# JOINT INSPECTION OF ADULT SUPPORT AND PROTECTION

**Renfrewshire, March 2025**

## Contents

# Joint inspection of adult support and protection in the Renfrewshire partnership

## Joint inspection partners

Scottish Ministers requested that the Care Inspectorate lead a second phase of joint inspection and development of adult support and protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland.

## Phase two

This programme follows our phase one inspections. We published an overview report which summarised the findings and key themes identified. Phase two is linked to the Scottish Government's improvement plan for adult support and protection, and the national implementation groups which support it.

## The joint inspection focus

We halted our joint inspection of adult support and protection in the Renfrewshire partnership in March 2020 due to the Covid-19 pandemic. This meant we did not publish a report. We provided feedback to the Renfrewshire partnership on our findings based on the work we were able to complete, including suggested areas for improvement. The partnership prepared an improvement plan to address these. In 2024, as the final element of our phase two joint inspection of adult support and protection programme, we determined to carry out a joint inspection of adult support and protection in the Renfrewshire partnership and publish a report. Our 2024 joint inspection read fewer records of adults at risk of harm compared to the phase one programme.

The Scottish Government published updated codes of practice in July 2022. The Renfrewshire partnership indicated it fully adopted the codes of practice.

The focus of this inspection was on whether adults at risk of harm in the Renfrewshire partnership area were safe, protected and supported.

The joint inspection of the Renfrewshire partnership took place between November 2024 and March 2025. We scrutinised the records of adults at risk of harm for the one-year period, from November 2023 to November 2024.

## Quality indicators

Our quality indicators[1] for these joint inspections are on the Care Inspectorate's website.

[1] https://www.careinspectorate.com/images/documents/5548/Adult%20support%20and%20protection%20quality%20indicator%20framework.pdf

## Progress statements

To provide Scottish Ministers with timely high-level information, this joint inspection report includes a statement about the partnership's progress in relation to our two key questions.

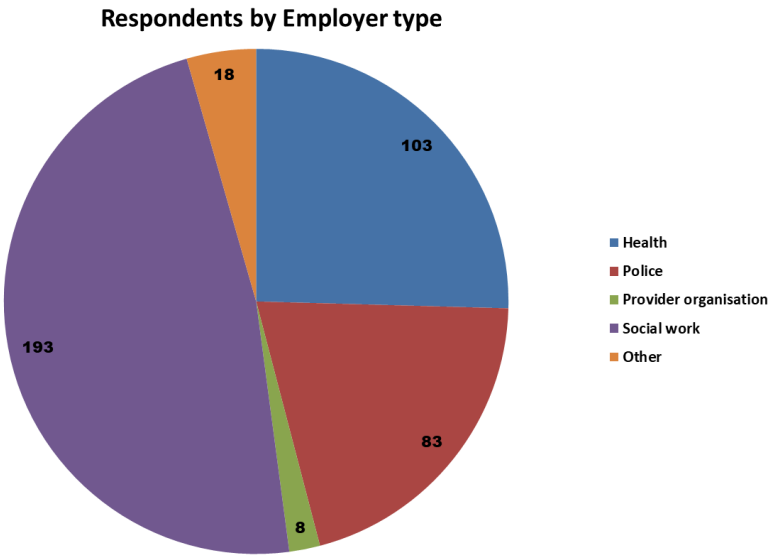
- How good were the partnership's key processes for adult support and protection?
- How good was the partnership's strategic leadership for adult support and protection?

## Joint inspection methodology

In line with the targeted nature of our inspection programme, the methodology for this inspection included five proportionate scrutiny activities.

**The analysis of supporting documentary evidence** and a position statement submitted by the partnership.

**Staff survey**. Four hundred and five staff from across the partnership responded to our adult support and protection staff survey. This was issued to a range of health, police, social work and third sector provider organisations. It sought staff views on adult support and protection outcomes for adults at risk of harm, key processes, staff support and training and strategic leadership. The survey was structured to take account of the fact that some staff have more regular and intensive involvement in adult support and protection work than others.

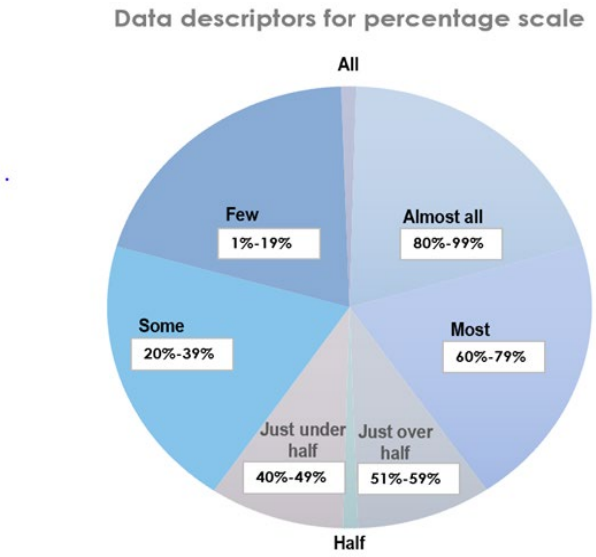


**The scrutiny of social work records of adults at risk of harm**. This involved the records of 20 adults at risk of harm who did not require any further adult support and protection intervention beyond the initial inquiry stage.

**The scrutiny of the health, police, and social work records of adults of risk of harm.** This involved the records of 20 adults at risk of harm for whom inquiries have used investigative powers under sections 7-10 of the 2007 Act. This included cases where adult support and protection activity proceeded beyond the inquiry with investigative powers stage.

**Staff focus groups.** We carried out three focus groups and met with 35 members of staff from across the partnership to discuss adult support and protection practice and adults at risk of harm.

## Standard terms for percentage ranges




This report uses these terms to refer to our results for the sample of records we read.

## Summary – strengths and priority areas for improvement

### Strengths

- The partnership's consistent delivery of high-quality adult support and protection work was commendable and impressive.

- The partnership consistently carried out competent, effective and timely initial inquiries into concerns about adults at risk of harm. Council officers always carried them out using investigative powers when warranted.

- The partnership routinely undertook investigations into concerns about an adult at risk of harm. These were of sound quality and fully in line with the Scottish Government's revised code of practice for adult support and protection (2022). And it conducted adult protection case conferences to a high professional standard.

- The partnership's strategic leaders exercised energetic leadership for adult support and protection across the partnership. They engendered a positive, confident, "can-do" culture for adult support and protection.

- Strategic leadership for adult support and protection was accomplished with elements that were sector leading. Prominent among them was the well-established commitment to rigorous multi-agency audits of the records for adults at risk of harm. And reporting audit findings in a frank, open, and transparent manner. This drove change and improvement.

- The adult protection committee's innovative approach to communicating with partnership staff who work in adult support and protection was highly commendable. Its efforts to inform and promote adult support and protection, including to the public, were highly successful.

### Priority areas for improvement

- The partnership should continue its efforts to improve the quality of chronologies and risk assessments for adults at risk of harm.

- The partnership should make progress with adults at risk of harm attending their adult protection case conference.

- The partnership should continue its endeavours to improve representation of adults with lived experience of adult support and protection, at strategic level in the partnership.

## How good were the partnership's key processes to keep adults at risk of harm safe, protected and supported?

### Key messages

- Adults at risk of harm were safer and had better wellbeing due to the collective activities of the partnership to protect and support them.
- The partnership's consistent, collaborative delivery of key processes to keep adults at risk of harm safe, supported and protected was impressive.
- Initial inquiries into concerns about adults at risk of harm were consistently prompt, competent, and effective.
- The partnership routinely undertook sound, rigorous investigations into concerns about an adult at risk of harm. And it conducted adult protection case conferences to a high professional standard.
- Health professionals and police officers worked productively alongside social workers. They made a vital contribution to keeping adults at risk of harm safe, protected and supported.
- The partnership should continue to strive to improve the quality of chronologies and risk assessments for adults at risk of harm.
- The partnership should ensure adults at risk of harm attend their adult protection case conference where appropriate.

**We concluded the partnership's key processes for adult support and protection were very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm.**

### Screening and triaging of adult protection concerns.

The partnership's adult services referral team (ASeRT) was a dedicated team that processed all referrals to social work and specialist teams, this included adult protection referrals. They received adult protection referrals by a variety of methods and processed them promptly and efficiently. A duty manager oversaw this process and determined if the adult protection referral required to proceed to the initial inquiry stage. Almost all partnership staff surveyed considered the partnership's screening and triaging process effective and were confident about how to make an adult protection referral.

## Initial inquiries into concerns about adults at risk of harm

### Interagency referral discussions

In common with some other partnerships in Scotland, the Renfrewshire partnership did not carry out interagency referral discussions. It convened multi-agency meetings for complex cases. These meetings effectively determined the way forward for inquiry and investigative activity.

Overall, the partnership's initial inquiries were consistently prompt, competent, and effective, with purposeful collaboration among partners. This was one of its several key strengths for adult support and protection. Council officers carried out all initial inquiries that used investigative powers. All initial inquiries complied with the general principles set out in the Adult Support and Protection (Scotland) Act 2007. The partnership appropriately informed almost all adults at risk of harm who were the subject of an initial inquiry. All initial inquiries were timely, and all clearly and succinctly referenced the application of the three-point criteria. All communication among partners was good or better for effectiveness, with just under half of this very good for effectiveness. All initial inquiries had clear evidence of management oversight and sign off. Almost all initial inquiries were good or better for quality, with most of these very good for quality.

Our staff survey results related to initial inquiries and were consistently positive. Almost all staff expressed favourable views about aspects of initial inquiries – including their knowledge of the three-point criteria, what constituted adult protection harm, and how and when to make an adult protection referral.

## Inquiries including the use of investigatory powers

### Chronologies

Chronologies for adults at risk of harm is one of the three elements of management of risk – risk assessment and protection plans are the other two. Also, if adult support and protection interventions are to take account of the adult at risk of harm's past and present trauma, this has to be referenced. And chronologies are a vehicle to do this.

All adults at risk of harm in our sample who required a chronology had one. Quality was variable, with some good. While these figures showed room for improvement with chronologies, they were better than those from the partnership's own audits in 2022 and 2024. The partnership worked to improve quality of chronologies via training and guidance for staff. And it was developing an electronic recording application Eclipse to support staff to prepare competent chronologies. Chronologies did not contain an analysis of relevant life events for the adult at risk of harm. The partnership should rectify this.

### Risk assessments

Almost all adults at risk of harm in our sample had an up-to-date risk assessment. This was a significant improvement on the partnership's own 2022 audit when only half of the adults at risk of harm had a risk assessment. The views of multi-agency partners informed all the risk assessments. Most risk assessments were good or better for quality. The partnership's approach to preparing risk assessments for adults at risk of harm was to embed them in its investigation reports. This was the detailed record of the partnership's inquiry into the adult protection concerns for the adult at risk of harm and their circumstances. The partnership could improve the quality of its risk assessments for adults at risk of harm by creating specific fields to document the risks, likelihood of occurrence of the risks, impact on the adult at risk of harm, and the protective factors.

### Investigations

Inquiries with investigative powers was one of many strengths for the Renfrewshire partnership. Its highly consistent approach to carrying them out and recording them was sound, collaborative and effective. The partnership carried out a competent investigation for all the adults at risk of harm in our sample. Almost all were timely. A council officer proficiently enacted investigative powers in all of them. And a second worker participated when warranted. Almost all investigations were good or better for quality, with just over half of these very good for quality. Investigation reports routinely documented trauma experienced by the adult at risk of harm. All investigations effectively determined if the adult was at risk of harm. Appropriate involvement by the police in investigations was an area for improvement in the partnership's improvement plan. Our 2025 record reading findings were that the police were always involved in investigations when appropriate.

## Adult protection initial case conferences

Initial adult protection case conferences was another strength for the Renfrewshire partnership. This was in part due to a constructive programme of continuous improvement for them. The partnership convened an initial adult protection case conference for almost all adults at risk of harm in our sample who required one. Almost all case conferences were timely and effectively determined the required multi-agency actions to keep the adult at risk of harm safe, supported and protected. And social work invited all relevant professionals to attend. Case conferences were consistently high-quality, with almost all good or better for quality, and most of these very good for quality. The minutes of case conferences were well-drafted, comprehensive records of the purposeful discussions. Social work circulated them promptly to all parties invited.

Improving the attendance by professionals at case conferences was an area for improvement in the partnership's improvement plan. Our record reading results showed the partnership's improvement actions – issuing revised guidance for staff, staff briefing sessions, were partly successful. And further improvements were needed. Health professionals almost always attended adult protection case conferences when invited. They consistently provided invaluable information, and insightful analysis to the deliberations of case conferences. Police officers attended around half the adult protection case conferences when invited. Albeit an improvement from the partnership's 2024 audit, when there was no police attendance in the small sample of case conferences examined, further improvement was warranted. The partnership recently issued a protocol that aimed to ensure police always attended adult protection case conferences when invited.

Encouraging adults at risk of harm to attend their case conference was an area for improvement in the partnership's improvement plan. The partnership's improvement actions – helpful changes to how it conducted case conferences, revised guidance – were partly successful. The partnership always invited the adult at risk of harm to their case conference when warranted. It always clearly recorded reasons for not inviting them if this was appropriate. Adults at risk of harm seldom attended their case conference when invited (a few attended when invited). The partnership readily acknowledged this needed to improve. Improving the attendance and meaningful participation in their case conferences by adults at risk of harm was a national issue. The Renfrewshire partnership had a representative on the national implementation group that was creating guidance on how adults at risk of harm can be better supported to engage with their case conference.

### Adult protection plans / risk management plans

Preparation of protection plans for adults at risk of harm was an area for improvement in the partnership's improvement plan. Our record reading results clearly show the partnership's improvement actions – issuing helpful guidance for staff, training, and instituting a sound system to prepare protection plans – were successful. Almost all adults at risk of harm who required a protection plan had one. Almost all protection plans were good or better for quality, with just over half of these very good. Protection plans were SMART (specific, measurable, achievable relevant, and timebound). And suitably identified parties responsible for carrying out protective actions.

### Adult protection review case conferences

The partnership consistently carried out adult protection review case conferences in almost all cases when the adult at risk of harm required one. Social work convened all of them timeously, and all effectively determined required actions to ensure the adult at risk of harm was safe, supported, and protected.

### Implementation / effectiveness of adult protection plans

The partnership's multi-agency implementation of protection plans for adults at risk of harm was consistently effective. It purposefully adopted the core group approach to monitoring and reviewing the implementation of protection plans. These core groups worked well.

### Large-scale investigations

The partnership undertook large scale investigations in line with national guidance. The Care Inspectorate was appropriately involved, as were other relevant organisations. Large-scale investigations were competent, and consequently adults at risk of harm involved were safer.

## Collaborative working to keep adults at risk of harm safe, protected and supported.

### Health involvement in adult support and protection

NHS Greater Glasgow and Clyde were partners with six health and social care partnerships including Renfrewshire. NHS Greater Glasgow and Clyde operated a public protection team that was responsible for adult support and protection. Renfrewshire health and social care partnership was responsible for community health teams.

The Renfrewshire partnership submitted the health records of adults at risk of harm from a broad range of health services. Most had evidence of adult support and protection concerns recorded therein. Health professionals always shared information appropriately and effectively. Health professionals always carried out medical examinations on adults at risk of harm when required. A suitable health professional participated as a second worker in investigations most of the time when required. Almost all health involvements made a good or better contribution to positive outcomes for adults at risk of harm.

Health staff felt confident and competent to carry out adult support and protection work as required by their role. Health staff felt valued and supported.

NHS Greater Glasgow and Clyde used the NHS Public Protection Accountability and Assurance Framework and toolkit to self-evaluate their performance. They produced an annual report and accompanying action plan to support further improvement work. A development emanating from this work was a public protection information website for staff. This included information about adult support and protection. Health was a significant and valued partner and contributed to all aspects of adult support and protection, from strategic leadership to frontline staff's identification of adults at risk of harm.

### Police involvement in adult support and protection

Police Scotland were key partners for adult support and protection in Renfrewshire. Police officers were prompt and diligent to identify adults at risk of harm and ensure they were safe, supported, and protected.

From the initial contact response for adult protection, the service screened episodes effectively. It promptly shared information with partner agencies. It always effectively assessed all contacts made to the police about adults at risk of harm for threat of harm, risk, investigative opportunity and vulnerability (THRIVE).

In almost all cases in our sample the initial attending officers' actions were good or better. Their competent practice contributed to the multi-agency adult protection response for adults at risk of harm. Police officers routinely assessed risk of harm, vulnerability and wellbeing well. They took account of the wishes and feelings of the adult at risk of harm. They ensured adults at risk of harm who needed support got it. When officers recorded adult concerns, they did it efficiently and promptly on almost all occasions, using the interim vulnerable persons database (iVPD).

Police officers' attendance at adult protection case conferences had improved somewhat. The service introduced governance structures to ensure more consistent attendance by officers with the right level of experience to contribute purposefully to case conferences. The service supported this with revised training for case conference participation. And it developed a toolkit to help staff have a clear knowledge and understanding of their role in adult support and protection.

Police Scotland adopted very effective improvements so that at every stage of involvement officers considered adult support and protection. They introduced governance arrangements and escalation protocols, which ultimately enhanced the safety and wellbeing of adults at risk of harm.

## Key adult support and protection practices

### Information sharing

For the records in our sample, almost all staff shared information about adults at risk of harm appropriately and effectively. The partnership's suite of adult support and protection documentation emphasised the critical importance of partners sharing information. Health professionals got feedback from social work half of the time after they made an adult protection referral. Social work was working to improve this.

### Management oversight and governance

Management oversight and governance was a strong element of the Renfrewshire partnership's approach to adult support and protection. The standard of recording in the social work, police, and health records was consistently high. There was evidence line managers read the social work, police and health records in our sample almost all of the time. Almost all social work records contained a record of decisions made via supervision. All social work records had evidence of governance, and almost all police records had this. Some health records had evidence of governance. Evidence of exercise of governance was less apparent in health records. This was not necessarily a deficit due to the types of health records scrutinised.

## Safety outcomes for adults at risk of harm

Almost all adults at risk of harm in our sample experienced some improvement to their safety and protection. Responses to our staff survey were congruent with this finding. Most staff surveyed considered they made a positive difference to adults at risk of harm via adult support and protection interventions; adults at risk of harm got the support they needed to keep safe and had a safer quality of life.

## How good was the partnership's strategic leadership for adult support and protection?

### Key messages

- The partnership's strategic leaders exercised motivational leadership for adult support and protection across the partnership. This led to an empowering, supportive ethos for adult protection across the partnership.

- Strategic leadership for adult support and protection was highly effective with elements that were sector leading. The well-embedded commitment to rigorous multi-agency audits of the records for adults at risk of harm was creditable. And the partnership reported audit findings in a forthright, accessible way.

- The adult protection committee communicated exceptionally well with partnership staff who worked in adult support and protection. Additionally, its approaches to inform and promote adult support and protection to all interested parties was highly fruitful.

- The partnership should continue its endeavours to improve adults with lived experience of adult support and protection represented at a strategic level in the partnership.

**We concluded the partnership's strategic leadership for adult support and protection was very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm.**

## Vision and strategy

The Renfrewshire adult protection partnership had a well-established vision statement for adult support and protection. It communicated this effectively to partnership staff, partners, and the wider community. The vision statement featured prominently on the partnership's documents about adult support and protection. Most staff surveyed thought the partnership provided them with a clear vision for their adult support and protection work. Strategic leaders' strong leadership for adult support and protection engendered a positive culture for adult support and protection across the partnership. A collective view expressed at a staff focus group was, ***"it feels safe to work in this partnership".***

The partnership's adult support and protection improvement plan (2024) was a well-designed and well-written document. It appropriately drew on and aligned to the joint inspection of adult support and protection team's quality improvement framework 2024.

Examples of strategic leaders' ability to deliver improvements they identify quickly and efficiently included purposeful amendments to the initial inquiry template, and development of a protocol to support police attendance and participation in adult protection case conferences.

## Effectiveness of strategic leadership and governance for adult support and protection across partnership

Renfrewshire's community protection chief officer group (COG) exercised strategic governance for adult support and protection, child protection, multi-agency public protection arrangements, violence against women and girls, multi-agency risk assessment conferences, tackling poverty and reducing alcohol and drug harms. It provided sound governance for adult support and protection. It was well-informed about adult support and protection issues. It prioritised adult support and protection appropriately. The independent convener of the adult protection committee was a member of the chief officer group and contributed suitably.

The partnership's adult support and protection committee exercised excellent, high-quality leadership and governance for adult support and protection across the partnership. There was compelling evidence for this assertion. The adult protection committee's commitment to the rigorous, multi-agency audits of the records for adults at risk of harm was highly commendable. Its communication and promotion of adult support and protection to partnership staff, partners and the wider community was exemplary. For example, 134 members of staff from across the partnership attended the adult protection committee's first online drop-in session. This afforded staff the opportunity to learn about the work of the committee. An average of 60 staff routinely attended these sessions. The adult protection committee ran very successful staff briefings about adult support and protection in 2024. They were exceptionally well-attended – almost 500 delegates attended. Delegates feedback was universally positive. In 2024, the partnership held a successful, well-attended conference about adult support and protection for its staff. Delegates from the third sector also attended.

Most staff surveyed considered the adult protection committee exercised effective leadership for adult support and protection. Frontline staff at our focus group confirmed this.

The adult protection committee had subgroups for learning and development and continuous improvement. Police, health, and social work delegates contributed purposefully to the work of the adult protection committee. They demonstrated a strong commitment to collaborative leadership for adult support and protection across the partnership.

### Effectiveness of leaders' engagement with adults at risk of harm and their unpaid carers

The adult protection committee should have an adult with lived experience of adult support and protection represented on it. And an unpaid carer representative. These were areas for improvement in the partnership's improvement plan. The partnership acknowledged it was an ongoing challenge to get strategic-level representation from individuals with lived experience of adult protection. It was working to achieve this.

Positively, the Renfrewshire adult protection committee appointed an unpaid carer as a delegate. And a representative from the independent advocacy service. The partnership worked productively with the local You First Advocacy organisation to develop and improve its engagement with adults at risk of harm. The partnership had a representative on the national implementation group that was developing good practice guidance on eliciting feedback from adults at risk of harm.

### Delivery of competent, effective and collaborative adult support and protection practice

The findings of our record reading comprehensively showed the partnership's adult support and protection services were highly competent and of high quality. This enhanced safety, health, and wellbeing for adults at risk of harm. Partnership staff worked diligently and collaboratively to keep adults at risk of harm safe and supported. Importantly, strategic leaders had robust, rigorous systems in place – audit and self-evaluation – to inform them about the quality and effectiveness of adult support and protection services, and identify areas for improvement.
The results of our record reading clearly showed the partnership's implementation of the Scottish Government's revised code of practice for adult support and protection was successful and timely. It effected required changes to their key processes for adult support and protection straightforwardly and proficiently.

Other adult protection partners, the Scottish Fire and Rescue Service, the Scottish Ambulance Service and local housing services, contributed well to the partnership's collaborative efforts to ensure adults at risk of harm were safe, protected and supported. The Scottish Fire and Rescue Service and local housing services made an invaluable contribution to Renfrewshire's community safety hub. This afforded a daily update and sharing of information about adults at risk of harm. It encouraged a joint, integrated approach to delivering the best possible outcomes for vulnerable individuals.

Renfrewshire's collaborative care home support team continued to build on the success of the clinical and care oversight group and multi-disciplinary teams established at the outset of the Covid-19 pandemic in May 2020. These initiatives strengthened and enhanced professional clinical and care oversight and governance of care homes and care at home services. They fostered inclusive collaborative working with care homes and care at home services.

### Quality assurance, self-evaluation and improvement activity

The partnership's commitment to robust, regular multi-agency audits of adult support and protection practice and self-evaluation was sector leading. These approaches were well-embedded. It carried out a sound multi-agency audit of the records of adults at risk of harm in 2022, and a more extensive multi-agency audit of 62 adults at risk of harm records in 2024. These exercises purposefully used the tools for record reading developed by our joint inspection of adult support and protection team. These were the tools for the comprehensive analysis of episodes that had proceeded to full investigation and beyond stages, and the tool for analysis of initial inquiry episodes. Input from the joint adult support and protection team provided record reading training to the multi-agency audit team, to good effect. Crucially, the reporting of the results of these multi-agency audits was open and transparent. And officers reported them to the adult protection committee and others comprehensively and accessibly. They clearly signposted areas for improvement.

Social work carried out frequent thematic self-evaluations of adult support and protection practice. These were single-agency exercises, but there was a proposal to extend them to multi-agency activities. Social workers received feedback on findings – strengths and areas for improvement.

The partnership held a staff survey in Autumn 2024 to gather feedback on how staff experienced adult support, processes and procedures, and to help identify key areas of improvement. They received 265 responses from across the partnership, with 98 per cent of respondents agreeing the partnership made positive differences to adults at risk of harm through adult support and interventions. The survey also identified areas for improvement, such as ensuring appropriate feedback on adults at risk of harm referred by partner agencies.

The partnership laudably conducted a survey of adults at risk of harm who had lived experiences of adult support and protection interventions. Numbers of respondents was relatively small. Adults at risk of harm reported their experience of adult support and protection was positive, with a beneficial impact. The views of unpaid carers who cared for an adult at risk of harm were favourably reflected in the survey responses. The partnership planned to develop and extend this survey.

### Learning reviews

The partnership conducted an adult learning review in 2023. The adult protection committee valued the constructive feedback offered by the Care Inspectorate. The adult protection committee issued appropriate guidance on learning review methodology. It aligned with national guidance. Strategic leaders endorsed the partnership's aspiration to be a learning organisation. Chief officers effectively cascaded learning to staff. They established effective approaches to communicate with staff across the partnership – such as seven-minute briefings. Key managers undertook training to do learning reviews.

## Summary

### Key processes

The Renfrewshire partnership's key adult support and protection processes were consistently sound, effective, and delivered good safety, health and wellbeing outcomes for adults at risk of harm. It handled initial inquiries into concerns about adults at risk of harm promptly, competently and collaboratively. It complied fully with the Scottish Government's revised code of practice for adult support and protection (2022). The partnership's approach to the management of risk for adults at risk of harm was sound. Quality of chronologies warranted further improvement. Full investigations or inquiries with investigative powers and adult protection case conferences were particular strengths for the Renfrewshire partnership. It undertook them to a high-quality professional standard. Supporting adults at risk of harm to attend their adult protection case conference was an area for further improvement. Health professionals and police officers made invaluable contributions to the safety, health, and wellbeing of adults at risk of harm.

### Strategic leadership

The Renfrewshire partnership's strategic leadership for adult support and protection was highly effective overall, with elements of excellence. Strategic leaders from across the partnership exercised dynamic, knowledgeable leadership for adult support and protection. This engendered a positive, vibrant culture for adult support and protection throughout the partnership. Strategic leaders' engagement and communication with frontline staff who undertook adult support and protection work was exemplary – almost 500 delegates attended the partnership's recent adult protection staff briefing events. The adult protection committee innovatively communicated with frontline staff about its work. Strategic leaders strongly endorsed the partnership's longstanding commitment to carrying out and transparently reporting upon rigorous multi-agency audits of the records of adults at risk of harm. This work was sector leading and effectively underpinned and drove improvements for adult support and protection. The partnership acknowledged it needed to improve the representation of adults with lived experience of adult support and protection at a strategic level.

## Next steps

We asked the Renfrewshire partnership to update its existing improvement plan to address the priority areas for improvement we identify. The Care Inspectorate, through its link inspector, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland will monitor progress implementing this plan.

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