



# Feedback Report

July – September 2026

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# Quarterly Feedback Report

**July – September 2026**

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## About us

We are the independent champion for people who use health and social care services in Royal Borough of Greenwich. We're here to make sure that those running services, put people at the heart of care.<sup>1</sup>



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## What did we hear in July – September 2026?

Between July and September 2026, we heard from 528<sup>2</sup> residents. During this reporting period, residents shared feedback about a range of local health and care services. We reviewed this feedback to identify themes that appeared repeatedly. While we heard some positive interactions with staff and services,

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<sup>1</sup> Image above taken from community event at the Children's Centre in August 2026.

<sup>2</sup> Feedback collected through calls and emails to us, meetings between us and local groups or advocates, research reports and outreach and engagement events until 16 September.

recurring concerns emerged around **long waits and uncertainty about what happens next, difficulties moving between different parts of the health and care system, and whether services are accessible to people with different communication needs.**

The following quotations have been selected because they provide examples of these recurring themes. They are grouped by issue and show, in residents' own words, some of the barriers and concerns raised about accessing services, waiting for care, navigating between services and communicating with staff.

We have also grouped quotations about what residents said worked well, highlighting approaches and practices that made a positive difference to their experience.

Where residents identified the service or provider concerned, we have included this beneath the quotation. Each quotation describes an individual experience. Naming a provider shows where that experience occurred; it does not mean that the issue is recurring within that organisation. The quotations have been selected because they illustrate themes that recurred across the feedback we received as a whole.

## Long Waits for Care and Treatment

**“ Still waiting for treatment after 2 years and 3 months... I have been in pain for over 2 years.**

*Queen Elizabeth Hospital – Gynaecology department*

**“ Long wait for MRI results. Long wait for follow-up GP appointment.**

*Queen Elizabeth Hospital – Radiology department and Plumstead Wickham Lane Surgery*

**“ Waiting time – GP referral took around a year.**

*Queen Elizabeth Hospital – Neurology unit*

## **Feeling Unheard or Poorly Treated**

**“ Persistently interrupted and rushed during GP telephone consultation... aggressive and unsympathetic tone, was rude and dismissive...**

*Royal Arsenal Medical Centre*

**“ I feel I’m not heard and just being used to collect data for NHS...**

*Queen Elizabeth Hospital*

**“ Nurses were rude, bullying and intimidating.**

*Queen Elizabeth Hospital – Ward 1*

## **Difficulty Navigating Between Services**

**“ GP sending me back and forth from the pharmacy. Delay with the service appointments and I did not get medication during emergency.**

*Triveni GP practice*

**“ Have to make appointments to get hearing aid batteries at QEH, while in Lewisham hospital, I can just walk in and get them.**

*Queen Elizabeth Hospital, Audiology department*

**“ They didn't provide me with information in Easy Read... It felt like I was passed about and had to keep saying the same thing to different people.**

*Queen Elizabeth Hospital*

## **What Residents Said Worked Well**

**“ The GP had a Nepali interpreter which made the communication easier.**

*GP practice*

**“ My experience of QEH has been very positive. I have been treated compassionately and very competently.**

*Queen Elizabeth Hospital*

**“ The process was efficient and went on smoothly. The staff was lovely [and] explained every bit of the process properly.**

*Queen Elizabeth Hospital*

**“ Helpful staff... follow up letters with plan good info. Positive nurse – clear helpful – finding team reassuring. Nurse Kitty... very helpful.**

*Queen Elizabeth Hospital – Neurology Unit*

## What This Feedback Tells Us

Residents' experiences show that access is not simply about whether a service is available. It also depends on how long people wait, whether information is provided in an accessible format, whether appropriate language support is available and how easily people can move between different parts of the health system.

Long waits were a concern at several stages of care, including referrals, diagnostic results, follow-up appointments and treatment. The experiences suggest that delays can accumulate across a pathway, leaving residents in pain or uncertainty for extended periods. Clearer information about expected waiting times, available support and who to contact for an update or if symptoms worsen could help reduce uncertainty while people wait for care.

Communication had a significant influence on residents' overall experience. Compassionate staff, clear explanations and helpful follow-up information made people feel reassured and supported. In contrast, residents who felt rushed or dismissed reported feeling less confident in their care.

Some residents found it difficult to navigate between services. Being passed between services or departments and having to repeat the same information and encountering different access arrangements created frustration. These experiences suggest a need for better coordination and more consistent information across services.

The feedback includes both positive and negative experiences, sometimes concerning the same provider. This suggests that good practice exists but is not experienced consistently. The positive examples, such as providing an

interpreter, explaining procedures clearly and giving helpful follow-up information, show the practical approaches that residents value and that could be applied more consistently.

## Provider Response

Healthwatch Greenwich approached Queen Elizabeth Hospital for a response to the issues raised by the residents:

### Long Waits

The teams apologise for the long waits that patients are experiencing currently and recognise the distress this is causing. They are working through the current waiting lists and are prioritising appointments based on clinical urgency while working to move all appointments forward as additional capacity is made available.

### Poor standards of care and not being heard

At QEH we are working hard to meet our Trust values and have implemented several improvement programs to address concerns in care, communication and experience. We are sorry that we are still not achieving this for all our patients and will continue to work hard the teams across QEH to deliver a high standard of care.

### Hearing Aid Batteries

The Audiology lead has confirmed that appointments for hearing aid battery replacement at QEH is not required. Patients can attend at any time to have these changed. As a result of this feedback, we have now started a joint piece of work with Audiology, the LGT patient experience team and Healthwatch Greenwich to offer a better more comprehensive service for our community.

## Community Experience – Greenwich Nepali Group



Healthwatch Greenwich and the Royal Borough of Greenwich Public Health team held a 'Staying Well, Ageing Well' session with older members of Greenwich's Nepali community. Residents came together to learn about staying well as they age, take part in practical activities, ask questions and share their experiences of local health services.

The session covered physical activity, healthy eating, mental wellbeing, long-term conditions and free NHS Health Checks. Residents had their blood pressure checked, tested their knowledge through a health quiz and practised exercises designed to improve strength and balance.

### **Making prevention practical and relevant**

The session showed the value of making preventative health information practical. Blood pressure checks prompted residents to ask what their results meant and why high blood pressure needs to be identified even when someone feels well. The

strength and balance exercises similarly allowed people to try an activity rather than simply being told about its benefits.

Residents were pleased to learn that eligible adults could receive a free NHS Health Check, but some were surprised that the service had not been promoted more widely. This raised an important question: a preventative service cannot benefit people who do not know that it exists or how to access it.

Residents wanted more opportunities to receive preventative health information and checks in trusted community settings, rather than having to rely solely on finding their way into formal health services.

### Digital access and digital exclusion

Alongside the positive response to the session, residents described a very different side of their experience: the struggle to get through the front door of local health services. They spoke about difficulties securing GP appointments, completing online forms and using self-service screens. **“[first], it is hard to get a GP appointment. [And then] The fill-it-out-yourself iPad is very difficult.”**

These systems may appear simple to the people who design them, but they can create barriers for those not digitally savvy and people who do not speak English confidently.

Residents also described feeling anxious during triage when asked to judge how serious their condition was before they could receive help. That is a difficult decision for anyone. It becomes even harder when someone is frightened, in pain, unsure what their symptoms mean or trying to communicate in another language. **“In an emergency, they just give you a screen and it’s difficult if you don’t know English.”**

The community setting gave residents the time and confidence to explain these problems properly. These experiences may never be captured by an online form, a brief appointment or a system that records whether a process was completed but not how difficult it was to complete.

### Why the community setting matters

In a familiar and supportive setting, residents had time to ask questions, try activities and explore information without the pressure of a brief appointment or an unfamiliar digital process. This made preventative information clearer, more relevant and easier to act on.

Preventative services are more likely to reach older Nepali residents when they are promoted through trusted community networks, supported by appropriate language and accessible information, and accompanied by human and non-digital routes into care. Their effectiveness depends not only on what is available, but also on whether people know about it and can realistically access it.



## **Practical improvements for local services**

The session highlighted that making a preventative service available does not automatically make it accessible. Services that rely on people speaking confident English, using digital systems or navigating care independently may not reach residents who could benefit most.

The residents at this event were clear, preventative services are more likely to be successful when information and support are available through trusted community settings, in appropriate languages and accessible formats, with human support and non-digital routes into care. Effectiveness depends not only on what support is available, but also on who knows about it, who can access it, and who is missing out. This matters because digital exclusion and language barriers are recurring themes in Healthwatch Greenwich's engagement with residents from marginalised communities. If services are only designed around confident English speakers and digitally able users, existing health inequalities will be reinforced rather than reduced.

## Community Experience – Kaweyan Afghan Women



Healthwatch Greenwich spoke with women from the Kaweyan Afghan community about their experiences of local health and care services. The discussion drew on their own experiences and their knowledge of the wider Afghan community in Greenwich. Their accounts provide insight into how gender, ethnicity, language, age and digital exclusion can combine to shape women's experiences of care.

### Accessing health and care services

Women described difficulties getting GP appointments, language barriers and challenges navigating digital systems. These barriers often overlapped, making access to care feel unnecessarily complicated. **"The process should be shorter and less complex."**

For some women, limited English and low confidence using digital systems created uncertainty about how local health services worked. This made it harder to book an appointment, explain a health concern and understand what should happen next. Some older women who spoke English as an additional language described facing a number of these barriers at the same time.

Women described delays following diagnosis or referral and uncertainty about what was happening with their care. Their concern was not only how long they had to wait, but whether referrals or follow-up had been arranged, what the next stage would be and when they could expect to hear from a service.

The issue was not simply a lack of information. Women needed services to close the loop by confirming that a referral or follow-up had been arranged, explaining what would happen next, giving a realistic indication of when they could expect to hear and identifying who they could contact if nothing happened. Without this, they were left unsure whether their care was progressing or whether they needed to chase it themselves.

### Having to prove that something is wrong

Several women described feeling that their symptoms or concerns were dismissed or not taken seriously. Some said they had to raise the same issue repeatedly, sometimes across multiple contact points, before further investigation, support or treatment was offered. Women did not experience this solely as poor communication: some linked it to being both women and members of global majority communities. This contributed to a sense of being overlooked and raised concerns for them about whether gender and ethnicity influenced the extent to which their concerns were heard and acted upon.

### How trust is damaged

One woman described an interaction with a doctor at her GP practice that had affected her confidence in returning for care, ***"The doctor shouted at me. Now I'm scared to go back."***

This experience shows how communication can affect access to care and is more than a matter of patient experience. A negative experience does not end when the appointment finishes, it can reduce someone's trust in health and care services and make them less confident about seeking help again when they need it. The consequences may be even more serious for someone who is already uncertain about how the health and care system works, has difficulty communicating in English or has limited alternative ways to obtain advice and support.

### **Rebuilding confidence and trust**

Above all, women wanted to be heard, believed and treated with respect when accessing care services. Women wanted ways of accessing care that did not assume everyone speaks fluent English, is confident online or understands how to navigate the health and care system. They wanted services to communicate with them more effectively, to be more culturally aware, and have greater understanding of women's health concerns.



This matters because the barriers described by the women we spoke to do not simply sit alongside one another; they combine to create unequal access to care. A digital-only route can make it harder to obtain an appointment. The absence of language support can then limit a woman's ability to explain her symptoms or understand clinical advice and unclear follow-up can leave her without the information needed to understand what will happen next. When communication, follow-up and trust break down, the system demands the greatest persistence and confidence from the women it may already serve least effectively.

## Vijay's story: Two services, two very different experiences.

When Vijay developed red, itchy, bloodshot eyes, he was worried and wanted advice about what he should do.

Vijay contacted, his GP practice (Woodland Surgery), using its online WhatsApp system. The digital system was convenient and easy for Vijay to use while he was working. He answered questions about his symptoms and sent a photograph of his eyes. He was told that a GP would call him, but Vijay says the call never came.

***"Woodland Surgery said that a GP would call me before the end of the day, but they did not call me back, so I rang them back after 24 hours."***

When Vijay contacted the surgery again, he says he was told that the GP had tried to call him twice. ***"I checked my phone log, and I had not received any calls from Woodland Surgery. The receptionist was rude and not helpful. She said that I [now] couldn't get an appointment for 2 weeks... I am thinking about choosing another GP practice because it's not OK how the receptionist spoke to me."***

He was then told he would need to fill in the form a second time and provide the information about his symptoms all over again to book another appointment. For Vijay, this was frustrating because he had already completed a form, explained what was happening and sent a photograph through the practice's online system.

***"To have to answer all the questions again was kind of tedious."***

Meanwhile, his eye symptoms were getting worse and was affecting his work.

***"Both my eyes were really bloodshot, so I had to keep taking time off from my job. I don't get paid if I'm not there, so I was worried about how I would manage if I'm not getting paid"***

**“There wasn't any reassurance...”**

Vijay liked using the digital service, it was convenient for him at work, and he had successfully submitted all the requested information. What was missing was a way to resolve the failed contact, discuss his worsening symptoms and understand what he should do next.

***“There wasn't any reassurance from the GP practice. It was very robotic... I just wanted to speak to a GP so I could have discussed what I needed to do to treat my eyes.”***

Three days after completing an online form and sending a photograph, Vijay received a text from his GP with details of opticians providing minor eye condition services.

**A very different experience at local optician**

Vijay then contacted Page and Small Opticians and was offered an appointment later that day.

This time, his experience felt very different.

***“The optician was extremely thorough, explaining what he was looking for with each test, as well as when I should go to the Emergency Department if my eyes did not get better.”*** This meant that Vijay did not have to take another unpaid day off from work.

Vijay needed further advice after beginning treatment. The optician contacted him directly, without Vijay needing to complete forms, access digital platforms, send a photograph or navigate unhelpful reception staff.

***“Both the optician and receptionist were very reassuring and helpful when I needed further advice. They wanted to help me and made it really easy for me to contact them and get the help I needed, and they followed up, without any chasing, to make sure I was OK and the treatment was working. Fantastic care”***

**What made the difference for Vijay**

Vijay’s experience highlights a gap in what happens when digital contact does not proceed as planned. The online route allowed him to submit his symptoms and a photograph, but when the promised telephone contact did happen, there appeared to be no straightforward way to recover the process. Vijay and the practice had different accounts of whether calls had been made, his previously submitted information was not carried forward, and he was asked to start again.

This transferred responsibility back to Vijay. While his symptoms were worsening, he had to chase the practice, repeat information and find another route to advice. The issue was the absence of an effective next step when the original process failed. The interaction with reception staff compounded the failure in the process. Rather than helping Vijay recover the pathway, it contributed to him feeling let-down and dismissed.

The practice directed Vijay to a minor eye conditions service, where he obtained a same-day appointment. This raises the question of whether earlier signposting could have shortened his route to appropriate care.

## Provider Response

Healthwatch Greenwich approached Woodland Surgery for a response to the issues raised by the residents:

We take patient feedback seriously and welcome the opportunity to reflect on any concerns raised about the service we provide. Our team works hard to provide a safe, accessible and responsive service to our patients. We recognise that, as with any healthcare service, there may be occasions where a patient's experience does not meet the standard we aim to provide, and we are committed to learning from concerns where they arise.

We have made further efforts to investigate the circumstances described in the feedback. Unfortunately, despite carrying out a detailed review of our patient records and the routes through which patients can contact the practice, we have been unable to identify a patient or consultation which corresponds to the information provided.

Our review has not identified a current or historic patient registered with the practice matching the first name provided, nor have we been able to identify a corresponding interaction through our WhatsApp-based access platform. We have therefore been unable to establish that the account described relates to a patient of Woodland Surgery or to identify the consultation in question.

We remain committed to listening to patient feedback and using it constructively to improve our service. If further information becomes available which enables us to identify the patient or consultation concerned, please do provide this to us, subject of course to the appropriate consent and confidentiality requirements, and we will undertake a further review and respond to any substantiated concerns.

Thank you again for giving us the opportunity to respond.

## **Daisy's story: "I was worried before... I feel very reassured now"**

When Daisy had a bladder ultrasound scan booked at Queen Elizabeth Hospital, she was told that she did not need a full bladder. Daisy was confused; she'd had these scans before and was always previously told that a full bladder was important.

**"I didn't think that was right, so I contacted four different district nurses, who all said that I should have a full bladder for the scan, so I was really confused that the hospital told me something different."**

The conflicting information meant Daisy wasn't sure she was preparing correctly for her scan. She had to spend time checking the hospital's advice, placing the burden on her to resolve the uncertainty. Had she followed the original instructions, there was a risk that the scan might not have gone ahead, leading to further delay and another appointment. Moreover, the conflicting information reduced her confidence in the process.

In April, Daisy had the scan and expected to hear about the results a few weeks later. By July, she was still waiting. For Daisy, having a history of repeated problems with her catheter, not knowing her results made her feel anxious.

**"I was so worried about getting my results because my catheter has blocked a lot of times before and then I needed antibiotics, as well as them bringing forward my catheter change to stop it blocking... I ended up having Sepsis last year, so I was really worried that it was taking so long to get my results."**

Daisy had made multiple attempts to find out when she might get her results. With no results and no clear information on when she might get her results, Daisy contacted Healthwatch Greenwich.

We contacted the Ultrasound Department at Queen Elizabeth Hospital about the delay, and the conflicting information Daisy had received. As a result, the department then contacted Daisy and arranged an appointment to discuss her results. In addition, her GP Practice (Plumstead Health Centre) checked her ultrasound results and spoke to Daisy's son to help make sure she understood the information she had been given.

### **What Daisy's experience tells us**

Daisy's experience shows a lack of consistent preparation information, unclear responsibility for communicating results and no guidance on where or who is responsible for monitoring what happens next.

Her experience shows how communication failures at different stages of the same pathway can combine. Before the scan, she had to resolve contradictory advice about how to prepare. After the scan, she had to make repeated attempts to obtain results. Rather than being guided through the process, Daisy was left to check the instructions, monitor the delay and pursue different services herself. Healthwatch Greenwich's intervention helped reconnect those parts of Daisy's care.

Healthwatch Greenwich will use Daisy's experience, alongside wider feedback from residents, to identify communication gaps. We will raise these issues with the relevant services and seek assurance about how patients will be kept informed throughout the diagnostic pathway.

## Provider Response

Healthwatch Greenwich approached Queen Elizabeth Hospital for a response to the issues raised by the residents:

### Daisy's story

We are very sorry for Daisy's experience and wholeheartedly agree that good communication is essential and we welcome the opportunity to work with Healthwatch Greenwich and our community to review wider feedback to understand how patients are kept informed throughout the relevant diagnostic pathway and where there are opportunities to improve that communication.

## Next Steps

We will share the findings from this report with the relevant commissioners and providers, ask them to respond to the issues raised and set out any action they intend to take. We will follow up on their responses and report on progress.

We will continue listening to residents and communities, particularly those who experience barriers to care, to understand whether changes are improving access, communication and trust in local services.

## Contact Us

For more information or to request this report in another format:

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