



Improvement Action Plan

Healthcare Improvement Scotland: Unannounced Acute Mental Health

Services safe delivery of care inspection

Forth Valley Royal Hospital, NHS Forth Valley 25 – 26 August 2025

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: Neena Mahal

Date: 03/09/2026

Date:

NHS board Chief Executive

Signature: _____

Full Name: Ross McGuffie

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18 Week Action Plan Update – September 2026

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed	Progress update
Requirement 1. Domain 1	NHS Forth Valley must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures.	Mar 2026	Head of Service	The NHS Forth Valley Surveillance Systems Policy has been approved and implemented. A local SOP for CCTV use in the MHU has also been developed, approved, and implemented. All CCTV cameras in the MHU have been mapped and are supported by appropriate signage.	Complete April 2026	

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Requirement 2 Domain 1	NHS Forth Valley must ensure effective governance and oversight of all necessary staff training to support all staff to safely carry out their roles. This includes but is not limited to, Basic Life Support, Public Protection, Prevention and Management of Violence and Aggression Training and Training in relation to Specialist Admissions.	Feb 2026	Chief Nurse/Head of Service	Weekly training monitoring is now established and embedded within governance reporting.	Complete February 2026	
		Mar 2026		The Pentana dashboard is now in place to monitor training requirements, and new Turas Learn reporting has strengthened oversight.	Complete March 2026	

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		July 2026		Overall compliance is improving but has not yet reached target levels in all areas. Current overall compliance is 74%, with individual modules ranging from 60% to 90%. Prioritising a phased approach to training has supported 80%+ compliance in Public Protection, M&H, Violence & Aggression, Fire Safety and Hand hygiene. Whilst we haven't achieved initial compliance aim for all training, this phased approach continues to operate with controls and monitoring in place, and a revised aim of 95% compliance by September 2026. Adult resuscitation training has improved to 86%. Face-to-face training has also risen to 37% and is expected to reach 44% by 1 June 2026 based on booked sessions. Child and Adolescent Mental Health training has increased to 49%, Perinatal training to 73%, PAMOVA to 86%, and Public Protection training to 88%.	On track November 2026	Mandatory training compliance in the Mental Health Unit has increased from 74% at the previous update to 88% currently. Although below the 95% target, this figure includes staff on long-term sick or maternity leave, who account for much of the outstanding non-compliance. TURAS cannot exclude these staff from the available reporting. Compliance continues to improve and now stands at 91% for the Adult Resuscitation module and 78% for the face-to-face element. NHS Forth Valley aims to
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						achieve 95% compliance for both the TURAS module and face-to-face Adult Resuscitation training by end of November 2026. Additional face-to-face training sessions have been scheduled throughout November to accommodate remaining staff requiring training. We will continue to monitor compliance levels to maximise attendance at the additional training sessions to support delivery of the target. Child and Adolescent Mental Health training has increased to 98%, Perinatal training to
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						97%, PAMOVA to 94%, and Public Protection training to 93%. Work is continuing to improve compliance figures; this is tracked and monitored via workforce governance routes. Linkage has been undertaken with National Turas team to explore additional reporting in relation to cyclical nature of training expiration to aid compliance monitoring.
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Requirement 3. Domain 1.	NHS Forth Valley must demonstrate how it supports the ongoing development of skills and knowledge through adequate supervision and appraisal for staff	Feb 2026	Chief Nurse	A supervision calendar is in place, and supervision data is reported through workforce and clinical governance structures.	Complete February 2026	
		July 2026		Compliance has risen to 50%; this is expected to be at 60% by mid June and on track for 95% compliance by July 2026. This is monitored weekly via Turas reporting by CNM and reported on monthly via local governance structures.	Complete July 2026	Appraisal compliance has increased to 96% and will continue to be monitored through workforce and clinical governance structures.
		Dec 2026		Supervision arrangements are still at an early stage, and tracking tools are now in place. Current compliance is 12%. Compliance is expected to be 95% by December 2026.	On track December 2026	Clinical supervision compliance is on track at 50%, with established monitoring arrangements supporting delivery of the December 2026 target.

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Requirement 4 Domain 1	NHS Forth Valley must ensure processes are in place to continue to mitigate the risk of access to the roof in the outdoor space and monitor the impact of any interventions in place	Sept 2025	Head of Service	Anti-climb paint has been effective, with no further incidents of roof access. To further mitigate risk, installation of rolling roof bars is currently being explored and costed.	Complete January 2026	The measures implemented to prevent access to the roof continue to be effective, with no further incidents reported.
		July 2026		The Estates Oversight Group is now established, with monitoring embedded through local governance reporting, supported by newly formed local estates delivery groups.	Complete July 2026	The Estates Oversight Group remains established and provides monitoring of environmental risks through local governance arrangements.
				Delivery of the Mental Health Built Environment Quality and Safety Assessment Toolkit remains on track for completion by July 2026.	Complete September 2026	Mental Health Built Environment Quality and Safety Assessments have now been completed, with findings informing any further environmental mitigation required to support ongoing assurance.

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Requirement 5. Domain 1.	NHS Forth Valley must ensure improvement actions are compiled with and progressed with agreed timescales to reduce ligature risk identified through significant adverse event reviews and HSE improvement notices.	Dec 2027	Head of Service	The improvement programme in response to the HSE Improvement Notice commenced in May 2026 and is progressing through phased delivery, with installation and enabling works underway across wards to ensure safe implementation and minimise disruption. Ward 3 remains on track for completion by end August 2026. Delivery timelines reflect the scale and complexity of the estates programme, with progress actively managed around contractor availability, procurement lead times, the coordination of works within live clinical environments and available capital (Board investing £1m/yr from overall £6.5m annual capital budget).	On track for Dec 2027	The actions associated with the HSE Improvement Notice were completed on 19 th August 2026. The wider environmental improvement programme continues through phased delivery of replacement doors, windows and furniture across the Mental Health Unit. Ward 3 furniture replacement is complete, with further environmental improvements progressing across the remaining wards through the established estates programme. The overall programme remains on track and is expected to be completed by December 2027.
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				The Estates Oversight Group is now embedded as the central governance mechanism for environmental risk reduction and environmental improvements. This includes oversight of ligature reduction work. This provides clear escalation routes and strengthens assurance through an established governance structure, improving visibility of risks and progress at a service level, leading to visibility and assurance at Board level. Whilst strengthening oversight, ongoing focus is required to ensure all actions are delivered within agreed timescales and that risks continue to be actively managed.	Complete January 2026	
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		March 2026		The training package has been adapted to reflect local context and is nearing completion, with launch anticipated in early June.	Complete July 2026	The NHS Forth Valley Ligature Awareness eLearning programme is available on TURAS Learn, with compliance monitoring in place.
		December 2026		This will be made available to all relevant staff, with compliance monitored through clinical and staff governance processes, in line with the expectation that 95% of inpatient nursing staff will complete the training by December 2026.	On track December 2026	Current compliance is 38% against implementation date of June 2026. Progress against the agreed target is monitored through workforce and clinical governance structures, with work continuing towards the 95% compliance target by December 2026. A phase implementation approach is in place, with senior charge nurse and CNM monitoring oversight local.

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Requirement 6. Domain 1.	NHS Forth Valley must ensure effective oversight of ligature risk assessments and any identified risks to ensure these are effectively mitigated	April 2026	Head of Service	Oversight of ligature risk assessments through the Health and Safety Committee is now standing agenda item; following a presentation in May 2026. Assurance and updates are being provided via attendance from members of the Ligature Working Group. 70% of ligature risk assessments are complete and will be fully completed by July 2026. This reflects that a reporting route into the Health and Safety Committee is established in practice, with the committee acting as the forum for action and scrutiny, in line with the agreed governance structure.	Complete July 2026	The Estates Oversight Group, local delivery groups and Ligature Working Group provide governance oversight of the Mental Health Unit environment and ligature risks. Assessments are complete across all wards, with identified actions progressed through established governance arrangements to reduce risk and provide assurance.
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		Feb 2026		The Ligature Working Group has been successfully re-established, providing a multidisciplinary forum to support coordination and oversight of ligature risk activity. Oversight through governance groups is established but elements of reporting, consistency of assessments, and quality assurance are not yet fully embedded. An audit tool is in development and will be applied across all comparable wards with aim of completion by September 2026.	Complete August 2026	A quality assurance audit tool has been developed and is now being applied alongside ligature risk assessments to provide additional assurance regarding the consistency, quality and oversight of assessments and associated action plans across services.
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Requirement 7. Domain 1.	NHS Forth Valley must ensure management processes to identify ongoing risk and ensure timely review, oversight and implementation of adverse event improvement actions align with the National Framework for Reviewing and Learning from Adverse Events.	February 2026: Completion of improvements within the electronic adverse event reporting system	Associate Medical Director/Chief Nurse/Head of Clinical Governance (Director of Nursing – starts March 2026)	NHS Forth Valley has completed alignment of its adverse event reporting processes within Safeguard (Ulysses) with local policy and procedure, the Healthcare Improvement Scotland Adverse Events Framework and the principles set out within the Blueprint for Good Governance. This milestone was achieved in February 2026.	Complete February 2026	Test of new report in respect of adverse event reporting and performance due at Clinical Governance Working Group
		December 2026: Full implementation of aligned processes		The Adverse Event Policy, together with the associated Significant Adverse Event Review and Local Management Team Review procedures, has been updated and is now operational. This provides a clear and consistent framework for the reporting, review and management of adverse events in line with national expectations.	Complete February 2026	
				Performance reporting in relation to adverse event reporting compliance and review timescales is being developed collaboratively with Clinical Governance and Health and Safety colleagues. This will strengthen assurance	On track for December 2026	

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						October 2026, with subsequent Directorate level reports thereafter (at next available Directorate level CG meeting)
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				The training package to support phase 1 of the Safeguard enhancements has been completed, including impact scoring, strengthened manager sign-off and alignment with Healthcare Improvement Scotland timescales. NHS Forth Valley also has an agreed timeline for transition to the Healthcare Guardian system, with associated improvement activity being incorporated within this programme of work through a phased approach to implementation, with completion anticipated in 2027.	On track for April 2027	Mapping sessions for adverse event app within Healthcare Guardian underway and on track for 2027 timescale.
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				The NHS Forth Valley Community of Practice will go live at the end of May 2026 to support the systematic sharing of learning summaries arising from Significant Adverse Event Reviews, Local Management Team Reviews and Child Death Reviews. These summaries will be available to colleagues across NHS Forth Valley in order to strengthen organisational learning, increase visibility of improvement themes and support the wider dissemination of learning identified through review activity. NHS Forth Valley is also now submitting all learning summaries arising from Significant Adverse Event Reviews to Healthcare Improvement Scotland for the national Community of Practice. All improvement plans arising from Significant Adverse Event Reviews are now tracked through Pentana, with reporting to Directorate-level Clinical Governance groups to support oversight and	Complete July 2026 Complete February 2026	Community of Practice for NHS Forth valley went live July 2026 LMTR process mirroring that of SAER action plan tracking on schedule for December 2026 completion.
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				accountability. Work is underway to implement the same approach for Local Management Team Review improvement plans, with completion scheduled for December 2026. NHS Forth Valley also continues to participate actively in the Healthcare Improvement Scotland Adverse Event Network in support of national learning, shared improvement and continued alignment with the Adverse Events Framework.		
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Requirement 8 Domain 1	NHS Forth Valley must ensure systems and processes are in place that support the effective identification and mitigation of risk to ensure a safe environment for all patients	July 2026	Head of Service / Chief Nurse	NHS Forth Valley MHL D service has implemented the inclusion of questions relating to sexual safety in initial assessments and MDT records. The newly developed formulation based clinical risk assessment tool incorporating assessment of sexual safety will be presented at the May 2026 MHL D CG group.	Completed July 2026	The new formulation-based Clinical Risk Assessment Document has been approved and is now live within the electronic patient record system. Implementation is underway across all Mental Health and Learning Disability services, supported by a TURAS module and face-to-face training to ensure consistent application of the revised assessment process.
		May 2026		This new risk assessment tool has been formatted for the electronic patient record, and a TURAS module is in development with training on its use planned. It is planned that this will be embedded by the end of July 2026.		CRAD training compliance in the Mental Health Unit is currently 49% for face-to-face training and 38% completion of the TURAS module. Delivery and monitoring of training remain ongoing, with progress reported

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		March 2026		A ward level Sexual Safety Charter is in development, supported by local lived experience panel members to ensure co-production. Sexual Safety Champions have been identified to support implementation, promote awareness, and act as a local point of contact for staff in relation to sexual safety practice.	Complete August 2026	through established governance arrangements. The Sexual Safety Charter has been co-produced and implemented across inpatient services. Sexual Safety Champions are established within clinical areas to support implementation, promote awareness and provide a local point of contact for staff and patients in relation to sexual safety.
		April 2026		An improvement programme informed by the National Sexual Safety Collaborative and Sexual Safety Standards has been established with stakeholder engagement. Benchmarking has been completed and identified areas for improvement which will inform the programme priorities	Complete April 2026	

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Requirement 9 Domain 1	NHS Forth Valley must ensure fire safety doors are maintained in a safe working order that enables safe fire evacuation and reduces the restriction of movement around older adult wards	May 2026	Head of Service / Director of Estates	Local processes are in place to identify and address required improvements to fire safety doors, supporting a timely and coordinated response. Arrangements are in place for routine monitoring through the Estates Oversight Group, with escalation of risks and required actions to the Health and Safety Committee for action, and reporting to the Clinical Governance Working Group for assurance, though escalation routes to Health and Safety are still embedding.	Complete January 2026	
				Work is progressing to review current fire doors and identify safer and more suitable design solutions. Input has been sought from Fire Safety Officers, with options now being developed and considered by clinical and estates teams to ensure any proposed changes balance safety, functionality and patient needs. This work is approaching a	Complete August 2026	The review of fire door design and associated environmental improvements has progressed through the established estates governance structure. Recommendations have been considered through the MHU Estates

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				recommendation stage, with proposals due to be presented through the Estates Oversight Group to support decision-making and alignment with wider infrastructure plans.		Oversight Group, with environmental improvements incorporated into the wider programme of estates works. Routine monitoring and escalation arrangements remain in place to support ongoing assurance.
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Requirement 10. Domain 1.	NHS Forth Valley must ensure effective and appropriate governance approval and oversight of policies and procedures that are in place	Dec 2026	Head of Clinical Governance Locally Associate Medical Director	At the point of reporting, 45.3% of clinical policies and guidelines are within their scheduled review date, against a target of achieving 95% compliance by December 2026.	On track December 2026	A structured review programme for clinical policies and guidelines remains in place, supported by a risk-based prioritisation approach. Progress is monitored through Directorate Clinical Governance Groups and the Clinical Governance Working Group, providing oversight and accountability for delivery. Compliance currently stands at 59%, compared with the board target of 95% by December 2026. Continued focus is being placed on progressing outstanding reviews to support achievement of the target.
				A comprehensive review programme is in place to address this gap, supported by a structured prioritisation approach using a Red-Amber-Green (RAG) rating system. This approach ensures that higher-risk and time-critical documents are prioritised and progressed in a timely and proportionate manner.		
				Focused work has also been undertaken to strengthen governance and accountability arrangements. This has included confirming and assigning appropriate	Complete March 2026	

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				authorship for all policies and guidelines. In parallel, the Mental Health and Learning Disability (MHLD) Clinical Governance Lead is actively engaging with local clinical governance meetings to develop a Standard Operating Procedure (SOP), which will clearly define expectations in relation to policy ownership, review, and approval. As part of the formal governance process, nine completed policies are scheduled for submission to the Mental Health and Learning Disability Clinical Governance Working Group (MHLD CGWG) for approval.		
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				Regular reports and updates are now being sighted through governance groups across the MHL D business units, strengthening visibility of progress and supporting local accountability for delivery. In addition, oversight of this work across all parts of the system is being maintained through the Clinical Governance Working Group on a scheduled quarterly basis.	Complete March 2026	Completed with increased assurance reporting into CGWG every meeting
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				The MHLG Clinical Governance Group, through its Clinical Guidelines Working Group, will continue to oversee the updating, management and assurance of clinical policies and guidelines, in support of the wider Board objective to achieve 95% of documents within review date by December 2026.	On track December 2026	Compliance has improved from 45.3% in June 2026 to 59% currently, representing an increase of 13.7%. During the reporting period, further policies and guidelines have been reviewed, updated and approved through established governance processes. Work will continue to prioritise overdue and high-risk documents to support progress towards the Board target of 95% compliance by December 2026.
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Requirement 11. Domain 2.	NHS Forth Valley must ensure that there are clear assurance processes and systems and these are planned and organised in a way that provides assurance that high quality care is being delivered	February 2026	Chief Nurse	The Quality and Safety Steering Group has been established at organisational level as the Safety Steering Group, providing a stronger forum for oversight of quality and safety across the system The group reports directly to the Quality, Safety & Experience Board.A revised assurance reporting template has been developed and is currently being trialled. This is intended to support structured, consistent reporting and enhance the quality, transparency and standardisation of information presented to the group.	Complete August 2026	The Quality and Safety Assurance Report is now incorporated within routine governance and assurance arrangements. Quality measures, associated action plans and improvement activity are reported through established governance structures, providing oversight of quality, safety and risk across Mental Health and Learning Disability services. The reporting framework continues to support organisational assurance and escalation where required.
				At this early stage, formal written reports from Mental Health and Learning Disabilities (MH&LD) are in development. Key areas of work such as the Sexual Safety Measurement Plan, Excellence in Care Assurance reporting and the Scottish Patient Safety Programme (SPSP) Transition of Care improvement work will be reported via the Safety Steering Group. There is clear evidence of	Complete August 2026	

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				appropriate senior clinical representation and oversight, including attendance and contributions from the Chief Nurse and senior MHL D staff. Arrangements are now in place to strengthen formal reporting, with a comprehensive MHL D report planned for the next Safety Steering Group meeting. This will support triangulation and assurance across governance structures and align with reporting to the MHL D Clinical Care Governance Committee (CCGC), Clinical Governance Working Group and Committee, and the Quality Programme Board.		
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Requirement 12. Domain 2.	NHS Forth Valley must ensure there is oversight and consistent application of screening tools to identify the risk of falls or pressure sores across all wards in the MHU	June 2026	Chief Nurse	NHS Forth Valley MHU introduced the agreed Falls and Pressure Injury risk screening tools across the MHU in March 2026.	Complete March 2026	Governance monitoring is now embedded, with oversight provided through Directorate Clinical Governance Groups and the Quality and Safety Steering Group.
				Application of the tools is being audited and recorded locally, with current compliance at 45% Falls and 50% Purpose T. Additional training sessions are planned for June 2026 to support improved uptake and compliance with revised compliance aim of 95% by October 2026. A targeted quality improvement approach will be implemented, focusing on priority areas and informed by learning from the Safer Together Collaborative and aligned with SPSP Adults in Hospital improvement work. Compliance is monitored weekly and reported through MHL D Clinical Governance and the Clinical Management Group to support ongoing oversight and improvement. The Purpose T pressure injury	Complete August 2026	Improvement activity continues with support from the Quality Improvement Team and Practice Development Unit to embed consistency of application and support sustained achievement. Application of the screening tools on admission and reassessment is required for all patients within older adult wards. A process is also in place within adult

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				risk assessment tool has been introduced across the MHU. Education to support its application is being provided by the Tissue Viability team and through online learning resources, alongside wider practice development support. Education and support are also being delivered through the Practice Development Unit to support consistent application of these policies and associated assessment tools, including HCSW Skills Days, safer mobility learning opportunities, and the NMAHP Graduate Stepping Forward Programme.		wards to ensure screening is completed on admission and repeated throughout admission where clinically indicated.
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Requirement 13. Domain 4.1	NHS Forth Valley must ensure that the care environment is in a good state of repair to support effective cleaning and that effective assurance systems are in place to support the reporting of environmental issues and the monitoring of the care environment	June 2026	Chief Nurse	The Estates Oversight Group is now in place, with monitoring built into local governance reporting. Local estates delivery groups have also been established to support this work. Implementation of the Mental Health Built Environment Quality and Safety Assessment Toolkit remains on schedule and is expected to be completed by July 2026.	Complete September 2026	The Estates Oversight Group and local estates delivery groups continue to provide oversight of the Mental Health Unit environment through established governance arrangements. Mental Health Built Environment Quality and Safety Assessments have now been completed, with findings informing future environmental improvement priorities and any further mitigation required to support ongoing assurance.
				IPC reports are submitted every six weeks to the Clackmannanshire and Stirling Operational Unit Infection Control Group, supported by ward-level reports that provide a clear reporting route from ward to Board level.	Complete February 2026	

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Requirement 14. Domain 4.1	NHS Forth Valley must ensure consistent recording of flushing of infrequently used water outlets to improve compliance and provide assurance in line with current national guidance	August 2025	Chief Nurse	Effective oversight of Infection Prevention and Control (IPC) is maintained through local operational infection control groups, which support the flow of information between ward teams, service delivery, and the Board Infection Control Committee.	Complete January 2026	
				Ward-level infection control meetings are now in place to strengthen local oversight, enable timely discussion of IPC issues, and support escalation where required. Key themes and concerns are fed through to wider governance forums, with oversight from specialist IPC advisors and the Chief Nurse.	Complete January 2026	

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		Feb 2026		Twice weekly flushing of infrequently used water outlets is now embedded within the MHU, supported by strengthened audit and monitoring arrangements. Sustained improvement has been demonstrated, with recent data showing consistent 100% compliance. Ongoing oversight remains in place to ensure standards are maintained and compliance continues to be evidenced over time.	Complete April 2026	
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Requirement 15. Domain 4.3	NHS Forth Valley must ensure there are clear and consistent systems and processes in place for the monitoring and mitigation of any severe and or recurring staffing risk to support longer term workforce planning.	April 2026	Chief Nurse	Safecare has been implemented, alongside daily huddles and twice-daily recording of professional judgement. Professional judgement continues to be recorded twice a day, and daily staff huddles remain in place. Operational guidance has been developed to strengthen escalation pathways and standardised definitions and documentation. This is currently out for consultation across the wider NHS Forth Valley network. Governance reporting is established from ward to board level. The annual nursing blueprint has been reviewed and is nearing completion, with final approval from Finance expected by June 2026.	Complete February 2026	
		April 2026			Complete February 2026	

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Requirement 16. Domain 4.3	NHS Forth Valley must ensure there are clear, consistent systems and processes in place to support and monitor wider system oversight, of identified staffing or safety risks within the MHU	February 2026	Chief Nurse	Participation in the whole system huddle has continued with work ongoing to improve the effectiveness and efficiency. Safecare has been implemented, alongside daily huddles and twice-daily recording of professional judgement. Professional judgement continues to be recorded twice a day, and daily staff huddles remain in place. Reporting through NMAHP Workforce Governance provides structured oversight of workforce risks within the wider governance framework, supporting their identification, monitoring and escalation, with mitigations and controls kept under ongoing review.	Complete February 2026 Complete February 2026	

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Requirement 17. Domain 4.3	NHS Forth Valley must demonstrate how it supports, monitors and reviews the provision of adequate time to lead and resources available to clinical leaders	March 2026	Chief Nurse	E-roster is now fully implemented as the central monitoring system. Time to lead is reviewed weekly, with any issues escalated through workforce governance structures. Since the last update, time to lead has increased to 80% of the Senior Charge Nurse working week.	Complete March 2026	
Requirement 18. Domain 6.	NHS Forth Valley must ensure meaningful activity is consistently provided, including weekends and that activity plans are completed and updated	April 2026 February 2026	Head of Service	A seven-day timetable of therapeutic activities has been established in line with the agreed timescale. A monitoring process is now in place within MHLD to support oversight of the consistency of delivery, with reporting through Clinical Governance. To support implementation, audit cycles are undertaken to monitor consistency and identify any challenges, this will continue to be addressed through ongoing monitoring and improvement activity.	Complete April 2026	

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Requirement 19. Domain 6.	NHS Forth Valley must ensure that patients' privacy and dignity is maintained, adult support and protection issues are assessed at all times including having appropriate toilet and showering facilities that support dignity and privacy in a mixed sex environment.	March 2026	Head of Service	NHS Forth Valley MHL D has established a structured and risk based approach to maintaining patient privacy, dignity, and safeguarding within mixed sex inpatient environments. This includes defined gender based zoning in Ward's 2 and 3, including dedicated toilet and showering facilities. A mandatory risk assessment is required for any deviation from standard placement, and the use of environmental and staffing mitigations. These arrangements are supported through routine multidisciplinary review, with all mixed sex placements subject to daily reassessment to ensure that risks remain appropriately managed and that transfer to gender appropriate accommodation occurs at the earliest opportunity. A structured review of the evidence base relating to single sex and mixed sex mental health environments is underway with the first	Complete March 2026	The ward configuration review is now complete. It used a multi-source approach, bringing together service user views, the available evidence base, adverse event reporting, and environmental and operational findings. The completed review and recommendations now need to progress through the established governance channels for consideration and approval.
		June 2026			Complete August 2026	

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				meeting scheduled for end of May. This work is intended to inform future service development, including environmental design and operational practice, and to ensure that current arrangements remain aligned with best available evidence.		
Recommendation 1 Domain 2.	NHS Forth Valley should consider the benefit of extending access to reflective session to staff in older adult wards within the mental health unit	June 2026	Director of Psychology / Chief Nurse	Work is progressing as planned to introduce reflective practice groups for older adult wards, with the first session scheduled for 18th June 2026. Support has been established from Psychology and Lead Nurses, and a staff questionnaire has been circulated to ensure the groups are shaped to be meaningful, accessible, and beneficial for teams.	Complete June 2026	Reflective practice has been extended across all Mental Health Unit wards, including older adult services. Monitoring arrangements have been established through to support oversight of participation and consistency. Ongoing evaluation will support continued development and sustainability of reflective practice across services.

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