O-live

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The Smart Health Ecosystem (S.H.E)

From the governed between-visit interval to ambient health infrastructure — how supervised, auditable execution becomes the foundation health systems are rebuilt on.

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A blueprint for turning the unowned hours of healthcare into governed, accountable infrastructure.

· HOW TO READ THIS DOCUMENT

A vision paper that earns its horizon.

This paper describes three phases. Only the first is for sale today. We say so plainly, because the discipline of separating what runs now from what comes next is itself part of what O-live sells.

DOCUMENT INTEGRITY NOTE

Every figure in this paper is either third-party sourced or explicitly labelled as a management target. Nothing is presented as validated that has not been measured. Forward financials live in the data room, not here.

Contents

01	**Executive summary**	The wedge, the interval, and why governance — not intelligence — is the product.
02	**The case for change**	The sourced economics of a system built to react, not prevent.
03	**The gap is accountability**	As intelligence commoditises, value migrates to supervised execution.
04	**Phase 1 — The governed execution layer**	What clinics rent today: the between-visit interval, made auditable.
05	**Phase 2 — The interval beyond the clinic**	Hospitality and workplace intervals — sequenced behind clinic proof.
06	**Phase 3 — Ambient health infrastructure**	The horizon: homes, districts and cities where governance travels with care.
07	**Governance by design**	Supervision, audit, escalation and data sovereignty across every phase.
08	**Call to action**	The Founding Twelve and the seed round.

Healthcare's largest unowned space is a stretch of time.

A patient sees their clinician for a handful of hours a year. The other **8,755 hours**, they are on their own — and that is where every protocol succeeds or quietly dies. Nobody owns those hours. O-live exists to govern them.

O-live is a **governed execution layer**: infrastructure that preventive and longevity clinics rent to deliver supervised, auditable patient outcomes in the between-visit interval. Practitioner-validated protocols, human-in-the-loop supervision, an escalation path and an audit trail — sold B2B2C to the only buyer whose revenue depends on the result.

What this is not

- Not a consumer health app — clinics bring their cohorts; O-live carries **zero consumer CAC**.
- Not a diagnostics company — diagnostics feed the layer; they are not the layer.
- Not another intelligence platform — the category already builds those, and they are commoditising fast.

What this is

- Accountable execution a clinician can put their name on, in the hours the clinic could never attend.
- Governance as the product: the audit trail, escalation and contestability **are** the offering.
- A three-phase path from clinics, to other supervised intervals, to ambient health infrastructure.

THE POSITIONING LINE

"The category builds the intelligence layer. O-live builds the accountability layer. Clinicians don't need smarter data — they need supervised execution they can put their name on. That is what regulators require, what clinics pay for, and what a data-aggregation model cannot retrofit."

The phases are strictly sequenced. **Phase 1** — the governed execution layer for clinics — is the only active commercial motion. **Phase 2** extends the same governed-interval model to hospitality and workplace settings once clinic product-market fit is proven. **Phase 3** is the full Smart Health Ecosystem this paper takes its name from: health as governed infrastructure in homes, districts and cities. One motion, proven, before any second front.

Spending more than ever. Achieving less than ever.

The global chronic-disease model is mathematically unsustainable. We treat decades-long, lifestyle-driven conditions with a system built for acute problems — and the demand curve is accelerating faster than any budget.

90%
PREVENTABLE
Most chronic disease is driven by lifestyle, not fate.
WHO

<5%
SPENT ON PREVENTION
In most developed markets — the least funded, biggest lever.
OECD

$47T
PROJECTED BURDEN
Global chronic-disease cost trajectory by 2030.
WHO / WEF

1.6B
AGED 65+ BY 2050
The demand curve for healthspan is accelerating.
UN, 2024

£150B
UK ANNUAL COST
Ill health among working-age adults, to the UK economy.
TIMES HEALTH COMMISSION

$6.8T
WELLNESS ECONOMY
Yet people keep getting sicker, younger.
GWI, 2025

A system built to react, not prevent

Data is episodic	Collected at check-ups or after symptoms emerge — too late to change the trajectory.
Care is fragmented	Wearables, labs, clinics and coaches operate in silos that never speak to one another.
Nobody is accountable	Between appointments, no one supervises whether the plan is actually happening — and no record exists either way.

The lifespan–healthspan gap is widening: across Europe the average person now spends twenty or more years of a longer life in poor health. Private-pay preventive and longevity clinics have emerged precisely to close that gap — and they are the first buyers in healthcare whose commercial survival depends on what happens **between** visits, not during them.

The gap is not intelligence. It is accountability.

People already have wearables, labs and diagnostics — and large models can already turn a wall of biomarkers into a plausible plan. Interpretation is commoditising. What has not commoditised, and cannot, is **accountability for what happens next**.

Where the value migrates

A wave of well-funded platforms is racing up the intelligence curve — aggregating hundreds of data sources into coaching layers sold as APIs and white-label apps. Their growth is not a threat to O-live's category; it activates it. As insight becomes cheap and abundant, the scarce thing becomes supervised execution: who checked, who escalated, who signed, and what record proves it. That work is human-in-the-loop, regionally regulated and deliberately lower-margin — structurally unattractive to venture-scale data platforms regardless of capability. The moat is **motivation, not permission**.

THE INTELLIGENCE CATEGORY

- Aggregates data into coaching layers
- Sells APIs and white-label apps to product teams
- Compliance bolted on as a feature
- Carries consumer-acquisition burn
- Optimises engagement metrics

O-LIVE — THE ACCOUNTABILITY LAYER

- Delivers supervised outcomes between visits
- Sells B2B2C to clinics with aligned incentives
- Governance and audit trail ARE the product
- Zero consumer CAC — clinics bring cohorts
- Optimises adherence, retention, provable results

Why incumbents don't enter

Remote-monitoring incumbents are structured around reimbursement codes; the private-pay preventive interval sits outside their economic logic. Consumer platforms need scale economics that human supervision dilutes. The between-visit interval in private-pay preventive care is therefore genuinely unoccupied — not because it is invisible, but because it is only economically rational for a business designed for it from the start.

> The pattern in the category's graveyard confirms it: well-funded ventures with real technology failed by selling to consumers what should have been sold as governed outcomes to institutions — the buyer never felt the pain. O-live's buyer does: clinic revenue depends on adherence, retention and provable outcomes, which is exactly what the layer measures.

PHASE 1 · ACTIVE

The governed execution layer clinics rent.

O-live sells to owner-operated, physician-led preventive and longevity clinics — practices with existing patient cohorts, no IT department, and revenue that lives or dies on retention and provable outcomes. One clinic signed inherits hundreds of patients. The layer runs as a closed loop, with supervision and record-keeping built into every step:

1 · **Capture**	Wearable, lab and behavioural signals unified — anchored by an exclusive API integration with a CQC-regulated diagnostic laboratory network.
2 · **Validate**	Protocols are practitioner-validated before anything reaches a patient. The clinician signs; the system records the sign-off.
3 · **Execute**	Supervised delivery through the between-visit interval — nudges, check-ins and course corrections under human oversight, not autopilot.
4 · **Escalate**	Defined thresholds route drift and risk back to the practitioner. Escalation is a designed path, not a hope.
5 · **Prove**	Every action is auditable. The clinic gets a defensible record of outcomes — the asset that drives retention, referrals and regulatory confidence.

The six dimensions of clinic operations

O-live assesses and builds against six dimensions of how a clinic actually runs: **Data In** (what enters the practice), **Data Home** (where it lives), **Protocol Engine** (how plans are generated and validated), **The 8,755** (what happens between visits), **Proof & Retention** (what outcomes can be evidenced), and **Governance** (who is accountable, and how it is recorded).

PROOF ALREADY IN PLACE

1M+ health assessments delivered through an established screening partner under NDA — supervised, longitudinal preventive data at scale, with zero paid acquisition. Exclusive biomarker integration with a CQC-regulated laboratory network: 160+ tests and 10,000+ practitioners historically served across the UK and EU.

Diagnosis before prescription. Assessment before adoption.

O-live does not open with a software demo. It opens the way a clinician would: assess first, then treat. Clinics enter through an assessment-first pathway, and founding terms recognise the work done together on the way in.

1 · **Clinic Operations Index**	A free scorecard across the six dimensions — a clinic sees, in minutes, where its between-visit interval leaks revenue and risk.
2 · **Structured engagement**	A paid, scoped engagement built on the clinic's own operations — a full diagnostic of data flows, protocol validation and governance gaps, proving movement on a named metric before any platform commitment is asked for.
3 · **Founding Twelve licence**	Twelve founding clinics convert to the platform licence on founding terms — shaping the product their own operations validated.

Why this sequence

The sequence does three jobs at once. It ensures nothing is encoded on assumption — workflows are proven in live, paid delivery before they become product, so what a clinic adopts has already worked in a practice like theirs. It qualifies rigorously in both directions: the Founding Twelve are selected through work done together, not through a demo. And it means the platform is shaped by validated clinical operations rather than a product team's guesses. Concierge-deliver, then encode.

> Clinical standards on the instruments are reviewed under O-live's clinical lead, so what a clinic receives is a defensible assessment — not marketing dressed as one.

THE BUYER'S ECONOMICS

A preventive clinic's revenue is retention revenue. Every patient who drifts in the 8,755 hours is churn the clinic paid to acquire and failed to keep. O-live is priced against that loss — infrastructure rented to keep the promise the clinic made in the consultation room.

PHASE 2 · OPENS AFTER CLINIC PROOF

The same interval exists beyond the clinic.

The between-visit interval is not unique to medicine. Any institution that promises an outcome it cannot supervise after the guest, member or employee walks out the door faces the same structural gap — and the same governance answer applies.

Hospitality — the weeks between stays

Longevity retreats and wellness-led hotels sell transformation measured in days, then lose the guest for the fifty weeks that determine whether it held. A governed aftercare interval — supervised, auditable, clinically reviewed — converts a stay into a continuing relationship and a repeat booking. This motion opens only once the clinic model is proven, because outcomes must travel with their governance conditions or they degrade.

Workplace — the hours between interventions

Employers fund health screenings, wellbeing programmes and executive health assessments, then receive no governed follow-through and no defensible record of outcomes. The same layer — validated protocols, supervised execution, audit trail — turns wellbeing spend from a perk into an accountable programme. As with hospitality, this front is deliberately held.

THE SEQUENCING PRINCIPLE

Results replicate only when the conditions travel with them. A method that holds only where no one is checking is a posture, not a method. O-live opens a second front only when the first can prove its outcomes clinic-to-clinic — one motion, proven, before any expansion.

International expansion follows the same rule. Regulatory tailwinds — including the emergence of dedicated longevity-governance frameworks in markets such as Dubai — validate the category thesis and strengthen the investment narrative. They become active market fronts only after UK clinic product-market fit, not before.

PHASE 3 · DIRECTION OF TRAVEL, NOT A ROADMAP

Ambient health infrastructure — governance that disappears into life.

Follow the logic of the governed interval far enough and it stops being a product category and becomes infrastructure. If supervised execution works between clinic visits, it can work between everything — in the home, the neighbourhood, the city.

This is the Smart Health Ecosystem in full — S.H.E: environments where prevention is the default because the accountability layer is already present. Homes whose ambient signals feed a supervised care record rather than an app graveyard. Districts where population-level risk is modelled and acted on under clinical governance rather than surveillance. Cities that treat healthspan as a utility layer alongside energy and mobility — not by collecting more data, but by making someone accountable for what the data demands.

Why governance-first is the only road there

Trust compounds	Ambient health at civic scale is only politically and ethically viable if supervision, contestability and data sovereignty are native — the properties O-live builds from day one, at clinic scale, where they can be proven.
The record travels	The longitudinal, practitioner-signed record built in Phase 1 is the asset that makes ambient care safe: every intervention traceable to a validated protocol and an accountable human.
Intelligence is assumed	By this horizon, insight is a commodity everywhere. What differentiates a health-first environment is not what it knows — it is what it is accountable for.

STATED PLAINLY

Phase 3 is a thesis, not a commitment. No timelines, revenue projections or deployment claims are attached to it. It exists in this paper for one reason: to show investors and partners that the wedge being built today is the foundation of something categorically larger — and that the discipline of proving each phase before opening the next is how it stays credible.

The fuller articulation of this horizon lives in the founder's narrative work on predictive prevention — a framework asset that gives O-live a category story competitors cannot copy, without a single unverifiable claim on the balance sheet of this paper.

07 · GOVERNANCE BY DESIGN

The principles that travel across every phase.

These are not compliance features bolted on to satisfy a checklist. They are the product — the reason a clinician can put their name on the between-visit interval, and the reason the model can eventually scale to settings where trust is everything.

Human-in-the-loop supervision	No protocol reaches a patient without practitioner validation. Execution runs under oversight with defined escalation thresholds — the system assists the clinician; it never replaces the signature.
Audit trail as asset	Every recommendation, action and escalation is recorded and attributable. The record is the clinic's defensible proof of outcomes — and the substrate regulators, insurers and future phases build on.
Contestability	Patients and practitioners can see why a recommendation was made and challenge it. Decisions that cannot be explained cannot be governed.
Data sovereignty	Individuals own their data. Permissioning is dynamic, traceable and revocable — who sees what, when, and for how long. No third-party resale, no ad-based monetisation, ever.
Regulatory alignment	Designed for GDPR and UK clinical-governance expectations from first principles, drawing on founder experience operating a CQC-regulated diagnostics business. Compliance posture is confirmed with qualified professionals as the platform develops.
Encryption from capture	Signals are encrypted from the point of capture through storage and use. Security is architecture, not policy.

WHY THIS IS THE MOAT

Supervised, auditable, regulation-aligned execution is what is permitted to operate where pure AI apps cannot — and it is precisely the low-margin, human-supervised, regionally regulated work that venture-scale data platforms have no motivation to do. Governance is simultaneously the product, the permission and the defence.

Two ways to build this now. Two ways to follow it.

FOR CLINICS — THE FOUNDING TWELVE

Twelve founding clinics will shape the governed execution layer around their own operations. Entry begins with the free Clinic Operations Index, and founding terms recognise the work done together on the way in. Owner-operated, physician-led preventive and longevity practices — this was designed for you.

FOR INVESTORS — THE SEED ROUND

O-live is raising a £2M seed round (S/EIS eligible) to prove product-market fit in the UK clinic market — funding the build, the Founding Twelve conversion, and the runway discipline that keeps the company alive through the proof-to-capital gap that has killed better-funded peers. Detailed financials and the data room are available under NDA.

Phase 2 & 3 partners

Hospitality groups, employers, developers and public bodies aligned with the governed-interval thesis are invited to register interest now. These conversations open in sequence — after clinic proof, not before. That discipline is why the thesis will still be credible when we call.

How to engage

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> This isn't about being early to a trend. It is about being the accountable layer everything else will need — built in the only order that keeps it true.

GLOSSARY & SOURCES

Key terms.

Smart Health Ecosystem (S.H.E)	The full three-phase architecture this paper describes: governed execution in clinics (Phase 1), extended to other supervised intervals (Phase 2), maturing into ambient, accountable health infrastructure (Phase 3).
Governed execution layer	Infrastructure a clinic rents to deliver supervised, auditable patient outcomes in the between-visit interval — the accountability layer, as distinct from the intelligence layer.
The between-visit interval	The 8,755 hours a year a patient spends outside clinical supervision — healthcare's largest unowned space.
Governance as product	The audit trail, escalation path, practitioner validation and contestability sold as the offering itself, not bolted on as compliance.
Human-in-the-loop	Execution that runs under clinician oversight, with sign-off recorded and escalation thresholds defined by design.
Concierge-deliver, then encode	O-live's build discipline: workflows are proven in live client delivery before they are encoded into software.
The Founding Twelve	The twelve founding clinics whose operations shape the platform, entering through an assessment-first engagement on founding terms.
Healthspan	Years lived in good health, free from chronic disease — the gap between healthspan and lifespan is the category's demand driver.
Data sovereignty	The principle that individuals fully own and control access to their health data — dynamic, traceable, revocable permissioning.
Ambient health (Phase 3)	The horizon state in which supervised, governed care is embedded in homes, districts and cities — accountability, not surveillance.

Sources

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United Nations (2024) — global population ageing projections.
Global Wellness Institute (2025) — Wellness Economy Monitor.
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NHS England (2022) — chronic conditions and healthcare spending.
Internal O-live materials (2025–26) — positioning brief, defensibility analysis, operating plan.

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