Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Car Parking Charges in the Health and Social Care Sector

15 February 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Gordon Dunne
Mr Mark H Durkan
Ms Pam Lewis

Witnesses:

Mr Conrad Kirkwood	Department of Health, Social Services and Public Safety
Dr Bernie Stuart	Department of Health, Social Services and Public Safety

The Chairperson: Let me apologise to the witnesses for keeping them waiting and for putting this item further down the agenda. I will hand over to you to introduce yourselves and make your presentation, after which we will ask questions.

Dr Bernie Stuart (Department of Health, Social Services and Public Safety): I will not go through the paper that we sent the Committee. I will just give you a brief overview, and then, if you have any questions, we will answer them.

Our revised draft policy on car-parking management has just been out for public consultation. The Department's first policy on this matter was issued in 2008, and that was in response to concerns about a lack of consistency on charging and the need to apply some kind of rigour. Therefore the charging policy dates from then. It is four years since it came out, so we have decided to review it.

The original policy put in place a matrix of exemptions for car-parking charges, and certain guidance was given on how charging was to be applied. There are a few changes that we have had to take account of. We still place a great deal of emphasis on the need to manage traffic. Now, in 2012, there is more emphasis on the green agenda and the need to encourage other methods of transport besides cars than there would have been in 2008. There are the DRD healthy transport plans, many more initiatives for car-sharing, incentives to park-and-ride and so on. We are trying to move forward from the 2008 policy, bring it up to date and regularise it.

Neither of the two policies is prescriptive. The 2008 policy allowed for charging on main hospital sites and included criteria for exemption. At the time, charging was not widespread; however, since the introduction of the 2008 policy, car-parking charges have been introduced on several other hospital

sites, such as Craigavon Area Hospital, Daisy Hill Hospital and, more recently, at the Antrim Area and Causeway hospitals. One of the tenets of the last policy was the need to take account of local circumstances and car-parking abuse. The guidance was reinforced by the British Parking Association's 'Charter for Hospital Parking', which establishes principles for charging. The British Parking Association has 650 corporate members and has established certain principles that you should abide by in your car-parking policy. It establishes that a car-parking space is not a gift but a valuable asset that needs to be paid for. You need to ration and regulate the demand for spaces, especially where there is more demand than availability. Impact on the environment, which I spoke about earlier, is stressed; so too is the need to maintain the car park, reinvest the income and maintain a certain security.

The new policy goes a little bit further. The new policy is not drastically different from the old one. The new policy tries to broaden the possibility of car-park charging to sites other than main hospital sites. Traffic and the use of cars is, probably, more widespread and becoming greater than it was even then. The new policy does not insist that you charge; it allows for charging on sites other than main hospital sites depending on whether there is a suitable business case. Not every site will be suitable; on some small sites charging would not be financially viable. However, there may be sites, such as those in town centres, where it is necessary because you would not want them to be abused by shoppers, for example, and people be prevented from getting to their GPs.

The consultation on the policy closed in December and contained a series of questions; it was not just about charging. The consultation had a reasonable number of respondents; it looked at equality issues as well, as we are required to do with any new policy. Most respondents agreed with the proposed changes. However, when people ticked that they were not in agreement, they were asked to provide an explanation, although in some cases they did not do so.

I will go through the details of the main issues that arose from the consultation: the extent and publication of exemptions; the availability of capital to support changes or availability of spaces; essential car usage; the availability of enough spaces; alleviating pressure on those spaces; and the amount of staff charging. With regard to free parking, some staff, as you might expect, felt that they should be exempted because of their professions, for example. The policy implies that staff should be charged on sites where the public and visitors are charged. That was an issue for some people, although not a huge number. We were very interested in people's answers on whether exemptions were working. In general, people felt that the exemptions matrix seemed to work pretty well. However, a concern was the publicity surrounding that. The exemptions might not be clear to people who are, perhaps, infrequent visitors to hospital and then have a period when they visit regularly. Therefore, one thing that we will reinforce following consultation is that there should be better communication of exemptions.

Exemptions are different from cost recovery for people who are on low incomes. Exemptions relate to frequency of visits; for example, renal or cancer patients would be eligible. Each trust has discretion to give free parking under certain circumstances. That discretion was widely recognised as a good thing because there could be individual circumstances that you could not legislate for in the matrix. Similarly, people wanted publicity on the availability of information on the hospital travel cost-recovery scheme. We will, therefore, take account of that.

The next issue was the availability of capital to support the new charging. People asked whether there would be enough money to install barriers and man car parks. We have taken that into account. A business case will be required. We would not submit a business case for two or three spaces; there would have to be a certain number of spaces in order to do that. An example is the new car park at Antrim Area Hospital. It was implemented under an invest-for-efficiency scheme. We could get more efficiency out of that space.

Essential car usage was raised by some staff; they asked whether they could have a space if they need their car for work. Consultation with trusts indicated that staff will not have to pay for a space on every site that they visit. However, they will have to pay for a space at their base car park, just like anybody else, and claim for other sites. Not charging staff would make the entire idea of charging completely unviable. Some 60% to 80% of those who park on a site may be staff, so they need to be part of the management of the spaces.

Availability of spaces was an issue highlighted by staff. If you are paying for space, you must have it, and there is huge pressure on the spaces that we have. City sites have greater pressure than rural ones, but it is an issue that indicates that strong traffic management will be important.

In alleviating the pressure on spaces, the healthy transport plans and the initiatives that I spoke about at the beginning should be promoted more. We need to incentivise those ways of getting to work that do not involve one person in one car while making sure that, as far as possible, there are enough spaces available. There were various incentives. At Craigavon Hospital, for example, you pay more for a space near the door while the spaces further away are cheaper. Such incentives seem to work well. The other issue was the amount of money paid. It was not patients and visitors who raised that; they were generally fairly content with the level of charging, but the amount that staff had to pay. Discussions with UNISON indicate that, as long as the charge is modest, people can live with it. At the moment, the maximum charge on any site is less than £250. There was a suggestion that we could apply a fixed cost as a percentage of income, but it had to be kept modest so that staff were not being over-penalised for the use of their cars.

Finally, there was an equality impact assessment (EQIA). We screened that out on a regional basis with the clear consensus from our in-house team that it needed to be evaluated from an equality basis on each site because the circumstances are completely different in each area. You need to take account of local conditions; for example, if there is car-park charging on the road outside, it has to be pretty much the same price. You cannot incentivise people to park in the hospital grounds rather than on the road if they are not patients. All that needs to be taken into account, including the number of people using it, and so on.

As to the way ahead and what we are planning to do next, we are just finishing the analysis of the consultation exercise. You have a summary of that. We plan to adapt the policy over the next few weeks with the idea of issuing it within the next month or so. We would be very interested to hear your views or anything you might want to add to the consultation or to answer any questions.

The Chairperson: OK, Bernie. Thank you very much for your presentation. I have a couple of points. We had the Department in earlier talking about community care and meals on wheels. I do not know whether you heard that, but there was an issue about a departmental circular or policy that all trusts should take on board; yet not all trusts are taking it on board. Some of them are ignoring what the Department wants around charging for meals. You said that the guidance on car-parking provision and management was issued in June 2008, and you go on to set out some of the key principles; where does the cost issue sit? If the Department has a strategy or policy, do trusts ignore what the Department wants and just charge their own price?

Dr Stuart: No. The 2008 policy focused largely on traffic-management issues rather than finance. It was a permissive policy, so you could charge in order to manage staff. Because of the constraints on the Budget and on the health service, the focus in 2012 is probably more that we are not saying that you must charge, but it is now becoming more accepted that you can charge in order to make money for the sites as well —

The Chairperson: Will you put a figure on the amount that you can —

Dr Stuart: We have a gross figure of what is brought in; we do not have the net figures. It is about £2·5 million a year. We reckon that if we charged more widely on all the viable sites, that could probably go up by perhaps £500,000 or £750,000. It has gone up over recent years as car-park charging has become more of a feature. However, our policy is not to insist. I think what you are leading up to is whether we intend making charging compulsory.

The Chairperson: No; I am not suggesting that. I am not saying that I agree with car-parking charges; I am asking whether the Department is looking at a cap on how much hospitals can charge.

Dr Stuart: Yes.

The Chairperson: Given your point about the city centre, the City Hospital can charge anything up to £10, whereas the highest charge in the Ulster Hospital is £4·50 for more than 8 hours. However, the Ulster Hospital brought in more than £1 million in 2008, 2009 and 2010, and the City Hospital brought in £874,000, £883,000 and £828,000 in those respective years.

Dr Stuart: Part of the charging strategy is to encourage quick turnover, particularly on the sites. You do not want people using the City Hospital site as a park-and-ride facility.

The Chairperson: My point is that you do not necessarily have to charge big prices to make money; the comparison between the Ulster and City Hospitals shows that.

Dr Stuart: The City Hospital has special planning constraints around it because of its location. It is in a certain zone, and the parking charges are restricted by the planning permission.

Mr Conrad Kirkwood (Department of Health, Social Services and Public Safety): A planning restriction was placed on the building of the multi-storey car park at the hospital, which necessitates the kind of charge that there is at the City Hospital.

The Chairperson: OK. I am interested in the Royal site.

Mr Wells: Aren't we all.

The Chairperson: We do not have details on how much revenue was collected by the contractor.

Dr Stuart: That was one of the early PFI contracts and is our only PFI car park. We have no mechanism for renegotiating that contract, which is up in 2016.

The Chairperson: Have we no mechanism to find out what profit it has made? There is speculation that it could be anything from £1 million up.

Dr Stuart: I do not think that we can. We can ask, but they have no obligation to tell us, as far as we know.

Mr Kirkwood: That is correct; they have no formal obligation to release that information to us.

The Chairperson: Will you ask them formally?

Dr Stuart: Yes, we will, but I do not think that they have to answer.

The Chairperson: It might be useful to keep it in the back of your mind that it is up for renegotiation in 2016. We should not be caught sleeping on those deals.

Dr Stuart: There has been quite a bit of discussion about the requirement to provide enough space. It is embroiled in legal discussions, which may or may not be completed before 2016.

The Chairperson: If the Department is getting a handle on that across the board, how is there such a difference between the Royal and the Ulster Hospitals in relation to staff car parking? It is £60-odd for full-time staff. At the City Hospital it is £78 annually to park there for full-time staff; it is £206 at the Royal. You need equality across the board. If the Department is doing that, it needs to set costs for staff.

Dr Stuart: That is one of the issues that came up in the original policy. The original 2008 policy brought a bit more consistency, and we have had quite a bit of discussion as to whether we should have a single charge across the region for all staff. Because of local circumstances, we advised that that is not really possible, because city and rural areas have very different constraints on their sites. We are trying to move gradually towards more consistency, possibly across a trust first and then more region-wide. Many charges have been in place for a while. As I said earlier, we may be moving towards a percentage of Agenda for Change, but it is not yet mandatory. Consistency is something that the trades union is keen to progress.

The Chairperson: Staff are employed by the Belfast Trust, and the two hospitals are now under the one management. In that case, I would park in the City and walk over to the Royal to save more than £150.

Mr Kirkwood: I understand that that has already been discovered by way of some of the consultation. The suggestion in the Belfast Trust is for about 0·7%, capped at £250. That would achieve equity across sites and also some equity in the amount of money that someone pays whether they are part time or full time.

The Chairperson: I would be more inclined to bring it down than put it up. If you are talking about equity, you do not need to bring it up to £250; you could bring it down.

Dr Stuart: However, if you are going for a salary percentage, not everyone would pay the same. We hope that, after the policy has been agreed, charges would become more consistent. I do not think that this policy will get us to the point where they are all the same; perhaps it might do so at the next revision.

The Chairperson: Are there any plans that additional car parking or renovation of car parks will be done through PFI, or have we learnt our lesson?

Dr Stuart: Every business case has to consider the best option. You will have seen the discussions on PFI. I cannot say that we will never do PFI, but, at the moment, I would be very surprised if PFI turned out to be the best value for money on any site.

Mr Wells: That has to be one of the most tactful answers that I have heard in years: that PFI may not be the best option. The company at the Royal has long since paid the capital cost; everything that comes through the gate is pure profit. I have had cause to use it, and I had to wait 40 minutes to get in and there was a queue behind me. Occupancy is basically 100%. That is a licence to print money. Why did we not have a claw-back provision that, once the company had paid off the capital cost, some portion of that would go back to funding essential care in the Royal?

Dr Stuart: Hindsight is 100%. I remember attending a PFI seminar at which I learned that the public sector participant entered with a bit of naivety into many of the early PFIs and not just the car-park ones. That is all that I can say, really.

Mr Wells: When Linfield sold a striker in those days to Manchester United — I am sure that you are wondering where this is going — they got £100,000 up front and then a proportion according to what he achieved if he got capped for Northern Ireland or whatever. Therefore, they had a claw back; so it was not revolutionary. The company saw the trust coming, because we have given it a licence to print a vast amount of money every year. The thing is not even manned; it is controlled by a machine. You stick your money in and you get your ticket.

That is not all: as it turned out, it is totally inadequate. I am getting complaints, because this is a regional service that affects all constituencies, not just those in the Belfast Trust area. People tell me that they have to allow at least an hour at peak periods to get parked in the first place. We have given some lucky company the National Lottery every day. Belfast City Hospital is bringing in £882,000, and the Ulster Hospital is bringing in more than £1 million. What on earth is the Royal bringing in? We should know that, at least. We should have had a claw back, but why on earth did we not make it big enough in the first place?

Dr Stuart: There is a requirement on the company to provide another tier of car parking if the demand is there. That has been the subject of a legal dispute for some time. We cannot pre-empt the outcome; however, in effect, the trust is saying that the PFI provider should provide the extra tier, while the PFI provider is saying that it is not required to do so. That is taking some time to resolve. I would be surprised if it is resolved before 2016.

Mr Wells: In 2016, will the only issue be what the company charges, or can the trust resume ownership?

Dr Stuart: Oh, yes; the trust can resume ownership in 2016 when the contract ends.

Mr Wells: Well, then, you would be very wise to build the second tier and bring in the money. To be honest, that car park might need to double in size because the present situation is chaotic. You must be getting complaints about it.

Dr Stuart: Conrad may want to talk about the extra work that the Belfast Trust did.

Mr Kirkwood: The Belfast Trust carried out extra work on the Broadway site to produce additional spaces; it has attempted to rationalise parking on the site. There are other areas, apart from the main car park to which you referred, that would have been managed by Car Park Services (CPS). That seemed unwise, given contractual wranglings and problems. The exercise took place in order to rationalise as much of the space as possible. Moreover, you have to appreciate that on a site as compressed as the Royal's and being unable to build another multi-storey facility, the only other tool available, having gone through healthy transport plans and done everything to encourage people to come to the hospital by different means, might be to dictate the supply based on price. However, if you increase the price on the Royal site, you make a gift of that increase to the contractor, which you would not wish to do. Therefore that tool, which could be used to affect the demand for spaces, is not open to them either. However, they have carried out an exercise to rationalise spaces and provide additional spaces.

Mr Wells: You said that you have started to charge at the Antrim and Causeway hospitals. That is good. Parking is desperately difficult at Antrim Area Hospital. Apparently, people park there, get a taxi to Aldergrove and go on their holidays; they use it as a free car park. That was only discovered during the snow, when it was noticed that many cars never seemed to move; their owners were in Marbella. It is typical of Antrim people to think of that; I waited for Pam to leave before I made that comment.

You say that you will recoup the costs over two and four years. If you do as well as Craigavon, for example, which received £330,000 a year or Altnagelvin, which received £116,000, why will it take two to four years to recoup the costs? What on earth did the machinery cost?

Mr Kirkwood: Additional spaces were provided at the rear of Antrim Area Hospital. The intention was to charge patients and visitors only at the Antrim site and not to charge staff. Therefore additional spaces were provided to the rear of the hospital so that staff could be segregated. That also avoided the problem of staff who were coming in early in the morning and, typically, parking close to the door of the hospital. The additional spaces to the rear of the hospital allowed them to be moved to the rear to make better parking access for patients. There was a cost associated with that to the order of £100,000, on top of the additional costs for machinery.

Mr Wells: I understand that, but how can it take four years to recoup the cost of the machinery at the Causeway Hospital? Would it not be better to give a man in a yellow coat a money bag and a hut? Would that not be cheaper, if it is to cost you £300,000?

Dr Stuart: The return on the money includes all costs, not just the cost of the capital.

Mr Kirkwood: I understand that in association with implementing the car park, there will be a requirement for an additional element of security staff to be available on site. They will deal with problems that people might have with money, change, the machine breaking and not giving access, and disabled parkers who will perhaps need additional assistance if there is a problem with trying to get the ticket out of the machine or getting to their car. There are, therefore, other staff running costs to be recouped.

Mr Wells: Would a man in a yellow coat in a hut not do that? He will not charge you £380,000. I know that some people think that manual labour is a Spanish footballer, but there are people who can physically do this job; you do not need a machine. We seem to have gone for a very expensive option, when someone who has a bit of common sense could be at the gate and look for the blue badge, check staff and check people who are going in for chemotherapy or whatever.

Mr Kirkwood: I want to give an explanation on that point. The most recent occasion on which the man at the gate was used was in a survey at Lagan Valley Hospital. The intention was to determine who should not have been using the car park and to determine proper usage; however, it created a backup of people trying to get access to the hospital, and it created road-traffic problems. We have to be careful with that. Some work was put in at Antrim to make more road space available so that we did not have a backup further onto the main road that might have caused an incident.

Mr Wells: I seem to have been at every hospital in Northern Ireland, including Craigavon. When I was last there, they had a system in which you paid into the front two car parks. There was also a free car park at a considerable distance, which staff and the more fit and happy visitors were happy to use. I was a bit annoyed when Michael McBride talked about the over-45s and the very elderly; had it not been such a serious subject, he would have been hearing from my solicitor. For the over-45s, like myself, who can still walk, there is no problem with parking there and coming the whole way up to the main building. That seems to work very well, and there seems to be quite a high level of public satisfaction with it.

Mr Kirkwood: It worked very well. Craigavon and Daisy Hill have come online with charging since the previous policy was in place. They were very circumspect in how they did it; they made it free further away from the hospital and more expensive closer to it. That has worked. That is good, because those sites are dispersed in such a way that they can do that. However, if you are on a more compressed site, with a pressure on space, it is harder to make free space available. There is not enough space. I agree that it has worked well on both those sites.

Dr Stuart: It can be translated. If you are going to charge everywhere, you can have a differentiated rate of parking for people so that parking closer to the hospital is more expensive.

The Chairperson: We are moving round all the hospitals.

Mr Wells: You installed the machinery in Downpatrick and you have fantastic car parks over a huge space, but you have not started charging. What happened there?

Dr Stuart: The previous Minister stalled the decision while he considered it; therefore we did not start charging.

Mr Wells: I am not encouraging you to start. However, I noticed the other day that the equipment there is in pristine condition; it has never been used. It looks as though there will be a 50-year pay-back period for the car park if you are not going to charge people for using it.

Dr Stuart: Charging will probably come into operation once the new policy comes in.

Mr Dunne: The next Minister will bring it in.

The Chairperson: Gordon wants to declare an interest as one of those who went to Marbella. *[Laughter.]*

Mr Dunne: Definitely not.

Thank you very much. It is very interesting to see the differences in charging across trusts. There has been significant investment in car-parking provision at the Ulster Hospital, which obviously has to be welcomed. As a local user of the hospital, I commend the good work being done there. Are there any further plans for the Ulster Hospital in relation to car parking?

Dr Stuart: With every new development, car parking has to be taken into account. I am not sure of the full detail of what is associated with the new scheme. However, car parking availability is considered for every new development and new build on the hospital site and will be part of any new scheme. I will have to come back to you on that, because I am not sure of the detailed numbers.

Mr Dunne: How did you find customer satisfaction with the present system at the Ulster Hospital?

Mr Kirkwood: There has been no formal customer satisfaction questionnaire, if you will. The consultation showed that people complained not so much about the rates as the availability of spaces on the site.

Mr Dunne: For the public?

Dr Stuart: Yes. If you drive up there at any time of day, you will see cars parked alongside McDonald's. There is quite a bit up there.

Mr Dunne: I have noticed that within the past year or so; it is a fairly recent thing.

Dr Stuart: Some sites, such as the Royal, are very compressed. The City and the Ulster hospitals have huge turnovers of people every day. They are not big sites, so there is not much space for additional car parking. That is a cause of great concern, and we are keeping it under review.

Mr Dunne: Additional staff car parking has been provided at the Ulster.

Dr Stuart: Yes.

Mr Dunne: That has been an improvement.

Mr Kirkwood: You need to be aware of the difference in cost between flat car parking, which costs roughly £1,000 a space to deliver, and multi-storey car parking, such as the one at the Ulster, which costs roughly £10,000 a space to deliver. That is because of the cost associated with a multi-storey building.

Mr Dunne: Therefore it costs ten times more a space.

Dr Stuart: Yes.

Mr Dunne: Are you happy with the cost of car parking at the Ulster Hospital in comparison with what is charged at hospitals in other trusts?

Dr Stuart: If you look at the matrix, you can see that the consistency might not be what you would like it to be. I suppose that we would hope to see charges becoming more consistent in the longer term. I do not think that we will ever see the same charges right across Northern Ireland, because as you say, the Downe Hospital will never have the same demand as, for example, the City hospital or the Royal.

Mr Kirkwood: You will notice that charging at the Royal and Ulster sites is more expensive; that is because of the accelerator used. The difficulty at both sites is the pressure on the number of spaces. The accelerator ramps up quite quickly, particularly at the Ulster site, to encourage people to move off the site quickly, whereas it may be a little slower at other sites.

Mr Dunne: The information that we have is that it costs £4·50 to park at the Ulster for over eight hours. Is that right?

Dr Stuart: Yes.

Mr Dunne: Yet it costs £10 at the City.

Mr Kirkwood: The City has a particular planning restriction that differentiates it from other sites.

Dr Stuart: The city centre, if you work there, is also easily accessible from the site.

Mr Dunne: That is a problem. The other issue at the Ulster was that people were parking there and getting the bus into Belfast. Is there still a risk of that?

Dr Stuart: I talked about local circumstances. You have to take into consideration, particularly for the Belfast sites, that we do not want people using hospital car parks as a park-and-ride facility. Parking fees and structures have to take that into account.

Mr Dunne: Following this review, you will still leave the discretion with the trusts?

Dr Stuart: The exemption matrix applies as before. There is encouragement to become more consistent. At this stage, they will have to consult locally with trades unions and the public in the region in order to bring about any changes. Perhaps later we will move towards mandated consistency, but not at this point.

Mr Dunne: Are there plans to bring in charges at the Erne Hospital and at the Omagh Hospital, when it is built?

Dr Stuart: Yes, they would be covered by the policy in the same way as the rest. They would not be mandated, but it is likely that there will be charges at them.

The Chairperson: The Assembly research paper says that the financial exchange between the trust and the car-park services at the Royal site amounts to some £40,000 a year. Conrad, did you say that the Belfast Trust spent money on additional car parking at the Royal site because there are issues with the car park?

Mr Kirkwood: The Belfast Trust produced additional temporary spaces on the Broadway site and will get them to the window of opportunity in 2016.

The Chairperson: Will you give us the detail of where you mean on the Broadway site and how much was spent?

Dr Stuart: It is beside the two Broadway towers. They have temporary planning permission because the legal dispute is under way. It is a temporary measure.

Mr Kirkwood: There are 200 spaces, which are used by staff who have been moved out to that car park so that there is more space closer to the hospital for patients.

Dr Stuart: Staff have been given a cheaper rate to park there.

The Chairperson: How much did that cost?

Dr Stuart: We will give you an answer to that in writing. It has a limited planning permission.

The Chairperson: There is also the issue of the Belfast Trust doing away with property.

Finally, you get free car parking at the City Hospital on Christmas Day, if any of you want to go there. On behalf of the Committee, I would like to thank you very much for coming. It was a useful exercise. Again, I apologise for keeping you to the end.

Dr Stuart: No problem. We will get back to you on those points.