DIRECT DEMOCRACY & SORTITION ASSEMBLIES

A Civic Architecture for the British Isles

DDSA-NHP-001 | Edition 1.0

NBI Health Provision

Architecture, workforce, capital & governance — the health

DOCUMENT INFORMATION

Version: 1.0
Author: Ian R. Graham
Document ID: DDSA-NHP-001

CLASSIFICATION

Confidentiality: Public Domain
Distribution: Unrestricted — For civic, academic, and public use

---

USAGE NOTICE & PERMISSION

"We inherit the lessons of the past, not its chains."

— DD&SA Founding Principle

dd-sa.org

A living document — subject to civic deliberation and democratic revision.

Contents

“We do not turn time back; we move forward with the wisdom its patterns reveal.”

Preamble

This document sets out the complete architectural framework for the New British Isles (NBI) Health Provision — the civic successor to the National Health Service. It has been developed within the Direct Democracy and Sortition Assemblies (DD&SA) constitutional framework as part of A Civic Architecture for the British Isles.

The document addresses eight interconnected domains: spatial architecture, facility tiers and transfer protocols, workforce establishment, capital costs, financing, programme timeline, and transition governance. Together they constitute a complete, costed, and constitutionally coherent blueprint for the transformation of health provision across the NBI over a 25-year civic transition.

The NHS is not reformed here. It is replaced — systematically, equitably, and without compulsory redundancy — by a civic architecture that is owned by the people it serves, governed by residents selected by lot, financed against real assets, and built to a single standard that guarantees the same quality of care in every grid across the NBI regardless of geography or socioeconomic circumstance.

Section 1: Spatial Architecture

1.1 The Core Allocation Formula

The NBI Health Provision is founded on a single allocation principle: one Super Hospital per 12,000 residents. Applied to a projected NBI population of 70 million:

Against the current registered estate of more than 20,000 facilities operating under NHS and private hospital SIC codes, this represents a consolidation ratio of approximately 3.4:1. The reduction in facility numbers is not a reduction in care — it is the elimination of fragmentation, duplication, and the structural inefficiency that fragmentation produces.

1.2 The Two-System Hybrid

A single geographic rule applied uniformly across the NBI cannot simultaneously guarantee access in sparsely settled areas and produce sensible allocation in high-density urban zones. The spatial architecture therefore operates as a two-system hybrid governed by a population density threshold.

Urban Health Zones

Any contiguous area in which population density meets or exceeds 800 persons per square mile across three or more adjacent grid cells is designated an Urban Health Zone. Within that Zone, the 20x20 mile grid is suspended. Super Hospital allocation reverts to direct population sub-catchment mapping at a ratio of one Super Hospital per 12,000 residents, positioned by civic planners to minimise average travel time within the Zone.

The three-adjacent-cells clause prevents a single anomalously dense ward from triggering Zone designation in isolation. It captures all major NBI cities and commuter belts while correctly excluding market towns, coastal resorts, and semi-rural districts that function well under the grid model.

Rural Grid Zones

Below the 800/sq mi density threshold, the 20x20 mile grid applies with a tiered facility model rather than a binary hospital/no-hospital outcome.

1.3 Three-Tier Facility Hierarchy

Tier 1 — Super Hospital

Full acute, surgical, specialist, and emergency provision. Serves a catchment of 12,000. Located in all urban sub-catchments and in rural grids above the 6,000-population threshold.

Tier 2 — Civic Health Station

Primary, urgent, diagnostic, and community care. Serves rural grids between 1,500 and 6,000 population. Permanently staffed; no full surgical suite. Operates under formal transfer protocols to the nearest Tier 1 facility.

Tier 3 — Outreach Unit

Scheduled mobile provision for the most sparsely settled grids. No permanent building. Digitally connected to the nearest Civic Health Station via the Sovereign Digital Network.

1.4 National Facility Count

Total built facilities: approximately 6,067, against a current estate of 20,000+. Consolidation ratio: 3.3:1.

Section 2: Transfer Protocols

Transfer protocols carry a rights implication within the DD&SA architecture. They are not operational guidelines. They are constitutionally binding standards that give substance to the Civic Guarantee of timely access to care.

Standard T1 — Maximum Transfer Time

The 45-minute standard is grounded in clinical evidence on time-sensitive conditions. Stroke thrombolysis, major trauma, and STEMI all exhibit sharply deteriorating outcomes beyond the 60-minute intervention window. The 45-minute transfer target leaves 15 minutes for clinical handover and preparation.

Standard T2 — Capacity Reservation

Standard T3 — Clinical Decision Authority

Standard T4 — Digital Pre-Notification

Section 3: Workforce Establishment Model

3.1 Beds First, Staff Second

Staffing ratios are derived from bed counts, which are in turn derived from the catchment allocation formula. The standard international benchmark is 2.5 acute beds per 1,000 population.

A purpose-built, fully digital, single-system 30-bed facility operating without legacy infrastructure, PFI overhead, or trust bureaucracy is architecturally capable of delivering full acute care. Current NHS staffing ratios are inflated by structural fragmentation, not by clinical necessity. The NBI model eliminates that inflation at design stage.

3.2 Tier 1 Super Hospital Establishment (30 Beds)

Clinical Staff

Support and Infrastructure

Absent from this establishment: trust boards, directors of finance, HR departments, procurement teams, communications offices, commissioning liaisons, and PFI contract managers. These roles exist in the NHS because each trust is a semi-autonomous corporate entity. In the NBI model, every Super Hospital is a node in a single civic system. Those functions are handled centrally once, not replicated 5,667 times.

3.3 Tier 2 Civic Health Station Establishment

3.4 National Workforce Aggregate

3.5 The Rationalisation Argument

This figure requires immediate unpacking. The clinical workforce — doctors, nurses, AHPs — is largely preserved. The reduction falls almost entirely on four structural categories that exist for organisational reasons, not care reasons: trust replication overhead (est. 120,000–150,000), the commissioning layer (est. 60,000–80,000), locum and agency dependency, and administrative duplication from system incompatibility. The NBI's single-system civic architecture renders each of these categories structurally redundant by design.

Section 4: Capital Build Programme

4.1 Cost Per Facility

Current NHS benchmark: £600,000–£900,000 per bed for new-build acute hospitals. For a 30-bed Super Hospital, that produces a benchmark range of £18M–£27M. Three NBI-specific factors reduce this materially.

- Standardised design: a single civic specification replicated 5,667 times reduces per-unit cost by 20–30% once the supply chain is organised.
- No PFI financing: NBI Super Hospitals are civic assets built with civic capital. No financing premium, no 25-year service contract.
- Programme scale economies: 5,667 units over 25 years is the largest single public construction programme in British history. Supply chain contracts at that scale command significant unit price reductions.

4.2 Gross Capital Requirement

4.3 Asset Realisation From the Existing Estate

The existing NHS estate is valued at approximately £42 billion in current land and building assets. The private hospital estate adds a further estimated £8–12 billion. Under NBI transition, this estate is systematically realised: urban sites transferred to civic planners, non-viable sites sold, and approximately 800–1,000 structurally suitable buildings converted to Civic Health Stations or ancillary functions.

4.4 Net Capital Requirement

At £2.24 billion per year average over 25 years, the NBI Health Provision capital programme represents less than 1.4% of the current NHS annual revenue budget. This is smaller than the NHS's annual IT spend, smaller than the agency staffing bill, and smaller than the annual cost of PFI interest payments on the existing estate.

Section 5: Civic Infrastructure Bond Financing

5.1 What a Civic Infrastructure Bond Is

A Civic Infrastructure Bond (CIB) is a fixed-term, fixed-return debt instrument issued by the NBI Civic Finance Authority against a specific, identified asset programme. It differs from a conventional government bond in three critical respects.

- Asset backing: CIBs are backed by the replacement asset value of the Super Hospitals being built — not an abstract fiscal promise against future tax revenue.
- Ring-fencing: CIB proceeds are constitutionally ring-fenced to the NBI Health Provision capital programme and cannot be redirected to general expenditure.
- Civic ownership of return: repayment comes from the revenue savings the programme generates, not from new taxation.

5.2 CIB Issuance Structure

Total issuance is £48 billion rather than £56 billion because accumulated revenue savings from year seven onwards fund a growing proportion of capital spend directly, meaning £8 billion of the net capital requirement is never borrowed.

5.3 Annual Revenue Saving

5.4 Four Constitutional Safeguards

- Programme Lock: proceeds are constitutionally bound to the NBI Health Provision capital programme. No assembly can redirect them without a supermajority constitutional amendment.
- Independent Audit: the Civic Finance Authority is institutionally separated from the Health Provision executive. The Civic Audit Assembly reviews issuance and expenditure annually, with findings published to the SDN.
- Repayment Source Restriction: CIB repayment is funded exclusively from documented health system revenue savings — not from new civic levies or unrelated asset sales.
- Maturity Cap: no CIB tranche may be issued with a term exceeding 15 years, embodying the DD&SA principle of intergenerational equity.

5.5 Complete Fiscal Summary

Section 6: Twenty-Five Year Programme Timeline

6.1 Why 25 Years

The transition timeline is set at 25 years to match the actual generational rhythm of institutional change. It reduces annual capital commitment to a fiscally unassailable figure, allows workforce transition to occur almost entirely through natural attrition, and reframes the programme from radical disruption to managed civilisational upgrade.

The three public-facing headline figures are: £2.24 billion per year — less than the NHS spends on agency nurses alone. Zero compulsory redundancies — the workforce transition happens at the pace of natural change. 25 years — not a revolution; a renovation.

6.2 Phased Build Schedule

6.3 Revised Annual Capital Spend

6.4 Workforce Transition Through Natural Attrition

The NHS loses approximately 8% of its non-clinical workforce annually through retirement, voluntary departure, and career change. Over 25 years, the entire current non-clinical and administrative workforce turns over twice through natural attrition alone.

Section 7: DD&SA Sequencing Logic

7.1 The Governing Principle

The sequencing logic is not administrative. It is constitutional. Two DD&SA principles determine it without ambiguity.

- The Civic Floor: no resident shall fall below a guaranteed minimum standard of provision. The programme must therefore prioritise areas where the current standard is furthest below that floor.
- Evidence-based sortition deliberation: sequencing decisions of this magnitude cannot be made by technocrats or ministers. They are made by a sortition-selected body working from published evidence criteria.

7.2 The Civic Need Index

The Civic Need Index (CNI) is a composite measure calculated for every 20x20 mile grid across the NBI. It has four equally weighted components.

The CNI produces a ranked list of every grid across the NBI. The Civic Health Sequencing Assembly reviews, challenges, and ratifies that ranking annually. Their deliberations are published in full to the SDN. Their ratified ranking is constitutionally binding on the build programme for the following year.

No minister, assembly majority, or regional lobby can move their area up the queue. The CNI is calculated independently, ratified by residents selected by lot, and fully transparent on the SDN. The programme structurally moves toward its own ethical foundation with every facility built.

Section 8: Transition Governance Framework

8.1 The Four Permanent Civic Bodies

Body 1 — Civic Health Sequencing Assembly (CHSA)

A standing sortition-selected assembly of 150 residents, reselected in thirds every two years. Its sole mandate is the annual ratification of the Civic Need Index ranking and the consequent build programme for the following year. It has one constitutionally binding power: the ratified annual sequencing order, which no other body can override. All deliberations are published to the SDN within 48 hours. No resident may lobby it privately.

Body 2 — Civic Health Build Authority (CHBA)

The executive body responsible for physical delivery of the programme: design standards, modular procurement, site preparation, construction contracts, commissioning, and handover. Its leadership is appointed by open civic process, confirmed by sortition assembly, and serves fixed five-year terms renewable once. It builds in the sequence ratified by the CHSA. Budget variance above 5% on any facility triggers automatic CHSA and Audit Assembly notification.

Body 3 — Civic Health Transition Authority (CHTA)

Manages the interface between the dissolving NHS and the emerging NBI Health Provision. Three specific responsibilities: administering the Civic Workforce Transfer Instrument; managing dual-running protocols including patient record migration and clinical standard harmonisation; and executing the legal dissolution of NHS trusts, managing PFI contract exit, and transferring assets to the civic estate. The CHTA holds the only direct legal powers in the framework — specifically, the power to dissolve NHS trust entities.

Body 4 — Civic Health Audit Assembly (CHAA)

A permanently constituted sortition-selected oversight body of 60 residents, reselected annually in full. It holds the other three bodies to account across the entire 25-year programme through four constitutionally entrenched powers: the power to demand full financial and operational disclosure within 14 days; the power to commission independent technical audit at any time; the power to refer any body or individual to a Consequence Hearing for Civic Rule breach; and the power to publish findings directly to the SDN without editorial interference.

8.2 The Three Constitutional Instruments

Instrument 1 — Civic Workforce Transfer Instrument (CWTI)

Three strengthening clauses: the Redeployment Guarantee (redeployment offer within 90 days, full salary protection for 24 months during retraining); the Pension Continuity Clause (all NHS pension entitlements transfer to the NBI Civic Pension System without actuarial reduction); and the Civic Rule Breach Clause (any attempt to use trust dissolution as a mechanism for workforce reduction beyond the natural attrition model is a Civic Rule breach).

Instrument 2 — NHS Trust Dissolution Protocol (NTDP)

Operates in four sequential stages, each mandatory before the next may proceed.

Instrument 3 — Programme Continuity Covenant (PCC)

8.3 Dual-Running Protocol

During the 25-year transition, both systems operate simultaneously. Five binding rules govern the interface.

8.4 Decennial Constitutional Review

At years 8, 16, and 24, a specially convened Residents' Assembly of 400 sortition-selected residents conducts a full constitutional review of the programme. It assesses consistency with the NBI's evolving civic values, fiscal performance within parameters, and whether constitutional amendments are required to address unforeseen circumstances. It cannot alter the PCC supermajority threshold. It can recommend amendments to operational parameters — facility specifications, staffing ratios, technology standards — reflecting accumulated operational learning. These go to the full constitutional amendment process.

8.5 Governance Framework Summary

Closing Statement

The NBI Health Provision architecture documented here is complete at the structural level. It answers every material question a constitutional lawyer, an economist, a clinician, or an ordinary resident might reasonably ask of a proposal to replace the National Health Service.

It is spatially equitable. It is fiscally credible. It is constitutionally coherent. It is clinically grounded. It is architecturally honest about the scale of what it proposes and arithmetically precise about the means by which it proposes to achieve it.

Above all, it is designed — not argued. The structural engineer builds the house and walks away. What remains is not a manifesto. It is a blueprint.

"We do not turn time back; we move forward with the wisdom its patterns reveal."

Ian R. Graham BA (Hons) | DD&SA-POL-NHP-001 | April 2026

— END OF DOCUMENT —