Witness Name: Ifti Majid

Statement No: **WITN0263132**

Dated: 23 February 2026

THE NOTTINGHAM INQUIRY

SECOND WITNESS STATEMENT OF IFTIKHAR MAJID

I, Iftikhar Majid, will say as follows: -

1. I have been Chief Executive Officer ("**CEO**") of Nottinghamshire Healthcare NHS Foundation Trust ("**the Trust**") since 1 December 2022.

2. This is my second witness statement and is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 requests dated 16 January 2026 (the "**Request**").

3. I drafted this statement, with support from the external solicitors acting for the Trust in respect of the Inquiry, in writing and by video conference. I also had some assistance from subject matter experts at the Trust, also in writing and by video conference, for instance in locating a document. At all times this was under my direct oversight.

Structure of and approach to this statement

4. My statement adopts the following structure:

- Opening summary views.
- The Well Led inspection – an overview of the process, its early findings and the Trust response - Integrated Improvement Plan, Mental Health Act oversight, data timelines, Board Assurance Framework, disconnect with NHS England Assessment
- Actions the Trust has taken and approach to the Action Plan
- Section 29A Warning Notice and submissions made by the Trust.
- Journey and trajectory of the organisation
- Moving forwards – action already taken and next steps

Opening views as to the findings of the September 2025 Care Quality Commission ('CQC') inspection report

5. I found the CQC's September 2025 inspection report a difficult read **[CQCM0029106].** As with each of the regulatory and investigation reports that have been issued in relation to the Trust during my tenure, however, I have sought to appropriately recognise the progress and improvements that are reflected in the report, while seeing the areas identified for further work as a catalyst for continued improvement and as presenting the Board with a valuable opportunity to sense check and adjust some aspects of our approach to date. The report provides a fair assessment of an organisation that has made progress in establishing quality and safety systems while not moving quickly enough on culture, staff experience, and equality and diversity. As can sometimes be the case with a report of this nature, I believe some characterisations lack important context about the regulatory environment we have navigated, and in some cases I disagree with specific assertions where I

believe the evidence does not support the strength of language used. I accept, however, that these reflections do not detract from the key areas of improvement the CQC identified as needing further (or in some cases) renewed focus.

6. Since June 2023, we have operated under Regulatory Enforcement Undertakings and National Oversight Framework Level 4 oversight and significant CQC regulatory activity and requisite actions. We made a strategic decision to prioritise quality and safety stabilisation in response to this regulatory environment. The report acknowledges progress we have made in these foundational areas, including improvements in patient safety infrastructure, governance frameworks, and clinical leadership.

7. I accept that we should have maintained greater focus on culture change alongside our quality and safety work. While we implemented cultural initiatives during this period – including leadership development programmes, Freedom to Speak Up expansion, and Creating Compassionate Cultures training – these have not gained the traction required to shift staff experience and engagement at the pace our colleagues deserve. Cultural change requires sustained organisational focus, consistency of leadership attention, and the proactive investment of time over an extended period. During this period, our organisational bandwidth was necessarily directed toward two things: ensuring patient safety and quality of care and meeting the reactive demands of regulatory compliance and mandated improvement activity. Both were non-negotiable priorities. Together, however, they inevitably constrained the capacity available to embed cultural change with the depth and consistency that drives lasting results.

8. I welcomed the CQC's recognition of the progress we have made across many areas of the organisation. The fact that no services remain rated inadequate represents a fundamental shift from where we were.

9. The CQC's recognition of strengthened clinical leadership and accountability frameworks reflects genuine progress made under exceptional pressure. I was particularly pleased that the CQC acknowledged the substantial investment and positive impact in patient safety – including the expansion of our patient safety team, implementation of the Patient Safety Incident Response Framework, development of SafeNow real-time dashboards, and strengthened family liaison and mortality review processes. The recognition of our Freedom to Speak Up developments, improvements in governance structures, and the compassionate leadership demonstrated by members of our executive team matters deeply, because these foundations will enable us to build the culture our staff and service users deserve.

10. I also noted and welcomed the positive observations regarding triumvirate working within our care groups. This has been a deliberate area of investment and focus, and I was encouraged that the shift from what had historically been an operationally driven organisational focus, toward a quality-driven approach, has been recognised and seen as moving in a positive direction. This reflects the conscious effort we have made to embed collaborative, integrated leadership across our services, placing clinical quality and patient experience at the heart of decision-making. Hearing that external reviewers could see this shift starting to take root was important validation of the start of the cultural change we are working to achieve.

11. I am fully committed to addressing every area identified for further development. The feedback about crisis care experiences – where people felt dismissed, unsupported, or experienced lack of compassion at their most vulnerable moments – is particularly painful to read and represents failures we must address with urgency. The workforce equality and diversity findings, showing that colleagues from minority backgrounds and disabled colleagues consistently report worse experiences than their peers, is unacceptable and demands accelerated action with clear accountability. The estates issues relating to dormitory accommodation and long-term segregation environments directly impact the dignity and human rights of people in our care. I accept our responsibility to act promptly and decisively, working collaboratively with system partners to secure the necessary resources and deliver sustainable solutions. that will make a lasting difference.

12. In our formal responses to the CQC, I have sought to provide additional organisational context on specific aspects of the report. This context does not diminish the validity of the concerns raised but I hope may assist in understanding some of the constraints and prioritisation decisions we navigated during a significant and sustained period of regulatory oversight.

13. I wrote to the CQC on 4 December 2025 [**WITN0263133**] ahead of publication, to provide additional context on specific aspects of the report alongside our formal factual accuracy submissions. While this additional context was not substantially reflected in the published report, I recognise that regulatory assessments necessarily focus on findings and required improvements rather than contextual explanation, and our action plan and organisational response reflects and addresses the report's findings in full.

14. The Trust formally challenged the CQC's Section 29A Warning Notice, specifically contesting the assertion that there was 'no strategic appetite' to address estates issues, while fully accepting the seriousness of the regulatory concerns regarding dormitory accommodation and long-term segregation environments. Our representations, submitted on 13 November 2025 [WITN0263134], set out the extensive efforts we have made to secure funding, the external constraints we have faced, and the 87% completion rate of our dormitory eradication programme. I maintain that while outcomes have taken too long to achieve and people in our care have been affected, the characterisation does not accurately reflect the sustained strategic commitment and proactive efforts we have demonstrated.

15. Our representations against the Section 29A Warning Notice also address the CQC's concerns around long-term segregation environments. I want to be clear that we fully accept the need to improve these environments and recognise their profound importance to the dignity and wellbeing of the patients who live in them. Our representations did not seek to challenge that need – they sought to evidence the sustained efforts we have made to bring about those improvements, and to address the inference that we had not tried hard enough to do so. We specified that all patients in long-term segregation have access to natural light, bathroom facilities, and therapeutic activities in accordance with the Mental Health Act Code of Practice – consistent with all three high secure hospitals – with the single exception at Arnold Lodge being a time-limited clinical decision to prevent serious self-harm. We evidenced sustained efforts to secure improvement funding, including supporting the National High Secure Business Case (March 2024) [WITN0263135, WITN0263136, WITN0263137,

[WITN0263138, WITN0263139] identifying £135 million required for Rampton A&B Blocks – funding beyond our local system allocation and requiring national investment. This demonstrates strategic commitment constrained by funding, not absence of appetite.

16. The CQC issued its decision on our representations on 26 January 2026 [WITN0263140] While acknowledging that the dormitory eradication ground was not fully substantiated, the CQC upheld the concern regarding long-term segregation environments, requiring significant improvement by 30 April 2026. We accept this decision, and our focus is on delivery. Our action plan commits to significant improvements to these environments, with a project plan in place by 30 April 2026 [WITN0263141], works delivered throughout 2026/27 from our capital allocation, and active engagement already underway between our estates service and Forensic Care Group.

On the Language and Tone Used

17. The report uses strong descriptions in some areas, including 'no proactive strategic appetite,' 'grip and control mindset,' 'guarded in its vision,' and 'blame culture.' In our representations, I have sought to provide additional evidence and context where I believe it would assist understanding – for example, regarding our sustained estates improvement efforts and governance frameworks that were in place even while requiring strengthening. My intention is to ensure an accurate record of our efforts and constraints, not to diminish the serious concerns raised. Independent external assessment has value precisely because it surfaces perspectives that those inside an organisation

may not see clearly, and I am committed to engaging seriously with what these findings tell us.

On the Scope and Methodology of the Assessment

18. The inspection methodology differed from some other oversight processes we have experienced, particularly in not including direct observation of Board, Committee, or Executive Leadership Team meetings. Conclusions about board dynamics, executive collaboration, and strategic alignment were therefore based on interviews and document review. By contrast, NHS England's Director of Making Data Count **[NHFT0015833]** attended our public Board meeting in September 2024 and provided strongly positive feedback, commending the quality of executive presentations, strength of Non-Executive challenge, and describing our Integrated Performance Report as 'exemplary.' Both methodological approaches have value, and the different perspectives help us understand how we are perceived versus how we operate in practice.

On the Phase of Organisational Development We Are In

19. It is important to recognise that we are an organisation transitioning from turnaround to sustainable transformation. For the past two and a half years, we have necessarily focused on stabilising governance following a catastrophic incident, responding to regulatory enforcement action, rebuilding accountability structures, and strengthening patient safety systems under intense external scrutiny. This stabilisation phase was essential – the improvements in safety governance, patient safety infrastructure, and clinical leadership that the CQC recognised happened because we maintained sustained focus on foundational requirements. However, I accept that turnaround mode is by nature somewhat transactional, often perceived as 'top down' and directive in nature and is not

the environment in which cultural transformation thrives. We are now consciously transitioning from stabilisation to broader transformation, and the CQC's assessment captured us at this pivot point.

The Well Led inspection

On the Integrated Improvement Plan and Strategic Direction

20. The report raises concerns about strategic alignment between our Making a Difference 2022-2027 strategy **[CQCM0027394]** and the Integrated Improvement Plan (IIP) **[NHFT0003275]**. Our Making a Difference strategy was developed and published in 2022 following stakeholder engagement, setting out our five-year ambitions for improving care delivery, supporting our workforce, and embedding continuous improvement.

21. The Integrated Improvement Plan was not a discretionary strategic choice but a legally mandated requirement, imposed as a condition of Regulatory Enforcement Undertakings **[CQCM0013499]** following the events of June 2023. We were required as part of our legal undertakings to develop and deliver an IIP that addressed immediate patient safety concerns, stabilised governance, and demonstrated measurable progress to enable transition out of NOF4 oversight, hence our initial turnaround focus. The nature and scale of this mandated work inherently required and directed a considerable amount of organisational focus, executive time, and Board attention during this period. Our intention was that the IIP would complement – not replace – our longer-term strategy, providing the structured mechanism to stabilise the organisation so that full delivery of our strategic ambitions could resume. I accept that our communication and articulation about this relationship could have been clearer. That staff reported confusion about direction is feedback I take seriously, and

we should have done better at explaining why the IIP had to take precedence in the short term and what the pathway back to full strategic delivery would look like.

Mental Health Act Oversight

22. The report highlighted concerns about Mental Health Act oversight, including gaps in board-level visibility and two instances where the Legislation Operational Group was not quorate in early 2025. I accept these findings. We have acted by establishing a standalone Mental Health Act Committee of the Board in September 2025, strengthening accountability routes from ward to board, addressing quoracy issues, and enhancing assurance reporting.

23. Formal oversight arrangements were in place prior to this period. Our Quality Committee – a Board committee chaired by a Non-Executive Director – had explicit responsibility for MHA and MCA oversight, with the Trust-wide Mental Health Legislation Oversight Group providing regular compliance reporting. Our representations to the Warning Notice included an annex showing 25+ MHA-related reports presented to Quality Committee between April 2024 and October 2025. The issue was not an absence of governance, but that governance needed to be more visible, systematic, and effective at driving pace. I recognise, however, that how governance structures are perceived externally is important.

Data Timeliness

24. The report expresses concern that board data was two months in arrears, suggesting this limited the Board's ability to respond to current risks. I understand this concern. Our Board meets bi-monthly, and data undergoes

structured validation and triangulation before publication – an approach that prioritises data integrity. A review of other mental health trusts rated Outstanding for Well-Led shows they typically report performance two months in arrears in bi-monthly board cycles, suggesting this is standard practice across the sector.

25. The Board is not dependent solely on scheduled meetings for risk oversight. We have comprehensive mechanisms providing continuous visibility: weekly Executive Team meetings with dedicated quality and safety time, monthly committee meetings with more contemporaneous data, daily SafeNow meetings and incident review forums, and established escalation routes for immediate updates when risk profiles change. I accept we could articulate more clearly about why we prioritise data quality over immediacy at the Board and about the real-time oversight mechanisms operating between board meetings.

Board Assurance Framework

26. Board Assurance Frameworks use standardised risk management language to identify causal factors, controls, and consequences, and it was in that context that the language in our 'people risk' entry was drafted. The intention was to describe the causal factors contributing to poor colleague experience, with mitigations focused entirely on organisational and leadership actions – reflecting the Board's understanding that this was an organisational accountability issue, not an individual one. The reference to leaders not acting in line with expected behaviours was intended to explicitly acknowledge leadership accountability. However, when the CQC highlighted how this language could be read, I recognised immediately that it was a clumsy use of

language for somebody reading it without context. Whatever the intention, the way it was expressed fell short of the standard we should hold ourselves to. We revised the BAF risk description straight away to ensure it unambiguously reflects organisational and leadership accountability for culture.

NHS England's Assessment of Our Progress

27. NHS England's regional and national teams (including the RSP team) have worked intensively with us since June 2023, with sustained access to our governance processes, board papers, and improvement plans. Their assessment of our progress has acknowledged improvements in governance, clinical leadership, and patient safety systems, while noting continued focus needed on culture and staff experience. Their overall assessment has been of an organisation making appropriate progress on a difficult journey.

What actions the Trust has taken and will take in response to the findings of the inspection

28. We have not waited for the publication of this report to begin acting on the concerns identified. While the formal inspection took place in September 2025, we began implementing improvements immediately based on the early feedback we received, and this work has continued with pace and focus ever since.

29. When we received the published report on 14 January 2026, we shared it widely across the organisation and with our stakeholders. We briefed our Board of Directors and the Council of Governors and shared the report with our system partners.

30. We shared the full report with all staff, accompanied by direct email communications and a personal open letter [WITN0263142 , WITN0263143] from me that acknowledged both the difficult findings and the areas of progress recognised by the CQC, and set out my commitment to acting on every area identified for improvement. We held open forums with staff across all care groups and locations, providing opportunities for colleagues to ask questions, raise concerns, and contribute ideas for improvement.

Our Approach to the Action Plan

31. We submitted a formal action plan to the CQC on 12 February 2026 [WITN0263141]. I was determined that this would not be a top-down, executive-produced document. We co-developed this plan with frontline staff who deliver care every day, patients and carers who experience our services, our equality and diversity networks, our Freedom to Speak Up champions, and our system partners. We have held structured listening sessions across all care groups, engaged with our Patient and Carer Reference Groups, consulted with medical leaders on triumvirate working, and ensured Board members, Non-Executive Directors and Governors provide strategic coherence.

Action Plan Development: Priority Areas

32. In developing our Action Plan, submitted on 12 February 2026, we concentrated on three priority areas: Board leadership and strategy, culture and equality, diversity and inclusion, and the Patient and Carer Race Equality Framework.

Board Leadership, Development and Strategy:

33. There is a transition underway to a refreshed senior leadership team at the Trust, following the previous Chair completing his maximum term and in light of

my forthcoming retirement. We have appointed a new Trust Chair who brings fresh perspective and challenge to board dynamics. The Trust is actively recruiting the next CEO, with recruitment progressing well to help ensure continuity of leadership. We are launching a Trust Strategy refresh that will provide clearer alignment between our long-term ambitions and current improvement priorities, ensuring everyone in the organisation understands our direction.

34. Alongside these structural changes, we have committed to a programme of Board development to strengthen board effectiveness, cohesion and the quality of challenge and oversight. As I set out in my open letter, this development programme will focus on ensuring the Board operates with a shared understanding of our strategic priorities, clear collective ownership of our improvement journey, and the skills and confidence to provide the rigorous, compassionate leadership our organisation needs at this critical point in its journey.

Culture and Equality, Diversity and Inclusion:

35. We are increasing visibility of the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Patient and Carer Race Equality Framework (PCREF) data at Board and Committee level. Three external providers have been identified to deliver specialist training. This includes development of a trauma-informed toolkit aimed at strengthening a culture of psychological safety for both patients and staff, particularly in raising concerns. I want to acknowledge the foundations already in place at the time of the inspection: we have 127 trained EDI Ambassadors across

the organisation and four active staff networks representing nearly 700 colleagues. We have Diversity and Inclusion Recruitment Guardians sitting on all senior appointment panels at Band 8c and above. Our Parallel Learning Partnerships programme is now in its third cohort, creating reciprocal learning relationships between minoritised staff and senior leaders. Trust-wide Active Bystander training is being rolled out.

Patient and Carer Race Equality Framework (PCREF):

36. We have a dedicated Associate Director with responsibility for PCREF, and a Trust-wide Carers Lead now in post. Our PCREF Steering Group is operational with Terms of Reference agreed and a supporting dashboard providing population-level data on ethnicity, detentions, restraint and deaths. Regular Board reporting is now embedded – PCREF will not disappear from board agendas. We are establishing a Feedback Task and Finish Group that will be chaired by an external community representative, not a Trust leader, ensuring authentic community voice shapes our approach.

Section 29A Warning Notice - Dormitory Eradication and Long-Term Segregation

37. I want to address this directly because it is the most serious regulatory action we face. The Trust formally challenged the CQC's issuing of the Section 29A Warning Notice, specifically contesting the assertion that there was "no strategic appetite" to address estates issues, while fully accepting the seriousness of the regulatory concerns regarding dormitory accommodation and long-term segregation environment risks.

38. To be absolutely clear, I accept that 18 patients continuing to sleep in dormitory accommodation is unacceptable and impacts their privacy and dignity. I accept that some patients in long-term segregation have lived in environments that do not consistently meet all aspects of the Mental Health Act Code of Practice. These are failures that affect the daily lives and fundamental dignity of people in our care, and I do not seek to minimise them.

39. However, the Trust has challenged the characterisation that we had "no proactive or strategic appetite" to address these issues. This language suggests a lack of proactivity, and it does not reflect the reality of the sustained efforts we made within constraints. Our formal representations, submitted on 13 November 2025, set out in extensive detail:

- The 87% completion rate of our dormitory eradication programme, delivering 116 ensuite bedrooms through Phases 1 and 2 (Sherwood Oaks completed December 2022, Blossomwood completed August 2025).
- The operational impossibility of completing Blossomwood and Cherry Ward concurrently due to 93-101% occupancy rates and no available appropriate decant space in the system. meaning they had to be planned sequentially to minimize impact on patients:
- External planning constraints (Fern House granted listed building status July 2023, requiring complete redesign).
- Cost escalation beyond our control (construction inflation of 24.5% in 2021 and 15% in 2022, increasing costs from £4.5m to £17.3m).

- Financial constraints meaning we could not start work we might not be able to finish without guaranteed multi-year funding.
- Sustained engagement with NHS England throughout (formal papers January 2024, funding requests April 2024, national roundtable June 2024, updated business cases October 2024 and May 2025).
- National funding ultimately secured in August 2025 (£10.8m), with project formally re-mobilised October 2025 and completion targeted for March 2027.

40. The capital funding required to deliver improvements to long-term segregation environments exceeds our entire system allocation, necessitating national investment. It is that constraint, not absence of strategic appetite, that has determined the pace of progress. Our representations evidenced sustained strategic commitment within those constraints, including our March 2024 support for the National High Secure Business Case, the June 2022 Outline Business Case for Women's Seclusion and ICU facilities at Arnold Lodge, the April-May 2024 Seclusion Review, and our Five-Year Estates Strategy explicitly prioritising therapeutic environment improvements at Rampton.

41. The Trust challenged the specific language used – 'no strategic appetite' – because our view was that a conclusion framed as 'insufficient resources secured despite sustained efforts' would more accurately reflect the situation. This distinction matters for how staff, patients, and the public understand our commitment, and it more accurately reflects what is and is not within the Trust's direct control. National capital funding constraints are a well-known challenge across the NHS.

42. The CQC issued its decision on our representations on 26 January 2026. While the CQC acknowledged that the dormitory eradication ground of the Warning Notice was not fully substantiated, they upheld the concern regarding long-term segregation environments, requiring significant improvement by 30 April 2026. We accept that decision and our focus is now entirely on delivery. We are absolutely committed to bringing about the necessary improvements to long-term segregation environments and to the eradication of dormitory accommodation at Cherry Ward within the timescales agreed in our action plan.

Estates and the Section 29A Warning Notice

Current Position:

43. For Cherry Ward dormitories, we will submit a full planning application by March 2026 with a completion target of March 2027, subject to the £10.8 million national capital approval we secured in August 2025. The funding is ring-fenced, a dedicated Programme Director is in post, and governance oversight is in place from programme board through to Board.

44. For long-term segregation environments, design work is underway with our estates service actively engaging with the Forensic Care Group to establish project requirements, supported by a dedicated task and finish group. Strengthened governance arrangements mean every patient in long-term segregation has a named advocate, with enhanced oversight of care plans, regular multi-disciplinary review, and clearer escalation routes. Reporting on these environments is now standard, giving the direct visibility of conditions, patient experience, and progress against improvement milestones, with named accountability for delivery sitting at the highest level of the organisation.

On the Organisation's Journey and Trajectory

45. We have been on a journey of improvement. We remain a trust that requires improvement, but this is not an organisation that has stood still. The CQC's own data shows: no services rated inadequate, four services with improved overall ratings, improvements in the majority of quality statements assessed, safety governance strengthened across 83% of service groups, and outstanding ratings in perinatal services and children's community health services. These represent fundamental shifts in how we operate, delivered while managing regulatory enforcement action and intense external scrutiny.

On What Would Have Been More Helpful

46. In our formal representations and supplementary submissions, I have provided additional context in several areas: specific examples of behaviours underlying strong characterisations; acknowledgment of our position as an organisation recovering from crisis under enforcement action; clarification between absence of arrangements versus arrangements requiring strengthening; and evidence of governance structures that existed even while needing enhancement. This context is offered to ensure accurate understanding of our efforts and constraints, not to diminish the validity of concerns raised.

Moving Forward

47. We are using this report as a catalyst for ongoing and strengthened improvement. The findings about crisis care experiences, workforce equality and diversity, staff engagement and culture, and estates are serious and demand urgent, sustained action with clear accountability. We are committed to delivering that action.

48. We are also using this as an opportunity to be honest with ourselves and our staff about where we are on our journey. We have made progress from a point of crisis where we needed bring about immediate improvements in quality and safety, but we have much further to go. We are transitioning from stabilisation to transformation, and that transition requires different leadership, different conversations, and different ways of working.

Actions Already Taken Since the Inspection

49. I want to set out clearly what we have already done since the assessment in September 2025, because I believe it demonstrates our commitment to improvement and our willingness to act without waiting to be told.

On Governance and Accountability:

50. We established a standalone Mental Health Act Committee at Board level in September 2025, immediately following the assessment – plans were in place to do this prior to the assessment. This committee is chaired by a Non-Executive Director, meets bi-monthly, and provides dedicated focus on MHA compliance, restrictive practice oversight, and environmental issues affecting detained patients. This was not a response to the published report – it was a direct response to early feedback that board-level oversight needed strengthening, and we acted on it straight away.

51. We also secured Board approval in July 2025 for our revised accountability framework, which has clarified escalation routes from ward to care group to committee to Board. This framework is still embedding, but it provides much clearer lines of sight and accountability than we had before.

On Medical Leadership:

52. We have accelerated Valuing Medical Leadership Programme, which was established in early 2025, and 62 senior medical leaders have now completed development training covering NHS finance, data-driven planning, and organisational priorities. Feedback shows 98% of participants report improved confidence in financial leadership and strategic contribution.

53. We have ring-fenced protected leadership time in job plans for medical leaders in triumvirate roles, and we have prioritised medically led Quality Improvement projects to ensure medical voices are visible in service transformation. Five of our medical leaders have secured places on national advanced leadership programmes, with five further applications in progress. This investment is deliberate and sustained – we are building the pipeline of medical leadership capability our organisation needs.

On Crisis Care:

54. Prior to the inspection, we recognised we needed to strengthen senior leadership oversight significantly, appointing new Care Group Directors of Nursing and an Associate Director for the Urgent Care Unit, with an additional Associate Director of Nursing currently being recruited.

55. The Rapid Improvement Board – established in 2023 and chaired by the Chief Nurse – meets monthly to provide grip, pace and accountability on crisis pathway performance, staff experience, and the behaviours patients encounter at point of contact. This is supported by a weekly Operational Delivery Group.

56. We introduced consultant-led admissions and 24/7 out-of-hours consultant support in August 2025, ensuring senior clinical presence when people are

most at risk. We moved from weekly to daily breach reviews, enabling much faster intervention and more accurate real-time reporting through SafeNow (see paragraphs 513-515 of my First Witness Statement, WITN0263001). Risk assessment compliance has improved to 93.6% against our 95% target, with focused training underway to close the gap.

57. We have made significant changes to how people access crisis support. We have increased workforce capacity in our crisis assessment line, recruiting additional staff to ensure people in crisis can reach us when they need to. Critically, we have brought call handling in-house, ending reliance on external provision and ensuring that when someone contacts us at their most vulnerable, they are speaking directly with our own trained staff who understand our services, our patients, and our values. These changes represent a fundamental shift in how crisis care is experienced at the point of contact – an area the CQC specifically identified as requiring improvement – and reflect our commitment to ensuring people feel heard, supported, and treated with compassion.

Three Core Priorities for Our Action Plan

58. The action plan we submitted on 12 February 2026 is structured around three core priorities, each with clear ownership, measurable milestones, and defined timescales.

Priority 1: Strengthen Board Coherence and Strategic Leadership

59. We are refreshing the Trust Strategy through to 2029, through an evidence-based review of population health needs – including health inequalities – and strong engagement with patients, carers, staff and stakeholders. A Board Development session is planned for 26 February with Public Health Consultants

to review population health data, conduct an environmental scan, and agree an engagement plan for the refreshed strategy. The Strategy and Partnerships Committee has been re-formalised and meets monthly until June 2026 to provide strong oversight of strategy development, with staff engagement sessions already booked over the coming three months.

60. Our new Chair will drive Board cohesion and effectiveness through structured development and visible leadership. A programme of Board development is underway to strengthen collective ownership of our improvement priorities and the quality of oversight and challenge.

61. We are strengthening our governance arrangements, embedding the Trust Accountability Framework supported by training, improved access to data and dashboards. We have completed a full re-audit of Fit and Proper Person Tests for all Board members, with 100% compliance. Our Mental Health Legislation Committee has been convened from September 2025, with a compliance dashboard being implemented to drive and evidence improvement.

Priority 2: Embed Culture, Staff Experience and EDI Throughout the Organisation

62. We are consolidating our current culture, engagement, EDI and organisational development work into a clearly defined Strategic Cultural Improvement Plan, aligned to our refreshed strategy. We recognise that the CQC's findings on workforce equality and diversity reflect a serious and unacceptable reality for too many of our colleagues, and we are under no illusion about the scale of the work required. This plan will include colleague engagement opportunities, defined leadership standards and associated development support, a

comprehensive organisational development programme, and clear EDI improvement targets directly linked to WRES and WDES improvements. Cultural improvement will be monitored through our People and Culture Committee using a heatmap data analysis approach, with WRES and WDES indicators tracked as Board-level Key Performance Indicators with defined improvement trajectories reported on publicly.

63. We will implement the principles of a Just and Restorative Culture [WITN0263144] from Board to ward with clear executive accountability at every level. We will establish a recognition framework that celebrates values-led leadership and makes visible the behaviours we want to see. We will create transparent 'You said, we listened, together we...' feedback loops so staff see that speaking up leads to change. Strengthened reporting, investigation and follow-up processes for discrimination and harassment will demonstrate to staff that we mean what we say and that every concern will be taken seriously.

64. We are implementing PCREF across four workstreams with measurable targets for EDI improvements and a published Health Inequalities Plan. PCREF Leads are being actively recruited across each Care Group, with PCREF Ambassadors being recruited across all Care Units to support frontline engagement and delivery. Our PCREF Steering Group has been operational since January 2026, with community leaders contributing across all four workstreams to ensure co-production and local accountability. Three external providers have been identified to deliver specialist training, including development of a trauma-informed toolkit aimed at strengthening psychological

safety for both patients and staff. A formal PCREF Launch Event is planned, supported by a comprehensive communications programme and a dedicated PCREF webpage launched on 13 February 2026.

Priority 3: Deliver Safe, Dignified Estates

65. For Cherry Ward dormitory eradication, we are in the design stage and will submit a full planning application in early 2026/27. The scheme budget is £16.8 million, with £10.8 million agreed from NHS England subject to final sign-off, and the remainder funded from our annual capital plan. Construction is targeted to commence November 2026, with completion in March 2028 and patients repatriated in April 2028. The project is governed by a dedicated Dormitory Eradication Project Board led by the Executive Director of Strategy and Partnerships.

66. For long-term segregation environments, our estates service is actively engaging with the Forensic Care Group, with meetings planned for February and March 2026 to establish project requirements, supported by a dedicated task and finish group. It is important to note that there are two distinct elements to this work: immediate improvement works, which will be funded from our 2026/27 block capital allocation and delivered throughout 2026/27; and longer term structural improvements to these environments, which require national capital investment beyond our system allocation and for which we will maintain active partnership with NHS England and the Integrated Care Board. A project plan covering both elements will be in place by 30 April 2026. Monthly Board oversight and transparent communication to patients, families and staff about

progress and any barriers is now standard, ensuring that accountability for delivery sits at the highest level of the organisation.

Summary

67. I fully accept the CQC's findings on those areas identified as requiring improvement. With respect to the areas where we sought to provide additional context by way of challenge, I accept the CQCs decision after reviewing our evidence and our action plan and organisation response evidences our commitment to address all of the findings.

68. In our formal representations and supplementary submissions, I have provided additional organisational context—on the IIP being a legal requirement, on our sustained efforts to secure estates funding, on governance structures that existed even while needing strengthening, and on our data governance practices. This context is offered to ensure accurate understanding of the constraints we operated within and the efforts we made, not to excuse shortcomings.

69. We remain absolutely committed to working in open partnership with CQC, learning from this assessment, and delivering the improvements our staff and the people we serve deserve.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 23 February 2026

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3	WITN0263134	Representations to CQC – 13 November 2025
4	WITN0263135	RE: High Secure Hospitals – Strategic Capital Planning
5	WITN0263136	High Secure Strategic Capital Planning March 2024
6	WITN0263137	High Secure Funding Opportunity Costs
7	WITN0263138	High Secure Strategic Capital Planning Scoping Information – January 2024
8	WITN0263139	High Secure Capital Scoping – Funding Opportunity – 17 January 2021
9	WITN0263140	Decision of CQC – 26 January 2026
10	WITN0263141	Trust Action Plan
11	NHFT0015833	Nottinghamshire Healthcare NHS Foundation Trust Board Observation Feedback
12	CQCM0027394	Making a Difference 2022-2027 strategy
13	NHFT0003275	Integrated Improvement Plan
14	CQCM0013499	Regulatory Enforcement Undertakings
15	WITN0263142	Letter from Ifti Majid to all staff – 14 January 2026
16	WITN0263143	An open letter from Ifti Majid – 14 January 2026
17	WITN0263144	Just and Restorative Culture diagram