Highlights

2.1%

GROWTH IN INPATIENT AND DAY CASELOAD

£147.9 million

STRONG YEAR-END CASH BALANCES

32 080

TRAINING DAYS DELIVERED

99.2%

PATIENT SATISFACTION RATING OF GOOD, VERY GOOD AND EXCELLENT

UNITED KINGDOM operations

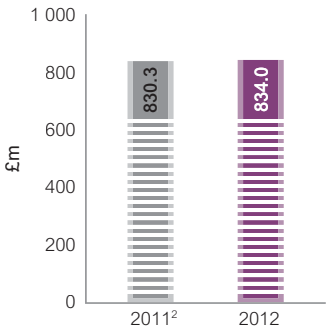
UNITED KINGDOM OVERVIEW

The strength of our long-standing partnership with the National Health Service (NHS), spanning more than a decade was a key buffer against lower Private Medical Insurance (PMI) and self-pay volumes in the last year.

Performance overview

The United Kingdom (UK) operating business (BMI OpCo) experienced a difficult trading year, characterised by continuing recessionary pressures and ongoing NHS reforms. Revenue from continuing operations rose by 0.4% to £834.0 million, although earnings before interest, tax, depreciation and amortisation (EBITDA)[1] declined 6.6% to £176.1 million, affected by a fall in insured PMI volumes. The UK results have been impacted by certain material, non-cash adjustments relating to the General Healthcare Group (GHG) portfolio of 35 UK hospital properties initially acquired in 2006 GHG PropCo 1). Further details regarding these exceptional items can be found on pages 35 and 36.

UK Revenue



UK Operating profit[1]

Financial summary

£m	2012	2011[2]	% change
Revenue	**834.0**	830.3	0.4
Operating profit[3]	**106.1**	127.4	(16.7)
Operating profit before capital items	**106.4**	117.1	(9.1)
Capital items	**(0.3)**	10.3	
Operating profit margin[1,3] (%)	**12.8**	14.1	
Profit for the year from continuing operations[3]	**5.7**	40.0	(85.8)
Net debt	**1 712.9**	1 785.4	4.1
Capital expenditure including intangible assets	**41.2**	43.9	(6.2)

1 Excluding capital items.
2 Restated to exclude discontinued operations.
3 Excluding exceptional items relating to GHG PropCo 1.

Executive Committee

01 | Stephen Collier (55)
Chief Executive Officer
Qualifications:
Barrister; LLB (Hons), LLM, Dip AL
Joined in 1982

02 | Craig Lovelace (39)
Chief Financial Officer
Qualifications:
BSc (Hons) Land Management, FCA
Joined in 2010

03 | Duncan Empey (65)
Group Medical Director
Qualifications:
MB, BS, LRCP, MRCS, MRCP, FRCP
Joined in 2008

04 | Martin Johnson (39)
Managing Director – Commercial, Business Improvement, Technology and Infrastructure
Qualifications:
BEng Mechanical Engineering, Chartered Engineer, MSc Business Management, Lean Six Sigma Master Black Belt, PRINCE2 Practitioner, Diploma NLP
Joined in 2012

05 | Catherine Vickery (37)
General Counsel and Company Secretary
Qualifications:
Solicitor, BA (Hons) Jurisprudence and PGDip Legal Practice
Joined in 2005

06 | Elaine Young (47)
Managing Director – Hospitals
Qualifications:
MBA
Joined in 2011

HEALTH POLICY AND REGULATION: UK

There has been no major change in the key players in the UK independent healthcare sector, with General Healthcare Group (GHG) remaining the biggest private provider by scale and network.

Key market drivers

Social trends

The country's ageing population remains one of the most significant social trends affecting the UK healthcare market. Between 1930 and 2010, life expectancy at birth in the UK increased by around a third, from 58.7 to 78.2 years for men and from 63.0 to 82.3 for women. During the debate about "National Wellbeing", when asked what affected their wellbeing, health was the most common response from individuals[1].

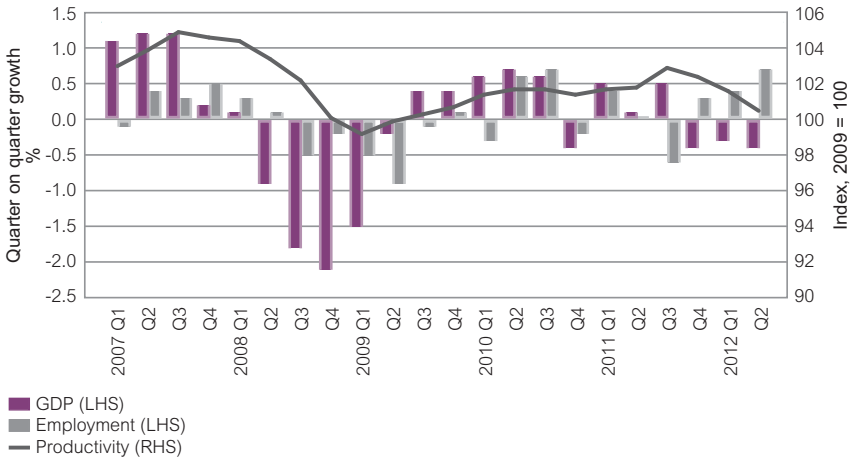
Between 2010 and 2051, the proportion of people aged 65 and over is projected to increase from 17% to 24%, while the proportion aged 85 and over is projected to increase from 2% to 7%. By 2051, life expectancy for men aged 65 is projected to be 25.9 years, and 28.3 years for women aged 65[2].

This trend continues to have funding implications, since a lower percentage of people of working age will result in less tax revenue being generated. This has formed a major part of the debate around the future role of the NHS. In particular, it has renewed the focus on integrated care initiatives and is likely to drive higher competition for increasingly scarce healthcare resources, requiring greater involvement from the independent sector.

The UK economy

Recent movements in the UK economy have been somewhat contradictory. The labour market has shown greater resilience than expected, having risen from its low point at the end of 2009.

UK output, employment and output per worker productivity, 2007 to 2012 (seasonally adjusted)



Source: Office for National Statistics

1 Measuring National Wellbeing, ONA 24 July 2012.
2 ONS Population change (2012 Edition).

By contrast, gross domestic product (GDP) has fallen by approximately 4% over the same period. While it also recovered somewhat from its low point in mid-2009 when its cumulative decline exceeded 6%, the subsequent recovery lost momentum. Over the last two years, GDP has fluctuated around a broadly flat trajectory prior to October 2012's preliminary announcement of 1% quarter-on-quarter GDP growth[3]. In the last six months, average independent forecasts for 2013 have fallen from 1.7% to 1.1%[4].

For the 2011/2012 period, public sector net borrowing was £121.6 billion, £4.4 billion lower than the Office for Budget Responsibility had originally forecast[5]. In October 2011, the chancellor cleared the Bank of England to increase the scale of its quantitative easing programme from £200 billion to £275 billion due to the deterioration in the economic outlook. By July 2012, the Monetary Policy Committee (MPC) had announced its intention in increase this to £375 billion.

Consumers have continued to feel pressured. Despite the modest recovery in employment growth, wage settlements look set to remain weak. Excluding bonuses, the average wage settlement has increased slightly to 1.6% from 1.5% in the three months to June 2012[6]. Income per head in the second quarter of 2012 at £4 927 was 13.2% down compared to its pre-recession peak of £5 675 in the first quarter of 2008[7].

UK health policy

In March 2012, the Health and Social Care Act 2012, described as one of the most important regulatory developments in the UK healthcare system for some time, gained royal assent, more than 14 months after first being tabled in the House of Commons.

Under the Act, general practitioners (GPs) and other clinicians will be given much more responsibility for spending the health budget in England, while greater plurality of provision will be encouraged. As organisations respond to the Act, it is hoped that there will be significant opportunities for independent healthcare operators to be part of the solution.

Number of subscribers for health cover products and total UK spending on health cover products, 2009 to 2012[8]

Market	Subscribers at 1 January 2009 000	Subscribers at 1 January 2012 000	Spending in 2008 £ million	Spending in 2011 £ million
Private medical cover	4 322	3 971	4 174^	4 252^
Health cash plans*	2 873	2 593	507	467
All health cover (excluding dental plans)	**7 195**	**6 564**	**507**	**467**
Growth		(8.8%)		(7.9%)

^ Includes derived spending by companies that self-insure medical expenses.
** Includes a small amount of dental cover spending.*

Impact on the private market

Private Medical Insurance

The private medical cover market has been vulnerable to business cycles, but in 2012 showed signs of stabilising. Future demand for medical cover will largely depend on the strength of the UK economy, but pressures on NHS services during a period of lower spending growth may also offer some stimulus for private medical cover going forward. As indicated in the table below, subscriber numbers for private medical cover (covering medical insurance and self-insured medical expenses schemes) were down 8.8% in total from 2009 to 2011, and total health cover spending decreased by 7.9% in real terms after adjusting for retail price index (RPI) inflation.

Movements in demand for private medical cover confirm that, of the 351 000 subscribers that dropped out of the sector since 2008, 216 000 were company paid and 135 000 were individual paid, which represents a 6.8% decline in company paid volumes and 12% decline in individual paid subscribers.

In the period under review, Laing & Buisson's Health Cover report[8] showed the decline in policy numbers slowing to just 0.2%, reflecting modest growth in the corporate market offset by a fall of 4.2% in the individual market. Meanwhile, claims paid on PMI decreased by 3.6% in real terms in 2011. This disparity is in part explained by a combination of co-payments and insurer claims management initiatives.

This data is contradicted by Datamonitor[9], which suggests that the decline in lives covered continued through the year at 3.0%, with corporate policies reducing by 1.7% and personal policies by 6.5%. Their recent report does not forecast any immediate turnaround in subscriber numbers.

3 ONS The Productivity Conundrum, Interpreting the Recent Behaviour of the Economy.
4 Forecasts for the UK economy: A comparison of independent forecasts, October 2012.
5 Public Sector Finances, September 2012.
6 Chartered Institute of Personnel and Development – Labour Market Outlook Report Summer 2012.
7 National Accounts, ONS October 2012.
8 Laing & Buisson, Health Cover UK Market Report, 2012.
9 Datamonitor, UK Private Medical Insurance 2012.

Self-pay patients

The self-pay market remains encouraging, with more patients considering paying for their own treatment when they are not covered by PMI and as more procedures are restricted by the NHS. Industry commentators suggest most independent providers have seen continued growth in self-pay volumes, albeit flattening more recently.

Despite budgetary pressure, there has been a small improvement in adherence to NHS waiting list time targets during the year under review. The monthly referral to treatment statistics[10], published by the Department of Health, show that in August 2012 there were 298 682 inpatients whose "pathways" were completed in hospital, 92.7% of whom had been seen within 18 weeks (up from 90.4% in the previous year).

However, the median waiting time increased from 8.1 weeks in August 2011 to 8.3 weeks in August 2012 and analysis shows that trauma and orthopaedics, which represents a large proportion of BMI's caseload, achieved only 88.6% of patients being seen within 18 weeks. NHS waiting list times are still projected to rise, in particular with restrictions being placed on the number of non-urgent operations being carried out.

The National Health Service

The principal aim behind many of the proposals in the Health and Social Care Act 2012 ("the Act") was to increase choice for patients. Commissioning responsibilities will move from Primary Care Trusts to Clinical Commissioning Groups (CCGs) by April 2013, which will devolve more responsibility to GPs. CCGs will decide on care for patients, advise them on where to go for treatment and pay the provider. The majority of stakeholders have accepted the provisions of the Act, and are progressing with the changes required.

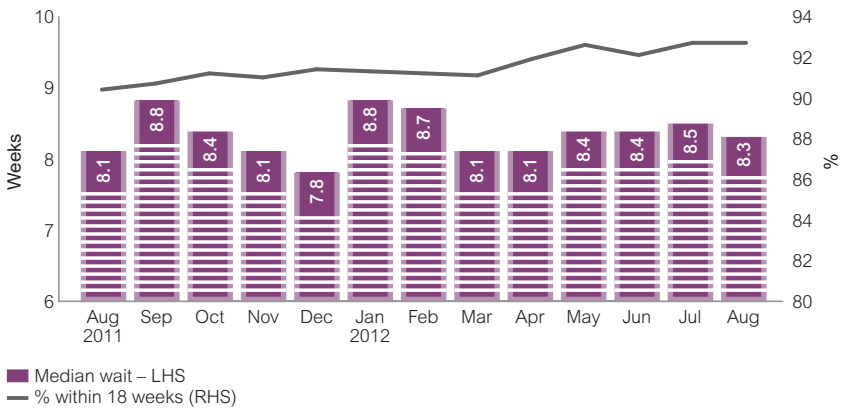
As of October 2012, key dates have been agreed for the implementation of the CCG authorisation process. CCGs have applied to be authorised in four separate waves, with all CCGs having submitted their applications to the NHS Commissioning Board.

At the same time as this large-scale restructuring, the NHS is being put under great pressure to realise significant cost savings of £15 billion to £20 billion over the period 2014 to 2015. Spending on health services in the UK more than doubled in the last decade, growing from £53 billion in the 2000/2001 period to £120 billion in 2010/2011[11]. In July 2012, the Institute of Fiscal Studies estimated that public health service funding is likely to remain tight up to 2020, with its financial burdens exacerbated by high levels of long-term debt, particularly from the repayment of Private Finance Initiative (PFI) costs to independent contractors.

In July 2012, the Office for Budget Responsibility added to the debate on the sustainability of the current scope of the NHS, releasing its projection that if productivity growth in healthcare did not improve on its historic trend of 0.8% per year, health spending would need to rise by 3.6% per year in real terms for output to keep up, equivalent to adding 7.5% of GDP to health spending by 2061/2062.

Despite continued economic uncertainty and resistance from certain sectors of government to independent sector involvement, the market generally accepts that independent sector provision will become increasingly important in the medium term, as NHS funding comes under continued pressure. All political parties have reached consensus on the proposals of the Dilnot Report, which proposes that individual funding should play a role in social care, and similar principles could be applied to health in future, although the processing of the Act has bolstered resistance from some sectors.

Referral to Treatment (RTT) waiting times, England



Source: NHS Referral to Treatment waiting times data, August 2012, Government Statistical Service

10 National statistics on NHS referral to treatment waiting times 18 October 2012.
11 Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland, NAO June 2012.

Regulatory overview

The principal regulator for GHG in England is the Care Quality Commission (CQC). BMI Healthcare and the legal entities of the managed sites are registered as providers with the CQC under the Health and Social Care Act. Each site is registered as a location providing regulated services which may include:

- Treatment of disease and disorder;
- Surgical procedures; and
- Diagnostic and screening.

In the transition application, all sites declared compliance with the outcomes for the 16 key essential standards which are directly related to the quality and safety of care. Annual routine unannounced inspections have been carried out at the majority of sites. The main focus of these inspections was to determine that patients:

- Are treated with respect, involved in discussions about their care and treatment, and are able to influence how the service is run;
- Receive safe and appropriate care that meets their needs and supports their rights;
- Are protected from abuse and that staff respect their human rights; and
- Are cared for by staff who are properly qualified and competent to do their job.

The inspections have found a high level of compliance with these standards at all sites.

The Health and Social Care Act makes changes to the way healthcare is regulated. Under the provisions of the Act, an independent regulator for NHS foundation trusts (Monitor) has been established as the sector regulator for health. Monitor's role will change to take on a number of new responsibilities, including regulating all providers of NHS-funded services in England which includes providers from the independent sector. Monitor has been garnering stakeholders' views on proposals for the provider licence and expect to be ready to issue licences to NHS foundation trusts in April 2013, and other providers from April 2014 subject to the results of the consultation.

The provision of healthcare in Scotland and Wales is regulated by Healthcare Improvement Scotland and the Healthcare Inspectorate Wales, respectively.

HOSPITAL OPERATING REVIEW: UK

GHG is the largest provider of private acute care in the UK. Under the BMI Healthcare brand, GHG operates a national network of 61 hospitals across the UK, comprising 2 979 beds, 183 operating theatres and 54 in-house pharmacies.

Introduction

GHG offers a full range of healthcare services including imaging services, physiotherapy, oncology, orthopaedics, weight loss and women's health services.

Business structure

Following Netcare's acquisition of GHG in 2006, the UK business was split into an operating business (BMI OpCo) and a property business which owns the properties and leases them to BMI OpCo.

The property business comprises two property-owning subgroups. The first subgroup (GHG PropCo 1) owns 35 UK hospital properties acquired in 2006. The second subgroup (GHG PropCo 2) owns the six UK hospital properties acquired from Nuffield in 2008.

The GHG PropCo 1 debt facility is ring-fenced from BMI OpCo and GHG PropCo 2 and is non-recourse to Netcare and its South African operations. The leases concluded between BMI OpCo and GHG PropCo 1 remain secure for the next 19 years, with an additional 10-year renewal option.

Business performance

BMI OpCo experienced a difficult trading year, characterised by continuing recessionary pressures and ongoing NHS reforms. GHG's results have been impacted by certain material non-cash adjustments relating to GHG PropCo 1. Exceptional items and the results of discontinued operations are discussed under the headings Exceptional items relating to GHG PropCo 1 and Discontinued operations, respectively. GHG's financial performance discussed below excludes the exceptional items and the results of discontinued operations.

Overall caseload grew by 2.1% (2011: 4.2%), largely driven by NHS Choose & Book (C&B) growth which offset a continued decline in PMI volumes. Self-pay volumes have shown limited growth after two years of decline, although the rate of growth remains heavily influenced by levels of consumer confidence in the wider economy.

Revenue from continuing operations rose by 0.4% to £834.0 million (2011: £830.3 million), although the fall in PMI volumes contributed to a 6.6% decline in EBITDA to £176.1 million (2011: £188.6 million). EBITDA is reflected before capital items of £811.7 million (2011: £10.3 million credit), the largest of which is the impairment of GHG PropCo 1 goodwill of £811.4 million.

EBITDA margin declined to 21.1% (2011: 22.7%), mainly as a result of the continued shift from private patient volumes to lower-margin NHS volumes, and more inpatient to day-case procedures. However, operational efficiency and continuing cost rationalisation programmes have mostly offset this effect.

Net financial expenses from continuing operations of £354.2 million (2011: £124.9 million) includes £124.1 million net interest expense and £225.0 million relating to the exceptional non-cash movements in the interest rate swap contracts, as discussed later. In addition, net financial expenses were adversely affected by a £6.6 million (2011: £2.8 million credit) non-cash charge, representing the ineffective portion of the movement in fair value of the interest rate swaps.

A tax benefit of £201.8 million (2011: £36.5 million) was recognised during the year, which included the following credits:

- £130.1 million relating to the change in the basis of the deferred tax calculation on the GHG PropCo 1 assets (refer to Exceptional items relating to GHG PropCo 1 for further details);
- £43.5 million relating to the tax effect of the GHG PropCo 1 interest rate swaps fair value adjustments; and
- £27.2 million as a result of a further 2% reduction in the UK statutory company tax rate to 23%.

GHG therefore recorded a profit after tax from continuing operations of £5.7 million (2011: £40.0 million). After exceptional items and including profit on discontinued operations, GHG recorded a loss after tax of £825.3 million (2011: £41.6 million profit).

Net debt declined £72.5 million in the year to £1 712.9 million. The majority of the debt (£1 578.9 million) is held in GHG PropCo 1. BMI OpCo's net debt declined by £53.0 million to £91.7 million year-on-year, partly as a result of the deconsolidation of Health and Surgical Holdings Ltd (Transform) with gross debt amounting to £20.2 million.

Closing cash balances remain strong at £147.9 million compared to £130.6 million at 30 September 2011. The sale of the Care Fertility Group Ltd (Care) in June 2012 contributed to this, resulting in net cash proceeds of £23.5 million.

GHG continues to meet all financial covenants on the BMI OpCo, GHG PropCo 1 and GHG PropCo 2 debt facilities.

Working capital continued to be tightly controlled and improvements made in 2011 were sustained.

Exceptional items relating to GHG PropCo 1

The GHG PropCo 1 banking facilities have a maturity of October 2013 at which time the outstanding balance of approximately £1.5 billion falls due for repayment. The prevailing macro-economic environment within the UK, the state of debt markets across Europe and the negative value of GHG PropCo 1's interest rate swap contracts make the refinancing of the GHG PropCo 1 debt challenging. While GHG PropCo 1 will diligently seek a refinancing solution before October 2013, a solution was not yet in place as at the date of this report.

As a result of the GHG PropCo 1 debt maturity being less than 12 months from the release of Netcare's 2012 results, changes in the underlying accounting assumptions related to GHG PropCo 1 were required.

The accounting adjustments required as a consequence of the changes in assumptions are reflected in the table below.

Impairment of goodwill

The once-buoyant UK property market has declined significantly since 2006. During the 2012 impairment review on the goodwill carried in respect of GHG PropCo 1, a non-cash impairment charge of £811.4 million was recorded against the GHG PropCo 1 goodwill. This review included taking detailed external valuation advice and inputs.

Interest rate swap contracts

GHG will no longer be able to apply hedge accounting principles to the interest rate swap contracts associated with GHG PropCo 1. Consequently, non-cash movements in the fair value of the swaps of £122.4 million have been taken directly to the income statement from 1 April 2012.

In addition, a cumulative fair value loss on the GHG PropCo 1 interest rate swap contracts had been retained in the cash flow hedge reserve within equity. In light of the discontinuation of hedge accounting on the GHG PropCo 1 interest rate swap contracts, a portion of the non-cash cumulative fair value loss in the cash flow hedge reserve amounting to £102.6 million was charged from the reserve to the income statement.

Income statement impact of exceptional items relating to GHG PropCo 1 debt facilities

	£m
Impairment of goodwill	**811.4**
Interest rate swap contracts	**225.0**
Fair value losses on swaps not hedge accounted	**122.4**
Reclassification of the cumulative swap loss to the income statement	**102.6**
Tax	**(173.6)**
Total exceptional items	**862.8**

HOSPITAL OPERATING REVIEW: UK (continued)

Taxation

The tax impact of the aggregate adjustments described previously resulted in a non-cash deferred tax credit of £173.6 million to the income statement.

Further details of the adjustments can be found in note 2 to the Group annual financial statements and on page 160 of the Chief Financial Officer's review.

Discontinued operations

In line with its strategic focus on its core acute hospital business, the BMI OpCo disposed of Care and Transform in June and July 2012, respectively. Care is a specialist fertility provider and Transform specialises in low-cost cosmetic surgery. Care and Transform have been classified as discontinued operations and their results have been reflected separately in the income statement. A capital profit of £31.6 million has been recognised on the disposal of these businesses.

Investment in infrastructure and facilities

Hospitals

GHG continued to invest in its infrastructure and facilities to enhance the quality of its hospital portfolio, with capital expenditure for the year amounting to £41.2 million (2011: £43.9 million). During the year GHG:

- Completed the refurbishment of BMI The Park Hospital in Nottingham, with a major extension to the existing building including a new intensive treatment unit, new endoscopy suite and theatre, and the refurbishment of three existing theatres;
- Completed the refurbishment of seven theatre suites and three existing wards, and built new oncology and paediatric wards at BMI The Alexandra Hospital, South Manchester;
- Completed new operating theatres and refurbishments at BMI The Ridgeway Hospital in Swindon; and
- Continued to refurbish a number of wards at BMI Priory Hospital in the West Midlands, for completion in 2013.

Decontamination centres

BMI also completed the transfer of decontamination services from the majority of the BMI hospitals to specialist hubs which it owns and operates. A fourth decontamination hub in Kent was opened during the year, which will service both internal and external customers.

The upgrade of the decontamination facilities at the Maidstone hub, in line with Care Quality Commission guidelines, was completed. The project to upgrade a number of decontamination facilities across the portfolio is ongoing.

Information Technology (IT) systems

The PeopleSoft IT system implementation was rolled out during the year. This solution has 14 modules covering patient administration, charging and billing, pharmacy dispensing, stock control, ward and theatre management, procurement and financials. The system is already proving more reliable and easy to use, reducing the risk of error. The rollout and associated training across the BMI network is expected to be mostly complete by the end of 2013.

Best patient care

BMI's goal is to provide the best care for patients with the highest quality outcomes, in a location that is convenient to them. Patient feedback informs progress against this goal, which during the year showed 99.2% of patients rate the quality of care provided as excellent, very good or good.

Relationships with doctors

Building good relationships with consultants and with local GPs is critical to GHG. Dialogue with GPs and consultants has continued during the year with presentations, clinical conferences and engagement forums around the country. These engagements enable the sharing of information with GPs and consultants and provide a chance for them to give feedback to management. GHG plans to build on and develop these forums as a platform that contributes to providing the best care for patients.

Investing in people

GHG continues to focus on staff engagement and development. This resulted in an increased frequency of line management briefings, as well as staff communications from the Chief Executive Officer. The package of non-financial benefits was also expanded. The Night of the Stars Awards, which recognises the dedication and contribution of staff, remained a highlight for the year.

For more information see Our people: UK report on page 88.

Managing GHG's environmental impact

This was the first year that GHG made payment to the UK Government as part of its obligations under the Carbon Reduction Commitment. GHG was required to purchase carbon allowances at a cost of £571 000 to cover regulated emissions of 47 594 tonnes of carbon dioxide equivalent (CO_2e). During 2012, GHG's focus was to maintain the initiatives and programmes currently underway as part of its environmental management programme. A review of existing environmental and waste policies was also initiated.

ONLINE *For more on managing GHG's environmental impact see the Environmental report: UK.*

Looking ahead

The year ahead is anticipated to remain challenging for BMI OpCo, given the persistence of global economic uncertainty, the budgetary and structural uncertainties in the NHS and the impact of austerity measures on the UK economy.

Multi-year contracts have been renewed with the majority of PMI insurers and there are encouraging signs of stabilisation and growth in some parts of this market. NHS volumes are expected to continue growing albeit at a lower rate; however, NHS tariff pressures are expected to continue. The efficiency strategies and improvements implemented during the year, position BMI OpCo well for a recovery in the market.

United Kingdom hospitals

Hospital	Registered beds 2012	2011
Northern Region	**770**	807
Albyn Hospital	**44**	44
The Alexandra Hospital	**170**	170
The Beardwood Hospital	**31**	31
The Beaumont Hospital	**34**	34
Carrick Glen Hospital[1]	**18**	19
The Duchy Hospital[1]	**27**	27
Fernbrae Hospital	**16**	20
Gisburne Park Hospital[1]	**29**	35
The Highfield Hospital	**57**	57
The Huddersfield Hospital	**29**	29
King's Park Hospital[1]	**21**	23
The Lancaster Hospital	**27**	27
Ross Hall Hospital	**101**	101
Sefton Hospital[1]	**19**	23
The South Cheshire Private Hospital[1]	**32**	32
Thornbury Hospital	**77**	77
Transform Pines Hospital		20
Woodlands Hospital[1]	**38**	38
Central Region	**722**	722
The Chiltern Hospital	**66**	66
The Droitwich Private Hospital	**46**	46
The Edgbaston Hospital	**55**	55
The Foscote Hospital[2]	**16**	16
The Lincoln Hospital	**32**	32
The Manor Hospital	**23**	23
The Meriden Hospital	**61**	52
The Oxford Clinic[1]		22
The Park Hospital	**93**	92
The Priory Hospital	**118**	118
The Sandringham Hospital	**35**	35
The Saxon Clinic	**40**	40
The Shelburne Hospital	**44**	31
St Edmunds Hospital	**40**	40
Three Shires Hospital[4]	**53**	54

Hospital	Registered beds 2012	2011
London Region	**649**	664
Bishops Wood Hospital	**47**	42
The Blackheath Hospital	**69**	69
The Cavell Hospital	**41**	45
Chelsfield Park Hospital	**50**	50
The Clementine Churchill Hospital	**141**	141
Coombe Wing[3]	**22**	22
Fitzroy Square Hospital[1]	**17**	17
The Garden Hospital	**30**	30
The Kings Oak Hospital	**52**	52
The London Independent Hospital	**78**	80
The Riverside Hospital		14
Shirley Oaks Hospital	**50**	50
The Sloane Hospital	**32**	32
Southend Private Hospital[1]	**3**	3
Weymouth Hospital[2]	**17**	17
Southern Region	**838**	845
The Bath Clinic	**75**	75
The Chaucer Hospital	**60**	60
The Esperance Private Hospital	**50**	50
Fawkham Manor Hospital	**32**	39
Goring Hall Hospital	**52**	52
The Hampshire Clinic	**65**	65
The Harbour Hospital[1]	**40**	40
McIndoe Surgical Centre[2]	**30**	30
The Mount Alvernia Hospital	**90**	90
The Princess Margaret Hospital	**80**	80
The Ridgeway Hospital	**50**	50
The Runnymede Hospital	**52**	52
Sarum Road Hospital	**48**	48
The Somerfield Hospital	**48**	48
Werndale Private Hospital	**28**	28
The Winterbourne Hospital	**38**	38
Total[5]	**2 979**	3 038

1 Core hospitals held under long-term lease.
2 Hospitals operated under management contract.
3 NHS partnership hospitals.
4 Interest in associate.
5 There are 41 hospitals owned by GHG PropCo and held under long-term leases by BMI OpCo which are included in the table above.

CLINICAL GOVERNANCE REPORT: UK

99.2%
PATIENT SATISFACTION RATING OF GOOD, VERY GOOD AND EXCELLENT

GHG works within a robust clinical governance framework, which aims to ensure that risks are managed effectively and that there is continuous improvement in the quality of care delivered to our patients.

Introduction

Each hospital has a local framework through which safety, effectiveness and patient experience are monitored and analysed. The Clinical Governance Board provides oversight of clinical governance, ensures that lessons at local level are communicated across the business and drives quality improvement.

Our standards are continuously reviewed to ensure alignment with regulations, the latest research, national guidelines, accreditation requirements and contractual obligations. To maintain the highest standards we must support clinical outcomes through providing our patients with the appropriate environment, equipment and consultants, as well as staff who deliver excellent care.

To this end we continue to keep up with the latest technological developments in healthcare through focused investment. Recruiting and retaining appropriately skilled staff is also critical, as is providing opportunities for learning and development for our staff.

For more on our learning and development initiatives see Our people: UK report on page 88.

There has been ongoing development of reporting systems to facilitate the best available data on which to base our clinical governance processes. In addition to being used for external reporting requirements, this data informs clinical governance at all levels within GHG.

Ensuring the highest standards for consultants

All consultants are granted and retain practicing privileges based on their ongoing ability to provide a standard of excellence in their particular specialty. All are registered with the General Medical Council (GMC) and hold a licence to practice. The work we have done to support the revalidation process will stand us in good stead following the announcement from the Secretary of State for Health that the process will commence in December 2012.

The revalidation process comprises a new system of checks that will ensure the UK's 230 000 licensed doctors are keeping up to date with the latest developments in their fields and are fit to practise. Based on annual appraisals, the system will include feedback from patients, doctors, nurses and other colleagues. All doctors have been assigned a responsible officer and must be registered with a designated body. GHG is the designated body for over 250 consultants and the Group Medical Director is their responsible officer. The first revalidation of GHG's consultants will commence in April 2013.

Patient safety

Infection prevention and control

This focus continues under the leadership of the GHG Head of Infection Prevention and Control in liaison with the link nurses in BMI hospitals. The infection prevention and control protocols which have been

named internationally as Care Bundles, have been implemented in all hospitals and are subject to ongoing audit. Rates of healthcare-associated infections in BMI hospitals compare favourably with the NHS, notably against the two infection rates published by the Health Protection Agency: methcillin resistant staphylococcus aureus (MRSA) bacteraemias and clostridium difficile. This is due to effective pre-admission assessment and the high standard of clinical care delivered during and after surgery.

GHG had 0.63 cases per 100 000 bed days of clostridium difficile from October 2011 to September 2012 while the NHS reported 16.7 cases per 100 000 bed days.

GHG had no cases of MRSA bacteraemia from October 2011 to September 2012 while the NHS reported 1.2 cases per 100 000 bed days.

Environmental cleanliness is also an important factor in infection prevention. Our patients rate the cleanliness of our facilities highly, with cleanliness of rooms scoring 93.4% and bathrooms 93.1% in our patient satisfaction survey.

Venous thromboembolism

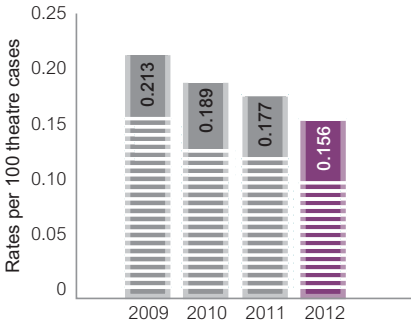
GHG has been awarded venous thromboembolism (VTE) Exemplar Centre status by the Department of Health across all its hospitals, a first for an independent healthcare group. This provides further assurance of patient safety and care in minimising the risk of deep vein thrombosis and pulmonary embolism. GHG established a national thrombosis team, chaired by the Group Chief Pharmacist, which is responsible for implementing the Venous Thrombosis Prevention Policy. The policy was launched alongside a new VTE risk assessment tool, patient information leaflets, prevention protocols, training packages and regular audits to ensure ongoing compliance. All patients undergo an appropriate VTE risk assessment to inform an individual prevention strategy.

Effectiveness

Unplanned returns to theatre and unplanned readmissions

As medical technology and clinical quality continue to advance, the average length of hospital stay for BMI patients gets shorter. All surgery carries a risk of complications and these may result in an unplanned return to theatre. The decline in total number of unplanned returns to theatre is indicative of fewer complications.

Unplanned returns to theatre October to September



The rate of unplanned readmission due to clinical complication within 31 days to BMI hospitals reduced from 0.228 in the prior year to 0.198 for October 2011 to September 2012. This is the lowest in four years.

Patient-reported outcomes

All NHS patients who have undergone hip and knee replacement, varicose vein surgery or inguinal hernia repair are given the opportunity to complete both pre- and post-operative questionnaires. This provides data on the health gain achieved from the surgery. For the year under review, patients treated by BMI have demonstrated above-average health gain. Measurement of patient-reported outcomes for hip and knee replacement surgery will be implemented for all private patients in the coming year.

Patient experience

We continually monitor our patients' experience of care through our patient satisfaction survey, which is administered by an independent third party. We continue to focus on increasing the response rate, and in the 12 months ending September 2012, over 69 000 patients completed the questionnaire. Each hospital analyses the monthly reports and implements appropriate action to address any issues of dissatisfaction or areas that have scored lower than others. We are pleased to report that our rating for overall quality of care (good, very good and excellent) is 99.2% (2011: 99.1%).

Looking ahead

Informed by patient feedback and our continued clinical governance activities and programmes, our focus areas for the year ahead will be to:

- Further develop and enhance the availability of meaningful performance and quality indicators for patients, consultants, referrers and commissioners;
- Audit compliance with Care Bundles to ensure that these have been effectively implemented, measured by infection rates;
- Extend the collection of patient-reported outcomes to include hip and knee replacement for private patients; and
- Audit compliance with prescription of VTE prophylaxis.

OUR PEOPLE: UK

146 195
E-LEARNING MODULES COMPLETED

32 080
TRAINING DAYS DELIVERED

GHG remains committed to investing in our people from both a development and a recognition perspective to ensure that our patients are treated in a safe and caring way.

Introduction

The structural changes introduced by the Chief Executive Officer (CEO) in 2011 continued in 2012. The senior leadership team has been expanded to include regional directors and a wider group of senior corporate directors. This more inclusive structure has enhanced our capability to properly plan for succession.

Three committees have been established to bring more operational insight to the strategic focus of the senior leadership team. The committees are the Corporate Board, representing all corporate support functions; an Operations Board representing the regions and hospitals; and the Support Functions representing sales and marketing, information technology (IT) and procurement.

Employee distribution

Employee numbers have decreased by 7.3% to 7 449. This is in line with GHG's approach to manage headcount by reviewing each vacancy following a resignation to ensure that, where possible, teams are restructured or existing staff are developed to fulfil requirements. In addition, localised structural reviews have resulted in some redundancies.

Staff turnover increased to 22.5% (2011: 19.0%), which is a reflection of renewed activity in the UK healthcare employment market as the newly created Clinical Commissioning Groups seek to recruit their workforces.

Training and development

BMiLearn

GHG's commitment to developing high quality talent continued with the launch of BMiLearn. This online learning system greatly extends our portfolio of training resources and was implemented in all sites. With open access to all materials for all staff,

Employee turnover

	2012	2011
Permanent employees at the beginning of the year	**8 034**	8 234
Increased:	**1 088**	1 330
Appointments	**1 088**	1 330
Decreased:	**1 673**	1 530
Resignations	**1 153**	940
Retirements	**102**	75
Dismissals	**106**	113
Deaths	**12**	10
Redundancies	**128**	255
Other	**172**	137
Permanent employees at the end of the year	**7 449**	8 034
Annual employee turnover (%)	**22.5**	19.0

a total of 1 888 courses were delivered covering 68 426 training interventions.

BMiLearn has been extremely well received and generated much interest and activity. Sites have welcomed the extensive opportunities for training and development which can be easily assimilated within the workplace and during work time. Our Skillport online training system continued to provide mandatory training courses.

Succession planning

In ensuring robust succession planning, GHG recognises the need for a high calibre management pool and succession strategies that direct senior-level career paths. Initiatives to strengthen talent management processes during the year included:

- Making the availability of positions transparent by advertising all vacant roles internally;
- Using assessment centres for all hospital manager roles to ensure consistency and provide data for development planning; and
- Introducing a new Director of Operations role to provide accelerated development to hospital manager roles coupled with open advertisement and assessment centre selection.

To further support the training and development of management and senior leaders, BMI has funded places on Ashridge Management College's Advanced Management Programme for high potential individuals identified through the assessment centres. BMI has worked with Ashridge faculty to put together an extended programme of events linked to the course to which a wider pool of BMI managers are invited.

Recruitment cost reduction

The strategy to move more recruitment activity in-house and onto social media platforms has been highly successful. This approach has delivered cost savings in agency fees of over £1.5 million and savings on print and advertising media of £400 000.

The revised recruitment process comprises three levels:

- Senior management recruitment: conducted in conjunction with a small number of trusted partners;
- Middle management: conducted in-house using trusted partners and social media; and
- High volume recruiting: extensive use of social media platforms for targeted sourcing.

The success of this process has received both internal and external recognition. The recruitment team won Team of the Year at the Night of the Stars Awards and were finalists in the prestigious Recruiter Magazine Recruitment Team of the Year Awards.

Employee attraction and retention

Strong emphasis has been placed on creating an attractive package of benefits for employees. Benefits include private medical cover, friends and family discounts, free health assessments, discounted gym and fitness class membership, a confidential counselling and advice helpline and life insurance. In addition, staff have access to a portfolio of low- or no-cost initiatives including Christmas chocolates, gifts for international nurses' day, a cycle to work scheme, restaurant vouchers and bonus bonds. Staff are also encouraged to get involved in community and charity initiatives such as workplace giving schemes and participating in national charity events. Staff retention has been further strengthened due to new opportunities for career progression emerging from the restructuring at senior levels.

Night of the Stars

In line with the South African operations the Night of the Stars Awards recognise exceptional staff contribution. A monthly award scheme provides an opportunity to acknowledge examples of extraordinary commitment to patients and colleagues, culminating in identifying the Carer of the Year. Annual awards include the Tell the World Award for community outreach, the Star Idea Award, the Best Patient Care Award, the EcoNomics green Award, the Star Team Award, the Florence Nightingale Award and the Star Hospital Award.

The Night of the Stars gala event was held at Madame Tussauds in a vibrant evening at this famous venue which gave all participants a real sense of recognition while celebrating exceptional care, service, initiative and team spirit.

Employee engagement and communication

Throughout the year a series of strategic workstreams has enabled line managers to provide operational input at an early stage in implementing programmes or initiatives. The workstreams draw on experience and expertise across the business, including hospitals, regions and head office to gain a full exchange of perspectives. A reconfigured set of workstreams will reflect the priorities of the new financial year.

Start the Year event

Each year a conference is held for the top 200 managers in the business to reflect on the achievements of the past year and set out the objectives for the year ahead. In the year under review this event was held at the Royal College of Physicians in Regents Park and, in addition to presentations from the CEO and Chief Financial Officer (CFO), included workshops on major initiatives supporting the upcoming year's objectives.

Pulse survey

The GHG staff "pulse survey" was again conducted in 2012, and achieved the same high level of participation. Staff continued to rate their enjoyment of working for the company very highly, and the vast majority indicated that they would recommend GHG as a place to work. The notable improvement in staff satisfaction is particularly satisfying and suggests that GHG is managing to empower the regions and make full use of the infrastructure created over the last four years.

Looking ahead

The business has set challenging targets for the year ahead against a backdrop of difficulties within the health sector but slowly emerging confidence in other sectors. The focus areas for the coming year include:

- Continuing to develop performance management to contribute to a culture of high performance, including new tools for setting key performance indicators (KPIs) and managing performance;
- Ensuring the workforce structure is well adapted to individual hospitals, considering both hospital size and source of business. This includes reviewing structures, fixed versus variable work patterns and KPIs;
- Consolidating the BMI training and development tool with personal development planning, and launching a wider range of modules covering clinical topics and head of department-level management sessions, to ensure all staff are best equipped to perform effectively;
- Communicating regularly with staff and wider stakeholders regarding the prominent UK debt refinancing, to ensure people are well informed throughout the process; and
- Meeting the requirements of new legislation that requires that all staff within a company are registered with a pension scheme, with BMI's deadline set at September 2013. Development is underway and will be supported by extensive internal communications.