

SEED ROUND · PRIVATE & CONFIDENTIAL

The operating layer for health systems moving care out of hospitals.

One open person record carrying clinical, operational and governance data, self-hosted, with the shift measured continuously rather than declared annually.

Three shifts are now national policy. None of them are measurable.

SHIFT 01

Hospital → Community

Care moves closer to home, but the record does not follow it.

SHIFT 02

Analogue → Digital

Records are digital; the data behind the decisions is still days or weeks old.

SHIFT 03

Treatment → Prevention

Prevention requires population-level targeting that operational systems cannot do.

Systems are mandated to shift care left. They cannot yet show whether it is happening, at what pace, or who is being left behind. Meanwhile the commissioning layer itself is moving — England’s integrated care boards merged from 42 to 26 on 1 April 2026.

Transformation is reported in board papers, **not in data.**

01

The record is fragmented

Acute, community, mental health, social care and primary care each hold a different version of the same person.

02

Progress is self-declared

Maturity is assessed by survey and narrative, months after the fact.

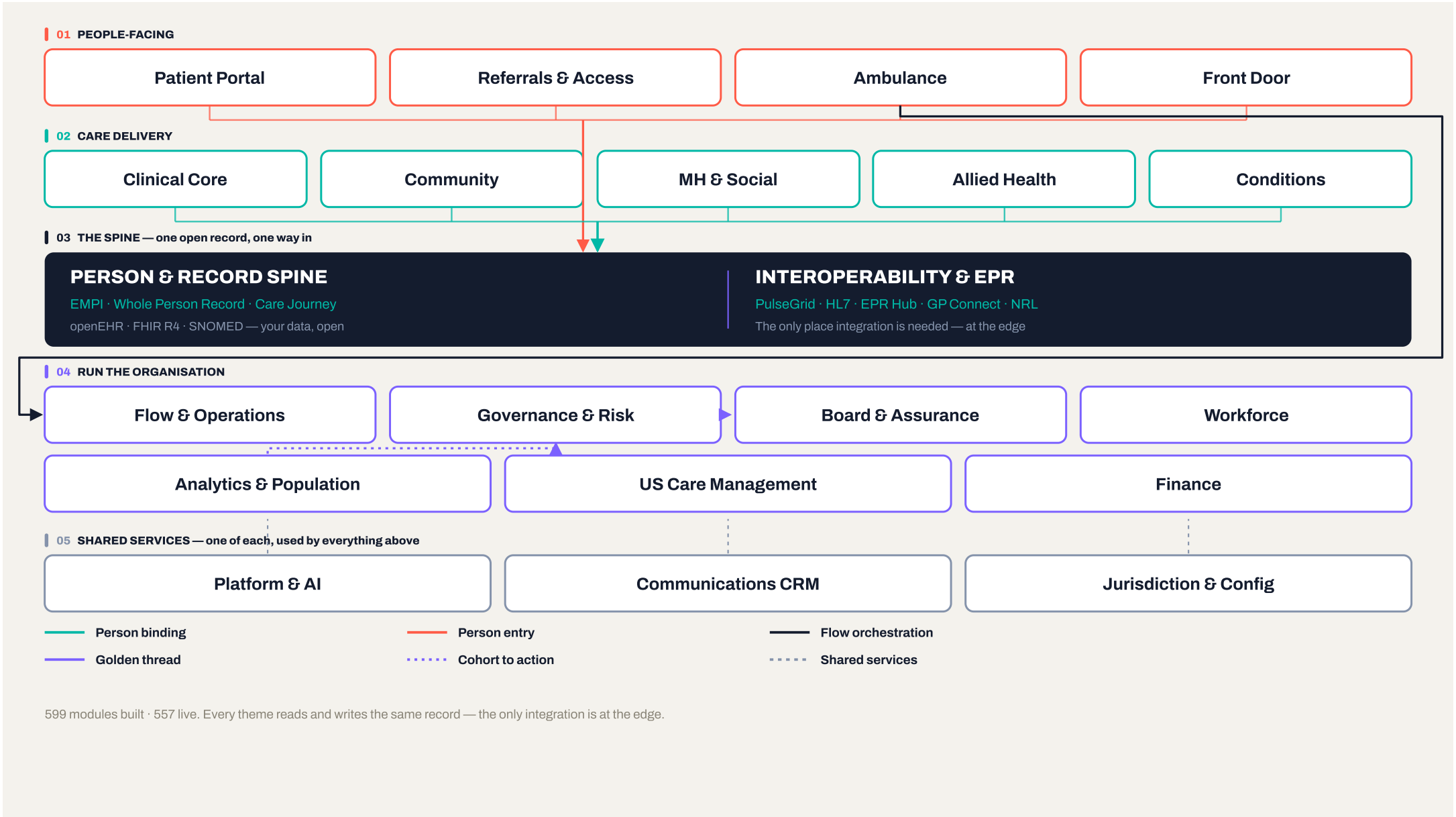
03

Equity is invisible

Aggregate improvement hides widening gaps in older and more deprived populations.

The scale of it: a two-million-population system runs **40 to 80 separate systems** and employs **80 to 150 people** whose job is moving data between them. That headcount is the integration layer, and it is the most expensive one available.

One platform. One person record. Everything else plugs into it.



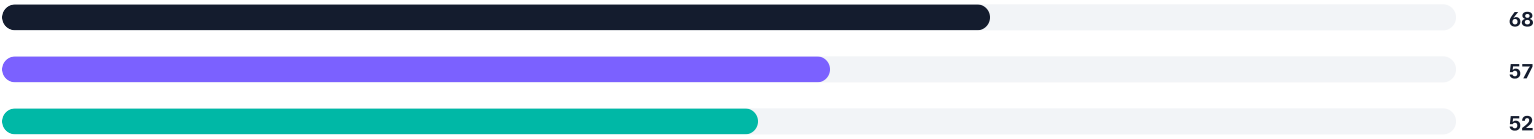
LeftShift Intelligence™ — is the system actually shifting care left?

● SEEDED DEMONSTRATION

62/100

COMPOSITE INDEX

- Digital shift
- Community shift
- Prevention shift



A single index for whether a system is shifting care left, with an equity modifier that penalises uneven progress — so a system cannot score well by improving only its easiest cohorts. The index is computed by the platform; the values shown are seeded demonstration data, not a deployment.

The index resolves to operational reality.

• SEEDED DEMONSTRATION

+14%

Avoided admissions

Admissions prevented against the counterfactual

−0.8d

Hospital length of stay

Mean reduction across the acute estate

89%

Urgent community response

Within the two-hour standard

73%

Virtual ward utilisation

Occupied capacity against commissioned

These are the measures the platform computes, at seeded values. There are no audited client outcomes yet, and we will not present these as though there were. First reference deployments are what turns them into audited ones.

Every number resolves to a named list of people.

• SEEDED DEMONSTRATION

High risk, no active case	Risk-stratified but unallocated — handed to the neighbourhood team for case-finding	776
Hypertension recall due	QOF register with no recorded reading in the review window — routed to recall	542
Core20 access gap	Eligible but not engaged, weighted by deprivation decile — routed to outreach	318

Cohorts are derived from live population data, prioritised by urgency, and handed to the team that can act. Every tile drills through to exactly the set it counts, and the count reconciles — that is a platform standard, not a feature.

The board pack writes itself. A human signs it off.

GENERATED

From live operations

Pathway movement, areas requiring action and a drafted executive narrative, composed from the same record the wards are using.

TRACEABLE

Incident to objective

Event, theme, systemic issue, risk, board objective — one chain, evidence carried at every promotion, counts that reconcile.

GATED

Review before publication

Every AI output is held for approval. Sign-off is a recorded signature ceremony on a tamper-evident audit chain.

Non-SaMD by design: the platform surfaces recorded data and computed indicators for a human to act on. It does not diagnose, and it does not publish without a signature.

Configured per jurisdiction, not rebuilt per customer.

JURISDICTION PACKS

16 configured today

England, Scotland, Wales, Northern Ireland, Ireland, Crown Dependencies, Gibraltar, Jamaica, Antigua, Montserrat, Kenya, Oman, Saudi Arabia, United States. Policy, pathways and coding travel as configuration.

STANDARDS

openEHR · SNOMED · FHIR

Vendor-neutral record, OMOP for secondary use, national canonical-model conformance. There is no lock-in argument to win because leaving is a designed property.

REGULATORY POSTURE

Non-SaMD by design

Intelligence and orchestration, not diagnosis. The boundary is asserted per module and reviewed at every regulated release.

One codebase, 599 modules, 557 live. Variance is modelled in a signed, versioned jurisdiction profile — never forked into local code, which is what makes the sixteenth jurisdiction cost the same as the second.

Land at a pound. Expand per employee. **Scale per head.**

Community Edition	Perpetual licence. Self-hosted platform base with operational products at national-platform parity	£1 / instance
Governance & Assurance	Banded by workforce with anti-cliff floors. No patient records, so no clinical certification gate. This is the revenue engine	£55–28 / employee
Population Platform	The whole clinical platform, governance included for the same scope with no double charge	£1.00–3.50 / head

A 12,000-staff trust is about **£480k a year**, against the **£400–700k** it already spends across eight separate governance products. UK governance and assurance software spend is **£150–250m a year**, £85–145m of it inside English trusts. Software gross margin above **80%** — self-hosted, no per-seat infrastructure cost. [● VERIFIED PRICING CARD](#)

Built by people who have worked
inside health systems, not sold to
them from outside.



Martin Carpenter

FOUNDER & CHIEF STRATEGY OFFICER
FBCS · FIOD · CHCIO

Health CIO in a Crown Dependency health and care system and a non-executive director at an NHS foundation trust. Initiated the roughly \$1.5bn acquisition of EMIS from an operating CIO seat at Optum UK. Sole architect and IP owner of the platform.



Hassan Chaudhury

CO-FOUNDER & CHIEF COMMERCIAL OFFICER
VICE-CHAIR, HIMSS UK & IRELAND

One of the UK's foremost digital-health export specialists. Built the national offer for Healthcare UK and the Department for Business and Trade, advising commercial teams across more than 90 countries. Co-founder, CIO and CCO of Health iQ through its 2019 exit.



Professor Marc Farr

CO-FOUNDER & CHIEF DATA & ANALYTICS OFFICER
HSJ 100 MOST INFLUENTIAL, 2025

Chief Data and Analytical Officer at East Kent Hospitals and NHS Kent and Medway. Founder of Beautiful Information, national chair of the Chief Data and Analytical Officers Network, and president of the Data Observatory.

Engineering, Azure and test leads on sweat equity. Chief executive hire is the first use of proceeds. Clinical advisory board on request.