healthwatch Redbridge

Mulberry Ward Maternity Report

April 2026

Project Details

Service	Mulberry Ward, Whipps Cross Hospital
Date of visit	16th February 2026
Type of visit	Unannounced. This visit was carried out in response to findings from previous visits to the ward, and took place with the agreement of NHS staff.
Visit times	9:30pm – midnight
Healthwatch representatives	Donna Young, Project Support Worker; Rafat Kiani, Research and Engagement Coordinator
Sent to	Cathy Turland, Chief Executive, Healthwatch Redbridge; Hanan L'Estrange-Snowden, Head of Hospital Patient Experience & Engagement, Whipps Cross; Lynn Maycroft, Deputy Head of Midwifery, Whipps Cross
Participants	13 (5 couples and 3 additional fathers)

Disclaimer

This report reflects the experiences shared with Healthwatch Redbridge representatives during the visit described, and observations made at the time. It is not a complete or representative account of all patient or staff experiences on Mulberry Ward. Ward information and staffing figures were provided verbally during the visit and have not been independently verified.

About Healthwatch Redbridge

Healthwatch Redbridge is the independent consumer champion for health and social care in the London Borough of Redbridge. We listen to local people's experiences of health and care services and use that insight to help improve them. We have the power to enter and view services, and to share what we find with the people who plan and deliver care locally.

This report is available in other formats on request. Please contact us for details.

Acknowledgements

Healthwatch Redbridge would like to thank all of the families who took the time to speak with us during the visit. Sharing experiences of birth and postnatal care requires trust, and we are deeply grateful to everyone who contributed.

We would also like to extend our sincere thanks to the Whipps Cross Patient Experience Team, the Mulberry Maternity Ward staff and Barts Health NHS Trust for their support and engagement throughout the visit. Their openness and cooperation helped ensure that families were able to share their experiences safely and honestly.

Contents

Executive Summary

Healthwatch Redbridge carried out a visit to Mulberry Ward at Whipps Cross Hospital, part of Barts Health NHS Trust, in early 2026 as part of our ongoing work to understand maternity experiences at the hospital. The visit followed two visits carried out in September 2024 which identified concerns around communication, staffing at night, and cultural sensitivity. Subsequent meetings were held with senior leadership at Whipps Cross Hospital to address our concerns and to act on the findings.

The ward has undergone significant refurbishment since 2024, and the improvements to the physical environment were noted positively – families commented on the privacy offered by individual rooms, and staff noted that the ward felt calmer and better organised.

A number of significant concerns were also raised, several of which are consistent with those identified in 2024. Families described delays in call bell responses, inconsistent quality of care across shifts, and interactions with some staff that were experienced as dismissive or lacking in compassion. In two cases, concerns about babies' wellbeing raised questions about the robustness of monitoring and the quality of communication when clinical issues arose.

Several families also described feeling that responsibility for difficulties in their care was attributed to them at distressing moments. This is a particular concern where families from minority ethnic backgrounds, or those whose first language is not English, may face additional barriers to having their concerns heard and addressed.

The concerns raised during this visit are also consistent with the findings of a number of major national maternity and neonatal enquiries, which highlight systemic challenges around communication, responsiveness, discrimination and basic standards of care across English maternity services.

Healthwatch Redbridge makes eight recommendations aimed at supporting a more consistent, compassionate and responsive environment on Mulberry Ward.

Key findings at a glance:

- The ward refurbishment was welcomed by both families and staff.
- Call bell response times were a consistent concern, particularly at night.
- The standard of care was experienced as variable across shifts.
- Two families raised concerns about monitoring of their babies' wellbeing.
- Families from minority ethnic backgrounds described additional barriers to being heard.
- Basic standards including linen changes were not consistently maintained.
- Partner support – including access to food and reclining chairs – was inadequate.
- Discharge delays caused distress for families who had been on the ward for several days.

Introduction

Healthwatch Redbridge carried out a visit to Mulberry Ward at Whipps Cross Hospital, part of Barts Health NHS Trust, in early 2026 as part of our ongoing work to understand maternity experiences at the hospital. This visit forms part of a longer programme of engagement.

In September 2024, Healthwatch Redbridge was invited by the senior midwifery team at Whipps Cross Hospital to support improvement efforts on Mulberry Ward. Two unannounced night-time visits were carried out, during which patients, partners, and staff shared a wide range of concerns affecting both patient experience and staff wellbeing. These included issues with communication and interpreter access, inconsistent cultural sensitivity, and a serious incident of discriminatory behaviour reported by a patient.

Families also raised concerns about long waiting times, the outdated and cramped ward environment, limited privacy, and inadequate accommodation for partners.
Staff described significant pressures linked to reduced night-time staffing levels, heavy reliance on agency staff, and insufficient clerical support during busy periods.

Clinical safety concerns were also identified, including poor escalation routes, delays in obtaining medical reviews, and the need for staff to physically transport results to the Labour Ward.

These findings formed the basis of the recommendations later reviewed with senior maternity leads and the Patient Experience Team in November 2025.

Progress on these recommendations was delayed during 2024–25 due to changes in senior leadership roles within the maternity service. Several key posts were vacant for a period, and new senior leads needed to be appointed before the follow-up meeting commenced.

Once the leadership team was re-established, Healthwatch Redbridge met with senior maternity leads and the Patient Experience lead in November 2025 to review the original recommendations. During this meeting, the team discussed which actions had been completed, where improvements were visible, and which areas required further work. The visit undertaken in February 2026 was a follow-up assessment after the full refurbishment of Mulberry Ward.

Redbridge is one of the most diverse boroughs in London, with 66.6% of residents from ethnic minority backgrounds and 24.5% for whom English is not a first language. Maternity services need to be responsive to this diversity and equipped to support all families, including those navigating services in their second language or who may face additional barriers to being heard.

The Government's national maternity and neonatal agenda has brought renewed focus to the safety and quality of maternity care across England. The concerns identified on Mulberry Ward need to be understood in that wider context, which is explored in the national context section of this report.

Methodology

Healthwatch Redbridge carried out the visit to Mulberry Ward at Whipps Cross Hospital, part of Barts Health NHS Trust, on Monday 16th February 2026 between 9.30pm and Midnight. The visit was conducted by two Healthwatch Redbridge representatives and was carried out as an unannounced visit supported by the Senior Leadership of Whipps Cross Maternity and the Patient Experience Team. The purpose of the visit was to understand patient and partner experiences during nighttime hours.

Rafat Kiani, Research and Engagement Coordinator, and Donna Young, Project Support Worker, spoke with patients and relatives. Staff were also invited to share their responses, however few were available to be interviewed at that time.

All participants shared their experiences voluntarily and anonymously. No personal identifying information is included in this report. The quotes used throughout are drawn directly from conversations during the visit.

In total, Healthwatch Redbridge representatives spoke with thirteen individuals whilst on Mulberry Ward (5 couples and 3 additional fathers).

Ward Overview

Mulberry Ward contains 40 beds in total, including twelve beds in bays and twenty eight single rooms with ensuite facilities. The ward has fifteen new Cardiotocography (CTG) machines available for foetal monitoring. A new infant feeding lead was appointed in November 2025. Staffing levels were reported as five midwives during the day and five at night.

The ward has recently undergone a significant refurbishment, and the improvements to the environment were evident during the visit and reflected in feedback from both families and staff.

National Context

The experiences shared by families on Mulberry Ward are consistent with the findings of several major national maternity and neonatal enquiries, and it is important to consider them in that light.

The Independent Investigation into Maternity and Neonatal Services in England (Baroness Amos) [LINK]

This investigation published initial reflections in December 2025, followed by an Interim Report in 2026. It identifies recurring themes across English maternity services, including women not being listened to, lack of communication and information when risk profiles change, slow responses to concerns, and the impact of dismissive or judgemental interactions. Families on Mulberry Ward described similar experiences.

The investigation also highlights the disproportionate impact of poor maternity care on women of colour, working-class women, younger parents and those with mental health challenges. This is relevant to the experience of one couple on Mulberry Ward – whose first language was not English – who reported being repeatedly dismissed when using the call bell, spoken to rudely, and having concerns about their baby's health not promptly addressed.

The Thirlwall Inquiry (2024) [LINK]

The Thirlwall Inquiry makes 66 recommendations relating to communication, escalation and timely medical review. Recommendation 42 reinforces that staff must be held accountable for poor behaviours, while Recommendation 52 emphasises the need for the NHS to learn from families' experiences. One couple on Mulberry Ward experienced a prolonged delay in discharge because a doctor was not available to review blood results – a direct example of the escalation and timely review challenges identified by the Inquiry.

The Ockenden Review (2022) [LINK]

The Ockenden Review highlights the need for a culture where staff feel empowered to escalate concerns, and for timely access to medical review. Local Action for Learning 36 emphasises the use of standardised communication tools such as SBAR.

The NHS England Interpreting Services Improvement Framework (2025) [LINK]

This Framework notes that failures in interpreting provision have contributed to avoidable harm, referencing evidence that inadequate interpreting services have been linked to serious adverse outcomes. Although interpreting was not raised as a direct concern during this 2026 visit, the 2024 Mulberry Ward report highlighted communication difficulties for families whose first language is not English. This remains relevant given Redbridge's diverse population.

Taken together, these national enquiries reinforce the seriousness of the concerns raised during this visit and demonstrate that the issues identified on Mulberry Ward reflect wider systemic challenges across English maternity and neonatal services.

Key Findings

Findings:

Ward Environment

The refurbishment of Mulberry Ward was welcomed by families and staff. The ward appeared clean and well-maintained. Corridors were tidy and equipment was stored to one side. Facilities including a milk room were available, and signage was visible throughout.

A midwife spoken to briefly during the visit described the ward as generally quieter and calmer since the refurbishment, with equipment better organised and easier to locate. She noted that patients had given positive feedback about the privacy offered by individual rooms.

Families echoed this, with the availability of single rooms noted positively. However, one couple recovering from a caesarean section said they were declined a side room despite seeing what appeared to be empty rooms nearby, with no clear explanation given.

One couple arrived to find their assigned room had a broken door, described as a known and ongoing issue. A disagreement between the midwife in charge and a porter preceded their move to another room, which then had a heating fault and required a portable heater.

While the refurbishment represents a significant improvement, these experiences indicate that some facilities and maintenance issues remain to be resolved.

Key Findings

Findings:

Communication and Responsiveness

Concerns about communication and responsiveness were raised consistently across the visit and affected families at different stages of their care.

Several families reported delays in call bell responses and described some staff as appearing unwilling to engage when they did attend. One father, after seeking help, was asked: "Are you in a rush or are you running away?" – a comment the family found difficult.

One couple described a noticeable drop in the standard of care following a shift change. Their allocated midwife was described as unhelpful, though another midwife later provided the support they needed. Inconsistency between staff members was a recurring theme, with families describing a mixture of attentive interactions alongside encounters they found dismissive or abrupt.

"Some staff were kind and supportive while others were rude or dismissive."

"Some midwives were helpful, others were not."

One couple had a particularly difficult experience during triage and admission. After attending twice – the first time being sent home, the second time returning due to anxiety – they felt their emotional state was not adequately recognised. The wait in triage involved sitting in uncomfortable chairs, which they understood as a capacity issue, but found difficult to reconcile with being admitted to a ward where several rooms appeared to be empty.

Across the visit, a clear theme was that families wanted to be listened to, kept informed, and given honest explanations when things were delayed or subject to change.

Key Findings

Findings:

Monitoring and Clinical Safety

Two accounts raised concerns about the monitoring of babies and the communication of clinical information.

In the first, a couple described their baby developing a rash which was initially assessed as normal. It was not until three days later that the baby was assessed for jaundice. National guidance consistently emphasises the importance of taking families' concerns seriously and conducting timely observations, and this account represents a notable departure from that standard.

In the second, a couple whose baby was delivered by emergency caesarean section described a series of events they found distressing. After their waters broke, they were given the option to wait before induction, which they chose. They were told to return within 24 hours to receive antibiotics. When they returned and were booked for induction, the administration of antibiotics was not treated with urgency, despite the family raising this. The mother had not been offered appropriate pain medication until she sought advice from a midwife she knew personally and asked for it directly.

The induction was carried out several hours after the scheduled time. The baby was found to be in distress, and an emergency caesarean was performed. The baby did not breathe independently for three minutes and was admitted to NICU.

When the parents asked for an explanation, they were told the outcome had occurred because they had declined immediate induction at first attendance. They considered this account to be inaccurate and felt that responsibility was being attributed to them at a moment of significant distress. They felt strongly that concerns about patient safety had not been adequately addressed during their care.

"We felt blamed and judged at what was an already distressing time."

These accounts raise questions about escalation, monitoring and the culture of accountability on the ward.

Key Findings

Findings:

Dignity, Respect and Equality

Several families described interactions in which they felt they were not treated with the dignity and respect they were entitled to.

One couple described an encounter with a receptionist they experienced as aggressive and dismissive. The father reported witnessing the same staff member behave in a similar manner towards a pregnant woman with children. This experience caused significant distress and anxiety for the couple, despite the positive clinical care they had otherwise received from midwives.

The experiences of the couple whose first language was not English are particularly notable. They reported being repeatedly dismissed when using the call bell, spoken to rudely, and having concerns about their baby's health not promptly addressed.

Taken together, these experiences suggest they may have faced additional barriers because of their background. This is consistent with the findings of the Interim Baroness Amos investigation report and other national enquiries, which document the disproportionate impact of poor maternity care on families from minority ethnic communities.

One couple described feeling under pressure to breastfeed within two hours of delivery. In the context of a high-risk pregnancy and emergency C-section, they experienced this as insufficiently sensitive to their situation.

Partner and Family Support

Fathers and partners spoken to during the evening visit described their overall experience on the ward as broadly positive, though they shared concerns about call bell delays and linen changes. All three fathers spoken to individually felt that, despite these issues, they were able to support their partners and newborns.

A number of practical concerns were raised affecting partners' ability to remain on the ward. Food was not available to partners, meaning they had to leave to eat – in one case, after 8pm when hospital catering was closed, a father had to leave the site entirely. The suggestion was made that a payable option for partners would be a reasonable and welcome addition.

Reclining chairs for partners were available on request but were not present in rooms as standard. Families suggested these should be provided in all rooms as a matter of course.

Key Findings

Findings:

Basic Standards of Care

Several families reported that bed sheets had not been changed for multiple days. This was raised by both couples spoken to during the evening visit and mentioned independently by all three of the fathers. Basic standards of comfort and hygiene are important to the overall experience of care, particularly for women recovering from surgery.

Discharge

One couple described a prolonged delay in discharge which they attributed to difficulty in locating a doctor to review blood results. This caused significant frustration, particularly as they had already been on the ward for several days. The couple felt that clearer communication about expected timeframes and more reliable access to medical review for discharge would have made a significant difference to their experience.

Recommendations

Based on the experiences shared during this visit, Healthwatch Redbridge makes the following recommendations to Barts Health NHS Trust:

1. Improve responsiveness and nighttime support

Review nighttime call bell response times to ensure women recovering from labour or surgery receive timely assistance. Where delays are unavoidable, staff should proactively explain the situation and reassure families.

2. Strengthen communication throughout care

Provide clear, consistent updates about next steps, changes to care plans, and expected timeframes for reviews or discharge. Ensure staff take time to listen to and acknowledge concerns, and that families are given honest explanations rather than reassurances that leave questions unanswered.

3. Ensure consistent monitoring when concerns are raised

When families raise concerns about a baby's wellbeing, monitoring should continue until concerns are properly addressed. Clear explanations should be given about why monitoring is paused, continued or changed.

4. Promote respectful and culturally sensitive interactions

Reinforce expectations for professional, respectful behaviour from all staff, including reception teams. This should include refresher training in compassionate communication and cultural sensitivity. Language or tone that is dismissive, abrupt or attributing of blame is not acceptable at any stage of care.

5. Maintain basic standards of care

Introduce a structured approach to checking and refreshing bed linen, to support the comfort and dignity of women on the ward – particularly those recovering from surgery.

6. Improve discharge coordination

Review medical staff availability to reduce delays in discharge, and ensure families are given realistic, up-to-date information about expected timeframes for reviews and results.

7. Improve partner and family support

Provide reclining chairs as standard in all rooms and explore options to ensure partners can access food without needing to leave the ward, particularly in the evening.

8. Increase awareness of post-birth support options

Ensure all families are informed about their right to request a birth reflection meeting and how to access it, so that those who wish to discuss their experience have a clear route to do so.

Conclusion

The refurbishment of Mulberry Ward is a visible and welcome improvement, and there were examples of kind, attentive care shared during the visit. However, the concerns raised – about responsiveness, communication, monitoring, dignity and basic standards – are significant, and in several cases are consistent with those identified in the 2024 report. The fact that similar themes are also reflected in major national maternity enquiries underlines the importance of addressing them with sustained commitment.

Next Steps & Engagement

Healthwatch Redbridge submitted our initial findings to Barts Health NHS Trust in March 2026. Upon receipt, Barts Health promptly escalated the urgent findings identified during the visit and has begun to address the recommendations put forward (Please see Addendum below). We recognise and appreciate Barts Health's openness and willingness to engage with the issues highlighted, as well as their transparent approach in responding to the concerns raised.

Addendum

Escalated Concerns and Follow-up Actions

Following the visit to Mulberry Ward in February 2026, several concerns were raised directly by patients and partners that required urgent attention. Healthwatch Redbridge shared these findings with the Maternity Team and the Patient Experience Lead. The actions taken in response are summarised below.

1. Delayed Call Bell Responses

Concern:
All couples reported prolonged waits for assistance during the night. Some staff were perceived as irritated or disengaged when responding, causing distress for women recovering from caesarean sections who were unable to mobilise independently.

Action Taken:
A focused audit of call bell response times has been initiated to identify variation between day and night. The Maternity Team has been asked to incorporate this into the routine audit schedule for the ward. Since February 2026, there has been additional recruitment of 5 Maternity Support Workers and 3 Preceptorship Midwives."

2. Inconsistent Delivery of Basic Care

Concern:
One couple reported that their bed sheets had not been changed for three days. Three additional fathers also noted delays in linen changes. These issues contributed to feelings of neglect and discomfort.

Action Taken:
Themes relating to communication and expectation setting have been identified. These are now being incorporated into monthly development days to support more consistent delivery of basic care. Throughout the day, there has been an increase in comfort rounds, and there is now additional information available to patients on how to request a bed change.

3. Delay in Recognising Potential Jaundice in a Newborn

Concern:
A baby with an initial rash was described as “fine”, but three days later the parents were informed that the baby required assessment for jaundice. This delay caused the parents significant anxiety.

Action Taken:
A clinical review was undertaken, confirming that the newborn’s care followed expected pathways, with appropriate investigations and follow up completed.

Addendum

4. Dignity, Respect and Inclusion – Reception Staff Behaviour

Concern:
A father reported feeling targeted by the entrance receptionist and witnessed the same staff member verbally abusing a pregnant woman with children.

Action Taken:
The concerns regarding the receptionist's behaviour have been escalated locally and are being managed through Human Resources processes.

Barts Health NHS Trust Response

The following response was provided by Shahida Trayling, Director of Nursing & Governance, Barts Health NHS Trust, following receipt of this report.

We welcome Healthwatch Redbridge's continued partnership and the opportunity to reflect on the experiences of women, birthing people, partners and families who took part in the February 2026 visit. The report highlights both improvements and, sadly, several areas where our service has fallen short of the standards we expect for safe, compassionate and equitable maternity care.

Since the February visit we have seen a decline in negative Friends and Family Test (FFT) feedback relating to care at night. Our positive satisfaction score is 94%, with a response rate above 95% — reflecting the significant work of the team and the impact of development days focused on customer care. We have also been onboarded onto the national Perinatal Equity and Anti-Discrimination Programme (PEADP) to strengthen support for families whose first language is not English, and have made significant progress towards Bronze accreditation under the Capital Midwife Anti-Racist Programme.

We acknowledge the concerns raised and take them very seriously. We would welcome working with Healthwatch Redbridge on a co-produced action plan to ensure sustainable improvements for the communities we serve.

Improvements implemented since February 2026, against each recommendation:

1. **Improve responsiveness and night-time support —** A full-time ward manager now provides senior oversight. We have five midwives on each day and night shift, and since February have recruited five maternity support workers, three preceptorship midwives and three safety flow co-ordinators to strengthen escalation and responsiveness. Our FFT response rate is above 95%, with a significant decline in negative feedback on care at night.
2. **Strengthen communication throughout care —** We have revised our postnatal checklist and introduced checklist boards on the ward.
3. **Ensure consistent monitoring when concerns are raised —** The ward manager is now available throughout the day for any escalations.
4. **Promote respectful and culturally sensitive interactions —** We have undertaken extensive equality and diversity work, including national programmes and quality improvement to reduce disparities for communities who experience them, and have "Language on Wheels" interpretation available 24/7.
5. **Maintain basic standards of care —** We have increased comfort rounds and introduced visible information on how to request bed changing when required.
6. **Improve discharge coordination —** We have recruited additional doctors to improve cover, and updated our newborn checklist so families do not wait unnecessarily before discharge.
7. **Improve partner and family support —** Six recliner chairs have been ordered and delivered since February.
8. **Increase awareness of post-birth support options —** Our Consultant Midwife who leads Birth Reflections clinics has updated a poster visible to all women, birthing people and families, and a debrief has been added to the postnatal checklist so people have the opportunity to discuss their birth before leaving hospital.

Barts Health NHS Trust Response

Points of clarification

- CTG machines: the ward has **[figure to confirm]** new CTG machines for foetal monitoring.
- Newborn rash and jaundice: the rash described was clinically assessed as erythema toxicum, a common newborn rash requiring no treatment. The jaundice subsequently observed can also be normal in newborns; the two conditions are not linked. A clinical review confirmed the baby's care followed expected pathways.
- Entrance staff: the staff member referred to in the report was verified as a security officer.

Healthwatch Redbridge

Redbridge Institute of Adult Education
Gaysham Ave, Gants Hill Cres, Ilford IG2 6TD

Website: www.healthwatchredbridge.co.uk

Telephone: 020 8553 1236

Email: info@healthwatchredbridge.co.uk

Facebook: Healthwatch Redbridge

X/Twitter: @hwredbridge

Instagram: @healthwatchredbridge

LinkedIn: Healthwatch Redbridge

Bluesky: @healthwatchredbridge.bsky.social

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