CIVIC COMMONWEALTH OF THE BRITISH ISLES

Direct Democracy & Sortition Assemblies

NBI HEALTH PROVISION

Architecture, Workforce, Capital & Governance

A Civic Architecture for the British Isles

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"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.

> *The Civic Floor is not a promise. It is the engine of sequencing. The programme builds first where the people have been failed the longest.*

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:

> *70,000,000 ÷ 12,000 = 5,833 Super Hospitals (baseline)*

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.

Grid Population	Provision
24,000+	Super Hospitals at 1:12,000 ratio
6,000–24,000	Minimum 1 Super Hospital regardless of ratio
1,500–6,000	1 Civic Health Station
Below 1,500	Scheduled outreach + guaranteed transfer within 20 miles

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

Population Segment	Population	Super Hospitals	Civic Health Stations
Urban zones (>800/sq mi)	~42M	3,500	—
Suburban/town grids	~20M	1,667	—
Rural grids (above floor)	~6M	500	—
Rural grids (below floor)	~2M	—	~400
Total	70M	~5,667	~400

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

No patient presenting at a Civic Health Station requiring Tier 1 intervention shall wait longer than 45 minutes from the clinical decision to transfer to arrival at a Super Hospital, under standard conditions. In exceptional geographic circumstances — defined as any grid cell where 45 minutes cannot be met by road — dedicated air transfer provision shall be permanently assigned to that cell.

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

Each Super Hospital shall at all times maintain a minimum of 8% of its acute bed capacity as reserved intake for Civic Health Station transfers. This reservation is not discretionary and cannot be reallocated to elective or planned admissions. It is monitored in real time via the Sovereign Digital Network.

Standard T3 — Clinical Decision Authority

The decision to transfer from Tier 2 to Tier 1 rests solely with the senior clinical practitioner on duty at the Civic Health Station. No administrative, budgetary, or capacity consideration may delay or override a transfer decision made on clinical grounds. Any instance of administrative interference with a transfer decision is a Civic Rule breach subject to Consequence Hearing.

Standard T4 — Digital Pre-Notification

Upon making a transfer decision, the duty practitioner shall transmit a full digital patient record to the receiving Super Hospital via the Sovereign Digital Network within five minutes. The receiving team shall confirm readiness within ten minutes of notification. Failure to confirm within ten minutes triggers automatic escalation to the nearest available alternative Super Hospital.

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.

12,000 × 2.5 ÷ 1,000 = 30 acute beds per Super Hospital

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

Role	Headcount
Consultants (5 core specialties)	15
Registrars and junior clinical staff	12
Registered nurses (1:5 ratio, 24/7 four-shift)	28
Senior charge nurses / ward leads	4
Allied Health Professionals	18
Emergency and urgent care practitioners	6
Clinical subtotal	83

Support and Infrastructure

Role	Headcount
Scheduling, records and patient coordination	6
Reception and civic interface staff	4
Domestic, catering and portering	10
Estates and biomedical equipment maintenance	4
Civic facility management	2
Support subtotal	26

Tier 1 Total Establishment: 109 staff per Super Hospital

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

Role	Headcount
Primary care practitioners (civic clinicians)	4
Practice nurses and nurse practitioners	8
Mental health and community wellbeing practitioners	3
Diagnostic technician	2
AHP generalist	2
Patient coordinator and SDN records operator	3
Domestic and facilities	3
Tier 2 Total	25

3.4 National Workforce Aggregate

Tier	Facilities	Staff per Facility	Total Staff
Tier 1 Super Hospitals	5,667	109	617,703
Tier 2 Civic Health Stations	400	25	10,000
Tier 3 Outreach Units	—	—	~3,000
Central Civic Health Coordination	—	—	~2,500
NBI Health Provision Total			~633,000

3.5 The Rationalisation Argument

	Headcount
Current NHS (all UK nations)	1,730,000
NBI Health Provision	633,000
Reduction	~1,097,000
Reduction as percentage	63%

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.

Cost per Super Hospital: £16M (build, equip, and commission) Cost per Civic Health Station: £3.5M

4.2 Gross Capital Requirement

Item	Units	Unit Cost	Total
Tier 1 Super Hospitals	5,667	£16M	£90.67B
Tier 2 Civic Health Stations	400	£3.5M	£1.4B
Tier 3 Outreach Units	150 teams	£0.8M	£0.12B
SDN Health Infrastructure	1	£4B	£4B
Central Civic Coordination Facilities	1	£0.5B	£0.5B
Gross Capital Requirement			£96.69B

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.

Conservative estate realisation estimate: £35 billion over the build programme period

4.4 Net Capital Requirement

Gross capital requirement	£97.0B
Less: existing estate realisation	−£35.0B
Less: private sector asset transfer	−£6.0B
Net capital requirement	£56.0B

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

Tranche	Timing	Amount	Term	Coupon
1 — Foundation	Year 1	£4B	15 years	3.2%
2 — Ramp	Year 4	£8B	15 years	3.1%
3 — Production A	Year 7	£10B	12 years	3.0%
4 — Production B	Year 12	£10B	12 years	2.9%
5 — Completion	Year 17	£8B	10 years	2.7%
6 — Final	Year 21	£4B	8 years	2.5%
7 — Reserve/Contingency	Year 23	£4B	6 years	2.4%
Total		£48B		

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

Saving Category	Annual Saving (Est.)
Workforce reduction (non-clinical, phased)	£18B
Agency and locum elimination	£3.2B
Commissioning layer abolition	£4.5B

PFI contract exit (phased)	£3.8B
Procurement consolidation	£6B
IT system consolidation onto SDN	£2.5B
Total annual revenue saving at full operation	£38B per year

Annual debt service at peak: ~£1.4B — under 4% of the £38B annual saving it is funded by.

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

Metric	Figure
Net capital requirement	£56B
Total CIB issuance	£48B
Total debt service cost (all tranches)	~£19B over programme life
Funded by annual savings of	£38B per year
Payback period from savings	18 months of full-operation savings
NBI civic health estate value at completion	~£90B (owned, unencumbered)
Net civic wealth created	~£71B after all debt service

The NBI Health Provision capital programme is not a cost. It is a civic wealth creation programme that happens to deliver universal health infrastructure as its output.

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

Phase	Years	Super Hospitals Built	Cumulative	Facilities Consolidated
1 — Design, pilot, proof of concept	1–3	150	150	800
2 — Supply chain and ramp-up	4–6	450	600	3,000
3 — Steady production rate	7–15	2,700	3,300	11,000
4 — Completion and commissioning	16–22	2,100	5,400	18,000
5 — Snagging and integration	23–25	267	5,667	20,000+

6.3 Revised Annual Capital Spend

	10-Year Programme	25-Year Programme
Net capital requirement	£56B	£56B
Annual capital spend (average)	£5.6B/yr	£2.24B/yr
Peak annual spend	~£8B	~£3.5B
As % of current NHS capital budget	47–80%	19–35%

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.

Workforce Category	Current Headcount	Required Reduction	Compulsory Redundancies
Trust management and executive	~45,000	45,000	Zero
Administrative and clerical	~280,000	220,000	Zero
Commissioning layer	~70,000	70,000	Zero
Agency/locum (converted to civic posts)	~120,000	60,000	Zero
Clinical staff (largely preserved)	~1,215,000	Marginal	Zero

Every single workforce reduction the NBI Health Provision requires over 25 years can be achieved through natural attrition, voluntary transition, and redeployment. The compulsory redundancy figure is zero.

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.

Build first where civic need is greatest, as determined by a standing Civic Health Sequencing Assembly working from a published, annually updated Civic Need Index.

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.

Component	Measures	Highest Score
Health Deprivation Score	Mortality, disease burden, life expectancy variance, mental health prevalence	Worst health outcomes
Current Provision Deficit	NHS bed numbers, GP ratios, waiting times, facility age/condition	Most underserved grids
Population Vulnerability Index	Age profile, socioeconomic deprivation, disability, geographic isolation	Most vulnerable populations
Transition Readiness	Land availability, civic infrastructure, transport connectivity, supply chain proximity	Most operationally viable

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

The transition is not administered. It is governed. Administration is the execution of decisions made elsewhere. Governance is the legitimate, accountable, resident-anchored making of decisions in real time, for the duration.

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)

Upon formal dissolution notice being served on an NHS trust by the Civic Health Transition Authority, every employee of that trust is automatically and irrevocably transferred to civic employment under NBI Health Provision terms. No employee may be made compulsorily redundant as a consequence of trust dissolution. Civic employment terms shall be no less favourable than the employee's existing terms in any material respect.

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.

Stage	Action
1 — Dissolution Notice	Served by CHTA when Super Hospitals are operational and CWTI fully executed
2 — Asset Transfer	All land, buildings, equipment, and digital assets transfer to the NBI civic estate
3 — Liability Settlement	Outstanding claims and obligations assumed by the NBI Civic Justice system
4 — Constitutional Deregistration	Trust formally deregistered as a legal entity; dissolution published to the SDN

Instrument 3 — Programme Continuity Covenant (PCC)

The NBI Health Provision Capital Build Programme constitutes a Civic Continuity Commitment. No Residents' Assembly, Sortition Assembly, or civic body of any tier may suspend, cancel, or materially alter the programme's constitutional mandate, sequencing authority, or financing architecture without a supermajority constitutional amendment requiring approval by no fewer than three consecutive Civic Assemblies across no fewer than six years.

8.3 Dual-Running Protocol

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

Rule	Requirement
T1 — SDN Priority	All new patient records created on SDN from Year 1. Legacy records migrated as dissolution approaches. No clinical decision may be made without SDN access from Year 5.
T2 — Clinical Standard Harmonisation	A joint NBI-NHS Clinical Standards Board maintains a single clinical standard applying in both systems until the last trust is dissolved.
T3 — Cross-System Staff Deployment	NHS employees may be seconded to NBI Super Hospitals. NBI clinicians may be deployed to support NHS trusts experiencing critical staffing failure.
T4 — Patient Choice	Any patient whose NHS trust has not yet been dissolved retains the right to access care at any commissioned NBI Super Hospital within their grid area.
T5 — No New NHS Capital	From PCC ratification, no new capital investment may be made in NHS trust infrastructure beyond essential maintenance.

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

Element	Function	Body / Instrument
Annual sequencing	Ratifies build order by civic need	CHSA
Physical delivery	Builds, commissions, hands over	CHBA
System transition	Dissolves NHS, transfers workforce	CHTA
Accountability	Audits, publishes, refers breaches	CHAA
Workforce protection	Guarantees civic transfer, no redundancy	CWTI
Legal dissolution	Winds down trusts, transfers assets	NTDP
Programme durability	Binds future assemblies constitutionally	PCC
Long-horizon legitimacy	Reviews at years 8, 16, 24	Decennial Review

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