
# Including Digitally Excluded Communities: Engagement Report

## July to October 2023

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healthwatch Kingston upon Thames

# Contents

# 1 Executive summary

This report is one of two (the other is our 'Including Communities' report) that share findings from our community engagement with Kingston residents over twenty months. During this period, to support Kingston, as a Marmot borough, Healthwatch Kingston has tripled our community engagement activity with people with protected characteristics and people who are not often heard from.

Our 'Including Communities' work, developed relationships with local people and community organisations who directly supported:

- People with English as a second language.
- People living with a learning disability or a physical disability.
- Neurodivergent people.
- People experiencing homelessness.

Between July and October 2023, to build upon our work, Healthwatch Kingston ran a further series of face-to-face "we'll come to you" focus groups with digitally excluded local residents, 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.

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.

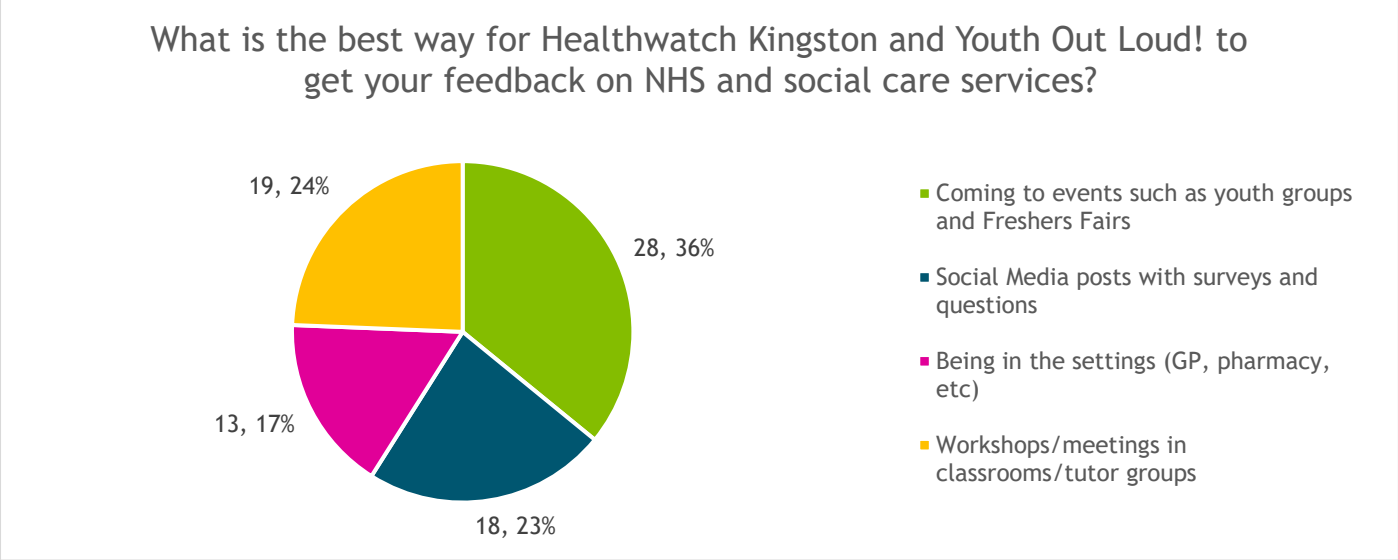
Our Including Digitally Excluded Communities engagement took place at:

- Kingston 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.

Interestingly, Healthwatch Kingston found use of digital technology did not always lead to a willingness to engage digitally.

We also asked 42 young people (13-17 years) at Kingston College Freshers' Fair and two youth clubs (Kingsnympton and Chessington), about the best way for Healthwatch Kingston (and Youth Out Loud!) to get their feedback on NHS and social care services. The answers to our multiple-choice question surprised us.

Even though young people are users of digital technology, only 23% (18/42) of respondents said that 'social media posts with surveys and questions' was the best way to engage with them.




By comparison, their preferred way to engage was, 'coming to events such as youth groups and Freshers' Fairs' (36%, 28/42). 24% (19/42) chose, 'workshops/meetings in a classroom/tutor groups', and the least popular way for us to engage was 'being in the settings (GPs and pharmacy etc.)', with only 13/42 (17%) young people choosing this method of engagement.

One young person said:

> *Most young people ignore them [social media surveys]."*

Another suggested a possible solution:

> *Use social media as a boost, make it applicable to all young people."*

## Have you heard of Healthwatch Kingston?

Overall, prior to this community engagement, around one third of the digitally excluded people had heard of Healthwatch Kingston. Awareness of Healthwatch Kingston was understandably

higher (three-quarters had heard of us) within specific groups where we have had longer term engagement and relationships had been built over time (such as with learning disability and neurodivergent groups).

## 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.'

We learned of a range of similar issues and barriers. 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 groups included:

**Kingston Migrant Advocacy Service (MAS)**

- The lack of online health and social care service information in first languages was a large barrier, e.g. the completion of online surveys in English only.
- Using a translator and visiting the group meant we would get the feedback we wanted and could ask additional questions without translating surveys and survey responses.
- Important to know what has changed as a result of their feedback, and they wanted reports translated into a language they could understand.

### Kingston Eco-Op

- 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.
- Happy to share feedback when someone comes in to engage with the group.
- Engaging with family members and carers/keyworker staff was important as people with a learning disability often share their experiences of health and social care services with people that support them.

### Fastminds

- Community engagement requests via email can be easily forgotten, so it is best to get feedback from neurodivergent people in person, 'there and then' to avoid any potential procrastination or before they become distracted by something else.
- Closed questions are better, as open questions can be misinterpreted and neurodivergent minds can wander off topic.
- Prefer to meet in person or have a visit to their group as it is often easier for people to share their stories without feeling overwhelmed and exhausted by sometimes overly long, online surveys.

### Kingston Association for the Blind (KAB)

- Only three out of the 22 blind and visually impaired people we engaged had Wi-Fi in their homes.
- The majority of health and social care service websites were not appropriate due to the inaccessible font size and layout of the webpage information.
- It would be helpful to have a phone number to call to enable community engagement.

### Cambridge Road Estate Community Group Foodbank

- Visit the group and engage with people who attend.
- Leave a contact telephone number after visiting the group, so that people could make contact if they didn't want to speak on the day of our visit.
- Return with report and news on changes that have been made due to their input.

We were reminded, however, that some people do not want to be engaged with, or lacked energy to do so because of their experience accessing services or their health conditions.

Participants that were happy to engage, suggested a range of ways to improve engagement with digitally excluded communities.

Migrants at the Hong Kong group wanted to be able to give feedback on health and social care services, and have their difficulties highlighted with people that can make improvements. They suggested the best way to do this was to attend their group. The majority or responses we received supported this and suggested ways to ensure that our engagement work didn't disrupt their own planned activities. These included alternative ways to raise awareness, such as talking with paid and unpaid carers, advertising in the talking newspaper (for people who are blind or vision impaired) and for the NHS and social care services to regularly promote Healthwatch Kingston in public meeting presentations, in healthcare locations and as part of patient and service user information (e.g. hospital patient discharge packs).

Different digitally excluded groups we engaged with asked for different engagement solutions to meet their specific needs. Some required closed questions and others preferred open, whereas some either needed or preferred alternative methods to facilitate their involvement, such as a phone number to call.

We also listened to what digitally excluded communities wanted from us after they had been engaged with. People said they wanted our reports made available to them. This meant engagement teams revisiting the groups that they had engaged with to feedback the report findings. Others wanted a copy of our report when it was published, or our reports to be provided in different 'accessible' formats such as translated into Easy Read, into the first language of the people we engaged with, and converted into audio.

People were keen to know where the information they had shared had gone, to see changes were being made to improve services and that their feedback was being listened to and was making a difference.

This 'Including Digitally Excluded Communities' report is informed by people who wanted to be engaged with. Healthwatch Kingston hopes that their views and experiences will be considered by those planning, commissioning and delivering information about health and social care services to Kingston residents. Our recommendations for the NHS and social care system influencers, commissioners, providers and engagement professionals are set out below. Healthwatch Kingston has committed to learn from what we have listened to, so that we can continue to improve our engagement with digitally excluded and other communities. We hope others will too.

# 2 Healthwatch Kingston recommendations

A key reminder from our 'Including Digitally Excluded Communities' work was 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.

To respectfully feedback to digitally excluded communities we need to use a range of non-digital forms (such as returning to community groups we engage with, 'you said we did' style posters/presentations/reports, telephone, audio and printed newsletters).

We hope that the following recommendations will be useful.

**Recommendations about how communications and engagement professionals can better engage digitally excluded communities in our work:**

1. **Healthwatch Kingston recommends that communications and engagement professionals**, planning to meaningfully engage with digitally excluded groups, allocate resources to support face to face outreach. This needs to include time to co-design accessible information that supports appropriate delivery and follow up with target groups (and as necessary, their families/friends/carers), so groups can engage in ways that suits them (such as advertising in the talking newspaper for people who are blind or vision impaired, "we'll come to you" meetings and easy read and audio reports etc.).

2. **Healthwatch Kingston recommends that communications and engagement professionals**, planning to meaningfully communicate and engage with digitally excluded groups, ensure adherence to 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. Communications and engagement professionals should also consider engaging the 'Plain English Campaign' to review their organisation's website, approve and then maintain annual accreditation of the Internet Crystal Mark that shows it is clear, well-designed and accessible and other accessibility software such as Recite Me.

3. **Healthwatch Kingston recommends that communications and engagement professionals,** consider how NHS and social care services can regularly promote the statutory service function provided by Healthwatch Kingston in their public meeting

presentations, in health and care locations (such as General Practice waiting rooms) and as part of patient and service user information (e.g. hospital patient discharge packs).

4. **Healthwatch Kingston recommends that communications and engagement professionals**, if hosting a meeting, consider the suitability of the engagement room, as fluorescent lights, outside noise/noise in the room, can be a particular challenge for neurodiverse people with audio processing disorder.

**Recommendations about how digitally excluded communities can better access information about health and social care services:**

5. **Healthwatch Kingston recommends that communications and engagement professionals** refer to 'recommendation 3' (page 5) in our 'Including Communities' report which reads: 'SWLICB and Kingston Place leads to ensure core and targeted health and care information, education, promotion and engagement is available in relevant languages for RASM, also in accessible formats for people with disabilities, the digitally excluded and other seldom heard from communities.'

6. **Healthwatch Kingston recommends that SWL ICS and Kingston Place leads** explore ways to ensure services are informed that people are blind or partially sighted.

**Healthwatch Kingston would also like to request the following updates:**

**An update from RBK** about what plans are in place to continue to help digitally excluded people through the 'Empowering Residents Through Digital Inclusion' project and what support is being provided to people that have completed the project to help them embed their new digital skills and continue to access the benefits that technology can provide.

**An update from SWL ICS** about how support for digitally excluded people, identified in the 'SWL ICS Strategy and NHS Joint Forward Plan Insight from people and communities' report (published in March 2023) has influenced the SWL ICS Digital Inclusion Strategy.

# 3 Introduction

'There is no universally accepted definition of digital exclusion. It typically refers to sections of the population not being able to use the internet in ways that are needed to participate fully in modern society.'

In 2023, the Digital Poverty Alliance, called for 'greater help for an estimated 11 million UK citizens lacking digital life skills' and that 'basic, inclusive design requirements must be enforced for all essential services.'

'Digital exclusion: a review of Ofcom's research on digital exclusion among adults in the UK' (published in March 2022) found that 'user choice, cost issues, and a lack of skills or confidence are all contributory factors in digital exclusion.' The Ofcom review report also noted, 'Those more at risk of digital exclusion included older citizens; the most financially vulnerable; those not working; people living alone; and people impacted by a limiting condition e.g. hearing or vision impairment.'

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:

'Digital exclusion has further alienated those who speak English as a second language. Most service providers are now moving towards providing information and registrations online. Despite the efforts of providing alternative languages on online platforms such as One Click, barriers around assessing information online remains an issue for refugees, asylum seekers and migrants who are socially excluded. Many do not have the computer skills required or access to a computer or the Internet.'

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.

## Common themes from the SWL ICS review

Many of the reports were about specific services: e.g. bereavement, diabetes, multiple sclerosis (MS), maternity, rehabilitation or specific groups of service users, such as people with a learning disability, and people with sight loss. As it was impossible to prioritise any of the hundreds of specialised findings and recommendations, common themes were identified by SWL ICS as priorities. These included:

- Social isolation
- Communication and information
- General Practice (GPs, nurses etc.) access
- Service access and referral times
- The role of community, voluntary and peer support groups
- Inequalities, diversity and inclusion, and,
- Digital exclusion.

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.

Reports noted that overcoming digital exclusion was not just a case of having spaces and the support to gain skills, many people also needed financial support for IT. Importantly, there was a clear identified need for non-digital access routes and for face-to-face appointments.

In addition, even with support, not everyone had the cognitive ability to learn or wanted to engage digitally, and there was an acknowledgement that a range of access methods needed to be offered.

Five years on from the health and care sector ambitions set out in '**Prosperous Lives for All: The Refugee and Migrant Strategy 2016-2019**', our '**Including Communities**' report, and this 'Including Digitally Excluded Communities' report, has highlighted that refugees, asylum seekers and migrants still felt at a disadvantage when trying to access NHS and social care services because they did not have a computer or were not computer literate:

*" Being digitally excluded causes me major access issues. There is a need for further support for digitally excluded people."*

Our review of support services for digitally excluded people indicated a good range of information and advice about skills development, training and how to get access digital equipment. Information on how to reach digitally excluded communities and the importance of non-digital forms of communication was less available.

Healthwatch Kingston notes that RBK has taken steps to address local digital exclusion through initiatives like the 'Empowering Residents Through Digital Inclusion' pilot project that aims to help bridge the digital divide and to ensure digitally excluded borough residents can gain access to the benefits that technology can provide.

Other support to improve skills and access to technology does exist in Kingston such as 'Digital technology services for communities', provided by Kingston Voluntary Action through Superhighways. This service provides advice, practical support and skills development for small organisation and beneficiaries. Learn English and Home are also developing a digital resource library.

## Tackling health and care inequalities

People from disadvantaged groups can struggle to have their basic needs met due to a complex mix of social, economic, and geographical factors, with real and perceived stigma and discrimination also playing a part. Refugees, asylum seekers and other migrant communities are particularly vulnerable to health conditions. Healthwatch Kingston notes (based on our engagement work and other evidence) that digital exclusion coupled with language and cultural barriers continue to be common challenges and contribute to health and care inequalities.

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 'Inclusive Kingston: Equality, Diversity and Inclusion Strategy, 2021-25' covers all nine of the protected characteristics outlined in the Equality Act - these are nine aspects of identity that are legally protected from discrimination:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race

- Religion or belief
- Sex
- Sexual orientation

In addition, Kingston Council treats 'Care Experience' as a protected characteristic. 'Care experienced people include anyone who, at any stage in their life, for any length of time (no matter for how short a time period):

- Has been in care; or
- Is currently in care; or
- Is from a looked-after background, including adopted children who were previously looked-after. This could be looked after in the UK or overseas and strives to ensure that other priority equality groups are also considered.'

## Context

In 2020, Healthwatch Kingston submitted a bid to the Care Quality Commission (CQC) to deliver a workshop. Our 'Opening closed environments: A partnership approach' workshop proposal was successful at securing funding to deliver targeted engagement with people with profound and multiple learning disabilities. Unfortunately, due to the coronavirus pandemic, this work was postponed for public health and safety reasons. In March 2023, upon invitation from the CQC to local Healthwatch, we submitted our 'Including Digitally Excluded Communities' proposal to the CQC, that aimed to learn what might prevent people who are digitally excluded from sharing their experiences of health and social care with the CQC. Healthwatch Lincolnshire and Healthwatch Enfield were eventually chosen by the CQC to do the work (our proposal was a 'close third'). However, recognising the importance of the work, and our extensive engagement to inform our 'Including Communities' report, the Healthwatch Kingston Board agreed for us to run the 'Including Digitally Excluded Communities' engagement as part of our 2023/24 core work programme.

# 4 Engagement methodology

To build upon the findings from our 'Including Communities' work and to find out how Healthwatch Kingston could better engage people who were digitally excluded in our work we ran seven "we'll come to you" focus groups with digitally excluded local residents. These focus groups ran between July and October 2023, and also asked people what would help them might better access information about health and social care services. Our engagement took place at the following community-based groups that support people who are digitally excluded:

- Kingston Migrant Advocacy Services (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 approached each digitally excluded community group engagement differently and worked with people attending each group as well as the organisers to co-produce how Healthwatch Kingston could best gather feedback from group attendees.

During the two visits to Eco-op we engaged people with a learning disability in a side room and people came in to meet with us separately to share their views and staff supported our conversations.

When engaging with members of the Kingston Migrant Advocacy Service (MAS) 'Lunch Club', we moved around the room, speaking to individuals one to one, but at the Kingston MAS 'Welcome Café' (where we met with a group of migrants from Hong Kong) we spoke to a group with the support of a volunteer translator.

At Kingston Association for the Blind (KAB) we introduced ourselves to the whole group and we followed up after our introduction by speaking to smaller groups at their tables.

With Fastminds (ADHD) we spoke to all group attendees, and at the Cambridge Road Estate Community Foodbank we moved around and spoke to people individually.

The numbers involved in discussions varied at each group:

- 20 people at KAB
- 10 at Fastminds
- 30 migrants from Hong Kong at MAS
- 42 Young People (13-17 years) from Kingston College Freshers Fair and two youth clubs (Kingsnympton and Chessington).
- 2 separate individual responses (while at other community engagement events).

Additionally, 33 (included people engaged with at the MAS 'Lunch Club' and the Cambridge Road Estate Community Foodbank) responded to printed surveys which Healthwatch Kingston provided in Easy Read/Plain English for people with a learning disability to complete on their own if people did not want support. We also used the Easy Read surveys at other engagement sessions, as the larger font size also worked for people with visual impairments. Most people completed the survey with support, unless it was a group discussion, where we worked through the questions together as a group and a member of staff made notes.

This Including Digitally Excluded Communities report has also been informed by our Including Communities work, where we engaged with:

- People experiencing homelessness.
- Young people (13-17 years).
- Refugees, asylum seekers and other migrant communities.
- People with learning disabilities.
- Neurodiverse people.
- People from areas in Kingston with high deprivation.
- People with English as a second language.
- Community Libraries for people with limited mobility to leave their home.
- People with physical and mental disabilities.

# 5 What digitally excluded communities told us

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.

## 5.1 Engagement and service access issues and barriers

There was no doubt that poverty and digital exclusion are intrinsically linked, but one respondent noted, it's not always about money:

*"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."*

*"I have not given feedback before as never thought about it. I never know where it [information] is going or if there will be an outcome."*

*"After my online account was hacked, I lost confidence in online systems being able to protect my personal details and I am now concerned to use online services."*

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."*

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.

Lack of digital skills:

*"I'm just getting used to the technology, as I lack the skills."*

*I am pay as you go, but prefer to phone as can barely text."*

*I can use a laptop, but some websites are easy to use, and others are tricky."*

*I have a laptop but never use it. I need someone to help me with my laptop."*

*I can go online, but I cannot fill out forms online. I find it a little bit difficult sometimes and need help."*

*I am able to use them [laptops/smart phones], I just don't use them a lot."*

*Just to say in my experience 2/3 of LD are not able to use a computer so don't know what is going on!" And many of our older carers, and those who just won't use technology, are in the same boat."*

Personal preference to not use digital services:

*I do not want to use a computer. I do not want anyone to force me to use one."*

*Online is a channel of communication, not the only channel and not always my favourite channel."*

*I don't go online. I don't want to."*

Why bother? Unsure it will make any difference:

*People want to know what is going to happen with information when given. Will it make a difference to them?"*

Inaccessibility for people with physical disabilities and long-term conditions:

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 message from their doctor to fill out a form, they had sent it via text. 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.

*It can get embarrassing to ask for help. You open the survey and it is two lines and a waste of the other persons time."*

*Some websites are OK, but most are not accessible."*

*What if you have dyslexia? Or if you are dyspraxic, so it hurts to write. Or its a dual dual diagnosis and you can't concentrate?"*

Some did not usually give feedback, as generally the format to do so is inaccessible to them e.g. they might be given iPads when they are visually impaired. They also wanted to let us know that there is nothing to inform services that people are blind or partially sighted.

Long surveys and other online forms:

*Long questions. Too many questions."*

*Online forms can time you out and you can lose what you have added, so you need to start again."*

*Sometimes, when the survey is too long, when you have to go back a page or two, the online survey crashes and I then loose interest."*

## 5.2 Have you heard of Healthwatch Kingston?

Overall, prior to our engagement, around one third of the digitally excluded people had heard of Healthwatch Kingston. Awareness of Healthwatch Kingston was higher (three-quarters) within specific groups where we have had longer term engagement as relationships had been built over

time (such as with learning disability and neurodivergent groups). Here is what some people who didn't know about us said:

*Nothing stopping me but never heard of Healthwatch Kingston."*

*I am not sure who Healthwatch Kingston are."*

*Not heard of you. Happy to share answers when people come in."*

### 5.3 How can we improve engagement?

We were reminded that some people don't want to be engaged with, or lacked the energy to do so because of their experience accessing services or due to the effects of their health conditions:

*I don't want to give feedback as it was a good experience, and nothing needs to change. I do not know what I would do if it was a bad one."*

*I have no energy to complain or share my experiences after being pushed around from one service to another."*

*When things have gone wrong it takes a few weeks to face it again because of my neurodiversity."*

*I have ADHD, I hate forms, I can easily forget tasks, it needs to be a 'there and then' question and answer. I too easily forget to follow up on questions in an email or a letter. I also get overwhelmed after incidents. Later never happens."*

Other people we met with shared a range of ways that Healthwatch Kingston and other health and social care services could improve engagement with digitally excluded communities:

*If you're putting on a meeting you need to consider the room. Fluorescent lights, outside noise/noise in the room, (because some people with neurodivesity have audio processing disorder)."*

The migrants from Hong Kong group wanted to be able to give feedback on health and social care 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. The majority or responses we received supported this and suggested ways to ensure that our engagement work didn't disrupt their own planned activities. These included alternative ways to raise awareness, such as talking with paid and unpaid carers, advertising in the talking newspaper (for people who are blind or vision impaired) and for the NHS and social care services to regularly promote Healthwatch Kingston in public meeting presentations, in healthcare locations and as part of patient and service user information (e.g. hospital patient discharge packs):

*Offer an alternative contact to the survey like a phone number."*

*Go where people are i.e. playgroups (get more responses and more convenient) FACE TO FACE."*

*Hard copies and face to face meetings are imperative or their voices are never heard! But people will need support to get to a meeting or better go to them as many have activities booked, attend day service, during the week 10-4'*

*Just like what you have done today. Come and talk to us."*

*Talking newspaper is very valuable (Advertise there)."*

*Come to us people need to be heard".*

*Come to us. Happy to talk. Don't mind you being here – you wouldn't be interupting. I would need someone to help me do the surveys."*

*Face to face. You get a much better understanding of someones feelings than with just words."*

*Coming to groups such as the lunch club (MAS) and playgroups, without intruding on the activity."*

*I prefer face to face. Phone is better than online. Nothing is paper anymore, it is frustrating."*

*Be respectful of existing organisations work. Work with us to find a suitable time."*

*I prefer to talk to the people. Prefer they come to me. As long as not interrupting my activity."*

*Plan ahead (too many organisations reaching out in a short space of time."*

*Like the idea of HW coming in once every 3 months. Don't mind being interrupted, nice to talk with you."*

*Use carers/support workers/librarians and group organisers as key sources."*

*I talk to staff at day centres (Eco-Op) and Healthwatch would be welcome to talk to the staff."*

*Come to day centres or contact support staff so they can tell me about it."*

*Speak to different ones (staff) to get a more rounded picture."*

*I would talk to the doctor myself or my social worker or key worker."*

*I have spoken to my carers at home sometimes about it (experiences of NHS and social care)."*

*I talk to my key workers, happy for them to feedback with whoever they feel appropriate."*

*I talk to my carers and happy for them to share information with Healtwatch Kingston.'*

*Promote information about Healtwatch at point of service (e.g. in doctors' waiting rooms and patient hospital discharge packs)."*

*Coming to events, having signs in NHS General Practices/hospitals, add to details on NHS paperwork. Having something with both 'box ticking' and comment box."*

*There needs to be more information about Healthwatch Kingston in NHS and social care settings."*

*Currently never been on my mind as a place to give feedback to. Better and wider promotion in healthcare locations would raise profile and facilitate patient feedback. Maybe a touch screen facility at the exit to all healthcare locations."*

*Give an alternative contact, so that people who do not wish to speak at the time can make contact at a later date."*

*Ease of communication. Telephone easier than written."*

*If I can call/text/email. Speaking to a person is easier."*

*Posters for people providing a phone number and encouraging people to phone with their feedback."*

*Translated surveys if there is time for people to respond in their first language, but then you'll have to translate responses into English. Or use a translator to get immediate feedback in face-to-face meetings."*

Different digitally excluded groups we engaged with asked for different engagement solutions to meet their specific needs, such as, some required closed questions and others preferred open, whereas some either needed or preferred alternative methods to facilitate their involvement:

*We [people with ADHD] hate filling in forms. Much prefer in-person feedback and it's good to ask us closed questions as we tend to make our answers more complicated than they need to be if we are asked open questions – our minds tend to take us elsewhere, especially if we are unsure about the questions."*

*Questions should have both tick boxes and open questions."*

*Meeting people face to face and talking, not just having tick boxes, but open questions and giving people plenty of time to say what they want to say."*

*It is easier to elaborate face-to-face. Face-to-face meetings much better than online meetings. I feel less engaged in online meetings."*

*Tailored to needs of group (large print, easy read, languages, closed questions,) not easy with online survey or websites."*

*A phone number would be best to give feedback and audio books are really helpful."*

*Other forms of communication (Email/webforms) are not accessible for us [blind or visually impaired people]. A phone number needs to be given."*

*Only need printed information with scanner. Do not handwrite or draw on the document.' *Scanners can enlarge, transfer to computer or speak the document."*

*If not face-to-face, provide plain letters with a phone number to call."*

*Give people time to feedback."*

*There are too few characters allowed for responses on some platforms, this means you cannot give the detail you want and can lead to confusion over the situation."*

### 5.4 How do you give feedback now?

A food bank respondent said, *I don't normally give feedback."*

A carer for people with special educational needs said, *We do not give feedback'*

A person with a learning disability said, *I respond to how did we do questions"* Others with a learning disability shared:

*I speak to support staff."*

*Face to face. Not happy doing forms."*

*I speak directly to people providing the service. Worried things get swept under the carpet if I don't. I complained about the home I live in. No activities and people don't care because they don't have to live here. They go home and leave us there."*

### 5.5 What do you want after we have engaged with you?

People said they wanted our reports made available to them. This meant engagement teams revisiting the groups that they had engaged with to feedback the report findings:

*Come back with the report."* *Feedback the way we gave it to you."*

*In person presentation on the findings/reports as it is important for people with ADHD to close the cycle (engage-report-changes-re-engage)."*

*Someone to come in and explain report. I have ADHD so unlikely I will read it myself."*

Others wanted a copy of our report when it was published, or our reports to be provided in different 'accessible' formats such as translated into Easy Read, into the first language of the people we engaged with, and converted into audio:

*We can help you turn your reports into Easy Read."*

*We are from Hong Kong, it would be helpful to have translated reports."*

*When the work is done, provide reports in audio."*

*Report/feedback in audio. The bank send me my statement along with an audio CD of the statement."*

*Acknowledge you received feedback from me in the report and give feedback in the way that I gave you the information (at an event, by phone…).”*

*Would like copy of report when published.”*

People also wanted to know where the information they had shared had gone, to see changes were being made to improve services and that their feedback was being listened to and was making a difference:

*Service improvements.”* *I want to know it had been acted upon.”*

*How do we know this has made a difference?”*

*Would like to know outcomes and follow on steps.”*

*People want to know what is going to happen with information when given. Will it make a difference to them.”*

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

However, some digitally excluded people we spoke with were ‘happy’ to contribute their views and experiences but not interested in knowing anymore, ‘happy’ to ‘leave Healthwatch to it’ and ‘look into it’:

*Nothing. Happy just to give feedback.”* *I am happy to give feedback.”*

*Nothing. Happy I have shared the information.”*

*Look into it. I don’t want any feedback. I’m happy to share my story and leave Healthwatch to it.”*

# 6 Conclusion

This 'Including Digitally Excluded Communities' report shares findings from our community engagement with Kingston residents. Healthwatch Kingston listened to 137 people (95 digitally excluded and 42 young people) who contributed their views and experiences in different ways. Our focus 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.

Listening to digitally excluded communities has reminded us:

- 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.
- To ensure co-preparation/design/production/delivery of engagement plans with target groups and other relevant stakeholders.
- 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).
- 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.
- 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).

The Healthwatch Lincolnshire 'CQC Digital Inclusion' report and the Healthwatch Enfield 'Understanding Digital Exclusion' report provided similar learning to our own on how to better involve digitally excluded communities in our work.

In June 2023, the House of Lords 'Communications and Digital Committee' published a paper on digital exclusion. It noted, 'Not everyone wants to be online, or online all the time. And some services are better in person. Private and public service providers should avoid viewing digital as a cheap substitute for good customer service. Adequate provision must be maintained for those

who cannot or do not wish to use online services.' The committee also found, 'too many online services have poor accessibility for those with additional needs.'

Healthwatch Kingston hopes that our learning from this 'Including Digitally Excluded Communities' report, informed by us listening to local digitally excluded residents, will help guide our health and social care leadership teams to ensure their organisations provide accessible information about their services and to champion improved, inclusive engagement with digitally excluded communities in Kingston and across south West London.

# 7 Next steps and thank you

Healthwatch Kingston will share this report with Healthwatch England and the Care Quality Commission and continue work with local health and social care influencers, commissioners and providers of services to ensure formal responses to our recommendations are made and, where feasible, that actions are taken to address the needs identified by the digitally excluded Kingston residents who participated.

In addition, Healthwatch Kingston re-commits to improve our engagement with digitally excluded communities and, in order to feedback the findings from this community engagement to participants the way we have been asked, we will:

- Work with the Royal Borough of Kingston upon Thames Involve team of learning disability advocates to produce a Plain English/Easy Read version of this report
- Work with Kingston Association for the Blind to create an audio recording for people who are blind or have sight impairment
- Re-visit each digitally excluded group we engaged with to deliver 'you said we did' presentations and share information in accessible formats.
- To standardise our approach across communications and engagement professionals, we will also explore co-producing an including digitally excluded communities' engagement toolkit with communities and other stakeholders.
- Within our limited, annual statutory funding, we will use the learning from this report to help us ensure as many Kingston residents as possible are meaningfully involved in our work. This may mean less community engagement work is feasible (as our resources will only go so far) but we commit to co-working with target communities and the organisations that support them, to ensure we can maximise the insight we gather from our engagement activities.

Healthwatch Kingston would like to thank everyone who participated in this 'Including Digitally Excluded Communities' engagement work.

If you have any questions about this report, please contact:

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Healthwatch Kingston 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 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.

## *Tell us what you think about the NHS and social care*

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