Disability Access and Facilities

Statement of Minimum Standards

1.	**INTRODUCTION** The Trust has a clear obligation under The Equality Act 2010 as an employer, service provider, and possibly as an education provider. Part 4, Part 5 and Part 13 particularly apply. Employers have a duty not to treat people with disabilities less favourably than others for a reason related to their disability, unless this can be justified, and to make adjustments to assist employees or applicants for employment who have disabilities. This is currently a reactive duty but anticipating where staff with disabilities could be employed can be more cost effective when planning refurbishments, building extensions, etc. The Act has also made it unlawful for service providers to treat people with disabilities less favourably than others for reasons relating to their disability. The concept of making 'reasonable adjustments', such as providing extra help or making changes to the way a service is provided, was introduced in October 1999 and extended in October 2004 by the Act's predecessor the Disability Discrimination Act to include alterations to overcome physical barriers to access. This access statement has been written to provide guidance to the Design Team on the approach to equalities and specifically access for people with disabilities within BSUH. The statement works from the premise that BSUH wishes to facilitate independence and social inclusion within the design wherever possible. The design must therefore create the conditions for people with disabilities to access the very best health care. The building will incorporate reasonable adjustments throughout, so that people with disabilities have their specific needs met. This will occur through recognition of the environmental problems facing people with diverse disabilities and the incorporation of intelligent design solutions which can do so much to minimise these difficulties. Therefore, for instance, seating areas will include integral wheelchair bays rather than a segregated area, to give just one example. There should always be the option of human contact/assistance. This will help to ensure an enabling environment where any individual can move as safely and independently as they are (reasonably) able. Not all will be able to or would wish to tap into the hi-tech way-finding assistance approach, so simple and straightforward strategies and design should be at the core of

	way-finding development for the new hospital. However investment in hi-tech solutions should continue to be developed to ensure that the new hospital and indeed the whole of the site is an enabling environment for all who utilise its services.
1.1	The Equality Act 2010 states that outlines the following three requirements: The first requirement is a requirement, where a provision, criterion or practice of A's puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage. The second requirement is a requirement, where a physical feature puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage. The third requirement is a requirement, where a disabled person would, but for the provision of an auxiliary aid, be put at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to provide the auxiliary aid.
1.2	This builds on and supersedes the Disability Discrimination Act 2005[1] which incorporated the needs of people with different disabilities such as hearing impairment, as well as physical disability. Brighton and Sussex University Hospitals NHS Trust therefore acknowledges that to comply with its mandatory obligations under Part 2 Section 2 Chapter 2 Section 20 of the Equality Act 2010 and the General Duties under the Disability Discrimination Act 2005 its services need to be physically accessible, with facilities that enable and support independence for all disabled people. The Equality Act (October 2010) has therefore brought together a number of different acts and legislations in the interests of simplicity and increased co-ordination. The act has brought in new rights and aims to fill current gaps in protection.
1.3	As detailed in our Equality and Human Rights Policy [2], the Trust is committed to creating a culture in which equality of opportunity are promoted actively

[1] The Disability Discrimination Act 2005 (DDA 2005) built on and extended earlier disability discrimination legislation, principally the Disability Discrimination Act 1995.

[2] http://nww.bsuh.nhs.uk/working-here/equality-and-human-rights/?locale=en

	and in which unlawful discrimination is not tolerated. The Trust accepts that to accommodate the needs of the diverse community it serves; it must develop a greater awareness and understanding of equality and diversity amongst its workforce.
1.4	The purpose of this document is to make its staff and contractors aware of the minimum standards to ensure disabled people can access our services and facilities.
1.5	The Trust accepts that in pursuing this aim it may create challenges to the culture of the organisation, but understands that the rewards and benefits in reducing health inequalities within our communities and improving the working lives of our staff justify this endeavour.
2.	**STATEMENT OF MINIMUM STANDARDS** [3]
2.1	**Introduction**
	The Trust considers that the following issues must be included as part of all new build schemes. Whilst setting out this requirement the Trust accepts that not all of its current premises will comply with this standard. The list is not definitive and should be considered as a guide to the various elements of a design.
2.2	**Access to Building**
	a) A level approach should be provided from the site boundary and car parks to building entrances, with gradients less than 1:20. b) The surface width of footpaths should be a minimum of 1.8 metre wide. c) Firm durable slip resistant surfaces should be provided. d) Route of access to the building should be clear metre wide. e) Firm durable slip resistant surfaces should be provided.

[3] Sections 2.-2.18 all reference **BS 8300:2001**

Design of buildings and their approaches to meet the needs of disabled people. Code of practice British Standards Institution / 31-Oct-2001 / 173 pages ISBN: 0580384381

	f) Route of access to the building should be clearly identified and illuminated. g) Vehicle and pedestrian routes should be separate wherever possible.
2.3	**On site Car parking**
	a) Sufficient disabled bays should be provided. The bays should be designed to those specified in British Standard, BS-8300. b) Disabled parking bays should be positioned close to building entrance. c) Disabled parking bays should be 3.6 metre wide and 6 metre long. d) Disabled parking bays should be clearly identifiable with surface markings and driver head height signs stating bays designated for Blue Badge Holders. Disabled parking for visitors and staff needs to be clearly identified. e) Dropped kerb/level access should be provided from parking bays to the pedestrian route.
2.4	**Ramped Access**
	a) Ramps should be designed to those specified in British Standard, BS-8300. b) Ramps should have a gradient of no more than 1 in 20. c) Hand rails should be fitted to both sides of the ramp. d) Firm durable slip resistant surfaces should be provided. e) A level landing areas of at least 1.2 metre long should be provided at the foot and head of the ramp to allow space for manoeuvrability through doors. f) A kerb edging should be fitted on the open side of any ramp, at least 100 millimetres high, which contrasts visually with the ramp. g) Ramps should be well lit.
2.5	**Accessible Entrances**

	a) The main entrances should be clearly signposted. b) Entrance should be easily identifiable by lighting and visual contrast. c) Level landing should be provided in front of entrance door (Minimum 1500 millimetres by 1500 millimetres. d) Surface should not impede movement of wheelchairs. e) Threshold should be level or not more than 15 millimetres high. f) Internal floor surface (including door matting) should not form trip hazard or impede wheelchair movement.
2.6	**Doors to Accessible Entrances**
	a) Doors should be equipped to ensure the maximum opening pressure is as close as possible to 20 Newtons. b) Effective clear width of single door or one leaf of a double door should be a minimum of 800 millimetres. c) Minimum vision panels zone to leading edge should be 500 – 1500 millimetres high. d) Automatic door opening systems should be used wherever reasonably possible.
2.7	**Manually Operated Non-Powered Entrance Doors**
	a) Doors should be equipped to ensure the maximum opening pressure is as close as practicable to 20 Newtons. b) Unobstructed space of 300 millimetres on pull side of door leading edge. c) Latches should be operable with one hand using a closed fist. d) Door furniture should contrast visually with the surface of the door. e) External door furniture should not be cold to the touch. Plastic coated handles should be used.
2.8	**Glass Entrance Doors and Screens**
	a) Manifestations (clearly defined markings) should be provided at 2 levels 850 – 1000 millimetres and 1400 – 1600 millimetres.

	b) Manifestation should contrast visually with background. c) Manifestation to be a logo 150 millimetres high or bands 50 millimetres high. d) Glazed doors adjacent to screens clearly differentiated by use of minimum 125 millimetres top and side rails and 400 millimetres kick zone to bottom of door.
2.9	**Entrance Lobbies**
	a) Dimensions of Internal lobbies should comply with Building Regulations Part M Table 10 b) Floor finishes in lobby should not impede wheelchair access. c) Floor surface provided should remove rainwater from shoes and wheelchairs by inclusion of barrier matting at entrance door. d) Columns etc projecting more than 100 millimetres into lobby should be contrasting rail/guarding.
2.10	**Entrance Hall and Reception**
	a) Reception point to be easily identifiable. b) Approach to be direct and free from obstructions. c) Wheelchair access should be provided. d) The reception counter should provide a low access area at 800 millimetres. e) A clear space under the reception counter of 700 millimetres should be provided to allow wheelchair user access. f) Knee recess should be provided of 500 millimetres. g) Reception desk to accommodate standing and seated visitors if reception desk is fitted. h) Non-slip floor finish should be provided. i) An induction loop system should be fitted at the reception desk. j) Chairs with and without armrests should be made available in all

	waiting areas. Quiet areas suitable for patients who are distressed, or need additional privacy (e.g. for breast feeding) must also be provided in all waiting areas.
2.11	**Internal Doors**
	a) Effective clear width of single door or one leaf of double door should be minimum 750 millimetres. b) Doors should be equipped to ensure the minimum opening pressure is as close as practicable to 20 Newtons. c) Unobstructed space of 300 millimetres provided at leading edge of door on pull side. d) Latches should be of a type operable with one hand using a closed fist. e) Door furniture should contrast visually with the surface of the door. f) Any doors held open or not self-closing should have a visually contrasting colour to the leading edge. g) Vision panels should be provided from 450 – 1500 millimetres high to all circulation doors. h) Push button key pad locks should not be used.
2.12	**Vertical Circulation – Stairs**
	a) Stairs and landings should be designed to those specified in British Standard, BS-8300. b) All step nosings should be distinguishable through contrasting colour. c) Risers should not be open. d) A suitable continuous handrail should be fitted on each side of the stairs.
2.13	**Lifts and Platform Stair Lifts**
	a) Lifts and platform stair lifts should be designed to those specified in British Standard, BS-8300. b) Signage on all lifts should be clear, both when entering and exiting the

	lift. c) All visual indicators and lift call buttons should be visible and usable by passengers both standing or seated positions. d) Lighting should enhance accessibility and the lighting itself needs to ensure people with visual impairment are catered for. e) Audible announcements within the lift car and on landings should be suitable for both visually and hearing impaired people. f) Call buttons should be tactile and in symbols. g) Car floors and ramps should feature slip resistant materials. h) Handrails should be provided inside the lift carriage. i) Seating should be provided inside the lift carriage.
2.14	**Refreshment Facilities**
	a) Wheelchair access should be provided to beverage points. b) Worktops should be 850 millimetres. c) A clear space under the worktop of 700 millimetres should be provided to allow wheelchair user access. d) Water delivery should be controlled and taps should be lever controlled. e) Chairs with and without armrests should be made available.
2.15	**Switches, Outlets and Controls**
	a) Sockets and telephone points should be positioned at 400 to 1000 millimetres. b) Light switches should be located at 900 to 1100 millimetres to line in with door handles for ease of location. c) Light switch plates should contrast visually with the background.
2.16	**Wheelchair Accessible Unisex Toilets**
	a) Accessible toilets should be located adjacent to the entrance / waiting

	areas. b) The door should be outward opening and should not obstruct any exit route. c) Dimensions of the accessible toilet should be in accordance with British Standard, BS-8300. d) Facilities in the accessible toilet should be in accordance with British Standard, BS-8300. e) The cistern flush should be located on the transfer side of the toilet. f) A shower curtain should be fitted inside of the toilet, to provide privacy for a carer to leave the toilet.
2.17	**Lecture and Conference Facilities**
	a) Stages and podiums should be accessible. Provide a ramp or lift platform wherever necessary. b) Sound systems should incorporate an induction loop facility.
2.18	**Dementia**[4]
	a) Visual contrast should be introduced throughout the older people's wards for instance toilet seats which contrast with the pan, contrasting doors to walls so as to minimise cognitive confusion. b) Toilet fittings should either be traditional or clearly signified (such as "push button for flush" signage for flush levers if it is not obvious from the design) c) Natural day light should be enhanced wherever possible. d) Soft furnishings and covers should be colour contrasted with flooring. e) Mirrors should be coverable or removable. f) Floors should be non-slip.

[4]Taken from: Dementia Gateway better knowledge for better practice (2010). Social Institute for Excellence. http://www.scie.org.uk/publications/dementia/environment/index.asp

	g) Reflective glazing should be minimised. h) Sink and showers should be thermostatically controlled and have an overflow mechanism.
2.19	**Other Issues**
	a) Internal signage should be clear using bold colour contrasts and symbols. b) Floor surface should be well maintained, avoiding deep pile and thick underlay. It should be non reflective with tactile and colour difference on changes in levels and at the bottom and top of stairs. c) Floor coverings should be designed specifically to meet the needs of all users. d) There should be a sensitive use of decor that uses bold contrasts of colour to help highlight doors, light switches, handrails, steps and telephones etc. e) Induction loop systems should be available at all reception points, training, consultation rooms and meeting rooms, portable or handheld system should be made available to use within the building. f) Visitors' audiovisual devices such as smart phones will be fed real time information from strategic wi fi points throughout the building to assist with way finding. g) Patient call and fire alarms should include audio and visual and tactile communication. h) A choice of seating with and without armrests and a variety of heights should be made available in all waiting areas, consultation rooms, training rooms, meeting rooms and offices. i) All clinical areas should have at least one fully adjustable height examination couch and a policy of communicating its availability to all staff. j) Accessible emergency exists should be provided on all ground floors. k) All other equipment provided in the building should meet the needs of all users. l) All accessible emergency exists should be clearly signed.

	m) Safe refuge points should be provided on all upper floors. n) All safe refuge points should be clearly signed. o) External and internal design should provide clear manoeuvrability space for mobility and visually impaired disabled people. p) Ensure public transport arrangements are considered in the development of all services. q) Ensure that wayfinding and access solutions i.e. signage, smart phones and hearing loops are complemented by appropriate staff or volunteers who can provide assistance to people with disabilities when requested.
4.	**NOTICE FOR CONTRACTORS**
4.1	The Trust expects that ALL contractors and their agents will comply fully with The Equality Act 2010.

Brighton 3T's

Accessibility Workshop 27th September 2010

Attendees:

Anna Barnes- BSUH

Cassandra Blowers- BSUH

Lyn Beun- BSUH

Allison Cannon- BSUH

Nikola Fieldhouse- Deaf/Blind Association

Nick Groves- BSUH

Jon Hastie- Brighton and Hove Federation of Disabled People

Adrian Hitchcock- BDP

Justin Muil- LO'R

Martin Mclachlan- BSUH

Duane Passman- BSUH

Abigail Pride- BSUH

John Wilkinson- BSUH

Key decisions – in bold

Electric Wheelchairs / Mobility scooters

We have touched on this a couple of times. The issues that we've encountered elsewhere are that the size of these vehicles is increasing to the extent that some are almost road-going - often equipped with lights/indicators/ rain covers for complete weather protection, baggage racks and wing mirrors. I've seen these driven into hospitals and along the streets to departmental entrances – The current scheme does not support this – the passenger lifts are designed only for 'pedestrian' traffic for example. We need to discuss whether we set a limit on

type of ‘wheelchair’ – where a transfer to hospital wheelchair takes place if necessary, where the owners ‘wheelchair’ stays in the meantime – number and location of charge points. If mobility scooters are accessing the hospital entrances, then the routes will need to be established to ensure dropped kerbs are provided at all kerb crossing points.

Smaller electric wheelchairs should be expected throughout the hospital – and in some cases inpatients will want to bring these into their bedrooms. This means considering cleaning / charging and storage – or is the policy inpatients discouraged from bringing in their personal chairs?

The workshop participants agreed that maximising independence was a key issue for people with impaired mobility, so would not be happy with a “blanket ban” on large scooters. However, there was a distinction between inpatient and outpatients with it feeling legitimate to limit the use of the “road going vehicles” to outpatient areas, and to leave appropriate parking spaces for these vehicles adjacent to ward areas.

It was noted that limitations on public transport (which should ease in the next few years) created a perverse incentive for people to arrive in these vehicles. It was agreed that information should be sent out to visitors outlining the maximum size vehicle which could be accommodated.

BDP was asked to identify the maximum size/weight that the building will be able to accommodate.

The building should be designed to allow mobility scooter access to OPD areas (subject to the limitations above), and some OPD C/E rooms should be sized appropriately. It was agreed that users would not be expected to use their mobility scooter in IP areas.
There was also the issue of safety for other users of the building, so a reminder of sensible speed limits would be required. .

<u>Automatic Doors</u>

It is sensible that access doors to the building are automated – allowing free access without resorting to staff assistance etc. The main doors may well need to be the large diameter rotating type which provide protection to draught and air turbulence to the interior. Whilst these are ok for wheelchair users, many feel uncomfortable with negotiating these and prefer a traditional activated swing door- these are often provided as additional side doors alongside the rotating door drum. The issue here is that depending upon wind speed and direction, the activators are often not strong enough to push against the wind pressure to open – particularly where at the base of a multi storey building – so we’ll need to check

this. I imagine that since our car parking is at basement level we will need to configure the access doors between the car park and the lift core, to be automated. The route between the core and the accessible bays in the car park will have to be defined although segregation from cars will not be possible. The clear headroom in the car park may prove too restrictive for the 'top-box' style wheelchair arrangements which some disabled drivers have as part of their mobility package – so we will need to define the constraints and propose alternative parking locations – how is this communicated to the disabled driver – via appointment card?

Automatic revolving doors were accepted as the best method of regulating temperature and conserving energy. It was agreed that an alternative, maintained automatic side door should be made available for people who are uncomfortable using revolving doors.

BDP will continue to investigate alternatives given the anxiety that revolving doors cause for mobility- and cognitively-impaired users.

Accessible WCs

Various comments have been made regarding the availability of right and left handed transfer accessible WCs. On other projects we have alternated the provision by floor – generally associated with a public core. At present we don't have this arrangement linked to public circulation other than Level 1 and Level 6 being the public floors – both provided with public facilities including accessible WCs. There is no simple pattern of accessible WCs floor by floor – I suspect this will be seen as unacceptable; how do we resolve this…probably by looking at pulling to the reception areas WCs that could then be accessed from cores on levels 2,3,4,5,7 – 12.

For staff the issue is to be able to access an accessible WC within 40m of their place of work. This can sometimes prove to be difficult to arrange given the constraints of departmental layouts – however we do have the benefit of staff change (incl WCs) on each floor so should find this will assist in meeting this target.

I've highlighted the issues / conflicts around combining the function of independent wheelchair user and assisted WC provision – they are not mutually compatible. The principle is that in Public areas (including outpatient public wait areas) we should provide the 'Part M' independent w'chair user WC and within hospital departments then we provide assisted WC models.

It was agreed that right- and left-handed WCs would be available on each floor but not in pairs, so this might mean users' going to another department on the same floor to access an appropriately-handed toilet. Information would be made available to explain the various locations

It was agreed that toilets should where possible be within departments (to discourage drug users from entering the building to use the public toilets). This will also need to be addressed in the security policy

There was a discussion about balancing the needs of some users for shelving with the needs of others to not have visual clutter or obstacles – recessed shelves could be a solution but would be expensive. BDP to investigate all options.

Wayfinding

The question of Braille is often raised – ie apply this to handrails, key information points, notices on doors etc. etc. The issue then is the prevalence of individuals who have the skills to take advantage of this – in truth it tends to be a small proportion of the patient population as loss of sight due to degenerative conditions – generally an aging population who will not have had the benefit of learning Braille earlier in life. Also those adult groups who suffer sudden loss of sight will similarly not have had the benefit of being able to acquire the skills. The upshot is then probably not of great benefit to include this.

Another issue is the language used in signage – ie whether there is a predominant ethnic population that would mean offering dual language signs and literature would be of benefit.

Useful devices are touch screen stations which can give information in different languages at a selection button for example.

Braille is the communication device of choice for people who are blind or partially sighted from birth so should be maintained.

The group also recommended the use of pictograms and symbols and plain English wherever possible.

There was a discussion about using airport-style signage, ie. using numbering only to give the location of a department as numbering is a default international language.

It was recommended that the Sussex Interpreting Service should be contacted for additional advice. Wakefield was recommended as a good example of way-finding. A way finding group will be needed to look at this issue in more detail.

Multifaith

This will need to be flexible in delivering different functions. Ritual washing will have to be accommodated along with sacrament / sacred text storage etc.

To be covered elsewhere.

Visitor Patient and Staff Food choice

Accessibility and discrimination issues also include cultural / religious concerns and constraints around type / timing of meals. The accessibility policy will need to include reference to Trust's approach to dealing with menus and food orders, food being brought into the hospital – stored and served etc. by patient's relatives or carers. There may also be issues Trust wide with Staff bringing in their own food which will have to be stored and cleared – consider provision at Staff Rest beverage bays.

To be covered elsewhere.

Induction Loops for Deaf

Whilst these are referenced in the policy – there probably needs to be a sense check on the locations of all fixed induction loops.

Staff training will be needed to ensure that these are made available. Key points where they are needed will be reception and meeting rooms. Once again, the portable systems can be used throughout the building if visitors are told they can request them before arrival. It was agreed that this should be specified at 1:50 level drawings

Trust DDA advisor / auditor

It would be very helpful to have the Trust's DDA adviser involved in this workshop to establish some views on the above plus some of the difficult issues we face on this site:

It's steeply sloping – 4 storeys between the south and north elevation of stage 2…which means that all around the site are gradients which far exceed anything that wheelchair / frame users can contemplate.

Bariatric Patients.

Whilst there will be a separate policy on Bariatric Patient management etc. this patient group will represent similar accessibility issues such as the availability of suitable inpatient accommodation .

Mental Health Service users and carers.

Balancing the risk of rooms designed for physically impaired / physically disabled users with the safeguards for patient's which also have a mental health issue – which may include self harm for example – will require further thought; the prevalence of support rails, curtain rails and design of furniture and arrangement of doors can all be ligature risks – how is the Trust going to balance or resolve this?

The issue of ligatures was considered to be important in A&E areas. However, for people with limited mobility, it was thought important for hooks/curtain rails etc to be robust and weight bearing, so the mental health self harm risks should be managed though staff observation.

Recessed shelves for mobility aids (eg. walking sticks, crutches) was suggested for reception areas so people don't have to place them on the floor.

Dementia wards require sympathetic design; this will be discussed at a separate workshop, e.g. colour contrast, bathroom fittings etc.

Accessibility monitoring in the 3T Design Process

Draft Process