



Better Access to Healthcare Buildings

A good practice booklet produced by the
'Better Access To Health'
Public Involvement Group



June 2009

Acknowledgements

The achievements of the 'Better Access to Health' panel are also due to the contributions of past members.

Margaret Aitken

John Gallagher

Alan Graham

Morag MacKay

Jabeen Mohammed

Carly Munro

Thanks are also due to the following members of staff for their help in producing this booklet:

Margaret Campbell

Tony Curran

Gerry Groome

John Hughan

John Main

Alex McIntyre

Brian Wilson

Please note that some of the recommendations made in this booklet were suggested following Financial Close of the New Stobhill and Victoria buildings (procured under Private Finance Initiative conditions). For that reason they may not have been included in the design of these buildings. For more information about this contact the Community Engagement Team on : 0141 201 4809 or community.engagement@ggc.scot.nhs.uk



Contents

Foreword	2
Introduction.....	3
1. Background to the 'Better Access To Health' group	4
2. Why accessibility matters.....	6
3. Engaging with key stakeholders.....	8
4. Car parking.....	10
5. Roads and paths	11
6. Entrances	12
7. Reception and waiting areas.....	13
8. Accessible toilet facilities.....	15
9. Changing facilities	17
10. Consultation and treatment rooms.....	18
11. Inpatient ward areas.....	19
12. Signage/ wayfinding issues.....	20
13. Lighting.....	22
14. Corridors, floors, doors and doorways	23
15. Lifts.....	24
16. Security and evacuation procedures.....	25
17. Further information and resources.....	26



Foreword

I take great pleasure in commending this good practice booklet. It is the product of a long term Public Involvement Project which I am delighted to be associated with. This booklet stands in support of the boards commitments to achieving good design as set out in its “Design Action Plan”. It provides evidence of the added value that can be brought to a project by having productive discussions about accessibility with the patients and public who use our healthcare buildings.

Good access to premises is a keystone to their functionality. Of course this functionality goes much further than making sure that buildings have level access at entrances or quality accessible toilets. It is also about the details of how a building is used including the quality of its signage or the management of accessible car parking.

I believe this booklet makes many sensible recommendations which will be of great assistance to our staff in designing new build or refurbished premises, and shall ultimately help us in our efforts to deliver the highest quality medical care in world class accessible buildings.

Grant Carson

Non-Executive Director for NHS Greater Glasgow and Clyde



Introduction

This booklet has been produced by the 'Better Access To Health' (BATH) Patient Focus and Public Involvement Group. It draws together some of the key access issues identified by the group in relation to the patient and carer experience of NHS buildings and also includes guidance produced by the 'Fair For All' Disability Team.

These issues are chiefly concerned with the procurement, design, product selection and management of healthcare premises.

The booklet has been written for use by planning teams but is also relevant to facilities managers and anyone planning to carry out alterations to existing premises. It is not definitive guidance and is not a substitute to technical advice. Rather it has been written from the patient and visitor point of view as a document that will support and add value to the NHSGG&C Design Action Plan. As our understanding of accessibility increases, whether through technical innovation or changes in practice, this overview will also be subject to future update and amendment. To do this it supports an approach that is shaped by local circumstances and the views of the patients and carers who use healthcare buildings.

Where possible the guide has been structured to identify ways in which the process of improving accessibility can be clearly shown and includes sections that are relevant from the start through to the finish of a project. The guide also sets out advice on how to further engage with disabled people in order to add value to the design process.

The BATH group are (clockwise from top left), Alan Henderson, Agnes McGroarty, Terry Robinson, Salma Jaffri, Barbara Walker, Deborah MacMillan, Donald Anderson



“It is rewarding to be able to have an input into the planning of new hospital buildings to ensure that in future they will be accessible to all”

1. Background to the ‘Better Access To Health’ group



The BATH group meets 4-6 times a year. The group worked with the New Stobhill/Victoria project teams to add value to the work of the architects.

The ‘Better Access To Health’ (BATH) group was established in 2004 to advise NHS Greater Glasgow and Clyde on physical design issues related to the first phase of its hospital modernisation programme, the New Stobhill and Victoria hospitals. The access group consists of members of the public who have a specific interest in, and experience of disabling hospital facilities.

The group worked with the New Stobhill/ Victoria hospital project teams and the Community Engagement Team to add value to the work of the architects of these buildings, to ensure that each building offered reasonable access in excess of DDA requirements. In 2006 the BATH group agreed to broaden its remit to include involvement in other new hospital projects. The group meets 4-6 times per year.

For more information about ‘Better Access To Health’ contact:

The Community Engagement Team
NHS Greater Glasgow and Clyde
Dalian House, 350 St Vincent Street, Glasgow
Email: community.engagement@ggc.scot.nhs.uk

Tel: 0141 201 4809



The access group consists of members of the public who have a specific interest in, and experience of disabling hospital facilities.



The New Stobhill and New Victoria Hospitals will offer reasonable access in excess of DDA requirements.

2. Why accessibility matters

Meeting the design needs of everyone is an ambitious target, and arguably an impossible task, particularly when the design needs of one person might conflict with the requirements of someone else. Despite this NHS Greater Glasgow and Clyde is committed to designing, as far as possible, accessible healthcare buildings. In doing so it recognises that there is a compelling case for reducing, where it can, the unnecessary physical barriers imposed on patients and carers by the poor design or management of buildings and spaces.

The following facts underpin the case for providing high quality access:

1. Approximately one third of NHS service users – patients, their families and visitors – are disabled – that is, they have physical, sensory, learning or mental health impairments or other long term health conditions. (Disability Rights Commission)
2. The NHS has an interest in creating inclusive environments for disabled employees and prospective disabled employees. Disabled people form a significant part of the working age population in Scotland.
3. It is not only disabled people who benefit from inclusive design. There are also a significant number of people who would directly or indirectly benefit. Besides older people these include families with small children under the age of five, carers, friends and relatives who accompany people with disabilities. (Disabled Persons Transport Advisory Committee, DPTAC)
4. It is widely accepted that NHS Greater Glasgow and Clyde possesses many premises that are unfit for purpose and fail to take into account the

“I look forward to the day when guidebooks such as this are no longer necessary and disabled people have equality in all aspects of life, including access to the health service”



access requirements of significant numbers of patients, visitors and staff. For example, inaccessible toilets and shower facilities, narrow corridors, small examination rooms, or poor signage/ wayfinding.

5. When constructing new facilities it is considerably more cost-effective to provide for access at the design stage, rather than by making retrospective adjustments during the construction phase or after occupation.
6. In its single equality scheme NHS Greater Glasgow and Clyde has made a commitment to ensuring that it tackles all forms of institutional disability related discrimination, including access to premises.
7. Inaccessible and poorly designed built environments are increasingly being highlighted as an infringement of disabled people’s civil liberties. Most access experts now agree that following the introduction of part 3 of the Disability Discrimination Act (1995), it is simply a question of ‘when’ a legal test case will compel service providers to make the necessary adjustments/ planning action to ensure that DDA requirements are met.

“In the past hospitals were often built with poor access for the disabled which made a visit or a stay extremely difficult”

3. Engaging with key stakeholders

The ‘Better Access To Health’ process shows how community engagement on accessibility issues can have a positive impact on the accessibility of buildings, particularly when considering detailed design issues.

To add value to accessible design, the ‘BATH’ group supports a community engagement approach that facilitates ongoing dialogue with service users. This approach recognises service users as the experts on their own access needs, many of whom will have developed considerable expertise in planning and access issues.

The ‘BATH’ group can provide some access advice whilst there are a number of access forums across NHS Greater Glasgow and Clyde that can provide assistance and guidance on access issues including the Glasgow Access Panel and West Dunbartonshire Access Panel (see further information and resources, pages 26-34).



The 'BATH' group recommends that planners consider the following when starting community engagement on specific projects:

- Engagement between service users (e.g. local access forum members), architects and planning teams should occur throughout the life time of a project, from beginning through to commissioning.
- The terms of reference for community engagement should emphasise that accessible design is not only about meeting the aspirations of service users but is also about taking on board the important input of other key stakeholders including clinical staff and expert advisors (e.g. Healthcare Associated Infection).
- Where new developments are planned, and depending on cost consideration, thought should be given to creating mock ups of clinical spaces (e.g. through the development of exemplar rooms, electronic fly through model or use of scale models) or undertaking post occupancy evaluations of what has worked in previous projects and what has not worked.
- Service users are well placed to help planning teams and contractors during the review stage of a completed development.
- Hospitals and hospital campuses should consider establishing an access panel consisting of disabled service users and others with a stake in access who can advise on the key issues.

4. Car-parking

A sufficient number of designated accessible car-parking spaces should be provided next to entrances of buildings, especially main entrances. (If possible in excess of 5% of total)

Accessible parking spaces should:

1. Be close to building entrances.
2. Conform to good practice guidelines to allow for the space needed to enable people to get out and into a wheelchair beside the door, and also allow a wheelchair to be removed from the boot.
3. Consider the differing needs of disabled car users and users of accessible mini-vans.
4. Be clearly marked, using signage that follows accessible signage guidelines.
5. Be situated on level ground with safe and easy access to the pavement.
6. In some cases car-parking should be provided under a covered area to protect against rain.

Where the car-parking area is barrier controlled, the intercom systems should meet the needs of people with sensory impairments and communication difficulties.

Assistance points/ buttons should be installed in the car-parking areas.

Operating this area

Control and management of accessible car-parking spaces is critical to good access to healthcare premises. Accessible parking spaces should have signs clearly stating monitoring procedures and penalties for misuse.

“By being consulted early we can help prevent the costly job of changing access later on”

5. Roads and paths

- Healthcare premises should provide monitored patient transport ‘drop off’/ ‘pick-up’ points and short stay waiting areas for patient transport.
- External drainage covers should be wheelchair friendly.
- Paths should have non-slip surfaces.
- Car drop off areas should have a mix of dropped and raised kerbs. This helps wheelchair users enter and exit black taxis and other vehicles. These areas should be clearly marked.
- There should be a sheltered seating area for people waiting to be picked up or escorted.
- Paths should be kept clear of potential obstacles such as benches and bollards.
- Handrails and resting places should be provided along pathways.



Paths should be kept clear of obstacles such as rails and bollards.



“Being a member of the group has increased my knowledge and understanding of other disabilities which ensures that I now consider all aspects of disability”

6. Entrances



Automatic sliding door should be used in preference to those that swing or rotate.

Entrance doors should be easy to find from the approaches and colour-contrasted with the surrounding area. All signs should be clear and well lit. The colour of handles should contrast with the door, and handles should be easy to grip.

Automatic sliding doors are preferred to swing or rotate doors as they allow unobstructed access. However the BATH group recognise that they can be difficult to maintain. Where swing doors are used they should have automatic release hold open devices.

Lighting should not cause glare on doors or windows near to entrances.

Doorways should be wide enough to accommodate people in wheelchairs and a person accompanied by an escort or an assistance dog.

Weather mats should be textured and flush with the floor so as not to cause a slip or trip hazard for people with mobility problems.

Glazed doors should have markings on them to clearly demonstrate that they are there.

7. Reception and waiting areas



Reception desks should be easily accessible to wheelchair users with a dropped section with knee space.

All reception desks should be fitted with an appropriate induction loop. The “ear” symbol denoting the presence of an induction loop should be prominently displayed. A sign at the desk should explain clearly to people using hearing aids how they can benefit from the induction loop.

Hospital entrances should contain a payphone at a suitable height for a person using a wheelchair and seating should be installed next to it. Text phones should be available where possible.

Where appropriate visual and audible paging systems should be installed in waiting areas so that people with sensory impairments are aware that it is their turn when they are called.

Reception areas with glass screens and windows should be kept free of stickers and notices as this may obscure the service user’s view of staff.

Continues overleaf



Reception desks should be easily accessible to wheelchair users with a dropped section with knee space.

“I got involved to have a say in what will be happening in the NHS when it comes to the rights of disabled people, especially where the health service designs new buildings”

Reception and waiting areas continued

Operating this area

Waiting areas should take into consideration the space requirements of wheelchair users or prams. This could include un-seated space or contain furniture that is moveable.

Furniture colour should contrast with floor and walls.

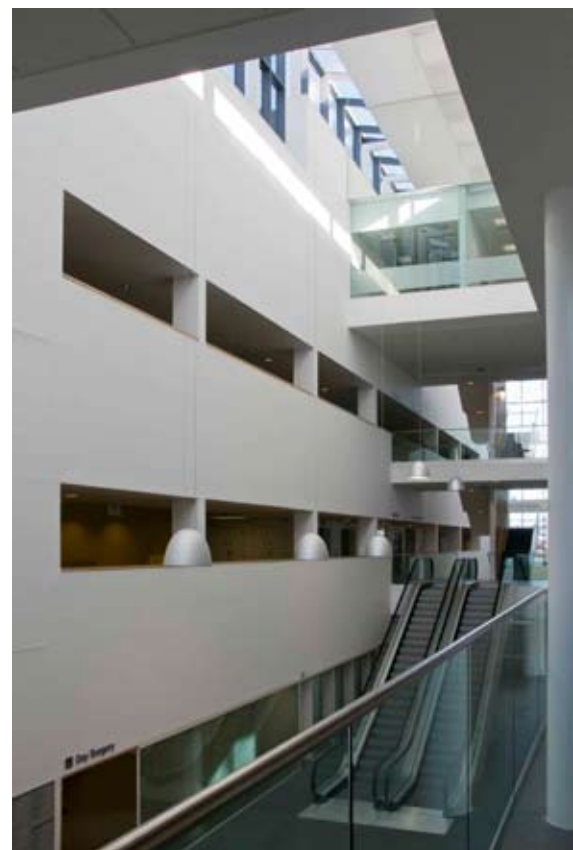
The BATH group advocate the use of wheelchairs in preference to the traditional portering chair.

Radios should not be played at reception desks as this can interfere with induction loop systems, as well as impede communication.

Display stands should not cause an obstruction.

Where there is a television in place, it should not be placed too high up on the wall. A hearing enhancement system and subtitles for people with hearing impairments should be considered.

Staff should ensure that induction loop systems are switched on.



The atrium at the New Stobhill Hospital.

8. Accessible toilet facilities

Where only one toilet can be provided it should be a wheelchair accessible toilet.

All fittings (such as wash hand basins, doorhandles, door locks, coathangers, towel dispensers, light switches and mirrors) should be at a height, which can be reached by someone using a wheelchair.

Where appropriate emergency floor dropped call cords should be provided in all accessible toilets. The BATH group recognise that this system might not be suitable in all healthcare settings (e.g. mental health) and that a different system may be more appropriate.

Emergency call cords should be linked to staffed areas. The call cord system should also include a flashing light inside and outside the toilet to indicate to a deaf person that the alarm has been raised.

Taps could be of the lever type to aid those with dexterity difficulties.

Consideration should be given to having toilet sheet dispensers rather than rolled paper dispensers in some toilets.

Continues overleaf



The BATH Group visit The New Stobhill Hospital.

Accessible toilet facilities continued

Ongoing attention should be paid to ensuring that moving/ lifting support fixtures should be durable and able to withstand heavy use. Safety checks should be considered.

Sanitary fittings, grab rails etc should contrast with their backgrounds, both on the wall and on the floor.

Toilets should include a mechanism to open the door from the outside in the event of an emergency.


The weight of doors should be considered and the force required to open the door, particularly those with springs. When there is no spring on the door a horizontal bar should be considered, fitted to the inside of the door

Operating this area

The accessible toilet should not be used for storage of equipment, resources or other materials.

If sanitary-wear machines are available in a facility, they should also be available in accessible toilets.

9. Fully accessible toilets including changing facilities



This area may require a height adjustable changing bench to allow for changing an incontinence pad.

A hoisting system would also be required to allow for safe transfer to a changing bench. User instructions should be available.

In the event that it is not possible or appropriate to develop a specific changing facility it is recommended that a policy is developed that protects the health, safety and dignity of patients and their carers.

10. Consultation and treatment rooms

Where possible all fittings (such as wash hand basins, door handles, door locks, coat hangers, towel dispensers, light switches and mirrors) should be at a height, which can be reached by someone using a wheelchair. However, it is recognised that this might be a health and safety issue for staff if they have to repeatedly stoop, particularly with regard to mirrors. In this case consideration should be given as to whether a specific treatment/ consulting room/s be fitted with accessible features. If this were the case then consideration should also be given to developing a protocol for use.

The room used for consultation should be suited to the particular needs of the service user. For example: it has adjustable examination tables and chairs if needed.

There should be sufficient space within the consulting room to accommodate a wheelchair.

Operating this area

Where possible desks should not be placed below windows as this can obscure vision due to glare from windows. Where the desk is placed beneath a window thought should be given to providing some means of adjusting the lighting (e.g. curtains).

Portable induction loop systems should be available for staff to assist with communication.

A procedure for communication support should be available to patients, carers and visitors who require it. For example, British Sign Language (BSL) Interpreters. Patients should be made aware of this before they attend. The procedure should be advertised within each department.

Attention should be paid to room layouts and the positioning of furniture that does not impede access i.e. furniture such as plants, water coolers etc.

11. Inpatient ward areas



Where inpatient wards include a locked entry system this should include a visual and audio capability to indicate when a door is locked/unlocked. A voice and video intercom system should also be installed.

Where toilet cubicles are installed in bedrooms they should where possible face the bed.



Typical inpatient area in the New Victoria Hospital



This sign for disabled toilet facilities was developed by the University of Stirling Dementia Care Research Centre and shows a mix of high contrast text and pictorial symbols.

12. Signage and wayfinding

The use of volunteer way finders should be considered where appropriate.

Pre-visit information should be developed and sent out to patients in advance of their visit.

All signs should be well lit.

Where possible signage content should avoid jargon. It should be simple, short and easily understood.

Text and lettering should be written in a clear uncomplicated font. (For example, a 'sans serif' typeface is recommended. This book uses the typeface Arial.)

Signage finish should be consistent throughout the building.

Signage should be clearly visible, non-reflective and free of glare from lighting or windows.

The colour of signage should be in contrast with its background.

Signage should be located in similar positions throughout the building, so that people become familiar with positioning. This is particularly important for people with visual impairments.

Signage should be placed at consistent heights. The use of suspended signs should be avoided wherever possible. Where unavoidable, the text should be able to be read from distance and the sign must not obstruct fire exit signs.

Signs should be placed at each point of entry in corridors. Longer corridors benefit from the use of additional signs at regular distances.

Where appropriate signage should combine pictorial symbols, arrows and Braille. Signage systems should also consider the use of symbols, 'super



graphics', colour and artwork as way finding aids or landmarks. i.e. colours indicating departments or floors.

Signs which identify rooms are situated on the wall in case the door is open when someone needs to see the sign.

Floor plans should be placed at main entrances and at designated areas within buildings, such as outside lifts and close to stairways. These should have easily distinguishable symbols to locate lifts, staircases and other points of interest.

Electronic signs giving information about waiting times, staff on duty etc should be considered in outpatient clinics.

Text guides to the premises could be considered for compilation and published on the Internet and made available in suitable offline media. This enables the listener to understand the layout of the premises before their visit.

Tactile maps should also be considered. Text guides and tactile maps are complementary and the two provide good understanding of premises to a wide range of customers and clients. For further information on tactile maps, contact the Centre for Accessible Information, RNIB 0121 665 4252.

Audio descriptions should also be considered, similar to those found in galleries and theatres. Here the speech is generated electronically, based on the information being relayed to the visible signs. Patients, carers, visitors, or staff could loan headsets, for a refundable deposit.

13. Lighting



All areas within the hospital should be well lit with attention paid to limiting shadow or sudden changes in lighting levels.

Planning teams should discuss with service users their requirements regarding lighting, possible use of shaded glass and its potential effects on the general ambience of the environment. Bright lights can cause difficulties for people who lip-read or use facial expressions to help understand what is being said.

Attention should be paid to limiting shadow or sudden changes in lighting levels. This is particularly helpful for people with visual impairments and deaf or hard of hearing people who lip-read. Too much natural light can be disturbing and distracting for those with visual problems.

Consideration should be given to making light adjustable, for example, in interview/consulting rooms. This can make it easier for patients who lip read or who are partially sighted.

Surfaces of signs, walls should not be highly polished and should have non-reflective finishes.

Both natural and artificial lighting should be arranged so that the faces of staff can be clearly seen and are not in shadow.

In areas where patients, visitors and staff can control lighting, light switches should contrast with walls.



14. Corridors, floors, doors and doorways



Hand rails (colour contrasted with the walls) should be considered along long corridors. These could be integrated with bump rails.

Doors, corridors and doorways should afford easy access for people who use wheelchairs and who are unassisted.

Where appropriate kick plates should be fitted to all doors.

Door openers should be installed that allow for the easy and unrestricted passage of wheelchairs.

Flooring should not be polished where this delivers a glossy finish.

Barrier matting should be flush with floor. Durable materials should be used.

In order to deliver uninterrupted flow through public areas it is recommended that fire extinguishers and heating should be recessed where possible.

Steps should be clearly marked with a highly visible colour contrasted nosing/ edging.

Tactile flooring should be installed at the top and bottom of sets of steps.

Careful consideration should be given to choice of materials so as to avoid creating a trip hazard.

Tactile flooring should be installed at the beginning of escalators as well as visible markings. As with above point careful consideration should be given to choice of materials so as to avoid creating a trip hazard.

Stairs should contrast with stair risers if at all possible.

Operating these areas

Seating/ benches/ rest areas should be provided at intervals throughout facility. Seating should be provided at a variety of heights and widths, some with arms, and some without arms.



15. Lifts

Lift walls should avoid a shiny or shiny metal finish.

Lifts should also include an audio and visual system to indicate that an emergency is being attended to.

Lifts should have an audio commentary indicating floor level.

A wall mirror is not always appropriate in a lift, particularly in larger sized lifts that affords good wheelchair access/ turning.

Press button panels and floor indicators should be at a sufficient level for all to see.

Push buttons should also have clear, embossed and/or braille numbers.

The press button panel should have buttons, which clearly indicate floor level. i.e. Large clearly marked buttons with colour contrast.

16. Security and evacuation procedures



Pictorial symbols should be included on all fire evacuation signs. This will help people with learning difficulties, people with dementia and people who have difficulty reading English.

Attention should be paid to access to 'staff only' areas. A swipe card entry system or similar is not always appropriate for staff members with manual dexterity issues. In these circumstances a proximity reader is a more appropriate option.

All fire exit signs should indicate which exits are suitable for wheelchair users.

An evacuation alarm system should include an audio and visual (e.g. coloured flashing beacon lights) means of alerting staff and visitors.

Operating this area

All health care buildings should have an evacuation plan.

Refuge points should be kept clear of obstacles. They should be clearly signed and maps or plans of facilities indicate refuge point's location.

Emergency exits should be checked regularly to make sure they are not blocked by equipment or other obstacles.

17. Further information and resources

Local NHS access groups

'Better Access To Health' group

Dan Harley

Community Engagement Team
(Hospital Modernisation Programme)
NHS Greater Glasgow and Clyde

Dalian House
350 St Vincent street
Glasgow G3 8YU

Tel: 0141 201 4420

Email: dan.harley@ggc.scot.nhs.uk



Greater Glasgow and Clyde Access Panels

Glasgow Access Panel

Charlie Murphy

Unit 17

Chapel Street Estate

Glasgow G20 9BD

Tel: 0141 946 8488

Email: charlie@glasgowaccesspanel.org.uk

Website: www.glasgowaccesspanel.org.uk

West Dunbartonshire Access Panel

Margaret Maceira

9 Isly Crescent

Old Kilpatrick

Glasgow G60 5EW

Tel: 01389 382067

Email: maceiras.2@ntlworld.com

Continues overleaf

Further information and resources continued

East Renfrewshire Access Panel

Liz Duguid (Secretary)

83 Holehouse Road
Eaglesham G76 0JF

Tel: 01355 302533

Email: lizguguid@btinternet.com

Website: www.eastrenfrewshire.gov.uk/accesser

Renfrewshire Access Panel

Susan Leckie

50 Glencairn Road
Paisley PA3 4LP

Tel: 0774 703 6028

Email: rap123@hotmail.co.uk

Helensburgh and Lomond Disability Access Panel

John Hallett

Dhuhill Lodge
Sinclair Street
Helensburgh G84 9AT

Tel: 01436 673058

Fax: 01436 670252

Email: hallettjha@aol.com



East Dunbartonshire Access Panel

c/o East Dunbartonshire Council for Voluntary Services

19 Donaldson Crescent

Kirkcintulloch, G66 1XF

Tel: 0141 578 0291

www.edap.org.uk

Other helpful organisations

Describe Online

Terry Robinson B.Sc

82 Albert Road

Crosshill, Glasgow G42 8DR

Tel: 0141 423 2683,

Mobile: 07771 610 002

Email: terry@describe-online.com

RNIB Centre for Accessible Information

Royal National Institute of Blind People

105 Judd Street

London WC1H 9NE

Tel: 020 7388 1266

Fax: 020 7388 2034

Continues overleaf

Further information and resources continued

Health Facilities Scotland

Health Facilities Scotland (www.hfs.scot.nhs.uk) is a division of National Services Scotland who can advise NHS staff on estates and environment, including topics such as: building and architecture; procurement; safety; property management; hazards and safety action notices and fire safety.

Contact details for Health Facilities Scotland:

4th Floor Empire House
131 West Nile Street
Glasgow G1 2RX

Telephone: 0141 332 3455

Fax: 0141 332 0703

Website: www.hfs.scot.nhs.uk

Scottish Disability Equalities Forum

Scottish Disability Equalities Forum (www.sdef.org.uk) has established local access panels, which can carry out audits on buildings to assess how accessible they are for disabled people.

Contact details for Scottish Disability Equalities Forum:

12 Enterprise House
Springkerse Business Park
Stirling FK7 7UF

Telephone: 01786 446456 - Access Team 01786 473152

Fax 01786 450902

Email: general@sdef.org.uk



Publications

British Standards (2001), BS 8300:2001, **Design of buildings and their approaches to meet the needs of disabled people – A code of practice.**

www.bsi-global.com/Building/Disability/bs8300.xalter

British Standards (1999), BS 5588-8:1999, **Fire precautions in the design, construction and use of buildings. Code of practice for means of escape for disabled people.**

www.bsi-global.com/Fire/Detection/bs5588series.xalter

Barker, P., J Barrick and R Wilson (1995), **Building Sight.**

www.jmuaccess.org.uk/6.asp

Barker, P., and Fraser, J. (2000) **Sign Design Guide**, Pub: JMU Access Partnership and the Sign Design Society. ISBN 1858784123

Bright, K.T., et al (2004) **Buildings for all to use**, CIRIA, London

Bright, K.T., et al (2004) **Colour Contrast and Perception**, 2nd Edition, Pub: The Research Group for Inclusive Environments, The University of Reading, UK.

Bright, K.T (2004) **Disability: Making Buildings Accessible – Special Report** (Second Edition), Ed: Pub: Workplacelaw Network, Cambridge. ISBN 1-900648-84-9.

Communities Scotland. **National Standards for Community Engagement.**

Equality and Human Rights Commission (formerly Disability Rights Commission) (2004), **Good Signs – Improving signs for people with a learning disability**, (www.drc-gb.org).

Further information and resources continued

Equality and Human Rights Commission (formerly Disability Rights Commission) (2004) **Improving Hospital Services for Disabled People.**

Fair for all (2006), **Improving NHS services for disabled people.** www.drc.org.uk/fair4all/achievingfairaccess/

Health Facilities Scotland (2007) **Fully accessible toilets.**

Health Facilities Scotland (2006), **Planning notes 36 part 1: general medical practice premises in Scotland.**

Health Facilities Scotland (2006), **Planning notes 36 part 2: NHS dental premises in Scotland.** NHS National Services Scotland

Health Facilities Scotland (2007) **Wayfinding: effective wayfinding and signing systems guidance for healthcare facilities.** NHS National Services Scotland

JMU Access Partnership (2001) **Colour and Contrast – a design guide for the use of colour and contrast to improve the built environment for visual impaired people,** The University of Reading and ICI Paints, Pub: ICI Paints, Slough, Berkshire. (CD Format).

JMU Access Partnership (2000), **Sign design guide.**

www.jmuaccess.org.uk/6.asp

NHS Scotland Property and Environment Forum (2002), **Access audit checklist: access for disabled people in healthcare premises.**

NHS Estates (2005), **Way finding: effective way finding and signing systems guidance for healthcare facilities.** 2nd edition.



Oxley, P. (2003) **Inclusive Mobility**, Cranfield Centre for Logistics and Transport, Pub: Department for Transport, (www.mobility-unit.dft.gov.uk).

Royal National Institute for the Blind (2006), **See it right**.

www.rnib.org.uk/xpedio/groups/public/documents/publicWebsite/public_seeitright.hcsp

Scottish Accessible Information Forum (2003), **The access guide**.

Scottish Executive (2006), **The Disability Discrimination Act (1995): implementation of section 21: access audit progress information**. HDL (2006) 6. www.show.scot.nhs.uk/publicationsindex.htm

Scottish Executive (2006), **Inclusive design. Planning and Standards Advice Note: PAN 78**. www.scotland.gov.uk/Resource/Doc/95636/0023150.pdf

Scottish Executive (2005), **Fire safety policy for NHS Scotland**. HDL (2005) 53. www.show.scot.nhs.uk/publicationsindex.htm

Scottish Executive (2002), **The building standards amendment (Scotland) regulations 2001**. HDL (2002) 35. www.show.scot.nhs.uk/publicationsindex.htm

Other useful contacts

- Action for Blind People (www.actionforblindpeople.org.uk)
- Centre for Accessible Environments (www.cae.org.uk)
- Changing Places www.changingplaces.org)
- Fair For All: Disability (www.drc.org.uk/fair4all/achievingfairaccess)
- JMU Access Partnership (www.jmuaccess.org.uk)

Further information and resources continued

- Royal National Institute for the Blind (www.rnib.org.uk)
- Scottish Accessible Information Forum (www.saifscotland.org.uk)
- Scottish Building Standards Agency (www.sbsa.gov.uk)
- Sense Scotland (www.sensescotland.org.uk)
- UPDATE (www.update.org.uk)



Notes

If you would like this document in Braille or audio-tape format, please contact:

If you would like this document in another language, please contact:

Ma tha sibh ag iarraidh an fhiosrachaidh seo ann an cànan eile, cuiribh fios gu:

如果您需要该信息的其它语言版本，请联系：

اگر این اطلاعات را به زبانی دیگر میخواهید لطفاً با این ادرس تماس بگیرید:
إذا رغبت في الحصول على هذه المعلومات بلغة أخرى، الرجاء الاتصال بـ:

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸੰਪਰਕ ਕਰੋ:

اگر آپ یہ معلومات کسی اور زبان میں حاصل کرنا چاہتے ہیں تو براہ مہربانی رابطہ کریں:

Eğer bu bilgiyi bir başka dilde istiyorsanız lütfen bağlantı kurunuz:

Jeśli chcesz uzyskać te informacje w innym języku skontaktuj się z:

Telephone 0141 201 4809