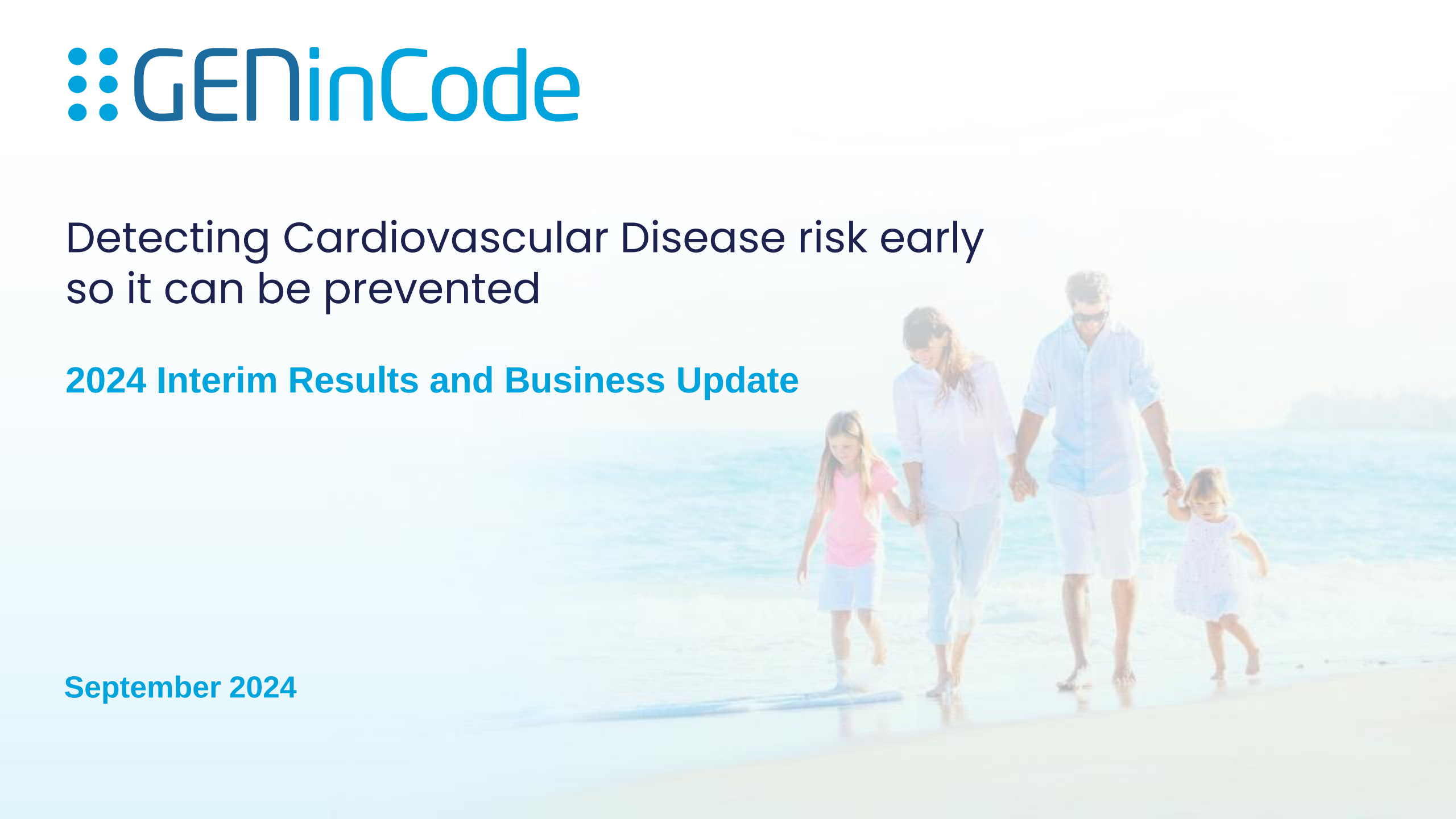
GENinCode

Detecting Cardiovascular Disease risk early so it can be prevented

2024 Interim Results and Business Update



September 2024

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Contents

GENinCode

Introduction

GENinCode

Genetic testing Company specialising in polygenic risk assessment for prevention of cardiovascular disease (CVD) and risk of ovarian ovarian cancer

Revenue generating, scale-up and expansion underway with reducing operating costs. Business transitioning to break-even over the medium-term.

Test products: CE marked, US CLIA and CAP approved. FDA '*De Novo*' filing submitted for CIC-Score with significant progress and feedback supporting approval

Established in 2007 with major investment in technology development

Globally leading evidence base: Published clinical studies on >150,000 patients over 15 years supporting clinical adoption and regulatory pathway

IP-protected tests focused on predictive and preventive care, improving patient outcome and reduced costs of treating CVD for healthcare systems

Multiple test products complementary to CVD for lipid diagnosis and thrombotic risk.

Market

Cardiovascular disease (CVD) **is the leading cause of death worldwide**

Over 17.9M deaths annually from CVD, accounting for c.31% of all deaths globally

Global annual cost of CVD to reach >$1.04Tn by 2030

Unmet need to accelerate genetics in CVD as additive to current standard of care to improve risk assessment and prevent CVD

Global standard of care for assessing CVD requires update to include genetics and enable a step change in predicting the onset, risk assessment and improved treatment of CVD

Financial and Operational Highlights

- H1 revenues increased 46% to £1.39m (30 June 2023: £0.95m) - Growth in UK, EU and US business
- First US commercial sales for **LIPID inCode** for the diagnosis of familial hypercholesterolemia ("FH") and **CARDIO inCode** for the genetic risk of coronary artery disease ("CAD")
- FDA *'De Novo'* completion of substantive review. Ongoing FDA discussions ongoing around 'Additional Information'
- *American Journal of Preventive Cardiology* publication on CARDIO inCode-Score https://www.sciencedirect.com/science/article/pii/S2666667724000291, ESC Preventive Cardiology and ESC Annual Congress presentations
- US commercial programs starting with Atrium, IU Health and UT South Western health institutions
- US Notice of Allowance (granted patent status) for CARDIO inCode
- NHS expansion of LIPID inCode for FH diagnosis and expansion in North of England
- Growth of LIPID inCode in University Clinic Dresden, Germany for primary care diagnosis of FH
- Growth of LIPID inCode and THROMBO inCode in Spain and Italy for diagnosis of FH
- CARDIO inCode pilot progressing in Extremadura, Spain
- NICE guideline recommendation for The Risk of Ovarian Cancer Algorithm (ROCA) test
- Successful completion of secondary placing of £3.7m (Gross £4.0m) to support scale up and expansion.
- Reduced Adjusted EBITDA loss of £2.16m (30 June 2023: loss of £3.37m).
    - *Reflecting Increased revenues and reduced operating costs*
- Cash reserves of £2.92m at 30 June 2024 (31 Dec 2023: £2.48m).

Product Portfolio: Cardiovascular Disease (CVD)

		CAP ACCREDITED **CLIA** certified	FDA	CE | UK CA	CE
CARDIO inCode	Assessment of the coronary genetic risk and CVD risk stratification	✓	✓	✓	✓
LIPID inCode	Diagnosis and management of hypercholesterolemia	✓		✓	✓
THROMBO inCode	Diagnosis and management of genetic thrombophilia and thrombosis risk	✓ Q1 2025		✓ Q4 2024	✓
SUDD inCode	Diagnosis of the cause of sudden cardiac death and familial heart disease	✓ 2025		✓ 2025	✓*
ROCA test	Early detection of familial ovarian cancer	✓ Est 2026		✓	✓

*Sudd inCode EU clinical lab services under ISO15189

Process, Reporting and Treatment Pathway

1 Sample Collection

2 Sample Sent to Lab

3 Sample Analysis in Lab

4 View Results Online

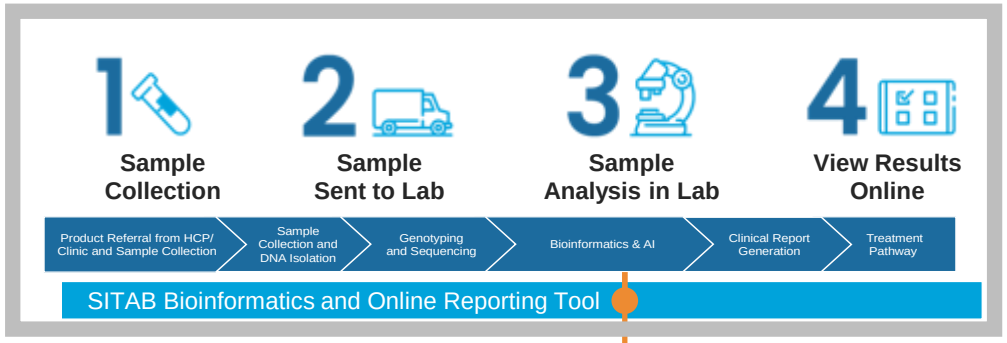
Product Referral from HCP/ Clinic and Sample Collection → Sample Collection and DNA Isolation → Genotyping and Sequencing → Bioinformatics & AI → Clinical Report Generation → Treatment Pathway

SITAB Bioinformatics and Online Reporting System

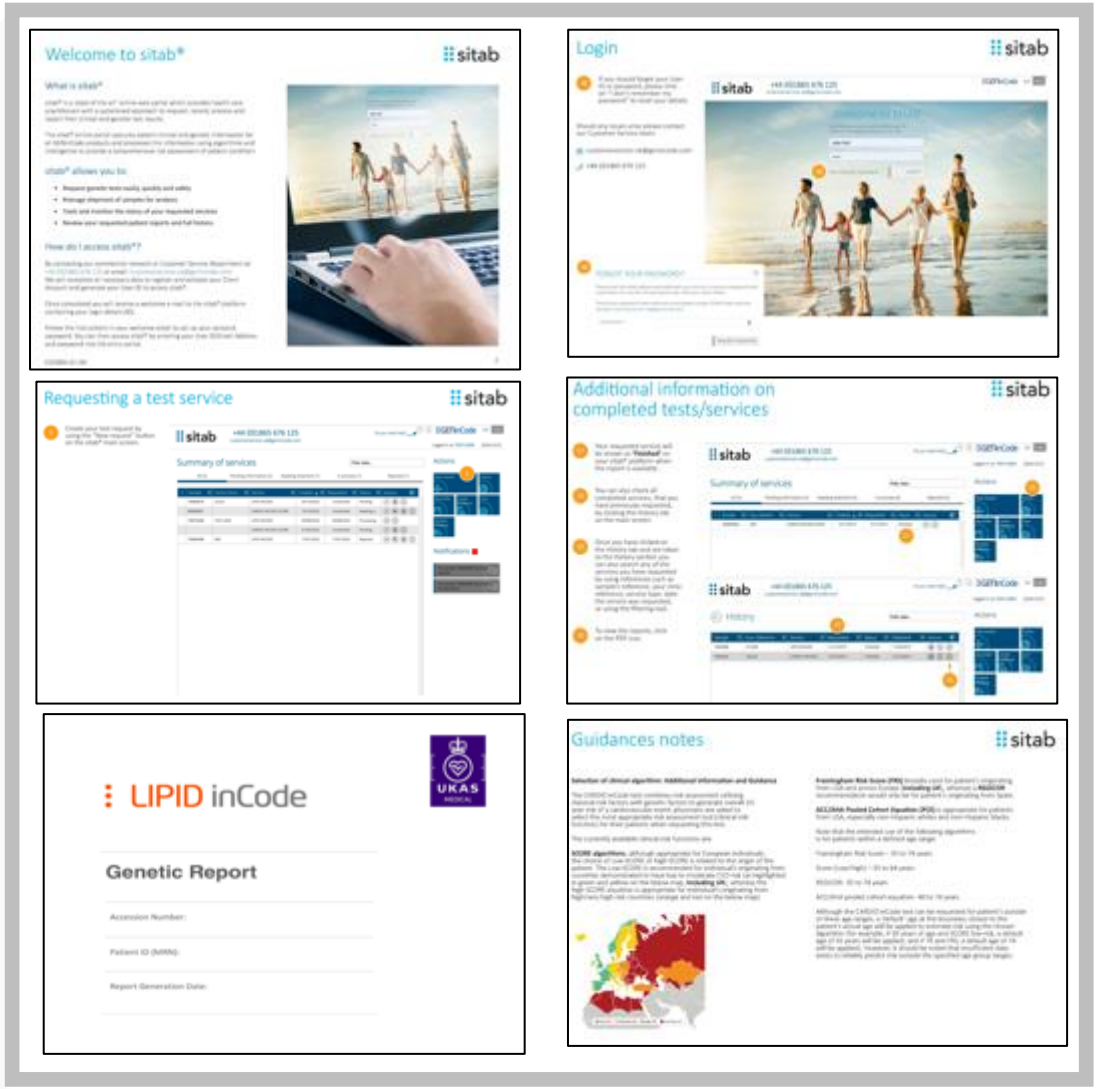
Services & kit product format

SITAB proprietary software and algorithms for analysis and interpretation of data

SITAB Bioinformatics and Online Reporting System

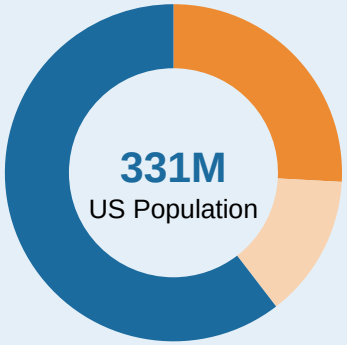


SITAB proprietary software and algorithms for analysis and interpretation of data



Cardiovascular Disease is the Leading Cause of Death Worldwide[1]

In the US

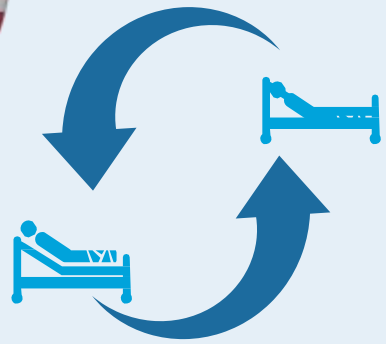


85.6M Americans living with CVD

(Set to rise to 131M over next two decades)[4]

Nearly 1/3rd of all deaths[2]
655,000 deaths/year[3]

805,000 heart attacks a year in the US
605,000 first heart attack
200,000 recurrent attacks



$351Bn

Estimated annual direct and indirect cost of CVD and stroke to US hospitals and lost productivity over **$351Bn** annually in 2014-15. (Set to rise to **$818Bn** by 2030)[5]

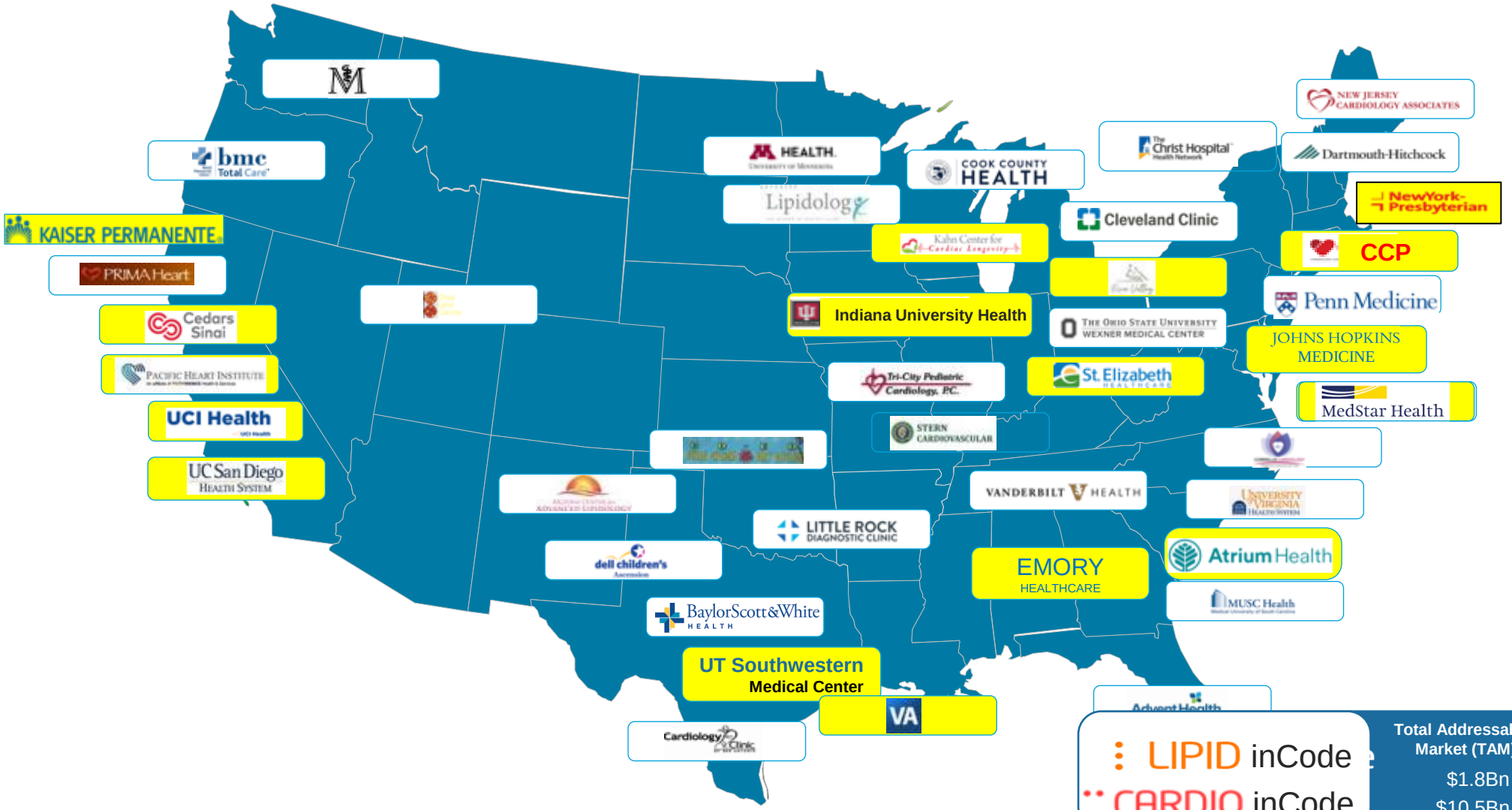
Global cost of CVD[6]

2010 **$863Bn**

2030 **$1.04Tn**

1. WHO – 2021 : CVD leading cause of mortality
2. Circulation: 2022;145:e153–e639. DOI: 10.1161/CIR.0000000000001052
3. www.cdc.gov 2021
4. Science News: Cardiovascular Disease costs will exceed $1 Trillion by 2035: February 14 2017
5. www.acc.org AHA 2019 AHA Heart Disease and Stroke: Stats & www.ahajournals.org Abstract 207:Burden of CVD on Economic Cost. Comparison of outcomes in US and EU
6. World Heart Federation – Champion Advocates Programme - 2021

Targeted Program Sites: ~20 sites onboarding



Targeted Program Sites: ~20 sites onboarding

California

Onboarding/ ordering

Other California onboarding;

- Orange County Memorial
- California Heart
- National Heart Institute
- Cardiac Consultants

	Total Addressable Market (TAM)	Serviceable Available Market (SAM)
LIPID inCode	$1.8Bn	$240m
CARDIO inCode	$10.5Bn	$4.25Bn

US Strategy: CARDIO inCode & LIPID inCode

US Highlights

- Commercial onboarding of targeted Institutions
- Growing demand and profile for LIPID inCode and CARDIO inCode PRS tests
- First US revenue and billed insurance claims

Regulatory:

- CAP and CMS CLIA certification US Inc laboratory in Irvine, California.
- CARDIO inCode-Score FDA '*De Novo*' submission (Nov 2023) substantive review complete. Ongoing discussions

Reimbursement:

- CARDIO inCode CPT PLA coding (0401U) approved by American Medical Association.
- Pricing: CMS in range $500-$760/test
- MolDx submission for reimbursement in preparation.

Commercial:

- KOL focus, education and SITAB portal implementation.
- Commercial Payer Discussions progressing for benefits investigation and 'out of network' payer coverage
- Service based testing started across institutions, community clinics and executive health

Polygenic risk and incident coronary heart disease in a large multiethnic cohort

Carlos Iribarren [a,*], Meng Lu [a], Roberto Elosua [b,c], Martha Gulati [d], Nathan D. Wong [e], Roger S. Blumenthal [f], Steven Nissen [g], Jamal S. Rana [a,h]

- The study evaluated the predictive performance of **CARDIO inCode-Score® (CIC-Score)** in a large multiethnic cohort of more than 63,000 subjects over 14 years for incident coronary heart/artery disease.
- CARDIO inCode-Score was;
  - **Independently** associated with an increased (lifetime) risk of incident CHD.
  - Showed incident CAD was **consistent across sexes and race/ethnic groups**.
  - Provided **additional risk stratification** within categories of the Pooled Cohorts Equations (PCE) risk, particularly in individuals with borderline and intermediate PCE risk.
  - **Identifies individuals at higher risk who would benefit from statin therapy or intensified treatment.**
  - Can be used in **combination with traditional clinical risk factors** to improve the accuracy of risk prediction for CAD.

American Journal of Preventive Cardiology
Volume 18, June 2024, 100661
Online: Mar. 18, 2024

The study underlines the need for 'polygenic risk score' lifetime risk assessment in conjunction with traditional clinical risk assessment to optimize preventive care strategies to lower the future risk of CHD.

Kaiser Permanente Publications - Last 12 months

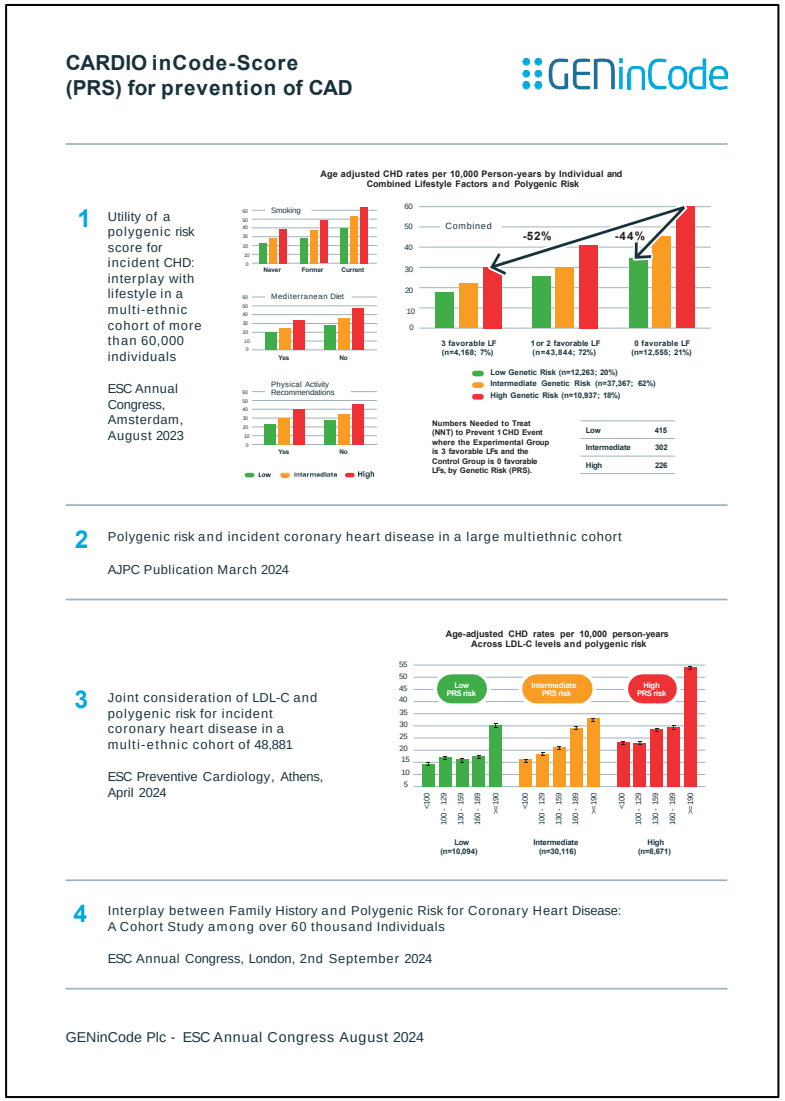
CARDIO inCode-Score

1. *Utility of a polygenic risk score for incident CHD: interplay with lifestyle in a multi-ethnic cohort of more than 60,000 individuals* - ***ESC Annual Congress, Amsterdam, August 2023***

2. *Polygenic risk and incident coronary heart disease in a large multiethnic cohort* - ***AJPC Publication March 2024***

3. Joint consideration of LDL-C and polygenic risk for incident coronary heart disease in a multi-ethnic cohort of 48,881- **ESC Preventive Cardiology, Athens, April 2024**

4. Interplay between Family History and Polygenic Risk for Coronary Heart Disease: A Cohort Study among over 60 thousand Individuals **ESC Annual Congress, London, 2nd September 2024**



CARDIO inCode: AHA statement - Polygenic Risk Scores

Circulation
Volume 146, Issue 8, 23 August 2022; Pages e93-e118
https://doi.org/10.1161/CIR.0000000000001077

AHA SCIENTIFIC STATEMENT

(6–8) With accruing data on the population genetic determinants of CAD, and increased availability of both healthcare-associated and consumer-driven genetic testing - the latter now pursued by over 26 million individuals - a genetic predictor of CAD may serve as another risk-enhancing factor that is both broadly available and quantifiable early in life.(9)

A CAD "polygenic risk score" (PRS) captures the net, inherited susceptibility to CAD conferred by many common genetic variants as a single, quantitative risk factor following a normal distribution. PRS that quantify a genetic predisposition to CAD have been validated in multiple population-based cohorts.(10–12) Notably, ample data suggest that CAD PRS may identify subsets of the population more likely to benefit from lifestyle modifications and from statin therapy.(13–15),(16) More recently, the use of a genome-wide set of common genetic variants improved the prognostic capabilities of CAD PRS, particularly for identifying those with the highest genetic predisposition.(17) In addition, application of a genome-wide PRS to a large, population-based cohort demonstrated the potential discriminative benefit of a genome-wide CAD PRS when added to select clinical risk factors.(18)

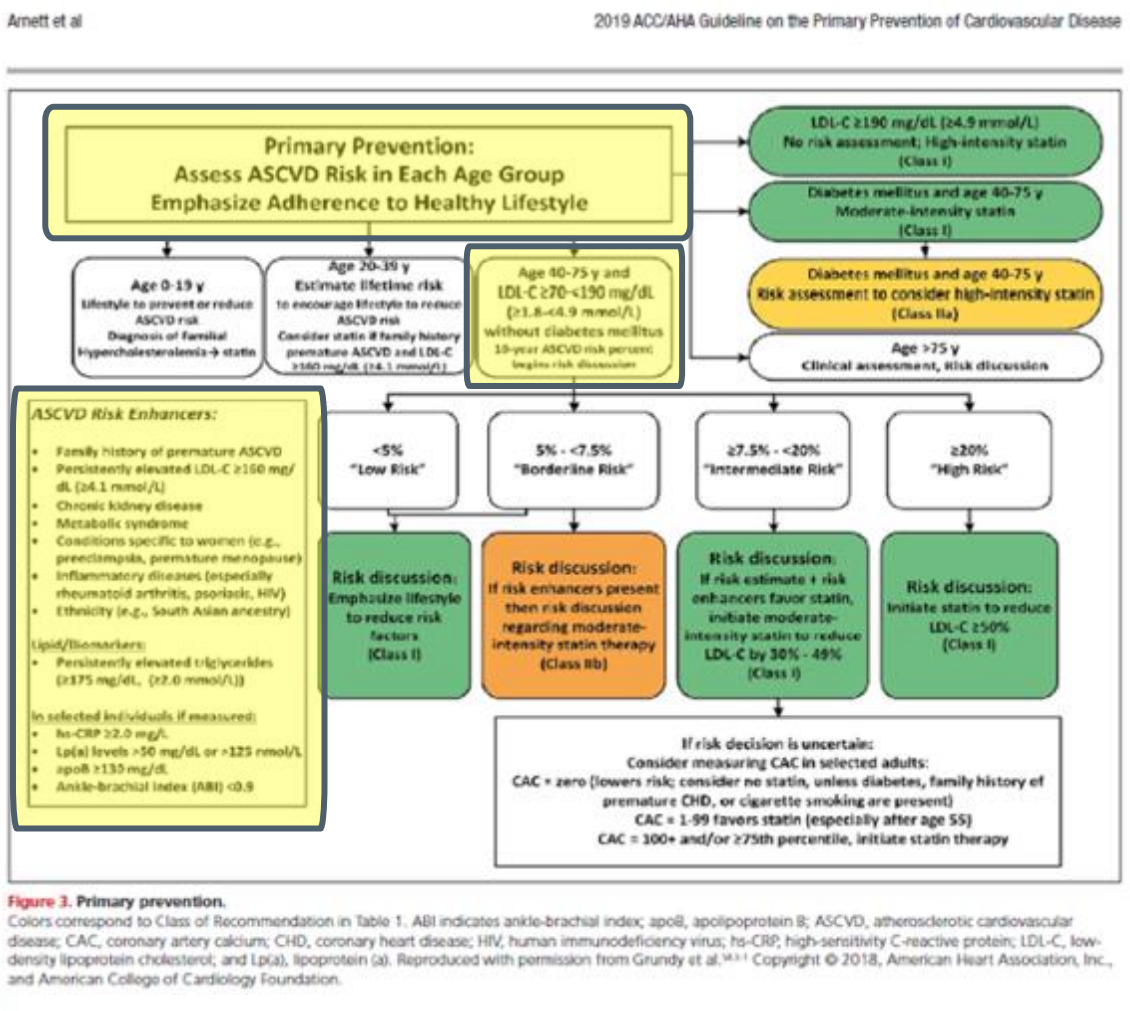
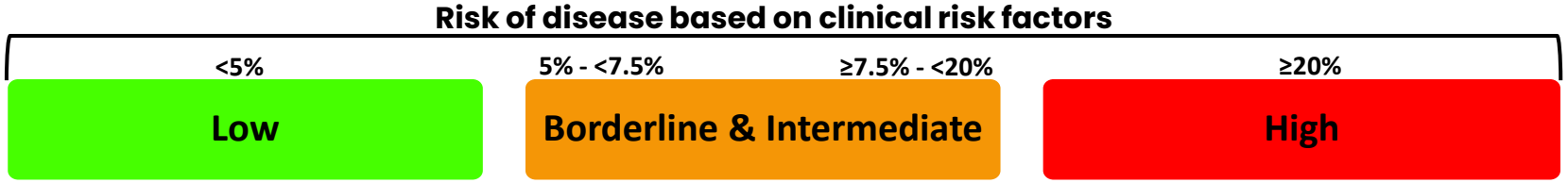


Figure 3. Primary prevention.
Colors correspond to Class of Recommendation in Table 1. ABI indicates ankle-brachial index; apoB, apolipoprotein B; ASCVD, atherosclerotic cardiovascular disease; CAC, coronary artery calcium; CHD, coronary heart disease; HIV, human immunodeficiency virus; hs-CRP, high-sensitivity C-reactive protein; LDL-C, low-density lipoprotein cholesterol; and Lp(a), lipoprotein (a). Reproduced with permission from Grundy et al.[4,5] Copyright © 2018, American Heart Association, Inc., and American College of Cardiology Foundation.

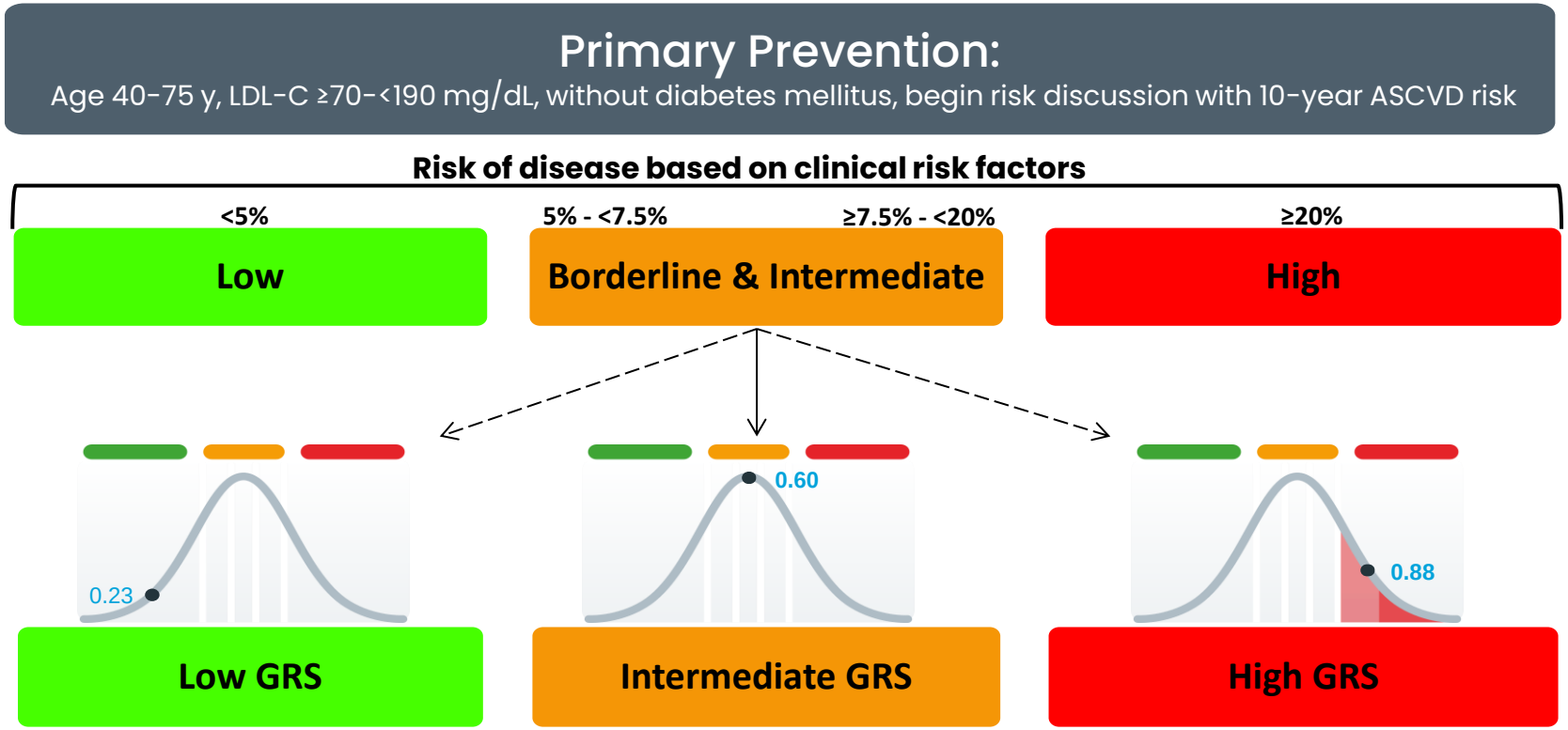
European Society of Cardiology (ESC) statement on Polygenic Risk Scores expected Q1.2025

CARDIO inCode - Polygenic Risk Score: Clinical utility

Primary Prevention:
Age 40-75 y, LDL-C ≥70-<190 mg/dL, without diabetes mellitus, begin risk discussion with 10-year ASCVD risk

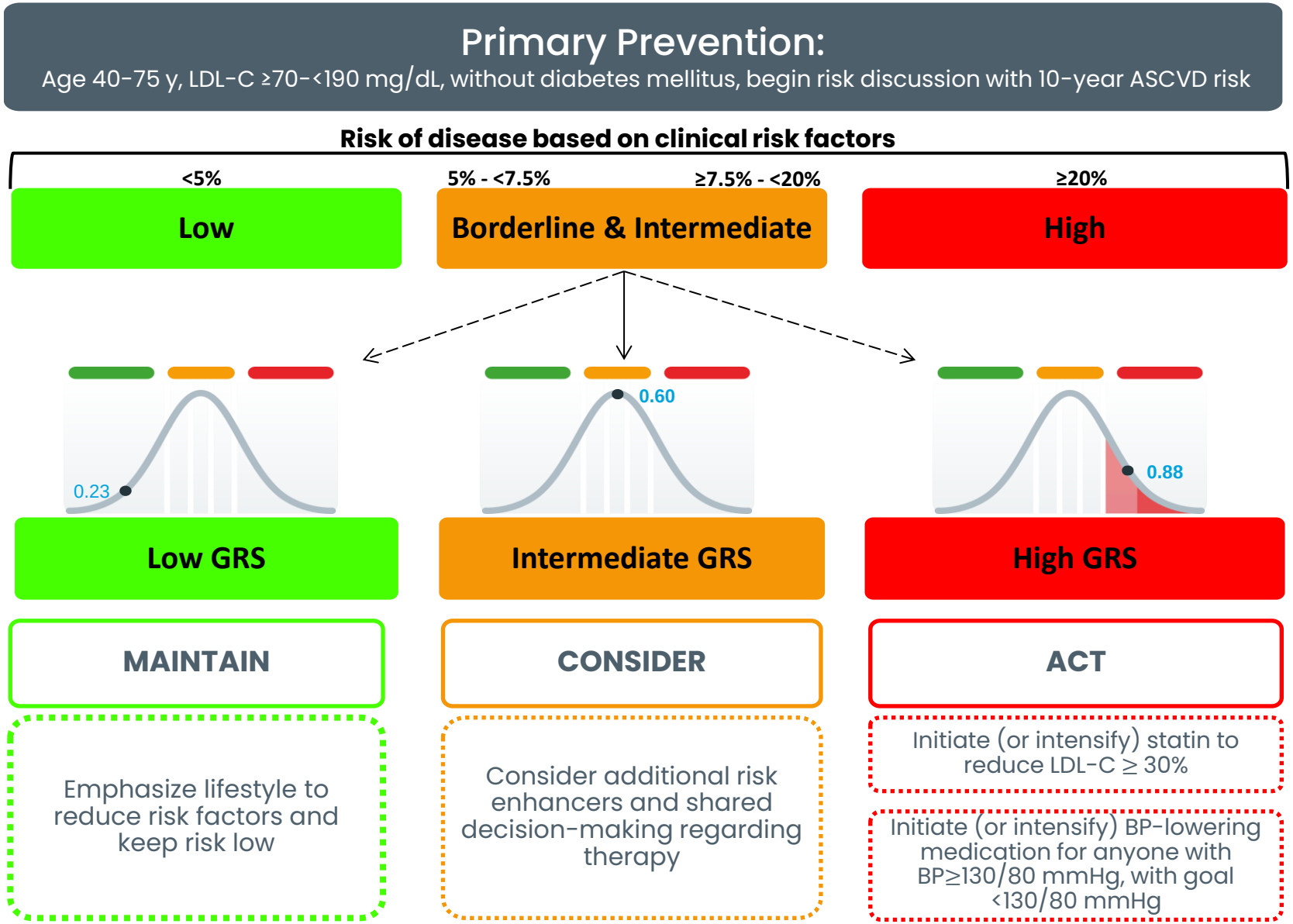


CARDIO inCode - Polygenic Risk Score: Clinical utility



Risk reclassification and stratification based on genetic risk score (GRS)

CARDIO inCode - Polygenic Risk Score: Clinical utility



Risk reclassification and stratification based on genetic risk score (GRS)

CARDIO inCode: US Market Assessment

Initial CARDIO inCode Target Market: **21M**
Receptive Physicians **~8.5M**, if covered by insurance

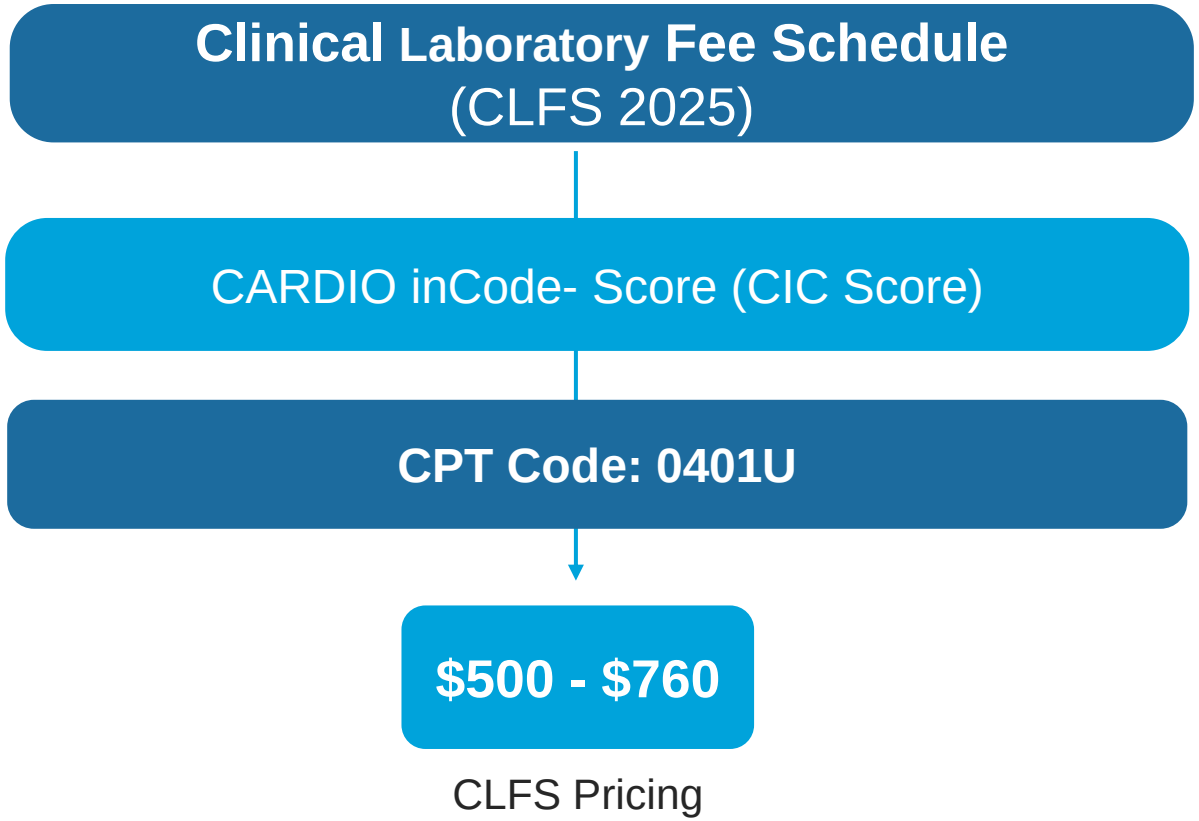
About half of physicians[3] would order **CARDIO inCode**, if covered by insurance, for two types of patients: intermediate risk who are not compliant or controlled, and low risk patients with family history. Prior authorisation, expected by payers, reduces the number of physicians who would order. Assumes physicians expect to order the test once per patient, i.e., no recalculation of risk scores.

(Approx 86M Americans living with CVD)

Target Patients for Cardio inCode (*based on physicians interviewed*)	**Patients in Target Segment**	**No. Likely to get Prescription**
Intermediate Risk[1] **Patients inadequately controlling risk** e.g., not taking statins or making lifestyle changes (estimated 33% of intermediate-risk patients)[3]	9M	4.4M
Low Risk[1] **Patients with family history** (estimated 13% of low-risk patients)[2]	12M	4.1M
Total	21M	8.5M

1. Goff, David C Jr et al. “2013 ACC/AHA guideline on the assessment of cardiovascular risk: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines.” Circulation. 2014
2. Moonesinghe, Ramal et al. “Prevalence and Cardiovascular Health Impact of Family History of Premature Heart Disease in the United States/ 2007-2014.” JAHA. 2019
3. EVERSANA interviews with 45 potential prescribers of CiC. January 2021. Sample size may not be representative of market opportunity

CARDIO inCode: Reimbursement Rates - CMS

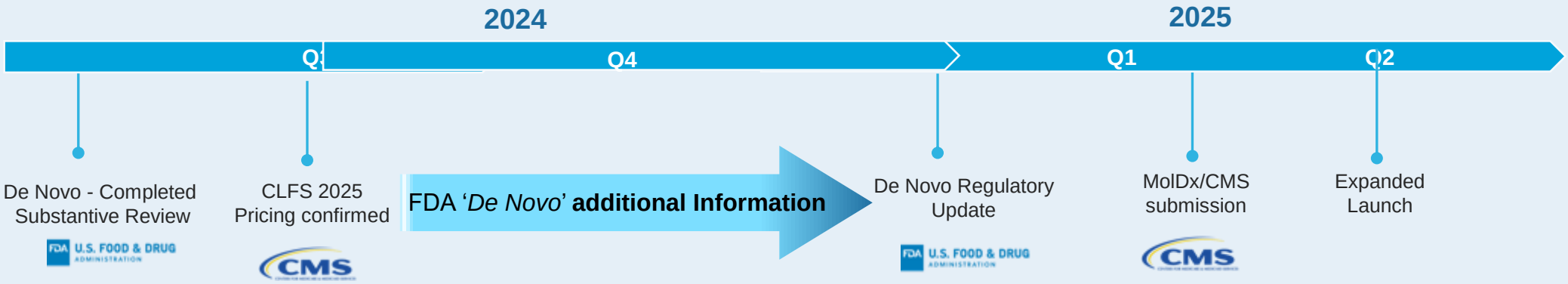


Key Coding/Reimbursement Activities

- CARDIO inCode-Score **CPT PLA coding (0401U) approved** by the **American Medical Association**
- Discussions ongoing with **CMS** (Centers for Medicare and Medicaid Services and MolDx**)** for final coverage pricing
- **Clinical utility studies underway** to support payer tech assessments and improve dossiers
- Private payer engagements ongoing

CARDIO inCode: US Regulatory and Reimbursement Summary

Indicative US Regulatory Timeline



CLFS Pricing (LDT)	**$500 - $760**
- Self Pay/OOP	**$400**
Regulatory	
- FDA Approval	**Estimated Q4.24**
- LDT	**CLIA/CAP approved**
Evidence base	**Clinically leading evidence base**
Guidelines	**Policy statement AHA. ESC statement expected Q1.25**

LIPID inCode: US Launch

Familial Hypercholesterolemia (FH) is a global autosomal (inherited) genetic disorder of lipid metabolism causing raised blood cholesterol, the early onset of cardiovascular disease and premature mortality (mainly from heart attacks). FH responds well to drug treatment so early diagnosis is vital.

FH testing represents a **$1.8Bn** market opportunity in the US

Value Proposition

Monogenic + Polygenic FH Test

- **FH testing now defined as 'Tier 1' genomic test** by Centers for Disease Control and Prevention **(CDC)**
- **LIPID inCode is the first commercially available Monogenic + polygenic FH test** offered on the market
- **Scientific expert panels support the inclusion of polygenic risk** for patients that are negative for monogenic FH

HCP Adoption

Engagement with Key Influencers

- **Targeted engagement plan focused** on engaging top **250 physicians** in lipidology and preventative cardiology
- Supporting key programs and conferences with **FH foundation, National Lipid Association** (NLA), and the **American Society of Preventative Cardiology** (ASPC)

Access and Distribution

Favorable Reimbursement Environment

- **Established ICD-10 and CPT Codes for FH Testing** should enable rapid adoption of testing with targeted payers
- **Favorable reimbursement policies** in place for FH testing with **IDNs, regional, and national payers**

LIPID inCode: US Market Assessment

The US target market for **LIPID inCode** includes **1.6M** patients with diagnosed FH and undiagnosed probable FH

Physicians see **LIPID inCode** as a targeted test for patients with suspected, probable, or confirmed familial hypercholesterolemia

Target Patients for LIPID inCode	Patients in Target Segment
Clinically diagnosed FH: Estimated 200K-400K Patients ICD-10 code for Familial Hypercholesterolemia (FH) These patients have not been tested for FH genetic variants	0.4M[1]
Undiagnosed Probable FH Predictive modeling based on clinical features in US population	1.2M[2]
Total	1.6M

1. Eversana RWD, Familial hypercholesterolemia patient cohort. Sept 2022 (SAM) + FH Foundation
2. Kullo et al, Familial Hypercholesterolemia: A reportable disorder. Circulation 2020

LIPID inCode: Family Heart Foundation - DISCOVER FH program

- Collaboration with FH Foundation to use LIPID inCode for testing in US Primary Care settings for the diagnosis of familial hypercholesterolemia (“FH”)
- First phase funded by a grant from the US DOD, the DISCOVER FH collaboration relates to “Research to improve early diagnosis of familial hypercholesterolemia (FH) and the implementation of diagnostic tools, including paediatric population.”
- LIPID inCode also provides physicians with polygenic hypercholesterolemia (high levels of cholesterol) and coronary heart disease risk (CARDIO inCode).
- Partnership includes: **UT Southwestern Medical Center, University of Pennsylvania, Geisinger, West Virginia University, Mayo Clinic and Veterans Asscoiation**
- Less than 30% of people with FH in the US have been identified, despite the efforts of the Centers for Disease Control and Prevention (CDC) to prioritize FH for early detection, cascade screening and proactive treatment with cholesterol-lowering drugs

FAMILY HEART FOUNDATION

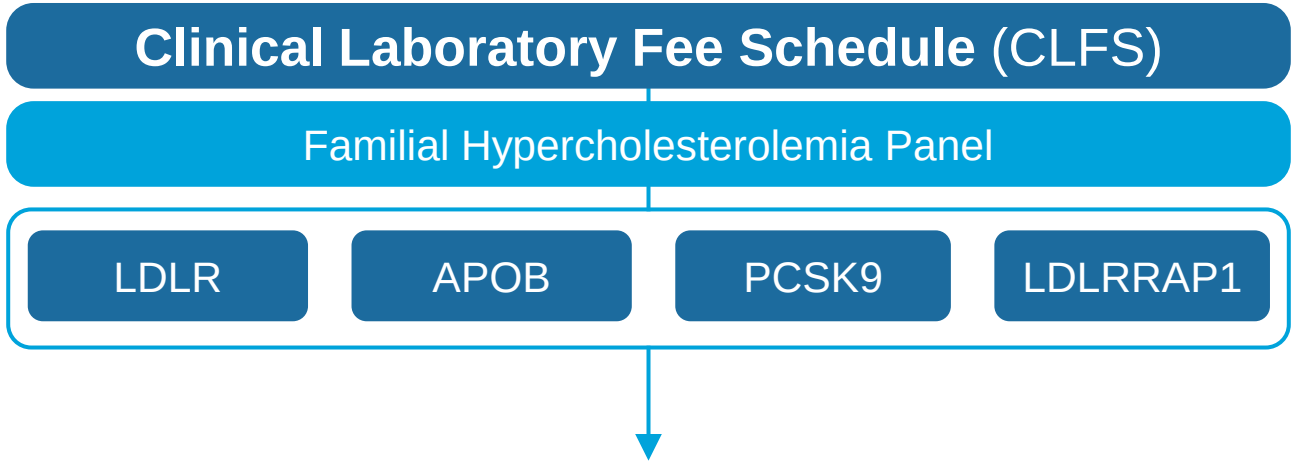
More families. More hearts.

LIPID inCode: Reimbursement Rates

Favourable coverage and reimbursement rates in place for FH testing from most National/Regional commercial payers

Key Reimbursement Activities

- Established Lipid inCode **billing policy and patient assistance programs (PAP)**
- **Identified key targets** and defined the engagement strategy for **IDNs, national, and regional payers**
- Completing infrastructure build to **support RCM implementation and commenced payor claims**
- **Credentialing activities** underway with **targeted payers**
- **Out of network contracting** started in **Q1 2024**
- **Billable testing started in Q2 2024**



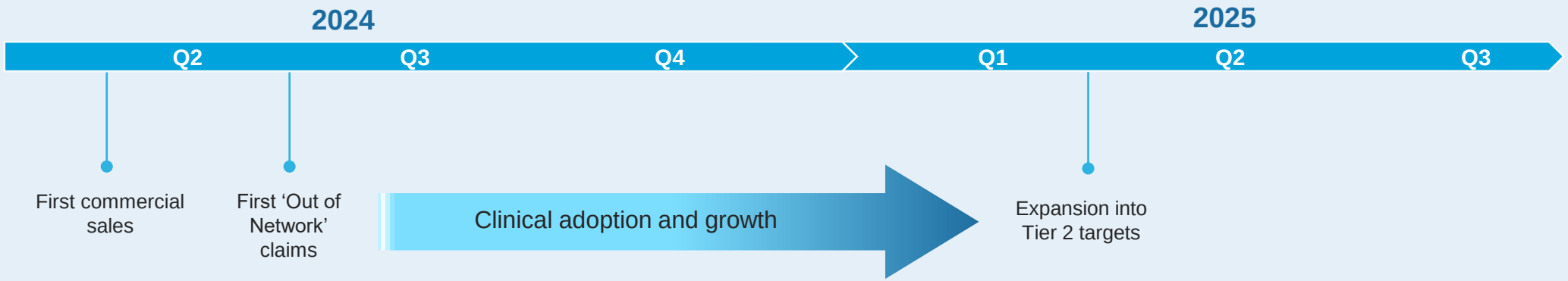
$1,198[2]

Average Reimbursement*

*Average reimbursement for all private payers combined
1. Copy of Clinical Laboratory Fee Schedule, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched
2. Senergene RWD FH testing reimbursement trends, Average reimbursement for targeted private payers tied to CPT codes 81401, 81405, 81406, 81407

LIPID inCode: US CLIA Lab Diagnostic Test

Indicative Regulatory Timeline



Reimbursement/Insurance	**~$1200**
Self Pay/OOP	**~$450**
Regulatory - LDT	**CLIA/CAP approved**
Evidence base	**Clinically leading evidence base**
Guidelines	**CDC 'Tier 1' public health & AHA/ACC guidelines**

UK Strategy: Cardiovascular Disease Prevention

Management of cholesterol and CVD genetic risk

Familial Hypercholesterolemia (FH) is a global autosomal (inherited) genetic disorder of lipid metabolism causing raised blood cholesterol, the early onset of cardiovascular disease and premature mortality (mainly from heart attacks). FH responds well to drug treatment so early diagnosis is vital.

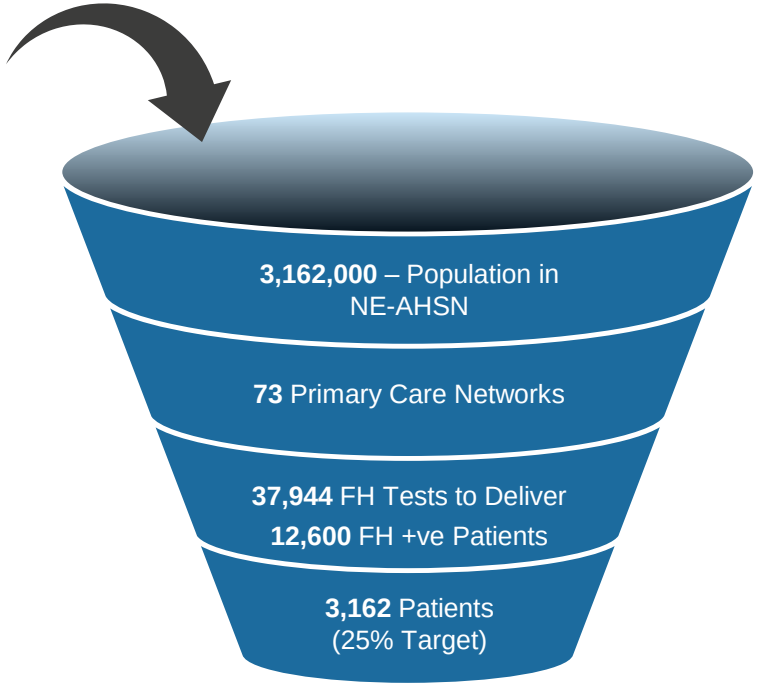
- Collaboration with NHS for GENinCode to deliver FH to support '**2019 NHS Long Term Plan**' to increase the detection of people with FH
- **Completed and published** successful NHS FH comparative study in January 2022
- **Successfully completed FH test pilot with NE-AHSN** (Centre of Excellence for familial hypercholesterolemia & NHS FH strategy)
- **2023 - Agreed NHS implementation plan** and initial funding with NE-AHSN for introduction of LIPID inCode
- Advancing other NHS England trusts for implementation of LIPID inCode

NHS **Case Study**

- FH estimated to affect 1 in 250 of the UK population i.e., between 230k-260k people
- Roughly 7% of this population have been genetically diagnosed in England
- UK NHS target is to detect 25% of FH population by 2024

NHS: AHSN's – Introduction of LIPID inCode testing

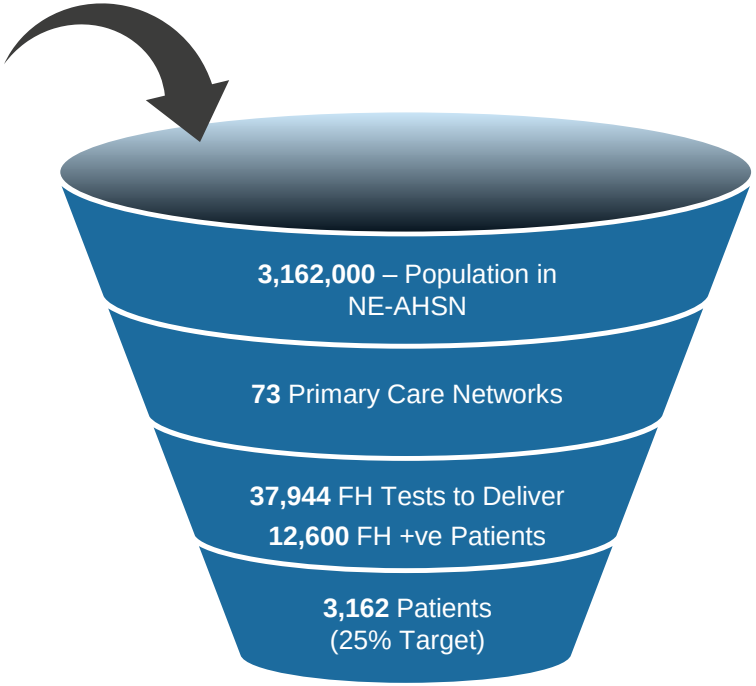
NHS Long-Term Plan to improve FH diagnosis rates to at least **25%** of FH patients by **2024**



- Phased implementation of LIPID inCode now started to help achieve NHS targets

NHS: AHSN's – Expansion of LIPID inCode testing

NHS Long-Term Plan to improve FH diagnosis rates to at least **25%** of FH patients by **2024**



- Phased implementation of LIPID inCode now started to help achieve NHS targets
- Pharma collaborative discussions targeting patients most in need of lipid lowering medications
- Focus on PCSK9 inhibitors and new therapies

EU Strategy

- Spanish year-on-year revenue growth of 21% driven by THROMBO inCode and LIPID inCode
- LIPID inCode growth supported by Spanish regions ‘FH’ detection plan
- Regional roll-out of CARDIO inCode for Cardiovascular Prevention in Primary Care
  - Extremadura region – CARDIO inCode pilot in Primary Care expected results late 2024
  - Catalunya regional pilot planned. Andalucia. Basque and Madrid negotiations ongoing.
- Growth via strategic alliance for CARDIO inCode, THROMBO inCode and LIPID inCode
  - **Synlab** – Collaboration in IVF Clinics but also building alliances in some LATAM countries
  - **Longwood** – Public healthcare product implementations
  - Other collaborations to extend commercial activities in some LATAM countries
- Expanding direct business operations in Italy
  - Extending collaborations with Fondazione SISA (LIPID inCode)
  - Direct commercial promotion with CARDIO inCode, THROMBO inCode, LIPID inCode and SuDD inCode
- Strengthening LIPID inCode sales in Germany with Uniklinikum (based on NHS model)

The ROCA test recommended in new NICE Guidance

- Risk of Ovarian Cancer Algorithm (ROCA) test is a ‘first in class’ risk assessment for the early detection of familial ovarian cancer
- New NICE Guidance: Ovarian Cancer; Identifying and managing familial and genetic risk (March 2024)[1]
- Three broad aspects to the guidance
  1. Identifying individuals who should be offered genetic testing.
  2. Genetic testing
  3. How to support individuals who have a positive result from genetic testing
     - Preventative surgery
     - Surveillance using the ROCA Test
- This is the first time that a surveillance test has gained a position in any ovarian cancer care pathway globally.

The ROCA Test was the **only** surveillance test recommended by NICE. This was based on a comprehensive review of the peer-reviewed literature, ROCA was recognised as the most accurate surveillance test.

“Given the evidence related accuracy and staging, the committee agreed ”the ROCA Test + TVUS surveillance would be the preferred method if the person has chosen to delay or not to have risk-reducing surgery”

1. NICE Guidance: Overview | Ovarian cancer: identifying and managing familial and genetic risk | Guidance | NICE

ROCA commercial roll-out

NHS commissioning

- 2024-2025: Targeting roll out in 4-6 regions supported by local Cancer Alliances. SAS model
- Early engagement with NHS for a centralised ROCA service, supported by Specialised Services
- Many supportive gynae oncologists / geneticists / genetic counsellors across the UK

Europe

- **Switzerland** – Completed agreement with Genesupport.ch. Onboarding close to completion
- **Austria** – Completed agreement with Ordensklinikum
- **Germany, Spain** to follow

US

- Ongoing considerations, based on progress in NHS and EU

Financial Review: 2024 Interim Results

First half revenues £1.4M, 46% year-on-year growth

Gross Profit margin increased to 53% (2023: 49%) due to improving geographic margin mix from UK and US

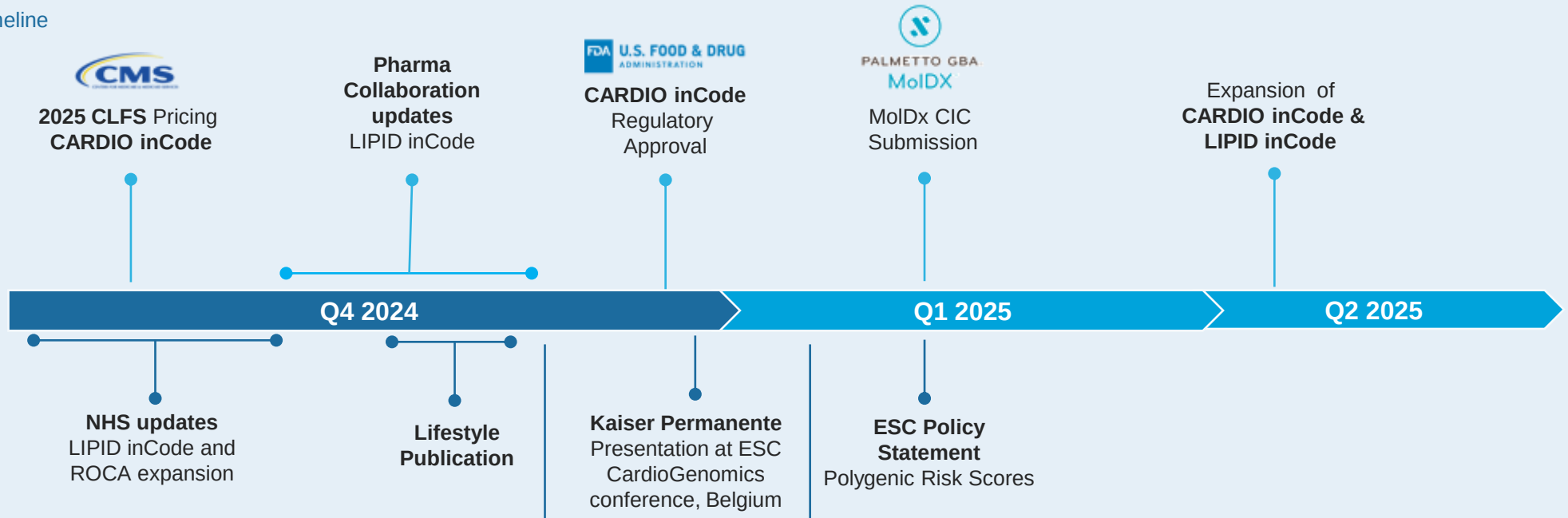
Reduced operating losses reflecting growth in revenues and margin, and reductions in salaries, staffing, consultancy fees, marketing, and development costs

Adjusted EBITDA loss £2.2m (2023 £3.4m)

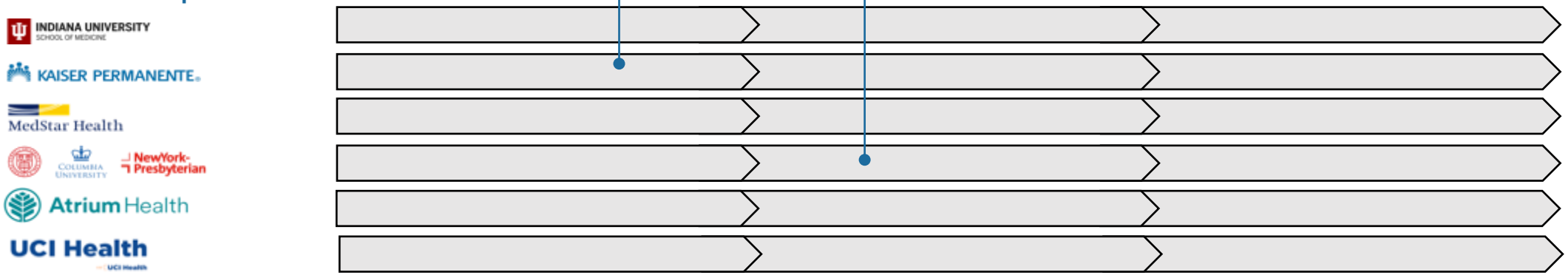
Cash balances – £2.9M at end June 2024 (2023: End Dec £2.5M). Net fundraising proceeds of £3.7m completed in January 2024. June 2024 excludes R&D Tax Credit £0.37m

Key Events and Expected Newsflow

Indicative timeline



Collaboration Updates



Summary and Outlook

- Commercial expansion of LIPID inCode and CARDIO inCode in the US market
- Progress *De Novo* FDA regulatory submission for approval of CARDIO inCode to accelerate US sales
- Expansion of the NHS programme for LIPID inCode, introduction of CARDIO inCode and collaborative developments with pharma
- Expansion of the MVZ Uniklinikum, Germany collaborative programme
- Expansion of CARDIO inCode commercial pilots into Catalonia and introduction to other Spanish regions
- Following NICE guideline recommendation for The ROCA test, commence commercial programs in the NHS
- Continued strengthening of the commercial, marketing and selling teams to support revenue growth.
- Significant increase in year-on-year revenue growth and reduced losses targeting breakeven/profit over the medium term

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Appendices: P&L

	H1 2024 £'000	H1 2023 £'000	+/- £'000	Full yr 2023 £'000
Revenue	**1,389**	**950**	**439**	**2,160**
Cost of sales	(659)	(483)	(176)	(1,138)
Gross profit	**730**	**467**	**263**	**1,022**
GM %	53%	49%	3%	47%
Administrative expenses	(2,890)	(3,836)	946	(7,751)
AEBITDA	**(2,160)**	**(3,369)**	**1,209**	**(6,729)**
Depreciation/Amortisation	(172)	(174)	2	(351)
Share based payments	(143)	(51)	(92)	(71)
Operating Loss	**(2,475)**	**(3,594)**	**1,119**	**(7,151)**
Other Income	61	110	(49)	176
Finance Charge	(23)	(23)	-	(48)
Loss Before Income Tax	**(2,437)**	**(3,507)**	**1,070**	**(7,023)**
Income Tax	8	6	2	7
Loss for the Financial Period	**(2,429)**	**(3,501)**	**1,072**	**(7,016)**
Exchange diff on translation of foreign ops	68	312	(244)	334
Loss attributable to equity shareholders	**(2,361)**	**(3,189)**	**828**	**(6,682)**

Appendices: Balance Sheet

	H1 2024 £'000	H1 2023 £'000	+/- £'000	Full yr 2023 £'000
ASSETS				
Non-current assets				
Intangible assets	128	149	(21)	138
Property, Plant & Equipment	305	545	(240)	425
Right of use asset	242	310	(68)	282
Goodwill	149	149	-	149
Total non-current assets	**824**	**1,153**	**(329)**	**994**
Current assets				
Inventory	79	76	3	84
Trade and other receivables	805	689	116	582
Financial assets	38	22	16	42
Cash and cash equivalents	2,915	5,183	(2,268)	2,484
Total current assets	**3,837**	**5,970**	**(2,133)**	**3,192**
Total assets	**4,661**	**7,123**	**(2,462)**	**4,186**
Equity				
Shareholders' Equity				
Share capital	1,770	958	812	958
Share premium	18,482	15,551	2,931	15,551
Other reserves	502	249	253	291
Retained deficit	(17,940)	(11,996)	(5,944)	(15,511)
Total equity	**2,814**	**4,762**	**(1,948)**	**1,289**
LIABILITIES				
Non-current liabilities				
Trade and other payables	0	938	(938)	-
Lease liability	180	249	(69)	221
Contingent consideration	191	166	25	178
Current liabilities				
Trade and other payables	1,378	911	467	2,395
Lease liability	81	72	9	78
Deferred tax	17	25	(8)	25
Total liabilities	**1,847**	**2,361**	**(514)**	**2,897**
Total equity and liabilities	**4,661**	**7,123**	**(2,462)**	**4,186**

Appendices: Cash Flow Statement

	H1 2024	H1 2023	+/-	Full yr 2023
	£'000	£'000	£'000	£'000
Loss before taxation	**(2,437)**	**(3,507)**	**1,070**	**(7,023)**
Adjustments	277	247	30	296
Operating Loss before working capital changes	**(2,160)**	**(3,260)**	**1,100**	**(6,727)**
Working capital changes	(1,229)	(1,563)	334	(779)
Net cash outflow from operating activities	**(3,389)**	**(4,823)**	**1,434**	**(7,506)**
Investing activities	60	(38)	98	136
Financing activities	3,696	(35)	3,731	(94)
Net increase in cash and cash equivalents	**367**	**(4,896)**	**5,263**	**(7,464)**
Cash and cash equivalents at beginning of period	2,484	9,732	(7,248)	9,732
Exchange gains/(losses) on cash and cash equivalents	64	347	(283)	216
Cash and cash equivalents at end of period	**2,915**	**5,183**	**(2,268)**	**2,484**