Spire Healthcare

Looking after you

Putting patients at the heart of everything we do

Spire Healthcare Group plc

Annual Report 2017

As a leading independent hospital group we are totally focused on looking after people. See how we put patients at the heart of everything we do.

Spire Healthcare is a leading independent hospital group in the United Kingdom and the largest in terms of revenue. We deliver high standards of care, with integrity and compassion and from high-quality facilities to our insured, Self-pay and NHS patients.

www.spirehealthcare.com

Financial highlights

Revenue (+0.6%)

£931.7m

2016: £926.4m

Self-pay revenue growth (+9.7%)

£186.9m

2016: £170.4m

Conversion of EBITDA to cash

106%

2016: 115%

Adjusted basic earnings per share** (-25.0%)

14.4p

2016: 19.2p

EBITDA* (-7.4%)

£150.0m

2016: £162.0m

Profit for the year (-68.7%)

£16.8m

2016: £53.6m

Operating profit before exceptional items (-14.9%)

£92.1m

2016: £108.2m

Proposed final dividend per share (+0.0%)

2.5p

2016: 2.5p

Please see pages 18 and 19 for full financial KPIs, and page 152 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.

Contents

At a glance

Spire Healthcare provides diagnostics, in-patient, daycase and out-patient care throughout the UK. We also own and operate the sports medicine, physiotherapy and rehabilitation brand, Perform.

What we provide

Providing high-quality patient care is our top priority. To improve our patient offering, we invest consistently in a wide range of services and treatments at each stage of the care pathway: from initial GP referral, through consultation, diagnosis and treatment, to recovery and rehabilitation.

A growing market

Growing and ageing population

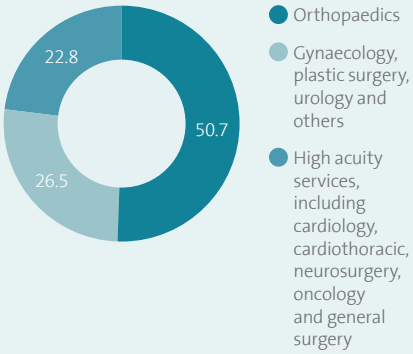
Driven by a growing and ageing population – with a higher incidence of long-term and chronic conditions, such as cancer, obesity and diabetes.

NHS funding gap

Funding and capacity constraints are forecast to continue throughout this Parliament and beyond. The independent sector can help to bridge the gap.

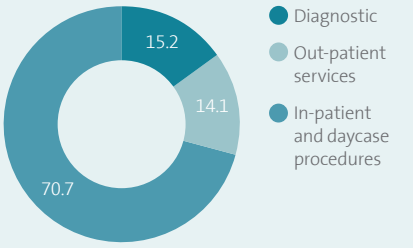
A well diversified business

2017 Percentage of revenue*



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

2017 Key activities (%)*



* Excludes other revenue. Further details can be found on page 34.
Source: Company information.

Our services

Consultants

Improving the quality of our facilities and providing a wide range of services and highly-trained staff, so that our experienced consultant body can deliver outstanding healthcare.

Working with consultants throughout their careers to develop their skills and their private practices.

Diagnostics

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

Treatment and surgery

Offering a wide range of treatment and surgery, including good outcomes for routine procedures such as knee and hip replacements, and specialist procedures across our network, providing choice to patients.

Recovery

From high dependency and intensive care units to our injury rehabilitation facilities, getting patients back on their feet as fast as possible.

Primary care

Working with GPs to facilitate speedy, convenient and fully informed referrals. Enabling patients to make a considered choice at the start of the care pathway. We are investing in our own hospital-based primary care service to offer patients convenience and to facilitate speedier referrals.

Read more
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Spire Bristol

Good to Outstanding

Read more Page 16

Spire Leicester

Spire Healthcare aims to be the 'best place to practice'

Read more Page 24

Spire Portsmouth

Operational excellence in everything we do

Read more Page 30

Spire Little Aston

First choice for self-paying patients

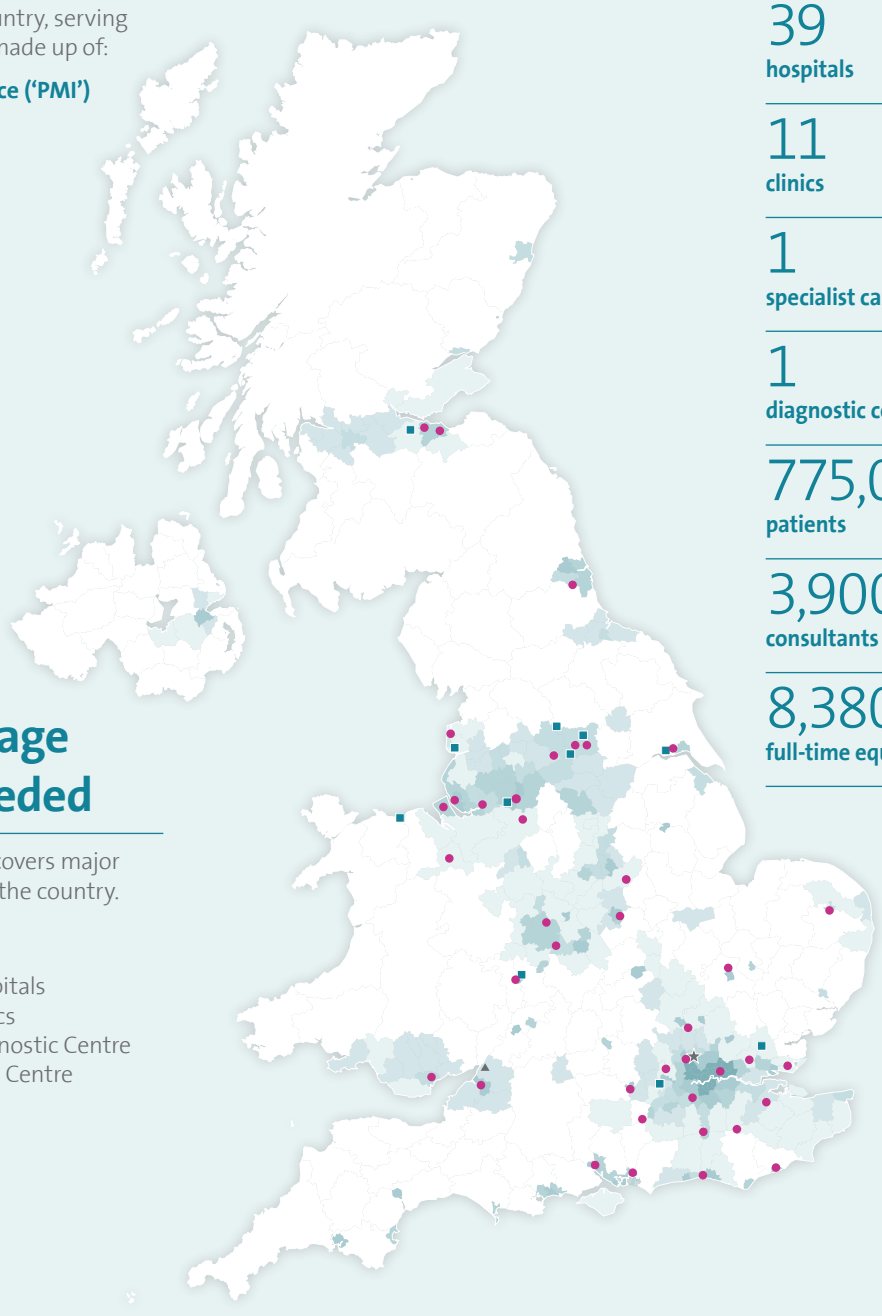
Read more Page 42

Who we serve

Our hospitals span the country, serving a diversified patient mix, made up of:

- **Private medical insurance ('PMI')**
- **Self-pay**
- **NHS patients**

Read more Page 4 and 5



39 hospitals

11 clinics

1 specialist cancer care centre

1 diagnostic centre

775,000 patients

3,900 consultants

8,380 full-time equivalent staff

Service coverage where it's needed

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

Map key

- Spire Healthcare Hospitals
- Spire Healthcare Clinics
- Spire Healthcare Diagnostic Centre
- Specialist Cancer Care Centre

People per sq km

- 0–250
- 250–500
- 500–1,000
- 1,000–1,500
- 1,500–2,500

Our market

Spire Healthcare serves a market subject to major long-term trends. The UK's population is growing. People are living longer, often with multiple co-morbidities. The NHS is the UK's most valued institution, but it is struggling under the longest budget squeeze in its history. Private provision can play a key role in helping to meet the UK's increasing healthcare needs.

Market context

UK health spend (2015)

£185bn

Source: Office for National Statistics.

UK private acute medical care market (2015)

£5.6bn

Source: LaingBuisson Private Acute Medical Care UK – Market Report 4th Edition.

UK private acute medical care market forecast growth (to end 2019)

5.0%

Source: LaingBuisson Private Acute Medical Care UK – Market Report 4th Edition.

Serving an ageing population

Trend

In 2016 the population of the UK was

66m

its largest ever. It is projected to reach over

74m

by 2039

And it is ageing. Those over 65 are forecast to grow from

18%

of the population (2016) to nearly

25%

by 2046

As people live longer they tend to be subject to longer term multiple co-morbidities –

58%

of people over 60 compared to

14%

under 40

Commentary

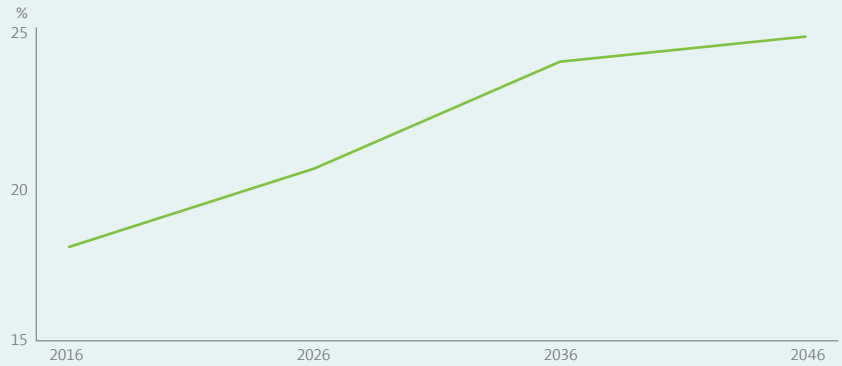
People with long-term conditions account for about 50% of all GP appointments, 64% of all out-patient appointments and over 70% of all in-patient bed days. The number of people with three or more long-term conditions is predicted to reach 2.9 million in 2018 (up from 1.9 million in 2008).

Treatment and care for people with long-term conditions takes an estimated 70% of total health and social care expenditure. The ageing population and increased prevalence of long-term conditions will inevitably create rising demand for healthcare services and have a significant impact on resources.[1]

Spire opportunity

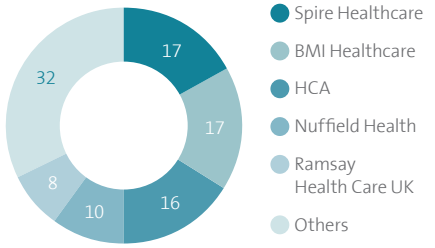
Spire Healthcare has traditionally provided outstanding care and outcomes for orthopaedic patients, particularly those receiving hip and knee replacements later in life. Additionally, Spire Healthcare has invested heavily over recent years in higher acuity services, including cancer and cardiac, ideally positioning the Company to care for the growing number of mature patients with multiple and challenging co-morbidities.

Aged 65 and over of the UK population (%)



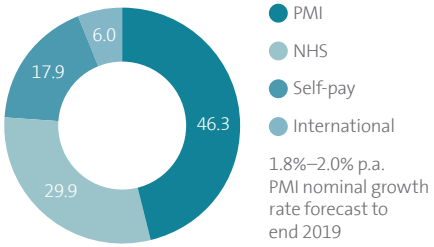
Source: Office for National Statistics.

Private sector providers' revenue (%)



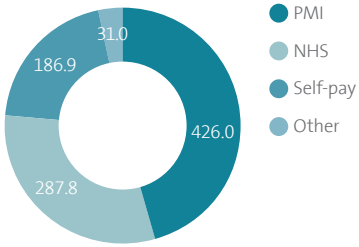
Source: LaingBuisson Private Acute Medical Care UK – Market Report 4th Edition.

Revenue split – independent acute medical hospitals and clinics (%)



1.8%–2.0% p.a. PMI nominal growth rate forecast to end 2019

2017 Spire Healthcare revenue (£m)



Source: Company information.

Healthcare resources struggling to meet demand

Trend

The NHS delivers comprehensive healthcare to the nation. It is a treasured national institution and is widely considered to be both efficient and unique in offering care to all, free at the point of care. Spire is proud to be a partner to the NHS. However, it is under the most intense strain it has ever faced – hit by underfunding, staff shortages, ever rising demand, a fragmented structure and the systemic division between health and social care.

Historically, spending on the NHS has grown by an average 3.7% per year. From 2010–2011 to 2020–2021, average growth is expected to be 0.9%. The NHS is suffering the longest budget squeeze in its history.

In the last 30 years the number of NHS beds has halved, admissions have doubled and bed stays have halved. The UK now has 2.6 beds per 1,000 people. In Germany it's over eight and it is 6.1 in France. The NHS is estimated to be running at about 95% occupancy.

As at December 2017, the NHS was short of an estimated 42,000 nurses, 11,000 hospital doctors and 12,000 nurse support workers.[2]

In the same month, the percentage of A&E patients being treated within the politically important 95% four-hour target reached its lowest ever level at 77.3%, and the Government instructed the postponement of selected non-urgent surgery.[3]

Commentary

A national debate is starting to emerge on whether the NHS is correctly structured and adequately funded for the 21st century.

There is increasing acceptance that the country needs to spend more on healthcare as a percentage of gross domestic product ('GDP').

The private sector, while likely to remain relatively small, can help the NHS deliver outstanding healthcare and provide choice to consumers.

In the UK, healthcare spending as a share of GDP is projected to fall to

6.6%

by 2021, according to The Economist. This compares with the EU average of

9.9%

or the G7 average of

11.3%

(2015)

The UK spends less per head of population than nine other EU countries and ranks sixth in the G7

Spire opportunity

Lengthening waiting times and rationing of treatment within the NHS is increasingly reflected in demand for private healthcare – particularly on a Self-pay basis. The private sector also provides capacity for the NHS, optimising usage of facilities and helping to maintain provision in periods of highest demand.

Spire Healthcare's nationwide presence, modern facilities and capacity is well placed to provide services to both local NHS commissioners and providers, and to self-paying patients.

Spire Healthcare's strategy puts the patient first and centre. We are re-engineering every aspect of our service to enable patients to access our services quickly, efficiently and on a cost assured basis.

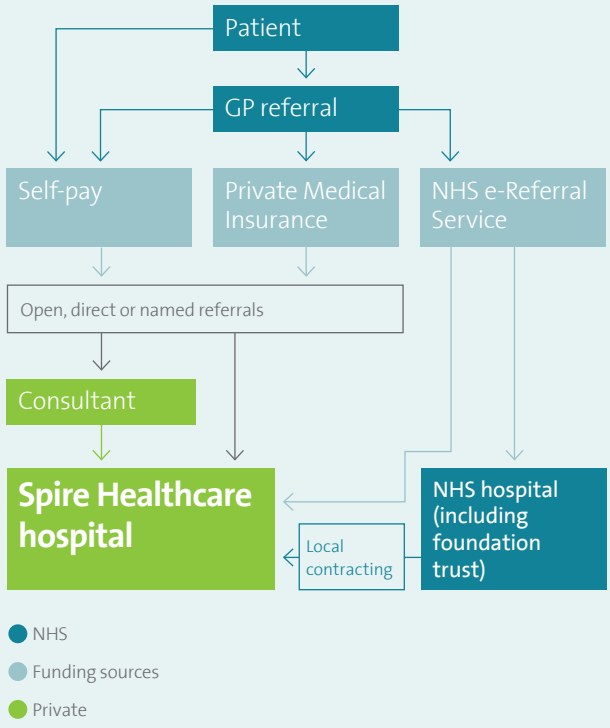
1 Sources: https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity and Department of Health (2012) Report. Long-term conditions compendium of Information: 3rd edition.
2 Source: https://www.theguardian.com/society/2017/dec/19/nhs-hospitals-unable-fill-thousands-vacant-posts-labour-says.
3 Source: https://www.theguardian.com/society/2018/jan/11/number-of-a-and-e-patients-treated-within-four-hours-at-lowest-ever-level.

Business model

Spire Healthcare is a well-diversified business and an important and growing part of the UK's healthcare system. Our business is built on providing outstanding care, clinical outcomes and value to our patients.

The patient pathway

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.



Our resources and relationships

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

Our resources

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 up-to-date technology and comfortable treatment facilities.

Highly skilled employees
Our 8,380 employees are highly skilled and our nursing and medical support staff have the expertise to provide an excellent standard of patient care.

Clinical Governance
During the year under review the Care Quality Commission ('CQC') completed their first round of comprehensive inspections across all of our hospitals and results have been published for all sites. We are pleased to report that our overall performance is in line with the rest of the private sector and continues to far exceed the NHS average.

Our relationships

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 outstanding healthcare. All our consultants are on the General Medical Council's Specialist Register.

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 to be treated, in hospitals that combine excellent clinical outcomes and levels of infection control with 'hotel style' levels of service.

Payors
Treatment is funded by a PMI, the NHS or patients who Self-pay.

Our operating model

By investing in excellent medical facilities and patient care, and operating efficiently to drive margins and generate strong cashflows, we are able to create a virtuous circle, which allows us to reinvest in future growth whilst providing shareholder returns.

Investment
We invest consistently in further capacity, equipment and services. With the ability to deploy further capital from strong cash flow, we are able to invest in future expansion and to benefit from market consolidation opportunities as they arise.

Revenue
Our sources of revenue are well diversified, and we are focused on driving growth from all of our three payor groups.

Operating efficiencies
We drive margin through a close focus on improving operational efficiency, balancing central protocols and procurement with empowerment of local teams to drive local growth and performance.

Cash flow
Strong cash conversion enables us to reinvest in future growth.

How we create value

Through our operations, we create and deliver measurable value for our stakeholders.

Consultants
A well-run hospital with supportive management and clinical teams helps us attract and retain the best clinicians

92%
of consultants believe our hospitals go out of their way to make a difference to their working relationship

Employees
We provide a wide range of training, and a flexible and supportive working environment

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

Shareholders
We aim to continue to pay a dividend in line with our policy and to return excess cash to shareholders when available

2.5p
Proposed final dividend per share (+0.0%)

Chairman's statement

Garry Watts, Chairman

"In a year of considerable change and challenge, I am proud to report that Spire Healthcare's 8,380 staff, and the leading consultants we work with, provided over 775,000 private and NHS patients with outstanding clinical care and outcomes. Exceptional patient care is our business."

Performance

The Company's performance over the year showed further growth in our key private patient income and reasonable progress on our three new major capital investment projects that became operational during the year. Group revenue was £931.7 million, £5.3 million ahead of 2016. On an underlying basis, the Group delivered consistent gross margins of over 48%. Operating profit, however, fell significantly to £42.9 million. This was the result of both our new hospital openings; of exceptional and other material items totalling £49.2 million in the year arising from the patient compensation costs in respect to Ian Paterson's historical practises; the write down of our Specialist Cancer Care Centre in Essex; and the decision to cease work on the development of a central London site.

Additional information on exceptional and other items is shown on pages 124 and 125. Our cash flow, however, remained robust and our total dividend has been maintained at 3.8p.

Revenue grew by 0.6% despite in-patient and daycase admissions decreasing by 1.8% to 269,300 patients (2016: 274,100 patients).

Revenues from Private Medical Insurance ('PMI') sources declined slightly in 2017, while underlying revenues (see further information on page 35) in our Self-pay payor group grew strongly, increasing by 12.0%. Underlying revenues from the NHS also declined by 0.5% due to patient choice and eligibility for treatment beginning to be actively restricted by Clinical Commissioning Group ('CCG') policies in response to NHS cost pressures in the second half of 2017.

Dividend

The Company continues to be strongly cash-generative, which will enable 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, continuing our stated dividend policy which aims to pay at least 20% of profit after taxation each year.

Care quality

The quality of our patient care is of paramount importance. It is at the heart of what we do.

Three of our hospitals are rated 'Outstanding' by the Care Quality Commission ('CQC'), 20 hospitals and two clinics as 'Good', and 11 as requiring improvement in certain areas. Overall, our quality of care is rated at the forefront of the independent sector. More detail on our clinical performance, quality of care, and the unstinting efforts we are making to improve further, can be found in our Clinical review on pages 20 to 25.

Following the completion of the criminal proceedings against Ian Paterson (a consultant who previously had practising privileges at two Spire Healthcare hospitals), we were able to agree to settle all current and known claims against Spire Healthcare. A charge amounting to £28.7 million for the cost of such settlement is included in the results for the year, in addition to other costs associated with the matter.

We deeply regret the circumstances but are pleased that the unfortunate victims of Mr Paterson's activities have now received compensation. Your Board is determined that the lessons learnt from this affair will be applied throughout Spire Healthcare.

Developments during the year

In the first half of 2017, we completed and opened two new hospitals in Manchester and Nottingham – we continue to develop their full potential. In the second half of the year, after major investment in expanded theatre capacity and additional staff at our 2014 acquisition, Spire St Anthony's Hospital started to deliver improved performance.

Acquisition approach

During the year we received an approach from Mediclinic, our principal shareholder, with an offer to purchase the outstanding shares in the Company. The Board concluded that the offer did not value the Company sufficiently and we were unable to reach agreement. Mediclinic continues to have a seat on the Board and remains a valued international collaborator.

Board developments

In October, we were delighted to secure the services of Justin Ash as Chief Executive Officer ('CEO'). Justin has a wealth of relevant experience. He was previously chief executive of Oasis Dental Care where he built the UK's first national consumer driven dental brand. Prior to that he was Managing Director of Lloyds Pharmacy, where he grew the estate from 1,250 to 1,750 outlets and led a refocus of the business towards health services.

In May, Peter Bamford joined the Board as the Company's Deputy Chairman and Senior Independent Director. Peter is chairman of both Superdry Plc and B&M European Value Retail SA. He previously held a number of senior executive roles at Vodafone Group plc and has served on the boards of public companies for the last 21 years. He brings considerable leadership experience and maintains a strong independent presence on our Board.

At the end of July, we regretfully announced that Andrew White, an Executive Director and our former Chief Operating Officer, had passed away following a period of illness. Andrew joined the Company in 2015, he was a trusted colleague and made a significant contribution during his time with us. He is greatly missed.

Following Andrew's death, Simon Gordon assumed the role of interim Chief Executive Officer in addition to his role as Chief Financial Officer. Our thanks go to him for his additional contribution over this difficult period.

Subsequent to the year end, on 1 March 2018, Simon Gordon, our Chief Financial Officer ('CFO'), resigned from the Board and will leave the Group at the end of March 2018. Simon has been CFO since 2012 and, whilst I was undergoing treatment for an illness last year, also assumed the role of interim CEO. Personally, and on behalf of the Board, I would like to thank him for his services to the Group in both roles and to wish him every success in the future.

Strategy

Our new CEO has brought further clarity and purpose to our established strategy. In his Review on pages 10 to 14, Justin gives further details on the Company's renewed and absolute focus on improving our offering to patients and enhancing clinical outcomes. Before we embark on further major expansion we will continue to develop and embed the highest levels of clinical performance in every one of our hospitals across the country.

Our people

Delivering our strategy depends on our people, it is they who deliver outstanding care, personally, every day to our patients. Thanks go to all our staff, every one of who is a highly valued member of the Spire Healthcare family. It is by working together closely and making a positive contribution to the business that they drive our strong culture.

Outlook

2017 was a year of considerable change and challenge but with some notable achievements. During 2018 we will concentrate on developing our people, on refining our systems and building the returns on our recent investments in new hospitals and additional capacity. In doing so, we will be able to deliver outstanding treatment and care to more people and continue to build Spire Healthcare's nationwide reputation for quality and excellent outcomes.

Garry Watts
Chairman
1 March 2018

Chief Executive Officer's Q&A

Justin Ash, Chief Executive Officer

"We need to be the best in everything we do – caring for our patients, working with our consultants, recruiting and retaining our staff, achieving the best outcomes, and delivering value.

I am determined that Spire Healthcare will be famous for delivering the very best in quality and clinical care. Quality will define and differentiate us."

What have been your initial impressions since joining Spire Healthcare?
I have found that Spire provides outstanding care to thousands of patients across Britain every day.

My many visits to our hospitals and our CQC ratings show that Spire Healthcare staff are devoted to caring for our patients, well qualified and dedicated. Their work is underpinned by good governance practices. I've seen this in every hospital I've visited and the many staff I've met, as well as the patients I've spoken with.

Spire Healthcare clinical standards are good, with lots of examples of outstanding best practice and interesting improvement projects. There are, nonetheless, variations in quality. Three of our hospitals – Spire Cheshire, The Montefiore and Sussex hospitals – are rated 'Outstanding' by the CQC, and we have excellent equivalent results in Spire Cardiff and Edinburgh hospitals. Twenty more are rated 'Good', while some were rated 'Requires Improvement' on their first CQC inspection. Overall, this puts Spire Healthcare on a par with private sector healthcare standards.

Similarly, Spire Healthcare runs effective operations, good local marketing campaigns and has seen success in growing its private patient base. The estate is well invested and often innovative, for example, developing a da Vinci robot in Spire Southampton Hospital and knee robots in Spire Edinburgh and Bushey hospitals. It has strong central teams, and good local hospital leadership under its hospital directors. As with clinical standards, there is also lots of opportunity to be more consistent as a unified group.

My overall impression is of a good, well-run healthcare provider, with lots of exciting opportunity to improve operational performance, patient recruitment and deliver more consistently outstanding quality for the benefit of our patients.

What was performance like in 2017?

I joined in late October 2017, after a period of some volatility in operating performance.

Where our work matters most, with patients, Spire Healthcare cared for 269,300 in-patient and daycase patients during the year. Clinical quality remained high, with good outcomes and only one incident of MRSA or MSSA, and c.difficile infection rates reducing further to 0.13 per 10,000 bed days. You can read details on this in our Group Medical Director's review on pages 20 to 25.

Headline financial performance figures can be found in the Chairman's statement, and the CFO reviews them in detail on pages 32 to 43. The results were mixed overall. Spire Healthcare experienced a reduction in NHS-funded care, especially contracts with NHS Trusts, and NHS-funded care actually declined in the second half of the year. This was driven by cost saving measures by the NHS. Income from Private Medical Insurance ('PMI') funded care declined slightly, while treatment and care for patients who chose to Self-pay increased strongly by 12.0%, an encouraging trend, which we expect to continue.

A major variance to expectations was the slower-than-planned build-up of the three new sites: Spire Manchester, Spire Nottingham and Spire St Anthony's hospitals. These are all outstanding facilities that I'm delighted to have in the Group. Improving their performance will be a key feature of our forward strategy.

How do you see trends in Spire Healthcare's markets?

The trends in our three main payor groups are connected to a certain degree.

PMI is currently about half of our business, but it remains largely a benefit provided by companies for their employees. As such, overall growth in PMI is linked closely to the health of the economy and has remained flat. Forward growth in this sector, in the short term, will come from growing market share.

The independent sector provides valuable capacity for the **NHS** as it seeks to deliver care in the face of well publicised cost, capacity and staffing pressures. Our NHS business is important to us and we will continue to build close working partnerships with our local commissioners and GPs. Major contracts with NHS trusts are unlikely to grow in the future, while e-Referral is still not fully adopted. This provides choice for NHS patients, underpinned in the NHS constitution, and Spire Healthcare's wide participation in this is an asset. Overall, we seek to hold share in the NHS market.

Our major growth opportunity lies in those patients who elect to **Self-pay**. Their reasons for choosing to pay for private treatment vary. They may wish to be seen faster as waiting times on the NHS continue to rise, or seek treatments that are unavailable within the NHS. They may feel that they can self-insure more competitively and flexibly than through PMI products. They may just value the convenience of having their treatment when and where they want, in hotel-level surroundings, with well-invested facilities. Whatever their motivation, the macro market drivers suggest that Self-pay will be our key growth sector. We intend to grow our market share aggressively in this area.

> "I want every member of the Spire Healthcare family to judge themselves on the quality of the care they deliver to our patients."

Chief Executive Officer's Q&A
Continued

What are your immediate priorities?
Consistently high-quality and outstanding clinical care are fundamental to our business.

I think patients see us as good, but maybe not the best everywhere – and in truth, while some of our hospitals are outstanding, others are less consistent. Raising standards to the highest levels and ensuring consistency of approach and delivery across the Company, in every hospital, is our first and last priority. We want all our hospitals to be 'Good' or 'Outstanding'. All of the time. I intend Spire Healthcare to be famous for both its quality of care and its ability to evidence that quality.

We also need to optimise operational performance, particularly in our recent major investments. I have conducted a review of lessons learnt about the cultural and operational changes required in developing and moving into new facilities, and drawn on my extensive experience of buying and opening new healthcare sites. All three new hospitals are top of my list to steer to robust financial performance, as well as being great centres of patient care. I was delighted that Spire St Anthony's Hospital was recently re-rated 'Good' by the CQC and see much evidence that all three sites will deliver strong returns. I am pleased to say that Spire Manchester and St Anthony's hospitals are making good progress. Both should be profitable in 2018. Spire Nottingham Hospital will take further work to achieve its full potential.

We will also rapidly be enhancing Spire Healthcare's marketing capability, especially digitally, to make our Self-pay offering transparent and easy to access, as well as improving our call services. This will support our Self-pay growth ambitions.

With more central support, an increased focus on leadership, training and human resources, enhanced leadership, and a lot of hard work, I am confident Spire Healthcare will deliver excellent outcomes in the months ahead.

We will continue to invest in our current estate, with a view to continuing to be the lead investor in the sector. At the same time, in the short to medium term we will be focused on increasing the return on capital and cash returns of historical and new investments, and cautious about further new hospital developments until the case for them is proven by results.

How do you see Spire Healthcare's services developing?
In a number of ways – all aimed at increasing patient, staff and partner satisfaction.

Clinically, we will focus on specific elements of our care, including our patients' understanding of their mobility after a procedure, and their comfort with what drugs to take and how to recover effectively on their return home. We want to empower our patients to a speedy recovery and active life.

We will continue to develop service lines in demand in the private sector, in particular Spire Healthcare has a growing paediatric and cardiology capability.

Operationally, we will have one best way of working in increasing areas, aligning all our hospitals around simple, national systems and operating approach – one 'Spire Way' of working – while leaving room for local best practice and strong leadership by our hospitals' senior management teams.

We need to improve engagement with our partners, which slipped last year. Based on targeted understanding of consultants and the development of their private practices, we will provide the support and services that they need. We wish consultants to grow their practice with us, and to feel that Spire Healthcare is the very best place to bring patients, as well as further developing a mutual respect for the importance of governance on the granting and overseeing of practising privileges. Spire Healthcare works hard to ensure that GPs recommend patients to us based on sound knowledge of our capabilities and this will continue.

I am also excited by the early success of Spire GP. People with busy lives are turning to this service for flexible and bespoke care, and we will soon roll this out to all our sites.

> "In the last three months, the executive committee and I have developed our strategic framework to support a renewed focus on growing our business. We have put in place five clear strategic priorities to help us achieve the growth we believe we can deliver. This aims to drive improving returns on capital."

In practical terms, some of the enablers involved include increasing investment in digital tools, communication, customer feedback and service development, and hospital infrastructure.

What do you see as key in helping your team to deliver?

Sometimes, in healthcare, people get very excited about technology, which does indeed play a vital role in Spire Healthcare's well invested proposition. I get most excited about our people. Everything we do depends on them, they deliver our promise to patients every day.

Healthcare is hard work, requiring passion and commitment, be that in Spire Healthcare or any other provider. I am committed to increasing the training and recognition needed to support and engage that commitment, and we have a number of initiatives underway to do this. It is also well recognised that in some areas there are shortages of qualified staff. This makes it even more important to attract, train, retain and develop our staff in a much more considered and consistent manner.

Success is also linked directly to leadership, particularly at the key hospital director and matron levels. Here we are launching an externally validated programme to identify, evaluate, train, motivate and develop consistently great leaders, to complement our many internal conferences and specialist skills events. I have enjoyed joining the first cohorts on our new hospital director programme.

Spire Healthcare will continue to foster a well-structured environment and culture that encourages feedback and values ideas, learning and constant improvement. Should it be needed, Spire Healthcare also runs a highly robust and confidential whistleblowing procedure to ensure everyone feels free to hold us to account for the highest standards of conduct and care.

You can read more about our focus on human resources in the Our people section on pages 44 to 47.

How important is the culture of Spire Healthcare on the success of the business?

Since joining Spire Healthcare I have spent a lot of time in our hospitals meeting many colleagues, and it was clear right from my first visits that we have a strong, positive culture across the business. Our colleagues are passionate about the work they do and the care they provide to our patients. They are fundamental to the success of the business so it is hugely important to me that they are highly engaged.

The innovative ideas, feedback and suggestions that I have heard first hand from colleagues are invaluable so we have introduced mechanisms to further encourage this, along with promoting collaborative working across our hospitals and support functions. I believe our values help demonstrate and represent how we work together so we will further increase awareness of these and what they mean to our colleagues in their day-to-day roles.

Recognising the contribution of our colleagues is a key element of our culture and I am confident that our new recognition scheme will reinforce the importance we place on this.

How do you see Spire Healthcare's strategy developing?

The summary of our ambitions is that we aim to be the most recognised and respected healthcare provider brand in the UK. I call that being the 'go to' brand in UK independent healthcare.

We will become famous for our clinical quality and customer care.

This will underpin growth in all three payor sectors. We will work with the NHS to see us as their preferred local option for high-quality treatments, and with PMI providers to feel comfortable signposting Spire Healthcare as the benchmark provider in all our services. A high-quality brand will underpin our communication with people who are increasingly looking for a Self-pay route to fast, effective and personalised treatment.

Accelerating growth and developing the market-leading national brand that makes Spire Healthcare the first choice of all patients – but particularly those self-paying – will depend on outstanding performance, transparency in pricing and clinical excellence.

We will seek continuous improvement and consistency in our relationship with consultants, in the capability of our teams and in operational excellence at all levels. All this aims to support a steadily improving return on the recent substantial capital investment in Spire Healthcare.

Simply put, we will aim to run outstanding hospitals, totally focused on delivering outstanding quality of care, consistently in all our sites. That's how Spire Healthcare will grow to be the UK market leader.

Justin Ash
Chief Executive Officer
1 March 2018

Our strategic priorities

Famous for quality and clinical care

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

Build on the systems already in place to reinforce best practice standards of patient care by:

- increasing clinical resources to assess and support quality improvement;
- enhanced clinical reviews of all sites, so patients can be assured of Spire Healthcare standards;
- contributing to and using all available national quality information;
- achieving external accreditations from specialist organisations in addition to the CQC;
- embedding a 'quality first' culture;
- awarding incentives only on the achievement of quality standards; and
- Project Outstanding.

First choice for private patients

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

Drive growth across the business, with particular emphasis on 'Self-pay' by:

- improving the performance of new sites;
- aligning our sales and marketing functions to leverage scale and best practice;
- developing advanced services to meet emerging needs; and
- continually investing in our sites to provide a high quality patient environment.

Most recommended customer experience

We aim to lead our sector in customer care.

Build on local excellence and make it consistent across the portfolio by:

- improving the efficiency of the reservation, admission and discharge processes;
- bringing these activities on-line for ease of patient use;
- doing more to prepare patients for their stay and for their return home;
- further enhancing standards in accommodation and catering; and
- focusing on 'top box' scores in the Friends and Family test as a measure of success.

Best place to practice

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

Improve our consultant relationship management by:

- a programme of engagement to understand their needs and to meet them;
- using technology to make patient and theatre booking easier and more flexible;
- providing proven, modern equipment to support our consultants' practice;
- ensuring network-wide CMA Compliance; and
- rigorously assessing and governing practising privileges so all consultants who work at Spire Healthcare represent the highest sector standards.

Best place to work

We want to be recognised as a Top 100 employer.

Drive performance through an aligned organisation by:

- setting clear capabilities for each role, and supporting teams to achieve them;
- improving employee communications and engagement to build a more confident, purposeful culture focused on results;
- introducing a new reward and performance framework, with quality as a condition, to encourage excellence and delivery;
- strengthening recruitment with a new centrally co-ordinated team; and
- closing our gender pay gap and being a strong contributor to the communities in which we work.

These strategic priorities are being facilitated by operational excellence, with initiatives including:

Workforce planning
A predictive workflow tool, ensuring an effective and safe skill mix and efficient wards and outpatient departments.

Best practice telephony
A technology-led programme to raise private pay call response and conversion.

Project Outstanding
Our initiative to deliver our clinical and non-clinical standards consistently in order to provide outstanding quality care, as rated by the CQC. You can read more about this in the Clinical Review on pages 20 to 25.

Investing
Capital to upgrade and improve our existing sites and raise return on capital across the business.

How will we measure our progress?

Famous for quality and clinical care	First choice for private patients	Most recommended customer experience	Best place to practice	Best place to work
• CQC site ratings and Spire audit ratings • NJR/PROMs performance • Unplanned returns to theatre and unplanned readmission rates • Infection rates • Post-operative mortality rates	• Patient satisfaction: percentage patients Extremely Likely to recommend Spire Healthcare • Patient satisfaction: Quality of care • Satisfaction on discharge	• Annual consultant satisfaction survey scores	• Employee engagement; semi-annual survey • Competency assessment and continuous improvement	• Revenue by payor • Self-pay growth above market • Return on Invested Capital

Five reasons to invest in Spire Healthcare

01

Spire Healthcare bridges the gap between rising healthcare demand and projected NHS budgets

With NHS funding tightening and healthcare demand growing, Spire Healthcare is well positioned to help bridge the gap. Spire healthcare is able to benefit from its inherent 'payor hedge' as more people elect to be PMI or self-paying patients. Strong growth in Self-pay in particular is set to continue as Spire Healthcare rolls out its enhanced consumer proposition.

02

Spire Healthcare benefits from scale in a market that demands excellence

The hospital environment is rightly subject to regulation and oversight, and rising patient expectation on service and quality. Spire Healthcare's national network allows it to simultaneously enforce consistent standards, assess performance and raise quality of delivery by leveraging its central resource and information systems. This delivers a strong patient proposition and payor confidence. National scale also brings economic benefit in buying, distribution and increasingly marketing and sales effectiveness.

03

Spire Healthcare is able to invest in its future and target returns

Robust operating cash flows enable Spire Healthcare to sustain a healthy capital expenditure programme and maintain an attractive dividend payout ratio.

Going forward, Spire Healthcare will focus on maintaining and developing its existing hospitals and clinics. The payback periods for such incremental investments tend to be much shorter; therefore better returns on the capital investment should be achievable.

04

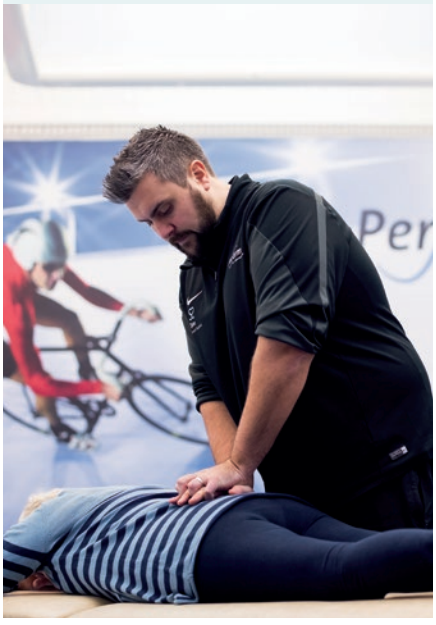
Spire Healthcare is well structured to lead on private growth

Whilst continuing to focus on relationships with each of its three major payor groups, it is increasingly prioritising investment designed to accelerate Self-pay growth. Developing our Self-pay opportunity whilst driving participation in existing robust healthcare insurer arrangements. The majority of its hospitals are able to accommodate the flexibility required by the Self-pay patient, while continuing to support the local NHS demands.

05

Spire Healthcare has a track record on innovation and learning

As well as opening new sites, Spire Healthcare is often first to develop new services, such as the da Vinci robot at Spire Southampton Hospital. Spire is actively developing bariatric, paediatric, cardiology and cancer services. Like all innovation, not all developments succeed at first, but as with the best innovative organisations, it learns and then re-invests in adapted services. This drive to innovate and grow existing and new service lines remains a key feature of its investment proposition.



Strategic priorities

Best place to work

Famous for quality and clinical care

Image:
Kate Hoffmann
Matron; Spire
Bristol Hospital

Good to Outstanding

We want all our hospitals to be rated 'Outstanding' by the CQC (or the required equivalent); regulatory recognition of the excellent care that we deliver to patients across the country every day of the year. Our 20 hospitals and two clinics currently rated as 'Good' are on a journey to 'Outstanding'.

Spire Bristol Hospital received its CQC report in April 2017, rating it Good or Outstanding across all domains, and Good overall. Led by Hospital Matron and Head of Clinical Services, Kate Hoffmann, the team in Bristol is now working on an action plan to be Outstanding across the board.

Kate credits the support that is available to all our hospitals: "The central team has really helped us in understanding the CQC's approval and the evidence they look for – simplifying the audits, spreadsheets and data we need to supply.

"And their support can directly improve our patient service – the legal team recently provided us with specialist legal consent forms we needed for the family of a patient with learning disabilities. Meaning that the patient, the family and our clinical team were all assured and happy, and a full and proper consent process was undertaken.

"We're able to develop our own initiatives to improve patient care."

Rated 'Outstanding'

3 hospitals

Five additional hospitals have one 'Outstanding' domain with all other domains rated 'Good'

"We, in turn, share our expertise with other hospitals – matrons, heads of department – we all help. I've worked in centrally controlled organisations and it doesn't necessarily work in complex hospital environments. At Spire Healthcare we're a team – the centre supports us to deliver outstanding care in each of our hospitals.

"This means we're able to develop our own initiatives to improve patient care. We were one of the first private hospital's in the country to have a critical care outreach team – and our concierge service, where every patient is greeted and guided through their stay individually, has won one of Spire Healthcare's Inspiring People Awards. David will even carry your bags and help you to your car – that's outstanding!"

Looking after you

Central support for all our hospitals

In the last year we have doubled the size of the central team dedicated to supporting our hospitals in their drive to be Outstanding across the board. Team members offer mentoring, hands-on assistance, CQC mirror inspections, reports and action plans, and specialist clinical support where necessary.

Alison Dickinson, Chief Nursing Officer, comments: "To date we have concentrated on ensuring that all our hospitals have the leadership and specialist resources they need – that clinical leads are in place in specialist areas like resuscitation, pre-op assessment, medicine management, cancer – that incidents are fully reported, investigated and learnt from. In other words, making sure that Spire Healthcare's Clinical Standards are in place, understood and met.

"Each hospital that was rated Requires Improvement will undergo a clinical review as a priority in the first quarter of 2018. Over the next two years we will be focused on helping our hospitals to become Outstanding across all aspects of our care."

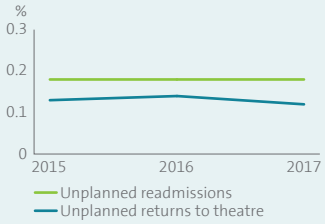
Key Performance Indicators

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.

Famous for quality and clinical care

Unplanned returns and readmissions

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



C.difficile (infection rate per 10,000 bed days)

0.13

Infection rates continued to remain extremely low

MRSA (infection rate per 10,000 bed days)

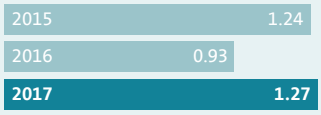
0.06

We reported a single case of MRSA across all 39 hospitals throughout 2017

Post-operative mortality* (per 10,000 anaesthetic episodes)

1.27

Post-operative mortality rates increased slightly over the very low rates reported in 2016



* Within 31 days of surgery.

Most recommended customer experience

Patient satisfaction: Net Promoter Score

83%

Our Net Promotor Score ('NPS'), a measure which aligns our reporting with the NHS and other providers, remained high at 83%

Patient satisfaction: Quality of care

98%

Patients rated the overall quality of care 'Excellent' or 'Very good'

Best place to practice

Consultant satisfaction

-10%

Consultant satisfaction fell to 67% in 2017. We are committed to working closely with our consultants in delivering quality patient care

Best place to work

Employee Engagement Survey

-7%

Percentage of participants in the staff engagement survey who said what they do at work makes a positive difference

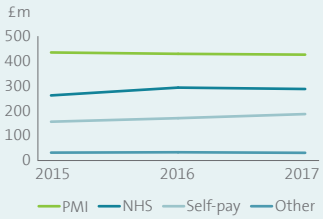
The survey was reintroduced in 2017, with 70% of all employees taking part.

First choice for private patients

Revenue by payor

£931.7m

Revenue growth continued in 2017, up by £5.3 million in the year (0.6%). Self-pay growth was strong which mitigated NHS revenue pressure in the second half of 2017



Self-pay revenue growth

£186.9m

Self-pay revenue increased by 9.7% in the year to £186.9 million

2015	£156.2m
2016	£170.4m
2017	**£186.9m**

Financial and operating measures

EBITDA margin

16.1%

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

2015	18.1%
2016	17.5%
2017	**16.1%**

Conversion of EBITDA to cash

106%

Conversion of EBITDA to operating cash flow before exceptional items and taxation decreased to 105.6%

2015	104%
2016	115%
2017	**106%**

Underlying EBITDA margin

17.3%

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

2015	18.3%
2016	18.2%
2017	**17.3%**

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

Net debt/EBITDA

3.08

Net debt to EBITDA decreased only marginally despite £119.5 million of capital expenditure spent in 2017, and the cash funding of the Paterson settlement of £27.6 million

2015	2.62
2016	2.67
2017	**3.08**

Clinical staff costs as a percentage of revenue

19.6%

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

2015	18.9%
2016	18.9%
2017	**19.6%**

Other direct costs* as a percentage of revenue

33.2%

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

2015	33.0%
2016	33.6%
2017	**33.2%**

*Comprises direct costs and medical fees. For more information, see page 36.

Underlying clinical staff costs as a percentage of underlying revenue

18.8%

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

2015	18.3%
2016	18.3%
2017	**18.8%**

Supply-side constraints to nursing resource continue to exist. Management is focused on continuous improvement of recruitment and training.

Underlying other direct costs as a percentage of underlying revenue

33.0%

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

2015	33.3%
2016	33.5%
2017	**33.0%**

Management actions alongside case mix changes have generated medical fee savings in the year.

Following the appointment of our Chief Executive Officer, we have updated our KPI's to reflect the new strategy, which is focused on Self-pay growth. Therefore we have removed theatre utilisation, theatre numbers and patient discharges from our KPI's as they are no longer relevant and have been have replaced with Self-pay revenue growth. Further information on our KPIs can be found on pages 18 and 19, and full APM definitions can be found on page 152.

Clinical review

Spire Healthcare aims to be 'famous for quality and clinical care'. Continuous improvement drives the delivery of outstanding clinical quality and performance for our patients.

Dr Jean-Jacques de Gorter, Group Medical Director

"In terms of clinical performance and safety, post-operative mortality within 31 days remained low whilst at the same time, rates of returns to theatre, unplanned transfers and readmissions all remained low, following on from last year's strong performance."

Clinical review

As Group Medical Director, I am responsible for ensuring we deliver safe and high-quality clinical care, defining our clinical governance strategy, deploying plans to deliver on quality goals and ensuring adequate resources are available to meet those goals. The national Clinical Services team sets the clinical standards, audits compliance and reports on the clinical performance of our 52 facilities. We also provide hands-on support to our hospitals, working side-by-side with senior management teams, to drive continuous improvement by identifying and sharing best practice across England, Scotland and Wales.

During 2017, I am proud to report that every Spire Healthcare hospital that underwent a rated inspection by the Care Quality Commission ('CQC') in England achieving a rating of at least 'Good', with three hospitals achieved the highest rating of 'Outstanding'. In addition, our two hospitals in Scotland both received a rating of 'Very Good' from Health Improvement Scotland and Spire Cardiff Hospital received a very favourable inspection report (Healthcare Inspectorate Wales do not issue ratings).

Whilst we have, to date, prepared for these inspections by strengthening our performance management and assurance systems, we are now investing in growing our specialist support teams to enable our hospitals to deliver our quality goals – for every hospital and clinic inspected in 2018 to be rated at least 'Good'; for every hospitals and clinic to be rated at least 'Good' in 2019; and for the majority of hospitals and clinics to be rated 'Outstanding' in 2020.

Opportunities to improve, identified by the CQC, are acted upon immediately. As a result, Spire Healthcare's ratings rose from 67% 'Good' or Outstanding' in 2017 to 69% at the time of writing, which is in line with the independent sector average and ahead of NHS partners (45%).

Of special mention are Spire Sussex, Cheshire and The Montefiore hospitals , which were rated 'Outstanding', and Spire St Anthony's Hospital which was re-rated to 'Good'.

Nevertheless, 11 of our hospitals are currently rated 'Requires Improvement'. Whilst the majority of these are rated 'Good' in the Caring, Effective and Responsive domains, we are focusing on improving our systems and processes at these sites to ensure they achieve a rating of at least 'Good' overall. This will require improvements to be made in relation to the compliant management of drugs, refurbishing carpeted areas where patients are cared for, and remedying gaps in the perceived strength of local leadership.

We are committed to resolving these issues with the utmost urgency. Actions include the recruitment of a medicines management specialist to drive improvements in drugs management; a programme of replacement of carpets in patient areas and concerted improvements in leadership capability. You can read more about this in the Our people section on pages 44 to 47.

Highlights

0.06
We reported a single case of MRSA across all 39 hospitals in 2017

69%
Spire Healthcare hospitals rated 'Good' or 'Outstanding'

3
Spire Healthcare hospitals rated 'Outstanding'

All Spire Healthcare sites rated 'Requires Improvement' have published an action plan response to the CQC findings on their websites for scrutiny by patients. We are prioritising our central clinical resources to support these hospitals, with all of them undergoing a clinical review in the first quarter of 2018.

We performed well in patient reported outcome measures ('PROMs'), of the top 10 hospitals (NHS and Independent) in England for health gain following hip replacement (April 2016–March 2017), three were Spire Healthcare hospitals – Spire Cambridge Lea, Leeds and Sussex hospitals. In relation to knee replacement, two Spire Healthcare hospitals featured in the top 10 – Spire Washington (which ranked top) and Portsmouth hospitals.

Case study

Learning from others

Nurses value professional development and training, so we not only help our nurses to extend their professional competencies through formal training but also encourage them to apply for sponsorships, scholarships and awards.

Vincenzo Calascibetta, a nurse at Spire London East Hospital, has been awarded a prestigious Florence Nightingale Foundation Travel Scholarship. He will be travelling to Australia to study acute post-operative pain management.

Vincenzo became a nurse in 2011, moving to England in 2015 and joining Spire London East Hospital the following year.

In Sydney, he will observe pain management services at the Royal North Shore Hospital and at the Pain Management Research Institute. He will also attend a two-week multidisciplinary pain management workshop.

Vincenzo said: "This will give me an amazing chance to travel and to observe closely nursing practices in another country which I think will really help me. I strongly believe that these kind of experiences promote professional and personal growth.

"My ultimate goal is to work as part of a pain management team and this experience will really put me on the right road to achieving that."

Spire London East Hospital Matron, Patricia Turner, said: "The Florence Nightingale Institute is close to all nurses' hearts. We were ecstatic when Vincenzo won the scholarship. He will bring his learning back from Australia to share with us and the Company – and we will support him in writing his paper for publication. It will benefit so many people."

Famous for clinical quality and care

Unplanned returns (%)

0.12%

C.difficile (infection rate per 10,000 bed days)

0.13

MRSA (infection rate per 10,000 bed days)

0.06

MSSA (infection rate per 10,000 bed days)

0.13

Inpatient surgical mortality (per 10,000 anaesthetic episodes)

0.13

Source: Company information.

Summary of inspection results

The following table shows the percentage of published CQC reports receiving a positive rating (Good or Outstanding) by domain for the independent sector. Figures correct as of 1 February 2018.

Hospital	Published Reports	Overall rating	Safe	Effective	Caring	Responsive	Well led
Spire Healthcare	**36**	**69%**	**56%**	**82%**	**100%**	**94%**	**69%**
Sector excl. Spire Healthcare	137	69%	55%	78%	100%	93%	67%
NHS	294	45%	34%	66%	98%	48%	48%

Infection control continues to feature as one of Spire Healthcare's strengths. With only a single case of MRSA bacteraemia in 2017 and very low rates of other healthcare acquired infections, we continually outperform NHS providers according to data published by NHS England. Indeed, surgical site infection following hip and knee replacement reduced once again to the lowest level on Spire Healthcare's record.

In other clinical performance and safety indicators, post-operative mortality within 31 days rose slightly (1.27 per 10,000 theatre episodes), whilst rates for returns to theatre (0.12%), unplanned transfers (0.05%) and readmissions within 31 days (0.18%) all remained exceptionally low following on from last year's strong performance.

Safety and effectiveness of care is a reflection of the dedication and engagement of clinical teams. Combined with our ambition to improve further and to challenge practice that does not meet our high standard, our goal is to lead the sector on quality. In 2017, we reported 16 'Never Events' across our 39 hospitals which whilst a slight reduction on the number reported in 2016, is not in keeping with our drive to be the best. We will build on our programme of human factors training which we launched last year and redouble our efforts to reduce these further.

Over the last year, following a commissioned review into Spire Healthcare's systems and processes for risk management, we have updated our approach to reporting, investigating and acting upon lessons from clinical and non-clinical incidents, in order to make care safer and more responsive.

We have also introduced a programme of human factors training for our colleagues and made this available to consultants who practise with us.

Our peer-review system for clinical assurance (the 'Clinical Review') is now well established and has proven to be an effective assessment of regulatory compliance and performance. We have invested further to strengthen and grow the capacity of this team under the leadership of the Chief Nursing Officer in order to undertake more frequent assessments of our clinical compliance.

We continue to innovate to make care safer and to provide us with assurance in this regard. By the end of 2017, we completed the roll out of two new platforms to support cancer care – the Ardeo pathway system to collect and track a patient through their breast cancer and chemotherapy treatments, and iQemo – a system to electronically prescribe validated and approved chemotherapy protocols in line with published best practice. In parallel, we also undertook analysis of thousands of surgeons and interventional physicians to assess their intervention rates, looking to benchmark every individual with their specialty peers – an exercise we will repeat on an annual basis with a view to understanding and acting upon outliers. We believe we are the only provider in the sector to be doing so.

At the start of 2018 we launched 'Project Outstanding', our initiative to systematically articulate what 'Outstanding' looks like – both clinical and non-clinical – and to deliver this consistently across our network with the aim of leading on quality as rated by the CQC. In the absence of every hospital being re-inspected by the CQC this year, we also plan to apply for and achieve a number of additional external independent accreditations over and above those we have already achieved – such as the Macmillan environmental accreditation and the Joint Advisory Group ('JAG') accreditation for endoscopy.

More and more information on quality is being published and we are entirely supportive of the Private Healthcare Information Network ('PHIN') initiative which seeks to collect, analyse and publish information on both quality and costs in line with the requirements of the Competition and Markets Authority ('CMA'). We have been submitting data for many months and have extended our collection of PROMs beyond hip and knee replacement and cataract surgery to include cosmetic procedures using our digital platform, My Clinical Outcomes.

We also plan to support patients to make more informed decisions by helping them to better understand their treatment options as well as their risks and benefits, by updating our approach to procedure specific consent. We believe that engaged patients who are aware of the treatment options available to them, cared for by talented and dedicated professionals, ultimately experience the best possible outcomes. We remain passionate and determined to deliver the highest quality care for all those who choose us to look after them.

Dr Jean-Jacques de Gorter
Group Medical Director
1 March 2018

Strategic priorities

Best place to practice

Image:
Monika Kaushik
Consultant Breast Surgeon; Spire Leicester Hospital

Spire Healthcare aims to be the 'best place to practice'

We work closely with consultants at every stage of their career – from their earliest years to retirement – helping them build and maintain their private practices with tailored clinical, operational, business and marketing support.

Monika Kaushik is a Consultant Breast Surgeon at Spire Leicester Hospital. Her experience of working with one of our hospitals is typical of the support we give to consultants as they grow their private practices.

"In 2014, after my appointment as a Consultant at University Hospitals of Leicester NHS Trust, I wanted to develop a private practice. One call to Spire Healthcare resulted in a meeting the next day with the Hospital Director, the hospital team, a full hospital tour and a really useful conversation.

They already had a successful Tuesday one-stop breast clinic, but my idea was to open a Saturday morning clinic which would be easier for busy working women to attend. Spire Healthcare was immediately supportive and, after a few teething issues around business administration and bookings, the clinic has gone from strength to strength.

> "Spire Healthcare was immediately supportive and the clinic has gone from strength to strength."

Together, we have used advertising, GP evening talks and word of mouth to promote our services. And looking ahead, after this year's work review, we're planning to introduce 10-minute free consultations for women with any cosmetic breast concerns, together with more editorial in Spire Leicester Hospital's newsletter and a series of GP talks on aftercare for breast patients."

David Macdonald's (based at Spire Leeds Hospital) career started in 1992 – making him one of our longest established Orthopaedic Consultants. In David's view, maintaining a successful private practice is based on two factors – your chosen hospital partner having an excellent local reputation and word of mouth reflecting the quality of your work.

"I always tell younger consultants, don't spread yourself too thinly. Choose a hospital partner that can provide all the capacity and back-up you need and work with them. Spire Leeds Hospital has everything – imaging, high dependency unit, cardiologists – to reassure patients and consultants that they will receive a comprehensive, quality service.

"At a local level, Spire Healthcare invests constantly to keep equipment up-to-date – and at a national level, if the need is there, they will invest in cutting-edge technology to improve patient services – like the computer assisted surgery I provide for the most complex joint reconstructions."

Looking after you

Investing in the future

Mark Rochester, a Consultant Urological Surgeon at Spire Norwich Hospital, has seen his relatively new private practice transformed over the last year by our investment in a Holmium laser, enabling HoLEP laser prostatectomy for benign prostate enlargement.

Mark commented: "I was having to fit some of my private patients in around the edges of my work at our NHS hospital, but now that Spire Norwich Hospital has the equipment, we can offer patients all the clinical benefits of a shorter hospital stay and post-operative catheterisation time, with excellent outcomes – at a time and place that's best for them.

"We had to make the investment case, but since then there's been a significant increase in the number of patients I've been able to treat. It's the gold standard, and still relatively rare in the private sector."

£36.9m

Purchase of medical equipment in 2017

Operating review

Spire Healthcare aims to deliver operational excellence

The operations team is focused on delivering the core elements of our strategy – being 'first choice for private patients', delivering 'the most recommended customer experience', and 'operational excellence'. In 2007, many initiatives laid foundations for future success in these areas.

10 years of looking after people

£119.2m
Investment in capital projects in 2017
(2016: £149.5m)

98%
Friends and Family Test

134
Operating theatres in the Spire Healthcare hospital network

In 2017, our patients continued to rate our care and attention highly, with 98% of patients overall saying that they would be extremely likely or likely to recommend Spire Healthcare to their family and friends. Patients at Spire Leeds, Parkway and Sussex hospitals reported a 100% Friends and Family score.

We continued to invest in the capacity and services to maintain high levels of recommendation by our customers.

At the end of 2017, our operating theatre network grew to 134, including six new theatres at Spire Manchester Hospital and five at Spire Nottingham Hospital. Across the network, 66 MRI and CT scanners support rapid diagnostics, while our pathology services undertook 1.8 million tests.

In 2018, we have ambitious plans to sustain that investment, and make our private services even easier to access, broader and more transparent in price and quality of outcome. We also aim to be even more operationally efficient in running and scaling-up existing and new capacity.

New builds and acquisitions

Developments during 2017 included:

- Spire Manchester Hospital (six theatres, 76 beds, ITU) opened in January; and
- Spire Nottingham Hospital (five theatres, 56 Beds, ITU) opened in April.

Spire Manchester and Spire Nottingham hospitals were our first entirely new build hospitals, Spire St Anthony's Hospital our first acquisition and major expansion.

A number of lessons have been learnt in relation to the scale and complexity of such projects. Achieving full operating efficiency in the new build sites is slower than we had expected, but additional central resources and targeted development programmes implemented in 2017 will ensure positive contributions in the future.

Investment in existing facilities

Investments during 2017 included:

- Spire Methley Park Hospital – refurbishment of administration areas, bedrooms and theatres, and creation of a new daycase suite and theatre – opened in September;
- Spire Bushey Hospital – satellite out-patient and diagnostic centre with 14 consulting rooms, associated treatment rooms, out-patient diagnostic clinics, state-of-the-art MRI, X-ray and ultrasound – opened in November;
- new MRI scanners at Spire Hull and East Riding and Thames Valley hospitals, and a replacement scanner at Spire South Bank Hospital; and
- new CT scanner at Spire Hull and East Riding Hospital.

During the year, we invested £119.2 million in enhancing facilities and new equipment across our existing estate.

Spire Bushey Hospital, our largest facility in the south-east, is benefiting from a two-phase investment which will significantly increase its capacity. The first phase involved the building of a dedicated diagnostic and outpatient centre in Elstree, Hertfordshire. It not only offers state-of-the-art diagnostic facilities but also frees the way for the second phase of the development, adding

During the year, we invested £119.5 million in enhancing facilities and new equipment across our existing estate.

capacity in the main hospital. This will create six new consulting rooms, 10 extra beds and a new theatre – offering the potential for an additional 1,400 private surgical patients a year.

In September, we completed the £7.6 million transformation of Spire Methley Park Hospital. A new operating theatre, equipped with leading-edge technology, has enabled more complex surgery, while five extra beds, a new physiotherapy unit, gymnasium, daycase unit and discharge lounge, an on-site pharmacy and a total redesign of the out-patient department have further increased capacity.

Planned 2018 investments

In 2018, we will continue to invest in the latest equipment, to add capacity and capability in our hospitals.

Planned investments include:

- phase 2 expansion of Spire Bushey Hospital (one additional theatre, six consulting rooms and 10 beds);
- Spire Murrayfield and Shawfair Park hospitals (new MRI scanner).
- Spire Cheshire Hospital (new MRI scanner);
- Manchester Parkway One Pathology Laboratory (regional and national Histopathology hub); and
- the ongoing large-scale refurbishment project at Spire Cambridge Lea Hospital, comprising the expansion and refurbishment of the daycase unit; a new Joint Advisory Group ('JAG') accredited endoscopy suite; and the upgrade of the Level 1 Critical Care extended recovery area.

New private services

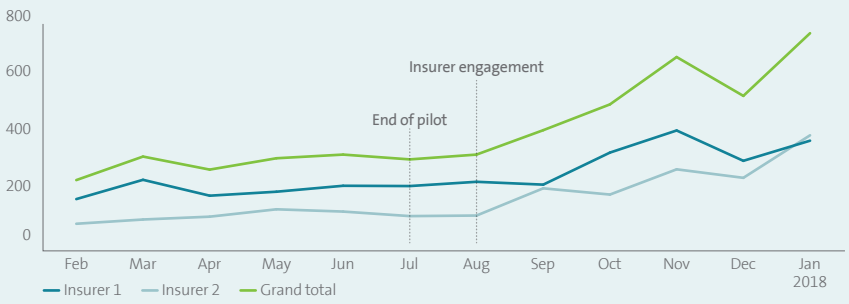
In 2017, we launched our **Children and Young People's Service**. Working with the CQC, we developed a safe, effective and compliant service with approved clinical standards. We also sought input from our PMI partners to ensure our service took into account and resolved the key issues they and their customers were experiencing.

With our hospitals working together as a network, we are now able to offer a range of paediatric services from initial consultation and diagnosis through to treatment and surgery on a broad national basis.

We also launched **Spire GP**, our hospital based primary care service. Planned to be available at all our hospitals by the end of 2018, Spire GP provides quick and easy access to professional private GP services at a time and location that suits our customers.

The launch also marked our first online customer service – offering patients the opportunity to book and pay for GP appointments from their mobile, laptop or tablet – the first step in a full range of planned online services.

Directly booked appointments 2017



The goal is one 'Spire Way' of working, to free up strong local hospital leadership to run great hospitals, support their consultants and patients and grow the local business.

Improving service for our PMI partners, we successfully completed the pilot of a **Direct Booking Portal** and from the late summer rolled it out across our full network. The portal was developed in response to our insurance partners seeking to support their members to book more easily into our consultants' clinics and avoid the need for lengthy telephone calls. The portal provides claims management teams with direct access to electronic diaries, booking and appointment confirmation. By year end we had scaled up from around 200 referrals per month in the pilot to over 600; totalling over 4,000 direct bookings for the year.

Building on this success we are working to make the portal available to more of our insurance partners. We are also piloting a **Direct to Patient** service, giving insured patients direct access to support them to select appointments with our consultants.

We are increasing investment in marketing and services to drive further growth in **self-paying** patients. Our central team of sales trainers work across the network to support the hospital based Self-pay sales teams. They focus on improving sales conversion through the coaching and reinforcement of quality enquiry handling, enquiry management and sales process. They also co-ordinate the best use of the Self-pay CRM system standardising its use, training its users and recommending developments to improve the user experience and enquiry data collection.

Continuous operational improvement

A range of work streams aimed at delivering operational excellence, consistently, across all our hospitals, is being driven forward by enhanced central resources, working with hospital senior leadership teams. The goal is one 'Spire Way' of working, to free up strong local hospital leadership to run great hospitals, support their consultants and patients and grow the local business.

Specific programmes tested in 2017 to be fully implemented in 2018 include:

- after a review of our telephony capability identified overwhelming customer demand, resulting in a frustrated customer experience, we piloted across six hospitals a workstream to identify the opportunities to improve our telephony capability. This includes improved call routing to ensure a positive impact to customer experience and the ability to measure performance to drive further improvements;
- headline improvements across the six pilot hospitals include 20% increase in Self-pay appointment bookings compared to non-pilot hospitals.
- a relaunch of our website to raise search optimisation and usage; and
- an ongoing development of a workforce planning tool which uses best in class acuity assessment and on-line updates to create a safe and efficient staff rota and bookings allocation.

The NHS standard acute contract requires discharge summaries to be sent electronically – the so-called **e-discharge**. Our SAP system already links to many GPs' systems across the country. In 2017, we trialled e-discharge notes at Spire Alexandra and Spire Sussex hospitals. In 2018, we will extend the benefits to other hospitals, ensuring notes are with GPs within 24 hours. The next step will be to send clinic letters to GPs electronically.

During 2017, our **coding** teams implemented the NHS's new tariffs and upgraded to HRG4+[1]. This included the creation of a co-morbidity tick-sheet to bridge the gap between terminologies used by clinicians and coders. The result ensures that all secondary conditions relevant to any one patient can be clearly documented and accurately coded.

All our hospitals have had at least one coding review during the year, highlighting areas where improvements can be made to the accuracy of clinical coding. A summary of findings is provided for each site and, where necessary, action plans provided to support improvement.

In addition to the on-site reviews, our central team analyses monthly coding outputs in order to identify potential inaccuracies. The reviews and monthly analysis have increased coding accuracy and income.

2017 saw the Private Healthcare Information Network ('PHIN') publish quality measures about private hospitals online for the first time as a result of the Competitions and Markets Authority Private Healthcare Investigation Order. We support PHIN's objectives of improving transparency around quality and cost and continue to actively work with PHIN and the industry as new sections of the regulation are implemented on a phased basis. In addition, we continue to work with our consultants to ensure patients have the information they need to make informed choices.

Further work is also underway on our website to raise the level of information available to patients.

1 HRG – Healthcare Resource Group. NHS Tariff prices are applied to units of healthcare, based on groups of services that are clinically similar and require similar resources to deliver. HRG4+ is the latest set of such groups, used in present prices.

Strategic priorities

Famous for quality and clinical care

Most recommended customer experience

Image:
Val Price
Matron; Spire Portsmouth Hospital

Operational excellence in everything we do

Operational excellence helps our Consultants and staff deliver the best experience and outcomes for our patients – through the most efficient use of our resources.

Theatre utilisation is one of the key performance indicators of operational excellence. Maximising the productivity of our operating theatres requires efficiency throughout the patient pathway – from original booking, through smooth admissions processes, comprehensive pre-assessments, timely starts, full lists and appropriate post-operative care, to prompt discharge.

All of which requires focus, firmness and flexibility – from everyone involved.

Spire Portsmouth Hospital achieved theatre utilisation rates of 79% in January 2017, and by October it had improved still further, to 84%. Hospital Director, Heather Dob, explains their approach.

> "We're fully focused on maximising theatre usage."

"Our operating theatres work up to three sessions a day, six days a week, and we have more orthopaedic consultants who want to treat their patients here than we can easily accommodate.

"So, we're fully focused on maximising theatre usage. Senior managers, Matron and myself have weekly and daily planning meetings, working flexibly to ensure every list is full. We concentrate on starting on time. We make sure that the right equipment and consumables are in theatre. Very soon we will have one of our store staff in theatre at all times to improve that link still further.

"We work hard to ensure that patients are properly prepared and pre-assessed – this year we created a patient briefing video, featuring our staff, taking patients right through the pathway.

"And we try to optimise productivity per hour, making sure, where appropriate, that patients are treated in endoscopy suites or as out-patients, and using the theatres for high-value procedures as much as possible."

Looking after you

Developing our leaders

The quality of our hospital leadership is crucial to the delivery of excellence. Heather Dob, Spire Portsmouth's Hospital Director, is a former Matron who has been with us since 2002. She is currently in her second stint as Hospital Director at Portsmouth and typical of the best leaders, she knows every aspect of the hospital's operations, but leads her team with delegated responsibilities. As she says: "I lead a team that is completely focused on providing flexible capacity for our consultants and patients. It's all in the detail."

84%

Theatre utilisation at Spire Portsmouth Hospital

How we manage our theatres is central to effective patient flow in a hospital

Group financial review

Revenue growth continued in 2017, up £5.3 million in the year (+0.6% on 2016). Self-pay growth was strong throughout the year (+9.7%) and mitigated NHS revenue pressure in the second half of 2017.

Simon Gordon,
Chief Financial Officer

"Continued strong conversion of earnings to cash flow led to a modest increase in year end net debt leverage, notwithstanding significant further investment in capital expenditure in the year and the settlement of Paterson claims."

Highlights

Revenue (+0.6%)

£931.7m

Revenue increased by 0.6% to £931.7 million (2016: £926.4 million)

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

105.6%

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

Self-pay revenue growth (+9.7%)

186.9m

Self-pay revenue increased by 9.7% to £186.9 million (2016: £170.4 million)

Capital investments

£119.2m

Investment in capital projects totalled £119.2 million (2016: £149.5 million)

EBITDA (-7.4%)

£150.0m

EBITDA[2] down 7.4% to £150.0 million (2016: £162.0 million)

Net debt

£462.8m

Net debt increased to £462.8 million, with leverage at 3.09 times EBITDA (2016: £432.3 million and 2.67 times EBITDA)

Adjusted basic earnings per share (-25.0%)

14.4p

Adjusted, basic earnings per share (2016: 19.2p)

Please see page 152 for full APM definitions.

Selected financial information

(£ million)	Year ended 31 December 2017 Total before exceptional and other items	2017 Exceptional and other items[5]	2017 Total	2016 Total before exceptional and other items	2016 Exceptional and other items[5]	2016 Total	Variance (on total after exceptional and other items) %	Underlying variance %[1]
Revenue	**931.7**	**–**	**931.7**	**926.4**	**–**	**926.4**	**0.6%**	**1.0%**
Cost of sales	**(492.2)**	**–**	**(492.2)**	(485.9)	–	(485.9)	1.3%	1.7%
Gross profit	**439.5**	**–**	**439.5**	**440.5**	**–**	**440.5**	**(0.2%)**	**0.4%**
Other operating costs	**(347.4)**	**(49.2)**	**(396.6)**	(332.3)	(15.2)	(347.5)	14.1%	13.7%
Operating profit	**92.1**	**(49.2)**	**42.9**	**108.2**	**(15.2)**	**93.0**	**(53.9%)**	**(47.5%)**
Net finance costs	**(20.2)**	**–**	**(20.2)**	(19.8)	–	(19.8)	2.0%	
Profit before taxation	**71.9**	**(49.2)**	**22.7**	**88.4**	**(15.2)**	**73.2**	**(69.0%)**	
Taxation	**(14.0)**	**8.1**	**(5.9)**	(11.8)	(7.8)	(19.6)	69.9%	
Profit for the year	**57.9**	**(41.1)**	**16.8**	**76.6**	**(23.0)**	**53.6**	**(68.7%)**	
EBITDA[2]			**150.0**			**162.0**	**(7.4%)**	**(4.7%)**
Basic earnings per share, pence	**14.4**	**(10.2)**	**4.2**	**19.2**	**(5.8)**	**13.4**	**(68.7%)**	
Total dividend paid/proposed per share, pence[3]			**3.8**			3.8	–	
Operating cash flows	**158.4**	**(34.4)**	**124.0**	183.9	(6.5)	177.4	(30.1%)	
Capital investments			**119.2**			149.5	(20.3%)	
Net debt at the year end[4]			**462.8**			**432.3**	**7.1%**	

1 Excludes the impact of Spire Manchester, Spire Nottingham, Spire St Anthony's hospitals and Lifescan (referred to as 'underlying'). See page 39.
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 24 May 2018. If approved, it will be paid on 26 June 2018 to shareholders on the register of members as at 1 June 2018.
4 Net debt is calculated as total debt (comprising obligations under finance leases and borrowings), less cash and cash equivalents. 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 and in 2016 the Group's review of its deferred tax approach on freehold properties giving rise to a material taxation charge in that year. See note 9 to the consolidated financial statements.

Analysis by payor

(£ million)	Year ended 31 December 2017	2016	Variance %	Underlying variance %[1]
Total revenue	**931.7**	**926.4**	**0.6%**	**1.0%**
Of which:				
PMI	**426.0**	429.3	(0.8%)	(1.5%)
NHS	**287.8**	293.4	(1.9%)	(0.5%)
Self-pay	**186.9**	170.4	9.7%	12.0%
Other[2]	**31.0**	33.3	(6.9%)	(6.8%)
	931.7	**926.4**	**0.6%**	**1.0%**
Of which:				
In-patient/daycase	**637.2**	629.9	1.2%	1.6%
Out-patient	**263.5**	263.2	0.1%	0.8%
Other	**31.0**	33.3	(6.9%)	(6.8%)
	931.7	**926.4**	**0.6%**	**1.0%**
Number ('000s)				
Total in-patient/daycase admissions	**269.3**	**274.1**	**(1.8%)**	**(1.8%)**
Of which:				
PMI volumes	**118.4**	123.5	(4.1%)	(4.6%)
NHS volumes	**101.5**	104.2	(2.6%)	(1.8%)
Self-pay volumes	**49.4**	46.4	6.5%	6.5%

1 Excludes the impact of Spire Manchester, Spire Nottingham, Spire St Anthony's hospitals and Lifescan (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').

Growing revenue

(£ million)	2016	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	Other	2017	Growth
Underlying revenue	872.1	(9.8)	19.1	(0.7)	0.4	**881.1**	**1.0%**
Non underlying revenue	54.3	(1.1)	(0.9)	0.8	(2.5)	**50.6**	
Total revenue	926.4					**931.7**	**0.6%**

Revenue for the year ended 31 December 2017 increased by £5.3 million, or 0.6%, to £931.7 million (2016: £926.4 million).

Underlying revenue grew by £9.0 million, or 1.0%, to £881.1 million (2016: £872.1 million). Of the underlying revenue growth of 1.0%:

- a decrease of 1.8% in the volume of in-patient and daycase admissions accounted for a 1.1% decline in revenue in the year, with Self-pay admissions growth compensating for volume declines in both NHS and PMI business;
- the Group reported a 1.6% increase in rate for in-patient and daycase admissions (average revenue per case) equivalent to an increase to total revenue of 2.2%. This was the result of modest increases in case mix complexity and PMI contractual price increases, which delivered growth in average revenue per case across all payor groups, most particularly in PMI and Self-pay activity in the year (notwithstanding reductions to applicable NHS tariffs of 3.9% from April 2017); and
- a decline in out-patient revenues, which was directly linked to in-patient and daycase surgical volumes. The impact of reduced NHS volumes was felt less than private activity (as it carries less out-patient revenues) and as a consequence the decline in out-patient revenues accounted for only a 0.1% decline in underlying revenues overall.

The reduction in non underlying revenues includes the impacts of the closure of Lifescan in 2016 and the closure of operations in Manchester during January 2017 whilst activity was transferred between the old and new sites.

PMI

(£ million)	2016	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	2017	Growth
Underlying PMI revenue	401.1	(11.9)	6.4	(0.7)	**394.9**	**(1.5%)**
Non underlying revenue	28.2	0.5	1.4	1.0	**31.1**	
Total PMI revenue	429.3				**426.0**	**(0.8%)**

PMI revenue for the year ended 31 December 2017 decreased by £3.3 million, or 0.8%, to £426.0 million (2016: £429.3 million). Underlying revenue declined by £6.2 million, or 1.5%, to £394.9 million (2016: £401.1 million). Of the underlying decline in PMI revenue of 1.5%:

- a decrease of 4.6% in the volume of in-patient and daycase admissions accounted for a 3.0% reduction in PMI revenue in the year;
- the Group reported a 3.0% increase in rate for in-patient and daycase admissions (average revenue per case), equivalent to an increase to PMI revenues overall of 1.6%. This rate increase was a combination of contractual increases to prices and a modest increase in the complexity of work undertaken in the year; and
- out-patient revenues contributed 0.2% to the overall decline in PMI revenues, performing significantly better than the volume led decline in in-patient and daycase admissions in the year.

NHS

(£ million)	2016	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	2017	Growth
Underlying NHS revenue	282.6	(4.1)	2.8	(0.1)	**281.2**	**(0.5%)**
Non underlying revenue	10.8	(1.9)	(2.3)	–	**6.6**	
Total NHS revenue	293.4				**287.8**	**(1.9%)**

NHS revenue for the year ended 31 December 2017 decreased by £5.6 million, or 1.9%, to £287.8 million (2016: £293.4 million). Underlying NHS revenue declined by £1.4 million, or 0.5%, to £281.2 million (2016: £282.6 million). Of the underlying decline in NHS revenue of 0.5%:

- a decrease of 1.8% in the volume of in-patient and daycase admissions accounted for a 1.5% decrease in NHS revenue in the year, skewed heavily to NHS local contract work (see below);
- against the backdrop of a weighted decrease to NHS tariff for the Group of 2.8% for the financial year, the average revenue per case for NHS admissions increased by 1.3% over 2016. Growth in in-patient and daycase rate (average revenue per case) contributed 1.0% to underlying NHS revenue growth in the year. This was the result of a further concentration of case mix to higher yielding procedures (notably in orthopaedics) offsetting the impact of NHS tariff decline from April 2017; and
- out-patient revenue was stable during the year as a consequence of the bias in performance towards NHS e-Referrals relative to NHS local contract work (which often carries little or no out-patient element).

The underlying revenue decline in NHS revenue of 0.5% is split as follows:

- NHS e-Referral (previously NHS Choose and Book) revenue grew by 5.5% in the year ended 31 December 2017;
- NHS local revenue declined by 26.2% in the same period. Management had expected NHS local contract revenue to decline in 2017 due to removal of fines linked to referral to treatment time key performance indicators. This reduced the appetite of NHS trusts to outsource work; and
- NHS e-Referrals revenue account for 86.0% of underlying NHS revenue in the year ended 31 December 2017, up from 81.2% in the prior year.

Self-pay

(£ million)	2016	In-patient/ daycase volume	In-patient/ daycase rate	Out-patient	2017	Growth
Underlying Self-pay revenue	156.6	7.6	8.5	2.7	**175.4**	**12.0%**
Non underlying revenue	13.8	0.3	0.1	(2.7)	**11.5**	
Total Self-pay revenue	170.4				**186.9**	**9.7%**

Self-pay revenue for the year ended 31 December 2017 increased by £16.5 million, or 9.7%, to £186.9 million (2016: £170.4 million). Underlying revenue grew by £18.8 million, or 12.0%, to £175.4 million (2016: £156.6 million). Of the underlying growth in Self-pay revenue of 12.0%:

- an increase of 6.5% in the volume of in-patient and daycase admissions accounted for a 4.4% increase in Self-pay revenue in the year;
- the average revenue per case for Self-pay in-patient and daycase admissions grew by 7.9% over the prior year, contributing 5.7% to the increase in Self-pay revenue in the year. Price increases in 2017 were largely inflationary, with the balance of the increase in average rate per case arising from improved case mix complexity; and
- out-patient activities in 2017 grew 0.2% as price increases were tempered in order to drive in-patient and daycase demand. Overall the increase in Self-pay out-patient revenue drove 0.1% of the increase in underlying Self-pay revenue for the year.

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 £2.3 million, or 6.9%, in the year, to £31.0 million (2016: £33.3 million). Of the £2.3 million decrease in revenue, £1.8 million relates to pathology revenue which has reduced as a result of a refocusing of the Spire pathology service to support the hospital network rather than third-party external contracts.

Cost of sales and gross profit

Cost of sales increased in the year by £6.3 million, or 1.3%, to £492.2 million (2016: £485.9 million) on revenues that increased 0.6% in the year. Underlying cost of sales increased in the year by £7.5 million, or 1.7%, on underlying revenues that increased by 1.0% in the year. Underlying gross margin for the year of 2017 was 48.2%, compared with 48.5% in 2016.

Cost of sales as a percentage of relevant revenue are as follows:

	Group		Underlying	
	Year ended 31 December		Year ended 31 December	
	2017	2016	**2017**	2016
Clinical staff	**19.6%**	18.9%	**18.8%**	18.1%
Direct costs	**22.1%**	22.2%	**21.9%**	21.7%
Medical fees and other	**11.1%**	11.3%	**11.1%**	11.7%
Cost of sales	**52.8%**	52.4%	**51.8%**	51.5%
Gross margin	**47.2%**	47.6%	**48.2%**	48.5%

Overall, the Group has substantially mitigated the impact on gross margin arising from the effective 2.8% reduction in NHS Tariff effective April 2017 (3.8% reduction in tariff on an annualised basis). The flow through impact of this price reduction in the year is approximately 0.8%, significantly higher than the 0.3% underlying gross margin decline reported.

Management actions alongside case mix changes have generated medical fee savings in the year. Procurement initiatives have resulted in savings in direct costs of drugs, prostheses and consumables which have significantly mitigated the margin pressure arising from NHS tariff.

Supply-side constraints to nursing resource continue to exist; clinical staff costs as a percentage of revenues have increased in 2017 compared to the prior year. Management is focused on continuous improvement of recruitment and training and development processes in the business as well as rostering and productivity improvements designed to limit use of agency staff.

Other operating costs

Other operating costs for the year ended 31 December 2017 increased by £49.1 million, or 14.1%, to £396.6 million (2016: £347.5 million). Excluding exceptional and other items, other operating costs for the year increased by £15.1 million, or 4.5%, to £347.4 million.

Underlying other operating costs increased in the year by £45.4 million, or 13.7%, to £375.9 million (2016: £330.5 million). Excluding exceptional and other items, underlying other operating costs for the year increased by £11.4 million, or 3.6%, to £326.7 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	**2017**	2016	**2017**	2016
Gross profit margin	**47.2%**	47.6%	**48.2%**	48.5%
Hospital and central overheads	**(24.2%)**	(23.3%)	**(23.6%)**	(23.0%)
Depreciation and amortisation	**(6.2%)**	(5.6%)	**(6.1%)**	(5.6%)
Rent	**(6.9%)**	(6.8%)	**(7.3%)**	(7.2%)
Loss on disposal of assets	**–**	(0.2%)	**(0.1%)**	(0.4%)
Operating margin	**9.9%**	11.7%	**11.1%**	12.3%
EBITDA margin	**16.1%**	17.5%	**17.3%**	18.3%

EBITDA and underlying EBITDA

EBITDA for the year ended 31 December 2017 decreased by £12.0 million, or 7.4%, to £150.0 million (2016: £162.0 million). Underlying EBITDA decreased by £7.5 million, or 4.7%, from £159.7 million to £152.2 million.

The Group EBITDA margin of 16.1% compares to 17.5% in 2016 and was impacted by the start-up nature of new hospitals opening. The Group underlying EBITDA margin of 17.3% compares to 18.3% in 2016 and the movement is the result of hospital and central overhead and rent increases explained below.

Hospital and central overhead costs have increased as a consequence of the opening of new hospitals in Manchester and Nottingham and the annualised impact of the expansion of Spire St Anthony's Hospital. In addition 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 opposite.

Underlying depreciation charged in the year increased by £5.3 million, or 10.9%, to £54.0 million (2016: £48.7 million) as the Group continues to invest in capacity and capability across the existing network of hospitals.

Total depreciation charged in the year of £57.4 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 £1.2 million, or 1.9%, to £63.9 million (2016: £62.7 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 2017, the charge to the income statement was £1.0 million (2016: £0.4 million), or £1.1 million inclusive of National Insurance (2016: £0.6 million). Further details are contained in note 21 on pages 134 to 136 of the financial statements.

Exceptional and other items

(£ million)	2017	2016
Ian Paterson claims and related costs	**28.7**	–
Strategic review – write-offs and aborted costs	**14.4**	–
Hospital set-up and closure costs	**3.4**	1.1
Executive medical leave and death in service	**0.9**	–
Business reorganisation and corporate restructuring	**0.6**	5.3
Write-off intangible assets	**–**	1.3
Hospital reversal of impairment on property, plant and equipment	**–**	(1.9)
Loss on disposal of property, plant and equipment	**–**	8.9
Other	**0.7**	0.5
Total exceptional costs	**48.7**	15.2
Income tax credit on exceptional items	**(8.0)**	(0.6)
Total post-tax exceptional items	**40.7**	14.6

1 Other exceptional items in 2017 predominantly relate to the Mediclinic takeover bid, relocation of HR and payroll functions and release of an onerous lease provision. In 2016 the costs primarily relate to National Insurance on Directors' Share Bonus Award granted at the time of the IPO.

Following the completion of the criminal proceedings against Ian Paterson (a consultant who previously had practicing privileges at Spire Healthcare) earlier in 2017, Spire Healthcare settled all current and known claims against Spire relating to his practice at Spire Healthcare. Accordingly, Spire Healthcare has provided £28.7 million in relation to this settlement, plus related costs, of which £26.1 million has been paid. Spire Healthcare is currently pursuing legal action against its insurers to seek recoveries against this settlement and related costs, which may give rise to future exceptional income being recognised in the income statement. No account has been taken of these further recoveries in the results for the year ended 31 December 2017.

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. As part of the process, the decision was taken to cease the provision of radiotherapy services at the Spire Cancer Care Centre in Baddow (Essex) as a consequence of poor commercial performance. The charge for the year includes £10.3 million for the write-off of fixed assets, net of recoverable value, and a provision for site closure costs. Additionally, certain well progressed capital projects, notably the development of a hospital in Central London, have been aborted and the costs associated with these projects have been charged as exceptional items in the year due to the fundamental change in development strategy.

Hospital set-up and closure costs include the pre-opening expenses for the two new hospitals opened during 2017 (Spire Manchester and Spire Nottingham hospitals), plus the decommissioning costs of the former Manchester hospital site.

An Executive Director had a period of illness during 2017. Costs associated with his remuneration during his medical leave were duplicative to the business. After sadly passing away in July 2017, Spire Healthcare made a death in service payment which has also been included in exceptional items.

In the year ended 31 December 2016, business reorganisation mainly comprised staff restructuring costs and the closure costs relating to an onerous contract. In the year, the Group's goodwill in relation to the Lifescan business was written-off following a strategic review and the closure of this operation. Hospital set-up costs refer to pre-opening costs for the new Spire Manchester and Spire Nottingham hospitals. The reversal of the impairment is the result of the reassessment of the lives of medical and other equipment following the relocation of the assets from the previous Spire Manchester Hospital to the new hospital facility and other Group hospitals following its closure. Hospital closure costs relate to the decommissioning of the assets related to the previous

Spire Manchester Hospital. Corporate restructuring related to an internal Group reorganisation and transaction costs relating to the Asset Swap Transaction as described below. Except for the corporate restructuring costs, which were capital in nature, and write-off of intangible assets, all other exceptional costs are expected to be tax deductible.

On 31 August 2016, as a result of the development of a new hospital facility in Manchester and the closure of the previous Spire Manchester Hospital (previously held under an operating lease), the freehold interest in Spire Wirral Hospital with a net book value of £11.7 million was disposed of, and leased back in a sale and leaseback transaction. The consideration for the sale was realised in the form of a non-cash asset, being the freehold of the previous Spire Manchester Hospital, which was simultaneously acquired by the Group (the 'Asset Swap Transaction'). The overall loss on these transactions was £7.7 million before sale costs of £1.2 million.

For 2017, £4.0 million (2016: £3.7 million) in respect of wages, salaries and social security costs note 8 on page 123 is included in write-off and aborted project costs, executive medical leave and death in service, business reorganisations, hospital set-up costs, hospital closure, other and corporate restructuring costs.

(£ million)	2017	2016
Other items		
Compliance set-up costs	**0.5**	–
Total other items	**0.5**	–
Income tax credit on other items	**(0.1)**	–
Deferred tax reassessment of temporary difference on property	**–**	8.4
Total post-tax other items	**0.4**	8.4

Compliance set-up costs include amounts incurred in 2017 to meet the requirements of General Data Protection Regulations ('GDPR') regulations effective May 2018. Management expect further material costs to arise in 2018 in advance of the effective date to meet these new regulations and for Spire Healthcare to fulfil its extended obligations under these new regulations.

Full details of exceptional items are disclosed in note 9 on page 124.

Net finance costs

Net finance costs increased by 2.0% to £20.2 million (2016: £19.8 million) as a result of incremental increase in finance lease costs.

Taxation

The taxation charge for the year is impacted by exceptional and other items in both 2017 and 2016. The table below provides a reconciliation of the total taxation charge for the year to the adjusted tax charge for the year, before exceptional and other items.

	Year ended 31 December	
(£ million)	2017	2016
Tax on profit	**5.9**	19.6
Tax credit on exceptional and other items	**8.1**	0.6
Reassessment of temporary difference on property	**–**	(8.4)
Adjusted tax charge before exceptional and other items	**14.0**	**11.8**
Profit before taxation and exceptional and other items	**71.9**	88.4
Adjusted effective tax rate before exceptional and other items	**19.5%**	**13.3%**

For the year ended 31 December 2017, the effective rate of 19.5% before exceptional and other items is reduced by the UK Government's announcement of 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 in 2017 of £0.5 million 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 in the future.

For the year ended 31 December 2016 the effective tax rate of 13.3% is reduced (relative to the 20.0% prevailing UK corporation tax rate) by prior year adjustments to deferred taxation (£2.4 million credit) and the impact on deferred tax net liabilities of previous changes to the future rate of UK corporation tax (£5.2 million credit).

Profit after taxation

The profit after taxation for the year ended 31 December 2017 was £16.8 million (2016: £53.6 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 International Financial Reporting Standards ('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.

Adjustments have been made to exclude the trading results of any new and redeveloped hospitals, closure or disposal in both current and prior periods. We have therefore excluded the results of Spire Manchester, Nottingham and St Anthony's hospitals and Lifescan in arriving at 'underlying' in this annual report. The Group ceased trading the Lifescan product in H2 2016, Manchester hospital was transitioned to a new and larger site during January 2017 (which resulted in a period of operational closure), the new hospital in Nottingham was operational in late April 2017 and Spire St Anthony's Hospital was redeveloped in the comparitive period, including the construction of a new six surgical theatre complex which opened in late 2016. APM definitions can be found on page 152.

	Year ended 31 December	
(£ million)	**2017**	2016
Revenue	**931.7**	926.4
Adjustments:		
New hospital openings (Spire Nottingham and Spire Manchester hospitals)	**(24.5)**	(21.6)
Hospital redevelopment (Spire St Anthony's Hospital)	**(26.1)**	(30.1)
Lifescan closure	**–**	(2.6)
Underlying revenue	**881.1**	872.1
Operating profit before exceptional items	**92.1**	108.2
Adjustments:		
New hospital openings (Spire Nottingham and Spire Manchester hospitals)	**3.5**	(3.0)
Hospital redevelopment (Spire St Anthony's Hospital)	**2.1**	2.9
Lifescan closure	**–**	(0.5)
Underlying operating profit before exceptional and other items	**97.7**	107.6
Underlying depreciation and amortisation on underlying assets	**54.5**	52.1
Underlying EBITDA	**152.2**	159.7
EBITDA	**150.0**	162.0
Adjustments:		
New hospital openings (Spire Nottingham and Spire Manchester hospitals)	**1.0**	(3.9)
Hospital redevelopment (Spire St Anthony's Hospital)	**1.2**	2.1
Lifescan closure	**–**	(0.5)
Underlying EBITDA	**152.2**	159.7

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)	**2017**	2016
Profit before taxation	**22.7**	73.2
Adjustment for:		
Exceptional items	**49.2**	15.2
Adjusted profit before tax	**71.9**	88.4
Taxation (1a)	**(14.0)**	(11.8)
Adjusted profit after tax	**57.9**	76.6
Weighted average number of ordinary shares in issue (No.)	**400,614,357**	399,995,435
Adjusted basic earnings per share (pence)	**14.4**	19.2

1a Reported tax charge for the period adjusted for the tax effect of exceptional items.
GAAP basic earnings per share can be found in note 12 of the financial statements on page 127.

Cash flows analysis for the year

	Year ended 31 December	
(£ million)	**2017**	2016
Opening cash balance	**67.9**	78.9
Operating cash flows before exceptional items and income tax paid	**158.4**	186.3
Exceptional items	**(31.3)**	(5.9)
Net income tax paid	**(3.1)**	(3.0)
Operating cash flows after exceptional items and income tax paid	**124.0**	177.4
Net cash used in investing activities	**(118.3)**	(149.9)
Net cash used in financing activities	**(34.4)**	(38.5)
Closing cash balance	**39.2**	67.9
Closing net indebtedness	**462.8**	432.3

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 £158.4 million, which constitutes a cash conversion rate from EBITDA for the year of 105.6% (2016: £186.3 million or 115.0%). The net cash inflow from movements in working capital in the year was £15.1 million (2016: £24.4 million), 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 year was £118.3 million. Capital expenditure for the purchase of property, plant and equipment in the year totalled £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 investing activities for the prior year ended 31 December 2016 was £149.9 million. Capital expenditure for the purchase of property, plant and equipment totalled £149.5 million, which included the development of the new Spire Manchester and Spire Nottingham hospitals and theatre development at Spire St Anthony's Hospital.

Net cash used in financing activities for the year ended 31 December 2017 was £34.4 million, including interest paid of £19.2 million and dividend paid to shareholders of £15.2 million.

Net cash used in financing activities for the year ended 31 December 2016 was £38.5 million, including interest paid of £21.9 million and dividend paid to shareholders of £14.8 million.

Borrowings

At 31 December 2017, the Group had bank debt of £425.1 million (2016: 424.1 million), drawn under facilities which mature in 2019 and finance lease debt of £76.9 million (2016: £76.1 million). Additionally, the Group has a revolving loan facility of £100.0 million (2016: £100.0 million undrawn) available until July 2019, which was undrawn at 31 December 2017.

(£ million)	2017	2016
Cash	**(39.2)**	(67.9)
External debt (including finance leases)	**502.0**	500.2
	462.8	432.3

As at 31 December 2017, net indebtedness was 3.09 times EBITDA (2016: 2.67 times).

Risk management

The principal risks faced by the Group are identified in the Principal risks section on pages 52 to 55.

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 27 to the financial statements on pages 139 to 141.

The consolidated cash and cash equivalents as at 31 December 2017 was £39.2 million (2016: £67.9 million). Surplus cash balances are held with UK-based investment-grade banks.

Simon Gordon
Chief Financial Officer
1 March 2018

Strategic priorities

First choice for private patients

Most recommended customer experience

Image:
Tom Ryder
Business Development Manager, talks with his colleagues at Spire Little Aston Hospital

First choice for self-paying patients

We want Spire Healthcare to be the UK's first choice private healthcare brand, famous for clinical quality and customer care. Nowhere is this more important than in the growing market for discerning, self-paying patients.

In the past year, Spire Little Aston Hospital has seen 60% growth in patients self-paying for orthopaedic procedures. Some of this demand is driven by lengthening NHS waiting lists, but growing market share in a highly competitive local market is the result of our hospital's ability to develop, market and deliver a compelling customer value proposition.

Business Development Manager, Tom Ryder, explains: "We have an excellent clinical reputation, outstanding consultants and can offer great care – but beyond that, success in the Self-pay market is down to doing the basics well, converting enquiries, and then delivering throughout the patient journey.

"You have to get your message out to the right people. We work with the central Commercial Marketing team, using insight data to understand our local demographics better, targeting and constantly refining our direct mail, advertising and digital communications. We've aligned our GP events programme with our marketing so that local doctors are better informed about our services.

"We have an excellent clinical reputation, outstanding consultants and can offer great care."

In the past year, Spire Little Aston Hospital has seen

60%

growth in patients self-paying for orthopaedic procedures

"You have to build trust from the very first enquiry. Our sales team is motivated, well-trained, knowledgeable and committed to helping patients. We aim to respond to any enquiry, personally, on the phone, within one hour.

"And you have to be able to guide people, who are often first-time buyers of private healthcare, through the process, offering them inclusive care packages with price certainty and alternative financing options through personalised medical loans. We're finding that successful marketing is bringing in younger patients – they're typically more used to financing packages – so we're offering Spire's financing to spread the cost.

"Every single colleague in the hospital is united in promoting our hospital's services and Self-pay proposition options as an accessible and more affordable way to benefit from private healthcare."

Looking after you

Linking to Primary Care

Louise Downie, Spire Little Aston's Primary Care Manager, is part of a transformation in our approach to working with primary care providers.

In her view: "Primary care is changing to meet increasing demand – GP practices are merging and patients are increasingly being seen by Advance Nurse and Musculoskeletal Extended Scope Practitioners rather than GPs.

"As a result, we've extended our programme of information and educational events to this the wider primary care audience, explaining the benefits of new services and equipment, building relationships between them and our Consultants, and making the referral process as easy as possible.

"And Spire Healthcare is changing. We're working closer with our sister Spire hospitals, and we're getting much more support and databased guidance from central management. The result is that we're more focused, more efficient – and our customers benefit."

Our people

We have over 13,000 nurses, theatre staff, allied health professionals, non-clinical support colleagues and bank staff, working together to deliver outstanding care to our patients across the United Kingdom. We are committed to doing more to support them and to attract new talent for the future.

Our values

Driving clinical excellence
We stretch ourselves to achieve fantastic results

Doing the right thing
We make sound and considered judgements

Caring is our passion
We put patients at the heart of everything we do

Diversity

Overall employees

Senior Managers

Board

Male
Female

Diversity

Clinical educational events held

1,500

Attendees at educational events

23,000

Money raised by our hospitals for their local charities

£53k

Our challenges

It has been widely reported that there is currently a shortage of nurses and doctors in the UK. The number of registered nurses is falling for the first time since training cuts in 2010, and 96% fewer EU nurses have registered since the Brexit vote. Given the length of training required, these shortages will take several years to make good.

With the shortage of nurses, it is more important than ever that we are successfully recruiting and retaining colleagues to account for natural turnover and to meet our patient needs where we have invested in new and expanded facilities.

Engaging our colleagues

Our colleagues interact with thousands of patients every day and play a crucial role in delivering the highest quality care and outcomes. It is therefore more crucial than ever that we set our colleagues up to succeed and engage closely with them, particularly given our competitive market.

Our annual engagement survey saw an overall engagement score of 81% that exceeded external benchmark rates of 73%[1], but was 7% lower than the last survey. The results showed colleagues feel positive about the type of work they do and value the teams they work in. Over 80% of colleagues who responded to the survey are proud to work for Spire Healthcare, feel they make a positive difference and would be happy with our care for a friend or relative.

Whilst the feedback from the engagement survey showed largely high scores, they were lower than in the 2015 survey and the results highlighted a number of areas to focus on. As a result, we are relaunching our performance management process, reviewing incentives and recognition, and introducing a number of new communication and engagement activities.

We are committed to acting on the feedback from our colleagues. To ensure we have clear focus on making improvements following the 2017 survey, we introduced a simple action plan process for teams to use across the business to make positive change.

Culture and values

Our colleagues are at the heart of our business, they are our lifeblood, representing who we are, our positive culture and live our values each day. Our values demonstrate how we work together and provide us with a common language that all colleagues can recognise and relate to. Following Justin Ash's appointment, we refreshed our values slightly to reinforce the importance of clinical excellence and that celebrating our successes is important.

We are committed to supporting the communities in which we operate, and we run a comprehensive programme of GP/clinical education events across our network of hospitals. In 2017, 1,500 events were attended by over 23,000 GPs, nurses, physiotherapists and other healthcare professionals.

1 Ixia External Benchmarking, based a mixture of over 50 public and private organisations across multiple sectors.

Keeping it simple
We make complex things easier

Delivering on our promises
People can trust us to do what we say we'll do

Succeeding and celebrating together
We work together, learn from each other and celebrate success

Image:
Justin Ash reaffirming Spire Healthcare's values at the Senior Leadership Conference in December 2017.

Last year, over £53,000 was raised by the hospitals for important local and national charitable causes. Next year, it is our aim to go further and raise more, and build upon the good work our colleagues already do.

Our commitments

We are committed to delivering on our promises and making Spire Healthcare a 'destination employer' – attracting, recruiting, training and retaining the best.

To do this we are committed to:

- being an employer of choice – based on an outstanding recruitment process, our quality performance culture, and with an aligned reward framework;
- growing our own – both at the key leadership roles in hospitals and with our qualified clinical and other colleagues – through training and development, a clear competency framework and apprenticeships to attract and develop new talent; and
- setting ourselves up to succeed through stronger human resources support, comprehensive workforce planning and effective communications across all our hospitals.

Our priorities

In 2017, we strengthened our central human resources capability and made step changes towards delivering on our commitments. We developed a Human Resources Business Partner structure to closely support each of our hospitals.

Leadership is a key driver and influence on our culture so developing values-based **leadership competencies** for our senior hospital management teams was a top priority in 2017. All senior hospital

Case study

Tomorrow's team

Spire Healthcare is leading developments in healthcare education – developing apprenticeship schemes that will train our hospital teams of tomorrow. We are working with universities across the country to develop new degree courses – enabling our staff to work and learn together.

Jack Longhurst is a theatre healthcare assistant at Spire Parkway Hospital. Jack worked in a pharmacy before joining Spire Healthcare two years ago. He is currently on his Level 3 Healthcare Support Worker qualification, a new apprenticeship which became available in May 2017.

His next step will be as one of the first cohorts in the University of Derby's new three-year Operating Department Practitioner ('ODP') degree course, starting in January 2019.

As Jack says: "I asked about training in my first interview and Spire Healthcare has supported me all the way since. It's really exciting to be one of the first to do this new university apprenticeship course – I can continue to work and get paid, and I don't have to take out a loan for university fees. I'll go to Derby three times a year but the rest of the time I'm in the hospital with my theatre team. At the end of the course I'll be a fully qualified ODP, thanks to Spire Healthcare."

Deborah Barker, Spire Healthcare's national lead for developing apprenticeships and university relationships, comments: "In the new Level 3 Apprenticeship Standard, delivered by our supplier Eurosource Solutions Ltd, there are Theatre and Adult Nursing pathways, making it much more flexible and appropriate in hospitals. On completion of the qualification, Jack will be able to assist a fully qualified ODP to scrub in minor cases – and it qualifies him for the Degree Apprenticeship programme we are developing with the University of Derby. We're committed to developing apprenticeships across the country – helping to develop the next generation of healthcare professionals."

Leadership competencies

management teams will be assessed against these and in February 2018 a dedicated leadership development programme at Ashridge Business School began.

Ensuring new recruits are a good cultural fit who will understand and support our values helps to set new colleagues up for a successful and rewarding career with Spire Healthcare. To enable this, the criteria from our leadership competencies will be used as a part of our recruitment processes in the future. To further improve our **recruitment** processes both internally and for candidates, we are aiming to reduce hiring time, assure candidate quality and improve retention.

During 2017, we completed a detailed review of our **reward framework** (including all benefits) to help develop a simple, clear framework that can be used across all roles and functions to provide consistency and fairness.

Our **communications and engagement** activity helps promote and maintain our culture. We invested more in these areas in 2017 across a number of channels and activities. We held our first leadership conference in over two years in December, attended by 200 leaders across our hospitals and central functions. The new CEO and executive team engaged the leaders in developing our forward strategy and, following the event, 95%[2] of delegates responded positively when asked if they were excited about the future of≈Spire Healthcare.

In 2018, we will continue to build on our engagement activities such as town hall forums, an executive leadership hospital visits programme and 'all hands' conference calls for all colleagues.

As demonstrated in our values, it is important that our colleagues always feel able to do the right thing. Whilst we encourage an open culture whereby issues can be raised and handled at a local level, we realise that there may be times where it is not appropriate, or a person may not feel comfortable, to raise a concern through their line management.

Whistleblowing

We want colleagues to feel confident and empowered to raise any issues of concern 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, if necessary, anonymously. 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. In 2017, we received two calls to the whistleblowing helpline.

Anti-bribery and corruption

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

Gender pay gap ('GPG') reporting

Spire Healthcare's workforce across all our hospitals and clinics is 75% female and includes 24% temporary workers (predominantly bank staff comprising nurses and other clinical staff).

We are required to report GPG figures for our main employing entity – Spire Healthcare Limited – covering 98% of all relevant employees of Spire Healthcare Group. 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 GPG required by the Gender Pay Gap Regulations is expressed as an average figure. It represents the percentage difference between average hourly earnings for men and women. 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.

Key findings

The overall median GPG in both Spire Healthcare Limited and the Spire Healthcare Group (7.9% and 7.8% respectively) is considerably lower than the Office for National Statistics ('ONS') provisional national average of 18.4% (as per their publication of 26 October 2017). The bonus GPG for 2017 should be treated with caution. Firstly, less than 3% of employees received a bonus in the period under review. This means that the data is based on a relatively small number of employees. Secondly, the data has been heavily skewed by a limited number of legacy share awards granted in 2014 to a very small number

95%[2]

of delegates responded positively when asked if they were excited about the future of Spire Healthcare.

of senior employees (who were all male). These share awards were partly related to legacy arrangements which pre-dated the Company's IPO in 2014. As these awards crystallised in value during 2016/17, they are included in our 2017 reporting.

How we are responding to the GPG

Spire Healthcare is committed to diversity and inclusivity, and in particular supporting women to become leaders within the business.

We believe that the completion of our Reward Framework Project and the introduction of the Leadership Development Programme, both discussed, under 'Our priorities', will provide greater consistency between roles and locations, assist reducing pay anomalies and, in time, help our GPG.

In addition, we recently undertook a review of our approach to maternity pay. Previously, Spire Healthcare only provided statutory maternity pay (SMP) to eligible employees. We have reviewed the level of maternity benefits which we offer and we have **enhanced our maternity pay** so that employees receive 100% of pay for six weeks, followed by 50% of pay (plus SMP) for the next 18 weeks, to further improve reward and retention. This change was implemented in June 2017.

We will continue to monitor our GPG and we are committed to taking steps and spotting opportunities to reduce it further.

Gender pay gap

Top pay quartile
(across Spire Healthcare Limited and the Combined Group)

75% women

	Spire Healthcare Limited	Spire Healthcare Group (including Spire Healthcare Limited, Spire Healthcare Group plc and Montefiore House Limited)
Number of employees (includes bank workers)	11,326*	11,536*
Women's hourly rates within Spire are:		
Mean	17.1% lower	20.5% lower
Median	7.9% lower	7.8% lower

Pay quartiles:
(How many men and women are in each quarter of our payroll)

	Men	Women	Men	Women
Top quartile	25%	75%	25%	75%
Upper middle quartile	14%	86%	14%	86%
Lower middle quartile	16%	84%	16%	84%
Lower quartile	19%	81%	20%	80%

Women's bonus pay is:		
Mean	96.8% lower*	98.1% lower*
Median	60.0% lower	60.0% lower
Who received bonus pay?		
Men	2.9%	2.9%
Women	2.4%	2.4%

* Employees who received salary during the year.

2 Leadership Conference feedback survey – To what extent do you agree with the following statement: I am excited about the future of Spire Healthcare 94.87% favourable (48.72% Strongly agree; 46.15% Agree).

Looking after our environment

Spire Healthcare realises that we have a 'duty of care' to the environment as well as our patients and we continue to promote a low carbon culture across our hospitals. We continually review how we operate our buildings and infrastructure to improve the carbon efficiencies.

A key focus is to reduce carbon emissions associated with our usage 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 £ 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, has 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 will 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 Carbon Reduction Commitment ('CRC') Energy Efficiency Scheme and will report our carbon emissions to the Environment Agency accordingly.

Our mandatory 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.

Spire Healthcare was invited to participate in the Carbon Disclosure Projects ('CDP') again in 2017. We made our third submission to the CDP this year and Spire Healthcare have been graded C which demonstrates our knowledge of our impact on climate change issues.

Capital investment in low carbon infrastructure

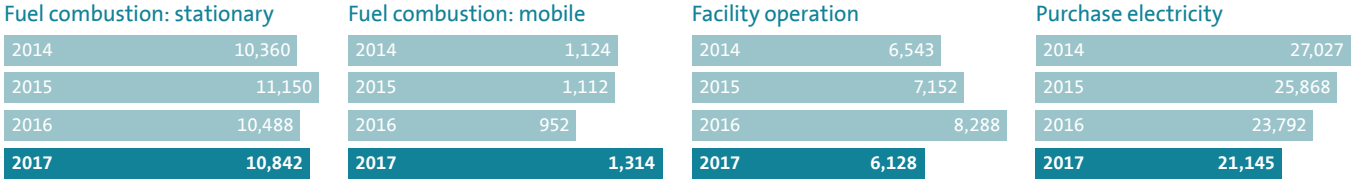
We continue to invest in our engineering infrastructure to improve energy efficiencies. Key projects this year included investment in areas such as lighting, mechanical ventilation, building controls, heating and domestic hot water services. These projects are having a positive impact on relevant Energy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

High Efficiency Lighting – after the success of our lighting replacement projects previously reported, we have invested heavily in this area in 2017 to reduce our carbon footprint and also benefit from the much improved light quality that this technology brings. On the back of the measured energy and aesthetic benefits of our internal upgrade to LED lighting in previous years, we have invested in excess of £2.5 million across 22 of our hospitals together with our finance offices at Regents Gate. We intend to invest further again 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 Dunedin, St Anthony's, Leicester and Fylde Coast hospitals during 2017, which will deliver a reduction in as consumption 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 replaced ageing systems at Spire Leeds and Tunbridge Wells hospitals in 2017. The new systems now include high-efficiency control and heat recovery systems that help deliver this critical air in the most efficient way.

Total emissions 2017 (tCO_2e)



Greenhouse Gas Emissions (GHG)
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 set 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 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. These include emissions associated with:

- fuel combustion: stationary (natural gas; and red diesel for backup generators); mobile (vehicle fuel);
- purchased electricity; and
- 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 Of Business, Energy and Industrial strategy emissions factor update published in 2017. There are no notable omissions from the mandatory scope one and two emissions. Approximately 7% of emissions are based on estimated data.

GHG emissions data
The GHG emissions for Spire Healthcare for the reporting period January – December 2017 were 39,429tCO_2e, tabulated by emissions source below. The 'facility operation' emissions are attributable to the use of medical gases, carbon dioxide and nitrous oxide, (5,201tCO_2e) and leakage of refrigerant gases (927tCO_2e). This is 9% lower than the emissions reported for 2016 (43,520 tCO_2e).

For purposes of baselining and ongoing comparison, it is required to express the GHG emissions using a carbon intensity metric. The intensity metric chosen is £m revenue. Spire Healthcare's revenue in 2017 was £931.7m, giving an intensity of 42.3 tCO_2e per £m revenue, 10% lower than last year.

Engineering Governance and Compliance

Our central engineering team was expanded in 2017. This development 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 audit 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 supplements the formal annual audits with regular routine visits which ensure the engineering governance system is dynamic with the continuous addition, closure and re-assessment of risk.

Risk management and internal control

The Group's risk management and internal control systems are overseen by two Board committees, with overall responsibility lying with the Board of Directors as a whole.

The Audit and Risk Committee, with the assistance of the Clinical Governance and Safety Committee ('CGSC'), provides the Board with a consolidated view of key risks from all levels of the Group, advice on the Group's overall risk appetite and strategy, and on the effectiveness of the Group's risk management and internal control processes.

The risk management framework is designed to identify, evaluate and mitigate the risks that the Group faces at all levels. This 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 2016, the Group implemented risk management software to support its approach to risk management. This software has been implemented across the Group and is now populated by risk registers for all hospitals. This allows a greater degree of oversight and analysis across the Group as well as enhancing integrated governance. Risk management is supported by a detailed framework and methodology to ensure that all hospital and business-level risks are identified and assessed consistently across all of Spire Healthcare.

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. 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 2018, the Group will continue to evolve its approach to and use of risk management to drive quality improvement.

Each hospital has a risk register and supporting governance structure, with processes for managing and reporting risks. Work is ongoing to create a consolidated overview across the Group, with this being a priority area for 2018. In 2018, the risk management framework will be fully embedded and integrated with clinical governance and patient experience indicators to drive risk management as a cornerstone of outstanding quality.

Significant risks facing the Group are managed through risk registers and are assessed in terms of consequence and likelihood. Each risk has an identified lead who works to monitor and mitigate that risk. Risk registers are reviewed on a regular basis at all levels in line with the Group's risk policy framework and/or in response to changes in the risk environment (for example following a change in regulations).

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 strategy section on page 14.

Clinical risks

During 2017, the CGSC chaired by Professor Dame Janet Husband focused on key clinical risks and trends including the review of notifiable incidents and external regulatory inspections across the Group. A copy of the CGSC Report can be found on pages 74 and 75.

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 the hospital operations and is led by the Group Medical Director, oversees a national programme of clinical audits, in addition to conducting on-site clinical reviews of every hospital and non-hospital unit, 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 18 and 19;
- the Group is subject to substantial levels of external inspection and review, both by the range of national healthcare regulators 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 2017.

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 management 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 need for an Internal Audit function was reassessed by the Audit and Risk Committee early in 2017 and it was agreed that an Internal Audit function should be established. A process to recruit a Head of Audit was undertaken and the function established at the end of Q2 with a remit to establish the audit function and create a risk-based audit approach for 2018.

A small team of experienced, professional Internal Auditors is being assembled and the function will be fully staffed by the end of Q1, 2018.

Internal Audit works closely with the other internal assurance mechanisms, i.e. Clinical Audit, Health and Safety Audits (including engineering) and Risk Management to align reviews where possible. Additionally, the Risk Management process moved its formal reporting line from Legal to Internal Audit in Q4.

Continuous learning

The Group recognises the importance of improving services by learning from events that fall below the expected 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 an independent whistleblowing service to facilitate reporting of any issues or concerns that staff may have that they are unwilling to raise via any other channel.

Viability Statement

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 adopted a period of three years for the assessment. A three-year period was selected as it corresponds with the Board's strategic planning horizon. Whilst existing bank facilities extend until July 2019, this viability assessment has also considered the ability of the Group to refinance bank facilities at the end of 2018 based on current market-lending multiples.

The assessment conducted considered the Group's revenue, EBITDA, operating profit, cash flows, risk management controls and loan covenants over the three-year period. 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 may be summarised as follows:

- 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 (this links with *Availability of key medical staff*);
- a key hospital is subject to temporary suspension of trade, with a permanent adverse impact on revenues, for example, due to failure to meet Care Quality Commission ('CQC') regulatory standards (this links with *Compliance with laws, regulations and other applicable requirements*);
- 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 (this links with *Cyber security*);
- 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 (this links with *Macroeconomic conditions and Government policy*); and
- the business is subject to significant uninsured losses arising from medical malpractice, negligence or similar claims (this links with *Insurance*).

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.

Principal risks

The Group's financial and operational risks, how they have changed and how they are managed are shown below.

Key:

- Risk increased
- Risk remained stable
- Risk decreased

Risk theme	Risk description and impact	Risk change 2017	How we manage the risk
Clinical care	The Group's future growth depends upon its ability to maintain its reputation for high-quality services by meeting its quality goals. Poor clinical outcomes, negative media comment or patient, GP and/or consultant dissatisfaction could reduce the quality ratings, which could lead to a loss of patient referrals and lost earnings.	→	Spire Healthcare continually monitors its clinical standards, policies and procedures through the Board's Clinical Governance and Safety Committee ('CGSC'). During 2017, regular management information and associated reporting has been provided to the Executive Committee. Management information is subject to continuous improvement to best leverage underlying clinical data. There is a schedule of regular Clinical Reviews using the Care Quality Commission's ('CQC') key lines of enquiries. Each hospital is reviewed at least annually with an action plan for improvement as well as an overarching improving plan across the Group. 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. 'Project Outstanding' was launched in early 2018 with the overarching objective of achieving a rating of Outstanding across the Group by 2020.
Government policy	Change in the medium-term public funding of NHS services provision, and/or the prioritisation of this funding to particular service lines over time (elective healthcare, A&E, community care, etc.), 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 (pricing arrangements) 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.	↑	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 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.

Risk theme	Risk description and impact	Risk change 2017	How we manage the risk
Compliance with laws, regulations and other applicable requirements	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 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, such that the Group may not be able to operate one or more of its hospitals, causing a significant reduction in profit. The CQC has continued its inspection regime which assesses and rates hospitals and makes these results publicly available. If a hospital fared badly in one of these inspections, it could result in that hospital being assessed as 'Inadequate' which could have significant regulatory and reputational impacts. As at the end of 2017, no Spire Healthcare hospitals had received an 'Inadequate' rating. The introduction of the General Data Protection Regulation ('GDPR') will bring tighter controls and responsibilities to how the Group controls and processes personal data. The Group is aware that HMRC has indicated it will hold a public consultation on reforms to the IR35 Regulation. It will be important that the Group understands the impact that any changes would have. In addition, the Group could fail to anticipate legal or regulatory changes leading to a significant financial or reputational impact.	↑	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, the Executive Committee has appropriate visibility to ensure robust decision-making, and 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. A GDPR implementation board is leading on preparation for GDPR. Progress has included a detailed gap analysis and the identification of associated risks and mitigations.
Insurance	Healthcare companies, including Spire Healthcare, are sometimes subject to actions alleging negligence, malpractice and other legal claims that may involve large potential damages and significant defence costs, whether or not the defendant is ultimately found liable. The Group 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.	→	The Group holds third-party liability insurance to partially cover patient, third-party and employee personal injury claims, and is partially self-insured up to predetermined levels, above which its third-party liability insurance applies. The Group reviews and maintains insurance adequacy of cover annually with the Group's broker.

Principal risks
Continued

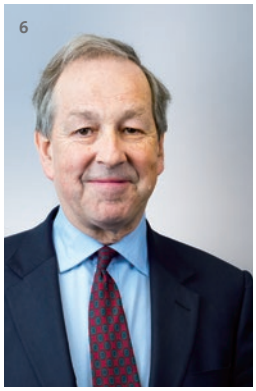
Risk theme	Risk description and impact	Risk change 2017	How we manage the risk
Concentration of PMI market	The PMI market is concentrated, with the top four companies (Bupa, AXA, Aviva and VitalityHealth (formerly PruHealth)) having a market share estimated at over 85%. Loss of an existing contractual 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 bargaining power in any ongoing commercial arrangements.	→	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 should provide a natural fit to the local requirements of all the PMI providers. The Group continues to ensure we have long-term contracts in place with our PMI partners to avoid co-termination of contractual arrangements.
Availability of key medical staff	Growing demand for healthcare, changes to the working requirements and a limited supply of appropriately qualified key medical staff may lead to a shortage of medical staff. Profitable growth, in line with the Group's strategy, requires an expansion of clinical services in hospitals, particularly including more complex surgical procedures and ongoing treatment of higher-risk patients, which could be impacted by a shortage of key medical staff. In order to expand our directory of services at hospital level, in line with our strategy, it is vital to have access to appropriately qualified, clinical staff. The market may see salary rates rise as competition for staff increases and, as a result, the Group's costs may increase and its profits may reduce. There may be further complexity to recruitment post-Brexit.	→	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. 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 has looked to ensure that all significant contracts run for a minimum of a year to avoid co-termination of contractual arrangements across its PMI base. The Group believes consultants are attracted by its advanced facilities, technology and equipment, excellent brand and reputation, the availability of a broad range of treatments, skilled nursing staff and medical support staff, and the efficiency of administrative support. 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, though these fell in 2017.
Macroeconomic conditions	Approximately 70% 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 number of insured individuals 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.	→	The Board manages this risk by regularly reviewing market conditions and economic indicators to assess whether actions are required. As successfully employed in the recent 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.
Competitor challenge	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. The potential impact would be the loss of market share due to a new competitor and reduced profitability and cash flow.	→	The Group maintains a watching brief on new and existing competitor activity and retains the ability to react quickly to changes inpatient and market demand. The Group considers that a partial mitigation of the impact of competitor activity is ensured by providing patients with high-quality care and by maintaining good working relationships with GPs and consultants.

Risk theme	Risk description and impact	Risk change 2017	How we manage the risk
Cyber security	The Group's information technology platform supports, among other things, management control of patient administration, billing and financial information and reporting processes. In common with other corporate organisations, 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 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 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.	→	Spire Healthcare'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, Spire Healthcare has created multiple layers of business protection 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 us to keep pace with the increasing risk profile, ensuring that the risk to Spire Healthcare has remain stable.
Investment plans and execution	The capital investment programme (which includes IT system developments) at any time consists of a number of individually significant projects simultaneously in progress. With any major project there are risks, such as major cost overrun or substantial delay in delivery, or disruption to business activities during capital builds which could impact upon the expected returns, the Group's planned profit growth and future cash flow.	→	The Group conducts a financial and operational appraisal process to evaluate the expected returns on capital during the evaluation phase of the project. Comprehensive project management is employed throughout the project, from the evaluation, to the bid process, agreement of contract terms and conditions, cost forecasting, as well as regular monitoring and management of progress. Regular reporting of all significant projects to the executive sponsor and the Board is provided. Learnings from recent new builds will strengthen the process going forward.
Liquidity and covenant risk	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.	→	The Group actively monitors and manages its liquid asset position, its financial liabilities falling due and the cover against its loan covenants. The Board has considered the risk in detail as part of its assessment of the viability of the Company.

The Strategic Report, from pages 1 to 55, was reviewed, approved by the Board and signed on its behalf on 1 March 2018.

Garry Watts
Chairman
1 March 2018

Board of Directors



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 C D N

Non-Executive Chairman

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 C D E

Chief Executive Officer

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

Current external appointments

- non-executive board member of Al Nadhi Medical Company
- non-executive chairman of The New World Trading Company Co.
- vice chair of NHS Partners 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.

3. Simon Gordon D E

Chief Financial Officer

Simon Gordon joined Spire Healthcare as Chief Financial Officer in July 2011 and became an Executive Director of the

Company in June 2014. Simon served as interim Chief Executive Officer between June 2017 and the end of October 2017. Simon resigned from the Board on 1 March 2018.

Skills and previous experience
Simon has a broad range of financial experience and brings invaluable knowledge of both audit and transaction advisory projects for both listed and private companies to the role. He qualified as a chartered accountant with KPMG before spending eight years as group finance director of Virgin Active. During his time at Virgin Active, the business grew from break-even to £150 million EBITDA, operating in five countries. This growth was achieved by a successful combination of organic development and acquisition.

4. Peter Bamford N R

Deputy Chairman and Senior Independent Director

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 21 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, being their chairman from 2010.

5. Dame Janet Husband A C N

Independent Non-Executive Director

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
- non-executive director 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 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 A C R

Independent Non-Executive Director

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 A C R

Independent Non-Executive Director

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

Current external appointments
- non-executive director and chair of the audit committee of easyJet plc
- 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 member of the board of trustees of Save the Children UK until December, 2017.

8. 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 Partners.

Current external appointments
- non-executive director of Avio S.P.A. (Italy)
- 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 Sahara Africa. Prior to joining Cinven, he worked with an international consulting firm on multidisciplinary engineering projects in the UK and southern Africa.

9. Danie Meintjes

Non-Executive Director

Danie Meintjes was appointed as a Non-Executive Director in August 2015. The Company does not consider Danie 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
Danie joined the Mediclinic International group in 1985, where he has held a number of senior positions. He was appointed as a director of Mediclinic International Limited (South Africa) in 1996 and then became its chief executive officer in April 2010. Danie holds a Bachelor of Personnel Leadership from the University of the Free State (South Africa) and has also attended the Advanced Management Program at Harvard Business School.

Danie will not seek re-election at the annual general meeting in May 2018. Mediclinic International PLC has nominated Dr Ronnie van der Merwe as its appointment to the Board from 24 May 2018.

Executive Committee

Board committee membership:

D Disclosure Committee

Management committee membership:

E Executive Committee

Committee Chair

Justin Ash C D E

Chief Executive Officer

See biography on page 56.

Simon Gordon D E

Chief Financial Officer

See biography on page 56.

1. Dr Jean-Jacques de Gorter E

Group Medical Director

Dr Jean-Jacques de Gorter joined Bupa Hospitals as director of clinical services in 2005 before being appointed Spire Healthcare's Group Medical Director in 2007. He is responsible for driving the Group's clinical governance, compliance and quality strategy.

Prior to joining Bupa he served as a medical director for NHS Direct. Jean-Jacques has also been a non-executive director at the Milton Keynes University Foundation Trust, chairing its Quality Committee. He graduated from Charing Cross and Westminster Medical School, practised in the UK, Australia and New Zealand and subsequently completed his MBA at Cranfield School of Management.

2. Peter Corfield E

Chief Commercial Officer

Peter Corfield joined Spire Healthcare in October 2015 as Group Commercial Director and has responsibility for delivering revenue growth through our payor groups and identifying new business opportunities. He was appointed Chief Commercial Officer in January 2018 with additional responsibility for business development across the hospital portfolio.

Prior to joining Spire Healthcare, he held a number of senior executive and board roles within the financial services industry in the UK, most recently as managing director of Ageas Retail Direct. Prior to this, Peter worked for both Zurich Financial Services Group and Royal Bank of Scotland in various roles that covered Europe, Middle East and Japan.

3. Neil McCullough E

Group Development Director

Neil McCullough joined Spire Healthcare on its formation in 2007 as Hospital Director at Spire Cambridge Lea Hospital before joining the executive team in 2011. In his role, Neil oversees Spire Healthcare's business development strategy both at the local hospital level and corporately.

Following an early career in accounting and finance, Neil moved into healthcare in 1993 working with Bupa UK Membership, where he held a number of senior sales and relationship management roles. He joined the Bupa Hospitals business in 1998, holding hospital general manager roles in both Birmingham and East Anglia. Neil then moved into preventative healthcare with Bupa Wellness in 2002, where, as sales director, he led the rapid expansion of the business for five years.

4. Daniel Toner D E

General Counsel and Group Company Secretary

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.

Daniel is a director of NHS Partners Network, an organisation that represents independent sector organisations that provide NHS services. Previously, he worked for international law firm Freshfields Bruckhaus Deringer, in industry and within the commercial directorate of the Department of Health.

5. Antony Mannion D E

Director, Strategy and Investor Relations

Antony Mannion joined Spire Healthcare as Investor and Public Relations Director in March 2012, having spent seven years at SSL International plc, until its acquisition by Reckitt Benckiser Group plc in 2010, as group legal director and head of acquisitions.

Prior to SSL International plc, Antony worked as a corporate lawyer at Freshfields in London and Paris, then as an investment banker at Citicorp in London and New York, and at Standard Chartered in Singapore. Antony has a wide range of experience in all areas of corporate finance, and has worked on significant acquisition and IPO transactions in both the UK and overseas.

Chairman's Governance Letter

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

Dear Shareholder,

Executive Directors
It was with great sadness that we announced the death of Andrew White in July following a period of illness. Andrew joined Spire Healthcare towards the end of 2015 and was appointed an Executive Director the following June. He made a significant contribution during his time with us, and his enthusiastic and positive approach are deeply missed.

I stepped back from my position as Executive Chairman at the end of June due to an illness and resumed my previous role of Non-Executive Chairman. At this time Simon Gordon agreed to act as Chief Executive Officer on an interim basis until a full-time appointment was made. I remained engaged with the business during my period of treatment.

Chief Executive Officer
We were delighted to appoint Justin Ash as the Company's new Chief Executive Officer from 30 October 2017. The Board believes Justin's skillset is particularly suited to developing Spire Healthcare as the premier UK private hospital group and to creating and delivering a strategy focused on our private patients.

Deputy Chairman and Senior Independent Director
I would like to take the opportunity to thank John Gildersleeve for his wise counsel and contribution to our Board. John served as our Senior Independent Director from Admission in July 2014 but chose not to seek re-election at last year's annual general meeting.

After an extensive search which I led with the assistance of Heidrick & Struggles, we were delighted to appointed Peter Bamford as Deputy Chairman and Senior Independent Director. Peter brings considerable plc board and leadership experience and the appointment maintains a strong independent presence on our Board. He gave considerable focus to ensuring that there was appropriate scrutiny of decision-making during my period of illness. Peter also chairs our Nomination Committee.

The table on page 61 summarises all of the changes to the Board made during 2017.

Subsequent to the year end, on 1 March 2018, Simon Gordon, our Chief Financial Officer, resigned from the Board and will leave the Group at the end of March 2018. Further details of Simon's departure are set out in the Directors' Remuneration Report on pages 78 to 95.

Simon has made a significant contribution to Spire during his time with the Group, and I would like to thank him in particular for his extensive contribution to the transformation of the business from private ownership to public listing, and more recently for fulfilling the interim CEO role in difficult circumstances.

We also recently received notification from Mediclinic Jersey Limited, our largest shareholder and a wholly-owned subsidiary of Mediclinic International PLC, that Danie Meintjes would not seek re-election at the annual general meeting in May. It has nominated Dr Ronnie van der Merwe to replace Danie as a Non-Executive Director of the Company from the conclusion of the meeting.

Governance

The Company did not comply with two aspects of the UK Corporate Governance Code, one on a short-term basis during the year, and you can read further about these and the Board's responses on page 62. The appointment of Justin Ash as Chief Executive Officer and Peter Bamford as Senior Independent Director has strengthened the Board.

As in previous years, the Board has taken the matter of governance extremely seriously and continues to perform well with the Non-Executive Directors all providing extensive challenge to management.

2017 performance evaluation

The Board's evaluation in 2017 was led by Peter Bamford and facilitated using Thinking Board, Independent Audit Limited's governance assessment process. Independent Audit Limited is a reviewer of board performance and is independent of the Company. This was the first time since Admission that an external third-party had been engaged by the Company and the review covered areas including strategy, Board and management succession, Board culture, balance and diversity, meetings and processes, investor relations, decision-making, risk management and Board committees.

The principal conclusions of Independent Audit Limited's review were presented by their lead facilitator and discussed at our meeting 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 page 65 as well as an update on the actions identified from last year's evaluation. The Board will again use the services of an independent third party to facilitate its evaluation in 2018.

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

Changes to your Board during 2017

Individual	Event	Date
John Gildersleeve	Stepped down as Deputy Chairman and Senior Independent Director	26 May 2017
Peter Bamford	Appointed as Deputy Chairman and Senior Independent Director	26 May 2017
Dame Janet Husband	Re-appointed as an independent Non-Executive Director following the completion of initial three-year appointment period	26 May 2017
Tony Bourne	Re-appointed as an independent Non-Executive Director following the completion of initial three-year appointment period	26 May 2017
Simon Gordon	Chief Financial Officer acted as interim Chief Executive Officer	13 June 2017 to 29 October 2017
Garry Watts	Resumed previous role of Non-Executive Chairman	1 July 2017
Andrew White	Sadly passed away and ceased to be an Executive Director	22 July 2017
Simon Rowlands	Appointment as a Non-Executive Director renewed for a further year	23 July 2017
Justin Ash	Appointed as Chief Executive Officer	30 October 2017

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 55.

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, 24 May 2018 at the offices of Freshfields Bruckhaus Deringer LLP, Northcliffe House, 28 Tudor Street, London EC4Y 0AY.

Garry Watts
Chairman
1 March 2018

Corporate Governance Report

Compliance with the UK Corporate Governance Code in 2017

The 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 'UK 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.2.1	From 14 March 2016 to 12 June 2017, the roles of Chairman and Chief Executive Officer were exercised by Garry Watts.	Simon Gordon was appointed interim Chief Executive Officer on 13 June 2017 and the roles were split. Garry Watts resumed the position of Non-Executive Chairman on 1 July 2017.
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
- Danie Meintjes 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 1 March 2018. 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 in the table 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
Danie Meintjes	Chief executive officer of Mediclinic International PLC, which controls 29.9% of the voting rights in the Company as at 1 March 2018

Key roles and responsibilities

Garry Watts
Non-Executive 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.
He 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.
He 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; and
- 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 Executive Chairman and the Chief Executive Officer

Between 14 March 2016 and 12 June 2017, Garry Watts served as both Executive Chairman and Chief Executive Officer. Simon Gordon was appointed as interim Chief Executive Officer on 13 June 2017. Garry Watts resumed the role of Non-Executive Chairman on 1 July 2017.

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

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 2017

During the year, the Board met for seven 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 65.

The agenda at scheduled meetings in 2017 covered standing agenda items, including: a review of the Group's performance by the Chief Executive Officer or Chief Operating Officer, the current month's and year to date financial statistics by the Chief Financial Officer and a review of clinical performance. 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.

During October and November, the Board devoted considerable attention to the potential offer for the Company received from Mediclinic International PLC. Before reaching its decision to reject the potential offer the Board gave consideration to the views of all stakeholders. Danie Meintjes did not attend Board meetings when the potential offer was discussed.

Also in 2017, the Board focused on major elements of the Group's operations by:

- reviewing the opening of the two new hospitals at Manchester and Nottingham, and progress made at Spire St Anthony's Hospital; and
- receiving, reviewing and approving other major capital expenditure proposals.

The Board received regular briefings on the trial of Ian Paterson and agreed the basis for a settlement fund for the benefit of his victims.

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 2017 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 2018

It is planned that the Board will convene on seven formal scheduled occasions during 2018, 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 2018 targets and also review succession planning during the year. Its activities will include:

- review and approve the 2017 Annual Report;
- review the proposed final dividend for 2017;
- review the revised five-year strategic plan and approve the 2018 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.

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.

Board evaluation

2017 Action plan update

The 2016 Board evaluation identified three principal areas of focus and associated actions to address them during 2017.

Area of focus	Actions	Progress
1) Risk management	• Continue to develop risk reporting, especially clinical, and the risk register to ensure the Board has adequate oversight of risk management and risk appetite. • Develop the relationship and interaction between the Audit and Risk Committee and CGSC. • Discuss and understand the Board's risk appetite.	Regular reporting of Audit and Risk Committee and CGSC matters at each other's meeting is now a standing item. Adèle Anderson, chair of the Audit and Risk Committee, has been appointed a member of the CGSC to further strengthen the link.
2) Board composition	• Appoint a strong Senior Independent Director to replace John Gildersleeve when he leaves the Board. • Review the roles of the Chairman, Senior Executive Director and the Executive Directors.	The Board was pleased to appoint Peter Bamford as Senior Independent Director in May 2017. His appointment ensures a strong independent presence on our Board.
3) Strategy	• Provide a mid-year strategy session update to the Board on progress made.	Following his appointment Justin Ash has taken the opportunity to review the Group's strategy and to present the results thereof to the Board in January 2018.

2018 Action plan

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

Area of focus	Actions
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.
2) Risk management	• Maintain oversight and evaluation of risk management. • Continue to develop internal risk management capabilities and processes. • Oversee General Data Protection Regulation implementation project. • Ensure IT security remains robust.
3) Board information	• Review information flows to/from Board.

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 disclosed below.

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 66).

Catherine Mason served as Chief Operating Officer until October 2017, when she left the organisation. The Group is currently in the process of recruiting Catherine's replacement.

Board meetings

The attendance of the Directors who served during the year ended 31 December 2017, 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[1,6]	5 (7)
Deputy Chairman and Senior Independent Director	
John Gildersleeve[2]	0 (3)
Peter Bamford[3]	4 (4)
Executive Directors	
Justin Ash[4]	1 (1)
Simon Gordon	7 (7)
Andrew White[5,6]	2 (4)
Non-Executive Directors	
Adèle Anderson	7 (7)
Tony Bourne	7 (7)
Dame Janet Husband	7 (7)
Danie Meintjes[7]	5 (7)
Simon Rowlands	7 (7)

1 Garry Watts resumed the role of Non-Executive Chairman on 1 July 2017.
2 John Gildersleeve stepped down as Deputy Chairman and Senior Independent Director on 26 May 2017.
3 Peter Bamford was appointed Deputy Chairman and Senior Independent Director on 26 May 2017.
4 Justin Ash was appointed Chief Executive Officer on 30 October 2017.
5 Andrew White sadly passed away on 22 July 2017.
6 During the year both Garry Watts and Andrew White were unfortunately unable to attend some meetings due to their medical treatment.
7 Danie Meintjes excused himself from Board meetings which discussed Mediclinic International PLC's potential bid for the Company.

Governance framework in 2017

Garry Watts
Chairman

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 UK 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;
- 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, Simon Gordon, 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 remuneration packages for the Chairman, Executive Directors and Group Company Secretary; and
- recommends and monitors the level and structure for other senior management remuneration.

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 pages 58 to 59.

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

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 includes both sessions on clinical and statutory regulations, and hospital visits.

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. 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 56 and 57.

Appointments to the Board

Recommendations for appointments to the Board are made by the Nomination Committee. The Nomination Committee follows a formal, rigorous and transparent procedure for the appointment of new Directors to the Board. Further information is set out in the Nomination Committee Report on pages 76 and 77.

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.

During the Chairman's illness in 2017, the other Directors ensured that adequate governance standards were maintained at Board and committee meetings that he missed.

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 appointment, Peter Bamford completed a detailed induction programme that included meeting with other members of the Board and the senior leadership team. He undertook a thorough familiarisation of the business which included a visit to Spire Bristol Hospital. The Company's brokers and legal adviser also met with Peter to provide insight into the healthcare industry and provide training on directors' statutory duties respectively.

Justin Ash, on appointment as Chief Executive Officer, spent considerable time learning about the business through a number of hospital visits and meeting colleagues. He also received training on his statutory duties.

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 John Gildersleeve, offered themselves for election or re-election at the third annual general meeting in May 2017 and, in future, will be re-elected in accordance with the requirements of the UK Code.

All Directors, except for Simon Gordon who leaves the Company on 31 March 2018 and Danie Meintjes who will not seek re-election, will stand for election or re-election at the annual general meeting in 2018. The biographical details of each Director standing for election or re-election is included in the 2018 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 2018 annual general meeting relating to the election of the Directors.

The biographical details of all current Directors are set out on pages 56 and 57.

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 (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 70 to 73 and identifies its members, whose details are set out on page 57.

The report describes the Audit and Risk Committee's work in discharging its responsibilities during the year ended 31 December 2017, and its terms of reference can be found on the Group's website at www.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 70 to 73 and pages 74 and 75, 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 2017 was led by the Chief Financial Officer and the Director, Strategy and Investor Relations and they attend a majority of the meetings. During the year, there were in excess of 230 individual meetings, conference presentations, group lunches and telephone briefings with investors.

The chair of the Remuneration Committee led a consultation on executive remuneration in February 2017 with both major shareholders and voting agencies.

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.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

During the year, the Board approved its first Modern Slavery Act statement which confirmed that Spire Healthcare is committed to acting ethically and with integrity in all its business dealings, and to implementing and enforcing systems and controls to prevent modern slavery in our own business and our supply chains. We are also committed to ensuring there is transparency in our approach to tackling modern slavery in our own business and supply chains. Spire Healthcare expects the same high standards from all of its contractors, suppliers and other business partners. All suppliers are required to comply with the law as well as our policies and codes to combat the use of forced, compulsory or trafficked labour, or anyone held in slavery or servitude, whether adults or children. We expect our suppliers in turn to hold their own suppliers to the same high standards. All supplier-facing staff receive training to raise awareness on the requirements of the Modern Slavery Act and are required to support the continued risk assessment and roll-out of our due diligence processes.

A copy of our Modern Slavery Act statement can be found on our website.

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 2017 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.

Results of our third annual general meeting held on 26 May 2017 were:

	Summary of resolution	Total votes for %	Total votes against %	Votes withheld
1	2016 Annual Report and Accounts	99.96	0.04	12,059
2	2016 Directors' Remuneration Report	99.58	0.42	1,088,678
3	Final Dividend	100.00	0.00	0
4 to 11	Election or re-election of Directors	Between 91.91 and 99.85	Between 0.15 and 8.09	Maximum 11,830,224
12	Reappointment of Auditors	99.98	0.02	1,160,559
13	Auditors' remuneration	100.00	0.00	0
14	Political expenditure	98.39	1.61	1,000
15	Authority to allot shares	95.61	4.39	0
16	Disapplication of statutory pre-emption rights*	94.31	5.69	1,484,171
17	General meetings to be held on 14 clear days' notice*	98.18	1.82	0

* 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
1 March 2018

Audit and Risk Committee Report

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, Committee Chair

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 2017.

Risk management and internal controls

Internal audit and risk management remained areas of particular focus for the Committee during the year and we allocated a significant proportion of each meeting to ensure a robust discussion on both matters.

Internal Audit function

As highlighted in our last annual report, we planned to set-up an in-house Internal Audit function and at the end of Q2 we appointed our new Director of Internal Audit and Risk. A small team of Internal Audit professionals were hired during the remainder of the year and the function should be fully resourced by the end of Q1 2018.

2017 and 2018 Internal Audit Plans

The 2017 Internal Audit Plan was focused on areas of higher risk and covered:

- a revenue audit (completed on behalf of Spire Healthcare by KPMG LLP);
- a review of physical asset assessments and maintenance through the buildings maintenance system; and
- an audit of business continuity planning.

Summary reports are sent to me as chair of the Committee when published and also included in the quarterly activity report to the Audit and Risk Committee.

Our Internal Audit Plan for 2018 continues to focus on areas identified as higher risk. Additionally, a regular, risk-based rotational Internal Audit of each of the 39 principal hospital sites (initially covering Finance (including Revenue, Billing and Stock Management), HR, IT, Payroll, Health and Safety, and Hospital Governance) will commence in Q2 2018, such that each hospital is intended to be audited at least once every three years.

An Internal Audit Plan will continue to be approved by the Committee on an annual basis.

Risk management

This year, a new risk management framework was implemented, following the review of risk management by the Board noted in last year's update.

Each hospital has a risk register and supporting governance structure, with processes for managing and reporting risks. In 2018, further work will be done to embed the risk management framework and integrate it with clinical governance and patient experience indicators to drive risk management as a cornerstone of outstanding quality.

Significant risks facing the Group are managed through risk registers and are assessed in terms of consequence and likelihood. Each risk has an identified lead who works to monitor and mitigate that risk.

An overview of the risk management and internal controls processes are contained on pages 50 to 55. The Committee, with the assistance of the Clinical Governance and Safety Committee ('CGSC') (which focuses on key non-financial risks, including patient and clinical risks), carried out the following during the year:

- monitored the work carried out by the CGSC in relation to the risks within its remit;
- monitored the Group's system of internal control;
- monitored the risks and associated controls over the financial reporting processes, including the process by which the Group's financial statements are prepared for publication; and
- reviewed reports from the external auditor on any issues identified during the course of its work, including on control weaknesses.

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 2017:

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 mis-coding 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. 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. Internal audit work (commissioned from a third party) was carried out to test the adequacy of clinical coders, 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. During 2017 an internal audit, supported by an external partner, was completed on Revenue and Billing function in a sample of hospitals which did not identify any significant errors or omissions. This area will remain a focus of the risk focused internal audit plan of hospitals during 2018.
• 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.	
Inappropriate capitalisation of development costs	Expenditure on capital projects has been significant in both 2016 and 2017. This expenditure covers a number of schemes across the network, most notably the development of two new hospitals in Manchester and Nottingham and the expansion of Spire St Anthony's Hospital. There is a risk of inappropriate capitalisation of costs to these projects to enhance reported earnings	The Committee considered the controls over capital expenditure incorporated within the Group's project management procedures, as implemented by the business development team. The Committee noted that the work carried out by Ernst & Young LLP supported its own independent findings in this area.
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 impairment tests performed by management and the appropriateness of the assumptions applied. For properties where headroom on the impairment test was limited the Committee reviewed the further evidence to support the specific site cash flow profile which supported the carrying value of the property.

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 2018 to ensure that changes to reflect the new regulatory environment and best practice are incorporated.

Other activities in 2017

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 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. 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.

In May, the Committee discussed the mandatory requirement for companies to rotate their external auditor every 10 years. Although noting that the 10-year period technically began with the Company's Admission in 2014, rather than an earlier point, the Committee agreed that a full external auditor tender should be linked to the end of Debbie O'Hanlon's term as lead audit partner.

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

- reviewing its proposed plan for the 2017 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 ending 31 December 2017, 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 2018.

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 2017 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 2017 is fair, balanced and understandable, and has affirmed that view to the Board.

Recent accounting developments

The Committee gave particular focus to IFRS 16 *Leases*, which will be adopted in the year ending 31 December 2019, focusing on the implication for reported results, the methodology in which the standard would be adopted, and the implication for systems and process.

The Chief Financial Officer also updated the Committee on the Group's adoption of IFRS 9 *Financial Instruments* and IFRS 15 *Revenue from Contracts with Customers*

in 2018. Please see note 2 of the financial statements on page 120 for further information.

Our priorities for 2018

We will continue to enhance and improve our Risk Management structure within the organisation and better evaluate our principal risks using an enhanced Board Assurance Framework. Our Internal Audit team will be fully resourced during Q1 and will start undertaking regular audits in each of our hospitals on a risk rotational basis and following up on agreed improvements to ensure they are effectively implemented as well as completing a number of key corporate audits around governance. We will evaluate our Clinical Assurance programme to ensure its independence and focus remain appropriate and works closely with the internal audit function.

Non-audit services and independence

There are certain services termed 'excluded services' that are not permitted to be provided by the external auditor, including where the auditor may be required to audit its own work, would participate in activities that would normally be undertaken by management or is remunerated through a 'success fee' structure.

Ernst & Young LLP provided no non-audit services to the Group during the year ended 31 December 2017 (2016: 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 51.

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 in Our people on page 46.

Audit and Risk Committee at a glance

Committee membership and meeting attendance

The Audit and Risk Committee members at the end of 2017 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 shown in brackets):

Member	Committee member since	Position in Company	Committee meetings attended in 2017
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	5 (5)

Committee members biographies are shown on pages 56 and 57.

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 Committee invites the external auditor, the 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 Committee or Chair of the Committee 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 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 and holding roles including chief financial officer of KPMG UK, chief executive officer of KPMG's captive insurer and chief financial officer of KPMG Europe. Adèle Anderson also currently chairs the audit committees of both easyJet plc and intu properties plc.

Role and responsibilities

The 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 relating to whistleblowing.

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

Annual evaluation of the Committee's performance

The evaluation of the Committee's performance was carried out in November 2017 which confirmed that it continued to perform effectively.

Adèle Anderson
Chair, Audit and Risk Committee
1 March 2018

Clinical Governance and Safety Committee Report

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, Committee Chair

Dear Shareholder,

On behalf of the Clinical Governance and Safety Committee (the 'Committee' or 'CGSC'), I am pleased to present our fourth annual report on the Committee's oversight of the Company's clinical services, promotion of best practice and clinical governance.

Robust and effective clinical governance is fully recognised throughout the Company as the keystone to delivering excellence in every aspect of patient care.

Firstly, I would like to acknowledge the support the Committee has received from the Board as a whole as well as that of individual non-executive members who have attended our meetings held in different Spire Healthcare hospitals around the country.

I am extremely grateful to the central leadership team who have provided the Committee with a comprehensive review of clinical quality across our business. Early in the year we welcomed Alison Dickinson in her new role as Chief Nursing Officer. She has been working closely with our Group Medical Director, Dr Jean-Jacques de Gorter, driving forward a programme of continuous development and ever improving clinical quality.

The appointment of our new Chief Executive Officer, Justin Ash, has brought new energy and focus to our drive for clinical excellence. While much has been accomplished during 2017, our Group Medical Director recently launched 'Project Outstanding' which will introduce a programme of clinical and non-clinical workstreams to ensure that outstanding quality is delivered in everything we do within every hospital and clinic across our network.

2017 activities

During 2017, the CGSC met on seven occasions, three of which were at one of the Company's hospitals. When holding our Committee meetings at hospitals, we extend the visit in order to engage with Hospital Directors, their senior management teams and front line staff.

We also have a tour of the hospital facilities and discuss issues with members of the Medical Advisory Committee and other consultants in different specialties. These extended Clinical Governance visits give Committee members better insight into the particular strengths of an individual hospital as well as an appreciation of the local healthcare environment and specific challenges. Hospitals visited this year were to Spire Gatwick Park, Spire Manchester and Spire Leicester.

Our clinical governance framework continues to underpin our approach to clinical assurance. The Committee regularly reviews a comprehensive set of data from our Clinical Reviews, our Quality Reports and a number of key performance indicators, including patient safety incidents.

Our clinical assurance methodology follows that of the Care Quality Commission ('CQC') domains – Safe, Effective, Responsive, Caring, and Well-led.

This approach allows us to align our own assessments with CQC inspections and to develop our services accordingly in a continuous bid to deliver outstanding care across our network.

This framework is augmented by a continued programme of Themed Reviews, which this year focused on:

- cancer, an area the Company continues to develop and where the drive for high standards involves co-ordinating our approach to bring our cancer teams together and working to strict protocols;
- complaints management, where the Company redesigned its approach to improve the patient experience;
- pharmacy, where the Company has reorganised its service under a single management and governance programme;

- pathology, where the service has been redesigned with a new framework reporting directly to the clinical team; and
- Resident Medical Officers (RMOs), where we gained solid assurance from NES, our preferred supplier, on the appropriate selection, training and management of this key clinical cadre of trained medical practitioners.

In addition to regular governance reports the Committee receives 'Responsible Officer Reports' reviewing consultant appraisal and revalidation data as well as a recently introduced new metric of monitoring surgical intervention ratios across different specialties. This allows benchmarking of surgical procedures and is already proving to be a useful tool in assessing specialist practice and understanding practice trends.

A culture of empowerment, team working and transparency is fostered to the benefit of all our staff and patients. In this light, whistleblowing is seen as a valuable tool for raising and understanding issues and oversight of its inquiry is an important role for the Committee both in identifying and rectifying any patient related concerns.

As discussed in my report last year, during 2017 the Committee worked closely with the Audit and Risk Committee ('ARC') in jointly reviewing our approach to risk. The two committees have clarified and revised their terms of reference, with the ARC being responsible for overall risk, while the CGSC concentrates on patient safety. The CGSC also has oversight of patient related aspects of Health and Safety Governance and Information Governance.

Regulatory inspections

Of the Spire Healthcare hospitals in England inspected by the CQC last year, three were rated 'Outstanding' and 20 'Good' overall. There were also many examples of hospitals rated 'Outstanding' and 'Good' for individual domains across our group. In addition, our two hospitals in Scotland were rated 'Very Good' by Healthcare Improvement Scotland and Spire Cardiff Hospital received a favourable inspection report (Healthcare Inspectorate Wales does not give ratings).

The process of preparing for and undergoing regulatory inspection has been immensely valuable in bringing teams together and in sharing information and best practice.

Hospital visits

At a personal level, I have now begun a second round of informal visits to all our hospitals. I do this primarily to listen to staff and patients; their engagement is extremely valuable in furthering my understanding of our services and of individual hospital culture. They also help to provide a strong link between the Board of Directors and our patients as I visit individual patients on the wards to ask about their experience. I am delighted to report that all the patients I have spoken to this year have been unanimous in their praise of our staff and their care.

Health care, in all its guises, and however technically advanced it may become, will always be an intensely personal activity. I thank all our staff for their dedication to delivering the highest quality treatment and care.

Clinical Governance and Safety Committee at a glance

Committee membership

The Clinical Governance and Safety Committee must have at least two members, one of whom must be an independent Non-Executive Director. The Board appoints the Chair of the Committee who must be an independent Non-Executive Director.

Member	Committee member since	Position in Company	Committee meetings attended in 2017
Dame Janet Husband (Committee Chair)	July 2014	Deputy Chairman and Senior Independent Director	7 (7)
Tony Bourne	July 2014	Independent Non-Executive Director	7 (7)
Garry Watts	July 2014	Executive Chairman	2 (7)
Justin Ash	October 2017	Chief Executive Officer	1 (1)

The maximum number of meetings that the member could have attended during 2017 is shown in brackets. Committee members' biographies are shown on pages 56 and 57. Andrew White was also a member of the Committee until he sadly passed away on 22 July 2017. Garry Watts was unable to attend a number of meetings due to his medical treatment. The Group Company Secretary, or their appointed nominee, acts as secretary to the Committee.

Role and responsibilities

These include:

- promoting a culture of high quality and safe patient care and experience;
- reviewing the Group Medical Director's Clinical Assurance Report and the quarterly review of serious adverse events;
- monitoring patient health and safety matters;
- reviewing patient information governance matters;
- reviewing the clinical matters on the Whistleblowing Register; and
- promoting continuous clinical improvements.

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

Developing our work

While our Committee is functioning well, our approach and areas of focus will continue to be enhanced, linked to our annual evaluation of performance and the Company's needs.

During 2018, the Committee looks forward to overseeing new approaches to quality governance, in particular to working with Justin Ash and his leadership team in their drive to deliver outstanding care across every hospital and every service in the Company.

Professor Dame Janet Husband
DBE FMedSci, FRCP, FRCR
Chair, Clinical Governance and Safety Committee
1 March 2018

Nomination Committee Report

The Committee's principal activities in the year have been the arrangement of interim leadership, and the recruitment and appointment of our new Chief Executive Officer.

Peter Bamford, Committee Chair

Dear Shareholder,

The Nomination Committee (the 'Committee') plays a key role in appointing the right individuals to the Company's Board and senior leadership team, and in their ongoing evaluation and development.

In the first part of the year under review, the Committee was chaired by John Gildersleeve, in his role as Deputy Chairman and Senior Independent Director. In anticipation of his retirement, in March the Committee reviewed a list of candidates to succeed him in the role, prepared by Heidrick & Struggles, an independent worldwide executive search firm. This review resulted in my appointment and I was pleased to join the Board as Deputy Chairman and Senior Independent Director at the end of May 2017. I look forward to chairing the Nomination Committee.

Director and Senior Management changes

Following my appointment, the Committee's immediate focus was on the arrangements required to ensure continuity of leadership in the face of Andrew White's tragic illness and to enable Garry Watts to revert to Non-Executive Chairman of the Company. We again used Heidrick & Struggles in our executive search, and in August the Committee was able to review a strong list of candidates for the role of Chief Executive Officer. I am pleased to report that we were able to secure the services of Justin Ash as permanent Chief Executive Officer.

The Committee's thanks go to Simon Gordon, who, as interim Chief Executive Officer, was able to provide excellent leadership during the transition period.

Since his appointment as Chief Executive Officer, the Committee has engaged positively with Justin Ash and we are now supporting him in his plans to further strengthen the Company's senior leadership team.

Performance evaluation

In November, the Committee completed its annual performance evaluation. In discussing the findings, it was agreed that the Committee would become more actively involved in the development of skills and capabilities within the Executive Committee and other members of the senior leadership team, and in succession planning. To this end, post year end, at our February 2018 Board meeting, the Committee's Terms of Reference were modified to reflect this change in emphasis, and are available on the Company's website.

Diversity and inclusion

In the Committee's report last year we noted the publication of the Hampton-Alexander review of gender leadership in FTSE companies and in this year's Annual Report we publish details of the Company's staff diversity and gender pay gap, in line with reporting requirements (see the Our people section on pages 44 and 47).

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 2018 to review the continuation in office, and potential re-appointment, of all members of the Board. Following this review, the Committee recommended to the Board that all Directors except for Simon Gordon, who resigned as an Executive Director on 1 March 2018, and Danie Meintjes, who has announced that he will not stand for re-election, be re-appointed, and hence all Directors will seek election or re-election at the annual general meeting.

Peter Bamford
Chair, Nomination Committee
1 March 2018

Nomination Committee at a glance

Committee membership and meeting attendance

The Nomination Committee members at the end of 2017 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 shown in brackets):

Member	Committee member since	Position in Company	Committee meetings attended in 2017
Peter Bamford (Committee Chair)	May 2017	Deputy Chairman and Senior Independent Director	5 (5)
Dame Janet Husband	July 2014	Independent Non-Executive Director	7 (7)
Garry Watts	July 2016	Non-Executive Chairman	7 (7)

Committee members' biographies are shown on pages 56 and 57. John Gildersleeve also served as a member of the Nomination Committee until 26 May 2017 when he resigned as a Director of the Company.

The majority of Committee members were independent Non-Executive Directors at all times during the year, in line with the provisions of the UK Corporate Governance Code. The Board appoints the Chair of the Committee, who must be either the Chairman of the Board or an independent Non-Executive Director.

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

Role and responsibilities

The 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 Committee will regularly examine 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 Committee will 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, 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 will have sufficient time to devote to the role and do not have any conflicts of interest

The Committee will utilise 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 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 will be reviewed, followed by the shortlisting of candidates for interview, based upon the objective criteria identified in the specification. Committee members will interview the shortlisted candidates, together with other Directors as appropriate, and identify a preferred candidate. Following these meetings, subject to satisfactory references, the Committee will make a formal recommendation to the Board on the appointment.

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

Directors' Remuneration Report

Our proposed remuneration policy provides alignment to our strategy to be famous for quality, and provide medium- and long-term strategy for shareholders.

Tony Bourne,
Committee Chair

Dear Shareholder,

I am pleased to present the Directors' Remuneration Report for 2017. This year's report also includes a slightly updated Remuneration Policy. The previous Remuneration Policy received strong support when last approved at the 2015 annual general meeting. Shareholder approval for a new policy will need to be sought at this year's annual general meeting under the three-year renewal cycle set out under the UK voting regime. Further detail regarding the policy renewal is set out below.

Alignment between pay and performance

While the Company has made positive progress in a number of strategic areas, trading conditions for Spire Healthcare remained challenging during 2017.

The Company's performance showed further growth in our key private patient income and reasonable progress on our three new major capital investment projects. Operating profit was significantly impacted by exceptional and other material items totalling £49.2 million for the year and was lower than the range targeted at the start of the year.

Taking into account the Group's performance, the Committee has determined that no bonus will be paid to any of our Executive Directors for 2017. In addition the LTIP award that was based on performance over the three years to 31 December 2017 will lapse in full as threshold performance was not achieved. While these incentive outcomes are disappointing, they demonstrate the rigour of our approach to pay and our desire to align remuneration with both business performance and shareholder returns.

As we look ahead, the Board is excited by the new strategy put forward by the management team. We are optimistic that successful execution of this strategy will lead to long-term value for our shareholders and that this will be positively reflected in future incentive outcomes.

For 2018, we have decided that certain quality performance targets will constitute a hurdle ('underpin') for the payment of any bonuses. This applies across the entire management of the Company from Chief Executive Officer to senior leadership teams in hospitals and demonstrates our commitment to quality.

Board changes during the year

In October 2017, Justin Ash joined the business as our new Chief Executive Officer. Justin has a proven track record in healthcare and the Board was delighted to have secured his appointment. Justin did not participate in any of the Company's incentive arrangements in respect of 2017. For 2018, the structure of his incentive arrangements and the maximum opportunity will be aligned with the existing package for Executive Directors, save that the level of bonus deferral into shares will be increased from one-third to one-half of any bonus earned. The Committee has made this change in order to increase alignment with our shareholders. In addition, shareholders will note that no buy-out awards were made to Justin on his appointment to the role.

Prior to Justin's appointment, the Board had to respond to certain unplanned and unfortunate circumstances. Firstly, it was with great sadness that we reported that Andrew White passed away following a period of illness. In his time with the Company, Andrew made a significant contribution to the business and it was our plan for Andrew to play a pivotal role in the future direction of Spire. Andrew is deeply missed by all of us.

Secondly, during the year Garry Watts stepped down from the role of Executive Chairman, to resume his previous non-executive Chairman role while he underwent medical treatment. In light of this, Simon Gordon agreed to undertake the role of interim Chief Executive Officer until Justin joined the business.

Further details regarding the remuneration decisions taken in respect of each of the above are set out in the main body of the report.

Annual evaluation of the Committee

The annual evaluation of the Committee's performance was carried out in November 2017 which confirmed that it continued to perform effectively.

AGM and Remuneration Policy renewal

The current remuneration policy was approved by shareholders at the 2015 annual general meeting, and at the time of adoption this policy received support from more than 99% of shareholders. This policy was relatively simple and straightforward in nature with Executive Directors participating in an annual bonus which was partly deferred into shares and a share-based long-term incentive plan subject to performance targets assessed over three years.

Shareholders will note that the key terms of the previous policy have been largely retained and that maximum incentive opportunities also remain unchanged. The only structural change proposed is for future LTIP awards to be subject to a post-vesting two-year holding period. This change will increase alignment with the long-term shareholder experience and more closely conforms with recent developments in best practice.

While the overall structure of remuneration for 2018 will remain substantially unchanged from prior years, during the year the Remuneration Committee intends to undertake an in-depth, holistic review of our arrangements to ensure that they remain aligned with our long-term strategy and shareholders' interests. As in prior years we would seek to engage with shareholders regarding the outcomes of this review.

We remain committed to having an open and transparent dialogue with shareholders on remuneration. If you have any questions about the content of this year's Directors' Remuneration Report you may contact me via companysecretary@spirehealthcare.com.

The Remuneration Committee looks forward to your continued support at the 2018 annual general meeting.

Tony Bourne
Chair, Remuneration Committee
1 March 2018

Remuneration Committee at a glance

2017 highlights

The Committee began the process to review the Company's Remuneration Policy which will be presented to shareholders for approval in 2018.

Agreed new and revised remuneration arrangements for the Company's Executive Directors.

Committee membership and meeting attendance

The Remuneration Committee members at the end of 2017 and the number of Committee meetings they each attended during the year are as follows (the maximum number of meetings that the member could have attended is shown in brackets):

Member	Committee member since	Position in Company	Committee meetings attended in 2017
Tony Bourne (Committee Chair)	July 2014	Independent Non-Executive Director	6 (6)
Adèle Anderson	August 2016	Independent Non-Executive Director	6 (6)
Peter Bamford	May 2017	Deputy Chairman and Senior Independent Director	3 (3)

Committee members' biographies are shown on pages 56 and 57. John Gildersleeve also served as a member of the Remuneration Committee until 26 May 2017 when he resigned as a Director of the Company.

The Remuneration Committee must have at least three members, all of whom must be independent Non-Executive Directors, and the Board appoints the 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 Committee.

Role and responsibilities

The Remuneration Committee has delegated 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 Executive Directors;
- 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.

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

Remuneration Policy Report

The following section sets out our Directors' Remuneration Policy that will be put to a binding shareholder vote at the annual general meeting in May 2018. If approved, it will be effective from this date.

The current policy was approved by shareholders in 2015, and therefore a new policy is being presented to shareholders under the standard three-year renewal cycle. The key features of the current policy have been retained and remain unchanged under the new policy. The current policy received strong shareholder support and the Remuneration Committee is of the view that the structure continues to be aligned with prevailing market and best practice.

As part of the renewal process the Committee has taken the opportunity to make minor updates to certain detailed aspects of the policy (e.g. remove references to legacy arrangements) and to reflect developments in market and best practice over the last three years, in particular, the addition of a holding period for future LTIP awards.

Remuneration Policy table

Fixed remuneration

Element	Purpose and link to strategy	Operation	Maximum opportunity	Performance measures
Salary	To provide fixed remuneration that is appropriate for the role and to secure and retain the talent required by the Group.	The Committee takes into account a number of factors when setting salaries, including: • scope and responsibility of the role; • the skills and experience of the individual; • salary levels for similar roles within appropriate comparators; • overall structure of the remuneration package; and • pay and conditions elsewhere in the Group. Salaries are normally reviewed annually.	While there is no defined maximum opportunity, salary increases normally take into account increases for full-time employees across the Group. The Committee retains discretion to make higher increases in certain circumstances, for example, following an increase in the scope and/or responsibility of the role, or a significant change in market practice or the development of the individual in the role. Current salary: • Justin Ash: £615,000 (from 30 October 2017)	None
Benefits	Fixed element of remuneration providing market competitive benefits to both support retention and recruit people of the necessary calibre.	A range of role-appropriate benefits may be provided to Executive Directors, including such items as private medical cover (for the Executive Director and their family), participation in an income protection scheme, life assurance, an annual health assessment (for the Executive Director and their spouse) and a car allowance. Additional benefits may also be provided where the Committee considers this appropriate (e.g. on relocation). Executive Directors are also eligible to participate in any all-employee share plans operated by the Company from time-to-time on the same basis as other eligible colleagues. The Committee keeps the benefits package offered to existing and new Executive Directors under review.	Whilst no maximum limit exists, individual benefit arrangements take into account a number of factors, including market practice for comparable roles within appropriate pay comparators. Participation in any HMRC-approved all-employee share plan is subject to the maximum permitted by the relevant tax legislation.	None
Retirement benefits	Fixed element of remuneration to assist with retirement planning. Retirement benefits are provided to both support retention and recruit people of the necessary calibre.	Executive Directors can opt to join the Company's defined contribution scheme, receive a contribution into a personal pension scheme, take a cash supplement or any combination of the three. The employer defined contribution level, the contribution into a personal pension scheme and/or cash supplement are kept under review by the Committee. The retirement benefits are not included in calculating bonus and long-term incentive quantum.	The maximum level of retirement benefits is 25% of base salary, and the current provision for the Executive Directors is 18% of base salary. They are set by taking into account a number of factors, including market practice for comparable roles at appropriate pay comparators. For new Executive Directors, the nature and value of any retirement benefits provided will be, in the Committee's view, reasonable in the context of market practice for comparable roles and take account of both the individual's circumstances and the cost to the Group.	None

Variable remuneration

Element	Purpose and link to strategy	Operation	Maximum opportunity	Performance measures
Annual bonus	To incentivise and reward the achievement of annual financial, operational and individual objectives that are key to the delivery of the Group's strategy.	Objectives are set annually to ensure that they remain targeted and focused on the delivery of strategic goals. The Committee sets targets that require appropriate levels of performance, taking into account internal and external expectations of performance. As soon as practicable after the year end, the Committee meets to review performance against objectives and determines payout levels. The Committee may adjust payments to ensure they are reflective of overall performance. A portion of any bonus (as determined by the Committee) is normally deferred into an award of shares under the Deferred Bonus Plan ('DBP'). Currently at least one-third of any bonus is deferred for a period of three years with the Chief Executive Officer deferring one-half of any bonus. DBP awards may be in the form of conditional share awards or nil-cost options or any other form allowed by the Plan rules. This deferred bonus element is not normally subject to any further performance conditions, although it is subject to continued employment. Further details of the malus and clawback provisions applicable are set out on page 82.	Maximum award opportunity for Executive Directors is 150% of base salary for each financial year, a portion of which is normally deferred into an award of shares under the DBP.	Awards are based on a combination of financial, operational and individual goals measured over one financial year. At least 50% of the award will be assessed against the Group's financial metrics. The remainder of the award will be based on performance against strategic objectives and/or individual objectives. A sliding scale between 0% and 100% of the maximum award pays out for achievement between the minimum and maximum performance thresholds. For annual bonuses in respect of 2018, the targets will be based on profit and certain strategic metrics. Further details are set out in the Annual Report on Remuneration. The details of measures, targets and weightings may be varied by the Committee year-on-year based on the Group's strategic priorities.
Long Term Incentive Plan (LTIP)	To incentivise and reward the delivery of long-term strategic objectives. To align the interests of the Executive Directors with those of shareholders. To assist recruitment and retention of Executive Directors.	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. The Committee will review performance against the targets set to determine the level of vesting. The Committee may adjust vesting outcomes to ensure that they are reflective of overall performance. Awards may be in the form of conditional share awards or nil-cost options or any other form allowed by the Plan rules. Further details of the malus and clawback provisions applicable are set out on page 82. Awards granted in 2018 and future years will normally be subject to a two-year holding period.	The maximum award opportunity (at grant) for Executive Directors in respect of a financial year is 200% of base salary.	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 2018, 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.

Notes to the policy table performance measures and targets

Annual bonus

The annual bonus performance measures are designed to provide an appropriate balance between incentivising Executive Directors to meet financial targets for the year and to deliver specific strategic, operational and personal goals. This balance allows the Committee to review the Group's performance in the round against the key elements of our strategy, and appropriately incentivise and reward the Executive Directors.

Bonus targets are set by the Committee each year to ensure that Executive Directors are focused on the key financial and strategic objectives for the financial year. In doing so, the Committee usually takes into account a number of internal and external reference points, including the Group's business plan.

Long Term Incentive Plan

The Committee believes it is important that the performance conditions applying to LTIP awards support the long-term ambitions of the Group and the creation of shareholder value. The Committee continues to consider that EPS and relative TSR metrics remain appropriate measures of long-term performance. Since 2017 awards have included Operational Excellence metrics to provide qualitative measures which are strategically important given the highly regulated and quality sensitive nature of the healthcare sector.

The Committee will keep the measures and weightings under review to ensure that the most appropriate measures to incentivise the long-term success of the Group are used.

Recovery provisions (malus and clawback)

Prior to vesting, the Committee may cancel or reduce the number of shares subject to, or impose additional conditions on LTIP and DBP awards in circumstances where the Committee considers it to be appropriate ('malus'). Such circumstances may include: a serious misstatement of the Group's audited financial results; a serious miscalculation of any relevant performance measure; a serious failure of risk management or regulatory compliance by a relevant entity; serious reputational damage to the Group; or the participant's material misconduct.

In addition, for cash bonus and LTIP awards the Committee may also apply malus and/or claw back in certain extreme circumstances (including those listed above) for up to two years following the determination of the relevant performance outcome.

Prior to applying malus or clawback, the Committee will take into account all relevant factors (including, where a serious failure of risk management or regulatory compliance or serious reputational damage has occurred, the degree of involvement of the employee in that failure or damage in question and the employee's level of responsibility) in deciding whether, and to what extent, it is reasonable to operate malus and/or clawback. The Committee is satisfied that the above provisions provide robust safeguards against inappropriate payment of incentive awards.

Recruitment policy

In determining remuneration for new Executive Directors, the Committee will consider all relevant factors, including the calibre of the individual and the external market, while aiming not to pay more than is necessary to secure the required talent. The Committee would seek to act in what it considers to be the best interests of the Group and its shareholders. Normally, the Committee will seek to align the new Executive Director's remuneration package to the Remuneration Policy, as set out above.

Salary and benefits (including any retirement benefits) will be determined in accordance with the policy table above. In certain instances, the Committee may decide to appoint an Executive Director to the Board on a lower-than-typical salary, with the intention of gradually increasing the salary to move closer to the market level as they build experience in the role. Normally, benefits will be limited to those outlined in the policy table above, including a relocation allowance in certain circumstances.

The maximum level of variable pay (excluding any buyouts) that may be awarded to a new Executive Director will be limited to 350% of base salary, which is consistent with the policy table above. Incentives will normally be granted under the existing plans; however, where appropriate, the Committee may tailor the award (e.g. time frame, form, performance criteria) based on the commercial circumstances.

The Committee may 'buy out' remuneration terms a new hire has had to forfeit on joining the Group. Buyout awards are intended to be of comparable commercial value, and capped accordingly. The Committee will take into account all relevant factors when determining the quantum and form/structure of any buyout, including any performance conditions attached to any forfeited awards, the likelihood of those conditions being met, and the proportion of the vesting/performance period remaining.

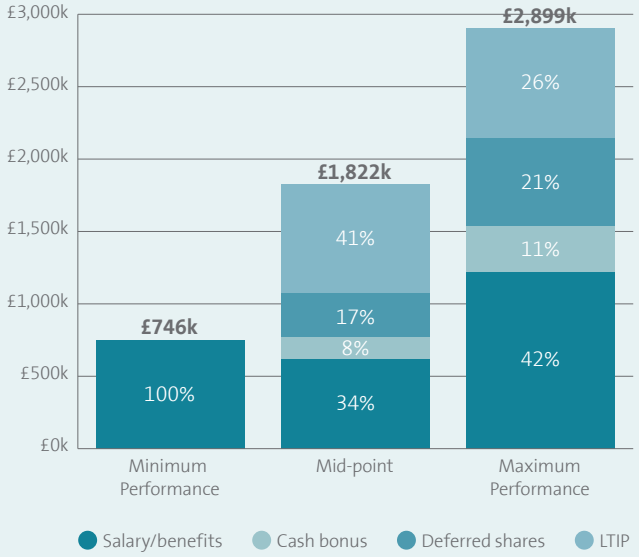
The service contracts for new appointments will be consistent with the policy described below. Where an Executive Director is appointed from within the organisation, the policy of the Group is that any legacy arrangements would be honoured in line with the original terms and conditions. Similarly, if an executive is appointed following an acquisition of, or merger with, another company, legacy terms and conditions would be honoured.

Illustration of the remuneration policy

The remuneration arrangements have been designed to ensure that a significant proportion of pay is dependent on the delivery of stretching short-term and long-term performance targets aligned with the Group's objectives, and on delivering shareholder value. The Committee considers the level of remuneration that may be received under different performance outcomes to ensure that this is appropriate in the context of the performance delivered and the value added for shareholders.

The chart below provides illustrative values of the annual remuneration package for the Chief Executive Officer in 2018 under three assumed performance scenarios. This chart is for illustrative purposes only and actual outcomes may differ from those shown. In accordance with the disclosure regulations, share awards have been shown at face value, with no share price growth, dividend accrual or discount rate assumptions.

Chief Executive Officer – Justin Ash



	Assumed performance	Assumptions
Fixed Pay	All Performance Scenarios	• Consists of total fixed pay, including base salary, benefits and retirement benefits. • Base salary – salary effective as at 1 January 2018. • Benefits – based on 2017 values (annualised). • Retirement benefits – 18% of 2018 salary
Variable Pay	Minimum Performance	• No pay-out under the annual bonus. • No vesting under the LTIP.
	Mid-point	• 50% of the maximum pay-out under the annual bonus. This represents 75% of base salary. A portion of the bonus is deferred into shares under the DBP. • 50% vesting under the LTIP. This represents 100% of base salary.
	Maximum Performance	• 100% of the maximum pay-out under the annual bonus. This represents 150% of base salary for both Executive Directors. A portion of the bonus is deferred into shares under the DBP. • 100% vesting under the LTIP. This represents 200% of base salary.

Executive Director service contracts and payments for loss of office

The key employment terms and other conditions of the current Executive Directors are set out below:

Provision	Policy
Notice period	12 months' notice by either the Group or the Executive Director. This is also the policy for new recruits.
Benefits	The Group may agree that certain benefits will be specified within the Executive Directors' service contracts. The current Executive Directors are contractually entitled to private medical cover (for the Executive Director and his family), income protection, life assurance, an annual health assessment (for the Executive Director and their spouse) and a car allowance.
Termination payment	The Group may terminate employment by making a payment in lieu of notice ('PILON') equivalent to (i) 12 months' base salary, and (ii) the cost of specific benefits (including retirement benefits). Upon termination by the Group, the Group can determine whether a PILON is made as a single lump sum or paid in instalments, subject to mitigation. Where the sum is paid in instalments, the Executive Director has a duty to use reasonable endeavours to secure alternative employment as soon as reasonably practicable. In the event the Executive Director commences alternative employment with a salary above a de minimus level, there will be a pro rata reduction in the PILON payments.
Immediate termination	The service contract of an Executive Director may also be terminated immediately and with no liability to make payment in certain circumstances, such as the Executive Director bringing the Group into disrepute or committing a fundamental breach of their employment obligations.
External appointments	Executive Directors may accept one position as a non-executive director of another publicly listed company that is not a competitor of the Group, subject to prior approval of the Board. External appointments to any other company (and treatment of any fees) are also subject to the prior approval of the Board.

In the event that the employment of an Executive Director is terminated, any compensation payable will be determined in accordance with the terms of the service contract between the Group and the employee, as well as the rules of any incentive plans in which they participate. Where appropriate, the Company may also make a payment in respect of outplacement costs, legal fees and the cost of settling any potential claims.

Where an Executive Director's employment with the Group ceases prior to the payment of the annual bonus in respect of a financial year, the Committee in its absolute discretion will determine whether any bonus should be paid and the extent to which deferral into shares should be applied. Any awards would normally be prorated. Malus and clawback provisions will also apply. For the avoidance of doubt, in the event the Executive Director is dismissed for misconduct, no bonus will be payable.

The treatment of share awards made by the Company is governed by the relevant share plan rules. The following table summarises the leaver provisions of share plans under which Executive Directors may currently hold awards.

Plan	Leaver reasons where awards may continue to vest	Vesting arrangements
Deferred Bonus Plan (DBP) and LTIP	Death Injury, ill health or disability Retirement The transfer of the individual's employing company or business out of the Group Any other scenario in which the Committee determines good leaver treatment is justified	LTIP awards will vest to the extent determined by the Committee, which, unless the Committee determines otherwise, will be calculated on the basis of the achievement of any performance conditions at the relevant vesting date and, unless the Committee determines otherwise, the period of time that has elapsed between grant and cessation of employment/directorship. The vesting date for such awards will normally be the original vesting date, although the Committee has the flexibility to determine that awards can vest upon cessation of employment. Unless the Committee determines otherwise, LTIP awards will normally continue to be subject to any holding period which applies to an award. DBP awards will normally vest in full on the original vesting date, although the Committee has the flexibility to determine that awards can vest earlier. DBP and LTIP awards will continue to be subject to the malus provisions outlined on page 82 until the vesting of the awards. LTIP awards granted from 2015 onwards are subject to a clawback provision, as described above.
	Any other reason	Awards lapse in full.

Where Executive Directors participate in any HMRC-approved all-employee share plans, the leaver treatment will be consistent with the relevant legislation and on the same terms as all other employees.

Non-Executive Chairman and Non-Executive Directors

The Group seeks to appoint Non-Executive Directors who have relevant professional knowledge (and/or specific technical skills) to support the current expertise of the Board and to match the healthcare sector within which the Group operates.

In the event of the appointment of a new Non-Executive Chairman and/or Non-Executive Director, remuneration arrangements will normally be in line with those detailed in the relevant table below.

Remuneration of independent Non-Executive Directors, with the exception of the Chairman, is determined by the Chairman and the Executive Directors. The remuneration of the Chairman is determined by the Committee. Directors are not involved in any decisions in relation to their own remuneration.

The table below sets out the remuneration policy with respect to Non-Executive Directors. Fees to Non-Executive Directors will not include share options or other performance-related elements. Non-Executive Directors do not participate in the Group's bonus arrangements, share incentive schemes or retirement benefit plans.

Approach to setting remuneration for Non-Executive Directors	Opportunity
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. Fees are reviewed periodically. When setting fee levels, consideration is given to a number of factors, including responsibilities and market positioning. Where appropriate, benefits to the role may be provided. Travel and other reasonable expenses (including fees incurred in obtaining professional advice in the furtherance of their duties and any associated taxes) incurred in the course of performing their duties may be paid by the Group or reimbursed to Non-Executive Directors.	The total fees paid to Non-Executive Directors will remain within the limit stated in the Articles of Association of the Company. Individual fees reflect responsibility and time commitment, as well as the skills and experience of the individual. Additional fees may be paid for further responsibilities, such as chairmanship of committees. Any benefits provided will be reasonable in the market context and take account of the individual circumstances and benefits provided to comparable roles. Expenses reasonably incurred in the performance of the role may be reimbursed or paid for directly by the Group, as appropriate, including any tax due on the benefits. Non-Executive Directors will also be covered by the Group's indemnity insurance. The fees as at 31 December 2017 were: • Non-Executive Chairman: £295,000; • Deputy Chairman and Senior Independent Director: £140,000; • independent Non-Executive Director basic: £55,000; • non-independent Non-Executive Director basic: £50,000; • Chair of Audit and Risk Committee: £10,000; • Chair of Remuneration Committee: £10,000; and • Chair of the Clinical Governance and Safety Committee: £15,000.

Under the terms of his appointment, Garry Watts is entitled to private medical cover (for both himself and his spouse and any dependent children), life assurance, annual health assessment (for both himself and his spouse) and office facilities to perform his duties as Chairman. Medical expenses insurance and life assurance will be provided under the Group's arrangements or, if he obtains equivalent benefits directly, the Group will meet his costs (up to a specified cap).

Non-Executive Chairman and Non-Executive Directors' letters of appointment

The Non-Executive Chairman and Non-Executive Directors have letters of appointment that set out their duties and responsibilities. They do not have service contracts with either the Group or any of its subsidiaries.

The key terms of the appointments are set out in the table below. This is the policy for current and any new Non-Executive Directors.

Provision	Policy
Period	In line with the UK Corporate Governance Code, the Chairman and all independent Non-Executive Directors are subject to annual re-election by shareholders at each annual general meeting. After the initial three-year term, the Chairman and the Non-Executive Directors are typically expected to serve a further three-year term.
Termination	The appointment of the Chairman is terminable by either the Group or the Director by giving 12 months' notice. The appointment of the Deputy Chairman is terminable by either the Group or the Director by giving three months' notice. The appointment of any independent Non-Executive Director is terminable by either the Group or the Director by giving two months' notice. The Non-Executive Director nominated by Mediclinic International PLC or any other shareholder representative is pursuant to the terms of any relationship agreement and is currently terminable without notice.

Further detailed provisions

The DBP and LTIP will be operated in accordance with the relevant plan rules. The Committee may adjust or amend awards only in accordance with the provisions of the relevant plan rules. This includes making adjustments to awards to reflect one-off corporate events, such as a change in the Group's capital structure. In accordance with the plan rules, awards may be settled in cash rather than shares, where the Committee considers this appropriate.

The performance conditions applicable to incentive awards may be amended on an appropriate basis determined by the Committee, if an event occurs or circumstances arise that cause the Committee to consider the performance condition is no longer a fair measure of performance.

Under the DBP and LTIP, participants may receive an additional amount, in cash or shares, to take account of the value of dividends the participant would have received on the shares that vest.

In the event of a change of control of the Company, LTIP awards may vest to the extent that the Committee determines, taking into account the extent to which any performance conditions have been satisfied, and such other factors as the Committee considers relevant in the circumstances, provided that, unless the Committee determines otherwise, awards will be adjusted to reflect the period of time that has elapsed between grant and cessation of employment/directorship; DBP awards will normally vest in full. Alternatively, awards may be exchanged for equivalent awards in the acquiring company.

The Committee may make any remuneration payments (including vesting of incentives) and payments for loss of office, notwithstanding that they are not in line with the Policy set out above, where the terms of that payment were either agreed: (i) prior to the implementation of the policy approved in 2014; (ii) during the term of, and were consistent with, any previous policy approved by shareholders; or (iii) at a time when the relevant individual was not a Director of the Company and, in the opinion of the Committee, the payment was not in consideration for the individual becoming a Director of the Company.

The DBP and LTIP incorporate dilution limits. These limits are 10% in any rolling 10-year period for all plans and 5% in any rolling 10-year period for executive share plans. Shares issued out of treasury will count towards these limits for so long as this is required under institutional shareholder guidelines. Shares issued, or to be issued, pursuant to any awards granted on or before the date of Admission will not count towards these limits. In addition, awards that lapse shall be disregarded for the purposes of these limits.

The Committee may make minor amendments to the Policy set out above for regulatory, exchange control, tax or administrative purposes or to take account of a change in legislation without obtaining shareholder approval for that amendment.

Remuneration arrangements throughout the Company

The Policy for our Executive Directors is designed in line with the remuneration philosophy and principles that underpin remuneration across the Group. When making decisions in respect of the Executive Directors' remuneration arrangements, the Committee takes into consideration the pay and conditions for employees throughout the Group. As stated in the policy table, salary increases are, in practice, normally aligned to the general employee population. The Committee does not directly consult with our employees as part of the process of determining executive pay.

Differences in Remuneration Policy for all employees

The remuneration of the wider employee population is based on the same reward philosophy, whilst the components of remuneration vary with seniority. All employees, including Executive Directors, receive a salary and role-appropriate benefits. Role-specific annual bonus arrangements are operated across the Group. Only senior individuals who can have significant influence on the performance of the Group as a whole are invited to participate in the long-term incentive plans. This provides those individuals with an incentive to help achieve the Group's medium- and long-term objectives and create shareholder value, whilst ensuring their remuneration varies to the extent these goals are achieved.

Consideration of shareholder views

The structure of remuneration for Board members was first presented to shareholders in the Prospectus prior to Admission. Since Admission, we have regularly engaged with shareholders regarding our approach to remuneration and we remain mindful of shareholders' views and emerging market and best practice when evaluating and setting future remuneration strategy.

This Remuneration Policy will be presented to shareholders for approval at the 2018 AGM.

Annual Report on Remuneration

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 2017. This comprises the total remuneration received over the full year from 1 January 2017 to 31 December 2017.

	Justin Ash[1]		Simon Gordon[2]		Andrew White[3]	
(£000)	**2017**	2016	**2017**	2016	**2017**	2016
Salary	**105.8**	–	**447.4**	363.1	**212.9**	182.5
Benefits	**3.4**	–	**17.3**	16.8	**7.6**	6.4
Retirement benefits	**19.0**	–	**80.5**	62.5	**36.5**	31.1
Annual bonus (including deferred element)	**–**	–	**–**	–	**–**	–
Long-term incentives[4]	**–**	–	**–**	422.4[5]	**–**	–
Sub-total	**128.2**		**545.2**	864.8	**257.0**	220.0
Legacy arrangement – Directors' Share Bonus Plan Award[6]	**–**	–	**–**	200.0	**–**	–
Total	**128.2**	–	**545.2**	1,064.8	**257.0**	220.0

1 Justin Ash was appointed as Chief Executive Officer on 30 October 2017 on a salary of £615,000 per annum.
2 Simon Gordon stepped down from the Board on 1 March 2018.
3 Andrew White sadly passed away and ceased to be an Executive Director on 22 July 2017.
4 The 2015 LTIP award is based on performance to 31 December 2017; as noted below this award will lapse in full and therefore no value is shown for 2017.
5 In line with the disclosure regulations, the LTIP value for 2016 has been restated to reflect the share price on 20 March 2017, being the date of vesting (333.5 pence). The restated amount includes a cash dividend equivalent payment of £8,440. On 30 March 2017, Simon Gordon exercised his 2014 LTIP award over 124,113 shares, selling 58,539 shares at an average price of 327.5 pence to cover tax and NIC due.
6 These awards were granted in 2014 and were granted in respect of performance prior to Admission. There are no further outstanding awards under this plan. Details of awards vesting in 2016 were set out in last year's Remuneration Report.

Additional notes to the table

Salary

Justin Ash's salary on appointment was £615,000 per annum. Simon Gordon's salary was increased from £367,500 to £373,013 per annum on 1 April 2017.

In June 2017, Garry Watts stepped down from his role as Executive Chairman, and Simon Gordon was appointed Interim Chief Executive. To reflect this role change and his expanded duties over the coming months, the Committee determined that Simon Gordon would be paid an interim salary supplement of £12,666 per month (equivalent to a total salary of £525,000 per annum) for a period of six months. This arrangement came to an end on 12 December 2017.

Benefits

The benefits consist of private medical cover (for the Executive Directors and their families), life assurance and income protection cover. Simon Gordon 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. Simon Gordon is a member of the Spire Healthcare Pension Plan. Amounts above the HMRC annual allowance are paid as taxable cash supplements.

Annual bonus

For the 2017 financial year, the maximum bonus opportunity for Simon Gordon was 150% of base salary. The annual bonus targets were set at the beginning of the financial year, with 70% of the award being assessed against EBITDA and 30% assessed against a balanced scorecard based on strategic targets including productivity, customer, quality and staff measures. The threshold EBITDA target for 2017 was set at £160.0 million and no bonus would be payable if this threshold was not achieved.

Once again the Company made progress in a number of areas, however, a number of internal and external factors impacted the business. This meant that it did not achieve the minimum EBITDA threshold of £160.0 million. Although Simon Gordon largely met his individual objectives under the balanced scorecard, the Committee determined that no bonus will be paid in respect of 2017.

The Committee note the importance of enabling our shareholders to understand the basis of bonus outcomes and the Company will therefore seek to provide expanded disclosure in respect of any bonuses paid in future years.

Justin Ash was not eligible for a bonus in respect of 2017.

Long Term Incentive Plan (LTIP)

The performance period for awards granted in 2015 ended on 31 December 2017. This award was based on targets linked to EPS and relative TSR performance.

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 2017, 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 2017 EPS was below the threshold of 23.8 pence. Therefore this award will lapse in full.

Awards under the LTIP were granted on 30 March 2017. 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 2019. The maximum award granted to Executive Directors was equivalent to 200% of base salary. Justin Ash and Garry Watts did not receive LTIP awards in 2017.

The Committee determined that in addition to the value created for shareholders over the period, measured by EPS and relative TSR performance targets, 2017 awards should also include an element based on Operational Excellence. Further details of the performance conditions applying to the 2017 awards are set out below.

LTIP

- Conditional award over shares were made in 2017 equivalent to 200% of base salary in the form of nil-cost options.
- Performance will be measured over the period from 1 January 2017 to 31 December 2019.

	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%)	18.5p[1]	20.5p	21.8p	23.2p
Operational Excellence:				
Regulatory Rating (15%)[2]	n/a	85% achieve 'Good' or above[1]	90% achieve 'Good' or above	100% achieve 'Good' or above
Net Promotor Score (15%)	82[1]	83	84	85

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 There is straight line vesting between the points shown.
4 The 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

Under the DBP, awards are deferred for a period of three years and are conditional on continued employment. There are no further performance conditions attaching to these shares although they remain subject to a malus provision. No award was made under the DBP in 2016 or 2017. The following award over shares was granted under the DBP in 2015 and relates to the 2014 bonus which was disclosed in the 2014 Annual Report and Accounts:

	Type of award	Date of award	Shares awarded	Shares exercisable
Simon Gordon	Conditional Share Award (in the form of nil-cost options)	1 June 2015	10,922[1]	1 June 2018 to 1 June 2025

1 The share price used to determine the number of deferred shares subject to award was £3.606, the mid-market closing share price on 29 May 2015.

The following table provides details of all outstanding awards, as at 31 December 2017, 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
Simon Gordon	Conditional Share Award (in the form of nil-cost options)	1 April 2015	193,905	£3.610	£700,000	31 December 2017
		30 March 2016	197,628	£3.542	£700,000	31 December 2018
		30 March 2017	223,146	£3.294	£735,000	31 December 2019

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. 2015 and 2016 awards are subject to EPS and relative TSR performance conditions. The 2017 award is subject to EPS, relative TSR performance and Operational Excellence conditions.
2 As noted above, the 2015 Award will lapse in full.

Andrew White's estate

Andrew White sadly passed away and ceased to be an Executive Director on 22 July 2017. Andrew received an LTIP award over 221,628 shares on 30 March 2017. As announced to the market in August 2017, the Remuneration Committee agreed that Andrew White's estate would receive:

- cash bonus award for 2017 of £136,875. The bonus payment was pro-rated by 50% in respect of the first six months of the year before Andrew White commenced sick leave on 30 June 2017 and was further pro-rated by 50%, being the proportion of bonus maximum that would accrue for on-target AOP performance; and
- vesting of a total of 134,339 shares (c. 32% of maximum) in respect of the 2016 and 2017 LTIP awards to the date of Andrew White's death as allowed for in the LTIP rules. Each award was pro-rated for time worked by Andrew White during the performance periods, i.e. up to 22 July 2017 and all performance metrics associated with each award were waived.

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

The basic fee for independent Non-Executive Directors was increased from £50,000 to £55,000 per annum from 1 April 2017. This was the first increase in Non-Executive Directors fees since Admission. The fee for the chair of the Clinical Governance and Safety Committee was also increased from £10,000 to £15,000 per annum from 1 April 2017.

The following table sets out the total remuneration for the Non-Executive Directors for the year ended 31 December 2017.

			Total remuneration	
(£000)	Fees	Benefits[5]	**2017**	2016
Adèle Anderson	63.8	1.3	**65.1**	25.6
Peter Bamford[1]	89.9	4.6	**94.5**	–
Tony Bourne	63.8	1.3	**65.1**	60.0
John Gildersleeve[2]	62.5	–	**62.5**	150.0
Dame Janet Husband	67.5	11.8	**79.3**	60.0
Robert Lerwill[3]	–	–	**–**	30.0
Danie Meintjes[4]	50.0	–	**50.0**	50.0
Simon Rowlands	50.0	–	**50.0**	50.0
Total	447.5	19.0	**466.5**	425.6

1 Peter Bamford was appointed Deputy Chairman and Senior Independent Director and chair of the Company's Nomination Committee on 26 May 2017.
2 John Gildersleeve stepped down as Deputy Chairman and Senior Independent Director on 26 May 2017.
3 Robert Lerwill stepped down as an independent Non-Executive Director on 27 June 2016.
4 As a Non-Executive Director nominated by the principal shareholder, Danie Meintjes's fees are paid to a subsidiary company within the Mediclinic International PLC group.
5 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 such cases, the Company will ensure that the Non-Executive Director is not out of pocket by settling the related tax via the PAYE Settlement Agreement. 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[1] (as Non-Executive Chairman) Jun 17 – Dec 17	Garry Watts[1] (as Executive Chairman) Jan 17 – Jun 17	Garry Watts[1] (as Executive Chairman) Mar 16 – Dec 16	Garry Watts[1] (as Non-Executive Chairman) Jan 16 –Mar 16
Salary/fees	**223.8**	**300.0**	479.0	51.8
Benefits	**3.0**	**2.7**	2.4	0.5
Retirement benefits	**–**	**–**	–	–
Annual bonus	**–**	**–**	–	–
Long-term incentives	**–**	**–**	–	–
Sub-total	**226.8**	**302.7**	481.4	52.3
Legacy arrangement – Directors' Share Bonus Plan Award[2]	**–**	**–**	233.2	–
Total	**226.8**	**302.7**	714.6	52.3

1 Garry Watts resumed his previous role of Non-Executive Chairman on 1 July 2017. He remained on a salary of £600,00 per annum until 30 September 2017 when it became £295,000 per annum. Between 14 March 2016 and 30 June 2017 he acted in the capacity of Executive Chairman.
2 These awards were granted in 2014 and were granted in respect of performance prior to Admission. There are no further outstanding awards under this plan. Details of awards vesting in 2016 were set out in last year's Remuneration Report.

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.

Although Garry Watts was eligible for a bonus in respect of his executive role, no bonus will be paid for 2017, in line with other Executive Directors.

On 1 July 2017, Garry Watts resumed the role of Non-Executive Chairman. Since 1 October 2017 he 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 Executive Chairman. Reasonable expenses incurred will be reimbursed by the Company.

Implementation for 2018

The following table summarises how remuneration arrangements will be operated for 2018. Shareholders will note that, for the fourth year, the maximum opportunity under the incentive plans will also remain unchanged.

Salary and benefits

- Following the year end, the Committee reviewed the base salaries as part of the annual salary review process.
- Justin Ash's salary will remain unchanged for 2018 at £615,000.
- No changes to benefits for 2018 – benefits include private medical cover, permanent health assurance, income protection, life assurance, an annual health assessment and car allowance. Company contributions retirement benefits remain at 18% of salary.

Annual bonus

The maximum opportunity will remain at 150% of salary.

- The performance targets in respect of the 2018 bonus will be based as to 75% on EBITDA and 25% on operational objectives. No bonus will be paid unless a minimum quality trigger or Group earnings targets are met. The detail of targets for the coming year is commercially sensitive; however, the Committee will look to provide disclosure regarding targets and bonus outcomes in next year's report.
- For the Chief Executive Officer, one half of any bonus earned will be deferred into shares for three years.

LTIP

- Conditional award over shares will be 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. The 2018 award will continue to include an element based on Operational Excellence.
- The Remuneration Committee have reviewed the targets for the performance period to ensure that they suitably reflect both internal and external expectations over the performance period. The Committee are satisfied that the target ranges for the 2018 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. The Committee have made some minor refinements to the Operational Excellence measures, while maintaining the stretch of targets.

	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]	n/a	85% achieve 'Good' or above[1]	90% achieve 'Good' or above	100% achieve 'Good' or above
Friends and Family (15%)[3]	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'. 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.
3 The measure of customer satisfaction has been changed to better align with the key measure of performance used in the business.
4 There is straight line vesting between the points shown.
5 The 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).

Shareholding guideline

- Executive Directors are expected to build up and maintain, over a period of five years, a shareholding equivalent to twice their respective base salaries.
- Justin Ash has until 30 October 2022 in order to reach his shareholding requirement.

Non-Executive Directors

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	£140,000
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

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 2017	As at 31 December 2016	Proportion of shareholding guideline achieved[1]
Non-Executive Chairman			
Garry Watts	**503,577**	503,577	
Executive Directors			
Justin Ash[2]	**173,600**	n/a	36%
Simon Gordon	**537,332**	471,758	183%
Andrew White[3]	**n/a**	–	
Non-Executive Directors			
Adèle Anderson	**–**	–	
Peter Bamford[4]	**5,000**	–	
Tony Bourne	**11,904**	11,904	
John Gildersleeve[5]	**125,761**	125,761	
Dame Janet Husband	**10,231**	10,231	
Danie Meintjes	**–**	–	
Simon Rowlands	**214,516**	214,516	

1 Calculated based upon the closing share price on 31 December 2017 of 253.6 pence.
2 Justin Ash was appointed Chief Executive Officer on 30 October 2017 and he held 89,100 shares on this date.
3 Andrew White sadly passed away and ceased to be an Executive Director on 22 July 2017 and he did not hold any shares as at this date.
4 Peter Bamford was appointed as Deputy Chairman and Senior Independent Director on 26 May 2017 and he did not hold any shares as at this date.
5 John Gildersleeve stepped down from the Board on 26 May 2017 and his share interests are shown as at this date.

There have been no changes to Directors' shareholdings between 31 December 2017 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 2017. 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[3]	0	–	–
Simon Gordon	614,679	10,922	–
Andrew White[4]	n/a	n/a	
Non-Executive Directors			
Adèle Anderson	–	–	–
Peter Bamford	–	–	–
Tony Bourne	–	–	–
Dame Janet Husband	–	–	–
John Gildersleeve	–	–	–
Danie Meintjes	–	–	–
Simon Rowlands	–	–	–

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 Justin Ash was appointed Chief Executive Officer on 30 October 2017.
4 Andrew White sadly passed away and ceased to be an Executive Director on 22 July 2017.

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
Danie Meintjes[1]	20 August 2015	Not applicable	20 August 2018
Simon Rowlands[2]	24 June 2014	2 months	23 July 2018

1 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, Danie Meintjes was appointed to the Board on 20 August 2015. Danie Meintjes is considered to be a non-independent Non-Executive Director. Mediclinic Jersey Limited has given notice that Danie Meintjes will not stand for re-election at the 2018 annual general meeting.
2 Simon Rowlands appointment was renewed for a further one-year period and a letter of appointment dated 23 July 2017 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.

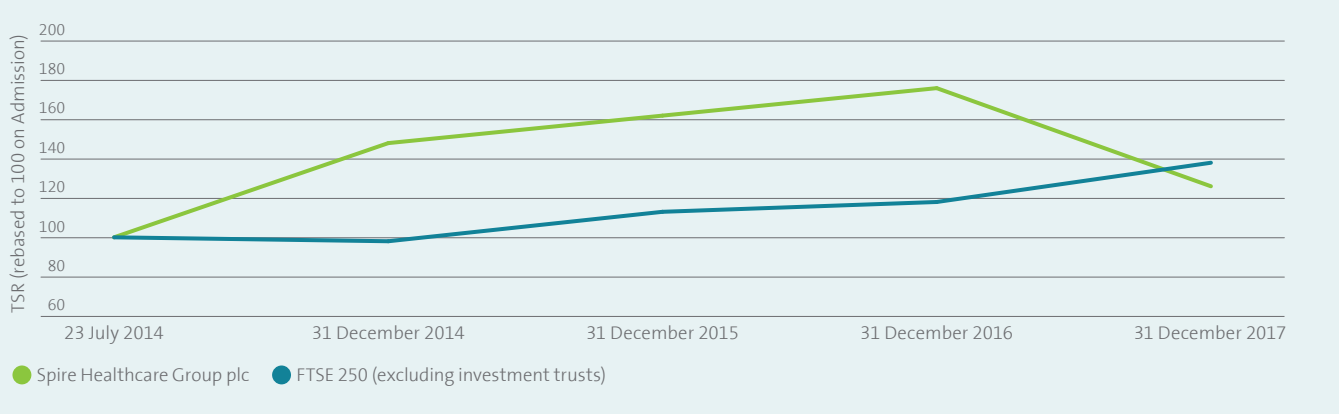
Service contracts

Justin Ash will put himself up for election at the annual general meeting to be held on 24 May 2018. 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.

Following Simon Gordon's decision to step down as a Director of Spire Healthcare Group plc on 1 March 2018, he will be leaving the business on 31 March 2018. His contract of employment is terminable on 12 months' notice which the Company intends to pay to him when he leaves the business. The Company does not intend to make any further cash payments for loss of office. All arrangements will be consistent with the shareholder approved Remuneration Policy.

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.

	2017	2016	2015	2014
Chief Executive's single figure remuneration (£000s)[1,2]	**128.2**[1]	320.5	1,095.8	6,223.1
Annual bonus payout (% of maximum)	**0%**	0%	0%	34%
LTIP vesting (% of maximum)[3]	**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 did not have any LTIP awards vesting in respect of 2017; for other participants (including Simon Gordon) the LTIP based on performance to 31 December 2017 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 2016 and 2017.

	Chief Executive Officer/Executive Chairman % change[1]	Other employees % change
Base salary	n/a	1.5%
Benefits	n/a	-0.6%
Annual bonus	n/a	0%

1 As noted above, Justin Ash was appointed Chief Executive Officer on 30 October 2017. Consequently, full year comparable data is not available.

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)	2017	2016	% change
Total remuneration	**281.7**	268.0	5.11
Distributions to shareholders	**15.2**	14.8	2.70

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 £57,950 (2016: £19,500). During 2017, 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, Chief Financial Officer, 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 2017 annual general meeting

The following table sets out the voting in respect of the resolution to approve the Company's 2016 Directors' Remuneration Report, put to shareholders at the Company's annual general meeting held on 26 May 2017:

Resolution	Votes for	% of vote	Votes against	% of vote	Votes withheld
Approve the 2016 Directors' Remuneration Report	323,221,140	99.58%	1,364,890	0.42%	1,088,678

The Directors were pleased with the response received from shareholders to the resolution proposed. This report on Directors' remuneration will be put to an advisory vote at the annual general meeting on 24 May 2018. 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 1 March 2018. The Company's Remuneration Policy was approved at its annual general meeting in 2015 and received 99.56% of the vote in favour from shareholders. It is next intended that the Remuneration Policy will be put to a binding vote at the annual general meeting on 24 May 2018.

Details of all resolutions passed at the annual general meeting held on 26 May 2017 can be found on page 69.

Share prices

The market price of a Spire Healthcare Group plc ordinary share at 31 December 2017 was 253.6 pence and the range during the year was 221.5 pence to 361.0 pence.

Tony Bourne
Chair, Remuneration Committee
1 March 2018

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 2017.

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 55 and the Directors' Remuneration Report on pages 78 to 95, 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 Corporate social responsibility on pages 48 and 49;
- employees, which can be found in the Human Resources review – Our people on pages 44 to 47;
- the Corporate governance statement, set out on pages 62 to 67; and
- Our strategy set out on pages 14 and 15.

A description of the Group's exposure and management of risks is provided in the Strategic Report on pages 50 to 55.

Information regarding the Company's Gender Pay Gap Reporting and charitable donations can be found in the Human Resources review – Our people on pages 44 to 47.

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, Northcliffe House, 28 Tudor Street, London EC4Y 0AY on Thursday, 24 May 2018 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 2017 of 2.5 pence (2016: 2.5 pence) per ordinary share making a proposed total dividend for the year of 3.8 pence per share (2016: 3.8 pence). Subject to shareholders approving the recommendation at the annual general meeting, the final dividend will be paid on 26 June 2018 to shareholders on the register as at 1 June 2018.

The Company paid an interim dividend in respect of the year ended 31 December 2017 of 1.3 pence per share on 12 December 2017.

Board of Directors

The following changes were made to the Board of Directors during the year:

- John Gildersleeve stepped down as Deputy Chairman and Senior Independent Director on 26 May 2017;
- Peter Bamford was appointed Deputy Chairman and Senior Independent Director on 26 May 2017;
- Andrew White sadly passed away on 22 July 2017 and ceased to be an Executive Director; and
- Justin Ash was appointed Chief Executive Officer and an Executive Director on 30 October 2017.

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, except for Simon Gordon who leaves the Company on 31 March 2018 and Danie Meintjes who will not stand for re-election, 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 56 and 57.

Further information on the contractual arrangements of the Executive Directors is given on page 84. The Non-Executive Directors do not have service agreement.

Subsequent to the year end, Simon Gordon resigned from the Board on 1 March 2018. A search is underway for his replacement.

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 68 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 launched the 'Spire Healthcare discussion channel', a new communication channel established to provide colleagues, on a regular basis, with audio updates from our leadership team – covering topics which are pertinent to our business; from our strategic direction to operational and people highlights. 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 Our people on pages 44 to 47.

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 281,631 ordinary shares of 1 pence each (2016: 670,559). Further details can be found in note 19 on page 132.

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 page 132.

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 page 132.

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 2018 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 92.

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 1 March 2018, 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
Woodford Investment Management LLP	16.02
The Capital Group Companies, Inc	4.83
Norges Bank	4.32
GIC Private Limited	3.95

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 78 to 93. 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.

Information required	Location in Annual Report 2017
Amount of interest capitalised	Note 7 on page 123
Long-term incentive schemes	Directors' Remuneration Report pages 78 to 95
Equity securities allotted for cash	Note 19 on page 132
Parent and subsidiary undertakings	Note 15 on page 130
Subsisting significant agreements	Page 98
Controlling shareholder relationships	Pages 69 and 98

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 2017 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 2017.

Going concern
The Group is financed by a bank loan facility that matures in July 2019. The Directors have considered the Group's forecasts and projections, and the risks associated with their delivery, and are satisfied, based on prevailing market conditions, that the Group will be able to refinance this bank loan facility, on terms largely comparable to the current facility, before it matures.

On the same basis, the Directors are also satisfied that the Group will be able to operate within the covenants imposed by the current bank loan facility for the foreseeable future. In relation to available cash resources, the Directors have had regard to both cash at bank and a £100.0 million committed undrawn revolving credit facility. Accordingly, they have adopted the going concern basis in preparing these financial statements.

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
1 March 2018

Statement of Directors' responsibilities

The Directors are responsible for preparing the Annual Report and Accounts for the year ended 31 December 2017, 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 56 and 57, 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 2017, 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
1 March 2018

Simon Gordon
Chief Financial Officer
1 March 2018

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 2017 and of the Group's profit for the year then ended;
- the financial statements have been properly prepared in accordance with 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; 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 which comprise:

	Group	Parent Company
Balance sheet as at 31 December 2017	✓	✓
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 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.

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.

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 55 that describe the principal risks and explain how they are being managed or mitigated;
- the Directors' confirmation set out on page 99 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 99 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 12 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 51 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 revenue by changes to the pricing master file. • Misstatement due to management posting fraudulent manual journal entries to revenue. • Inappropriate capitalisation of costs to property, plant and equipment. • Property carrying values (hospital assets).
Audit scope	• We performed an audit of the complete financial information of four Group companies and audit procedures on specific balances for a further 14 Group companies. • The Group companies where we performed full or specific audit procedures accounted for 100% of revenue and 100% of Total assets.
Materiality	• Overall Group materiality of £3.5 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 judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in 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 revenue by changes to the pricing master file **2017: NHS revenue** £287.8m 2016: £293.4m **2017: PMI revenue** £426.0m 2016: £429.3m *Refer to the Audit and Risk Committee Report (pages 70 to 73); Accounting policies (pages 115); and note 6 of the consolidated financial statements (page 123).* Inappropriate revenue recognition by way of management manipulation of the pricing master file, resulting in inaccurate patient invoicing in respect of PMI and NHS revenue. The high volume of patient transactions, for which pricing is individually agreed by procedure with PMI providers and the NHS, leads to a higher likelihood of material misstatement through intentional changes to individual pricing on the pricing master file. We considered that the pressure to achieve forecast results or targets increases the risk of financial reporting manipulation by management.	To gain assurance over revenue recognised during the period, we tested the two-way correlation between revenue and trade receivables and three-way correlation between revenue, trade receivables and cash for the year. We also tested other revenue and receivables transactions that didn't conform to our expectation of typical revenue postings. In order to specifically address this fraud risk, we performed the following procedures: • we understood and evaluated the controls that have been designed and implemented to prevent or detect misstatements due to fraud associated with changes to the pricing master file. We adopted a fully substantive approach to addressing this fraud risk, and as such did not test or rely on the controls identified; • for PMI revenue, we have tested a representative sample and agreed prices from SAP billings (revenue) to insurer contracts, price lists, or other supporting correspondence as applicable. In instances where no contract was available, we have traced settlement of the invoice directly to cash; • we used a data analytics tool to address the fraud risk for NHS revenue. We used publicly available NHS national tariff base prices and Market Force factors to check the pricing accuracy of the NHS revenue for the year. For the population outside of the National Tariff, we have agreed a sample of the billings to underlying signed agreements with NHS or other supporting correspondence as applicable, including cash; and • we investigated whether there had been pricing disputes with insurers or the NHS during the year through discussion with senior finance and commercial management, legal counsel, review of Board and Executive Committee minutes and verifying this to correspondence, where available. Additionally we searched journal descriptions for key words that might indicate the existence of pricing disputes; and • we reviewed the ageing of accounts receivable to identify instances of aged debt which might indicate a pricing dispute with the customer.	We did not identify material errors on pricing, nor evidence of management manipulation of revenue through this means. Furthermore, we did not identify any indicators of pricing disputes with insurers or 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 **2017: PMI** £426.0m 2016: £429.3m **2017: NHS** £287.8m 2016: £293.4m **2017: Self-pay** £186.9m 2016: £170.4m *Refer to the Audit and Risk Committee Report (pages 70 to 73); Accounting policies (page 115); and note 6 of the consolidated financial statements (page 123).* 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 and low value revenue transactions, results in limited opportunity for management to fraudulently misstate revenue at a transactional level, (other than through manipulation of changes to the pricing master file as considered on page 102). For management to be able 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 of the journal entry process, including the journal entry process for the consolidation, and adjusting journals which are posted directly to the financial statements. We have used our understanding of this process to develop our journal testing approach. • 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 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 **2017: Costs capitalised** £119.9m 2016: £160.4m *Refer to the Audit and Risk Committee Report (pages 70 to 73); Accounting policies (page 116); and note 13 of the consolidated financial statements (page 128).* Given management's bonus structure and analysts' expectations of the Group's performance, for example earnings per share, we consider the risk of inappropriate capitalisation to be a fraud risk. In the prior year, the Group had three large development projects (Spire Manchester, Nottingham and St Anthony's hospitals) which were substantially completed in this year. The capital expenditure for FY17 is across several existing hospitals and over all property, plant and equipment categories. Given the scale of the 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 understood and evaluated the controls that have been designed and implemented to prevent or detect misstatements due to fraud or error associated with the inappropriate capitalisation of costs on hospitals. We identified an operating control deficiency and as a result adopted a fully substantive approach to address this fraud risk. • We selected a sample of costs capitalised during the year to address the nature of the items capitalised, and to assess whether the items have been appropriately capitalised in accordance with IAS 16. Our sample included both high and low value items. We obtained the invoice to verify the existence and valuation of each item, and also obtained evidence that the expenditure was authorised based on the delegation of authority matrix. We verified that the expenditure was capital in nature by reading the descriptions and details on the invoices and supporting documentation. We obtained evidence certified by third-party surveyors to support the value of work completed by the main contractors for large project samples selected. • Where internal costs were capitalised, we verified that the costs were directly attributable to the relevant project by obtaining calculation of staff cost multiplied by percentage time allocated to specific projects, correspondence from project managers confirming the percentage time for staff to be allocated, and payslips to confirm staff costs. • 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 material 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
Property carrying values (hospital assets) **2017: Freehold property carrying value** £582.9m 2016: £575.2m *Refer to the Audit and Risk Committee Report (pages 70 to 73); Accounting policies (page 116); and notes 5 and 13 of the consolidated financial statements (pages 122 and 128)* 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 we consider that there is a risk that properties are held in the financial statements at an inappropriate carrying value.	• We obtained a comparison of each hospital's EBITDA for 2017 to its budget. We selected certain freehold and long leasehold hospital properties to focus on, specifically those which show notable underperformance compared to budget and prior year in percentage terms. • We obtained management's value-in-use calculation for the selected hospitals. We have understood the process and controls behind the preparation of management's underlying three-year forecast, given management's reliance on the plan for the value-in-use model. We have reviewed performance against budget to assess management's ability to accurately forecast. • We tested the reasonableness of management's cash flow forecasts by comparing to prior year actuals and the prior year forecasts. We discussed the forecasts with management to understand local factors regarding strategy and market forces which had been taken into account in the forecasts. We corroborated the key assumptions to evidence. We focused our procedures on two hospitals which had minimal headroom. • We engaged our valuation specialist to assist us in verifying the appropriateness of certain key inputs to the discounted cash flow model, such as the discount rate, certain growth rates and the terminal growth rate.	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 manipulation of accrued patient revenue. In the current year we have concluded that, due to the size of the accrual at any point in the reporting period, any manipulation is unlikely to be material and have removed this as an area of significant risk.

An overview of the scope of our audit

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 four (2016: four) entities ('full scope components') which were selected based on their size or risk characteristics. For a further 14 (2016: 19) entities ('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% (2016: 100%) of the Group's revenue and 100% (2016: 100%) of the Group's total assets. For the current year, the full scope components contributed 92% (2016: 88%) of the Group's revenue and 68% (2016: 69%) of the Group's total assets. The specific scope components contributed 8% (2016: 12%) of the Group's revenue and 32% (2015: 31%) 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 consolidated profit before tax amount to more than 100%.

For the remaining 17 non-dormant entities we performed other procedures, including analytical review and testing of the clerical accuracy of the consolidation to respond to any potential risks of material misstatement of the Group financial statements.

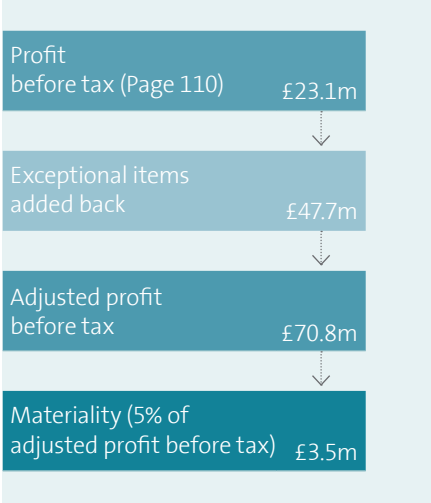
The audit of the entities within the Group is undertaken by one audit team which is led by the senior statutory auditor.

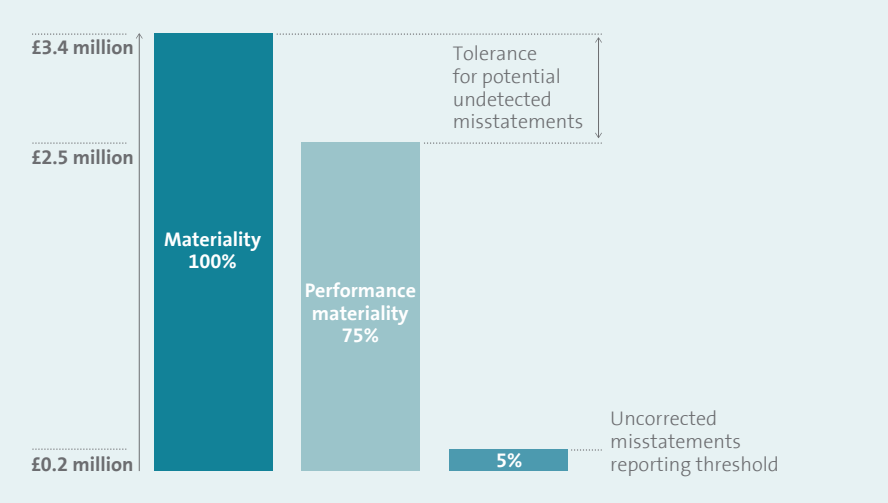
Changes from the prior year

There have not been any significant changes to the scope of our audit from the prior year.

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 £3.5 million (2016: £4.1 million), which is 5% of adjusted profit before tax (2016: 5% of adjusted profit before tax). We have adjusted profit before tax for certain exceptional items amount to £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 £1.5 million of exceptional items which are not significant.

We determined materiality for the Parent Company to be the same as materiality for the Group.

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% (2016: 75%) of our planning materiality, namely £2.5 million (2015: £3.1 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 subsidiary entities was £0.5 million to £2.5 million (2016: £0.5 million to £2.8 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 £0.2 million (2016: £0.2 million), which is set at 5% of 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 99, including, the Strategic Report set out on pages 2 to 55 and Governance report set out on pages 56 to 99, 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 99 – Statement of Director's 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 70 to 73** – 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 set out on page 99** – 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 99, 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, and the Data Protection Act of 1998. 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 Group 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; and
- 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 Group 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 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 10 years, covering the years ended 31 December 2008 to 31 December 2017.
- 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.

Debbie O'Hanlon (Senior statutory auditor)
for and on behalf of Ernst & Young LLP, Statutory Auditor
London
1 March 2018

Notes applicable where this report is published electronically:

1 The maintenance and integrity of the Spire Healthcare Group plc website is the responsibility of the Directors; the work carried out by the auditor does not involve consideration of these matters and, accordingly, the auditor accepts no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.
2 Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Consolidated income statement

For the year ended 31 December 2017

(£ million)	Notes	2017 Total before exceptional and other items	2017 Exceptional and other items (note 9)	2017 Total	2016 Total before exceptional and other items	2016 Exceptional and other items (note 9)	2016 Total
Revenue	6	**931.7**	**–**	**931.7**	926.4	–	926.4
Cost of sales		**(492.2)**	**–**	**(492.2)**	(485.9)	–	(485.9)
Gross profit		**439.5**	**–**	**439.5**	440.5	–	440.5
Other operating costs		**(347.4)**	**(49.2)**	**(396.6)**	(332.3)	(15.2)	(347.5)
Operating profit/(loss)	5,9	**92.1**	**(49.2)**	**42.9**	108.2	(15.2)	93.0
Finance income	7	**0.1**	**–**	**0.1**	0.2	–	0.2
Finance cost	7	**(20.3)**	**–**	**(20.3)**	(20.0)	–	(20.0)
Profit/(loss) before taxation		**71.9**	**(49.2)**	**22.7**	88.4	(15.2)	73.2
Taxation	9,11	**(14.0)**	**8.1**	**(5.9)**	(11.8)	(7.8)	(19.6)
Profit/(loss) for the year		**57.9**	**(41.1)**	**16.8**	76.6	(23.0)	53.6
Profit/(loss) for the year attributable to owners of the Parent		**57.9**	**(41.1)**	**16.8**	76.6	(23.0)	53.6
Earnings per share (in pence per share)							
– basic	12	**14.4**	**(10.2)**	**4.2**	19.2	(5.8)	13.4
– diluted	12	**14.4**	**(10.2)**	**4.2**	19.1	(5.8)	13.3

The notes on pages 115 to 142 form an integral part of these financial statements.

Consolidated statement of comprehensive income

For the year ended 31 December 2017

(£ million)	2017	2016
Profit for the year	**16.8**	53.6
Other comprehensive income for the year	**–**	–
Total comprehensive income for the year attributable to owners of the Parent	**16.8**	53.6

The notes on pages 115 to 142 form an integral part of these financial statements.

Consolidated statement of changes in equity

For the year ended 31 December 2017

(£ million)	Notes	Share capital	Share premium	Capital reserves	EBT share reserves	Retained earnings	Total equity
As at 1 January 2016		**4.0**	**826.9**	**376.1**	**(5.6)**	**(203.8)**	**997.6**
Profit for the year		–	–	–	–	53.6	53.6
Other comprehensive income for the year		–	–	–	–	–	–
Dividend paid	24	–	–	–	–	(14.8)	(14.8)
Share based payments	21	–	–	–	–	0.4	0.4
Corporation tax on share based payments		–	–	–	–	0.6	0.6
Deferred tax on share based payments		–	–	–	–	(0.3)	(0.3)
Purchase of shares held in the EBT	19	–	–	–	(1.8)	–	(1.8)
Utilisation of EBT shares for Directors Share Bonus Award	19	–	–	–	5.2	(5.2)	–
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**
Other comprehensive income for the year		**–**	**–**	**–**	**–**	**–**	**–**
Dividend paid	24	**–**	**–**	**–**	**–**	**(15.2)**	**(15.2)**
Share based payments	21	**–**	**–**	**–**	**–**	**1.0**	**1.0**
Utilisation of EBT shares for 2014 LTIP Award	19	**–**	**–**	**–**	**1.3**	**(1.3)**	**–**
Balance at 31 December 2017		**4.0**	**826.9**	**376.1**	**(0.9)**	**(168.2)**	**1,037.9**

The notes on pages 115 to 142 form an integral part of these financial statements.

Consolidated balance sheet

As at 31 December 2017

(£ million)	Notes	2017	2016
ASSETS			
Non-current assets			
Property, plant and equipment	13	**1,036.9**	991.5
Intangible assets	14	**517.8**	517.8
		1,554.7	1,509.3
Current assets			
Inventories	16	**30.1**	28.1
Trade and other receivables	17	**104.5**	119.1
Cash and cash equivalents	18	**39.2**	67.9
		173.8	215.1
Non-current assets held for sale	4	**5.6**	–
		179.4	215.1
Total assets		**1,734.1**	1,724.4
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	19	**(0.9)**	(2.2)
Retained earnings		**(168.2)**	(169.5)
Equity attributable to owners of the Parent		**1,037.9**	1,035.3
Total equity		**1,037.9**	1,035.3
Non-current liabilities			
Borrowings	20	**498.0**	495.7
Deferred tax liabilities	11	**72.6**	71.2
		570.6	566.9
Current liabilities			
Provisions	22	**17.9**	16.7
Borrowings	20	**4.0**	4.5
Trade and other payables	23	**101.5**	100.3
Income tax payable		**2.2**	0.7
		125.6	122.2
Total liabilities		**696.2**	689.1
Total equity and liabilities		**1,734.1**	1,724.4

These Consolidated financial statements and the accompanying notes were approved for issue by the Board on 1 March 2018 and signed on its behalf by:

Justin Ash
Chief Executive Officer

Simon Gordon
Chief Financial Officer

The notes on pages 115 to 142 form an integral part of these financial statements.

Consolidated statement of cash flows

For the year ended 31 December 2017

(£ million)	Notes	2017	2016
Cash flows from operating activities			
Profit before taxation		**22.7**	73.2
Adjustments for:			
Depreciation	13	**57.4**	51.9
Impairment of property, plant and equipment	13	**10.3**	0.5
Reversal of impairment on property, plant and equipment	13	**–**	(1.9)
Loss on disposal of property plant and equipment	5	**0.4**	10.8
Write-off intangible assets	14	**–**	1.3
Finance income	7	**(0.1)**	(0.2)
Finance costs	7	**20.3**	20.0
Share based payments	21	**1.0**	0.4
		112.0	156.0
Movements in working capital:			
Decrease in trade and other receivables		**14.6**	15.6
(Increase)/decrease in inventories		**(2.0)**	0.9
Increase in trade and other payables		**1.3**	6.8
Increase in provisions		**1.2**	1.1
Cash generated from operations		**127.1**	180.4
Income tax received		**–**	1.4
Income tax paid		**(3.1)**	(4.4)
Net cash from operating activities		**124.0**	177.4
Cash flows from investing activities			
Interest received		**0.1**	0.2
Purchase of property plant and equipment		**(119.2)**	(149.5)
Proceeds on disposal of property plant and equipment		**0.8**	(0.6)
Net cash used in investing activities		**(118.3)**	(149.9)
Cash flows from financing activities			
Interest paid		**(18.8)**	(21.5)
Repayment of bank borrowing		**(0.4)**	(0.4)
Purchase of shares held in the EBT		**–**	(1.8)
Dividends paid to equity holders of the Parent	24	**(15.2)**	(14.8)
Net cash used in financing activities		**(34.4)**	(38.5)
Net decrease in cash and cash equivalents		**(28.7)**	(11.0)
Cash and cash equivalents at 1 January		**67.9**	78.9
Cash and cash equivalents at 31 December	18	**39.2**	67.9
Exceptional and other items			
Exceptional and other items paid included in the cash flow		**(31.3)**	(5.9)
Total exceptional and other items	9	**(49.2)**	(15.2)

The notes on pages 115 to 142 form an integral part of these financial statements.

Notes to the financial statements

For the year ended 31 December 2017

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 2017 were authorised for issue by the Board of Directors of the Company on 1 March 2018.

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 2019. The Directors have considered the Group's forecasts, projections, ability to refinance, 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 12 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 £100.0 million committed undrawn revolving credit facility. Accordingly, they have adopted the going concern basis in preparing these financial statements.

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.

Interest income

Interest is recognised on an effective interest rate basis.

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, impairments, hospital closures and set-up costs, business acquisition costs, medical malpractice provision, aborted project costs and executive medical leave and 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.

2. Accounting policies continued

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.

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.

2. Accounting policies continued

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

i) Financial assets other than derivatives

Initial recognition and measurement
All financial assets are recognised initially at fair value plus directly attributable transaction costs. The Company's financial assets include cash and short-term deposits and trade and other receivables.

Financial assets within the scope of IAS 39 are classified as financial assets at fair value through profit or loss, loans and receivables, held-to-maturity investments, available-for-sale financial assets, or as derivatives designated as hedging instruments in an effective hedge, as appropriate. The Company determines the classification of its financial assets at initial recognition.

Subsequent measurement
Trade receivables are generally accounted for at amortised cost. The Company reviews indicators of impairment on an ongoing basis and where such indicators exist, the Company makes an estimate of the asset's recoverable amount.

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.

Losses arising from impairment are recognised in the Consolidated income statement in Other operating costs .

ii) Financial liabilities other than derivatives

Financial liabilities within the scope of IAS 39 are classified as financial liabilities at fair value through profit or loss, loans and borrowings or as derivatives designated as hedging instruments in an effective hedge as appropriate. 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, plus directly attributable transaction costs.

Subsequent measurement
After initial recognition, interest-bearing loans and borrowings are subsequently measured at amortised cost using the effective interest rate method. Gains and losses arising on the repurchase, settlement or otherwise cancellation of liabilities are recognised respectively in interest receivable and interest payable.

iii) 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.

2. Accounting policies continued

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 21). 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.

The social security contributions payable in connection with the grant of the share options is considered to be an integral part of the grant itself, and the charge will be treated as a cash-settled transaction.

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 2017, but either they were not applicable to or did not have a material impact on the Group:

- Amendments to IAS 7 *Disclosure Initiatives*
- Annual Improvements to IFRSs 2014–2016 Cycle: Clarification of the scope of the disclosure requirements in IFRS 12
- IAS 12 (Income taxes) *Recognition of Deferred Tax Assets for Unrealised losses*

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*
IFRS 9 *Financial Instruments*	1 January 2018
IFRS 15 *Revenue from Contracts with Customers*	1 January 2018
Clarification to IFRS 15 *Revenue from Contracts with Customers*	1 January 2018
Amendments to IFRS 2: *Classification and Measurement of Share based Payment Transactions*	1 January 2018
Annual Improvements 2014–2016 Cycle	1 January 2018
IFRIC 22 *Foreign Currency Transactions and Advance Consideration*	1 January 2018†
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.

† At the date of authorisation of these financial statements, these standards and interpretation have not yet been endorsed or adopted by the EU.

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 9, IFRS 15 and IFRS 16 are discussed on page 120.

2. Accounting policies continued

IFRS 15 *Revenue from Contracts with Customers*

IFRS 15 '*Revenue from Contracts with Customers*' will be 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 will adopt IFRS 15 with effect from 1 January 2018 using the Modified Retrospective approach.

Analysis

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. Out-patient cases and other revenue represent approximately 30% of the Group's revenue. Out-patient 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 current revenue recognition policy is in line with the requirements of IFRS 15 five-step model.

Disaggregated revenue disclosure

Spire Healthcare reports disaggregated revenue by material revenue stream (i.e. type of payor: PMI, NHS and Self-pay) and other revenue which includes consultant revenue, third-party revenue streams (e.g. pathology services) and of 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 Healthcare reports revenue split between in-patient/daycase, out-patient 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. Uninvoiced revenue is accrued at period ends. Invoices for the combination of services provided to patients are generally produced within three days of discharge. Spire Healthcare believes that these disclosures satisfy the requirements of IFRS 15 to enable the reader to understand the nature, amount, timing and uncertainty of revenue and cash flows.

IFRS 16 *Leases*

IFRS 16 '*Leases*' will be effective for annual periods beginning on or after 1 January 2019 with early adoption permitted for entities that apply IFRS 15 at or before the date of initial application of IFRS 16.

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 Group has completed an initial assessment of the potential significant impact on its Consolidated financial statements but has not yet completed a detailed assessment of all leases. At 31 December 2017, the Group's future minimum lease payments under non-cancellable operating leases amounted to £1,587.6 million, on an undiscounted basis. In addition, the nature of expenses related to those leases will now change as IFRS 16 replaces the straight-line operating expense with a depreciation charge for right-of-use assets and interest expense on lease liabilities. No significant impact is expected for the contracts currently accounted for as finance leases.

IFRS 9 *Financial Instruments*

IFRS 9 '*Financial Instruments*' will be effective for annual periods beginning on or after 1 January 2018. IFRS 9 sets out requirements for recognising and measuring financial assets, liabilities and some contract to buy or sell non-financial items. The standard replaces IAS 39 'Financial Instruments: Recognition and Measurement'.

IFRS 9 new impairment models requires the recognition of impairment provisions based on the expected credit loss ('ECL') model which replaces the 'incurred loss' model in IAS 39. Under the new loss allowance method, it can be measured on either of the following bases:

- 12 month ECLs: these are ECLs that result from possible default events within the 12 months after the reporting date; and
- Lifetime ECLs: these ECLs that result from all possible default events over the expected life of the financial instrument.

Concerning impairment, the Directors expect to apply the simplified approach to recognise lifetime ECLs for the Group's trade receivables. This will result in an insignificant increase to the impairment provision on adoption of IFRS9 and going forwards greater judgement due to the need to factor in forward looking information when estimating the appropriate amount of provision. In applying IFRS 9 the Group must consider the probability of default occurring over the contractual life of its trade receivables.

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

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.

Estimates

Deferred tax liabilities and assets

The Group owns a portfolio of freehold and leasehold property interests. In previous years, the Group had recognised a deferred tax liability in its financial statements in respect of capital gains tax and other taxes based on the assumption that a proportion of the freehold properties would have been disposed of in future years, whilst the remaining properties were realised through use. This calculation previously required judgement about the timing and number of the related property disposals, which was potentially impacted by changes to plans made by the business over time and, in particular, changes in business plans in respect of the holding or disposing of properties.

Deferred tax assets are recognised for unutilised trading losses and capital losses. Deferred tax assets are recognised to the extent that it is probable that taxable income will be available in future against which they can be utilised. Future taxable profits are estimated based on business plans which include estimates and assumptions regarding economic growth, interest, inflation rates and taxation rates.

During 2016, the Group considered it to be appropriate to reassess the basis for calculating deferred tax on the property portfolio and has since based the assessment on solely held-in-use basis. In 2016 this gave rise to a material tax charge of £8.4 million (refer to note 11).

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 14.

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 25.

Share based payments

At the end of each reporting period, the Group revises its estimates of the number of options that are expected to vest based on the non-market vesting conditions. It recognises the impact of the revision to original estimates, if any, in the income statement, with a corresponding adjustment to equity.

The assumptions considered to be most critical in estimating share based payments are contained in note 21.

Provision for medical malpractice claims

In the measurement of such provisions where the recognition criteria are met, the typical complexity of claims – for example, in respect of their outcome and the extent of damages (if any) assessed on the Group – requires management to use estimation. Such estimates are typically based on professional advice on expected outcomes and historical information on similar claims.

In some cases, judgement is also required, for example, as to whether the criteria for recognising provisions are met and whether a reliable estimate of the outcomes can be made.

Further details of claims and the amounts provided are given in note 22.

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. Non-current assets held for sale

As at December 2017, the Group's management have committed to sell two properties which previously formed part of the Group operations, Spire St Saviour's Hospital which closed in 2015 and Whalley Range, Manchester which is due to close in April 2018. The properties are expected to be sold within twelve months, have been classified as held for sale and are 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.

(£ million)	2017
Spire St Saviour's Hospital (note 13)	**2.0**
Whalley Range property (note 13)	**3.6**
	5.6

5. Operating profit

Arrived at after charging/(crediting):

(£ million)	2017	2016
Rent of land and buildings under operating leases	**63.9**	62.7
Depreciation of property, plant and equipment	**57.4**	51.9
Ian Paterson claims and related costs (see note 9)	**28.7**	–
Reversal of impairment on property, plant and equipment (see note 13)	**–**	(1.9)
Impairment of property, plant and equipment (see note 13)	**10.3**	0.5
Write-off intangible assets	**–**	1.3
Loss on disposal of property, plant and equipment	**0.4**	10.8
Staff costs (see note 8)	**282.1**	268.0

Impairment losses and reversals of impairment are included in other operating costs.

6. 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)	2017	2016
Insured	**426.0**	429.3
NHS	**287.8**	293.4
Self-pay	**186.9**	170.4
Other	**31.0**	33.3
Total	**931.7**	926.4

7. Finance income and costs

(£ million)	2017	2016
Finance income		
Interest income on bank deposits	**0.1**	0.2
Finance costs		
Interest on bank facilities	**11.8**	12.7
Interest on obligations under finance leases and hire purchase contracts	**9.2**	9.1
Financed costs capitalised in the year	**(0.7)**	(1.8)
Total finance costs	**20.3**	20.0

Finance costs capitalised during the year were calculated based on a weighted cost of borrowing of 3.4% (2016: 3.5%).

8. Staff costs

The average number of persons employed by the Group (including Directors) during the year, analysed by category was as follows:

(No.)	2017	2016
Clinical	**6,301**	6,128
Non-clinical	**5,043**	4,848
	11,344	10,976

The average number of full-time equivalent persons employed by the Group during the year, analysed by category, was as follows:

(No.)	2017	2016
Clinical	**4,391**	4,245
Non-clinical	**3,990**	3,810
	8,381	8,055

The aggregate payroll costs of these persons were as follows:

(£ million)	2017	2016
Wages and salaries	**242.1**	230.4
Social security costs	**21.6**	20.4
Pension costs, defined contribution scheme	**18.4**	17.2
	282.1	268.0

Included in wages and salaries and social security costs for year ended 31 December 2017 are exceptional items of £3.7 million (2016: £3.4 million) and £0.3 million (2016: £0.3 million), respectively. Refer to note 9 for further details.

Pension costs are in respect of the defined contribution scheme; unpaid contributions at 31 December 2017 were £1.8 million (2016: £1.6 million).

9. Exceptional and other items

(£ million)	2017	2016
Ian Paterson claims and related costs	**28.7**	–
Write-off and aborted project costs	**14.4**	–
Hospital set-up and closure costs	**3.4**	1.1
Executive medical leave and death in service	**0.9**	–
Business reorganisation and corporate restructuring	**0.6**	5.3
Write-off intangible assets	**–**	1.3
Hospital reversal of impairment on property, plant and equipment	**–**	(1.9)
Loss on disposal of property, plant and equipment (also referred to as the Asset Swap Transaction)	**–**	8.9
Other[1]	**0.7**	0.5
Total exceptional costs (see also other items)	**48.7**	15.2
Income tax credit on exceptional items	**(8.0)**	(0.6)
Total post-tax exceptional items	**40.7**	14.6

1 Other exceptional items in 2017 predominantly relate to the Mediclinic takeover bid, relocation of HR and payroll functions and the release of an onerous lease provision. In 2016 the costs primarily relate to National Insurance on Directors' Share Bonus Award granted at the time of the IPO.

Following the completion of the criminal proceedings against Ian Paterson (a consultant who previously had practicing privileges at Spire Healthcare) earlier in 2017, Spire Healthcare settled all current and known claims against Spire relating to his practice at Spire Healthcare. Accordingly, Spire Healthcare has provided £28.7 million in relation to this settlement, plus related costs, of which £26.1 million has been paid. Spire is currently pursuing legal action against its insurers to seek recoveries against this settlement and related costs, which may give rise to future exceptional income being recognised in the income statement. No account has been taken of these further recoveries in the results for the year ended 31 December 2017.

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. As part of the process, the decision was taken to cease the provision of radiotherapy services at the Spire Specialist Cancer Care Centre in Baddow (Essex) as a consequence of poor commercial performance. The charge for the year includes £10.3 million for the write-off of fixed assets, net of recoverable value, and a provision for site closure costs. Additionally, certain well progressed capital projects, notably the development of a hospital in Central London, have been aborted and the costs associated with these projects have been charged as exceptional items in the year due to the fundamental change in development strategy.

Hospital set-up and closure costs include the pre-opening expenses for the two new hospitals opened during 2017 (Spire Manchester and Spire Nottingham hospitals), plus the decommissioning costs of the former Manchester hospital site.

An Executive Director had a period of illness during 2017. Costs associated with his remuneration during his medical leave were duplicative to the business. After sadly passing away in July 2017, Spire Healthcare made a death in service payment which has also been included in exceptional items.

In the year ended 31 December 2016, business reorganisation mainly comprised staff restructuring costs and the closure costs relating to an onerous contract. In the year, the Group's goodwill in relation to the Lifescan business was written-off following a strategic review and the closure of this operation. Hospital set-up costs refer to pre-opening costs for the new Spire Manchester and Spire Nottingham hospitals. The reversal of the impairment is the result of the reassessment of the lives of medical and other equipment following the relocation of the assets from the previous Spire Manchester Hospital to the new hospital facility and other Group hospitals following its closure. Hospital closure costs relate to the decommissioning of the assets related to the previous Spire Manchester Hospital. Corporate restructuring related to an internal Group reorganisation and transaction costs relating to the Asset Swap Transaction as described below. Except for the corporate restructuring costs, which were capital in nature, and write-off of intangible assets, all other exceptional costs are expected to be tax deductible.

On 31 August 2016, as a result of the development of a new hospital facility in Manchester and the closure of the previous Spire Manchester Hospital (previously held under an operating lease), the freehold interest in Spire Wirral Hospital with a net book value of £11.7 million was disposed of, and leased back in a sale and leaseback transaction. The consideration for the sale was realised in the form of a non-cash asset, being the freehold of the previous Spire Manchester Hospital, which was simultaneously acquired by the Group (the 'Asset Swap Transaction'). The overall loss on these transactions was £7.7 million before sale costs of £1.2 million.

For 2017, £4.0 million (2016: £3.7 million) in respect of wages, salaries and social security costs (see note 8) is included in write-off and aborted project costs, executive medical leave and death in service, business reorganisations, hospital set-up costs, hospital closure, other and corporate restructuring costs.

9. Exceptional and other items continued

(£ million)	2017	2016
Other items		
Compliance set-up costs	**0.5**	–
Total other items	**0.5**	–
Income tax credit on other items	**(0.1)**	–
Deferred tax reassessment of temporary difference on property	**–**	8.4
Total post-tax other items	**0.4**	8.4

Compliance set-up costs include amounts incurred in 2017 to meet the requirements of General Data Protection Regulations ('GDPR') effective May 2018. Management expect further material costs to arise in 2018 in advance of the effective date to meet these new regulations and for Spire Healthcare to fulfil its extended obligations under these new regulations.

10. 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)	2017	2016
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

11. Taxation

(£ million)	2017	2016
Current tax		
UK corporation tax expense	**4.5**	2.1
UK corporation tax adjustment to prior years	**–**	0.4
Total current tax	**4.5**	2.5
Deferred tax		
Origination and reversal of temporary differences	**1.7**	16.3
Effect of change in tax rate	**(0.5)**	(5.2)
Reassessment property temporary differences (notes 3 and 9)	**–**	8.4
Adjustments in respect of prior years	**0.2**	(2.4)
Total deferred tax	**1.4**	17.1
Total tax expense	**5.9**	19.6

Corporation tax is calculated at 19.25% (2016: 20.0%) of the estimated taxable profit or loss for the year. The effective tax rate on profit before taxation for the year was 26.0% (2016: 26.8%).

11. Taxation continued

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)	2017	2016
Profit before taxation	**22.7**	73.2
Tax at the standard rate	**4.4**	14.6
Effects of:		
Expenses not deductible for tax purposes	**0.5**	2.7
Adjustments to prior year	**0.2**	(2.0)
Reassessment of property temporary differences (notes 3 and 9)	**–**	8.4
Difference in tax rates	**(0.5)**	(5.2)
Increase from impairment of fixed assets	**1.3**	–
Disposal of subsidiary company	**–**	0.8
Write-off of intangible assets	**–**	0.3
Total tax expense	**5.9**	19.6

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.

During 2016, the Group considered it to be appropriate to reassess the basis for calculating deferred tax on the property portfolio and has now based the assessment on solely held-in-use basis (see note 3). This gave rise to a material tax charge in 2016 which is excluded from tax on underlying profit.

Deferred tax

	Property, plant and equipment	Share based payments	Losses	Provisions and other temporary differences	Total
At 1 January 2016	77.8	(0.9)	(23.0)	(0.3)	53.6
Recognised in profit or loss	0.3	0.3	14.3	(1.0)	13.9
Change in tax rates	(5.1)	–	–	(0.1)	(5.2)
Reassessment of property temporary differences (note 3)	8.4	–	–	–	8.4
Recognised in equity	–	0.3	–	–	0.3
Disposal of subsidiary company	–	–	0.2	–	0.2
At 1 January 2017	**81.4**	**(0.3)**	**(8.5)**	**(1.4)**	**71.2**
Recognised in profit or loss	**(5.5)**	**0.1**	**7.1**	**0.2**	**1.9**
Change in tax rates	**(0.5)**	**–**	**–**	**–**	**(0.5)**
At 31 December 2017	**75.4**	**(0.2)**	**(1.4)**	**(1.2)**	**72.6**
Disclosed within liabilities	**75.4**	**(0.2)**	**(1.4)**	**(1.2)**	**72.6**

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.

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.

11. Taxation continued

The Group has unrecognised deferred tax assets as at 31 December 2017 as follows:

(£ million)	2017	2016
Trading losses	**0.9**	0.9
Capital losses	**0.1**	0.1
Tax basis for future capital disposals	**17.9**	17.9
	18.9	18.9

These amounts are the expected tax value of the gross temporary difference at the enacted long-term tax rate of 17% (2016: 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.

12. 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.

	2017	2016
Profit for the year attributable to owners of the Parent (£ million)	**16.8**	53.6
Weighted average number of ordinary shares	**401,081,391**	401,081,391
Adjustment for weighted average number of shares held in EBT	**(467,034)**	(1,085,956)
Weighted average number of ordinary shares in issue (No.)	**400,614,357**	399,995,435
Basic earnings per share (in pence per share)	**4.2**	13.4

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.

	2017	2016
Profit for the year attributable to owners of the Parent (£ million)	**16.8**	53.6
Weighted average number of ordinary shares in issue	**400,614,357**	399,995,435
Adjustment for weighted average number of contingently issuable shares	**861,612**	1,576,430
Diluted weighted average number of ordinary shares in issue (No.)	**401,475,969**	401,571,865
Diluted earnings per share (in pence per share)	**4.2**	13.3

13. Property, plant and equipment

(£ million)	Freehold property	Long leasehold property	Equipment	Assets in the course of construction	Total
Cost:					
At 1 January 2016	**673.3**	**158.5**	**298.9**	**38.6**	**1,169.3**
Additions	9.7	14.2	32.6	103.9	160.4
Disposals	(15.3)	(2.3)	(25.7)	–	(43.3)
Transfers	18.7	6.4	2.6	(27.7)	–
At 1 January 2017	**686.4**	**176.8**	**308.4**	**114.8**	**1,286.4**
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)**
At 31 December 2017	**666.8**	**316.0**	**367.1**	**4.7**	**1,354.6**
Accumulated depreciation and impairment:					
At 1 January 2016	**94.7**	**40.7**	**138.4**	**–**	**273.8**
Charge for year	11.7	4.7	35.5	–	51.9
Disposals	(3.0)	(2.0)	(24.4)	–	(29.4)
Impairment	–	0.4	0.1	–	0.5
Reversal of impairment	–	–	(1.9)	–	(1.9)
At 1 January 2017	**103.4**	**43.8**	**147.7**	**–**	**294.9**
Charge for the 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)**
At 31 December 2017	**91.6**	**50.6**	**175.5**	**–**	**317.7**
Net book value:					
At 31 December 2017	**575.2**	**265.4**	**191.6**	**4.7**	**1,036.9**
At 31 December 2016	583.0	133.0	160.7	114.8	991.5

Assets held for sale are in relation to Spire St Saviour's Hospital and Whalley Range, Manchester. Further details are shown in note 4. The impairment in 2017 is the result of the closure of the Spire Specialist Cancer Care Centre in Baddow (Essex) further details as shown in note 9.

As at 31 December 2017, included in the net book value of property, plant and equipment above is £20.3 million (2016: £21.7 million) relating to assets held under finance leases on which there was a depreciation charge of £1.2 million in the year (2016: £1.2 million).

The amount of borrowing costs capitalised during the year ended 31 December 2017 was £0.7 million (2016: £1.8 million). The rate used to determine the amount of borrowing costs eligible for capitalisation was 3.4% (2016: 3.5%) which is calculated on a weighted cost of borrowing.

14. Intangible assets

(£ million)	Goodwill
Cost or valuation:	
At 1 January 2016	520.1
Written-off	(1.3)
At 31 December 2016	518.8
At 31 December 2017	**518.8**
Impairment:	
At 1 January 2016, 31 December 2016 and 31 December 2017	**1.0**
Carrying amount:	
At 31 December 2017	517.8
At 31 December 2016	**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 (2016: £nil) and no event has given rise to amounts written-off (2016: £1.3m).

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 2022.

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. Revenue growth is projected to be in line with past experience averaging 4.3% for the five-year period (2016: 4.1%). Cost assumptions are consistent with the Group's historical track record, after taking account of headline inflation at 3.0% (2016: 1.0%).

A long-term growth rate of 2.25% (2016: 2.25%) has been applied to cash flows beyond 2022, 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% (2016: 9.0%).

A sensitivity analysis has been performed in order to review the impact of changes in key assumptions. For example, an increase of 3.0% in the pre-tax discount rate to 12.0%, with all other assumptions held constant, did not identify any impairments. Similarly, zero growth in the period beyond 2022, with all other assumptions held constant or combined with a 1.0% increase in the pre-tax discount rate, did not identify any impairment. The pre-tax discount rate would need to increase to 12.4%, with all other assumptions held constant, in order to reduce recoverable value equal to the carrying amount.

15. Subsidiary undertakings

As at 31 December 2017, 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

* Direct shareholding of the Company.
\+ Ownership interest is 50.1%.
^ Incorporated in the British Virgin Islands (BVI) and registered at Harneys Corporate and Trust Services Limited, Craigmuir Chambers, Road Town, Tortola, VG1110, BVI.
\# Incorporated in Luxembourg and registered at 2 Boulevard Konrad Adenauer, L-1115 Luxembourg.

On 5 October 2017, Didsbury MSK Limited was incorporated by the Registrar of Companies.

On 21 November 2017, Medicainsure Limited, Spire Links 2 Limited and Spire Property 2 Limited, were struck off by the Registrar of Companies.

16. Inventories

(£ million)	2017	2016
Prostheses, drugs, medical and other consumables	**30.1**	28.1

Cost of sales for the year ended 31 December 2017 includes inventories recognised as an expense amounting to £179.0 million (2016: £177.3 million).

17. Trade and other receivables

(£ million)	2017	2016
Amounts falling due within one year:		
Trade receivables – net	**50.3**	58.0
Accrued income	**14.4**	22.8
Prepayments	**29.1**	27.2
Other receivables	**10.7**	11.1
Total current trade and other receivables	**104.5**	119.1

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 doubtful receivables 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 is considered to be an approximation to its fair value.

The ageing of trade receivables that are past due but not impaired:

(£ million)	2017	2016
Not past due and not impaired	**38.5**	38.3
Past due 0–30 days, and not impaired	**4.6**	8.0
Past due 31–90 days, and not impaired	**3.7**	6.7
Past due and more than 91 days, and not impaired	**3.5**	5.0
Total	**50.3**	58.0

Trade receivables comprise the following wider customer/payor groups:

(£ million)	2017	2016
Private medical insurers	**29.5**	34.0
NHS	**11.6**	10.8
Patient debt	**4.3**	4.9
Other	**4.9**	8.3
Total	**50.3**	58.0

The movement in the allowance for impairment in respect of trade receivables during the year was as follows:

(£ million)	2017	2016
At 1 January	**5.0**	5.7
Provided in the year	**5.0**	4.6
Utilised during the year	**(6.1)**	(5.3)
At 31 December	**3.9**	5.0

18. Cash and cash equivalents

(£ million)	2017	2016
Cash at bank	**17.0**	53.9
Short-term deposits	**22.2**	14.0
	39.2	67.9

19. Share capital and reserves

	£0.01 ordinary shares	
	Shares	£'000
Issued and fully paid		
At 31 December 2017	**401,081,391**	**4,010**
At 31 December 2016	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.

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 2017, the EBT purchased no shares (2016: 561,860 shares acquired at an average price per share of £3.18 per share).

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 2017, 281,631 shares (2016: 670,559) were held by the EBT in relation to the Directors' share bonus award and long-term incentive plan.

At 1 January 2017, the EBT held 670,559 shares. In March 2017, 228,100 number of shares were exercised in relation to the 2014 Long term incentive plan ('LTIP') and in April 2017, 26,489 number of 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.

At 1 January 2016, the EBT held 1,692,242. In April 2016, 801,825 number of shares were exercised in Tranche 1 of the Directors' Share Bonus Award and in August 2016, 781,718 shares were exercised for Tranche 2 (refer to Note 21). A purchase of 561,860 shares was made in July 2016 for an average price of £3.18 per share; and at 31 December 2016, the EBT held 670,559 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)	2017	2016
Secured borrowings		
Bank loans	**425.1**	424.1
Obligations under finance leases	**76.9**	76.1
	502.0	500.2

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)	2017	2016
Total borrowings (measured at amortised cost)		
Amount due for settlement within 12 months	**4.0**	4.5
Amount due for settlement after 12 months	**498.0**	495.7
	502.0	500.2

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:

	2017		2016	
(£ million)	Minimum payments	Present value of payments	Minimum payments	Present value of payments
Within one year	**8.7**	**6.2**	8.7	7.0
After one year but not more than five years	**36.6**	**19.2**	35.8	21.2
More than five years	**220.3**	**51.5**	229.8	47.9
Total minimum lease payments	**265.6**	**76.9**	274.3	76.1
Less amounts representing finance charges	**(188.7)**	**–**	(198.2)	–
Present value of minimum lease payments	**76.9**	**76.9**	76.1	76.1

Property leases, with a present value liability of £76.6 million (2016: £75.4 million), expire in 2040 and carry an implicit interest rate of 12.9% (2016: 12.9%). Rent is reviewed annually with reference to RPI, subject to a floor of 3.0% and a cap at 5.0%.

Terms and debt repayment schedule

The maturity date is the date on which the relevant bank loans are due to be fully repaid, as at the balance sheet date.

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	2017	2016
Senior finance facility	July 2019	2.00%	**425.1**	424.1
Revolving credit facility (undrawn committed facility)	July 2019		**100.0**	100.0

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 2.00% over LIBOR (2016: 2.00% over LIBOR).

20. Loans and borrowings continued

Changes in liabilities arising from financing activities

(£ million)	1 January	Cash flows	Non cash changes	31 December
2017				
Bank loans	**424.1**	**(10.0)**	**11.0**	**425.1**
Lease liabilities	**76.1**	**(9.2)**	**10.0**	**76.9**
Total	**500.2**	**(19.2)**	**21.0**	**502.0**

Reconciliation of net change in cash and cash equivalents to net debt

(£ million)	2017	2016
Bank loans	**424.1**	423.1
Obligations under finance leases	**76.1**	75.3
	500.2	498.4
Cash at bank	**(53.9)**	(42.8)
Short-term investments	**(14.0)**	(36.1)
Net debt at 1 January	**432.3**	419.5
Net decrease in cash and cash equivalents	**28.7**	11.0
Loans movement	**1.0**	1.0
Movement in obligations under finance leases	**0.8**	0.8
	30.5	12.8
Net debt at 31 December	**462.8**	432.3

21. 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 £1.0 million in the year ended 31 December 2017 (2016: £0.4 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 (2016: £0.2 million).

The following table analyses the total cost between each of the relevant schemes, together with the number of options outstanding:

	2017		2016	
(£ million)	Charge £m	Number of options (thousands)	Charge £m	Number of options (thousands)
Long Term Incentive Plan	**1.0**	**1,946**	0.4	950
Deferred Bonus Plan	**–**	**29**	–	–
	1.0	**1,975**	0.4	950

21. Share based payments continued

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:

	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**

	2016			
	Directors' Share Bonus Award* (thousands)	LTIP (TSR condition) (thousands)	LTIP (EPS condition) (thousands)	Deferred Bonus Plan (thousands)
At 1 January	1,638	1,003	1,003	29
Granted	–	475	475	–
Exercised	(1,584)	–	–	–
Surrendered	–	(486)	(486)	–
Cancelled	(54)	–	–	–
At 31 December	–	992	992	29
Exercisable at 31 December	–	286	286	–
Weighted average contractual life	–	1.9 years	1.9 years	1.4 years

* The Directors' Share Bonus Award was divided into two equal tranches, the first of which vested on 23 July 2015 and the second tranche vested on 23 July 2016. The number of options that vested depended on conditions relating to share price on the relevant dates. The second tranche, which vested on 23 July 2016, resulted in 781,718 options (23 July 2015: 801,824 options) being issued. All qualifying options relating to the Directors' Share Bonus Award were exercised during 2016. For further details, see the Directors' Remuneration Report, on pages 78 to 95 .

The weighted average remaining contractual life for the share options outstanding as at 31 December 2017 was 1.3 years (2016: 1.9 years).

21. Share based payments continued

Share options outstanding at the end of the year have the following expiry date:

Grant – vest	Expiry date	Exercise price (£)	Share options thousands 2017	2016
LTIP grants				
30/09/2014 – 31/12/2016	30/09/2024	–	**32**	572
01/04/2015 – March 2018	01/04/2025	–	**547**	547
30/03/2016 – March 2019	30/03/2026	–	**631**	865
30/03/2017 – March 2020	30/03/2027	–	**737**	–
Deferred Bonus Plan				
01/06/2015 – 01/06/2018	01/06/2025	–	**29**	29

The following information is relevant to the determination of the fair value of the awards granted for the years ended 31 December 2017 and 2016, respectively, under the schemes:

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**

2016	LTIP (TSR condition)	LTIP (EPS condition)	Deferred Bonus Plan
Option pricing model	Monte Carlo	Fair value at grant date	n/a
Fair value at grant date (£)	2.32	3.60	n/a
Weighted average share price at grant date (£)	3.60	3.60	n/a
Exercise price (£)	Nil	Nil	n/a
Weighted average contractual life	3.0 years	3.0 years	n/a
Expected dividend yield	n/a	n/a	n/a
Risk-free interest rate	0.6%	n/a	n/a
Volatility	37%	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.

22. Provisions

(£ million)	Medical malpractice	Business restructuring and other	Total
At 1 January 2017	**14.3**	**2.4**	**16.7**
Increase in existing provisions	**35.2**	**0.7**	**35.9**
Provisions utilised	**(31.0)**	**(1.6)**	**(32.6)**
Provisions released	**(1.7)**	**(0.4)**	**(2.1)**
At 31 December 2017	**16.8**	**1.1**	**17.9**

Medical malpractice relates to commitments to patients in respect of the removal or replacement of the PIP brand of breast implants, and estimated liabilities arising from claims for damages in respect of services previously supplied to patients. 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 practicing 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 and closure costs relating to the Specialist Cancer Care Centre in Baddow (Essex).

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 £7.5 million (2016: £6.7 million).

Provisions as at 31 December 2017 are materially considered to be current and expected to be utilised at any time within three years.

23. Trade and other payables

(£ million)	2017	2016
Trade payables	**49.0**	49.7
Accrued expenses	**36.5**	38.3
Social security and other taxes	**6.0**	3.5
Other payables	**10.0**	8.8
	101.5	100.3

24. Dividends

(£ million)	2017	2016
Amounts recognised as distributions to equity holders in the year:		
– final dividend for the year ended 31 December 2016 of 2.4 pence per share (2016: 2.4 pence)	**10.0**	9.6
– interim dividend for the year ended 31 December 2017 of 1.3 pence per share (2016: 1.3 pence)	**5.2**	5.2
Total	**15.2**	14.8

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 24 May 2018. 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. 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:

	2017		2016	
(£ million)	Land and buildings	Other	Land and buildings	Other
Not later than one year	**65.4**	**1.1**	63.1	1.1
Later than one year and not later than five years	**259.1**	**2.2**	249.7	2.2
Later than five years	**1,263.1**	**–**	1,282.9	–
	1,587.6	**3.3**	1,595.7	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 2017, the Group held consignment stock on sale or return of £23.0 million (2016: £22.1 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)	2017	2016
Contracted but not provided for	**65.5**	63.8

26. Contingent liabilities

The Group had the following guarantees at 31 December 2017:

- the bankers to Spire Healthcare Limited have issued a letter of credit in the maximum amount of £1.5 million (2016: £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 22 for details of a contingent liability in respect of Medical Malpractice.

27. 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 estimate of incurred losses 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 17 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.

27. Financial risk management and impairment of financial assets continued

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 2017 (£ million)	**425.0**	**425.0**	**100.0**
Effective interest rate (%)	**2.42%**	**2.42%**	
31 December 2016 (£ million)	425.0	425.0	100.0
Effective interest rate (%)	2.40%	2.40%	

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 2017				
Variable rate instruments	**(0.3)**	**0.3**	**(0.3)**	**0.3**
At 31 December 2016				
Variable rate instruments	(0.3)	0.3	(0.3)	0.3

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 2017 (2016: £100.0 million undrawn).

27. Financial risk management and impairment of financial assets continued

The following are contractual maturities, at as the balance sheet date, of financial liabilities, including interest payments and excluding the impact of netting agreements:

2017 (£ million)	Carrying amount	Maturity analysis: 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**

2016 (£ million)	Carrying amount	Maturity analysis: Contractual cash flows	Within 1 year	Between 1 and 2 years	More than 2 years
Trade and other payables	55.9	55.9	55.9	–	–
Bank borrowings	424.1	456.0	10.9	11.3	433.8
Finance lease liabilities (present value)	76.1	270.4	8.5	8.5	253.4
	556.1	782.3	75.3	19.8	687.2

Bases of valuation

The 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 and expected short-term settlements, except for floating rate debt, which is after the deduction of £1.8 million (2016: £2.9 million) of issue costs.

As at 31 December 2017, the Group did not hold any financial instruments measured at fair value (2016: nil).

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 2017 were £1,037.9 million (2016: £1,035.3 million) and net debt, calculated as total debt (comprising obligations under finance leases and borrowings), less cash and cash equivalents, amounted to £462.8 million (2016: £432.3 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.

At the balance sheet date, the Group's committed undrawn facilities, and cash and cash equivalents were as follows:

(£ million)	2017	2016
Committed undrawn revolving credit facility	**100.0**	100.0
Cash and cash equivalents	**39.2**	67.9

28. 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 56 to 59.

Compensation for key management personnel is set out in the table below:

Key management compensation

(£ million)	2017	2016
Salaries and other short-term employee benefits	**3.5**	3.2
Post-employment benefits	**0.4**	0.4
Share based payments	**0.9**	0.3
	4.8	3.9

Further information about the remuneration of individual Directors is provided in the audited part of the Directors' Remuneration Report on pages 78 to 95.

There were no transactions with related parties external to the Group in the year to 31 December 2017 (2016: nil).

29. Events after the reporting period

2017 final dividend

For 2017, the Board has recommended a final dividend of 2.5 pence per share, amounting to approximately £10.0 million, to be paid on 26 June 2018 to shareholders on the register at the close of business on 1 June 2018.

Company balance sheet

As at 31 December 2017

(Registered number: 9084066)

(£ million)	Notes	2017	2016
ASSETS			
Non-current assets			
Investments	C9	**832.2**	831.1
		832.2	831.1
Current assets			
Other receivables	C7	**122.0**	80.8
Income tax receivable		**0.2**	1.1
Cash and cash equivalents	C6	**0.1**	12.1
		122.3	94.0
Total assets		**954.5**	925.1
EQUITY AND LIABILITIES			
Equity			
Share capital	19	**4.0**	4.0
Share premium		**826.9**	826.9
EBT share reserves	19	**(0.9)**	(2.2)
Retained earnings		**122.0**	93.9
Total equity		**952.0**	922.6
Current liabilities			
Trade and other payables	C8	**2.5**	2.5
Total liabilities		**2.5**	2.5
Total equity and liabilities		**954.5**	925.1

The profit attributable to the owners of the Company for the year ended 31 December 2017 was £42.2 million (2016: £44.7 million).

The financial statements on pages 143 to 149 were approved by the Board of Directors on 1 March 2018 and signed on its behalf by:

Justin Ash
Chief Executive Officer

Simon Gordon
Chief Financial Officer

Company statements of changes in equity

For the year ended 31 December 2017

(£ million)	Share capital	Share premium	EBT share reserves	Retained earnings	Total
At 1 January 2016	4.0	826.9	(5.6)	68.8	894.1
Profit for the year	–	–	–	44.7	44.7
Other comprehensive income for the year	–	–	–	–	–
Purchase of shares held in the EBT	–	–	(1.8)	–	(1.8)
Share based payment	–	–	–	0.4	0.4
Utilisation of EBT shares for Directors' Share Bonus Award	–	–	5.2	(5.2)	–
Dividend paid	–	–	–	(14.8)	(14.8)
As 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 Award	**–**	**–**	**1.3**	**–**	**1.3**
Dividend paid	**–**	**–**	**–**	**(15.2)**	**(15.2)**
As at 31 December 2017	**4.0**	**826.9**	**(0.9)**	**122.0**	**952.0**

Company statements of cash flows

For the year ended 31 December 2017

(£ million)	2017	2016
Cash flows from operating activities		
Profit/(loss) before taxation (excluding dividend received)	**0.3**	(0.1)
Adjustments for:		
Interest income	**(2.1)**	(1.3)
Finance costs	**0.1**	–
	(1.7)	(1.4)
Movements in working capital:		
Increase in trade and other receivables	**(39.9)**	(36.3)
Increase in trade and other payables	**–**	0.5
Income tax received	**–**	0.3
Net cash used in operating activities	**(41.6)**	(36.9)
Cash flows from investing activities		
Interest received	**2.1**	1.3
Finance costs	**(0.1)**	–
Dividend received	**42.8**	43.6
Net cash generated from investing activities	**44.8**	44.9
Cash flows from financing activities		
Purchase of shares held in the EBT	**–**	(1.8)
Dividend paid to equity holders of the Parent	**(15.2)**	(14.8)
Net cash used in financing activities	**(15.2)**	(16.6)
Net decrease in cash and cash equivalents	**(12.0)**	(8.6)
Cash and cash equivalents at beginning of year	**12.1**	20.7
Cash and cash equivalents at end of year	**0.1**	12.1

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 (£ million), 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 14 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)	2017	2016
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)	2017	2016
Cash at bank	**0.1**	0.2
Short-term investments	**–**	11.9
	0.1	12.1

C7. Other receivables

(£ million)	2017	2016
Amounts owed by subsidiary undertakings	**122.0**	80.8
	122.0	80.8

The amounts owed by subsidiary undertakings bear interest at LIBOR plus 2.00% (2016: LIBOR plus 2.00%). The amounts are unsecured and repayable on demand.

C8. Trade and other payables

(£ million)	2017	2016
Amounts owed to subsidiary undertakings	**2.4**	2.3
Accruals	**0.1**	0.2
	2.5	2.5

The amounts owed to subsidiary undertakings bear interest at LIBOR plus 2.00% (2016: 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 2016	830.7	830.7
Additions – IFRS 2 costs	0.4	0.4
At 1 January 2017	**831.1**	**831.1**
Additions – IFRS 2 costs	**1.1**	**1.1**
At 31 December 2017	**832.2**	**832.2**

Details of the Company's subsidiaries at the balance sheet date are in note 15 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 £952.0 million (2016: £922.6 million) as at 31 December 2017, and cash amounted to £0.1 million (2016: £12.1 million).

Credit risk

As at 31 December 2017, the Company had amounts owed by subsidiary undertakings of £122.0 million (2016: £80.8 million). The Company's maximum exposure to credit risk from these amounts is £122.0 million (2016: £80.8 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.

C10. Capital management and financial instruments continued

(£ million)	2017	2016
Financial assets: Carrying amount and fair value		
Loans and receivables		
Cash and cash equivalents	**0.1**	12.1
Amounts owed by subsidiary undertakings	**122.0**	80.8
	122.1	92.9

All of the above financial assets are current and not impaired.

(£ million)	2017	2016
Financial liabilities: Carrying amount and fair value		
Amortised cost		
Amounts owed to subsidiary undertakings	**2.4**	2.3
	2.4	2.3

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 2017 the Company had short-term borrowings of £2.4 million (2016: £2.3 million) owed to subsidiary undertakings, which are repayable on demand and bear interest at LIBOR plus 2.00% (2016: LIBOR plus 2.00%). Interest on these borrowings in the year amounted to nil (2016: 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 £122.0 million (2016: £80.8 million) and £2.4 million (2016: £2.3 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 2017, 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 2017, there was no breach in the required covenants.

C12. Related party transactions

The Company's subsidiaries are listed in note 15 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)	2017	2016
Amounts owed from subsidiary undertakings	**122.0**	80.8
Amounts owed to subsidiary undertakings	**(2.4)**	(2.3)
	119.6	78.5

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)	2017	2016
Amounts invoiced to subsidiaries	**40.6**	36.3
Amounts invoiced by subsidiaries	**(0.1)**	(0.4)
Dividend received from subsidiaries	**42.8**	43.6

Amounts invoiced to/by subsidiaries relate to general corporate purposes.

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 78 to 95.

(£ million)	2017	2016
Short-term employee benefits*	**0.7**	0.5
Pension contributions	**–**	–
Share based payments*	**–**	–
Total	**0.7**	0.5

* 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.

Directors' interests in share based payment schemes

Refer to note 21 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

2017 final dividend

For 2017, the Board has recommended a final dividend of 2.5 pence per share, amounting to approximately £10.0 million, to be paid on 26 June 2018 to shareholders on the register at the close of business on 1 June 2018.

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 tax voucher. 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.

Financial calendar

2018 annual general meeting (London)	24 May 2018
Ex-dividend date for 2017 final dividend	31 May 2018
Record date for 2017 final dividend	1 June 2018
Payment date of 2017 final dividend	26 June 2018
Announcement of 2018 half year results	September 2018

Analysis of ordinary shareholders As at 31 December 2017

	Private		Institutional and other		Total	
Investor type	**2017**	2016	**2017**	2016	**2017**	2016
Number of holders	**93**	69	**498**	461	**591**	530
Percentage of holders	**15.73%**	13.02%	**84.27%**	86.98%	**100%**	100%
Percentage of shares held	**0.32%**	0.50%	**99.68%**	99.50%	**100%**	100%

	1–1,000		50,001–500,000		Institutional and other		Total	
Shareholdings	**2017**	2016	**2017**	2016	**2017**	2016	**2017**	2016
Number of holders	**86**	79	**295**	261	**133**	117	**77**	73
Percentage of holders	**14.55%**	14.91%	**49.92%**	49.25%	**22.50%**	22.08%	**13.03%**	13.76%
Percentage of shares held	**0.01%**	0.01%	**0.81%**	0.75%	**5.74%**	5.37%	**93.44%**	93.89%

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, closure or disposal in current or prior periods.		
Underlying revenue	Revenue adjusted for the trading results of Spire Manchester, Nottingham, St Anthony's hospitals and Lifescan.	Provides a comparable measure of adjusted revenue performance over time.
Underlying operating profit	Operating profit adjusted for the trading results of Spire Manchester, Nottingham, St Anthony's hospitals and Lifescan.	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, St Anthony's hospitals and Lifescan.	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, St Anthony's hospitals and Lifescan, 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, St Anthony's hospitals and Lifescan, 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 2017, 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
CO_2e	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
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
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
HMRC	HM Revenue & Customs

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
tCO_2e	tonnes of equivalent carbon dioxide
TSR	total shareholder return
UK	the United Kingdom of Great Britain and Northern Ireland
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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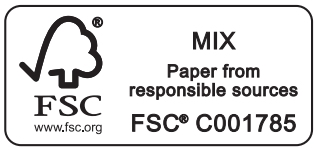

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