

Safeguarding

CAA Meeting, 21 October 26



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CQC's role

CQC's main objective is to *'protect and promote the health, safety and welfare of people who use health and social care service.'*

Section 3, Health and Social Care Act 2008



Working in partnership, putting the pieces together

Effective multi-agency working is central to safeguarding

CQC is part of a wider 'stakeholder landscape'

The Local Authority is responsible under the Care Act 2014. However, as the regulator CQC needs to refer as needed, seek assurance and manage regulatory risk effectively

CQC holds power of entry

Consider:

- Joint Working Protocol with ADASS
- Engagement with Safeguarding Adults Boards
- Engagement with Providers



National safeguarding reform

- 01 Stronger national oversight** New national bodies and reform proposals strengthen scrutiny of learning, escalation and accountability.

- 02 A joined-up view of harm** Safeguarding, safety, quality and organisational culture are increasingly being considered together — not as separate systems.

- 03 Working together** Move towards better data and more connected information-sharing

Consider how concerns are connected, escalated and learned from

Expert Reference Group on organisational abuse

Building shared understanding and taking collective action.

WHAT THE GROUP IS

An Expert Reference Group focused on organisational abuse and closed cultures across health and social care.

- Builds shared understanding across safeguarding, safety and culture.
- Shapes practical work to support earlier collective action.

WHAT WE HAVE DONE SO FAR

- Used the CQC rapid review to strengthen the evidence base and shared understanding.
- Tested learning and emerging priorities through the ERG round table in Jan 2026.
- Turned that learning into a focused work programme for 2026/27.

PRIORITIES FOR 2026/27

- Good-practice guidance for large-scale safeguarding enquiries.
- Clarify the interface between safeguarding and patient safety in health settings.
- Raising awareness and sharing learning, public webinars held and resources published.

The next phase is about converting shared learning into clearer, more consistent system responses.

Sources: CQC organisational abuse rapid review (March 2025); ERG round-table findings (Jan 2026); ERG 2026/27 work programme.

Culture – how do we do things round here:

Think about
the wider risks
to others (inc.
organisational
abuse)

Listen well
to people

Show our
workings out –
and record
how we made
our decisions

Consider
contextual
information as
part of
decision-
making

Look at wider
themes and
trends and
engage well with
partners such as
the local
authority

Professional
Curiosity

Early warning signs, and themes and trends

LOOK BEYOND THE SINGLE INCIDENT

Watch the pattern —
not only the event.

Harm can become normalised through everyday routines, repeated omissions and decisions that appear minor when viewed separately.

EVERYDAY PRACTICE	Repeated restriction, inflexibility, neglect or loss of dignity.
CULTURE	Fear of speaking up, defensive leadership or people and families being dismissed.
SYSTEM CONDITIONS	Staffing instability, weak supervision, poor training or persistent resource pressure.
GOVERNANCE	Incidents and concerns handled separately, with no provider-wide view of patterns.

Provider action: consider low-level concerns and ask what they reveal about the service, its leadership and its culture.

Sources: CQC organisational abuse rapid review (March 2025); ERG round-table findings (September 2026).

Discussion: what would help you act earlier?

What do you need to recognise and respond to organisational abuse and closed cultures?

- Which signs or patterns are hardest to see, name or challenge?
- Where does information become fragmented inside or between organisations?
- What gets in the way of early escalation and collective action?
- What guidance, tools, examples or partnerships would make the biggest difference?