



THE WOODBERRY
PARTNERSHIP

INSPECTION REPORT

ROWNHAMS MANOR

CQC RATING GUIDE: 'GOOD'



Privately Commissioned Inspection for

Rownhams Manor

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Date of Inspection:
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Executive Summary

Oyster Care's stated aim is to offer care and support that focuses on resident well-being and quality of life. This is being built and delivered in a series of new purpose built care homes across the south of England. As part of Oyster's quality assurance programme, additional privately commissioned inspection visits have been commissioned from outside care professionals. This is to ensure the organisation makes use of an external eye, acting as a 'critical friend', to further improve and enhance the quality of leadership and the quality of care at their care homes. An introduction to the author is available at the end of the report.

This is the report from a day spent at **Rownhams Manor**. Rownhams Manor is a new purpose built residential care home for older people including people living with dementia, located in Southampton. The facilities are impressive and the environment is amongst the most highly sought-after in the residential care market. The home opened recently in May 2024 and there were 25 people in residence.

The key finding of this inspection was that the team had made an excellent start in all regards. Residents and relatives were complimentary about the care provided and the observed care was of an outwardly high standard. The staff team had bonded noticeably well considering the service was less than one year old. Staff at all levels spoke appreciatively of their working conditions and support they received and there was a sense that everyone wanted everyone else to succeed. The atmosphere was positive and cheerful and there was a palpably kind and caring culture. Staff were attentive and helpful when interacting with residents and they attempted to make peoples' living conditions as happy as possible. There was good evidence of meaningful activity and positive and proactive community engagement.

Regulatory compliance and governance systems were robust, ably demonstrated and were quickly becoming embedded. Medication systems were safely managed. Mandatory training and staff supervision were up to date. There were plenty of staff on duty and they had been properly recruited in line with regulation. The lunchtime experience was well managed.

The home's environment was clean and well presented, with domestic staff sharing in the pride of the new service. Care planning was also of a high standard and the matters identified around daily record keeping were more 'discussion points' than

particular concerns or deficits. These issues, picked up for consideration and improvement and these are discussed during the report and clarified in the recommendations section.

The whole team deserved credit for an excellent start so far. The home passed the 'mum' test comfortably.

CQC Rating Guide

This is a ratings guide for this service on the basis of what was seen, heard, witnessed and experienced on the day of inspection. It is for guide purposes only. The methodology used for conducting the inspection and preparing the rating is discussed in more detail in a separate section at the end of the report:

	Inadequate	Requires Improvement	Good	Outstanding
Safe			X	
Effective			X	
Caring			X	
Responsive			X	
Well-Led			X	

Overall: Good

This was a comfortable 'Good' rating. There were no concerns raised. With the home less than half full I would not consider awarding a rating higher than 'Good' at this stage. There is still a long way to go to get the home fully set up.

CQC Key Question - Safe

The following CQC quality statements apply to this key question:

- Learning culture
- Safe systems, pathways and transitions
- Safeguarding
- Involving people to manage risks
- Safe environments
- Safe and effective staffing
- Infection prevention and control
- Medicines optimisation

Staffing Levels

The home is registered for a maximum of 66 older people, including some people living with dementia. There were 25 people in residence on the day of my visit. The home was set out over two floors, with only the ground floor open to residents at this stage.

Staffing levels across the home were as follows:

Ground Floor – (25 people in residence.)

(am) 1 deputy manager, 1 senior care assistant and 3 care assistants

(pm) 1 deputy manager, 1 senior care assistant and 3 care assistants

(nights) 1 night team leader, 1 senior care assistant and 2 care assistants

The home was staffed to grow its occupancy numbers. The manager stated that minimum safe numbers would be one care assistant less than stated above, for all shifts.

First Floor

Not yet open.

Ancillary Staff

In addition to the care staff there were kitchen staff (chef or sous chef and kitchen assistant each day), maintenance manager, front of house manager, head housekeeper, lifestyle manager and domestic team (including dedicated laundry staff). Hairdressing and chiropody services were contracted externally.

The team was managed by the manager (supernumerary) and a care manager (also supernumerary). This was a good level of ancillary staff for a home of this size.

The manager undertook a regular dependency monitoring exercise as one way of ensuring the staffing was sufficient, as well as her own observations and input from care staff. From my observations during the day there were more than enough staff to care for the current resident group. There were many examples of staff having the time to speak with people, listen to them and engage with them in addition to completing personal care tasks. Ancillary staff were engaged with the residents and there was clear evidence of a 'one team' approach. Both the management team and the staff team were of the view there were comfortably enough staff to care for people appropriately.

Staff Vacancies

The home was fully staffed for its current number of residents and was in a good position to accept more people as referrals came in. There were some further staff who had been recruited pending regulatory checks and these included several care assistants, a senior care assistant and a lifestyle assistant to work alongside the lifestyle manager.

The 'second phase' of staff recruitment had also begun. Recruitment was underway for another deputy manager, three care assistants, a night senior care assistant and another housekeeper.

No agency staff had ever been used at the home.

Staff Recruitment Files

I looked at the recruitment information for several staff recently recruited to the home. The files were stored securely on the Coolcare system, were well put together and contained all the information required by regulation and other information indicative of good and safe recruitment practice. Information seen included:

- Recent photographs
- Full employment histories
- Medical information to ensure people are fit to work
- Contracts

- ID
- Suitable references
- Job descriptions
- Interview notes
- Training information
- DBS information
- Evidence of relevant qualifications
- Supervision notes

Open Safeguarding Cases

The manager advised there were no open safeguarding cases at the home. A recent referral had been closed. The manager had a good understanding of safeguarding and what needed to be referred.

Medication Management

The medication trolleys were kept in a secure medical room on the ground floor. There was another medical room on the first floor for when it opened. The systems were ably demonstrated by the care manager. I found that the medication systems were safe and well-managed.

- Keys were kept by the senior member of staff in charge.
- Storage temperatures were monitored daily for both the medication room and the refrigerator. Records indicated that the storage temperatures were within safe ranges.
- Specified room cleaning schedules were completed daily.
- The trolleys were tidy and well organised and attached to the wall when not in use.
- Medication was delivered regularly in original packaging – a non MDS approach.
- There were no controlled drugs in the building, but there was the correct storage facilities on site for if and when it was needed.
- Do not disturb tabards were worn by staff administering medication.
- PRN protocols were in place and well written.

The home used an electronic medication system (EMAR). The EMAR system involved scanning the medication boxes prior to administration and the system generated a MAR chart. The system prompted all prescribed medication

administration and so it was not possible to 'forget' any medication or not sign for it. The key to demonstrating the system is being used correctly is to ensure the stock present in the boxes and packets matches exactly the amounts recorded on the computer system. I undertook ten random stock audits and all were correct.

Premises Safety & Management

The home was new and was spotlessly clean and well presented. No unpleasant odours were noted anywhere. The home was warm and cosy, with ambient temperatures being suitable for older and more sedentary people.

Domestic staff worked safely with their cleaning materials. Sluice rooms were locked at all times. COSHH cupboards were also locked when not in use.

Laundry Room

This room was spacious with both an 'In' and an 'Out' door. It was clear that soiled laundry was stored correctly and washed separately on a sluice wash. Dissolvable red bags were used for safe storage and laundering.

Kitchen

The home had received its first environmental health inspection, scoring 5 – 'Very Good,' which is the highest score available.

Kitchen practices were not assessed further at this visit.

CQC Key Question - Effective

The following CQC quality statements apply to this key question:

- Assessing Needs
- Delivering evidence-based care and treatment
- How staff teams and services work together
- Supporting people to live healthier lives
- Monitoring and improving outcomes
- Consent to care and treatment

Supervision & Appraisals

The home employed 37 staff. The provider used a system called Coolcare to monitor the frequency of supervision and appraisal meetings. The system showed all supervisions to be up to date, other than one person whose probationary period meeting had been booked for the following day. The home had not been open long enough for appraisals to be due, but these would be conducted annually. Minutes of supervision and probation review meetings were kept on personnel files and were signed by both parties.

The staff team had bonded very well considering the service was less than one year old. Staff at all levels spoke appreciatively of their working conditions and support they received and there was a sense that everyone wanted everyone else to succeed. One staff member said, *“I’ve worked in smaller homes but honestly I feel more supported here than at any of the others. My colleagues are great.”* Another member of staff commented, *“This is the nicest place I’ve worked in a long time. There’s great support.”* One staff member who had achieved a promotion said, *“I doubted myself at first, but there’s been loads of support and encouragement. The manager is fantastic.”*

Training

When new staff were appointed to work at the home they were expected to undertake basic training to do their jobs. Mandatory training compliance figures were high, at **91%**. The missing 9% were new staff who were in the process of completing their required training during their inductions. This meant the mandatory training statistics were as high as they could be.

Mandatory training was wide-ranging, incorporating autism, learning disabilities, COSHH, dementia awareness, dignity in care, dysphagia, end of life care, equality

and diversity, fire safety, first aid, basic food hygiene, GDPR, health and nutrition, health and safety, infection control, MCA/DoLS, medication, mental health awareness, moving and handling, oral hygiene, pressure area care, falls awareness and safeguarding.

Several members of the team made positive remarks about the training manager who had conducted most of the mandatory face-to-face training.

Mental Capacity - DoLS

The management team had a good understanding of DoLS processes. A clear matrix was in place and showed that 5 DoLS applications had been correctly made for people who fell into all 3 of the following criteria:

- a) those who lack capacity to consent to their care and treatment in the home due to dementia or severe illness;
- b) those who are not free to leave the home as and when they please (i.e. staff would stop or divert them if they tried to);
- c) those who need continuous monitoring (i.e. staff control all their medication, nutritional intake, activities etc).

None of the applications been determined (approved) by the local supervisory body as yet. The team were aware of the need to submit CQC notifications when the applications were finally determined.

Eating and Drinking

I witnessed the lunchtime experience in the ground floor dining room, which was a positive, sociable experience. Good practice included:

- Appropriate classical music was playing during lunch.
- Tables were nicely laid and clear menus were on display.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- Napkins were available.
- There were plenty of staff around and they interacted with residents well, being focused on their needs and wishes.
- One person was able to use a plate guard to assist them to eat by themselves.

- Choices of different drinks were given to people.
- Choices of main courses were given to people in a way appropriate for them and there were also choices of desserts.
- The chef was involved in the serving out process.
- Feedback from residents about the quality of food was positive, although one person said the portion sizes could be a bit big sometimes and they would find slightly smaller portions more appetising.

See Recommended Action 1.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area, staffed by friendly and enthusiastic front of house staff. There was a fully working tea and coffee bar with fresh cakes that were made every day by the chef. The manager's office was easily accessible at the side of the main reception. Information such as the home's registration certificate and the complaints policy were displayed prominently.

The home did not as yet have a CQC rating, but this would be displayed after the first inspection.

Design and Adaptation

The home was designed and purpose built for people who have mobility restrictions. All bedrooms had en-suite toilets and wet room showers. Full assisted bathing facilities were also available on each floor.

Communal Rooms

The lounges and dining rooms were welcoming, clean and very nicely furnished. There were a variety of different lounges and dining rooms in the home, including a state-of-the-art cinema room, library area, garden rooms and a sweet shop. There was also a fully kitted out hairdressing salon.

Impressive and well stocked snack and hydration stations were available in both lounges.

Bedrooms

The occupied bedrooms were nicely personalised with people's own belongings and photographs of their families. This enabled them to feel settled at the home. The bedrooms were fitted with smart televisions, refrigerators and the facility for a telephone line.

Garden

The secure gardens around the home were newly planted, but well kept and presented. Some of the ground floor rooms had areas outside their patio doors for individual people to sit and enjoy the weather during the summer months.

CQC Key Question - Caring

The following CQC quality statements apply to this key question:

- Kindness, compassion and dignity
- Treating people as individuals
- Independence, choice and control
- Responding to people's immediate needs
- Workforce wellbeing and enablement

Residents

All of the interactions between the staff and residents at the home were full of positivity and compassion. The staff exhibited attentiveness, cheerfulness, and friendliness consistently. Residents were engaged with kindness and patience, with many of the staff fostering an atmosphere of playful banter and laughter. Staff members allocated time beyond personal care duties to spend meaningful social time with the residents. Feedback from residents was most positive and grateful about their experiences of living at the home. Quotes included:

“There are some lovely staff here. They are all very nice.”

“The food is excellent, superb, good variety and plenty of vegetables.”

“The staff are particularly kind – and tolerant too. With some people they hear the same thing over and over again and they never complain.”

“We are definitely in the right place given our circumstances.”

“They look after both of us very well and we have nothing to complain about.”

“I like the activities. We play with balloons, do exercises and yesterday we did some flower arranging. We had a singer in here once and they were good.”

“You can have a cup of tea or coffee whenever you want and they bring it for you.”

“This home is like a holiday camp, but better.”

“I have no concerns. Everyone is very helpful.”

“The home is a lovely design and the staff can't do enough for us. The staff are well trained and educated in what to do. The toilets are clean, which I appreciate. It's 101% good.”

Everyone living at the home had a good sense of wellbeing. The standard of personal care was high throughout the home. People were supported to be clean, well-presented and wearing properly fitting clothing. Staff were attentive to people's care needs, for example several staff were seen ensuring people had their correct assessed walking aids with them when they stood up.

Visitors

Visiting was able to take place unrestricted. The feedback received from visitors was similarly positive to the resident quotes in the previous section.

The carehome.co.uk website rated the home as 9.3 out of 10 from the first 8 reviews, which was indicative of very high satisfaction levels from people who used that website for feedback. Reviews were written in the most complimentary terms.

Privacy and Dignity

People were treated with dignity and respect throughout the day. Staff were observed to knock on doors prior to entering peoples' bedrooms. This indicated a respect for people's personal space. Call bells were left within reach of people spending time in their bedrooms and were answered quickly. Staff were alert to situations where peoples' dignity may be compromised and intervened without fuss.

There was one situation where continence products were stored in full view in a person's bedroom. This unnecessarily advertised the person's continence issues and therefore was somewhat undignified.

See Recommended Action 2.

Confidentiality

Care plans were stored electronically and were password protected.

CQC Key Question - Responsive

The following CQC quality statements apply to this key question:

- Person-centred care
- Care provision, integration and continuity
- Providing information
- Listening to and involving people
- Equity in access
- Equity in experiences and outcomes
- Planning for the future

Care Plans

The electronic care planning system was Person Centred Software, which I have seen implemented successfully in different care environments. Care plans were written following detailed assessments of people and contained plenty of person-centred information. The care plans I read were well-drafted and informative. Specific care plans were in place for individual health conditions.

The management team were clear about the needs of people the home was able to meet and the kind of needs that were not suitable.

Care plans had been reviewed on a monthly basis, as prompted by the computer software. Established scoring systems were used to ensure that risks to people were identified and managed effectively. The system produced a list of required risk assessments that were completed for all. These included people's risk of developing pressure ulcers, risk of becoming malnourished (MUST & Waterlow) and moving and handling risk assessments. These risk assessments had also been regularly reviewed.

I was given access to read the care plans through the login and password of a staff member. It would be better if there were to be 'Guest Professional' login set up. This would be a read-only access account that visiting professionals could use.

See Recommended Action 3.

Consent to Care and Treatment

Mental capacity assessments (MCAs) were in place where there was a doubt about individual people's capacity to consent to various specific aspects of their care. Best

interest decision making documents had been prepared when people lacked the capacity to consent to a specific decision. For example, in one resident's case there were separate MCAs and best interest processes for use of a sensor monitoring mat, flu vaccinations, living at Rownhams Manor behind a key coded door and medication administration.

The MCA template on PCS is effective, as the questions asked will lead the author to an appropriate conclusion. In some cases there was unnecessary peripheral information written under each question, which made the documents more difficult to follow. For example, for Resident 1, the question of whether she could understand what a sensor monitoring mat was contained, "*[Resident 1] does not retain to press the buzzer when she gets out of bed and as a result she is a falls risk.*" This may be the case but that information would be recorded elsewhere. The answer should be something like, "*I spoke with resident 1 and she could / could not understand what the sensor mat was for.*"

Section 3 of the documents are where the best interest decisions are recorded. This section should simply be a statement of what was decided and who had been involved in making the decisions, rather than a re-hash of previously stated information. Answering each of the questions more succinctly and directly will make them clearer and easier to follow.

See Recommended Action 4.

Daily Care Records

Hygiene charts were in place for everyone and these indicated personal care had been given regularly and as required. However, there were four residents (identified to the team) who had not been marked as having been supported to have a bath or shower in the past month. The personal care plans in question made general reference to these people preferring a basic wash, but staff might explore other options with them each day and offer them a bath or shower. When discussing each case with the manager it transpired that none of these people would be likely to agree to a bath or shower in most circumstances. The care plans should be updated to reflect this. As the care plans were written it suggested that the residents should have been supported to receive many more baths and showers than was likely or realistic.

See Recommended Action 5.

The team had made a recent change to record the application of emollient creams on the PCS system. This had started well and will be followed up in more detail at future inspections.

There was nobody living at the home who required their fluid intake to be monitored for a clinical reason. Records were made in some cases when people had taken drinks, but this was not done consistently. This meant that available records tended to indicate people had only been offered and then consumed small amounts of fluids. For example, Resident 2 was recorded over the past few days as having been offered only 880, 680, 750, 200, 200 and 200ml of fluids. Resident 3 was recorded as having been offered 280, 560, 750, 430, 150 and 0ml of fluids. It was clear from watching the care take place that fluids were promoted consistently and, in reality, much more fluid would have been offered than had been recorded.

The team have a decision to make here. Either record all fluids offered, including the jugs available in peoples' rooms, to indicate how fluids are being promoted, or, instruct staff not to record fluid amounts for people unless there is a specific clinical need to do so. Both ways are acceptable, but the observed records fell between the two approaches and were not accurate or helpful.

See Recommended Action 6.

Activities Arrangements

The lifestyle manager was not working on the day of inspection, but other staff ensured some activities took place. These included a chair exercises session and some pumpkin decorating for Halloween. Several residents described how they found some of the activity sessions engaging.

Specific activities were advertised for each day during the month. These included quizzes, board games, meditation, ladies club, pamper afternoons, card games, poetry reading sessions, cinema evenings, gentleman's club, cheese and wine evening, flower arranging, baking sessions and much more.

The manager described some important community engagement, which had been a helpful part of getting the home known in the local area. There had been a professionals lunch, where local people such as solicitors, chiropractors, police and

others had been invited to view the home and share a lunch. The home had sponsored Southampton City Farm and this meant there could be regular trips there for residents. The team did some fundraising for the local 'Men Shed' group. Some school links had been forged and there had been a well attended summer fayre.

CQC Key Question – Well Led

The following CQC quality statements apply to this key question:

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Freedom to speak up
- Workforce equality, diversity and inclusion
- Governance, management and sustainability
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability – sustainable development

CQC Notifications

CQC notifications had been submitted as required.

Registered Manager

Oyster Care's Chief Executive (Tim Buckley) was registered as manager. This was done primarily to get the home's registration approved when the home opened.

The manager, Sam Squibb, was an experienced manager who had been registered before. Sam had applied to CQC to be registered as manager with CQC, although there had been some unforeseen delays in submitting the application due to problems with CQC's new portal system. Sam believed that the application had now been received and accepted as valid by the CQC and she was awaiting interview.

The home had yet to be inspected by CQC and was unrated.

Management Governance and Audits

A robust internal auditing system was in place, as was the case throughout Oyster Care's homes. The auditing system was robust and covered a wide range of key areas. The sheer amount and depth of the auditing gave confidence the home was well run. The management team believed in the governance system and felt it would certainly help to keep them safe as both the home and the organisation grew. Actions identified through the audits were placed on a home action plan.

Audits for September 2024 included:

- Daily walk around checks
- Daily clinical oversight
- Catering audit
- Fire drill audit
- First impressions audit
- Lifestyle audit
- HR (personnel file checks) audit
- Finance audit
- First aid box checks
- Dining experience audit
- Care plan management audit (10% minimum)
- Medication audits
- Complaints and compliments
- Meetings (for example, heads of department, housekeeping, night staff etc) with full minutes
- CQC notifications
- Safeguarding review
- DoLS review
- Pressure ulcer audit
- Moisture lesion audit
- Bed rails checks
- Wounds review
- Weights and weight loss management information
- Infections review
- Duty of candour review
- Equipment log
- Hoists and slings audit
- Maintenance certificates review (all in date from LNT handover)
- Dependency tracker
- Call bell response time analysis (very good response times)
- Accidents and incidents review, with graphical and trend analysis
- Lists of any distressed behaviour.

Other auditing took place weekly and bi-monthly. Every day there was a resident of the day process. These were monitored both by the management team and by senior management staff of Oyster Care. The systems were early in their development, but were built to cope with significant growth.

Provider Visits

The home's management team were full of praise for the support they had received so far by the senior management team of Oyster Care.

The provider had an in-depth MGV (monthly governance visit) that the regional director completed every month for each home, in addition to the other support that would be provided to the team.

The regional director was present throughout the inspection day.

Management and Leadership Observations.

The management team and the whole staff team had made an excellent start and the home was a positive and cheerful place to visit.

It was striking how well the staff team had bonded very well considering the service was less than one year old. Staff at all levels spoke appreciatively of their working conditions and support they received and there was a sense that everyone wanted everyone else to succeed. This tends not to happen by accident and was a sure sign that the home was being well led by the management team.

Residents and their relatives were highly complimentary about the care provided and all of the observed care on the day was of an outwardly high standard. The atmosphere was positive and cheerful and there was a palpably kind and caring culture.

The management team were open and welcoming towards constructive criticism and this showed a good attitude towards continuous improvement.

Required and Recommended Actions

The following list consists of matters picked up during the inspection process that would be either in breach of regulation, arguably in breach of regulation, issues that CQC inspectors commonly criticise if not seen as correctly implemented and general good practice suggestions. The regulations in question are the HSCA 2008 (Regulated Activities) Regulations 2014, The Care Quality Commission Registration Regulations 2009 and The Mental Capacity Act 2005. There are other regulations that can be relevant, but these ones cover the vast majority of issues to consider.

1	Please consider the main meal portion sizes that each person would like, in an attempt to make the food as appetising as possible.
2	Please store continence products discreetly in peoples' private bedrooms.
3	Please consider having a read-only 'guest professional' login available. This would give appropriate access to the PCS system that is not under an individual staff member's personal account.
4	Please work towards staff answering the questions in the mental capacity assessments (MCAs) directly and more succinctly, particularly in sections 2 and 3.
5	Please update the personal care plans for people who are unlikely to agree to baths or showers to reflect this fact.
6	Please decide whether to record all fluids offered and consumed for all residents or to only record fluids offered and consumed by residents who have a clinical need for the monitoring.

Inspection Methodology

The inspection took place over one full day on site at the home. Evidence was obtained in the following forms:

- Observations of care and staff interactions with residents.
- Observations of general living and activities.
- Discussions with people who lived at the home.
- Discussions with staff who worked at the home, including management staff.
- Inspection of the internal and external environment.
- Inspection of live contemporaneous care records.
- Inspection of live contemporaneous management records.
- Inspection of medication management systems.

The main inspection focus was against compliance with the following regulations:

- HSCA 2008 (Regulated Activities) Regulations 2014.
- The Care Quality Commission Registration Regulations 2009.
- The Mental Capacity Act 2005.

Full account is also taken of the following key guidance, although this list is not designed to be exhaustive:

- CQC's recently published Single Assessment Framework (SAF) and its associated Quality Statements.
- The recently retired Key Lines of Enquiry (KLOEs), as these were always a good technical guide for what appropriate quality care looks like.
- NICE guidelines on decision making and mental capacity.
- NICE guidelines on medication management.
- A whole variety of CQC's clarification documents from over the years.
- RIDDOR guidance on reporting injuries and dangerous occurrences.

The ratings awarded for each key question are professional judgements based on over 25 years' experience of inspecting and rating care services. I believe the most meaningful rating is a 'description,' not a 'score.' It is a 'narrative judgement,' not a 'numerical calculation.' This inspection does not attempt to mimic CQC's current complex scoring system.

Introduction to Author

Simon Cavadino

Simon has worked in the provision, management and regulation of social care and healthcare services for over 25 years. He currently works with a range of different care provider organisations, offering advice on the Health and Social Care Act (2008) and its accompanying regulations. He is able to undertake detailed compliance advice work and/or senior-level management advice and coaching. Simon trades under the banner of The Woodberry Partnership.

During his career Simon has worked as an inspector for the Commission for Social Care Inspection (CSCI) and for the Care Quality Commission (CQC). He has undertaken detailed inspection, registration and enforcement work during his two spells working for the national regulator.

Simon has also worked for care provider organisations in both the private and voluntary sectors, achieving high quality services wherever he has worked. His most notable career achievement was as Director of Operations for a private sector provider, where he commissioned, built, opened and ran 25 sought-after care services for adults with a learning disability over a period of 8 years.

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