Appendix D: Alternatives Summary

Introduction

1.1 Across the range of consultation activities, there were some suggestions made for alternatives to, or variations on, the main proposals. Most often, these focused on maintaining or improving local services. For example:

- An enhanced 'status quo' - retaining and improving the current sites instead of building a new hospital;
- Building the new hospital in a different location (with various suggestions made as to the most suitable area or site, but the most common being the open space opposite St Helier Hospital, and the West Park and Headley Park locations in the Epsom area);
- Building the new SECH, but still retaining the full range of acute services at the remaining two sites (i.e. having three A&E departments, etc.);
- Having up to four smaller 'SECHs' to offer better coverage of the whole area; and
- More general alternatives, e.g. increasing funding to help the NHS meet the ongoing challenges and recruit more staff.

1.2 Other proposed alternatives were more radical in nature, and called for further redevelopment or centralisation, including:

- Building the new SECH at Sutton, but only retaining one of the other two sites;
- Demolishing the current Epsom and/or St Helier Hospitals, and starting them again (rather than trying to renovate older buildings that may be no longer fit for purpose); and
- Increased centralisation, i.e. focusing on just one 'super hospital'.

1.3 The above summary is covered in more detail below.

Alternative configurations (i.e. three/four SECHs, one super-hospital etc)

Consultation Questionnaire

1.4 A few questionnaire respondents supported the idea of further centralisation, often in the context of the existing hospitals' buildings being too old or expensive to refurbish:

> *Why not just spend the full amount on a single new hospital on the Sutton site which could be world class [and] include all services needed for the catchment area?... You could then sell off the land from both St Helier hospital and Epsom General to fund this new hospital and build much needed affordable housing to both sites.*

> *The building in St Helier hospital is not fit for purpose for either services. There needs to be one building to serve the public, keeping too many buildings is waste of money and patient time.*

1.5 A few others suggested:

- Closing one of Epsom or St Helier, and having two SECHs;
- Closing one of St Helier and Epsom and retaining the other as a centre for elective surgery;

1.6 On the other hand, some others felt that the area was sufficiently large and well-populated to justify both building a new hospital AND maintaining the current range of acute services at the existing two sites:

> *The area is too large, with travelling times much higher than you are quoting, to lose services in Epsom and St Helier. A new hospital should be in addition to what we have now.*

1.7 A few also suggested having a larger number of smaller SECHs i.e. three or four (e.g. on the basis of better area coverage, and claims that these could be built quickly and respond more flexibly to accommodate clinical services as the evolve)

Written Submissions

1.8 The following illustrative quotations reflect the views of those who wished to see the Trust retain and expand existing services AND provide a new hospital:

> *I feel that NHS services need to be and should be expanded rather than combined in one location. A new site in Belmont would be fantastic, in addition to existing services - but not at the expense of losing St Helier - that's just scandalous*

> *If the government wishes to build an extra third specialist emergency care hospital at Sutton, IN ADDITION (I stress, IN ADDITION TO, not in substitution for, St Helier's and Epsom hospitals I would be in favour as long as both St Helier's and Epsom hospitals also remain specialist emergency care hospitals as well (i.e. providing all services, including A&E and maternity services on all three sites). Greater London has a population of 8.9 million people; we need more hospitals providing all services, not fewer*

> *I am not against a new hospital in Belmont but that should be built on top of keeping and improving St Helier's as well, not at its expenses*

1.9 Others suggested four 'smaller' specialist emergency hospitals sites across Sutton, Epsom & St Helier e.g. to provide better coverage.

> *We are more than ever convinced that consideration should be given to building 4 new, smaller, SECHs using the 3 sites at Sutton (for 2 SECHs) Epsom and St. Helier (one SECH each), rather than one monolithic 300 bed SECH at Sutton*

> *It seems to us that there is one missing option which might be explored. This is to build 4 new, smaller SECHs, 2 of which might be built at Sutton and one each at St Helier and Epsom. Each of these could be planned flexibly to provide up to 75 single rooms to accommodate all 6 core (major) services. They could be networked by specialist doctors, nurses and clinical staff and managed as one by the Trust, backed up by rapid transit arrangements (road and air ambulance). These 4 SECHs might be built concurrently or in stages. These smaller SECHs could help remodel or break the mould used for large scale monolithic, inflexible buildings (like St Helier) and now proposed for Sutton, which are guaranteed to become obsolete too soon and unmanageable for too long*

1.10 On the other hand, there was also some support for consolidating services even further, for example:

- Providing fewer services than proposed at St Helier and Epsom: the district hospital services will not be needed as most of the services would be covered at the new hospital
- Providing ALL services on one single site
- Closing St Helier altogether

> *Regarding the future of the two current sites, I believe that it would be difficult to justify all of the services identified on the page of your consultation brochure headed "District Hospitals at both Epsom and St Helier"*

at St Helier. A strong case could be made for diagnostic and some outpatient services but not much more, as the planned new location would not involve too extensive travel… The situation in Epsom is different, because of the distance and more complicated travel links. I therefore see that Epsom Hospital should continue (in a lesser reduced form than St Helier) to provide more of the services you outlined on the respective page of your brochure

I do not see the case for keeping any existing care at both The St. Helier and Epsom Hospital as per the plans. I do not see any evidence for why only six 'Core Services' seeing 300 patients a day is an acceptable way of spending the £500,000,000 of Public Investment already granted

I think this is a missed opportunity to go even further and merge all services onto a single site super-hospital. Many of the inefficiencies and staffing problems will persist and patients would receive better care from a single site despite the increased travel distance

Why refurbish St Helier why not sell off this large site to help to pay for new blocks at St Georges, Croydon, and Sutton?

CCG Outreach Meetings

1.11 A range of views were expressed at the CCG outreach meetings. There was some support for increased centralisation, but others favoured keeping the 'status quo' (their views are covered in more detail later in this appendix):

You just need one functioning site to do everything (Maternity pregnant / child within the last year)

If you put all of those resources in one place it would be better for staff and for patients (Maternity pregnant / child within the last year)

Alternative locations for an SECH

Consultation Questionnaire

1.12 Some questionnaire respondents suggested building the new hospital in a different location, with various suggestions made as to the most suitable area or site.

1.13 The most commonly suggested alternative locations for a SECH included West Park near Epsom the open land opposite St Helier (it was also suggested that this open space could be used as a temporary car park, in order to carry out rebuilding work on the site of the existing St Helier Hospital car park and address the 'decanting' issue).

1.14 At least one respondent suggested selling off all three sites in order to fund the building of a new hospital on a completely new site.

CCG Outreach Meetings

1.15 At least one CCG Outreach meeting attendee was interested in whether a wider range of locations had also been considered:

Why have you only chosen Sutton, St Helier or Epsom for the location of the new hospital? (16-24)

Social Media

1.16 There was a suggestion to build a new 'state of the art hospital' at the former West Park Hospital site (in Epsom) as there is a lot of land and excellent road networks. It was said this would also provide a more 'future-proofed' option that takes into account the rising local population;

Alternative use of money (renovation of both existing hospitals etc)

Introduction

1.17 Other suggestions were made for:

- An enhanced 'status quo' - retaining and improving the current sites instead of building a new hospital;
- More general alternatives, e.g. increasing funding to help the NHS meet the ongoing challenges and recruit more staff.
- Demolishing the current Epsom and/or St Helier Hospitals, and starting them again (rather than trying to renovate older buildings that may be no longer fit for purpose);

Consultation Questionnaire

1.18 Many questionnaire respondents supported an enhanced 'status quo' whereby the two existing hospitals would be enhanced or improved, in preference to building a new hospital:

> *Could the money be used to refurbish the existing hospitals and to invest in more staff including consultants at both Epsom and St Helier?*
>
> *Sell Sutton hospital land, use that money to improve St Helier and Epsom.*

1.19 There was some support for having one or more of the hospitals serve a different role or focus on a particular specialty, occasionally with a view to promoting the various sites as 'centres of excellence' in different fields (some examples are given below):

> *1. St. Helier to be refurbished. 2. Epsom to develop specialist clinics/treatments for chronic conditions [and] perform routine day surgeries. 3. Sutton to be a centre for satellite clinics (Moorfields and others). Sutton to provide community care and mental health provisions.*
>
> *Perhaps have three levels. So urgent care only at Epsom, mid-level care and urgent care at St Helier, and specialist hospital at Sutton.*
>
> *Maybe keeping St Helier open and downgraded - making Epsom the critical care centre and turning Sutton into a cancer excellence site given its proximity to Marsden?*
>
> *Each facility should focus on different things: St Helier for maternity and accidents and emergencies, Sutton for cancer and Epsom for all other procedures.*

Written Submissions

1.20 The most popular alternative suggestion made via written submissions was for the proposed £500m funding to be spent not only on retaining acute services at St Helier, but also further improving and expanding the current site (rather than building a new hospital). Other options offered via the residents' submissions were few and far between, but including suggestions such as:

- Investing in and expanding all current sites as well as providing a new hospital (see above);
- Investing in and expanding all current sites instead of building a new hospital;
- Providing more funding and expanding services, rather than removing them

As the Hospitals in London as Kings and Guy's Hospital have had a lot of money spent on them. St Helier should get the same money spent on it

Rather than downsizing we should be re-building or refurbishing St. Helier hospital that's what will be needed any way with current forecasts for population growth, it will be delaying the inevitable fact that these services need expanding not reducing

While I am glad that the Government has allocated £500m of funding to the Epsom and St Helier Hospital Trust, I am convinced that this money should be spent at St Helier Hospital on its current site because that is where it is most needed

1.21 Some wanted to see the Trust invest in existing sites rather than make the proposed changes, for example:

I don't understand why the money already given can't be used to improve our local services to their former levels

St Helier and Epsom hospital buildings require drastic demolition/rebuild – it should be funded by local charges matched by Government funds. Sadly, British people do not appreciate that for which they do not contribute

In some ways it would be better to rebuild St Helier (so a new hospital like the new UCLH on the existing site) and temporarily move services to Epsom during a rebuild, then rebuild Epsom to an equally high quality (or vice versa)

CCG Outreach Meetings

1.22 As mentioned above, some outreach meeting participants favoured keeping the 'status quo', with increased investment into the existing Epsom and St Helier hospitals.

What about the status quo? Use the money to fix St Helier and Epsom (Deprived communities/low income)

Consider putting all the funding back into Epsom and St Helier. People are familiar with the current hospitals and overall most do not want any changes going forward. Even though the building is old, it will be hard to learn how to navigate a new building (Disability/physical, sensory)

Social Media

1.23 Similar suggestions were made via social media channels, including:

- Spending the £500m on renovating and restoring St Helier and Epsom;
- Spending more than the proposed £500m to invest in St Helier and Epsom Hospitals (rather than build a new hospital) as well as St George's and Kingston Hospitals;

But what if that £5,000,000 of taxpayer's money was being badly spent? What if spending £2,000,000 would do job of improving Epsom/St. Helier and leave the rest at St. George's Trust/Croydon Uni Hospital and Kingston Hospital NHS? More people. More help. More bang for your buck?

500 million would be plenty to renovate and restore both hospitals! With our growing community in Epsom this hospital iis sorely needed!

I think Epsom and St. Helier hospitals are best placed for acute services. If the money is focused on these two hospitals with £100,000 already invested in St. Helier there is enough if Belmont needs a further hospital maybe build an intensive care unit on the side of the Marsden.

Deliberative Residents' Research

1.24 In some of the deliberative groups, while the proposed model of care was understood, there were questions around why the funding allocated cannot be split three ways to ensure that each hospital is improved. Some suggested that there could be a UTC built at each of the three sites and questioned why Sutton loses out in the Epsom and St Helier options. Many participants, while less concerned about their own ability to access the hospitals, acknowledged that transportation will be key for some groups – especially the elderly or disabled.

Travel and transport (e.g. more bus lanes, buses, extended tramlines etc)

1.25 Given that many objections to the model of care and the proposals were prompted by concerns around travel and accessibility, it is unsurprising that questionnaire respondents suggested various improvements and mitigations in terms of transport, for example:

Better public transport in general, but with specific examples being:

- A better bus service in general i.e. more buses/more frequent etc.
- A direct bus shuttle bus needed to/from the SECH
- A bus service connecting hospitals (St. Helier, Sutton, Epsom)
- A better train service i.e. more trains/more frequent etc.
- A closer train station to hospital (whichever ends up being the location)
- A tram line being added/extended
- Underground/tube line extended/needed
- Improvements to public transport out of hours services i.e. Sundays, evenings, 24-hour service etc.
- Some tie-in with the Oyster scheme e.g. Oyster cards to be accepted outside London, or the SECH to be included in Oyster zones
- Cheaper/free public transport fees
- Implementation of 'Go Sutton' system
- Improvements to TFL services/inclusion of SECH in TFL zone/accepting TFL passes etc
- Better advertising/more information about public transport services e.g. timetable information
- Specific improvements to a particular bus route/train service etc.

Better transport options arranged through the NHS, for example:

- A hospital vehicle service
- Better taxi services i.e. more/cheaper/owned/ran by the hospital

Improvements to parking facilities:

- Increasing parking facilities in general: more spaces, larger, multi storeys, staff parking

- Cheaper/free parking fees
- Park and ride facilities to get to the hospital(s)
- Better disabled parking facilities

Improvements to roads and local infrastructure:

- Redesigning access to the hospital(s), e.g. changing the entrances etc.
- Improvements to local roads and traffic systems e.g. changes to one-way systems etc.
- Better road maintenance
- Better road directions
- Consideration of other issues e.g. traffic congestion, challenges in built-up/populated areas,
- Specific improvements to particular roads (e.g. A217), roundabouts, bridges etc.

Improvements for users of other transport modes, including more environmentally sustainable options e.g. improvements for pedestrians and cyclists.

Other suggestions and possible mitigations

Consultation Questionnaire

1.26 Various other suggestions or variations on the proposals were made via the consultation questionnaire, including:

Retaining the current services at the two existing sites and using Sutton as an out-patient centre;

Providing 'critical services' at Epsom and St Helier, and 'non-critical' services at Leatherhead and Sutton;

Centralising intensive care onto one site (e.g. Sutton) but retain birthing centres, general surgery etc. at the other two hospitals;

Having a greater number of smaller emergency units, spread across the area

Keeping A&E at St Helier at Epsom, but with an additional walk-in centre in Leatherhead;

Increasing walk-in facilities generally, and updating GP practice hubs to allow them to fulfil the role of a basic minor injuries unit;

Having all inpatient care delivered on one site, with outpatient care only delivered in local areas (to alleviate concerns that the model will lead to 'fragmentation of care')

Creating locally sited 'first aid' type centres, to stabilise any emergencies before moving to a main hospital;

Promoting St Helier as a teaching hospital, to increase its funding;

Prioritising building a new diagnostic centre instead of a new acute hospital;

Directing some Surrey Downs residents to East Surrey hospital, to relieve pressure on health services in the ESHT area and reduce journey times;

Re-thinking the current Trust boundaries: splitting up ESHT and merging each part with neighbouring Trusts (e.g. to reflect Merton residents' much greater proximity to London, etc).

1.27 A few respondents made suggestions about the type of role their current hospital might fulfil even if it is not chosen as the SECH site:

St Helier has the potential to survive, it just needs a lot of thought and planning of departments if this new hospital gets the approval - think carefully about the future of St. Helier: a stroke rehab centre, care of the elderly wards, improved renal unit, enhance the eye unit, a woman's health centre, upgrade the fracture clinic, a larger blood testing centre and an excellent A&E open 24 hours a day with a GP out of hours service and Saturday chemist and pharmacy help to begin with.

Epsom hospital was a good second choice for consideration and would have been acceptable as a new hospital. Unfortunately [the] site has been reduced in size for a number of reasons and would not prove suitable for the acute solution, by size. The current level of treatment is particularly high, and any changes in consultancy staff would harm its high level of proficiency. This hospital should remain as an integrated high-quality care hospital.

1.28 Some staff welcomed the proposals as an opportunity to think creatively about ways of enhancing care; others were keen that the proposals show allow particular specialisms to be maintained or developed further:

The potential to create a specialist emergency care service on a blank surface … also gives the opportunity to think creatively about what extra options could be available i.e. a women & children's centre, linking-up with the Royal Marsden on the Sutton site with access to cancer services/drug trials with the ICR. This will also free up any space currently used in St. Helier & Epsom to grow existing specialist services i.e. orthopaedics, ophthalmology / audiology etc.

Consideration for increased access to diagnostics e.g. echo or nerve conduction studies would be great. This will help with increasing patient flow for the in-patient bed base as often patients cannot be discharged due to waiting for such tests. [Also] specialist test access e.g.: vascular ultrasound for giant cell arteritis (which they have at St Georges) will make us one of the few centres to have such services... I particularly like the fact that the children's services will be moving along with adult services. The role of developing an adolescent & young adult space e.g.: in-patient ward or outpatient ward should be considered. We could develop ourselves as one of the few hospitals in the UK to offer this dedicated service.

As the regional renal unit we bring in a lot of patients from outside our catchment area. Additionally we currently have a well-established and renowned specialist combined rheumatology-renal vasculitis service. We should look at options that would allow this to be maintained, if not expanded within the current proposal.

My hope would be that neurological conditions such as stroke and vascular dementia would receive the same high level of medicine and work closely with AMH St Georges Hospital as was envisaged in the old proposal.

1.29 Specifically, a handful of staff raised queries in relation to renal services, mainly seeking clarity on where these would be situated and whether they would be co-located with other services (e.g. outpatient care), while a handful of respondents were disappointed about a lack of information about how the proposals would affect mental health and psychiatric services:

I am concerned that there is no mention of whether the renal unit would be part of this new hospital. It is a well renowned supra-regional service, which has made it possible for many of the other specialties/services to 'punch above their weight' in a District General hospital. It would also be a very helpful resource for the Marsden if it was co-located next to them. I cannot overstate the concern at the 'silence' on the future of the renal unit in the model proposed.

For Renal services this [Sutton?] is a poor solution if out-patients is on a different site. It will split up the renal unit and therefore the staff, which will lead to disjointed patient care and will lead to the split up of the team who look after these patients.

Have SLaM been considered? As people's mental health impacts on hospital admissions in physical acute hospitals too.

I am disappointed about the lack of information about the inclusion of psychiatric services of all types such as inpatient beds for patients with dementia, older people with functional conditions, working age psychiatry beds, CAMHS beds and learning disability beds. Liaison psychiatry services are vital too and should be 24/7 covering all ages which they are not currently at both hospitals - your model would require 3 services instead of 2.

1.30 In relation to maternity services, there were some detailed concerns raised, for example, about the numbers of transfers and longer hospital stays that may be required, and a possible fragmentation in the service as a result of having antenatal and postnatal services provided in a different location to where women are giving birth:

Statistically women are now older (30+) when they have their first child, particularly in more affluent areas like Surrey, and there are more pre-existing health issues such as obesity and diabetes. Only 45% are considered low risk and there is currently a 25-30% transfer rate for home births to major acute services. Keeping it local in midwife led units with fewer consultants in both Epsom and St Helier but with another unit at the SECH for the most difficult births might be an option to consider.

As a midwife my may concern is the lack of capacity in the new maternity services. With an almost 30% LSCS rate recently, increasingly high-risk women i.e. more older mothers, more IVF, to say the majority of women will stay in 7-24 hours is rubbish. Post-operative women will often need longer, vulnerable women will need longer as will women will get infections, those have feeding problems and mothers will certainly need to stay with their baby to enable breastfeeding when they are in the neonatal unit.

I am particularly concerned that maternity services will not be within minimal or existing travelling time for those who fall within the catchment area. This is the only devolved area of care in the new hospital where, in the main, admission is either not planned or brought to the hospital as an emergency. I am worried that there is the potential for negative outcomes if maternity services are only available on one site and the increased length of a journey time could result in complications with delivery because the mother has not got to the unit in time.

[If St Helier is chosen] all services i.e. maternity, could continue to be contained within the one unit, which i personally feel mothers would prefer instead of going to two sites for antenatal and post-natal care and delivering their babies in a different hospital.. My concern is team working among maternity will become fragmented and care disjointed for mothers to be. I feel we could lose a sense of continuity of care for maternity. Additionally, staff will have lots more travel to and from sites to cover staff sickness/shortage at the last minute causing increased travel time and expense to workers. I feel the whole of maternity, gynae and early pregnancy should remain together in one hospital with access to emergency and elective theatres including birth centre whether that be at St Helier or Sutton site.

1.31 There was a specific concern raised in relation to the ability of Pharmacy services to operate across three sites, though with some suggestion as to how this could be alleviated:

Many services (e.g. Pharmacy) are already challenged working on 2 sites so working across 3 would be almost impossible. Outpatient dispensing services could be outsourced or FP10 used or all prescribing for out-patients transferred to GPs. Pharmacy must be at the centre of any multidisciplinary approach to patient care…

1.32 There were some comments emphasising the need to increase 'step down' facilities for rehabilitating elderly patients who may not need an acute bed, for example:

One respondent proposed re-opening Wilson Hospital: *'ideal to house bed blockers and ease pressure on St Helier and St George's Hospitals'*;

Another felt there should be a nursing home attached to every hospital, and to consider re-purposing the Jubilee Centre in Wallington as an elderly care facility

1.33 One staff member was concerned about services for the elderly being *"managed on a post acute site when the teams to support them will be elsewhere. … There are very few elderly people in hospital who are not at risk of becoming acutely unwell".*

1.34 Others wrote of a need to integrate emergency and acute services with social care services generally. The following comment did so with reference to some particular challenges in the Surrey area:

> *In comparable regions, the ICS/ICPS include all or nearly all the hospital trusts serving that region. In Surrey we have the complexity of several integrated care systems… I do not think the proposals have sufficiently considered social value… nor have they considered the inter-connections between emergency and other health and social care services and the benefits to be gained by designing a system that promotes care integration across clinical and social pathways, as with the successful perinatal services… A successful proposal must solve some of the access issues and also how emergency services connect with and benefit from the surrounding health and social care infrastructure, including ongoing support after discharge, otherwise you will continue to suffer increasing problems due to readmissions and will reap poorer outcomes.*

1.35 Some other comments asked that the following also be considered:

Cross-boundary issues i.e. taking account of neighbouring CCGs' plans

Reducing the usage of other externally leased properties, such as the corporate offices based in East Street, if these can be relocated to the main sites

Offering free or affordable on-site accommodation for visitors, potentially run by charitable providers (i.e. along the lines of Ronald McDonald House in Tooting)

The best ways to improve the working environment for staff e.g. by involving them in some of the design decisions and ensuring they can access suitable accommodation, childcare etc on-site.

The environmental impacts associated with building work and the new hospital's design e.g. by reusing building materials, and incorporating green spaces into the design to promote wellbeing and biodiversity

The patient experience for those with particular needs such as autism and severe anxiety

Consulting with Air Ambulance Kent Surrey Sussex (AAKSS) and London Air Ambulance about incorporating a helipad into the new hospital's design;

Ensuring a range of affordable food and drink options on site

Whether updating Royal Marsden and allowing it to use the Sutton ICU could be an opportunity to sell the 'grossly expensive' Marsden site in Fulham and use the proceeds for further research

Consideration of issues around end-of-life care;

The impacts of COVID-19, in terms of future service provision.

Written Submissions

1.36 One possible mitigation suggested via written submissions were for ESHT to invest in re-balancing health inequalities

Surely a better solution is to use the funds available to reduce health inequalities in South West London

1.37 Another was to provide more beds than currently proposed:

The numbers were laughed at only four more beds required to what we have now, 1048 up to 1052. If, as was said on a number of occasions, this is a once in a generation opportunity, then let's make sure the plans cover the future. With medical science making operations and treating illnesses today that were not possible 10 years ago we should ensure bed numbers. Why not cater for 1200 beds. This would show the public that you, as a Trust, are looking to the future and not reliant on your computer modelling which when announcing only four more beds required shows negative reaction. It just does not sound right and at each of your presentations hard to sell

We request an urgent rethink on total bed spaces to be provided (Tadworth and Walton Residents Association)

I would also like to find out more about aftercare given that the preferred option is to send patients home as soon as possible to recover in their own home. From personal experience many patients do not have access to downstairs toilets, washroom facilities or a carer to help them with medication, dressings etc so can involve a life changing decision to move to a nursing home because of these needs. Most of the private nursing homes can range up to £2,000 or more per week so not always feasible or practical to stay at home. Would it not be better to allocate some of the money to provide more nursing homes given the ageing population in the borough? An option could be for a small co-pay towards the cost of this if required

Social Media

1.38 One individual who engaged via social media felt that it was better for the Trust to address the root cause of staffing issues, rather than reacting to it by centralising services.

Anything else…

Consultation Questionnaire

1.39 Some respondents wanted to find out more information, with some specific requests relating to the following:

Clarity about how infectious cases will be dealt with (e.g. kept separate) and about whether the microbiology lab will remain at St Helier;

Details of any land sales proposed as part of the programme, and in particular information about what would happen to the land currently identified for the new acute unit at St Helier/Epsom in the event of Sutton being chosen;

What happens to Queen Mary's Hospital for Children in each option;

The proportions of ambulances anticipated to go to each site under each option;

Whether claims about the proportion of services remaining at the current sites are really accurate, and can they be expressed in terms of a) how many of the current staff posts will be at each site under each option, and b) the numbers of patients using each major service (i.e. how many there are at present and where they would go under the options);

Questions about the onus placed on the patient to decide which site they should present to, especially parents with children: *Is the plan for all those under the age of 16 to go to SECH A&E as indicated in the pre-consultation business case?*

Whether the new centralised A&E would have access to specialist Paediatric consultants during daytime hours: *If it did not, then, as a medical doctor myself, I would continue to drive my daughter to Chelsea & Westminster Hospital to be seen by a paediatrician rather than have her assessed by generalised A&E consultants, who might miss a rare diagnosis and would not have the same experience of dealing with children, e.g. doing paediatric blood tests and lumbar punctures.*