Itúy

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Executive Summary

UK Market Entry and Asset Transformation

01

The Decision Question

Should the [OPERATOR] enter the UK market by taking control of the Midlands elective centre and scaling it into an integrated elective + diagnostics + rehabilitation platform?

02

Strategic Rationale

- Sustained elective backlogs and diagnostics shortfalls create immediate demand.
- A diversified model:Theatres + Diagnostics + Rehab
- Asset-backed entry offers a tangible foothold in a 60-90 minute catchment area

03

The Board Ask

- Approve entry route and capex phasing.
- Agree payor mix guardrails.
- Sign off governance and quality model.
- Mandate contracting plan with commissioners/insurers.

The Recommendation

Proceed with Option A (lease-to-operate). This path minimizes upfront capital exposure while capturing the upside of a high throughput model.

Market Context & Investment Thesis

Market gaps in elective and diagnostic capacity support a high-throughput, diversified platform

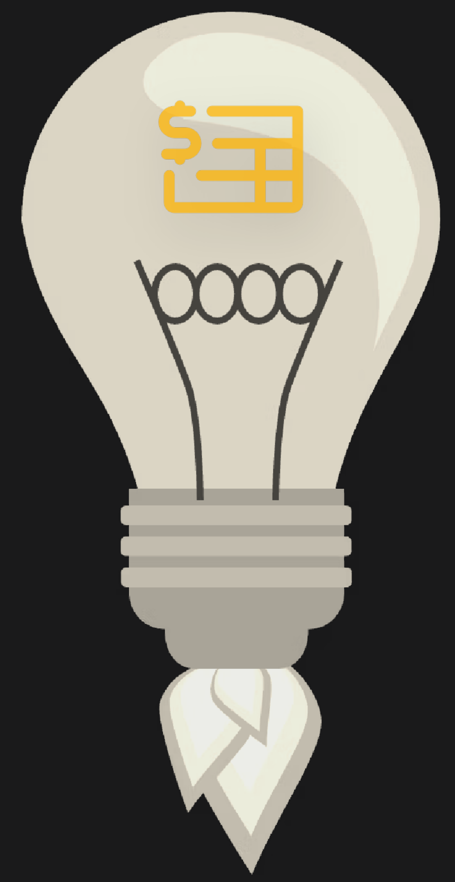
Market Context
(The Why)

Elective backlog
Persistent demand across orthopaedics, ENT, ophthalmology, women's health, and urology

Diagnostics gap
Significant shortfalls in imaging and endoscopy create stable contracted volume opportunities

The ‘backbone’
Sustainability requires an NHS backbone combined with private growth (insured + self-pay)

Investment Thesis
(The How)



Transform
Take an under-utilised elective site and convert it into a high-throughput planned-care centre

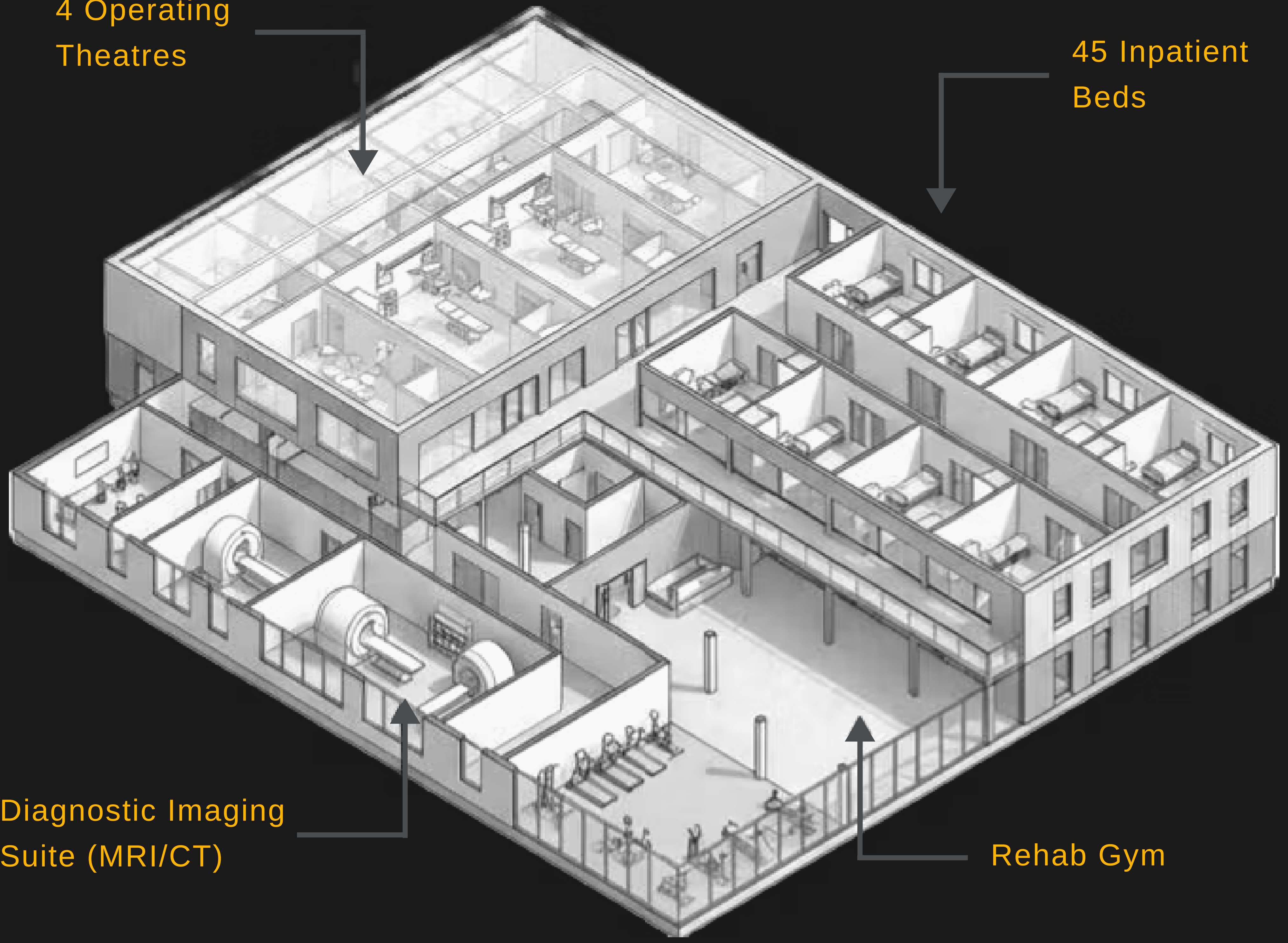
De-risk
Reduce dependency on theatre revenue by building diagnostics and rehab as parallel revenue engines

Optimize
Use operating discipline (pathway design, list optimisation) to expand EBIT margin as utilisation ramps

Asset Profile: Midlands elective center

The Estate

42,500 sq. ft clinical + support estate with convertible shell space



Location Strategy

Midlands region with a 60-90 minute catchment covering multiple ICBs

Operating Capabilities

- Lead Specialty: Orthopaedics-led elective hub
- Service Mix: ENT, opthalmology, general surgery, gynaecology, urology
- Support Zones: Diagnostics (MRI/CT/X-ray/US) and Rehab (gym/hydrotherapy)

Strategic Option Matrix

Option A (lease-to-operate) balances speed of entry with managed capital exposure

FEATURES	Option A: Lease-to-operate	Option B: Acquired freehold	Option C: Joint Venture
STRUCTURE	Operating lease with staged capex and purchase option	Acquire freehold/long lease up front	Shared equity/governance with local partner
PROS	Fast entry; limited upfront exposure; ability to 'learn before committing	Maximum strategic freedom; refinance potential	Local market access and risk sharing
CONS	Less long-term estate control; landlord dependency	High upfront capital; higher downside risk if ramp slows	Complex governance; slower decision-making
BEST WHEN	Asset is underutilised and capex needs phasing	High conviction on demand + execution	Partner brings essential referrals or workforce

Decision Gates

Capital commitment is strictly gated against three specific validation proof points.

Evidence: Confirmed referral volumes via GP network.

Validation: Initial commissioner/insurer appetite confirmed.

Gate 1: Demand Proof

Evidence: Credible staffing model (theatres, anaesthetics).

Validation: Detailed list-fill plan to reach 80% utilisation.

Gate 2: Operational Proof

Evidence: Blended payor mix validation.

Validation: Cost base analysis confirming progression to 20% EBIT margin.

Gate 3: Unit Economics Proof

If gates are missed, project halts or pivots before full capital commitment.

Financials & Unit Economics

Maturity targets project ~£32-35m revenue with a 20% EBIT margin

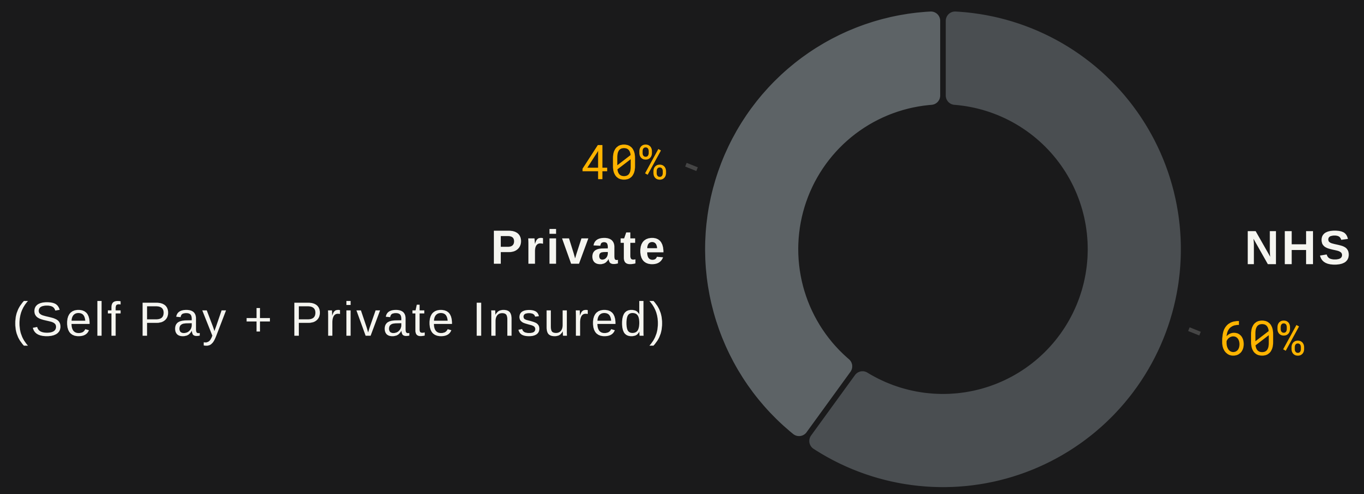
~ £32-35m

Projected Revenue

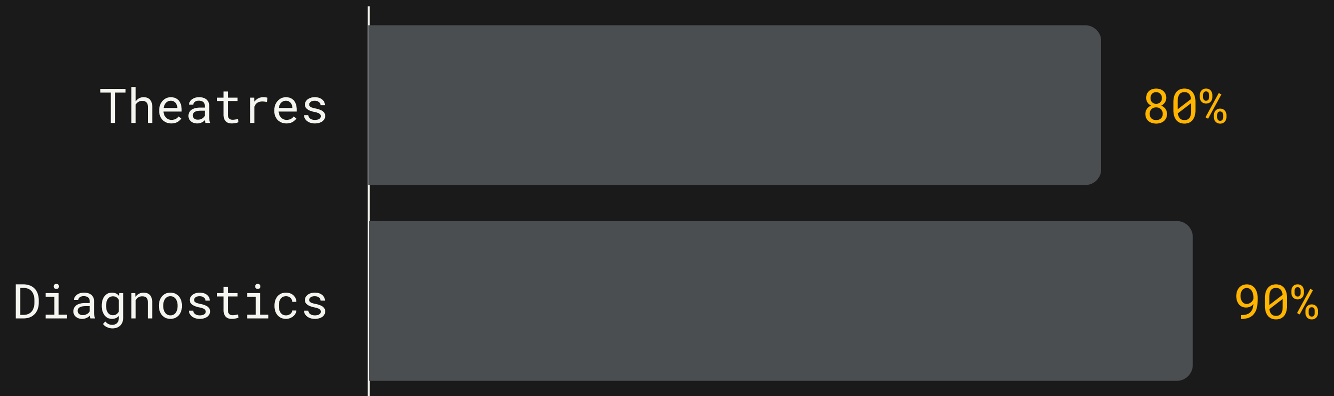
~ 20%

Operating Margin

Target Payor Mix (Year 5)



Utilization Caps



Base Assumptions

- **Commercial Inflation**: NHS +3%; Private +4%
- **Cost Inflation**: People +4%; Utilities +3.5%
- **Marketing**: Tapers to 5% by Year 5
- **Rent**: Illustrative £1.5/year (+3.5% escalation)

Risk Register & Mitigation

Governance Failure

Early Warning Indicator: Rising audits, audit gaps

Active Mitigation: UK-compliant governance framework; strong clinical leadership

Workforce Constraints

Early Warning Indicator: High agency spends, ROTA gaps

Active Mitigation: Cross-skill teams, international recruitment pipeline, competitive pay bands

Diagnostic Comissioning Delay

Early Warning Indicator: Slow contract sign-off, low scan volumes

Active Mitigation: Phase installation; pursue mixed NHS + private model; tele-radiology cover

Under-filled Theatre Lists

Early Warning Indicator: Low referral conversion, cancellations

Active Mitigation: Lock referral pathways, build consultant panel, extend hours once stable

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Disclaimer: This document is a sample artifact intended for illustrative purposes only. Any data, insights, or evaluations contained herein are merely indicative and do not constitute professional advice or verified market intelligence.

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