Mountain Healthcare Limited

The Horizon SARC

Inspection report

2 Ida Road
Walsall
WS2 9SR
Tel: 01922646709

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Overall summary

We carried out a focused inspection of healthcare services provided by Mountain Healthcare Limited at The Horizon SARC (Sexual Assault Referral Centre) on 3rd and 4th August 2021.

The purpose of this inspection was to determine whether Mountain Healthcare Limited were now meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008.

During this inspection we focused on compliance with the warning notices issued on 18 February 2021 relating to:

Are services safe?

Are services well-led?

We found that the provider was still in breach of the regulations and we have issued warning notices in relation to Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 17 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We do not currently rate the services provided in sexual assault referral centres.

Background

Mountain Healthcare Limited (MHL) provides sexual assault referral centre (SARC) services in different parts of the country. NHS England has commissioned MHL to provide the 'West Midlands Children and Young Person Sexual Assault Service' for children who live in the West Midlands geographical area covering 14 local authorities and four police forces. This SARC provides forensic medical examinations and some related health services for children aged under 18 or 18-25 with complex needs who have experienced sexual assault or abuse. This service is registered with CQC as The Horizon SARC to provide the regulated activities of diagnostic and screening procedures, and treatment of disease, disorder or injury.

Summary of findings

As Mountain Healthcare are a limited company, they must have a manager registered with the Care Quality Commission as part of the conditions of their registration. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the provider runs the service. The registered manager for this service is the organisation's Clinical Services Director who is also part of the MHL senior leadership team. However, a SARC manager, who is part of the Forensic Nurse Examiner (FNE) team, conducts the day-to-day management of the SARC.

We last inspected the service in December 2020 and we judged that Mountain Healthcare was in breach of CQC regulations. We issued warning notices on 18 February 2021 in relation to Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and on 15 January 2021 in relation to Regulation 17 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider submitted further information in relation to Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a decision was made not to rely on the contents of this warning notice during the focused inspection.

The report on the December 2020 inspection can be found on our website:

https://www.cqc.org.uk/location/1-8733088419/reports

This focused inspection was conducted by a CQC Children's Services Inspector and a CQC Health & Justice Inspector. Prior to this focused inspection we reviewed the action plan and an array of documents submitted by Mountain Healthcare Limited to demonstrate how they would achieve compliance.

We reviewed eight children and young people's case records and the following documentation:

- Case Tracker
- Mountain Healthcare Limited Governance and Auditing Structure
- Notes Audit Log
- Case Review Rota
- Staff Supervision/Appraisal Tracker
- Staff Mandatory Training Tracker
- Risk Register
- Strategy Meeting Attendance Tracker 2021
- Strategy and Safeguarding Manager Job Description

At this inspection we found:

- In two of the cases important information had not been shared with children's social care and/or partnering agencies in the safeguarding alert and the Multi Agency Referral Form (MARF) to help them identify, assess and respond to risks.
- The providers operational governance processes did not identify shortfalls in information sharing with partnering agencies. The case review process did not recognise that important information had not been shared with children's social care and/or partnering agencies.
- Children and young people's voices were not consistently demonstrated in case records. This means that the provider could not always evidence how well children and young people engaged with the assessment and examination.
- The risk register failed to identify gaps in information sharing to support other partnering agencies to make effective safeguarding decisions and there were no clear actions to mitigate this risk.

Summary of findings

- A supervision and appraisal tracker had been implemented to demonstrate operational and safeguarding supervision had taken place for Forensic Nurse Examiners (FNEs) and Forensic Medical Examiners (FMEs)

We identified regulations the provider was not meeting and have issued warning notices under section 29 Health and Social Care Act 2008. The provider must:

- Improve the quality of information sharing and analysis with children's social care and/or other partnering agencies to help them identify, assess and respond to risks.
- Improve the arrangements for assessing and monitoring the quality of information sharing.

We identified areas where the provider should make improvements. The provider should:

- Ensure the voice of children and young people are better represented in documentation to enable better analysis of risk and information sharing.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?	**Enforcement action** 
Are services well-led?	**Enforcement action** 

Are services safe?

Our findings

At our last inspection we found that safeguarding practice was variable, and in some cases, it was not of an acceptable standard. These are the areas reviewed during this focussed inspection:

Safety systems and processes

The provider used a template known as a 'safeguarding alert form' to communicate information to local authorities in relation to children and young peoplewho were already known to children's social care and a 'Multi Agency Referral Form' (MARF) for children and young people who had no current involvement with children's social care.

We reviewed eight patients case records and found in two case records important information had not been shared with children's social care and/or partnering agencies in the safeguarding alert form or MARF to help them identify, assess and respond to risks. The limited information and analysis shared with children's social care was insufficient to support them and/or other partnering agencies to make effective safeguarding decisions.

A 'medical records, safeguarding and professional curiosity' audit form had been completed for both case records, however it failed to recognise the lack of analysis and important information sharing with children's social care and/or other partnering agencies. A safeguarding audit was completed for a selection of case records designed to help examiners ensure safeguarding considerations had been properly addressed for each child, however for the eight cases we reviewed this had not been completed.

The SARC Manager used a safeguarding tracker tool to ensure that referrals were made to partnering agencies/other healthcare professionals and that follow up actions were completed.

We saw the SARC Manager had engaged with each local authority to clarify their preferred safeguarding reporting pathway, however this did not address quality of referrals.

We saw evidence the SARC Manager was tracking attendance at strategy meetings and in April 2021 the provider had employed a new Strategy and Safeguarding Manager to enhance multi-agency working and improve attendance at strategy meetings.

We found the voices of children and young people were not consistently demonstrated in all the case records. This meant the provider could not always evidence how well children and young people engaged with the assessment and examination.

Are services well-led?

Our findings

At our last inspection we found that the systems used to monitor the quality of the service and mitigate risks to children using the service were ineffective. These are the areas reviewed during this focussed inspection:

Governance and management

Since the inspection in December 2020, the provider has implemented a supervision and appraisal tracker to demonstrate that operational and safeguarding supervision had taken place for Forensic Nurse Examiners (FNEs) and Forensic Medical Examiners (FMEs).

However, we found the operational governance processes had not effectively identified shortfalls in information sharing. The case review process incorporated a daily and weekly documented review of case records. The purpose of this review was to enable the provider to be assured activities relating to each examination were carried out and that all follow-up actions, for example safeguarding referrals, were taken.

We reviewed two case records against the review process and found the provider had not identified that important information had not been shared with children's social care and/or partnering agencies. This meant the daily and weekly case reviews were not effectively allowing the provider to challenge or evaluate the quality of information shared with partnering agencies.

The provider used a risk register to address organisational and service risks. The risk register showed a number of identified risks with an assessment of their seriousness based on the likelihood and impact on the service or on children and young people using the service. Each risk had a clearly defined outcome, with clear direction and accountability. However, the risks in relation to limited information sharing with children's social care and/or other partnering agencies to support safeguarding decision making had not been recognised on the risk register, therefore actions to mitigate this risk were not evident.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance