

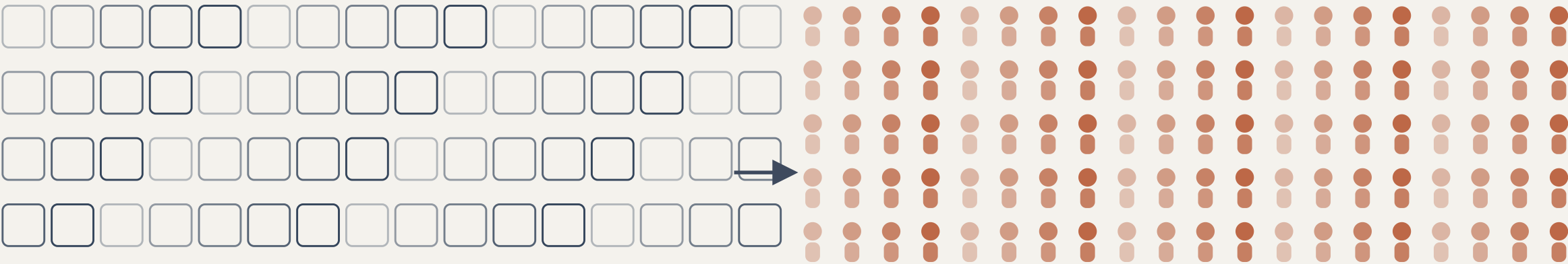


Health systems run in real time. Their data does not.

We built the platform that fixes that, and we build it in a way nobody else can match on cost or speed.

The system moves continuously. The data stands still.

WHAT A TWO-MILLION-POPULATION SYSTEM RUNS ON



40 to 80

separate systems, none of them the whole record

80 to 150

people whose job is moving data between them

That headcount is the integration layer. It is the most expensive one available, and it is the one nobody budgeted for.

“I sold health software into public systems, then had to run them. Dozens of separate systems, and stitching them together by hand became somebody’s day job. The integration never arrived. The lock-in always did.”

Martin Carpenter · Founder & Chief Strategy Officer

No airline or bank would run on data that is weeks old. Health does, every day, and everyone inside it has quietly accepted it. I did not want to sell another point solution into that.

Three jobs. Dozens of systems. **One platform.**

Every health system has to do these three things. Almost none of them does it with fewer than dozens of products — procurement after procurement, integration after integration, and people whose actual job is keeping them all in step.

Hold the record	The person, across every setting — GP, hospital, community, mental health and social care.
Run the operation	Flow, capacity and the binding constraint, computed from that same live record.
Govern the organisation	Incident, risk and board assurance, on one tamper-evident thread.

This is one platform that does all three. And because it is one, the incident recorded on a ward becomes the risk on the board’s register without anyone re-keying it. That is not a bundle. It is the thing the bundle was pretending to be.

Stop buying systems. **Run one.**

One open record — openEHR, FHIR, SNOMED — carrying clinical, operational and governance in a single platform you host yourself. Enter for a pound, prove it on your own estate, expand when you choose.

The data stays in an open standard, so leaving is always possible. That is deliberate. We would rather you stayed because you want to than because you cannot get out.

It is built. It is running. You can see it.

WHAT EXISTS TODAY, AT BUILD B-429

599

modules built

one platform, not a suite of acquisitions

557

live today

the rest await credentials, not development

13

national-platform products mapped

operational parity, product for product

16

jurisdictions configured

from one codebase, no forks

This proves the platform exists and runs. It does not prove outcomes at scale in your organisation, and we will not claim it does.

Buying that proof is what this round is for.

Shorter, simpler, safer. And worth doing.

Everyone in the NHS is frazzled. They do not want another system. They want their day back.

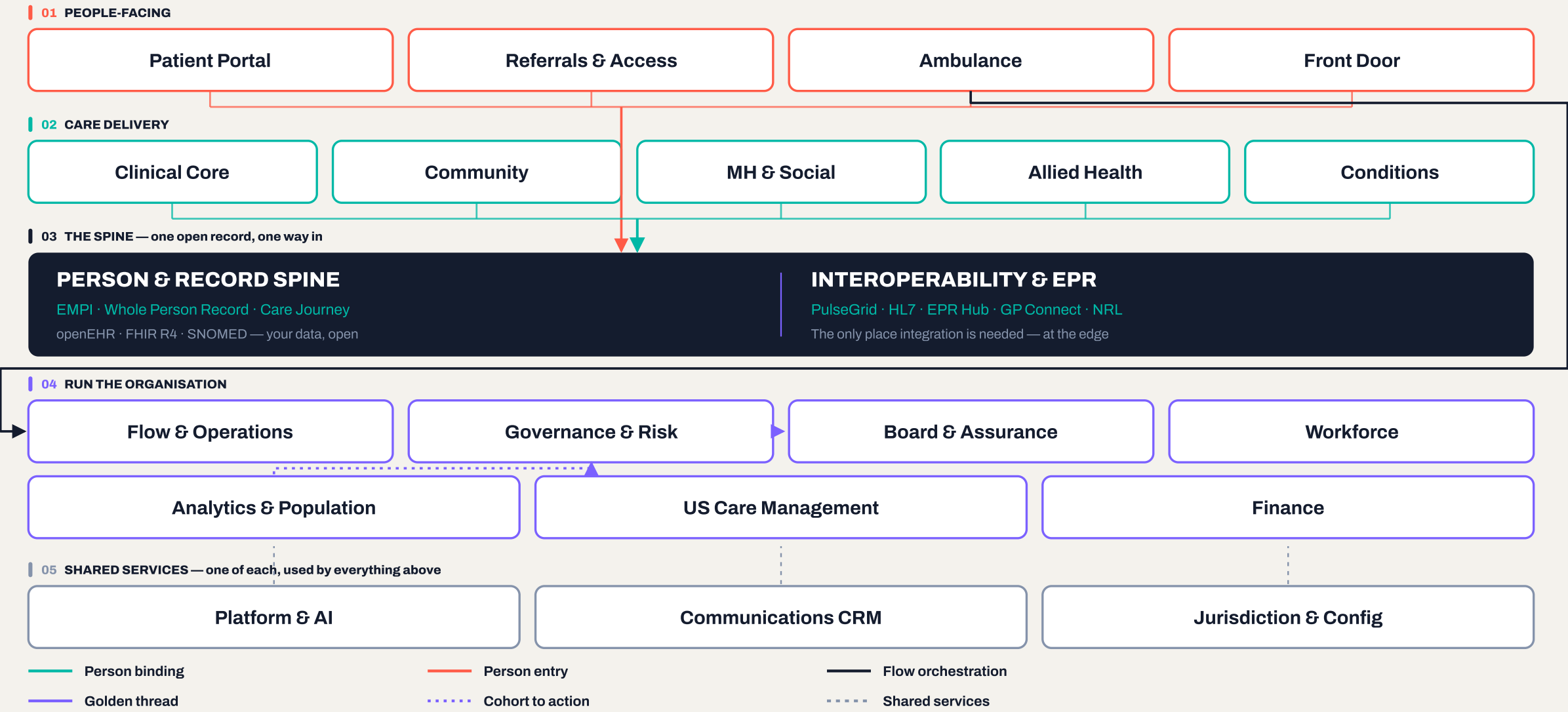
Shorter	The same patient stops being typed into three systems. It is already there.
Simpler	One place to look. A nurse sees the whole person, not six fragments to assemble.
Safer	Deterioration, medication risk and the thread from incident to board are computed from live data, not reconstructed afterwards.
More rewarding	The people employed to move data between systems get to do the job they trained for.

Bugs fixed in near real time. Features in weeks, not years.

A founding team built what conventional vendors take years and nine figures to produce. The same engine maintains it: defects are found and corrected continuously rather than held for a release train, and a change a customer asks for arrives in days or weeks — not the next quarter, and not the next roadmap.

Humans and process assure every change: clinical safety review, test and release gates. Speed does not come out of the safety case.

One record. Everything reads it.



599 modules built · 557 live. Every theme reads and writes the same record — the only integration is at the edge.

Why buy Board, Risk and Incident as three products?

ONE CHAIN, FIVE SURFACES, COUNTS THAT RECONCILE



Every promotion carries its evidence forward, so the board sees the ward. De-escalation needs abating signal, not a calendar date.
Buy this as four products and the chain breaks at every seam — which is where it breaks today.

We sell governance first, not clinical software.

Board assurance, risk, incidents, information governance, AI governance. It holds no patient records, so there is no clinical certification gate and no multi-year integration.

Boards buy it inside one financial year. The clinical platform follows into an organisation that already trusts us.

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

THREE WAYS IN, ONE PLATFORM UNDERNEATH

Community Edition

£1 per instance, perpetual

Self-hosted platform base on open standards, with operational products at national-platform parity

Governance & Assurance

Per employee, £55 down to £28 a head

Board, risk, incident, IG and AI governance. No patient records, so no clinical certification gate

Population Platform

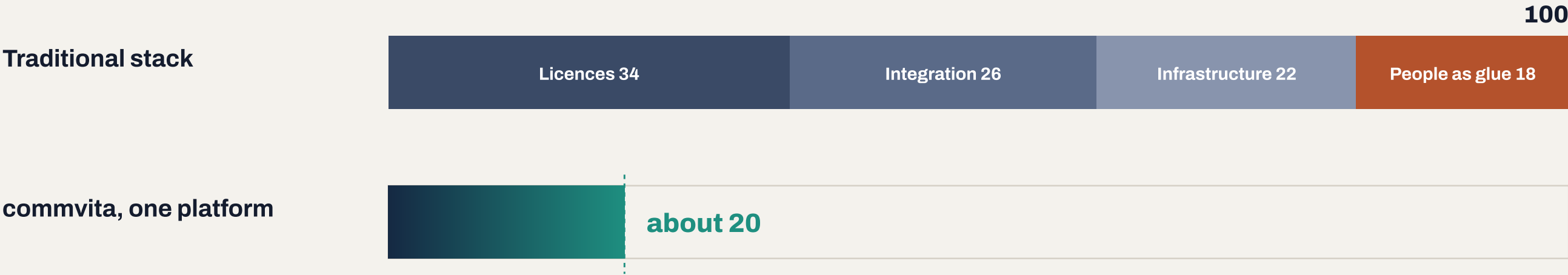
Per head of covered population

The whole clinical platform. Governance included for the same scope, with no double charge

Each step is the same platform with more of it switched on.

The fourth segment is people.

WHAT IT COSTS TO RUN, INDEXED TO 100



The ambition is an 80% reduction in total cost of ownership. Note what the fourth segment is: the stack does not just cost licences and integration, it costs the people paid to stand between the systems.

Illustrative model. Actual reduction depends on the systems replaced and the integration burden removed — a planning target, not a guarantee.

The NHS proves it. The world scales it.

PROVE · UK

Governance revenue

The hardest regulatory bar in the world.
What survives here sells anywhere.

SCALE · GULF

Middle East

Saudi and Oman packs already built. Arabic, ministry structures, national governance. Capital, greenfield estates, procurement in months not years.

DEVELOP · CARIBBEAN, SUB-SAHARAN AFRICA, MIDDLE EAST

The clinical model

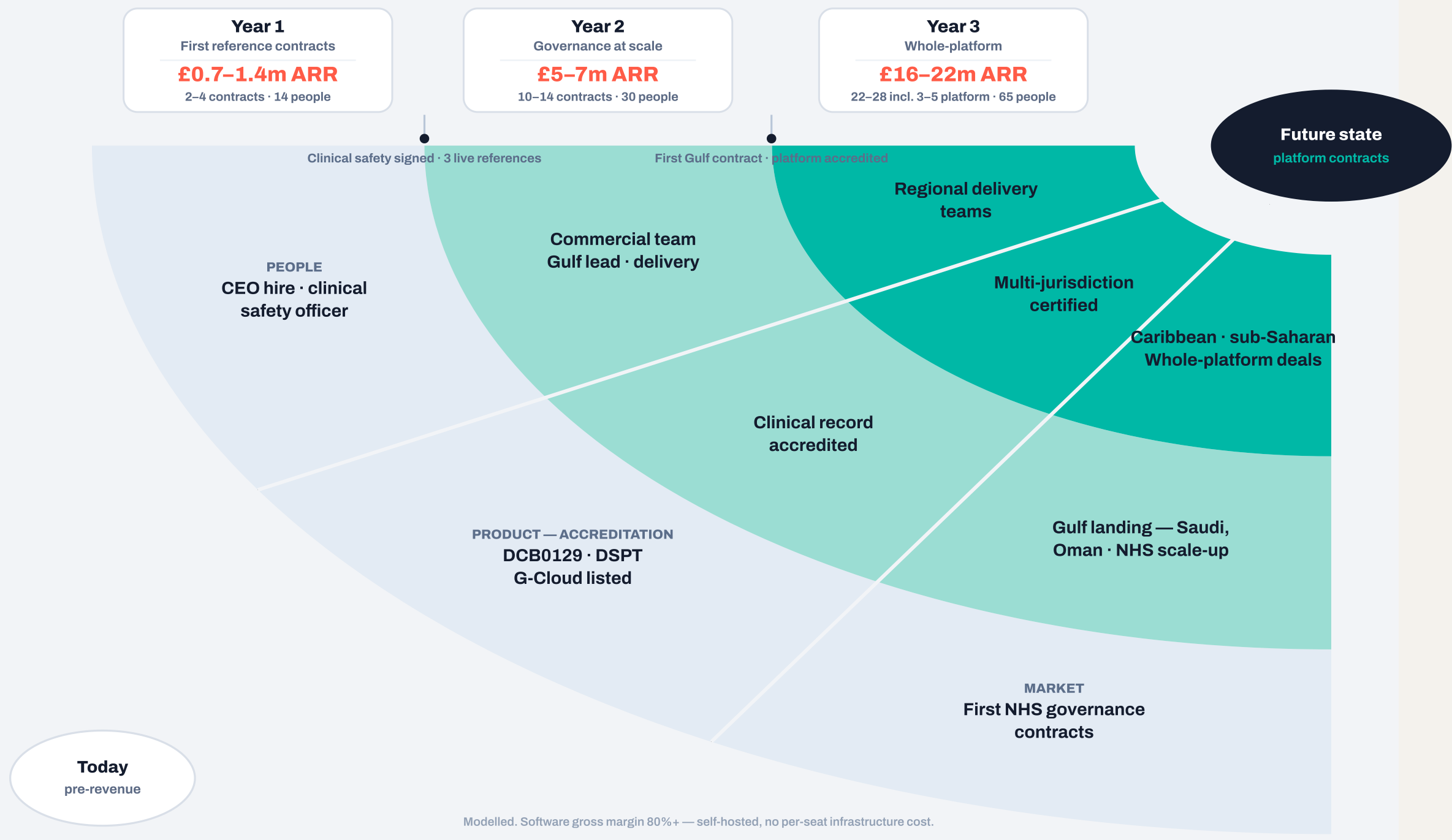
Opportunities where clinical accreditation is less of an issue. Lighter regulatory drag lets us develop and evidence the whole-system clinical model at pace, then bring it back.

No revenue. That is what this round buys.

The product exists. The commercial proof does not, and we are not going to dress it up. Safety assurance, procurement listing and the first paying references are the work in front of us.

Build risk is largely retired. What is left is commercial risk, and it is the cheapest kind to buy down at this stage.

From pre-revenue to platform contracts.



Sold it. Ran it. Measured it.



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.

“No airline, bank or logistics operator would run on data that is weeks old. Health should not have to either.”



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.

“Digital health can do considerably more than it currently does.”



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.

“Flow data and an open record in the same place changes what analytics can answer.”



£2m for 7%.

£2m	7%	18 _{mo}
RAISE	EQUITY	RUNWAY

Three things by the end of it: safety assurance complete, first paying governance contracts, and a Gulf landing.

£26.6m pre-money · info@commvita.com

Product for product, on open standards.

RTT PTL Dashboard	Elective care coordination (Waiting List Management / RTT)
CommVita Flow	Care coordination — patient flow / OPEL
Discharge Hub	Care coordination — care transfer hubs / discharge
Population Health + Open Phenotypes	Population Health Management
NHS Supply Chain	Inventory management / supply chain
A&E Demand Forecasting	UEC demand & capacity forecasting
Winter Pressures Forecast	Winter / UEC pressures
Diagnostics Capacity	Diagnostics capacity & imaging waits
Theatre Productivity	Theatre scheduling & utilisation
PulseGrid — Integration Assurance	Foundry data integration & pipeline monitoring
OMOP Transformation / Clinical Studies	Secondary use / SDE-adjacent analytics
Virtual Ward Hub	Virtual wards / acute-at-home
FDP CDM — Trust Data Console	Canonical Data Model (DAPB4121) — the FDP data layer