healthwatch
Nottingham & Nottinghamshire

Culture and Care Review: Priory Hospital Arnold

A Review of Culture and Patient Experience

Who is Healthwatch Nottingham & Nottinghamshire?

Healthwatch Nottingham & Nottinghamshire is the local independent patient and public champion. We hold local health and care leaders to account for providing excellent care by making sure they communicate and engage with local people, clearly and meaningfully, and that they are transparent in their decision making. We gather and represent the views of those who use health and social care services, particularly those whose voice is not often listened to. We use this information to make recommendations to those who have the power to make change happen. This is a part of our statutory role under Regulation 44 of The NHS Bodies and Local Authorities Regulations 2012.[1]

Why is it important?

You are the expert on the services you use, so you know what is done well and what could be improved. Your comments allow us to create an overall picture of the quality of local services. We then work with the people who design and deliver health and social care services to help improve them.

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**Artificial intelligence (AI) was used to cross-check themes and support the editing of this report. All raw patient data was fully anonymised. All final insights were verified by human authors.*

[1] The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, UK 2012

Contents

1 Executive Summary

Following a fatal incident in December 2022, Priory Hospital Arnold (PHA) underwent comprehensive structural and leadership changes. This Culture and Care Review was specifically commissioned to evaluate whether these high-level operational improvements have successfully embedded within the daily lived experience of the patients on the wards.

The review reveals a divergence between physical security and clinical culture. PHA has achieved robust mechanical safety compliance, demonstrating adherence to protocols regarding locks, mirrors, and alarm systems. Most of the staff who took part in this review felt able to raise concerns with managers and were confident these would be acted on and handled fairly. However, over half of the patient participants explicitly stated they did not know about Martha's Rule (the right to an urgent second opinion) and the staff also had limited knowledge of it.

The hospital's patient relational safety culture remains in a state that could be improved. While staff often view the environment as secure, patients report a different reality, sometimes characterised by a lack of trauma-informed engagement, particularly during night shifts when oversight is perceived to diminish. A recurring theme was patients feeling their concerns were not consistently listened to or acted on. In one detailed account, a patient described their physical pain being dismissed as part of their mental illness.

This suggests that while the physical and policy changes to safety have been made, the everyday culture of listening to patients, believing them and responding still varies across wards and shifts.

The review makes six recommendations, the two most urgent being a proper record of physical comfort with independent clinical review, and stronger senior oversight of the night shift, with four further recommendations covering Martha's Rule, cultural curiosity, advocacy access and relational handovers.

2 Introduction and Background for Review

In June 2026, Healthwatch Nottingham and Nottinghamshire (HWNN) was commissioned by the Nottinghamshire Safeguarding Adults Board (NSAB) to conduct an independent Culture and Care Review at Priory Hospital Arnold (PHA). While hospitals are regularly audited on their paperwork and clinical outcomes, this Culture Review is different. Its goal is to look beneath the surface to understand the lived experience of the people on the wards: the patients, the frontline staff, and families who support them.

2.1 The Catalyst: Learning from the Past

This review was prompted by a serious incident in December 2022 involving a patient leaving the hospital without authorisation, ultimately leading to their death. As referenced in a Nottinghamshire Safeguarding Adults Board (NSAB) report[2], a subsequent Safeguarding Adult Review (SAR – not publicly available) was carried out to identify gaps in how the hospital operated at that time and to implement practice changes. NSAB wanted to check whether PHA's new safety measures were not merely policies but were actually changing in practice how patients felt on the wards.

2.2 The Hospital's Role in the Region

PHA is a private mental health facility, but it plays a crucial role in the local NHS system. It provides Acute and Psychiatric Intensive Care Unit (PICU) beds primarily for patients funded by the Nottinghamshire Healthcare NHS Foundation Trust (NHFT). Because the local NHS Trust often lacks enough of its own specialist PICU beds, PHA is a key destination for local people in the middle of a severe mental health crisis.

[2] **Report to Adult Social Care and Public Health Select Committee**, Nottinghamshire Safeguarding Adults Board (NSAB) 2024

This review took place during a time of scrutiny for mental health services across Nottinghamshire. Following high-profile safety failures in the region, the Care Quality Commission (CQC) conducted a special review of local services in 2024.[3]

2.3 National Drivers for Change

Two major national policies shaped the focus of the visit:

Martha's Rule: Launched nationally in 2024, this policy gives patients and their families the right to an urgent second opinion from a different clinical team if they feel their concerns are being ignored and the patient's condition is worsening.[4] This data collection checked if this safety net was available and known to patients at PHA.

The Patient Carer Race Equality Framework (PCREF): This is a national mandate to ensure that patients from minority ethnic backgrounds receive equal care, as they are more likely to receive poorer quality of care and/or less access to services.[5] [6]

2.4 The Approach: Measuring "Soft" Safety

Since the 2022 incident, Priory Arnold has invested heavily in "hard" safety of physical changes like new airlock doors, anti-tailgating signs, and mirrors to eliminate blind spots. While these are important, national guidance from the CQC on "Closed Cultures" warns that an over-reliance on locks and security can sometimes make a hospital feel more like a prison than a place of healing.[7]

This review used the Manchester Patient Safety Framework (MaPSaF) [8] to explore if the hospital had moved from a "Reactive" culture (only fixing things after they break) to a "Generative" culture (one that actively listens and learns). The analysis looked for Trauma-Informed Care, which asks, "*What happened to you?*" rather than just "*What is wrong with you?*". When a patient speaks up, are they believed?

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[3] **Special Review of Nottinghamshire Healthcare NHS Foundation Trust**, Care Quality Commission (CQC) 2024

[4] **Martha's Rule: Implementation and Pilot Sites**, NHS England 2024

[5] **Patient and Carer Race Equality Framework (PCREF)**, Nottinghamshire Healthcare NHS Foundation Trust

[6] **State of Care 2022/23: Inequalities in Care**, Care Quality Commission (CQC) 2023

[7] **Guidance on Identifying and Responding to Closed Cultures**, Care Quality Commission (CQC)

[8] **The Manchester Patient Safety Framework (MaPSaF)**, NHS England

By combining survey data, in-depth interviews, and independent observations, this report aims to tell the story of Priory Hospital Arnold in 2026.

2.5 Safeguarding

About this review and how we protect people

This review looked at people's experiences of care, safety and culture at PHA, based on an independent visit on 9 June 2026. It is not an inspection, an audit, or an investigation into individual or past events. It is a picture of what people told us and what we saw on one day. Because it is a snapshot, it reflects the experiences of the people who chose to take part at that time. It may not represent everyone's views, or the service as a whole, on other days or other times of the day.

Ahead of the visit, we asked the hospital to identify patients who had the capacity to take part, and we spoke with patients on that basis. Everyone we met was invited to take part, and not everyone chose to, which was their right. Everyone who did take part was happy to.

Some people told us about things they felt were still happening or had happened before. We have included what they said, in their own words, as their account. Our role is to listen and pass on what people tell us, not to look into individual cases.

People spoke to us because they trusted us to protect their anonymity. We have kept the details in this report general, to minimise the risk of individuals being identified.

3 Methodology

3.1 Overview of the Concurrent Triangulation Design

To provide the Nottinghamshire Safeguarding Adults Board (NSAB) with a robust and balanced evaluation, this review utilised a Concurrent Triangulation Design. This is a mixed-methods approach that involves the collection and analysis of three separate data streams. By analysing multiple sources, the aim is that the final findings are not dominated by a single perspective but are instead rooted in a cross-verified reality of ward life.

The three pillars of this design, Quantitative (the survey numbers), Qualitative (what people said in their own words), and Observational (what our team saw on the wards), act as a system of checks and balances, allowing identification of areas where PHA policies align with or diverge from patient and staff experiences.

3.2 Participant Profile and Demographics

Total Population: 39

- **Age:** 48% (19 out of 39) of the population are aged 18–35
- **Gender:** 61.5% (24 out of 39) of the population are female
- **Ethnicity:** 71% (28 out of 39) of the population are White British
- **Participation:** 33.3% (13 of 39) of patients at Priory Arnold participated in the survey or interviews

3.3 The Quantitative Pillar: Survey Trends

The quantitative analysis focused on identifying high level trends across the hospital's four wards (Newstead, Bestwood, Clumber, and Rufford).

Data Source

10 total survey responses (Patient $n = 3$ and Staff $n = 7$).

Note: Three groups of visiting families were invited to share their views. The survey was open for the full week of the visit and extended to the Tuesday morning with the provider's agreement. However, no completed family surveys were received.

Framework

1–5 Likert scales were used. This is a rating system used to measure opinions, beliefs, and attitudes. It asks people to show how much they agree or disagree with a statement. The surveys used these scales to measure core safety domains, including physical safety, night-shift responsivity, handover confidence, and management support.

Function

The survey numbers acted as a quick way to check the hospital's culture. For example, six out of seven staff who responded believed that security changes had improved ward safety, while one of three patients surveyed said they still felt unsafe or uncomfortable. This gap between how staff and patients judged the same aspect of safety showed where to look more closely in the interview data. It helped measure the difference in how the hospital is seen by the people giving the care versus the people receiving it.

3.4 The Qualitative Pillar: Thematic Narrative

While the surveys highlighted *what* was happening, the qualitative analysis of the 10 in-depth patient interviews provided context and detail about *why* and/or *how*.

Data Source

10 semi-structured interviews representing 25.6% of the current patient population.

Framework

Analysis followed Braun & Clarke's Six-Phase Thematic Framework.[9] This process involved reviewing interview notes and applying codes.

- **Deductive Coding:** Evidence based on pre-identified themes was highlighted.
- **Inductive Coding:** New themes emerged directly from the voices of the patients. For example, stories about how safe patients feel around the staff, including examples of when they felt respected and times when they felt ignored.

[9] **Using thematic analysis in psychology**, V. Braun and V. Clarke 2006

Function

In line with best practices for small-sample mental health research, the focus was on the depth and consistency of narratives to draw out themes. For example, when more than one patient from different wards independently described loudness at night, the theme was weighted as a systemic finding rather than an isolated incident.

Note: In this review, a single incident was not viewed as an outlier just because it happened to one person. Instead, it is highlighted as a specific incident that reveals or may suggest a failure of the safety net.

3.5 The Observational Pillar: Independent Verification

To ground the subjective reports of staff and patients, five independent HWNN Authorised Representatives (AR) provided narrative records of the visit.

Data Source

5 sets of AR observations, including a live observation of a Multi-Disciplinary Team (MDT) ward round and airlock security transitions.

Framework

ARs were tasked with observing the Security of the ward. This included:

- **Mechanical Compliance:** Verifying if staff actually stopped to check mirrors and lock doors in the airlocks.
- **Environmental Cues:** Notes on the observed vaping in communal areas and the "*tense and uncomfortable atmosphere*".
- **Clinical Curiosity:** Observing whether staff interactions were task-focused (checking a box) or person-centred (sitting down to speak with a patient).

Function

This provided the independent eye to verify if the changes and physical improvements had actually resulted in a corresponding shift in ward atmosphere.

3.6 Synthesis and Triangulation

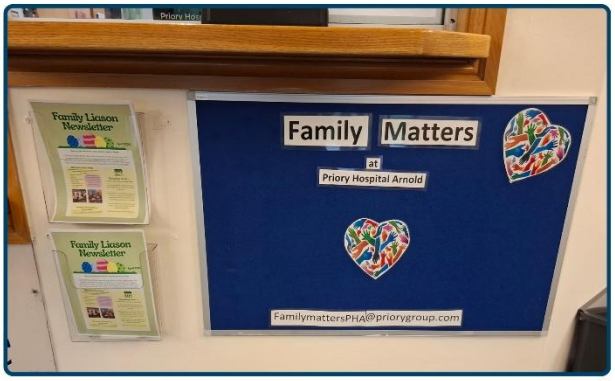
The final analysis phase involved merging these three streams into the Triangulation Matrix. Data was explored in the context of the statutory requirements of the Mental

Health Act Code of Practice and the clinical standards set by NICE.[10] [11]

Findings were noted as aligned or divergent, with notes on how, and any related risks. These form the basis of the RAG table and recommendations. They represent the areas where management oversight may not be addressing the patient's lived reality.

3.7 Limitations and Weighting

- **Small Sample Size:** With 10 patient interviews and 10 surveys (seven staff, three patient), the findings need to be read in that context and considering the sample size, responses may not be fully representative across wards and shifts.
- **No ward or shift identifiers:** The staff survey did not capture ward or shift, so responses cannot be broken down that way. We cannot say where views differ.
- **Candour Bias:** (whether people felt able to speak freely). ARs noted staff presence during at least three of the 10 patient interviews. The patient's ability to speak freely may have been limited by this, albeit staff presence was necessary for safety reasons.
- **Daytime, single visit:** Observation took place during the day only, so night-time practice, which several of the concerns relate to, was not directly observed.
- **Admin Inflation:** Of the 7 staff respondents, 3 identified themselves as "Admin" roles. One of these respondents rated safety as "Very Safe" while explicitly stating they "*do not work on the wards*." Therefore, safety metrics may be inflated by staff who do not witness ward-level subcultures or night shifts.
- **No family responses:** The family survey received no responses, so family experience is not represented. The hospital did and does make efforts to engage families, and we saw a family liaison contact and newsletters on display.



[10] **Mental Health Act 1983**: Code of Practice, Department of Health and Social Care 2015
[11] **NICE Guideline NG27**: Transition between inpatient mental health settings and community or care home settings, National Institute for Health and Care Excellence (NICE) 2015

4 Summary of Findings

Five core themes were identified that define the current culture at Priory Hospital Arnold. While the hospital has made significant strides in improving its physical security, there is, at times, a difference between how staff perceive safety and how patients actually experience it.

4.1 Environment and Institutional Openness

While this review identifies multiple areas for improvement, the data also revealed areas of cultural strength. The hospital operates under a physical and professional environment that many patients and staff value.

Patient Perspective

Over half of the total participants (7 out of 13) spoke positively about the individual care they received from specific staff, as well as the quality of the hospital environment. One patient described staff as *"kind and respectful"* and noted that the ward doctor was *"amazing."* Another noted that staff *"do try to help you"* and felt that respect was a two-way street. One patient expressed a strong sense of belonging, stating they *"love the ward"* and that staff always have a plan to help when they feel triggered. For these patients, the presence of a consistent, familiar staff team provided a vital sense of security. It is important to note that some patients with positive feelings for particular staff did highlight concerns with others.

> "Staff are kind and respectful...the doctor here is amazing."
>
> *– Summary quote from patient interview*

Staff Perspective

Quantitative data showed an exceptional level of consensus regarding leadership, with six out of seven staff respondents feeling "Very Supported" by their line manager.
All seven staff respondents indicated they feel very comfortable raising concerns with management, and all seven expressed confidence that the hospital would act upon these concerns fairly.

Qualitative comments highlighted the reduction in agency staff and the end of the previous "clique" culture. As one staff member put it: *"Much more of a team nowadays and open culture. Staff are encouraged to share ideas and ask questions."* Another noted that the rare use of agency workers has made it much easier to embed new safety standards and rules of practice, as the permanent team now has a shared sense of ownership over the ward culture. Five out of seven staff respondents reported working at the hospital for over two years, a further reflection of workforce stability.

Observation

ARs consistently praised the physical therapeutic environment, describing wards as "*light, airy*," and "*very clean*." Fresh decoration has successfully removed the cold, formal feel often found in secure settings.

The HWNN team also observed a high level of institutional openness during the visit. Staff were fully cooperative with the review process, facilitating unrestricted access to all areas. A member of staff accompanied the Visit Lead on a comprehensive walk-around of each ward, introducing them to patients in communal areas and knocking on bedroom doors to ensure those who were out of sight were given an equal opportunity to participate.

Summary

The hospital has successfully created a stable, high-quality physical environment and a workforce that feels valued and supported by leadership. This stability has fostered moments of genuine connection and trust between staff and patients. The openness with which the hospital approached this independent review serves as a positive indicator of a culture that is willing to be transparent and learn from external feedback.

> "They help straight away and always have a plan. I love the ward."

– Summary quote from patient interview

4.2 The Night Shift Dip

This review found that a "Night Shift Dip" remains an issue, where the professional standards of the day shift can give way at times to a more disrupted evening setting. This pattern is consistent with concerns identified in the SAR as referenced in section 2.1.

Patient Perspective

All survey respondents (three out of three) rated the night worse than day. The 10 patient interviews provided a more varied picture. Of the five patients who explicitly discussed the night shift, four provided negative accounts regarding noise, rowdiness, or staff behaviour. The other said the problem they had faced was resolved after the person involved was removed, and they now feel safer.

A common theme among these reports was that staff members chatting in hallways at night prevented sleep. Some patients described the atmosphere during the night shift as *"rowdy,"* with drug-seeking behaviour and loud music going unchecked by staff.

"Staff are sat all night in the hallway chatting loudly and laughing with each other while people are trying to sleep"

– Summary quote from patient interview

Staff Perspective

The survey data shows a split in perception within the workforce. While four out of seven staff respondents reported "no difference" between day and night, three out of seven admitted that a "slight" or "significant" difference in ward culture exists. As one staff member noted: *"Not all information seems to be handed over correctly; in morning meetings information can be brief, and important things seem to be missed."*

Observation

During the visit, ARs did not observe night shift care. In the day, they observed a highly organised and calm environment where incidents were managed professionally. However, even during these hours, there were signs of rule-softening that could easily escalate at night. On one ward, AR notes reflected that patients seemed on edge because individuals who had been violent earlier that day were allowed to be among their peers. This daytime tension is combined with the patients' detailed accounts of night-time noise and rowdiness.

Summary

Taken together, patient accounts point to a recurring dip in responsiveness at night, where monitoring can take precedence over meaningful engagement. Staff may be prioritising observation tasks over interaction (like the 15-minute 'Level 2' checks defined in the Mental Health Act Code of Practice) [10 above], which risks leaving some patients feeling unsafe and unheard during the night. The team did not observe night-time care directly, so this finding rests on patient accounts, consistent with concerns raised in the SAR as referenced in section 2.1.

4.3 The Struggle to be Believed

In mental health research, Epistemic Injustice occurs when a person's status as a patient causes staff to dismiss their valid concerns as symptoms of their illness. This review found that this remains a cultural barrier at PHA, in tandem with lack of awareness and understanding of Martha's Rule.

Patient Perspective

Across three different wards, four out of thirteen total participants described experiences where their concerns or desire to be involved in their care were ignored because they felt they are viewed only through the lens of mental illness. One mentioned being unfairly left off the list to meet with The Independent Mental Health Advocate (IMHA). One patient described being left in severe physical pain over a sustained length of time, and said staff did not believe the level of their pain, treating their distress as part of their mental illness.

One patient also described their cultural needs being assumed from their appearance rather than asked about. This is the kind of concern the Patient and Carer Race Equality Framework (PCREF) is designed to prevent.

> "Sometimes they listen, sometimes not"
>
> *– Summary quote from patient interview*

Awareness of Martha's Rule was low across the participant group. Out of 13 total participants, seven (five interviewed and two surveyed) explicitly stated they had "no knowledge" of the right to a second opinion. For four participants, awareness could not be determined as they did not mention the rule and were not asked directly. Only two participants (one interviewed and one surveyed) confirmed they were aware of the rule and had been informed about it by the hospital. The reactions from those who were unaware were notably significant. Several patients immediately made notes to follow up, with one even returning to the room specifically to check the details so they could use it.

Staff Perspective

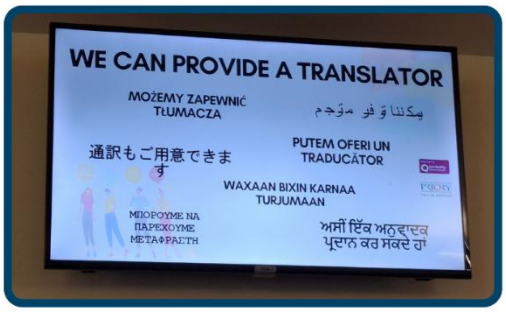
Quantitative data from staff suggests a workforce that believes it is highly responsive, with four out of seven respondents stating that safety concerns are "taken seriously and explored." All seven reported that their current workload "always" or "often" allows them to provide safe, high-quality care. However, their written comments give a more nuanced picture. One staff member said that while they want to provide person-centred care, current staffing levels and heavy workloads make it *"hard to facilitate all patient needs"* and engage in deep conversation. Another framed this as a problem of resource rather than will: *"Unfortunately, mental health is underfunded, so the obvious but unattainable: more staff and more time with patients."*

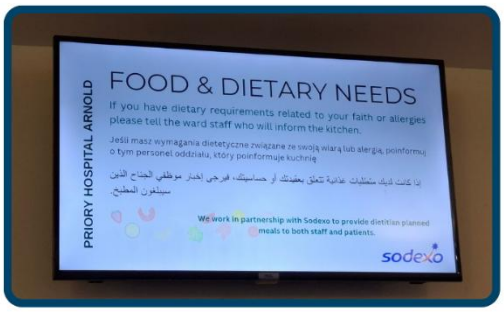
This indicates that the high safety ratings from staff may be based on their successful completion of mechanical protocols, such as door locking, rather than on a deeper clinical curiosity about why a patient is distressed. For staff, listening may often be constrained by the pressure to move to the next task, so that patient concerns can be unintentionally dismissed as symptomatic behaviour rather than treated as urgent clinical information. This is further reflected by the fact that six out of the seven staff respondents wrote *"more staff"* as the single thing they would change to make the ward safer.

The majority of staff were also unfamiliar with Martha's Rule or needed more information about it. Five responded "no" and two were "not sure" when asked whether they had received any training or briefing on Martha's Rule during their time at Priory Arnold. This suggests that while the policy exists, it is not yet embedded in training, nor has the verbal communication of escalation rights become a standard part of the patient experience.

Observation

ARs observed that staff were pleasant and all noted that staff seemed to know patient names and engage with them relationally. However, some noted lack of curiosity during routine ward life. The team also saw that information supporting cultural and religious inclusion was on display, including a PCREF poster setting out the hospital's commitments, and reception displays offering translation in several languages and inviting patients to share their faith or dietary needs. The framework and information were visibly in place.





Summary

Where a patient's needs fall outside of psychiatric treatment, such as physical pain, some described a struggle to be believed. These were individual accounts, but serious ones, sitting alongside a wider theme of concerns not always being listened to or acted on. On cultural care, the framework and information are in place, but in the account, we heard they did not reach the individual, so the work now is embedding them consistently in day-to-day practice.

4.4 Handover Integrity

While PHA has a new handover policy, analysis of this Culture Review shows that vital relational details can still be lost.

Patient Perspective

One patient missed a ward round due to an off-site appointment. The following week, staff referenced "*last week's notes*" as if the patient had been present and interviewed. This suggests that some clinical notes may be copied over rather than reflecting actual interaction.

Other patients spoke of inconsistency, where staff responsiveness depends entirely on the individual personality of the person on shift. One patient described how staff would promise to address a concern only to later act as if the conversation never happened. These inconsistencies could suggest a risk that care can become task-led rather than person-centred.

> “Staff promise they're doing something but then don't and act like they don't know what you're talking about.”
>
> *– Summary quote from patient interview*

Staff Perspective

Numerical data from the seven staff survey respondents reveals a significant lack of agreement regarding the reliability of shift handovers. Only one staff member reported being "Very Confident" that vital patient information is consistently transferred. In contrast, three out of the seven respondents identified inconsistencies in the process, stating either that the policy is "not always consistently followed" or that the quality of the handover "depends on the nurse" on shift.

As noted by staff regarding morning briefings, the brevity of meetings often leads to items being missed. Another noted: *"More time is needed for a more in-depth handover."* Without sufficient time, handovers focus only on the basics, missing highlights like who needs comforting about their medication levels, safety, or specific physical health updates.

Observation

ARs observed that while ward rounds could be inclusive, the overall environment could also be "*hectic*," with staff interactions appearing "*very task-focused*" rather than exploratory. This was underscored by a clinician's admission during an observed ward round that *"staff don't have time here to develop a relationship"* with patients due to the high-pressure environment.

Summary

Data showed indications of a culture where the routine completion of paperwork may be prioritised over the meaningful exchange of information. Policies exist on paper, but the quality of information sharing is inconsistent. If staff are under too much pressure to

perform deep handovers, they may rely on brief summaries that miss the human context. The risk is that crucial information about a patient is missed between shifts.

4.5 Physical Security vs. Relational Dignity

The hospital has invested heavily in hardware: mirrors, airlocks, and extra locks. While six out of the seven staff respondents feel these changes have "definitely" made the ward environment safer, patients feel differently. Six out of the thirteen total patient participants indicated that they did not feel safe or expressed specific safety concerns during their stay.

Patient Perspective

Privacy is lacking, according to some patients. One patient described singing songs in the bathroom to prove they were safe while staff looked away. One patient felt their privacy had not always been protected, though they said this had improved over time. They wanted more time alone, particularly when showering.

There was an expectation voiced by one patient that expected the ward to be a *"jungle"* but they were pleasantly surprised by the fresh decoration, though another patient argued staff are merely *"keeping"* patients rather than caring for them. During a ward round, a patient reported to our team that they had asked a staff member to step back and give them more space during observations. The staff member declined, and the patient, already in distress, said they wanted to hit them. The staff member replied, *"go on then."* The patient said they felt deliberately provoked. Close observation levels are set for individual safety reasons, but this exchange was experienced as antagonistic rather than protective.

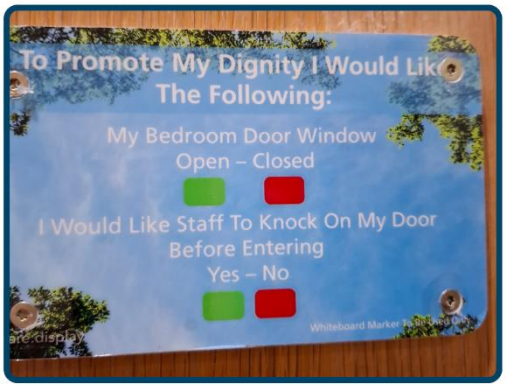
Staff Perspective

Staff numerical data reveals a high level of confidence in the hospital's physical safety measures, with six out of the seven respondents rating the environment as "Quite safe" or "Very safe" following the implementation of the new airlock and mirror protocols. However, qualitative comments from the frontline suggest that this safety may come at a cost to care. Several staff members explicitly noted that it can be challenging to do things like provide grounds leave or meaningful one-to-one time. Several staff noted that spending more time with patients, though desirable, is hard to achieve under

current staffing and funding pressures. Staff comments suggest that physical space and security acts as a necessary substitute for the relational oversight they currently lack the time to provide.

Observation

All ARs noted mostly calm, person-centred interactions between staff and patients. They also noted that the hospital's tighter security of the building was visible in movements they observed on the ward. ARs saw staff locking every door behind them and consistently checking ceiling mirrors at transition points. While this shows that procedural safety is now a standard habit, ARs also noted a "restless energy" and a "tense atmosphere" in some spaces. Set against this, bedroom doors carried personal dignity preferences, such as whether a patient wanted staff to knock before entering, and the team observed staff consistently knocking during the visit.



While some patients live under constant observation that they feel is invasive, others were observed in communal spaces despite having been violent earlier that day, causing a sense of unease and hyper-vigilance among their peers. Vaping in communal areas, which we had been told at induction was not permitted on the wards, appeared to go unchallenged. This could suggest that staff energy is concentrated on high-level mechanical security tasks (like airlock protocols).

Summary

PHA has invested heavily in physical security but less in relational security, hardening the building security but not so in softening the culture for patients. The main focus may be too weighted on containment, such as locking doors and regular checks, rather than understanding why a patient may be distressed.

4.6 Triangulation Matrix

Safety Domain	Patient Perception	Staff Perception	AR Observation	Alignment
Institutional Openness	7 out of 13 (6 interviewed, 1 surveyed) provided accounts of staff kindness or support	6 out of 7 feel very supported by leadership; 7 out of 7 very comfortable raising concerns	Staff provided unrestricted access and proactively introduced ARs to patients	Aligned (Strength)
Night Shift Care	7 out of 13 (4 interviewed, 3 surveyed) identified a care drop at night	3 out of 7 acknowledge a difference in ward culture at night	Night shift was not directly observed; daytime incident management appeared organised	Divergent (Perception Gap)
Martha's Rule	7 out of 13 (5 interviewed, 2 surveyed) did not know about Martha's Rule	6 of 7 not familiar with or needed more information on Martha's Rule	Signage on rights was visible, but escalation rights were not mentioned in observed ward rounds	Aligned (Knowledge Gap)
Handovers	9 out of 13 (6 interviewed, 3 surveyed) feel staff do not always know their needs	3 out of 7 admit the process is inconsistent	ARs noted some ward rounds were hectic; a clinician admitted staff lack time to develop relationships	Aligned (Risk)
Security vs. Dignity	6 out of 13 (4 interviewed, 2 surveyed) feel unsafe or uncomfortable	6 out of 7 believe security changes improved ward safety	ARs saw staff check mirrors and lock doors, some interactions appeared task-led	Divergent (Experience Gap)

5 Conclusions

This 2026 Culture and Care Review reveals a facility in a state of partial recovery. Priory Hospital Arnold has addressed a number of security and policy requirements identified in previous reviews. The physical environment is clean, the airlocks are functional, and the habit of staff stopping to check mirrors at transition points has become a standardised part of daily practice. Maintaining these standards of ward presentation and cleanliness will continue to set a baseline for a high standard of therapeutic care.

Staff numerical data shows that all respondents feel "very" or "somewhat" supported by their managers, are confident in speaking up and that any concerns will be taken seriously. This finding aligns with the high-performance benchmarks set by the National Guardian's Office. These national standards emphasise that the primary indicator of a healthy speak-up culture is psychological safety (an environment where workers feel safe to speak up about safety risks or clinical errors without fear).[12]

With most participating staff feeling well supported, the hospital is prioritising management responsiveness as the key to preventing institutional blindness. Furthermore, five out of the seven staff respondents identified leadership and workforce changes as the biggest improvement to Priory Arnold since 2023, suggesting the hospital is successfully building the transparent, accountable workforce foundation. Formalising and sustaining these successful leadership engagement practices will ensure the current open culture is sustained and protected.

However, a culture is not only defined by a space and its staff satisfaction, but equally by how it is perceived and experienced by those it cares for. The primary conclusion of the Culture and Care Review is that there is an inconsistent culture of support. The new leadership team has been highly successful in making staff feel valued and heard. While a fully "Open Culture" (a transparent, collaborative environment where staff, patients, and families communicate freely) may not be possible in a setting where patients naturally feel restricted in a mental health ward, there is more that can be done to move towards it consistently for patients.

[12] **National Speak Up Data and Annual Report**, National Guardian's Office 2024

5.1 Stabilisation of the Workforce

Unlike many mental health facilities that struggle with a revolving door of temporary staff, Priory Arnold has significantly reduced its reliance on agency workers. This shift toward a permanent, substantive team has allowed for a much higher degree of individual recognition on the wards. ARs observed that staff knew every patient by name and used personal details to check in on them in a non-invasive, friendly manner. This creates one of the necessary foundations for trust. For example, one patient was able to develop specific keywords with regular nurses who understood their personal history. This level of rapport is only possible in an environment where staff are consistent and familiar.

5.2 Physical Therapeutic Environment

Authorised Representatives consistently noted that the wards were "*light, airy*," and "*very clean*," with fresh decoration that moved away from a cold, institutional feel. Patients explicitly noticed these improvements, with some admitting they were pleasantly surprised by the environment they had initially feared. Staff were observed as calm and respectful. This environmental stability acts as a crucial soft safety measure, helping to lower initial anxiety during the high-stress period of admission.

5.3 The Say/Do Gap in Safety

There is a clear divergence in how safety is defined. To staff, safety is primarily being demonstrated through compliance: The door is locked, the alarm is tested, the patient is observed. To patients, safety is connection: Does the staff member believe me when I say I am in pain? Do they respond to my safety concerns? Currently, PHA is excelling at the former but is at times behind with the latter. This has created an environment that feels safer to management but more restrictive to some patients.

5.4 Raising Concerns and Being Believed

Another risk identified is the ongoing lack of believing and responding to patients' concerns. Ignoring patients repeated expressions of pain and discomfort are not just administrative errors; they are cultural red flags. One serious account of physical pain being dismissed, alongside a wider theme of concerns not always being believed,

suggests a risk that physical or other non-psychiatric needs can be overlooked when they are read as part of a patient's mental illness.

5.5 The Advocacy Vacuum: Martha's Rule

No family responses were received despite the hospital's invitation and engagement, and our effort in prompting and extending the survey deadline. The more substantive concern is the low awareness of Martha's Rule. With many patients placed from out of area, and few aware of their right to an urgent second opinion, there are limited external routes to raise the alarm when a patient feels their concerns are not being heard. Until that right is actively understood by patients and families, the burden of catching a deteriorating situation rests almost entirely on ward-level listening, which this review found to be inconsistent.

5.6 RAG Assessment Table

Priority	Theme	Required Action
RED	Physical Health	Ensure persistent physical health complaints are independently reviewed.
RED	Night Shift	Strengthen senior management oversight to ensure consistency in care 24 hours a day.
AMBER	Martha's Rule	Proactively inform patients and families of their rights, specifically Martha's Rule.
AMBER	Cultural Competency	Ensure every patient's cultural, religious, and personal identity is accurately recognised and respected
AMBER	Independent Advocacy Access	Consistently ensure advocacy is available to all patients who are entitled to it.
AMBER	Handover Quality	Prioritise relational continuity and physical health context in handovers to ensure patient info is shared.

6 Recommendations

Since the 2022 incident, Priory Hospital Arnold has established a strong foundation of clinical safety and workforce stability. The hospital has successfully achieved high levels of staff morale and an open, supported permanent workforce. The physical environment is also of a high standard and the institutional openness shown by management during this review indicates a culture that is confident in its practice and willing to welcome external scrutiny.

Underpinning the actions below is the review's central message: patients experience safety as connection, being believed, listened to and treated with dignity. Relational care and dignity should be given the same weight as physical and procedural safety, with staff supported to meet distress with engagement rather than only containment.

To move the hospital further from a 'Reactive' to a 'Generative' safety culture, the Nottinghamshire Safeguarding Adults Board and PHA leadership should ensure the following actions are taken. They are listed in order of priority, with the most pressing first:

1. Record Physical Comfort and Apply Independent Clinical Review

Ensure that physical pain and comfort levels are recorded with the same clinical rigour and frequency as behavioural risks. Physical wellbeing should be a visible and mandatory part of routine observation logs to ensure a holistic view of patient safety.

Ensure that any patient reporting persistent physical health complaints (such as pain, seizures, or infection) is automatically escalated for a review by a clinician independent of the immediate ward team. The outcome must be to ensure that physical distress is never dismissed as a psychiatric symptom, preventing the diagnostic overshadowing (when physical symptoms are wrongly put down to someone's mental health) identified during this review.

2. Strengthen Senior Oversight of the Night-Shift Culture

Ensure that senior management oversight extends consistently into the night shift. The outcome should be a professional, therapeutic environment 24 hours a day, where staff responsivity and environmental noise levels are managed to support patient sleep and recovery.

3. Proactively Communicate Escalation Rights (Martha's Rule)

Ensure that training on Martha's Rule for staff is implemented, and that the rule is verbally explained to and understood by every patient and their family. This right must be made a standardised part of the admission and induction process, moving beyond passive signage to ensure patients feel empowered to use it.

4. Embed Cultural Competency and Individualised Care

Build on the Patient and Carer Race Equality Framework (PCREF) already in place, with its board-level accountability and patient and carer involvement, by embedding it consistently in day-to-day frontline practice, so that each patient's cultural, religious and personal identity is asked about and respected rather than assumed.

5. Ensure Transparent Access to Independent Advocacy

Ensure that Independent Mental Health Advocates (IMHAs) have unimpeded and real-time information regarding who is on the ward, and that patients have prompt access to an IMHA, so advocacy reaches everyone entitled to it.

6. Protect the Human Side of Care Across Shifts

Ensure that shift handovers pass on the personal side of each patient's care, their emotional state, history and triggers, not just the clinical facts. Staff must be provided with sufficient protected time for these handovers and for post-incident debriefs to ensure the human context of care is not lost during staff changes.

Reference List

1. **The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012**, UK 2012
2. **Report to Adult Social Care and Public Health Select Committee**, Nottinghamshire Safeguarding Adults Board (NSAB) 2024
3. **Special Review of Nottinghamshire Healthcare NHS Foundation Trust**, Care Quality Commission (CQC) 2024
4. **Martha's Rule: Implementation and Pilot Sites**, NHS England 2024
5. **Patient and Carer Race Equality Framework (PCREF)**, Nottinghamshire Healthcare NHS Foundation Trust
6. **State of Care 2022/23: Inequalities in Care**, Care Quality Commission (CQC) 2023
7. **Guidance on Identifying and Responding to Closed Cultures**, Care Quality Commission (CQC)
8. **The Manchester Patient Safety Framework (MaPSaF)**, NHS England
9. **Using thematic analysis in psychology**, V. Braun and V. Clarke 2006
10. **Mental Health Act 1983**: Code of Practice, Department of Health and Social Care 2015
11. **NICE Guideline NG27**: Transition between inpatient mental health settings and community or care home settings, National Institute for Health and Care Excellence (NICE) 2015
12. **National Speak Up Data and Annual Report**, National Guardian's Office 2024

Appendix

Sample Survey Questions from Patient Survey

Section 1: About Your Stay

1. Which ward are you currently on?

☐ Newstead
☐ Bestwood
☐ Rufford
☐ Clumber
☐ Not sure

2. How long have you been at Priory Arnold?

☐ Under 1 month
☐ 1 to 3 months
☐ Over 3 months
☐ Not sure

Section 2: Physical and Emotional Safety

This section is about how safe and comfortable you feel on the ward, including at different times of day. There are no right or wrong answers.

3. Overall, how safe do you feel on the ward?

☐ Not safe at all
☐ Could be better
☐ Neutral
☐ Quite safe
☐ Very safe

4. How safe do you feel during the night compared to the day?

☐ Not safe at all
☐ Could be better
☐ Neutral
☐ Quite safe
☐ Very safe

5. The hospital has made a number of changes to the building and environment in recent years. How does the physical environment on the ward make you feel?

☐ It makes me feel safe and looked after
☐ It makes no difference to how I feel
☐ It makes me feel more anxious or distressed
☐ Not sure

6. Please tell us more about what makes you feel safe or unsafe here:

Section 3: Trust and Information

This section is about how well staff understand what matters to you, and how information is shared between them.

7. Staff work in shifts, which means different people will be caring for you at different times of the day and night. When there is a shift change, do you feel the staff coming on already know what is important to you?

☐ Yes
☐ Somewhat
☐ No

8. When you have shared something difficult with staff, how did you feel afterwards?

☐ I felt heard and taken seriously
☐ I felt dismissed or not believed
☐ Not sure
☐ I have not shared anything difficult

9. Everyone has different needs and things that are important to their sense of safety. This might include things that have happened to you in the past, things that affect how you feel around certain people, or other personal circumstances. Do you feel staff understand and respect what you need to feel safe?

☐ Yes
☐ Somewhat
☐ No
☐ Not applicable

10. Please share an example of a time a staff member was particularly kind or helpful:

Section 4: Raising Concerns and Power

This section is about whether you know what to do if something feels wrong, and your rights as a patient.

11. If you were worried about your safety or your care, would you know how to say something or tell someone?

☐ Yes
☐ No
☐ Not sure

12. How confident are you that if you raised a concern or complaint, staff would change things for the better?

☐ Not at all
☐ Somewhat
☐ Very
☐ Not sure

13. You have the right to ask for a second medical opinion if you feel your health is getting worse and you do not feel listened to. This is sometimes called Martha's Rule. Has anyone told you about this right?

☐ Yes
☐ No
☐ I have heard of it but don't know how to use it

Section 5: Dignity and Choice

This section is about how staff treat you day to day and how much say you have in your own care.

14. How well do staff respect your privacy (e.g., during 1:1 observations or when you are in your room)?

☐ Not at all
☐ Could be better
☐ Neutral
☐ Quite well
☐ Very well

15. Do staff involve you in making choices about your daily care and treatment in a way that makes you feel heard and respected?

☐ Not at all
☐ Could be better
☐ Neutral
☐ Quite involved
☐ Very involved

16. What one thing would make your experience at Priory Arnold better?

Acknowledgements

We would like to thank everyone involved in this project. To all those who participated in our survey and interviews, thank you for sharing your insights with us.

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