INCOME GENERATION

CAR PARKING CHARGES ~ BEST PRACTICE FOR IMPLEMENTATION

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PREFACE

This document updates a document issued in 1996 under the title: *Income Generation – Car Parking Charges: A Guide to Implementation*. It gives information and advice on operating commercial car parking schemes in the NHS as income generation activities.

The document should be read in conjunction with *Income Generation – Best Practice. Revised Guidance on Income Generation in the NHS* (Chapter 30 of the Finance Manual), which was republished in February 2006. This can be found at:- http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4130667&chk=tEqfI2

NHS bodies should also refer to *Health Technical Memorandum 07-03: Transport Management and Car-parking*, also published in February 2006, and *Estatecode*, published 2002 (with an updated version due to be issued in early 2007).

Income generation powers enable NHS bodies (abiding by specific rules) to raise additional income for health services by marketing any spare capacity resulting from a non-core function, or by exploiting intellectual property rights.[1] Charging for car parking on healthcare sites is a common example of an income generation scheme. This document provides advice on the issues to be considered when setting up a car parking scheme or when reviewing existing ones, including what kind of car parking scheme to offer, what charges to impose and what concessions to consider.

The Health Select Committee in their report *NHS Charges*, published July 2006, recommended that trusts be advised to:-

- Issue all regular patients, or their visitors, with a 'season ticket' that allows them reduced price, or free parking;

- Introduce a weekly cap on parking charges for patients;

- Provide free parking for patients who have to attend on a daily basis for treatment; and

- Inform patients before their treatment begins of the parking charges, exemptions and reduced rates that will apply.

This revised document also seeks to incorporate their recommendations.

[1] NHS bodies is a term used throughout this document. It refers to Special Health Authorities, NHS trusts (including Mental Health Trusts and Ambulance Trusts), Primary Care Trusts and NHS Foundation Trusts. The Secretary of State's powers to make more income available applies to: Special Health Authorities by virtue of the Income Generation Powers of Special Health Authorities Directions 2005; NHS trusts by virtue of Schedule 2 paragraph 15 of the NHS and Community Care Act 1990 and section 7 of the Health and Medicines Act 1988; Primary Care Trusts by virtue of section 18A(5) of the NHS Act 1977 and section 7 of the Health and Medicines Act 1988. Section 14(3) of the Health and Social Care (Community Health Standards) Act 2003 gives Foundation Trusts the power to make additional income available in order to carry on its principal purpose better.

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CHAPTER 1: ISSUES TO CONSIDER REGARDING CAR PARKING SCHEMES

1. Car parking on healthcare sites should only be considered as part of a wider travel plan which the NHS body should have in place. Travel plans aim to offer a package of practical measures to improve accessibility and influence transport to an individual site or within an organisation. They aim to lessen the environmental impact of transport arrangements, reduce transport journeys to NHS sites for employee business requirements, manage transport to ease congestion, reduce emissions from exhausts, encourage active travel modes such as walking and cycling as part of the Department of Health's wider public health agenda, as well as to relieve car parking shortages by reducing reliance on single user car travel. Comprehensive information on travel plans and other issues can be found in *Health Technical Memorandum 07-03: Transport management and car-parking.*

2. However, assuming it is decided that car parking should be offered on healthcare sites as part of this travel plan, there will be many other issues to consider. These will probably include:

   - **Site congestion:**

     - What the overall number of spaces will be, and how these will be positioned in relation to traffic flow to prevent vehicles becoming blocked in;

     - How misuse of the car park (particularly if based near a town centre or motorway) by people using healthcare facilities for free or cheap parking will be avoided;

     - Where access routes for emergencies and the emergency services will be;

     - Ensuring that fire regulations are complied with.

   - **Customer service:**

     - Where spaces should be in relation to healthcare services;

     - The distance that patients and visitors will have to walk;

     - The designation of priority spaces for certain users (e.g. disabled) at appropriate places;

     - Considering whether there should be spaces available specifically for regularly attending patients e.g. dialysis patients;

     - Considering how to maintain the required turnover of available spaces to meet service and patient needs.

   - **Staff:**

     - Considering whether priority spaces should be available for staff on the basis of need or status.

- **Security:**

  - The security arrangements that will need to be in place to protect both people and property.

- **Local Residents:**

  - Considering how any upsurge in off-site parking as a result of car parking charges at a healthcare site will be addressed;

  - Addressing disturbance factors such as noise and light pollution;

  - Considering how any increase in car related crime locally as a consequence of improved security in the healthcare site car park will be addressed.

CHAPTER 2: ADVANTAGES OF CAR PARKING CHARGES

3. NHS bodies are allowed to charge for car parking and to raise revenue from it as an income generation activity as long as certain rules are followed. Income generation activities must not interfere to a significant degree with the provision of NHS core services. They must be profitable, as it would be unacceptable for monies provided for the benefit of NHS patients to be used to support commercial activities, and this profit must be used to improve health services.

4. Providing car parking services will inevitably incur overheads which must be paid for. If no charges were imposed, maintenance costs would have to be found from elsewhere at the risk of diverting funds from patient services. Charging for car parking will allow revenue to be raised, which can be used to improve and maintain car parking services to a level that people expect. For instance:

   - **Vehicle Security -** Healthcare sites are particularly prone to theft, both of and from cars, and:
     - patrols;
     - security lighting;
     - barriers; and
     - closed circuit television,

   can improve security and significantly reduce this type of criminal activity.

   - **Personal security -**This is of particular concern to night staff. Sufficient lighting, patrols and closed circuit television all assist in deterring crime and making people feel safe.

   - **Further utilization of security personnel -** In addition to acting as deterrents, security staff can take on other tasks, eg;
     - ensure that roads and access points are free from obstructions;
     - assist in fire, and other emergency procedures; and
     - assist in the removal of unauthorised personnel.

   - **Maintenance and development -** Issues to consider include:-
     - Keeping road surfaces, road markings, lighting, ticket barriers and machines etc in good working order;
     - Creating further car parking spaces as the need arises in time;
     - Investing in other modes of transport for staff and patients, e.g. buses and bikes, in order to fit in with the NHS body's wider travel plan.

5. **Note:** Profits after maintenance costs have been paid for must be used to improve local health services.

CHAPTER 3: WHICH SYSTEM TO CHOOSE?

6. Once the decision has been made that, in principle, car parking charges should be levied, the next step is to look at the different ways this can be achieved. There is no universally appropriate system. What works best will depend upon the nature of each individual site.

7. There are almost as many capital cost permutations as there are healthcare sites, hence the importance of shopping around for the most suitable and cost effective solution.

8. Staffed - where an attendant carries money and issues tickets to drivers on arrival.

   - Factors to consider:

     - This method will have a low capital cost and outlay;

     - There may be a lack of flexibility for other duties e.g. security;

     - There may be potential audit problems through manual handling of cash;

     - Sickness and holidays etc will need to be covered (as it takes 1.4 people to give "one" person coverage, assuming not staffed twenty-four hours per day, seven days per week);

     - There will be a negative impact on income if the attendant fails to appear on duty, or has to leave car park during the day;

     - Personal safety issues of those carrying cash in public will have to be addressed.

9. Pay and display - where the driver pays for and collects a ticket from a machine in the car park. The ticket is then displayed inside the car. Tickets are checked periodically by an attendant. (This is the most common form of paid parking).

   - Factors to consider:

     - Capital costs will be moderate, and revenue costs lower than with attendant only system;

     - There will be a high compliance rate if regularly checked;

     - Staff on patrol will be able to take on other duties in between ticket checks;

     - Pay and display machines are resistant to vandalism and fraud and therefore minimise losses (see "Day to Day Management");

     - This method will not generate as much income as a barrier system due to evasion and ticket swapping (but ticket swapping can be minimised by keeping valid ticket times at a low level, e.g. 4 hours);

     - An enforcement system will be needed, e.g. wheel clamping.

10. Barrier - where the driver obtains a ticket from an automatic system, this can either be:

- manual variable charge tariff, (motorist collects ticket on entry and pays attendant at barrier on exit);

- automated variable charge tariff, (bar coded ticket collected at entry - read by machine in order to raise barrier);

- fixed charge tariff, (motorist puts coins into machine by exit barrier, allowing it to open);

- fixed and variable systems can be mixed e.g. having a variable charge during the day and a fixed rate at night.

- Factors to consider:

  - This method will have the highest capital cost of the three systems;

  - 100% of revenue should be collected;

  - Passcards will be needed, allowing staff access to special areas;

  - Emergency access needs to be maintained at all times. Barriers can be equipped with a keyswitch to allow them to be raised for access by emergency and service vehicles.

CHAPTER 4: INTERNAL/EXTERNAL MANAGEMENT

11. Some NHS bodies manage their schemes in-house, others by using outside contractors. Outlined below are some of the factors worth considering when making your choice. A SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis, or something similar, may provide a useful tool in aiding decision making at this stage.

12. Internal Management:

- Potential benefits:

  - greater income possibilities;

  - complete control of the scheme.

- Points to consider:

  - How will the scheme be financed? The use of private finance should be considered as a matter of course;

  - lease or purchase?

  - managerial input and commitment is required;

  - are the necessary skills available in-house?

13. External Management - This may be on the basis of sub-contracting the complete operation to an experienced car park management business, or be developed through a joint venture between the NHS body and the external operator, where both parties agree to invest in the scheme – see "Public-Private Partnerships in *Income Generation – Best Practice.*.

- Potential benefits:

  - lower risks;

  - focused management;

  - specialist external skills;

  - economies of scale.

14. Whichever form of external management is eventually selected there are a number of points which require consideration in any contract. (see also Risk Analysis, page xx) Whilst it is recommended that the policy lead on pricing structure should be held at all times by the NHS body, not the contractor, a contract should allow the contractors enough scope to operate efficiently and make a reasonable return for their efforts (bearing in mind that the NHS body must also make a profit in order to abide by the income generation rules). It would be self-defeating to have too onerous a set of terms and conditions, but important areas for consideration are:

  - each party's contractual obligations;

- scope of agreement (exclusions/exclusivity/geography);

- contract period;

- standard of service and service to be provided;

- collection and payment of any monies receivable;

- description of contract management procedures, including agreed and measurable performance targets;

- production of annual audited accounts/auditors' fees;

- inspection of documents by NHS body nominated personnel;

- performance review, scope, timing;

- staffing and supervision;

- contract price and price rise clauses;

- powers conferred upon each party by the other under the agreement (if any);

- equipment and materials;

- assignment or sub-letting;

- procedures to cover complaints on either side;

- insurance;

- use of NHS body premises;

- default;

- termination;

- insolvency of contractor.

15. A typical arrangement would be where the outside contractors:

- guarantee the NHS body a minimum income;

- and finance the civil engineering, signs, barriers/machines and installation costs.

16. When choosing a partner NHS bodies should consider:

- do they have experience in the NHS?

- is the company financially sound?

17. The amount of NHS input will vary, but a *key objective* in any joint venture between the public and private sectors is that the latter should assume a *major part of the risk.* NHS bodies should:

    - avoid wide ranging guarantees or other contingent liabilities; and

    - set a ceiling on the NHS contribution to the project.

Legal Advice

18. It must be noted that in any major undertaking of this nature sound legal advice is important to ensure a strong formal agreement. It is therefore imperative to employ the services of suitably qualified legal officers.

CHAPTER 5: VIABILITY OF THE SCHEME

19. Having decided upon the most appropriate car parking scheme and the way in which you would prefer to manage it, the next stage is to assess the financial viability of the enterprise through a feasibility study.

20. NHS bodies should look at transport and car parking in a holistic way and determine a car parking structure accordingly, taking into account the different parking needs of staff, patients and visitors. For patients and visitors consideration will need to be given to healthcare needs and ability to pay.

21. In order to later develop a robust business case, the following questions should be answered:

What are our Costs?

22. These break down into two areas, which could include:

- **Capital costs:**

  - pay and display machines;

  - barriers;

  - cabins;

  - signs;

  - road markings;

  - fencing;

  - lighting;

  - closed circuit television.

- **Revenue costs:**

  - staffing;

  - uniforms;

  - rental of equipment (wheel clamps etc);

  - parking permits, stickers and notices;

  - pay and display tickets and consumables;

  - equipment maintenance and repair;

  - public liability insurance (this may be covered by existing insurance arrangements, but should be checked).

23. It may be prudent to set aside a sum to cover potential public relations costs associated with the launch of the new or revised car parking scheme.

How Much Should we Charge?

24. It must be remembered that you are in competition with both other means of transport and alternative car parking facilities. Hence attention should be given to:

    - the regularity of public transport and its charges;

    - other car parking charges in the area;

    - availability of free parking on nearby streets and roads;

    - your catchment area;

    - the need to cover costs;

    - the need to disincentivise non service users;

    - the need to make a profit to be used to improve health services.

Variable Charging – Staff

25. Some NHS bodies operate a different charging structure between staff and patients/visitors. NHS bodies will want to consider:

    - how much staff charges should be discounted by;

    - if staff should pay at all (some NHS bodies don't charge employees);

    - if there should be variable charging of staff for different "qualities" of parking. (e.g. more secure parking/proximity to workplace).

Variable Charging – Patients/Visitors

26. Whilst NHS bodies will have to ensure that they raise sufficient income from charges so that a profit remains after maintenance costs are met, they should be sensitive in considering the position of those patients/visitors who have to use their car parks regularly.

27. NHS bodies are strongly recommended to have some kind of ‘season ticket’ arrangement, allowing free or reduced price parking for:

    - patients with a long-term illness or serious condition requiring daily or regular treatment;

    - relatives/prime visitors of patients with a long-term illness or a serious condition requiring daily or regular treatment.

28. NHS bodies are also recommended to have a weekly cap on car parking charges for patients/visitors having to attend on a daily basis.

29. For other users, NHS bodies should consider whether a sliding time scale of charges should be in place. Some NHS bodies charge proportionately more for the first 3-4 hours; others do not charge at all for a stay of under 15 minutes.

Turnover per Annum

30. The proposed scale of charges should be extrapolated to estimate income, where:

Tariff x spaces x daily occupancy rate x 5 days x 52 = annual revenue. (Weekends excluded from example as revenue much more variable).

31. It is impossible to be prescriptive here as each site will have its own set of characteristics. When estimating income from a proposed scale of charges NHS bodies will want to consider:

- how many available spaces will be set aside for patients/visitors;

- of these how many will be used by those with passes for free/concessionary parking;

- what will be the percentage occupancy of spaces for staff and patients/visitors;

- what will be the percentage turnover rate per day for staff and patients/visitors;

- what are the likely operational/maintenance costs which will need subtracting;

- VAT – car parking charges currently attract VAT at the standard rate on revenue received.

CHAPTER 6: CONSULTATION AND MARKETING

Consultation

32. There is no statutory obligation to consult in relation to car parking charges, however NHS bodies are well advised to communicate and engage the views of staff and other interested parties at a very early stage in the development of a draft plan of a car parking scheme, in order to explain the scheme's purpose and function and where the income will be invested, as well as to allay concerns and to obtain feedback.

33. This consultation would typically involve discussions with key commissioners and staff representatives. It is good practice to also involve patients and visitors wherever possible, as they are likely to accept charges better if they feel that they have been involved in the process, rather than merely having charges imposed on them without consultation. Disabled users of the car park should also be included to ensure that their needs are met. There is likely to be a strong reaction from the media and local residents, and therefore good PR will be required to satisfy their concerns. Ease of passage is often gained by explaining that charges are necessary to pay for the level of maintenance and security that people expect and assurances that any excess income will be invested in the local health service (bearing in mind that by asserting that profits will be invested in local health services, those health services will be expected to improve, otherwise criticism could ensue).

34. Whilst it may appear a good idea to also conduct some market research amongst potential users on the subject of what they would be willing to pay; it needs to be borne in mind that:

    - there are bound to be a certain amount of negative feelings which could be blown out of proportion; and

    - attitudes often differ markedly from behaviour (evidence has shown that charges are quickly accepted as being reasonable by the vast majority of users).

Marketing

35. Marketing will be important at the time of introduction of the car parking scheme. However, some initial marketing at the outset is also helpful. In addition to normal publicity channels (particularly to staff via team briefings, house magazines, websites, notice boards and attachments to pay advice slips), it is worth considering:

    - Open days for staff/patients to learn more about the scheme;

    - External signs situated near the tariff display boards, or printed on the reverse of tickets, information stating succinctly, where the proceeds would go (eg to improve security or enhance patient care).

36. The major benefits of paid car parking, to the users, are controlling car parking, improving accessibility to services, flow around the site and better security arrangements. These need emphasising and quantifying both in the consultation period and once the scheme is in operation.

CHAPTER 7: THE BUSINESS CASE

37. If the costings and market research indicate that a car parking scheme is viable, then a thorough business case needs to be constructed. This will show those providing financial support that the scheme has been carefully evaluated in terms of the:

    - appraisal of a broad range of options (including the status quo);

    - explanation of the benefits and how these differ between options;

    - explanation of how forecasts have been derived and how costs differ between options;

    - identification of risks, contractual obligations, and differences between options;

    - involvement of the private sector and the resultant risk reduction potential;

    - calculations of net present values of shortlisted options; and

    - management of the scheme, including audit arrangements.

38. The case should show convincingly that the option proposed offers the best value for money, because it:

    - has greater benefits/lower risks, at no more cost; or

    - is cheaper, without sacrificing benefits or incurring greater risks; or

    - has greater benefits/lower risks at justified extra cost.

39. There are three stages in building up a business case:

    - **The strategic context** - how the car parking scheme fits in with the NHS body's strategic direction, business plan and travel plan. Gives the outline case for the investment, and its affordability.

    - **The outline business case** - appraising the options. The objective of the outline business case is to identify the highest ratio of benefits to costs options.

    - **The full business case** - a more precise and detailed specification of the preferred option. Allows validation of earlier work although its primary task is to develop the preferred solution.

<u>Risk Analysis</u>

40. This is a useful tool in the preparation of a business case. It examines the implications of key uncertainties and compares the options.

41. For each car parking option you should ask what important objectives or benefits are uncertain and then consider:

    - What is the worst change in each of these that may occur? (For example car crime actually increases);

- What is the best change that may occur? (For example attendance at clinic sessions markedly increases);

- What difference would either of these changes make?

- How likely are they to happen?

42. Also for each option you should ask what important *costs* are uncertain, ie:

- What is the worst situation that can arise for each cost item? (For example maintenance costs rise faster than the opportunity to increase prices);

- What is the best situation that can arise for each cost item? (For example a local philanthropist donates a sum of money for use in improving car parking);

- What difference would either of these changes make?

- How likely are they to happen?

43. Where a Public-Private Partnership is being considered, it is important to consider which significant risk lies with each party, to identify:

- responsibility if the costs or income differ from forecast?

- what are the obligations on each party?

- is the NHS body's contribution clear?

- have the risks been transferred to the private sector?

- what rights and flexibilities does the NHS body retain?

- what would happen if standards were not met?

- is the project viable as a whole, and for both parties? And

- what would happen if the contractor becomes insolvent?

CHAPTER 8: DETAILS OF THE SCHEME

44. Whilst schemes will differ, dependent on local circumstances, these are some of the areas which need consideration:

- **Staff Parking -** Depending on the scheme, payment could take the form of:

  - a ticket purchased on the day;

  - a displayed permit - concessionary (or free) parking;

  - a "direct debit" payment via payroll; or

  - smart card, for barrier systems.

  Should some grades of staff have priority parking over others in terms of:

  - guaranteed spaces?

  - proximity to the healthcare site?

  - enhanced security features?

  If so, should they pay more? and if yes, how much more? Will there be any negative impact here in terms of overall staff morale?

  Thought will also have to be given to the needs of:

  - on call staff;

  - compulsory resident medical staff;

  - NHS students.

- **Patients/Visitors -** Permits for free or concessionary parking for patients/visitors using the car park daily/regularly (see *Viability of the Scheme*).

- **Disabled Users** – sufficient spaces should be conveniently located near the entrance of buildings and other access issues addressed. NB – NHS bodies have a statutory duty under the Disability Discrimination Act 2005 to have disability equality schemes in place to eliminate discrimination and harassment of disabled persons. Car parking schemes on healthcare sites should be operated in light of this.

- **Special Cases -** These issues will require additional consideration:

  - emergency services;

  - short stay (drop off and pick up) e.g. by maternity and A&E;

  - taxis;

  - delivery vehicles;

- volunteers;

- motorcycles;

- bicycles.

- **Rule Breaking -** Car clamping is common, although normally a last resort when dealing with those who either do not pay their car parking fees or park in prohibited areas. A multi-stage approach is used in many healthcare sites, for example:

  - first offence - polite notice;

  - second offence - verbal warning;

  - third offence - clamping.

CHAPTER 9: ADVERTISING AND PROMOTING THE SCHEME

Informing Patients/Visitors and Staff

45. It is very important that the details of the scheme are transparent for all users, including patients and their visitors. As well as what the income raised will be used for, they will want to know what the charges will be and what concessions they may be entitled to ahead of their visit to the healthcare site, particularly if they will be due to attend over several days or on a long term basis. NHS bodies should ensure that this is done wherever possible. Details of car parking charges and any concessions in place could be included in the literature sent out to the patient ahead of their appointment, as well as details on the availability of financial assistance under the Hospital Travel Costs Scheme or NHS low income scheme.

46. It is good practice to have clear information on these issues readily available to patients and their visitors, in appointment letters, by briefing appropriate staff who can pass on the information and by displaying the information on websites, beside ticket machines in car parks and in waiting rooms etc.

47. Staff will also wish to know the details of the scheme as it relates to them, eg the location of staff parking spaces, what concessions are available to them, how charges will be collected (daily tickets, seasonal permits, deductions from salary) etc.

48. NHS bodies have a responsibility to have a clear complaints procedure in place and to communicate this to service users.

CHAPTER 10: MANAGING THE SCHEME

49. Once the decision has been made to go ahead, it is vital that the resulting car parking scheme is effectively managed. This falls into two areas:

    - Day to day management;

    - Business planning and monitoring.

50. However, the single most important criterion is to ensure that staff resources of a sufficiently high calibre are devoted on an on-going basis to the car parking scheme to ensure that it is effectively managed and meets audit requirements.

Day to Day Management

51. Whilst it is obviously important to ensure that the usual areas, e.g. staffing and complaints, have a workable structure, the issue of *auditing* is likely to be the single biggest management factor in any car parking scheme, bearing in mind that car parking could well generate the largest amount of physical cash on the healthcare site. Auditing and anti-fraud procedures need to reflect this.

52. Pay and Display machines are available which provide anti-fraud security via the automatic printing of audit control statements upon withdrawal of the self locking cash box (This includes value and number of tickets, a breakdown of coins accepted and total amount of money in the box).

53. Example of "Audit Trail" (For Pay and Display Machines Run by External Contractor):

    - Every cash box extraction is accompanied by the issue of an audit statement of the cash box contents;

    - The cash is counted and each coin value plus the total is checked and ticked by the counter. A note of any discrepancy is made;

    - Every machine generated audit ticket is retained on site after signature by the counter;

    - A daily cash sheet is produced in duplicate, detailing against each machine the audited sum, the counted sum, and any discrepancies between the two;

    - Discrepancies due to foreign coins, equipment tolerance, coin jams, equipment failure, vandalism etc, should be recorded;

    - Triplicate paying-in books, one copy to be retained on site for audit;

    - Monthly summary statement produced;

    - Random checks by internal audit.

Business Planning and Monitoring

54. Income generation activities are required by Treasury to be entirely self-supporting, and the Crown will not bear any losses sustained. It is consequently essential that you put in place

an adequate financial information system to provide the level of detail required and to monitor and control activities. You must be able to demonstrate that income generation activities will make a useful contribution to overall financial objectives and that schemes cover their costs and make a reasonable return on any assets used.

55. When self-managing a paid car parking facility it is important to adopt a disciplined approach and treat it as a distinct business, separate from the rest of the healthcare body. Four accountancy/planning procedures can help enormously in the successful management of the scheme. These are:

- The Annual Business Plan;
- Memorandum Trading Accounts;
- The Profit and Loss Projection; and
- Cash Flow Forecasts.

Annual Business Plan

56. This should satisfy three important criteria, it should be:

- simple;

- accurate; and

- useful.

57. It should include information and statistics such as:

- history - where is the business now?

- goals - where does the business want to be?

- assumptions - are they correct?

- objectives, quantified in financial terms;

- resource allocation - how are objectives achieved?

- checking - is the plan realistic?

- sensitivity analysis - is the plan flexible?

- any pertinent differences from the original business case, for example new competition or legislative changes?

Memorandum Trading Accounts (see *Income Generation – Best Practice* for more details)

58. Income generation in NHS bodies will be monitored by SHAs. The annual turnover level at which schemes must be accompanied by a Memorandum Trading Account (MTA) is £50k, although the maintenance of MTAs for smaller schemes is also recommended. Previous guidance advised that MTAs must be available on demand for

audit purposes and this is still applicable, however we now also advise that MTAs must be sent to the SHA with NHS trusts' annual accounts.

59. NHS trusts are advised that it is best practice to provide a full account of all schemes in the Operating and Financial Review section of their Annual Reports. This should include information about the scale of resources devoted to significant projects (or groups of projects which together are of a significant size), value for money and information about the efficient use of public sector assets and indicators of commercial performance. Those trusts with higher levels of income generation activity may wish to consider publishing a separate report of their commercial activity. Where financial systems cannot identify the full costs or particular activities, a reasonable apportionment of joint costs should be made and the justification for those figures should be kept for inspection by external auditors.

60. The outline minimum specification of memorandum trading accounts for income generation are as follows:

    1. Gross Income

    2. Direct costs (see note 1 below)

    3. Contribution (1 – 2)

    4. Indirect costs and overheads (see note 2 below)

    5. Net profit (3 – 4)

    Note 1. Direct Costs should include all the costs which are directly attributable to the establishment and operation of the Income Generation scheme. These will probably include staff, maintenance, depreciation, consumables, utilities, transport, administration and insurance.

    Note 2. Indirect Costs and Overheads should consist of an apportionment of a fair share of the costs incurred in facilitating the income generation scheme and insurance charges.

    Notional insurance should be assessed at:

    0.01% of salaries and wages of direct staff;

    0.25% of stock in trade; and

    0.05% on replacement costs of fixed assets.

    Note 3. Net profit/capital employed expressed as a percentage = return on capital employed. This should be around 3.5% for commercial services where there is no competition or for inter- and intra-Departmental services, and 5.5% - 15% (depending on the level of risk) for commercial services where there is competition from the private sector. The return on capital employed achieved should be stated under the Memorandum Trading Account.

Profit and Loss Projection

61. The Memorandum Trading Account can be worked up from the Profit and Loss projection using Table 1 below.

TABLE 1 - PROFIT AND LOSS PROJECTION FOR FIRST YEAR OF OPERATION **SCHEME TITLE:**		
	£	£
Gross Revenue Less VAT @ 17.5% NET REVENUE		
LESS REVENUE EXPENDITURE		
Payroll Rental of equipment - (e.g. telephones and wheel clamps) Uniforms Public liability insurance Parking permits, stickers and notices Pay & Display tickets & consumables Equipment maintenance and repair		
NET REVENUE EXPENSE		
Repayment of Capital and Finance Cost		
RESIDUAL SUM		

Cash Flow Forecast

62. To be completed on a monthly basis using Table 2 below.

TABLE 2 - CASH FLOW FORECAST **SCHEME TITLE:**								
	Month				Cumulative			
	Budget £	Actual £	Variance £	%	Actual £	Budget £	Variance £	%
RECEIPTS								
Capital introduced Disposal of Assets Loans Received Sales (inc. VAT) Other Income Other Receipts								
TOTAL RECEIPTS								
PAYMENTS Capital Items Loan Repayments Wages Rental of equipment Insurance Consumables Payment to creditors Advertising/PR Administration Share of overheads Expenses Interest Charges VAT								
TOTAL PAYMENTS								
NET CASHFLOW = RECEIPTS - PAYMENTS								

63. The headings within the Profit and Loss and Cash Flow Forecasts can of course be tailored to suit individual circumstances.

CHAPTER 11: AGENDA FOR SCHEME DEVELOPMENT

64. Outlined below is a typical action sequence in the most likely chronological order. Not all actions may necessarily apply in each situation, as circumstances will vary, particularly where a decision is taken to manage the scheme internally.

- Policy decision to examine car parking and potential for introduction of charges;

- SWOT analysis of scheme types and internal/external management;

- Feasibility Study – assess scheme viability;

- Market Research;

- Development of Business Case - including operational details and management arrangements;

- Tendering process (where applicable);

- Marketing, implementation and promotion of scheme;

- Auditing and accounts;

- Reviewing the scheme, addressing any problems encountered.