Stockton-on-Tees BOROUGH COUNCIL
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Adult Social Care and Health Select Committee

Agenda

Date: Tuesday 20 February 2024 at 4.00 pm

Venue: Jim Cooke Conference Suite, Stockton Central Library, Church Road, Stockton-on-Tees TS18 1TU

Cllr Marc Besford (Chair)
Cllr Nathan Gale (Vice-Chair)

Cllr Stefan Barnes
Cllr John Coulson
Cllr Lynn Hall
Cllr Vanessa Sewell
Cllr Carol Clark
Cllr Ray Godwin
Cllr Susan Scott

AGENDA

4 Minutes

To approve the minutes of the last meeting held on 23 January 2024. (Pages 7 - 12)

8 CQC / PAMMS Inspection Results - Quarterly Summary (Q3 2023-2024) (Pages 13 - 48)

Stockton-on-Tees BOROUGH COUNCIL
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Adult Social Care and Health Select Committee

Agenda

Members of the Public - Rights to Attend Meeting

With the exception of any item identified above as containing exempt or confidential information under the Local Government Act 1972 Section 100A(4), members of the public are entitled to attend this meeting and/or have access to the agenda papers.

Persons wishing to obtain any further information on this meeting, including the opportunities available for any member of the public to speak at the meeting; or for details of access to the meeting for disabled people, please

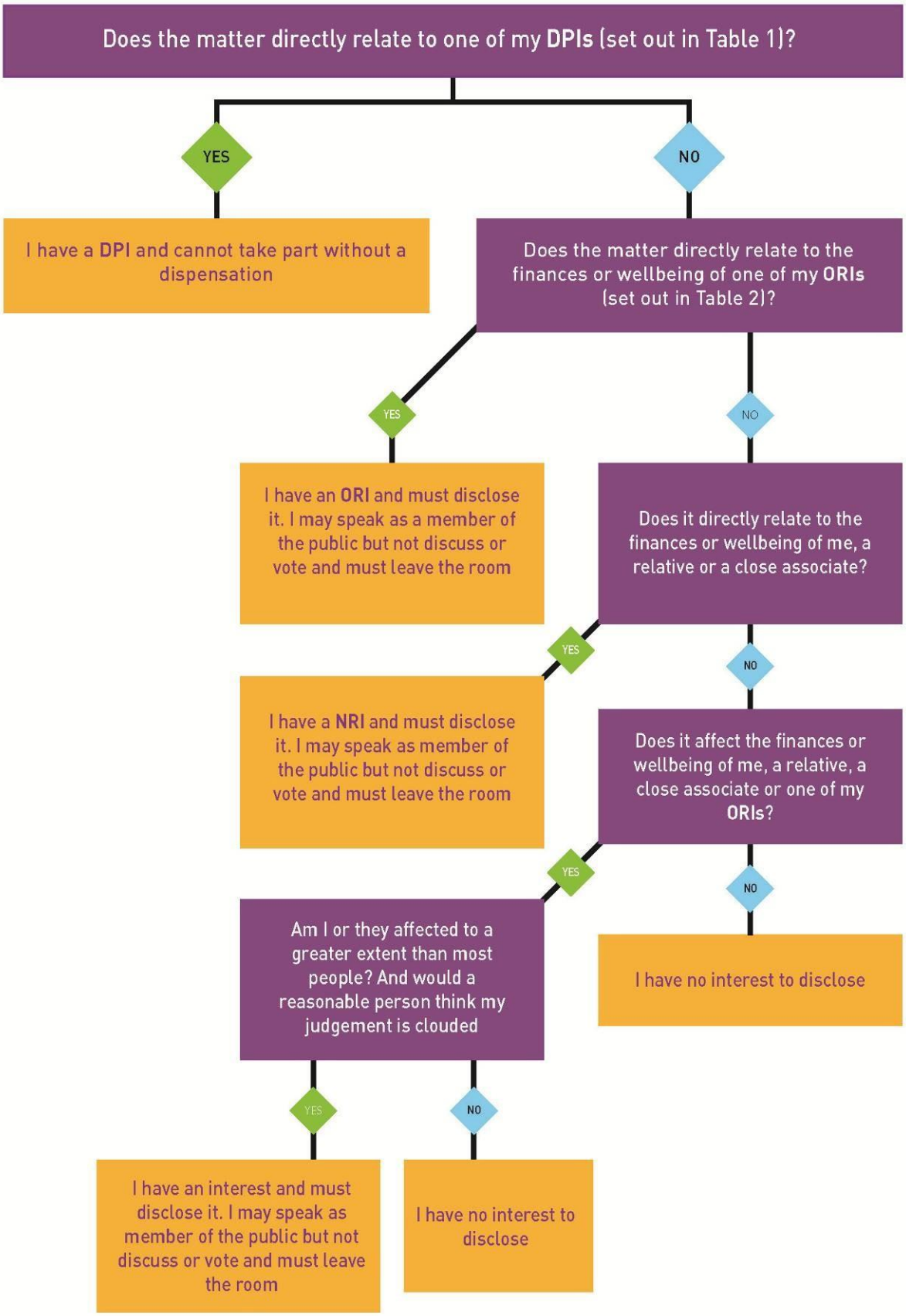
Contact: Scrutiny Support Officer Rachel Harrsion on email rachel.harrison@stockton.gov.uk

Stockton-on-Tees BOROUGH COUNCIL

KEY - Declarable interests are:-

- Disclosable Pecuniary Interests (DPI's)
- Other Registerable Interests (ORI's)
- Non Registerable Interests (NRI's)

Members – Declaration of Interest Guidance



Stockton-on-Tees BOROUGH COUNCIL

Table 1 - Disclosable Pecuniary Interests

Subject	Description
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain
Sponsorship	Any payment or provision of any other financial benefit (other than from the council) made to the councillor during the previous 12-month period for expenses incurred by him/her in carrying out his/her duties as a councillor, or towards his/her election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract made between the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners (or a firm in which such person is a partner, or an incorporated body of which such person is a director* or a body that such person has a beneficial interest in the securities of*) and the council — (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land and property	Any beneficial interest in land which is within the area of the council. 'Land' excludes an easement, servitude, interest or right in or over land which does not give the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners (alone or jointly with another) a right to occupy or to receive income.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the council for a month or longer.
Corporate tenancies	Any tenancy where (to the councillor's knowledge)— (a) the landlord is the council; and (b) the tenant is a body that the councillor, or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners is a partner of or a director* of or has a beneficial interest in the securities* of.
Securities	Any beneficial interest in securities* of a body where— (a) that body (to the councillor's knowledge) has a place of business or land in the area of the council; and (b) either— (i) the total nominal value of the securities* exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the councillor, or his/ her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners have a beneficial interest exceeds one hundredth of the total issued share capital of that class.

* 'director' includes a member of the committee of management of an industrial and provident society.

* 'securities' means shares, debentures, debenture stock, loan stock, bonds, units of a collective investment scheme within the meaning of the Financial Services and Markets Act 2000 and other securities of any description, other than money deposited with a building society.

Stockton-on-Tees BOROUGH COUNCIL

Table 2 – Other Registerable Interest

You must register as an Other Registrable Interest:

a) any unpaid directorships

b) any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority

c) any body

(i) exercising functions of a public nature

(ii) directed to charitable purposes or

(iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management

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ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

A meeting of Adult Social Care and Health Select Committee was held on Tuesday 23 January 2024.

Present: Cllr Marc Besford (Chair), Cllr Nathan Gale (Vice-Chair), Cllr Carol Clark, Cllr John Coulson, Cllr Lynn Hall, Cllr Susan Scott and Cllr Vanessa Sewell.

Officers: Carolyn Nice, Sarah Bowman-Abouna (A,H&W) and Gary Woods (CS).

Also in attendance: Dr Judith Donkin, Felicity Brown (Billingham & Norton PCN), Dr Nick Steele, Daniel Hallsworth (BYTES PCN), Dr Barnaby Morgan (North Stockton PCN), Dr Dhirendra Darg, Ian Forrest (Stockton PCN), Emma Joyeux and Rebecca Warden (North East and North Cumbria Integrated Care Board)

Apologies: Cllr Ray Godwin.

ASCH/42/23 Evacuation Procedure

The evacuation procedure was noted.

ASCH/43/23 Declarations of Interest

There were no interests declared.

ASCH/44/23 Minutes

Consideration was given to the minutes from the Committee meeting held on 19 December 2023.

AGREED that the minutes of the meeting on 19 December 2023 be approved as a correct record and signed by the Chair.

ASCH/45/23 Scrutiny Review of Access to GPs and Primary Medical Care

The fourth evidence-gathering session for the Committee's review of Access to GPs and Primary Medical Care focused on contributions from the Borough's four Primary Care Networks (PCNs). Clinical Directors and / or Operational Leads for each PCN were in attendance to discuss their responses to the following key lines of enquiry:

• Awareness of any access issues within your PCN area: Several elements were having an impact on GP access – these included a post-pandemic backlog (for both physical and mental health problems), long waits for secondary care which was resulting in patients contacting primary care providers for support in the interim, and the loss of experienced staff and the subsequent lag in training new staff to fill this void (who, in the short-term at least, were unable to work at the level of those older professionals who had left general practice). That said, PCN representatives also acknowledged improvements to access, some of which had come as a result of COVID-19 and the need to work in different ways – innovation, particularly through the use of technology, had led to the emergence of alternative pathways regarding access

to services, though this in turn further increased demand which was very challenging to meet given the lack of an uplift in resources. As such, waiting times were further compromised.

Further to a Committee query, it was confirmed that all PCN areas used the OPEL system to monitor pressures which individual practices were under – this enabled any critical needs to be identified, something which the Hartlepool & Stockton Health (H&SH) GP Federation could assist with in terms of its digital staffing pool (it was noted that H&SH did not charge more for these staff to provide assistance). Members subsequently noted the focus on shortages of nursing staff.

Reflecting on the various access options outlined within the combined PCN submission, Members welcomed the range of mechanisms available, though also drew attention to the challenges faced by those who were not as technologically minded when it came to online services. Regarding waiting times, the Committee was reminded that this was a national issue, and efforts to mitigate the impact of delayed contact with health providers had resulted in the 'Waiting Well' initiative (a programme offering targeted support to certain groups of patients waiting for treatment).

Reference was made to a previous evidence session where Members were informed about the difficulties in attracting professionals to the Tees Valley area. One of the PCN Clinical Directors present, who was also a GP trainer, spoke of the challenges of getting practitioners with the right qualities into the region and noted that the training scheme was not overly appealing / rewarding (as such, it was stated that there had been a period when training places were undersubscribed). The Committee heard that those people who had qualified were not always staying in the area, hence the need to look further afield for the skills required – it was subsequently reported that there was a higher level of international graduates in the North East than in other regions across the country.

Members highlighted the services provided by pharmacies and the impact of this on general practices – there was, however, little mention of this in the PCNs responses to the questions posed by the Committee. PCN representatives gave assurance that practices worked closely with pharmacists as part of their clinical teams, and that pharmacies were very much embedded within the primary care offer. The Committee welcomed this assurance and pointed to the opportunities pharmacies provided to relieve pressure on the overall health system (particularly those based outside town centres), with Members encouraging all practices to value each one equally. In response, it was stated that a number of pharmacies were operating under great strain at present, and that caution was needed around the expectation that they would address access issues – this may lead to unintended consequences.

• Management of patient contact (systems, prioritisation, triage): PCNs highlighted a variety of in-person, telephone and digital tools / systems which were used to manage patient contact. The need to ensure (as far as possible) continuity of care was emphasised as this led to a more efficient service, with patients saved from having to repeat their story time and again to different professionals – key to this was administrative / reception staff within practices who develop knowledge of / rapport with patients. Whilst electronic options had evolved to further enable contact with practices, PCNs acknowledged that it was important to avoid digital exclusion, particularly in the context of an ageing population and the critical need to ensure access for all. In related matters, it was also vital that those who chose to use digital /

online mechanisms were not prioritised over those who preferred alternative, non-electronic methods of communication.

Members welcomed the continued focus on providing different forms of contact opportunities for patients, as well as the desire to keep phonelines open (an important factor for elderly residents) – the call-back feature which had been introduced by a number of practices was also praised. Previous complications in achieving the dual rollout of COVID and flu vaccines within practices was noted – Members were reminded that these vaccines were commissioned and stored differently, hence the challenges in them being administered during the same appointment. However, health bodies would try to ensure future rollout was as streamlined as possible.

The Committee noted the recent national rise in reported cases of measles and asked if this was translating into increased contact with local practices. It was stated that, although there were yet to be any significant outbreaks of measles across Teesside, discussions had taken place at the Stockton-on-Tees Health and Wellbeing Board, and a UK-wide vaccination catch-up campaign was in the pipeline. One of the main issues was a lack of vaccination uptake within inner-cities, as well as the usual lower inoculation rates in areas of greater deprivation.

• Mechanisms for the public to raise concerns about access issues and how this is communicated / managed / responded to: Again, multiple opportunities for patients to raise issues were outlined via written, verbal or online means. Patient Participation Groups (PPGs) within each practice were also highlighted. One PCN area had recently undertaken work to identify the best route for providing comments on practices – this was resulting in enhanced options for digital feedback, though not at the expense of more traditional ways.

Difficulties in being able to liaise with a Practice Manager was flagged by the Committee, though it was cautioned that getting involved in individual cases would be very time-consuming for these professionals and would add to the significant pressure they were already under. Assurance was given that practices tried to absorb feedback from as many sources as they can, including annual surveys (which are usually circulated to a small sample of patients), suggestion boxes, the Friends and Family Test, and PPGs. It was also emphasised that practices do not have to wait for negative feedback to take action in order to improve services.

One of the North East and North Cumbria Integrated Care Board (NENC ICB) representatives in attendance drew attention to the requirement to improve patient experience and contact within the national capacity and access improvement plans previously shared with the Committee – Members were informed that all practices continued to work on this. PCN representatives also confirmed that comments in relation to practices were available on publicly accessible platforms (e.g. Google reviews).

• Do practices seek feedback around access and how has this informed arrangements?: All PCNs outlined the proactive measures in place to capture views from patients, and examples were given as to how this had led to changes in service delivery, including improvements to telephony systems and clarity around out-of-hours access provision.

The issue of patients failing to attend their appointment was raised by the Committee, as were the difficulties that individuals could encounter when trying to cancel an

appointment. The merits of following-up with those patients who do not attend was discussed – some practices did make contact, though it was also noted that this could be quite stressful for the patient and a decision to follow-up may need careful consideration based on an individual's case history. NENC ICB personnel added that many practices sent text message reminders prior to appointments which included cancellation options – however, did not attend (DNA) rates remained high.

Continuing the theme of non-attendance, it was felt that the ability to book appointments a long way in advance had the potential to lead to patients forgetting. Some practices were also placing more emphasis on providing positive statistics (i.e. the percentage of those who had attended as opposed to those who had not) within their waiting areas in the hope that this would further encourage attendance.

• Summary of any planned changes within PCN practices to improve access or improve patient experience: A range of developments were taking place across all PCN areas to further improve access and, crucially, the overall patient experience. Technological advances in terms of cloud-based telephony systems, eConsultations and website strengthening were highlighted, as were considerations around triage, recruitment and estate expansion.

Drawing the session to a close, the Committee Chair thanked all PCN representatives for their contributions.

Looking ahead to the next Committee meeting in February 2024, a final evidence-gathering session for this review was intended and would focus on patient / public views around the issue of access to GPs. A key aspect of this was the proposed engagement with Patient Participation Groups (PPGs) that existed within each of the Borough's general practices, and suggested questions for the PPGs were tabled and subsequently agreed. A flavour of the feedback received would be provided at the February 2024 meeting, though more detail would be given as part of the Committee's informal 'summary of evidence' session which was due to take place in March 2024.

AGREED that:

1) the submissions from the Stockton-on-Tees Primary Care Networks (PCNs) be noted.

2) the questions for the Patient Participation Groups (PPGs) within each of the Borough's general practices be circulated as proposed (no changes required).

ASCH/46/23 SBC Director of Public Health Annual Report 2022

Consideration was given to the SBC Director of Public Health Annual Report 2022. Introduced by the SBC Director of Public Health, the report contained the following:

- Foreword (SBC Cabinet Member for Health, Leisure and Culture)
- Introduction (SBC Director of Public Health)
- Covid-19 in Stockton-on-Tees
- Supporting our residents
- Living with Covid-19
- Looking Ahead
- Progress in 2022/23

The Committee was informed that, under the Health and Social Care Act (2012), the Director of Public Health had a duty to prepare an independent annual report. As a consequence of COVID-19, production of this yearly requirement had been interrupted as the Council sought to manage the impact of the pandemic. This 2022 report aimed to capture an overview of key activity from a public health perspective since COVID-19 emerged. It also sought to summarise the learning from this period from a public health perspective and describe some of the activity since (in response to this learning).

Members commended the structure and content of the report, though felt it would have been useful to include a specific section detailing the impact of COVID on young adults with a learning disability and acknowledging the support provided to help these individuals during this time.

Mindful that this latest version was marked '2022', the Committee looked forward to considering the next annual account in the early part of the next (2024-2025) municipal year.

AGREED that the SBC Director of Public Health Annual Report 2022 be noted.

ASCH/47/23 Regional Health Scrutiny Update

Consideration was given to the latest Regional Health Scrutiny Update report summarising developments regarding the Tees Valley Joint Health Scrutiny Committee, the Sustainability and Transformation Plan (STP) / Integrated Care System (ICS) Joint Health Scrutiny Committee, and the North East Regional Health Scrutiny Committee. Attention was drawn to the following:

• Tees Valley Joint Health Scrutiny Committee: The last meeting was held on 15 December 2023 (note: the meeting was not quorate for some of the items considered) and included a presentation on community water fluoridation plans, a NHS dentistry update, non-surgical oncology outpatient transformation proposals, and a Tees Valley winter planning update.

During consideration of the work programme for the remainder of the 2023-2024 municipal year, the Committee requested an informal briefing on Tees, Esk and Wear Valleys NHS Foundation Trust's (TEWV) use of restraint, a source of previous Member concern – this was likely to be arranged for late-February / early-March 2024.

The emergence of details of a proposed 'Partnership Agreement' as part of the ongoing development of the 'Group' model between North Tees and Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) led to an informal (remote) Committee meeting being hastily arranged. This took place on 2 November 2023 to allow Members to consider and comment on these developments / proposals – a statement on behalf of the Committee was then submitted back to the 'Group' for consideration by the Joint Partnership Board as part of its final ratification of the 'Partnership Agreement' (which was due to be agreed on 15 November 2023).

• Sustainability and Transformation Plan (STP) / Integrated Care System (ICS) Joint Health Scrutiny Committee: No further developments regarding this Joint Committee since the previous update in October 2023. In related matters, North East and North Cumbria Integrated Care Board (NENC ICB) guidance on staying well and assisting

services during the current cold season, information on a festive safe sleeping for babies campaign, and details regarding NTHFT leading an initiative to promote careers in health and social care were relayed.

• Changes to Health Scrutiny Arrangements: Attention was drawn to the impending introduction of new health scrutiny arrangements would come into force from 31 January 2024. The main focus of the changes was the removal of the power of health overview and scrutiny committees (HOSCs) to formally refer matters of concern relating to major service reconfiguration to the Secretary of State. Instead, the Secretary of State may act proactively, further to a request that he or she may receive from anyone – although such action would be subject to consultation with the HOSC, amongst others. Guidance had been produced summarising these changes and was included within the papers for this meeting.

AGREED that the Regional Health Scrutiny Update report be noted.

ASCH/48/23 Chair's Update and Select Committee Work Programme 2023-2024

Chair's Update

The Chair reminded Members about the need to familiarise themselves with the forthcoming changes to health scrutiny arrangements (as outlined within the previous Regional Health Scrutiny Update item).

Work Programme 2023-2024

Consideration was given to the Committee's current work programme. The next meeting was due to take place on 20 February 2024 and was scheduled to feature the Teeswide Safeguarding Adults Board (TSAB) Annual Report 2022-2023, a related SBC safeguarding report, the latest CQC / PAMMS quarterly update (Q3 2023-2024), and the next evidence-gathering session for the ongoing Access to GPs and Primary Medical Care review.

Reference was made to the recent request for suggestions for Committee visits to frontline services – Members were encouraged to forward any proposals by the end of the week (26 January 2024).

AGREED that the Chair's Update and Adult Social Care and Health Select Committee Work Programme 2023-2024 be noted.

CARE QUALITY COMMISSION (CQC) INSPECTION OUTCOMES
&
STOCKTON-ON-TEES BOROUGH COUNCIL (SBC)
PROVIDER ASSESSMENT AND MARKET MANAGEMENT SOLUTIONS (PAMMS) ASSESSMENT REPORTS

QUARTER 3 2023-2024

The CQC is the national inspectorate for registered health and adult care services. Inspection reports are regularly produced, and these are published on a weekly basis.

The CQC assesses and rates services as being 'Outstanding', 'Good', 'Requires Improvement', or 'Inadequate'. Where providers are found to be in need of improvement or inadequate, the CQC make recommendations for improvement and / or enforcement action. Specific actions taken in each case can be found in the relevant inspection report.

Where inspections are relevant to the Borough, a summary of the outcome is circulated to all Members each month. An update from Adult Services is included which summarises the position in relation to service provision and any actions taken at that time.

Quarterly Summary of Published CQC Reports

This update includes inspection reports published between October and December 2023 (inclusive). These are included at **Appendix 1** and contain the results of all inspections of services based in the Borough (irrespective of whether they are commissioned by the Council).

During this quarter, **5** inspection results were published. Please note: there is a time lag between dates of the inspection and the publication of the report. In addition, where concerns are identified by the CQC, re-inspections may take place soon after the initial report is published. When the outcomes are made available within the same quarter, the result of the most recent report is included in this update.

The main outcomes from the reports are as follows:

- 3 Adult Services were reported on (3 rated 'Good')
- 1 Primary Medical Care Services was reported on (1 'Not rated')
- 1 Hospital / Other Health Care Services was reported on (1 rated 'Requires Improvement')

A summary of each report and actions taken (correct at the time the CQC inspection report was published) is outlined below. Links to the full version of the reports, and previous ratings where applicable, are also included.

PAMMS Assessment Reports

SBC are utilising the Provider Assessment and Market Management Solutions (PAMMS) in the quality assurance process. PAMMS is an online assessment tool developed in collaboration with Directors of Adult Social Services (ADASS) East and regional Local Authorities. It is designed to assist in assessing the quality of care delivered by providers. The PAMMS assessment consists of a series of questions over a number of domains and quality standards that forms a risk-based scoring system to ensure equality of approach. The PAMMS key areas are:

- Involvement and Information
- Personalised Care and Support
- Safeguarding and Safety
- Suitability of Staffing
- Quality of Management

Following the PAMMS assessment, the key areas are scored either 'Excellent', 'Good', 'Requires Improvement' or 'Poor', and an overall rating is assigned to the assessment using these headings. **Appendix 2** shows **11** reports published between October and December 2023 (inclusive), the overall outcomes of which can be summarised as follows:

- 8 rated 'Good'
- 3 rated 'Requires Improvement'

APPENDIX 1

ADULT SERVICES

(includes services such as care homes, care homes with nursing, and care in the home)

Provider Name	**Nightingales Community Care Limited**	
Service Name	**Nightingales Community Care Limited**	
Category of Care	**Home Care Agency**	
Address	Enterprise House, 6-8 Yarm Road, Stockton-on-Tees TS18 3NA	
Ward	**n/a**	
CQC link	https://api.cqc.org.uk/public/v1/reports/cb346e00-0dc2-444b-9ba3-62798f229ebd?20231007120000	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Good**
Safe	**Good**	**Good**
Effective	**Not inspected**	**Good**
Caring	**Not inspected**	**Good**
Responsive	**Not inspected**	**Good**
Well-Led	**Good**	**Good**
Date of Inspection	**23rd, 24th May & 29th June 2023** (focused inspection)	
Date Report Published	**7th October 2023**	
Date Previously Rated Report Published	**23rd December 2017**	

Further Information

Nightingales Community Care Ltd is a domiciliary care agency providing personal care and support to people living in their own homes. Not everyone who used the service received personal care. The CQC only inspects where people receive personal care – this is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of inspection 11 people were receiving personal care.

This inspection was prompted by a review of the information the CQC held about this service. As a result, they decided to undertake a focused inspection to review the key questions of 'safe' and 'well-led' only.

People and relatives were happy with the service and the care people received. They were complimentary about staff calling them 'efficient', 'caring' and 'friendly'. There were systems in place to keep people safe. Staff safeguarded people from abuse. Risks to people's health, safety and wellbeing were managed. There were enough staff to meet people's needs and safe recruitment processes were followed. Medicines were safely administered and managed. The

provider had effective systems to review incidents, check appropriate action had been taken and identify learning. The provider and staff protected people from the risk or spread of infection.

The service was well managed. The provider, manager and staff promoted a positive culture in the service. The provider had an effective quality assurance process in place which included regular audits and spot-checks. People, relatives and staff were regularly consulted about the quality of the service through regular communication, meetings and reviews.

For those key questions not inspected, the CQC used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained good based on the findings of this inspection. The CQC found no evidence during this inspection that people were at risk of harm.

Provider Name	**The Five Lamps Organisation**	
Service Name	**Parkside Court Extra Care Scheme**	
Category of Care	**Care at Home – Extra Care**	
Address	Cumbernauld Road, Thornaby, Stockton-on-Tees TS17 9FB	
Ward	**Stainsby Hill**	
CQC link	https://api.cqc.org.uk/public/v1/reports/a0dd4ef9-d78f-4214-8521-8a90b01bf4e0?20231118130000	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Requires Improvement**
Safe	**Good**	**Requires Improvement**
Effective	**Not inspected**	**Good**
Caring	**Not inspected**	**Good**
Responsive	**Good**	**Requires Improvement**
Well-Led	**Good**	**Requires Improvement**
Date of Inspection	**21st, 27th July, 17th, 21st August & 4th September 2023**	
Date Report Published	**18th November 2023**	
Date Previously Rated Report Published	**15th November 2022**	

Breach Number and Title

None.

Enough improvements had been made at this inspection and Parkside Court are no longer in breach of Regulation 17 HSCA RA Regulations 2014 Good governance.

Level of Quality Assurance & Contract Compliance

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

Parkside Court have been engaging well over the last year. The previous manager did take part in the Well-Led Programme, though no-one from the organisation has expressed interest since. The service has engaged well through their interim manager. They have helped with driving forward activity provision and work alongside other service colleagues.

Supporting Evidence and Supplementary Information

The service completed an Action Plan after the last inspection to show what they would do to improve Regulation 17 (Good governance). The overall rating for the service has changed from 'requires improvement' to 'good'.

The CQC found that the service was well-managed and has implemented additional quality checks to monitor the service more effectively. The service, management and staff worked in partnership with other health professionals to achieve positive outcomes for people. Systems were in place to ensure risks to people's health, safety and wellbeing were well documented and managed. Staff safeguarded people from abuse, medicines were administered and managed safely, and people were protected from the risk or spread of infection. Safe recruitment processes were always followed and there are enough staff to meet people's needs. Staff knew how to effectively communicate with people and detailed methods in care records. Care plans were also person-centred and reflected individual needs and wishes. People and relatives knew how to raise any concerns and the service had a suitable complaints procedure in place. The service promoted an open and honest culture. People and relatives were regularly consulted about the quality of the service through surveys and reviews. People and relatives were happy with the service and the care received, and were complimentary about care staff, describing them as 'great', 'very good' and 'friendly'. Comments from relatives included, '[Family member] gets the same group of carers who are lovely and friendly. They're smashing'.		
Participated in Well Led Programme?	**Yes** (with previous manager)	
PAMMS Assessment – Date (Published) / Rating	**17/06/2022**	**Good**

Provider Name	**Milewood Healthcare Ltd**	
Service Name	**Alexandra House**	
Category of Care	**Mental Health / Learning Disability**	
Address	Summerhouse Square, Norton, Stockton-on-Tees TS20 1BH	
Ward	**Norton Central**	
CQC link	https://api.cqc.org.uk/public/v1/reports/b697e3bf-0dcb-4b40-9635-9066d48d7286?20231212130000	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Good**
Safe	**Good**	**Good**
Effective	**Not inspected**	**Good**
Caring	**Not inspected**	**Good**
Responsive	**Not inspected**	**Good**
Well-Led	**Good**	**Good**
Date of Inspection	**17th & 20th November 2023**	
Date Report Published	**12th December 2023**	
Date Previously Rated Report Published	**8th August 2018**	

Breach Number and Title
None.
Level of Quality Assurance & Contract Compliance
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
Management and staff maintain good engagement with the Quality Assurance and Compliance (QuAC) Officer through open and transparent communication. The management team attend the Provider Forum and engage in initiatives arranged by the Transformation Officers.
Supporting Evidence and Supplementary Information
Service-users were safeguarded from abuse and avoidable harm. Thorough processes were in place to report any safeguarding concerns. Staff were aware of how to report concerns and were confident these would be addressed by the Registered Manager. The provider assessed risks to ensure people were safe, promoting positive risk-taking to help people gain skills and independence. Service-users reported that they had thrived whilst living at the service due to this approach.

The inspector reported that there was a well-established team of skilled staff working at Alexandra House. The Registered Manager ensured that staffing levels were adapted to meet service-users' needs. Additional staff were used to enable people to participate in social activities they enjoyed. Service-users were supported to receive their medicines safely. Thorough processes were in place to ensure medicines were stored, administered, and recorded appropriately. The provider and Registered Manager were committed to ensuring there was a positive culture within the service – this helped achieve positive outcomes for service-users. The Registered Manager was visible in the service – they worked directly with people living at the service and led by example. The Registered Manager had the skills, knowledge, and experience to perform their role and had a clear understanding of people's needs, as well as effective oversight of the service. Governance processes were thorough and effective – they were used to monitor, assess, and drive forward improvements to ensure the service consistently provided good quality care.		
Participated in Well Led Programme?	**Yes**	
PAMMS Assessment – Date (Published) / Rating	**22/08/2023**	**Good**

PRIMARY MEDICAL CARE SERVICES

Provider Name	**Grace Dental Care Partnership**	
Service Name	**Grace Dental Care**	
Category of Care	**Dentists**	
Address	49 Tunstall Avenue, Billingham, Stockton-on-Tees TS23 3QB	
Ward	**Billingham East**	
CQC link	https://api.cqc.org.uk/public/v1/reports/97f1f8ba-b2f3-4577-b1bb-ac3eec47383c?20231011070046	
	New CQC Rating	**Previous CQC Rating**
Overall	**Not rated**	**n/a**
Safe	**No Action**	**n/a**
Effective	**No Action**	**n/a**
Caring	**No Action**	**n/a**
Responsive	**No Action**	**n/a**
Well-Led	**No Action**	**n/a**
Date of Inspection	**15th September 2023**	
Date Report Published	**11th October 2023**	
Date Previously Rated Report Published	**n/a**	

Further Information

Grace Dental Care provides NHS and private dental care and treatment for adults and children. The CQC carried out this announced comprehensive inspection under section 60 of the Health and Social Care Act 2008 as part of its regulatory functions.

The findings were as follows:

- The dental clinic appeared clean and well-maintained.
- The practice had infection control procedures which reflected published guidance.
- Staff knew how to deal with medical emergencies. Appropriate medicines and life-saving equipment were available.
- The practice had systems to manage risks for patients, staff, equipment and the premises.
- Safeguarding processes were in place and staff knew their responsibilities for safeguarding vulnerable adults and children.
- The practice had staff recruitment procedures which reflected current legislation.
- Clinical staff provided patients' care and treatment in line with current guidelines. Improvements could be made to the detail recorded in dental care records.
- Patients were treated with dignity and respect. Staff took care to protect patients' privacy and personal information.
- Staff provided preventive care and supported patients to ensure better oral health.
- The appointment system worked efficiently to respond to patients' needs.

- The frequency of appointments was agreed between the dentist and the patient, giving due regard to National Institute of Health and Care Excellence (NICE) guidelines.
- There was effective leadership and a culture of continuous improvement.
- Staff felt involved, supported and worked as a team.
- Staff and patients were asked for feedback about the services provided.
- Complaints were dealt with positively and efficiently.
- The practice had information governance arrangements.

There were areas where the provider could make improvements. They should:

- Take action to ensure the clinicians take into account the guidance provided by the College of General Dentistry when completing dental care records.
- Implement a system to ensure patient referrals to other dental or health care professionals are centrally monitored to ensure they are received in a timely manner and not lost.

HOSPITAL AND COMMUNITY HEALTH SERVICES
(including mental health care)

Provider Name	**Tees, Esk and Wear Valleys NHS Foundation Trust**	
Service Name	**Tees, Esk and Wear Valleys NHS Foundation Trust**	
Category of Care	**Mental Health (adults and children / young people)**	
Address	West Park Hospital, Edward Pease Way, Darlington DL2 2TS	
Ward	**n/a**	
CQC link	https://api.cqc.org.uk/public/v1/reports/56271cd7-1406-4aaa-b33f-5c463d57373d?20231025090307	
	New CQC Rating	**Previous CQC Rating**
Overall	**Requires Improvement**	**Requires Improvement**
Safe	**Requires Improvement**	**Requires Improvement**
Effective	**Good**	**Good**
Caring	**Good**	**Good**
Responsive	**Requires Improvement**	**Requires Improvement**
Well-Led	**Requires Improvement**	**Requires Improvement**
Date of Inspection	**18th April to 2nd June 2023**	
Date Report Published	**25th October 2023**	
Date Previously Rated Report Published	**10th December 2021** (Trust-wide)	

Further Information

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provide mental health and learning disability services in County Durham and Darlington, Teesside, North Yorkshire, York and Selby. The Trust have 167 services across 66 locations.

The CQC carried out unannounced inspections of four of the inpatient mental health services provided by TEWV, and short-notice (24 hours) announced inspections of two of the community services. They also inspected the 'well-led' key question for the Trust overall.

The CQCs rating of the Trust stayed the same ('requires improvement'). Key findings included:

- There was effective leadership and management at local level in most services, however some of the Trust's systems and processes did not operate effectively at a senior level. This meant that whilst the CQC rated 'well-led' as 'good' in most core services, the Trust was rated as 'requires improvement' for the overall 'well-led' key question.
- The Trust did not always have enough suitably trained staff to deliver safe care in all services. This was due to high vacancy rates, high sickness rates and significant reliance on temporary staff in some services. There was low compliance with specific modules of mandatory training. This included modules directly related to patient safety such as moving and handling, positive and safe care (restraint) and resuscitation.

- Some areas of the Trust's estate continued to present risks to quality and safety. Action plans to remove environmental ligature risks had not all been completed. Seclusion facilities were not always fit for purpose. Some wards had blind spots which had not been identified or mitigated; the Trust acted on these at the time of the inspection.
- The Trust's reducing restrictive practice programme for 2022-2023 had failed to reduce overall rates of restraint. The use of restraint had increased by 17% in the Trust's services since the previous year. The Trust continued to use prone and mechanical restraint without appropriate challenge and oversight by senior leaders. However, there had been a reduction in the use of prone and supine restraint, with an increase in less intensive forms of restraint.
- Staff did not always consistently take appropriate action to reduce risk to people using services. Some patients in acute mental health services were able to access leave from wards without appropriate risk assessment. Some patients' physical health was not always monitored appropriately in acute mental health, forensic and learning disability inpatient services. Risks were not always shared and handed over effectively between shifts on some wards.
- People continued to wait too long to access services. Waiting times for community mental health services had not improved since the last inspection. There were significant waiting times in child and adolescent mental health services and for neurodevelopmental assessments. The Trust's locality model had introduced variation where some patients faced inequity of access to services because of where they lived. The Trust needed to work with both Integrated Care Boards to improve access to services.
- Staff did not always receive, or record that they had received, regular supervision and appraisal. This meant that the Trust did not have effective systems in place for oversight of whether staff received appropriate opportunities for support and development.
- The Trust did not have effective systems to consistently collate, analyse and present information about quality and performance in a way that identified risks and challenges, or supported effective decision making. There were examples of early warning signs in frontline services which had been missed by the Trust's risk management and audit processes.
- The Trust had a backlog of 100 serious incidents requiring investigation. There were further backlogs in incidents requiring routine investigation and in incidents resulting in patient deaths requiring review through the Trust's learning from deaths processes. The Trust's backlogs delayed opportunities to learn lessons and make improvements to prevent incidents recurring. The Trust had experienced several similar incidents where learning was not evident. The Trust were receiving external support to manage the incident backlog.
- The Trust had experienced several high-profile incidents. The impact of the incidents had resulted in lasting and persistent changes to the culture of the Trust which included an over-cautious approach from senior leaders to recognise and celebrate improvement.
- Where there had been incidents or treatment which caused harm to patients, the Trust's approach had not always ensured staff and leaders reached out to people who had been harmed by its practices. The Trust missed opportunities and appeared reluctant to consistently engage with people who used services, staff and others who had negative experiences or had been involved in incidents.
- The Trust did not always act in accordance with the requirements of the duty of candour by failing to make an apology without delay for incidents resulting in harm.

However:

- Forensic inpatient secure wards, wards for people with a learning disability or autism, and wards for older people had all improved since the last inspection. The Trust no longer had any services which were rated 'inadequate'. The leadership and safety of community mental health services for working age adults had improved since the last inspection in December 2021, and ratings had improved to a rating of 'good' overall.

- Leaders were experienced, visible and approachable. Leaders at all levels had ensured that improvements were made since the last inspection. The Trust had made improvements to its fit-and-proper persons process.
- Executives and non-executives were passionate about the Trust's delivery of safe, high-quality care and were aware most of the Trust's challenges, risks, and issues.
- The Trust had a clear vision and strategy, understood by all staff and driven by the Chief Executive. The CQC was able to see progression towards the Trust's achievement of its strategic goals. Staff demonstrated the Trust's values in the care they provided.
- Staff felt supported and valued and had confidence in the Trust's 'freedom to speak up' process. The Trust had undertaken work to understand the risks of closed cultures across the services it provided.
- The Trust was making improvements to its information management systems which included a refreshed patient record system which had been co-created with staff, service-users and carers, and was clinically designed.
- There continued to be good and improved engagement with staff, stakeholders, and partners. The Trust was ambitious about co-creation and had several programmes in place to enhance opportunities for involvement.
- The Trust had implemented a recognised methodology with a clear and embedded approach to quality improvement which involved staff at all levels, with examples of where quality improvement approaches had been used to improve services and processes. However, the Trust's approach to quality improvement was sometimes related more to problem-solving than innovation.
- The Trust had sought feedback on its governance processes and had made significant changes to governance arrangements which had made it easier for services to escalate risks to the board.

An extensive list of actions the Trust must and should take is listed on pages 9-14 of the full report.

APPENDIX 2

PAMMS ASSESSMENT REPORTS
(for Adult Services commissioned by the Council)

Provider Name	**Royal Mencap Society**	
Service Name	**71 Middleton Avenue**	
Category of Care	**Learning Disability Residential Home**	
Address	71 Middleton Avenue, Thornaby, Stockton-on-Tees TS17 0LL	
Ward	**Village**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**14th August 2023**	
Date Assessment Published	**19th October 2023**	
Date Previous Assessment Published	**1st February 2022**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Middleton Lodge is a learning disability residential setting that provides support for six adults.

Care plans were written based upon staff's intimate knowledge of residents, reflected their needs well and promoted independence. Recommendations for improvements to records relating to mental capacity and completion of best interest decisions were made as this was lacking.

Staff are appropriately trained, and training is monitored by management. Staffing levels were appropriate and there is no agency usage as staff cover shifts and there are a number of bank staff for contingency. A supportive work environment was reported by staff and they also spoke highly of the support received by management. Supervisions are carried out regularly and appraisals are merged with this process.

Cleaning schedules and daily audits for were in place, however were not always completed. Weekly audits were in place, however did not always identify issues. Some areas of the home required attention and the provider is liaising with the property owner to address these.

Plans and Actions to Address Concerns and Improve Quality and Compliance		
The provider will complete an Action Plan to address areas identified for improvement to ensure full compliance.		
Level of Quality Assurance & Contract Compliance Monitoring		
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)		
Level of Engagement with the Authority		
Middleton Avenue engage really well, they attend leadership meetings and Provider Forums, and engage well with training. The manager has been really proactive in pushing for a better care response in the home and has worked closely with the matrons to access the Virtual Frailty ward. Staff at Middleton Avenue are described as dedicated and engaging by the Transformation Team.		
Current CQC Assessment - Date / Overall Rating	**11/02/2023**	**Good**

Provider Name	**Anchor Hanover Group**	
Service Name	**Millbeck**	
Category of Care	**Residential**	
Address	High Street, Norton, Stockton-on-Tees TS20 1DQ	
Ward	**Norton Central**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Requires Improvement**
Involvement & Information	**Good**	**Requires Improvement**
Personalised Care / Support	**Good**	**Requires Improvement**
Safeguarding & Safety	**Requires Improvement**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**13th September 2023**	
Date Assessment Published	**25th October 2023**	
Date Previous Assessment Published	**1st December 2022**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Observations of interactions and care provided to residents evidenced that staff treat residents with dignity and respect. Staff were seen to promote independence and choice whilst taking part in activities, drinks, snacks, and meal choices, and sought consent before providing care. Care plans were person-centred, detailed how to support residents on a good and bad day, and recorded individuals' preferences – however, care plans lacked evidence of service-user involvement. Residents were supported to maintain relationships with family and friends.

Medication management was found to be good. Medications including controlled drugs were stored securely and administered correctly. All staff who administer medication are trained to level 3 and complete competency assessments every six months. Regular medication audits were in place and Action Plans completed. The home records and reports incidents / near-misses and shares lessons learned. There were some areas of improvement identified around topical administrations, PRN, self-medication, and covert medication.

Access to the building is via a key coded door, however visitors were observed to know and use the code independently. The electronic visitors log was not working over the course of the assessment and an alternative was not put in place in a timely manner.

Equipment in use was serviced and maintained, however for some regular servicing, the most up-to-date service certification was not present in the home at the time of assessment.

There was a range of audits in place, however some audits were not robust enough to identify service certification that were out-of-date.

Appropriate up-to-date documentation was not held on file for people who provide additional services (i.e. the hairdresser).

Staff's overall training compliance is high; staff feel supported at work and receive regular supervision and appraisal, however the frequency in the company policy is not in-line with the contract. That manager has raised this with supervising staff to increase frequency. The manager collates complaints and compliments and also has a 'reflective practice' file in place which contains incidents / safeguarding from which the home has identified lessons learned and implemented improvements to the service.
Plans and Actions to Address Concerns and Improve Quality and Compliance
The provider will complete an Action Plan for all questions assessed as 'Requires Improvement' and the Quality Assurance and Compliance (QuAC) Officer will monitor this for progress through contractual visits.
Level of Quality Assurance & Contract Compliance Monitoring
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
The provider has a good relationship with the QuAC Officer and responds to requests for information in a timely manner. The provider has engaged with the Local Authority transformation initiatives such as the Well-Led Programme, and the Deputy is currently enrolled in the latest cohort.

Current CQC Assessment - Date / Overall Rating	**13/12/2018**	**Good**

Provider Name	**Milewood Healthcare Ltd**	
Service Name	**Beechwood House**	
Category of Care	**Residential – Learning Disabilities / Mental Health**	
Address	1 Priory Gardens, Norton, Stockton-on-Tees TS20 1BJ	
Ward	**Norton Central**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**n/a**
Involvement & Information	**Good**	**n/a**
Personalised Care / Support	**Good**	**n/a**
Safeguarding & Safety	**Good**	**n/a**
Suitability of Staffing	**Good**	**n/a**
Quality of Management	**Good**	**n/a**
Date of Inspection	**10th July 2023**	
Date Assessment Published	**6th November 2023**	
Date Previous Assessment Published	**n/a**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The care plans were paper-based, clear, concise, and well ordered. They were very person-centred, written in the first person, and covered all relevant areas of daily living, what was important to the service-users, and how staff could support them to achieve these preferred choices. One service-user noted, 'I like to choose my clothes each day and I always like to wear make-up and jewellery'.

The care documentation could be enhanced by the addition of a specific care plan around DoLS, listing pertinent dates, conditions of the DoLS, and any RPR or IMCA involvement. Documentation should clearly evidence that least restrictive options have been considered, and any decisions made on behalf of the service-user is in their best interest.

The service operates a robust 'key worker' system, and the name of the service-user's allocated 'key worker' is recorded on the front sheet of their care file. 'Key workers' are involved in a monthly review of the care plans and compiling a monthly report with the service-user.

Risk assessments had been completed for relevant areas including accessing the community, self-harm, alcohol misuse, diabetes, and psychosis. Behaviour support plans included a reason for the assessment, triggers or warning signs for risk occurring, and RAG-rated actions to prevent, minimise risk and de-escalate situations. These were clear to follow and completed with a good level of detail. Behaviour statistics are compiled and feed into the review process.

Staff spoken with understood safeguarding principles and could give examples of types of abuse such as physical, financial, organisational, and emotional. Staff had an understanding of where they can escalate any concerns both within the organisation and outside agencies, such as the CQC and the Safeguarding Team.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medication Optimisation Team, and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. Medication front sheets were in place for all service-users and were generally completed to a good standard (one photograph was found to be undated). Medication was given as prescribed and no gaps in administration recording were identified. Time sensitive medication was administered in line with directions and the time recorded for all administrations. Accurate PRN protocols were in place and of a high standard regarding dosage instructions, form, and strength. Protocols were service-user specific, with clear indication as to when a PRN medication or variable dose would be administered. Evidence was seen of six-monthly competencies for staff who administer medications, however, competencies for applying topical preparations were not included.

Recruitment records were viewed for four members of staff with varying lengths of service. Application forms had been completed documenting qualifications and employment history. Interviews were carried out by two people, notes recorded and held on file. DBS checks had been carried out and two references received prior to the employment commencing. Files contained two forms of identification, right to work checks, signed contracts of employment, a confidentiality declaration, and confirmed receipt of staff handbook during induction. It is recommended that a job description is also held on file.

An easy-read guide is available for service-users setting out how to make a complaint. This includes contact details for the CQC and the company's Managing Director, but should also include details of the Local Authority and Local Government Ombudsman. Service-users spoken with were quite happy that they could just 'speak to staff' to raise any concerns and felt any issue would be dealt with appropriately.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the small number of areas identified as requiring improvement – progress will be monitored and validated.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider engages well with the QuAC Officer and Transformation Managers. The Registered Manager and Deputy Manager regularly attend the Provider Forums and recruitment events.

Current CQC Assessment - Date / Overall Rating	**10/11/2022**	**Requires Improvement**

Provider Name	**Milewood Healthcare Ltd**	
Service Name	**Oxbridge House**	
Category of Care	**Residential – Learning Disabilities / Mental Health**	
Address	187 Oxbridge Lane, Stockton-on-Tees TS18 4JB	
Ward	**Fairfield**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Requires Improvement**	**Requires Improvement**
Involvement & Information	**Requires Improvement**	**Requires Improvement**
Personalised Care / Support	**Requires Improvement**	**Requires Improvement**
Safeguarding & Safety	**Good**	**Requires Improvement**
Suitability of Staffing	**Poor**	**Requires Improvement**
Quality of Management	**Requires Improvement**	**Requires Improvement**
Date of Inspection	**17th July 2023**	
Date Assessment Published	**6th November 2023**	
Date Previous Assessment Published	**6th September 2019**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans had not been reviewed and updated to reflect any change in need of the service-user. There were not always appropriate risk assessments in place for needs identified in the care plan. Initial assessments and care documentation was not in place for two service-users who had recently moved into the home. Completion of the daily notes was inconsistent, and on a number of occasions, notes were missing for several consecutive days.

Staff confirmed that service-users had been involved in the décor choices in the home. Communal colours were chosen with service-user input, and a service-user spoken with discussed shopping for 'things for my room'. The service-users spoken with confirmed they were asked whether they were happy with the service or had any suggestions for improvements.

All staff spoken with could recall the training they have received around safeguarding and list the types of abuse. All staff were able to explain the whistleblowing process and who they would report concerns to. Appropriate safeguarding information was on display in the home.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. Several gaps were found in MAR sheets and some time-sensitive medication had not been given in line with directions. The quality of PRN protocols was not consistent, and some lacked the person-centred information required to allow the staff member to make an informed decision to administer the medication. Controlled drugs were stored appropriately in a secure cupboard fixed to the wall. Monthly reconciliation of the stock of controlled drugs had not been consistently carried out. No competencies had been carried out for staff who apply topical preparations, and one staff member was administrating medication without an up-to-date competency assessment.

Agency profiles were not up-to-date, and some did not contain records of training completed. During the assessment, there were agency staff on shift that profiles were not available for. Discussion confirmed that inductions had been carried out for these staff, but this was not documented. There was no evidence of reviews of comments / complaints or safeguarding alerts to identify trends and learn from the incidents. The complaints file contained two brief investigation reports, but no records of the original complaint or any responses. Service-user care plans and historical daily notes were kept in boxes in different rooms. This was discussed with the manager during the assessment, and it was recommended that they were transferred to a lockable cupboard within those rooms.
Plans and Actions to Address Concerns and Improve Quality and Compliance
The provider will complete an Action Plan to address the areas identified as requiring improvement – progress will be monitored and validated by the QuAC Officer.
Level of Quality Assurance & Contract Compliance Monitoring
Level 2 – Moderate Concerns (Supportive Monitoring)
Level of Engagement with the Authority
There had been poor engagement with the Authority and the QuAC Officer was not made aware of the suspension of the manager. The previous manager was allocated a place on the Well-Led Programme but did not complete the first session as they did not come back after the break.

Current CQC Assessment - Date / Overall Rating	**19/01/2023**	**Good**

Provider Name	**Milewood Healthcare Ltd**	
Service Name	**Glenthorne Court**	
Category of Care	**Residential – Learning Disabilities / Mental Health**	
Address	377 Norton Road, Stockton-on-Tees TS20 2PJ	
Ward	**Norton Central**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**7th August 2023**	
Date Assessment Published	**16th November 2023**	
Date Previous Assessment Published	**11th March 2022**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were very person-centred, completed to a good standard, reviewed regularly, and updated to support any change in need that may have been identified. Risk assessments had been completed for relevant areas and included the extent of the risk, possible outcomes, triggers or warning signs, and action to be taken. They were clear to follow and contained a good level of personal detail.

Staff were very confident in explaining the role of the keyworker and the additional responsibilities the role carries. Staff were all aware of which keyworker is responsible for which service-user and were able to go into detail how keyworkers formulate care plans and how these are reviewed in partnership with the service-user.

The home appeared very clean during the days of the assessment. Plentiful supplies of PPE and hand sanitiser were available, and staff were observed to wear PPE appropriately. The kitchen was clean, tidy, and well ordered, including the fridge / freezer and cupboards. The manager carries out a quarterly infection control audit and any actions are signed off when complete. Daily and weekly cleaning schedules are in place and were consistently completed and included a management check. Cleaning tasks are allocated to night staff and some gaps were found in the recording.

The home was maintained to a high standard and no visible hazards were apparent during the visit. Fire exits were clear, and fire extinguishers and the fire system are regularly serviced. Smoke alarms are in place throughout the home.

Entrance and exit to the property are key coded and visitors are asked to produce identification, and to sign in and out of the property.

Recruitment records were viewed for five members of staff with varying lengths of service. Application forms had been completed documenting qualifications and employment history. Interview notes were held on file, all staff files contained two references (one of which was an employer reference and the other was a character reference), and references were dated prior to the start of employment. DBS checks were in place and completed prior to start date. Files contained job descriptions, signed contracts of employment, confidentiality declaration, and confirmed receipt of staff handbook during induction.

The medication care plans evidenced the service-user's involvement, with clear details of where and how they prefer to take their medication. Discussion confirmed that staff support service-users to know the medication they are taking and what they are taking it for. Medication front cover sheets were in place and were completed to a very high standard – additional person-centred information was included, such as how service-users prefer to take their medication. MAR charts were reviewed – there were no gaps in recording and appropriate codes were being used. All medication checked had the date of opening noted and directions on the MAR sheet corresponded with the label on the medication.

Staff were generally aware of MCA and DoLS, and could recall carrying out recent training in this area. Staff spoken with were unaware of the five principles of the MCA and felt further training would be beneficial.

Service-user's information was held securely in a lockable office and no files were left unattended during the assessment. Laptops were in use but were locked when left. No breaches of confidentiality were apparent during the visit.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the small number of areas identified as requiring improvement – progress will be monitored and validated.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider engages well with the QuAC Officer and Transformation Managers. The Registered Manager and Deputy Manager regularly attend the Providers Forums and recruitment events.

Several staff members have attended Medication Optimisation training and have signed up for the Level 3 Medication Diploma.

Current CQC Assessment - Date / Overall Rating	**13/07/2019**	**Good**

Provider Name	**The Poplars (Thornaby) Limited**	
Service Name	**The Poplars Care Home**	
Category of Care	**Residential / Nursing / Dementia**	
Address	375 Thornaby Road, Thornaby, Stockton-on-Tees TS17 8QN	
Ward	**Village**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Requires Improvement**
Involvement & Information	**Good**	**Poor**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Requires Improvement**
Suitability of Staffing	**Good**	**Requires Improvement**
Quality of Management	**Requires Improvement**	**Requires Improvement**
Date of Inspection	**9th October 2023**	
Date Assessment Published	**28th November 2023**	
Date Previous Assessment Published	**11th November 2022**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans and risk assessments in place were seen to be person-centred, of a good quality and contained the required information, and there was evidence of regular reviews. Observations of staff interactions with residents evidenced they treat residents with dignity, respect and obtained consent before providing care and support.

There was some, however, limited evidence of resident / family involvement in care and support planning. One care plan viewed showed evidence of residents' involvement on their care plan, but this was not consistent across all care plans. Some consents were seen to be signed by staff on behalf of the residents without further information on the reason.

Feedback from residents was positive – residents confirmed they were offered a range of activities available, and they could request activities they would like to do. The home has a programme of regular 'parties' (i.e. Easter, Summer, Halloween, and Christmas) in which families are invited to attend. The home is also involved with services / businesses in the local community. Residents also confirmed they enjoyed the food and there is plenty of choice.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medication Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. Medications were managed, stored and administered safely.

Safer recruitment practices were mostly followed. The home uses two agencies when required to ensure appropriate staffing levels, however some staff members did not have completed inductions with their profile. Appropriate documentation was held on file for visitors providing professional services. Staff receive appropriate training and support. Although training and information was provided, some staff did not fully understand whistleblowing policy, and the complaint information in the home did not contain contact details for the Local Authority.

The premises are safe, secure and managed appropriately – relevant safety certification, servicing and maintenance was in place and up-to-date. Overall, the environment was to a good standard. The manager has a range of audits in place with an overarching Action Plan to track and monitor and actions identified.		
Plans and Actions to Address Concerns and Improve Quality and Compliance		
The provider will complete an Action Plan to address the areas identified for improvement to ensure full compliance and improve quality. Progress towards meeting the Action Plan will be monitored by the Quality Assurance and Compliance Officer (QuAC).		
Level of Quality Assurance & Contract Compliance Monitoring		
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)		
Level of Engagement with the Authority		
The manager engages well with the QuAC Officer. There has been limited engagement with the Transformation Managers and support initiatives available.		
Current CQC Assessment - Date / Overall Rating	**16/05/2023**	**Good**

Provider Name	**T.L. Care Limited**	
Service Name	**Beeches Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	Green Lane, Newtown, Stockton-on-Tees TS19 0DW	
Ward	**Newtown**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Requires Improvement**	**Requires Improvement**
Involvement & Information	**Requires Improvement**	**Requires Improvement**
Personalised Care / Support	**Good**	**Requires Improvement**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Requires Improvement**	**Requires Improvement**
Quality of Management	**Good**	**Good**
Date of Inspection	**3rd October 2023**	
Date Assessment Published	**7th December 2023**	
Date Previous Assessment Published	**13th January 2023**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

There was no evidence within the care plans of service-user / family involvement. There were no documents to evidence review meetings / one-to-ones taking place, and it was not clearly identifiable who the keyworker for each service-user was. Of the service-users spoken with during the assessment, none could identify that they had a keyworker or were aware of the system.

One service-user confirmed he had not received any information on his admission about the service and facilities, or how to raise a complaint or contact the care provider, and that he found all of this out for himself.

All care files contained MUST assessments and a nutritional needs care plan, although some plans did not include the most up-to-date MUST information. Service-users spoken with confirmed that there was plenty of choice and variety in the meals provided. Kitchen staff explained how they cater for a variety of dietary needs including texture-modified diets, fortified diets, and that the menu contains healthy options. Care plans contained details on how to support individuals with mealtimes and promote their independence, preferred portion size, and where the service-user prefers to eat was also noted.

Observation of care staff interaction showed that service-users remained safe and that their needs were met. Staff were observed to safely support service-users with transfers and mobilising, for example assisting a service-user from their wheelchair to an easy chair in the lounge. Staff were heard to constantly advise the service-user of the next steps and give gentle encouragement.

All service-users spoken with explained that staff are rushed off their feet and never stop, and felt that there needed to be more staff in the building. Staff interviewed also explained that they felt there were not enough staff on duty on occasions and were often left to handle duties alone.

Recruitment records were viewed for four members of staff with varying lengths of service. Application forms had been completed, documenting qualifications and employment history. Interviews were carried out by two people, however on two of the files there was only interview notes from one person held. One applicant had gaps in their employment history but there was no evidence that this had been investigated. Discussion with staff confirmed that the in-house induction covers policies and procedures, orientation of the building, mandatory training, shadowing and familiarisation of service-user's care plans. Only two of the staff files viewed had evidence of a competency-based induction, signed-off by the staff member and management to confirm understanding.

There was a lack of evidence in the staff files to support that regular 1:1 supervisions and an annual appraisal were taking place. It is a contractual requirement that staff receive six supervision meetings a year together with an annual appraisal, to support performance management.

The home uses an electronic training system called 'Elfy' - the system records training compliance and alerts the manager when training is going out-of-date. At the time of the assessment, compliance for mandatory training was only 71%, which is below contractual requirements.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. Although the majority of front-covers in place had all the required information recorded, two were missing information on the support the service-user required with medication. MAR charts were reviewed and were generally completed to a high standard, with only a couple of signatures missed. There were some occasions when service-user's medication was out-of-stock. Medication audits need to be more robust in order to identify and investigate such events. Although evidence was seen of good quality PRN protocols, others were identified as missing, inaccurate, or not service-user-specific.

All staff were confidently and passionately able to explain what they would do if they had suspected or witnessed some type of abuse or had concerns regarding the care delivered in the home. Staff were able to talk around taking concerns higher if they were not taken seriously by management, and how they could do so. All staff were aware of what whistleblowing is and were aware of the relevant places they could take concerns such as Local Authority and CQC.

Plans and Actions to Address Concerns and Improve Quality and Compliance
The provider will create a draft Action Plan for review by the QuAC Officer, which will then be approved and monitored until completion through contractual visits and reviews.
Level of Quality Assurance & Contract Compliance Monitoring
Level 2 – Moderate Concerns (Supportive Monitoring)
Level of Engagement with the Authority
The home is inconsistent in the submission of NEWS scores. The manager does not attend the Provider Forum and has limited engagement with the Transformation Team.

Current CQC Assessment - Date / Overall Rating	**13/10/2022**	**Requires Improvement**

Provider Name	**Elysium Care Limited**	
Service Name	**Stockton Lodge Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	Harrowgate Lane, Stockton-on-Tees TS19 8HD	
Ward	**Hardwick & Salters Lane**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Requires Improvement**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Requires Improvement**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Requires Improvement**
Date of Inspection	**13th November 2023**	
Date Assessment Published	**21st December 2023**	
Date Previous Assessment Published	**19th August 2022**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Stockton Lodge is a residential and dementia care setting currently supporting 38 adults.

There was a comprehensive range of care plans covering all aspects of care. Care plans were highly personalised, detailed to their specific needs and preferences. Residents were encouraged to be as independent as possible; care plans included examples of what residents can do for themselves on good and bad days. There was evidence of care plans being agreed with the resident and families; agreement forms were seen to be signed by families where residents are not able to consent themselves.

There was evidence of support in maintaining relationships with family and friends. Visits were observed during the assessment, with family and friends seen sitting in the lounges, taking residents on walks, spending time in the courtyard, and eating lunch and joining in with other residents at mealtimes.

There was evidence of an effective key worker structure used by the home; keyworker information is marked clearly in the care plans and displayed in resident rooms. The home is looking to upgrade posters in resident rooms with an addition of photographs to make this more accessible.

Staff were confident describing the Mental Capacity Act (MCA) principles and how they are put into practice in their daily work. All staff carried a small, laminated card on their person which covered the MCA and safeguarding procedures.

Supervisions and appraisals are carried out regularly and staff spoke highly of the support received by management. A supportive work environment was reported by staff, with many noting an improvement following a change in manager at the home.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. Medications are stored and administered safely. Staff wear red tabards when administering medication to avoid disturbance. Staff were seen to administer medication in different ways in line with resident's preferences. Recommendations were made around ensuring care plan reviews were more personalised and focused on individual care; many were seen with basic and repetitive monthly notes. Daily notes could be improved; many were not completed until mid-afternoon with a small, whole day recap and contained generic statements such as 'care needs met'. Care plan pictures were dated, however, some were updated at the front, but then not reflected across all documents. Overall, a good assessment for Stockton Lodge with positive feedback gained from residents, family and staff. Family, friends and advocates spoken with spoke highly of the manager, staff, and the care residents received.
Plans and Actions to Address Concerns and Improve Quality and Compliance
The provider has completed a small Action Plan and addressed areas identified for improvement, including training around care planning, and implementing daily audits of daily notes and fluid and diet charts.
Level of Quality Assurance & Contract Compliance Monitoring
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
Stockton Lodge engage with QuAC Officer when required. They are extremely good with engagement of the Activity Co-ordinator Network. Stockton Lodge regularly participate in collaborative events with other care homes. The manager also attends Provider Forums.

Current CQC Assessment - Date / Overall Rating	**30/09/2022**	**Good**

Provider Name	**Voyage 1 Limited**	
Service Name	**Saxon Lodge**	
Category of Care	**Learning Disability**	
Address	South Road, Norton, Stockton-on-Tees TS20 2TB	
Ward	**Norton South**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Requires Improvement**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**6th November 2023**	
Date Assessment Published	**21st December 2023**	
Date Previous Assessment Published	**3rd October 2019**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Saxon Lodge is a learning disability residential setting that provides support for nine adults. Residents who were able were encouraged to be as independent as possible. Residents were involved in putting together the weekly food shopping list as well as discussing plans for activities.

There was evidence of support in maintaining relationships with family and friends. The home has open visiting times 24 hours a day and families were seen visiting frequently. Residents were also encouraged to be a part of the community in which they live, taking part in daily activities outside of the home in the local surrounding areas.

Care plans were largely well written and included staff's intimate knowledge of residents. Each plan was individualised, contained great detail reflecting needs and preferences, and promoted independence. There was detailed information on resident life history, and it was clearly documented that resident's families had been included.

The manager confirmed many files were stored at Head Office due to recruitment practices, and the home is reliant on the external system for recruitment and filing / storage (as per company procedure). Staff files, where available, had inconsistencies across the board, with pertinent documents contained in some, yet missing from others – particularly offers of employment and signed contracts. There was evidence of missing references, right to work, DBS, and interview notes from staff files. Staff and recruitment documents were stored electronically but many were not clearly labelled and difficult to identify.

Daily notes were found to be stored openly within the home and not restricted due to the sensitive information they contained.

Care plans and resident documentation stored electronically had a number of documents that had been misfiled, with several files and documents found within other resident's folders. There was evidence of copy / paste in several care plans, with evidence of resident names changing throughout the document. There was no evidence that Risk Assessments are reviewed regularly. Photographs were not dated to confirm likeness of the individual and some did not appear to have been updated for some time. There was good evidence of an effective and supportive key group structure used by the home due to the nature of the disabilities and the number of one-to-one hours. The provider was able to evidence how resident's specific needs impacted the carers involved in their key group. Staff were able to describe how they ensured that the principles of the Mental Capacity Act (MCA) are put into practice in their daily work. Staff are appropriately trained, and training is monitored by management to a high percentage of completion. Supervisions and appraisals are carried out regularly and staff spoke highly of the support received by management. A supportive work environment was reported by staff, though some staff did raise concerns over the staffing levels. During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. All MAR charts were completed to a good standard, with clear directions enabling staff to safely administer medicines. The home was reminded to ensure discontinued items are clearly recorded. Overall, a positive assessment for Saxon Lodge. Family members and advocates spoken with were happy with the care residents received and the place in which they live. Staff spoke highly of the home and the residents and were happy with the care they delivered.
Plans and Actions to Address Concerns and Improve Quality and Compliance
The provider will complete an Action Plan to address areas identified for improvement, including improvements in care plan writing, documentation storage, staffing levels, and recruitment. This will be monitored by the QuAC Officer.
Level of Quality Assurance & Contract Compliance Monitoring
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
Saxon Lodge engages with the QuAC Officer when required, but engagement with other Local Authority initiatives is minimal.

Current CQC Assessment - Date / Overall Rating	**30/06/2023**	**Good**

Provider Name	**Care Matters (Homecare) Limited**	
Service Name	**Care Matters (Homecare) Limited Stockton**	
Category of Care	**Care at Home (Standard)**	
Address	Unit 11, Halegrove Court, Cygnet Drive, Stockton-on-Tees TS18 3DB	
Ward	**n/a**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Requires Improvement**
Involvement & Information	**Good**	**Requires Improvement**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Requires Improvement**	**Good**
Quality of Management	**Good**	**Requires Improvement**
Date of Inspection	**4th & 5th December 2023**	
Date Assessment Published	**28th December 2023**	
Date Previous Assessment Published	**12th July 2021**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

An electronic system is used for care planning, risk assessments, daily logs, governance, and call scheduling. Care plans were personalised and detailed with a focus on maximising independence, and evidenced service-user involvement. Care plan reviews were overdue by one month (due three-monthly). Feedback from service-users was positive – this was evidenced by review of quality assurance surveys, discussion with service-users and observations during care calls. Risk assessments were in place where necessary, including environmental risk assessments for individual service-users' homes which included recording of emergency information such as stopcock locations.

Staff were seen to treat service-users with dignity and respect, consent was obtained where appropriate, and independence was promoted. Appropriate PPE was worn and infection control measures adhered to. Medications were safely handled and recording was largely appropriate, however, some recommendations have been made to ensure the system prompts recording of the dose of administered PRN medications.

Staff training was up-to-date, however, staff spoken with felt that face-to-face training should be reintroduced following the change to e-learning as a result of the pandemic. The provider has several pieces of training equipment in the office which could be used, and this has been fed back to the manager.

Staff files were reviewed and recording of recruitment checks requires some improvement – there was no evidence of exploration of employment gaps and no evidence of verbal verification of references received for the recruitment process.

The provider is making continued efforts to recruit and whilst the provider is able to deliver the service, the impact on staff was noted. Staff were understanding of the difficulties and efforts

being made by the provider to resolve this. Rotas were reviewed and some showed long shifts with no travel time or breaks accommodated. Staff supervisions and appraisals have not been completed regularly in recent months due to workload demand and capacity, however, the provider has been working to rectify this. Staff spoke highly of the Service Manager and reported feeling able to approach him with any queries or concerns – a good culture amongst staff was also reported. Meetings are scheduled for managerial staff, however, care staff reported that they do not receive updates and a recommendation has been made to improve this. The provider is clearly committed to obtaining feedback and regular surveys are carried out alongside audits of service delivery. Audits are completed regularly and Action Plans put in place where necessary, with ongoing monitoring by the manager and care co-ordinators. Some closer attention to detail is required within these audits as issues were identified by the Quality Assurance & Compliance (QuAC) Officer that had not been identified by the auditor and therefore not actioned. There is a robust complaints procedure in place and evidence that the provider acts on lessons learnt and service improvement.
Plans and Actions to Address Concerns and Improve Quality and Compliance
An Action Plan will be drawn up from the PAMMS assessment, and the QuAC Officer will monitor and review all the evidence for compliance through contractual visits.
Level of Quality Assurance & Contract Compliance Monitoring
Level 2 – Moderate Concerns (Supportive Monitoring) This is due to previous poor compliance with the electronic call monitoring system and is likely to reduce to Level 1 (Standard Monitoring) following evidence of sustained compliance.
Level of Engagement with the Authority
The provider engages and works well with the QuAC Officer. The Transformation Team also report good engagement, noting that the provider keeps in contact around various initiatives and attends Provider Forums.

Current CQC Assessment - Date / Overall Rating	**07/01/2021**	**Good**

Provider Name	**Royal Mencap Society**	
Service Name	**Chestnut House**	
Category of Care	**Learning Disability Residential Home**	
Address	141 Acklam Road, Thornaby, Stockton-on-Tees TS17 7JT	
Ward	**Mandale & Victoria**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Requires Improvement**	**Good**
Involvement & Information	**Good**	**Excellent**
Personalised Care / Support	**Requires Improvement**	**Good**
Safeguarding & Safety	**Requires Improvement**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Requires Improvement**	**Good**
Date of Inspection	**20th & 21st November 2023**	
Date Assessment Published	**29th December 2023**	
Date Previous Assessment Published	**31st January 2022**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

A full PAMMS assessment took place following the 'light touch' assessment completed in November 2021.

Care plans evidenced staff knowledge and familiarity of the residents and took into consideration residents likes and dislikes; independence and choice were vehemently promoted. Care plans are mostly accessed via an online system, however the manager advised that the transition between paper-based and electronic-based care planning has not yet been completed and so several records were not available online. This transition was ongoing at the time of the last PAMMS in 2021. Paper-based records were reviewed and assurance was available that the relevant information is held on file, however it is not easily accessible and recommendations have been made to complete this promptly.

The environment was a relaxed and homely one; rooms were personalised and staff had a good understanding of resident needs. Residents were involved in meal planning, grocery shopping and culinary tasks, and a healthy lifestyle was promoted. Information was in accessible formats and displayed appropriately around the home, however there was no information displayed about how to make a complaint. The home did have mechanisms in place to handle complaints and have recently introduced a 'grumbles jar' which residents have been using, with support of staff, to raise issues in a more formal way. This also allowed for recording of feedback and actions were seen to have been taken on any issues raised so far. Residents' meetings take place quarterly. Surveys with key stakeholder groups such as residents, families / friends and staff have not been carried out in the last year. Records and monitoring of quality-of-service provision require some improvement which led to the quality of management domain being scored as 'Requires Improvement'.

On discussion with staff, they were able to detail several pertinent topics to the role, such as safeguarding and the Mental Capacity Act. They were aware of key worker allocation and able

to inform which of the residents have DoLS in place. Staff files were reviewed and appropriate recruitment processes and records were seen. Staffing levels were appropriate and training up-to-date. Staff report a good relationship with the manager who they feel is supportive and approachable. Regular staff meetings take place.

The manager of the home is onsite regularly and has a very good relationship with residents and staff. A 'monthly audit tool' is in place which covers a range of areas such as residents care plans, residents last appointments, health and safety, staffing and Improvement Plan / Action Plan. The Action Plan identifies level of priority, who is responsible, expected completion date and actual completion date. Improvement Plans show all actions are complete.

The home did not have a mechanism in place to ensure visiting professionals have appropriate DBS checks or Liability Insurance, however the manager advised anyone who provides professional services in the home is not left unsupervised with residents. There were a small number of areas within the home which required attention, however on discussion with the home manager, she confirmed these issues have been raised with the proprietor. They continue to manage general maintenance in-house and will continue with their efforts with the landlord. PPE was available throughout the home and infection control checks and measures were in place. Statutory safety certification such as Fixed Wiring, Gas Safety and Asbestos's report were in place and in date.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. Staff have received medicines related training, however not all have completed the level 3 medication administration training (required as per SBC contract). Staff confirmed that they receive regular competency checks and feel confident in carrying out the task. There were some minor areas of improvement identified and recommendations made to this effect.

Plans and Actions to Address Concerns and Improve Quality and Compliance
The provider will complete an Action Plan to address areas identified as 'Requires Improvement' to ensure full compliance.
Level of Quality Assurance & Contract Compliance Monitoring
Level 2 – Moderate Concerns (Supportive Monitoring)
Level of Engagement with the Authority
The management team have a positive relationship with the QuAC Officer. The provider does engage with the Transformation Team but this could be improved.

Current CQC Assessment - Date / Overall Rating	**01/04/2020**	**Good**

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