Stockton-on-Tees BOROUGH COUNCIL

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Adult Social Care and Health Select Committee

Agenda

Date:
Tuesday 23 June 2026 at 4.30pm

Venue:
Council Chamber, Dunedin House, Columbia Drive, Thornaby, Stockton-on-Tees TS17 6BJ

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

Cllr Stefan Barnes, Cllr Carol Clark, Cllr John Coulson, Cllr Lynn Hall, Cllr Jack Miller, Cllr Vanessa Sewell, Cllr Sylvia Walmsley

Agenda

1. Livestreaming

This meeting will be filmed for live and / or subsequent broadcast on the Council's website. The whole of the meeting will be filmed, except where there are confidential or exempt items, and the footage will be on the website for 12 months. A copy of it will also be retained in accordance with the Council's data retention policy.

If you attend and make a representation to the meeting, you will be deemed to have consented to being filmed. When admitted to the Council Chamber you are also consenting to being filmed and to the possible use of those images and sound recordings for livestreaming and / or training purposes. If you do not wish to have your image captured, please contact Democratic Services prior to attending the meeting.

If there are any technical difficulties with the livestreaming, the meeting will still proceed.

2. Evacuation Procedure (Pages 7 - 10)

3. Apologies for Absence

4. Declarations of Interest

5. Minutes (Pages 11 - 20)

To approve the minutes of the last meeting held on 19 May 2026.

Ged Morton
Director of Corporate Services
Monday 15 June 2026

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.

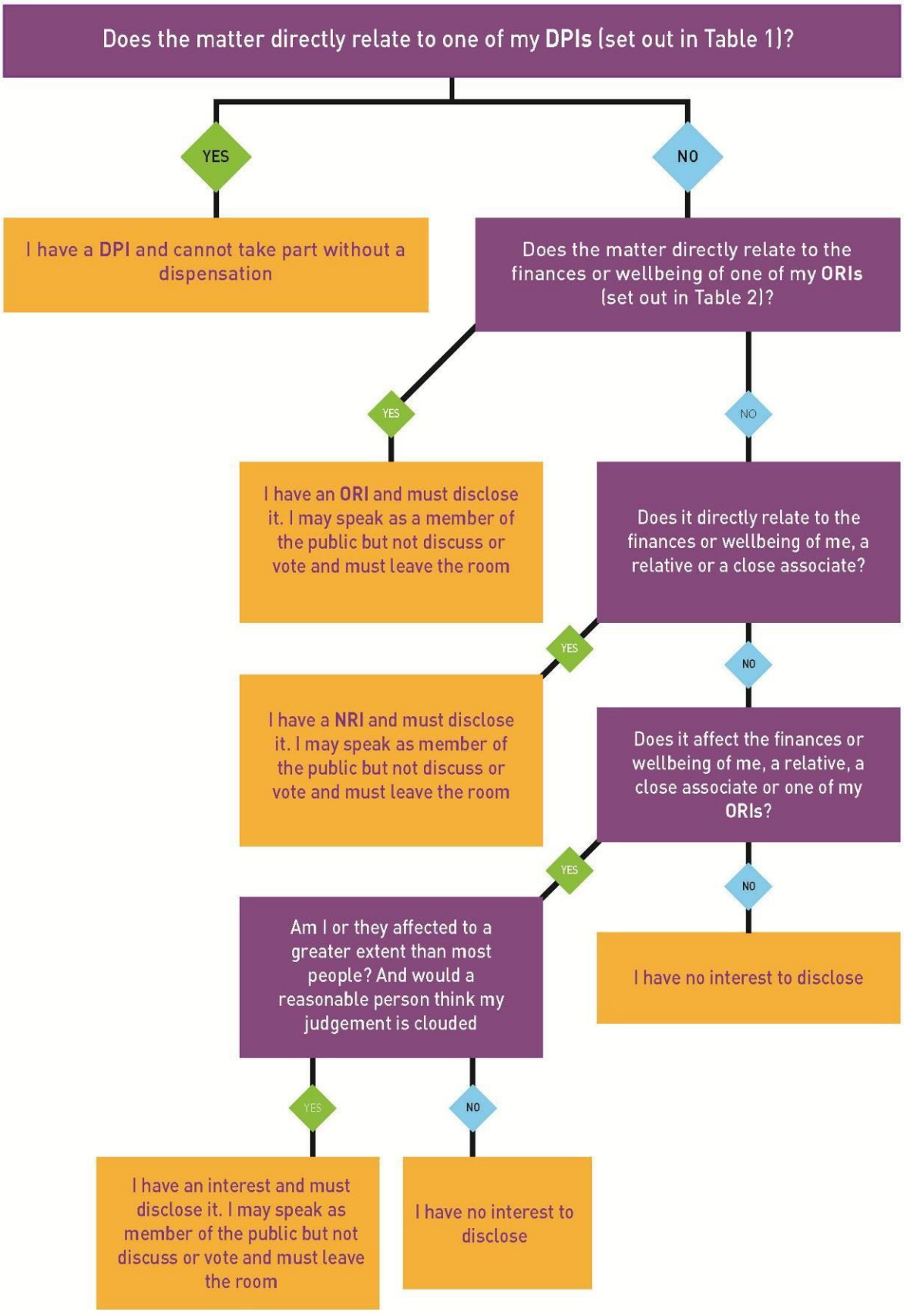
Contact: Senior Scrutiny Officer, Gary Woods on email gary.woods@stockton.gov.uk

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.

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

Council Chamber, Dunedin House
Evacuation Procedure & Housekeeping

Entry

Entry to the Council Chamber is via the South Entrance, indicated on the map below.

In the event of an emergency alarm activation, everyone should immediately start to leave their workspace by the nearest available signed Exit route.

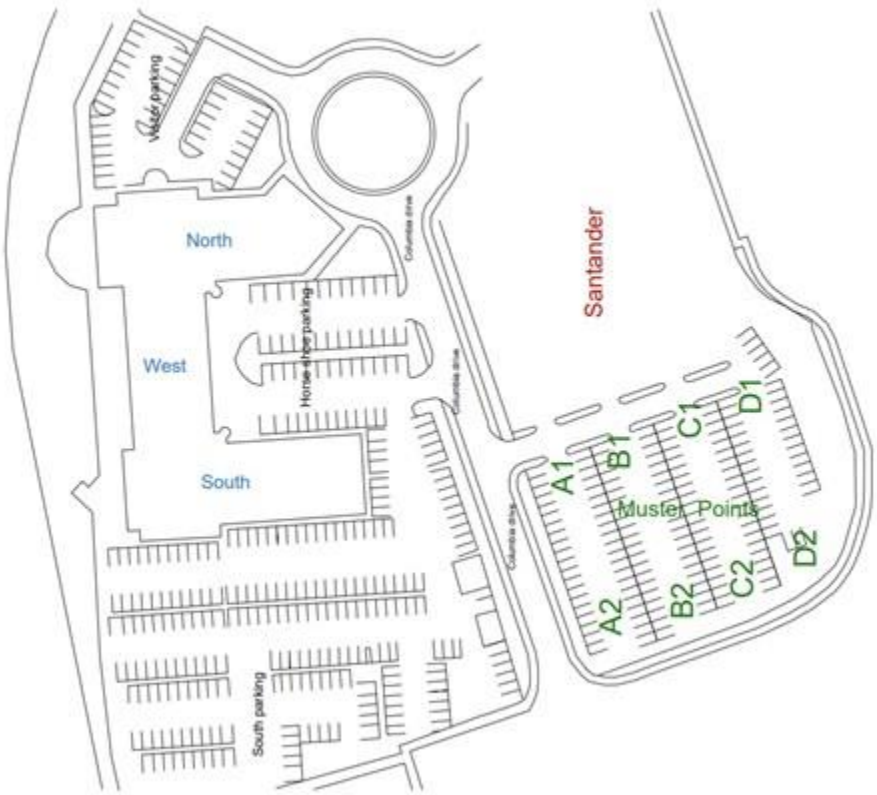
The emergency exits are located via the doors on either side of the raised seating area at the front of the Council Chamber.

Fires, explosions, and bomb threats are among the occurrences that may require the emergency evacuation of Dunedin House. Continuous sounding and flashing of the Fire Alarm is the signal to evacuate the building or upon instruction from a Fire Warden or a Manager.

The Emergency Evacuation Assembly Point is in the overflow car park located across the road from Dunedin House.

The allocated assembly point for the Council Chamber is: D2

Map of the Emergency Evacuation Assembly Point - the overflow car park:



All occupants must respond to the alarm signal by immediately initiating the evacuation procedure.

When the Alarm sounds:

1. **stop all activities immediately**. Even if you believe it is a false alarm or practice drill, you MUST follow procedures to evacuate the building fully.

2. **follow directional EXIT signs** to evacuate via the nearest safe exit in a calm and orderly manner.

    - do not stop to collect your belongings
    - close all doors as you leave

3. **steer clear of hazards**. If evacuation becomes difficult via a chosen route because of smoke, flames or a blockage, re-enter the Chamber (if safe to do so). Continue the evacuation via the nearest safe exit route.

4. **proceed to the Evacuation Assembly Point.** Move away from the building. Once you have exited the building, proceed to the main Evacuation Assembly Point immediately - located in the **East Overflow Car Park**.

    - do not assemble directly outside the building or on any main roadway, to ensure access for Emergency Services.

5. **await further instructions.**

    - **do not re-enter the building under any circumstances without an "all clear"** which should only be given by the Incident Control Officer/Chief Fire Warden, Fire Warden or Manager.
    - do not leave the area without permission.
    - ensure all colleagues and visitors are accounted for. Notify a Fire Warden or Manager immediately if you have any concerns

Toilets

Toilets are located immediately outside the Council Chamber, accessed via the door at the back of the Chamber.

Water Cooler

A water cooler is available at the rear of the Council Chamber.

Microphones

During the meeting, members of the Committee, and officers in attendance, will have access to a microphone. Please use the microphones, when invited to speak by the Chair, to ensure you can be heard by the Committee and those in attendance at the meeting.

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Adult Social Care and Health Select Committee

A meeting of the Adult Social Care and Health Select Committee was held on Tuesday 19 May 2026.

Present: Cllr Marc Besford (Chair), Cllr John Coulson, Cllr Lynn Hall, Cllr Jack Miller, Cllr Vanessa Sewell, Cllr Sylvia Walmsley

Officers: Sarah Bowman-Abouna, Angela Connor (A,H&W), Gary Woods (CS)

Also in attendance: Rebecca Warden (NHS North East and North Cumbria Integrated Care Board); Rachel Scrimgour (South Tees Hospitals NHS Foundation Trust); Judith Connor, Matt Neligan, Helen Wilson (University Hospitals Tees)

Apologies: Cllr Carol Clark

ASCH/9/26 Livestreaming

The Chair announced to those present that the meeting would be livestreamed.

ASCH/10/26 Evacuation Procedure

The evacuation procedure was noted.

ASCH/11/26 Declarations of Interest

There were no interests declared.

ASCH/12/26 Minutes

Consideration was given to the minutes from the Committee meeting held on 21 April 2026.

AGREED that the minutes of the meeting on 21 April 2026 be approved as a correct record and signed by the Chair.

ASCH/13/26 North Tees and Hartlepool NHS Foundation Trust – Quality Account 2025-2026

Senior University Hospitals Tees (UHT) personnel were in attendance to provide the annual presentation to the Committee on the North Tees and Hartlepool NHS Foundation Trust (NTHFT) Quality Account, a document which NHS Trusts had a duty to produce each year.

Marking the second full cycle since the formal creation of UHT as a hospital ‘group’, 2025-2026 had seen a move to produce the first UHT Quality Account (the draft of which had been shared with the Committee prior to this meeting and was included within the papers) reflecting on performance against the joint 2025-2026 quality priorities for both NTHFT and neighbouring South Tees Hospitals NHS Foundation

Trust (STHFT). It was emphasised that the Committee's focus would remain on the achievements and challenges of the North Tees and Hartlepool offer.

Led by the UHT Deputy Chief Executive / Chief Strategy Officer, and supported by the UHT Deputy Director of Quality, UHT Deputy Director of Nursing, and STHFT Compliance Manager, the presentation opened with the new UHT approach to the Quality Account and its purpose in providing assurance on quality, safety and patient experience. With a reminder of the spread / composition of local services and the nine shared quality priorities for 2025-2026 (covering the three key headings of 'Patient Safety', 'Clinical Effectiveness', and 'Patient Experience', NTHFT-related elements included the following:

- Patient Safety & Learning from Incidents: The Trust had no medication-related 'never events' (serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations) and had seen a 50% reduction in time-critical medication omissions. A unified incident reporting system (Healthcare Guardian) was now live across UHT.

- Medication Safety & ePMA: Electronic Prescribing and Medicines Administration (EPMA) 2.0 (to improve the range of medicines administered) was now fully embedded at NTHFT, and there had been successful pharmacy recruitment in Lipid Clinics (further recruitment would support medicines reconciliation performance). Guidance had been produced to support high-quality discharge letters, and UHT-wide medicines dashboards were intended to assist with the availability of data and benchmarking.

- Infection, Prevention & Control: There was now enhanced respiratory IPC support, improved audit and compliance structures, and a reduction in *C Difficile* infections (CDI) – 59 against a threshold of 66. Both Trusts within the UHT footprint had developed IPC pathways and care plans within electronic patient records for CDI and MRSA, and undertook weekly healthcare associated infection (HCAI) reviews. *C Difficile* reduction remained a priority for 2026-2027.

- Learning from Deaths and Mortality: NTHFT had recorded 1,198 deaths during 2025-2026. 53 case record reviews were conducted, and no deaths were judged more likely than not to have occurred due to care issues. To further understanding, there had been an increase in resource for the UHT Learning from Deaths Team, the appointment of a Medical Senior Mortality Lead, the introduction of a single UHT Learning from Deaths framework, and combined reporting reflecting on insight from the Medical Examiner, child deaths, and the lives and deaths of people with a learning disability and autistic people (LeDeR).

- Clinical Effectiveness & Audit: NTHFT was 99.4% compliant with National Institute for Health and Care Excellence (NICE) guidance, with 112 audits relating to the Trust reviewed by the UHT Clinical Effectiveness Group. A new GIRFT (Getting It Right First Time) & Audit Panel was also providing stronger oversight of patient outcomes.

- Patient Experience and Complaints: Friends and Family Test (FFT) scores for NTHFT were above the national average, with improved oversight of this feedback made available via Clinical Services Unit (CSU) dashboards (which fed into the UHT Experience of Care Council). A unified UHT complaints policy was now in

place, Family Liaison Officers were embedded, and two external audits had been completed – it was acknowledged that further work was required around the timeliness in responding to formal complaints.

- Mental Health & Vulnerable Groups: Several important developments had occurred across both NTHFT and STHFT during the year, headlined by a joint UHT Mental Health Strategy going live. A suicide prevention plan had been endorsed locally (with a pilot initiated around child suicide attempts which linked in with schools), and 1,267 staff had completed training in mental health awareness. In addition, 'Right Care, Right Person' (an approach aiming to ensure vulnerable people received the right support from the right emergency services) was implemented, and a trauma-informed care programme was launched.

- Urgent and Emergency Care: An average of 55 patients were being seen at the NTHFT Emergency Assessment Suite per day – this facility had helped reduce ambulance handover delays and improve patient flow.

- Comparison to last winter… North Tees: A graphic illustrated performance against a range of measures for the 14-week winter season (3 November 2025 to 8 February 2026) in comparison to the same period in 2024-2025 – this showed increases in 111 contacts (up 3.4%), 999 calls (up 3.9%), and ambulance arrivals to the Emergency Department (up 2.5%). Whilst average category 2 response times (25% reduction), average handover times (4.9% improvement), and the number of A&E attenders being seen within four hours (up 0.1%) all demonstrated improved patient flow and decreased delay, the number of patients waiting more than 12 hours in A&E had increased by 44.8% (from 4.9% to 7.1%) – UHT was working to reduce (and, by 2027, eliminate) so-called 'corridor care'.

- UHT Investment: As part of a £49 million UHT investment to support the 10-year health plan and improve performance and patient experience, allocations towards the University Hospital of North Tees site covered an additional MRI scanner (£3.5m), a new discharge lounge (£4m), and significant development of its critical care function (£22.24m).

- Staff and Culture: Reflecting a positive reporting culture, Freedom to Speak Up concerns had increased at NTHFT (albeit with a noticeable dip in quarter 3 of 2025-2026), with the highest theme being 'inappropriate behaviour'. Next steps included the introduction of Clinical Services Unit (CSU)-level 'People Plans' and the continuation of visible leadership and engagement between senior officers and the wider workforce.

- Staff Friends and Family Test – NTHFT: Graphics demonstrated the percentage of staff selecting 'agree' or 'strongly agree' to three key NHS Staff Survey 2025 questions – 'Q25a: *Care of patients / service users is my organisation's top priority*', 'Q25c: *I would recommend my organisation as a place to work*', and 'Q25d: *If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*'. All three metrics had declined since 2021, with a 5% decrease for both Q25a and Q25d. UHT noted the challenges in bringing together two individual NHS Trusts with different workforce cultures and gave assurance that staff networks had been strengthened (with a particular focus on equality, diversity and inclusion, and the staff carers' group).

- What does this mean?: Whilst NTHFT had made good progress with antibiotic access usage and patient flow through Urgent and Emergency Care (UEC), there was still work to do regarding mortality review capacity (UHT was expecting an increase of these over the next 12 months) and antimicrobial consumptions (rising antibiotic resistance had been identified as an issue).

- Looking forward to 2026-2027 – Quality Priorities: It was proposed that, of the nine 2025-2026 quality priorities, one would be carried forward into 2026-2027 (regarding clinical effectiveness (mortality review processes)), five would be revised and carried forward to allow for further embeddedness and completion of actions (covering patient safety (learning from incidents, medication safety, and infection reductions) and patient experience (use of patient / carer feedback, and complaints), and three would be discontinued.

  A graphic showed how the six proposed 2026-2027 priorities were aligned to strategic UHT objectives, and how each one would be measured through the key themes of 'outcomes', 'processes', 'experience', 'workforce capacity', and 'population health'. Consideration was also being given to making these priorities more relatable to the public by publishing them in 'plain English'.

The presentation concluded by highlighting the specific achievements of some of UHTs Clinical Service Units – this included the NTHFT Endoscopy Service being reaccredited by the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy for its highest standard of achievement (as well as winning team and individual annual awards), the new estate for the Emergency Assessment Suite at University Hospital of North Tees, and a winter Care Co-ordination Centre (CCC) pathway pilot which saw more than 300 patients aged 65 or over receiving care at home or in the community (avoiding admission to the acute site).

Thanking the UHT officers for the information provided, the Committee began its response by querying when any proposals to change existing service delivery to different hospital sites would be announced (slide 2). In response, it was stated that the vast majority of patients would continue to access care within the locations in which it was currently provided, but that there would be some services (in particular, specialist treatment) which would be streamlined into one setting over the next 5-10 years to ensure sustainability. Any proposals would require a pre-consultation business case to be developed and would be shared with local scrutiny committees (who were viewed as important consultees). It was envisaged that the any changes to service delivery would be implemented in early-2027 at the earliest.

The Committee spoke of the positive developments around the local Community Diagnostic Centre (CDC) in Stockton and asked if there were any plans to add a DEXA (Dual-Energy X-ray Absorptiometry) scanner to the facility so bone density checks could be offered. Members heard that whilst there were no specific plans on this at present (no capital funding had been made available in this regard), UHT would consider this and provide a response after the meeting.

Regarding medication safety, attention was drawn to the referenced discharge letter (slide 7), with Members seeking assurance on how UHT / NTHFT was checking that guidance was being followed to produce high-quality documentation. It was stated that improved processes around medicines reconciliation were contributing to a reduction in medication incidents and better discharge letter content, but that efforts

would be made to seek feedback from patients (and GPs given the letters were also sent to them) to ascertain if information was accurate and detailed enough.

Concern was expressed at the further rise in the number of patients waiting over 12 hours in A&E (slide 16), with the Committee seeking clarity around why this trend was continuing. UHT officers noted that although there had been a 44.8% increase, the actual numbers involved were relatively small when compared with total A&E attendance, with NTHFT still performing very highly in terms of Emergency Department equivalents across the country. That said, well-known winter pressures affected all NHS Trusts, and NTHFTs achievements in this area continued to mean that some patients were being diverted to its A&E from neighbouring Trusts. Efforts to ensure effective patient flow would be maintained and were a key feature within UHTs proposed 2026-2027 quality priorities.

Staying with this theme, Members asked if the ageing University Hospital of North Tees estate was contributing to A&E waits and what the situation was with plans for a replacement / new hospital site. The Committee heard that constructive conversations had been held with the Tees Valley Mayor and other partners (including Stockton-on-Tees Borough Council (SBC)), but that the technical process around a new hospital was lengthy and complex. UHT had agreed a strategic outline case to seek funding, and this would be the major endeavour over the next decade to ensure local populations had the services they deserved.

Attention turned to the staff Friends and Family Test (FFT) results (slide 21), with concern expressed over the downward trend of all three stated measures. It was reiterated that bringing together two separate NHS Trust workforces (with very different cultures) was always likely to bring its challenges, but that senior leaders had tried to be visible and ensure an open-door policy to have conversations and address any issues. There continued to be a focus on staff networks.

Noting its third-party statement of assurance for last year's NTHFT Quality Account (2024-2025) which included reference to previous NHS Staff Survey results indicating that 30% of NTHFT employees did not feel secure in raising concerns about unsafe medical practice, and 40% were not confident the Trust would address their concerns, the Committee asked what had been done in response to this data. Members heard that survey feedback was able to be broken down at an individual service level, and that, where identified, teams were required to devise improvement plans (monitored by the UHT People Committee). Emphasising the value of the continued promotion of the Freedom to Speak Up initiative, officers added that, if desired, further information could be provided to the Committee in relation to the UHT 'People Plan' at a later date.

The Committee sought clarity on why three of the existing quality priorities were being dropped for 2026-2027 (slide 23). UHT officers confirmed that, rather than being dropped, they had become 'business-as-usual' elements, re-worded or complete (i.e. mental health strategy now implemented). Work would continue around these topic areas even though they were no longer Quality Account priorities.

Flagged by the Committee in its statement of assurance for last year's NTHFT Quality Account, the subject of cancer-related targets was once again raised, with Members noting the lack of 2025-2026 data within both the presentation and the draft UHT Quality Account document. UHT officers confirmed that this information had only been validated that morning (hence its absence from the draft document), and that

confirmation of performance could be provided after the meeting. National challenges in relation to treatment times associated with cancer were noted, as were local improvements around screening.

Members drew attention to previous media on racial abuse and violence towards NHS staff and queried what was being done about this (and whether there would be a greater emphasis on it within the latest Quality Account document). UHT officers stated that there had been unacceptable incidents reported by staff and that leaders were highlighting this (and the action being taken to support affected staff) at a national (NHS England) and local community level.

In more general matters, the Committee sought comments on the recent media regarding potential job losses across the UHT footprint and reiterated previous concerns around nursing sufficiency. Assurance was given that any reductions in workforce would not impact nursing / ward staff, but would instead come from not backfilling certain vacancies (e.g. clerical / admin roles, where digital advancements could complete required tasks), natural turnover, and voluntary redundancies. UHT anticipated a decrease of 558 staff (this was in the context of an increase of 2,000 staff since 2019-2020) – this would be covered in more detail at a forthcoming Tees Valley Joint Health Scrutiny Committee meeting.

The recently announced new strategic alliance between South Tyneside and Sunderland NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust was noted by the Committee and, given UHTs experience of bringing two Trusts together, Members asked what advice officers would give on developing formal partnerships such as this. The importance of putting patients first and ensuring appropriate and effective pathways for care was emphasised, as was the need to prioritise support for the workforce to deliver such services. Getting the latter right would increase the likelihood of positive patient experience.

Bringing the item to a close, Members were reminded of the opportunity for the Committee to provide a third-party statement of assurance for inclusion within the final published UHT Quality Account 2025-2026 document. It was proposed, and agreed, that a draft statement be composed and shared after the meeting for comment, with final approval delegated to the Committee Chair and Vice-Chair.

AGREED that:

1) The update on the 2025-2026 performance of North Tees and Hartlepool NHS Foundation Trust, and the priorities for quality improvement in 2026-2027, be noted.

2) A statement of assurance be prepared and submitted to University Hospitals Tees, with final approval delegated to the Committee Chair and Vice-Chair.

ASCH/14/26 Monitoring the Impact of Previously Agreed Recommendations – Access to GPs and Primary Medical Care

Consideration was given to the assessments of progress on the implementation of the recommendations from the Committee's previously completed review of Access to GPs and Primary Medical Care.

Presented by the North East and North Cumbria Integrated Care Board (NENC ICB) Head of Commissioning – Neighbourhood Health South, and supported by the Stockton-on-Tees Borough Council (SBC) Director of Public Health, this was the second progress update following the Committee's agreement of the Action Plan in July 2024. Developments regarding those outstanding actions linked to the Committee's recommendations were highlighted as follows:

- Recommendation 1 (*All relevant health bodies (North East and North Cumbria Integrated Care Board (NENC ICB), Cleveland Local Medical Committee (CLMC), Hartlepool & Stockton Health GP Federation (H&SH), NHS Trusts, and general practices) engage regularly and constructively around the issues raised as part of this review to ensure that patients are approaching / receiving care from the most appropriate services based on need*): Whilst the previous Stockton Place-Based Committee had now been stood down and replaced with new governance arrangements (following a requirement for the NENC ICB to reduce running costs), there continued to be regular and constructive engagement between system partners in relation to general practice issues – this included the progression of temporary list closures (Melrose Surgery and Dr Rasool), and an in-hours closure to allow staff to attend a colleague's funeral (Densham Surgery). A central General Practice, Pharmacy and Optometry Team had also been formed (hosted by the ICBs Newcastle / Gateshead Neighbourhood Health Team) – this would support the implementation of consistent and timely processes in respect of general practice issues and responses to contractual changes which were required to be reviewed, approved and enacted.

  Regarding the action which sought to improve links between local Planning Services functions, SBC Public Health and the NENC ICB in terms of new housing developments and the potential impact of these in relation to health service demand / pressures, the Tees Valley Strategic Estates Group continued to be held on a bi-monthly basis (chaired by the ICBs Strategic Head of Estates), with good attendance from a range of system partners (the new requirement to co-produce a 'Neighbourhood Health' plan by the 28 May 2026 was also highlighted). Specific NENC ICB links to both SBC Public Health and SBC Planning Services were noted, with the NENC ICB also part of the Tees Valley Care and Innovation Zone (TVCHIZ) Estates & Facilities Workstream which brought partners together to maximise the use of current assets for the delivery of Neighbourhood Care services and identify any gaps where investment may be required for new builds.

- Recommendation 2 (*All relevant health bodies continue efforts to increase public / patient understanding about accessing the most appropriate services (including in the context of the Pharmacy First initiative), using all available communication mechanisms (both print and digital) and links through local community networks (e.g. community partnerships), to ensure key messages are reinforced*): The NENC ICB continued to have a strong social media presence, and supported practices and wider partners by sharing key messages and branding that could be further disseminated. Examples of local practices promoting services and other opportunities for patients to get help were also provided.

  Targeted support continued to be offered to four practices in relation to the pursuit of increasing the number of patients (original target 95%) with online accounts enabled with full prospective access. Whilst a minimum level was not written into the GP contract (as the contract implied all patients should have online access unless exclusions applied), the percentage of online accounts had increased for all

four practices since the previous update in September 2025, though the Riverside Medical Practice remained low (30.6%) – a likely result of last year's merger with the Arrival Medical Practice whose offer specialised on support for asylum seekers.

- Recommendation 3 (*Councillors and local MPs be supported in helping with these communication messages as leaders in their communities (as well as their role in raising concerns expressed by the community) and encourage positive feedback as well as concerns (to help share and spread learning and best practice*): As per recommendation 2 above, the NENC ICB continued to have a strong social media presence, and supported practices and wider partners with key messaging on websites and social media channels. Regarding 'Did Not Attends' (DNAs), practices continued to promote the importance of keeping or cancelling appointments, with DNA rates in the Borough (3.7% for the last five months) similar to the Tees Valley position (3.83% in February 2026).

  GP-related information continued to be made available to Councillors / MPs to share, and NHS messaging was often relayed by the SBC and the Community Wellbeing Champions.

- Recommendation 6 (*All general practices move towards providing the full use of digital telephony capabilities (including call-back functionality), with appropriate staff in place to support these arrangements*): As previously reported, good progress had been made around cloud-based telephony (CBT) systems, with all practices now having this function (it was confirmed that issues had now been resolved for the three practices (Marsh House Medical Centre, Kingsway Medical Centre, and Dr Rasool) which had submitted 'exceptional circumstances' in relation to his provision).

- Recommendation 11 (*NENC ICB consider its complaint / compliment reporting mechanisms so future data can be provided at a local general practice level*): All local practices had the link to the 'you and your GP practice charter' (a new element within the latest GP contract) on their websites and informed patients how to submit feedback – the ability to submit feedback was also available on the NENC ICB website and feedback received by the ICB was reported through the Tees Valley Quality and Variation Group and up through the NENC ICBs Primary Care Sub-Committee. Two pieces of feedback had been received to date – one positive (Elm Tree Medical Centre), and the other (Yarm Medical Practice) leading to improved processes for parents seeking to access an appointment for their child.

The Committee was reminded that the topic of access to GPs remained an evolving area and that the NENC ICB would continue to work with practices to ensure contractual requirements were being met, and support them and patients to deliver / use available services.

Thanking the NENC ICB for another comprehensive update, Members spoke of personal challenges in accessing their digital health records (e.g. via the NHS and other apps) and the need for this to be as simple as possible. Subsequent discussion covered the inability for information entered on the NHS app to be deleted (anything queried by the patient had to be addressed through an additional entry, not the removal / amendment of a previous record).

With reference to those practices receiving support around the provision of online accounts with full prospective access, the Committee felt the public would be surprised to see Yarm Medical Practice lagging behind others given the area may be viewed as being more IT-literate (though also pointed out the challenges often faced by communities with a larger population of older people in relation to digital platforms). The NENC ICB commented that recent changes within the practice may account for its performance and that it would continue to be supported to increase numbers. Members drew attention to their awareness of positive developments involving the practice which had seen patient satisfaction increase.

Given one recommendation still had associated actions that were yet to be deemed 'fully achieved', it was agreed that a further update on this would be provided to the Committee in around six months.

AGREED that the Access to GPs and Primary Medical Care progress update be noted and the assessments for progress be confirmed as stated.

ASCH/15/26 Health and Wellbeing Board - Previous Minutes (January 2026)

Consideration was given to the minutes of previous Health and Wellbeing Board meetings which took place in January 2026.

AGREED that the minutes of Health and Wellbeing Board meetings which took place in January 2026 be noted.

ASCH/16/26 Chair's Update and Select Committee Work Programme 2026-2027

CHAIR'S UPDATE

The Chair had no further updates.

WORK PROGRAMME 2026-2027

Consideration was given to the Committee's current work programme. The next meeting was due to take place on 23 June 2026 where anticipated items would include a response from Norton Medical Centre to its latest Care Quality Commission (CQC) inspection outcomes, the latest CQC / PAMMS quarterly report, the PAMMS Annual Report (Care Homes) for 2025-2026, and a regional health scrutiny update. It was also intended for a draft scope and plan for the Committee's next in-depth review of Protection of Property to be presented for approval.

AGREED that the Chair's Update and Adult Social Care and Health Select Committee Work Programme 2026-2027 be noted.

Chair: …….

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

QUARTER 4 2025-2026

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 January and March 2026 (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, **8** 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:

- 2 Adult Services were reported on (2 rated 'Good')
- 4 Primary Medical Care Services were reported on (2 rated 'Good'; 1 rated 'Requires Improvement'; 1 not rated)
- 2 Hospital / Other Health Care Services were reported on (1 rated 'Good'; 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 **12** reports published between January and March 2026 (inclusive), the overall outcomes of which can be summarised as follows:

- 12 rated 'Good'

APPENDIX 1

ADULT SERVICES

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

Provider Name	**Elysium Care Limited**	
Service Name	**Stockton Lodge Care Home**	
Category of Care	**Residential / Residential Nursing**	
Address	Harrowgate Lane, Stockton-on-Tees TS19 8HD	
Ward	**Hardwick & Salters Lane**	
CQC link	https://www.cqc.org.uk/location/1-3624613029/reports/AP17813/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Good**
Safe	**Good**	**Good**
Effective	**Good**	**Not assessed**
Caring	**Good**	**Not assessed**
Responsive	**Good**	**Good**
Well-Led	**Good**	**Good**
Date of Inspection	**10th October – 6th November 2025**	
Date Report Published	**23rd February 2026**	
Date Previously Rated Report Published	**30th September 2022** (focused inspection)	
Breach Number and Title		
n/a		
Level of Quality Assurance & Contract Compliance		
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)		
Level of Engagement with the Authority		
The provider has good levels of engagement with the Quality Assurance & Compliance (QuAC) Officer; the manager is open to support and keen to make continuous improvements. The manager has good levels of communication with the QuAC Officer, responding to information requests and submitting performance data in a timely manner.		

Engagement and Support from Transformation Managers
Stockton Lodge engage with the Transformation Team across a number of initiatives, including Provider Forums, training, and Activity Co-ordinator Network, and bring residents into the community for events alongside other care home residents. The manager responds to communication promptly. The Transformation Team will work with the care home to encourage more innovative opportunities.
Supporting Evidence and Supplementary Information
The service is a residential care home providing support to older people living with dementia and physical disabilities. The inspection took place due to the length of time since the CQCs last visit. The provider had a good learning culture and people could raise concerns. People were protected and kept safe. Staff understood and managed risks. The facilities and equipment were not always clean or well-maintained; however, action was taken to address issues highlighted and any risks were mitigated. There were enough staff with the right skills, qualifications and experience. Staff managed medicines well and involved people in planning any changes. People were encouraged to take part in a range of meaningful activities to promote their wellbeing. People were positive about the quality of their care. They felt safe and were involved in planning their care. People said they received high quality care from staff who treated them as individuals. One person said, '*It's great here. Not my own home but as good as it gets. I'm very critical about everything. Things must be right, or I would soon be complaining*'. People also said the service provided lots of interesting activities to keep people physically and mentally active. Some people could not directly tell the CQC about their experience. The CQC used a structured observation tool to assess whether they received good care – this approach showed people were included and listened to, and staff consistently interacted positively with them. One person told the CQC, '*The staff are brilliant and know what they are doing. I never have anything to worry about*'. People knew staff and the registered manager well. One person told the CQC, '*The manager is very good. Friendly and approachable and I've seen her with the staff, and they appear to respect her*'.

Participated in Well Led Programme?	**No**	
PAMMS Assessment – Date (Published) / Rating	**10/10/2025**	**Good**

Provider Name	**Partners4Care Limited**	
Service Name	**Partners4Care Limited**	
Category of Care	**Care at Home (Complex / Standard) / Supported Living**	
Address	Suite 4, Durham Tees Valley Business Centre, Orde Wingate Way, Stockton-on-Tees TS19 0GA	
Ward	**n/a**	
CQC link	https://www.cqc.org.uk/location/1-9572545492/reports/AP19071/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Requires Improvement**
Safe	**Good**	**Requires Improvement**
Effective	**Good**	**Not assessed**
Caring	**Good**	**Not assessed**
Responsive	**Good**	**Not assessed**
Well-Led	**Good**	**Requires Improvement**
Date of Inspection	**18th November – 15th December 2025**	
Date Report Published	**23rd February 2026**	
Date Previously Rated Report Published	**23rd June 2023** (focused inspection)	

Breach Number and Title
n/a
Level of Quality Assurance & Contract Compliance
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
The provider engages well with the Quality Assurance & Compliance (QuAC) Officer, responding to request for information and submitting performance data.
Engagement and Support from Transformation Managers
The Transformation Team and Partners4Care have historically maintained a positive and constructive working relationship. Prior to the implementation of the new Care at Home contract, Partners4Care's management team were consistently engaged, actively participating in Provider Forums and wider development sessions. Since the introduction of the new contract, there has been a noticeable reduction in their attendance at these forums and related engagement activities. However, Partners4Care have continued to contribute meaningfully in several key areas, including recruitment initiatives – most notably international recruitment – and ongoing collaboration through mechanisms such as the Supported Living Framework review. The change in engagement levels may reflect internal shifts within the organisation, including evolving business priorities and changes in management structure. Despite this, we will

continue to share relevant information, maintain open communication channels, and seek opportunities to strengthen engagement with Partners4Care over the coming year.

Supporting Evidence and Supplementary Information

Partners4Care Limited were registered to provide care to people living with dementia, people with sensory impairment, physical disabilities, and mental health conditions. The service was also registered to provide care and support to people with a learning disability and autistic people.

The CQC assessed the service under 'Right Support, Right Care, Right Culture', as it was registered to provide care and support to this population group. The CQC expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence, and good access to local communities that most people take for granted. 'Right Support, Right Care, Right Culture' was the statutory guidance which supported the CQC to make assessments and judgements about services providing support to people with a learning disability and / or autistic people.

Not everyone who used the service received personal care. The CQC only inspects where people receive personal care – this is to help with tasks related to personal hygiene and eating. Where they do, the CQC also considered any wider social provided. At the time of the assessment, there were four people receiving personal care under Care at Home Complex Framework and five people receiving personal care under Supported Living.

The assessment was carried out because the CQC had received some concerns relating to the standards of care provided to people and to follow-up their last inspection, where the CQC found a breach of good governance. Improvements were found at this assessment, and the provider was no longer in breach of this regulation.

The provider was committed to providing a non-discriminatory and inclusive approach within the service, both for people using the service and staff. They were committed to ensuring they met the needs and expectations of people, through a person-centred approach.

The provider had a robust assessment process, which involved people and, where appropriate, their family members or advocates. Detailed and person-centred care plans were created to help guide staff when supporting people. Care plans included information on how to safely manage risk.

People's needs were met by a consistent team of staff who had undergone a safe recruitment process. Information was available in a variety of formats to meet individual's communication needs. People were given choice wherever possible and consent was obtained when staff were providing support. Where people lacked capacity to make informed decisions, best interest decisions were made and documented.

People's needs were regularly reviewed with their involvement. Staff liaised with other professionals to promote people's health and wellbeing.

Staff had the necessary training to support people's individual needs and felt confident in asking for additional training if they felt it necessary. They received regular support through supervision, appraisals and meetings. Staff spoke positively of the support they received from the provider and of the training that enabled them to meet the individual needs of people.

The provider had made improvements to their governance and audit systems since the CQCs last inspection, but it was found there was still some information missing from Actions Plans – this was fed back to the nominated individual who assured the CQC necessary changes would be made.

People's Experience of the Care at Home Complex service
People and their relatives were happy with the standard of care and support being delivered. The provider ensured they had opportunities to give their views about the service and these were taken into account. A relative told the CQC, '*Yes, I do [feel involved in care planning], [my other family member] is the main carer, but we are both involved*'.

People's needs were assessed before they used the service to ensure their care reflected their needs, preferences and wishes. People received their care from regular staff who knew their needs well.

People knew how to make a complaint and were confident the provider would respond appropriately to any concerns they had. A relative told the CQC, '*If we have any concerns, I can raise it on the [provider's] App. It just works and they respond very quickly*'.

Staff treated people with respect and maintained their dignity when providing their care. A relative told the CQC, '*Yes, staff do [treat my relative with dignity and respect]. [Other family member] will point things out to them if needed*'.

People's experience of the Supported Living service
People and their relatives were happy with the standard of care and support being delivered. People told the CQC they were happy and liked the staff who supported them. One person stated, '*I think I do like the staff, I like them to take me out places… Staff help me to take my [medicine] every morning*'.

The CQC visited two Supported Living locations where they spoke with people and carried out observations. Although people could not always have detailed conversations, the CQC observed very positive interactions between people and staff. A person said, '*Staff help me to get a shower, take me shopping, getting the essentials what I need and help me with medicines and with meals, they help me with this too*'.

Relatives were happy with the way their loved ones were supported and told the CQC the staff had the right skills and training. One relative said, '*Staff are dedicated, hardworking and kind; they look after [my family member] and the other person [who lives in the house] very well*'.

Participated in Well Led Programme?	**No**	
PAMMS Assessment – Date (Published) / Rating	**21/05/2021**	**Requires Improvement**

PRIMARY MEDICAL CARE SERVICES

Provider Name	**Riverside Medical Practice**	
Service Name	**Riverside Medical Practice**	
Category of Care	**Doctors / GPs**	
Address	Alma Street, Stockton-on-Tees TS18 2AP	
Ward	**Stockton Town Centre**	
CQC link	https://www.cqc.org.uk/location/1-540979543/reports/AP13781/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Good**
Safe	**Requires Improvement**	**Good**
Effective	**Good**	**Good**
Caring	**Good**	**Good**
Responsive	**Good**	**Good**
Well-Led	**Good**	**Good**
Date of Inspection	**8th – 10th December 2025**	
Date Report Published	**9th February 2026**	
Date Previously Rated Report Published	**4th February 2016**	

Further Information

Riverside Medical Practice is a GP practice and delivers service to 10,748 patients under a contract held with NHS England. The National General Practice Profiles states that 92% of the practice population are white, 4% are Asian, 2% are black, and less than 1% are mixed race and of another ethnicity. Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the 2nd decile (2 of 10) – the lower the decile, the more deprived the practice population is relative to others. This assessment considered the demographics of the people using the service, the context the service was working within and how this impacted service delivery. Where relevant, further commentary is provided in the quality statements section of this report.

CQC view of the service

- The service had a good learning culture and people could raise concerns. Managers investigated incidents thoroughly. The facilities and equipment met the needs of people, were clean and well-maintained. Risks in the environment were not always managed. There were enough staff with the right skills, qualifications and experience. The provider did not always check staff immunisation records on recruitment. The provider made sure staff received training and regular appraisals to maintain high-quality care. Staff did not use Patient Group Directions (PGDs) appropriately. Staff managed emergency medicines well.

- People were not always involved in assessments of their needs at medication reviews. Medication reviews were not always comprehensive. Staff reviewed assessments taking account of people's communication, personal and health needs. Care was based on

latest evidence and good practice. Staff made sure people understood their care and treatment to enable them to give informed consent.

- People were treated with kindness and compassion. Staff protected their privacy and dignity. They treated them as individuals and supported their preferences. People had choice in their care and treatment. The service supported staff wellbeing.

- People were involved in decisions about their care. The service provided information people could understand. People knew how to give feedback and were confident the service took it seriously and acted on it. The service was easy to access and worked to eliminate discrimination. People received fair and equal care and treatment. The service worked to reduce health and care inequalities through training and feedback. People were involved in planning their care and understood options around choosing to withdraw or not receive care.

- Leaders and staff had a shared vision and culture based on listening, learning and trust. Leaders were visible, knowledgeable and supportive, helping staff develop in their roles. Staff felt supported to give feedback and were treated equally, free from bullying or harassment. The practice did not have an established Freedom to Speak Up Guardian which all staff were aware of. Staff understood their roles and responsibilities. The provider worked with the local community to deliver the best possible care and were receptive to new ideas. There was a culture of continuous improvement with staff given time and resources to try new ideas. Policies and procedures did not always include planned review dates or timeframes.

- The CQC found a breach of regulation in relation to safe care and treatment. It had asked the provider for an Action Plan in response to the concerns found at this assessment.

People's experience of this service

- People were positive about the quality of their care and treatment. Recent survey results, including from the National GP Patient Survey and the NHS Friends and Family Test, showed people were satisfied with services. The National GP Patient Survey 2025 data showed that 87% of respondents would describe their overall experience of this GP practice as good. This was higher than the national average of 75%. There was an active Patient Participation Group (PPG) which represented the views of people using the service.

Provider Name	**Norton Medical Centre**	
Service Name	**Norton Medical Centre**	
Category of Care	**Doctors / GPs**	
Address	Billingham Road, Norton, Stockton-on-Tees TS20 2UZ	
Ward	**Norton Central**	
CQC link	https://www.cqc.org.uk/location/1-552779884/reports/AP13990/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Requires Improvement**	**Requires Improvement**
Safe	**Requires Improvement**	**Requires Improvement**
Effective	**Good**	**Requires Improvement**
Caring	**Good**	**Good**
Responsive	**Requires Improvement**	**Inadequate**
Well-Led	**Inadequate**	**Requires Improvement**
Date of Inspection	**2nd October 2025**	
Date Report Published	**6th March 2026**	
Date Previously Rated Report Published	**6th March 2025**	

Further Information

Norton Medical Centre delivers a General Medical Services (GMS) contract to a patient population of over 16,000 – this is part of a contract held with NHS England. The last assessment of this service was carried out in October 2024 when it was rated as 'Requires Improvement' overall (and for the key questions of 'Safe', 'Effective' and 'Well-Led'). The key question of 'Responsive' was rated as 'Inadequate'. The CQC also imposed urgent conditions on the providers' registration at that time. This focused assessment was carried out to check that the improvements needed had been made.

CQC view of the service

- The practice lacked a good learning culture. Managers did not always listen to concerns when they were raised and staff did not always feel supported to raise them. The Patient Participation Group (PPG) also told the CQC that their concerns were not always taken seriously. The facilities and equipment met the needs of people, were clean and well-maintained, and any risks were mitigated. Team leads carried out appraisals for staff; leaders stated they would consider allocating this to management in the future in an attempt to improve relationships with staff. The provider did not always ensure medicines and treatments were safely managed. The provider had not taken steps at the time vaccines were administered to assure themselves that a member of staff was suitably trained and competent to administer these vaccinations. The CQC also noted errors in a sample of Patient Specific Directions (PSD).

- People were involved in assessments of their needs. Staff reviewed assessments taking account of people's communication, personal and health needs. Care was based on latest evidence and good practice. Staff made sure people understood their care and treatment to enable them to give informed consent. Staff involved those important to people and took

decisions in people's best interests where they did not have capacity. The CQC identified concerns around how teams within the practice worked together.

- People were involved in decisions about their care. The service provided information people could understand within the waiting rooms. People knew how to give feedback, although the CQC was not assured this was always listened to. People received fair and equal care and treatment. The service worked to reduce health and care inequalities through training and feedback. The CQC saw there were still ongoing issues with access. People were involved in planning their care and understood options around choosing to withdraw or not receive care.

- Some leaders lacked a shared vision and culture based on listening, learning and trust. Staff did not always feel supported to give feedback. Staff understood their roles and responsibilities.

- The CQC found breaches of regulation in relation to safe care and treatment, good governance and fit and proper persons employed. It has asked the provider for an Action Plan in response to the concerns found at this assessment.

- This service is being placed in special measures. The purpose of special measures is to ensure that services providing inadequate care make significant improvements. Special measures provide a framework within which we use our enforcement powers in response to inadequate care and provide a timeframe within which providers must improve the quality of the care they provide.

People's experience of this service

- People were positive about the quality of their care and treatment once they were able to book an appointment.

- Recent survey results, including from the National GP Patient Survey and the NHS Friends and Family Test, showed people were satisfied with services but still struggled with access to the practice.

- There was a Patient Participation Group (PPG). Representatives from the PPG described feeling unsure of their role. They told the CQC they often felt useless and not informed or consulted with in relation to changes made within the practice.

Provider Name	The Densham Surgery	
Service Name	The Densham Surgery	
Category of Care	Doctors / GPs	
Address	The Health Centre, Stockton-on-Tees TS18 1HU	
Ward	Stockton Town Centre	
CQC link	https://www.cqc.org.uk/location/1-540731286/reports/AP19210/overall	
	New CQC Rating	Previous CQC Rating
Overall	Good	Good
Safe	Good	Good
Effective	Good	Good
Caring	Good	Good
Responsive	Good	Good
Well-Led	Good	Requires Improvement
Date of Inspection	23rd January 2026	
Date Report Published	13th March 2026	
Date Previously Rated Report Published	24th June 2025	

Further Information

The Densham Surgery is a GP practice and delivers services to 3,763 patients under a contract held with NHS England. Data from the National General Practice Profiles shows that 88.30% of the practice population is 'White' and 7.72% is 'Asian', with the remainder made up of other ethnic minority groups. Information published by the Office for Health Improvement and Disparities indicates that the level of deprivation within the practice population is in the third decile (3 out of 10) – the lower the decile, the more deprived the practice population is relative to others. This assessment considered the demographics of the people using the service, the context the service was working within, and how this impacted service delivery. Where relevant, further commentary is provided in the quality statements section of this report.

Leaders and staff had a shared vision and culture based on listening, learning and trust. Leaders were visible, knowledgeable and supportive, helping staff develop in their roles. Staff felt supported to give feedback and were treated equally, free from bullying or harassment. Staff understood their roles and responsibilities. Managers worked with the local community to deliver the best possible care and were receptive to new ideas. There was a culture of continuous improvement with staff given time and resources to try new ideas.

Since the last inspection, the practice had made improvements and was no longer in breach of regulations in relation to good governance.

Provider Name	**McCormick & Harrington Limited**	
Service Name	**McCormick & Harrington Limited** (also known as Billingham Dental)	
Category of Care	**Dentists**	
Address	69-71 Queensway, Billingham, Stockton-on-Tees TS23 2LU	
Ward	**Billingham Central**	
CQC link	https://www.cqc.org.uk/location/1-7099746353/reports/AP18091/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**n/a**	**n/a**
Safe	**Regulations met**	**n/a**
Effective	**Regulations met**	**n/a**
Caring	**Regulations met**	**n/a**
Responsive	**Regulations met**	**n/a**
Well-Led	**Regulations met**	**n/a**
Date of Inspection	**18th February 2026**	
Date Report Published	**27th March 2026**	
Date Previously Rated Report Published	**n/a**	

Further Information

McCormick Harrington Limited is known locally as Billingham Dental and provides NHS and private dental care and treatment for adults and children. The service provides cosmetic treatments, some of which are not in scope of CQC regulation and are not covered in its inspection.

The CQC carried out this announced on-site inspection on 18 February 2026. The practice had seven treatment rooms. At the time of the CQCs inspection, there was a total of 25 staff. The CQC gathered feedback from staff and spoke to a range of staff during its inspection, including four dentists, five dental nurses, one dental therapist, two receptionists and the practice manager. The CQC found that the practice had met regulations.

CQC view of the service

- The practice had effective systems to identify and manage risks, including infection prevention and control.
- Staff had the skills, knowledge and experience to carry out their roles.
- Recruitment procedures reflected current legislation and there was effective leadership and a culture of continuous improvement.
- Staff provided care and treatment in line with current guidance. They treated patients with dignity and respect and ensured access to care, support, and treatment when required.

People's experience of this service

- On the day of the inspection, the CQC spoke with and saw patient feedback from five patients. Patient feedback provided a positive view of the dental team and care provided by

the practice. Comments included, '*I am always happy with this practice, staff and Dentist are really good*', '*Everything was great no problems at all*', '*The staff in the practice are polite and patient. Over the year the service I have received has been very good*', and '*In all my 60 years I have never felt so at ease…*'.

- Patients commented positively about the standards of cleanliness.
- Patients felt able to book appointments within an acceptable timescale for their needs and said they had enough time during their appointment without feeling rushed.
- Patients told the CQC they were given clear information to help them make an informed choice about their treatment and any associated costs. They were involved in decisions about their care. '*The dentist was very attentive and suggested various options for the treatment*'.
- Patients said when they were prescribed medicines, sufficient information was given.
- Patients stated that they were supported to maintain their oral health and were provided with appropriate information and resources.
- The practice shared patient feedback with the team. The CQC was told this was reviewed and where suggestions had been made, appropriate action would be taken.

HOSPITAL AND COMMUNITY HEALTH SERVICES
(including mental health care)

Provider Name	**Diaverum UK Limited**	
Service Name	**Stockton Dialysis Clinic**	
Category of Care	**Clinic**	
Address	University Hospital of North Tees, Hardwick, Stockton-on-Tees TS19 8PE	
Ward	**Hardwick & Salters Lane**	
CQC link	https://www.cqc.org.uk/location/1-253520840/reports/LAP-01956/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Not rated**
Safe	**Good**	**Not rated**
Effective	**Good**	**Not rated**
Caring	**Good**	**Not rated**
Responsive	**Good**	**Not rated**
Well-Led	**Good**	**Not rated**
Date of Inspection	**11th November 2025**	
Date Report Published	**16th February 2026**	
Date Previously Rated Report Published	**5th October 2017**	

Further Information

Stockton-on-Tees Dialysis Clinic is operated by Diaverum, an independent healthcare provider. The clinic opened in 2004 as a nurse-led satellite facility. There are 16 dialysis stations in the Unit, which is operated in partnership with South Tees Hospitals NHS Foundation Trust. The clinic provides renal care to NHS patients over the age of 18 in the local area, as well as holiday patients.

The CQC conducted an on-site assessment visit of Stockton Dialysis Clinic on 11 November 2025. This was a short-notice announced assessment, which meant the clinic was informed at 4.00pm on the day before the visit. The CQC assessed the Dialysis Services assessment service group at this location. The service was last inspected in 2017 and was not rated at that inspection.

CQC view of the service

- **Safe**: The CQC found that the service had robust systems and processes in place to keep patients and staff safe. The environment was safe, clean and well-maintained, and the staff had the required qualifications, training and skills. Risks were assessed and managed, and there were good processes in place to report and learn from incidents.

- **Effective**: The CQC found that patients' needs were assessed, and their care, support and treatment reflected these needs. Leaders within the organisation, both locally and nationally, instilled a culture of improvement, which was evidenced through a comprehensive audit

programme. Patients were encouraged to be actively involved in their own treatment through a shared care programme, and patients stated that they felt well supported.

- **Caring**: The CQC saw that patients were treated with kindness, empathy and compassion. The service supported patients to make choices about their treatment and worked with them to achieve the best possible outcome for each individual. Staff stated that they felt well-supported at work.

- **Responsive**: The CQC found that all service-users had individualised care plans in place, which reflected their own personal needs and choices. Patients could access care in ways that met their personal circumstances and protected equality characteristics. The service had good links with local NHS Trust partners, and were able to escalate any concerns quickly.

- **Well-Led**: The CQC found that leaders promoted an open culture of continuous learning and improvement. There were robust governance systems and processes in place to ensure that services were safe and effective. Staff worked with NHS colleagues to deliver care that was person-centred and integrated. Staff stated that senior managers were visible and supportive and this was witnessed during the CQCs visit.

Provider Name	**Direct Medical Transport Limited**	
Service Name	**HQ**	
Category of Care	**Ambulances**	
Address	The Future Building, Tees Way, North Tees Industrial Estate, Stockton-on-Tees TS18 2RS	
Ward	**n/a**	
CQC link	https://www.cqc.org.uk/location/1-20400650335/reports/LAP-01965/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Requires Improvement**	**n/a**
Safe	**Requires Improvement**	**n/a**
Effective	**Requires Improvement**	**n/a**
Caring	**Good**	**n/a**
Responsive	**Requires Improvement**	**n/a**
Well-Led	**Inadequate**	**n/a**
Date of Inspection	**10th & 11th September 2025**	
Date Report Published	**12th March 2026**	
Date Previously Rated Report Published	**n/a**	

Further Information

Direct Medical Transport was registered with the CQC in February 2019 to deliver the regulated activities: Transport services, triage and medical advice provided remotely. The service had a Registered Manager and a Nominated Individual.

At this assessment, the CQC assessed one assessment service group: Patient transport services where it assessed 33 quality statements.

The CQC visited the following areas as part of the assessment: the ambulance station, associated offices, and the ambulance during patient transport.

This was the first inspection for this service.

At this assessment, the CQC identified breaches of regulations 12 (safe care and treatment), 13 (safeguarding service users from abuse and improper treatment) and 17 (good governance).

APPENDIX 2

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

Provider Name	**St. Martin's Care Limited**	
Service Name	**Woodside Grange Care Home**	
Category of Care	**Residential / Nursing / Dementia**	
Address	Tedder Avenue, Thornaby, Stockton-on-Tees TS17 9JP	
Ward	**Stainsby Hill**	
	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	**9th December 2025**	
Date Assessment Published	**1st January 2026**	
Date Previous Assessment Published	**10th March 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The home had now fully transferred over to electronic care planning. Care plans were individually tailored and person-centred. Each resident had a front page which contained pertinent information such as name, date of birth, room number, NHS Number, date of admission, resuscitation status, Deprivation of Liberty Safeguards (DoLS), photograph, allergies, GP details, and next of kin / emergency contact. The home had a range of care plans and assessments in place to ensure residents needs were adequately met and their welfare protected. Care plans and risk assessments were reviewed at least monthly and with any change in need / updates as required.

Mental Capacity Assessments (MCA) were seen to be in place for residents; those residents who were deemed to lack capacity had appropriate DoLS authorisations in place. Best interest decisions were also seen to be in place (i.e. use of lap belt on wheelchairs, medication, etc.). DoLS dates of expiry were seen to be recorded. Care plans contained details of any Do Not Attempt CPR (DNACPR) and associated paperwork uploaded; decisions were seen to be reviewed annually. Care plans also contained details of residents' nutritional requirements and Malnutrition Universal Screening Tool (MUST) assessments were in place and were reviewed monthly.

Although residents had an allocated key worker which was recorded on their care plan, this information was not readily available for residents and relatives, and staff were unsure on the key worker system. This was discussed with the home manager.

Management of medications was found to be good; the home had recently moved over to Electronic Medication Administration Records (eMARs). Care plans detailed how residents liked to take their medications; medicines were found to be stored and administered safely, and appropriate records maintained.

Staff interactions were observed to be genuine, positive and respectful. Residents' general wellbeing was observed to be maintained; residents looked well-presented and bedrooms were seen to be personalised.

Safer recruitment practises were followed within the home; staff files contained an application form, with employment history and evidence of gaps in employment history explored, interview notes, at least two references, Right to Work checks (where required), and Disclosure and Barring Service (DBS) certificate information. Staff were found to have the required knowledge, understanding and training for the role. Staff confirmed they received appropriate induction at the start of employment and received ongoing support via regular supervision, training and annual appraisal. An agency file was in place and contained the staff members agency profile, including photograph, details of checks in place such as DBS, right to work and induction. Appropriate documentation was in place for visiting professionals. Training compliance at the time of the assessment was 94.9%. The home was staffed in line with the dependency tool staffing requirements.

The home was found to be safe and secure, however, some areas of the home required attention to be in line with infection prevention control guidance, such as bathrooms with rust on shower chairs and handrails around the home that were significantly chipped. The home had completed the Dementia Care Home Guide and maintained a rating of 5 on their most recent Inspection from the Food Standards Agency.

Appropriate service certification was in place and in date such as gas safety, fire system maintenance and servicing, emergency lighting, Legionella checks, etc.

Information was available in the home to support people to raise any concerns such as complaints, safeguarding, and whistleblowing information. Meetings and surveys were in place for staff, residents and relatives. The manager had appropriate logs in place to record complaints / compliments and safeguarding concerns, however, the lessons learned from these was not consistently completed.

A range of audits were in place, including catering, mattress, mealtime experience, daily walkaround and Infection Prevention Control, however, the environmental IPC issues were not identified in the audits. Regular care plan audits were not undertaken by the management of the home. A home improvement audit was in place, however, not all identified work was seen to be included.

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 by the Quality Assurance & Compliance (QuAC) Officer 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 engages well with the QuAC Officer, responding to requests and ensuring submission of performance data.		
Engagement and Support from Transformation Managers		
The manager of Woodside Grange and the CEO of St. Martin's Care maintain strong engagement with the Transformation Team and wider partners. They are regular participants in Provider Forums and the Learning Disability Network, and they frequently propose initiatives that support the broader care sector. Most recently, they presented at the Safeguarding Adults Week Provider Forum, showcasing their work with the North East Ambulance Service (NEAS) to offer paramedic placements that enhance understanding of the residential care sector – particularly in relation to safeguarding. They also shared how they deliver monthly Safeguarding Adults sessions for staff to strengthen early identification and swift resolution of potential safeguarding concerns. This was positively received by other providers, several of whom indicated they plan to adopt the practice. Staff at Woodside Grange also participate in training delivered by the Transformation Team and have engaged well with the Learning and Skills Team regarding Level 3 Medication Diplomas for administering staff. Additionally, the management team has expressed interest in contributing to research opportunities and has identified a potential research area that may support future funding bids. We will continue to work closely with the home over the coming year.		
Current CQC Assessment - Date / Overall Rating	**18/02/2025**	**Good**

Provider Name	**Akari Care Limited**	
Service Name	**Wellburn House**	
Category of Care	**Residential Care**	
Address	Wellburn Road, Fairfield, Stockton-on-Tees TS19 7PP	
Ward	**Fairfield**	
	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**	**Requires Improvement**
Date of Inspection	**12th & 13th January 2026**	
Date Assessment Published	**19th January 2026**	
Date Previous Assessment Published	**17th February 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were well written, with lots of person-centred detail on needs and preferences. Care plans explained the independence level of residents, and how a good or bad day can change the level of support they may need. Observations demonstrated that staff sought consent prior to providing care and support. Staff were observed to treat residents with dignity and respect, addressed residents by their name, and allowed time to make their choices. Residents' bedrooms were seen to be personalised to each resident. Staff offered choices and had a good understanding of resident's preferences, and were also observed asking residents when they would like their care tasks completing.

Resident and family involvement in care plans was evidenced, and a good 'resident of the day' meeting format was used to encourage feedback from residents each month. Staff were observed to seek feedback from residents informally, for example after finishing their meal. Feedback was also requested more formally through 'resident of the day' which asked for feedback each month on staff, if their choices and wishes were respected, food and drink, the cleanliness of the home, activities, and any improvements they felt could be made.

A good activities programme was in place which included a range of in-house activities, entertainers, social club visits, sensory sessions, and church visits. Activities were in place seven days a week, both morning and afternoon. The Activity Co-ordinator also spent one-on-one time with residents to plan tailored activities to an individual's goals. The programme was displayed around the home in easy-read, though was also verbally explained to residents.

The home's current food hygiene rating was 5 (as of February 2025). Residents were offered a good variety of drinks, meals and snacks. Observation of residents being asked, and asking for, food and drink outside of mealtimes was made in addition to the tea trolley regularly moving around the home. Hydration and snack stations were posted around the home. Residents spoken to confirmed they enjoyed the food and drinks available in the home. Staff were observed to give residents choices of meals and portion sizes.

Residents in the home stated they felt safe and well looked after. The home demonstrated a relaxed environment with positive and respectful interactions. All staff confirmed they received training around Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), and Safeguarding. Staff were confidently able to explain how they implemented this training into practice day-to-day. Staff knew of the correct steps to follow to report any concerns.

The home environment was welcoming, clean and tidy, and free from malodour. Communal spaces were plentiful, well-lit, and well decorated. The home had completed the Dementia Friends accreditation and had begun to tailor their home to be more dementia-friendly. A good standard of hygiene was followed, with good infection control practices being in place. Staff were all bare below the elbow, with hair tied back, and used personal protective equipment correctly. Good cleaning practices were observed. Toilets, bathrooms and equipment were clean, free from rust, mildew, or product build-up. On walkaround, the home was found to be safe. Doors to high-risk rooms, stairwells and exits were locked. Key-coded doors were around the building. Stairwells and fire exits were free from blockages. A range of appropriate service certification was in place and in date.

Medication rounds observed followed good hand hygiene and person-centred practices; staff had a good understanding of how residents liked to take their medications. Medication rooms were clean, tidy, and appropriately secured. Medication trolleys were secured to the wall in the room and locked. Medications were clearly labelled, with dates of opening and expiries. Controlled drugs were stored in a locked cupboard; a countersigned count book was in place. Medication administration records (MAR) were completed accurately. Every resident had a good standard of front covers to their MAR. MAR charts reviewed had no gaps in recording, and no overwriting or crossing out. Protocols were in place to a good standard for medications taken as and when required. The manager undertook regular medication audits across all units within the home, and staff competencies took place six-monthly, in line with Stockton-on-Tees Borough Council's (SBC) contract.

Safer recruitment practices were in place. Staff files were well organised and contained evidence of appropriate pre-employment checks. All staff had Disclosure and Barring Service (DBS) certificates. A comprehensive induction was completed by all new members of staff, completed alongside the Care Certificate for those new to care. All staff received bi-monthly supervisions and an annual appraisal (meeting SBC contract requirements). All staff confirmed they felt there was enough staff on duty to meet the needs of the residents, and visibility of staff throughout the assessment was good.

Audits included management, maintenance, domestic and infection control, and kitchen. Daily logs and walkarounds were also in place. The home had a working 'home development plan' in place for any areas of improvement identified. A range of appropriate and in date service certification was seen and kept on file. A safeguarding log was in place to track safeguarding alerts. Regular resident surveys were taken, with results compiled into a report to be displayed and shared. Regular staff meetings took place, with good attendance, and minutes were shared. Regular resident and family meetings took place, with a 'you said, we did' board on display for resident comments.

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas of improvement were identified in this assessment.

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority		
Wellburn House have a good level of engagement with the Local Authority. The manager is receptive to both the Quality Assurance & Compliance (QuAC) and Transformation Teams, and responds timely to any requests. The manager is always on time with submissions.		
Engagement and Support from Transformation Managers		
Wellburn House engage well with opportunities and initiatives through the Transformation Team, including attending Provider Forums, Activity Co-ordinator Networks, training, and events in the community. They collaborate with other care homes and residents across Stockton and are open to joined-up working.		
Current CQC Assessment - Date / Overall Rating	**04/04/2025**	**Good**

Provider Name	**HC-One Limited**	
Service Name	**Victoria House Nursing Home**	
Category of Care	**Residential / Residential Dementia / Nursing**	
Address	Bath Lane, Stockton-on-Tees TS18 2DX	
Ward	**Stockton Town Centre**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Requires Improvement**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**13th January 2026**	
Date Assessment Published	**29th January 2026**	
Date Previous Assessment Published	**23rd January 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The home had recently transitioned to the Nourish electronic care planning system. Care plans were person-centred, clearly outlining residents' preferences, life histories (via the biography and additional information sections), Deprivation of Liberty Safeguards (DoLS), and mental capacity.

Regular meetings for residents and their families were held, with upcoming dates clearly displayed on noticeboards. The 'Resident of the Day' approach included contacting next of kin to gather their views, preferences, and any updates. The manager also operated an open-door policy, ensuring easy access for residents, relatives and staff.

During the assessment, family and friends were seen visiting throughout the day. Care plans showed that residents were supported to spend time in the community, either with staff or their families.

The home provided a wide range of activities led by two dedicated Activity Co-ordinators, with a varied programme displayed across the home. During the visit, residents were observed enjoying The Dodgers, Musical Moments, and interactive games such as balloons and skittles. Activity photos were regularly shared on the home's Facebook page.

Staff consistently demonstrated dignity, respect and kindness, encouraging independence and maintaining positive relationships with residents.

During mealtimes, staff showed good knowledge of residents' dietary needs and used show plates effectively. The daily menu was clearly displayed, and residents were given free choice, with all alternative requests accommodated.

Professionals visiting during the assessment provided positive feedback.

A key worker system was in place, and staff were aware of the residents they were allocated to support. They described tasks such as contributing to care planning and helping with shopping for toiletries and clothing. One staff member warmly noted that, regardless of allocation, they strived to provide the same dedicated support to all residents whenever needed.

Noticeboards clearly outlined how residents could give feedback or raise concerns, including options for doing so if they felt uncomfortable speaking directly with staff.

A staff survey was completed in December 2025; however, the required annual resident / relative survey under Local Authority contract has not yet been completed. Plans were in place to address this within the next few weeks.

The Daily Kitchen Diary showed that all required checks, including fridge / freezer temperatures and food temperature monitoring, were completed and within expected limits. The Maintenance Manual recorded water, wheelchair, electrical, and general health and safety checks, all of which were up-to-date.

Staff audited 10% of care plans monthly, with management reviewing findings, assigning actions, and confirming completion. The manager also conducted additional audits, including daily walkarounds and organisation-led quality audits. All servicing and maintenance tasks were within date, with current certifications held on file.

Hand hygiene during mealtimes and medication rounds did not meet required standards. Staff did not wash or sanitise hands between tasks, and electronic devices were visibly unclean. Despite this, overall Infection Prevention Control (IPC) measures were satisfactory.

Medication administration was observed to be safe and person-centred, though competency checks were being completed annually rather than every six months (as required by Local Authority contract).

Observations showed positive interactions between staff and residents, who appeared relaxed and secure. The home maintained a calm atmosphere throughout the assessment, with clear evidence of strong, supportive relationships.

Staff confidently described different types of abuse, the signs to look for, and the steps they would take to report concerns, including informing management and external agencies. They were also familiar with the whistleblowing policy.

The home environment was clean, well-maintained, and dementia-friendly. The home held a 5-star Food Standards rating (September 2024).

IPC information was clearly displayed throughout the home, including guidance on handwashing and winter precautions. An Infection Control Champion was in place, and hand sanitiser and paper towels were readily accessible.

The medicines room was clean, secure and equipped with suitable storage systems. However, there were some gaps in the fridge temperature records, and one expired PRN (as-required) medication was identified, although it had not been administered.

The home included several dementia-friendly features such as colour-contrasted handrails, toilet seats, bedroom doors, and clear bathroom signage. The manager was working with the Local Authority to complete the dementia-friendly guide, with several planned improvements to further enhance the environment. Additionally, two staff members acted as dementia coaches within the home.

Staff visibility during the assessment was strong, with team members present throughout the home and engaging actively with residents. Call bells were heard infrequently, and when they did ring, responses were prompt. Staff files contained the required recruitment documents, but some checklists were incomplete due to documents being stored on online portals. Advice was provided to update the checklists to reflect this. Reference verification was not evidenced, as this was handled by the organisational recruitment team. Only minor recommendations were made.
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.
Engagement and Support from Transformation Managers
The home has demonstrated some initial engagement with the initiatives and opportunities offered, including Council-led activities and Provider Forums, reflecting an awareness of the support available and a willingness to engage where capacity allows. While participation to date has been limited, this appears to be influenced by competing operational pressures rather than a lack of commitment to engaging. The Transformation Team will continue to build positive relationships with the home, clearly communicate the benefits of involvement, and offer tailored support to encourage greater participation.

Current CQC Assessment - Date / Overall Rating	**29/09/2017**	**Good**

Provider Name	**Stockton Care Limited**	
Service Name	**Cherry Tree Care Centre**	
Category of Care	**Residential / Residential Dementia**	
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	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**26th – 28th January 2026**	
Date Assessment Published	**6th February 2026**	
Date Previous Assessment Published	**27th February 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Pre-admission assessments were in place and included relevant life history information. Care plans were generally person-centred and reviewed at least monthly, with updates made in response to changes in need. However, a small number of care plans required greater detail to fully reflect individual needs. Occasional use of copied review text was identified; while no inaccuracies were found, this practice was not aligned with best practice and was being addressed. Daily care notes were personalised and generally of good quality, with continued improvement encouraged, particularly in relation to personal care documentation.

Mental Capacity Assessments (MCA) were present but required improvement in quality and completeness. In several cases, decision-specific detail was insufficient, and there were occasions where additional assessments would have been appropriate. Deprivation of Liberty Safeguards (DoLS) and Do Not Attempt Resuscitation (DNACPR) documentation was appropriately recorded and reflected within care records, with clear evidence of oversight where conditions were attached.

Risk assessments, including Waterlow scores and Personal Emergency Evacuation Plans (PEEPS), were up-to-date and generally of good quality. It was noted that some planned welfare checks were not consistently completed, and management had been advised to strengthen oversight through planned care monitoring to ensure required checks were undertaken.

Residents and relatives reported feeling safe, and staff demonstrated awareness of safeguarding responsibilities and reporting processes. Safeguarding policies were current and accessible, with clear logs of concerns and Care Quality Commission (CQC) notifications. However, several safeguarding enquiries were ongoing at the time of assessment. These identified weaknesses in managerial oversight, including insufficient investigation, incomplete follow-up actions, and failure to update risk assessments after

incidents. Further learning was anticipated, and additional management support had been recommended, and subsequently implemented, to strengthen incident analysis and oversight.

Staff recruitment files were well organised, with appropriate checks, including Disclosure & Barring Service (DBS) clearance in place. Induction processes followed recognised frameworks, and training compliance was at 100%, supported by clear records and oversight.

Medicines were managed safely, with appropriate storage, temperature monitoring, accurate Medication Administration (MAR) records, and up-to-date policies. Medication audits demonstrated effective governance with competency checks being undertaken six-monthly (as per SBC contract).

Infection Prevention and Control (IPC) arrangements were generally robust, supported by regular audits and a 5-star food hygiene rating. However, issues were identified in some bathrooms, including unclean equipment and damaged pull cords, representing an IPC risk. Immediate action was taken to address the unclean equipment.

The environment was secure and well-maintained, with clear fire exits, appropriate equipment checks, and effective visitor controls. A dementia-friendly environment was noted, and the home had completed the dementia friendly home guide (as per SBC contract). A manager's audit file was reviewed, containing a clear index, frequency guidance, and an aligned filing system. Evidence demonstrated that audit findings were discussed in supervisions and staff meetings, with associated lessons learned reports. A wide range of audits were in place, including IPC, food hygiene, skin integrity, MCA and DoLS, DNACPR, maintenance, kitchen, and domestic audits.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan for all areas identified that require improvement and the Quality Assurance & Compliance (QuAC) Officer will monitor progress against this to ensure the expected standard has been achieved and the acting manager receives support from more senior colleagues. Additionally, work will continue in relation to the ongoing safeguarding enquiries and any actions requiring monitoring by the relevant team.

Level of Quality Assurance & Contract Compliance Monitoring

Level 2 – Moderate Concerns (Supportive Monitoring)

Level of Engagement with the Authority

Since the last PAMMS assessment, the home has continued to see changes in management. The current acting manager is becoming acquainted with the role and has been supported by colleagues so far; further support has been identified as being required and the QuAC Team will maintain oversight over this. The home is currently under level 2 monitoring as a result of this and the current open safeguarding enquiries. A good working relationship is held between the provider and the QuAC Officer.

Engagement and Support from Transformation Managers

Cherry Tree have a positive and engaging relationship with the Transformation Team, and participate in a number of opportunities, such as Provider Forum, activity networks, activities in the community, training, and most recently registered interest in supporting care home research. The Transformation Team will continue to encourage and engage with the acting manager and wider staff at Cherry Tree to sustain the positive work within the home.

Current CQC Assessment - Date / Overall Rating	**01/10/2024**	**Good**

Provider Name	**CEL Homecare Limited**	
Service Name	**CEL Homecare Teesside**	
Category of Care	**Care at Home**	
Address	98 Church Road, Stockton-on-Tees TS18 1TW	
Ward	**n/a**	
	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	**Requires Improvement**	**n/a**
Quality of Management	**Good**	**n/a**
Date of Inspection	**2nd & 3rd February 2026**	
Date Assessment Published	**17th February 2026**	
Date Previous Assessment Published	**n/a** (not previously assessed)	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Overall, care plans were service-user focused, though would benefit from review to be more person-centred. There were a few examples found of incorrect names or pronouns used. Good life histories of service-users were given, which were included well in care plans. There were good instructions on how to care for the service-user. Likes, dislikes, preferences, abilities and independence levels were reflected in allocated care tasks.

Service-users spoke highly of their carers, said they had a good time with them, and they were friendly and polite. Service-users were confident that carers knew how to care for them properly. On observations, carers communicated effectively with service-users and gave clear instructions and explanations for what they were there for and going to do.

Care plan reviews were not taking place three-monthly in line with Stockton-on-Tees Borough Council (SBC) contract requirements and were being completed bi-annually. On review, the full care plan was reviewed including re-assessment to capture any changes to need or risk, with additional updates where there was a requirement.

Risk assessments were in place with all care plans, however, were not always seen to be completed, or were generic in nature, and were not always reviewed alongside care plans. Service-users with repositioning requirements had an associated care plan and risk assessment. Those with moving and handling requirements had a plan in place, with consideration of risks and their independence levels.

Daily notes were recorded consistently. Carers included reviews of the call, with a good summary of what had taken place. Notes were factual, free from opinion, and confirmed which tasks were completed for and by the service-user.

Service-user goals were considered, with examples seen of progression for those who had completed their original goal and had now set a new one. This was not being used consistently, though was beginning to be implemented more based on feedback.

Staff confirmed they had received training in Safeguarding, Mental Capacity Act (MCA), and Deprivation of Liberty Safeguards (DoLS), and that this was refreshed annually. Staff gave confident examples of signs to look out for to identify safeguarding needs and knew the correct processes for concerns. Service-users confirmed they felt safe with their carers and felt well looked after. Good standards of infection control practices, food and hand hygiene, and waste management was observed during calls. Not all residents had environmental risk assessments in place, so many care plans were missing key knowledge and risks for the service-user's home.

Medications were primarily used in blister packs. Service-users were asked prior to taking their medications if they were ready to take them, or if they had already for those who only required prompting. Medication Administration Records (MARs) viewed were completed accurately. Medications administered or observed to be taken were recorded correctly, with any not taken or administered recorded with the reason. Medication was stored as per service-user wishes. Staff administering medications were all trained to Level 3 and received bi-annual competencies in line with the SBC contract. Medication audits took place monthly.

Staff files were well structured and evidenced that safe recruitment practices took place. Attention to detail was required as several files viewed had missing paperwork that had not been received from Head Office and filed or had incomplete or unsigned documentation. Staff had appropriate Disclosure Barring Service (DBS) certificates and identification and right-to-work checks. A comprehensive induction took place which included the Care Certificate; finished inductions did not always include a final sign-off signature, though. Staff supervisions were evidenced as being completed in line with the SBC contract, in addition to an annual appraisal.

Rotas viewed evidenced sufficient staffing levels for packages of care, though were not always planned efficiently to limit calls being attended late, particularly as the day progressed. Travel time was not being considered accordingly in line with SBC contract to ensure rota efficiency – this would be addressed in the PAMMS Action Plan for improvement. On review of call notes, those attended late or ran short were not always followed up after repeated instances.

Staff spoke highly of management and the support received. Staff felt comfortable raising concerns and reported that communication with the office while on calls was good. Staff confirmed that concerns were taken seriously and that the manager was quick to act.

Manager care plan and medication audits took place monthly; no additional audits were taking place at the time of assessment. A range of meetings took place, including with staff, and service-users and their families. Surveys were taken annually. It could not always be evidenced where feedback had been acted on. The manager was working to create a working document to identify trends, track actions, and monitor continuous improvements.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider is to create an Action Plan to address the areas of improvement found; some areas have already been rectified. The Action Plan, once finalised, will be monitored by the Quality Assurance and Compliance (QuAC) Officer for compliance.

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 level of engagement with the Local Authority and is responsive to the QuAC, Transformation, and Brokerage Teams. The provider engages well with forums, initiatives and training that is offered. Monthly reporting is submitted timely.	
Engagement and Support from Transformation Managers	
CEL continue to work effectively and collaboratively with the Transformation Team. Their manager and director maintain a strong presence at all Provider Forums and team-led events, demonstrating consistent commitment to sector engagement. They are proactive across the wider provider network, building productive relationships with organisations such as Skills for Care, and regularly contributing to development initiatives – particularly with Stockton Riverside College – where they support new qualification design and wider workforce development activity. As a newer provider on the framework, CEL have shown a positive and open approach to understanding Stockton's expectations and ways of working. They remain responsive to communication, readily attend meetings, and engage constructively with the team. We value their ongoing partnership and look forward to continuing to work closely with them in the years ahead.	
Current CQC Assessment - Date / Overall Rating	**Not yet assessed**

Provider Name	**Willow View Care Limited**	
Service Name	**Willow View Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	1 Norton Court, Norton Road, Stockton-on-Tees TS20 2BL	
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	**9th – 13th February 2026**	
Date Assessment Published	**26th February 2026**	
Date Previous Assessment Published	**10th March 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were developed with comprehensive person-centred detail, including a fully completed 'Who I Am' section that was created with meaningful involvement from individuals and their loved ones – this ensured that personal histories and relevant information were accurately captured. Each person's profile displayed essential information, along with an up-to-date photograph. Observations confirmed that staff consistently delivered care in a manner that upheld people's privacy and dignity, and discussions with individuals supported this as their usual experience. Bedrooms were personalised to reflect residents' preferences, and people were well presented, demonstrating a respectful and attentive approach to their care. The dementia unit was currently undergoing renovation, and the dementia-friendly guide had been completed by the provider and was due to be assessed / signed off in the coming weeks by the Local Authority representative.

Risk assessments and PEEPs (personal emergency evacuation pans) were in place and reflected individuals' needs, with associated detail captured in care plans, though some repositioning and welfare checks were not consistently completed at the required intervals. Monthly reviews of assessments and care plans were generally completed, though on some occasions outdated or misplaced information remained within plans, prompting a reminder to ensure review processes were more robust. Daily notes were supplemented with person-centred detail. Meal choices were varied, but promotion of the alternative menu required strengthening, and it was suggested that information on food and drink availability at any time be added to the welcome pack. Residents were observed to be offered appropriate choice regarding meals and drinks, supported by the availability of snacks, hydration stations, and the tea trolley. The home received a 5* rating following a food hygiene assessment in August 2025.

Staff demonstrated a positive and professional approach, and people reported feeling safe and well supported during their time at the home. Staff were confident in recognising different types of abuse, understood reporting mechanisms, and had completed safeguarding and whistleblowing training. Medicines were generally stored and administered safely, with secure

trolleys, appropriate temperature monitoring, and correct disposal processes in place. There were some areas of risk management which required improvement and were addressed promptly at the time of inspection. Equipment was in good condition, with up-to-date servicing, though documentation required better organisation. Policies relating to medicines, including controlled drugs, covert administration and homely remedies, were current, and staff competencies and regular audits were in place. Safeguarding information was clearly displayed throughout the home, supporting awareness among residents, visitors and staff, with a detailed information board displayed in reception.

A review of staff files showed that key documents, such as induction booklets and Disclosure and Barring Service (DBS) checks, were generally in place, and staff had access to policies and procedures, though several inconsistencies were identified. While DBS checks had been completed, some staff started before clearance was fully confirmed and with no evidence of supporting risk assessments available. Supervision and appraisal records also showed delays, and there was no formal system to track probation or induction requirements. Overall, while the foundations of good practice were evident, improvements were required to strengthen the record-keeping process.

Those spoken with reported positive relationships with staff and management, expressing confidence in raising concerns and feeling assured these would be handled appropriately. Staff described a supportive workplace culture and demonstrated awareness of key policies, including bullying and harassment, complaints, safeguarding and whistleblowing. Systems to record and monitor complaints, safeguarding concerns and CQC notifications were in place, and associated documentation was generally well maintained. Meetings with residents, families and staff were held regularly, with evidence that feedback was sought and acted upon. While some audits were not always completed at the required frequency and follow-up actions were not consistently recorded, the introduction of the new electronic system had strengthened oversight.

Plans and Actions to Address Concerns and Improve Quality and Compliance

An Action Plan will be created to address the areas of improvement identified through this assessment – this will be monitored and overseen by the Quality Assurance and Compliance (QuAC) Officer.

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

Willow View continue to work closely with the authority, including social care teams, Transformation Managers and the Quality Assurance and Compliance Team. Staff are engaging and responsive to queries.

Engagement and Support from Transformation Managers

Engagement with the Transformation Team initiatives has been limited over the past year as the home's manager has been focused on addressing other urgent priorities. Despite this, the manager has remained responsive to communication.

Going forward, we anticipate and will encourage more proactive engagement with the Transformation Team to support ongoing quality improvement. The relationship remains positive, and there is a clear willingness from the provider to work collaboratively as capacity allows.

Current CQC Assessment - Date / Overall Rating	**25/11/2024**	**Good**

Provider Name	**Vestra Homecare Limited**	
Service Name	**Vestra Homecare Hartlepool**	
Category of Care	**Homecare Agency**	
Address	Unit 19, Hartlepool Enterprise Centre, Brougham Terrace, Hartlepool TS24 8EY	
Ward	**n/a**	
	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	**9th – 11th February 2026**	
Date Assessment Published	**10th March 2026**	
Date Previous Assessment Published	**n/a**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Vestra utilise their Hartlepool registered office as their base to run their Stockton service, hence why their service name is Vestra Homecare Hartlepool.

Care plans were individually tailored and person-centred, containing personal and pertinent details including likes and dislikes, preferences and abilities. Care plans were seen to include details of any advanced decisions such as Lasting Power of Attorney and Do Not Attempt Resuscitation (DNAR). Where a service-user had a DNAR in place, details of where it was located in the property was recorded. Care plans viewed were all seen to be signed and dated by the service-user (or the service-user's representative) and the assessor to confirm the care plan had been prepared with the service-user / representative.

All service-users were seen to have care plans in place which covered medical history, sight, speech, hearing and communication, personal hygiene, continence care, memory and mental health, nutrition and hydration, finances, pressure care, medication, and mobility. Assessments were in place for pressure care, medication, moving and handling, and environment. Reviews of quality of care were carried out every three months, however, this did not include a review of the care plans and risk assessments (the contract requires care plan and risk assessment reviews to be carried out at least every three months).

Care staff were observed to treat service-users with dignity and respect, and feedback from service-users was positive. Care staff sought appropriate consent prior to providing care and support, were patient, and did not rush service-users. Service-users confirmed they felt safe at home with the level of support they received. All carers were observed to check if there was anything else they would like them to do before leaving the call. None of the service-users spoken to had any concerns / complaints to share, but confirmed they would speak to the carers or ring the office if they did.

Feedback from staff was also positive; staff confirmed they received appropriate induction, training, supervision and appraisal, and regular team meetings. Staff felt management had an open-door policy and were approachable. Safer recruitment practice was seen to be followed, references were obtained and verified, gaps in employment history explored, and DBS certificates obtained.

Rota's viewed showed calls were planned without any overlap of calls, however, calls were scheduled immediately after each other with no travel time allocated (as per contractual requirements).

There were appropriate mechanisms in place to assess and monitor the quality of the service. Quality Assurance surveys were carried out every three months with service-users, with action taken where required. Annual surveys were carried out with service-users and employees. Monthly and quarterly governance reports were completed, identifying issues considering complaints, safeguarding, accidents, and incidents. An Action Plan was produced from findings and any lessons learned identified.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the three individual questions identified as 'Requires Improvement' to ensure full compliance and improve quality. Progress towards completing the Action Plan will be monitored by the Quality Assurance & Compliance (QuAC) Officer.

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, responding to requests for information and submitting performance data in a timely manner.

Engagement and Support from Transformation Managers

Vestra's management and senior leadership team engage positively and constructively with the Transformation Team. They regularly attend Provider Forums and development sessions, and are open to both one-to-one meetings with the team and wider engagement with management colleagues. Communication is a particular strength; Vestra are proactive, responsive, and consistently maintain open lines of contact via email and other opportunities for discussion. Over the past year, Vestra have been transparent and collaborative in their approach to addressing any challenges, working closely with us to find effective solutions. They have robust quality assurance processes in place and demonstrate a clear commitment to the delivery of high-quality care, with staff wellbeing embedded at the heart of their service. We look forward to continuing our positive working relationship with Vestra throughout the duration of their contract.

Current CQC Assessment - Date / Overall Rating	**12/12/2025**	**Good**

Provider Name	**Prestige Care (Roseville) Ltd**	
Service Name	**Roseville Care Centre**	
Category of Care	**Nursing / Residential / Residential Dementia**	
Address	Blair Avenue, Ingleby Barwick, Stockton-on-Tees TS17 5BL	
Ward	**Ingleby Barwick North**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Requires Improvement**
Involvement & Information	**Good**	**Requires Improvement**
Personalised Care / Support	**Good**	**Requires Improvement**
Safeguarding & Safety	**Good**	**Requires Improvement**
Suitability of Staffing	**Good**	**Requires Improvement**
Quality of Management	**Good**	**Requires Improvement**
Date of Inspection	**16th – 18th February 2026**	
Date Assessment Published	**12th March 2026**	
Date Previous Assessment Published	**17th February 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The home used an electronic care planning system. Care plans were personalised and detailed, with each resident having a front page showing their photograph, room number, 'Do Not Attempt Cardiopulmonary Resuscitation' (DNR) status, and whether any restrictions on their liberty were in place. This front page also provided an overview of risks, preferred conversation topics, medical information, care needs, required equipment, and key contact details. It offered clear and useful information for doctors, specialists, social workers, advocates, friends, and family.

Each resident had an 'About Me' section describing what was important to them, the people who mattered most in their lives, how best to communicate with them, and their personal preferences. Care records updated live throughout the day, showing amber when tasks were overdue and green when completed. Although electronic plans could not show signatures, discussions with residents or families were recorded in the care plan notes or monthly reviews.

Care plans included relevant risk assessments, and Personal Emergency Evacuation Plans (PEEPs) were available both electronically and in printed form. Electronic versions were kept up-to-date, and printed copies stored in the fire bag were confirmed as current and reviewed monthly. Nutritional assessments were completed consistently. Food and fluid charts were updated throughout the day, recording what was offered and what was consumed. A full health passport could be produced from the electronic system.

Care plans and risk assessments were reviewed monthly. Daily charts for nutrition, mobility, toileting, hygiene, mattress checks, and meals were completed consistently. Daily notes were a mix of system-generated options and free-text entries, updated throughout the day.

Staff interactions with residents were observed to be warm, patient and respectful. Staff communicated clearly and adapted their approach based on each resident's abilities. Residents were never rushed and were given time to make decisions or respond.

Residents gave positive feedback about the food. They were offered choices at mealtimes, and observed mealtimes were calm and supportive. Residents were encouraged to eat, supported to be as independent as possible, and provided with adaptive cutlery, plates and cups when required.

Service certificates were in date, overseen by the onsite maintenance manager. A range of audits are completed daily, weekly, monthly, and quarterly, managed electronically with clear oversight. Maintenance, cleaning, laundry, and kitchen logs were up to date. Fire safety records, including equipment checks, drills, and alarm tests, were maintained.

Medication rooms were clean, organised and secure. Controlled medication was stored in locked cupboards and medicines were organised by individual resident. Trolleys were kept in locked rooms. Temperature checks for rooms and refrigerators were recorded daily, with only a few gaps noted. Clear instructions were displayed for staff if temperatures fell outside the safe range.

During the assessment, staff used moving and handling equipment safely and always sought residents' consent before beginning a task. Safeguarding information was displayed throughout the home.

The medication policy was in date. No gaps were found in the electronic medication administration records (EMAR). Guidance for 'as needed' medicines was up-to-date, and staff recorded both the reason for giving them and the outcome. Medication labels were mostly clear, with only minor issues noted. Administration of patches and variable-dose medicines was fully documented. The manager conducted regular audits, including controlled drug checks.

Staff files were well organised and contained full recruitment documentation, including interview notes, references, right-to-work checks, identification, enhanced criminal record checks, contracts, qualification certificates, and acknowledgements of policies and procedures. Nurse registration checks were in place. Staff had completed induction booklets linked to the care certificate; all were fully completed, although two lacked a final manager signature. Training completed during induction was recorded. Staff had bi-monthly supervision sessions and annual appraisals. Records reviewed were individualised rather than generic. Staff were knowledgeable about safeguarding, types of abuse and whistleblowing, and knew how to report concerns internally and externally.

The home was clean and uncluttered, although some décor showed wear. Laundry was well organised and equipment issues were addressed promptly. Hand hygiene reminders were prominently displayed. Cleaning schedules were complete. Safety data sheets for cleaning products were available and supported by risk assessments, reviewed annually. The kitchen was clean and well maintained, with a five-star food hygiene rating achieved in April 2025.

Risk assessments were completed for all residents who required equipment. The manager kept a detailed file of standard risk assessments and safe work procedures. The home included features supportive of people living with dementia, such as coloured handrails, distinctive bedroom doors, and clear bathroom signage. The manager was familiar with local dementia care guidance and remained in contact with the Dementia Community Link Worker.

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas were identified that were 'Requires Improvement'.

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 Quality Assurance & Compliance (QuAC) Officer and responds to requests for information in a timely manner.		
Engagement and Support from Transformation Managers		
Roseville communicates well with the Transformation Team and currently engage at a moderate level, including attending Provider Forums, Activity Co-ordinator Network, and Transformation Team-organised events in the community alongside other care homes and their residents. We will continue to discuss further opportunities that support the care home to engage to a higher level.		
Current CQC Assessment - Date / Overall Rating	**22/08/2024**	**Good**

Provider Name	**Hales Group Limited**	
Service Name	**Parkside Court**	
Category of Care	**Housing with Care (Extra Care)**	
Address	Cumbernauld Road, Thornaby, Stockton-on-Tees TS17 9FB	
Ward	**Stainsby Hill**	
	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	**Requires Improvement**	**n/a**
Quality of Management	**Good**	**n/a**
Date of Inspection	**23rd – 25th February 2026**	
Date Assessment Published	**20th March 2026**	
Date Previous Assessment Published	**n/a**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Service-users were actively engaged in organising and participating in a wide range of communal activities and fundraising events, such as raffles, which both fund events and provide donations to the local community. Photographic evidence reflected strong participation and a positive community atmosphere.

Care plans were person-centred and 'About Me' profiles were completed on the care planning system. Feedback from service-users was consistently positive, highlighting respectful treatment and strong relationships with staff. Comments indicated that staff go 'above and beyond', and overall observations confirmed a pleasant, supportive environment.

The service's care planning template provided comprehensive risk assessments, with appropriate risk reduction measures and clear actions should risks occur. Care plans were reviewed annually, or when a change in need occurred, though the Local Authority contract requires this to be three-monthly, and this had been identified for improvement action. Care tasks were recorded using system preset options, supported by person-centred notes. Some missed or refused calls were not consistently documented, though a recent managerial audit identified this, and follow-up actions were underway. Appropriate food hygiene practices were observed during meal support.

People using the service demonstrated understanding of how to identify and report potential abuse and reported feeling safe within the environment. Medicines were seen to be managed safely. There were some recording issues noted within medication administration records which were identified both in recent audits and during the PAMMS assessment – these would be addressed through staff training and supervision. Staff medication competency assessments were completed at least annually (in line with contractual requirements).

Recruitment documentation was managed centrally and accessed by the manager via an online portal. Several gaps were identified in records, and the system did not clearly evidence that

appropriate Disclosure & Barring Service (DBS) levels (enhanced with barred list) were completed. References were present for a recently recruited staff member, but there was no record of follow-up phone verification, which had been highlighted as good practice. The induction process was well structured, and staff were found to have completed the Care Certificate (in line with contractual obligations). Annual appraisals were undertaken, however, supervisions were taking place on a three-monthly basis, whilst the Council contract required this to be bi-monthly. Training compliance was monitored through an online system, managed centrally, though records were inconsistent, making it difficult to determine who had completed mandatory training. It appeared that training compliance was over 90% completion, however, several entries lacked dates and appeared incomplete.

Monthly medication and care plan audits were completed by the provider, though the current system makes it difficult to clearly track audit completion. It was recommended that the manager introduce a more robust audit schedule, including contingency arrangements for absences.

It had been recommended that systems managed centrally were reviewed to ensure they were functional and that the manager was able to be assured that appropriate processes were being followed and information shared (for example, satisfaction surveys were collated centrally but feedback had not been provided locally), as well as the aforementioned recruitment issues.

Plans and Actions to Address Concerns and Improve Quality and Compliance
The manager began work immediately to address areas of improvement noted, some of which are noted within the report. A formal Action Plan will be created and progress monitored and signed off by the Quality Assurance and Compliance (QuAC) Officer.
Level of Quality Assurance & Contract Compliance Monitoring
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
Both the provider and manager engage well with the Local Authority.
Engagement and Support from Transformation Managers
Parkside Court continues to maintain a positive and constructive relationship with the Transformation Team. The management team participates actively in the quarterly Housing with Care meetings, engaging alongside other care providers, housing colleagues, QuAC Officers and the strategy team. They have hosted one-to-one sessions to share their approach to managing the scheme and have made effective use of opportunities offered by the Transformation Team, including collaboration with North Tees education teams to support resident wellbeing. We anticipate continued productive engagement with the manager and wider team over the coming months.

Current CQC Assessment - Date / Overall Rating	**Not assessed**

Provider Name	**Hales Group Limited**	
Service Name	**Aspen Gardens**	
Category of Care	**Housing with Care (Extra Care)**	
Address	George Stephenson Boulevard, Hardwick, Darlington Lane, Stockton-on-Tees TS19 8BG	
Ward	**Bishopsgarth & Elm Tree**	
	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	**Requires Improvement**	**n/a**
Quality of Management	**Good**	**n/a**
Date of Inspection	**9th & 10th March 2026**	
Date Assessment Published	**24th March 2026**	
Date Previous Assessment Published	**n/a**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Residents' care plans contained person-centred information detailing their preferences, abilities and, where consent was given, a photograph on their online care profile. Observations and discussions with residents and relatives confirmed that staff treated individuals with kindness and respect, were familiar with personal preferences and routines, and consistently upheld privacy and dignity. Overall, residents appeared well-supported, and their wellbeing was well-maintained.

Care plans were detailed and comprehensive, covering all relevant risk assessments, along with actions and risk-reduction measures. Care plans were reviewed annually, or when a change in need occurred, though the Local Authority contract required this to be three-monthly, and this had been identified for improvement action. Care tasks were accurately recorded using system presets, supported by personalised notes reflecting the care delivered and the individual's presentation.

Monthly audits of medication, visit notes and digital tasks were completed, with appropriate follow-up actions taken. Personal records were generally accurate and securely stored; however, there were issues raised with staff access to service-users' bank cards and PINs which, whilst signed consent was seen to be in place, breached both SBC contract requirements and internal policy. Staff reported frequent connectivity issues with the online system, leading to delays and inaccuracies in recording, with several devices also noted as faulty. A review of the system's reliability and equipment was recommended to ensure accurate reporting and reduce staff frustration.

People living at Aspen Gardens reported feeling safe and well-supported. Staff demonstrated good awareness of safeguarding, recognising signs of potential abuse, and following appropriate reporting processes. Medication was managed safely, with secure storage, accurate Electronic Medication Administration (EMAR) records, and regular audits supported by a current

medication policy. The premises were found to be safe, with effective security measures, clear fire safety responsibilities, and relevant health and safety documentation in place. Environmental risks within individual flats were assessed through the 'My Environment Risk Assessment Management Plan', covering lone-working, hazards, and emergency shut-off points.

Recruitment documentation was managed centrally and accessed by the manager via an online portal. Several gaps were identified in records, and the system did not clearly evidence that appropriate Disclosure & Barring Service (DBS) levels (enhanced with barred list) were completed. References were present for a recently recruited staff member, but did not meet safer recruitment standards. Additionally, there was no record of reference follow-up phone verification, which had been highlighted as good practice. The induction process was well structured, and staff were found to have completed the Care Certificate (in line with contractual obligations).

Supervisions and appraisals were mostly in line with company policy, though not compliant with the SBC requirement for bi-monthly supervision. While mandatory training was largely up-to-date, staff reported that medication, moving and handling, and EMAR training were insufficient, with limited access to equipment for practical competency assessment. Plans were in place to deliver further practical training, and support was being arranged for staff with overdue modules.

As with its sister service in Borough (Parkside Court), it had been recommended that systems managed centrally were reviewed to ensure they were functional and that the manager was able to be assured that appropriate processes were being followed and information shared.

Plans and Actions to Address Concerns and Improve Quality and Compliance
A formal Action Plan will be created and progress monitored and signed off by the Quality Assurance & Compliance (QuAC) Officer.
Level of Quality Assurance & Contract Compliance Monitoring
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
Both the provider and manager engage well with the Local Authority.
Engagement and Support from Transformation Managers
The long-standing manager at Aspen Gardens maintains an excellent working relationship with the Transformation Team. The service engages consistently in Provider Forums and the Housing with Care Operational Group, working closely with partners across housing, care, quality assurance, and strategy. Aspen Gardens regularly accesses training opportunities provided by the Transformation Team and proactively identifies areas for improvement. Recently, the manager escalated concerns around hospital discharge processes, working jointly with the team and the hospital's Integrated Discharge Lead to resolve issues. We look forward to ongoing collaboration with the manager and wider team in the months ahead.

Current CQC Assessment - Date / Overall Rating	**Not assessed**

Provider Name	**Allison House Thornaby Limited**	
Service Name	**Allison House**	
Category of Care	**Dementia Residential / Nursing**	
Address	Fudan Way, Thornaby, Stockton-on-Tees TS17 6EN	
Ward	**Mandale & Victoria**	
	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**	**Requires Improvement**
Quality of Management	**Good**	**Good**
Date of Inspection	**5th February 2026**	
Date Assessment Published	**31st March 2026**	
Date Previous Assessment Published	**19th March 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The home used an electronic care-planning system. Care plans were seen to be person-centred and detailed the ways in which individuals wished to be supported, as well as their likes / dislikes and information about their life history. All residents also had both an initial assessment and a current assessment, along with a range of relevant care plans and assessments. Information was consistent across all documentation, and was clearly person-centred and tailored to each individual resident.

Residents at Allison House were living with dementia and, as such, the involvement of family members and friends was essential to the care planning process. The manager completed a thorough pre-admission assessment, which formed the basis of the initial care plan. Family members spoken with confirmed that they were actively involved in developing these initial plans and continued to participate in discussions regarding ongoing care needs. The atmosphere was seen to be appropriate for residents living with dementia, with orientation points throughout the unit, appropriate signage, and coloured fittings in bathrooms. The home had completed their Dementia Friends accreditation.

There were two Activity Co-ordinators who organised weekly programmes based on their knowledge of each resident and through ongoing conversations with families and friends. An activity board was displayed with pictorial prompts to support understanding. Visitors spoken with confirmed that regular activities were offered and that residents were encouraged to take part, while their individual preferences were respected. Activities observed during the assessment aligned with the published schedule, and visitors were seen to be included in the sessions.

Risk assessments were in place and reflected the individual needs and presentations of the residents, with this information appropriately incorporated into their care plans. However, there were occasions where fluid requirements were not met and no escalation was noted. Personal Emergency Evacuation Plans (PEEPs) were up-to-date and accurately outlined each individual's

needs. The care plan system automatically generated a hospital passport using the information held, ensuring it was readily available when required.

Medication rounds were completed to a high standard. During observation, the staff member demonstrated a warm and personable approach with residents, maintaining a relaxed and positive rapport. They informed individuals about their medications, accurately checked each item against the Medication Administration Record (MAR), and upheld good hand hygiene practices. The staff member also showed strong awareness of each resident's individual medication needs and preferred methods of taking their medications. Staff responsible for administering medications confirmed that they held the appropriate qualifications and were able to confidently describe current medication procedures. They were aware that they received regular competency assessments and felt that refresher training and ongoing support were sufficient. Nurses demonstrated clear understanding of correct practices for both covert and PRN (when required) medications, while care staff were able to accurately explain the proper application of topical treatments.

The manager had implemented a new dependency assessment tool to determine the appropriate staffing levels of registered nurses and care assistants. This assessment was completed monthly, as well as following the admission of a new resident, or when the needs of an existing resident changed. Staffing numbers on each day of the assessment were as shown on the dependency tool and rota. Staff reported that any unexpected absences were typically covered by off-duty team members, and agency staff were also used when required to ensure that minimum staffing levels were maintained.

A relatives survey was completed in October 2025, and the results were presented in a bar-chart format. No staff survey had been undertaken since December 2024. Feedback from surveys, along with lessons learned from complaints and safeguarding alerts, should be translated into clear actions and communicated effectively to staff.

The manager conducted a series of scheduled audits which were found to be thorough and effective in identifying any issues. All service information and safety checks were stored in a central file, which also included a summary sheet detailing certificate renewal dates. The manager reviewed compliance as part of her Health and Safety audits. All required certificates were available and in date. The last Food Standard Agency visit was 19 February 2025 and the home retained its five-star rating.

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 & Compliance (QuAC) Officer.

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, is responsive to requests, and submits performance information in a timely manner.

Engagement and Support from Transformation Managers		
Allison House engages in a number of opportunities, including networking, training and activities, and the manager participated in the first cohort of the Well-Led Programme. The manager, staff and residents are part of community events alongside other care homes and take part in initiatives that support people living in their care. The Transformation Team will continue to discuss further opportunities for the care home.		
Current CQC Assessment - Date / Overall Rating	**30/07/2022**	**Good**

Provider Name	**T.L. Care Limited**	
Service Name	**Ingleby Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	Lamb Lane, Ingleby Barwick, Stockton-on-Tees TS17 0QP	
Ward	**Ingleby Barwick South**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Requires Improvement**
Involvement & Information	**Good**	**Requires Improvement**
Personalised Care / Support	**Good**	**Requires Improvement**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Requires Improvement**
Quality of Management	**Good**	**Requires Improvement**
Date of Inspection	**25th February 2026**	
Date Assessment Published	**31st March 2026**	
Date Previous Assessment Published	**17th March 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The home used an electronic care planning system, and management developed the initial plans based on information gathered during a thorough pre-admission assessment. The care plans reviewed included detailed front pages outlining a summary of needs, associated risks, medical history, key contacts, and information relating to power of attorney and Do Not Attempt Resuscitation (DNAR) decisions. The plans were comprehensive and demonstrated a stronger focus on person-centred care. Work to complete life histories for each resident was ongoing. Care plans could provide more information about how to promote independence and maintain existing skills for the individual. There was no evidence within the care plans to support that the resident had been involved in setting goals.

Residents spoken with confirm that they felt their views, choices and preferences were listened to and reflected in service delivery. Feedback on the service was solicited day-to-day by staff and management, and through meetings and the completion of questionnaires. Findings and actions were displayed on a 'You said, we did' board.

The activities board displayed a 'monthly dates' for your diary produced by Hill Care and a weekly planner for the home. The programme of activities included group activities and one-to-one interaction for those residents who preferred this. At the time of the assessment, the Activities Co-ordinator was off, but staff were observed carrying out activities.

Lasting Power of Attorney (LPA) for finance and / or health and welfare was recorded correctly and DNAR were in date, signed by the GP and evidenced resident and family involvement. Some mental capacity assessments were included within the care plan, but these needed to be in place for more areas of care delivery, and least restrictive options should be evidenced.

Appropriate assessments were in place to support residents' health and wellbeing. The outcomes of these assessments were consistently reflected within the care plans. Food and fluid records were completed within the electronic care planning system; however, more detail

around portion size should be consistently recorded. Malnutrition Universal Screening Tool (MUST) scores were completed and regular weights taken and recorded.

Residents confirmed that they were provided with information in relation to food choices, they were informed of options available, and menus were on display in the dining rooms. During mealtimes, staff were observed encouraging residents to be independent with eating and drinking, encouraging them to use cutlery and cups independently, whilst staying close by to assist them where required. Portions of varying sizes were plated up to reflect the choice of the individual residents, and a second portion was observed to be offered. The last Food Standard Agency visit was 10 December 2025 and the home retained its five-star rating.

The observed medication rounds were conducted to a good standard. The trolley was cleaned prior to use, and good hand hygiene practices were consistently followed. The staff member communicated clearly throughout the process, obtained consent from residents before administering medication, and demonstrated respectful and engaging interactions. The staff member also showed strong awareness of each resident's individual medication needs and preferred methods of taking their medications. The medication room was observed to be clean, well-organised, and securely locked during routine walkarounds, except when actively in use. Completion of both fridge and room temperature records was inconsistent, and therefore assurance of safe storage could not be fully evidenced. All examined medicines had clear and legible labels; however, the date of opening was not always recorded. Medicines requiring refrigeration were stored appropriately.

Residents and family members spoken with were confident that they could, and would, raise any concerns, and that they would be supported through the process. None of the residents could remember having cause to make a complaint. During the assessment, the manager was seen to adopt an open-door policy, and was observed to walk around the floors chatting to residents and visitors. The manager was able to demonstrate that complaints were handled effectively, within the organisation's required timescales, and that complainants were kept updated on progress. The complaints file contained copies of all correspondence and full details of any investigations undertaken. Records also showed that service improvements were implemented as a result of investigation findings. However, there was currently no formal process for sharing lessons learned with staff.

The atmosphere was seen to be appropriate for those residents living with dementia, with orientation points throughout the unit. Previously, the home was working closely with the Community Link Worker from the LiveWell Dementia Hub, and the current manager planned to recommence this work.

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 & Compliance (QuAC) Officer.

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, is responsive to requests, and submits performance information in a timely manner.

Engagement and Support from Transformation Managers		
The manager communicates and responds with the Transformation Team and attends the Provider Forums and other meetings where capacity allows. The home is also interested in pursuing the research projects and opportunities. The activities team are also starting to re-engage with events and community activities.		
Current CQC Assessment - Date / Overall Rating	**07/08/2025**	**Requires Improvement**

Agenda Item 7

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

23 JUNE 2026

PAMMS Annual Report 2025-2026

Summary

The Committee will be presented with the latest PAMMS Annual Report covering the 2025-2026 period.

Detail

1. Stockton-on-Tees Borough Council (SBC) is utilising the Provider Assessment and Market Management Solutions (PAMMS) in its 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 assessment is a requirement of the Framework Agreement (the Contract) with providers, and they are contractually obliged to engage with the process.

2. In 2022, the first PAMMS Annual Report was presented to the Committee covering the 2021-2022 period. The 2025-2026 version will therefore be the fifth edition of this document.

3. In preparation for this agenda item, Members may wish to refresh themselves with the previous (2024-2025) report which was presented to the Committee in June 2025, as well as the subsequent discussion points – this can be found at the following link: https://moderngov.stockton.gov.uk/mgAi.aspx?ID=4830.

4. The SBC Quality Assurance and Compliance (QuAC) Manager is scheduled to be in attendance to present the report which is included within the papers for this meeting (see attached).

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PAMMS Assessment Annual Report 2025 - 2026

Introduction

SBC are utilising the Provider Assessment and Market Management Solutions (PAMMS) in our 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 us assess the quality of care delivered by providers. The assessment is a requirement of the Framework Agreement (the Contract) with providers, and they are contractually obliged to engage with the process.

The PAMMS Assessment

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 domains are:

- Assessment, Care Planning & Review.
- Service User Experience.
- Staff Knowledge & Understanding.
- Staff Training & Recruitment.
- Environment, Equipment & General Safety; and
- Leadership, Quality Assurance & Management.

Having a clear set of quality standards within PAMMs provides a framework and baseline for assuring the quality of CQC regulated adult services in Stockton–on–Tees. The system ensures that the degree of oversight, monitoring and support is applied in a consistent way across all providers and is a key component utilised in our Quality Assurance Strategy for CQC Regulated Adult Services.

Priorities for 2025 - 26 were focussed on homes that have a place on the Older Persons Residential Framework Agreement 2024 -2029, due to our contractual commitment to this Framework Agreement. Assessments were planned around priority of support / level of risk, taking into account factors including, date and rating of last CQC / PAMMS assessment, outcomes from most recent CQC / PAMMS assessment report, other intelligence and data that increases the risk of service quality deterioration and the number of PAMMS assessments that can be completed within current team resources.

The summary tables below details the PAMMS assessments undertaken by the Quality Assurance and Compliance (QuAC) Team throughout 2025 - 26. They are listed in alphabetical order and covers contracted Nursing, Residential, LD and Mental Health (MH) Care Homes.

We also conducted PAMMS assessments on our newly contracted providers delivering Care at Home and Housing with Care services that are new providers within the borough, and that we had not previously assessed before. Their ratings are detailed in the tables below.

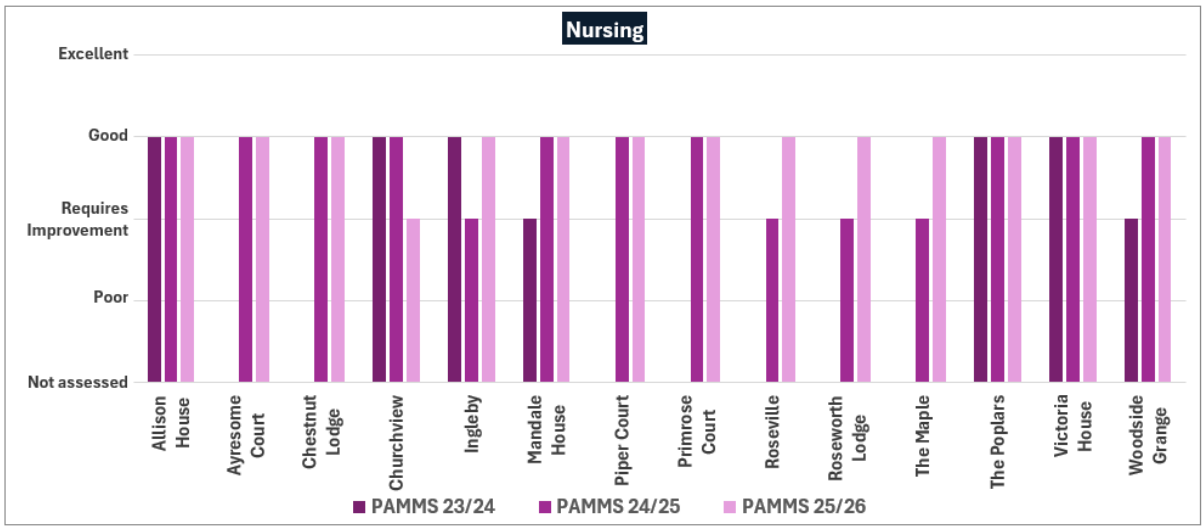
For comparison and trend analysis, the PAMMS Assessment ratings for 2023 - 24 and 2024 - 25 are included also.

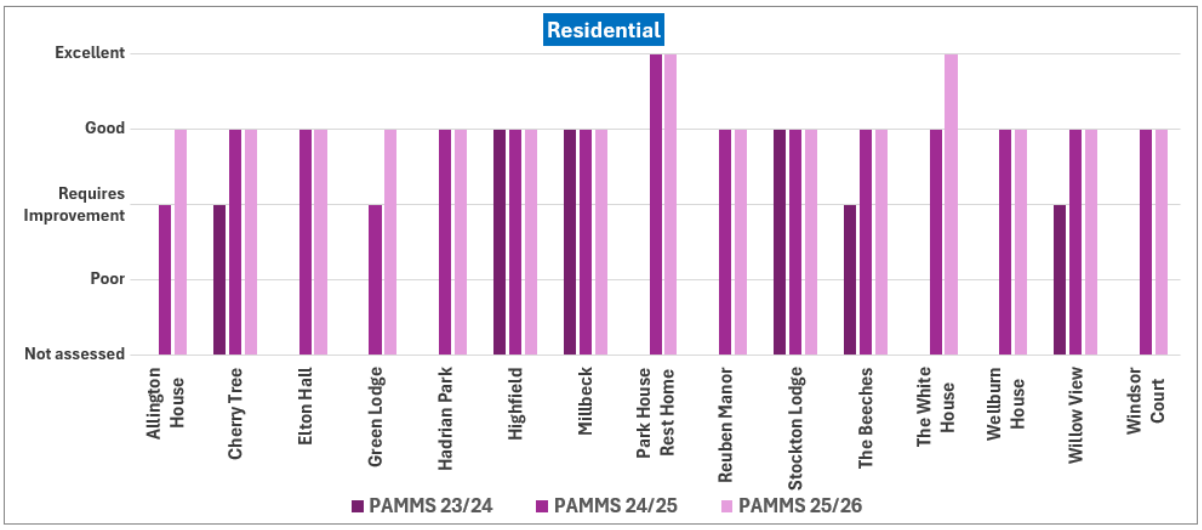
PAMMS Assessment Summary for Contracted Care Homes

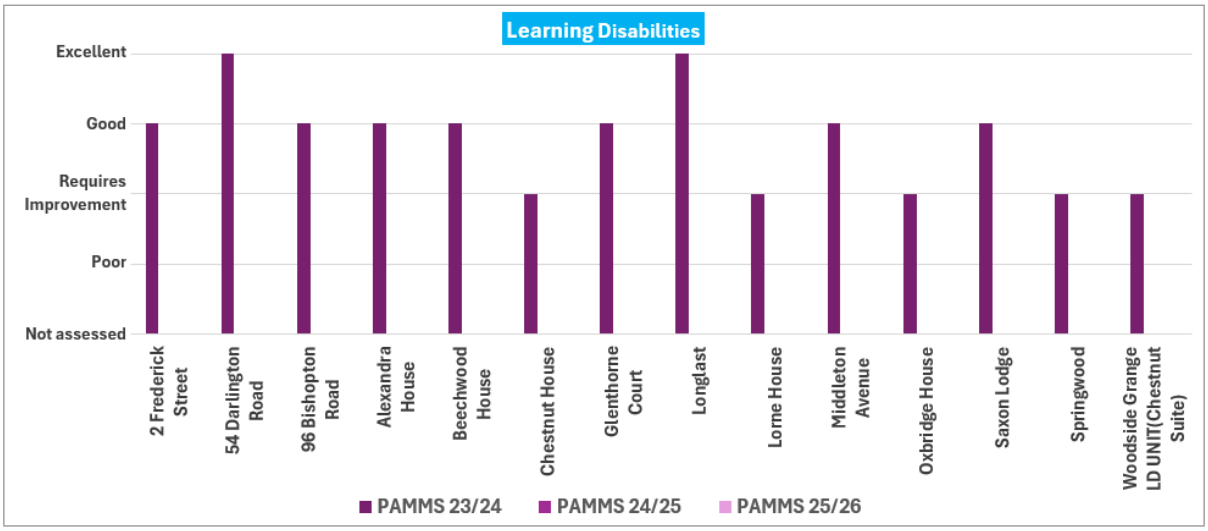
Care Home		PAMMS 25/26		PAMMS 24/25		PAMMS 23/24	
	Service	PAMMS Rating 25/26	Date Assessment Completed 25/26	PAMMS Rating 24/25	Date Assessment Completed 24/25	PAMMS Rating 23/24	Date Assessment Completed 23/24
Nursing	Allison House	Good	Mar-26	Good	Mar-25	Good	Mar-24
	Ayresome Court	Good	Jul-25	Good	Jun-24	Not Assessed	
	Chestnut Lodge	Good	Nov-25	Good	Nov-24	Not Assessed	
	Churchview	Requires Improvement	Sep-25	Good	Jan-25	Good	Feb-24
	Ingleby	Good	Mar-26	Requires Improvement	Mar-25	Good	Jan-24
	Mandale House	Good	Dec-25	Good	Feb-25	Requires Improvement	Feb-24
	Piper Court	Good	Aug-25	Good	Oct-24	Not Assessed	
	Primrose Court	Good	Sep-25	Good	Oct-24	Not Assessed	
	Roseville	Good	Feb-26	Requires Improvement	Feb-25	Not Assessed	
	Roseworth Lodge	Good	Jul-25	Requires Improvement	Aug-24	Not Assessed	
	The Maple	Good	Dec-25	Requires Improvement	Sep-24	Not Assessed	
	The Poplars	Good	Dec-25	Good	Jan-25	Good	Nov-23
	Victoria House	Good	Jan-26	Good	Oct-24	Good	Feb-24
	Woodside Grange	Good	Jan-26	Good	Mar-25	Requires Improvement	Mar-24
Residential	Allington House	Good	Oct-25	Requires Improvement	Feb-25	Not Assessed	
	Cherry Tree	Good	Feb-26	Good	Feb-25	Requires Improvement	Mar-24
	Elton Hall	Good	Dec-25	Good	Mar-25	Not Assessed	
	Green Lodge	Good	Oct-25	Requires Improvement	Aug-24	Not Assessed	
	Hadrian Park	Good	Dec-25	Good	Jan-25	Not Assessed	
	Highfield	Good	Aug-25	Good	Jan-25	Good	Feb-24
	Millbeck	Good	Jul-25	Good	Sep-24	Good	Oct-23
	Park House Rest Home	Excellent	Jun-25	Excellent	Oct-24	Not Assessed	

	Reuben Manor	Good	Aug-25	Good	Aug-24	Not Assessed	
	Stockton Lodge	Good	Oct-25	Good	Jan-25	Good	Dec-23
	The Beeches	Good	Nov-25	Good	Jan-25	Requires Improvement	Dec-23
	The White House	Excellent	Nov-25	Good	Aug-24	Not Assessed	
	Wellburn House	Good	Jan-26	Good	Feb-25	Not Assessed	
	Willow View	Good	Feb-26	Good	Mar-25	Requires Improvement	Apr-24
	Windsor Court	Good	Jul-25	Good	Aug-24	Not Assessed	
Learning Disabilities	2 Frederick Street	Not Assessed		Not Assessed		Good	Mar-24
	54 Darlington Road	Not Assessed		Not Assessed		Excellent	May-24
	96 Bishopton Road	Not Assessed		Not Assessed		Good	Mar-24
	Alexandra House	Not Assessed		Not Assessed		Good	Aug-23
	Beechwood House	Not Assessed		Not Assessed		Good	Nov-23
	Chestnut House	Not Assessed		Not Assessed		Requires Improvement	Dec-23
	Glenthorne Court	Not Assessed		Not Assessed		Good	Nov-23
	Longlast	Not Assessed		Not Assessed		Excellent	Mar-24
	Lorne House	Not Assessed		Not Assessed		Requires Improvement	Apr-24
	Middleton Avenue	Not Assessed		Not Assessed		Good	Oct-23
	Oxbridge House	Not Assessed		Not Assessed		Requires Improvement	Nov-23
	Saxon Lodge	Not Assessed		Not Assessed		Good	Dec-23
	Springwood	Not Assessed		Not Assessed		Requires Improvement	Feb-24
	Woodside Grange LD UNIT (Chestnut Suite)	Not Assessed		Not Assessed		Requires Improvement	Aug-23
Mental Health	The Edwardian	Not Assessed		Not Assessed		Not Assessed	
	The Hollies	Not Assessed		Not Assessed		Not Assessed	

The graphs below detail the ratings progression 2023 – March 26 categorised by the category of care home (e.g. Nursing, Residential, LD and MH).

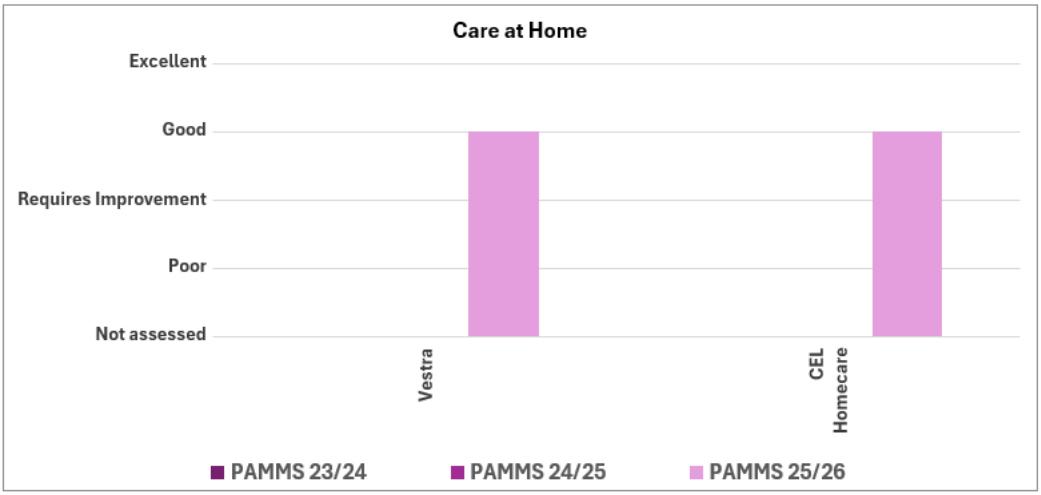






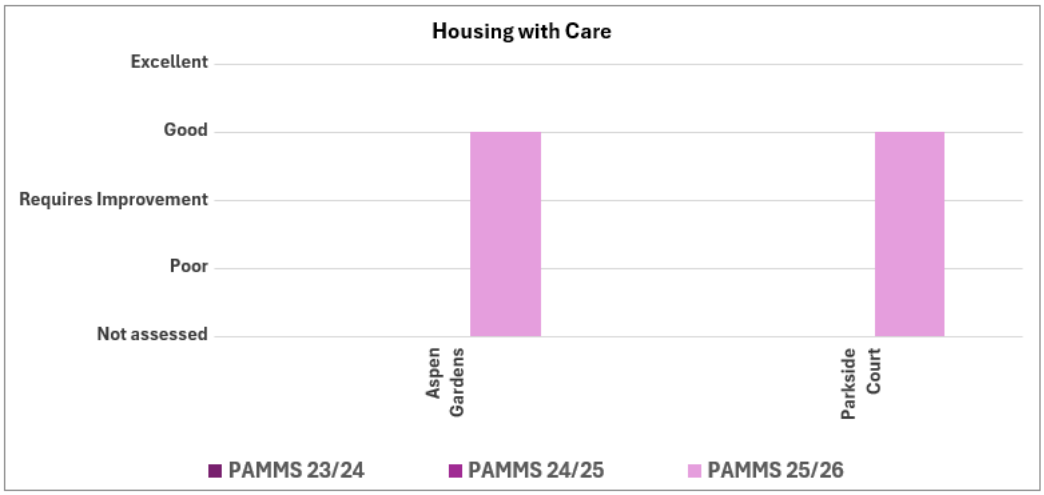
PAMMS Assessment Summary for Contracted Care at Home

Care at Home	PAMMS 25/26		PAMMS 24/25		PAMMS 23/24	
Service	PAMMS Rating 25/26	Date Assessment Completed 25/26	PAMMS Rating 24/25	Date Assessment Completed 24/25	PAMMS Rating 23/24	Date Assessment Completed 23/24
Vestra	Good	Mar-26	Not Assessed		Not Applicable	
CEL Homecare	Good	Feb-26	Not Assessed		Not Applicable	



PAMMS Assessment Summary for Contracted Housing with Care

Housing with Care	PAMMS 25/26		PAMMS 24/25		PAMMS 23/24	
Service (Hales Group)	PAMMS Rating 25/26	Date Assessment Completed 25/26	PAMMS Rating 24/25	Date Assessment Completed 24/25	PAMMS Rating 23/24	Date Assessment Completed 23/24
Aspen Gardens	Good	Mar-26	Not Assessed		Not Applicable	
Parkside Court	Good	Mar-26	Not Assessed		Not Applicable	



Key themes from assessments that scored an ‘Excellent’ or ‘Good’ rating.

- Care plans emphasised the individual’s strengths, abilities, and interests, supporting a person-centred approach that promoted meaningful involvement with family, friends, the community, and preferred activities. They clearly reflected the wishes of the service user, including their goals and aspirations, along with the support they expected from staff to help achieve them.
- Care plans were comprehensive, clearly organised, and easy to follow. They incorporated tailored details reflecting each individual’s preferences, daily routines, specific needs, and key social contacts.
- A strong Key Worker system was in operation. Each service user’s allocated Key Worker was identified within their care plan and displayed in their bedroom. Key Workers were actively involved in monthly care plan reviews, and service users were aware of their Key Worker and understood how the system worked.
- Medication was handled safely and appropriately. Staff demonstrated a respectful, calm, and considerate approach, always obtaining consent prior to administering medication.
- The registered manager conducted thorough and consistent monthly audits across all aspects of the service. These audits were used to critically assess performance and highlight areas for improvement. Where required, detailed action plans were produced, outlining clear steps and timescales for completion. In addition, the provider carried out regular monthly reviews to ensure effective governance systems were maintained.
- Robust recruitment procedures were in place, ensuring that all staff members were recruited safely and in line with required standards, including agency staff where deployed.
- Staff consistently supported choice and independence, encouraging residents to make decisions about their everyday lives.
- Residents expressed satisfaction with the quality of meals provided and confirmed they were given a choice of food options each day.
- Positive feedback was received from both residents and their families regarding the standard of care and support delivered.
- Positive service user feedback in Care at Home and Housing with Care settings including service users feel safe in their homes, high satisfaction with care provided and a clear understanding of how to raise concerns or complaints.
- The service provided a varied and engaging programme of activities, designed to meet both individual preferences and group interests, promoting social interaction and overall wellbeing.

Key Themes from assessments that scored a ‘Requires Improvement’ rating.

- Life history sections (“Who I Am” and “About Me”) within the care planning system were often incomplete or lacked sufficient detail.
- Previous improvements to care planning had not been sustained over time.
- Assessments contained inconsistent and conflicting information, with key details (e.g. medical diagnoses) not always accurately transferred into care plans.
- Care plan reviews were not always meaningful, with evidence of content being copied and pasted rather than properly reviewed or updated to reflect changes in need and Important information identified during reviews was not consistently incorporated into care plans.
- The key worker system was not being used effectively, with residents and relatives often unaware of their allocated key worker.

- Minor gaps were identified in medication records, including occasional missing second signatures for controlled drugs.
- While audit systems were in place, there is an opportunity to strengthen managerial oversight to ensure actions and improvements are consistently embedded and sustained.

Two areas that have consistently shown a direct correlation with a 'Requires Improvement' (RI) rating in previous years are Quality of Management and Management of Medicines. These domains have shown real improvements in quality and service delivery throughout 25/26 as can be seen in the PAMMS outcome ratings above. However, these still remain the primary areas of concern and risk for homes, and we constantly monitor and review intelligence accordingly to ensure risks are mitigated through targeted support for providers.

Coordinated approach with North England Commissioning Support (NECS) Medicines Optimisation Team

Due to internal reorganisations of NHS England, the local Integrated Care Board (ICB) and NECS, coordinated working has continued for 25 – 26, but for 26 - 27 operational service delivery has had to evolve. NECS continue to undertake medicines audits within our care homes, but combined team visits were not possible due to their own internal priorities and operational commitments. We continue to receive their audit outcomes and utilise this intelligence for risk management and response planning.

NECS Meds Optimisation Team should have further details on their future plans in the new year, and we will review our strategy once there is confirmation.

Summary & Next steps

During 2025–26, there were clear improvements in PAMMS ratings across a number of services when compared to 2024–25, demonstrating a positive trajectory in quality and compliance. Several providers improved from 'Requires Improvement' to 'Good,' including services such as Ingleby, Roseville, Roseworth Lodge, The Maple, Allington House and Green Lodge, indicating that previously identified issues had been effectively addressed. Additionally, some services built on already strong performance to achieve 'Excellent' ratings, such as The White House, reflecting sustained high-quality care and well-embedded governance practices.
Overall, the proportion of services rated 'Good' or above increased, with fewer services remaining at 'Requires Improvement,' evidencing the impact of targeted support, strengthened management oversight, and a continued focus on key risk areas such as medication management and quality assurance.

Following on from a provider PAMMS Assessment, an action plan is developed highlighting those areas identified that need an improvement in quality/compliance to ensure they are being delivered to a 'Good' standard. The action plans are monitored regularly by the responsible QuAC Officer for progress and will be only signed off as compliant and complete when all identified areas demonstrate and evidence the required level of quality and service delivery.

PAMMS Assessments are shared with CQC and ICB to help inform their own intelligence gathering.

The key themes from the PAMMS assessments are shared with the Council's Transformation Managers so they can use the evidence to design projects and further interventions to support providers and improve quality of care.

During 2025 - 26 the Transformation Team:

- Care Home Engagement: Continued to undertake one-to-one visits to care homes to discuss opportunities and future plans for participation in initiatives and wider projects. This has resulted in increased engagement overall with the Transformation Team.
- Dementia Friendly Environment Accreditation: The roll-out of the Stockton-on-Tees Dementia Friendly Care Homes Guide continued in 2025/26, supporting homes to enable residents to live well with dementia. A further 11 homes have completed the process, bringing the total to 27 accredited homes, with 6 more currently progressing.
- Medicines Optimisation Training: Three Medicines Optimisation training sessions have been delivered over the past 12 months, with a further session planned. Over 70 care home staff have completed the training to date, with an additional 25 scheduled to complete in July 2026.
- Activity and Wellbeing Development: Funding and facilitation of the Level 2 Diploma in Wellbeing in Activity has continued, with over 20 learners completing the programme. The Transformation Team also continues to facilitate an Activity Coordinators Network three times per year, with average attendance of 25 coordinators.
- ASC Workforce Pathway: The ASC pathway developed with Stockton Riverside College continues to be delivered and reviewed in partnership with the sector. Care home providers are increasingly engaging as ambassadors, supporting students by sharing their knowledge and experience.
- Well Led Programme: A newly developed Well Led programme, facilitated by the Learning and Skills team, commenced a pilot in 2026 with a cohort of 10 new managers. Following evaluation, the programme will be refined and rolled out to a further 60 delegates across 2026/27.
- Veteran Friendly Framework (VFF): Care homes are working alongside the Transformation Team and Council colleagues to increase participation in achieving VFF status.
- Research in Care Homes: Research activity within care homes is strengthening, with over 10 homes actively participating in or preparing for projects, including VR technology in care homes and a saliva monitoring study for early detection of delirium.
- Care Academy Programme: Bi-monthly Care Academy programmes continue to support the recruitment pipeline into the care sector, providing a consistent flow of work-ready candidates for both care home and domiciliary care providers.
- Targeted Recruitment Activity: Bespoke recruitment events for individual providers have been delivered, including dedicated events with strong attendance, enabling direct engagement with potential candidates.
- Quarterly Recruitment Events: Recruitment events are now established as a quarterly offer, bringing together multiple providers across both care home and care at home settings to promote opportunities and attract new entrants into the sector.
- Partnership Working: Ongoing partnership work with national and regional organisations, including Skills for Care and DHSC programmes, continues to support development of the future workforce.
- Developing Future Workforce: Engagement with Stockton Riverside College supports student placements across a wide range of providers, with 14 care homes and services offering placements, helping to build a sustainable workforce pipeline.

- Market-Wide Engagement: Recruitment and workforce initiatives have seen strong participation from a broad range of care home and care at home providers, ensuring activity supports the wider provider market.

The PAMMS ratings are provided to social workers who can share with families searching for a care home so they can access up to date information about our view of quality.

The PAMMS summary briefing reports are also available on the Stockton Information Directory (SID) linked from the Older Persons Care Home Ranked List for families and potential residents to access.

A new PAMMS assessment programme is currently being delivered for 2026 - 27.

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Agenda Item 8

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

23 JUNE 2026

Norton Medical Centre: Response to latest CQC inspection

Summary

Following a recent Committee request, representatives of Norton Medical Centre will be in attendance to provide a response to the latest Care Quality Commission (CQC) inspection of its services (published in March 2026).

Detail

1. On 6 March 2025, the CQC published its findings following a mid-2024 inspection of Norton Medical Centre. The CQCs overall rating of the practice was downgraded to 'requires improvement' (from its previous 'good' rating given in early-2023), with the 'responsive' domain being deemed 'inadequate'.

2. Prior to the publication of these findings, the CQC served a Notice of Decision on Norton Medical Centre on 15 October 2024 for Failure to Comply with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Norton Medical Centre failed to provide assurance there was a safe system in place to triage service users safely.

   The CQC also served a warning notice on Norton Medical Centre on 8 November 2024 for Failure to Comply with Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Norton Medical Centre failed to establish and maintain a safe system of triage for service-users, and lacked oversight of significant event monitoring. Norton Medical Centre had until 10 February 2025 to comply with these regulations.

3. In response to the CQCs publication in March 2025, the Committee invited representatives of the practice to provide its response to the regulator's findings. The presentation given at the Committee meeting in May 2025, and subsequent discussion points, can be found at https://moderngov.stockton.gov.uk/mgAi.aspx?ID=4715.

4. On 6 March 2026, the CQC published its latest view of Norton Medical Centre following an inspection in October 2025. The practice's overall rating remained 'requires improvement', but whilst there the 'effective' and 'responsive' domains had been upgraded, the 'well-led' domain was downgraded to 'inadequate' – see https://www.cqc.org.uk/location/1-552779884/reports/AP13990/overall

	New CQC Rating	Previous CQC Rating
Overall	Requires Improvement	Requires Improvement
Safe	Requires Improvement	Requires Improvement
Effective	Good	Requires Improvement
Caring	Good	Good
Responsive	Requires Improvement	Inadequate
Well-Led	Inadequate	Requires Improvement

Prior to the publication of these findings, the CQC served a warning notice on Norton Medical Centre on 17 November 2025 for failing to meet the regulations relating to safe care and treatment at Norton Medical Centre.

5. Reflecting on these latest outcomes, the Committee agreed that the practice should provide a further response at a forthcoming meeting. Again, Members were particularly keen to understand how the practice would be seeking to address the issues raised by the regulator.

6. GP Partners from Norton Medical Centre, as well as the Interim Practice Manager, are scheduled to be in attendance at this meeting. A presentation has been provided in advance for consideration (see attached).

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SBC Adult Social Care and Health Select Committee

Norton Medical Centre

Dr Fazluddin, Dr Viva, Dr Al-Damlooji – GP Partners
Mrs Brown - Interim Practice Manager

Overview

Key issues identified by CQC

How are NMC addressing these issues?

Questions

Latest inspection

Inspection carried out 2nd October 2025

Clinical – Dr Julie Neary & Dr Laila Fazluddin

Management Team - Mrs Susan Hood (Practice Manager), Mrs Sinead Dowey (Operations Manager)
And Mrs Lauren Young (PA to Practice Manager)

Report published 6th March 2026

- Safe – requires improvement
- Effective – Good
- Caring – Good
- Responsive – requires improvement
- Well-led - Inadequate

Safe

Areas of improvements & strengths

Safeguarding – Good multi-agency working, systems have improved, staff are trained and aware of responsibilities

Clinical Systems & Continuity – Effective systems for referrals/tests/continuity of care, improved care coordination, concern on sustainability due to staffing changes

Environmental & Infection Control – Clean & well-maintained premises, strong infection preventions processes, H&S risks assessed and managed

Patient Safety in Practice – Staff able to recognise deterioration in patients, emergency meds/equipment available & maintained, evidence of reflective debriefing after incidents

Required Focus

Safety Culture & Learning – Non-open culture, incident recording, concerns dismissed, organisational learning

Staffing & Competency – Lack of Qualified/experienced staff, gaps in recruitment, leadership/management support

Medicines Safety – Errors in processes

Incident reporting & Governance – Incident recording, poor communication and poor sharing of learning

Norton Medical Centre

Responsive

Areas of improvements & strengths

Person Centred Care – Patients involved in decisions and care planning, care plan reflective of holistic needs, high satisfaction during appointments (87% felt needs met)

Equity & Inclusion – Strong focus on reducing inequalities and supporting vulnerable groups, use of coding and targeted communication, positive feedback from care homes and vulnerable patient groups

Future Planning – Improvements in end of life care and coordination, more structured palliative care processes and multidisciplinary working

Required Focus

Access to services – Access, consistency of triage/care navigation system

Listening & engagement– Approach to listening, complaints process, PPG support and engagement

Communication & Information – information accessiblity, over-reliance on systems, communication on updates/changes

Care Coordination – Improvement in working with partners (care homes/PCN etc), high 2nd care useage, sustainability of changes uncertain

Norton Medical Centre

Well-Led

Required Focus

Equality, Diversity & Inclusion – Closed/not inclusive culture, inappropriate behaviours, investigation of concerns, adherence to policies

Governance & Risk Management – Governance structures, information sharing, risks, coordination across leadership and teams

Partnership & Stakeholder Working – inconsistent engagement, sharing of key information

Learning & Improvement – Limited culture of continuous improvement, staff contribution/ideas, effective action plans

Leadership & Culture – No shared vision/strategy, staff experience & negative staff feedback

Leadership Capability – Skills, visibility, communication in leadership, lack of staff engagement

Freedom to speak up – Learning from incidents, raising concerns

Norton Medical Centre

Well-Led Action Plan

Leadership & Accountability
- Recruitment,
- “Vision” for NMC,
- Leadership structure and named leads
- Meeting structure
- Risk register
- Staff newsletter
- Communication with patients,
- “You said we did”

Staff Engagement, Wellbeing & Support
- Staff survey
- 1:1’s and appraisal

Patient & Public Involvement
- PPG
- Patient feedback

Responding to concerns
- Complaints process
- Freedom to speak up
- Incidents/SEA’s process

Monitoring & Demonstrating Improvement
- Regular reviews
- Engagement with staff
- Engagement with stakeholders for feedback (CQC, PCN, PPG)

Staff Survey

Focused on 8 areas; Safety & Speaking Up, Leadership & Management, Workload & Pressure, Learning from Mistakes, Behaviour, Respect & Culture, Wellbeing & Support, Confidence in Improvement

Specific questions on; What is working well and one change that would make a big positive difference

74% of staff strongly agree that mistakes are treated as an opportunity to learn

95% of staff strongly agree/agree that they feel safe to speak up if something does not feel right

64% of staff agree leadership communicate clearly with staff

61% of the staff agree that their workload is manageable

65% of staff strongly agree/agree that there is a culture of kindness and professionalism

43% of staff agree that they know there is wellbeing support available to them

48% of staff feel informed of the CQC improvement actions being taken

Norton Medical Centre

Staff Survey

What is working well at the practice at the minute?

“We have a manager (temp) who listens and helps and I feel I can approach”

“Working to improve things and genuinely caring about staff, much better atmosphere”

“The current partners and management team ”

“We have a good foundation of processes and people willing to work together towards improvement ”

“Staff morale feels positive. Staff genuinely care about the work they do.”

“New/Temp PM instilling confidence within the Practice”

“The energy just feels better and we know plans are happening behind the scene because we have been informed”

“Our team, atmosphere in the building is nicer.”

What one change would make the biggest positive difference?

“Think what is being done is making a positive difference. Thankyou”

“Consider hiring locum to help out with admin only whilst recruiting staff”

“We need more appointments and look to get AI support in managing workload”

“Clearly defined roles and acknowledgements of hard work”

“Obviously changes are still in process so time still needed. I feel once PM/senior management structure is in place this will make a big difference”

“The right PM to be appointed, to promote and support a steady ship from top to bottom”

“To have a permanent PM”

“Clearer communication to stop speculation amongst staff”

Norton Medical Centre

Changes

Locums in place to support with capacity and demand

Use of Digital Staff Pool

Review of duty day/admin day for the GP team with the aim to increase capacity

Recruitment in place for GP Partner and practice manager

Staff newsletter re-introduced with the first issue for May

Utilisation of skill/experience the team have and leadership in that area

Use of teamnet to support with incidents/complaints

Revised meeting structure

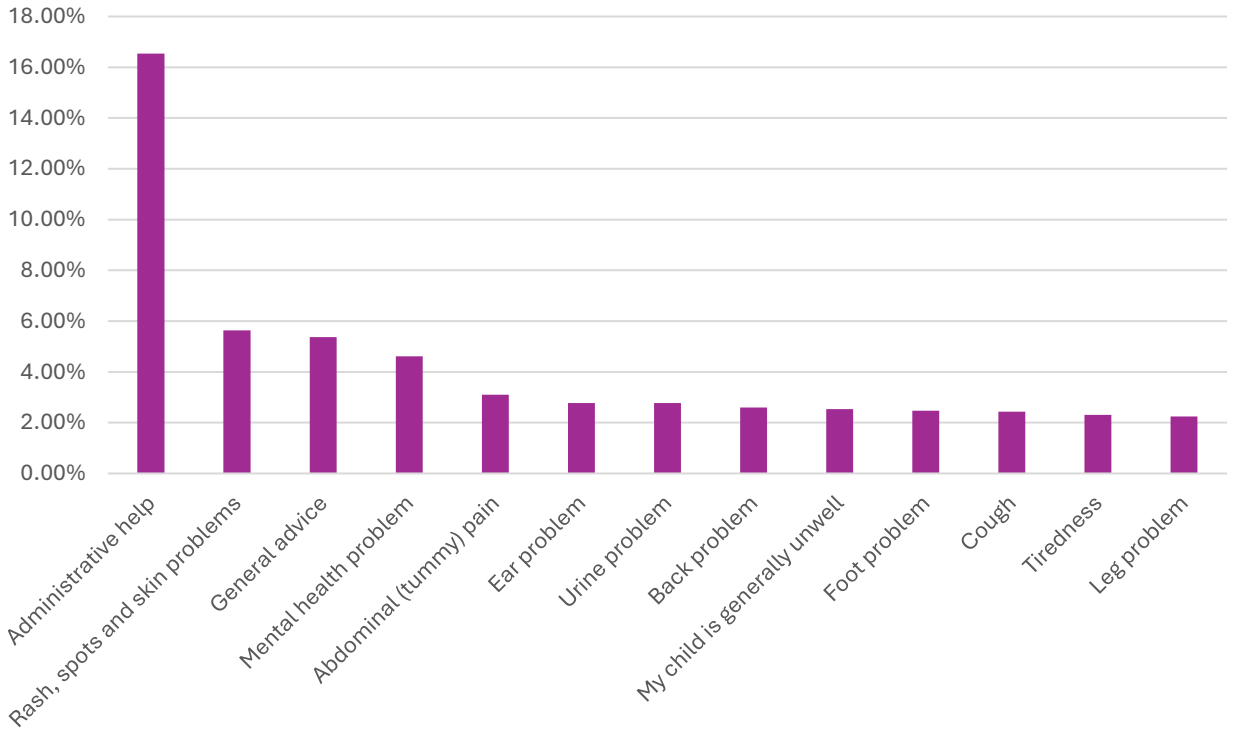
Review of pay structure and feedback to the team

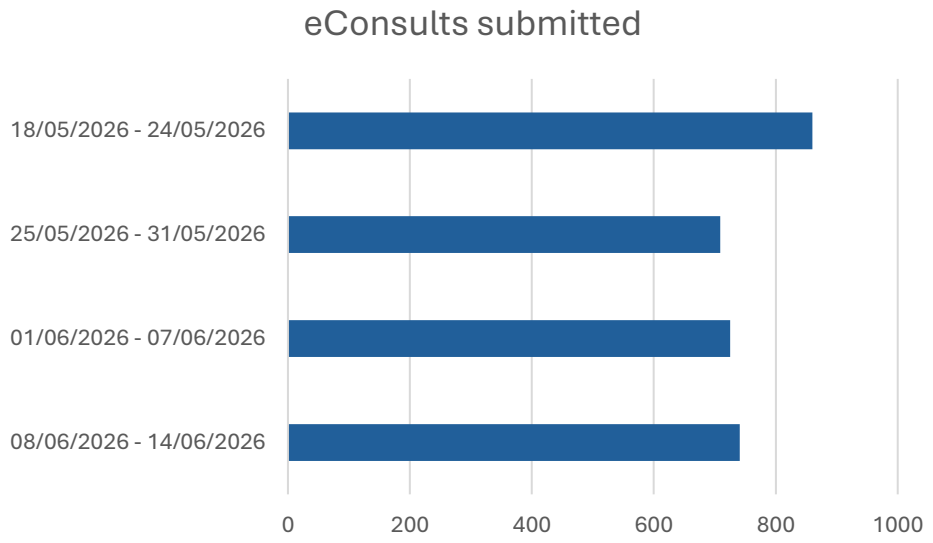
Working with PPG collating survey to go out to patients

Appraisals have started with the clinical team

Support from LMC, H&SH and PCN

Access





18th May – 14th June data

Norton Medical Centre

Questions

Norton Medical Centre

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

23 JUNE 2026

Regional Health Scrutiny Update

Summary

The Committee is requested to consider an update on the work of the regional health scrutiny committees. Some recent health-related developments impacting on the Tees Valley and / or wider North East and North Cumbria footprint are also highlighted.

Detail

Tees Valley Joint Health Scrutiny Committee

1. Middlesbrough Council is hosting this Committee during 2026-2027.

2. The first Committee meeting of the new municipal year took place on 2 June 2026 where agenda items included:

   - Appointment of Chair (Cllr David Jackson) and Vice-Chair (deferred) for 2026-2027
   - Minutes of the meeting held on 12 March 2026 (see **Appendix 1**)
   - NHS England / Northern Neonatal Network: Delivery of Neonatal Care across North East and North Cumbria Region
   - University Hospitals Tees (UHT): Quality Account 2025-2026
   - University Hospitals Tees (UHT): Planned Workforce Reductions
   - Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV): Adult Eating Disorder Services Review

   The next meeting was scheduled for 23 July 2026. Although the agenda was still to be confirmed, a request was made at the June 2026 meeting for an item to be included on access to specialist community perinatal mental health services.

Sustainability and Transformation Plan / Integrated Care System Joint Health Scrutiny Committee

3. Following a lengthy hiatus, Durham County Council (who supported this Joint Committee) contacted scrutiny teams across the region in November 2022 with the intention of arranging a meeting for late-November / early-December 2022. However, following liaison with senior NHS North East and North Cumbria Integrated Care Board (NENC ICB) representatives, it was deemed that in light of the ongoing ICS briefings to the Tees Valley Joint Health Scrutiny Committee, a meeting of this Joint Committee (which involved similar Councillors) was likely to be a duplication and would not add value.

4. In wider regional health matters, the NENC ICB has added a focus on **NHS dentistry** to its home page (see https://www.northeastnorthcumbria.nhs.uk/) – this link includes details on how to find routine dental services, getting urgent dental care, and being 'smile smart' (tips on protecting teeth and gums). Its Oral Health and Dental Strategy 2025-2027, the NENC ICB plan to improve oral health in the North East and North Cumbria, is also accessible.

5. The **'Here to help you'** webpage continues to provide information on choosing the right NHS service for your needs, keeping a well-stocked medicine cabinet, or getting your vaccines. Plus, there is lots of health advice and local support information (see https://northeastnorthcumbria.nhs.uk/here-to-help-you/).

6. A pioneering North East mental health support service for health and care staff was named a regional champion in the NHS Excellence Awards. Funded by the NENC ICB and delivered by Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust, the **North East and North Cumbria Staff Mental Health and Wellbeing Hub** was honoured in the 'Valuing Our People' category in the awards' inaugural year (see https://www.northeastnorthcumbria.nhs.uk/news/north-east-staff-wellbeing-hub-named-regional-champion-in-nhs-excellence-awards/).

7. Ahead of World Asthma Day (5 May), people across the North East and North Cumbria were encouraged to upgrade their old inhalers from 'blue to new' as part of a **major step forward in lung-health care**. The familiar blue reliever treatment, which had been used by millions of asthma patients for over five decades, was being upgraded to an improved anti-inflammatory reliever (combination) inhaler which not only relieved symptoms of asthma but also treated the underlying cause (see https://www.northeastnorthcumbria.nhs.uk/news/from-blue-to-new-patients-offered-upgrade-in-asthma-care/).

8. An article in May 2026 reflected on **improved performance against the NHS four-hour treatment standard** despite Accident and Emergency (A&E) departments across the region facing their busiest month ever in March 2026 (see https://www.northeastnorthcumbria.nhs.uk/news/busiest-month-ever-but-aes-make-steady-improvement/).

9. The NENC ICB is working with the North East Ambulance Service (NEAS), Healthwatch, and other partners to **improve NHS patient transport services** and consider ways to make it fairer, clearer and more consistent. People who use patient transport in the North East, along with carers and family members, are encouraged to take part in a survey and share their experiences and views before any decisions are made. The survey is open until 3 July 2026.

10. The NENC ICB 2025/26 Annual Involvement Report is now available. The report shares **what patients and the public told the NENC ICB about the services it commissions** and the changes it has been making. It also highlights the different ways people have been involved in the NENC ICBs work and the themes they raised.

11. Early-May 2026 marked an **important milestone for the NENC ICB** as it brought its transition programme to a close and started a new chapter as a strategic commissioning organisation. In line with national NHS guidance and the Model ICB Blueprint, the NENC ICB had reduced both running and programme costs while reorganising to support its new role and operating model. The five-year strategic commissioning plan sets out how the NENC ICB will work with partners to plan and commission services for the 3.2 million people it serves, building on its shared ambition of *Better health and wellbeing for all*.

12. More locally, a number of North Tees and Hartlepool NHS Foundation Trust developments have been publicised in recent weeks (see https://www.nth.nhs.uk/news/), including:

- A new perinatal pelvic health service (PPHS) has helped more than 450 women in a little under one year (May 2026) https://www.nth.nhs.uk/news/new-pelvic-health-service-helps-more-than-450-women-in-first-year/
- A Stockton man has been put forward as a finalist for a national award which recognises volunteers in the healthcare sector (May 2026) https://www.nth.nhs.uk/news/hospital-volunteer-shortlisted-for-award/
- Patients with suspected prostate cancer are being seen and diagnosed faster thanks to a new nurse-led biopsy service within the urology service at the University Hospital of North Tees (May 2026) https://www.nth.nhs.uk/news/new-nurse-led-biopsy-service-helping-to-speed-up-prostate-cancer-diagnosis/
- A hospital research team has been selected to be part of a national trial looking into a condition known as broken heart syndrome (May 2026) https://www.nth.nhs.uk/news/hospital-joins-national-trial-to-improve-treatment-for-broken-heart-syndrome/

North East Regional Health Scrutiny Committee

13. No meetings are currently scheduled.

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Thursday, 12 March 2026

TEES VALLEY JOINT HEALTH SCRUTINY COMMITTEE

A meeting of the Tees Valley Joint Health Scrutiny Committee was held on Thursday, 12 March 2026 at the Council Chamber, Civic Centre, Ridley Street, Redcar, Yorkshire, TS10 1TD.

PRESENT Councillors C Cawley, S Crane, J Coulson, L Hall, J Kabuye, M Besford, A Roy, M Layton and D Jackson.

OFFICIALS C Breheny, C Jones, T Gilchrist, L McCrindle, S McKenna, C Morton, Raine, J Todd, G Woods, J Young and G Jones.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors S Moore, N Johnson and Boddy.

38 **DECLARATIONS OF INTEREST**

The following declarations of interest (non-pecuniary) were raised: -

• Item 6 and Item 7 – Councillor J Kabuye is undertaking a PhD in public health focusing on mental health.

It was **RECOMMENDED** that the Committee note these declarations.

39 **APPOINTMENT OF VICE CHAIR 2025/26**

Members were invited to make nominations for the position of Vice-Chair, and the following were received:

Councillor Kabuye was nominated by Councillor Layton, seconded by Councillor Besford.

Councillor Jackson was nominated by Councillor Jackson, seconded by Councillor Coulsen.

RESOLVED that Councillor Kabuye be elected as Vice-Chair of the Tees Valley Joint Health Scrutiny Committee for the remainder of 2025/26.

40 **MINUTES OF THE MEETING HELD ON 11 DECEMBER 2025**

The minutes of the meeting held on 11 December 2025 were considered.

RESOLVED that the minutes be approved as a correct record, subject to

an amendment to include Councillor Besford's apologies.

41 **NORTH EAST AMBULANCE SERVICE (NEAS) NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2025/26**

The Committee received a detailed presentation from representatives of the North East Ambulance Service (NEAS) NHS Foundation Trust, including the Deputy Director of Quality and Safety, outlining performance against the Trust's Quality Account priorities for 2025/26 and emerging priorities for 2026/27.

In introducing the report, it was highlighted that NEAS had experienced a year of significant operational pressure, managing approximately one million calls across the region, whilst maintaining its position as one of the highest performing ambulance Trusts nationally. The Committee was advised that alongside performance, a strong emphasis continued to be placed on quality, safety and learning, particularly in ensuring that improvements were sustainable and patient-focused.

Members heard that the Trust had embedded a mature patient safety culture, evidenced by sustained high levels of incident reporting. Whilst approximately 2.7 per cent of calls resulted in recorded patient safety incidents, the majority were categorised as low or no harm. It was emphasised that this reflected a positive organisational culture, where staff were encouraged to report concerns and near misses, enabling the Trust to learn proactively and prevent more serious incidents from occurring.

The Committee also noted the Trust's strong performance in relation to patient experience, with complaints remaining consistently low at around 0.2 per cent of total activity. In contrast, levels of positive feedback and appreciations significantly exceeded complaints. It was advised that patient satisfaction across most service areas was in excess of 90 per cent, with the exception of the NHS 111 service, which had lower satisfaction levels but was subject to targeted investment and workforce expansion to improve responsiveness.

Particular attention was drawn to the Trust's quality priority relating to cardiac arrest and resuscitation outcomes, which had been a major focus throughout the year. Members were informed that this work had delivered measurable improvements, including an increase in 30-day survival rates and overall patient outcomes. The Trust was noted to already perform strongly in this area nationally, and further gains demonstrated a continued commitment to clinical excellence. Members were advised that although this would not remain a standalone priority in the forthcoming year, it would continue to be monitored closely through clinical audit processes to ensure progress was sustained.

A further key area of focus had been workforce development and staff wellbeing. Members heard that significant improvements had been made in clinical supervision arrangements, career pathways, and staff engagement. It was advised that the introduction of a clinical career framework and enhanced support structures had resulted in improved staff survey outcomes, with employees reporting that they felt more supported, valued, and invested in. The importance of supporting staff following traumatic incidents was also emphasised, alongside ongoing work to reduce stigma associated with mental health and to promote staff wellbeing initiatives.

Members also received an update on the work undertaken to improve communication and inclusivity, particularly for patients with learning disabilities. It was highlighted that NEAS had developed its own bespoke training package tailored specifically to ambulance services, which had received national recognition. This work had contributed to improved patient experience and more effective communication with vulnerable groups, although further work was planned to expand patient involvement mechanisms, including the establishment of a Patient Experience Panel.

During discussion, Members welcomed the positive performance outlined within the report and commended the Trust for its achievements in both clinical outcomes and organisational culture. Specific praise was given to the development of career pathways and the use of patient stories at Board level to inform service improvement. However, Members also raised a number of areas for further consideration. These included:

- The availability and accessibility of complaints mechanisms, particularly for individuals who may not be able to access digital platforms;
- The need to ensure that digital exclusion did not act as a barrier to feedback or service access;
- The importance of benchmarking performance against comparable organisations to provide broader assurance; and
- The continued need to prioritise staff mental health and wellbeing, ensuring that support mechanisms were consistently applied across all operational levels.

In response, Members were assured that multiple routes were available for patients to provide feedback, including through staff on scene, and that work continued to enhance accessibility. It was also acknowledged that benchmarking remained complex due to variations between ambulance services, though national learning networks were being utilised to improve comparative understanding.

In concluding the item, the Chair thanked representatives for a comprehensive and transparent presentation, recognising both the scale of demand faced by the service and the progress made in improving quality and safety.

RESOLVED that:

1. The update on the NEAS Quality Account 2025/26 be noted;
2. Members' comments be taken into account in finalising the Quality Account; and
3. A draft Statement of Assurance be prepared on behalf of the Committee and circulated for approval, with final sign-off delegated to the Chair and Vice-Chair.

42 **TEES ESK AND WEAR VALLEY (TEWV) NHS FOUNDATION TRUST URGENT CARE MENTAL HEALTH CRISIS UPDATE**

The Committee received a detailed update from the Director of Operations and Transformation and the General Manager for Adult Mental Health Urgent Care at Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust on the delivery and performance of crisis mental health services across the Tees Valley.

In introducing the report, the Director outlined the significant transformation that had taken place since the introduction of the 24/7 single point of access via NHS 111 (option 2) in April 2024. This model, supported by a dedicated mental health screening team, had been designed to improve the timeliness and quality of responses to individuals experiencing mental health crises. Members were advised that this approach had represented a deliberate deviation from some national models, enabling a more clinically informed triage process at the earliest point of contact.

Performance data presented to Members demonstrated substantial improvements across key indicators. Members noted that call answer rates had increased significantly since implementation, with the service now achieving rates in excess of 95 per cent, compared to a national average considerably below this level. Abandonment rates were reported to be significantly lower than national figures, where approximately 27 per cent of calls were not answered, demonstrating the relative effectiveness of the local model.

In addition, the Trust reported strong performance in relation to responsiveness, including a high proportion of calls answered within target times and a national ranking of 7th out of 54 providers for call answering performance. Members were advised that, while performance against some internal aspirational targets remained slightly below the desired level, the Trust's position compared favourably against national benchmarks, and continuous improvement was being driven through workforce and service redesign.

Members also noted sustained improvements in triage and assessment

processes, including increased rates of calls being answered by trained mental health professionals within seven minutes. It was advised that where an immediate response could not be achieved, robust callback systems were in place, with assurances provided that all patients received follow-up contact and appropriate clinical oversight.

With regard to clinical outcomes, Members were informed that the Trust was performing strongly against national standards for urgent and very urgent referrals. Data indicated that over 98 per cent of urgent referrals were seen within 24 hours, placing the Trust among the highest performing organisations nationally.

The Director further outlined developments in crisis pathway provision, including the continued success of crisis assessment suites, particularly in Middlesbrough, which had been operational for over a decade. These facilities were reported to manage a significant volume of self-presenting patients, alongside referrals from partner agencies such as the Police. Members noted that partnership working had been recognised through national awards, reflecting the effectiveness of multi-agency collaboration in preventing escalation and supporting patient safety.

The Committee also heard about ongoing work to expand capacity and develop community-based alternatives to hospital admission, including proposals for additional mental health crisis beds and enhanced neighbourhood-based models of care. These developments were framed within broader system changes, including the planned rollout of 24/7 neighbourhood mental health centres, which aim to integrate statutory and voluntary sector provision.

During the ensuing discussion, Members welcomed the clear evidence of improvement in crisis response performance and acknowledged that the update addressed many previously raised concerns regarding NHS 111 mental health provision. However, a number of important issues were highlighted for further consideration.

Members emphasised the need for greater transparency in reporting, particularly in relation to:

- The proportion of patients not receiving an initial response within seven minutes;
- The role and effectiveness of callback arrangements; and
- The inclusion of these measures within routine performance reporting.

In addition, Members raised concerns regarding data gaps and inequalities, specifically noting the absence of data relating to ethnicity and access for minority groups. The importance of understanding differential access and outcomes across diverse communities was

strongly emphasised.

A significant area of discussion related to the role of community and voluntary sector provision, including wellbeing hubs and drop-in services. Members expressed concern that current reporting did not fully capture activity within these services, particularly in Stockton, and therefore did not provide a complete picture of demand across the system. Members requested further information on the scale, impact and outcomes associated with such services, and specifically asked that data relating to walk-in presentations and community engagement be provided to the Committee.

Members also explored issues relating to system capacity and demand, noting the high volume of referrals and the continuing increase in individuals seeking support. Concerns were raised regarding the sustainability of current arrangements and the need to ensure that all individuals entering the system received appropriate and timely care, without being repeatedly redirected between services.

In response, the Director acknowledged the challenges associated with demand and workforce capacity, confirming that ongoing work was being undertaken to align staffing levels with peak demand periods and to develop new models of care. It was also noted that some community-based services were commissioned externally, which had implications for data availability and reporting.

In concluding the item, the Chair thanked TEWV representatives for a comprehensive and informative presentation, noting the significant progress made whilst also recognising the continued complexity of delivering mental health crisis services within a pressured system.

RESOLVED that:

1. The update on urgent care mental health crisis services be noted; and
2. Further information be provided to the Committee on community mental health provision, including walk-in activity, wellbeing hubs and associated demand and outcomes.

43 **TEES ESK AND WEAR VALLEY (TEWV) NHS FOUNDATION TRUST - QUALITY ACCOUNT FOR 2025/26**

The Committee received a comprehensive presentation from representatives of Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust regarding the development of the Trust's Quality Account for 2025/26 and the emerging priorities for 2026/27.

In introducing the report, the statutory requirement for NHS Trusts to

produce an annual Quality Account, setting out performance against key quality domains of patient experience, patient safety and clinical effectiveness, alongside priorities for improvement in the forthcoming year were outlined. Members were advised that the Trust was in the process of finalising its Quality Account, with stakeholder consultation scheduled prior to publication by the end of June 2026.

A central theme of the presentation was the Trust's continued commitment to co-production, with quality priorities developed in partnership with individuals with lived experience, carers and wider stakeholders. Members noted that this approach aimed to ensure that service improvement was grounded in real experiences and reflective of the needs of those accessing services.

The Committee was advised that the Trust's three overarching quality priorities remained as:

1. Improving patient experience through education and the use of lived experience;
2. Enhancing patient safety through a focus on relapse prevention; and
3. Strengthening clinical effectiveness through personalised approaches to urgent care.

In relation to patient experience, Members heard about work to embed lived experience within training, governance and decision-making processes. This included the development of co-creation frameworks, strengthened partnerships with external organisations, and initiatives to improve carer involvement. It was also acknowledged that, whilst significant activity was underway, work to ensure consistent strategic oversight and meaningful engagement of carers remained at an early stage.

The Committee was informed that, in respect of patient safety, the Trust had focused on relapse prevention and the development of personalised safety and wellbeing plans. Progress had been made in embedding new policies and training, supported by the Quality Assurance and Improvement Programme. However, Members were advised that further work was required to ensure consistency in practice, particularly in relation to post-discharge support and meaningful carer involvement.

With regard to clinical effectiveness, the presentation highlighted the implementation of the "My Story Once" approach, designed to reduce the need for patients to repeatedly recount their experiences when accessing different services. This work was supported by improvements in information sharing, digital systems, and workforce training, alongside the development of Trust-wide guidance promoting a "One Person, One Assessment" model of care.

Across all three priority areas, assurance was currently rated as “reasonable”, with clear evidence of progress but recognition that further work was required to demonstrate consistent impact and sustainability.

During discussion, Members welcomed the co-production approach and acknowledged the importance of embedding lived experience in shaping services. Members commended the increased focus on personalisation and improved information sharing, recognising these as critical to enhancing patient experience.

However, Members also raised a number of significant concerns and challenges. These included:

- The increasing demand for children and young people’s mental health services, including rising rates of distress and suicide;
- Long waiting times for neurodevelopmental assessments and CAMHS services, and the impact of delays on families;
- A perceived lack of communication and ongoing support for individuals awaiting assessment or treatment; and
- The need for stronger engagement with schools and community settings to support early intervention and prevention.

Members emphasised the importance of ensuring that children and young people had accessible routes to support and highlighted the value of early engagement and education in preventing escalation of need.

Further discussion explored issues relating to equality, diversity and inclusion, with Members seeking assurance regarding cultural competence and the Trust’s ability to meet the needs of diverse populations. It was acknowledged that this remained an area for development and the Director outlined ongoing work to improve understanding of inequalities, including initiatives aimed at becoming an anti-racist organisation and enhancing staff training.

Members also considered the challenges associated with data sharing and multi-agency working, noting the complexity of delivering truly integrated care across organisational boundaries. Whilst recognising existing partnership working, Members stressed the importance of continued progress towards a more unified and accessible system for both patients and professionals.

In response, the concerns raised were acknowledged, particularly in relation to waiting times and communication. It was noted that these challenges reflected wider national pressures and increasing demand. It was confirmed that work was ongoing to reshape pathways, improve communication, and strengthen partnership working, although resource constraints remained a significant limiting factor.

In concluding the discussion, the Chair thanked representatives for a comprehensive and candid presentation, recognising both the progress made and the challenges that remained.

RESOLVED that:

1. The update on the TEWV Quality Account 2025/26 be noted;
2. Members' comments be taken into account in finalising the Quality Account; and
3. A draft Statement of Assurance be prepared on behalf of the Committee and circulated for approval, with final sign-off delegated to the Chair and Vice-Chair.

44 WORK PROGRAMME 2025/26

Members reviewed the items scheduled within the current programme and those identified for future consideration during the 2026/27 municipal year. In doing so, the Committee recognised the breadth and complexity of issues within the health system, and the importance of prioritising those matters that presented the greatest impact on patient outcomes and service delivery.

In concluding the item, the Chair reiterated the importance of the Work Programme as a key mechanism for the Committee to discharge its scrutiny function effectively, ensuring transparency, accountability and continuous improvement across the health system.

RESOLVED that the Work Programme be noted.

45 ANY OTHER ITEMS WHICH THE CHAIR CONSIDERS URGENT

The Chair raised a few additional areas of concern, most notably in relation to neonatal and maternity service provision across the Tees Valley.

The Senior Democratic Services Officer advised that correspondence had recently been received from NHS England in respect of changes to neonatal services. Members were informed that the date as to when new pathway changes would come into effect was yet to be confirmed, but it was anticipated that plans were due to be implemented during summer 2026.

It was noted that since January 2026 NHS England had established an implementation board to oversee the changes. Representatives from all neonatal service providers were currently developing more detailed mobilisation plans, and this work included ongoing patient engagement activity.

In addition, a task and finish group had been established, which included patient representatives from across the region through a Parent Advisory Group as well as continuing work carried out by Care Co-ordinators from the Neonatal Network who have very close relationships with families. It was advised that as this work progressed across the region, there would be further opportunities for the involvement of families from the Tees Valley area, and this would be specific to focus on any impact for the local area.

The Senior Democratic Services Officer advised that NHS England commissioners had advised that additional information could be provided to Members, as the implementation plans progressed.

During discussion Members drew reference to patient pathways and those involving transfers between hospital sites, with concerns expressed regarding continuity of care, specialist expertise and the overall patient experience for families. Members emphasised that these issues were of significant public interest and fell squarely within the Committee's remit for scrutiny.

Members agreed that the Committee had an important role in ensuring that significant service developments or potential risks were subject to appropriate oversight, particularly where changes could affect patient safety, accessibility or service quality. There was a shared view that future work programming should continue to reflect both locally raised concerns and strategic system priorities, ensuring that the Committee remained proactive in its scrutiny role.

The importance of engaging with partner organisations, including Trusts, Integrated Care Boards and local authorities, was also highlighted, with Members noting that collaborative working was essential to gaining a comprehensive understanding of system pressures and performance.

In response to Members' comments, it was confirmed that the issues raised would be included within the forward Work Programme, with further scoping undertaken where necessary to determine the most appropriate approach to scrutiny. It was also noted that opportunities remained for additional briefings or reports to be scheduled, either at Committee level or through informal Member development sessions, should emerging issues require more immediate consideration.

RESOLVED that an invite be extended to NHS England commissioners to attend a meeting of the TVJHSC to discuss the proposed changes regarding Neonatal Critical Care pathways across the North East and North Cumbria.

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE
Work Programme 2026-2027

Date (4.30pm unless stated)	**Topic**	**Attendance**
21 April 2026	Monitoring: Action Plan – Stockton-on-Tees Adult Carers Support Service Stockton-on-Tees Wellbeing Hub Overview Report: SBC Adults, Health & Wellbeing (Adult Social Care / Strategy & Transformation) Regional Health Scrutiny Update	Graham Lyons Sarah Jones Cllr Pauline Beall / Carolyn Nice / Angela Connor / James O'Donnell / Jacqui Warrior
19 May	North Tees and Hartlepool NHS Foundation Trust (NTHFT): Quality Account 2025-2026 Monitoring: Progress Update – Access to GPs and Primary Medical Care Health and Wellbeing Board: Previous Minutes (January 2026)	Matt Neligan / Judith Connor / Helen Wilson / Rachel Scrimgour Sarah Bowman-Abouna / Rebecca Warden
23 June	Norton Medical Centre: Response to latest CQC inspection PAMMS Annual Report: 2025-2026 CQC / PAMMS Quarterly Update: Q4 2025-2026 Regional Health Scrutiny Update	Dr Laila Fazluddin / Dr David Viva / Dr Mohammed Al-Damlooji / Felicity Brown / Emma Joyeux / Rebecca Warden / Jennifer Long Darren Boyd Darren Boyd
21 July	SBC Adult Services Complaints Report 2025-2026 Tees Valley Care and Health Innovation Zone (TBC) Review of Protection of Property • (Draft) Scope and Project Plan	Carolyn Nice / Gemma Jackson / Lisa Williams Geraldine Brown / Chris Renahan Carol Malham
22 September	Healthwatch Stockton-on-Tees: Annual Report 2025-2026 (TBC) Monitoring: Progress Update – Reablement Service Overview and Performance Report: Adults, Health & Wellbeing (Public Health) CQC / PAMMS Quarterly Update: Q1 2026-2027	Natasha Douglas Rob Papworth Cllr Pauline Beall / Carolyn Nice / Sarah Bowman-Abouna Darren Boyd

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE
Work Programme 2026-2027

Date (4.30pm unless stated)	**Topic**	**Attendance**
	Review of Protection of Property • TBC	
20 October	Care and Health Winter Planning 2026-2027 (TBC) Review of Protection of Property • TBC	Sarah Bowman-Abouna
17 November	SBC Director of Public Health: Annual Report 2025-2026 CQC / PAMMS Quarterly Update: Q2 2026-2027 Review of Protection of Property • TBC Regional Health Scrutiny Update	Sarah Bowman-Abouna
15 December	Teeswide Safeguarding Adults Board (TSAB): Annual Report 2025-2026 Stockton-on-Tees Independent Complaints Advocacy: Annual Report Review of Protection of Property • TBC	Adrian Green / Carolyn Nice Philip Kerr
19 January 2027	Regional Health Scrutiny Update	
16 February	CQC / PAMMS Quarterly Update: Q3 2026-2027	
23 March	Overview and Performance Report: SBC Adults, Health & Wellbeing (Adult Social Care / Strategy & Transformation)	Cllr Pauline Beall / Carolyn Nice / Angela Connor

2026-2027 Scrutiny Reviews

- Protection of Property

Monitoring Items

- Access to GPs and Primary Medical Care (Progress Update) – TBC (late-2026)
- Reablement Service (Progress Update) – September 2026
- Stockton-on-Tees Adult Carers Support Service (Progress Update) – TBC (early-2027)

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE
Work Programme 2026-2027

Performance and Quality of Care (standing Items)

- SBC Adults, Health and Wellbeing – Overview Report
- SBC Director of Public Health – Annual Report
- SBC PAMMS (Care Homes) – Annual Report
- SBC Adult Services Complaints – Annual Report
- Healthwatch Stockton-on-Tees – Annual Report
- Care Quality Commission (CQC) – State of Care Annual Report
- Teeswide Safeguarding Adults Board (TSAB) – Annual Report
- North Tees and Hartlepool NHS Foundation Trust (NTHFT) – Quality Account

Regular Reports

- Regional / Tees Valley Health Scrutiny – Updates
- Care Quality Commission (CQC) / PAMMS – Quarterly Inspection Updates
- Health and Wellbeing Board – Minutes
- Care and Health Winter Planning – Update
- Tees Valley Care and Health Innovation Zone – Update

Other Reports (as required)

- Healthwatch Stockton-on-Tees – Enter and View Reports
- Care Quality Commission (CQC) – Inspection Reports (by email / by exception at Committee)

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