

# Addcounsel Limited

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

### Overall summary

We do not currently rate independent community mental health services.

This inspection was carried out as an announced, comprehensive inspection. We found:

- The premises were clean and well maintained.
- There were sufficient numbers of suitable, trained and supported staff to keep patients safe and meet their individual needs and preferences. Recruitment processes were robust to make sure people were cared for by suitable staff.
- Risk assessments and risk management plans were in place and reviewed regularly to ensure patients' individual needs were being met safely. Risk management was recognised as the responsibility of all staff.
- There was a holistic approach to assessing, planning and delivering care and treatment to patients in line with current evidence-based guidance, best practice and legislation.
- Patients, and others important to them, were fully and actively involved in all aspects of the planning and delivery of their care and worked in partnership with the staff team.

# Summary of findings

- Staff were kind and compassionate and treated people with dignity and respect. The service was tailored and delivered care to patients to meet their individual needs.
- Morale was high and staff were positive about their leadership. Staff were supported, felt valued and listened to by the management team.
- There were effective systems in place to monitor and improve the quality of the service provided. Where improvements were needed, plans were put in place and action taken to make improvements.

# Summary of findings

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# Addcounsel

## Services we looked at

Community-based mental health services for adults of working age

# Summary of this inspection

## Background to Addcounsel Limited

Addcounsel is an independent healthcare service which provides assessment, multi-disciplinary healthcare and treatment services to adults who are experiencing addiction and mental health problems.

The service provides private healthcare consultations and treatments in relation to addiction and mental health disorders associated with drugs, alcohol, sex and gambling, as well as mental health issues such as depression, anxiety, dementia, stress and eating disorders. This includes physical examinations, health assessments, prescribing and administration of medicines, and care and support during treatment.

Services are provided within patient's own homes or at private accommodation throughout the UK. The service supports anyone aged 18 years or over, including older adults. At the time of the inspection the service was

not providing community alcohol and drug detoxification. Patients with substance misuse issues were accepted into the service after detoxification by a different provider.

The service directly employs four staff; the chief executive officer, the registered manager who was also the clinical director, the relationship director and a clinical operations manager who was also a registered nurse.

Patients receive support from a multi-disciplinary team of professionals, including consultant psychiatrists, registered nurses, recovery managers, psychologist, private GP and therapy staff who are recruited to Addcounsel on a contractual basis. They work for the company on a sessional basis depending on need.

The service registered with the Care Quality Commission in April 2017 and has not been inspected previously. The service is registered to provide treatment of disease, disorder or injury.

## Our inspection team

The team that inspected the service comprised two CQC Inspectors and a specialist advisor, who was a consultant psychiatrist.

## Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

# Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the office where the service operates from
- visited a serviced apartment
- spoke with one patient who was using the service
- spoke with the registered manager who was the clinical director of the company
- spoke with the chief executive officer, quality and compliance director, relationship director medical director, consultant psychologist, recovery managers and the clinical operations manager
- looked at five care and treatment records of patients who had used the service since April 2017
- looked at a range of policies, procedures and other documents relating to the running of the service
- looked at staff records for three permanent staff and for six of the contracted staff.

## What people who use the service say

We spoke with one patient who was using the service. They expressed satisfaction with the care and support they were receiving. They told us that they had been provided with comprehensive information about the service and given ample opportunities to ask questions.

They spoke positively about the staff team that supported them and reported that any concerns they had about their care and treatment were addressed promptly. We were unable to speak to any other patients as they had recently left the service.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Are services safe?**

We do not currently rate independent community mental health services. We found the following:

- Patients were cared for in a clean and well-maintained environment.
- There were sufficient staff to meet people's needs safely.
- Patients using the service were safe. There was an open and transparent approach to safety. There were arrangements in place for assessing, monitoring and managing risks to patients and staff.
- Patients were protected from avoidable harm or abuse by staff that knew and understood the principles of safeguarding and how to report abuse.
- A system of staff recruitment was in place to ensure people were supported by suitable staff.
- Effective systems were in place for reporting and recording incidents, accidents and significant events. Lessons learnt were shared so that improvements could be made.

However:

- The environmental risk assessment template format did not cover potential ligature anchor points when patients received care and treatment at serviced apartments.
- The provider did not have a policy and procedure on the use of WhatsApp.

### **Are services effective?**

We do not currently rate independent community mental health services. We found the following:

- Patients' care and treatment was assessed, planned, delivered and reviewed regularly, in line with best practice guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment and carry out their roles.
- There was a range of staff disciplines and specialists within the multidisciplinary team to effectively support patients. Patients received coordinated and person-centred care.
- The service obtained consent to care and treatment in line with legislation and guidance.

However:

# Summary of this inspection

- The service did not use outcome measures to see how effective treatment was.

## Are services caring?

We do not currently rate independent community mental health services. We found the following:

- Staff treated patients with kindness, respect, compassion and were responsive to their individual needs.
- Staff working at the service understood the needs of patients and worked closely with people that were important to them.
- Patients were involved in all aspects of their care and treatment and had co-produced their care and risk management plans.

## Are services responsive?

We do not currently rate independent community mental health services. We found the following:

- Patients received care and treatment that was planned proactively and in partnership with them. The service was very flexible and responsive to people's individual needs and preferences.
- Comprehensive information about the service was available to people on the provider's website and through a patient guide.
- The service had arrangements in place to deal with patients' concerns, compliments and complaints in an appropriate way.

## Are services well-led?

We do not currently rate independent community mental health services. We found the following:

- Patients were supported by a highly motivated and dedicated team of management and staff who were trained and well supported.
- There were effective governance arrangements in place to monitor and improve the quality of care and identify risk.



# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. Patients voluntarily approached the service and were assumed to have the capacity to consent their care and treatment.

The consultant psychiatrist confirmed that where a patient lacked capacity to consent to a specific decision they would work within the legislation in the best interests of the patient.

# Community-based mental health services for adults of working age

|            |  |
|------------|--|
| Safe       |  |
| Effective  |  |
| Caring     |  |
| Responsive |  |
| Well-led   |  |

## Are community-based mental health services for adults of working age safe?

### Safe and clean environment

- The provider rented serviced offices at their location address. We observed a clean and comfortably furnished environment which was well-maintained. There were enough offices and meeting rooms to meet the needs of the patients. There was a kitchen available for patients and staff to access refreshments including hot and cold drinks. Most care and treatment was provided in patient's own homes.
- The offices and meeting rooms were cleaned regularly by cleaning staff contracted by the owners of the building. The provider was able to raise concerns to reception staff if any areas were not clean.
- Medical equipment was available for staff to use which included a blood pressure machine and thermometer. This equipment was recently purchased and did not require calibration. Visiting GP's used their own medical devices to take physical health measurements and bloods for monitoring. Staff had access to a sharps box for needle disposal following injections which meant that needles were disposed of safely.
- There was a service level agreement with an external company for the collection of clinical waste materials, portable appliance testing (PAT) and fire safety testing. We saw evidence of audits for fire safety and water testing, for example, to check the temperature of the water to detect legionnaire's bacteria was tested regularly. Kitchen appliances and equipment were in date for PAT testing which meant that the equipment

had been tested for electrical safety. Regular fire alarm testing occurred each week and there were plans in place should staff and patients be required to evacuate the building.

- We visited an apartment where a patient using the service received treatment and found that it was within a secure building, smoke alarms were fitted and the environment was very clean and comfortable. The patient did not share the apartment, other than with a member of staff who lived-in with them as part of their care and treatment. The patient had their own key to the building and apartment.
- The provider was able to use several apartments or flats for patients who required staff to live in with them. Each location was individually sourced to suit the patient's needs. Staff completed risk assessments, including health and safety, fire evacuation and cleanliness at each location. However, we found potential ligature anchor points were not identified within the risk assessment. We raised this at the time of inspection and the provider told us that they would not offer treatment to patients who presented with a high level of suicidal risk. However, it was still important for staff to be aware of them in case a patient's condition changed.

### Safe staffing

- The service employed four full-time staff who managed the service's business and clinical operations. This included the chief executive who was the nominated individual, the registered manager, relationship director and the clinical operations manager.
- The rest of the multi-disciplinary team (MDT) comprised of medical and healthcare specialists with backgrounds in psychiatry, nursing, recovery, holistic therapies, psychology, hepatology, functional and general medicine. These staff worked on a sessional basis when required. Two doctors worked at the service

# Community-based mental health services for adults of working age

- The service ensured that there were cover arrangements in place for when staff were on leave or off sick. Staff support was based on the individual assessed needs of the patient. For example, recovery managers worked for a full two weeks supporting people in their own homes as per the individual care plan. Two of the recovery workers we spoke with told us they had scheduled breaks during the working day when the patient was engaged in other activities.
  - An out-of-hours call service operated 24 hours a day, seven days a week. This allowed the service to respond immediately to requests for assistance.
  - The majority of staff had received and were up to date with, appropriate mandatory training. Training records confirmed that 90% of staff had completed mandatory training which included safeguarding of adults and children, fire safety, basic life support, infection control and health and safety. Thirteen staff had completed information governance training out of the 19 who were eligible. Where staff had not completed the training this was being followed up through individual supervision.
  - Staff were recruited safely and robustly with pre-employment checks completed to ensure they were suitable for their role. Where members of the required registration with or membership of organisations such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) or Health and Care Professions Council (HCPC), evidence of current registration and continuous professional development was available on the files viewed. Checks had been completed for all the executive directors, which included bankruptcy checks and written confirmation that they had not been involved in serious misconduct or mismanagement. This meant that specific checks for directors to ensure that a service can operate safely and effectively had been carried out.
- individual reviews and handover meetings. Risk management processes also ensured that live-in staff were supported to maintain appropriate boundaries with patients.
- Comprehensive risk management plans were in place for assessed risks. For example, we saw a detailed plan for a patient taking an overseas trip as part of their treatment plan. Staff worked in collaboration with patients to manage risk effectively. The manager reported that they did not take high risk patients and had an exclusion criterion which they followed as part of their risk management strategy. For example, detoxification services were not offered and patients were signposted to more appropriate services if they were acutely mentally unwell. The provider made the limitations of the service clear to patients. Before commencing treatment patients signed an agreement which outlined their roles and responsibilities and conditions regarding their treatment.
  - Staff had undertaken training in safeguarding adults and children and demonstrated a good understanding of the procedures that they would follow to raise a safeguarding alert. Safeguarding information was available in the patient information booklet and employee handbook. The registered manager was the safeguarding lead for the service.
  - Staff took appropriate steps to report and record any safeguarding concerns. For example, records demonstrated a safeguarding referral discussion had taken place with the local authority safeguarding team.
  - Staff we spoke with confirmed that there was a lone worker policy to which they adhered to keep themselves safe. The policy clearly outlined Staff demonstrated a good understanding of the individual risks and management plan relating to the patient they were supporting. Staff maintained regular contact with the office and MDT through the use of WhatsApp. Staff were required to check in with the office throughout the day. No clinical information was shared on the WhatsApp group. The provider did not have a policy or procedure on the use of this technology.

## Assessing and managing risk to patients and staff

- We looked at five care records. Risks to patients were assessed, monitored, updated regularly and managed on a day-to-day basis. A comprehensive risk assessment was undertaken for all patients referred to the service. Individual risks were discussed in the clinical governance meeting, multi-disciplinary meetings,

# Community-based mental health services for adults of working age

- At the time of the inspection medicines were not being prescribed. A policy and procedure for medicines management was available. When patients required prescription medicines these were prescribed by the consultant psychiatrist or private GP.

## Track record on safety

- There had been no serious incidents in the service since they registered in April 2017.

## Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and, also, what incidents should be reported.
- There was a culture of learning from incidents, which all staff understood and were involved in. For example, the service had commissioned an investigation following the transfer of care of a patient to another provider. Learning had been shared within the MDT and the recommendations of the investigation report implemented.

## Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong. The provider had a duty of candour policy and staff were aware of the need to be open and transparent when things went wrong.

## Are community-based mental health services for adults of working age effective?

(for example, treatment is effective)

## Assessment of needs and planning of care

- There was a holistic approach to assessing, planning and delivering care and treatment to patients. Care records viewed confirmed that patients had a comprehensive assessment of their needs upon referral. Patients' physical, mental health, nursing, risks and social needs were assessed fully.
- We reviewed five care and treatment records of patients who had received care and treatment since the service

opened in April 2017. These were person-centred, holistic and recovery-orientated. Care plans we viewed had been co-produced with the patients and detailed their own wishes and preferences.

- Staff securely stored paper treatment records in a locked cabinet in the location's administration office. Where staff worked remotely they sent weekly reports, which were password protected, electronically to the clinical operations manager. These were printed and stored within individual patient files.

## Best practice in treatment and care

- Staff planned and delivered care and treatment in line with current evidence-based guidance, best practice and legislation. For example, the consultant psychiatrist confirmed best practice guidelines relating to prescribing medicines established by the National Institute for Health and Care Excellence (NICE) were followed to safely treat patients.
- Patients had access to wide range of psychological therapies as recommended by NICE. This included cognitive behavioural therapy, psychotherapy, mindfulness-based cognitive therapy, art and music therapy. The service also offered a 12-step recovery support (a 12-step program is a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioural problems).
- Physical health assessments were carried out upon acceptance into the service and there was evidence of ongoing monitoring of physical healthcare. This included regular blood pressure monitoring, blood tests and electrocardiography monitoring. Patients were referred to specialists whenever necessary for further physical health care investigations.
- The service measured outcomes in terms of patient satisfaction. However, the service did not use outcome measures as a way to see how effective treatment was. The manager reported that this was an area that they would be developing as the service became more established.
- Staff completed a number of clinical audits in the service. These covered information governance, safeguarding, clinical files and health and safety. Where shortfalls were identified, action plans were in place to

# Community-based mental health services for adults of working age

ensure that improvements were made, for example, the health and safety audit identified that reception staff did not verify the identification of people attending the location and the actions required to address this.

## Skilled staff to deliver care

- Patients had access to a range of professionals to support their care and treatment. The MDT consisted of contracted staff, including the medical director, quality and compliance director, consultant psychiatrist, consultant psychologist, psychology staff, private GP, nutritionist, nurses, recovery managers, music and art therapists. Staff were appropriately qualified and experienced for their roles.
- The service had a corporate induction programme which was facilitated by the registered manager and clinical operations manager. Staff confirmed they had undertaken an induction which included the provision of a detailed employee handbook.
- Staff, where appropriate, received clinical and managerial supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). Recovery managers confirmed they met with their supervisor regularly to discuss individual patients, their performance and their development. Other healthcare professionals contracted to the service accessed clinical and professional supervision outside of Addcounsel, in accordance with their professional body.
- The service had not undertaken any appraisals as they had been operating for less than a year. Healthcare professionals working at the service under practising privileges were appraised by their main employer and were required to provide a copy of their appraisal to the service. An appraisal policy was available and detailed the appraisal process that staff would undertake when the time came.
- Staff were supported to undertake additional training relevant to their role. For example, the manager had undertaken level 4 safeguarding training for adults and children.

- There had been no staff performance issues since the service opened. The registered manager confirmed that they would access support from an external human resources company to address any performance concerns.

## Multi-disciplinary and inter-agency team work

- There was exceptional multi-disciplinary working that enabled people to access help and support from across the disciplines within the service. Staff reported that there was good communication within the team and updates and changes to patients' care and treatment was discussed during daily calls to the office, MDT and clinical governance meetings. We saw that staff kept clear minutes that showed staff completed and regularly fed back on actions.
- Staff in the service maintained effective relationships with other services and organisations. For example, patients GPs were contacted to obtain further medical history information and copied into any relevant correspondence.

## Good practice in applying the Mental Capacity Act

- Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. Patients voluntarily approached the service and were assumed to have the capacity to consent their care and treatment. The consultant psychiatrist confirmed that where a patient lacked capacity to consent to a specific decision they would work within the legislation in the best interests of the patient.
- In all five records we found that consent to treatment had been sought, discussed, recorded and regularly reviewed. A patient we spoke with confirmed that consent to treatment was discussed at each review.
- Mental Capacity Act training was available and had been completed by 100% of the staff, during their corporate induction. Whilst training in the Mental Capacity Act was not on the provider's list of mandatory courses, all staff received it as part of their induction programme.

**Are community-based mental health services for adults of working age caring?**

**Kindness, dignity, respect and support**

# Community-based mental health services for adults of working age

- We saw that staff spoke to a patient visiting the service in a respectful and caring manner. Staff spoke enthusiastically about patients and demonstrated a sensitive, caring and empathic approach to them.
- We spoke with one patient who expressed satisfaction with the care and support they were receiving. They told us that they had been provided with comprehensive information about the service and given ample opportunities to ask questions. They spoke positively about the staff team that supported them and reported that any concerns they had about their care and treatment were addressed promptly.

## The involvement of people in the care they receive

- People were supported to express their views and to be involved in making decisions about their care and support. Care and treatment records showed that patients were fully involved in planning their treatment. We saw evidence of collaborative risk management and the patient we spoke with confirmed their involvement in developing their care and risk management plan.
- Where appropriate the service involved and supported family members. This included the provision of family therapy where required.
- Patients were asked to give feedback on the service by completing a questionnaire during and at the end of their treatment. We viewed completed questionnaires and saw that the feedback was very positive.

**Are community-based mental health services for adults of working age responsive to people's needs?**  
(for example, to feedback?)

## Access and discharge

- The provider advertised the service as offering help with a broad range of mental health issues and bespoke 1-2-1 care for behavioural health.
- Referrals were received through patients, GPs, legal trusts and their families directly. The relationship director received all referrals which were then screened by the registered manager for their suitability for the services offered. If accepted, a comprehensive

assessment was completed with the involvement of the multi-disciplinary team. This included detailed background information about previous placements, life and risk history and relevant clinical reports.

- The service operated a recovery route model of care which aimed to support people and their families long-term. This ranged from 12 weeks to 12 months.
- The patient we spoke with confirmed that they had been involved in developing their crisis plan.
- Urgent and non-urgent referrals were assessed and seen very quickly. Where patients were unsuitable for the service the manager facilitated alternative arrangements with other independent providers. Patients were able to choose when and where they saw members of the MDT, for example, either at the location offices, private accommodation or in their own home.
- The service had no waiting list at the time of inspection.

## The facilities promote recovery, comfort, dignity and confidentiality

- Most care and treatment was provided in people's own homes or serviced apartments. The location had enough offices and meeting rooms to support treatment and care. For example, psychology sessions and psychiatric reviews were held at the location office. There was a kitchen available for patients and staff to access refreshments including hot and cold drinks.
- Patients were provided with personal security and a personal chef, if required, as part of their care and treatment. All staff had signed a non-disclosure agreement to protect patients' privacy. Patients were allocated a unique identification code so that their confidentiality was maintained.

## Meeting the needs of all people who use the service

- Staff undertook equality and diversity training to respond to patients' diverse cultural, religious and linguistic needs. When required, interpreters could be accessed and information made available in the patient's preferred language. The service had a diverse MDT; members were multi-lingual and fluent in over 15 languages.
- Patients were provided with a patient guide which included information about the service. Detailed

# Community-based mental health services for adults of working age

information was also available on the provider's website to explain how the service worked, how to make an enquiry, frequently asked questions and the types of bespoke care packages available and what costs applied before care and treatment was offered. The website also contained informal blogs by staff.

## Listening to and learning from concerns and complaints

- Patients had various opportunities to give feedback about the quality of care they received. For example, they were able to give feedback on their care and support during review meetings and direct feedback to staff on a daily basis. The patient we spoke with knew how to make a complaint.
- Patients were provided with information on how to make a complaint in the patient guide and through information on the providers' website. The service had not received any complaints since they started operating in April 2017. The integrated governance committee had oversight of any complaints or concerns received by the service so that any trends or themes could be identified to make improvements.
- The service had received three compliments from patients and their families.

## Are community-based mental health services for adults of working age well-led?

### Vision and values

- The service had a clear vision and values that were person-centred and ensured patients were at the heart of the service. All staff were committed to providing a high quality service which enabled patients to have a sustained recovery.
- The provider's website and patient literature emphasised the accessibility of the service and reflected the provider's vision and values.
- Staff we spoke with confirmed that the chief executive and registered manager were easily accessible.

### Good governance

- There was a clear organisational structure and staff understood their own roles and responsibilities. The management team worked closely with and supported staff so that patients received a high quality and responsive service.
- Governance arrangements were in place to assess, monitor and improve the quality of the service. There were appropriate incident and complaint reporting systems in place which enabled learning. There was a system for patient feedback. Staff received appropriate training, supervision and their work performance was monitored. Recruitment arrangements ensured that staff were vetted and had the relevant specialist skills and qualifications before commencing work.
- Audits were carried out in order to identify where areas of improvement were required and to identify any potential risks that may affect the quality of the service. Where any shortfalls were identified, action plans were in place.
- An integrated governance committee met bi-monthly and had oversight of all aspects of the service. The director of quality and compliance had recommended that the board appoint a non-executive director so that there was greater transparency within the organisation. Regular senior management and multi-disciplinary team meetings took place to discuss service developments, quality of service provision and learning from incidents and accidents.
- The service held a risk register which identified risks such as financial, reputational, business disruption and staffing risks. Risks and mitigation actions were reviewed at the integrated governance committee meetings.

### Leadership, morale and staff engagement

- All staff we spoke with consistently described morale as very high. They were proud to work for the service and be part of a team that ensured care was person-centred, collaborative and improved people's quality of life.
- Staff we spoke with told us the service had an open and transparent culture and they were able to raise any concerns with the registered manager and were listened to.

### Commitment to quality improvement and innovation

# Community-based mental health services for adults of working age

- The service had published information on nutritional therapy interventions at a bio-chemical level for addiction recovery on their website.