



THE WOODBERRY
PARTNERSHIP

INSPECTION REPORT

FURZE FIELD MANOR

CQC RATING GUIDE: 'GOOD'



Privately Commissioned Inspection for

Furze Field Manor

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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 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 **Furze Field Manor**. Furze Field Manor is a new purpose-built residential care home for older people including people living with dementia, located in Sayers Common, West Sussex. 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 17 people in residence.

The key finding of this inspection was that the team had made a good solid start to life at the home. Residents and relatives were highly complimentary about the care provided. The staff team had bonded well and were upbeat and positive. New staff said they had felt welcomed by the rest of the team. Staff spoke appreciatively of their working conditions and the support they received. The atmosphere was cheerful, kind and caring and there was plenty of good banter and laughter between staff and residents. There was evidence of meaningful activity and some early signs of proactive community engagement.

The home's environment was warm, clean and well presented. Regulatory compliance and governance systems were robust, ably demonstrated and were quickly becoming embedded. Medication systems were safely managed. Mandatory training had been provided to people on their inductions and staff supervision was up to date. There were plenty of staff on duty. The lunchtime experience was well managed, with the food very nicely presented.

The care plans were full of important, person-centred information, indicative of effort made to gather relevant information about people, including their life histories. However, some of the information in the care records was contradictory, especially

relating to some people's mental capacity and this needed reviewing and resolving. In several care planning sections there was a lot of information about care situations no longer relevant to the person that should have been archived, with only information relevant to active care remaining in the care plans. Some care plans switched between being drafted in the first and third person and so did not read well.

The provider had a clear system for staff recruitment. However, not all staff had given full and clear employment histories and some references did not contain 'evidence of conduct' in previous health and social care employment. These issues are discussed during the report and clarified in the recommendations section.

All things considered, the inspection findings showed a good start so far for the new home. The whole team responded well to the inspection process, were keen to learn and improve and this augured well for the future. The home was a pleasant place to spend a day and was a positive environment for the people who lived there.

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. However, attention to the recommendations will make the rating even more solid.

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 17 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 – (17 people in residence.)

(am) 1 deputy manager, 1 senior care assistant and 4 care assistants

(pm) 1 deputy manager, 1 senior care assistant and 4 care assistants

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

The home was staffed to grow its occupancy numbers and in practice there were often more staff than this on duty during the day. There were a couple of extra care staff on duty on the day of my visit, with some new care assistants on induction and shadowing the more experienced carers. The manager stated that it was safe to run on less night staff than stated above and that occasionally this had been necessary due to staff sickness.

Ancillary Staff

In addition to the care staff there were kitchen staff (chef or sous chef and kitchen assistant each day), maintenance manager (post vacant), front of house manager, head housekeeper and domestic team (including dedicated laundry staff). There was also a lifestyle manager and a lifestyle assistant who had recently joined the team. Hairdressing and chiropody services were contracted externally.

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

The management team undertook a regular dependency monitoring exercise as one way of ensuring the staffing was sufficient, as well as their own observations and input from care staff and residents. 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. Both the management team and the staff team were of the view that there were comfortably enough staff to care for people appropriately.

Staff Vacancies

The home had recently started to move into the 'second phase' of staff recruitment to grow the team further. Recruitment was underway for a laundry assistant and a maintenance manager (from phase one to replace staff members who had left).

No agency staff were being 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 most of the information required by regulation and other information indicative of good and safe recruitment practice. Information seen included:

- Recent photographs
- Medical information to ensure people are fit to work
- Contracts & ID
- Suitable references (see below)
- Job descriptions
- Interview notes
- Training information
- DBS information
- Evidence of relevant qualifications
- Supervision notes

Some of the personnel files looked at did not contain full employment histories. In one case (staff member 1) there were unexplained gaps between 2005 - June 2006, September 2008 – June 2010 and October 2010 – April 2012. In a second case (staff member 2) there were similar gaps and also some differences in declared employment history between the application form and the CV on file. CQC has clarified that a full employment history is necessary for each staff member, right back to the time of first employment, together with a written explanation of any gaps in employment.

Staff member 2 had two references on file from previous care providers, but these were non-committal, meaning there was no evidence of the person's conduct. This is specifically required by regulation. Many companies will seek to only give dates due to risk-averse referencing policies and where this happens (for health care jobs) the team should seek further information. This further information, usually gathered verbally by telephone calls, should be recorded on the written references.

See Recommended Actions 1 & 2.

Open Safeguarding Cases

The manager advised there were no open safeguarding cases at the home. A recent case had been closed.

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 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.

- Controlled drugs were correctly stored and a random stock audit tallied.
- 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.

There was one PRN protocol in place for Resident 1 that related to Lorazepam. The advice given from a palliative nurse was that the medicine should be given every day and this advice was being followed. This should be reviewed with the person's GP as a drug being given every day is not normally PRN.

See Recommended Action 3.

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 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. 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 presented as a cheerful group who spoke appreciatively of their working conditions and of the support they received. One staff member said, *“I’ve had other care jobs, but this is certainly a welcoming and pleasant place to work.”* Several new staff said they had all been made to feel welcome so far and their inductions had been positive and interesting.

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 **82%**, but the 18% ‘non-compliance’ was unavoidable as it all related to new staff who were still going through their induction processes. All of the staff providing direct care had completed 100% of their mandatory training.

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.

Mental Capacity - DoLS

The management team had a good understanding of DoLS processes. A clear matrix was in place and showed that 3 DoLS applications had been 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:

- Residents had the opportunity to clean their hands before eating.
- Tables were nicely laid and clear menus were on display.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- There were plenty of staff around and they interacted with residents well, being focused on their needs and wishes. There was much laughter and good cheer.
- Choices of different drinks were given to people, including wine. Refills were offered when people finished their drinks.
- Choices of main courses were given to people in a way appropriate for them and there were also choices of desserts. Second helpings were offered.
- The chef was involved in the serving out process and presented the food neatly to a very high standard.
- Feedback from residents about the quality of food was positive.
- The atmosphere was quiet during lunch, with one person describing it as the, *"Quiet sound of contented munching."*

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area, staffed by friendly 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 and garden rooms. There was also a fully kitted out hairdressing salon.

Impressive and well stocked snack and hydration stations were available on the ground floor.

Bedrooms

The occupied bedrooms were nicely personalised ('lived-in') with people's own belongings and photographs of their families. This enabled them to feel settled at the home. The occupied bedrooms stood in contrast to the unoccupied ones, which were nicely presented but like hotel rooms, awaiting occupancy and life.

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

The atmosphere was welcoming, upbeat, happy and cheerful. There was an obviously kind and caring culture present in the staff team and there was plenty of laughter and joviality evident. The staff were confident in what they were doing, which helped with the generally happy and relaxed atmosphere. Many of the residents were fun characters and all were complimentary about the care they received. Quotes included:

"This place is far better than the last care home I was at. The food is better. You only have to raise your hand if you need something. No problems at all. Can't fault it."

"I have no concerns. My room is quiet and nice."

"I especially like the food here. It's very good."

"The staff are terribly nice here."

"I was one of the first here. It's certainly been a good move for me."

"It's absolutely wonderful, honestly."

"You'd be hard pushed to find anywhere better."

"We've made a few friends, which is very important."

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.

Visitors

Visiting was able to take place unrestricted. The feedback received from visitors was exceptionally heartfelt, with one person becoming quite emotional when describing the effect the care received had had on their family. *"I'm more than 100% happy. I don't know how we would have survived without this place. This home is a godsend. The first time I came here I knew it was the right place."*

The carehome.co.uk website rated the home as 9.6 out of 10 from the first 11 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. Continence products were stored discreetly.

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 is a respected and widely-used system. Care plans were written following detailed assessments of people and contained plenty of relevant information. Effort had been made to gather information about peoples' life histories, which contributed towards making them person-centred. The care plans contained information about all of the usual areas of daily living. Specific care plans were in place for individual health conditions, such as osteoporosis.

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.

There were two generalised issues with the presentation of the care plans. Firstly, the care plans for Resident 2 moved between the first and the third person and so read poorly. It is up to the team to decide whether each care plan is drafted in the first or the third person, but it must be done consistently throughout the care plan. This issue applied to some of the other care plans as well.

The second issue was that some of the care plans contained a lot of irrelevant information about issues that no longer applied to people. For example, Resident 2's

‘Medical’ care plan contained information from July 2024 about when the person had loose bowels, but a couple of days later this complaint had cleared up. This information should not be in the care plan ‘action for staff’ section. It should be stored in a care notes or archive section that could be accessed if necessary but would not form part of the day-to-day instructions. There were lots of other examples of this, such as in Resident 4’s ‘Mobility’ care plan.

See Recommended Actions 4 & 5.

Consent to Care and Treatment

The team had submitted DoLS applications for three people (Residents 2, 3 and 4) due to them lacking capacity to consent to some key areas of their care. There were some contradictions and anomalies in some of the mental capacity assessments (MCAs) and the care plans which needed resolving and correcting, and these cases are taken in turn:

Resident 2 had three MCAs in place. One was for use of a call bell, a second was for use of a sensor monitoring mat and a third was for living at the home in a secure environment. All three MCAs were well written and contained good evidence for the judgement reached, but all concluded that Resident 2 had the capacity to consent to each specific decision. The MCAs had been reviewed on 18/11/24 and confirmed. In Resident 2’s ‘Medical’ care plan it stated (from a note written on 3/11/24) that an MCA determined she lacks capacity and a process of DoLS application was underway. This meant that the care plan entry contradicted findings of the MCAs.

Resident 3 had MCAs for residing at Furze Field Manor and use of a call bell. The MCA for living at the home determined that he lacked capacity to consent, while the MCA for use of the call bell determined that he had the capacity to use it. It was fine that the MCAs found different results and this was good evidence of considering capacity on a decision-specific basis. However, within the MCA for living at the home was some evidence about use of a sensor mat. It was not clear why he could not consent to the use of a sensor mat, especially as he understood the call bell. It would be best practice to remove the references to a sensor mat from that MCA and conduct a separate one for the use of the sensor mat. There was a line in Resident 3’s ‘Mental Capacity’ care plan that said, “*Mental capacity assessment completed and [Resident 3] has capacity.*” This contradicted the findings of the key MCA.

Resident 4 had two MCAs in place. One determined that she had capacity overall to choose to live at the home. Another determined she did not have capacity to understand the use of a sensor monitoring mat. The relevant care plans had not been updated with this information on recent review. Staff who review care plans need to be instructed to add relevant information to the care plans on review, as well as being given permission to delete information that has become obsolete.

See Recommended Actions 6 & 7.

Daily Care Records

Fluid balance charts were well recorded, as was information about when people had received necessary personal care, including baths and showers. Emollient cream applications were recorded on the EMAR system.

Activities Arrangements

The lifestyle team were new in post but had made a good start and were interacting well with residents. There were some fun activities taking place, such as flower arranging and doing games and puzzles. Other activities advertised included walks in the garden, baking, arts and crafts, pamper sessions, armchair aerobics, musical activities and film afternoons in the cinema.

The manager was aware of the need to work with the local community to get the home known. Each week some young students with disabilities came into the home to interact with the residents as part of their enrichment scheme. The team were looking to partner with a nursery and with some school age children for the future.

The management team spoke about some events that had made a particularly positive impact on some peoples' wellbeing. One person was interested in motor bikes and it was arranged for someone to bring their Harley Davidson bike to the home. The person had a great time looking over the bike and, *"It made his day."* Another resident with an interest in golf was taken to a local golf course, drove around in a buggy and did some putting. I would recommend that such things are prioritised as much as possible going forward, as these are excellent initiatives. I would further recommend that they are written up and showcased in simple ways so not to be lost in the mists of time.

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, Wendy Peacock, had been recently appointed and was intending to apply to CQC for registration as manager. This would involve getting a DBS check countersigned by CQC and then submitting that with the full application. This should now be done without delay.

CQC Rating

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 October 2024 included:

- Pressure ulcer audits
- Moisture lesions
- Bed rails (none in place)
- Wounds monitoring
- Weights and weight loss management information
- CQC notifications
- DoLS review
- Duty of candour (one letter sent as required)
- Complaints (none)
- Equipment log
- Hoists and slings audit
- Fire drill and fire drill audit
- Maintenance certificates (all in date)
- Dependency monitoring
- Call bell analysis (good response times so far)
- Accident and incident log, with graphical and trend analysis
- Dining experience audit
- First impressions audit
- First aid box check
- Clinical room audit
- Kitchen audit
- Catering audit
- Care plan audits by management (minimum 10%)
- Lifestyle audit
- Medication audits

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 provided to the team.

Management and Leadership Observations.

The home was being well run by the whole management team and this inspection visit showed evidence of a positive start to life at Furze Field Manor. Residents and relatives were highly complimentary about the care provided.

Staff spoke appreciatively of their working conditions and support they received. New staff reported feeling most welcome. The atmosphere was cheerful, kind and caring and there were plenty of good banter and laughter between staff and residents.

The whole team responded well to the inspection process, were keen to learn and continuously improve. This augured well for the future. It will be important to make the suggested improvements from this report, but there was every indication that the team would be in a position to do and would get the ongoing support to be successful.

The home was a pleasant place to spend a day and was providing an excellent environment for the people who lived there.

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 ensure all staff have provided a full employment history, right back to the time of first employment, together with a written explanation of any gaps.
2	Please ensure that references from health and social care providers contain 'evidence of conduct.' Where they are non-committal please attempt to follow up for more information.
3	Please review Resident 1's Lorazepam prescription with the GP to establish whether it should remain PRN.
4	Please ensure care plans do not switch constantly between the first and the third person.
5	Please remove old and obsolete information from the care plan 'action' sections and store elsewhere.
6	Please review all MCAs for Residents 2, 3 and 4 and ensure all care plan sections are updated with the results so the care records do not contradict. If any of the reviews determine that Residents 2, 3 and/or 4 do have capacity to consent to their care then the DoLS applications should be withdrawn.
7	Please talk to senior staff about the need to change and update care plans on review when people's needs change. This will include deleting old and obsolete information.

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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