Craig Bijou (Head of US Investor Relations, Smith & Nephew)

Good morning to all of you here today, and welcome to everyone joining on the webcast. My name is Craig Bijou, and I recently joined Smith+Nephew as the Head of U.S. Investor Relations after more than a decade as a sell-side research analyst covering med tech.

I'm very excited to welcome you to Smith+Nephew's New York Capital Markets Day, the second of two events, which we hosted this week. We have another full agenda today, but we have a couple of coffee breaks. And during those breaks, I would encourage you to visit our product fair, which is to the right of me. And with that, let me please introduce Deepak Nath, Chief Executive Officer.

Deepak Nath (CEO, Smith+Nephew)

Thank you, Craig. Thank you, and let me add my welcome to all of you. I'm absolutely thrilled to get everybody together here in New York for the second of our two capital market events. And so today, what we're going to do is bring to life the innovation behind several of our key technologies.

So you'll have an opportunity to hear from experts within each of the business units that demonstrates the strength and depth of the bench that we have. Importantly, you'll hear directly from key thought leaders who use our products every day and understand what our differentiated portfolio means to them.

So I'll start with a high-level recap of the key messages from our event a couple of days ago in London. First, our actions under the 12-point plan have created a fundamentally stronger business today than we were three years ago, and that's set up a springboard for future growth. You'll have heard our new strategy and three-year ambition at our London Capital Markets event.

Our new strategy, which we call RISE will elevate Smith+Nephew to the next level, accelerating growth and improving returns. So we expect to deliver 6% to 7% in organic growth and 9% to 10% in trading profit over the next three years. And through continued strong cash generation, we expect to reach $1 billion in free cash flow by 2028.

And that will be combined with 12% to 13% ROIC, which is significantly above our cost of capital. But let's start with a video that showcases our 170-year heritage from our foundation in the north of England to the global med tech company that we are today.

So we are rightly proud of our heritage and how we've developed our business to reach category-leading positions across key markets with a strong and diversified portfolio. Our combination of business units is unique with each focusing on improving treatment outcomes and each of them exposed to favorable underlying demographics as people live longer and have greater expectation of quality of life and activity levels in their later years.

And with technological advances meeting needs that were previously unmet. So we operate in a total global market -- addressable market of $50 billion that's today growing at about 6%. We're the second largest player in the fast-growth global sports medicine market that's worth $7 billion with leading positions in a number of categories, including meniscus repair, hip repair, coblation, and mechanical resection.

We're the second largest player in the fragmented global wound market that's worth $13 billion, and we have leading positions in biologics and single-use negative pressure wound therapy. While we have a smaller position in

the much larger orthopedics market, we have differentiated technology that allows us to remain relevant and provides avenues for future growth ahead of market in certain categories.

On Monday, I told you that we have one of the best management teams in the industry, a combination of homegrown talent and external hires that are ready to push our strategy forward. I highlighted that our executive committee possesses deep hands-on experience in their respective areas.

So this is a team of industry and functional leaders that have built, scaled and transformed businesses at every stage of growth. Some members of the executive committee are here in the room. The business unit presidents presented their strategies on Monday. But today, you will hear from their senior leaders.

This will give you an opportunity to experience firsthand how our executive committee has built and developed their own teams and clearly demonstrates the bench strength that we have to feed our strong succession talent pipeline. So this is what positions us to elevate our growth trajectory.

We've got the right leaders with the right expertise, aligned around a clear strategy committed to disciplined execution. Since I arrived as CEO in April of '22, my priority has been executing the 12-point plan. This plan had three pillars, designed to fix orthopedics, improve productivity across the enterprise, and accelerate our leading positions in sports and in wound.

Within orthopedics, we've addressed product availability issues, tackled high inventory and rightsized capacity, closing five manufacturing facilities to better match demand. We improved our Memphis site to industry standards and rewired our operations for greater efficiency.

At the same time, we strengthened our commercial engine by streamlining its structure, appointing the right leadership, shifting to more growth-oriented incentives, and tightening management of the business overall. And we've built out the hip, trauma, and the robotics portfolio.

So these actions together have returned trauma and hip growth to market levels or higher. And I'm proud that we've accelerated the underlying orthopedics business from about 1.9% in 2022 to about 5% in 2025. While we fixed orthopedics, we nurtured our sports and wound businesses and accelerated them or their growth to above market.

While we made strong progress overall, there are some areas where we did not meet our ambitions. In these, our product gap widened as U.S. market trends shifted. This remains a priority, and we are accelerating development to close the gap with a strong pipeline of new product introductions over the next 18 months, each of which will benefit from our more efficient commercial engine that we've built.

On inventory, we've taken positive steps to improve alignment between supply and demand and have laid the groundwork for continued inventory reductions, but are about a year behind where we thought we would be at this stage. We anticipate further margin improvement as a result of these positive actions.

Finally, in wound, we've made significant progress in single-use negative pressure therapy, which Cathy will talk you through later today. And we are refining our approach to traditional negative pressure in the U.S. to be more competitive in the long run.

So RISE is our bold new strategy to elevate Smith+Nephew. It is ambitious, yet achievable, positioning us for success over the next three years. We have four clear aims. First, we'll reach more patients by driving adoption of our differentiated portfolio and taking share across more indications, new settings, and geographies.

We'll reach more patients moving from our 15 million that we treat today to 20 million in 2028. We're sharpening our focus to maximize the reach of our most highly differentiated products through new market entry and expanded indications. So you'll hear examples today.

Second, we'll innovate to enhance the standard of care through accelerating new product launches and rapidly scaling our existing innovation platforms. We'll maintain our industry-leading cadence of new product introductions with more than 75 new product launches over the last five years.

So later, you'll hear more about how exciting orthopedics launches over the next 18 months, including our new LANDMARK Knee and solutions like TESSA, the first spatial surgery arthroscopic platform will change the landscape.

So third, we'll scale through strategic investment, allocating capital to high-growth and high-return opportunities aligned with our portfolio priorities. We see an opportunity for M&A to support our strategy and build on our areas of strength. We will remain disciplined only pursuing those opportunities that fit our strategic objectives.

We have a strong track record of M&A, such as in 2023s, we acquired CARTIHEAL, which brought us AGILI-C, which Hadi will talk about later today. And finally, we'll execute efficiently, driving group-wide productivity and asset efficiency, particularly in orthopedics to both expand margins and improve our returns overall.

So we'll build on the behaviors that we've embedded in our organization through the 12-point plan with our way to win, which is our program to be better every day through continuous improvement, the behaviors and the mindset that comes along with it.

So finally, I want to leave you all with some key messages. First, that the 12-point plan has delivered, and we are now a much stronger business with a solid foundation to deliver the next phase of growth.

We have an ambitious but achievable new strategy, which will enable us to reach 5 million more patients by 2028. So through increased investment, innovation, and execution, we will drive share gains in sports and wound moving from category leader to market leader in each of these businesses.

We'll continue to gain share in our core ENT market and expect to maintain share in orthopedics. Our positive actions to normalize supply and rightsize capacity in orthopedics and our new Ortho 360 model -- operational model will set us on a clear path to achieving 20% margin in this business unit by 2030.

And in that process, we will double ROIC in that business. So our continued focus on group-wide productivity and further operational efficiencies will drive trading profit growth. And finally, our strong cash generation provides optionality for strategic M&A to reinforce our success.

But today is all about innovation, the second pillar of RISE. We're going to explore some of our most exciting growth opportunities in more detail. So let's first start with Cathy Delane, who'll speak about unlocking value in advanced wound management. So Cathy, would you come up here?

Cathy Delane (SVP Global Marketing, Advanced Wound Management, Smith+Nephew)

Thank you very much, Deepak. So good morning, everyone. My name is Cathy Delane, and I lead global strategic marketing for the wound business. I'm pleased to be here today to talk about two exciting opportunities that we have in wound that will unlock further value for our business. In London, Rohit Kashyap, our President, spoke about five large market opportunities that we focus on.

I'm excited to share in greater detail two of these opportunities and to share our innovative solutions for those. Both opportunities create new markets by preventing wounds from occurring and reducing the risk of pressure injuries and surgical site complications.

Today, pressure injuries are one of the most burdensome conditions in wound care. It's impacting about 2.5 million patients in the U.S. alone every year. These injuries prolong the length of stay by up to nine days, and they take over 40% of the nurse time. And that leads to a $27 billion financial burden just here in the United States alone.

We have two products to help prevent pressure injuries. The first one is LEAF. It is a unique fast-growing patient monitoring system that is is a patient monitoring system that basically you put on the patient's chest. And by doing so, the nurses are reminded how and when to turn the patient.

We also have our ALLEVYN dressing that we've just launched here in the U.S. that can prevent pressure injuries by up to 94% and ALLEVYN Complete Care is a dressing that can both be used for pressure injuries and for chronic wounds. For chronic wounds, it does have 51% better exudate management than the market leader.

And it is also 4x more flexible, and it has a unique shear defense mode of action because it is the only dressing on the market that has nonbonded layers. This feature means it has 55% greater ability to absorb shear and friction. And so we are really excited about the opportunity to accelerate with the growth here in the U.S. and around the globe with ALLEVYN Complete Care.

Moving now on to another key opportunity in wound care is surgical site complications, where we are uniquely positioned to set a new standard of care that will drive improved patient outcomes. Surgical site complications are a significant underserved problem and complications can be devastating for patients, loved ones, and a huge financial burden for the health care systems.

There are two known factors that increase the risk of surgical site complications. The first is patient factors like BMI or other comorbidities. The second is related to the procedure. So how long do they spend in the OR or is the procedure an emergency procedure or not? Surgical site infections are the most common complications of surgery with an incidence rate of over 5%.

One infection alone can cost more than $20,000. We have two main solutions to help reduce surgical site complications. The first one is ALLEVYN Ag+ SURGICAL, and this is addressing we launched earlier this year here in the United States. And the second one is PICO, our single-use negative pressure wound device.

We launched ALLEVYN Ag+ SURGICAL earlier this year, featuring faster and more sustained antimicrobial action more than our leading competitors. And it has a superior reduction of reducing the bioburden and superior pad extensibility.

Finally, the dressing can manage over 2.5x more liquid than the leading product on the market, which is Mepilex Border Post-Op Ag. With PICO, we are committed to transforming the standard of care for surgical site complications across key specialties like orthopedics, OB/GYN, cardiothoracic, general surgery, and plastics.

These high-volume procedures represent significant underpenetrated opportunity to reduce complications and improve the outcomes. Today, single-use negative pressure wound therapy only represents about 20% penetration of a potential market sitting at about $1.7 billion. PICO is the first ever portable single-use negative pressure wound therapy device.

PICO protects the incisional wound by stimulating the biological healing process in the surrounding tissue and increases the lymphatic drainage, reducing the incidence of infections or other complications. It was launched in 2011, and we have continued to evolve the product since.

In 2014, we launched PICO 7Y and we also launched PICO 14. So we're continuously investing in the innovation pipeline for PICO. In 2018, Professor Kirsner at the University of Miami published a key study for us, proving that the efficacy of PICO in open wounds by extending the indication range.

So that means you can use PICO in both to prevent pressure -- both to prevent surgical site complications and in open wounds. In 2020, we reached an impressive milestone of having accumulated sales of 1 million PICO units sold since the launch.

It is one of the fastest-growing brands in Smith+Nephew and has consistently delivered double-digit growth over the last decade. I firmly believe we can maintain and if not, accelerate the growth with further investment and focused execution.

With PICO, we can reduce the incidence of surgical site complications by up to 63%, and we can reduce the average length of stay by up to 1.75 days. In short, the benefit of patient outcomes and financial savings for the systems is really significant.

Through our consistent investment in PICO, we have secured over 200 patents, both on the pump and the dressing design, which together deliver a unique mode of action to stimulate the biological healing process. We have over 310 studies, 60 are Level 1 RCT studies, the highest quality and the most reliable evidence that you can get.

The ultimate proof is the meta-analysis published in the Lancet, one of the world's most respected medical journals, which confirms the effectiveness of PICO. Last but not least, we have guidance from the National Institute of Clinical Excellence, NICE, which recommends PICO to reduce surgical site infections.

NICE is a U.K. government body that validates both the clinical and the cost effectiveness of medical technologies, and it provides a strong endorsement for our product. In conclusion, we will rise with PICO and our strategy is set.

We will significantly expand the number of patients we can reach. We will accelerate the innovation pipeline for PICO, and we will build on our leadership in single-use negative pressure wound therapy, and we will scale even further.

At the same time, we're investing in top talent to strengthen our selling capabilities in the OR to drive more effective execution. The unmet need and the market opportunity is clear. Our strategy is set, and I am confident that we have the right product and the right team to accelerate and to deliver on our ambition.

So it is now my pleasure to introduce our next speaker today. So Dr. Ravi Bashyal is the Director of Outpatient Hip and Knee Replacement Surgery at Endeavour Health in Chicago. He is the Medical Director and Chief Hip and Knee Replacement Consultant for the National Basketball Retired Players Association. He holds an academic appointment of Clinical Associate Professor of Orthopedic Surgery at the University of Chicago School of Medicine.

In his practice, he specializes in robotic minimal invasive hip and knee replacement, performing approximately 500 ultra-minimally invasive total hip and knee replacements every year, while actively participating in clinical research and education. He has published extensively on reducing surgical site infections and complications. So please join me in welcoming Dr. Bashyal to the stage.

Ravi Bashyal (Director of Outpatient Hip/Knee Replacement Surgery, Endeavour Health, Chicago)

Thank you. Thank you, Cathy, for that introduction. Thank you, Deepak and the team for having me here, and thank you all for being here. I'd like to take some time to speak to you about something that's been really passionate, a big passion of mine over the past 15 years. PICO and I happened to launch in the same year 2011. That's when I started practice, and that's when PICO was launched.

I've sort of built my thought process around this on something that I call Destination Zero or a journey to Destination Zero. And my goal is to eliminate high-cost and high-consequence surgical site complications, the most devastating of which is, of course, surgical site infection.

But I've been driven in this as a clinician who takes care of patients and has seen the devastating outcomes that occur when patients have these terrible complications. As a researcher who wants to continue to push and drive innovation in our field of orthopedics.

And then finally, as an administrator, I have administrative roles in our system and understanding that cost is something that we must contain and that we must continue to deliver high-efficiency, high-quality care. And regardless of what I want or how I want things to go, we continue to be constrained in those things, and we continue to be under pressure to deliver high-quality care with lower financial cost.

And so when all of those things come together, the journey to Destination Zero has been really the passion of my career. As Cathy alluded to, a surgical site complication essentially is when the incision you make doesn't do what it wants to do, okay? Anytime you do an operation, you're going to have an incision.

And the outcome of that incision, how it does is really sort of the first step of how the rest of the operation is going to do. That incision is the window or the door to whatever you've done underneath. Whether you're in orthopedics, OB/GYN, general surgery, whatever elegant surgery that you've done underneath that incision, it's all dependent on that incision healing well and that patient not developing an infection.

So my practice, I do about 600 hips and knees every year a little bit more than Cathy said if we bumped it up in the past couple of years. And I use PICO on 100% of those. The question really is how did I get there? And it wasn't because they said, you can be here and talk today if you do that.

PICO has fit and has been a huge partner in this journey that I've been taking to Destination Zero. And it's an innovative product that has fit what I have tried to do as opposed to me trying to fit it into something that I'm trying to talk about.

As a practicing orthopedic surgeon, especially within hip and knee replacement surgery, my number one fear is infection. And we'll get into why I'm so fearful of that, but infection is a devastating outcome, especially for hip and knee replacement patients. It's a devastating outcome for any surgery.

But if you have a hip and knee replacement and it gets infected, the outcomes are not good. They are costly. And I use that word very intentionally. When I say costly, of course, the first thing that comes into mind is finance. And of course, they are very expensive to treat, and we will go into detail on that.

But there's a cost to the surgeon and the patient that I think is sometimes underrecognized or underrepresented. We all know as the people taking care of these patients, how tough it is to take care of them. Most of us care very deeply about our patients and are in this for the right reason. And when they hurt, we hurt.

And infection is probably the thing that I'm scared of the most. My number two fear, persistent infection. And what that means is that somebody gets an infection, I've tried to cure it, but it doesn't work. And we'll talk about the rates of how much that happens.

But if you do develop an infection, you can have a 10% or 20% chance of that infection not being cleared or turning chronic and the outcomes there are even worse and even more devastating and even more costly.

My number three fear is a surgical site complication that's not infected yet. It's a race against time. Bacteria are everywhere, okay? And the longer that, that wound doesn't heal, even if it's not infected yet, the longer it drains, the longer it's not doing what we want it to do, it's just a race. Who's going to win? Are we going to get this thing to heal? Or is it going to become infected?

So those are the three things that weigh on my mind the most as a hip and knee replacement surgeon. And I would venture to say for most surgeons, the thing that's at the top of their mind. Why? Why is infection so devastating? Why is it so detrimental?

It's because infection in surgery and especially in hip and knee replacement is not an ear infection, okay? It's not treated simply by taking some medications and going home and you are better in a few days. It can be truly a life-costing event. The data that I show here is a mortality curve. And you may say, I thought that's for cancer.

It is, but it also applies to periprosthetic joint infection, which we've abbreviated as PJI. You have a better chance at five years of surviving prostate cancer, melanoma, or breast cancer than you do a deep periprosthetic joint infection. And that really puts things in perspective. And by no means does everybody with an infection die, okay?

That's kind of the worst-case outcome. But there's a lot of things in the middle that are not pleasant. okay? Around 10% of patients will experience some sort of surgical site complication. And depending on the specialty, you can have up to a 1% to 2% infection rate.

I always tell people that when a patient comes in to see me, they're coming in to see Dr. Bashyal, do my outpatient total joint, let's go home the same day. I saw your video with this basketball guy. I want you to do this. I want to play golf in three weeks.

And as part of it, they have to sign that consent form, right? And that consent form says, you can have a heart attack, you can have a stroke, you can die, you can lose your limb, but that's not actually what they're signing up for.

The consequence of that person getting an infection, me having to sit with that person and saying, "Sir, ma'am, I'm really sorry. You have an MRSA infection that's like the worst kind. It's chronic. I'm going to have to go in. I'm going to have to take your knee replacement out. I'm going to put in this thing we call a spacer, you're going to go home, you're going to have IV antibiotics for 6 or 12 weeks, your life is disrupted. You've got a PICC line. Someone is going to come to your house every day and put antibiotics into your body."

And if we're lucky, in three or four months, we're going to recheck you. And if everything is cleared, I'm going to go back in, do now your third operation, and I'm going to put in a revision knee. And all that stuff we were talking about before, go home the same day, play golf in three. No, no.

If you can walk around the block and you can do most of your daily living activities without too much pain, we're going to say home run, we saved your leg. That is not what these people are signing up for. And that's what keeps me up at night. It's also costly from a financial standpoint. So you can see sort of an ascending risk ladder here.

But when it gets to infection, they are not cheap to treat. You can see the average cost of treating a hip replacement infection and a knee replacement infection, and they are not insignificant. If you think about that in the context of how many of these procedures are being done and how they're going to continue to grow, it's simply unsustainable, okay?

And that's really where this has merged for me in that for a long time, I've been passionate about preventing infection for patients because we all care about our patients, but it takes time to develop data. Like I said, PICO and I launched at the same time.

Before orthopedic surgeons will really latch on to something, they want data as rightly they should. We practice evidence-based medicine. So it takes time to do that. And I'm really proud that in the past few years, we really now have that incontrovertible evidence that negative pressure allows wounds to heal more safely, more quickly and with lower rates of complications. That is without doubt.

If you believe in evidence-based medicine, you have to believe that. The issue becomes cost. How do we fit that into that ladder? And if we look at the cost to treat infection by 2030, a $5.6 billion load is not something that any of our systems can sustain. So I'm understanding now that with this driver, it's inevitable that the adoption of negative pressure to prophylactically treat high-risk wounds is coming.

It has to because we care about the patients. We're constrained financially, and there's no way that we can afford to keep doing this. Why are these infections so expensive? I've alluded to it a little bit. You cannot treat a joint infection with antibiotics alone. You need to do an operation, at least one, if you're lucky.

If you catch it quickly and you can do an acute washout, when you do that, at minimum, you're still changing out a component. And those components are not inexpensive. And this, again, if you're lucky.

By the way, even if you do that, there's a cost outside of the hospital when that patient goes home, getting IV antibiotics for 6 to 12 weeks, a huge cost to the system. And again, if you do develop an acute infection, even though we're going to do everything we can to try to cure that with a single modular component exchange, the success rates on those operations are not great.

And you have a 10% to 20% chance of becoming chronically infected where we go down the other path of taking everything out, putting in an antibiotic spacer and coming back months later to put in a revision joint.

These things are very, very expensive. So that's why those costs are so high. We didn't sort of pull data just and put everything together to make the cost seem higher. Those costs actually seem relatively low if you think about all these things that go into that.

Whenever I come to a conference, and I'm a big believer in Smith+Nephew recon products. I use them all and I love them. But if you come to a meeting, the focus has always been on advancing technology, implants, innovation, robotics. And those things are critically important.

We've always recognized that we can build a better knee replacement, build a better hip replacement, build a better way to put them into our patients. But the wound has kind of remained secondary. If you think about wounds and infections in the civil war, mortality was 60% from an operation.

You had basically a coin flip of if the operation succeeded or you died, okay? In the late 1800s, Lister, Halsted, they come up with sterile technique, things get better. And then we get to this point where we say, okay, we've got 10% surgical site complications, 1% to 2% infection rates. That's the cost of doing business guys.

We can't do any better. We're not perfect. 1% to 2% is the best we can do. And for a while, I think that was the best we could do. So yes, let's spend our time and energy getting the implants better because those weren't doing so great in the 1960s and '70s. Let's spend time putting the implants in the right place. Let's build a robot. Let's build a better way to do the joint.

But we kind of forgot about the wound. We said we're doing as well as we can. And I'm here to challenge that status quo. I think that single-use negative pressure is that technological leap that allows us to do better than the status quo when it comes to the wound.

As I said, for decades, we've just assumed that we can do no better. And what I've learned is that if we say 1% or 2% is good enough, once we get a little bit better than that, we're not going to try anymore, say, I'm doing pretty good. I'm better than average. If we aim for 0, we will do better. because now we have the technology to be able to do that, okay?

You can have an aspiration, but if you don't have a vehicle to achieve it, it's not going to work. But with single-use negative pressure, we now have that vehicle, and we need to reset our target. PICO has very clearly demonstrated that we can do better. This is the innovation that's going to allow us to bring those rates down.

The thing that truly keeps me up at night is that 60% of surgical site complications, if you look at the data, are preventable with prophylactic use of negative pressure. You identify the patient that's likely going to have a problem, you use it at the time of surgery and they don't have a problem.

It's a problem that we've figured out. And systems, again, can no longer afford from a financial standpoint, a 9% SSC rate or a 1% to 2% SSI rate. It's not sustainable, guys. It's just not going to happen. So something is going to drive this innovation.

My own journey, as I mentioned, when I started out, I thought I was doing pretty good. The American Association of Hip and Knee Surgeons on their patient-facing website says that you have about a 1% to 2% chance of getting an infection if you have a hip and knee replacement. It's the cost of doing business.

My rate is 0.5. I'm doing great. I don't need to change. I'm ahead of the curve. I'm doing awesome. What I've learned is that we can do better and that the current state of mind for me is that I can get to 0 or I should at least target 0. And my colleagues are say, why are you putting this up? You're going to get an infection tomorrow if you say this, but I'm going to say it because they've heard me say it for the past few years now.

I've not had a single infection for the past four years. And we've published that. I'm going to show that to you. We can do better than the status quo. Our target has to be 0. We have to be on a journey to Destination Zero, not on a journey to destination 1%. That's never going to work or all we'll do is keep doing the same.

And we must do all that we can to manage outcomes and costs. And yes, there is a cost to the dressing. But if you look at and we've published this recently, if you look at the cost analysis, you will actually save spend across the entire episode of care. And that's going to catch up with everybody.

If you're only looking at the actual surgical episode, I understand you might say, wow, why am I paying for this? But if you look at the entire episode of care, it's going to come. How does this work and what's the evidence? Cathy has gone over that in some detail. We have a pyramid of evidence, 60 randomized controlled trials, more and more coming out now. And that's why I think now is the time.

We are now in a position to say, this is evidence-based medicine from a clinical standpoint, an economic standpoint and a patient satisfaction standpoint. There's very few things that win on all. It's also really simple. You're going to hear about our great products. I love CORI. I love JOURNEY. I love all of our hip products, okay?

But you have to learn how to use them. And if for some reason, I wasn't using those, there's a hill that the guys have to climb to get me to use it. This is the dressing guys. You put it on the incision, and that's it. We don't actually even put them on, our PAs, our residents and our fellows are putting on it. It's not complicated. There is no learning curve. You just have to put it on and push a button.

And we won't go into detail about that. Cathy has talked about the mechanism of action. It's simple but elegant. The mechanism of action, it's not just a suction device. It is doing things deep to help these wounds heal better, faster and with a lower rate of complication.

As I said, we have a big, big pyramid of evidence, and it's no longer sustainable to say, I don't believe it works. Everybody knows that it works. The question is how and where do we implement it. There's some arthroplasty-specific data. This is a single randomized trial that looked at hip and knee replacements and showed better outcome.

And again, this is just one example. There are literally tens and tens of randomized controlled trials. This is my own work where we looked at our protocols, and I said, how does PICO fit into this? And we found that within our protocol, which relies heavily on PICO and a special irrigant that we went from that 0.6 where I thought was doing pretty well to 0, okay, literally 0.

And our reoperations went from 1.1% to 0.5%. Those are those SSEs that were not infected yet. That rate went down as well. As of December 1, I guess a little animation thing here, okay, just a few days before I came here. That's

our four-year anniversary. We started this whole innovative protocol on December 4, 2021, four years, about 2,400 primary joint replacements, zero infections.

If we don't target zero, we're never going to get there. I know that I'm due. It's going to happen, but I'm going to go from 0.6 to 0.01. And if I wasn't aiming for zero, I would have never gotten there. So at the end of the day, I don't think that every single surgical patient needs negative pressure.

But I do think that every single surgical practice, orthopedics, OB/GYN, general surgery, every single practice has at least some patients that would benefit from negative pressure. So if you're not using it at all, you're missing an opportunity to treat a surgical site complication that is preventable.

To wrap this up, surgical site complications, especially surgical site infection are costly, and I mean that in all senses of the word to patients, providers, and systems. There are many SSCs that are preventable and that we're not doing a good job of treating them prophylactically at this stage, and the data is clear.

And that last piece is why this hasn't been widely adopted yet, but we are at that sort of confluence of these rivers now where it is time to change this. Thank you for your time. Greetings from Chicago, come in the summer where it looks like that, not in the winter when it looks like that. Thank you for your time. Happy to take questions.

Cathy Delane (SVP Global Marketing, Advanced Wound Management, Smith+Nephew)

Thank you so much. So we're going to see if we have any questions. Let us start first with if there's questions here in the room.

Veronika Dubajova (Analyst, Citi)

Hi. Veronika Dubajova from Citi. Thank you so much for your presentation and your passion. Just curious sort of when you give these talks to your peers across the ortho space, how receptive they are to the idea of using PICO and just the feedback that you get from them. Thank you.

Ravi Bashyal (Director of Outpatient Hip/Knee Replacement Surgery, Endeavour Health, Chicago)

Yes. Thank you for the question. Excellent question. There's been a shift. I would say that when I gave this talk 10 years ago, they said, yes, where's the evidence? And now that shifted from, yes, we know there's evidence, but how much does it cost? And there's a lot of information that we need to get out on that sense.

Ravi Bashyal (Director of Outpatient Hip/Knee Replacement Surgery, Endeavour Health, Chicago)

I think people do understand that negative pressure works. Orthopedic surgeons, we kind of pride ourselves on not always knowing the nuances of all the little science that's there. They don't necessarily know the mechanism of action of how this is working, and we're delivering that through education now.

We're working on really getting that out. But they're very receptive. And we show this data, they understand. That paper that I just showed you was literally just published about two weeks ago. When you can go out and say 0, that raises their ears a little bit.

So they're very receptive to hearing about this, and then they want to learn more about how it works and how it fits into a cost structure. And again, in the past few months, we've really had the opportunity to publish across all of those.

Steven Haas (Hospital for Special Surgery, New York)

That's impressive, impressive data, and I commend you on it. And you've got me pretty convinced and maybe I should be used on everybody. Is there a group that you think that you -- it just should be standard of care? I mean it's not everybody, is it the obese, the diabetic? Who would you think that you're just wrong, simply wrong not to use it on?

Ravi Bashyal (Director of Outpatient Hip/Knee Replacement Surgery, Endeavour Health, Chicago)

Yes, that's a great question. And it's that 60% that have the preventable SSC. And if we look at who that is, it's patients with risk factors. So you can risk stratify. And if somebody has one or two or three risk factors, you decide how many before you put on an advanced dressing, things like BMI, diabetes, other comorbidities that are obvious to all of us.

What I found in my practice is that I can risk stratify, which is who is most likely to develop an SSC or I can consequence stratify, which is regardless of their risk profile, how devastating is the complication. And that is going to be different. If you're a trauma surgeon, you have to deal with what comes in the door. You don't have a choice.

As an arthroplasty surgeon, I've already supposed to have self-selected out the patients that I don't think are good candidates, right? Number two, the consequence of developing an infection is massive. So I don't push for people to use it on everybody. I say use it on the -- if you're using it on 0, you're missing something.

Use it where you think the highest risk is and you're going to find your happy space. I will tell you that among my colleagues in my hospital seeing this protocol, utilization has gotten to about 80%. So I think for their easiest cases, they don't do that. What's interesting is when I think about my outpatient program that we started about seven years ago, initially, I was using negative pressure on my highest risk patients, okay?

But then when I started doing outpatients, I can't afford for one of these guys to get an infection early on this, let's use it there. And they were technically my lowest risk patients, right? They're the healthiest, and then it met in the middle. I said, it doesn't matter if Mrs. Smith's BMI is 35 and not 40. If she gets an infection, it's just as terrible as if she had high risk or no risk.

So that's how I've gotten there. But I wouldn't advocate going to 100% right off the bat, find the space. You need to be thinking about the incision is the point of all of this, and it will organically grow.

Cathy Delane (SVP Global Marketing, Advanced Wound Management, Smith+Nephew)

Thank you.

Caitlin Roberts (Analyst, Canaccord)

Hi. Caitlin Roberts, Canaccord. Just thoughts on the other emergent technologies addressing joint infections such as implant material science and if these technologies are really more complementary and additive to the whole goal of zero infection and using PICO rather than necessarily competing against PICO, which seems like that way to me.

Ravi Bashyal (Director of Outpatient Hip/Knee Replacement Surgery, Endeavour Health, Chicago)

Yes. So I think it is a protocol. It is not any single thing that's going to change it. But out of all of the things, this is the single most powerful in my opinion. We will do research to show that. We have to have sort of it broken down by different variable. The other difference is PICO can go on every single incision.

It doesn't matter if you've used a competitive company, silver-impregnated knee or OXINIUM KNEE or the Smith+Nephew OXINIUM knee, whatever might be. And that's the beauty of the product is that it doesn't require new training, learning a new implant or being tied down to a single company. A PICO dressing can be put on a Zimmer knee, okay?

Cathy Delane (SVP Global Marketing, Advanced Wound Management, Smith+Nephew)

Any other questions here in the room? If not, I think maybe, Emily, do we have any questions from the...

Emily Heaven (Head of Investor Relations, Smith+Nephew)

We've got no questions from the webcast.

Cathy Delane (SVP Global Marketing, Advanced Wound Management, Smith+Nephew)

Okay. Well, thank you so much, Dr. Bashyal. Thank you so much.

Ravi Bashyal (Director of Outpatient Hip/Knee Replacement Surgery, Endeavour Health, Chicago)

Thank you for the time.

Cathy Delane (SVP Global Marketing, Advanced Wound Management, Smith+Nephew)

Thank you so much. So it's my great pleasure to introduce our next speaker. So Hadi, welcome.

Hadi el Heneidi (Senior Director of Global Marketing, Smith+Nephew)

Okay. All right. I'll take a slide. Okay. Thank you, Cathy. Thank you, Dr. Bashyal. Great speaker. Hello, everyone. My name is Hadi el Heneidi, and I am Senior Director of Global Marketing, celebrating my 10th anniversary with Smith+Nephew this year.

It's my pleasure to be presenting to you on behalf of the sports medicine business, where we treat injuries in the shoulder, knee, hip, and extremities. Today's focus is on what we call our big three, which are all category-defining technologies at various stages in their journey.

The REGENETEN Bioinductive Implant has been available for over 10 years and is the established leader in biological healing. The CARTIHEAL AGILI-C implant is earlier in its journey and offers a new treatment option to address damaged cartilage for underserved patients, including those with mild to moderate osteoarthritis.

Lastly, TESSA, our tracking-enabled spatial surgery assistant. This is pioneering dynamic real-time arthroscopic video-based navigation. It's currently under review with the FDA and pending commercial launch.

These three platforms are revolutionizing the world of sports medicine due to our focus on innovation and our strong commitment to market development. Developing a market is truly a team sport, investing in clinical evidence, medical education and commercial execution.

Together, we expect these three technologies to deliver around $400 million in revenue in 2028. All right. Let's dive into REGENETEN and its use in rotator cuff repair. First, let me orient you. This is an image of a shoulder. The rotator cuff consists of this group of muscles and tendons that come together to drive stability and move the arm around. Okay.

Rotator cuff tears are extremely common with an estimated 1.2 million tears surgically treated per year globally. Most often, the tendons tear as patients age. It's very painful. And unfortunately, about 25% of rotator cuff surgeries fail. Now they fail due to poor tissue quality and the tendon's inability to heal to the bone.

The traditional standard of care is to use suture anchors to treat the tear. Now this approach addresses the biomechanical side of the pathology, but not biology. Enter REGENETEN. The REGENETEN Bioinductive Implant is a novel way to address biological healing of tendons. It is a scaffold made of type 1 collagen placed over the tear.

Postoperatively, it aids healing and thickens the native tendon. It has been shown to reduce retear rates by 3x at the one-year follow-up mark in a randomized controlled trial. And a unique element to the REGENETEN implant that drives adoption is its well-designed insertion device, which makes the surgical technique very simple.

It goes in, it unfurls and it then is fixed to the tendon and bone. The implant is replaced by tissue, which promotes tendon healing within six months. I have a video, so you can see this in action. So it unfurls, staples go in, down to the tendon and then additional anchors down to the bone.

You can now see that tissue grows in and at six months, your rotator cuff is doing great. Now REGENETEN has been used in over 200,000 patients globally. It's actually available in over 30-plus countries, and it's delivered fantastic patient outcomes. However, having great technology in is not enough. You also must prove its value to get it reimbursed by health care systems.

Now Smith+Nephew has been committed to a 10-year market development journey to generate a wealth of evidence. Our evidence, it's unmatched and high quality, including two randomized controlled trials with over 30 publications from multiple sites published in high-tier journals, all highlighting consistent findings of positive outcomes.

Now all this evidence has changed the clinical practice guideline, which surgeons rely on in their clinical decision-making. We're actually very proud that earlier this year, the American Academy of Orthopedic Surgeons issued a strong recommendation to use bioinductive implants in rotator cuff repair based on that available evidence.

And guess what? That's solely REGENETEN evidence, our evidence. This is a huge deal that will support adoption by opening market access doors and insurance payers and convince more surgeons to embed REGENETEN into their clinical practice.

Now REGENETEN is indicated for tendon healing, and we see significant opportunity to expand its use beyond the rotator cuff. It's already being used in hip tendons and in the foot and ankle on things like Achilles tear, which we see a lot of those.

Now most recently, we received clearance to use REGENETEN for the repair of ligaments, which can be leveraged in the hip for capsule closure, which Dr. Ranawat will touch on later. All right. Let's now turn to CARTIHEAL AGILI-C and its use in cartilage repair.

The knee is primarily made up of three core tissue types: ligaments, meniscus, and cartilage. Now since cartilage is avascular, it doesn't heal well on its own and can cause significant pain. Cartilage damage also has various forms involving, let's say, just cartilage or cartilage with bone known as osteochondral defects and cartilage can be damaged in the presence of osteoarthritis.

So current methods of repair include microfracture, which is very durable beyond two years, cell-based therapy that requires two surgeries; and finally, osteochondral allograft transplants, which are limited by donor tissue availability in the U.S. and even more so globally. So all those current alternatives, they have their limitations.

Enter the AGILI-C implant. A new treatment option designed to help the body regrow healthy cartilage and heal damaged bone in the knee. It's highly effective with twice the pain reduction relative to the current standard of care, which is microfracture.

It's versatile since it can be used across a variety of sizes. And uniquely, it is the only cartilage repair technology that can be used in the presence of mild to moderate osteoarthritis. It's also convenient because it can be implanted in one surgery without any donor tissue.

Finally, earlier this year, a new Category 1 CPT code was created that we can leverage starting in 2027. This code is essential for future revenue growth. It gives us the opportunity to work with U.S. payers towards broader coverage, and it underlines the technology's widespread use, strong clinical data and surgeons championing for it. They want it.

All right. Here, you can see, I like this graph. Here, you can see AGILI-C's mechanism of action. On the left is cartilage regeneration, where mesenchymal stem cells differentiate into chondrocytes, cartilage cells. And that happens in the drill holes of the implant. And cartilage cells also migrate from healthy tissue from along the periphery of the implant. Now while on the bony side, on the right, the bone remodels because CARTIHEAL at its microscopic level, it's almost the same as bone.

All right. Let's now talk about the last of the big three, TESSA. Anterior cruciate ligament or ACL reconstruction surgery is all about visualization. And when you can't see, it can really be challenging to get good results. In fact, 34% of ACL reconstruction failures are caused by technical error. Now going all the way back to early 1919, surgeons would take a manual view looking through a keyhole.

Then in the early '70s, video visualization was introduced, creating the field of arthroscopic surgery. That's where a surgeon would see what they're doing via an arthroscope and then by looking up at a monitor. Since then, arthroscopy has barely changed.

Enter TESSA. This is the first of its kind arthroscopic video-based navigation system, which represents the next generation of arthroscopy by providing guided visualization and advanced imaging here in 2025. Everyone remembers using a map or printing out MapQuest directions back in the day. But now we all use Google Maps because we live in the future, which is digital, dynamic and has real-time updates.

TESSA applies that to arthroscopic surgery. So if the surgery is the journey and the surgeon is driving the car, TESSA gives the surgeon real-time assistance to stick to the surgical plan that he or she created at the beginning of the surgery, making sure that, that surgery is completed as planned.

TESSA takes surgeons away from that status quo that's analog with basic imaging and provides digital dynamic augmented reality that is personalized to that patient. The first application is femoral tunnel drilling, but the technology is purpose-built for any surgical application that leverages a camera where the surgeon is looking up at a monitor.

We could go from here to tibia to applications in the shoulder, hip and beyond. Well, I hope you've enjoyed learning more about sports as big three and how we're committed to accelerating innovative technologies.

We have high ambitions with our expertise in market development, meaning dedication to building evidence, getting reimbursement and delivering medical education, as you can see from REGENETEN, CARTIHEAL, and TESSA, all at different points on their journey.

But in summary, I want to underline that our purpose is to help people live a life unlimited and that patients are truly at the center of everything we do. These are two patient stories where we helped Chris get back to walking his dog and running to work after being treated with AGILI-C.

And Nick, he was treated with REGENETEN, so he could get back to what he loves doing, which is being a coach and a great dad to his kids. That's what gets me up and excited every morning and working here on team Orange, I get to impact millions of lives every day globally.

With that, I'd like to take a moment to introduce Dr. Anil Ranawat, who is an orthopedic surgeon at HSS focusing on sports injuries of the hip, knee, and shoulder. He is constantly pushing state-of-the-art advancements in joint restoration, including both nonoperative and operative management of these conditions.

He serves on numerous orthopedic boards, including AOSSM and EOA. And lastly, he's the orthopedic surgeon for the New York Rangers. So Dr. Ranawat will share with us his perspective on these sports big three technologies in terms of how they're used in his practice today and their potential in the future. Dr. Ranawat, it's a delight to welcome you here. Please join me on stage.

Anil Ranawat (Orthopedic Surgeon, HSS)

So thank you very much. It's an honor to be here. I really want to thank Deepak and the whole Smith+Nephew team. I've been doing this for a long time. And every talk I give is a different challenge. Although I am the Rangers doctor and Ravi is from Chicago, we lost to the Blackhawks 3-0 last night. So I'm a little upset about that.

So I'll quickly talk about my background, my patient demographics, why I think Smith+Nephew is really in the right position to innovate in the sports medicine field. And I'm not going to talk about anybody losing a leg, okay? I'm just going to be talking about people getting back in the game, okay?

That was a little shout out to Ravi, sorry. So I went to Duke, I went to Cornell. I was trained at HSS. HSS is up the road. I'm sure some of you guys have heard about it. It is probably the most famous, highest volume orthopedic hospital.

We have a couple of colleagues here who know a thing or two. I'm a professor of orthopedic surgery, and I'm a sports medicine doctor, and I carry a lot of titles. I worked with the Mets for 15 years, and now I've been with the Rangers for the last 10 years, and I work on a lot of boards and a lot of stuff like that.

But sports medicine innovation is my passion. My real disclosure is this, that my last name is Ranawat. My father was -- who just passed away was probably one of the most famous orthopedic surgeons in the world. My brother is my partner, is another very famous orthopedic surgeon.

My uncle in the U.K. was a famous orthopedic surgeon and my nephew in the U.K. is -- he is not close, but he's an orthopedic surgeon. So orthopedics is in my blood, and I don't do this for any other reasons except for as Ravi was saying, helping patients. We really do care.

There's a lot of ways I can make money. I'm a kind of a smart guy, but I want to help people, and this is an avenue how we can help people. And it's a classic story. When I was 17, I torn my ACL. I had surgery at HSS. Six months later, I was playing soccer again. And those standout moments, and I've trained now hundreds of doctors. We have multiple conferences.

So it's really passion of helping people is why we do this. So who are the people I help? Well, mostly young patients, not old patients. It goes from professional athletes to weekend warriors. Actually, I think I see a patient of mine in the room right now. There you go. I didn't know she was going to be here.

And I focus mostly on hip and knee, but also shoulder. And really, even though my name is synonymous with arthroplasty or joint replacement, I had to show some uniqueness that I was focusing on joint preservation and how can we maintain a healthy joint to get people doing all the crazy stuff they want to do.

And that's really what is my passion and always has been. And I came upon Smith+Nephew about 25 years ago, but really, I started to work with them in the last 10 years because I really saw innovation. There are a lot of companies that can make a different anchor or a different screw.

But that's not innovative, right? That's just kind of disruptive technology, meaning that it's just disrupting the market. It's not doing anything. We want to do progressive technology, progressive innovation. How do we really step forward? And my father always taught me one thing. You don't innovate based off another widget. You innovate based off a clinical problem, such as infection, clinical problem. Here's a solution.

Well, I'm going to show you multiple clinical problems and multiple solutions that Smith+Nephew is pioneering. Problem number one: tendon to bone healing doesn't work. Bone-to-bone healing works. You break your leg, you put a plate on the bone, it will heal.

If you are a fracture surgeon and your nonunion rate is 25%, as Hadi pointed out, with tendon-to-bone injury, you get fired, you would get sued and they would throw you out of this New York City. But it happens all the time. And some patients actually do okay with non-tendon to bone healing, but it's clearly a clinical problem.

And we always used to call it retear rate. It's actually a terrible term. It's not retear rate. You're blaming the patient. As surgeons, we always blame the patient. We're always perfect. It's actually failure of healing rate. So we have something that doesn't want to heal because it's dead dying tissue.

An older person's rotator cuff is avascular, and we want to revascularize it. Traditional methods just don't work as well. So clinical problem one. Clinical problem two: no cartilage repair works. Professor Robert Hunter from the U.K. in 1765. There's no good way to heal cartilage. And we've tried everything.

Hadi went through the gamut. I've tried every little implant. None of it really works. Then we have this new thing. It's a coral-based implant. So you're putting coral like you get in the ocean into the knee. And really what it does, its mechanism of action that's so profound is it takes away the dead bone, the subchondral bone edema, which is a driver of arthroplasty and it revascularize the bone and then it grows new cartilage.

So it's really interesting, and we have an RCT and it's really a game changer. And the most important thing we'll talk about later, it's really simple to do. Let's talk about knee replacements. Let's talk about all these robots here. We have all these fancy robots in navigation for knee replacement and hip replacement to fix grandma who's 75 to 85 years old with a surgery success rate of about 90%.

ACL surgery in your 14-year-old daughter has a 25% failure rate in her, and she has the rest of her life to live. So why are we focusing on an operation that's really, really good. When we have an operation that's not so good, and they have the whole runway. So let's take some of these awesome technologies and bring it to the patients that need the most, clinical problem.

And that's why ACL surgery needs advanced science. So let's go to tendon healing. How I use REGENETEN? It's pretty simple. You put a tendon back to bone with suture anchors or whatever you want to do, and you lay it on top and you suture it together with various devices. This is what it looks like of the hip. I am mostly a hip surgeon. I do it in the shoulder as well.

I kind of led this charge of bringing it to the hip. This is actually a really underdiagnosed problem, trochanteric bursitis, A lot of people have it. If you get over 50, 60 years old and one day you just wake up and like, "Oh God, the outside of my hip is freaking killing me, I can't do anything." And they always say it's bursitis. It's not bursitis. Your tendon is failing, and this is a way to make your tendon come alive again.

That's really what it is. It's -- I always used to call it. It's like crack for your tendon. It will make it come alive again. And really, with the impact here, again, it's not lowering the retear rate, it's improving the healing rate. It's a matter of perspective, but it's really a critical difference.

And the ability to do it on multiple levels, which is now foot and ankle, hip and even also now capsule, we'll talk about. So as we talked about, I use this now on the hip, I use it in the quad, I use it on a patellar tendon. I use it anywhere I have a tendon that's failing.

And my foot and ankle [cartilage is used] a lot more than Achilles. This is another application that I've been talking about that we do this arthroscopically. Realize we can put this implant open, you can make an incision and put it on or you can do an arthroscopic. There's a very nice arthroscopic application. So it's highly versatile about where you can use it, and it's highly versatile of how you put it in.

So here's a case, a 63-year-old female. She's had multiple cortisone shot for that outside hip pain. See some people when I mentioned the outside hip pain, like three people move their hip because I know they have it. And she went to this famous Greek surgeon, doctor iatros, no, I'm just joking. That's called doctor iatrogenic, who gave her five cortisone shots in tendon, pop the tendon off. And she could -- she went from a tennis player, squash, like a super athlete, she couldn't walk three blocks. And I'm like, wow, this is like a devascularized tendon.

So I repaired the tendon. I made an incision, multiple sutures and all that stuff and then that blue trimmed patch goes on top. And six months later, on a study that I performed with actually -- with Smith+Nephew, we did MRI data and all the MRI data. So this is objective data. It's not patient-reported outcome data. Patient-reported outcome data is good. We want to see how they're feeling, but objective evidence is objective evidence. And we have objective evidence in the shoulder and in the hip showing the tendon heals, heals thicker and a wider base.

And that's what she said, and she's back to playing everything she wants to do. So let's talk about the cartilage. The fascinating thing about this, it was an Israeli company that I was involved also with the RCT that they tried to do it on all gamut of cartilage disease, really young people, middle age and even some arthritis. Our golden rule is that you don't really do cartilage repair and arthritis. And this paper actually showed that you can, it has a role.

And there are a lot of patients that my joint colleagues can tell you that like they have a joint space on an x-ray. I don't want to do a replacement, but the patient can't move. We call them the tweeners. It's a huge market, right? You don't do a knee replacement too early. So there is another avenue to help these patients. And what do we normally do for those patients? We inject them forever and go, oh, my cortisone is going to work. No, that's not the case. So there's really an expanded level of indications. How I use this? It's pretty simple.

The technique is a press fit, you make a little hole. Another technique I do a lot is osteochondral allograft. What is that? That's a dead person. that they put in a refrigerator for two weeks, give it to you and then I have to fashion a hole and another hole, I have to make it. And it's I'm a glorified carpenter, I don't mind. But it's hard to do. It takes me 35 minutes. This takes me six minutes to do. And it's been shown to be maybe more effective because allograft after five years fail, these are not. And there's no issues of rejection and no issues of viral transmission.

There's a whole host of issues. And I go to India a lot. I go to all over different countries. There are a lot of countries you can't even get allograft. So this is a global company with a global product. So I really think this product will really be a game changer in our tool because we're fighting a really tough battle of early arthritis. And it's really something that's simple to do and the data is really good. This is what it looks like. You see a cartilage defect, you fill into a hole. And at nine weeks, you could see that cartilage mature, and it's really impressive.

And we have MRI data to show this. This was a New York City firefighter. He's 35. He had a crooked knee and arthritis, and they wanted to board him. Board him means that they say, you're done. And he was told to get a knee replacement. He's 35. That's a long time that even these guys in the front row could even sweat a little bit about. So what did I do? Well, I broke his leg, realigned his leg, put in some plugs and he came back to being on fireman. That's a game changing. And I'm going to have this guy have his own knee for 20 more years.

I'm not saying you may not ever have a knee replacement, but that's really a game-changing approach. What I really love about this implant is that it really completes the portfolio. It completes the deck. As Deepak said, Smith+Nephew is the leader in meniscus repair. It's a leader in ligament. It has all the other things that a lot of other companies have, but it didn't have this part of the bench, right? To win a game, to win a hockey game, you need to have every kind of play. You need a great goalie, you need this. And once in a while, you need an enforcer.

This is our enforcer. You don't know what enforcer, I'll tell you later. So let's talk about surgical accuracy. So as I was saying before, an ACL surgery is actually quite hard and very rudimentary with techniques. It's similar to doing a total knee with just a jig, right? We use manual guides. And the thing that's even harder is that we're not actually touching the bone, we're indirectly touching it. And we're indirectly looking from a 3D structure to a 2D picture.

And based on the knees deflection angle, all of my landmarks can dramatically change. You wonder why there's a 25% failure rate and you want to like tunnel map positions where we drill our holes are routinely off. And this is what I've always been saying, we've -- many companies have tried to jump into the space and say, let's do navigated pins and arrays ACLs, and it's always failed. This is a new approach because this is what I normally do. I use manual stuff, like a manual guide. This is the same way an ACL was done 45 years ago.

And I always would be like, God, my ortho -- look at all these toys they got. And I got a little piece of metal here. It's like give me something better. And that's what TESSA is. So TESSA, what you really want to think it is. It's your arthroscopic viewer is reading off an image, a CAT scan or an MRI and overlaps that image on the bone while I'm doing it real time. So it's actually better than robotics and navigation where I'm looking at a screen and at the patient here, that screen of navigation is on top of the patient. It is truly mind-blowing, this technology. And it's all based off QR codes.

Like when you go to LaGuardia, like you want to get -- you're waiting 45 minutes just to get a glass of water because you can't do that. But this QR code picks up immediately, and it's all -- creates a 3D meshwork. I can do my operation virtually based off the patient's anatomy and then I can reproduce it in seconds, real time. And I will tell you this, ACL femur is the tip of the iceberg. This is going to completely change arthroscopic surgery. And the other platforms for this are also profound, but we'll talk offline.

So I really think this little black box is analogous to my father's generation when they said, we're going to make total knees, we're going to give you jigs where they used to do everything freehand. It's going to be that much of a revolution. So as with any robotic navigation technology, Tessa, if you do compare something with Tessa versus manual, the computer AI-enabling technology will beat a manual hand, even an expert hand every single time, and it's not even close. And we've shown that already with a couple of papers that we're publishing right now.

So in conclusion, as I learned when I was a young medical student, you define clinical problems, tendon healing, cartilage repair strategies and how do I do an ACL on a 16-year-old young woman who has her whole life ahead of her properly. I really believe, and we've really shown that REGENETEN works. I mean there's science. It's done. We have pretty good evidence now that AGILI-C will really change how we do cartilage repair.

And TESSA to me, wow, that's like we are on the precipice of another generation really going forward. And that's really an exciting time. So this is my father and his last line would always be, the eyes only see what the mind knows. I know where this company is going. I know their moral compass and they have an innovative product line to take us there. Thank you.

Hadi el Heneidi (Senior Director of Global Marketing, Smith+Nephew)

All right. Thank you, Dr. Ranawat. All right, everyone. We're going to take some questions for Dr. Ranawat. We'll start perhaps in the room. Any questions from the room, please?

Veronika Dubajova (Analyst, Citi)

Hi. Thank you. Veronika from Citi. And thank you, Dr. Ranawat. The presentation was amazing. A couple of questions for me. First, on TESSA. Can you talk about how much time it adds to the surgery and just kind of how you think about the cost benefit? Obviously, it's been a big debate with robotics. So maybe help us understand that. And then I have a couple of other things, but maybe start with that.

Anil Ranawat (Orthopedic Surgeon, HSS)

Yes, yes. So I mean everything is about registration, right? Whenever you have -- even though this is not robotics, this is more AI-generated spatio-temporal onlay, say that 10 times. But the registration is the most important thing, and it has to be accurate. And I've been involved for -- with the development for a long, long time. And now for ACL femur, it takes us under two minutes. So that is very negligible. And it's -- the likelihood that you have to redo that is also meaning like, oh, it was a bad registration, is also very low.

Veronika Dubajova (Analyst, Citi)

And I guess, I mean, when I look at the failure rate, it seems like a no-brainer not to use it. When you have discussions with your peers, what are the reasons that you think they might say, look, TESSA is just not worth it?

Anil Ranawat (Orthopedic Surgeon, HSS)

Because they're lazy, right? And they don't care about their patients. But I'll ask the room, who in this room has known somebody who has re-torn their ACL, a young person. Yes. Talk about -- we're talking about devastating -- this is devastating for these kids. It takes one to two years of their life. It's profound. So I love Ravi's talk about cost. Yes, when I get someone who retears their graft and I see her crying in my office, moms crying, dad wants to punch me, I'm like, we got to get better. This can make us better.

Veronika Dubajova (Analyst, Citi)

Okay. That's really helpful. And then I wanted to ask about REGENETEN. Are you using it in all of your repairs?

Anil Ranawat (Orthopedic Surgeon, HSS)

Every glute, I do. Every patellar tendon, which is another rupture that's based off avascularity. Really -- so what happens when you get old? Sorry, but your tendons get avascular, hypocellular and then they slowly tear. These are not tears from a healthy 40-old who went skiing and popped his rotator cuff. And you can actually tell when you do the surgery and you push your probe on the cuff, not 40-year-old, the blood vessels, you see the blood vessels.

And when you push a probe on a 70-year-old, there's nothing there. And so what this gives you a way to revascularize. And that's really what PRP is trying to do. Everything that we're trying to do in tendonopathy. And if you can fix tendonopathy, I don't know -- there's no way that Hadi can give you an estimate of the global market of tendonopathy. It is -- it's like, okay, we're going to go after aging. That sounds good.

Veronika Dubajova (Analyst, Citi)

Thank you.

Hadi el Heneidi (Senior Director of Global Marketing, Smith+Nephew)

Other questions? Yes. Thanks.

Iseult McMahon (Analyst, BTIG)

Iseult McMahon, BTIG. Thanks for the talk today. I was curious how you're thinking about positioning of AGILI-C for Grade 3 and 4 lesions compared to some of the other products that are in the market today?

Anil Ranawat (Orthopedic Surgeon, HSS)

Yes. I mean the -- well, Grade 3 and 4 lesions are the ones you kind of want to do it for. You're saying -- so you're saying you're seeing almost bone, right? And so -- and I'm saying that, that's the ideal person to do it on. And the thing that I would -- I did for many years is osteochondral allografts. We thought we solved the problem, right? We can only really get them in the U.S. It's really hard to get them outside. And osteochondral allografts to AGILI-C is much more costly.

And we see at five years, our allograft data because we take a lot of data in HSS are falling off the rails. So the same thing that we thought with microfracture. Microfracture sound great until five-year data off the rails. So -- and then also the other things that -- what about autograft? Well, it's one of those things that, we should tell my dad or my brother or Mike and Steve and like, well, you're going to move one piece of cartilage, 1 centimeter over to another thing.

Like that sounds like only a sports medicine doctor would do that. They're like, so to me, you tell me right now, besides AGILI-C one cartilage product that works really well because there isn't. And there's a huge market for it.

Iseult McMahon (Analyst, BTIG)

And then just one more follow-up. What percentage of your cases are you seeing both bone and cartilage damage?

Anil Ranawat (Orthopedic Surgeon, HSS)

I mean, if you have 3 or 4, you almost always have bone damage. And what -- bone loss is something different. Bone loss, you may want to replace the bone, right? And if it's a little bone loss, you could still use this implant. But bone marrow edema, which is really early bone damage is what really hurts the patient. And that's why this is great because you're coring out that dead bone and putting in a new implant that then can revascularize and grow with new healthy bone.

That is almost more important to get rid of that bad bone than whatever cartilage you get on top. That -- and if you look at the drivers of arthroplasty, there are three drivers of arthroplasty, and it's never Kellgren and Lawrence, which means your amount of arthritis on x-ray. The drivers of arthroplasty are BMI, malalignment whether your legs are crooked and bone marrow edema. So I'm giving you a way to fix bone marrow edema.

Hadi el Heneidi (Senior Director of Global Marketing, Smith+Nephew)

Other questions in the room?

Anil Ranawat (Orthopedic Surgeon, HSS)

I think she has to ask a question.

Hadi el Heneidi (Senior Director of Global Marketing, Smith+Nephew)

Yes, please.

Anil Ranawat (Orthopedic Surgeon, HSS)

How's your...

Unknown Speaker (Attendee)

Dr. Ranawat. Thank you so much. You saved me in January. I came to you and had double hamstring tendon repair. I can say your bedside manner is second to none, and you made sure I made a full recovery. So thank you so much. And it's because he scared me into doing very little to let it recover.

How do you teach and talk to the other doctors in your profession around adhering to the recovery protocol that you instill? And how do you think some of these products are going to help with that, making sure that your patients make full recoveries?

Anil Ranawat (Orthopedic Surgeon, HSS)

As we started off, and I think -- and Ravi touched on it, is that we do this because we really care for the patients. And a huge part of that is your connection and how you have to be honest with them and saying, yes, it's going to be annoying for a month or so. I tell my rotator cuff patients, you will not like me in two weeks and then in six weeks, you're going to cook me dinner. You have to be honest with patients. And then you have to understand what's your fixation construct, right?

There are certain things I know if I put a lot of heavy middle screws and things like that, I can move them fast. And there are certain things I got to move them slow. So the thing about AGILI-C is that it's -- I can move those much faster than my OC allografts because it's -- their protocol is weight bearing as tolerated, which means you can put full weight on it right away versus most other cartilage repair strategies is like very limited weight bearing.

Right then that in itself a lot of patients are, put me on that one. So same thing with REGENETEN. We are -- one of the advantages of REGENETEN is that it's a faster rehab protocol because -- especially for partial cuffs, the fixation is -- it's an onlay. So that's a really important part of the process is understanding your device, understand if you can move it fast because of your fixation construct. And REGENETEN and AGILI-C are both constructs where I can move them fast.

Hadi el Heneidi (Senior Director of Global Marketing, Smith+Nephew)

Emily, anything from the webcast?

Emily Heaven (Head of Investor Relations, Smith+Nephew)

What impact could AGILI-C have on the rate of knee replacements?

Anil Ranawat (Orthopedic Surgeon, HSS)

I mean I think it's a different market, right? We're talking -- knee replacement is designed for bone-on-bone arthritis on x-ray. AGILI-C is designed for people with cartilage wear that have a preserved joint space. If you go to arthroplasty conference and have a preserved joint space and you put it up and you have to present that at your boards, you may not pass.

So it's a different thing. We're going after that huge market in the middle where it's injections, braces, PT, and these patients don't really have a great solution. And I can tell you, our arthroplasty colleagues don't want to see them because they're too early for arthroplasty. We traditionally didn't want to see them because we didn't really have a great solution. So if anything, we're expanding the pie, not stealing from the pie.

Hadi el Heneidi (Senior Director of Global Marketing, Smith+Nephew)

Good. Okay. All right. I think that will wrap up our Q&A section. Thank you again, Dr. Ranawat. So now we're going to transition to a well-deserved coffee break. Please enjoy some coffee and treats and come learn about some of the products with our experts. We'd like you back here at 10:45, please. Okay. Thank you.

[Break]

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

Welcome back, everyone. I hope you enjoyed the little break and hopefully got to see some of our innovative products at the product fair as well. My name is Mayank Shandil, and I lead our global marketing function across orthopedics and robotics. Over the next 10 minutes, I will take you through how we are going to build our competitive advantage across knees and robotics.

We have a strong track record of innovation across both robotics and enabling technology as well as implant design. With the acquisition of Blue Belt Robotics in 2016, we have pioneered the use of handheld robotics for total knee arthroplasty. In fact, Smith+Nephew remains the only company with FDA-approved robotic indications for partial, total and revision knees. The digital tensioner that we launched in 2023 was yet another unique solution that helps make the procedure more precise and reproducible. I will speak to this in subsequent sections.

On the implant side, we were the first to bring to market the asymmetric joint line with JOURNEY, which helps match the patients or the average patient's anatomy more accurately. Across our LEGION and JOURNEY platforms, we offer surgeons distinct choices on both implant geometry and materials to help personalize the procedure for every patient. Finally, I want to reiterate that when we speak of innovation with knees, we always mean procedural innovation that spans the robotics and tech, but also implant design.

While the robot is critical in the OR, it's the implant that the patient goes back home with and its design must accommodate varying needs in the future. So let's talk about those needs. The expectations from our stakeholders, starting with the patient, but across surgeons, OR staff, administrators, even payers are evolving rapidly. Our key objective will always remain the same, make patients happier and improve their satisfaction from knee replacement procedures.

And what we are seeing is personalization of the implant position makes patients more satisfied with their outcome. So future implant designs must accommodate this. Now while implant geometry plays an important role, it's really the technology, the robot that helps position the implants accurately, precisely and reproducibly every single time. The purpose of technology fundamentally has to be to make complex surgery easy and to make easy surgery more reproducible.

And finally, the shift from hospitals to ambulatory surgery centers here in the U.S. is driving a distinct need for streamlined workflows and efficiency. Cost of technology, its footprint and procedural breadth, even the number of instrument trays can all contribute to inefficiencies. So any solution we build for the future must address these needs.

So always starting with the patient, making sure technology is doing what it's supposed to do, i.e., making complex surgery easy, making easy surgery more reproducible while improving outcomes and doing all this while driving leaner workflows and higher efficiency. Now while we clearly understand what these needs are, as Smith+Nephew, we are also aware that our current knee portfolio is complex with as many as four knee brands.

Any solution we create for the future must ensure that we are not only evolving our knee procedural offerings, that's implant design and workflows, but also actively streamlining our knee portfolio so that we manage significantly fewer SKUs across our value chain.

As Craig Gaffin mentioned in London, we have created a comprehensive global operating model called Ortho 360 that will help us plan for country-level portfolio mix while not only ensuring business continuity with customers, but also providing granular data on things like stranded inventory and OpEx, which will help us drive our business more predictably. Making these strategic portfolio choices, we will reduce our overall SKU burden by nearly 40%, while at the same time, adding an innovative new femur design and more on that soon.

But before I get to that, let's dive a little bit deeper about how we are looking at the future of knee surgery. We have three key design priorities. First and foremost, it's the ability, like I said, to personalize the position of the implant for each patient's anatomy. And the implant design must accommodate for this personalization. Second, the implant and robotic solutions need to work together to unlock better outcomes.

And lastly, going back to that point I was making around efficiency, the solution must offer all of these benefits without adding significant cost or complexity in the OR, especially in the ASCs. So think of these three pillars as personalization, performance, and efficiency. So let's start with personalization. And without getting into too much technical detail, we know that satisfaction in a knee replacement procedure is driven significantly by the balance of soft tissue around it. These are all the ligaments that support the knee, especially on the inner and outer sides.

Till the invention of this device on your screens, most surgeons were using subjective ways to assess tension in these ligaments. We have since learned that this subjectivity can create variation in assessment, not just across different surgeons, but also for the same surgeon between their first and last cases on the same day. Our unique digital tensioner is a first step towards an objective assessment of each individual patient's soft tissue that will eventually help us personalize soft tissue tension for every type of patient.

Sticking with personalization, here's another great example of how our robotics and implant systems can help personalize the surgical process even in complex surgical settings. In a revision situation where there is bone loss and

there's limited reliance on anatomical landmarks, our CORI revision workflow simplifies the procedure through accurate implant placement and the ability to automatically plan for bone defects.

We can even use the digital tensioner typically used for more straightforward primary cases to dial in the right soft tissue tension for each patient, eventually improving functional outcomes even in these complex revision scenarios. With this simplified workflow, we have data that shows that this approach reduces the mental and physical strain on surgeons and their OR staff by 19% versus conventional procedures.

Okay. So I'm now going to switch from personalization to performance. But before I do, this is LANDMARK. Now I can't give too much away today, but there are three things that I want you to remember about our new knee. First, LANDMARK will incorporate the differentiated kinematics of our JOURNEY platform, along with the simplicity of use of our LEGION platform.

What that also means is that it's compatible with existing instruments and will allow us to retain our customers while being able -- while being offensive with conversions across fully cemented and cementless offerings. Second, LANDMARK will be our most robotically enabled knee ever, period. Think simplified workflows, advanced patellofemoral planning and execution and industry-leading soft tissue optimization and more.

And lastly, and perhaps most importantly, LANDMARK will have industry-leading and leanest tray configurations, including for robotic cases without compromising on intra-op options for the surgeon. So let's see how this translates into improved performance. The ability to dial in patient-specific alignment with pre-op planning without compromising on other functionality or survivorship is one of the holy grails of knee replacement today.

Typically, plus/minus 3 degrees on alignment is considered safe, although some surgeons can go beyond that. But within those 3 degrees, the LANDMARK design actually covers 90% of the patient population out there. So think of it as for 90% of patients, LANDMARK requires little to no deviation in the cuts to perfectly match the patient's anatomy compared to only 40% with other knee designs. This equates to easier workflows and less compromise on the position of the patellofemoral joint. This is the LANDMARK advantage with alignment.

Another area where LANDMARK has differentiation is the design of the patellofemoral joint. LANDMARK is designed to allow for the patella to find its natural position by changes made to the patella groove, along with the ability to prevent rotational compromise. I'd mentioned LANDMARK will be our most robotically enabled knee implant ever. This is another area where you will see this come to life.

I can't disclose too much at this stage here today, but please know that CORI's unique capabilities lend themselves really well to planning and executing the patellofemoral joint in a total knee. Besides improving function, this can also help reduce the incidence of anterior knee pain, which remains a common problem with knees even today. All of our new platforms across knees, hips and shoulder will have best-in-class tray configuration that drives efficiency.

For LANDMARK, we will be able to support a robotic total knee replacement with only three trays, offering multiple implant options as well as cemented and cementless fixation. This is significant since it not only reduces sterilization costs, but also the burden on OR staff. Remember, the ASCs are typically leaner on staff compared to hospital ORs. And finally, while we continue to innovate with our robotic platforms and implant systems, we also continue to generate valuable data across the episode of care.

Starting with our CORIOGRAPH Pre-Op Planning, all the way into intra-op and post-op data with outcomes and function, we have the ability to create this connected ecosystem that will eventually help us build algorithms, algorithms that could one day drive clinical decision-making in line with different patients with different anatomies, disease progression and even functional expectations.

Our exclusive partnerships, and I'll speak more to them when I talk about ASCs, enable us not only to capture this clinical data, but also critical health economic data that can unlock value for hospitals and ASCs and even payers and policymakers in the future. I'm very confident about our direction on robotics and knee surgery, and I'm convinced that this will create competitive advantage for Smith+Nephew in the coming years.

With that, it is now my pleasure to introduce Dr. Steve Haas from the Hospital of Special Surgery here in New York. Dr. Haas, besides being an accomplished surgeon, a global thought leader, has also been the Chief of Knee Service at HSS for the last 18 years. He's the current President of the American Knee Society, and he will talk to us about the evolution of implant design and enabling technology from his unique vantage point. Dr. Haas.

Steven Haas (Hospital for Special Surgery, New York)

Mayank, thanks very much, and thanks, Deepak, and thank everybody, for coming. This is actually an exciting time to come and present to you. A, I heard amazing things, like some of the stuff that Anil was saying is incredibly exciting, and I'm going to get rid of all my infections now because PICO is going to be on all my patients. So I'm excited for a lot of reasons. But the most exciting for me actually is I'm going to talk about LANDMARK, and CORI. And I think I hopefully can share why I think these are the next evolution of knee replacement.

I really think some game-changing things that are being done, okay? The expectations and demands of what we see in patients are -- they're not all older people. There are -- some of them are older, but it's many younger people now in their 40s and 50s having knee replacements. And even the older patients are much more active and they want to do things, as I said, ski, mountain climbing, racket sports, bungee jumping and even whatever that patient of mine is doing there. I don't know what that patient is doing, but she wanted to do that.

And if she couldn't do it, she wouldn't have been happy. So that's the goal that we should be trying to achieve, right? So I'm going to try to share a little time line and history of knee replacement to give you an idea of what was great and some things that maybe aren't so great, then they may not know. Knee replacement started in the 60s as a knee replacement. That's where the term came from. You lap the knee out and you put a big hinge in, and they didn't work too well, as you might imagine.

Knee replacement as its current form, was actually invented in the '70s and '80s at Hospital for Special Surgery by Anil's dad, Chit Ranawat, and in conjunction with John Insall, who is also -- both of them are my mentors. And John Insall was a [indiscernible] (01:36:44) bad, so he'd be very pleased to see Smith+Nephew taking the lead in this.

So -- but importantly, what they did is they turned knee replacement to a resurfacing operation. It's a terrible term. I'd outlaw if I could, because we don't really replace the knee. What we do is place a cap over the end of the bone that's about 1/3 of an inch thick, a cap over the thigh bone, a cap over the shin bone, right? And that was the 70s, 80s that worked very well. It relieved pain. The function was pretty good. It certainly improved the patients of the time. But they were no lefts and rights. They were symmetric devices all over and they only came one or two sizes.

So at that time, you fit the patient to the implant rather than the implant to the patient. Over the '90s, there were a bunch of refinements to that and a lot -- there were some increased sizes and a lot of improvements in technique and as far as the instruments that you were using to put it in. But the symmetric nature of them, in other words, no lefts and rights actually were maintained in most of the parts and a small amount of asymmetry was added to them.

But basically, they were pretty symmetric. If I put them next to you, you might not notice a difference between the ones in the '70s. And that brings us to the early 2000s. And actually, believe it or not, that most of the knees, a matter of fact, all the knees being put in by the major manufacturers, including Stryker, Zimmer and DePuy were designed and started in 2006 to 2013. And the biggest changes those have from those original designs from the '70s through the '90s were a lot more sizes.

They said, well, let's make a lot more sizes because that might have a better fit. but the shapes really weren't changed. The shapes are basically similar with only a little bit of asymmetry. They're basically symmetric devices. There were a lot of improvements in plastics. So the plastic processing got a lot better to improve longevity, and that was a good thing. And then we go into where we're going from there to now. Well, for most of the companies, what was done is they added polyethylene inserts.

So the inserts were changed and the inserts were changed to add some more sizes and some functionality. So I think some good changes, but no changes in the femur or the basic design. So let's see if -- there we go. And so what it ends up doing is there's a lot of limitations in that. The limitations really occur because you're working on an architecture that's 10 to 20 years old that won't accommodate what we're doing in the current concepts that I'll share with you later.

In addition, 3D printed porous technology came about, and that was a big sort of game changer because it was applied to the tibia and the patella wasn't applied to the femur. The femurs are the old femurs, but the tibia and patella, which I'll share with you later, had much better results. Okay. Well, why do we care to make the changes? What's -- Anil said they're doing 90%, 100% great. They're not. The reality is if you look at knee replacement as opposed to hip replacement, I think hip replacement is there.

But knee replacement, unfortunately, many of the patients do not achieve the goal of getting this great satisfaction. 10% to 20% of patients are not satisfied. And if you look at younger patients under 55, and we published on this, 15% are not satisfied with their operation and about 20% to 25% are only moderately satisfied. So we can do better, right? We should do better. And these new concepts have evolved to try to make that better.

And I'm going to share what those new concepts are. And they're actually -- and some of them are so simple, why weren't you doing this? The first is restoration of normal anatomy, normal anatomy of the femur and the tibia, a personalized alignment strategy. What we had done for years is we said everybody gets a straight leg. It didn't make a difference if you started off, you were born and developed a little bowlegged like a lot of men are or a little knock-kneed like a lot of women are. We just said everybody gets a straight leg. And that was the goal, straight leg.

And what we find now that if we personalize it, if we say, well, you started off before you got arthritis a little [boat], that's where we want to get you back to or knock-kneed a little bit knock-kneed, that's where we want to get back to. And if you do that on the femur, tibia and overall alignment, the results seem to be better, which makes sense. That's the way you were born. That's the way you develop, that's the way your body wants to be. All the soft tissues want to be happy that way.

Restoration of normal motion and knee motion is more complex than just bending. It actually -- there's a rotational motion and not just rotation, but rotation in a very specific pattern that the knee likes to rotate. And restoration of that motion is also an important aspect of it.

3D printed technology, as I've already mentioned, because we'd like to get bony integration rather than using cement for long-term fixation and robotics, which facilitates the first three and makes us, frankly, more accurate, more precise and allows us to do the top three things that we talked about. And LANDMARK, you'll see is the first implant that incorporates all these concepts into the design. The other ones do not, in many ways, done them. And I'm going to try to share this, and I hope I can explain this. I think it's -- you'll understand this pretty readily.

This, you're looking at the end of the thigh bone, the end of the femur bone. This is a cross-section showing the back there, and that's the front. What you'd like to do is match the anatomy on the back of the front, but you can see it's very asymmetric. It's just not asymmetric with left and right. You wear a different shoe on the left and right shoe, right? So your knees are the same way. They're asymmetric. But traditional knees aren't like that. Traditional knee replacements were meant to match in the front or the back.

So if you match, as I did here at the back, the front is not matching. They were actually designed to match the front and then they don't match the back. And the front is important because the front is where your knee cap is going. So if that's not right, the knee cap is going to have more pressure on herd. If the backs off, you're not going to move, you're not going to rotate, you're going to have instability. So having both is what you really want to do. And just to show you, this is real life. This is a robotic picture. The purple and gray is actually the bone, okay?

That's a cross-section of the bone on a robotic screen that I'm doing a case. The green is a cross-section of the implant. And as you can see, I've matched the back. I said, "Oh, I want to match the back," but that's the natural groove where the knee cap is going to sit, and that's the natural groove where it is in the implant. So I've got a decision to make. If I'm using that implant, I've got to say, well, I'm going to match -- I probably would match the front and say not match the back, but then I'm going to compromise that motion.

Remember, I talked about that rotational motion and the stability. So I'm going to make a compromise, and that's not ideal. That's not what you want to do, but that's what you had to do. And they had to do that because they're designed as essentially modifications of the knees that Dr. Ranawat did in the 1970s. LANDMARK was designed asymmetric and anatomic throughout the whole knee. So you match the back and the front at the same time, and it's designed to do that so that you can do that in a very reproducible way in most patients, back and front match.

This is, again, another aspect of personalized alignment is, again, some people are bowed, some people are knock-kneed. This is a diagram showing normal patients. The green dots are all the normal patients on the left, they're bowlegs. On the right, they're knock-kneed legs and straight in the middle, okay? It's a stick diagram. Okay. Most people are in the top category. They're mostly in that top category of alignment of the thigh bone, tibia bone and overall alignment, okay?

And LANDMARK is actually designed that because it has that anatomic shape, it can match 90% of people when it's just implanted the way we like and we know is safe and good to implant it. So the generally accepted way, 90% simple to do. Conversely, if you take current implants, all the other current implants that were designed from 2006 to 2013, you match many fewer, less than 40%, okay? Are you going to match their anatomy. So you're left with a compromise. You either say, well, I'm not going to match their native anatomy.

That's just the way it is or you say, I'll match the anatomy, but I'm going to have to put the knee in a position that we're not sure is going to be safe. So you have to compromise -- make these compromise that I think you just don't have to do. It doesn't make sense to do. The restoration of normal motion is actually a simpler one for LANDMARK because it builds on the legacy.

We have multiple published articles, including ones by me and many others, showing that the natural motion pattern of JOURNEY had the most -- it had the most natural rotational pattern of motion and stability than any other knee. We built on that, okay, and then added the ease and flexibility of LEGION. So it's a merger of those two so you can get the nice and normal rotation of a JOURNEY and combine that with ease of implantation and actually incorporate the most current technology into that.

It has, as Mayank talked about, this optimized patella groove because one of the reasons why people aren't as happy with their knees is because they feel pain in their knee cap. So if we can solve the knee cap issue, we've solved 10% of that 20% unhappy patient, okay? So all the other knee systems, essentially because they work off this old architecture that wasn't really designed for natural rotational motion. What they've done is they said, well, we know this is -- we need to do it. So they add an insert to do it.

But they weren't designed from the beginning from the ground up with this. And so I think that is, again, a compromise. 3D porous technology. This was a game changer in a way because for years, we started back, frankly, in the '90s to try to do non-cemented or porousing growth knees, and it didn't work. It didn't work that well. It didn't work as well as the gold standard at the time, which was cementing. So we moved away from it. But 3D printed technology has brought it back into the realm of possibility and commonly and growing use.

And this, I think, will show pretty well why? Because if you look at what you can do with 3D technology, on the left hand, you're looking at the architecture of bone in electron microscope. On the right is of the 3D printed technology. You can see that the architecture is very similar, and that similarity is promotes bone growth into it. And fewer -- there have been published fewer failures with this 3D printed technology compared to the older technology. And all the porous tibias.

Literally, every manufacturer has moved to porous -- the 3D printed technology for their tibias. And frankly, the patella, it's really the gold standard for that. And LANDMARK is the only knee. It's only major manufacturer that is going to have a 3D printed femur. It's actually the technology that they use for their porous technology. While they upgraded the tibias and patellas, they're using that 2006 to 2013 technology. They're using old stuff to do it, and that's clearly not the future. That's clearly not the future. It will be 3D technology.

Okay. We'll go a little bit into robotics because that's really an important aspect of why a differentiator for Smith+Nephew. History. Navigation was -- started navigation, which was very limited, didn't do any bone prep. NAVIO, which ultimately came MAKO, we give them credit. They were the first robotic system that was successful. Now what MAKO, just so you know what it is, is that arrow shows that it's a big robot.

So you have a large sort of truck that you have to bring into the operating room and bring into the surgical field, you have a haptic arm, which means I hold the arm in my hand and move that arm. So it's quite disruptive. You can imagine that big arm in the surgical field in front of me, it hurts my visualization, the help around the table for various things that are difficult. Plus you have two screens in the OR, to plan, one to track the leg. The other thing is you have to have a CT scan. It's only CT-based, and it requires you to manually test ligaments.

This is actually, I think, shocking to people who aren't in surgery. The way we assess ligaments, even with the robot, the robot is great. It measures precisely what things are. But literally, I tug on leg. I pull on it one way and pull on the other. Now if I drink a lot of coffee, I pull harder. If I got a lot of sleep, I pull harder. If I do it and Mike does it, Mike is probably stronger than me, so he's going to be -- he works out a lot, he's going to be pulling harder. It's just so variable, and we've shown that. And it's kind of crazy, but that's how it's done, right?

And that -- the robotic system requires that. The NAVIO was the first image-free and handheld robotics. And Smith+Nephew, as you know, acquired that and then updated it to a much more advanced system by miniaturizing all the electronics and CPU and making a much more handheld robotic piece. And I'll explain about the handheld robotics a little bit more as we go forward. Other robots came around 2000 also and including ROSA, VELYS, the ones that I'm sure you're aware of.

They shared a lot of similarities in some ways with the MAKO, only they tended to do less. A good example is the ROSA there, which is a big truck that you're pulling into the operative field, but that doesn't even cut anything. It doesn't -- all the ROSA does is it puts a guide in front of you that you have to then take a saw and cut through. So it doesn't do it. It's just an arm that goes in front of the leg. It doesn't actually do anything.

And so you have that whole device just to put a guide in front of you. So that's unfortunately not built in a way it should. But this is going to show essentially the handheld robot. And I've got it in my hand, I'm showing you what the handheld robot looks like, okay? That's a robot. That robot has a burr that comes out. And that burr goes out a specific distance and will remove the bone so that the implant is placed in the exact position because you essentially remove the bone, the thickness of the implant minus what you've already removed.

So the goal is to do it in a very specific manner, exact angle, exact depth. That device will I just put it against the bone. I -- so I have a video showing this that goes in and out. And so I'm looking at the screen. I just hold it and wave it up in front of the bone. And when I wave in front of the bone, the burr comes out just at the exact depth it should. It won't go further. It won't go different. It won't go in an area where it's not supposed to remove bone.

So it removes bone in the exact place it's supposed to, just like that big arm did. But instead of a big arm, I'm waving this burr in front of the bone and it essentially removes that bone in that area, okay? So the other thing you heard a little bit about is that a huge advantage here with CORI is it is image-free and image-based. So if you're doing a VELYS, it's image-free. So you have none of the advantages of image-based. You can't do pre-op planning with it.

Frankly, some of the models that it creates are not as precise, whereas the image-free and CORI has been shown to have incredibly precise images that are created. In addition, CORI has image-based. So conversely, if you're doing a MAKO and you're in Europe where it's very expensive and they don't want to get a pre-op CET or in a country that can't frankly afford it or your insurance company doesn't want to approve an extra test. Well, then you can do an image free.

You can't do a MAKO. You're stuck. You've got to get a CT scan. It's the only way you do it. Here, you have the ability to do MRI, CT, image-free, -- those options are incredibly valuable. And now do both. There are some patients who can't get a scan. It's inconvenient. I like the scans in some patients because I like that pre-op planning, especially in complex cases. I think it's very helpful. So having both is really the holy grail. You want to have both.

If you only have one, you're very much limiting both in this country and certainly worldwide. That's a huge, huge disadvantage. Okay. Robotic tension, you've talked a bit about that. The idea that you just tug on the leg and that's

the right way to do it is crazy. it's crazy to think about we manually do things like Anil talked about sticking a rod up the ACL and do it the way they did it 30 years ago. Well, we -- that's how his dad did, he tugged on it.

Now it's a bit more accurate because they got to see some data on the screen, but I still have all the variability of me just pulling on the leg. That's just kind of crazy. And this is the only FDA approval for revision, which obviously is an advantage. I thought this picture is a good display to kind of get this across. This is a MAKO in the room and the ROSA would be the same.

So if you're looking for efficiency in ambulatory surgery, you're going to hear from Mike about ambulatory surgery, but either efficiency in the OR and especially in AMSURG, the idea that what you have to do, you finish the case, they take the robot, that robot has to go into the room, then you have to drape the robot. Then you have to attach those black -- those little arrays on it, you have to attach them, then you have to register it. That takes time. As opposed to CORI, CORI for each cart, you get three or four handheld pieces.

So I also nicknamed them Cori, Rory, Lori and Dori. So I have Lori is waiting or Cori is waiting for me in the room. And essentially my OR tech, that's Angie. She's smiling there as she walks the cart into the room. One of them on the table already is the robot. I walk in, I plug it in. I mean that's efficiency. The idea that I've got to sit there and wait for them to drape a truck is just not the future.

So in conclusion, I hope I've shared with you why I think that this is really the next evolution. The anatomic implant is just, I think, the way that if you were starting today to make a knee, you would never make it the symmetric designs and just build on what was done 30 years ago. It's optimized for these high-level activities that I think our patients and I -- frankly, I know our patients want to do.

It has the natural rotational motion, 3D porous technology, wave of the future, why all femurs don't have it, it's kind of crazy, but Smith+Nephew will be the first major company to have it. And CORI, as I've said, mobile platform, image-free, image-based robotic tensioner and more indications. So that's my presentation. Thank you.

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

Thank you. Dr. Haas. I think we can now take some questions for Dr. Haas, starting with maybe some in the room.

Veronika Dubajova (Analyst, Citi)

Thank you so much, Dr. Haas. Veronika from Citi. Can I ask you three things about CORI? I think we speak to a lot of surgeons and they have different opinions on the technology versus MAKO, I think, predominantly. But I'm just curious how you feel about, obviously, the lack of haptic feedback, is that a concern for you?

Steven Haas (Hospital for Special Surgery, New York)

Yes. Actually, I have to say that -- and I don't want to criticize the haptic feedback from MAKO because I think that's good. But I think there's a misunderstanding maybe because Smith+Nephew doesn't emphasize much. Haptics -- what haptic refers to is that when you go to use the saw, you feel and it stops. It's in a sense, almost like -- it's not haptics like your phone to jiggle or make vibration. It stops. The CORI robot stops. We don't call it haptic. But if I went to burr -- a good example. If I have the burr and I'm waving it in front of the bone, it's removing the bone.

If I take it out of the defined surgical field, it stops. It pulls back. So it's not called haptics, but it automatically shuts off. So I think that if I was to say that what -- that needs to be presented to the people that they understand that because it's not like a burr that's just on all the time. It actually knows where it is and it will stop. So you don't feel it, it doesn't do anything that you feel in your hand, it just goes off or pulls back. So the haptics, I think, are probably a misunderstanding of the technology.

Veronika Dubajova (Analyst, Citi)

That's very helpful. And then burr versus saw, I think there are different schools of thought. You're clearly in the burr school of thought, but how do you think about it?

Steven Haas (Hospital for Special Surgery, New York)

Well, I'm actually a bit of a mix, and I'll explain how that is. With CORI, okay, you have -- you burr the distal part of the bone, which is pretty quick. It's literally 1 minute. And then the rest of it is cut because you -- then it positions a guide that you cut through and which is as fast as taking the robotic arm and doing it. So you do cut, you can burr the whole thing, but I don't because we have that cutting ability. Additionally, for the tibia, that's a great example. The tibia, we have a guide, which essentially is hooked up to CORI and will allow me to cut.

And if the cut isn't perfect, it's actually interesting because when we cut, saws when they cut deflect oftentimes. Like if they're very dense hard bone, when you're cutting with the saw, it can deflect. And frankly, people don't check that. But if they checked it -- and actually, MAKO says you can be 1 or 2 millimeters off, which is actually a few degrees. So I actually check -- make a check of that. And if I'm not exact because the burr is more precise.

The burr, when you burr it, you're within a half tray. Now you could just cut it and that's with the saw with the CORI and it would probably get the right alignment. But I check it and if it's not perfect, I make it perfect. And the CORI will make it perfect. And lastly, for revision -- so for revision, there's no doubt that burr is better. The bone is very fragile and the burr is like -- saw is not the right way.

Veronika Dubajova (Analyst, Citi)

That's super helpful. And then I was going to ask you, in your practice, what proportion of your knees are robotic? And then how much time does going robotic add to your standard procedure time?

Steven Haas (Hospital for Special Surgery, New York)

Great questions. It's about 85% to 90% of robotic. And as far as time-wise, if I'm doing the CORI on -- the easiest case I can do, the simplest case, I can do faster because I can -- it's a half hour to do -- like if you do a lot of knees, you can do manual knee in about a half hour. I probably can't do it in a half hour. But frankly, the vast majority have some level of complexity. For the average case, it's about the same. So the average time is 45 to 50 minutes to do -- I'm talking the opening the procedure, doing it and then closures after that, okay?

And if it's a complex procedure, the robot is faster. So -- and the reason why they're faster, you have a couple of extra steps in that you have to place pins, right? And you have to register registration, especially with CORIOGRAPH -- CORIOGRAPH registration, I'm actually hoping I win a competition here. There's a meeting ongoing down in Orlando called CCJR, and they asked to have our fellow submit who registered the robot the fastest. And I had -- we recorded him doing the registration on the case he was doing.

And he was -- he registered -- the whole registration was 1 minute, 29 seconds, which is really fast. So we're going to see if he wins the competition. But anyway, so that adds a little bit of time, but you save the time because when you do things manually, if you check what you're doing, you're often a little off. So I may recut things or have to redo things. The beauty of the robotics are and the tensioner is that I can make assessments of the soft tissue. To make really long story short, what we try to do is match the anatomy perfectly.

And then we modify the alignment a little bit to match the soft tissues perfectly. And because the robotic tension allows me to assess those soft tissues before I made any cuts, no cuts, I can then fine-tune that. So my cuts are almost always right from the start. Whereas when you do it manually, you're making some guesses. I'm using judgment and saying, well, that's how I want it. And sometimes you need to change that once you make all the cuts.

Veronika Dubajova (Analyst, Citi)

Okay. that's super helpful. Thank you.

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

Any other questions in the room? Emily, do we have any on the webcast? Right. Okay. Thank you Dr. Haas. fantastic.

Steven Haas (Hospital for Special Surgery, New York)

Thank you. Thank you.

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

All right. So we are going to change gears a little bit. Thank you, Dr. Haas, once again. Let's start talking about ASC. So before we get there, we've already heard from Dr. Haas his perspective on the evolution of both implant design and technology. And I trust it is clear to you how Smith+Nephew is working to build its differentiated value proposition for knee surgery. The other significant trend we talked about was the shift in care from hospitals to ASCs.

We talked about some of this, but understanding and serving the unique needs of this segment is going to be paramount to future success. This is honestly also an area where we think we have a competitive advantage. But before we get to that, let's review what makes this segment unique and important. So there are about 4,000 ASCs in the U.S. performing some type of orthopedic or sports medicine procedure, let's call them musculoskeletal procedures.

These centers already have and will continue to see strong double-digit growth as more surgeries move from multi-specialty hospitals into dedicated outpatient settings. However, the ASC care setting is very different from hospitals. The ORs are smaller with limited capacity for sterile reprocessing and storage. They usually operate with leaner staffing models while opting for higher efficiency and throughput. Ongoing reimbursement changes, we know will continue to drive an even higher procedural uptake.

And with growing volumes and a focus on throughput, recent mandates also require these centers to maintain and report on their patient outcomes, a task that can be burdensome with these leaner operating models. So as you can see, whether you're a surgeon or any ASC stakeholder, there is a fine balance across throughput, efficiency and outcomes that needs to be maintained constantly. At Smith+Nephew, we maintain a higher procedural penetration across both hips and knees versus market in our ASCs.

Around 25% of our total CORIs in the U.S. are installed in ASCs, and this trend is accelerating with 35% of CORIS this year being placed in ASCs. This strong segment performance is really a function of our robotic form factor, which is well aligned to ASC needs, our best-in-class tray efficiency solutions and our unique ability to leverage on our sports medicine business, where we enjoy market-leading positions.

Recently, we have rewired our commercial model to serve our ASC customers even better and have also forged some exclusive partnerships that help ASCs unlock more value. I'll dive into each of these in a little more detail. Let's start with CORI. CORI is the only robotic system handheld or otherwise that covers the knee procedural breadth all the way from partials to totals and revision knees. As of last week and a full quarter ahead of schedule, CORI can now also support reverse and anatomic shoulder procedures.

Very soon, we will have CORI-enabled hip replacement, giving musculoskeletal-focused ASCs this unique flexibility to use the same robotic platform for multiple procedures. Also, remember that CORI is small footprint and can be wheeled between ORs with quick setup and turnaround time, something that ASCs really value. CORI's overall cost of ownership is also significantly lower than larger arm-based robotics.

All these factors combined, it's really no surprise that we deploy 35% of our CORIs in ASCs in the U.S. Beyond the attractive form factor and procedural breadth of CORI, we will also have best-in-class tray configurations for our flagship brands across knees, hips and shoulders. As I've mentioned before, but I will gladly repeat, this really matters in ASCs, where OR space, sterile reprocessing space and staffing are all constrained and designed to maximize throughput and efficiency.

Compared with industry averages, our knee and hip platforms will offer, on average, a 50% reduction in OR trays, while our AETOS platform on shoulders will offer a 70% reduction. This is a result of deliberate design choices we are making to ensure we offer the leanest configurations without compromising on intra-op surgical options for the surgeon. Like I said earlier, there are close to 4,000 ASCs in the U.S. that perform musculoskeletal-focused procedures. Out of these 4,000, nearly 60% perform both sports medicine and orthopedic procedures.

And this is where our combined procedural portfolio shines. Whether it's the knee, hip and shoulder arthroplasty procedure or knee, hip and shoulder soft tissue repair, we have unique and clinically differentiated offerings across both. Our Sports Medicine business also carries capital with unique technologies like TESSA that we will be able to offer to over 60% of these ASCs. Given the recent CMS mandate that asks for ASCs to report on patient outcomes for every case, we have forged some unique and exclusive partnerships to enable this.

Not only do our strategic partners facilitate patient outcome reporting, but they also drive improved patient engagement and compliance across the episode of care. We also offer ASCs actionable analytics that optimize performance with real-time metrics and connectivity across multiple reporting systems. Lastly, and most importantly, these partnerships help generate clinical and health economic data across the patient journey, which will ultimately help us personalize these pathways for patients as well as ASCs.

All the portfolio and technology and partnership capabilities are underpinned by one thing, and that is our commercial model that drives relentless focus towards our ASC stakeholders. We have a dedicated ASC selling team that is a single calling point for all our ASC customers, and we continue to strengthen it. We are continuing to build flexible financing models and other partnerships that will enable us to deliver turnkey solutions for musculoskeletal-focused ASCs.

In summary, Smith+Nephew is uniquely positioned to meet the needs of the ASC segment through its enterprise portfolio strength, differentiated technology, strategic partnerships and a dedicated ASC organizational structure. I'm really excited about our future in this space. With that, I would like to introduce Dr. Mike Ast, who's also from the Hospital of Special Surgery in New York.

Besides being the Chief of Knee Service, Dr. Ast is also the Director of ASC Strategy at HSS and their Chief Medical Innovation Officer. Dr. Ast will share with us his perspective on how the ASC segment is evolving and where he sees it going in the future. So Dr. Ast, pleasure to have you here and welcome on the stage.

Michael P. Ast (Hospital for Special Surgery, New York)

Thank you very much. Thanks. Thanks, everybody. Thanks for being here today. Thanks for having me and allowing me to speak for a minute. If it's okay with everybody, I'm not going to stand behind a podium. It's very difficult for me to stand still for more than about 14 seconds. So I think we've heard a lot from some of my colleagues, actually some of my mentors and closest friends on the clinical side of everything that we do, and I am an orthopedic hip and knee replacement surgeon with similar volumes to Dr. Bashyal like we heard earlier.

But a lot of my focus is actually on the economic side because nowadays, you cannot be a physician, you cannot be a provider of care unless you understand the world we live in, unless you understand the impacts of a lot of the changes that are happening around us. And in my eyes, unless you're actually sitting in the driver's seat trying to help make all of that right because when we allow the external world to drive healthcare, generally, the dollars are affected, but the patients are affected.

And that's generally in a way that's not what we're looking for. So as people who care for patients, we want to make sure that we are the drivers and we understand. And the biggest driver that we've seen of changes in economics over the last couple of years are the trends of ASCs and specifically in orthopedics. The shift from inpatient care to outpatient care is undeniable. 10 years ago, people said, "Oh, it's never going to happen."

We're not going to see it. And then COVID happened and all of a sudden, it became very, very real. And I've spent the last decade of my career continuing to care for patients, but really focusing on the shift in the site of service that we see in orthopedics and how we can impact it, how we can help it and what the implications are for everything that we do? So this is a slide you'll see over and over again. It's a very interesting point because the inflection is right here in the middle.

Right around 2021, where the majority of hip and knee replacements being done in America were done as an inpatient, meaning an inpatient hospital with a stay in the hospital of 2 or more nights to outpatient, where it's either being done in a hospital or an ambulatory surgery center with a length of stay of less than 24 hours.

If you look today where we are, just at the end of 2025, we're sitting right around the 80-20, right? So 80% of hip and knee replacements done in the United States today are done as an outpatient with a length of stay of less than 24 hours and close to 40% are done completely in ambulatory surgery centers. And you notice that those trend lines have not started leveling off. And on the hip side, they look exactly the same.

And again, these trends are likely to continue dramatically into the future because this doesn't look like it's slowing down. It is better for patients. It is better for providers. It is much better for the healthcare system to optimize the

site of service for a variety of reasons, including clinical outcomes, operational outcomes, efficiency outcomes and economic outcomes.

And so the question then becomes, is there a particular driver for it? How does this change the way that industry investment and health care spending view orthopedics, sports medicine and the hip and knee replacement world? And then is there a position in which some companies are simply better suited and better placed to be doing the right thing?

And also, how are hospitals and healthcare systems going to look at this long term. HSS, as you heard, 106-year-old, the oldest and #1 specialty hospital in the world, the #1 orthopedic center in the world and the #1 in the United States for the last 16 years, 2 months ago, launched our first nationwide ambulatory surgery center platform to partner with hospital systems and surgeons around the country to help drive and control this shift from inpatient outpatient from hospitals to ASCs.

We would not have done that had we not known this is what's necessary to move care into the future. So in a room of investors, of people much smarter than me on the economic side, it's interesting to think, well, if the entire model is shifting, if all of healthcare is moving from the hospital to the ASC, at least in the orthopedics and sports medicine space, is the right thing to do to focus on legacy companies that have done really well in hospitals and health systems?

Or is it really important to understand how are these companies positioned moving forward into a very, very different market, into a very, very different place to provide this type of care and what does that customer look like? And I think that's really the fun part because this isn't isolated to the United States, and we hear it all the time, ASCs, that's only America. ASCs, that's the American market.

Now we're here at the American half of this investor meeting. So I think it's fine to talk about the American market, but this is not going to stay in the United States for very long. My travels to Europe, my travels to Asia are often about help us get our length of stay down. And in Germany, that was 3 weeks to 1 week.

But guess what, they're down to 2 days. In Southeast Asia, it was 6 weeks to 3 weeks to 1 week to same day. And throughout Canada and South and Latin America, we're seeing the same trends. So while you may see on this chart that some of the penetration in these areas are low today, as we look forward over the next 10 years, every one of them looks exactly like the United States did in 2014.

Every one of them, there were a couple of places, somewhat outliers, surgeons being called crazy like I was in 2013 when I sent my first hip replacement patient home on the same day of surgery, all of them look like that today, which means any forward-facing person involved in healthcare, whether it's on the investing side, the clinical care side or the leadership side is going to say, 10 years from now, it is very likely they look like the United States. And the growth is obvious.

No one in a group of -- amongst the group of investors needs to tell you that the ambulatory surgery center market is one of the largest profit center markets in all of health care. This is your standard consulting company slide that they come when they bring to our hospital and they say, "Hey, you should probably focus on surgery centers."

Yes, we already knew that. Thank you very much. However, it's still got to have the -- you can't convince the Board unless the consultants said it even if the surgeons have been screaming it for 15 years. And there's tailwinds and

headwinds to all of these markets. And I think it's critical to understand the tailwinds in the ASC are massive. They're massive, right?

The regulatory environment that Mayank alluded to a few minutes ago, the elimination of the inpatient-only list, which occurs as of January 1, the massive increase, 285 musculoskeletal codes being added to the ASC covered procedure list starting January 1, including revisions. This is going to be a huge opportunity and a huge tailwind, right?

Site neutrality, the one thing in Congress that currently has complete bipartisan support but won't pass is site neutrality because site neutrality brings to life the idea that what matters is the care of the patient, not the address of the building. And it's really hard to argue against that even though hospitals really want to because it's really, really bad for hospitals.

And if you are like a true economist, you start to worry about the local economic environment, in the markets where the hospitals will go out of business, right, it gets very complicated. But in the world of simple regulatory understanding, site neutrality is very, very popular. And if that ever happened, surgery centers would not be able to handle the massive influx of what happens.

The NOPAIN Act, right, an act specifically meant to get the use of certain pharmaceuticals into ambulatory surgery centers to drive the continued shift of higher acuity cases into surgery centers. Case mix, right, surgery centers in 2010 were all about hand and foot and ankle surgery, and we'll explain how that leads to a lot of the issues we see today versus today, a lot of spine, a lot of joints.

On Tuesday, Dr. Ranawat and I were in our surgery center. In one room, he was doing hip arthroscopies, in another room, I was doing hip and knee replacements. It's only 2 rooms, and we did nothing but cases that would never have been done in a surgery center 10 years ago. The day before that, my colleague did 5 spine surgeries and my other colleague did 5 joint replacements in 2 rooms, right?

Again, surgeries you never would have seen, and that was just Monday and Tuesday of this week. So that shift is real and the tailwinds are real. The headwinds are real as well. The mandatory reporting is a big thing. The vast majority of surgery centers in the United States of America don't have electronic medical records because it's not required in surgery centers.

So until they partner with somebody or until they bring in experts or until they partner with the right groups to try to help them do that, things like patient-reported outcome measure reporting, things like being able to get into value-based care by controlling their finances and understanding their costs a little better, working on their operational efficiencies. These are things that surgery centers have long been limited because they never needed it.

But now they do and those headwinds are real because these things are expensive, right? They cost money and most surgery centers are pass-through entities at the end of the year, they distribute every dollar to their surgeon owners and guess how much capital they have to invest in the next year. That's the number, right, 0. That's because surgeons are terrible business people, but we can talk about that another time, right?

Medicare Advantage, prior authorization, these are problems across all of healthcare, but even bigger in surgery centers where you simply don't have people to manage the problem. And then margin compression and specifically

anesthesia are the biggest problems we see across the country in surgery centers, and this is going to be a complex problem that's going to take a long time to figure out. What does that lead to?

It leads to platform consolidation, health care partnerships and a lot of things that might be good, they might be bad, but they can be very unpredictable. And this is why we go around the country. We joke all the time in the world of surgery centers, you say when you've seen one ambulatory surgery center, you've seen one ambulatory surgery center. Every one of them are a little bit different. They have a lot of variations to them.

And even how an industry needs to partner with them, it looks very, very different on each point. So flexibility, so experience in that center, so relationships with the people who are there become critical as you start to partner with surgery centers because they're just different places. So why are they different places? This is my favorite slide I ever show and I show it in every single talk I give about surgery centers because it's a little wacky.

So let me explain the difference between a hospital and surgery center in one picture. So this is my first ambulatory surgery center I had. It's in Lawrenceville, New Jersey. This is a lease that you see here on the left, that's Dan, on the right. Dan is my PA. I had another PA at the time his name is Steve. The patient on the table is Steve's dad. So we're operating on my PA's father. And we did this surgery. And so a couple of things you're going to notice about this room really interesting. This is a full wall-to-wall picture.

So while at HSS, the average OR size is about 600 square feet, similar to the average size of a studio apartment in New York City. This room is 385 square feet, almost half that size, which means not a lot of room for stuff, right? Not a lot of room for X-ray machines, not a lot of room for large console robots or navigation, not a lot of room for stuff. But that's not the most interesting part. You also notice what's missing are people.

Who do you see here? You see a single tech, that's Ben, the anesthesiologist who's back to us, a single anesthesiologist, a single PA, and I'm taking the picture. That's it. That's the whole room. At HSS, when I operated yesterday, I have 14 people in my room. There are students. I didn't know who they were. There are like 3 nurses. There are tons of people, right, because hospitals are wildly overstaffed.

And because of that, their costs are super high. Surgery centers keep those costs low, manage people much differently. But then the last and most interesting part of the picture that most people miss until you point it out. Take a look on the ceiling of the room, see the lights. So these are surgical lights. You can see them right here, right? Where are they pointing? Because they're not anywhere near the surgery, right?

They're pointing to the back left corner of the room. It's because they're broken. They don't work. The surgical lights in the facility were broken and they had been broken for a long time. You'll notice over the top of Dan's shoulder comes this little weird looking side light. That's the portable light we rented because it was cheaper to pay for a portable light that we could rent than to fix the OR lights. Let me give you a little counter distinction to the world of HSS.

Yesterday, in room 3, I was operating room 3 and 4. In room 3, a light bulb went out. During the case, I looked up and said, "Oh my gosh, light bulb is out." So I called the director of our operating rooms named Lenny, into my operating room during the procedure. I said, Lenny, the light bulb is out. It better be fixed before my next case and it better not slow down my turnover time or I'm canceling every case for the rest of the day.

And you guys can figure out how to make up the money yourself for a light bulb because surgeons act very differently when they don't own the place. I don't care how much it costs to fix that light. I want every single light working. When I owned the building, when I owned the center, I don't care if I have lights. Somebody light a candle and bring it in, I'll be fine. So you realize you're dealing with a completely different set of customers, right?

It's a completely different relationship you have, and nothing explains it better than those of you who've studied the implant world for a long time know that one of the biggest keys to successfully keeping a surgeon happy is their rep, right? That relationship between a surgeon and their implant representative was forever the most important thing in the world. How do I know?

When I joined my first practice, I had a partner named John. John had the same implant rep forever. His implant rep was the best man at his wedding and the godfather of his oldest daughter. And guess what, company John used, whatever company that rep was with. So when he switched from one company to the other, John switched, but he had never done a case in his 25 years in practice without Walt in the room. It's never going to happen.

Then we opened our surgery center. And our surgery center couldn't agree to a good contract with Walt's company. And the next day, John switched companies. Again, traditional methods of how companies interact with surgeons and their partners just don't work when you bring them to an ASC where the surgeons are owners. The patient population is different. The room size is different, sterilization is different.

Cash flow is different. So what do ASCs want? ASCs want a bunch of different things that often look very different than hospital partners did. They need significantly less variability because variability needs staff education. We've got space constraints and very much we need supply chain efficiency.

When you go to Dr. Ranawat and my surgery center in Mahwah, New Jersey next week, find a closet, doesn't exist. We don't have any. Last week, we negotiated with the real estate -- with the owner of the building, and thank you because he's a personal friend of Dr. Ranawat for an extra 25 square feet in the basement just because we had a bunch of boxes we couldn't figure out what to put, right? So space constraints are real.

And then we need a single point of contact because we don't have 65 administrators to talk to 65 different people across 65 different business units. We have Jeff and Jeff has to talk to everybody every day, all the time. So having a business model where Jeff just has to call one person is absolutely critical to the function because when Jeff isn't calling that person, he's cleaning a room.

He's scrubbing on Dr. Ranawat's case, and you see Anil laughing over there because somebody needed to go to the bathroom. So Jeff scrubbed in to help in the case, right? And so the customer base just looks totally different. And the other thing we need is data and access to partnerships that bring us opportunities. So these are 2 things I love, and Mayank mentioned, I'm the Chief of Innovation at our hospital and innovation is what I've done for most of my career.

But a lot of it is on the non-sexy side, right? Anil does innovation, makes the outcome of surgeries different. My mentor, my former boss, who now I'm his boss. Dr. Haas that you just heard from does innovation on the implant side. When I do innovation, it looks like this, so most people think it's really boring.

But you know what that screen down there at the bottom is, that tells me what's happening in every single operating room, every single day for every single center that we own. So I can look across the country and say, what's

happening in OR 3 in Dallas, Texas right now. And I know what they're doing, what cases are happening, what -- how long the OR was empty and not generating revenue and what was the reason that the case got canceled.

And I can see it like this. If any of you visited a hospital, the way that we used to run ORs was like a magnetic board, people drawn with a whiteboard marker on things, that's absurd in 2026, right? That's crazy. This is how we run our ORs now, but this is the access to technology that ASCs need to understand what efficiency looks like. And how about this giant eye chart up here, right? We call this to the surgeons in the room. This is called finance. This is how we pay you guys, right?

The idea here is that we can finally track financial metrics in a way that allow us to understand just because the surgeon is happy, are they actually making any money? Are we actually driving efficiencies? Are we driving revenue to where it needs to be so we can care for more patients? And New York is one of the few states where your certificate of need, your ability to open an operating room is directly related to the care for uninsured and underinsured patients.

I think that's wonderful. But how do I even know if I've done that, if I'm not tracking all my patients and I don't understand what my margins are, how do I -- how am I able to provide care to Medicaid patients and uninsured patients if I don't even have a handle on my finances. And so these are the types of partnerships that I look for now.

This is the type of innovation that I need so that I can simply go to work, do my knee replacements and hip replacements every day and send my patients home in a few hours. So again, for me, a lot of this -- we'll talk a little bit about Smith+Nephew. I think Mayank did a good job. For me, this is more about understanding if I'm looking at from an investor's perspective, I have to realize that Smith+Nephew just locked out, right?

This is not that Mayank is actually as smart as he looks, and he didn't even let you know he's actually orthopedic surgery. It didn't say on his title, which I thought was weird, but Mayank is actually a trained foot and ankle orthopedic surgeon. It is just that they made the right investments at the right times, and now you're seeing where it ends. And the reason is CORI is ideal, right?

Now CORI was purchased very early in the world of ASCs. So whether they think that I'm not really sure when -- with the acquisition of Blue Belt, but this is our ORs. This is actually OR1. Dr. Ranawat recognized it, Dr. Haas recognized it. And I thought it would be funny. So I took the CORI at the end of the case, this is the surgery I did on Tuesday. And just for fun, I took it from one side of the room all the way to the other without getting in anyone's way, right?

I showed you how small these rooms are. There's not a lot of space to do stuff like that. Yet in this room, I can go from the left side of the room around the bottom of the patient, you see this tray is the other side of this table right around to the other side, all within the same case. I challenge anyone to find a large console robot that can do that or that can even fit in this room. But certainly, that can do that at the end of the case.

Was that intentional by Smith+Nephew? I don't know, not really part of that group. But what I can tell you is it really worked out because as you see from the numbers, this is the robot that wins in ASCs. And by the way, there is no such thing as orthopedics not in ASCs. Anybody who thinks that the traditional model of hip and knee replacement surgery being done in hospitals is going to continue into the future is misguided.

We know that this is where we're going to be, and we just need to see -- to all of our partners see that as well and understand the unique situations. So what's next? I think the modern and slim inventory are critical. I think as we

heard from Dr. Haas, we're really talking about taking robotics at the next level, but also taking it to a place where it works in the site of service where we actually provide this care.

And the biggest growth opportunity, and again, this for better or for worse, I think Smith+Nephew just tripped and fell into this huge advantage. But all of the manufacturers of the devices that we use are going to have to have relationships in these surgery centers. They're going to have to know how to deal with a surgery center. And of all of the manufacturers who make what I do, hip and knee replacements, there's no one with a bigger presence already in the ASC.

And I think you see that when you start to see how we are able to interact with each of these partners. Smith+Nephew is not the exclusive partner we have in our surgery center. They're just the easiest to talk to. And for surgery centers moving forward and especially as they expand, that's going to be critically, critically important. So the future of CORI will allow us to do all of the surgeries we do in our surgery center.

This week, we did every one of these surgeries in our surgery center. We did hip scopes, we did total knees, we did total hips, we did partial knees, and we did total shoulders, all in this week in our surgery center, right? So this is where it's going to be and having a singular robot that I can move from side to side in the room is going to be really helpful for me. So again, I think Smith+Nephew is really pointing in the right direction.

And luckily, maybe just because of really good planning or maybe because of really good luck, really skating to where the puck is going, which I think is going to be a good thing for them in the future. So again, I'm not here to sell anything about Smith+Nephew, but I do think that they've made a good partner for us. They're arguably the largest ASC footprint of any of the major manufacturers of the work that I do.

And I think that's a huge advantage for them. The robotic system that you can see right here, is the only one that really is made for surgery centers. The rest will try to squeeze in or fit. But over time, I think we'll watch our other manufacturing partners shift more towards this, in which case, there's a huge strategic advantage to have been there first and have been doing it for a long time.

The implants we're using now, the CATALYSTEM, the LANDMARK Knee, these are ASC-driven and robotic-driven implants. And that's good for me. I like that. That's the kind of work that I do to preempt the question that Steve got, I do 100% of all of my procedures with robots, but I like robots. I think they're fun to play with. But really, for me, it's data management.

It's understanding the unique personality of ASCs and altogether figuring out that if you want to be in this business and see high single-digit, double-digit growth, you better be where the double-digit growth is happening. And that's the importance of the ASC to any of the companies that all of you are taking a look at. So with that, I like to show this slide again because it's kind of funny.

For 160 years, HSS has ended every one of their slides with the -- everyone that talks with the slide you saw Dr. Haas put up with a picture of our giant hospital in Manhattan. I'd like to introduce you to the 2025 version of how we ended, and these are our 5 surgery centers all over the country. Thank you.

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

That's fantastic. Thank you, Mike. Again, questions for Dr. Mike, asked from the floor.

Veronika Dubajova (Analyst, Citi)

Thank you so much for your presentation and some great stats in there. Obviously, all of Smith+Nephew's competitors also talk about why they have the right to win in ASCs. And they talk about different advantages that they have, access to capital, maybe businesses that span -- that are outside of orthopedics, ability to provide financing, they can get you a bed.

How does that -- how important is that for you? And I guess you talked about having a single point of contact for the implant business is important. But what about having a single point of contact for everything that an ASC buys? Is that an area of differentiation that would sway you one way or another?

Michael P. Ast (Hospital for Special Surgery, New York)

Yes. It's a really interesting topic. And I actually launched the ASC group for Stryker. So I've heard that line before. But it's actually fascinating in that much of those things happen really well if your only concentration is on new surgery centers. And so if you think that the only thing I'm going to do is work with new surgery centers, and I'm going to spend the next 20 years helping build out new surgery centers, there may be some real value in that.

And I want to -- I think the reality is when we came up with that tagline, there was a reason for it. But what we've actually seen is there's not that many new surgery centers. There are 3,800, right, right around 4,000, what Mike was saying, Medicare-certified surgery centers in the United States doing orthopedics. About 25% to 30% of them, it's probably closer to 40% at this point, currently do what we call high acuity orthopedics, spine and joint replacements.

That's the number. That's the market. We are -- because of certificate of need laws, because of how expensive it is to do anything right now, right, it's about $11 million to $20 million to build a new center. And by the way, it takes 3 years, and you've got tons of supply chain issues to do it. The real growth in surgery centers is not in new surgery centers. New surgery centers are great and when we can get them, that's awesome.

The real growth in surgery centers are in the existing surgery centers transitioning to high acuity surgery. And that is the misconception when you think about the importance of buying beds, they already own beds. And by the way, at our surgery center, I just I'd love to tell stories about because I think it is a perfect microcosm in the world.

Do you know how we upgraded our previous stretchers to be able to accommodate the longer length of stay of joints and spine patients because that's what you'll hear a lot of times from other companies, we went to Bed Bath & Beyond and bought Egg crates. And we put egg crates on our stretchers that made them comfortable enough to sit on for 3 hours.

And that was it. That was the upgrade we did to be able to do higher acuity cases at our surgery center. So I don't see a lot of existing surgery centers really spending a lot of money on new beds and new lights and things like that. They're very helpful. And if you're doing a de novo, that's a nice to have.

The other thing to think about, though, is most de novos are going to be done with someone else. Very few surgeons are going to take 100% surgeon-owned de novo because none of them have $19 million to put up, right? So you're going to see a lot of management companies, healthcare system partnerships.

In 2013, when I started doing outpatient joint replacements, there were literally a handful of health systems in America talking about surgery centers and maybe 6 that were any good at it, right? As of 2 weeks ago, 95% of health systems in America are either actively developing or already own surgery centers.

So once you get into healthcare system partnership, the beds, the lights, all that stuff goes away because they probably have a contract with Stryker or STERIS or something already. That doesn't get you to the product. And the product is still going to come down to that single point of contact for sports, orthopedics, joints, wound, and that's where I think the advantage really lies.

Veronika Dubajova (Analyst, Citi)

And then maybe a second question. Obviously, sometimes you'll be part of a hospital group that has a supply contract and you have to use supplier X, then you move to an ASC and the pricing terms from supplier Y are better. How often do surgeons switch when they make that transition? And how common is that?

Michael P. Ast (Hospital for Special Surgery, New York)

I think they switch a lot. It just depends on how -- if you've got your -- so if you're talking about a surgeon who happens to work at a hospital and happens to work at ASC is different than if the hospital also owns the ASC. I think when you talk about surgeons at the hospital versus surgeon at the ASC, they work very differently.

They might as well be different people, like you might as well just be a completely different person because every decision you make is going to be driven by convenience, driven by finance because ultimately, a lot of the other stuff washes away. If you're talking about a health system that also owns a surgery center, remember, most of the surgery centers are different companies.

Most even nonprofit health care systems, the ASCs are for-profit and separate LLCs in which case, when they drag contracts over, they do it sometimes, but not always. And one of the things you hear and one of the big misconceptions, especially when it comes to industry relationships is the price of the implants. So we hear, "Oh, my gosh, you're going to an ASC, I guess you're going to be paying $800 for that implant."

Do you know how much -- so average in the United States that you pay for an implants what $4,500?

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

Thereabouts.

Michael P. Ast (Hospital for Special Surgery, New York)

Right. Do you know how much I paid for implants back at that center that had no lights and average price we paid for implants was $11,000. I thought surgery centers pay less for money. That guy is just lying. No. At that center, we had what we call pass-through implant pricing or cost plus pricing, where the implant cost us nothing. It went straight to the insurer.

And by the way, they gave us 3% markup on it for storing the implant, which we didn't actually do, right? So the more expensive the implant, actually the more money we made. And those are very region-specific, very state

specific. But if you hear someone say something like, oh, ASCs, that just means the implants are going to be cheaper. All that tells you about the person you have the conversation with is they don't understand surgery centers.

Sometimes surgery centers need cheaper implants, sometimes they need more expensive Surgery centers can be very, very unique in that. And it's important not to get caught up in the -- well, it's got to be like this because actually, they can be really, really different and unique and interesting ways.

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

Thank you. Any other questions? Emily, anything on the webcast?

Emily Heaven (Head of Investor Relations, Smith+Nephew)

Just one asking about replacement cycle of ASCs. I think it must be related to you talking about not being more de novo -- not that many de novos. So if an ASC already has, for example, a MAKO, how easy would it be to convert them? And how often are they thinking about the replacement cycle?

Michael P. Ast (Hospital for Special Surgery, New York)

So I think that's fascinating because a lot of it will depend on how they got it. Very few ASCs are going to have spent a significant amount of upfront capital to acquire any of this technology. Most of them are on financing platforms of some kind where there's a rebate on implants or something like that, in which case, that cycle is literally as long as that contract lasted.

And if they find a year later that they weren't able to offset that cost and that they actually end up with a bill at the end of the year, that thing is gone. That thing has gone the next day. And so unlike hospitals who have often purchased these large capital equipment needs where they've spent $1 million and now they're sort of stuck with it for 10 years, and they're unwilling to change because they've got to pay off that investment.

On the surgery center side, since very few of these are capital outlays, they're much quicker actually to get rid of anything that didn't positively affect their bottomline. So if something was dragging on their finances or they didn't meet something or they're simply sitting with this lease liability on their P&L while they're trying to get investors, forget it. That thing is gone. And so the turnover cycle is going to be a lot faster.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

That's it.

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

Excellent. Thank you, Mike. That was fantastic. Appreciate it.

Michael P. Ast (Hospital for Special Surgery, New York)

Absolutely.

Mayank Shandil (Global SVP of Reconstruction and Robotics Marketing, Smith+Nephew)

All right. I think we can head into a quick break now. And when we come back, we'll have Deepak come back on stage with his closing comments, and then we'll have some Q&A with our BU presidents.

Deepak Nath (CEO, Smith+Nephew)

Hopefully, you found the sessions as energizing as I did. A lot of passion all around from surgeons who use our products to our own internal team. So on stage with me now, we've got our CFO, John Rogers.

We've got Rohit Kashyap, our President of Wound Business; Scott Schaffner, who is the President of our Sports division; and of course, Craig Gaffin, who leads our Orthopaedics business. So we're up here. So fire away your questions, and we'll take as many in the room as we have, and we'll turn that into the -- on to our phones. So fire away.

Caitlin Roberts (Analyst, Canaccord)

Hi. Caitlin Roberts, Canaccord. Just touching on AGILI-C, you noted the CPT code that will go into effect in 2027. Just some more color on the current commercial presence in the U.S. and then the expectations post the CPT code going into effect.

Deepak Nath (CEO, Smith+Nephew)

Scott, do you want to take that?

Scott Schaffner (President of Sports Medicine, Smith+Nephew)

Yes, sure. Thanks for the question. And as Hadi described, I mean, it is a journey. And a lot of what we're doing now in the U.S. in terms of establishing commercial presence has been really about how do we build the story around market access. And so establishing some critical mass, so some level of use as well as collecting the evidence that we needed to support the process of getting that CPT code, that's really been the focus.

It's all been about market access. And then, of course, building advocacy with some of the early users, surgeons who can help us articulate the story. So that's really been the focus. So commercial presence has been pretty limited to like let's build the market access story, knowing that when the CPT code comes in 2027, we'll have a stronger story from a reimbursement perspective.

But it is still part of a process, but it does give us the ability to engage more closely with all the commercial payers that are -- that will be a part of -- important stakeholders to this and a part of the overall CARTIHEAL story. So in the meantime, it really is sort of a journey that we'll be on. There isn't sort of one magic inflection point.

That will be an important step in the right process to get the code is a critical piece of it to establish the right payment levels and then ensure coverage, and that will be kind of a dialogue and steps that we take with all the different payers that will be involved. So it will be a process. But the potential, as we've talked about, we think, is huge just because of the degree of the unmet need and the fact that there are no great solutions out there today for what's a significant problem.

Deepak Nath (CEO, Smith+Nephew)

Two points to build on that. I mean, in terms of where it sits organizationally, it's currently with our biologics sales force within the sports division. So the organization that largely is been taking REGENETEN and representing that product. So that's the team that this will sit in. And in terms of where we are relative to our expectations at the time that we made the acquisition, we're essentially bang in-line with where we expect it to be.

So just to give you a little bit of that color. We previously said in terms of what's material in terms of revenues, it's really back-end loaded. It's more really close at this point, '28 through '30 period is when you start to see this become a more material part of our business. So just to ground you on those 2 data points.

Veronika Dubajova (Analyst, Citi)

Yes. Thank you, guys. I feel like I've asked all the questions and I feel bad going back to myself. But maybe just on wound and obviously, you articulated this ambition to grow high single digits on Monday. If I look at the business over the last couple of years, I think the growth rate has been trending around 5% to 6%.

So I know you talk about 5 areas of focus that you have, but maybe just help us understand what you think is the biggest needle mover that moves you from that 5% to 6% growth rate that we've been at into the high single digits. Thank you.

Rohit Kashyap (President of Advanced Wound Management and Global Commercial Operations, Smith+Nephew)

Thank you. Thank you for your question. Yes, you're right. We -- as we have mentioned, the -- for the last 3 years, as we've been fixing the foundation of the business, our growth has been about 6% or so, which is slightly above market, but in that area. And our ambition is to get this growth and are confident that we'll get it to the high single digits. there is not one single driver which has a disproportionate portion of that growth.

It actually is a couple of areas that we have talked about, which are principal drivers of that growth story. From a market -- looking at the market and both of those we touched upon today, but pressure injury prevention is a big component of it. And how we have featured and talked a lot about ALLEVYN Complete Care, but also how LEAF plays into that is a big component of it. I think just for time constraint, it's obviously, there's only so many things you can talk about.

But those 2 things together make a really nice bundle, if I can call it that, of offering for the customers to manage those patients. So that is a big market opportunity and a big part of our growth story as we go towards [indiscernible] (02:47:55). The other part is SSCs that we talked about today with -- and a perfect example from Dr. Bashyal and talking about that $1.7 billion opportunity, which is only 20% or less of penetration.

So even though we are averaging double-digit growth, we believe we can accelerate that growth. And just for clarity, that $1.7 billion does not assume that all the procedures will ever be treated with PICO, for example, because you saw that interchange with Dr. Haas and Dr. Bashyal where he's using 100% and then what is the right -- so we've applied that. So we really believe there's a lot of potential within that area.

And what we are doing is investing kind of what Scott already touched about is continue to strengthen the evidence because we have to go indication by indication or procedure by procedure to strengthen that evidence as well and continue to build on both the KOL aspects of it with who are going to be the champions just like Dr. Bashyal was today in order to drive and get the penetration of that.

So I would say anchor on those areas as being the biggest growth drivers. The third thing I would just say is, as we think about it, there is some disruption in the market in the biologics space, and we have accounted for that. But we think longer term, it might not be a '26, but as we look beyond that time horizon, we think that's an important part of our growth story as well as we move into that.

Veronika Dubajova (Analyst, Citi)

Just a quick follow-up on the biologics space. Obviously, I think you outlined your assumptions on Monday and one of the assumptions that you've made is that the LCD is going ahead. I guess, does -- if the LCD does not go ahead, does that change the magnitude of the headwind that you'd anticipate next year?

And how are you thinking about that? Because I mean, my perception is there's still some uncertainty about whether we end up with the LCD or not. And I just would like to understand your degree of confidence around that.

Rohit Kashyap (President of Advanced Wound Management and Global Commercial Operations, Smith+Nephew)

Yes. It's hard to predict my confidence on whether the LCDs will go ahead or not. But I think we have planned across all of those scenarios in terms of what it is and where we would press. So we have taken a balanced view across the different set of scenarios in coming up with what our projections are in that regard.

Deepak Nath (CEO, Smith+Nephew)

I mean just to add to Rohit's point, Veronika, what I like about the stack up within compound of growth is there's share capture opportunity clearly within AWC. I mean there's ALLEVYN Complete Care on its own and in combination with LEAF for pressure injury. I like the fact that we're set up for share capture because we have essentially not been doing that up to this point. And so that's one thing.

And then there's, of course, with single-use, what Rohit is alluding to is market growth opportunity, right? And then, of course, there's biologics. So you add these things up, it's a very nice mix of share capture, market growth, and it's actually multiple products across our diversified portfolio. So that's the nice thing about -- we're not reliant on any one product. We're not reliant on any one geography, and we're not reliant on any one category.

And taking a step back, one of the most beautiful things about our plan is going from 5% plus to 6% to 7% is we're not reliant on any one business unit, any one product or any one category. That is the most beautiful part of how we accelerate growth. And the other beautiful part of this program -- of this plan is that you get growth and you have profit growth on top, right?

And that is because the source of profit growth of the margin expansion is different from where we're getting the growth from, right? So that complementarity and that richness is what gives us the confidence of achieving this plan, right? So I just want to kind of add that.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

We've got lots of questions on the webcast, if no more in the room. So the first on the webcast is on CORI, you spoke about the competition from the likes of MAKO and ROSA and the advantages CORI may have in the ASC setting. Can

you provide a bit of color on the competitive landscape in the smaller handheld area, e.g. THINK Surgical and how that might change our position with CORI in the ASCs?

Deepak Nath (CEO, Smith+Nephew)

Craig, do you want to take that?

Craig Gaffin (President, Global Orthopaedics, Smith+Nephew)

Yes, sure. I'll take that. I mean Listen, I think the relative to think again, it comes back, we pioneered handheld robotics, right? So I think for us, we were the innovators. And I think it's, again, a testament to where the market. Mike was talking about maybe being lucky, but I wasn't there at the time, but I think we made some strategic plays, knowing where it was going in the footprint in the space.

So I think with Think again, it's both an open and they have obviously a partnership with Zimmer. But ultimately, it's about the procedural innovation as a whole. And I think that that's where the combination of CORI with the handheld robotic is going to be key because it's going to be able to go again across all procedures. And so when you think about ASCs, it's not just about knees.

It's about hips, it's about shoulders, it's about knees as well. And that value proposition that we're doing one platform with clear innovation to make the procedure smoother, easier, the workflow and ultimately providing the value and the benefit from a patient outcome is key. So...

Emily Heaven (Head of Investor Relations, Smith+Nephew)

Do you want to add anything?

Steven Haas (Hospital for Special Surgery, New York)

What I was going to comment about THINK. THINK is handheld. And I actually I think it was probably okay for Zimmer to try that because they needed something. But think actually all it is it places a pin. So it doesn't -- it has very limited functionality. It's just a guide to place a pin and then you have to cut saw -- use your saw to cut this. So it's really a navigation lead, really all it is.

And so I might as well use a device like that, why not do something like that if it's -- if all it is doing -- it's nothing doing robotic as much as it just places a pin, okay? And then the big issue is actually, which is quite surprising because I explored it, is their software which is key to robotics is having sophisticated software. And if you look at the software landscape, MAKO has reasonably good software, Smith+Nephew has great software. So those 2 more comparable.

The other ones are all really the software itself is relatively poor. And there's software that goes with it. In other words, a great example is they have -- they get a CT ahead of time, so it's image-based. And then it doesn't model the whole bone.

It you look and go, what do they forget when they do it. So maybe with future improvements, it could be better, but it's a limited -- it has limited capabilities because all is it places a pin, it places a guide. And it is really a navigation way more than a robotic system.

Deepak Nath (CEO, Smith+Nephew)

I mean, just to further build on these points, it's -- we've seen patent filings and things that in the world in the sphere of handheld robotics. It's not for us a complete surprise that others who are active in this area, right? And on the bucket of invitation being the best form of flattery, we feel very confident about the path that we've forged here. And to Dr. Haas's point, maybe over time, their subsequent generations get better.

But at this point in time, we feel super confident about what we've got in CORI, the years of development that we've put into it and the fact that the type of functionality we've added, we've really set the pace here. And plus, you've got an installed base with other competitors that they've got to attend to.

It's not an easy thing to just convert these things over. So I feel good about where we're positioned. I don't underestimate any competitor. I certainly don't underestimate some of our larger competitors.

But what we have is an organization that's got all of the components, whether it's the form factor and the functionality of CORI, the whole implant portfolio that's now redesigned with the needs of the ASC in mind that Dr. Ast passionately talked about.

That's a powerful value proposition and all the rewiring work we've done together with the commercial organization that's -- how do I put it that transcribes well. It's found its mojo. I think it's a powerful combination for us in the next 3 to 5 years.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

And then 2 questions that I'll combine. The first is, are there potential sales synergies between ortho and negative pressure wound therapy? And the second is, there seems to be some leverage across sports med and ortho in the ASC channel. Can you explain the benefit of having both businesses?

Deepak Nath (CEO, Smith+Nephew)

So maybe I'll take the negative pressure one to you, Rohit. And then maybe Craig and Scott, you can take turns answering the complementary question for that.

Rohit Kashyap (President of Advanced Wound Management and Global Commercial Operations, Smith+Nephew)

Yes. Definitely, again, it's the same procedure. It's the same -- so there's a leverage from a point of view of the procedure itself. And we continue to collaborate, especially in how we deliver education and how do we reach our customers. And there's still more potential in order to drive those I wouldn't even call them synergies, like present the full portfolio and a full solution for the best outcome for the patient, as Dr. Bashyal talked about.

So we'll continue to collaborate and partner with our ortho team on that. As I think about on the negative pressure side, our universe is, but however, not limited by just ortho. We have, as Cathy mentioned, specialties across OB/GYN, across -- procedures across OB/GYN, cardiothoracics, plastics and so on.

So our focus is also to continue to expand our opportunity and our penetration in those procedures as well. But definitely on the orthopedic side, continue to work by ourselves, but also with the team on the ortho side to continue to drive the penetration.

Deepak Nath (CEO, Smith+Nephew)

What we've got actually -- I mean you've -- both of you now have recently strengthened your corporate accounts function and team. And some of this is kind of an air game and some of it is a ground game.

But actually, what we've got is strengthened capabilities, particularly around contracting corporate accounts that allows for these types of combination deals to happen, keeping in mind that it's the playing field for you, Rohit, is broader than just ortho. Do you guys flip a coin and figure out who's going to through.

Scott Schaffner (President of Sports Medicine, Smith+Nephew)

Yes I think I want the coin toss on that. But I think it makes sense to kind of start with sports as well because that's sort of in many ways where the ASC journey begins as Dr. Ast and Mayank talked about. We have a very strong presence in the ASC today with our sports business being among the first procedures to really go that direction.

And as I look at it, we have the strongest sports portfolio among any of our largest competitors on the total joint side. And then as we look at our largest competitor in sports, they don't have a meaningful presence in orthopedics nor do they have a robot. So we're really well-positioned in that space to leverage the relationships, the experience that we have, the presence that we have in the ASCs.

And so it's kind of, I think, a natural evolution of Smith+Nephew as a partner with the ASCs. And kind of selfishly speaking, from the sports perspective, it certainly reinforces our strong presence in the ASCs that we're in today, knowing that we also have such a compelling story on the total joint side. So a really strong combination.

Craig Gaffin (President, Global Orthopaedics, Smith+Nephew)

Yes. I think the first part I'll start is the people, right? So hopefully, you can tell with us up here that we all get along and we're good friends. And Scott has been an incredible partner first off. So there's a tremendous amount of trust and confidence from a leadership standpoint. He was so kind that he allowed me to take his leader at the time from sports as well and bring him over to orthopedics.

So you now have that level of partnership, one layer below. And ultimately, how we look at these things is how 1 plus 1 equals 3, right? And sometimes, again, I might have to bend a little bit for him to win, but ultimately, it's a Smith+Nephew win, and that's what we look at. And I think we see this -- I think Dr. Ast did point out, that's the target in these retrofits. It's not -- the de novos are important by all means, but it's how do you take something that's in the transition.

And we're really fortunate, again, to have sports who's been the leader on that front. And we can point to a number of examples. I mean, a lot of examples here this year where we've been able to combine as business units to win and a number of CORI deals, a number of pull-through deals that happen on the ortho and the sports. And they're absolutely a valuable and vital partnership for us.

And I think it's why Smith+Nephew as a business unit and the 3 business units are so key. I probably would say, lastly, it just doesn't -- just not the recon, the joint recon part of it, too, is -- I'm sorry, on total shoulders. They've got tremendous relationships with a lot of these sports specialists who are doing total shoulders as well.

And we've had programs in place where we're driving funnel activity, conversions through those partnerships with the relationships they have because naturally, they do want to paint that ASC orange as much as possible, and there's real good reasons and they've been, again, tremendously valuable in those cases as well.

Deepak Nath (CEO, Smith+Nephew)

We've come -- I mean, just to add to what my colleagues have said, bringing our Recon and our sports offerings together was one of the things we called out in the 12-point plan. And some of you have been keeping track will have observed that we were generally tracking okay and observed in various settings that perhaps we set the bar too low in terms of the targets because that was one of the areas of the 12-point plan that looked green all the way through, which basically means maybe you're not reaching high enough.

But the reality is, as an organization, we've gotten stronger and stronger. It's an evolving landscape. Again, Dr. Ast, you eloquently put just what all the considerations are and how no 2 ASCs are like, right?

So we, as an organization, have had to evolve to kind of be mindful of and also keep pace with those dynamics, and we've made some not only organizational moves in terms of where we've housed this capability, but also how we come across as a single point of contact for these things, recognizing what's important but also strengthen the capabilities from people who are able to bring a combined offering together. So we've been evolving, and we have also kind of gotten stronger over the last couple of years.

John Rogers (CFO, Smith+Nephew)

And also from an incentive perspective, everyone on this stage is measured to a degree on group performance. So we're all incentivized to drive our performance at the group level as well as the BU level.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

I've still got more, so I'll keep going. What do you expect the revenue model for TESSA to look like? Is the majority of the value from direct sales consumables or from getting surgeons onto the Smith+Nephew ecosystem?

Scott Schaffner (President of Sports Medicine, Smith+Nephew)

Great question. If you want me to start -- kick off with that one.

Deepak Nath (CEO, Smith+Nephew)

Yes, please. Sure.

Scott Schaffner (President of Sports Medicine, Smith+Nephew)

There are a lot of different sort of components to the model, like a lot of enabling technologies that we have today at Smith+Nephew, the arthroscopic tower is an important kind of foundation in any account. And I think TESSA and technologies like it, they strengthen that proposition tremendously. And so there's certainly advantage to having that footprint in a particular account.

In terms of revenue, there's the capital piece of it that's a portion of it. There are kind of consumables associated directly with Tessa. For those of you who are in the room and had a chance to get your hands on it, you see that the

QR-coded instruments and markers, there's an element of that. There's an element of software and the capabilities within that.

But I think the bigger component of all of it is what is the question about the ecosystem and what does that do? Wherever there is TESSA, it opens the door and it facilitates all the procedures that we do, all the joint repair procedures starting with ACL and expanding from there. So I think we can measure the impact in a lot of different ways. Some of those directly from revenue from Tessa. Others will be how TESSA helps us drive the entire sports portfolio and beyond.

Deepak Nath (CEO, Smith+Nephew)

Well, one of the things, Scott, you put in place now for a number of years where you do push your organization for a balanced selling, right? So you're making sure that your sales organization is representing and actually making the whole portfolio count.

And that's one of the things that you kind of drove 5, 6 years ago kind of in your role. So that's one commercially part of the organization is actually working well, is that balanced portfolio selling, and we expect, as Scott said, to bring that approach to TESSA as well.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

Just check...

Deepak Nath (CEO, Smith+Nephew)

I'll monitor, Emily.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

Would it be possible to break out your high single-digit wound target into the 3 subsegments, Wound Care, bioactors and devices, specifically thinking about Advanced Wound Care, which has been growing around 2% in recent years?

Rohit Kashyap (President of Advanced Wound Management and Global Commercial Operations, Smith+Nephew)

Yes. I don't think we -- again, I'll go back to the answer I gave before. Obviously, our focus is growing with ALLEVYN Complete Care that will further accelerate with the market share that we plan on capturing in the pressure injury prevention that would contribute to the AWC growth and our AWC growth plans are to get back in that category where we have trailed the market to market growth or above.

And then in AWD, we have always had double-digit growth over the last several years. And with the continued growth in PICO as well as the contribution of LEAF, which is helping pressure relief prevention, but it actually is a device. It will help continue to accelerate that growth and mix.

In the biologics space, again, there's going to be some volatility in the growth just because of the dynamics of what we have discussed with the changes in reimbursement and all coming through. But -- so that -- those are the things that will drive as we see those different components of growth accelerating overall.

Deepak Nath (CEO, Smith+Nephew)

But bottomline, we're not going to give targets [with] the subsegment level.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

And then I think this is one for the docs. Can we expect 100% of major joint replacements to ever be performed robotically at some point in the future? How many years will it take to get to that point?

Steven Haas (Hospital for Special Surgery, New York)

I think virtually 100% eventually. Now the time, whether that's a 10-year horizon, the problem is going to be -- it's going to be standard of care. At some point in time, as I believe the results will get better and as we get more personalized in doing this, and there's documented evidence of it being better, and I believe that there's some of it now and it will come out.

And lastly, the robots just make it easier. And I think that the people train on the robot, they are used to the robot. Like I said, I do 15%, so I trained surgeons on how to not do it just in case it wasn't there, but they like it. And so the next generation is only going to be knowing how to do it with the robot.

Michael P. Ast (Hospital for Special Surgery, New York)

The only thing I would add to that is the way I look at robotics, if you want to just take a step back and see what the real value is, the value of robotics is the democratization of access to high-quality care, right? So every single surgery is done as if Dr. Haas did it.

You know what I mean, no matter who does it, no matter where it happens. So the timing question is hard because the answer really is going to be when does every market have access to it based on their health care system, based on the way that they work, based on the opportunity to get that.

So the answer is yes, eventually, much like we don't ride horse and buggies anymore anywhere, like now there's cars everywhere. There will eventually be robotics everywhere. The timing is going to be very dependent on the variety of factors that influence health care spending in multiple markets around the world.

Emily Heaven (Head of Investor Relations, Smith+Nephew)

Thank you. That's all the questions on the webcast for now.

Deepak Nath (CEO, Smith+Nephew)

There's one from Veronika. Just keep it coming, Veronika here.

Veronika Dubajova (Analyst, Citi)

Just maybe one, in terms of LEGION MS versus LANDMARK, kind of how do you think about the impact of that one versus the other? I guess, how much of a step-up in growth in U.S. knees should we already expect now versus once we get to third quarter and LANDMARK is out there?

Craig Gaffin (President, Global Orthopaedics, Smith+Nephew)

Yes. So again, our goal is to get back to market share or get back to market growth. And so I think that there's -- that's going to be, as I mentioned before, kind of a 2-step phase, right? So MS plays a critical role right now in getting into the segment that was cementless CR, MS stabilized knees.

So we believe that, that will be kind of the first phase to get there. And again, I'm really encouraged by what we see. One of the things we talked about the strength in commercial engine and our launch process. This is something that we have a pretty robust pipeline of people that we've balanced this kind of converting people, but a good long list of competitive targets. that will start that progression to get back to market growth.

And then I think as LANDMARK, as Dr. Haas laid out really well, the exciting piece about that for us is, one, that conversion over. So if you were a JRNY customer, it's going to be a really easy conversion.

So maintaining those customers because we're going to -- the design and the upgrade will give them what they wanted as well. And then it's just going to be this balance of going after competitive targets, which, again, we'll be proactively starting to identify and we'll have in the queue.

And upon launch, we will just be, again, this balance between putting to existing and then going after competitive targets. So that will be the driver, again, to get us to market growth. And certainly, market growth is the goal, but the ambition is to go above that as well. Hopefully.

Deepak Nath (CEO, Smith+Nephew)

Cool. Anything else, Veronika, are you done with?

Veronika Dubajova (Analyst, Citi)

I'm good.

Deepak Nath (CEO, Smith+Nephew)

Okay. Well, so with that, I just wanted to take a moment now to thank you all for joining us today and for your engagement throughout the session. And actually a special shout out to Dr. Haas, Dr. Ast, Dr. Ranawat and Dr. Bashyal's not here for taking the time out of your busy practices to be with you today. It made a big difference, and we really appreciate it behalf of my colleagues here.

So hopefully, to the audience, you can feel the excitement that runs through all of us at Smith+Nephew, and you now have a deeper understanding about how we provide innovative and differentiated solutions across a broad range of indications.

So with these 2 Capital Market Days, which were designed to share our vision for the next 3 years, I hope you leave with a clear sense of the ambition that's behind RISE and the confidence that we have, not only in the foundation, but also the focus to deliver. So our message is simple.

Our bold new strategy will elevate Smith+Nephew. It will accelerate growth and improve -- so we've built a strong foundation through the 12-point plan. And now we are ready to move to the next phase, delivering 6% to 7% organic growth, 9% to 10% profit growth and driving our ROIC to well above our cost of capital. And each business unit has a distinctive role to play.

Sports and Wound will lead innovation and execution to deliver above-market growth. And ortho will expand margins and through disciplined actions through and under Ortho360, we will operate this business better than we ever have before. We'll continue to prioritize productivity and operational efficiencies across the group and locking 300 to 400 bps of margin expansion.

This is an ortho by 2028 and actually on a path to deliver a 20% ortho margin by 2030. And strong free cash flow generation is an important part of our plans and it will give us the optionality to make strategic moves where I'll reinforce our success and create further value. So RISE is ambitious, but importantly, it is achievable, and it's about reaching 5 million more patients in 2028, driving share gains and elevating Smith+Nephew to the next level.

So we are confident in our ability to deliver, and we're excited about what lies ahead. So thank you again for your time, for your partnership, and we look forward to working together to bring the strategy to life. So thank you very much.