or
- **Audit and Risk Committee reporting** set out on pages 94 to 97 – the section describing the work of the Audit and Risk Committee does not appropriately address matters communicated by us to the Audit and Risk Committee/the explanation as to why the annual report does not include a section describing the work of the Audit and Risk Committee is materially inconsistent with our knowledge obtained in the audit; and
- **Directors' statement of compliance with the UK Corporate Governance Code** on page 76 – the parts of the directors' statement required under the Listing Rules relating to the Company's compliance with the UK Corporate Governance Code containing provisions specified for review by the auditor in accordance with Listing Rule 9.8.10R(2) do not properly disclose a departure from a relevant provision of the UK Corporate Governance Code.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion, the part of the directors' remuneration report to be audited has been properly prepared in accordance with the Companies Act 2006.
In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Strategic Report and the Directors' Report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In the light of the knowledge and understanding of the Group and the Company and its environment obtained in the course of the audit, we have not identified material misstatements in the strategic report or the directors' report.

We have nothing to report in respect of the following matters in relation to which the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept by the Company, or returns adequate for our audit have not been received from branches not visited by us; or
- the Company financial statements and the part of the Directors' Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- certain disclosures of directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit

Responsibilities of directors

As explained more fully in the directors' responsibilities statement set out on page 113, the directors are 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 directors determine 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 directors are responsible for assessing the group and parent company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the group or the parent company or to cease operations, or have no realistic alternative but to do so.

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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

The objectives of our audit, in respect to fraud, are; to identify and assess the risks of material misstatement of the financial statements due to fraud; to obtain sufficient appropriate audit evidence regarding the assessed risks of material misstatement due to fraud, through designing and implementing appropriate responses; and to respond appropriately to fraud or suspected fraud identified during the audit. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

Our approach was as follows:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Group and determined that the most significant are those related to the reporting framework (IFRS adopted by the EU, the Companies Act of 2006 and the Corporate Governance Code), the relevant tax compliance regulations in the UK, the Data Protection Act of 1998 and the EU General Data Protection Regulation. In addition, we conclude that there are certain laws and regulations which may have an effect on the determination of the amounts and disclosures in the financial statements being the Listing Rules of the London Stock Exchange, the Bribery Act of 2010 and certain laws specific to entities operating in the private healthcare provider industry.
- We understood how Spire Healthcare Group plc is complying with those frameworks by making enquiries of management, internal audit, those responsible for legal and compliance procedures and the company secretary. We corroborated our enquiries through the review of board minutes, communications with the Audit and Risk Committee and correspondence received from regulatory bodies.
- We assessed the susceptibility of the group's financial statements to material misstatement, including how fraud might occur by meeting with management and those charged with governance to understand where they considered there was a susceptibility to fraud. We also considered performance targets, forecasted results and bonus structures and their influence on efforts made by management to manage earnings or influence the perception of analysts. Where this risk was considered to be higher, we performed audit procedures to address each identified risk.
- Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures included the review of board minutes to identify any non-compliance with laws and regulations, a review of the reporting to the Audit and Risk Committee on compliance with regulations, enquiries with those responsible for legal and compliance, enquiries with the company secretary and with management.

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

Other matters we are required to address

- We were appointed as auditors by the Board in November 2008 to audit the financial statements of the Company for the period ending 31 December 2008 and subsequent financial periods. The period of total uninterrupted engagement, including the period prior to the Companies admission on the London Stock Exchange in 2014, is 11 years, covering the years ended 31 December 2008 to 31 December 2018.
- The non-audit services prohibited by the FRC's Ethical Standard were not provided to the Group or the parent company and we remain independent of the Group and the parent company in conducting the audit.
- The audit opinion is consistent with the additional report to the Audit and Risk Committee.

Use of our report

This report is made solely to the company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the company's members 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 company and the company's members as a body, for our audit work, for this report, or for the opinions we have formed.

Debbie O'Hanlon (Senior statutory auditor)
for and on behalf of Ernst & Young LLP, Statutory Auditor
Reading
27 February 2019

Consolidated income statement

For the year ended 31 December 2018

(£ million)	Note	2018 Total before exceptional and other items	2018 Exceptional and other items (note 9)	2018 Total	2017 Total before exceptional and other items	2017 Exceptional and other items (note 9)	2017 Total
Revenue	5	**931.1**	**–**	**931.1**	931.7	–	931.7
Cost of sales		**(497.6)**	**–**	**(497.6)**	(492.2)	–	(492.2)
Gross profit		**433.5**	**–**	**433.5**	439.5	–	439.5
Other operating costs		**(379.3)**	**(25.6)**	**(404.9)**	(347.4)	(49.2)	(396.6)
Operating profit/(loss)	6	**54.2**	**(25.6)**	**28.6**	92.1	(49.2)	42.9
Finance income	7	**0.2**	**–**	**0.2**	0.1	–	0.1
Finance cost	7	**(20.6)**	**–**	**(20.6)**	(20.3)	–	(20.3)
Profit/(loss) before taxation		**33.8**	**(25.6)**	**8.2**	71.9	(49.2)	22.7
Taxation	10	**(6.3)**	**9.4**	**3.1**	(14.0)	8.1	(5.9)
Profit/(loss) for the year		**27.5**	**(16.2)**	**11.3**	57.9	(41.1)	16.8
Profit/(loss) for the year attributable to owners of the Parent		**27.5**	**(16.2)**	**11.3**	57.9	(41.1)	16.8
Earnings per share (in pence per share)							
– basic	11	**6.9**	**(4.1)**	**2.8**	14.4	(10.2)	4.2
– diluted	11	**6.8**	**(4.0)**	**2.8**	14.4	(10.2)	4.2

The notes on pages 127 to 151 form an integral part of these financial statements.

Consolidated statement of comprehensive income

For the year ended 31 December 2018

(£ million)	2018	2017
Profit for the year	**11.3**	16.8
Items that may be reclassified to profit or loss in subsequent periods		
Net loss on cash flow hedges	**(0.5)**	–
Other comprehensive loss for the year	**(0.5)**	–
Total comprehensive income for the year attributable to owners of the Parent	**10.8**	16.8

The notes on pages 127 to 151 form an integral part of these financial statements.

Consolidated statement of changes in equity

For the year ended 31 December 2018

(£ million)	Notes	Share capital	Share premium	Capital reserves (note 19)	EBT share reserves (note 19)	Hedging reserve (note 19)	Retained earnings	Total equity
As at 1 January 2017		4.0	826.9	376.1	(2.2)	–	(169.5)	1,035.3
Profit for the year		–	–	–	–	–	16.8	16.8
Dividend paid	24	–	–	–	–	–	(15.2)	(15.2)
Share-based payments	25	–	–	–	–	–	1.0	1.0
Utilisation of EBT shares for 2014 LTIP Awards	19	–	–	–	1.3	–	(1.3)	–
As at 1 January 2018 as previously reported		**4.0**	**826.9**	**376.1**	**(0.9)**	**–**	**(168.2)**	**1,037.9**
Charge arising from adoption of IFRS 9	16	–	–	–	–	–	**(6.4)**	**(6.4)**
As at 1 January 2018 as restated		**4.0**	**826.9**	**376.1**	**(0.9)**	**–**	**(174.6)**	**1,031.5**
Profit for the year		**–**	**–**	**–**	**–**	**–**	**11.3**	**11.3**
Other comprehensive loss for the year		**–**	**–**	**–**	**–**	**(0.5)**	**–**	**(0.5)**
Total comprehensive income						**(0.5)**	**11.3**	**10.8**
Dividend paid	24	**–**	**–**	**–**	**–**	**–**	**(15.2)**	**(15.2)**
Share-based payments	25	**–**	**–**	**–**	**–**	**–**	**0.5**	**0.5**
Utilisation of EBT shares for 2014 DBP Awards	19	**–**	**–**	**–**	**0.1**	**–**	**(0.1)**	**–**
Balance at 31 December 2018		**4.0**	**826.9**	**376.1**	**(0.8)**	**(0.5)**	**(178.1)**	**1,027.6**

The notes on pages 127 to 151 form an integral part of these financial statements.

Consolidated balance sheet

As at 31 December 2018

(£ million)	Note	2018	2017
ASSETS			
Non-current assets			
Property, plant and equipment	12	**1,019.2**	1,036.9
Intangible assets	13	**517.8**	517.8
		1,537.0	1,554.7
Current assets			
Inventories	15	**29.4**	30.1
Trade and other receivables	16	**94.2**	104.5
Income tax receivable		**2.0**	–
Cash and cash equivalents	17	**47.7**	39.2
		173.3	173.8
Non-current assets held for sale	18	**2.0**	5.6
		175.3	179.4
Total assets		**1,712.3**	1,734.1
EQUITY AND LIABILITIES			
Equity			
Share capital	19	**4.0**	4.0
Share premium		**826.9**	826.9
Capital reserves	19	**376.1**	376.1
EBT share reserves		**(0.8)**	(0.9)
Hedging reserve	19	**(0.5)**	–
Retained earnings		**(178.1)**	(168.2)
Equity attributable to owners of the Parent		**1,027.6**	1,037.9
Total equity		**1,027.6**	1,037.9
Non-current liabilities			
Borrowings	20	**488.4**	492.1
Other payables	23	**2.3**	–
Deferred tax liabilities	21	**72.2**	72.6
		562.9	564.7
Current liabilities			
Provisions	22	**16.4**	17.9
Borrowings	20	**10.2**	9.9
Trade and other payables	23	**95.2**	101.5
Income tax payable		**–**	2.2
		121.8	131.5
Total liabilities		**684.7**	696.2
Total equity and liabilities		**1,712.3**	1,734.1

These Consolidated financial statements and the accompanying notes were approved for issue by the Board on 27 February 2019 and signed on its behalf by:

Justin Ash
Chief Executive Officer

Jitesh Sodha
Chief Financial Officer

The notes on pages 127 to 151 form an integral part of these financial statements.

Consolidated statement of cash flows

For the year ended 31 December 2018

(£ million)	Note	2018	2017
Cash flows from operating activities			
Profit before taxation		**8.2**	22.7
Adjustments for:			
Depreciation	12	**65.1**	57.4
Impairment of property, plant and equipment	12	**17.4**	10.3
Reversal of impairment on property, plant and equipment	12	**(1.2)**	–
Reversal of impairment on assets held for sale		**(0.5)**	–
Loss on disposal of property, plant and equipment	6	**0.1**	0.4
Finance income	7	**(0.2)**	(0.1)
Finance costs	7	**20.6**	20.3
Share-based payments	25	**0.5**	1.0
		110.0	112.0
Movements in working capital:			
Decrease in trade and other receivables		**4.0**	14.6
Decrease/(increase) in inventories		**0.7**	(2.0)
Increase in trade and other payables		**4.5**	1.3
(Decrease)/increase in provisions		**(1.5)**	1.2
Cash generated from operations		**117.7**	127.1
Tax paid		**(1.4)**	(3.1)
Net cash from operating activities		**116.3**	124.0
Cash flows from investing activities			
Interest received		**0.2**	0.1
Purchase of property, plant and equipment		**(73.7)**	(119.2)
Proceeds on disposal of property, plant and equipment		**1.4**	0.8
Proceeds on disposal of assets held for sale		**4.1**	–
Net cash used in investing activities		**(68.0)**	(118.3)
Cash flows from financing activities			
Interest paid		**(24.4)**	(18.8)
Repayment of bank borrowing		**(0.2)**	(0.4)
Dividends paid to equity holders of the Parent	24	**(15.2)**	(15.2)
Net cash used in financing activities		**(39.8)**	(34.4)
Net increase/(decrease) in cash and cash equivalents		**8.5**	(28.7)
Cash and cash equivalents at 1 January		**39.2**	67.9
Cash and cash equivalents at 31 December	17	**47.7**	39.2
Exceptional and other items (note 9)			
Exceptional and other items paid included in the cash flow		**(7.7)**	(31.3)
Total exceptional and other items	9	**(25.6)**	(49.2)

The notes on pages 127 to 151 form an integral part of these financial statements.

1. General information

Spire Healthcare Group plc (the 'Company') and its subsidiaries (collectively, the 'Group') owns and operates private hospitals and clinics in the UK and provides a range of private healthcare services.

The financial statements for the year ended 31 December 2018 were authorised for issue by the Board of Directors of the Company on 27 February 2019.

The Company is a public limited company, which is listed on the London Stock Exchange, incorporated, registered and domiciled in England and Wales (registered number: 9084066). The address of its registered office is 3 Dorset Rise, London, EC4Y 8EN.

2. Accounting policies

The principal accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

Basis of preparation

The financial statements have been prepared in accordance with International Financial Reporting Standards ('IFRS') as adopted by the European Union and on an historical cost basis. The Group financial statements are presented in UK sterling and all values are rounded to the nearest million pounds (£million), except when otherwise indicated

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Group's accounting policies. Further details on the Group's critical judgements and estimates are included in note 3

Going concern

The Group is financed by a bank loan facility that matures in July 2022. The Directors have considered the Group's forecasts and projections, and the risks associated with their delivery and are satisfied that the Group will be able to operate within the covenants imposed by the bank loan facility for at least twelve months from the date of approval of these financial statements. In relation to available cash resources, the Directors have had regard to both cash at bank and a £100 million committed undrawn revolving credit facility.

The Group has undertaken extensive activity to identify and mitigate its exposure to plausible risks which may arise from Brexit. Further information on this is provided in the Risk management and internal control section on pages 49 to 51. Based on the Directors' current assessment of the likelihood of the Brexit risks arising together with their assessment of the planned mitigating actions being successful, the Directors have concluded it is appropriate to prepare the accounts on a going concern basis.

Revenue recognition

The Group derives its revenue primarily from providing private healthcare services to both the public sector and private patients in the UK. Revenue from charges to patients is recognised when the treatment is provided.

Revenue from Contracts with Customers

IFRS 15 'Revenue from Contracts with Customers' was effective for annual periods beginning on or after 1 January 2018 with early adoption permitted. The standard (endorsed on 22 September 2016) establishes a five-step principle-based approach for revenue recognition and is based on the concept of recognising an amount that reflects the consideration for performance obligations only when they are satisfied and the control of goods or services is transferred. The criteria for revenue recognition are as follows: identify the contract with the customer, identify the performance obligation, determine the transaction price, allocate the transaction price to the performance obligations, and satisfying the performance obligation. It applies to all contracts with customers, except those in the scope of other standards.

Revenue is recorded as services are transferred to the patient, with the consideration based on the total amount the group expects to receive, taking account of discounts where they are quantifiable and probable. The criteria for revenue recognition are also satisfied as services are transferred to the patient over time.

Approximately 70% of the Group's revenue is derived from in-patient and daycase admissions. Revenue is recognised day by day, as services are provided to patients. These services are typically provided over a short time frame, that is, one to three days. Outpatient cases and other revenue represent approximately 30% of the Group's revenue. Outpatient cases generally do not involve surgical procedures and revenue is recognised on an individual component basis when performance obligations are satisfied. Similarly, other revenue, which includes consultant revenue and other third-party revenue streams, is recognised when performance obligations are satisfied and the control of goods or services is transferred. The previous revenue recognise policy was in line with the requirements of IFRS 15 five step.

The Group reports disaggregated revenue by material revenue stream (i.e. type of payor: PMI, NHS, Self-pay and Partnerships) and other revenue which includes consultant revenue, third party revenue streams (e.g. pathology services) and 'commissioning for quality and innovation payments' (CQUIN). Material revenue streams are consistent in nature, being the consideration received in return for the provision of healthcare services to patients. The timing and uncertainty of cash flows is similar for PMI and NHS business while Self-pay revenue is received in advance or collected by credit card shortly after treatment. In addition, Spire reports revenue split between In-patient/Daycase, Outpatient and Other. As noted above, in all cases, revenue is recognised as performance obligations are completed in the form of services being provided to patients. Unbilled revenue is accrued at period ends. Invoices for the combination of services provided to patients are generally produced within three days of discharge.

Interest income

Interest is recognised on an effective interest rate basis.

2. Accounting policies continued

Cost of sales
Cost of sales principally comprises salaries of clinical staff, consultant and clinical fees, medical services and inventories, including drugs, consumables and prostheses.

Other operating costs
Other operating costs mainly comprise non-clinical staff costs, rent associated with properties leased under operating leases, depreciation, maintenance and running costs of properties and equipment. It also includes administrative expenses, including the provision of central support services, IT and other administrative costs.

Operating profit
Operating profit is the profit arising from the normal, recurring operations of the business and after charging exceptional and other items, as defined below.

Operating profit is adjusted to exclude exceptional and other items to calculate the Key Performance Indicator 'Operating profit before exceptional and other items'.

Exceptional and other items
Exceptional items are those items which, by virtue of their nature, size or incidence, either individually or in aggregate, need to be disclosed separately to allow a full understanding of the underlying performance of the Group. Items which may be considered exceptional in nature include significant write-downs of goodwill and other assets, restructuring costs relating to strategy review, impairments, hospital closures and set-up costs, business acquisition costs, non-routine medical malpractice provision, aborted project costs and executive medical leave and non-routine death in service.

Other items are those items which the directors believe are relevant to the understanding of the results for the year and which are excluded from the adjusted measures, where the directors considered necessary to do so due to their nature or amount, to provide further understanding of the Group's financial performance and comparability between reporting periods. Other items include compliance set up costs and deferred tax adjustments in relation to revised property carrying values.

Cash and cash equivalents
Cash and cash equivalents comprise cash balances and call deposits. Bank overdrafts that are repayable on demand and form an integral part of the Group's cash management are included as a component of cash and cash equivalents for the purpose only of the statement of cash flows. There are no bank overdrafts in either year presented.

Taxation including deferred taxation
Total income tax on the result for the year comprises current and deferred tax. Income tax is recognised in the income statement except to the extent that it relates to items recognised directly in equity and other comprehensive income, in which case it is recognised directly in equity and other comprehensive income.

Current tax is the expected tax payable on the taxable result for the year, using tax rates enacted, or substantively enacted, at the balance sheet date, and any adjustments to tax payable in respect of previous years.

Deferred tax is provided on all temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes, except for:
- goodwill not deductible for tax purposes;
- the initial recognition of an asset or liability in a transaction that is not a business combination and which, at the time of the transaction, affects neither the accounting profit nor the taxable profit or loss; and
- investments in subsidiary companies where the timing of the reversal of the temporary difference is controlled by the Group and it is probable that the temporary difference will not reverse in the foreseeable future.

The amount of deferred tax recognised is based on the expected manner of realisation or settlement of the carrying amounts of assets and liabilities, using tax rates enacted, or substantively enacted, at the balance sheet date. A deferred tax asset is only recognised to the extent that it is probable that future taxable profits will be available against which the asset can be used.

Property, plant and equipment
Property, plant and equipment is stated at cost less accumulated depreciation. Major projects are treated as assets in the course of construction until completed when they are transferred to the appropriate asset class.

No depreciation is charged on freehold land or assets in the course of construction. Other assets are depreciated so as to write off the carrying amounts of the assets, less their estimated residual values, over their expected useful lives, as follows:

Freehold buildings and improvements	– 5 to 50 years
Leasehold buildings and improvements	– lower of unexpired lease term or expected life, with a maximum of 35 years
Plant and machinery	– 5 to 10 years
Fixtures, fittings and equipment	– 3 to 10 years

The expected useful lives and residual values of property, plant and equipment are reviewed annually and revised as appropriate. The review of the asset lives and residual values of properties takes into consideration the plans of the business and levels of expenditure incurred on an ongoing basis to maintain the properties in a fit and proper state for their ongoing use as hospitals. In the case of major facilities opening in new locations, the rate of depreciation is modified to reflect that the site is not always fully operational from the official opening date.

2. Accounting policies continued

Consolidation

The results of all subsidiary undertakings are included in the Consolidated financial statements. Assets, liabilities, income and expenses of a subsidiary acquired or disposed of during the year are included in the Consolidated financial statements from the date the Group gains control until the date the Group ceases to control the subsidiary.

Control is achieved when the Group is exposed, or has rights, to variable returns from its involvement with the investee and has the ability to affect those returns through its power over the investee. Specifically, the Group controls an investee if, and only if, the Group has:

- power over the investee (i.e., existing rights that give it the current ability to direct the relevant activities of the investee);
- exposure, or rights, to variable returns from its involvement with the investee; and
- the ability to use its power over the investee to affect its returns.

The Employee Benefit Trust (EBT) is treated as an extension of the Group and the Company.

Business combinations

Business combinations are accounted for using the acquisition method. The cost of an acquisition is measured as the aggregate of the consideration transferred measured at acquisition date fair value and the amount of any non-controlling interests in the acquiree. For each business combination, the Group elects whether to measure the non-controlling interests in the acquiree at fair value or at the proportionate share of the acquiree's identifiable net assets. Acquisition-related costs are expensed as incurred and included in other operating costs.

When the Group acquires a business, it assesses the financial assets and liabilities assumed for appropriate classification and designation in accordance with the contractual terms, economic circumstances and pertinent conditions as at the acquisition date.

Goodwill

Goodwill represents the excess of the cost of acquisition over the fair value of the assets, liabilities and contingent liabilities of acquired businesses at the date of acquisition. Goodwill is stated at cost less accumulated impairment losses.

Goodwill is allocated to one cash-generating unit and is not amortised but is tested annually for impairment, or more frequently if there is an indication that the value of the goodwill may be impaired.

Financial Instruments

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

i) Financial assets other than derivatives

Initial recognition and measurement

Financial assets within the scope of IFRS 9, are classified as financial assets at fair value through profit or loss, amortised cost or fair value through other comprehensive income.

The classification of financial assets at initial recognition depends on the financial asset's contractual cash flow characteristics and the Group's business model for managing them. With the exception of trade receivables that do not contain a significant financing component or for which the Group has applied the practical expedient, the Group initially measures a financial asset at its fair value plus, in the case of a financial asset not at fair value through profit or loss, transaction costs. Trade receivables that do not contain a significant financing component or for which the Group has applied the practical expedient are measured at the transaction price determined under IFRS 15.

In order for a financial asset to be classified and measured at amortised cost or fair value through OCI, it needs to give rise to cash flows that are 'solely payments of principal and interest (SPPI)' on the principal amount outstanding. This assessment is referred to as the SPPI test and is performed at an instrument level.

The Group's business model for managing financial assets refers to how it manages its financial assets in order to generate cash flows. The business model determines whether cash flows will result from collecting contractual cash flows, selling the financial assets, or both.

The Company's financial assets include cash and short-term deposits and trade and other receivables.

Subsequent measurement

Trade receivables are accounted for at amortised cost. The Group applies the IFRS 9 simplified approach to measuring expected credit losses, which uses a lifetime expected loss allowance for all trade receivables. Where there is a specific indicator of impairment, the Group makes an estimate of the asset's recoverable amount. Losses arising from impairment are recognised in the Consolidated Income Statement in Other operating costs.

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. On initial recognition, loans and receivables are measured at fair value plus directly attributable transaction costs. Subsequently, such assets are measured at amortised cost, using the effective interest rate ('EIR') method, less any allowance for impairment.

Amortised cost is calculated by taking into account any discount or premium on acquisition and fees or costs that are an integral part of the EIR. The EIR amortisation is included in interest receivable in the Consolidated Income Statement.

Derecognition

A financial asset is derecognised when the rights to receive cash flows from the asset have expired, or the Group has transferred its rights to receive cash flows from the asset including transferring substantially all the risks and rewards of the asset.

2. Accounting policies continued

Impairment

The Group recognises an allowance for expected credit losses (ECLs) for all debt instruments not held at fair value through profit or loss. ECLs are based on the difference between the contractual cash flows due in accordance with the contract and all the cash flows that the Group expects to receive, discounted at an approximation of the original effective interest rate. The expected cash flows will include cash flows from the sale of collateral held or other credit enhancements that are integral to the contractual terms.

ECLs are recognised in two stages. For credit exposures for which there has not been a significant increase in credit risk since initial recognition, ECLs are provided for credit losses that result from default events that are possible within the next 12-months (a 12-month ECL). For those credit exposures for which there has been a significant increase in credit risk since initial recognition, a loss allowance is required for credit losses expected over the remaining life of the exposure, irrespective of the timing of the default (a lifetime ECL).

For trade receivables and contract assets, the Group applies a simplified approach in calculating ECLs. Therefore, the Group does not track changes in credit risk, but instead recognises a loss allowance based on lifetime ECLs at each reporting date. The Group has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the receivables and the economic environment. To measure the expected credit losses, trade receivables have been grouped based on shared characteristics and the days past due. The group has concluded that the expected loss rates for trade receivables, are a reasonable approximation of the loss rates for each ageing bucket based on historical debt trends of our portfolio of customers for the last two reporting periods.

ii) Financial liabilities other than derivatives

Financial liabilities within the scope of IFRS 9 are classified as financial liabilities at fair value through profit or loss, or at amortised cost. The Company determines the classification of financial liabilities at initial recognition.

Initial recognition and measurement

All financial liabilities are recognised initially at fair value and in the case of loans and borrowings, net of directly attributable transaction costs.

The Group's financial liabilities include trade and other payables, loans and borrowings, and derivative financial instruments.

Subsequent measurement

After initial recognition, interest bearing loans and borrowings are subsequently measured at amortised cost using the effective interest rate ('EIR') method. Gains and losses arising on the repurchase, settlement or otherwise cancellation of liabilities are recognised respectively in interest receivable and interest payable in the profit or loss. Amortised cost is calculated by taking in to account any discount or premium on acquisition and fees or costs that are an integral part of the EIR. The EIR amortisation is included as finance costs in the statement of profit or loss.

Derecognition

A financial liability is derecognised when the obligation under the liability is discharged or cancelled or expires. When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified, such an exchange or modification is treated as the derecognition of the original liability and the recognition of a new liability. The difference in the respective carrying amounts is recognised in the statement of profit or loss.

iii) Derivative financial instruments

The Group may enter into derivative financial instrument arrangements to manage its exposure to interest rate risk. Derivatives are initially recognised at fair value on the date on which a derivative contract is entered in to and subsequently remeasured at fair value at each balance sheet date. Derivatives are carried as financial assets when the fair value is positive and as financial liabilities when the fair value is negative.

The Group applies cash flow hedge accounting to such derivatives if the criteria for doing so are met. At the inception of a hedge relationship, the Group formally designates and documents the hedge relationship to which it wishes to apply hedge accounting and the risk management objective and strategy for undertaking the hedge.

The effective portion of the changes in the fair value of derivatives that are designated and qualify as cash flow hedges is recognised in other comprehensive income. The gain or loss relating to the ineffective portion is recognised immediately in the income statement. The cash flow hedge reserve is adjusted to the lower of the cumulative gain or loss on the hedging instrument and the cumulative change in fair value of the hedged item.

Amounts deferred in equity are recycled in the income statement in the periods when the hedged item is recognised, in the same line of the income statement as the recognised hedged item. If cash flow hedge accounting is discontinued, the amount that has been accumulated in OCI is maintained if the hedged future cash flows are still expected to occur. Otherwise, the amount is immediately reclassified to profit or loss as a reclassification adjustment.

iv) Offsetting of financial instruments

Financial assets and financial liabilities are offset and the net amount reported in the Balance Sheet if, and only if, there is a currently enforceable legal right to offset the recognised amounts and there is an intention to settle on a net basis, or to realise the assets and settle the liabilities simultaneously.

Inventories

Inventories are stated at the lower of cost and net realisable value. Cost means purchase price, less trade discounts, calculated on an average basis. Net realisable value means estimated selling price, less trade discounts, and less all costs to be incurred in marketing, selling and distribution.

The Group holds consignment stock on sale or return. The Group is only required to pay for the equipment it chooses to use and therefore this stock is not recognised as an asset.

2. Accounting policies continued

Interest-bearing borrowings
Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost on an effective interest basis.

Borrowing costs
Borrowing costs that are directly attributable to the acquisition and construction of qualifying assets, which are assets that necessarily take a substantial period of time to get ready for their intended use or sale, are added to the cost of those assets, until such time as the assets are substantially ready for their intended use or sale.

All other borrowing costs are recognised as an expense in the period in which they are incurred.

Provisions
A provision is recognised in the balance sheet when the Group has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected, risk-adjusted, future cash flows at a pre-tax risk-free rate. Provisions are measured gross of any expected insurance recovery. Any such insurance recoveries are recognised in other receivables when the receipt of them is judged sufficiently probable.

Leases
The determination of whether an arrangement is, or contains, a lease is based on the substance of the arrangements at the inception date: whether fulfilment of the arrangement is dependent on the use of a specific asset or assets or the arrangement conveys a right to use the asset.

Leasing arrangements which transfer to the Group substantially all the risks and rewards of ownership of an asset are treated as if the asset had been purchased outright. The assets are included in tangible assets and depreciated over their estimated economic lives or over the term of the lease, whichever is the shorter.

The capital element of the leasing commitments is included in liabilities as obligations under finance leases. The lease rentals are treated as consisting of capital and interest elements. The capital element is applied to reduce the outstanding obligation and the interest element is charged to the income statement in proportion to the capital element outstanding.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

Sale and leaseback of properties
In circumstances where the Group sells a property to a third party and then enters into an agreement with the buyer to lease the asset back under an operating lease (a 'sale and leaseback transaction'), the asset is shown as disposed from property, plant and equipment. If the sale is at fair value, the profit or loss on disposal is recognised immediately in the income statement. If the sale price is below fair value, the profit or loss on disposal is also recognised immediately, except if a loss is compensated for by future rentals being below a market price, in which case the loss is amortised over the life of the lease. If the sale price is above fair value, the excess over fair value is deferred and amortised over the period of the lease.

Share capital
Ordinary shares are classified as equity. Incremental costs directly attributable to the issue of new shares are deducted from share premium. Where the employee benefit trust purchases the Company's equity share capital, the consideration paid, including any directly attributable incremental costs, is deducted from equity attributable to the Company's equity holders in both the Company and the Consolidated balance sheet until the shares are cancelled or reissued.

Dividend distribution
Dividend distribution to the Company's shareholders is recognised as a liability in the Group's financial statements in the period in which the dividend is approved by the Company's shareholders. Interim dividends are recognised when paid.

Pensions
The Group operates the Spire Healthcare Pension Plan, a defined contribution scheme. The assets of the scheme are held separately from those of the Group in independently administered funds.

Obligations for contributions to defined contribution pension schemes are recognised as an expense in the income statement as incurred.

Other employee benefits
Short-term employee benefit obligations are measured on an undiscounted basis and are expensed as the related service is provided. A provision is recognised for the amount expected to be paid under short-term cash bonuses if the Group has a present legal or constructive obligation to pay this amount as a result of past service provided by the employee and the obligation can be estimated reliably.

Share-based payments
The Group operates a number of equity-settled share-based payment schemes under which the Group receives services from employees as consideration for equity instruments (options) of the Group. The fair value of the employee services received in exchange for the grant of the options is recognised as an expense. Where the share awards have non-market related performance criteria, the Group has used the Black Scholes valuation model to establish the relevant fair values. Where the share awards have total shareholder return ('TSR') market-related performance criteria, the Group has used the Monte Carlo simulation valuation model to establish the relevant fair values (see note 25). The resulting fair values are recognised in the income statement over the vesting period of the options.

At the end of each year, the Group revises its estimates of the number of options that are expected to vest based on the non-market conditions and recognises the impact of the revision to original estimates, if any, in the income statement, with a corresponding adjustment to equity.

2. Accounting policies continued

Non-current assets held for sale

Non-current assets and disposal groups are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met only when the sale is highly probable and the asset (or disposal group) is available for immediate sale in its present condition. Management must be committed to the sale, which should be expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets (and disposal groups) classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Changes in accounting policy

New standards, interpretations and amendments applied

The following amendments to existing standards were effective for the Group from 1 January 2018, but either they were not applicable to or did not have a material impact on the Group:

- Amendments to IFRS 9 'Financial Instruments' with IFRS 4 'Insurance Contracts';
- Annual Improvements to IFRS Standards 2014–2016 Cycle (Amendments to IFRS 1 and IAS 28;
- Amendments to IAS 40: Transfers of Investment Property; and
- The Group applied IFRS 15 and IFRS 9 for the first time. The nature and effect of the changes as a result of adoption of these new accounting standards are described below.

IFRS 15 Revenue from Contracts with Customers

IFRS 15 'Revenue from Contracts with Customers' was effective for annual periods beginning on or after 1 January 2018 with early adoption permitted. The standard (endorsed on 22 September 2016) establishes a five-step principle-based approach for revenue recognition and is based on the concept of recognising an amount that reflects the consideration for performance obligations only when they are satisfied and the control of goods or services is transferred. It applies to all contracts with customers, except those in the scope of other standards. It replaces the separate models for goods, services and construction contracts under the current accounting standards.

Impact of adoption

The Group is in the business of providing healthcare services. During 2017, the Group completed an impact assessment of IFRS 15 and concluded that the adoption of IFRS 15 will have an insignificant impact on its consolidated results. As such, the Group has adopted IFRS 15 with effect from 1 January 2018 using the Modified Retrospective approach.

IFRS 9 Financial Instruments

IFRS 9 replaces IAS 39 Financial Instruments: Recognition and Measurement bringing all three aspects of the accounting together for financial instruments: classification and measurements; impairment; and hedge accounting. With the exception of hedge accounting, which the Group applied prospectively, the Group has applied IFRS 9 retrospectively, with the initial application date of 1 January 2018.

Impact of adoption

The loss allowance for trade receivables as at 31 December 2017 reconciled to the opening loss allowances on 1 January 2018 as follows:

	(£ million)
At 31 December 2017 – calculated under IAS 39	**3.9**
Amounts restated through opening retained earnings	**6.4**
Opening loss allowance at 1 January 2018 – calculated under IFRS 9	**10.3**

The group applies the IFRS 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for all trade receivables.

To measure the expected credit losses, trade receivables have been grouped based on shared characteristics and the days past due. The group has concluded that the expected loss rates for trade receivables, are a reasonable approximation of the loss rates for each ageing bucket based on historical debt trends of our portfolio of customers for the last two reporting periods.

Trade and other receivables are held to collect contractual cash flows, classified under the 'hold to collect' business model and measured at amortised cost. Under IAS39, trade and other receivables were classified as 'loans and receivables' and also measured at amortised cost. Contractual cash flows represent 'solely payments of principal and interest' (Trade and other receivables are not interest bearing).

Unbilled receivables, other receivables and cash and cash equivalents were assessed for expected credit loss, with the risk immaterial due to the nature of the financial assets under assessment. No ECL provision was recorded as a result of this assessment:

- There was no material accounting impact to the financial liabilities as a result of adopting IFRS 9; and
- There were no designated hedging relationships as at 1 January 2018 that required assessment under IFRS 9.

New standards, interpretations and amendments not applied

As at date of approval of the Group financial statements, the following new and amended standards, interpretations and amendments in issue are applicable to the Group but not yet effective and thus, have not been applied by the Group:

	Effective date*
Annual Improvements 2015–2017 Cycle	1 January 2019
IFRS 16 *Leases*	1 January 2019

* The effective dates stated above are those given in the original IASB/IFRIC standards and interpretations. As the Group prepares its financial statements in accordance with IFRS as adopted by the European Union (EU), the application of new standards and interpretations will be subject to their having been endorsed for use in the EU via the EU Endorsement mechanism. In the majority of cases this will result in an effective date consistent with that given in the original standard or interpretation but the need for endorsement restricts the Group's discretion to early adopt standards.

2. Accounting policies continued

The Directors do not expect the adoption of these standards, interpretations and amendments to have a material impact on the Consolidated or Parent Company financial statements in the period of initial application, except for IFRS 16 Leases. The Group's assessment of the impact of applying IFRS 16 is discussed below.

IFRS 16 Leases

The Group will adopt IFRS 16 on a fully retrospective basis on 1 January 2019 therefore prior year financial information will be restated to reflect the impact of the new accounting standard.

IFRS 16 introduces a single, on-balance sheet lease accounting model for lessees. A lessee recognises a right-of-use asset representing its right to use the underlying asset and a lease liability representing its obligation to make lease payments. There are recognition exemptions for short-term leases and leases of low-value items. The operating lease cost which the Group currently incurs will be replaced by a depreciation charge on the right-of-use asset (over the term of the lease) as well as an interest charge on the lease liability over the same period.

The Group has completed a detailed assessment of the potential impact of adopting IFRS 16 on its Consolidated financial statements at 1 January 2019 and has concluded that IFRS 16 will have a significant impact for the Group's financial statements owing to its large portfolio of properties which were previously accounted for as operating leases. The impact arising from non-property operating leases is negligible and the Group intends to adopt the recognition exemption for short-term leases (less than 12 months) and low value assets.

The results of this exercise are summarised below:

Information on the impact of IFRS 16 has been provided below with reference to the Group results for the year ended 31 December 2018.

(£ million)	As reported 2018	IFRS 16 adoption	As restated 2018
Other operating costs – operating leases	66.1	(66.3)	(0.2)
Other operating costs – depreciation	65.1	23.8	88.9
Operating profit	28.6	42.5	71.1
Finance income	0.2	–	0.2
Finance cost	(20.6)	(56.3)	(76.9)
Profit/(loss) before taxation	8.2	(13.8)	(5.6)
Taxation – movement in deferred tax	3.1	(2.2)	0.9
Profit/(loss) after taxation	11.3	(16.0)	(4.7)

(£ million)	As reported at 1 January 2018	IFRS 16 transition	As restated at 1 January 2018	As reported at 31 December 2018	IFRS 16 adoption	As restated at 31 December 2018*
Total assets	1,734.1	557.6	2,291.7	1,712.3	1.0	2,270.9
Tax liability – deferred tax	(72.6)	45.8	(26.8)	(72.2)	(2.2)	(28.6)
Total liabilities excluding tax liability	(623.6)	(633.0)	(1,256.6)	(612.5)	(14.8)	(1,260.3)
Total equity	1,037.9	(29.6)	1,008.3	1,027.6	(16.0)	982.0

* Includes IFRS 16 adoption during 2018 and IFRS 16 transition adjustment as at 1 January 2018.

The Group expects a decrease in net assets of £29.6 million in its opening balance sheet on 1 January 2018. This comprises Right-of-Use assets of £557.6 million, Lease Liabilities of £633.0 million, a Deferred Tax asset of £45.8 million and a charge of £29.6 million to retained profits.

3. Critical accounting judgements and estimates

In the application of the Group's accounting policies, the Directors are required to make judgements and estimates 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 these estimates. The following accounting policies have been identified as involving particularly complex judgements or subjective estimates:

Judgements

Leases

In the determination of the classification of a number of leases over hospital properties as operating leases, assumptions have been made about the discount rate applied to the annual rent payable over the remainder of the lease term compared against their respective fair values and of the useful economic life of the hospitals. Further information about commitments under these leases is given in note 26.

Exceptional and other items

Judgements are required as to whether items that are material in size, unusual or infrequent in nature should be disclosed as exceptional and other items. Deciding which items meet the respective definitions requires the Group to exercise its judgement. Details of these items categorised as exceptional and other items are outlined in note 9.

3. Critical accounting judgements and estimates continued

Estimates

Goodwill

Goodwill is considered for impairment at least annually or more frequently if there is an indication that goodwill may be impaired. This is achieved by comparing the value-in-use of the goodwill with its carrying value in the accounts. The value-in-use calculations require the Group to estimate future cash flows expected to arise in the future, taking into account market conditions. The present value of these cash flows is determined using an appropriate discount rate.

The assumptions considered to be most critical in reviewing goodwill for impairment are contained in note 13.

Property impairment

Property is considered for impairment at least annually or more frequently if there is an indication that carrying amount may be impaired. This is achieved by comparing the value-in-use of the property with its carrying value in the accounts. The value-in-use calculations require the Group to estimate cash flows expected to arise in the future, taking into account market conditions. The present value of these cash flows is determined using an appropriate discount rate.

4. Auditor's remuneration

During the year, the Group (including its subsidiary undertakings) obtained the following services from the Group's external auditor as detailed below:

(£ million)	2018	2017
Audit of these financial statements	**0.4**	0.4
Audit of the financial statements of subsidiaries of the company pursuant to legislation	**0.1**	0.1
	0.5	0.5

5. Segmental reporting

In determining the Group's operating segment, management has primarily considered the financial information in internal reports that are reviewed and used by the executive management team and Board of Directors (in aggregate the chief operating decision maker) in assessing performance and in determining the allocation of resources. The financial information in those internal reports in respect of revenue and expenses has led management to conclude that the Group has a single operating segment, being the provision of healthcare services.

All revenue is attributable to and all non-current assets are located in the United Kingdom.

Revenue by wider customer (payor) group is shown below:

(£ million)	2018	2017
Insured	**432.6**	426.0
NHS	**272.2**	293.3
Self-pay	**174.1**	160.2
Partnerships[1]	**27.0**	26.6
Other[2]	**25.2**	25.6
Total	**931.1**	931.7

1 Partnerships is a new category, previously included within Other.
2 Other revenue includes fees paid to the Group by consultants (e.g. for the use of Group facilities and services) and third-party revenue (e.g. pathology services to third-parties). 2017 data has been amended to show £5.5million CQUIN revenue within the NHS category. This was previously reported within Other.

6. Operating profit

Arrived at after charging/(crediting):

(£ million)	2018	2017
Rent of land and buildings under operating leases	**66.1**	63.9
Depreciation of property, plant and equipment (see note 12)	**65.1**	57.4
Ian Paterson claims and related costs (see note 9)	**1.0**	28.7
Reversal of impairment on property, plant and equipment (see note 12)	**(1.2)**	–
Reversal of impairment on assets held for sale (see note 18)	**(0.5)**	–
Impairment of property, plant and equipment (see note 12)	**17.4**	10.3
Loss on disposal of property, plant and equipment (see note 12)	**0.1**	0.4
Staff costs (see note 8)	**298.9**	282.1

Impairment losses and reversals of impairment are included in Other operating costs.

Inventory recognised as an expense in the current period is disclosed in note 15.

7. Finance income and costs

(£ million)	2018	2017
Finance income		
Interest income on bank deposits	**0.2**	0.1
Finance costs		
Interest on bank facilities	**14.5**	11.8
IFRS 9 gain arising on facilities extension[1]	**(3.3)**	–
Interest on obligations under finance leases and hire purchase contracts	**9.4**	9.2
Financed costs capitalised in the year	**–**	(0.7)
Total finance costs	**20.6**	20.3

1 Gain of £3.3 million that was recorded at the date of the extension

Finance costs capitalised during 2017 were calculated based on a weighted cost of borrowing of 3.4%.

8. Staff costs

(No.)	2018	2017
The average number of persons employed by the Group (including directors) during the year	**11,320**	11,344
The average number of full-time equivalent persons employed by the Group during the year	**8,441**	8,381

The aggregate payroll costs of these persons were as follows:

(£ million)	2018	2017
Wages and salaries	**255.5**	242.1
Social security costs	**23.2**	21.6
Pension costs, defined contribution scheme	**20.2**	18.4
	298.9	282.1

Other pension costs are in respect of the defined contribution scheme; unpaid contributions at 31 December 2018 were £1.9 million (2017: £1.8 million).

9. Exceptional and other items

(£ million)	2018	2017
Ian Paterson claims and related costs	**1.0**	28.7
Hospital set-up and closure costs	**0.8**	3.4
Executive medical leave and death in service	**–**	0.9
Business reorganisation and corporate restructuring	**4.7**	0.6
Hospital impairment on property, plant, equipment, write offs and aborted project costs	**17.9**	14.4
Other	**(0.3)**	0.7
Total exceptional costs (see also other items)	**24.1**	48.7
Income tax credit on exceptional items	**(9.1)**	(8.0)
Total post-tax exceptional items	**15.0**	40.7

Spire is continuing to pursue legal action against its insurers to seek recoveries of the Ian Paterson settlement and related costs. This may give rise to future exceptional income being recognised in the income statement. In 2018, a further £1.0 million expense has been incurred. No account has been taken of further recoveries in the results for the year ended 31 December 2018.

Hospital set-up and closure costs mainly are mainly due to closure and decommissioning of the Windsor clinic. Business reorganisation costs include internal group reorganisation costs associated with the strategic review that commenced in Q4 2017 and a cost reduction project covering hospitals and central functions. Property impairment primarily relates to the Spire Alexandra hospital, where a charge of £12.6 million was taken in the first half of 2018. Other property impairment costs in 2018 relate to the aborted development in 2017 of a hospital site in Central London and the write off of costs associated with a potential development in Milton Keynes.

In the year ended 31 December 2017, the completion of the criminal proceedings against Ian Paterson (a consultant who previously had practising privileges at Spire Healthcare) resulted in Spire Healthcare providing £28.7 million in relation to this settlement. In the final quarter of 2017, management undertook a strategic review of its current portfolio of sites and the future development options for the Group which resulted in write-offs and aborted project costs charged as exceptional items in the year of £14.4 million.

9. Exceptional and other items continued

(£ million)	2018	2017
Other items		
Compliance set up costs	**1.5**	0.5
Total other items	**1.5**	0.5
Income tax credit on other items	**(0.3)**	(0.1)
Total post-tax other items	**1.2**	0.4

Compliance set up costs include amounts incurred in 2018 and 2017 to meet the requirements of GDPR regulations.

10. Taxation

(£ million)	2018	2017
Current tax		
UK corporation tax expense	**–**	4.5
UK corporation tax adjustment to prior years	**(2.7)**	–
Total current tax	**(2.7)**	4.5
Deferred tax		
Origination and reversal of temporary differences	**(1.9)**	1.7
Effect of change in tax rate	**(0.2)**	(0.5)
Adjustments in respect of prior years	**1.7**	0.2
Total deferred tax	**(0.4)**	1.4
Total tax expense	**(3.1)**	5.9

Corporation tax is calculated at 19.0% (2017: 19.25%) of the estimated taxable profit or loss for the year. The effective tax rate on profit before taxation for the year was (37.8)% (2017: 26.0%). Deferred tax is detailed in note 21.

The effective tax assessed for the year, all of which arises in the UK, differs from the standard weighted rate of corporation tax in the UK. The reconciliation of the actual tax charge to that at the domestic corporation tax rate is as follows:

(£ million)	2018	2017
Profit before taxation	**8.2**	22.7
Tax at the standard rate	**1.6**	4.4
Effects of:		
Expenses not deductible for tax purposes	**1.1**	0.5
Adjustments to prior year	**(1.0)**	0.2
Difference in tax rates	**(0.2)**	(0.5)
Increase from impairment of fixed assets	**0.7**	1.3
Disposal of fixed assets	**(5.3)**	–
Total tax expense	**(3.1)**	5.9

Expenses not deductible for tax purposes relate mostly to depreciation on non-qualifying fixed assets, disallowable entertaining and professional fees.

The UK Government has announced a further decrease in the future UK corporation tax rate from 18% to 17% from April 2020. This change has resulted in a deferred tax credit arising from the reduction in the balance sheet carrying value of deferred tax liabilities to reflect the anticipated rate of tax at which those liabilities are expected to reverse.

11. Earnings per share

Basic earnings per share is calculated by dividing the profit attributable to equity holders of the Company by the weighted average number of ordinary shares outstanding during the year.

	2018	2017
Profit for the year attributable to owners of the Parent (£ million)	**11.3**	16.8
Weighted average number of ordinary shares	**401,081,391**	401,081,391
Adjustment for weighted average number of shares held in EBT	**(263,342)**	(467,034)
Weighted average number of ordinary shares in issue (No.)	**400,818,049**	400,614,357
Basic earnings per share (in pence per share)	**2.8**	4.2

For dilutive earnings per share, the weighted average number of ordinary shares in issue is adjusted to include all dilutive potential ordinary shares arising from share options. Refer to the Remuneration Committee Report for the terms and conditions of instruments generating potential ordinary shares that affect the measurement of diluted EPS. There are no instruments that are antidilutive for the periods presented which have been excluded from the calculation of diluted EPS.

	2018	2017
Profit for the year attributable to owners of the Parent (£ million)	**11.3**	16.8
Weighted average number of ordinary shares in issue	**400,818,049**	400,614,357
Adjustment for weighted average number of contingently issuable shares	**1,287,910**	861,612
Diluted weighted average number of ordinary shares in issue (No.)	**402,105,959**	401,475,969
Diluted earnings per share (in pence per share)	**2.8**	4.2

The Directors believe that EPS excluding exceptional charges and other items ("Adjusted EPS") reflects the underlying performance of the business and assists in providing insights of the performance of the group.

Reconciliation of profit to profit excluding exceptional charges and other items ("Adjusted profit"):

	2018	2017
Profit for the year attributable to owners of the Parent (£ million)	**11.3**	16.8
Exceptional charges (see note 9)	**15.0**	40.7
Other items (see note 9)	**1.2**	0.4
Adjusted profit (£ million)	**27.5**	57.9
Weighted average number of Ordinary Shares in issue	**400,818,049**	400,614,357
Weighted average number of dilutive Ordinary Shares	**402,105,959**	401,475,969
Adjusted basic earnings per share (in pence per share)	**6.9**	14.4
Adjusted diluted earnings per share (in pence per share)	**6.8**	14.4

12. Property, plant and equipment

(£ million)	Freehold property	Long leasehold property	Equipment	Assets in the course of construction	Total
Cost:					
At 1 January 2017 as previously reported	686.4	176.8	308.4	114.8	1,286.4
Restatement	–	–	46.4	1.2	47.6
At 1 January 2017 as restated	686.4	176.8	354.8	116.0	1,334.0
Additions	14.0	7.8	45.9	52.2	119.9
Disposals	–	(2.5)	(15.6)	–	(18.1)
Transfers	–	133.9	28.4	(162.3)	–
Assets held for sale	(33.6)	–	–	–	(33.6)
Reclassification	187.7	(173.5)	–	5.3	19.5
At 1 January 2018	**854.5**	**142.5**	**413.5**	**11.2**	**1,421.7**
Additions	**10.8**	**11.4**	**25.2**	**17.8**	**65.2**
Disposals	**(0.8)**	**(0.1)**	**(16.2)**	**–**	**(17.1)**
Transfers	**11.7**	**2.7**	**4.0**	**(18.4)**	**–**
At 31 December 2018	**876.2**	**156.5**	**426.5**	**10.6**	**1,469.8**
Accumulated depreciation and impairment:					
At 1 January 2017 as previously reported	103.4	43.8	147.7	–	294.9
Restatement	–	–	47.6	–	47.6
At 1 January 2017 as restated	103.4	43.8	195.3	–	342.5
Charge for year	9.3	9.1	39.0	–	57.4
Disposals	–	(2.3)	(14.6)	–	(16.9)
Impairment (note 9)	6.9	–	3.4	–	10.3
Assets held for sale	(28.0)	–	–	–	(28.0)
Reclassification	37.4	(17.9)	–	–	19.5
At 1 January 2018	**129.0**	**32.7**	**223.1**	**–**	**384.8**
Charge for the year	**16.3**	**7.0**	**41.8**	**–**	**65.1**
Disposals	**(0.8)**	**(0.1)**	**(14.6)**	**–**	**(15.5)**
Impairment (note 9)	**16.2**	**1.2**	**(1.2)**	**–**	**16.2**
At 31 December 2018	**160.7**	**40.8**	**249.1**	**–**	**450.6**
Net book value:					
At 31 December 2018	**715.5**	**115.7**	**177.4**	**10.6**	**1,019.2**
At 31 December 2017	725.5	109.8	190.4	11.2	1,036.9

Assets held for sale are in relation to Spire St Saviour's and Whalley Range, Manchester Hospitals. Further details are shown in note 18. The impairment in 2018 is the result of a write down of £12.6 million in the carrying value of the Alexandra Hospital and a write off of the £3.6 million of costs associated with the potential development of a site in Milton Keynes.

No assets are subject to restrictions on title or pledged as security for liabilities.

The cost of Equipment and Assets in the course of construction as at 1 January 2017 has been restated from £308.4 million to £354.8 million and £114.8 million to £116.0 million respectively, with a corresponding increase in accumulated depreciation on Equipment of £47.6 million. There is no net impact to the overall carrying value of property, plant and equipment as at 1 January 2017. This is a result of a correction to the initial classification that was applied to the underlying assets.

The cost of Freehold properties, Long leasehold properties and Assets in the course of construction as at 31 December 2017 has been adjusted to reflect a reclassification of certain assets. This is a result of a correction to transfers relating to those assets in 2017. The cost of Freehold properties and Assets in the course of construction increased by £187.7 million and £5.3 million respectively, with a reduction in Long leasehold properties of £173.5 million, with a corresponding increase in depreciation of £19.5 million. There is no impact to the overall carrying value of property, plant and equipment as at 31 December 2017. There is no change to the income statements for any of the years presented.

12. Property, plant and equipment continued

Impairment testing

The Directors consider property impairment at least annually or more frequently if there is an indication that carrying amount may be impaired. This is achieved by comparing the value-in-use of the property with its carrying value in the accounts. The value-in-use calculations require the Group to estimate cash flows expected to arise in the future, taking into account market conditions. The present value of these cash flows is determined using an appropriate discount rate and market conditions covering the five-year period to December 2023.

Management identified a number of key assumptions relevant to the property impairment calculations, being EBITDA growth, which is impacted by an interaction of a number of elements and assumptions regarding cost inflation, capex maintenance spend and discount rates. These variables are interdependent and the forecast cash flows reflect management's expectations based on current market conditions.

In addition to the above the Directors have obtained an independent external valuation. This valuation of £1.138 billion fully supports the carrying value of the freehold property portfolio.

13. Intangible assets

(£ million)	Goodwill
Cost or valuation:	
At 1 January 2017, 31 December 2017 and 31 December 2018	518.8
Impairment:	
At 1 January 2017, 31 December 2017 and 31 December 2018	1.0
Carrying amount:	
At 31 December 2018	**517.8**
At 31 December 2017	517.8

The goodwill arising on acquisitions is reviewed annually for impairment on 31 December or when there is an event that may indicate impairment. The recoverable amount of the Group's cash-generating unit exceeds its carrying value and no impairment charge has been recognised (2017: £nil) and no event has given rise to amounts written off (2017: £nil).

The Directors do not believe that any impairment is required in the current financial year.

Impairment testing

The Directors treat the business as a single cash-generating unit for the purposes of testing goodwill for impairment. The recoverable amount of goodwill is calculated by reference to its estimated value-in-use.

In order to estimate the value-in-use, management has used trading projections covering the five-year period to December 2023.

Management identified a number of key assumptions relevant to the value-in-use calculations, being revenue growth, which is impacted by an interaction of a number of elements of the operating model, including pricing trends, volume growth and the mix and complexity of discharges, assumptions regarding cost inflation and discount rates. These variables are interdependent and the forecast cash flows reflect management's expectations based on current market trends.

A long-term growth rate of 2.25% (2017: 2.25%) has been applied to cash flows beyond 2023, which is based on historic growth rates achieved by the sector, which have typically exceeded the retail price index ('RPI'). Pre-tax discount rates were based on the capital asset pricing model, utilising a sector-specific Beta in arriving at the equity premium and cost of debt based on current bank lending rates. A specific pre-tax discount rate was calculated to reflect the profile of cash flows inherent to the cash-generating unit and this was 9.0% (2017: 9.0%).

A sensitivity analysis has been performed in order to review the impact of changes in key assumptions. For example, an increase of 1.0% in the pre-tax discount rate to 10.0%, with all other assumptions held constant, did not identify any impairments. Similarly, reducing growth by half to 1.125% in the period beyond 2023, with all other assumptions held constant, did not identify any impairment. The pre-tax discount rate would need to increase to 11%, with all other assumptions held constant, in order to reduce recoverable value equal to the carrying amount.

14. Subsidiary undertakings

As at 31 December 2018, these Consolidated financial statements of the Group comprise the Company and the following companies, most of which are incorporated in, and whose operations are conducted in, the United Kingdom. All subsidiaries are 100% owned unless otherwise indicated.

Incorporated in England and Wales and registered at 3 Dorset Rise, London, EC4Y 8EN, unless otherwise stated	Principal activity	Class of share
Classic Hospitals Group Limited	Holding company	Ordinary
Classic Hospitals Limited	Non-trading company	Ordinary
Classic Hospitals Property Limited	Property company	Ordinary
Didsbury MSK Limited°	Dormant company	Ordinary
Fox Healthcare Acquisitions Limited	Leasing company	Ordinary
Fox Healthcare Holdco 2 Limited	Holding company	Ordinary
Lifescan Limited	Non-trading company	Ordinary
Links Bidco S.à r.l. Propco 8#	Property company	Ordinary
Montefiore House Limited+	Health provision	Ordinary
SHC Holdings Limited	Holding company	Ordinary
Spire Cambridge (Disposal) Limited	Non-trading company	Ordinary
Spire Fertility (Disposal) Limited	Non-trading company	Ordinary
Spire Healthcare (Holdings) Limited	Holding company	Ordinary
Spire Healthcare Finance Limited*	Holding company	Ordinary
Spire Healthcare Group UK Limited	Holding company	Ordinary
Spire Healthcare Holdings 1&	Holding company	Ordinary
Spire Healthcare Holdings 2 Limited	Holding company	Ordinary
Spire Healthcare Holdings 3 Limited	Holding company	Ordinary
Spire Healthcare Limited	Health provision	Ordinary
Spire Healthcare Properties Limited	Hospital leasing	Ordinary
Spire Healthcare Property Developments Limited	Development company	Ordinary
Spire Property 1 Limited	Property company	Ordinary
Spire Property 4 Limited	Property company	Ordinary
Spire Property 5 Limited	Property company	Ordinary
Spire Property 6 Limited	Property company	Ordinary
Spire Property 13 Limited	Property company	Ordinary
Spire Property 16 Limited	Property company	Ordinary
Spire Property 17 Limited	Property company	Ordinary
Spire Property 18 Limited	Property company	Ordinary
Spire Property 19 Limited	Property company	Ordinary
Spire Property 23 Limited	Property company	Ordinary
Spire Thames Valley Hospital (BVI Property Holdings) Limited^	Holding company	Ordinary
Spire Thames Valley Hospital Limited	Non-trading company	Ordinary
Spire Thames Valley Hospital Propco Limited	Property company	Ordinary
Spire UK Holdco 2A Limited	Holding company	Ordinary
Spire UK Holdco 4 Limited	Holding company	Ordinary

° Ownership interest is 80.0%.
Incorporated in Luxembourg and registered at 2 Boulevard Konrad Adenauer, L-1115 Luxembourg.
+ Ownership interest is 50.1%.
* Direct shareholding of the Company.
& Spire Healthcare Holdings 1 is an undertaking with unlimited liability. The registered address of the undertaking is 3 Dorset Rise, London, EC4Y 8EN
^ Incorporated in the British Virgin Islands (BVI) and registered at Harneys Corporate and Trust Services Limited, Craigmuir Chambers, Road Town, Tortola, VG1110, BVI.

15. Inventories

(£ million)	2018	2017
Prostheses, drugs, medical and other consumables	**29.4**	30.1

Cost of sales for the year ended 31 December 2018 includes inventories recognised as an expense amounting to £182.8 million (2017: £179.0 million).

16. Trade and other receivables

(£ million)	2018	2017
Amounts falling due within one year:		
Trade receivables	**45.1**	54.2
Unbilled receivables	**14.5**	14.4
Prepayments	**28.6**	29.1
Other receivables	**10.7**	10.7
	98.9	108.4
Allowance for expected credit losses	**(4.7)**	(3.9)
Total current trade and other receivables	**94.2**	104.5

Trade receivables comprise amounts due from private medical insurers, the NHS, patients, consultants and other third parties who use the Group's facilities. Invoices to customers fall due within 60 days of the date of issue. Some of the agreements with NHS customers operate on the basis of monthly payments on account with quarterly reconciliations, which can lead to invoices being paid after their due date.

The ageing of trade receivables is shown below and shows amounts that are past due at the reporting date. A provision for expected credit losses has been recognised at the reporting date through consideration of the ageing profile of the Group's receivables and the perceived credit quality of its customers. The carrying amount of trade receivables, net of expected credit losses, is considered to be an approximation to its fair value.

The loss allowance as at 31 December 2018 was determined as follows for trade receivables:

	Current	0-30 days	31-90 days	91-364 days	1-2 years	Total
Expected loss rate	1.3%	9.3%	32.9%	67.7%	100%	
Carrying amount (£ million)	33.0	6.1	2.3	2.3	1.4	45.1
Loss allowance	0.4	0.6	0.8	1.6	1.3	4.7

Trade receivables are written off when there is no longer a reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include, amongst others, the failure of a debtor to engage in a repayment plan with the group, and failure to make contractual payments for a period of greater than 2 years past due.

From 1 January 2018, the Group assesses on a forward looking basis expected credit losses associated with its debt instruments carried at amortised cost. The impairment methodology applied for trade receivables is the simplified approach, which requires expected lifetime losses to be recognised from initial recognition of the receivables.

Trade receivables comprise the following wider customer/payor groups:

(£ million)	2018	2017
Private medical insurers	**28.0**	29.5
NHS	**5.1**	11.6
Patient debt	**1.8**	4.3
Other	**5.5**	4.9
	40.4	50.3

The movement in the allowance for impairment in respect of trade receivables during the year was as follows:

(£ million)	2018	2017
At 1 January as previously reported	**3.9**	5.0
Adoption of IFRS 9	**6.4**	–
At 1 January as restated	**10.3**	5.0
Provided in the year	**2.6**	5.0
Utilised during the year	**(8.2)**	(6.1)
At 31 December	**4.7**	3.9

16. Trade and other receivables continued

The Group adopted IFRS 9 Financial Instruments from 1 January 2018 and now applies the IFRS 9 simplified approach to measuring Expected Credit Losses (ECLs) for trade receivables. Under this standard, lifetime ECL provisions are recognised for receivables using a matrix of rates dependant on age thresholds and customer types. The ECL rates are determined with reference to historical performance of each payor age group during the last two years.

Under the previous accounting standard (IAS 39) provision was made for debts reaching 12 months after due date. The change in accounting policy resulted in an adjustment through opening retained earnings.

To develop the ECL matrix, trade receivables were grouped according to shared characteristics (Payor/payor type) and the days past due. As the majority of the Group's debt is receivable from large, well-funded insurance companies, the National Health Service or from a large number of individuals, the Group has concluded that historical debt performance of the portfolio during the last two reporting periods provides a reasonable approximation of the future expected loss rates for each payor age category. The ECL matrix is refreshed at each reporting date. Trade debtors are not modified after initial recognition. No collateral is held in respect of trade debtors. Expected credit losses are calculated on a collective basis and are not allocated to individual financial assets.

17. Cash and cash equivalents

(£ million)	2018	2017
Cash at bank	**40.5**	17.0
Short-term deposits	**7.2**	22.2
	47.7	39.2

Cash and cash equivalents comprise cash balances, short-term deposits and other short-term highly liquid investments (including money market funds) with maturities not exceeding three months placed with investment grade counterparties which are subject to an insignificant risk of change in value.

18. Non-current assets held for sale

As at December 2018, the Group's management have committed to sell one property which previously formed part of the Group operations, Spire St Saviours Hospital which closed in 2015. The property is expected to be sold within twelve months, has been classified as held for sale and is presented separately in the Consolidated balance sheet.

The proceeds of disposal are expected to exceed the net carrying amount of the relevant assets and accordingly, no impairment loss has been recognised on the classification of these operations as held for sale, however, a reversal of impairment of £0.5 million in connection with the Whalley Range Hospital has been credited to the Income Statement in the year.

(£ million.)	2018	2017
Spire St Saviours property (note 12)	**2.0**	2.0
Whalley Range property (note 12)	**–**	3.6
	2.0	5.6

19. Share capital and reserves

	2018	2017
Authorised shares		
Ordinary shares of £0.01 each	**401,081,391**	401,081,391

	£0.01 ordinary shares	
	Shares	£'000
Issued and fully paid		
At 31 December 2018	**401,081,391**	**4,010**
At 31 December 2017	401,081,391	4,010

Capital reserves
This reserve represents the loans of £376.1 million due to the former ultimate parent undertaking and management that were forgiven by those counterparties as part of the reorganisation of the Group prior to the IPO in 2014.

Hedging reserves
This reserve represents the movement of fair value on hedging transaction of £0.5 million during the year. See note 28 for further information.

EBT share reserves
Equiniti Trust (Jersey) Limited is acting in its capacity as trustee of the Company's Employee Benefit Trust ('EBT'). The purpose of the EBT is to further the interests of the Company by benefiting employees and former employees of the Group and certain of their dependants. The EBT is treated as an extension of the Group and the Company.

During 2018, the EBT purchased no shares (2017: nil shares acquired).

19. Share capital and reserves continued

Where the EBT purchases the Company's equity share capital the consideration paid, including any directly attributable incremental costs, is deducted from equity attributable to the Company's equity holders until the shares are cancelled or reissued. As at 31 December 2018, 252,652 shares (2017: 281,631) were held by the EBT in relation to the Directors' share bonus award and long-term incentive plan.

(number of shares)	2018	2017
At 1 January	**281,631**	670,559
Exercised – 2014 LTIP	**–**	(254,589)
Exercised – 2016 & 2017 LTIP	**–**	(134,339)
Exercised – 2014 DBP	**(28,979)**	–
At 31 December	**252,652**	281,631

At 1 January 2018, the EBT held 281,631 shares. In April 2018, 10,922 shares were exercised in relation to the 2014 Deferred Bonus Plan ('DBP') and in June 2018, a further 18,057 shares were exercised in relation to the 2014 DBP. There were no new purchases of shares and at 31 December 2018 the EBT held 252,652 shares.

At 1 January 2017, the EBT held 670,559 shares. In March 2017, 228,100 shares were exercised in relation to the 2014 Long Term Incentive Plan ('LTIP') and in April 2017, a further 26,489 shares were exercised in relation to the 2014 LTIP. In December 2017, 134,339 shares were exercised in relation to the 2016 and 2017 LTIP which were awarded as part of the death in service package for Andrew White. There were no new purchases of shares and at 31 December 2017 the EBT held 281,631 shares.

The EBT share reserve represents the consideration paid when the EBT purchases the Company's equity share capital, until the shares are reissued.

20. Loans and borrowings

(£ million)	2018	2017
Secured borrowings		
Bank loans[1]	**420.4**	425.1
Obligations under finance leases	**77.7**	76.9
	498.1	502.0
Interest rate swaps	**0.5**	–
	498.6	502.0

1 In July 2018, the Group extended the maturity of its bank loan facility for a further three years and recorded this as a non-substantial loan modification not resulting in de-recognition. A modification gain of £3.3 million was recorded at date of extension, which in turn decreased the carrying amount of the loan held.

The bank loans and finance leases are secured on fixed and floating charges over both the present and future assets of material subsidiaries of the Group.

(£ million)	2018	2017
Total borrowings (measured at amortised cost) and interest rate swaps		
Amount due for settlement within 12 months	**10.2**	9.9
Amount due for settlement after 12 months	**488.4**	492.1
	498.6	502.0

Obligations under finance leases

The Group has finance leases in respect of three hospital properties and medical equipment. Future minimum lease payments under finance leases are as follows:

	2018		2017	
(£ million)	**Minimum payments**	**Present value of payments**	Minimum payments	Present value of payments
Within one year	**8.7**	**5.5**	8.7	6.2
After one year but not more than five years	**37.7**	**17.6**	36.6	19.2
More than five years	**210.5**	**54.6**	220.3	51.5
Total minimum lease payments	**256.9**	**77.7**	265.6	76.9
Less amounts representing finance charges	**(179.2)**	**–**	(188.7)	–
Present value of minimum lease payments	**77.7**	**77.7**	76.9	76.9

Property leases, with a present value liability of £77.7 million (2017: £76.9 million), expire in 2040 and carry an implicit interest rate of 12.9% (2017: 12.9%). Rent is reviewed annually with reference to RPI, subject to a floor of 3.0% and a cap at 5.0%.

20. Loans and borrowings continued

Terms and debt repayment schedule

The maturity date is the date on which the relevant bank loans are due to be fully repaid.

The carrying amounts drawn (after issue costs and including interest accrued) under facilities in place at the balance sheet date were as follows:

(£ million)	Maturity	Margin over LIBOR	2018	2017
Senior finance facility[1]	July 2022	2.25%	**423.8**	425.1
Revolving credit facility (undrawn committed facility)	July 2022		**100.0**	100.0

1 The difference between the accounting carrying value and the debt repayment schedule is attributable to the modification gain on the loan extension.

On 23 July 2014, the Group was refinanced, and it entered into a bank loan facility with a syndicate of banks, comprising a five-year, £425.0 million term loan and a five-year £100.0 million revolving facility. The loan is non-amortising and carries interest at a margin of 2.25% over LIBOR (2017: 2.00% over LIBOR). In July 2018, the Group extended the maturity of its bank loan facility for a further three years.

Changes in liabilities arising from financing activities

(£ million)	1 January	Cash flows	Non cash changes	Loan modification	31 December
2018					
Bank loans	**425.1**	**(15.2)**	**13.8**	**(3.3)**	**420.4**
Lease liabilities	**76.9**	**(9.4)**	**10.2**	**–**	**77.7**
Total	**502.0**	**(24.6)**	**24.0**	**(3.3)**	**498.1**

Aside from accrued interest there were no non-cash movements in 2017.

Reconciliation of net change in cash and cash equivalents to net debt

(£ million)	2018	2017
Bank loans	**425.1**	424.1
Obligations under finance leases	**76.9**	76.1
	502.0	500.2
Cash at bank	**(17.0)**	(53.9)
Short-term deposits	**(22.2)**	(14.0)
Net debt at 1 January	**462.8**	432.3
Net (increase)/decrease in cash and cash equivalents	**(8.5)**	28.7
Loans movement	**(1.3)**	1.0
Movement in obligations under finance leases	**0.8**	0.8
	(9.0)	30.5
Net debt at 31 December	**453.8**	462.8

Loans movement excludes the gain of £3.3 million that was recorded at the date of the extension.

21. Deferred tax

	Property, plant and equipment	Share-based payments	Losses	Provisions and other temporary differences	Total
At 1 January 2017	81.4	(0.3)	(8.5)	(1.4)	71.2
Charge/(credit) to the profit or loss	(5.5)	0.1	7.1	0.2	1.9
Change in tax rates	(0.5)	–	–	–	(0.5)
At 1 January 2018	**75.4**	**(0.2)**	**(1.4)**	**(1.2)**	**72.6**
Charge/(credit) to the profit or loss	**(0.4)**	**0.1**	**–**	**0.1**	**(0.2)**
Change in tax rates	**(0.2)**	**–**	**–**	**–**	**(0.2)**
At 31 December 2018	**74.8**	**(0.1)**	**(1.4)**	**(1.1)**	**72.2**
Disclosed within liabilities	**74.8**	**(0.1)**	**(1.4)**	**(1.1)**	**72.2**

Deferred tax on property, plant and equipment has arisen on differences between the carrying value of the relevant assets and the tax base. The losses relate entirely to non-trade losses.

21. Deferred tax continued

Deferred tax assets and liabilities are measured at the tax rates that are expected to apply in the period when the asset is realised or the liability settled, based on tax rates that have been enacted, or substantively enacted, at the balance sheet date. The Finance Act 2016, which included a further reduction in the UK corporate tax rate from 18.0% to 17.0% on 1 April 2020, has been enacted and so deferred tax assets and liabilities have been calculated at this rate unless the temporary difference is expected to reverse sooner than 1 April 2020 in which case the applicable rate of 18.00% to 19.25% has been used.

The Group has unrecognised deferred tax assets as at 31 December 2018 as follows:

(£ million)	2018	2017
Trading losses	**1.1**	0.9
Capital losses	**0.1**	0.1
Tax basis for future capital disposals	**18.6**	17.9
	19.8	18.9

These amounts are the expected tax value of the gross temporary difference at the enacted long-term tax rate of 17% (2017: 17%). A deferred tax asset has not been recognised in respect of these amounts due to uncertainties as to the timing of future profits that the trading losses could be offset against and whether capital gains will arise against which the capital losses and tax basis for capital disposals could be utilised.

22. Provisions

(£ million)	Medical malpractice	Business restructuring and other	Total
At 1 January 2018	**16.8**	**1.1**	**17.9**
Increase in existing provisions	**6.0**	**2.4**	**8.4**
Provisions utilised	**(6.8)**	**(1.3)**	**(8.1)**
Provisions released	**(1.3)**	**(0.5)**	**(1.8)**
At 31 December 2018	**14.7**	**1.7**	**16.4**

Medical malpractice relates to estimated liabilities arising from claims for damages in respect of services previously supplied to patients including commitments in respect of the removal or replacement of the PIP brand of breast implants. Amounts are shown gross of insured liabilities. Any such insurance recoveries are recognised in other receivables.

Following the completion of the criminal proceedings against Ian Paterson, a consultant who previously had practising privileges at Spire Healthcare, management agreed settlement with all current and known civil claimants (and the other co-defendants) and have made a provision for the expected remaining costs (see note 9). The provision in relation to Ian Paterson costs have been determined before account is taken of any potential further recoveries from insurers

Business restructuring and other includes staff restructuring costs, the cost of decommissioning two facilities and costs associated with the resolution of a customer contract

The provisions are shown gross of any expected reimbursement from insurers of the related risks. The reimbursement is recognised as a separate receivable when receipt of it is judged sufficiently probable. The amount included in other receivables in that respect was £7.7 million (2017: £7.5 million).

Provisions as at 31 December 2018 are materially considered to be current and expected to be utilised at any time within the next twelve months.

23. Trade and other payables

(£ million)	2018	2017
Trade payables	**47.7**	49.0
Accrued expenses	**29.1**	36.5
Social security and other taxes	**6.8**	6.0
Other payables – lease incentives	**2.4**	2.5
Other payables – other	**11.5**	7.5
	97.5	101.5

In 2018, non-current 'Other payables' are lease incentives totalling £2.3 million (2017: £nil).

24. Dividends

(£ million)	2018	2017
Amounts recognised as distributions to equity holders in the year:		
– final dividend for the year ended 31 December 2017 of 2.5 pence per share (2016: 2.4 pence)	**10.0**	10.0
– interim dividend for the year ended 31 December 2018 of 1.3 pence per share (2017: 1.3 pence)	**5.2**	5.2
Total	**15.2**	15.2

A final dividend of 2.5 pence per share amounting to a total final dividend of approximately £10.0 million, is to be proposed at the Company's annual general meeting on 16 May 2019. In accordance with IAS 10 *Events after the Balance Sheet Date*, dividend declared after the balance sheet date is not recognised as a liability in these financial statements.

25. Share-based payments

The Group operates a number of share-based payment schemes for Executive Directors and other employees, all of which are equity settled.

The Group has no legal or constructive obligation to repurchase or settle any of the options in cash. The total cost recognised in the income statement was £0.5 million in the year ended 31 December 2018 (2017: £1.0 million). Employer's National Insurance is being accrued, where applicable, at the rate of 14.3%, which management expects to be the prevailing rate at the time the options are exercised, based on the share price at the reporting date. The total National Insurance charge for the year was £0.1 million (2017: £0.1 million).

The following table analyses the total cost between each of the relevant schemes, together with the number of options outstanding:

	2018		2017	
(£ million)	Charge £m	Number of options (thousands)	Charge £m	Number of options (thousands)
Long Term Incentive Plan	**0.5**	**2,804**	1.0	1,946
Deferred Bonus Plan	**–**	**–**	–	29
	0.5	**2,804**	1.0	1,975

A summary of the main features of the scheme is shown below:

Long Term Incentive Plan

The Long Term Incentive Plan ('LTIP') is open to Executive Directors and designated senior managers, and awards are made at the discretion of the Remuneration Committee. Awards are subject to market and non-market performance criteria.

Awards granted under the LTIP vest subject to achievement of performance conditions measured over a period of at least three years, unless the Committee determines otherwise. Awards may be in the form of conditional share awards or nil-cost options or any other form allowed by the Plan rules.

Vesting of awards will be dependent on a range of financial, operational or share price measures, as set by the Committee, which are aligned with the long-term strategic objectives of the Group and shareholder value creation. Not less than 30% of an award will be based on share price measures. The remainder will be based on either financial and/or operational measures. At the threshold performance, no more than 25% of the award will vest, rising to 100% for maximum performance. For awards granted in 2017, vesting will be based on EPS (35%), relative TSR (35%) and Operational Excellence (30%) targets. The details of measures, targets and weightings may be varied by the Committee prior to grant based on the Group's strategic objectives.

Deferred Bonus Plan

The Deferred Bonus Plan is a discretionary executive share bonus plan under which the Remuneration Committee determines that a proportion of a participant's annual bonus will be deferred. The market value of the shares granted to any employee will be equal to one-third of the total annual bonus that would otherwise have been payable to the individual. The awards will be granted on the day after the announcement of the Group's annual results. The awards will normally vest over a three-year period.

The aggregate number of share awards outstanding for the Group and their weighted average exercise price is shown below:

	2018			
	LTIP (TSR condition) (thousands)	LTIP (EPS condition) (thousands)	LTIP (OE condition) (thousands)	Deferred Bonus Plan (thousands)
At 1 January	**863**	**863**	**221**	**29**
Granted	**763**	**763**	**655**	**–**
Exercised	**–**	**–**	**–**	**(29)**
Surrendered	**(88)**	**(88)**	**(44)**	**–**
Cancelled	**(552)**	**(552)**	**–**	**–**
At 31 December	**986**	**986**	**832**	**–**
Exercisable at 31 December	**32**	**–**	**–**	**–**
Weighted average contractual life	**2.0 years**	**2.0 years**	**2.0 years**	**n/a**

25. Share-based payments continued

	2017			
	LTIP (TSR condition) (thousands)	LTIP (EPS condition) (thousands)	LTIP (OE condition) (thousands)	Deferred Bonus Plan (thousands)
At 1 January	992	992	–	29
Granted	383	383	328	–
Exercised	(189)	(189)	(11)	–
Surrendered	(323)	(323)	(96)	–
Cancelled	–	–	–	–
At 31 December	863	863	221	29
Exercisable at 31 December	32	–	–	–
Weighted average contractual life	1.2 years	1.2 years	2.3 years	0.4 years

The weighted average remaining contractual life for the share options outstanding as at 31 December 2018 was 2.0 years (2017: 1.3 years).

Share options outstanding at the end of the year have the following expiry date:

			Share options thousands	
Grant – vest	Expiry date	Exercise price (£)	**2018**	2017
LTIP grants				
30/09/2014 – December 2016	30/09/2024	–	**32**	32
01/04/2015 – March 2018	01/04/2025	–	**–**	547
30/03/2016 – March 2019	30/03/2026	–	**–**	631
30/03/2017 – March 2020	30/03/2027	–	**591**	737
30/03/2018 – March 2021	28/03/2028	–	**1,594**	–
08/10/2018 – March 2021	28/03/2028	–	**587**	–
Deferred Bonus Plan				
01/06/2015 – 01/06/2018	01/06/2025	–	**–**	29

The following information is relevant to the determination of the fair value of the awards granted for the years ended 31 December 2018 and 2017, respectively, under the schemes:

2018	LTIP (TSR condition)	LTIP (EPS condition)	LTIP (OE condition)	Deferred Bonus Plan
Option pricing model	**Monte Carlo**	**Fair value at grant date**	**Fair value at grant date**	**n/a**
Fair value at grant date (£)[1]	**1.02/0.25**	**2.09/1.36**	**2.09/1.36**	**n/a**
Weighted average share price at grant date (£)[1]	**2.09/1.36**	**2.09/1.36**	**2.09/1.36**	**n/a**
Exercise price (£)	**Nil**	**Nil**	**Nil**	**n/a**
Weighted average contractual life	**3.0 years**	**3.0 years**	**3.0 years**	**n/a**
Expected dividend yield	**n/a**	**n/a**	**n/a**	**n/a**
Risk-free interest rate[1]	**0.9%/1.0%**	**n/a**	**n/a**	**n/a**
Volatility[1]	**36%/37%**	**n/a**	**n/a**	**n/a**

1 The disclosure indicates the inputs on two grant dates.

25. Share-based payments continued

2017	LTIP (TSR condition)	LTIP (EPS condition)	LTIP (OE condition)	Deferred Bonus Plan
Option pricing model	Monte Carlo	Fair value at grant date	Fair value at grant date	n/a
Fair value at grant date (£)	1.47	3.26	3.26	n/a
Weighted average share price at grant date (£)	3.26	3.26	3.26	n/a
Exercise price (£)	Nil	Nil	Nil	n/a
Weighted average contractual life	3.0 years	3.0 years	3.0 years	n/a
Expected dividend yield	n/a	n/a	n/a	n/a
Risk-free interest rate	0.2%	n/a	n/a	n/a
Volatility	34%	n/a	n/a	n/a

The expected volatility is based on the historical volatility of the Company and a comparator group of other international healthcare companies.

26. Commitments

Operating leases

The Group had future minimum lease payments under non-cancellable operating leases, based on rents prevailing at the year end, as set out below:

	2018		2017	
(£ million)	Land and buildings	Other	Land and buildings	Other
Not later than one year	**68.0**	**0.8**	65.4	1.1
Later than one year and not later than five years	**269.8**	**1.6**	259.1	2.2
Later than five years	**1,246.0**	**–**	1,263.1	–
	1,583.8	**2.4**	1,587.6	3.3

The Group has a number of long-term institutional lease arrangements. These include leases over 12 properties with a term up to December 2042, subject to renewal or extension over each of the 12 properties. The leases include key terms such as annual rental covenants and minimum levels of capital expenditure invested by the Group. Rent is indexed annually in line with RPI, upwards only and subject to a cap of 5.0%. The capital expenditure covenants measured on an average basis over each five-year period during the term of the leases, require the Group to incur, in total, £5.0 million of maintenance capital expenditure and £3.0 million of additional capital expenditure each year, such being subject to indexation in line with RPI.

Other operating leases are in respect of vehicles and medical transportation.

Consignment stock

At 31 December 2018, the Group held consignment stock on sale or return of £22.9 million (2017: £23.0 million). The Group is only required to pay for the equipment it chooses to use and therefore this stock is not recognised as an asset.

Capital commitments

Capital commitments comprise amounts payable under capital contracts which are duly authorised and in progress at the balance sheet date. They include the full cost of goods and services to be provided under the contracts through to completion. The Group has rights within its contracts to terminate at short notice and, therefore, cancellation payments are minimal.

Capital commitments at the end of the year were as follows:

(£ million)	2018	2017
Contracted but not provided for	**16.8**	65.5

27. Contingent liabilities

The Group had the following guarantees at 31 December 2018:

- the bankers to Spire Healthcare Limited have issued a letter of credit in the maximum amount of £1.5 million (2017: £1.5 million) in relation to contractual pension obligations and statutory insurance cover in respect of the Group's potential liability to claims made by employees under the Employers' Liability (Compulsory Insurance) Act 1969;
- under certain lease agreements entered into on 26 January 2010, the Group has given undertakings relating to obligations in the lease documentation and the assets of the Group are subject to a fixed and floating charge; and
- See note C11 for details of contingent liability in respect of lease arrangements and agreements.

28. Financial risk management and impairment of financial assets

The Group has exposure to the following risks from its use of financial instruments:
- credit risk;
- liquidity risk; and
- market risk.

This note presents information about the Group's exposure to each of the above risks, the Group's objectives, policies and processes for measuring and managing risk. Further quantitative disclosures are included throughout these financial statements.

The Directors have overall responsibility for the establishment and oversight of the Group's risk management framework.

The Group's risk management policies are established to identify and analyse the risks faced by the Group, to set appropriate risk limits and controls, and to monitor risks and adherence to limits.

Credit risk and impairment

Credit risk is the risk of financial loss to the Group if a customer or counterparty to a financial instrument fails to meet its contractual obligations, and arises principally from the Group's receivables from customers and investment securities.

Trade and other receivables

The Group's exposure to credit risk is influenced mainly by the individual characteristics of each customer. The Group's exposure to credit risk from trade receivables is considered to be low because of the nature of its customers and policies in place to prevent credit risk occurring.

Most revenues arise from insured patients' business and the NHS. Insured revenues give rise to trade receivables which are mainly due from large insurance institutions, which have high credit worthiness. The remainder of revenues arise from individual Self-pay patients and consultants.

The Group establishes an allowance for impairment that represents its expected credit loss in respect of trade and other receivables.

This allowance is composed of specific losses that relate to individual exposures and also a collective loss component established in respect of losses that have been incurred but not yet identified, determined based on historical data of payment statistics.

Note 16 shows the ageing and customer profiles of trade receivables outstanding at the year end.

Investments

The Group limits its exposure to credit risk by only investing in short-term money market deposits with large financial institutions, which must be rated at least Investment Grade by key rating agencies.

Market risk

Market risk is the risk that changes in market prices, such as interest rates, will affect the Group's income or the value of its holdings of financial instruments. The objective of market risk management is to manage and control market risk exposures within acceptable parameters, while optimising the return on risk.

Interest rate risk

The Group is exposed to interest rate risk arising from fluctuations in market rates. This affects future cash flows from money market investments and the cost of floating rate borrowings.

From time-to-time, the Group considers the cost benefit of entering into derivative financial instruments to hedge its exposure to interest rate volatility based on existing variable rates, current and predicted interest yield curves and the cost of associated medium-term derivative financial instruments.

Interest rates on variable rate loans are determined by LIBOR fixings on a quarterly basis. Interest is settled on all loans in line with agreements and is settled at least annually.

	Variable	Total	Undrawn facility
31 December 2018 (£ million)	**425.0**	**425.0**	**100.0**
Effective interest rate (%)	**3.26%**	**3.26%**	
31 December 2017 (£ million)	425.0	425.0	100.0
Effective interest rate (%)	2.42%	2.42%	

The following derivative contracts were in place at 31 December 2018 (no such arrangements were in place at 31 December 2017):

	Interest rate	Maturity date	Notional amount	Carrying value Asset/(Liability)
31 December 2018 (£ million)				
Interest rate swaps	**1.2168%**	**July 2022**	**213.0**	**(0.5)**

28. Financial risk management and impairment of financial assets continued

Sensitivity analysis

A change of 25 basis points in interest rates at the reporting date would have increased/(decreased) equity and reported results by the amounts shown below. This analysis assumes that all other variables remain constant.

	Profit or loss		Equity	
(£ million)	25bp increase	25bp decrease	25bp increase	25bp decrease
At 31 December 2018				
Variable rate instruments	**(0.5)**	**0.5**	**(0.5)**	**0.5**
At 31 December 2017				
Variable rate instruments	(1.1)	1.1	(1.1)	1.1

Liquidity risk

Liquidity risk is the risk that the Group will not be able to meet its financial obligations as they fall due. The Group's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without incurring unacceptable losses or risking damage to the Group's reputation.

Liquidity is managed across the Group and consideration is taken of the segregation of accounts for regulatory purposes. Short-term operational working capital requirements are met by cash in hand and overdraft facilities.

Typically the Group ensures that it has sufficient cash on demand to meet expected operational expenses for a period of at least 90 days, including the servicing of financial obligations. In addition to cash on demand, the Group has available the following lines of credit:
– £100.0 million of revolving credit facility, which was fully undrawn as at 31 December 2018 (2017: £100.0 million undrawn).

The following are contractual maturities, at as the balance sheet date, of financial liabilities, including interest payments and excluding the impact of netting agreements:

		Maturity analysis			
2018 (£ million)	**Carrying amount**	**Contractual cash flows**	**Within 1 year**	**Between 1 and 2 years**	**More than 2 years**
Trade and other payables	**61.6**	**61.6**	**61.6**	**–**	**–**
Bank borrowings	**420.4**	**481.9**	**14.3**	**15.2**	**452.4**
Finance lease liabilities (present value)	**77.7**	**256.9**	**8.7**	**9.0**	**239.2**
	559.7	**800.4**	**84.6**	**24.2**	**691.6**

		Maturity analysis			
2018 (£ million)	**Carrying**	**Contractual cash flows**	**Within 1 year**	**Between 1 and 2 years**	**More than 2 years**
Derivative financial liabilities					
Interest rate swaps	**0.5**	**0.6**	**0.6**	**0.2**	**(0.2)**
	0.5	**0.6**	**0.6**	**0.2**	**(0.2)**

		Maturity analysis			
2017 (£ million)	Carrying amount	Contractual cash flows	Within 1 year	Between 1 and 2 years	More than 2 years
Trade and other payables	59.0	59.0	59.0	–	–
Bank borrowings	425.1	445.8	11.5	434.3	–
Finance lease liabilities (present value)	76.9	265.6	8.7	8.7	248.2
	561.0	770.4	79.2	443.0	248.2

Capital management

The Group's objective is to maintain an appropriate balance of debt and equity financing to enable the Group to continue as a going concern, to continue the future development of the business and to optimise returns to shareholders and benefits to other stakeholders.

The Board closely manages trading capital, defined as net assets plus net debt. The Group's net assets at 31 December 2018 were £1,027.6 million (2017: £1,037.9 million) and net debt, calculated as total debt (comprising obligations under finance leases and borrowings), less cash and cash equivalents and the gain of £3.3 million that was recorded at the date of the extension, amounted to £453.8 million (2017: £462.8 million).

The principal focus of capital management revolves around working capital management and compliance with externally imposed financial covenants. Throughout the period and up to the date of approval of these financial statements, the Group complied with all covenants required by our lending group.

Major investment decisions are based on reviewing the expected future cash flows and all major capital expenditure requires approval by the Board.

28. Financial risk management and impairment of financial assets continued

At the balance sheet date, the Group's committed undrawn facilities, and cash and cash equivalents were as follows:

(£ million)	2018	2017
Committed undrawn revolving credit facility	**100.0**	100.0
Cash and cash equivalents	**47.7**	39.2

Bases of valuation

As of 31 December 2018, except for an interest rate swap, the Group did not hold financial instruments that are included in level 1, 2 or 3 of the hierarchy.

Management assessed that cash and short-term deposits, trade receivables, trade payables and other current liabilities approximate their carrying amounts largely due to the short-term maturities of these instruments.

The carrying value of the other financial instruments, being finance leases and debt, is approximately equal to their fair value based on review of current terms against market, except for floating rate debt, which is after the deduction of £3.8 million (2017: £1.8 million) of issue costs.

During the year ended 31 December 2018, there were no transfers between the levels in the fair value hierarchy.

As at 31 December 2018, the Group held the following financial instruments measured at fair value.

		Maturity analysis		
Liabilities measured at fair value (£ million)	Value as at 31 December 2018	Level 1	Level 2	Level 3
Financial liabilities at fair value through profit or loss				
Interest rate swaps	**(0.5)**	–	(0.5)	–
	(0.5)	–	(0.5)	–
Financial liabilities at fair value using hedge accounting				
Interest rate swaps	**(0.5)**	–	(0.5)	–
	(0.5)	–	(0.5)	–

Fair value hierarchy

The Group uses the following hierarchy for determining and disclosing the fair value of financial instruments by valuation technique:

- Level 1: quoted (unadjusted) prices in active markets for identical assets or liabilities;
- Level 2: other techniques for which all inputs which have a significant effect on the recorded fair value are observable, either directly or indirectly; and
- Level 3: techniques which use inputs which have a significant effect on the recorded fair value that are not based on observable market data.

During the year ended 31 December 2017, there were no transfers between the levels in the fair value hierarchy.

As at 31 December 2017, the Group did not hold any financial instruments measured at fair value.

29. Related party transactions

Key management personnel

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Group, directly or indirectly. They include the Board and Executive Committee, as identified on pages 84 to 87.

Compensation for key management personnel is set out in the table below:

Key management compensation

(£ million)	2018	2017
Salaries and other short term employee benefits	**2.9**	3.5
Post-employment benefits	**0.3**	0.4
Share-based payments	**0.4**	0.9
	3.6	4.8

Further information about the remuneration of individual Directors is provided in the audited part of the Directors' Remuneration Report on pages 101 to 109.

There were no transactions with related parties external to the Group in the year to 31 December 2018 (2017: nil).

30. Events after the reporting period

2018 final dividend

For 2018, the Board has recommended a final dividend of 2.5 pence per share, amounting to approximately £10 million, to be paid on 25 June 2019 to shareholders on the register on 31 May 2019.

Company balance sheet

As at 31 December 2018
(Registered number: 9084066)

(£ million)	Notes	2018	2017
ASSETS			
Non-current assets			
Investments	C9	**832.7**	832.2
		832.7	832.2
Current assets			
Other receivables	C7	**235.0**	122.0
Income tax receivable		**–**	0.2
Cash and cash equivalents	C6	**0.1**	0.1
		235.1	122.3
Total assets		**1,067.8**	954.5
EQUITY AND LIABILITIES			
Equity			
Share capital	19	**4.0**	4.0
Share premium		**826.9**	826.9
EBT share reserves	19	**(0.8)**	(0.9)
Retained earnings		**152.4**	122.0
Total equity		**982.5**	952.0
Current liabilities			
Income tax payable		**0.5**	–
Trade and other payables	C8	**84.8**	2.5
Total liabilities		**85.3**	2.5
Total equity and liabilities		**1,067.8**	954.5

The profit attributable to the owners of the Company for the year ended 31 December 2018 was £45.1 million (2017: £42.2 million).

The financial statements on pages 152 to 158 were approved by the Board of Directors on 27 February 2019 and signed on its behalf by:

Justin Ash
Chief Executive Officer

Jitech Sodha
Chief Financial Officer

Company statements of changes in equity

For the year ended 31 December 2018

(£ million)	Share capital	Share premium	EBT share reserves	Retained earnings	Total
At 1 January 2017	4.0	826.9	(2.2)	93.9	922.6
Profit for the year	–	–	–	42.2	42.2
Other comprehensive income for the year	–	–	–	–	–
Share-based payment	–	–	–	1.1	1.1
Utilisation of EBT shares for 2014 LTIP Awards	–	–	1.3	–	1.3
Dividend paid	–	–	–	(15.2)	(15.2)
As at 1 January 2018	**4.0**	**826.9**	**(0.9)**	**122.0**	**952.0**
Profit for the year	**–**	**–**	**–**	**45.1**	**45.1**
Other comprehensive income for the year	**–**	**–**	**–**	**–**	**–**
Share-based payment	**–**	**–**	**–**	**0.5**	**0.5**
Utilisation of EBT shares for 2014 DBP Awards	**–**	**–**	**0.1**	**–**	**0.1**
Dividend paid	**–**	**–**	**–**	**(15.2)**	**(15.2)**
As at 31 December 2018	**4.0**	**826.9**	**(0.8)**	**152.4**	**982.5**

Company statements of cash flows

For the year ended 31 December 2018

(£ million)	2018	2017
Cash flows from operating activities		
Profit before taxation	**46.4**	43.1
Dividend received	**(44.3)**	(42.8)
Profit before taxation (excluding dividend received)	**2.1**	0.3
Adjustments for:		
Interest income	**(3.5)**	(2.1)
Finance costs	**0.1**	0.1
	(1.3)	(1.7)
Movements in working capital:		
Increase in trade and other receivables	**(112.9)**	(39.9)
Increase in trade and other payables	**82.3**	–
Tax received	**(0.4)**	–
Net cash used in operating activities	**(32.3)**	(41.6)
Cash flows from investing activities		
Interest received	**3.3**	2.1
Dividend received	**44.3**	42.8
Net cash generated from investing activities	**47.6**	44.9
Cash flows from financing activities		
Finance costs	**(0.1)**	(0.1)
Dividend paid to equity holders of the Parent	**(15.2)**	(15.2)
Net cash used in financing activities	**(15.3)**	(15.3)
Net decrease in cash and cash equivalents	**–**	(12.0)
Cash and cash equivalents at beginning of year	**0.1**	12.1
Cash and cash equivalents at end of year	**0.1**	0.1

Notes to the Parent Company financial statements

This section contains the notes to the Company financial statements. The issued share capital and EBT share reserves are consistent with the Spire Healthcare Group plc Group financial statements. Refer to note 19 of the Group financial statements.

C1. Basis of preparation

The financial statements have been prepared in accordance with International Financial Reporting Standards ('IFRS') as adopted by the European Union and on an historical cost basis. The financial statements are presented in UK sterling and all values are rounded to the nearest million pounds (£m), except when otherwise indicated.

See note 1 for general information about the Company.

The financial statements have been prepared on a going concern basis as the Directors believe there are no material uncertainties that lead to significant doubt that the Company can continue as a going concern for at least 12 months from the date of approval of these financial statements.

The Company applies consistent accounting policies, as applied by the Group. To the extent that an accounting policy is relevant to both Group and Company financial statements, refer to the Group financial statements for disclosure of the accounting policy. Material policies that apply to the Company only are included as appropriate.

The Company has used the exemption granted under s408 of the Companies Act 2006 that allows for the non-disclosure of the income statement of the Parent Company.

The Company did not have items to be reported as other comprehensive income; therefore, no statement of comprehensive income was prepared.

C2. Significant accounting policies in this section

Investment in subsidiaries

The Company's investments in subsidiaries are carried at cost less provisions resulting from impairment. In testing for impairment, the carrying value of the investment is compared to its recoverable amount, being its value-in-use.

Share-based payments

The financial effect of awards by the Company of options over its equity shares to employees of subsidiary undertakings is recognised by the Company in its individual financial statements as an increase in its investment in subsidiaries with a credit to equity equivalent to the IFRS 2 cost in subsidiary undertakings. The subsidiary, in turn, will recognise the IFRS 2 cost in its income statement with a credit to equity to reflect the deemed capital contribution from the Company.

C3. Key estimates and assumptions in this section

Impairment testing of investments in subsidiaries

The Company's investments in subsidiaries have been tested for impairment by comparison against the underlying value of the subsidiaries' assets based on value-in-use calculated using the same assumptions as noted for the testing of goodwill impairment in note 13 of the Group financial statements.

C4. Staff costs and Directors' remuneration

The Company had no employees during the year, except for the Directors. The information on compensation for the Directors, being considered as the key management personnel of the Company, is disclosed in note C12.

C5. Auditor's remuneration

During the year, the Company obtained the following services from the Company's external auditor, as detailed below:

(£'000)	2018	2017
Amounts receivable by auditor and its associates in respect of:		
Audit of the Company's annual financial statements	**10.0**	10.0
	10.0	10.0

C6. Cash and cash equivalents

(£ million)	2018	2017
Cash at bank	**0.1**	0.1
	0.1	0.1

C7. Other receivables

(£ million)	2018	2017
Amounts owed by subsidiary undertakings	**235.0**	122.0
	235.0	122.0

The amounts owed by subsidiary undertakings bear interest at LIBOR plus 2.25% (2017: LIBOR plus 2.00%). The amounts are unsecured and repayable on demand. No allowance for expected credit losses has been included for amounts receivable from subsidiary undertakings. As described in the Directors' report, the Group has sufficient resources to satisfy Going Concern and Viability considerations. All subsidiaries are under common control and resources could be made available for settlement of debts as and when required.

C8. Trade and other payables

(£ million)	2018	2017
Amounts owed to subsidiary undertakings	**84.6**	2.4
Accruals	**0.2**	0.1
	84.8	2.5

The amounts owed to subsidiary undertakings bear interest at LIBOR plus 2.25% (2017: LIBOR plus 2.00%). The amounts are unsecured and repayable on demand.

C9. Investment in subsidiaries

(£ million)	Subsidiary undertakings	Total
Net book value		
At 1 January 2017	831.1	831.1
Additions – IFRS 2 costs	1.1	1.1
At 1 January 2018	**832.2**	832.2
Additions – IFRS 2 costs	**0.5**	0.5
At 31 December 2018	**832.7**	832.7

Details of the Company's subsidiaries at the balance sheet date are in note 14 to the Group financial statements.

At the year end, investments in subsidiaries were reviewed for indicators of impairment and no indicators for impairment were found.

C10. Capital management and financial instruments

The capital structure of the Company comprises issued capital, reserves and retained earnings as disclosed in the Parent Company statement of changes in equity totalling £982.5 million (2017: £952.0 million) as at 31 December 2018, and cash amounted to £0.1 million (2017: £0.1 million).

Credit risk

As at 31 December 2018, the Company had amounts owed by subsidiary undertakings of £235.0 million (2017: £122.0 million). The Company's maximum exposure to credit risk from these amounts is £235.0 million (2017: £122.0 million).

Liquidity risk

The Company finances its activities through its investments in subsidiary undertakings.

The Company anticipates that its funding sources will be sufficient to meet its anticipated future administrative expenses and dividend obligations as they become due over the next 12 months.

(£ million)	2018	2017
Financial assets: Carrying amount and fair value		
Loans and receivables		
Cash and cash equivalents	**0.1**	0.1
Amounts owed by subsidiary undertakings	**235.0**	122.0
	235.1	122.1

All of the above financial assets are current and not impaired.

(£ million)	2018	2017
Financial liabilities: Carrying amount and fair value		
Amortised cost		
Amounts owed to subsidiary undertakings	**84.6**	2.4
	84.6	2.4

C10. Capital management and financial instruments continued

The fair value of financial assets and liabilities approximates their carrying value.

All of the Company's financial liabilities have a maturity of less than one year.

Market risk

Interest rate risk and sensitivity analysis

As at 31 December 2018 the Company had short-term borrowings of £84.6 million (2017: £2.4 million) owed to subsidiary undertakings, which are repayable on demand and bear interest at LIBOR plus 2.25% (2017: LIBOR plus 2.00%). Interest on these borrowings in the year amounted to nil (2017: nil) and the Directors do not perceive that servicing this debt poses any significant risk to the Company given its size in relation to the Company's net assets.

IFRS 7 *Financial Instruments: Disclosures* required a market risk sensitivity analysis illustrating the fair values of the Company's financial instruments and the impact on the Company's income statement and shareholders' equity of reasonably possible changes in selected market risks. Excluding cash and cash equivalents, the Company has no financial assets or liabilities that expose it to market risk, other than the amounts owed by/to subsidiary undertakings of £235.0 million (2017 £122.0 million) and £84.6 million (2017: £2.4 million) respectively. The Directors do not believe that a change of 25 basis points in the LIBOR interest rates will have a material impact on the Company's income statement or shareholders' equity.

C11. Contingent liabilities

Lease arrangements with a consortium of investors

The Company has given a guarantee to a consortium of investors, comprising Malaysia's Employees Provident Fund (EPF), affiliated funds of Och-Ziff Capital Management Group and Moor Park Capital, in relation to the sale of 12 of the Spire Group's property-owning companies on 17 January 2013. With effect from 17 January 2013, the total third party annual commitments of the Group under these operating leases increased by £51.3 million per annum.

As a result of the sale, the Group has long-term institutional lease arrangements (up to December 2042, subject to renewal or extension), with the landlord for each of the 12 properties. The leases include key terms such as annual rental covenants and minimum levels of capital expenditure invested by the Group. The capital expenditure covenants measured on an average basis over each five-year period during the term of the leases, require the Group to incur, in total, £5.0 million of maintenance capital expenditure and £3.0 million of additional capital expenditure on the portfolio of 12 hospitals each year, such being subject to indexation in line with RPI. If the minimum rent cover ratio is not met, the Group is required to enter into an asset performance recovery plan in order to comply with the covenants, but no default would be deemed to have occurred. The Company is a party to this guarantee. As at 31 December 2018, the Group complied with the required covenants.

Lease agreements entered into by Classic Hospitals Limited

Under lease agreements entered into on 26 January 2010 by Classic Hospitals Limited, a subsidiary undertaking of the Company, the Company has undertaken to guarantee the payment of rentals over the lease term to August 2040, and to ensure that the other covenants in the lease are observed. The initial rentals payable under the leases in 2010 were £6.3 million per annum, which will be subject to an increase in future years. As part of these arrangements, the assets of the Company are subject to a fixed and floating charge in the event of a default. As at 31 December 2018, there was no breach in the required covenants.

C12. Related party transactions

The Company's subsidiaries are listed in note 14 to the Group financial statements. The following table provides the Company's balances that are outstanding with subsidiary companies at the balance sheet date:

(£ million)	2018	2017
Amounts owed from subsidiary undertakings – Spire Healthcare Finance Limited and Spire Healthcare Limited	**235.0**	122.0
Amounts owed to subsidiary undertakings – Spire UK Holdco 2A Limited and Spire Healthcare Limited	**(84.7)**	(2.4)
	150.3	119.6

The amounts outstanding are unsecured and repayable on demand.

The following table provides the Company's transactions with subsidiary companies recorded in the profit for the year:

(£ million)	2018	2017
Amounts invoiced to subsidiaries	**31.5**	40.6
Amounts invoiced by subsidiaries	**(0.1)**	(0.1)
Dividend received from subsidiaries	**44.3**	42.8

Amounts invoiced to/by subsidiaries relate to general corporate purposes.

C12. Related party transactions continued

Directors' remuneration

The remuneration of the Non-Executive Directors of the Company is set out below. Further information about the remuneration of individual Directors is provided in the audited part of the Directors' Remuneration Report on pages 101 to 109.

(£ million)	2018	2017
Short term employee benefits*	0.7	0.7
Pension contributions	–	–
Share-based payments*	–	–
Total	0.7	0.7

* Emoluments and share-based payment charges for the Executive Directors are borne by a subsidiary company, Spire Healthcare Limited. Share-based payment related charges for the Executive Chairman prior to Admission (i.e., Directors' Share Bonus Plan) are also borne by a subsidiary company, Spire Healthcare Limited. Please refer to Note 29 of the Group consolidation statements.

Directors' interests in share-based payment schemes

Refer to note 25 to the Group financial statements for further details of the main features of the schemes relating to share options held by the Chairman, Executive Directors and Senior Management Team.

Other transactions

During the year, the Company did not make any purchases in the ordinary course of business from an entity under common control.

C13. Events after the reporting period

2018 final dividend

For 2018, the Board has recommended a final dividend of 2.5 pence per share, amounting to approximately £10.0 million, to be paid on 25 June 2019 to shareholders on the register on 31 May 2019.

Shareholder information

Spire Healthcare website
Shareholders are encouraged to visit our website at www.spirehealthcare.com which has a wealth of information about the Company and the services it offers. There is a section designed specifically for investors at www.investors.spirehealthcare.com where shareholder and media information can be accessed. This year's Annual Report and Notice of annual general meeting, together with prior year documents, can also be viewed there along with information on dividends paid, our share price and how to avoid shareholder fraud.

Registered office and Group head office
Spire Healthcare Group plc
3 Dorset Rise
London EC4Y 8EN
Tel +44 (0)20 7427 9000
Fax +44 (0)20 7427 9001
Registered in England and Wales No. 09084066

Shareholder enquiries
All shareholder enquiries regarding your shares should be addressed to the Company's share registrar at the address on page 151, or as follows:

Equiniti Limited
Tel (UK only) 0371 384 2030*
Tel (non-UK) +44 (0)121 415 7047

For the hard of hearing, Equiniti Limited offers a special Textel service that can be accessed by dialling 0371 384 2255*
(or +44 (0)121 415 7028 from outside the UK).

* Lines are open from 8.30am to 5.30pm, Monday to Friday, UK time.

Managing your shares
Please contact our registrar, Equiniti Limited, to manage your shareholding if you wish to:
- register for electronic communications;
- transfer your shares;
- change your registered name or address;
- register a lost share certificate and obtain a replacement;
- consolidate your shareholdings;
- manage your dividend payments; and
- notify the death of a shareholder.

When contacting Equiniti Limited or registering online, you should have your shareholder reference number at hand. This can be found on your share certificate or latest dividend confirmation. You can manage your shareholding online by registering for Shareview at www.shareview.co.uk. This website has a 'frequently asked questions' section which addresses the most common shareholder problems.

All other shareholder enquiries not related to the share register should be addressed to the Group Company Secretary at the registered office or emailed to companysecretary@spirehealthcare.com.

Electronic shareholder communications
Registering for online communications gives shareholders more control of their shareholding. The registration process is via our registrar's secure website at www.shareview.co.uk.
Once registered you will be able to:
- elect how we communicate with you;
- amend your details;
- amend the way you receive dividends; and
- buy or sell shares online.

This does not mean shareholders can no longer receive paper copies of documents if they so wish. We are able to offer a range of services and tailor communication to meet your needs.

Share dealing services
UK resident shareholders can sell shares on the internet or by phone using Equiniti Limited's Shareview Dealing facility by either logging onto www.shareview.co.uk/dealing or by calling 0345 603 7037 between 8.00am and 4.30pm on any business day (excluding bank holidays).

In order to gain access to this service, the shareholder reference number is required, which can be found at the top of the Company's share certificates.

Sharegift
It may be that you have a small number of shares which would cost you more to sell than they are worth. It is possible to donate these to ShareGift, a registered charity, who provide a free service to enable you to dispose charitably of such shares. There are no implications for Capital Gains Tax purposes (no gain or loss) on gifts of shares to charity and it is also possible to obtain income tax relief. More information on this service can be obtained from www.sharegift.org or by calling +44 (0)207 930 3737.

Dividend allowance
From 6 April 2018 the Dividend Allowance has changed. To understand how you are affected and for further information, please visit the HMRC website at www.gov.uk/tax-on-dividends.

Dividends paid on shares held within pensions and Individual Savings Accounts (ISAs) continue to be tax free. Further information is available from HMRC at www.gov.uk/government/publications/dividend-allowance-factsheet.

Important: You will be required to retain details of any dividend payments you receive and complete Tax Returns where required. For further advice please contact a tax or financial adviser, who in the UK must be authorised by the Financial Conduct Authority.

Overseas dividend payment service
Equiniti Limited provides a dividend payment service to over 30 countries that automatically converts payments into the local currency by an arrangement with Citibank Europe PLC. Further details, including an application form and terms and conditions of the service, are available on www.shareview.co.uk or from Equiniti Limited by calling +44 (0)121 415 7047 or writing to them at Aspect House, Spencer Road, Lancing, West Sussex BN99 6DA (please quote Overseas Payment Service with the Company name and your shareholder reference number).

'Boiler room' scams
From time-to-time, in common with other listed companies, shareholders may receive unsolicited phone calls or correspondence concerning investment matters. These are typically from overseas-based 'brokers' who target UK shareholders, using persuasive and high-pressure tactics to lure investors into scams in what often turn out to be worthless, non-existent or high-risk shares in US or UK investments. These operations are commonly known as 'boiler rooms'.

Shareholders are advised to be very wary of any unsolicited advice, offers to buy shares at a discount or offers of free company reports. Further information on how to avoid share fraud or to report a scam can be found on our website at www.spirehealthcare.com.

2019 Financial calendar

2019 annual general meeting (London)	16 May 2019
Ex-dividend date for 2018 final dividend	30 May 2019
Record date for 2018 final dividend	31 May 2019
Payment date of 2018 final dividend	25 June 2019
Announcement of 2019 half year results	September 2019

Analysis of ordinary shareholders
As at 31 December 2018

	Private		Institutional and other		Total	
Investor type	**2018**	2017	**2018**	2017	**2018**	2017
Number of holders	**116**	93	**477**	498	**593**	591
Percentage of holders	**19.56%**	15.73%	**80.44%**	84.27%	**100%**	100%
Percentage of shares held	**0.22%**	0.32%	**99.78%**	99.68%	**100%**	100%

	1–1,000		1,001–50,000		50,001-500,000		500,001+	
Shareholdings	**2018**	2017	**2018**	2017	**2018**	2017	**2018**	2017
Number of holders	**94**	86	**306**	295	**123**	133	**70**	77
Percentage of holders	**15.86%**	14.55%	**51.60%**	49.92%	**20.74%**	22.50%	**11.80%**	13.03%
Percentage of shares held	**0.02%**	0.01%	**0.88%**	0.81%	**5.84%**	5.74%	**93.26%**	93.44%

Corporate advisers

Auditor
Ernst & Young LLP
1 More London Place
London SE1 2AF

Brokers
J.P. Morgan Cazenove
25 Bank Street
Canary Wharf
London E14 5JP

Numis Securities Limited
The London Stock Exchange Building
10 Paternoster Square
London EC4M 7LT

Legal advisers
Freshfields Bruckhaus Deringer LLP
65 Fleet Street
London EC4Y 1HS

Remuneration consultants
Deloitte LLP
2 New Street Square
London EC4A 3BZ

Registrar
Equiniti Limited
Aspect House
Spencer Road
Lancing
West Sussex BN99 6DA

Alternative performance measure definitions

Performance measure	Definition	Purpose
Conversion of EBITDA to cash	EBITDA divided by operating cash flows before exceptional and other items and taxation.	Intends to show the Group's efficiency at converting EBITDA into cash.
EBITDA	Operating profit excluding depreciation, amortisation, exceptional and other items, and profit or loss on disposal of assets.	EBITDA shows the Group's earning power independent of capital structure and tax situation with the purpose of simplifying comparisons with other companies in the same industry as it excludes non-cash accounting entries, such as depreciation.
EBITDA margin	EBITDA as a percentage of revenue.	Provides a comparable performance metric, expressed as a percentage of revenues.
Net debt	Interest-bearing liabilities, excluding borrowing costs, less cash and cash equivalents.	Measurement of net Group indebtedness.
Net debt/EBITDA	Net debt at the end of the period divided by EBITDA.	Indicates the Group's ability to service its debt from cash earnings.
Clinical staff costs as a percentage of revenue	Clinical staff costs and medical fees as a percentage of revenue.	Provides a comparable measure of cost performance over time in relation to revenue activity.
Other direct costs as a percentage of revenue	Other direct costs include, direct costs and medical fees as a percentage of revenue.	Provides a comparable measure of cost performance over time in relation to revenue activity.
Self-pay revenue growth	Self-pay revenue segment as shown in note 6 on the Consolidated financial statements.	Key pillar of Group's strategy.
Underlying – Adjustments have been made to exclude the trading results of any new and redeveloped hospitals, or closure disposal of any hospital or business in current or prior periods.		
Underlying revenue	Revenue adjusted for the trading results of Spire Manchester, Nottingham and St Anthony's hospitals.	Provides a comparable measure of adjusted revenue performance over time.
Underlying operating profit	Operating profit adjusted for the trading results of Spire Manchester, Nottingham and St Anthony's hospitals.	Provides a comparable measure of adjusted profit performance over time.
Underlying EBITDA	EBITDA as defined above, adjusted for the trading results of Spire Manchester, Nottingham and St Anthony's hospitals.	Provides a comparable measure of underlying EBITDA performance over time.
Underlying EBITDA margin	Underlying EBITDA as a percentage of underlying revenue.	Provides a comparable performance metric, expressed as a percentage of revenue.
Underlying clinical staff costs as a percentage of underlying revenue	Clinical staff costs and medical fees adjusted for the trading results of Spire Manchester, Nottingham and St Anthony's hospitals, as a percentage of underlying revenue.	Provides a comparable performance metric, expressed as a percentage of revenue.
Underlying other direct costs as a percentage of underlying revenue	Other direct costs (including direct costs and medical fees) adjusted for the trading results of Spire Manchester, Nottingham and St Anthony's hospitals, as a percentage of underlying revenue.	Provides a comparable performance metric, expressed as a percentage of revenue.

Glossary

The following definitions apply throughout the Annual Report 2018, unless the context requires otherwise:

Act	The Companies Act 2006, as amended
Acute care	active but short-term treatment for a severe injury or episode of illness
Adjusted EBITDA	represents the Group's operating profit, adjusted to add back depreciation and exceptional operating items
Admission	the admission of the Shares to the premium listing segment of the Official List and to trading on the London Stock Exchange's main market for listed securities
Articles	the Articles of Association of the Company
Board	the Board of Directors of the Company
c.difficile	Clostridium difficile
CAGR	compound annual growth rate
Cardiology	specialty which encompasses the treatment of patients with cardiovascular disease
CCG	Clinical Commissioning Group
CGSC	Clinical Governance and Safety Committee
Cinven	Cinven Partners LLP
CMA	the UK Competition and Markets Authority
Company	Spire Healthcare Group plc
CQC	Care Quality Commission
CO2e	carbon dioxide equivalent
CQUIN	commissioning for quality and innovation payment which is earned for meeting quality targets on NHS work
CRC Energy Efficiency Scheme	The CRC (Carbon Reduction Commitment) Scheme aims to incentivise energy efficiency and cut emissions in large energy users in the UK's public and private sectors.
CREST	the UK-based system for the paperless settlement of trades in listed securities, of which Euroclear UK and Ireland Limited is the operator
CRM	customer relationship management system/software
CT	computerised tomography
DBP	Deferred Bonus Plan
Directors	the Executive Directors and Non-Executive Directors
DPA	Data Protection Act
EBITDA	Operating profit, adjusted to add back depreciation, profit and loss arising from the disposal of fixed assets and exceptional items
EfW	Energy from Waste
EPS	earnings per share
ESOS	Energy Saving Opportunity Scheme
EU	the European Union
Executive Directors	the executive directors of the Company
FCA	the Financial Conduct Authority
GDP	gross domestic product
GDPR	General Data Protection Regulation
GHG	greenhouse gas
GMC	General Medical Council
GP	General Practitioner
Group	Spire Healthcare Group plc and its subsidiaries
HCA Holdings, Inc.	Hospital Corporation of America
HD	Hospital Director
Health & Safety Act	The Health & Safety at Work etc Act 1974
HIS	Health Improvement Scotland
HIW	Health Inspectorate Wales
HMRC	HM Revenue & Customs
HSE	Health and Safety Executive
IFRS	International Financial Reporting Standards, as adopted by the EU
IPO	initial public offering of Shares to certain institutional and other investors
ISO 14001	environmental management system
ISO 18001	health and safety management system
ITU	Intensive Therapy Unit
JAG accreditation	The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the Endoscopy Global Rating Scale standards.

KPI	key performance indicator
Lifescan	a former Spire Healthcare service, offering advanced healthcare CT scans, health checks and blood tests
Listing Rules	the listing rules of the FCA made under section 74(4) of the Financial Services and Markets Act 2000
LTIP	Long Term Incentive Plan
MAC	Medical Advisory Committee
MRI	magnetic resonance imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
NDC	Spire Healthcare's national distribution centre in Droitwich
NHS	the National Health Services in England, Scotland, Wales and Northern Ireland, collectively
NI	National Insurance
NIC	National Insurance Contributions
Non-Executive Directors	the non-executive directors of the Company
Official List	the record of whether a company's shares are officially listed, maintained by the FCA (the UKLA Official List)
Oncology	specialty which encompasses the treatment of people with cancer
Perform	formerly part of Spire Healthcare, specialised in sports medicine, rehabilitation and human performance
PHIN	Private Healthcare Information Network
PILON	payment in lieu of notice
PIP Claims	the claims relating to the supply of alleged faulty PIP breast implants
PMI	private medical insurance/insurer
PPE	property, plant and equipment
PPU	Private Patient Unit
PROMs	Patient Reported Outcome Measures
Public Health England	the executive agency, whose purpose is to protect and improve the nation's health and wellbeing, and reduce wealth inequalities
Registrar	Equiniti Limited
Registration Regulations	the Care Quality Commission (Registration) Regulations 2009
Regulated Activities Regulations	the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROCE	return on capital employed
SAP	global software developer/software
Self-pay	when a procedure or treatment provided is funded by the patient directly
Shareholders	the holders of Shares in the capital of the Company
Shares	the ordinary shares of 1 pence each in the Company, having the rights set out in the Articles
tCO2e	tonnes of equivalent carbon dioxide
TSR	total shareholder return
UK	the United Kingdom of Great Britain and Northern Ireland
UKAS	UK Accounting Standards
UK Code	the UK Corporate Governance Code issued by the Financial Reporting Council, as amended from time-to-time

Forward looking statements

Important information: forward-looking statements

These materials contain certain forward-looking statements relating to the business of Spire Healthcare Group plc (the 'Company') and its subsidiaries (collectively, the 'Group'), including with respect to the progress, timing and completion of the Group's development, the Group's ability to treat, attract, and retain patients and customers, its ability to engage consultants and GPs and to operate its business and increase referrals, the integration of prior acquisitions, the Group's estimates for future performance and its estimates regarding anticipated operating results, future revenue, capital requirements, shareholder structure and financing. In addition, even if the Group's actual results or development are consistent with the forward-looking statements contained in this presentation, those results or developments may not be indicative of the Group's results or developments in the future. In some cases, you can identify forward-looking statements by words such as 'could,' 'should,' 'may,' 'expects,' 'aims,' 'targets,' 'anticipates,' 'believes,' 'intends,' 'estimates,' or similar words. These forward-looking statements are based largely on the Group's current expectations as of the date of this presentation and are subject to a number of known and unknown risks and uncertainties and other factors that may cause actual results, performance or achievements to be materially different from any future results, performance or achievement expressed or implied by these forward-looking statements. In particular, the Group's expectations could be affected by, among other things, uncertainties involved in the integration of acquisitions or new developments, changes in legislation or the regulatory regime governing healthcare in the UK, poor performance by consultants who practice at our facilities, unexpected regulatory actions or suspensions, competition in general, the impact of global economic changes, and the Group's ability to obtain or maintain accreditation or approval for its facilities or service lines. In light of these risks and uncertainties, there can be no assurance that the forward-looking statements made during this presentation will in fact be realised and no representation or warranty is given as to the completeness or accuracy of the forward-looking statements contained in these materials.

The Group is providing the information in these materials as of this date, and we disclaim any intention or obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise.

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Designed by Gather
+44 (0)20 7610 6140
www.gather.london

Spire Healthcare Group plc
3 Dorset Rise
London
EC4Y 8EN

spirehealthcare.com