HEALTH COMMITTEE

Tuesday 6 June 2006

Session 2

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HEALTH COMMITTEE
15th Meeting 2006, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Mr Stewart Maxwell (West of Scotland) (SNP)
Margaret Smith (Edinburgh West) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE

Peter Barriball (Vinci Park UK Ltd)
Rosie Butler
Stephen Gordon (Consort Healthcare)
Susan Lloyd (Royal College of Nursing Scotland)
Gerry Marr (NHS Tayside)
Julie McAnulty (Lanarkshire Health United)
James McCaffery (NHS Lothian)
Morag Moore (NHS Ayrshire and Arran)
Ross Scott (Scottish Executive Health Department)
Kate Seymour (Macmillan Cancer Support)
Tom Waterson (Unison Scotland)
Bill Wright (Capability Scotland)

CLERKS TO THE COMMITTEE

Lynn Tullis
Simon Watkins

SENIOR ASSISTANT CLERK

Graeme Elliott

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 6 June 2006

[THE CONVENER *opened the meeting at 14:00*]

Items in Private

The Convener (Roseanna Cunningham): I call the meeting to order and welcome all the visitors to the Health Committee.

The first item is to ask committee members to agree to take items 3 and 4 in private. Item 3 is a discussion of the committee's approach to its consideration of the Adult Support and Protection (Scotland) Bill and item 4 is consideration of the appointment of an adviser on that bill. In both cases, it is normal practice to take such discussions in private. Does the committee agree to do so again today?

Members *indicated agreement*.

Hospital Car Parking Charges Inquiry

14:00

The Convener: Item 2 is evidence taking on car parking charges in Scottish hospitals, in the second in our series of single-session inquiries that we are holding this year. We are taking evidence in the form of a round-table discussion. Committee members have an issues paper that the Scottish Parliament information centre has prepared—it is a fairly brief, factual rundown of the situation.

In addition to committee members, 12 participants will be involved in the discussion, representing a number of different perspectives. We have representatives of patients, staff, health boards, car park operators and the Scottish Executive, so we have just about covered all the stakeholders, to use the jargon.

To clarify for those who have not been involved in a round-table discussion before, I will briefly run through how we will run it. I will ask everybody around the table to introduce themselves briefly and to say who, if anybody, they represent. Some participants are here as individuals but, if they represent an organisation, I ask them to let us know. The introductions are not an opportunity for opening statements. There are far too many of us to do that: it would take too long.

I ask committee members to introduce themselves as well. They are scattered round the table, so it is not an us-and-them set-up. I will direct discussion during the evidence-taking session and I hope to encourage some of the witnesses to cross-question each other. They should not sit back waiting for committee members to question them; they may also directly address other individuals around the table.

I want to ensure that a number of issues are covered: patient perspectives, which are important; staff perspectives, which are also extremely important; health boards' charging regimes, on which we need to hear directly from the health boards; and the monitoring and regulation of those regimes, which is the Scottish Executive's end of the matter.

To begin the discussion, I invite some perspectives from patients. Kate Seymour from Macmillan Cancer Support will briefly talk about issues of importance from national health service users' perspective. Macmillan published a research document entitled "Free at the Point of Delivery?", to which we will come. That will be the opening salvo.

I ask participants to introduce themselves. Obviously, I am Roseanna Cunningham, convener of the Health Committee.

Janis Hughes (Glasgow Rutherglen) (Lab): I am deputy convener of the committee.

Kate Maclean (Dundee West) (Lab): I am the MSP for Dundee West and a member of the Health Committee.

Susan Lloyd (Royal College of Nursing Scotland): I represent the Royal College of Nursing Scotland.

The Convener: I ask everybody to ensure that their microphones are pointed directly at their mouths. I also ask participants to ensure that, when they speak, they speak up and speak into the microphone. Otherwise, the discussion will be lost.

Susan Lloyd: I represent the Royal College of Nursing Scotland.

Tom Waterson (Unison Scotland): I am chair of Unison's Scottish health committee.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I am a member of the Health Committee and the MSP for Greenock and Inverclyde.

James McCaffery (NHS Lothian): I am director of human resources and organisational development for NHS Lothian.

Gerry Marr (NHS Tayside): I am the chief operating officer for NHS Tayside.

Morag Moore (NHS Ayrshire and Arran): I am the general manager of facilities for NHS Ayrshire and Arran.

Bill Wright (Capability Scotland): I represent Capability Scotland.

Kate Seymour (Macmillan Cancer Support): I represent Macmillan Cancer Support.

Shona Robison (Dundee East) (SNP): I am the MSP for Dundee East and a member of the Health Committee.

Ross Scott (Scottish Executive Health Department): I am from the Scottish Executive Health Department.

Helen Eadie (Dunfermline East) (Lab): I am the MSP for Dunfermline East and a member of the Health Committee.

Rosie Butler: I am here to represent my daughter Aimee and many other seriously ill children.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I am the MSP for Strathkelvin and Bearsden and a member of the Health Committee.

Julie McAnulty (Lanarkshire Health United): I am a carer and a member of the campaigning group Lanarkshire health united.

Mrs Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland and a member of the Health Committee.

Stephen Gordon (Consort Healthcare): I am the general manager of Consort Healthcare at Edinburgh royal infirmary.

Peter Barriball (Vinci Park UK Ltd): I am a regional manager for Vinci Park UK Ltd. We manage a number of hospital contracts, including at Ninewells hospital in Dundee.

Euan Robson (Roxburgh and Berwickshire) (LD): I am the MSP for Roxburgh and Berwickshire and a member of the Health Committee.

The Convener: Thanks. In case people were wondering, the other people around the table are the sound folk, the official reporters and the committee clerks. They will not take part in the discussion.

I ask Kate Seymour to set out her perspective on this matter, after which we will go straight into the discussion.

Kate Seymour: As you said, convener, last July we launched a report called "Free at the Point of Delivery?" Our previous research suggested that financial worries and pressures were sources of great concern and stress to cancer patients. Indeed, the costs of travel and parking for treatment proved to be the greatest by far of all the additional costs associated with having cancer.

The situation has arisen partly because the nature of cancer treatment—and, indeed, treatment for other conditions—has changed. For example, 10 years ago, people might have spent a long time in hospital undergoing chemotherapy and other cancer treatments. However, because four out of five people now have their radiotherapy as outpatients, their trips to and from hospital are more frequent. Moreover, there are now many different kinds of treatment and many different ways of receiving it. Some treatments are short—radiotherapy treatments can last only 15 minutes—whereas others can take all day or require an overnight stay.

Public transport is just not an option for cancer patients. For example, if you have just had chemotherapy or radiotherapy, the last thing you want to do is take a bus—or, in some cases, two or three buses—because you feel sick and tired and you are susceptible to infection.

Our report found that, in Scotland more than in other parts of the United Kingdom, hospital transport was particularly bad. I welcome the

Minister for Health and Community Care's statement that the issue will be examined. However, at the moment, cancer patients mainly use private cars to get to and from hospital.

The briefing paper on car parking charges mentions Scottish Executive guidance on hospital car park charging. We welcome that guidance, as it puts Scotland in a much better position than England, where hospitals use car parks to generate income. However, we are not completely sure whether that guidance also applies to car parks that are run by private companies. We are also concerned that, instead of staying in its current position, Scotland might be moving towards the English situation of having higher car park fees.

We acknowledge that there is pressure on space at hospitals. However, if people find themselves unable to park, they get worried about being late for their appointment. Moreover, if people are very ill, they want to be able to park close to where they receive treatment. Because of the frequency of their visits, particularly for radiotherapy treatment, cancer patients—and other patient groups—are affected by such problems. Indeed, those receiving chemotherapy might have to make frequent visits that in some cases could last for several days.

The situation in Scotland is complicated because it is patchy. Some hospitals do not charge for parking while others charge low parking fees. Moreover, because it is not well publicised, people are not always aware that many places give a free parking pass to those who, for example, are receiving radiotherapy. As a result, they miss out on that benefit. Such concessionary schemes should be better publicised.

We know that car parking charges at hospitals are a big issue for people. Much of the feedback that I have received is that people do not think about them—because they are so pleased that they are getting their treatment—until they realise what a big financial hit they have taken. Cancer patients often are on reduced incomes or have to give up their job and they have huge numbers of other costs. Many people have said to us that the costs of travel and parking for treatment are the final straw.

The Convener: Does Macmillan Cancer Support have any specific recommendations?

Kate Seymour: Yes. Our recommendation is that we would like people who come to hospital for cancer treatment to be exempted from car parking costs.

The Convener: I will ask Rosie Butler, Bill Wright and Julie McAnulty to make some comments on the back of what Kate Seymour said.

Rosie Butler: I can speak only as a parent. My daughter has been ill for five years with leukaemia. At the moment, we are able to access disabled parking. If we have to start paying for disabled parking, as well as imposing a financial burden—as Kate Seymour pointed out, looking after a seriously ill child has an effect on one's ability to earn—it will create a practical difficulty. Children who receive cancer treatment can continue to receive it for many years. Throughout that time, they can experience periods of medical emergency, when they require to get into hospital within 30 minutes of the call being made. What concerns me about NHS Tayside's proposed changes, under which disabled parkers and disabled passengers will have to pay for parking, is that I will be faced with a hard choice: either get my daughter into the hospital and worry about parking later or get a parking space and worry about the consequences of my daughter not receiving treatment when she is supposed to have it. Parents of seriously ill children should not have to take on that additional anxiety.

In this country, child health care is supposed to be free. For example, children who are under the age of 16 do not have to pay for NHS prescriptions. Increasingly, specialist services such as cancer treatments are based in centres such as Glasgow and Edinburgh. Once someone starts a treatment regime, they might have to travel quite a distance. Anything that gets in the way of a parent simply being with their child to help them get through what they need to do to get to the next day is an extra burden that drains everyone. I am extremely concerned about the effect that the proposed changes will have on other parents like me.

I will give a practical example. Last week, on 1 June, I met a fellow parent from the children's ward in Ninewells hospital who was desperately trying to find money to put in a parking meter. People are worried even before the charges are in place.

Bill Wright: Capability Scotland is concerned about disabled access. To pick up on the point about children, someone who is under two cannot get a blue badge, so even if there are spaces for blue badge holders the parents of such children cannot use them. Having to meet additional costs puts extra pressure on parents, as does the threat of not being able to find a space at all. They have to spend a lot of time at hospital. It is bad enough wondering how long it will take for their child to be seen without having to look at their watch and think about how much the parking is costing them. The provision of disabled spaces is particularly important. Their use is often not monitored, with the result that disabled spaces are taken up by the vehicles of able-bodied people.

Julie McAnulty: I am from Lanarkshire, where there are particular problems with public transport. Transport links across Lanarkshire are poor, because they are geared to allowing people to travel from any point in Lanarkshire into Glasgow, not to facilitating travel between two places in Lanarkshire. At the moment, that is not too much of a problem for people such as my mum and dad, who are elderly, because all their needs are met at our local hospital, which is Monklands hospital. If they needed to go to hospital in an emergency or for planned surgery, that is where they would go. However, under the proposals for the centralisation of services, the provision of elective and major surgery and accident and emergency services will be separated, which will create huge transport problems. If my mum or dad needed major surgery, they would have to travel to East Kilbride or Wishaw and people from East Kilbride and Wishaw would have to travel to Monklands.

14:15

Some people might park in hospital car parks unnecessarily—I am as guilty of that as anyone—but most of us have to travel several miles to get to hospital, which can only be done by taxi or car. That means that there is a captive market. I understand that one of the reasons for introducing car park charging was to reduce unnecessary parking. If centralisation goes ahead as currently planned, however, unnecessary parking simply will not happen. There will be a captive market, because people will have no choice.

The Convener: I want to ask the health board and other witnesses to come in at this point but, before that, I have a specific factual question for Ross Scott: how does the guidance that has been issued by the Scottish Executive fit in with respect to private car park operators?

Ross Scott: The first paragraph of the guidance states:

"This guidance applies both where car parking facilities are being provided and/or managed by NHS Boards and by private sector providers."

The Convener: It is useful to have that on the record.

Tom Waterson: Unison's understanding is that private finance initiative projects that existed before the Health Department letter was issued are exempt.

Ross Scott: When that guidance—NHS HDL(2004)19—was issued in 2004, it applied to future car parking regimes. Tom Waterson is quite correct: the new Edinburgh royal infirmary was in place before the guidance was issued.

The Convener: So the guidance is not retrospective.

Ross Scott: It is not retrospective.

The Convener: That is a useful clarification.

James McCaffery: We operate all our car parks throughout Lothian according to the tenets of the guidance. We are conscious of the issues regarding cancer, and we have recently introduced a pilot programme at the Western general hospital, in which cancer patients are given priority parking just outside the treatment areas. We call it valet parking, but people can simply park there. The intention is to extend to the Western general the discounts that operate at St John's hospital and Edinburgh royal infirmary to ensure that regular attenders—relatives and other visitors—get a discounted rate.

We work on a red and blue voucher basis, which offers significant discounts. Red vouchers enable free parking for relatives and visitors at Edinburgh royal infirmary, the cost of which NHS Lothian picks up under a commercial agreement with Consort Healthcare (Edinburgh Royal Infirmary) Ltd. Blue vouchers enable parking at a slightly discounted rate for people who attend regularly. St John's has two cost levels: one for patients who attend on a regular basis, which is £5 a month, and the other for relatives, which is £5 a week. We are cognisant of the fact that people who visit hospital on a regular basis should not pay the same as non-regular visitors. However, we do not make any money out of car parking. It is a major charge.

Gerry Marr: Tayside has been mentioned already, and the issue of transport has been raised in two witnesses' introductory remarks. Although we are addressing the subject of car parking today, we must remember that it falls within the wider context of transport, which includes green transport schemes and issues around how transport can be secured in a meaningful way. There is no ducking the issue.

Kate Seymour's report has been useful in helping us form our opinions about car parking. When we spoke to our review group that produced a report for the health board, we asked questions about cancer in particular. The review group asked why we should distinguish cancer. The group acknowledged how emotive cancer is and that it is very difficult for people when they suffer from it, but it asked us also to consider patients on renal dialysis, who might attend hospital three times a week, and elderly, relatively low-income patients with enduring illnesses—often more than one, including coronary heart disease and diabetes—whose attendance at hospital is no less frequent and who might end up in even more stressful situations over a longer period.

We have tackled the cancer issue head-on. The group's conclusion was that it should be a matter

not of distinguishing cancer treatment but of exploring how to develop schemes in which free car parking could be offered to people who need it, which would reduce their stress. Our fob scheme for free parking is not specific; it is spread across patients who are judged to need it.

Bill Wright talked about disabled parking and mentioned the introduction of car parking charges for the disabled. The overwhelming view that came back to us via our review group was that the disabled spaces were the subject of abuse and that disabled people were more concerned about the issue of access than about the issue of charging. We have increased our number of disabled spaces, as have many schemes, and we will work with disabled groups to find better ways of making it easier for disabled people to park on-site.

The reality is that both disabled spaces and ordinary spaces are the subject of abuse at our hospitals. Our commitment is first and foremost to try to make those spaces available to our patients.

The Convener: It would be useful if you could tell us whether the abuse has been quantified. Were you able to establish what percentage of spaces were being used in that way?

Gerry Marr: Yes. This gives me the opportunity to put the record straight on what I consider were misleading headlines about car parking charges in Tayside. Not all committee members will know Ninewells hospital. Car parks 5 and 6 are nearest to the hospital, and we surveyed their 240 spaces over a period of time when we were carrying out the review. In one car park, 65 per cent of the spaces were used by people who were there all day. In the other car park the figure was 85 per cent. Those car parks are exclusively for patients and their relatives, but the spaces were not being turned over in favour of patients. If they were used exclusively for patients and were turned over three times a day, 700 to 750 spaces a day could be used, but they were not being used for patients. Instead, they were being abused by people who were parking all day.

We have introduced what we call a variable car parking charge. We did that two years ago as an experiment in the area next to our cancer wards near the east wing. When we introduced the charge, the abuse stopped from day one and we never issued a variable charge. The variable charge is intended to prevent abuse. There will be no circumstances in which any patient or relative will be charged more than £1.50 for their visit to Ninewells hospital—I give a public guarantee of that. I am talking about a variable penalty charge for people who abuse spaces that are for patients and their relatives. If people choose to abuse the spaces, they will be penalised. However, when we ran the experiment, people immediately stopped the abuse, and we have never issued a variable charge.

Kate Maclean: I welcome this discussion. Although I asked for the inquiry to be conducted, I was not specifically having a go at Ninewells hospital or NHS Tayside. There is a huge problem throughout the whole of Scotland, with a patchwork of schemes having been allowed to develop so that there are different schemes between boards and within boards. I want the Executive as much as the boards to address that.

I am particularly concerned about disabled parking and accident and emergency parking at Ninewells hospital, which has not been mentioned yet. The NHS Tayside report says that disabled spaces

"are regularly abused by individuals displaying a blue badge but not allocated to them."

I do not understand why that cannot be dealt with. If I knew that somebody was abusing a blue badge, I would phone up the council and that blue badge would be rescinded. It seems to be an overreaction to conduct a review of car parking charges to deal with people who are abusing things. People should not abuse blue badges in hospital car parks or anywhere else. The situation could have been dealt with in the way that I have suggested.

On fly parking—that is, people abusing car parks—the guidance says:

"NHS Boards should investigate ways to control such parking, other than introducing excessive daily charges".

The guidance then gives options, one of which is

"to check at manual barriers the validity of parkers".

I do not know whether that is being done—perhaps the representative from Vinci Park UK Ltd can tell us what the company has done to deal with abusive car parking. Another option given in the guidance is to use different car parks for different categories of car park users. Perhaps we could also find out whether that is being done.

I am also concerned about the situation at accident and emergency units. I do not know what happens elsewhere, but at Ninewells hospital in Dundee people are given a token to allow them to get out of the car park after they have been to accident and emergency. Often, the driver will be accompanying the patient and will therefore not have the option of just dropping them off at the drop-off bay and then parking somewhere else. The report from NHS Tayside says that the system was "on occasions abused". I wonder what the nature of that abuse was and whether any steps have been taken to deal with it.

The review has not been well received in Tayside, as far as Ninewells hospital is concerned.

I am not aware of a lot of effort being made to deal with the issues that Gerry Marr raised about people abusing the car park.

To the witness from the Scottish Executive I say that we need a Scotland-wide review of car parking. When we are delivering health services in a different way, car parking will have to be suitable for people who have to travel much longer distances for services.

The Convener: Before I bring in Gerry Marr or the witness from Vinci Park UK Ltd, I want to bring in Rosie Butler, Helen Eadie and Julie McAnulty. It will be useful to hear their comments.

Rosie Butler: Parking at Ninewells is difficult, and it is difficult for the managers to deal with the problem. However, there is no point in doing something that disproportionately disadvantages a group that is already disadvantaged. I have a fob, but it is for car park 9, which is at the furthermost extreme, far away from the children's wards. Outside the children's wards there are two disabled parking spaces that cater for people going to out-patient clinics, but 1,000 patients go through those clinics in one day. The children's wards have 160 bed spaces with a regular turnover. It is therefore nigh on impossible to get a disabled parking space. My only option may be to go to an area where I have to pay for parking.

Helen Eadie: You and my husband will be glad to hear that I do not hoard newspapers all the time, but I kept this article from the *Edinburgh Evening News* last November, which has the headline "Free Parking for Saturday Shoppers". There is free parking for shoppers across the whole of Scotland. In some places you pay, but in many out-of-town shopping centres parking is free. I have a strong opinion about this—you will just have to accept that I do. It is morally wrong that we make people pay at hospitals but allow shoppers to park free. If society agrees that somebody has to pay for car parking, society should say that parking should be free at hospitals and that we should pay at shops. It is as simple as that.

Gerry Marr spoke about green transport plans. It would be interesting to know how many of the health boards represented round the table have a green transport plan in place.

This is a problem for the Scottish Executive and for health boards. The Minister for Transport, Tavish Scott, is in his silo and the Minister for Health and Community Care is in his silo. Do these people ever talk to each other? At that level, transport budgets should be helping with health budgets. Money should not come out of health budgets to provide car parking. I am absolutely opposed to that. Money should come into the transport budget from shopping budgets to fund car parking in hospitals. That should be done at community partnership level in local authorities. I would like people to comment on that.

How can it be right that we read headlines such as those in "Free at the Point of Delivery?" and in newspapers when we dig through the archives? For example, one chappie had to pay £1,600 in hospital car park charges in the year prior to his wife's death. That must be wrong. It just should not happen. I ask for people's opinions on that, because I feel that society has a big problem. People should not need to pay for car parking at hospitals. As a society, we should ensure that the Government ensures that people pay car park charges not at hospitals but at places such as the Gyle shopping centre.

14:30

Julie McAnulty: At most public buildings, fly parking is resolved by putting up a booth and a barrier, which are usually a sufficient deterrent. There would be no need for car park charges if there was sufficient patrolling. Why cannot security men patrol car parks to ensure that spaces are not being abused? If people abuse spaces their cars should be clamped. It is quite simple.

Other parking problems exist in the city hospitals, which I should mention, as Jean Turner and I are the only people here from Glasgow. At Victoria infirmary, 92 per cent of the parking is for staff but the staff have a problem with the prohibitive charges. I have a friend who is a nurse at Glasgow royal infirmary. When the car park charges started there, the charge for staff was £15 a month. The cost then went up to £25 a month and has now increased to £40 a month. In effect, £500 is docked from the staff before they even get through the door. That is really wrong.

Why cannot car parking at hospitals be funded by central Government? Why is car parking treated as a separate issue rather than as another piece of hospital equipment? We would not ask someone who needed dialysis to pay for their dialysis machine. Why must it be done in this way?

In my area, Wishaw general and Hairmyres hospital were built using PFIs and went significantly over budget. That is why, as most people probably know, NHS Lanarkshire is £20 million in debt at the moment. Although introducing car park charges might be a good way of raising revenue, I agree with Helen Eadie that it is morally wrong. We already pay taxes, so why should we be required to pay again?

The Convener: Susan Lloyd from the RCN will give the staff perspective. Gerry Marr has already stated that Tayside NHS Board does not raise revenue from car parking, but I am curious to

know whether other health boards are in the same situation. Perhaps the other health board representatives can pick up on that after we hear from Susan Lloyd.

Susan Lloyd: I support what Helen Eadie said about car park charges within our health service being morally wrong. The issue is important not only for staff but for visitors and relatives. At this year's Royal College of Nursing congress, we had quite a debate on car park charging. On the basis that the principle of the NHS is that care should be given free at the point of delivery, we voted for a motion to abolish all car park charges within health care settings. I know that that might be a bridge too far for some people round the table, but we should go forward with that in mind.

Car park charges have been increasing and, especially at PFI hospitals, they have become quite a lucrative business. The charges are unfair, unjust and inequitable for staff, patients and visitors. I work as a staff member in different areas within Lothian because I need to provide cross-site cover, so I know that the different charges at those hospitals are really bad. Car park charging puts a burden on staff, visitors and patients that is totally unacceptable.

The Convener: We should probably now hear from the health board representatives. We will hear first from Morag Moore and then from Gerry Marr.

Morag Moore: In Ayrshire and Arran, we do not charge for car parking, but we have just the same problems. We are fortunate in that we are a relatively rural area so we have been able to expand on our acute sites. However, we are rapidly running out of space.

It should be noted that, along with other boards, we are very much involved with the local authorities in drawing up green travel plans. However, I accept that we have not had the joined-up working that is needed. We have worked with Strathclyde Passenger Transport Executive and the three local authorities. We have just appointed a transport co-ordinator to pull some of that together, but it will take a long time to produce the baseline information, because that involves the Scottish Ambulance Service and the use of taxis, for example.

The comment about clamping was interesting. Clamping is illegal in Scotland—we have been through that repeatedly with the local population. In the various boards in which I have worked, that has been misunderstood. If a road is not public, there are some things that we cannot do. On our sites, the double yellow lines are relatively meaningless and clamping is illegal, so much of what the public think that we can do to prevent people from parking wrongly is not available to us. Our powers to do anything about people who consistently park wrongly are limited.

Through our disability discrimination group, we have considered many initiatives over the years, such as valet parking and various forms of barrier parking. We also have tokens, but people still abuse the system. If we used resources to patrol car parks, that would take resources away from security in our hospitals. We must balance the risk in what we do.

Gerry Marr: I will address Kate Maclean's question after making two general points. In the debate that we have had in recent weeks, the emphasis has been on the car user, but the reality is that many people from deprived areas of Dundee must pay for public transport to go to their hospital appointments.

The Convener: You and I have discussed that for many a long year. People not just from Dundee, but from an extremely large rural area, must rely on public transport. Ninewells is in Dundee, but it serves a much wider population.

Gerry Marr: I accept that. My point was that the discussion is about transport policies and infrastructure as much as it is about the narrower issue of paying for car parking.

The other general point is that there is no such thing as free car parking. Taxpayers pay for the NHS to manage and regulate car parks; that is taken out as a share of patient care. We estimate that if we, rather than Vinci Park, ran the car park, the cost would be equivalent to that of 200 major hip operations a year. We must be conscious that there are choices to be made. There is no such thing as a free car parking space; the taxpayer will pay for that one way or another, unless we leave car parking unregulated and abandon any responsibility to regulate on our patients' behalf.

I will respond to Kate Maclean's points. I can only report the car parking review group's advice to us, which was that we are in an anomalous situation, as the car park for accident and emergency is shared with that for cancer patients. It is an anomaly that patients who arrive for cancer treatment pay whereas people who go to A and E do not pay and are given a token. The group concluded that that position was not defendable.

We are creating six spaces outside A and E. The current system is that car parking is paid for on exit and not on entry, so people should not worry about being unable to access A and E. Unfortunately, the token system was abused and tokens were handed over to people to park inappropriately. We have monitored the situation a lot, as I am sure every other health board has. However, that is infinitely difficult to do, given the volume of traffic that moves through the site on any one day.

James McCaffery: We have spent the past year working up a policy as part of a green transport policy. Our major problem is that we deal with different locations throughout the Lothians—for example, the position in Edinburgh is completely different from that in West Lothian. The intention is to standardise charges on all our sites. We are discussing that with Consort Healthcare in relation to Edinburgh royal infirmary.

We do not have enough car parking at Edinburgh royal infirmary or the Western general. We are producing a scheme for a multistorey car park at the Western general that will cost us £5 million. I have worked in England and Scotland and I can say that the Western has among the worst facilities for car parking. It is important to provide parking for cancer patients, because people travel long distances for that treatment. However, the essential point is that we must pay that £5 million.

Taking into account staff transport and various other things, we currently spend the best part of £1.3 million on car parking charges and receive £816,000 in revenue. The gap between those figures is significant. In addition, we fund buses and other forms of transport. A third tramline that goes to Edinburgh royal infirmary is needed. We have had discussions about that with TIE Ltd, which will operate the tram system. TIE told us that an act of Parliament would have to be passed before such a tramline could be constructed. The problem is not car parking; a whole transport initiative must take place. It would make a huge difference if we could get such a service out to a site to which 25,000 to 35,000 people go each day.

The Convener: I invite Kate Maclean to repeat what she said a little while ago. Perhaps the representative from Vinci Park could then respond to the monitoring issue that she raised.

Kate Maclean: What steps have been taken to try to stop people abusing the car park at Ninewells hospital? Peter Barriball was a member of the group that produced the NHS Tayside report, which mentions the abuse of blue badges. Have any efforts been made to monitor and deal with that abuse and the abuse of the token system for people using accident and emergency services? People—commuters, I suspect—appear to use the car park all day. What efforts have been made to use the Executive's guidance on hospital car park charging, which states:

"NHS Boards should investigate ways to control such parking"?

What has been done at the board's request to investigate such abuses?

Peter Barriball: The brutal reality is that blue badges are among the most abused things in transport. Everywhere in the country, people who are not genuine blue badge holders use blue badges. There are expiry dates on blue badges, but there is no national register for them and the holder's photo is on the back, rather than the front. It should be remembered that in our work at Ninewells hospital, every other hospital with which we work and even on the streets, where we do enforcement work for councils, we are not policemen. We do not have the power to say to a person, "That's not your blue badge. You can't park there." Doing so would not be in our remit. Abuse can be reported to councils, but we are talking about European blue badges. A blue badge that one sees in Dundee will not necessarily have been issued there—it could have been issued anywhere in the country. In parts of London, the theft of blue badges from cars accounts for some 85 per cent of car crime.

The Convener: That is extraordinary.

Peter Barriball: It is. I am talking about places such as Islington and Brent.

The Convener: After the meeting, will you give us a reference so that we can find that information?

Peter Barriball: I got the figure from a council.

It is easy to steal blue badges, which can be worth £100 in pubs. A person simply has to break the car window. In Hatton Garden in London, where there are many jewellery shops, every single car on the street will have a blue badge.

Kate Maclean: Are you saying that if a car with a blue badge sits in a car parking space at Ninewells hospital every day from half past 7 until half past 5, you can not do anything about it and have to leave it there?

Peter Barriball: What would the owner be doing wrong? We could not enforce anything.

Kate Maclean: So you would not be proactive. The person would be taking up a parking space for which they were not paying, but you could not do anything about that. Could you not find out whether the car was legitimately parked?

Peter Barriball: Obviously, we could speak to our partners in the health board about the matter, but we do not have any power to question people.

Kate Maclean: So the answer to my question is that no steps would be taken.

Peter Barriball: It would be hard to take steps. What could we do? We are not the police. We do not have any enforcement powers. There is not much that we could do if somebody chooses to park all day in a place in which they should not park with a blue badge that does not belong to them. We could not do any more than the police could do if, every day, a person parked their car in

front of someone else's house in an ordinary street, even if they were seen running away from their car. Things are hard to prove. Terrible abuses of the system occur. Where the blue badges—

Kate Maclean: Let us leave blue badges to one side. Are any efforts made to monitor those who blatantly use the car park as a commuter car park all day, every day?

Peter Barriball: We can monitor and we see vehicles that we know about. Students can be seen coming into the car park, getting on the bus and going to university, for example, but they are ultimately not doing anything wrong. The signs say that it costs £1.50 to park a car all day—they do not say that people have to go to the hospital. That is one reason why the review group wanted to consider the management of the system.

The three-tier tariff was only ever intended to deter those people; that is what it was all about. If 10 people park all day—although there are probably far more than 10—10 patient spaces are taken. The £1.50 tariff is competitive in the town and makes it easier for people to take the bus rather than the car.

14:45

Kate Maclean: Does Ross Scott think that that situation falls within the guidelines in relation to investigating ways to control fly parking?

Peter Barriball: But people are not fly parking; they are paying for parking in a paying car park.

Ross Scott: I tend to agree. A car displaying a disabled pass might sit in the car park all day, but we would not know whether it belonged to a member of staff or someone else. We could follow it up only if we knew that it did not belong to someone attending the hospital.

Can I take the opportunity to respond to one or two other points?

The Convener: I want to bring in a couple of other people, but I will come back to you. I said that I would call Shona Robison and Jean Turner, and one or two others have indicated that they want to speak, too.

Shona Robison: One of the issues that has emerged is that we should consider and monitor to whom the blue badges are issued, rather than where they end up being used. There seems to be inequity not just in car parking charges but in public transport links to hospitals. Perhaps we need to widen the discussion to cover that. I am concerned that, as services move further away from people, public transport access will become critical. We certainly have to consider that.

We need to achieve charges that are not prohibitive—frequent users and disabled people should not have to pay for car parking—and to bring about equity throughout Scotland. The question is whether the Executive can strengthen its guidance to introduce equity into the system. That point is directed at Ross Scott.

Gerry Marr highlighted the real dilemma for us. If public transport ends up being more expensive than car parking charges, how do we get the people who can take public transport to hospital to do so? That would leave car park spaces for people such as Rosie Butler and her family. If public transport is more expensive, that would be a disincentive for people to use it. We need to weigh up those issues and ensure that car parking charges are neither prohibitive nor amount to a disincentive to use public transport. I stress that that applies to the people who can use public transport, because many cannot.

The Convener: I want to stick to the specifics that were raised on the monitoring of unauthorised use.

Dr Turner: I know that there are more cars now than there were when I first qualified in medicine, but there never used to be any difficulty for the car park attendant to ensure that the right person was in the right place. Perhaps we do not want to pay too many car park attendants; perhaps we are trying to save money on a wages bill. Gerry Marr mentioned costs. All patients, including cancer patients, carry the cost by having to go back and forward to hospital more frequently. A big cost has been saved over many years through the reduction in bed numbers and the fact that people are in and out of hospital faster. However, patients have to go back and forward to hospital more frequently and cover great distances. If someone lives in Kinlochrannoch, what buses take them to hospital in Dundee? If someone is ill, a bus or tram might not be the appropriate form of transport for them. A patient with cancer, chronic respiratory disease, cardiovascular disease or arthritis might be in agony getting on and off public transport. Many costs have been saved in the health service and the onus has been put on the patient. It is iniquitous that patients should have to pay. If there were no charges, the car parks could be better policed and the situation would be easier.

Gerry Marr: Can I comment?

The Convener: I will bring you back in, but I want to go to Ross Scott because a number of comments have been directed at him. I will add my own question: what precisely is the meaning of paragraph 3.5 in your guidance? The car park operators have expressed the view that they have almost no capacity to discourage unauthorised use, but paragraph 3.5 in the guidance is

specifically about how to do that. What does it mean in the context of what we have heard today?

Ross Scott: We have issued guidance to NHS boards on managing car parking better. Paragraph 3.5 addresses the difficulties with fly parking. We look to NHS boards to find suitable solutions to their own problems. We have given some examples and it is down to NHS boards to develop their own approaches. We cannot be prescriptive.

The Convener: We are looking for some indication that the guidance means something. In the context of what we have heard, it does not look like it means anything.

Ross Scott: In Tayside, the situation depends to some extent on the contract between Tayside NHS Board and the car park provider. We are obviously not privy to that contract.

We suggest the use of mechanisms such as manual barriers, staff passes and so on as possible ways forward.

Kate Maclean: What does "unauthorised user" mean? I have an office in Dundee city centre. If I paid £1.50 to park at Ninewells hospital all day and got the bus into town, would I be an authorised user or an unauthorised user?

Ross Scott: I reckon that you would be an unauthorised user because you are not a member of staff, a patient or a visitor.

Kate Maclean: Thank you.

The Convener: Right. I now have—

Ross Scott: Sorry. Can I pick up on one or two points that need to be addressed?

The Convener: Okay.

Ross Scott: Kate Maclean asked about a national policy; Shona Robison also touched on the issue. This might seem to be an excellent opportunity to develop a national policy, given that all the stakeholders are round the table. However, the difficulty with a national policy is that no two hospital facilities are the same. They are not in the same location, they do not have the same supply of and demand for car parking and they do not have the same transport links. A national policy is not really a feasible option.

Kate Maclean: I did not ask for a national policy.

Ross Scott: Well—

The Convener: I appreciate that it is perhaps not in your remit, but when these issues come up again and again in relation to health boards, it seems extraordinary to me that nobody is sitting down and thinking about the implications of what we are doing in the context of transport.

Ross Scott: The issues are always different in different facilities. There is not always the same problem.

The Convener: With respect, I do not think that the way to avoid the discussion is to say that the problem is different in different areas—of course it is.

Lots of people are beginning to jump up and down now and I want to make sure that everyone who wants to get in does so.

Tom Waterson: Given that is about 40 years since we put someone on the moon, it is incredible that we cannot work out a system for watching over a bit of concrete for an hour. I have never seen any evidence of fly parking. I have heard it said by the companies that provide the car parking service that fly parking is why they have to put up the cost, but I have not seen any evidence of fly parking. If the prices are high because of fly parking, why do the companies charge at night?

Janis Hughes: My first question concerns what Ross Scott said about national schemes. I accept the premise that hospitals in rural areas have different needs from hospitals in urban areas, but if we separate the issue of staff from the issue of patients and visitors, NHS staff are paid on national rates, so why should parking charges for staff vary throughout the country?

My second question is for Peter Barriball from Vinci Park UK. Ross Scott gave a clear definition of unauthorised parking. Will you clarify, on the back of Kate Maclean's question, what you do about those who park on an unauthorised basis as defined by the Scottish Executive?

Peter Barriball: We have probably not done much about people who should not be parking on site, because there is little that we can physically do. There are 2,400 spaces. We cannot check every car to see whether the individuals are the right people. They drive into a public car park, pay the tariff and drive away.

Janis Hughes: What about the suggested manual checks at barriers? For example, you could stop people and ask for a staff pass or an appointment card.

Peter Barriball: The vast majority of people will say that they are picking up or dropping off, or people will say, "It's none of your business." We have a barrier system at Aberdeen and we ask people for an appointment card. The vast majority of people say that they are dropping off, then they disappear and park where they should not. We are not police and we do not have the power to turn cars away or to arrest people. All that we can do is to take people at face value. If someone says that they have forgotten their appointment card, we would let them in. In Dundee, there are 23 car

parks and we would need to have someone managing each of them to prevent people from parking illegally.

Janis Hughes: I thought that that would probably be the role of a car park operator if there is a problem with illegal parking. Are you saying to the trust that, as an operator, you cannot assist it with the problem of unauthorised parking on the site?

Peter Barriball: We can assist, but we have no powers. If somebody drives into the car park and pays £1.50, we do not have the power to question them and make them prove who they are. In the real world, that will not happen. People just drive into the car park and they park all day.

Many of the people who park in the patient car parks—certainly at Ninewells—are staff who are parking in the nearest car park to the building. A lot of the parking review was about freeing up the parking spaces that are nearest to the building for patients and visitors. That is the reason for the two-tier tariff, which aims to deter staff and move some of them to car parks that are further away. The intention behind the ring-fenced tariff has been misrepresented. It was intended to manage parking so that patients and visitors could park near the building. However, we cannot check every car and ask, "Who are you and where are you going to park?" People lie to us.

The Convener: Before we go back to Ross Scott, could the chap from Consort Healthcare, Stephen Gordon, comment on what it does?

Stephen Gordon: We have a different situation. We have five car parks in Edinburgh, most of which are shared car parks. Staff are issued with a permit, which they pay for on a monthly basis, and they use it to access the car parks, so the staff are legitimate users. Non-staff users pay charges that range from £1.20 up to £10 for anything over six hours. In response to Tom Waterson's point, we find that that deters people from fly parking and using the car parks to commute to the centre of Edinburgh. However, we appreciate that the system catches everyone. It is not our intention to charge staff, visitors or patients £10. Our car parks at Edinburgh royal infirmary are short-stay car parks and the average length of stay is not 10 hours or six hours, but two hours.

The Convener: But what do you do to monitor unauthorised car parking?

Stephen Gordon: I agree with Peter Barriball that it is difficult to monitor. If people park for more than six hours, they pay £10 for the privilege. That is a deterrent, but it is difficult to—

Janis Hughes: But you do not make checks to see whether people are authorised users.

Stephen Gordon: If they do not hold a staff permit and they are paying to park there, we cannot make physical checks. As Peter Barriball said, the answer that we would get would not be, "Yes, I'm fly parking here. You've caught me, guv." That will not happen.

Tom Waterson: Can I just—

The Convener: No. I have a long list of people who want to come in on this point.

Janis Hughes: Can Ross Scott answer my question on national rates for staff?

15:00

Ross Scott: In the guidance, we have said that where there are charges for car parking, there should be concessions for staff. However, if we were to say that all staff had to pay a certain sum—£100 a year, say—we would have to start charging staff in NHS Ayrshire and Arran, who do not pay at the moment, or in places where there is no need for staff to pay for parking. The main driver is supply and demand—the spaces that are available and the demand for them.

I return to what Morag Moore said. I know that things are moving in NHS Ayrshire and Arran, but it probably has a higher ratio of car parking spaces to number of staff than the Western general in Edinburgh has. That is why we cannot make one policy and apply it to every facility.

Planning has to be done around what the local authority will allow. That was one of the issues with the new Edinburgh royal infirmary. The plan was to have a much larger car park than the City of Edinburgh Council would allow; only on a subsequent application to the planning committee did the car park become the size that it is.

There are transport issues—

The Convener: You have had enough time. Kate Seymour is next.

Kate Seymour: I have three points to make in response to issues that have been discussed.

First, with regard to the national policy, we welcome the fact that NHS Lothian is considering having the same rates throughout the Lothians. However, all this can be extremely complicated for patients, who do not always know whether they can get a concession or free parking, or how much parking will cost them. If we want to make it simple for people to park at hospitals, we might not be able to have a full national policy. However, I do not think that the idea of giving free parking to people who use a hospital frequently should be dismissed out of hand just because certain aspects of such a scheme would be complicated.

I echo what other people have said about fly parking. It is difficult to believe that a better way cannot be found of deterring people from using car parks when they should not be using them. I do not quite understand the thing about public car parks; I appreciate that the public use a hospital car park, but if it is reserved for people who are using the hospital, it is not a car park like one in the centre of Edinburgh. All sorts of parking systems are in use all over the place and I just do not believe that we cannot have a better system than the current one, which seems a bit like using a sledgehammer to crack a nut. I am sure that, as in the report that Helen Eadie mentioned, people end up paying huge parking charges because they have slipped through the net. In the end, we should ensure that that is not happening to anyone.

Finally, I want to respond to Shona Robison on public transport. There are people who use their cars to come to hospitals when they could use public transport. If someone has to get to the hospital because they have been told that someone is dying, although they might physically be able to do that by public transport, going by car would take them half the time, especially if they are elderly. It is difficult to differentiate between those who should use public transport and those who should not. Encouraging people to use public transport is a good principle, but if high parking charges are being used as a disincentive, or to encourage people to use public transport, I am worried that we will end up penalising the people whom we do not want to penalise.

Euan Robson: One group that appears to be missing from the guidance is people who are in training. They might be staff but not of the facility in question, or they might not yet be employed by the NHS, and it might be particularly difficult for them to bear the charges.

Someone in my constituency had to use a car to get to their facility to train, but they were being charged something like £40 a week for parking. Admittedly that was for a short period of time only, but it was an extreme burden for that individual, who was trying to devote their future services to the NHS. Perhaps Unison has a view on that. Why does the national guidance make no reference to any concession for those who are in training?

The Convener: Tom Waterson of Unison is on my list, so he will have the opportunity to respond to that later.

Gerry Marr: I have a final comment about the abuse of car parking facilities. People will remember my earlier comments about the pilot that we ran to trial 30 parking spaces at the east wing of Ninewells: we introduced a variable charge and the abuse stopped. That sounds like a very simple device to me. I would be happy for NHS Tayside to produce a written report for the committee on car parks 5 and 6 and the effect of variable charging. If that approach works, it would be an easier mechanism than some of the ideas that have been spoken about. I give a commitment to the committee to produce that report.

The Convener: That would be useful.

Gerry Marr: Although we are talking about car parking, the three challenges to our board are: our green transport policy, on which we are working with councils and which we will publish later in the year; the effectiveness and availability of patient transport; and, let us not forget, "Delivering for Health".

We have repatriated 46,000 episodes of care out of Dundee to Angus and our plan is to repatriate 27,000 episodes of care back into Perthshire. If one looks further into "Delivering for Health", and takes out-of-hospital care seriously, we must think about using community hospitals in rural Perthshire and Angus and finding ways of treating patients without requiring them to get into their cars and come to centres such as Dundee. We have done that to some extent in both Angus and Perthshire, but we must go further and give patients their choice of treatment place. We must also provide them with effective transport when they have to come to our hospitals, which is part of the bigger issue.

The Convener: Are you not in danger of exporting the car parking problem to other areas? I am thinking of the example of Crieff cottage hospital—if someone lives in St Fillans, they still have to get to Crieff.

Gerry Marr: That presents some of the same challenges. However, in Angus and Dundee—I cannot comment on Perth because we are in discussion with the council there—bus timetables do not fit in with the way that we run our business. All those matters need to be sorted out with the councils.

Dr Turner: In my constituency, a bus that served five hospitals was removed so that option was taken away from people. While we are making transport plans, other people are stopping bus services because they consider them to be unviable.

I do not see the difficulty in giving all hospital staff a badge for their cars so that attendants could check the cars and see whether staff were on duty. I do not see the difficulty in giving every patient a ticket for the car park when their hospital appointment is made. Further, I do not see any difficulty in reimbursing on the day of their appointment patients who go back and forward to the hospital umpteen times.

I noticed in the Macmillan report that one lady could not get her money because she had made an emergency hospital visit on a Sunday. Although people go back and forward for treatment, as Rosie Butler said, they sometimes have to make urgent visits, which create an added cost. Costs build up and people should be reimbursed quickly.

This is not rocket science. We keep talking about living in the 21st century and making use of information technology—could not some IT software note everybody's car number plate and cross-check it against their name?

The Convener: Seven people still want to speak. We will see where we are after that and have a wind-up discussion if there is time.

Julie McAnulty: There is no doubt that transport will become a major problem for all health boards as changes take place. Some years back in our area, Strathclyde Passenger Transport conducted a study into providing better links between places in Lanarkshire. SPT ended up binning the study because it said that the proposal was not financially viable and that it was unlikely that any company would be willing to take on the provision of services.

We have several rural villages peppered across Lanarkshire. To get from one of those villages to a hospital involves three bus changes. However, the buses stop after 6 o'clock, whereas people who are out at work during the day would normally visit someone in hospital in the evening. People might be able to get to the moon, but they cannot get across Lanarkshire very easily, at least not on public transport. In some cases such as that of my mother, who has dementia, public transport is totally inappropriate.

I want to pick up on a point that I find rather surprising and a bit disturbing. People seem to have an ambivalent attitude towards fly parking, in that it is seen to be okay as long as people pay. I would very much question the idea that the person who does not pay is a fly parker and the person who pays is a consumer. By how much would revenue be reduced if hospitals got rid of all the fly parkers who pay? Perhaps that question needs to be answered.

Rosie Butler: I want to backtrack a little bit to clarify things, given some of the perspectives that seem to exist around the table. My daughter is not a disabled driver. I am a non-disabled driver for a disabled passenger. People sometimes forget that. It is wholly impractical to get a wheelchair on a bus. I would not take my child on a bus because her system is so compromised that the risk of infection is too great. We are actively advised not to use public transport.

We have been to hospitals in Edinburgh, Dundee and Glasgow. When we go to Yorkhill, the mannie at the barrier asks where we are going and who we are seeing and we tell him what we are doing. However, at the hospital in Dundee, I have seen car parks 5 and 6 both full when I have arrived there at 8 o'clock in the morning. Why is it not possible to close those car parks until quarter to 9 so that staff cannot use them for long-stay parking and free parking is therefore available for patients and visitors?

The Convener: I will allow another question from Nanette Milne and then a very brief point from Shona Robison.

Mrs Milne: I want to ask the health board representatives whether boards have considered or implemented incentives to discourage staff from taking their cars to work if they are on site all day and do not use the car during the working day. For example, has any thought been given to offering staff bonuses for car sharing or for not taking their cars to hospital?

Gerry Marr: That is part of—

The Convener: Just a second, I have other people whom I want to bring into the discussion. After that, we can try to wind up the debate.

Shona Robison: Ross Scott suggested that policy on car parking was driven by the type of car park and the hospital site. Surely policy should be driven by the needs of patients. He said that a single policy could not be applied nationally, but I do not see why not. Why cannot the Executive say, for example, that patients and their relatives who are frequent users of hospital car parks—however "frequent" is defined—should not be charged? If the Executive had such a policy, we would have equity for patients across Scotland and people would not need to depend on the postcode lottery of what type of car park their hospital happens to have. Would that not be fairer?

Tom Waterson: Let me answer Euan Robson's point. Yes, we have made representations about the cost of parking for students and staff who are in training. Stephen Gordon said that staff are given a permit, but only some staff are given a permit. It needs to be made clear that not all staff are given a permit. Staff who do not have a permit and staff who are in training are forced to pay extortionate parking charges. We raised that issue three years ago at a hearing that Nigel Griffiths chaired on the problems at Edinburgh royal infirmary.

On the issue of monitoring, at that meeting Stephen Gordon also said:

> "The cost of providing a car parking space incorporates the cost of providing twenty-four hour security in the form of CCTV cameras and personnel, barriers and equipment to enforce the charges as well as for maintenance and upkeep of the spaces itself."

However, despite what he said at that hearing, it seems that we still have no way of getting round the problem of so-called fly parkers.

Unison is not opposed to car parking charges in Lothian per se, but we want equity and uniformity. For example, if I do not have a parking permit for Edinburgh royal infirmary, I have to pay £10 a day; at St John's hospital in Livingston, I pay only £1 a day; and if I am lucky enough to attend a health board meeting, I pay nothing. We might not have a national strategy, but we should at least have national principles for car parking charges.

15:15

Mr McNeil: Shona Robison, Julie McAnulty and Gerry Marr have all made the fundamental point that, although the Scottish Executive has issued guidance on hospital car parking charges, it has not issued any guidance on transport issues with regard to centrally delivered specialisations. It takes us back to the attitudes of the old health department, which pretended that the centralisation and specialisation of services was nothing to do with it. The Scottish Executive needs to review this matter.

The issue of transport is certainly important to people in my constituency, which has one of the lowest figures for car ownership in Scotland. Poor and disadvantaged people, regardless of their illness, are the ones who have to take three buses or the train, the bus and the taxi to get to their treatment. That costs a significant amount of money. I am happy to say that there are no charges for car parking at Inverclyde royal hospital, but I think that what we have heard today is only the tip of the iceberg. We should rein back a little bit; after all, I do not think that we are suggesting that someone who is visiting his or her general practitioner or dentist in the high street should not pay a parking fee. However, we should remember that health services are delivered not only by hospitals, and problems of access confront us all in our communities.

For me, this discussion has highlighted the futility of dealing only with the issue of car parking charges. I do not know whether anyone else agrees, but we need an overall strategy that addresses the problem of accessing services.

The Convener: Helen Eadie will be the last of the speakers in the open discussion. I did not ask for any opening statements, but I want to allot some time to closing statements that cover not only specific aspects of the current car parking problem but the general problem of transport and accessibility that has been flagged up.

Helen Eadie: The Macmillan report says that one

"hospital trust raised more than £250,000 from parking charges".

When I took one of my constituents to meet health board officials at the Western general hospital last week, I found the car park in an abysmal state. There were potholes everywhere. Can the representatives of the companies that run car parks tell us how much is spent on maintaining them? For example, the car park at Ninewells hospital is neither well lit nor well maintained.

What does Ross Scott from the Scottish Executive think of the suggestion that responsibility for all hospital car parks in Scotland should be shifted to the Minister for Transport's portfolio? After all, the minister is responsible for green transport plans and so on. I really do not believe that car park provision should come out of the health service budget.

The Convener: I will bring in Ross Scott, but not at this point. I want to get responses to the issues that have been raised. I ask people to address their remarks to the specific and general points that have been made. I do not expect us to come to a resolution here and now—in the next 25 minutes—but I would like to hear the responses of those around the table and any recommendations that they have in that regard.

I will take, in turn, the health boards, the operators, Ross Scott and the MSPs who have raised specific issues. I will then return to the patient or user representatives. I do not want this part of the meeting to go on for too long and I would be grateful if everyone could try to encapsulate their comments. If people have anything further to say, we are always open to receiving written evidence—it can be sent on after the meeting.

I turn to the health boards. Perhaps one representative will take the lead; if not, each of you can make a brief comment.

James McCaffery: In the last financial year, we spent £377,000 on the car parks at the Western. Expenditure of a further £531,000 is planned for this year and £5 million will be spent on a multistorey car park. We are totally aware of the need to regularise car parking charges across NHS Lothian. Two opportunities arise, first with regard to staff and, secondly, with regard to the rural aspects of St John's and other hospitals.

Over the past year, we have been working with staff organisations and a variety of other interest groups. Essentially, we need to ensure that we can provide car parking for people who need it, whether they are patients or relatives. Our intention with regard to staff, including those at the

Royal infirmary, is to ensure that parking is based on the ability to pay. We have not been able to do anything at the Royal infirmary because we have been having contract discussions with Consort. We hope to be able to change the car parking policy at the Royal quite soon.

The Western is an area of special interest because of the extent of the fly parking that happens there. It is important to look at the fact that we provide shuttle services between each of the hospitals. We are also in partnership with a number of local authorities to fund or part fund bus services. The committee should look not only at car parking but at our whole transport philosophy. It is important that we tie in with the four local authorities with which we work and more widely. Our major problem relates to hospitals such as the sick kids that have no car parking. That is a major problem for both Tom Waterson and us. We need to work with the local authorities towards a green travel policy and ensure that we provide car parking for patients.

Particularly with regard to cancer patients, we have a new philosophy of sending out information on where and when patients can park. We have got to take away the strain. If that works well, we will work on the same basis for renal and other patients. For those patients, it is essential not just to get them into the car park but to help them into the care area.

Gerry Marr: First, I will answer a point that Nanette Milne raised. The green plans that we are working on include car sharing schemes, incentives for people to cycle to work and the possibility of park and ride. I know that the situation is the same for NHS Lothian. Our plans will become public knowledge in the autumn.

On the specifics, we have presented to our board, and the board has accepted, a series of recommendations to meet our objectives. The first objective is to maximise the use of the car parks at Ninewells for patients and relatives. The second is to expand and develop the compassionate parking scheme—the contract means that free parking is not available to us. We have given a commitment to disability groups and groups such as Macmillan Cancer Support that we will work with them on the compassionate parking scheme. Our third objective, which is associated with the green transport policy, is to try and get cars off the site so that parking spaces are available to people who need them for the reasons that the patient representatives have set out today. We have given a commitment to report back to the board in an open and transparent way in six months' time and after a year.

Morag Moore: As I have said already, in Ayrshire, we do not charge for parking, but the issues are the same. We have appointed a transport co-ordinator, part of whose remit will be to look at how we can get people from rural areas to the two main acute hospitals. People have to take two buses or hope that someone can give them a lift. The difficulty for us is that everybody arrives at the same time of day and the car parks are empty in the evenings and on weekends. That suggests that we have to reconsider how we provide some of our out-patient services.

The Convener: Ross Scott, some specific questions have been directed at you, but I would also like you to comment on the broader strategic transport issue. It is probably not in your remit, but it would be helpful if you could comment on whether it would be helpful to have that coming from elsewhere.

Ross Scott: I am not sure what issues I still have to address. A question was asked about national policy. I think that only five NHS boards have car park charging at the moment. That means that having a national hospital car park policy would mean introducing car park charging where we do not already have it, if you take the line that staff should pay the same wherever they work.

The Convener: It could just as easily mean that the five health boards would be told to stop charging in order to come into line with the health boards that are not charging. It does not have to be just the one way, does it?

Ross Scott: No, it does not have to be just the one way, but you must bear in mind the fact that free parking might act as a disincentive to use public transport. There are pros and cons.

With regard to the possibility that the responsibility might lie with the Minister for Transport, that is more of a Cabinet decision than a decision that I can make. However, I assume that the committee will make some recommendations to the Executive—

The Convener: Yes, we will be discussing this matter further as a result of the conversations that we have had.

Ross Scott: If the issue is included in those recommendations, we will take the matter forward.

The Convener: We have not dealt with the extent to which the Executive is monitoring the charging regimes. Do you call the health boards in, assess them and examine their procedures? Have you ever told a health board that its regime is not appropriate?

Ross Scott: The HDL states that the income that is generated from car park charging can be used only for the development and maintenance of car parks. Health boards are not using car parks as a method of income generation, which happens south of the border—

The Convener: That is not really what I asked you, though.

Ross Scott: I am coming back to that. Recently, we undertook an exercise to seek assurance statements from NHS board chief executives or directors of finance to confirm that they are not generating income that is being used for purposes other than maintaining the car park.

The Convener: That is still not addressing the point that I asked about. Have you ever looked at a parking regime and said, "We think that's too expensive," or, "We think that's not an appropriate way to go about it"? Never mind the question of where the money goes, do you look at the regime at any point and say—

Ross Scott: The regime is the responsibility of the NHS board.

The Convener: So you are not involved in the issue at all.

Ross Scott: We asked to examine the Tayside regime, so we could comment on it. Our assessment of it was that it addressed the guidance that we had issued. Other than that, we were not prepared to comment on it because it was a local matter for NHS Tayside.

The Convener: I need to hear a wind-up statement from the operators in respect of some of the things that they have said to us, which, they will appreciate, we find rather astonishing. We were all surprised that there is no capacity to monitor or deal with unauthorised use of the car parks. What changes would you like to be made that would give you that capacity? What would enable you to do what we all thought that you were doing but which you are clearly not doing?

15:30

Stephen Gordon: In Edinburgh, we deal with the unauthorised use of car parks by charging. That is not the best way to go about it, but it is a deterrent to fly parkers to have to pay £10 for a day and the number of fly parkers is probably minimal as a result.

Car parking is a scarce resource, certainly in Edinburgh's case. There are 1,700 spaces at the Edinburgh royal infirmary and between 10,000 and 12,000 movements to and from the hospital each day. The travel surveys that we have undertaken show that 34 per cent of those people take public transport. The rest use their cars, walk or cycle and we think that between 50 per cent and 60 per cent of those people take their cars. It is difficult to squeeze approximately 6,000 car movements into 1,700 spaces, so the planning policy and the green transport plan—the bigger-ticket issues—are vital to solving the problem.

We manage our car parks, which is a 24-hour-a-day operation. The car parks are lit, they are covered by closed-circuit television and we have personnel there 24 hours a day. The management of the car parks in Edinburgh is patient focused and we try to ensure that patients or visitors who are coming to the hospital can find a space, which is not always the case at other hospitals. We would welcome the standardisation of the situation throughout NHS Lothian, especially if it puts patients and visitors first.

We could improve the communication on concessions, whether for patients or relatives. We need to work with our NHS Lothian partners on that. Concessions exist and are available to be used, but they are probably not as widely publicised as they should be. There is still work to be done on improving our communication with NHS Lothian on the concession passes that we have for patients and visitors.

Peter Barriball: I must echo the point that charging is one of the controls on people who should not be parking.

The Convener: Yes, but the problem is that, unfortunately, it is a control on people who cannot do anything but park as well as on those who should not be parking.

Peter Barriball: I appreciate that, but a clear part of the review at Ninewells was that patients and visitors to the hospital would never have to pay more than the tariff of £1.50, as it is at the moment. Charging is meant to be a control measure for the people who should not be there, not for those who should. We made it clear that if anybody, for a clinical reason, exceeded their time on a pay-and-display machine and was given a penalty notice, we would tear that up and throw it away without question. That will be our policy.

We have also said that the charging regime for the blue-badge car park and the accident and emergency car park will fund a huge increase in the number of free parking spaces that are given every day to the people who genuinely need them. Vinci Park has said—and it is in the review document—that the charging regime will not make us any money; we will give back all those spaces every day as free passes to increase the use of the car park by whoever the hospital decides. It is not for us to decide who gets free parking. We will say to the board, "Here are your parking spaces. Please use them as you wish."

We want it to be transparent that we get nothing out of it apart from managing the car parking better for patients and visitors and putting free parking spaces into the hands of those who need them most. However, it is ultimately almost impossible to stop somebody driving into a car park and parking their car where they should not

because they will lie and do all the things that people do in that situation. We do not have any powers. We cannot put a ticket on somebody's car for being parked in the wrong place.

The Convener: I specifically asked you to say whether there is anything that you would like to be able to do, and that we could say that you should be able to do, to make a difference to that.

Peter Barriball: To be truthful, I do not know what we can do to change it, short of insisting that fly parkers answer a question truthfully when they are asked, which will not happen. They will always say that they are picking up their mother. They do it in Aberdeen, and the only way that we could stop fly parking there was to charge £5 if people stayed for more than four hours.

Unfortunately, the biggest deterrent is money. The problem is that every member of staff, patient and visitor expects to drive into an empty space when they arrive at a hospital and we have to manage those expectations. We are wrong whether the car park is full or empty—we cannot win. It is a matter of managing what we have, and one of the ways of managing any parking operation is charging. In Edinburgh, the charge is high and it manages the spaces. It is about trying to use the resources best so that more patients and visitors can use the car park. It is not about revenue; it is about managing what we have.

The Convener: I will now ask some of the MSPs to raise some issues and make some statements. I do not want every committee member to do that, so I ask members not to speak unless they have a burning issue to discuss.

Kate Maclean: Our discussion reinforced what I thought about car parking at hospitals. The whole thing is a mess. It is a can of worms. I have to say that I was not expecting to find that the Scottish Executive's guidance on hospital car park charging is not worth the paper that it is written on. I am astounded by the things in the guidance about unauthorised users. In fact, the Executive does not have an opinion on that and it is not prepared to enforce the guidance.

I will be brief. There are three things that come out of our discussion. First, disabled people should not be charged for car parking at hospitals. Secondly, we should have a compassionate approach to people who have chronic conditions or cancer, who often need long appointments. It should be easy for them to access car parks that are convenient for the hospital. Thirdly, the Executive must conduct a review of car park charging at hospitals throughout Scotland and update and strengthen the guidance that is available. Quite frankly, the current guidance is not good enough.

Janis Hughes: The issue concerns many people, including staff, patients and relatives. However, to put the matter in perspective, we need to understand that many people do not have cars. For example, more of my constituents do not have cars than have cars. Those people want better transport links to hospitals and other ways of accessing the facilities.

What came out of our discussion today—and what I fail to understand—is why nothing can be done about unauthorised parking on what is, in effect, private property. I worked at Glasgow royal infirmary for years and people did not get past the barrier if they did not have a permit. I cannot understand why the Executive and the operators think that nothing can be done about that. That point was not answered today.

Shona Robison: I agree with Kate Maclean's comments about the Executive. I would like to see more equity for those who have to use hospital car park spaces. Disabled drivers and patients and relatives who are frequent users should pay no charge to park at hospitals. However, I also seek equity for those who do not have cars and who rely on patient transport or public transport, provision of which is patchy throughout Scotland. I would like the issue to be broadened to include that as well.

Dr Turner: Our discussion today has confirmed that the charging arrangements for car parking at hospitals do not manage the use of car parking space effectively. The question of access to hospitals for patients and staff should not be rocket science. Access was managed effectively in the past. Janis Hughes worked in a hospital and so did I. I worked in more than one hospital and know that people could not get past the wee parking attendant. He knew everybody and he made sure that people did not park where they should not.

For all the years that I worked in the NHS, I have never been convinced that anyone has taken patient access or staff access seriously. If we did, we would have worked out a transport plan—so that buses took people to hospitals—before we decided how to lose hospitals or beds. I do not understand why we have never come up with a system whereby very sick people are received at the kerb and taken into the hospital in a wheelchair so that the person who is delivering them can go away and park the car.

I have experienced problems with that on many occasions with a very infirm aunt. Because there are not enough disabled spaces, I had to leave her standing outside the hospital while I went away to park the car, hoping that she would not fall off her legs. There was nobody to come and help and no wheelchair. At Glasgow royal infirmary people have to walk for miles. They might be a chest,

heart or stroke sufferer—never mind a cancer patient—but they might have to walk a considerable distance within the hospital and signposting has not even been considered.

The Executive and the health boards do not take patient access or staff access seriously. I think that that has been proved today.

The Convener: I want each of the four people here who are representing the consumers, for want of a better word, to make a quick closing comment on what they have heard, what has surprised them—if anything—and whether their views have shifted in any way.

Bill Wright: What has surprised me is hearing all the statements about what cannot be done, especially from the car parking people. In the short term, we should concentrate on what can be done. For disabled people and people who are going for repeated treatment, there should be concessions and free parking. The situation should be clarified and it should be made simple for people to claim. I know someone whose daughter was in hospital for six months; it was only after a few months that anybody drew their attention to the fact that there were concessions. That should be highlighted.

Kate Seymour: I would agree. I have been surprised by the talk about fly parking. Peter Barriball said in his closing statement that charging is used to manage any car parking operation, but we are not talking about any car parking operation; we are talking about parking at hospitals and people who are often seriously ill but who, much of the time, have no choice but to use their car. All these issues are complex. People have different kinds of treatment, but it is not right that they should pay different amounts depending on the treatment that they are having. If someone is getting one kind of cancer treatment that is quick, it will not cost them much, but if they are in for six hours, it will cost them a lot.

There is a broader issue about public transport. The system across Scotland is very patchy at the moment, but parking will remain an issue because we are talking about seriously ill people for whom public transport and patient transport are often not an option. Although parking must be part of a broader transport plan, we cannot duck the issue. It needs to be dealt with at a national level. Due to the centralisation of some specialist services, even those who live in rural areas will at some point use central hospitals, so there is an impact on everybody in Scotland.

As Bill Wright said, patients need clarity. People do not know what is available to them. It is important that health boards and hospitals put across to patients what is available to them so that everyone gets the same treatment. What has not been mentioned today is the hospital travel cost scheme, which is particularly important for people who do not have a car but who might have to use a taxi or public transport to get to hospital. There is a scheme in the Highlands and Islands that is open to everyone and is limited by the distance people live from the hospital. Like the rest of the UK, Scotland's system is limited to people on certain benefits. If we are considering things more broadly than car parking, it would be worth considering whether people can be reimbursed in a different way as well.

Rosie Butler: I thank the committee for the opportunity to be here—it has been an interesting and helpful discussion. It has not changed my fundamental view that it is morally wrong to ask disabled people to pay for parking to access the hospital services that they need. They have to go to hospital—they do not have a choice—and they are held captive to whatever the market demands. I would urge managers and car park operators to think seriously about other measures to manage the demand on car parking and to do so in a way that does not have a knock-on effect on disadvantaged people, who will pay the price for it.

Julie McAnulty: My main point is the effect that centralisation will have on parking and transport. It is a serious problem which, in my area, will be practically insoluble. Our local hospital, Monklands, was built to solve a transport problem. If planned and emergency surgery are going to be separated, a lot more people will travel. It will be a serious problem and I urge the committee to consider it in depth.

Secondly, I do not understand why car parking is being treated as a separate running cost from all the other running costs of a hospital. It is a national health service. Some responsibility needs to be taken on here. There seems to be a bit of good cop, bad cop going on: the boards are saying, "We'd like to do this but we don't have enough money," while, to judge by this discussion, the Executive is taking a hands-off approach to the matter and saying that it is for the boards to decide for themselves. That is not good enough. We need some more joined-up thinking. If we need to fund these things, we should fund them properly, from the top. We have the money to do it. We have a £40 billion surplus in national insurance funds, which is growing by £6 billion a year. Could we not use a wee bit of that money for car parking?

15:45

The Convener: Could we have a final word from the staff and users?

Susan Lloyd: I would like a fair, equitable service throughout Scotland. I was surprised by what we have learned about the Scottish Executive guidelines. I would like more attention to

detail and for there to be better principles throughout Scotland. Public transport is an issue, as is cross-site cover and the rural areas. The centralising of services will have an impact—I found myself agreeing with quite a lot of what Julie McAnulty said about that. The RCN supports the abolition of car parking charges. Having heard everything that I have heard here, I stand by that. The NHS has to deliver a service that is free at the point of delivery.

Tom Waterson: I was not surprised by anything that I heard today. The same issues were raised three years ago at Nigel Griffiths's hearing about the Royal infirmary car park. We have heard Jim McCaffery and Steve Gordon talking about a breakdown in communications. Negotiation has gone on about whether to have equity across the board in Lothian. That was requested three years ago, but nothing has happened. Staff, visitors and patients are still being charged a disgusting amount of money—£10 a day. It is unforgivable. I do not see any reason for it. I asked earlier why staff, patients and visitors are charged at night. I would like Consort's and Meteor Parking's books to be opened, to let the public know exactly how much money they are making out of the sick, the disabled and the workers of Edinburgh and the Lothians.

The Convener: We have had quite a long session. Everybody has had an opportunity to contribute. Some have contributed more often than others, but that is always the way with these things. The committee will now take away the information and consider its next move. I thank everybody for the time that they have taken to come here and to sit through the session. We may see some of you again.

15:48

Meeting continued in private until 16:08.

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