Head First (Assessment, Rehabilitation and Case Management) LLP

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Head First (Assessment, Rehabilitation and Case Management) LLP, referred to as 'Head First' throughout this report, is an independent organisation specialising in providing assessment, rehabilitation and case management for adults, and some young people and children, with an acquired brain injury. The organisation works with approximately 100 brain injured people, their families and care workers, and over 40 people are directly supported by the service. This includes supporting people who use the service to directly employ support workers, some of whom may provide personal care. The service primarily supports people in their own homes but also people in rehabilitation centres and care settings. The majority of people who receive a service live in Sussex (West and East), Hampshire, Kent, Surrey, Essex, Hertfordshire or Berkshire. The service also supports some people who live further afield across England.

People's experience of using this service and what we found
People's care and support needs were personalised and they received a bespoke service from Head First. People spoke very positively about the service and the staff who supported them. In addition to people the service directly supported, Head First were proactive in helping people and their families who had not received compensation through legal channels, but were living with an acquired brain injury. This was achieved through sharing knowledge about acquired brain injury, in this country and around the world, to improve people's lives and support professional knowledge and development.

The service had been instrumental in setting up conferences about brain injury in the UK, invited speakers, including people and their families, at local and national events. Campaigning and promoting the use of bicycle helmets had also helped raise awareness for people about the risk of cycling without head protection, and fund-raised for a local group and the national charity. All these initiatives, and more, had a positive influence and impact on people living with an acquired brain injury.

People were complimentary about the service and staff who supported them. One relative had written, 'My uncle has some fabulous support workers and they always seem to be trying new ideas to support his progress and improve motivation and quality of life. They show a genuine interest in him and talk positively about him'.

Staff were recruited at the point people were assessed as being suitable to receive a service at Head First. People's specific needs were identified, new staff were recruited and training was tailored according to what people needed and wanted. Staff had regular supervisions with their line managers. Staff enjoyed working at the service and felt well supported in their roles. Working practices were discussed and areas for improvement were identified at staff meetings.

People were protected from the risk of harm by trained staff. Risk management was pre-emptive and people's risks were managed effectively.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported by kind and caring staff who knew them well. Overall management of people's care and support needs was overseen by case managers. One person commented, 'Head First have been my happiest care. I feel they're trained well and know how to assist me specifically'. People told us that their support staff arrived on time.

People were involved in all decisions relating to their care and support needs. Care plans were detailed and personalised. People knew who to contact if they had any concerns or wished to make a complaint.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (report published 17 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow-up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Head First (Assessment, Rehabilitation and Case Management) LLP

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector and an assistant inspector. The assistant inspector undertook telephone interviews with people who used the service.

Service and service type
Head First is a specialist service that assesses people who have an acquired brain injury, then provides personal care and support to these people and their families. Some people live in their own houses and flats and some are supported in care settings, such as nursing homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service 48 hours' notice of the inspection. We needed to be sure that the registered manager would be in the office to support the inspection. The inspector visited the office of the provider to talk with staff and review records on 18 October 2019. The provider later sent us a spreadsheet of people we could contact. The assistant inspector made telephone calls to people and their

relatives on 15 November 2019.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support out inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and one relative. We also spoke with the registered manager, two case managers and the HR manager. We reviewed a range of records. This included three people's care records and records relating to the management of the service, including policies and procedures. We looked at two staff files in relation to recruitment and staff supervision.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse and harm.
- For example, one person who was deemed to lack capacity to manage their financial affairs, had their finances looked after by a deputy who had been appointed through the Court of Protection. This person was given an amount of money to spend as they wished, but the overall management of their finances was the responsibility of their deputy.
- The registered manager explained that people living with an acquired brain injury were very vulnerable. The service worked with vulnerable adults in the community who generally lacked the ability to assess potential risks and who did not necessarily have 24/7 support. Therefore, the frequency of potentially risky episodes was relatively high. There was a robust safeguarding process in place to report and manage the risks and keep people safe. Staff were aware of the types of abuse that people could encounter and took appropriate action.
- The service worked hard to protect people from the risk of abuse. The registered manager said, "There's lots of safeguarding issues. We can only do what we can to protect people. Sometimes when we report any concerns, it can affect the relationship we have with our clients". The registered manager added they would always take action and intervene where they felt people were at risk, to protect their safety.
- A copy of the provider's safeguarding policy was provided to new staff with their offer of employment. New staff were required to sign this policy to confirm they had read and understood the contents. Staff completed safeguarding training.

Assessing risk, safety monitoring and management

- People's risks were identified, assessed and managed safely.
- Care plans included risk assessments in a range of areas, such as self-neglect, road safety and eating properly. One person's care plan showed the risks in their home, personal activities of daily living, health management, in the community, finances and in school. Detailed advice and guidance was provided for staff to follow.
- The registered manager explained that sometimes people's relatives who cared for them could be risk factors. For example, one relative did not understand that their family member had swallowing difficulties and needed guidance from support staff to help them understand what this meant and how the issue should be managed.
- One staff member said they would always arrange for someone to be available at a person's care setting if something went wrong. The staff member told us, "It can be family members getting very stressed and agitated. One person was arrested because he was in possession of an illegal substance. Another person needed staff on site because hot water was coming out of a radiator".

● People's risks in their own homes had been identified and assessed. One person confirmed that staff ensured they were safe in their home and said, "They make sure the area is clean and safe, and easy to access for me and my family".
● The registered manager told us of a project they had been involved with to promote the use of cycle helmets which raised money for a local Headway group and Headway's national charity. This made national news and highlighted the benefits of the prevention of injury.

Staffing and recruitment
● There were sufficient staff to meet people's needs. The amount of support people and their families required varied considerably according to people's individual needs. Some people had input and help from family members at home whilst others lived independently.
● When people were assessed as needing a service, staff were recruited in a bespoke way. Case managers had overall responsibility for overseeing the service each person received. One case manager said, "We get to know the client, family and therapists. Some therapists train staff who support people. Case managers are always problem solving". There was a 24 hour on-call service and case managers took turns to be on call. People or their relatives could contact a representative of the service day or night.
● One staff member told us, "We won't take on new referrals if we don't have the case managers. There's a big demand. If necessary we will refer people to another agency".
● When staff went to support people, the times they arrived and left were monitored electronically, and office staff had oversight of this. People told us that staff arrived on time. One person said, "Yes, they have never missed any calls". A relative told us, "I have seen the same member of staff turning up to support my dad". When asked if staff had time to spend with them, one person commented, "Yes, they do spend time with me, plus my wife often helps care staff as well".
● New staff were recruited safely. Staff files showed that all appropriate checks had been made before staff commenced employment. These included checks with the Disclosure and Barring Service which considered the person's character to provide care. References were obtained and employment histories verified.
● The provider information return included further information about staffing levels. It stated, 'The case managers at Head First are qualified nurses, occupational therapists or physiotherapists, and social workers, who are registered [with a professional body]. The clinical manager ensures the skill mix of the professional is matched with the needs of the clients. Ultimately the clients/families determine who they wish to work with and, on rare occasions, if the relationship does not develop, the case manager is changed in accordance with the client's wishes. The staffing levels are created according to dependency needs and funding restrictions, whilst ensuring the clients are safe'.

Using medicines safely
● Medicines were managed safely.
● One staff member explained, "People's ability to manage their own medicines varies considerably. It's about whether the person, a support worker or a family member can manage medicines. We're clear about what can and can't be done. We have a staff member who is a nurse and the lead for medicines. Staff complete Medication Administration Records (MAR) and send these in monthly for us to check". Records confirmed this.
● Assessments for people to administer their own medicines were completed.

Preventing and controlling infection
● People were protected by the prevention and control of infection by trained staff.
● One staff member explained that managing the risk of infection varied considerably according to people's individual needs. They told us, "It depends on the specific client and where it's required. We arrange training for support workers and nurses who are their case managers. We always liaise with the local GP".

Learning lessons when things go wrong

● Lessons were learned if things went wrong. The registered manager explained that reflective feedback was a way of looking at any issues and deciding what actions were needed. They provided an example of when a staff member went on holiday or was unwell, they always tried to ensure another member of staff who knew the person and their family well could step in at short notice.

● The registered manager explained the importance of assessing and regularly reviewing people's care and support needs, to ensure the service provided continued to be safe and appropriate.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care and support needs were assessed before they received support from the service.
- The registered manager said, "Solicitors refer people mostly. The solicitor wants an immediate needs assessment, so they can go to the insurance company under the Rehabilitation Code because this is what the client needs now. Investigations are completed and the solicitor will tell us to go ahead. We identify goals for people through an immediate needs assessment; we are very clinical. We have to keep good records and documentation because anything we do might get used in court".
- The 2015 Rehabilitation Code promotes the collaborative use of rehabilitation and early intervention in the compensation process. It is reviewed from time to time in response to feedback from those who use it, taking into account the changing legal and medical landscape.
- Case managers took responsibility and had oversight for a number of people. Some case managers have more people to support, others less, depending on people's needs. Following an in-depth assessment of people's needs, their risks were identified and evaluated and a management plan was drawn-up.
- Once people's needs had been assessed and agreement reached that they would receive a service, case managers then started the process of recruiting care staff to support them.

Staff support: induction, training, skills and experience

- Staff completed a range of training relevant to their role and specific to people's identified needs, with a focus on brain injury.
- New staff completed an induction programme which included training on topics such as, food hygiene, infection control, and moving and handling. Training was available electronically or delivered face to face. One staff member explained that professionals delivered training according to their expertise. For example, epilepsy training was organised through Epilepsy Action. Each case manager supported staff with their training, to identify training opportunities appropriate to people's identified care and support needs. One case manager explained, "All the training is linked back to the client".
- Staff who were new to care studied the Care Certificate, a universally recognised, vocational, work-based qualification comprising a set of standards to be met.
- According to the provider information return, some people may not have English as their first language. Staff were recruited who could speak people's preferred language, for example, Vietnamese in one instance.
- Care staff had regular supervisions with their case managers, who were their line managers. One case manager told us, "Formal supervisions occur at least annually, with an annual appraisal. There is more informal supervision and the team co-ordinator will support staff. I catch up fortnightly with team co-ordinators and I see daily reports". The case manager added, "There's an incredibly supportive team here and there's always someone to talk to. If you need supervisions between organised times, then that's set

up". Another case manager told us, "I never feel judged here and I know I will be supported. We are not perfect. I feel free to open up to how I feel. Team days are used for reflective learning".
● Records confirmed that staff received supervisions. One supervision record documented that the staff member was encouraged to reflect on the content of the session, any new learning and development needs and current progress in their role.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported by staff with their dietary needs as required. According to the provider information return, 31 people required their meals prepared for them by staff, and two people needed support from staff to eat their meals.
● People's nutritional needs were recorded in their care plans. Referrals were made to healthcare professionals, such as speech and language therapists, where required. For example, one person received all their nutrition and medicines via a Percutaneous Endoscopic Gastrostomy (PEG). Staff were trained in the management of the PEG and family members could also support staff if needed.
● Some people had been identified as being at risk of malnourishment because of their brain injury. For example, people might have an eating disorder or drug addiction which meant they might not be following a healthy diet. Qualified nurses at the service worked with people and case managers, as well as other healthcare professionals, to support people with their dietary needs.
● As part of their rehabilitation programme, people's healthcare needs were identified and met. People's healthcare needs were identified before they started to use the service. These needs were costed out by the service and, in the main, people received private healthcare that they paid for themselves, from compensation awarded as a result of a litigation claim for example. If a person required physiotherapy to support their rehabilitation, then the number of hours they needed was identified and a plan drawn-up to ensure they received the therapy they required.
● People confirmed they had access to healthcare professionals. A relative said, "They do arrange a doctor's appointment and will take him there". One person told us, "They also organise my appointments with the doctors and hospital".

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Consent to care and treatment was gained lawfully.
● The registered manager explained that capacity assessments were completed. Input might also be sought from independent capacity assessors to avoid any potential conflict of interest. The registered manager

added, "We have a training day for staff once a month. We have applied for DoLS for one person from the local authority. [Named person] can't go out on his own and he hasn't tried, but the front door is locked. We have applied for DoLS for people via the relevant local authority but only one has been completed to date".

● People had appointed deputies who managed their finances; these could be family members or solicitors. The case managers worked closely with people and their deputies, and people were encouraged to make decisions about their care. People's capacity could fluctuate as a result of their brain injury. For example, we were told of one person who had decisions taken in their best interests, because they lacked capacity. A staff member said, "With any decisions, we would want to get his view. As a case manager, I see part of my role as advocating on people's behalves".

● The MCA applies to anyone over the age of 16 years. Where people below this age received a service, then decisions were usually made for them by their parents, when the person lived with their family.

● Staff had completed training on the MCA.

● A relative confirmed that their family member was asked for their consent. They told us, "They do ask for his permission when they give him a shower for example. They ask him how he is doing". One person said, "They always ask me what I want and that's been the same from the beginning".

● If required, the service could provide expert reports for the courts in relation to care and rehabilitation and bests interests in relation to mental capacity.

● The service had also helped write a report that included recommendations for a House of Lords Select Committee with regard to acquired brain injury and mental capacity, and drawn up guidelines for supported decision making for the National Institute for Health and Care Excellence (NICE).

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by staff who knew them well. One person said that staff listened to them and added, "Definitely, staff like to know if I want anything". Another person told us, "I'm matched with a good support worker and the case manager was helpful with the planning. My wife and care staff support me with washing. Breakfast and lunch is provided and is there for me".
- Care and support was individually tailored to meet people's needs, by staff who understood about people's protected characteristics. Case managers were the point of contact between people and their relatives and co-ordinated all aspects of people's care. Care staff who undertook people's personal care understood the different approaches to enable a person-centred approach. The service people received was bespoke and was client-led. According to the provider information return, 'All work is agreed and undertaken with the clients and their families on an individual basis. Two members of staff have finalised a book on family survivors after brain injury and are keen to ensure there is further training and support for staff to use narrative to be able to see the situation of the brain-injured client and their family, from their perspective, thus promoting understanding and empathy'.
- The registered manager told us that equality characteristics were client-led. They explained, "Some clients have sexual health needs. Statistically we have quite a high proportion of younger males with brain injuries. Clients seek sexual relationships and sometimes need support to learn how to develop positive interactions to fulfil their needs".

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were encouraged to be involved in all aspects of their care.
- People and their relatives felt that staff listened to them and supported them to be as independent as possible. One person said, "Before, staff used to wash my body. Now my health has improved and I am able to wash myself".
- People were treated with dignity and respect. One person said, "Staff will ask me if I need to have a wash and they make sure the door is closed".

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Care plans were personalised and contained detailed information about people, their preferences, and how they wished to be supported. For example, one care plan documented that the person was at high risk of falls and could aspirate when drinking. A physiotherapist was consulted because of the falls and they had organised an exercise regime and trained care staff on how to implement this. This lessened the person's risk of falling. A referral had been made to a speech and language therapist about the person's risk of choking.
- One case manager said, "Initial assessments on clients are very much about what people were like before the injury, who and what is important to them". The case manager talked about one person who had a real love of music before their injury and this had continued. A local musician was organised to deliver individual sessions on music appreciation. The person was also a keen swimmer before their injury, so hydrotherapy sessions were organised to improve their fitness.
- The case manager said that feedback from the care staff who worked directly with people was important. Referring to one person who used the service, they explained, "Their sister and care team look after him. We try and involve him in discussions about how he's spending his time, what sorts of things he wants. He has been questioning his medication for a while, so we have set up a GP review and made a referral to the neuro-psychologist. He's had an MRI brain scan and we're waiting for an appointment for an EEG to see whether any changes can be made".
- We asked people if staff knew them well and were knowledgeable about their likes and dislikes. One person said, "They know that I like to talk about football". Another person told us they were involved in their care planning and said, "Yes, me and my wife did the planning with staff. They asked us both for our views about any additional support I might need or any changes I wanted".
- One case manager said, "We have to listen to what our clients want, and their wishes; we need to listen to their hopes. We all have hope and aspirations. We have to really understand what is meaningful to our clients and work alongside them". One person wanted to meet someone so they could form a lasting relationship and staff were supporting them to understand what a sexual relationship would mean for them. In the past, the service had supported brain injured people to parent successfully and safely.
- Encouraging people to be as independent as possible was the focus within people's care documents in a rehabilitation or maintenance plan (RoMP). One case manager told us, "We do discharge some clients, but there is usually a natural progression that people don't need us any more, unless they or the solicitors say so. The intention is that clients become independent, but they always know they can come back if they need us; they know we're here".
- According to the provider information return, technology was used where this was beneficial for people.

Examples of technology used could include communication aids or epilepsy monitors, as well as generic technology, such as voice activated systems that could control the environment.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were met. One staff member told us, "We have clients who communicate in alternative formats. Assistive technologies for some clients, like eye-gaze systems. (Eye-gaze systems enable people to communicate through eye movement.) One lady violinist was involved in a research project and was able to compose music. She selected notes with her eyes, completed excerpts of music and took part in a concert". Another person we were told about tried hard to communicate verbally and made noises and gestures to express their feelings. This person used communication aids and a touch-screen computer. They were receiving speech and language therapy to assist their development and progress with this.
● People's communication needs were documented within their care plans. Sustaining a traumatic brain injury could affect or change people's behaviour and personality. For example, one person could sometimes speak inappropriately to care staff. Care staff addressed this by touching the person gently on the shoulder, should they use unacceptable language. This worked well. Staff were trained in positive behaviour management.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy which stated that any complaint should initially be made to the relevant case manager. If possible, complaints were dealt with within 20 working days.
● Two complaints were documented and dealt with satisfactorily.
● People told us they knew how to make a complaint and who to contact. One person said, "I have a contact number saved on my phone". A relative commented, "I've never had to make a complaint, but I think there is a contact number in the care plan if I need it".

End of life care and support
● No-one who received support from the service was on end of life care at the time of the inspection.
● The registered manager told us that, when required, end of life care plans were co-ordinated between people, their relatives, staff at the service, the person's GP and any consultants involved.
● People's end of life wishes were recorded within their care plans.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- People received a high standard of personalised care that was bespoke; staff encouraged people's independence. People spoke positively of the service. One person told us, "I didn't pick Head First. I heard about it through a friend of mine. It's through their recommendation and I have to say the service is brilliant. The care staff are very supportive to me and my wife".
- People had access to advice and support from managers at the service day and night, if required. There was a rota of managers for people to access outside of working hours. The registered manager told us that one person had rung them in the middle of the night because they were worried and upset. The service knew it was important for people and their relatives to receive advice, guidance and emotional support at the time they needed it, and not just during office hours. If people contacted the service at any time, they would be responded to in person. This meant that when people were anxious or worried, someone from the service would be there for them.
- The registered manager worked tirelessly to improve and influence care and services for people with an acquired brain injury (ABI). This went beyond the people who were supported directly by Head First. The registered manager wrote to us about the additional work they were involved with. They told us, 'We attempt to support people who we do not work with, people with no litigation claim and people who may otherwise slip through the net. In doing so, we aim to support the development of knowledge across the country and globe, to improve the lives of individuals and families, and support professional knowledge and development'. The service was happy to provide advice and support to anyone in need, who had been affected by ABI.
- The registered manager and clinical manager had helped to establish the largest one-day UK brain injury conference which brought together professionals from across the sector with people and their families who had been affected by ABI, to share experiences, knowledge and research. People and/or family members spoke at each conference, providing a platform for often hidden and marginalised voices. These events were inclusive and ensured that people and their families had a voice and could share their experiences of ABI.
- The service had promoted the use of, and campaigned for, helmets for people on their bikes, as a preventative measure against head injuries. This helped raise awareness of the risk of head injury if people rode without a helmet.
- Recommendations in relation to ABI and capacity on supported decision making had been included in guidelines from the National Institute for Health and Clinical Excellence (NICE). This meant that people with an ABI were supported to make decisions because these guidelines were followed.

● The service provided speakers, for example, staff members, to speak at local, national and international events, to promote and share knowledge of ABI. These events were open to people and their families and provided opportunities for everyone to share experiences and learn from each other.
● The service was involved in undertaking ground-breaking research into brain injury, rehabilitation and case management. This included a book with contributions from family members and working with brain injury in a mainstream social work book.
● The work undertaken by the registered manager and staff at Head First had influence across international borders and, in recent years, they have had a presence in Brazil, USA, Canada, China, France, Belgium, Ireland, Spain, the Netherlands and Ukraine. This had a positive impact for people across the world who lived with a brain injury, including their families.
● In addition to the above, the service has a history of supporting severely injured people to leave long-stay settings and move into their own accommodation. One person had moved into their own home which they had bought. Staff supported them around the clock, with live-in 24 hour shifts.
● The registered manager was a published author of books about ABI and rehabilitation and an expert in the field.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives were asked for their feedback about the service. One relative had written, 'Thanks for all you are doing … you are excellent and just what we need. [Named person] has been neglected over the last few years by previous case managers [from another company]'.
● A questionnaire sent out to people in April 2019 identified that over 70 per cent of people had used the service for over five years. Everyone who responded felt they had the right amount of support from the service. Many people directly employed their support staff. One person stated, 'I'm so happy directly employing. I feel really listened to and in control. They [Head First] will always help, advise and listen'. People spoke positively about their case managers. One person had written, 'My case manager is a true gentleman, thoughtful and considerate, and I know that absolutely to the bottom of my heart'. People felt supported by Head First to live the lives the way they wanted. Another person commented, 'The service I receive from my case manager/Head First is first-class, A1 all the way and always has been'. A third person stated, 'My case manager/Head First are a total Godsend to me and have improved my life in too many ways to list'.
● Staff were recruited from a variety of backgrounds and their diverse needs were recognised and acknowledged. For example, one staff member's religion meant they did not recognise Christmas, so staff celebrated 'End of year' instead.
● Staff told us they enjoyed working for the service. One staff member said, "It's incredibly refreshing and a very different ethos. We have a very supportive team. It's a diverse role with lots of clients with different needs, and I like the variety. We have a lot of experienced staff from different professional backgrounds. We have peer supervision and good access to training'. Another staff member described the high level of support they received, as being a case manager could be complex and challenging, partly because of managing care staff at a distance. They explained, "It's about the support, the flexibility, the ability to be creative and the passion everyone brings to it. I am passionate about the clients; it is totally client-focused".
● Staff were asked for their feedback through a questionnaire in March 2019. Out of 20 responses, only three contained negative comments. Actions were taken and recorded to show changes that had been made, which helped to drive improvement. The majority of feedback included positive comments. One staff member wrote, 'Overall I have found Head First case managers and administrative staff to be very helpful'. Another staff member stated, 'I have worked in care and support for many years and Head First are, without doubt, the best in the industry. I have recommended them to other people that I know'.
● Case managers who worked with people living with ABI were members of a professional organisation, the

British Association of Brain Injury and Complex Case Management. Case managers abided by the professional code of conduct and ethics of this organisation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and staff understood the regulatory requirements. The registered manager told us, "We have a meeting every couple of months to look at what CQC require and we look at all the audits. We go through everything and make sure we're up to date".

● Incidents and accidents were recorded and reported. These were followed-up with staff and investigated, to prevent similar incidents from occurring again.

● The registered manager explained their understanding of duty and candour and said, "We have a professional duty of care. We have a code of ethics. All our case managers are qualified and there is integrity with the team, to make sure we all work together. We have a duty of care to everyone".

● Team meetings organised monthly enabled staff to discuss any clinical decisions, safeguarding concerns, and provided opportunities for peer supervisions. The team talked about the service, shared good practice and advised on what had worked well, with any areas for improvement.

Working in partnership with others

● The service had developed helpful ways of working in partnership with others. Working effectively in partnership was crucial in providing people with holistic care. The high quality of care and support that people received was dependent on effective co-ordination of all their needs. The service liaised with solicitors, health and social care professionals, people, their families, and contributed to court hearings.

● A case manager told us, "We have a large pool of people we can consult. For example, a psychologist will have a whole different range of skills. The key thing is whether the client will get on with them. We try and match people with healthcare professionals".