



# New Dialogue Data Review:

Health and social care inequalities in Kingston  
(2021-26)

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## Healthwatch Kingston, working with the local community

“As a small, dedicated team we have worked hard to make positive and impactful progress during very challenging times. We remain focused in representing and raising the voice of local people, working with our volunteers and health and social care partners in our shared ambitions to reduce inequalities, promote better engagement and equity and improve the lives of all in our borough.” – *Kathryn Yates, Chair, [New Dialogue \(The home of Healthwatch Kingston upon Thames\)](#)*

### 1. Executive summary

This five-year review of Healthwatch Kingston’s community engagement reports has revealed common and persistent themes (e.g. issues with accessible information etc.) across the period. The health and social care inequalities identified are system wide and have disproportionately affected people from minority ethnic groups, Disabled residents, migrants, refugees, digitally excluded people, carers, families with young children, and those facing socioeconomic deprivation.

While the breadth of Healthwatch Kingston’s insight reports demonstrate significant local efforts from service commissioners and providers to listen to the lived experience of patients and service users, the findings consistently show that barriers rooted in language, cultural understanding, digital exclusion, mistrust, stigma, accessibility, and fragmented services continue to restrict equitable access to health and social care in the Royal Borough of Kingston upon Thames.

Across settings, including residential care, hospitals, early years services, mental health, bereavement support, community services, and digital access—people describe challenges in navigating systems, securing appropriate information, receiving culturally responsive care, and experiencing joined-up communication.

Evidence highlights universal issues such as limited translation availability, inconsistent application of the Accessible Information Standard, lack of culturally relevant food and activities, long waits, poor transport accessibility, unclear pathways, low awareness of entitlements, and administrative complexity disproportionately affect minoritised communities, particularly those with low English proficiency or limited digital skills.

At the same time, the evidence also illustrates what works: compassionate staff, strong community and faith-based/life philosophy networks, accessible pharmacies,

co-production, meaningful face to face outreach-based engagement, and a local willingness to improve.

Importantly, the review underscores the value of centring lived experience in service design and the necessity of intersectional approaches to understanding need. Taken together, the findings in this 5-year review report highlight a clear opportunity for Kingston's health and social care system to strengthen culturally competent, accessible, and inclusive services, supported by better communication infrastructure, consistent translation support, and ongoing monitoring of health and social care inequalities.

## 2. Context

Following the priorities set out in the Healthwatch Kingston 2024–25 annual report, '[Unlocking the power of people driven care](#)', New Dialogue, the home of Healthwatch Kingston upon Thames, committed to a strategic review of our community engagement data from the past-5 years. The comprehensive review will shape our work tackling health and care inequalities by revealing patterns and themes among the experiences of different groups, communities and demographics within the borough.

This report, supporting the development of the Royal Borough of Kingston upon Thames (RBK) Director of Public Health (DPH) report 2025–26, takes a dedicated look at ethnicity, and the health outcomes among minoritised groups in Kingston, with the understanding that health and care inequalities are underpinned by the interconnected wider determinants of health: the individual, social and environmental factors. The review will share the voices of minoritised communities and their experiences of local NHS and social care services.

The Healthwatch Kingston 2024–25 annual report, '[Unlocking the power of people driven care](#)' identified the following key work area, to ensure that we continue to reach out to every part of society, especially people in the most deprived areas, so that those in power hear their views and experiences:

### **Key Work Area 2. Promoting positive health and reducing health and care inequalities**

- a) **Continue to monitor inequalities**, in particular, the health and care needs of people living with short, intermittent and long-term conditions.
- b) **Review Healthwatch Kingston community engagement data** from the past 5-years to explore what insights and cross-cutting themes exist

With these priorities in mind, New Dialogue welcomed the opportunity to share the insights of our review with the DPH at Kingston Council.

Kingston, as a Marmot Borough, has adopted the six ‘Marmot Principles’ set out in [‘Fair Society, Healthy Lives’](#) which set out evidence-based strategies for reducing health inequalities. The borough ‘Protected Characteristics Profile’ provides a dashboard which collates local data on the nine protected characteristics outlined in the Equality Act 2010.

The nine protected characteristics under the Equalities Act 2010 are:

- Age
- Sex
- Race
- Sexual orientation
- Marriage or civil partnership
- Pregnancy and maternity
- Gender reassignment
- Religion or belief
- Disability

Healthwatch Kingston supported the development of the [‘Prosperous Lives for All: The Refugee and Migrant Strategy 2016–2019’](#). The strategy set out how stakeholders might work together ‘to enable refugees, asylum seekers and vulnerable migrants to have a decent life and a prosperous future in the Royal Borough of Kingston Upon Thames’. The strategy noted:

‘Refugees, Asylum Seekers and [other] Migrants are amongst the most socially and economically marginalised groups in any society and, in order to improve their lives, they depend heavily on targeted advice, information and referring and signposting services, especially in the initial stages of their life in the UK. Depriving them of these services would be depriving those who rely on them of their human rights and actively preventing their integration.’

With the strategy last having a revision in 2019, Healthwatch Kingston welcomes RBK DPH Annual Report 2025–26.

## Terminology

The terminology used throughout this review is adopted to describe trends and disparities between the experiences of people with shared demographic characteristics.

We appreciate that there is not a one-size-fits-all approach to the language used to describe broad trends experienced by diverse groups of people with different, backgrounds, cultures, and perspectives. Equally there is not a one-size-fits-all approach to tackling disparities in treatment, access and outcomes for diverse communities.

Through our engagement we have heard from communities in Kingston about the language they prefer or that is less favourable to them, as such we approach the terminology of this report with the preferences of local people in mind. For example, throughout our engagement we have heard that the word “underserved” can sound very similar to “undeserved”, particularly for people where English is not the first language.

The 2023, NHS Race & Observatory consultation report ‘[The Power of Language](#)’ outlines the difficulty in applying aggregate terms to describe the people who experience racial and ethnic health inequalities. Where a collective term is necessary, we will use ‘people from minority ethnic groups/backgrounds’, however we recognise the importance of specificity and adaptability to context. We will also use ‘minoritised communities’ to describe people who experience inequalities, including, but not limited to, racial and ethnic inequalities.

‘Ethnicity’ is used in this review to refer to an individual’s identification with a group sharing some or all of the same culture, lifestyle, language, religion, nationality and history. Our demographic data for ethnicity is based on the self-identification of the people who have completed our surveys, engaged with us or shared their views and consented to provide this information.

For more information about the language used in this review visit the government style guide: ‘[Writing about ethnicity](#)’.

Healthwatch Kingston views experiences of disability through the [social model of disability](#) and understands that people are disabled by barriers in society, not by their condition, impairment or bodies. Where appropriate, we will use ‘Disabled’ with a capital

D to reflect that the response from society to disability creates a shared identity for Disabled people who may have very different impairments and needs.

### **Health and Care Inequalities and Intersectionality**

Health and care inequalities are unfair and avoidable differences in health between different groups of people. Health and care inequalities are about both the status of people's health and the disparities in the care that people receive and the opportunities that they have to lead healthy lives.

It is widely understood across the health and social care system there are racial and ethnic inequalities in health and care. This means that there is a significant impact on health outcomes, access to care, and overall life expectancy for people from minority ethnic backgrounds. Through an intersectional lens, these inequalities are seen as the result of overlapping factors, such as structural racism, socioeconomic inequality, language barriers, gender inequality, sexuality, disability, and immigration status, which combine to create compounded barriers to achieving equitable health.

The Health Foundation '[How racism affects health](#)' report notes that, racial health disparities are closely linked to social determinants of health, including housing, income, education, and neighbourhood conditions:

"People of colour are more likely to live in poor-quality, overcrowded, unaffordable homes, particularly in the private rental market, and are more likely to experience homelessness. Communities of colour also do not have equal access to a healthy external living environment, such as access to green space and clean air, and are at particular risk of community displacement."

The Health Foundation report outlines that while all people from minority ethnic groups are more likely to be in poverty or deep poverty than people from a White British background, the disparity is most pronounced in households headed by a person from a Bangladeshi background: "3 in 5 Bangladeshi and Pakistani children, and over half of Black children, live in poverty after housing costs, compared with a quarter of White children". This data demonstrates both the role of socioeconomic inequalities in health inequalities, and that the experience of ethnic and racial inequalities differs among people from different backgrounds.

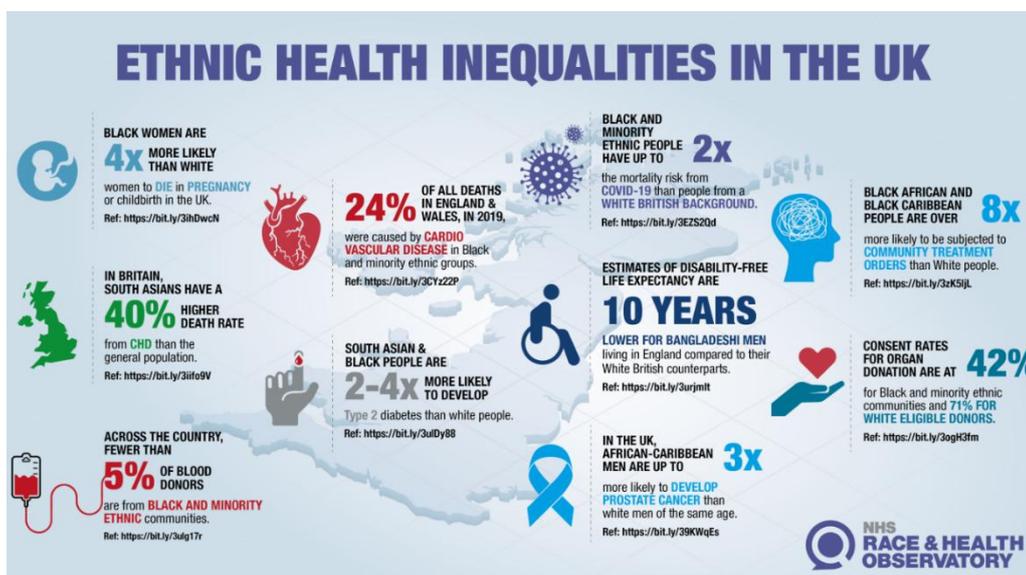
Work to address health and care inequalities should recognise the specific and contextual barriers felt by people from different cultural backgrounds and centre lived experiences in service design and delivery.

Healthwatch Kingston also notes that there are efforts being made to reduce these recognised disparities from both the NHS nationally and locally in the borough with the renewed focus on inequalities in the DPH report.

For more information about intersectionality in healthcare visit The Kings Fund, '[Back to basics – understanding lived experience and intersectionality in health and care](#)'.

For more information about the data evidencing racial inequalities in health visit the [Health Action Resource Platform](#).

For more information about ongoing work to address Healthcare Inequalities for people from minoritised backgrounds visit the [NHS Race & Health Observatory](#), and in '[Healthcare Inequalities Improvement Programme and NHS Race and Health Observatory \(RHO\): End of year report](#)'.



### 3. Introduction

Since 2021, Healthwatch Kingston has published over [60 reports and end of year activity updates](#). These reports span a wide range of issues—from Enter and View visits observing care settings and hospitals, to community engagement findings, safeguarding service reviews, and thematic insights into everything from bereavement services to support for neurodiverse residents, long-term conditions, early years

services, mental health services and support for Disabled residents and those with learning disabilities.

Together, they map out not only service activity, but peoples' service needs, providing a vital evidence base for improving local NHS and social care services.

What becomes immediately visible across the reports is the persistence of health and care inequalities affecting specific groups: Disabled adults, unpaid carers, digitally excluded residents, young families, people with long-term conditions, and communities experiencing loneliness or poor mental health. Through an intersectional lens this review will begin to explore whether, and how the experience of health and care inequalities among these groups are exacerbated by racial and ethnic inequalities.

Whilst this report aims to review the experiences of these communities it also illustrates the role local Healthwatch plays as an independent champion for residents and service users: translating lived experience into practical recommendations and influencing NHS, Kingston Council, Service Providers and voluntary-sector partners.

## 4. Methodology and reports

This report aims to bring together the insights and feedback shared with Healthwatch Kingston from minoritised communities to better understand where there are gaps in understanding and supporting the needs of people from minority ethnic groups. The review focuses on 10 main insight reports, with further highlights from the wider work of Healthwatch Kingston.

Where possible, Healthwatch Kingston aimed to co-design accessible surveys and engagement methods for our project work, making these available in a variety of formats – including online, large print, Easy Read, phone calls, care home visits, community events, focus groups, workshops, podcasts, short information films and public meetings.

We have also translated our surveys, survey responses, reports, and media where possible. However, while we recognise the importance of translation, limitations on funding greatly restricts our ability to offer accurate, professionally translated material.

**Healthwatch Kingston insight reports and projects informing this review:**

Projects	People engaged
1. <a href="#">Healthwatch Kingston ongoing Enter and View programme: Residential care, nursing homes, and supported living</a>	615
2. <a href="#">Healthwatch Kingston Enter &amp; View Report: Kingston Hospital Food and Hydration (published 5 July 2024)</a>	Not captured
<b>2025–2026 Reports</b>	
3. <a href="#">Health and care needs of socially isolated, physically Disabled adults (published 13 June 2025)</a>	39
4. <a href="#">The health and care needs of under-5s and their families report (published 13 June 2025)</a>	100
<b>2024–2025</b>	
5. <a href="#">Healthwatch Kingston Including Communities - Community Engagement Report (published 24 July 2024)</a>	334
6. <a href="#">Healthwatch Kingston Including Digitally Excluded Communities Report (published 25 July 2024)</a>	137
<b>2023–2024</b>	
7. <a href="#">Healthwatch Kingston Care Workforce Wellbeing: Engagement Report (published 28 September 2023)</a>	102
<b>2022–2023</b>	
8. <a href="#">London Ambulance Service Strategy 2023–2028: Healthwatch Kingston Community Engagement Report and Recommendations</a>	100
9. <a href="#">Bereavement Services and Support in Kingston - Community Engagement Report</a>	348
10. <a href="#">South West London Bereavement Services and Support: Gaps Workshops Report (this 'sister' report was published 13 June 2025)</a>	200

Other notable south west London Healthwatch reports and projects that reflect the experiences of minoritised communities, that include feedback from Healthwatch Kingston and Kingston residents include:

- [Patient and unpaid carer engagement across south west London community services \(published 19 September 2025\)](#)

- [The Delivery of the Accessible Information Standard in South West London GP Practices: What We Found \(published 6 March 2025\)](#)

## 5. Limitations with demographic data:

Collecting demographic information, such as ethnicity, through surveys provides valuable insights, but it also presents limitations. Not everyone chooses to share their demographic details, and as a result, we cannot always account for the ethnicity of every survey participant. This means that while our data highlights important trends, it may not fully represent the diversity of all respondents.

People from minoritised communities may be particularly reluctant to share demographic data for a range of understandable reasons, including concerns about how their information will be used, a lack of trust in public institutions, fear of being identified within small communities, previous negative experiences with services, fear of repercussions or uncertainty about where the data is used and stored, and burnout during completion of long surveys. These factors can make some individuals hesitant to disclose sensitive personal information, even when anonymised.

In some cases, we may not have taken demographic data, knowing that this information would make a survey respondent or focus group attendee identifiable, so in these instances we have themed responses by the event or engagement exercise.

## 6. Kingston demographics and ethnicity

Based on the most recent 2024 ONS data available via the [Kingston Data website](#), Kingston has a **population of 172,692** people, however the ethnicity breakdown (*figure 1 below*) is based on 2021 census data, and suggests that 31.7% (**53,234 in 2021**) of the Kingston population belong to minoritised ethnic groups, and **17%** of the total population does not speak English as a first language.

Other than English, the main languages spoken in Kingston, as reported by the [Kingston Joint Strategic Needs Assessment](#), are Tamil, Korean, Arabic, Polish and Bulgarian.

According to data provided by the Royal Borough of Kingston upon Thames, Christian Muslim, Hindu, Buddhist and Sikh are the most prominent religious affiliations.

Figure 1 ONS Census data revealing the number and percentage of people from each ethnic group

Source: ONS, Census 2021 📷 🗖

	Kingston upon Thames	London	England
Asian, Asian British or Asian Welsh	29,938	1,817,640	5,426,392
Asian, Asian British or Asian Welsh (%)	17.8	20.7	9.6
Black, Black British, Black Welsh, Caribbean or African	4,741	1,188,370	2,381,724
Black, Black British, Black Welsh, Caribbean or African (%)	2.8	13.5	4.2
Mixed or Multiple ethnic groups	8,996	505,775	1,669,378
Mixed or Multiple ethnic groups (%)	5.4	5.7	3
White	114,831	4,731,172	45,783,401
White (%)	68.3	53.8	81
Other ethnic group	9,559	556,768	1,229,153
Other ethnic group (%)	5.7	6.3	2.2

Date: 2021 | Source: ONS, Census 2021

## 7. Key themes by project or report

### 7.1 Healthwatch Kingston Enter and Views of Care Homes, Residential Care and Supported living (2023–26)

#### Context and methodology

Local Healthwatch have a legal power to visit health and social care services and see them in action. This power to Enter and View (E&V) services offers a way for Healthwatch to meet some of their statutory functions and allows them to identify what is working well and what could be improved within the provision of health and care services.

In the autumn of 2023, Healthwatch Kingston entered conversations with Kingston Council (RBK) and Kingston Care Governance Board (KCGB) to pilot an announced Enter and View (E&V) at a local care home. This led to Healthwatch Kingston being commissioned to run a series of E&V visits to 10 local care and nursing homes between 2024–25, with a further 10 E&V visits during 2025–26, where the remit of our work was expanded to supported living environments. In 2026–27 this project will continue to be commissioned by RBK and will also include Kingston Day Centres.

Whilst this wasn't a programme of work that was specifically aimed at minoritised communities, it has revealed relevant themes.

## Demographics

Over a 2-year period Healthwatch Kingston carried out a total of 20 E&V visits across residential care homes. These visits provide valuable insight into the demographics, lived experiences, and cultural responsiveness within Kingston's residential care sector. There were a total of 615 residents staying at the various settings Healthwatch Kingston visited, and the findings highlight a predominantly White British resident population (532–85%), limited visible cultural representation in many residential care environments, and ongoing challenges in ensuring inclusive, person-centred care for residents from minority ethnic backgrounds.

Demographic data also showed that around 80% of residents were women. Four residents identified as LGBTQ+ (three gay men and one bisexual resident), but the sexual orientation of most residents was recorded as straight or unknown. Religious diversity data was present but limited, with the majority identifying as Christian and small number identifying as Jewish, Muslim, Hindu, Buddhist, or Sikh. For 209 out of 615 residents, no religion or preference was recorded.

## Key Themes

**Languages:** Although English was spoken in every home, several residents required communication support in additional languages. While staff or other residents were sometimes able to offer this informally, language support was not consistently available across shifts or within relevant care areas.

**Cultural inclusion:** The E&V visits also revealed gaps in cultural inclusion. Although most provisions housed at least one or two residents from minority ethnic backgrounds, there was limited evidence of diverse cultural heritages being reflected in decorations, daily activities, or mealtime offerings.

A small number of homes demonstrated good practice by incorporating culturally relevant food, music, or celebrations, but these examples were exceptional rather than standard. In relation to meals, relatives and staff noted that residents on soft diets often had very limited choice, and minimal efforts were observed to improve the presentation of these meals.

**Outdoor activities:** Finally, while activities within the homes were varied, access to outdoor activities was restricted. Most residents were unable to leave the provision without support from friends or relatives, and homes with minibuses were typically only able to take a small number of residents out at a time. Although access to church services was identified at a number of homes, we did not observe any arrangements for residents following a different religion to attend events that were meaningful to them.

## Summary

These findings collectively point to the need for strengthened cultural awareness, dietary inclusion, language accessibility, and equitable access to community life within residential care settings across Kingston.

For more information on E&V's at HEALTHWATCH KINGSTON and to view all E&V related reports, please visit: [Residential care, nursing homes, and supported living | Healthwatch Kingston](#).

## 7.2 Healthwatch Kingston Enter and Views Kingston Hospital Food and Hydration (published 2024)

### Context

Healthwatch has legal powers called 'Enter and View' to visit health and care settings to observe services in action. Healthwatch Kingston, Healthwatch Richmond, and Kingston Hospital discussed the benefit of a series of Enter and View visits of Adult Inpatient Wards at the hospital that focused on food and hydration to help inform work being done by the hospital and to further support service improvements.

These visits were informed by work completed previously by Healthwatch (see [Kingston Hospital adult inpatient wards Enter and View report](#)) and evidence provided by Kingston Hospital NHS Foundation Trust.

This report helped to support improvements in food and drink services at Kingston Hospital and the Trust continues to audit nutrition and hydration to ensure hospital food and drink services comply with the NHS Nutrition Standards and that providers work with hospital dieticians to ensure menus achieve these.

The full report is available on the HEALTHWATCH KINGSTON website: [Healthwatch Kingston Enter and View Report Kingston Hospital Food and Hydration | Healthwatch Kingston](#)

## Methodology

Healthwatch Kingston and Healthwatch Richmond agreed to divide up the identified ward areas for our respective Enter and View visits. We agreed four wards (including a dementia friendly ward) and also observed public food and drink areas in the Emergency Departments and Outpatients.

## Key Themes

The findings from the report focused on what was working well in Kingston Hospital, identified problems or gaps in patient experience related to food and hydration services, made recommendations to improve care and accessibility and shared patient voices with the Hospital Trust and Healthwatch England.

While the report's primary purpose was to review food and hydration services, its data and patient feedback revealed themes that are relevant to understanding and addressing health and care inequalities more broadly, and findings still provide valuable insight into potential issues affecting people from minority ethnic backgrounds and other patient groups.

The detailed observations around special dietary provision, language and communication barriers, menu accessibility, and the challenges patients face when needing culturally or religiously appropriate food, highlighted areas where disparities could unintentionally arise.

Identified inequality areas highlighted in the report:

**Language barriers:** There was positive feedback from patients spoken to during the E&V visits about hospital staff being helpful, however, we learned there could be language barriers affecting menu choices.

**Accessible menus:** Patients with a learning disability or with English as a second language were not always supported to choose their own meals from accessible menus

**Menu choices:** Limited culturally/religiously appropriate meal options, people with longer hospital stays suggested some repetitive menu choices. Occasional errors were made

when providing food appropriate for a range of diets. One person shared that during Ramadan food was not available after an operation.

**Family and volunteers:** There was over reliance on volunteers/family to help patients choose meals.

**Signage:** Messaging and signage not always consistent or translated (both on screens and on notice boards).

### **Staff Feedback:**

“Non-English speakers’ family help choose in advance.” – hospital staff

“If family are not around to support someone with a learning disability or English as a second language, we choose for them. Unfair as no choice, but what is the alternative?” – hospital staff

“We have 26 patients on the ward at the moment; it is hard if someone has a learning disability as they don’t understand the menu we choose for them. Even if we had picture menus for every meal, we wouldn’t have enough staff or time to go through this, even though we feel bad.” – hospital staff

### **Recommendations and feedback sessions**

During our feedback session to the hospital, we were informed that sometimes, when a patient is in the emergency department, the hospital staff may not always have details about a patient’s dietary requirements, preferences, or mealtime support needs. We were reassured, that adjustments were made to accommodate a patient’s dietary and mealtime support needs as soon as possible after transfer from the Emergency Department to a ward.

Healthwatch Kingston recommended that Kingston Hospital create easy read menus and consider translating menus into key languages spoken by local communities, so patients can order their own food more easily when family/friends and translators are not available. In the meantime, we recommend improved use of available ‘picture menus’ on the wards.

We would also like to note that since the publication of our report, food services at Kingston Hospital have been recommissioned, and new vending machines offering healthier options have been installed in the Emergency Department. More recently,

patients in A&E have also reported that drinks and sandwiches are now available during long waits.

### 7.3 Healthwatch Kingston: Health and care needs of socially isolated, physically Disabled adults Report (published 13 June 2025)

#### Context

Social isolation can have a profound impact on mental and physical health. When we spoke to local Disabled adults, they told us about the obstacles to participation they experience. Inaccessible public transport, poor communication about what services are available and stigma are just some of the factors that limit physically disabled adults' ability to be part of the local community.

Our report involved the Healthwatch Kingston team facilitating four community engagement workshops across the borough, one online workshop and an accessible online survey. The report was informed by 39 residents. Whilst the number engaged with is small, socially isolated, physically Disabled adults experience barriers to sharing their lived experiences. The qualitative feedback gathered offers valuable insights.

#### Demographics

Of the 39 people who informed the report only 11 completed questions about demographics. Of those who shared that they were from a minority ethnic background, participants identified as 'Asian/Asian British', 'Mixed race', and chose to describe their ethnicity by their nationality, telling us they came from Afghanistan and Iraq.

The fact that some participants identified their ethnicity through nationality reflects how personal and culturally varied understandings of ethnicity are, and why gathering consistent demographic data can be challenging. Other backgrounds may have been represented but not reflected in the data due to the limited responses to demographic questions.

The [2021 Census data](#) suggested that: In 2021, 5.7% of Kingston upon Thames residents identified as being Disabled and 'limited a lot' and that just under 1 in 11 people (8.7%) identified as being Disabled and 'limited a little'.

This work was not directly focused on the barriers experienced by people from minority ethnic groups. However, the themes we identified, such as access, language barriers and digital exclusion are intertwined with the experience of racial and ethnic inequality.

## Key Themes

Key themes that may disproportionately impact people from minority ethnic communities:

**Transport:** Transport was identified as a major barrier, either the lack of transport or transport being inaccessible, leading to missed appointments, at hospitals, GPs and support services

**Access to information:** Accessing information, navigating service systems and digital exclusion often impacted people from refugee, asylum-seeking, or other migrant backgrounds.

**Language barriers:** Language barriers and digital exclusion may mean that people who don't speak English as a first language may face additional barriers in understanding the services that are available to support them.

## Summary

With the issues outlined above and the wider challenges noted in the full report, Healthwatch Kingston believe further investigation should be undertaken to examine the experiences of Disabled adults from minority ethnic backgrounds to understand the role that racial inequalities play in the experience of social isolation.

For the full report, please see: [Health and care needs of socially isolated, physically Disabled adults](#).

## 7.4 Healthwatch Kingston: Early Years – The health and care needs of under-5s and their families Report (published June 2025)

### Context

This report explores the health and care experiences of families with children aged 0–5 across the borough. This engagement highlighted the value of early years services and

the persistent challenges families face, particularly around fragmented support, long wait times, and navigating care for children with complex or neurodiverse needs.

## Demographics

100 people completed the survey and 83 said that they lived in Kingston, the remainder said that they used Kingston health and care services or young people's services. Out of the 100 participants, 54 people completed the demographic section of the survey, 30% of which identified as belonging to minority ethnic groups, suggesting a sample that is reflective of the diversity of the borough.

The following explores the data and responses of participants, to understand the lived experiences of minoritised communities as they navigate our NHS and social care services.

The 'Reflections about the inclusion of local communities' section from the Early Years report (below), identifies themes that are relevant to the experiences of people from minority ethnic groups, and the 'Considerations to support inclusion' section, outlines steps to address the identified disparities.

### Reflection about the inclusion of local communities:

- Feedback suggested a wide range of parenting experience, with many reflecting on both current and past early years care needs.
- Participants in our community engagement were predominantly White British, with limited representation from specifically Asian, Black, and other minority ethnic groups (although, as a combined total, the breakdown of participants does reflect the diversity of the local population).
- Participants from minority ethnic backgrounds did express concerns about cultural stereotyping or feeling dismissed, particularly when advocating for their children or navigating complex services.
- There were no reports of language barriers but examples of miscommunication, underpinned by a lack of cultural understanding.

### Considerations to support inclusion:

- Targeted outreach to underrepresented minoritised communities in Kingston is recommended to improve future engagement and service equity.

- Cultural competence training for staff across early years, health, and social care services should be embedded and monitored.
- Co-production of services with families from diverse backgrounds would support culturally responsive practices and build trust.

### **Feedback from minoritised groups**

#### **Impact on mental and physical health:**

“I suffered from post-natal depression because [of] the lack of support for new mothers and lack of community”

“As a non-driving mum who was new to (south of the borough) and subsequently diagnosed with Hashimoto's disease, I often found myself on the verge of passing out at the school gates. I love my amazing son and his energy made me smile on the worst of days but there is little to no support for isolated mums – and that support IF it comes at all only happens when they are at breaking point. I had no support whatsoever.”

“I had a traumatic birth and ended up with PPD/trauma. I had very little help with this despite being referred for a psychiatric assessment. My referral was rejected without any kind of screening, and I was told to either self-refer for generic help with depression or to attend a bonding with your baby group. Neither service was appropriate, in my opinion.”

“I have got really bad back and wrist as need to carry my daughter everywhere. She is 3 years old and still not walking.”

#### **Comments about health services:**

One respondent described a series of care failures during pregnancy, birth, and the postnatal period, and after moving house felt “dropped out of the system”. She felt her emergency C-section could have been avoided with better assessment.

The respondent told us she developed a chest infection whilst in hospital and reported delays in her son's tongue tie being recognised. She expressed feeling neglected and dismissed by staff during her stay and experienced inadequate and insensitive breastfeeding support:

“When I was finally well enough to be moved onto a ward I struggled to breast feed and late at night a nurse tweaked my nipple and said ‘what do you expect – of course it is going to hurt’”

After discharge, she said she received no guidance on breastfeeding after surgery and developed a womb infection. On reflection she shared that these were, “All really easily avoidable issues if people had been paying attention.”

Another respondent said, “Waiting times for mental health help are awful. Happy with most other experiences.”

One person shared that after her son’s medical diagnosis:

“No one gave me any support whatsoever or referred me to any services. I did everything myself. I then myself was diagnosed with (various conditions) but doctors initially refused to admit there was anything wrong, even though I felt as though my body was shutting down on me. Women need support and health screening post-partum. They should have hormones and vitamin levels checked. When my mum came to this country, the Government used to give pregnant women vitamins. Now no one cares.”

Another shared feedback on maternity services, health visiting, mental health services, dental services and ILL.

**Maternity services:** “...avoidable traumatic birth. Zero explanation as to why it had happened and atrocious care as an inpatient...”

**Health visiting:** “...there is such a blind push of supporting breastfeeding that common sense and experience count for nothing. I had to reach rock bottom physically and mentally before I made the decision to stop breastfeeding myself...”

**Adult mental health:** “...I recognise this is essentially down to funding of services and lack thereof, but I wasn’t able to access the help I needed to deal with PPD and trauma.”

**ILL:** “...inconsistent and long wait times, but I recognise that’s a national issue...”

**Dental services:** “...fantastic and can’t be faulted...”

“Overall, it’s (health services) good and I have the services ready to help me.”

“Enjoy the children's centres- we go to stay and play sessions and use the drop-in clinics.”

**Need for advocacy:** “I needed an advocate as a young unwell mum. My partner was unsupportive. No one seemed to care. Everyone was dismissive.”

**Importance of consistency of care:** “My child would have more reassurance when seeing familiar faces.”

“...Because when staff change there is rarely an adequate handover.”

Another shared that it was important for them to have “...Continuity of care and a familiar face for my child.”

**Cultural perspective:** When asked if respondents felt that the services they received were aware of, and responsive to, their cultural perspective and background, one person shared:

“I am not English although I was born here. I feel my attitude to parenting was dismissed as [over the top] just because I am more hands on.”

**Service communication:** We asked what more could be done to help different services communicate with each other to improve the respondents / their child’s experience, and respondents told us:

“Centralised records and people given time to read notes before appointments.”

“The wait times for the referral should be not that long. It must be sooner for those who need it, for example Speech and Language Therapists.”

For the full report, please see: [Early Years: The health and care needs of under-5s and their families report](#).

## 7.5 Healthwatch Kingston: Including Communities – Engagement Report (published 24 July 2024)

### Context

Whilst the engagement of this report was conducted between early 2022 and late 2023, continued communication and current insights would indicate that although there have been some improvements made, and a shift in focus, many of the themes within are still relevant.

This [Healthwatch Kingston Including Communities – Community Engagement Report](#) and its ‘sister’ [Including Digitally Excluded Communities: Engagement Report](#), share the findings of two years of engagement with minoritised communities and the most vulnerable in our society including: refugees, asylum seekers and other migrants, people from areas in Kingston with high deprivation and people with English as a second language.

### Methodology

Healthwatch Kingston attended health and wellbeing events and community groups (28 in total) across our borough and engaged with attendees from minoritised communities and the most vulnerable in our society.

During this engagement we worked closely with local NHS colleagues and VCSE organisations to develop and deliver wellbeing days for those experiencing homelessness, as well as engaging with [Migrant Advocacy Service](#) and [Refugee Action Kingston](#).

Through an extended period engagement, Healthwatch Kingston gathered 334 responses that informed the report’s recommendations. Whilst not everyone provided demographic information, the themes and issues identified within responses outlined the experiences of minoritised communities that participated.

Local people we engaged with across this 20-month period included:

- People experiencing homelessness
- Young people (16–18 years)
- Refugees, asylum seekers and other migrants (RASM)
- People with learning disabilities

- Neurodiverse people
- People from areas in Kingston with high deprivation
- People with English as a second language
- People with limited mobility to leave their home, through community libraries
- People with physical and mental disabilities.

Healthwatch Kingston collected responses through individual surveys and by speaking with people at engagement events and focus groups. Insights that arose from group discussions have been themed. Sometimes translators shared feedback from groups of friends and family, therefore individual surveys were not always completed.

Healthwatch Kingston would like to note that sensitivities were expressed by some community participants, who preferred to not share their ethnicity. Out of the 84 that shared demographic information with us, 33% (32 people) identified as White British, with 67% (52 people) identifying as non-White British.

## Key Findings

There were distinct differences in experience between some of the groups we engaged with in terms of access to NHS and social care services, but some of the more common challenges and barriers identified in the report were:

### Barriers & Confusion

**Booking & digital access:** “8am phone rush,” eConsult friction, reliance on librarians or family to book online; anxiety about whether to call GP vs 111 vs 999, and how follow ups work. These issues cluster in migrant/refugee outreach narratives.

**Language & interpreting:** Repeated mentions of needing a translator, waiting weeks for one, or frustration at front desks when English is limited. Confusion about whether interpreters are available in A&E and not being able to access one at the point of need.

**Knowledge of entitlements:** New arrivals describe paying the Immigration Health Surcharge yet not knowing how to access GPs, dentists, or which service are the NHS, and which are private. This conversation was most prominent when we spoke to the Korean community, and people from Hong Kong.

## Service Experiences

**GPs:** When seen, clinical care is often reported as being good; the hard part is getting in, particularly for those with language barriers, front desk interactions sometimes perceived as gatekeeping, or confrontational.

**Pharmacies:** Many positive reports (personal service, vaccines, blood pressure checks). Use of pharmacies could be increased to support improved navigation and prevention messaging. People also shared that they liked to visit pharmacies where staff may share the same language.

**Hospitals:** Feedback was generally positive about clinical teams (e.g. surgical/ward care), but A&E waits, parking, and follow up coordination can be a challenge, especially if a person is not registered with a GP. People expressed uncertainty about how or where to access follow-up care.

**Dentistry:** Registration difficulties, long waits, and high costs for dental care (NHS and private) remain widespread. Multiple respondents reported being pushed to private or DIY fixes for urgent problems, one person even reported buying a kit online to fix their teeth.

**Mental health and neurodiversity:** People reported long waits for assessments (e.g. Child and Adolescent Mental Health Services, Care Needs, Personal Independence Payment) and reliance on advocacy ([KCIL](#), [KCAH](#), [SPEAR](#)). Migrant/refugee groups face extra admin and language hurdles, plus stigma around mental health in some communities. We also heard that counselling could be challenging, as sometimes family or friends would have to interpret, meaning lack of privacy, and potential safeguarding risk due to conversations being manipulated.

**Stigma, discrimination and fear of reprisal:** Some respondents and translators shared that distrust, and the fear of reprisal or stigmatisation prevented people from particular minoritised groups from sharing negative feedback.

## General themes and wider impact

- Lack of communication/problems between GPs, hospitals, pharmacies and other support services
- Provision of safe and private space for confidential discussion at some service provider sites, e.g. pharmacy
- Crowded chaotic experiences in hospital Emergency Department (A&E)

- Long waits on the telephone

For the full report, and demographic breakdown please see: [Healthwatch Kingston Including Communities - Community Engagement Report](#)

**Feedback from report engagement:** Language barriers were a recurring challenge for those who were not able to speak English, and the lack of translators and interpreters was seen as a major factor in poor health outcomes. This was especially problematic if other family members or friends were unable to communicate in English.

“Have seen a doctor and they were very helpful, however it is sometimes hard with language barriers.”

“The GP is very good however I have to get my son to book the online appointments due to language barrier.”

“I have difficulty booking an appointment and have to call as I can’t use the online service due to language barrier. I feel that ‘you have to make everything sound worse’ just to get an appointment and see a doctor. However, the GP’s have been helpful once you get to see them and the GP receptions have also been happy to help book the appointments.”

“I have been struggling to get a follow up appointment after being in A&E, don’t know where to go or what next steps are. I hardly speak English, so when I call the GP, they get frustrated and hang up the phone. I’m still in pain with my leg but don’t know what to do.”

We heard similar stories regarding follow-up appointments with several people explaining that they would just “go back to A&E”

A group of migrants from Hong Kong we engaged with through the Migrant Advocacy Service, suggested a phone number for people with English as a second language to call, where a translator would answer to support calls to a health and or care professional, rather than them having to struggle, calling the professional first. They also spoke of issues with current appointment booking systems. One said (and others in the group agreed):

“You tick the button for a translator for your appointment, but you get to the appointment and there is no translator.”

They also suggested having a list of languages spoken at different sites, for example if a pharmacy has someone that speaks a different language. They can choose to use that pharmacy rather than struggling with another one where there is potentially going to be a language barrier.

Migrants from Hong Kong specifically asked if traditional Chinese medicine could be available through the NHS, as it was to them in Hong Kong:

“So many people would benefit from the receiving the same treatment they were getting in Hong Kong.”

Some migrant respondents were unaware of the role that pharmacy could play in their health and wellbeing, and there were some complaints about staff shortages, queues, confusion with prescriptions and communication between GPs and pharmacists.

Recent migrants from Hong Kong shared they were used to all medications being issued through doctors, and they did not realise that they were able to access pharmacists for over-the-counter medications and other services. They reported that they preferred to see a doctor, suggesting that more could be done to explain NHS services and procedures to people who are accustomed to alternative systems.

One refugee explained the problems they were having getting their medication for free. They were suddenly asked to pay for their prescription but did not have any money to do so. They were advised to bring along their HC2 (full help with health costs) form with them as proof they were exempt from fees.

**Challenges with A&E:** “Kidney problems during Ramadan meant I got the Emergency Department (A&E) at 5pm and had to wait 12 hours for a scan. I could only eat after sunset but was told there was no food left.”

Healthwatch Kingston were able to discuss this issue with Kingston Hospital who said that they would look to making immediate changes, so that food would be accessible during Ramadan to patients.

**Translation Services:** Another challenge identified at the events was not just about the lack of accessible translation services, but also for the people working as service translators. They have a problem parking and have to pay all their own parking and petrol costs. When there is an emergency situation, they have no choice and given current pay and the cost-of-living issues, one stated:

“Being a translator is becoming an expensive job!”

The refugees, asylum seekers and other migrant communities interviewed did not complain about the services provided at the hospital but there were concerns expressed as to what translation services were easily accessible or even available. They felt the guidance was unclear, as it implied you were able to have a translator if attending the hospital emergency department (A&E) but not for ongoing treatment and care.

**Dental services:** Some participants believed they were not entitled to register for a dentist, and some refugees, asylum seekers and other migrant communities were unsure about their entitlement or what the difference was between NHS dental care and private practice. Some also stated that they thought their children could get treatment but were too scared to take them as they didn't know how much it would cost. Others were told to dial 111 if they had an emergency or go to the Emergency Department (A&E) at Kingston Hospital.

“Can't get an appointment, have now bought a dental repair kit on Amazon and trying to fix my own teeth and fillings.”

**Financial services:** “As an asylum seeker I am not allowed to work, despite being a professional. My daughter is now missing her university course as she has to work to pay for our one-bedroom flat. I am being passed from pillar to post trying to access financial support.”

“Social Care, PIP, CAB wasn't very helpful. Waited 3 weeks to get a response from CAB.” This person had issues with housing and is a qualified dentist however due to his status as he is a refugee he isn't allowed to work or use his skills. He was frustrated that he can't better himself and feels that no one wants to help him. He told us he was signposted from one place to another but is having trouble with long term housing support.

**Stigma and discrimination:** We were also reminded of the negative impact of stigma and discrimination experienced by some participants which can be a major factor for some vulnerable communities who then become reluctant to approach services.

One young woman from Albania explained that counselling is not a concept understood in her country, and there is stigma associated with the need for mental health support. It becomes hard to access this type of service for fear of “looking weak”. We heard similar feedback in our bereavement work when talking to the Korean community about mental health support.

A homeless man explained his concerns with leaving Kingston: “My GP is in Lambeth, where I used to live. I now live in Putney in a hotel. I need to move my GP to Putney to have a head scan after a serious injury in Thailand and also follow up cancer treatment. After being attacked by youths in Lambeth and subsequently rescued by SPEAR in the middle of the night when I was sleeping in a tent on Clapham Common, I have been too frightened to go back to Lambeth.”

## 7.6 Healthwatch Kingston: Including Digitally Excluded Communities Report (published 25 July 2024)

### Context

In 2023, to build upon our [‘Including Communities’](#) work, Healthwatch Kingston ran a series of face-to-face “we’ll come to you” focus groups with digitally excluded local residents, to find out how we could better engage people who were digitally excluded and, how they might better access information about health and social care services.

The RBK [‘Prosperous Lives for All: The Refugee and Migrant Strategy 2016–2019’](#) (contributed to by Healthwatch Kingston), set out how stakeholders might work together ‘to enable refugees, asylum seekers and vulnerable migrants to have a decent life and a prosperous future in the Royal Borough of Kingston Upon Thames’. The strategy highlighted what refugees, asylum seekers and migrants faced as a result of digital exclusion.

During 2022, South West London Integrated Care System (SWL ICS) Communications and Engagement leads reviewed existing insight and engagement reports from health and care partners across south west London. Partners included: Healthwatch, Voluntary, Community and Social Enterprise (VCSE) sectors, NHS Trusts, and Public Health. The insights then helped to inform the [‘SWL ICS Strategy and NHS Joint Forward Plan Insight from people and communities’](#) report published in March 2023.

The analysis of the south west London engagement reports that explored digital exclusion, clarified that digital apps, websites, online community meetings and appointments had helped deliver health and care services. However, some groups, including older people, people with a learning disability, sight loss or people with English

as a second language, could be digitally excluded, and that digital exclusion increasingly meant social exclusion.

We would also note that intersectionality compounded by digital exclusion coupled with language and cultural barriers continue to be common challenges and contribute to health and care inequalities.

For the full report, please see: [Healthwatch Kingston Including Digitally Excluded Communities Report](#)

## Demographics

Healthwatch Kingston listened to 137 people (95 digitally excluded and 42 young people) who contributed their views and experiences as part of this community engagement in different ways.

Our Including Digitally Excluded Communities engagement took place at:

- [Migrant Advocacy Service](#) (twice) the ‘Welcome café’ (migrants from Hong Kong) and the ‘Lunch Club’
- [Kingston Eco-op](#) (twice) a local community project that promotes physical and mental wellbeing for adults with additional support needs (including people with a Learning Disability)
- [Fastminds](#) – ADHD Support Group
- [Kingston Association for the Blind](#)
- [Cambridge Road Estate Community Group](#) Foodbank ‘Tuesday Lunch Club’ at Queen Mary Hall.

We did not survey people for detailed demographics, as conversation were had in groups at the workshops.

## Key Findings

### Issues, barriers and ways to improve engagement

Ofcom’s 2022 Digital Exclusion Review sets out some of the key issues and barriers relating to:

- **Affordability:** Those who struggle to afford access to internet packages or suitable devices, and so either go without it or experience other financial strains to retain access'
- **Access:** Those who do not have an adequate internet connection at home or elsewhere (for a variety of reasons, not just affordability)
- **Ability:** Those who lack the digital skills and/or confidence to navigate the online environment safely and knowledgeably, or face barriers related to disability.'

Throughout our engagement, we learned of a range of similar issues and barriers experienced locally. These included:

- It's not always about money
- A lack of trust in sharing information online
- Language barriers
- A lack of digital skills
- Personal preference to not use digital services
- Unsure it will make any difference
- Inaccessible formats for people with physical disabilities and long-term conditions
- Long surveys and other online forms.

More detailed specific feedback from minoritised groups included:

**First language:** The lack of online health and social care service information in participants first languages was noted as a barrier

**Online Surveys:** Migrants from Hong Kong shared that they struggled to complete online surveys because of language challenges

**Websites:** Some people in the groups described not understanding websites, even when they had internet access

**Data:** Confusion over what is done with the data shared and request for in person updates as to outcomes of engagements

**Cultural barriers:** We found that a technical barrier may not always be the main issue with digital exclusion, and sometimes it was a cultural barrier due to low trust and unfamiliarity in new processes and systems

**Translators:** Using a translator and visiting the groups was a welcomed approach, and meant we would get feedback firsthand

**Change and Impacts:** It was important to communities we engaged with to know impacts and changed as a result of their feedback, and they wanted reports translated into a language they could understand

When you consider intersectionality, it's important to highlight other findings within the report, including:

- **Learning Disabilities:** People with a learning disability can require higher levels of support to use digital tools and were often reliant upon family members or carers/ keyworker staff to support them access information online.
- **Neurodiversity:** People with neurodiversity, wanted conversation in person and suggested that long forms were a challenge. They also highlighted the importance and use of text message reminders for services. And for this report its important to consider a person's first language (in case of an unavailable translator to avoid missed appointments)
- **Visual Impairment:** Only three out of the 22 blind and visually impaired people we engaged had Wi-Fi in their homes. Suggesting that people from a minoritised community who were blind may experience greater issues in accessing support, in a digital world, than the majority of society.

#### **Feedback from Including communities report:**

We asked why people felt digitally excluded and were told:

"Can use them (digital tools), but do not always have the data"

"Language. I speak very little English"

"No real issues with digital exclusion. But have never used it to access medical information. My mother who is 67 would prefer not to do things online and speak face to face."

"Too much about digital exclusion is based on wealth – can you afford a smart phone or laptop, not enough focus on the attitudes to this technology."

Others mentioned a lack of trust, confidence and concern about sharing information online:

“I do not trust where I am giving information to. I am unsure where it goes.”

Language barriers:

“There is a language barrier and I do not always understand the websites because of this. I much prefer face to face conversations.”

“We are from Hong Kong, it would be helpful to have translated reports.”

“When the work is done, provide reports in audio.”

Out of the 26 migrants from Hong Kong we engaged with, only one person said they would be able to fill in a survey online. This was due to the language barrier.

The migrants from Hong Kong group wanted to be able to give feedback on services, and have their difficulties highlighted with people that can make improvements but suggested the best way to do this was to attend their group but asked that engagement work didn't disrupt their own planned activities. Other suggestions included support with translators and making information available in other languages.

At Kingston Association for the Blind (KAB), most people we engaged with did not have access to digital technology (only three out of 22 had Wi-Fi at home) and others did not have enough vision to use the digital technology. One person showed us a text from their doctor asking them to fill out a form. As they could not use their phone for getting online, they went online with a tablet. This meant having to read every digit of a link and type it into their tablet to get to the survey. The also suggested using the talking newspaper.

We asked people at the workshops about what they would like to see from services after engagements where they have shared feedback. Participants told us:

“Some form of acknowledgement the feedback was received”

“What is going to be done about it. Would also expect some help with the issue I spoke about”

“I would like to know what has changed because of the feedback I gave”

“Maybe if we could see a 'you said we did' board. This would encourage others to give feedback”

**Listening to digitally excluded communities has reminded us:** Our focus for this engagement was to find out how Healthwatch Kingston could better engage people who were digitally excluded in our work and, how they might better access information about health and social care services. What we were told confirmed that “one size does not fit all” and, as a ‘digital first’ borough, it is important that all of us hear what people have said. Finding included:

**Varied engagement:** To not assume our usual methods of engagement (such as virtual meetings and attendance at public events) will be appropriate for all of our community activities.

**Co-production:** To ensure co-production/design/production/delivery of engagement plans with target groups and other relevant stakeholders.

**Face to face:** Outreach is the best way to meaningfully engage with some of our communities (e.g. face-to-face “we’ll come to you” focus groups and follow-ups). But it is resource intensive (co-preparation etc., engagement, collation, analysis, reporting, follow-up with groups to give feedback).

**Accessible information and plain English:** To be inclusive, there is a need for engagement tools and health and social care information in ‘Plain English’ and other languages and in formats that meet the ‘Accessible Information Standard’ so that people with a disability or sensory loss are given information they can understand, and the communication support they need.

**Always feedback:** To respectfully feedback to digitally excluded communities we need to use a range of methods (such as returning to community groups we engaged with, ‘you said we did’ style posters/presentations/reports, telephone, audio and printed newsletters).

## 7.7 Healthwatch Kingston: Care Workforce Wellbeing: Engagement Report (published 28 September 2023)

### Context

Changes to UK visa and settlement rules, meant that the care workforce continued to be a national concern, and in April 2025 the Department of Health published findings from the [Adult social care recruitment and retention workforce survey](#). This was a voluntary

survey completed by Care Quality Commission (CQC)-registered adult social care residential care and domiciliary care settings. And the care workforce was also noted in the recent updated from The Kings Fund: [What's In Store For Health And Care In 2026? | The King's Fund](#).

Whilst our Healthwatch Kingston Care Workforce and wellbeing report was published in May 2023, considering national concerns that our care workforce is depleting, and the care workforce has historically been dependent on international recruitment, findings from our RBK commissioned report are still be relevant in supporting the wellbeing of our Kingston paid carers.

For the full report, please see: [Healthwatch Kingston Care Workforce Wellbeing: Engagement Report](#)

## Methodology

Towards the end of 2021, in response to some concerns raised about the treatment of frontline staff in the care sector in Kingston, the RBK Quality Assurance Team ran a wellbeing survey for care workers.

The results of the RBK wellbeing survey showed an appetite for a frontline staff forum/virtual networking site, so that care workers could share experiences and information to improve their wellbeing in the workplace. This also included requests for an escalation pathway for concerns or complaints around equality and diversity issues in the workplace.

## Demographics

We spoke to 102 people, the majority of whom worked in either care homes, or home care, with some noting they worked in hospitals or in VCSE sector. And whilst the question in the survey on ethnicity was only completed by a small percentage of respondents, a diverse workforce contributed to this report. People shared that they came from the following backgrounds: Asian British: Indian, Pakistani, Tamil, Black/Black British: African, Caribbean, Eastern European, White: British / English / Welsh / Scottish/ Northern Irish and other backgrounds (but they preferred not to specify).

## Key Findings

**Wellbeing and Mental Health:** In general, most people said that their mental health was taken seriously, however, some said that they felt uncomfortable discussing mental health due to stigma or fear it would not be handled sensitively.

While many staff valued supportive colleagues and managers, others described a culture where stress was normalised and workers were expected to “just get on with it.”

**Physical Health:** Many felt their physical health was taken seriously at work however some respondents reported issues like, long hours, physical exhaustion, and reduced staffing that compromised workforce wellbeing, and others were concerned that their workload was physically or mentally unsustainable.

**Morale and Workplace Culture:** Positive influences on morale included team cohesion, supportive managers, and open communication. Whereas negative influences included inconsistent agency staffing, poor staff room facilities, lack of breaks, and insensitive comments from colleagues or clients.

**Discrimination, Race, Ethnicity, and Language:** The majority of respondents shared that they had not witnessed or experienced discrimination in the workplace, however 29% of the people that answered this question shared that discrimination was an issue, noted ‘race’ as being the main cause. Other forms of discrimination mentioned were ‘age’, ‘gender’, ‘pregnancy/parental’, ‘disability’ and others including ‘weight’, ‘height’ and ‘language’. We further learned discrimination came from both inside and outside of the care workforce:

“As usual some clients and their family can be rude, aggressive and unkind.”

“Some family members boss you around.”

“I have seen my work colleagues discriminate about the weight and colour of other members of staff.”

A couple of respondents noted that discrimination could be related to the health of the person in care:

“Some of the people we look after lack mental capacity and unaware of what they say and how they act.”

“I feel I am sometimes disrespected by individual residents with limited capacity but I feel this is part of my job.”

Some respondents explained their hesitancy in reporting ‘unacceptable behaviour’ and / or ‘discrimination’ in the workplace:

“I would be scared to report anything.”

“I am frightened of losing my job.”

“There isn’t any point to report, because comments can sometimes come from the people we look after, who are unwell.”

We asked staff ‘What would make you more confident to report discrimination in the workplace?’ a key theme from the responses was management acting on what was being said. This was especially apparent in the responses of people who have seen discrimination and did not feel confident to report unacceptable behaviour. Suggestions included:

“Knowing things will be dealt with by management.”

“A willingness from someone to listen.”

“A way to make the reporting confidential.”

“Supportive staff around me.”

“The promotion of a culture of openness.”

“Knowing I have the support if I ever needed it.”

**Cost-of-Living Pressures:** Workers described significant anxiety due to low pay, rising travel costs, and having to take additional shifts to cope financially. Some felt there were limited solutions available, contributing to a lack of motivation within the workforce.

## Summary

The Crae Workforce wellbeing report highlighted a need for:

- Stronger mental health support and understanding within the workplace
- Safe, confidential pathways to address discrimination
- Clearer communication pathways

- Better staffing stability, and ensuring adequate working breaks
- Improved benefits and working conditions
- And sustained collaboration between RBK, Healthwatch Kingston, and providers to act on care-worker feedback
- Rates of pay in Kingston need to be commensurate with other boroughs across south west London

## 7.8 London Ambulance Service Strategy 2023–2028: Healthwatch Kingston Community Engagement Report (published Feb 2023)

### Context

Along with other local Healthwatch across London, Healthwatch Kingston were invited by the London Ambulance Service NHS Trust as part of a pan-London consultation to inform a refreshed London Ambulance Service strategy for the next five years.

Responses to the Healthwatch Kingston community engagement generally praised the service provided by London Ambulance Service public facing staff. Complaints and issues were often caveated with notes about how difficult things appear to be and an appreciation for the challenges the London Ambulance Service faces in delivering their services.

This report highlighted general themes to support the strategy, and we heard from people facing a variety of barriers with a strong influence from people with learning disabilities, and Autism. We also spoke to people from Migrant Advocacy Services and Refugee Action Kingston.

Where language barriers, lack of translators, and confusion about the system affected people from diverse communities, especially those for whom English is not a first language, the recommendations should be considered as areas that may be further impacted by overlapping inequalities.

For the full report, please see: [London Ambulance Service Strategy 2023–2028: Healthwatch Kingston Community Engagement Report and Recommendations](#)

### Key Findings:

**Front-line Staff:** People were very appreciative of the quality of service provided by front-line LAS staff, but believe emergency services are being hampered by other parts of the health and care system

**When to use 111/999/LAS:** There was a common lack of understanding about when it was appropriate to use the service and when to use alternatives, this was especially evident among migrant, refugee and asylum-seeking communities when first entering the UK

**Immigration Health Surcharge:** Those in the migrant advocacy group from Hong Kong said they pay the 'Immigration Health Surcharge' to access NHS services but are given no information on what they are entitled to, how they access services or the difference between services in the UK and Hong Kong

**Performance:** Feedback suggested 111 are often unable to support someone who was trying to avoid using 999 or A&E departments at hospital

**Education:** People wanted more education for the community on how to support themselves before emergency intervention is required

**Waiting times:** People felt emergency support should be readily available, and that wait times were too long with most respondents believing this to be the result of people using emergency services when they could use their GP, pharmacy, or local voluntary/community sector organisation.

## Summary

Overall, 13 recommendations were made to inform the strategy including:

'Improve the accessibility of public messaging about when to call 111 and 999 through different media, including but not limited to, Plain English, Easy Read, short information films and translations into languages other than English. In addition, the London Ambulance Service should work with NHS and Local Authority partners to explore ways to work more effectively with Voluntary Community and Social Enterprise organisations to support improved understanding about 111 and 999 across all local communities.'

We also asked for a focus on processes to support London Ambulance Service staff to identify if the person needing emergency care is supported by an unpaid carer/young carer, or has a learning disability, ADHD or Autism.

We know from previous Healthwatch Kingston reports, like the [Including Communities](#), and [Including Digitally Excluded Communities](#) reports that accessing translators at the time of need can be difficult, and online systems not always an option. Therefore, there should be consideration locally on raising awareness about how and when to use emergency services, and that this information is made readily available in locally spoken languages like Korean, Tamil, Polish and Ukrainian, as well as in Easy Read.

## 7.9 Bereavement Services and Support in Kingston: – Community Engagement Report (Published July 22)

### Context

In 2022, Healthwatch Kingston and [Kingston Voluntary Action](#) were commissioned by [NHS South West London](#) to undertake a community engagement pilot project exploring people's experiences of bereavement and support services. The report from this pilot identified gaps, leading to the commissioning of a Phase 2 Gaps Initiative (2025) aimed at engaging groups not included in the initial pilot.

In addition, during 2023–24, to supported YOL!, Healthwatch Kingston was separately funded by the RBK, Community Resilience Fund, to create: [Youth Out Loud! film about bereavement / grief services and support](#). With further funding in 2025 to engage people with Learning Disabilities, Autism and ADHD on their experiences in grief bereavement.

Our collaborative community engagement work was also recognised as a quality exemplar by NHS England and NHS Improvement at the 2022 'Getting to Outstanding' event, the recommendations lead to Bereavement Support Practitioner at Kingston Hospital, used in commissioning processes at RBK, RBK has since created an bereavement information hub on [Connected Kingston](#) and findings were used to inform the [Kingston Carers Strategy](#).

The following information and community feedback reviews the original Healthwatch Kingston Bereavement Services and Support report and data, but this time with a focus on race and ethnicity, and the health outcomes and inequalities and lived experiences among people of minoritised communities.

Findings highlighted clear patterns of cultural, linguistic, social, and structural inequalities that shape how different population groups access, or struggle to access, bereavement services. These inequalities intersect across ethnicity, faith, language, disability, age, gender roles, and digital literacy, creating additional barriers for some communities.

Cultural and religious expectations around burial practices, linguistic accessibility, and community-based support all played significant roles in determining the quality and timeliness of bereavement support. We also can't forget that the Covid-19 pandemic further highlighted these inequalities, particularly for isolated migrant residents, digitally excluded individuals, and faith communities whose mourning practices were disrupted.

For the full report, please see: [Bereavement Services and Support in Kingston - Community Engagement Report](#)

## Methodology

This report was informed by 348 responses gathered through a mixed-methods community engagement approach. A combination of quantitative surveys and qualitative engagement activities and workshops were used to understand bereavement experiences across Kingston's diverse communities.

Data collection took place between August 2021 and February 2022, involving residents, bereavement service providers, voluntary sector organisations, and faith/community groups.

The engagement informing this report took place between 2021 and 2022, and substantial work has since been undertaken to strengthen bereavement support services in Kingston. The full impact of this work can be found here: [Healthwatch Kingston presented Bereavement Report findings at the Inclusive Kingston Borough Alliance | Healthwatch Kingston.](#)

This programme of work has focused on the lived experiences of local people from different backgrounds, and worked with community organisations, including MILAAP (Multicultural Day Centre) the Korean Culture and Arts UK CIC, Kingston Chinese Association, Tamil Information Centre and Kingston Migrant Advocacy, to hear a broad range of perspectives. In addition, we also spoke with Kingston Carers Network, KAG Advocacy, Kingston Centre for Independent Living (KCIL) and ran interfaith workshops to gather insights.

It is significant to note that the methodologies used to create these surveys, and the partnership work between Healthwatch Kingston, KVA, Kingston VCSE and faith, beliefs and life philosophy groups, meant that this project benefited from a wealth of multicultural input.

## Demographics

The public and frontline staff surveys involved a culturally diverse respondent group, with approximately 30% of public respondents identified as belonging to minority ethnic groups, broadly reflecting Kingston's wider demographics.

**Faith and cultural representation** was wide, including respondents who identified as Atheist, Buddhist Christian, Hindu, Muslim, Pagan, other belief systems.

**Ethnicities** represented included Asian British (Indian, Korean, Pakistani, Tamil), Arab, Eastern European, Western European, Black African/Caribbean, mixed ethnic groups, and White British, among others. Notably, language needs, cultural practices, and access to religiously appropriate services varied significantly across these groups, influencing access to bereavement support.

## Key Findings

**Cultural and religious needs:** Many faith communities, including Muslim, Hindu, Jewish, and Buddhist groups, require rapid burial or cremation, but faced delays due to slow death certification, coroner processes, or lack of appropriate burial space. For respondents, this created additional distress during a challenging time. This feedback highlighted structural gaps in culturally responsive bereavement support.

Faith organisations often provided essential support (emotional, practical, financial), but capacity varied between communities, leading to inconsistent levels of support across different minoritised groups. Some feedback included:

- **Muslim Communities:** We heard from Muslim participants that their faith communities created structured support groups linked to local mosques, providing immediate assistance following a death. They also sometimes offered financial support (e.g., deferring funeral payments until probate), which not all communities could do.
- **Hindu Communities:** We heard that Hindu participants were offered culturally significant help from their faith community such as support with food, legal

advice, and practical tasks. However, we heard of some challenges in accessing religious leaders for funerals.

- **Korean Communities:** Korean respondents relied heavily on Korean churches, community groups, and cultural associations however, faced practical barriers, such as limited English, difficulty navigating funeral processes, and expressed a need for culturally matched counselling.
- **Tamil Communities:** Some Tamil participants told us they received strong family and community support, but others highlighted: little awareness of services, limited translated resources, and stigma around speaking about death.

**Language barriers and accessibility:** across several groups, limited English language skills created major obstacles in, navigating legal or administrative processes after a death, not knowing what practical steps to take after someone dies, understanding funeral procedures, accessing counselling or emotional support, managing finances especially when online banking was involved and engaging with information that was untranslatable (like medical advice), and lack of accessible information in multiple languages.

**Elderly partners and gendered Intersectional vulnerabilities:** Older women in some communities faced compounded barriers where gender roles intersected with limited English, financial dependency, and sudden administrative burdens after a partner's death. Older migrants and isolated women were especially affected when the deceased partner had previously managed administrative tasks.

**Digital exclusion:** We heard issues about digital barriers, and digital literacy significantly affected older people, some minority ethnicity groups, and residents with limited English.

**Isolation and mental health:** From the participants we spoke to, findings suggested that people without family in the UK, especially older or recently migrated residents, were more likely to experience isolation during bereavement. We were told that some cultural norms discourage talking about grief or seeking professional help, putting individuals at risk of complex grief and mental health challenges.

**Culturally appropriate counselling and support:** Mental health concerns were further compounded by the prospect of using translators in counselling sessions, when a person spoke limited English. Several communities, particularly Korean and South Asian participants shared that they felt bereavement counselling would be more appropriate if delivered by:

- Someone from their cultural background
- Someone who speaks their language
- Someone who understands cultural stigma around grief and mental health

Long waiting lists for counselling – sometimes 3–4 months – further disadvantaged communities already hesitant or unable to engage with mainstream services.

**Practical information gaps:** Respondents frequently shared that in their communities they felt there was a lack of knowledge of funeral procedures, the role of coroners, and where to access bereavement, financial, and legal support

**Stigma and cultural norms around grief and mental health:** Some minority groups, particularly from South Asian, African, and East Asian backgrounds, shared that mental health remains taboo, that men in particular are discouraged from speaking about emotions and grief is often internalised or “bottled up”. This may lead to delayed help-seeking and increased risk of complex grief responses.

## Summary

This report made 14 recommendations to service providers, commissioners in Kingston and the SWL ICB. We also identified gaps in the findings where more could be done to engage with minoritised communities. This has led to further commissioning for Healthwatch Kingston and KVA to continue to develop this work.

## 7.10 South West London Bereavements Services and Support: Gaps workshops report (published 13 June 2025)

The south west London Bereavement Services and Support Gaps, community engagement project, was commissioned to build upon the 2022 pilot report from Healthwatch Kingston in partnership with KVA, that explored peoples’ lived experiences of bereavement across Kingston.

The pilot identified widespread gaps in awareness, accessibility and culturally relevant services, leading to a Phase 2 expansion across SWL. Phase 2 aimed at engaging communities who were not previously represented. While not initially a report looking at general themes from the community groups, it focused more on specific needs from minoritised community groups.

However, the report naturally identified inequalities and themes relating to race, ethnicity, culture, language, and faith, and more general disparities in sex, class, and age, and these are all important factors when considering inequalities and intersectionality. The engagement identified differences in how communities experience bereavement and access bereavement support and support services.

Crosscutting themes emerged organically from the lived experiences of workshop participants across diverse boroughs and communities. Workshops included participants and representation from African and Caribbean communities, refugee, asylum seeker and other migrant groups (including an LGBTQ+ asylum seekers group). Early pregnancy, early years and youth communities. Addiction support and faith-based groups, culturally distinct elder and dementia groups, and had mental health, neurodiverse representation. Each workshop offered a lens into how bereavement intersects with culture, identity and long-standing health and care inequalities,

The findings from this report aimed to strengthen bereavement support pathways across south west London.

For the full report, please see: [South West London Bereavement Services and Support: Gaps Workshops Report](#)

## Methodology

The initial report identified the following gaps, and grants were made available via KVA to run face to face workshops across south west London. The identified gaps included:

1. Children, young people and their families/friends/teachers
2. Survivors of bereavement by suicide
3. People experiencing homelessness
4. People experiencing funeral poverty
5. People with learning disabilities, special educational needs and disabilities and neurodivergent people (such as autism and ADHD)
6. Domiciliary (home care), care and nursing home workforce
7. Hospice and other palliative care focused teams
8. Residents in care and nursing homes
9. Recently widowed
10. Veterans and their families/friends
11. People from African and Caribbean communities
12. Refugees, asylum seekers and people from other migrant communities

13. People from LGBTQ+ communities
14. People living with frailty and/or dementia
15. People experiencing loss through pregnancy and/or fertility

## Demographics

As much of the community engagement was conducted through in-person workshops, complete demographic data was not always available. However, key themes were identified through the insights shared by the community groups who participated. The full list of community groups, along with their detailed feedback, can be found in the main report and accompanying appendices.

Phase 2 used a community-engagement approach, delivered through 13 locally run bereavement gaps workshops across south west London, reaching more than 150 participants from a wide range of backgrounds. Alongside these workshops, Healthwatch Kingston also conducted an online survey completed by 48 respondents, including questions added on behalf of the South West London ICB, which helped capture additional insights into bereavement and End of Life Care experiences.

Together, the workshops and survey responses were analysed to identify key service gaps, cultural needs, barriers and inequalities when accessing services.

## Feedback

**Cultural understandings of bereavement:** Many communities described bereavement as extending far beyond death, encompassing cultural loss, displacement, identity disruption, and community separation.

“Loss is not just about death, we grieve for what we leave behind, our home, our people, our way of life.” (Togetherness Community Centre – Adults 60+).

Asylum seekers described “dual trauma” when someone dies sometimes, they can be managing grief on top of migration-related trauma.

**Mismatch – Cultural Mourning Practices and UK Systems:** Some cultures keep the departed family at home until burial, unlike many UK mortuary systems (Rainbows Across Borders).

**Ceremonies:** Some ceremonies like Nine Nights provide structured community support, but services do not recognise or adapt to these practices (Dignitate).

**Expectations:** Some religious communities expect individuals to “fast and pray,” which may prevent people from seeking external emotional or psychological support (Dignitate).

**Support access:** Gaps in access may contribute to distress and poorer emotional outcomes.

**Language Barriers and Accessibility:** Several groups highlighted that they felt bereavement information is not accessible to people with limited English.

**Translators:** Participants emphasised the need for translated or spoken information rather than written materials (Togetherness Community Centre – Adults 60+).

**Trust:** Some refugee groups reported difficulty trusting services due to misunderstanding or lack of cultural context.

**Language limitations:** Findings suggested that language barriers can reinforce inequities in awareness, navigation, and uptake of support.

**Service uptake:** Lack of translated, accessible information perpetuates inequalities and reduces service uptake.

**Cultural Stigma and Community Judgement:** Participants from various ethnic backgrounds described fear of judgement within close-knit communities and concern that talking about grief would lead to gossip, social stigma or spiritual judgement. We heard about reluctance to disclose miscarriages, pregnancy loss or mental health issues due to cultural taboos.

**Seeking help:** These concerns were especially visible in comments from groups representing African diaspora, asylum seekers, and faith-based communities. These findings may imply that people from minoritised ethnic groups may delay or avoid seeking help due to stigma or social pressure.

**Intersection of Sexuality, Ethnicity and Immigration Status:** Rainbows Across Borders and LGBTQ+ asylum seekers highlighted an acute sense of cultural displacement, limited social networks, a distrust of institutions and feelings of deep isolation during bereavement.

**Homophobia and transphobia:** For some, these issues intersected with homophobia and transphobia within their own communities. Intra group stigma intensifies bereavement inequalities.

**Faith based needs and religious identity:** Several faith groups or culturally religious participants emphasised the need for faith informed support staff or faith-based support with an understanding of UK bereavement processes.

**Celebrating life:** Some communities reflected on the importance of celebrating life as part of grief rituals and recognised the vital role of faith leaders in providing emotional support. There was also a desire for bereavement spaces that respect religious practice.

**Spiritual and religious considerations:** Services that overlook spiritual and religious considerations may risk further alienating already minoritised communities.

**Lack of awareness:** Many participants were unaware of available bereavement services until they personally experienced loss.

"You don't know where to go until you need help, and by then, it's too late." (Cruse)

**Community-based support:** Places of worship, social groups, and cultural organisations were seen as essential bereavement support hubs

**Practical guidance:** Participants identified a clear need for structured information on legal, financial, and administrative tasks before and following a loss is crucial.

"It is also difficult when people die without writing a will, as family members often end up in conflict. For me, it is important that proper arrangements are made in advance so that survivors are not left with the burden of legal disputes." (Rainbows Across Borders)

## Summary

Although the Gaps report was not initially designed as an Equality Diversity and Inclusion study, the findings strongly suggest that bereavement support in south west London is experienced very differently across racial, ethnic, cultural, linguistic, and faith groups. These differences often compound existing health inequalities, particularly where services struggle to recognise or respond to the diverse needs of local communities.

The findings suggest several recurring issues, including a lack of culturally aware services, limited translation and communication support, and the impact of cultural stigma or fear of judgement on seeking helps.

Many people also face mismatches between traditional mourning practices and UK clinical pathways, alongside financial pressures that disproportionately affect minority ethnic communities. Migrants, asylum seekers and those with insecure immigration

status encounter additional barriers, including low awareness of available services. Taken together, these insights highlight a clear need for more inclusive, culturally aware, and linguistically accessible bereavement pathways, especially in diverse boroughs.

**What's working well and future improvements:** Participants welcomed clearer, structured information, noting that accessible practical guidance would empower families to feel more prepared and confident when navigating bereavement-related tasks, prevent conflict and reduce stress, support both immediate decisions and longer-term responsibilities, and offer reassurance by ensuring that loved ones are not left to manage complex legal and financial matters alone.

## 8. Conclusion

This 5-year 'New Dialogue Data Review: Health and social care inequalities in Kingston (2021–26)' concludes that addressing inequalities, particularly those linked to ethnicity, immigration status, disability, gender, language and digital access, requires coordinated cross-sector action, improved community-based practice, and sustained investment in inclusive engagement that reaches those who are often least heard.

Ensuring an independent voice remains at the centre of this work is vital as many of the communities most affected by inequality, particularly people from minority ethnic backgrounds, Disabled and other vulnerable communities, often lack safe, trusted routes to share their experiences. Independent voice advocacy, informed by the experiences of local patients, service users and the public are essential when influencing system change and health and social care service improvement.

## 9. New Dialogue and Healthwatch Kingston

On 28 November 2025, New Dialogue became the new home of Healthwatch Kingston upon Thames.

Since its creation, our organisation has been registered as the charitable company 'Healthwatch Kingston upon Thames', established to deliver the Healthwatch statutory service for the Royal Borough of Kingston upon Thames.

Following careful consideration, the Healthwatch Kingston Board agreed to change the charitable company name to 'New Dialogue'.

This change relates solely to our organisation's name. The legal entity remains the same, and there is no change to governance, staff, or the delivery of the Healthwatch Kingston upon Thames statutory service.

Healthwatch Kingston upon Thames was set up by the [Health and Social Care Act of 2012](#) to be the independent champion for local NHS and social care.

We seek the views of patients, service users, carers, and the public to help services work better for the people who use them. We play an important role in bringing communities and services together. Everything we say and do is informed by what local people tell us.

As well as encouraging those who run local services to act on what matters to people, we also share local views and experiences with [Healthwatch England](#) and the [Care Quality Commission](#), who make sure that the government put people at the heart of care nationally.

## 10. Contact Us

*[Tell us what you think about your NHS and social care](#)*

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