

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

QUARTER 3 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 October and December 2025 (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, **6** 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:

- 1 Adult Service was reported on (1 rated 'Good')
- 5 Primary Medical Care Services were reported on (3 rated 'Good'; 1 rated 'Requires Improvement'; 1 not rated)
- 0 Hospital / Other Health Care Services were reported on

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

PAMMS Assessment Reports

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

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

Following the PAMMS assessment, the key areas are scored either 'Excellent', 'Good', 'Requires Improvement' or 'Poor', and an overall rating is assigned to the assessment using these headings. **Appendix 2** shows **11** reports published between October and December 2025 (inclusive), the overall outcomes of which can be summarised as follows:

- 1 rated 'Excellent'
- 10 rated 'Good'

APPENDIX 1

ADULT SERVICES

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

| | | |
|---|---|----------------------------|
| Provider Name | Care Matters (Homecare) Limited | |
| Service Name | Care Matters (Homecare) Limited Stockton | |
| Category of Care | Care at Home | |
| Address | Unit 11, Halegrove Court, Cygnet Drive, Stockton-on-Tees TS18 3DB | |
| Ward | n/a | |
| CQC link | https://www.cqc.org.uk/location/1-5203586490/reports/AP15475/overall | |
| | New CQC Rating | Previous CQC Rating |
| Overall | Good | Good |
| Safe | Good | Good |
| Effective | Good | Not inspected |
| Caring | Good | Not inspected |
| Responsive | Good | Not inspected |
| Well-Led | Good | Good |
| Date of Inspection | 28th August – 14th October 2025 | |
| Date Report Published | 20th November 2025 | |
| Date Previously Rated Report Published | 7th January 2021 (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 care provider maintains a positive and professional relationship with the Quality Assurance and Compliance Team. They are consistently responsive to queries and requests, and there are currently no concerns regarding their performance or compliance. | | |
| Engagement and Support from Transformation Managers | | |
| Care Matters have shown strong and consistent engagement with the Transformation Team and wider partners throughout the recommissioning process. They contributed meaningfully to all engagement sessions, helping shape the new Framework. | | |

Since the contract began in November, we've had several one-to-one discussions to check how they are managing the changes. They've confirmed they do not require additional support, which reflects their strong internal management.

The manager and director have attended all Care at Home Development sessions and worked collaboratively with partners involved. They also take part in Provider Forums and recently shared their experience of a CQC inspection with the wider group, supporting shared learning across the sector.

Overall, Care Matters continue to demonstrate a proactive approach and a genuine commitment to partnership working, which is making a positive contribution to the success of the new arrangements.

Supporting Evidence and Supplementary Information

Risks to people were appropriately assessed and monitored, and safeguarding arrangements were effective.

People were generally supported by stable and well-trained staff and had their nutritional needs met, although some reported that care calls did not always occur at their preferred times; the provider has committed to reviewing staffing arrangements.

Medicines were managed safely, and assessments took account of individuals' communication, personal, and health needs. Staff worked collaboratively with other agencies to ensure smooth transitions and best outcomes, and people were supported to understand their care and give informed consent, with families involved when required. Care was person-centred, promoting choice and equality, and feedback systems were in place and acted upon.

People and relatives spoke positively about the kindness and knowledge of staff. While staff wellbeing was generally supported, some expressed concerns about communication and inclusion, and mixed feedback on service culture was noted; the provider had agreed to review these areas.

Systems to monitor and improve standards were in place, and managers engaged with the local community to deliver high-quality care.

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|---|-------------------|-------------|
| Participated in Well Led Programme? | No | |
| PAMMS Assessment – Date (Published) / Rating | 28/12/2023 | Good |

PRIMARY MEDICAL CARE SERVICES

| | | |
|---|---|-----------------------------|
| Provider Name | A Vita Limited | |
| Service Name | A Vita Limited (also known as A Vita Laser, Aesthetic and Beauty Specialists) | |
| Category of Care | Doctors / GPs | |
| Address | 22 High Street, Yarm, Stockton-on-Tees TS15 9AE | |
| Ward | Yarm | |
| CQC link | https://www.cqc.org.uk/location/1-13653797804/reports/AP10234/overall | |
| | New CQC Rating | Previous CQC Rating |
| Overall | Requires Improvement | Requires Improvement |
| Safe | Requires Improvement | Requires Improvement |
| Effective | Requires Improvement | Good |
| Caring | Good | Good |
| Responsive | Good | Good |
| Well-Led | Requires Improvement | Requires Improvement |
| Date of Inspection | 18th March & 24th June 2025 | |
| Date Report Published | 1st October 2025 | |
| Date Previously Rated Report Published | 1st August 2023 | |
| Further Information | | |
| <p>A Vita Limited provides a private aesthetics service for fee-paying clients. This service is registered with the CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services they provide.</p> <p>There are some exemptions from regulation by the CQC which relate to particular types of regulated activities and services, and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, they offered a range of non-surgical cosmetic interventions, such as dermal filler injections, anti-wrinkle treatments and laser hair reduction, which are not within CQC scope of registration. Therefore, the CQC did not inspect these services.</p> <p>The provider offered the following services which were within the scope of registration:</p> <ul style="list-style-type: none"> • Excision of lesions • Upper and lower blepharoplasty • Slimming medication <p>The CQC's previous inspection of this service took place in April 2023 when the service was rated as 'Requires Improvement' overall, with 'Requires Improvement' for the 'Safe' and 'Well-Led' key questions, and 'Good' for 'Effective', 'Caring' and 'Responsive' key questions. The reason for the assessment was to follow-up on the areas which were rated as 'Requires Improvement' at the last inspection.</p> | | |

CQC view of the service

- Two breaches of the legal regulations were found in relation to 'safe care and treatment' and 'good governance'.
- The regulation breach for 'safe care and treatment' was in relation to infection control and safe management of medicines.
- The regulation breach for 'good governance' was in relation to there being no clear oversight of governance.
- The CQC asked the provider for Action Plans in relation to both of these breaches of regulation.

People's experience of this service

- The CQC shared a link on its website during this assessment, with the provider, for clients to give feedback on their care. No responses were received.
- There was one piece of feedback to the Commission in the last 12 months.
- The service stated they used Salon Spy which was a review platform for hair and beauty salons. The service had a rating of 4.95 out of 5 stars, from in excess of 1,600 reviews.
- There was no feedback available specifically for the activities which were regulated by CQC.

NOTE: This service was archived on 26 September 2025. Archived services are ones which are no longer part of a provider's registration with CQC. You can find out more about archived services and how you can use the information on the CQCs page about [searching for the history of care services](#).

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|---|---|----------------------------|
| Provider Name | The Dovecot Surgery | |
| Service Name | The Dovecot Surgery | |
| Category of Care | Doctors / GPs | |
| Address | The Health Centre, Lawson Street, Stockton-on-Tees TS18 1HU | |
| Ward | Stockton Town Centre | |
| CQC link | https://www.cqc.org.uk/location/1-548988122/reports/AP16977/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 | Good |
| Date of Inspection | 9th – 14th October 2025 | |
| Date Report Published | 4th November 2025 | |
| Date Previously Rated Report Published | 21st June 2016 | |
| Further Information | | |
| <p>The Dovecot Surgery is a GP practice and delivers services to approximately 4,258 under a contract held with NHS England. The National General Practice Profiles states that 20.1% of patients are aged 65 years or over compared with the England average of 17.8%. 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.</p> <p>This was a comprehensive assessment, undertaken due to the length of time since the CQCs last assessment and the identification of potential risks.</p> <p><i>CQC view of the service</i></p> <ul style="list-style-type: none"> The service fostered a positive learning culture, with staff confident to raise concerns and incidents investigated thoroughly. People were kept safe, and staff understood and managed risks well. Facilities were clean, well-maintained, and met people's needs. While staff received training and appraisals, some risks remained. These included gaps in mandatory training, incomplete risk assessments, areas of prescribing oversight, and a lack of assurance that vaccination records were in place for both clinical and non-clinical staff. People were involved in assessments of their needs, and staff considered individuals' communication, personal, and health needs. Patients received care that was generally effective and informed by current guidance. Regular searches were used to support monitoring and diagnostic checks, and steps had been taken to recall patients at risk. Care was informed by current guidance. Some prescribing and monitoring practices required improvement to fully align with national standards. | | |

- 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. Areas for improvement in staff interactions were identified.
- People were involved in decisions about their care and offered a choice in how they accessed services. While feedback mechanisms were in place, response rates were low. Care was delivered fairly and in line with individual needs, and efforts were made to support accessibility and inclusion. The practice identified that improvement was needed in access, and enhancements had been made to the telephone system to support better responsiveness.
- Governance arrangements were not consistently robust. Improvements were needed in areas such as policy updates, oversight of mandatory training, risk assessments, and record keeping to ensure safe and effective care. However, leaders were visible, knowledgeable and supportive, and most staff described the practice as a positive and well-managed place to work. Staff told the CQC they felt confident to raise concerns, understood their roles and responsibilities, and were encouraged to contribute ideas for improvement.

People's experience of this service

- According to the 2025 National GP Patient Survey, 57% of patients reported a positive overall experience with the practice, which was below the national average of 75%. Additionally, 59% rated the reception and administrative team as helpful, compared to the national average of 83%. However, 84% said the healthcare professionals they saw or spoke with treated them with care and concern, which was comparable to the national average of 86%.
- The CQC received a total of 10 feedback responses over the past 12 months. The feedback highlighted a mix of positive and negative experiences. Several patients praised the practice for caring staff, helpful service, and smooth appointment processes. However, concerns were raised in areas including access to appointments, emergency preparedness, staff communication, and administrative processes.
- The Patient Participation Group (PPG) worked well with the practice. Meeting agendas were set together, and communication was open and timely. Members felt listened to, and suggestions were considered when possible. However, the group was small and did not fully reflect the wider patient population, especially in terms of age and ethnicity. Recruiting new members had been difficult. The PPG had helped raise issues like improving phone access and communication. The practice responded by upgrading the telephone system. However, some patients still reported problems getting appointments and support.
- The response rate to the NHS Friends and Family Test was relatively low, with 14 submissions received between August and September 2025. Despite this, results indicated a good level of patient satisfaction with the overall experience of care. Of those who responded, 85.71% said they would recommend the service to friends and family.
- Staff from an aligned care home provided positive feedback regarding the standard of care delivered by The Dovecot Surgery to their residents, specifically noting that the care received from the practice was excellent.

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|---|---|----------------------------|
| Provider Name | The Eaglescliffe Medical Practice | |
| Service Name | The Eaglescliffe Medical Practice | |
| Category of Care | Doctors / GPs | |
| Address | Sunningdale Drive, Eaglescliffe, Stockton-on-Tees TS16 9EA | |
| Ward | Eaglescliffe East | |
| CQC link | https://www.cqc.org.uk/location/1-542237827/reports/AP13776/overall | |
| | New CQC Rating | Previous CQC Rating |
| Overall | Good | Outstanding |
| Safe | Good | Good |
| Effective | Good | Outstanding |
| Caring | Good | Outstanding |
| Responsive | Good | Good |
| Well-Led | Good | Outstanding |
| Date of Inspection | 26th – 28th August 2025 | |
| Date Report Published | 25th November 2025 | |
| Date Previously Rated Report Published | 19th November 2015 | |
| Further Information | | |
| <p>The Eaglescliffe Medical Practice is a GP practice and delivers service to 12,961 patients under a contract held with NHS England. The National General Practice Profiles states that 94% of the practice population are white, 3% are Asian, and less than 1% are black, mixed race, or of another ethnicity. Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the 10th decile (10 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.</p> <p><i>CQC view of the service</i></p> <ul style="list-style-type: none"> The service had a good learning culture and people could raise concerns. Managers investigated incidents thoroughly. People were protected and kept safe. Staff understood and managed risks. The facilities and equipment met the needs of people, were clean and were well-maintained. There were enough staff with the right skills, qualifications and experience. Managers made sure staff received training and regular appraisals to maintain high-quality care. The service did not always detect and control potential risks in the care environment, and did not always make sure that medicines and treatments were safe and met people's needs, capacities and preferences. 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 worked with all agencies involved in people's care for the best outcomes and smooth transitions when moving services. 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.

- 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. 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.

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 93% of respondents would describe their overall experience of this GP practice as good, which was higher than the national average of 75%.
- There was an active Patient Participation Group (PPG) who represented the views of people using the service. Representatives from the PPG described how managers made positive changes because of feedback, such as changes to the appointments system and the website. Feedback received from people by the CQC was also positive.

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|--|---|----------------------------|
| Provider Name | Yarm Medical Practice | |
| Service Name | Yarm Medical Practice | |
| Category of Care | Doctors / GPs | |
| Address | 1 Worsall Road, Yarm, Stockton-on-Tees TS15 9DD | |
| Ward | Yarm | |
| CQC link | https://www.cqc.org.uk/location/1-541990737/reports/AP13906/overall | |
| | New CQC Rating | Previous CQC Rating |
| Overall | Good | Outstanding |
| Safe | Good | Good |
| Effective | Good | Outstanding |
| Caring | Good | Good |
| Responsive | Good | Good |
| Well-Led | Outstanding | Outstanding |
| Date of Inspection | 18th – 25th September 2025 | |
| Date Report Published | 25th November 2025 | |
| Date Previously Rated Report Published | 17th November 2015 | |
| Further Information | | |
| <p>Yarm Medical Practice is a GP practice and provides care and treatment to over 14,300 patients of all ages under a contract held with NHS England. Data from The National General Practice Profiles showed that the practice has a higher proportion of patients aged 60 and above, when compared to England and local averages. Information published by Office for Health Improvement and Disparities showed that deprivation within the practice population group is in the last decile (10 of 10), meaning the practice population is in the least deprived group 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.</p> <p>This was a planned comprehensive assessment carried out to assess the quality of services being delivered due to length of time since last inspection. Yarm Medical Practice was last inspected in December 2015, when it was rated 'outstanding' for the key questions of 'effective' and 'well-led', 'good' for 'safe', 'caring' and 'responsive', and was 'outstanding' overall.</p> <p><i>CQC view of the service</i></p> <ul style="list-style-type: none"> • Safe: People were safe and protected from avoidable harm. The service had a good learning culture and people could raise concerns. Managers investigated incidents thoroughly. Staff understood and managed risks. The facilities and equipment met the needs of people, were clean and well-maintained, and any risks mitigated. There were enough staff with the right skills, qualifications and experience. Managers made sure staff received training and regular appraisals to maintain high-quality care. • Effective: 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 worked with all agencies involved in people's care | | |

for the best outcomes and smooth transitions when moving services. 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.

- **Caring:** 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.
- **Responsive:** 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. 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. Patient feedback highlighted difficulties people had in accessing the service – the practice was working to improve this.
- **Well-led:** The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred 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 spoke highly of leaders and were heavily invested in the practice vision and ethos. Staff were well supported to give feedback and were treated equally, free from bullying or harassment. Staff had a thorough understanding of their roles and responsibilities, and were supported with development and training opportunities. Managers worked with the local community to deliver the best possible care and were innovative in exploring means of continuous improvement.

People's experience of this service

- The latest national GP patient survey showed that while overall patient experience was in line with local and national averages, and patients felt involved in their care, patient satisfaction with access via the practice website, phone or NHS app was below local and national averages.
- Patient feedback the CQC reviewed during this assessment showed that patient experience overall was mixed, with staff being described as kind, friendly and understanding, but with other patients stating that it was difficult to contact the practice, and that they found it hard to get an appointment.
- There was an active Patient Participation Group (PPG) who represented the views of people using the service. Representatives from the PPG described how leaders made positive changes because of feedback, such as improving privacy at reception and car parking arrangements.

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|--|---|----------------------------|
| Provider Name | Yarm Lane Dental Practice | |
| Service Name | Yarm Lane Dental Practice | |
| Category of Care | Dentists | |
| Address | 59 Yarm Lane, Stockton-on-Tees TS18 3DX | |
| Ward | Ropner | |
| CQC link | https://www.cqc.org.uk/location/1-189450392/reports/AP15376/overall | |
| | New CQC Rating | Previous CQC Rating |
| Overall | n/a | n/a |
| Safe | Regulations met | Regulations met |
| Effective | Regulations met | Regulations met |
| Caring | Regulations met | Not inspected |
| Responsive | Regulations met | Not inspected |
| Well-Led | Regulations met | Regulations met |
| Date of Inspection | 19th November 2025 | |
| Date Report Published | 3rd December 2025 | |
| Date Previously Rated Report Published | 1st June 2022 (focused inspection) | |
| Further Information | | |
| <p>Yarm Lane Dental Practice is in Stockton-on-Tees and provides NHS and private dental care and treatment for adults and children.</p> <p>The practice had three treatment rooms. At the time of the CQCs inspection, there was a total of 12 staff, of which there were three dentists, four dental nurses, three trainee dental nurses, and two receptionists. The CQC gathered feedback from staff and spoke to a range of staff during its inspection, including two dentists, one dental nurse, and two receptionists.</p> <p><i>CQC view of the service</i></p> <ul style="list-style-type: none"> • 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. <p><i>People's experience of this service</i></p> <ul style="list-style-type: none"> • On the day of the CQCs inspection, feedback from five patients was seen. Patient feedback provided a positive view of the dental team and care provided by the practice. Comments included, 'Excellent service...', '...the Dentists have been very caring and patient with me...', 'Friendly staff and helpful.', and 'Very good service, caring and considerate...' • 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.
- Patients said when they were prescribed medicines, sufficient information was given.
- Patients told the CQC 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)

None

APPENDIX 2

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

| | | |
|---|---|------------------------------|
| Provider Name | Elysium Care Limited | |
| Service Name | Stockton Lodge Care Home | |
| Category of Care | Residential / Residential Dementia | |
| Address | Harrowgate Lane, Stockton-on-Tees TS19 8HD | |
| Ward | Hardwick & Salters Lane | |
| | New PAMMS Rating | Previous PAMMS Rating |
| Overall Rating | Good | 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 | 22nd – 24th September 2025 | |
| Date Assessment Published | 10th October 2025 | |
| Date Previous Assessment Published | 27th January 2025 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>Stockton Lodge is a 42-bed home providing residential and dementia care. The home used an electronic care planning system; the system was well laid out and easy to use. Each resident had a dashboard / front page which contained pertinent information, however, some dashboards were found not to include the correct information such as Do Not Attempt Resuscitation (DNAR) status or allergies; this had been identified as an area requiring improvement. The home had a range of appropriate care in plans in place which were person-centred.</p> <p>Observations of staff interaction with residents demonstrated residents were treated with compassion and kindness. Staff were observed to promote dignity and respect in their working practice.</p> <p>The home had an Activity Co-ordinator and activity timetable in place. Activities were seen to be scheduled morning and afternoon, every day of the week. The activity programme was on display for residents in an accessible format. The programme included a range of activities and were seen to be well attended by residents.</p> <p>Mental Capacity Assessments were seen to be on file for residents, and those residents deemed not to have capacity had Deprivation of Liberty Safeguards (DoLS) best interest decisions in place. DoLS care plans were in place detailing if the resident had capacity and were seen to contain the pertinent information, including the date of authorisation, date of expiry, date to be</p> | | |

renewed, any conditions, and details of any Relevant Person's Representative where relevant. Care plans were also found to record any advanced decisions and appropriate documentation was maintained (for example, DNAR and Emergency Health Care Plans).

Care plans were seen to be person-centred and individual to residents to promote independence and maintain skills and abilities. Care plans were seen to details residents' preferences. The home used appropriate assessment tools to support with risk assessment of residents needs such as Malnutrition Universal Screening Tool (MUST) tools for nutrition, and Braiden for Skin integrity. All residents had a Personal Emergency Evacuation Plan (PEEP). Care plans and risk assessments were reviewed at least monthly, and family members spoken to during the assessment confirmed they were involved in their family members care plans. Family members confirmed they felt they could speak to staff / management about their family member's care and anything they would like to change.

All staff confirmed they had received appropriate safeguarding, Mental Capacity Act and DoLS training, and training was refreshed regularly.

The home's grounds were found to be well maintained; the external garden was nicely landscaped and well maintained. The home was observed to be clean and tidy with no malodour present. The décor was homely and welcoming. There were orientation points on the corridors with different murals on the walls such as shops, gardens, and benches for residents to rest. Dementia-friendly signage was observed on doors to different rooms, and red handrails were present throughout the corridors; one part of the home was adapted with dementia in mind, with different coloured door, etc. to help with orientation. The home had completed the Dementia Care Home Guide and had achieved the Dementia Accreditation.

Hand-washing signage and PPE was seen to be fully stocked and widely available, and bathrooms were found to be consistent to infection control. The home had an Infection Control Champion in place, and this information was on display.

The home last had their Food Standards Agency Inspection on 1 May 2025 and maintained a rating of 5/5.

The management and administration of medicines was found to be good. Staff were observed to handle medicines safely, securely and appropriately. Medication round was carried out in a person-centred manner, with appropriate hand-hygiene being carried out in between residents. The medication room was seen to be clean, tidy and secure. The medication trolleys were seen to be attached to the wall when not in use; controlled drugs were locked in a separate controlled drugs cabinet inside a locked cupboard. Medications were seen to be organised per resident. Appropriate records were maintained around the prescribing, administration, monitoring, and review of medications.

Entry to the home was restricted by double doors which were both key coded to prevent unauthorised entry to the home. The home was seen to be safe and secure; the kitchen, laundry and cleaning rooms had key-coded doors to prevent unauthorised access. Staff uniforms were in use with different uniforms / colours for different staff roles. Fire escapes were seen to be free from hazards and appropriate maglock, and alarms were seen to be in place. Smoke alarms and fire extinguishers were in place. Large pieces of furniture were seen to be secured to the walls and window restrictors in place. Appropriate service certification was seen to be in place and up-to-date.

Safer recruitment practices were in place including reference checks, Disclosure and Barring (DBS) checks, and right to work checks. Staff received induction at the start of employment, were subject to a probationary period, and received regular supervision and annual appraisal. The manager had appropriate checks in place for agency staff and visiting professionals.

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| <p>The manager used a range of information to be able to continually improve the home such as complaints / comments and compliments, residents / relative / staff meetings, audits, accidents / incidents / safeguarding monitoring and analysis, etc. There was a safeguarding file in place with a brief monthly analysis of number of incidents, outcome and other information, and evidence was seen of lessons learned in safeguarding's being discussed within staff supervision.</p> <p>The home had a range of audits in place which, overall, were seen to be carried out in line with the required frequency, except for the care plan audits – this had been identified as an area requiring improvement.</p> | | |
| <p>Plans and Actions to Address Concerns and Improve Quality and Compliance</p> | | |
| <p>The provider will complete a small Action Plan to address the three individual questions that were rated as 'Requires Improvement'. This will be monitored for compliance by the Quality Assurance & Compliance (QuAC) Officer.</p> | | |
| <p>Level of Quality Assurance & Contract Compliance Monitoring</p> | | |
| <p>Level 1 – No Concerns / Minor Concerns (Standard Monitoring)</p> | | |
| <p>Level of Engagement with the Authority</p> | | |
| <p>The manager engages well with the QuAC Officer, responding promptly to requests and submitting provider submission in a timely manner. The manager is responsive to ideas and suggestions to further improve the service.</p> | | |
| <p>Engagement and Support from Transformation Managers</p> | | |
| <p>The manager is receptive to communication from the Transformation Team and attends Provider Forums and training (Medicines Optimisation, Infection Prevention Control, etc.), as well as discussing training needs and asking for support.</p> <p>The home attends Activity Co-ordinator networking, and activities and events in the community with residents. The Transformation Team will continue to discuss opportunities and initiatives that support the quality within the home.</p> | | |
| <p>Current CQC Assessment - Date / Overall Rating</p> | <p>30/09/2022</p> | <p>Good</p> |

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|---|--|------------------------------|
| Provider Name | Indigo Care Services Limited (also known as Orchard Care Homes) | |
| Service Name | Green Lodge | |
| Category of Care | Residential | |
| Address | The Green, Billingham, Stockton-on-Tees TS23 1EW | |
| Ward | Billingham South | |
| | New PAMMS Rating | Previous PAMMS Rating |
| Overall Rating | Good | Requires Improvement |
| Involvement & Information | Good | Good |
| Personalised Care / Support | Good | Good |
| Safeguarding & Safety | Good | Requires Improvement |
| Suitability of Staffing | Good | Good |
| Quality of Management | Good | Requires Improvement |
| Date of Inspection | 6th – 8th October 2025 | |
| Date Assessment Published | 13th October 2025 | |
| Date Previous Assessment Published | 22nd August 2024 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>Care plans viewed were of a good standard. Individual care plans were personalised to the resident and had evidence including resident preferences in how they wished to be cared for. There was only one example found of information being conflicting, and no examples of incorrect names used. Front pages were detailed, with risks to be aware of, what the resident may like to talk about, a medical summary, equipment requirements, and key contacts. Care plans were seen to be reviewed monthly, and there was also evidence of care plans being updated more frequently as needs and preferences changed.</p> <p>Residents were treated with dignity, respect and kindness. Generally, staff were able to communicate well with those who were non-verbal or had limited communication, and staff were seen to be encouraging, polite and patient. There were lots of displays around the home which were colourful and engaging, but these were not always in accessible formats. Pictorial paperwork was seen, such as menus and activity timetables. A Resident's Guide was viewed; it was not currently in an easy-read format, though was under review. The home was beginning to tailor to being dementia-friendly as they undergo the Dementia Friend's accreditation, with most spaces having dementia-friendly signage.</p> <p>Care plans, risk assessments and best interest decisions were reviewed monthly. Reviews were personalised, though tended to be generic and some were repetitive. Most reviews seen were a recap of the care plan, explaining care needs as opposed to a review of the month, concerns, incidents, or anything needing monitoring for the next review. Evidence of involving residents and families in this was limited. Resident of the Day meetings were used and completed, though again did not always offer a lot of detail.</p> <p>Daily charts were completed frequently and reflected the needs of the residents. Notes were mostly recorded with details such as food and fluid amounts offered and taken, but this was not always consistently used. The new manager had implemented a weekly weight tracking system</p> | | |

for staff to colour-code and record paper-based weight tracking to ensure they were correctly monitoring and identifying weight changes.

A varied activities timetable was on offer and observed as attended well, with some good examples witnessed of full lounges where residents were encouraging each other to take part despite differing abilities. Residents afterwards told of how they had enjoyed the activity and liked how sociable they were in the home. Food choices were varied. Snacks and drinks were available to residents in communal areas, with choices of juice, water, biscuits, fruit and crisps. A tea trolley also moved around the home regularly. Those spoken with said they felt safe and looked after at the home, that the home helped them, they liked the food and activities, and spoke highly of staff.

All staff could recall having training on the Mental Capacity Act, Deprivation of Liberty, and safeguarding. Staff knew of the appropriate methods of reporting concerns if they had them; staff referred to the whistleblowing policy and knew where this was located.

Cleanliness practices around the home were to a good standard. Bathrooms were all clean, with 'I am clean' labels in use. There were good supplies of personal protective equipment and hand sanitisers. All staff were observed bare below the elbow with hair tied back. Food hygiene practices were also to a good standard; food was covered when in transit, and all food was labelled with the date. The home had their latest Food Standards Agency Inspection on 20 August 2025, attaining a rating of 5/5. The premises were safe and secured. High-risk rooms were locked when not in use, and stairwells and exits were key-coded and alarmed. The home was clean, tidy and fresh smelling, though would benefit from some cosmetic upgrades, particularly in communal spaces. A few items for repair were noticed and the manager had acted on these swiftly.

Medication rooms were clean and tidy, locked when not in use, and medication trolleys were attached to the wall in the rooms. Medications in the trolley were clearly labelled and included date of opening. Controlled Drugs were stored appropriately, with a double signed stock count in place and audits. Fridge temperatures were taken daily, and this was reported to management for oversight. All medications were on the Medication Administration Record (MAR) except one which was a recent addition and not yet uploaded. There were a few instances of labels not matching MAR charts, and the home were working with staff to ensure that this was checked and recorded correctly. Protocols were in place for medications taken as and when required. A range of manager oversight and audits were in place daily and monthly. Medication competencies were completed six-monthly in line with the Stockton-on-Tees Borough Council contract.

Staff files were completed to a good standard and evidenced safe recruitment practices. All staff had appropriate levels of identification, right to work, and Disclosure and Barring Service checks. References were verified and employment history checks were completed on any gaps. Induction paperwork was viewed; all staff completed a comprehensive induction which was evidenced to be tailored to their specific job role. All staff new to care completed the Skills for Care certificate as part of their induction. Training certificates were on file. Training completion at time of assessment was at 97% overall.

Supervisions were completed regularly and had made considerable improvements, though these did not adhere to the Stockton-on-Tees Borough Council contract as these were currently completed quarterly as per the provider's policy rather than bi-monthly. All staff were in the process of receiving their annual appraisal at the time of assessment. The previous year's appraisals for all staff were on file.

Monthly meetings took place for residents, their families and staff, with meeting minutes recorded and shared. Residents said that staff were supportive when they had problems and

helped to solve them. Staff spoken with felt that they could report to the managers if they had concerns and that they had an open-door policy. Annual surveys were taken by head office.

A range of health and safety certifications were in place and in date. The home utilised an online portal for auditing which was used by each department and management. Daily, weekly and monthly audits took place, and management received notifications of audits being completed in real-time. The new manager had implemented a situation report to compile all actions from the electronic system, in addition to any internal or external inspections, into a working Action Plan document which was shared and discussed with the regional manager, annotated and filed, to track continuous improvements.

Plans and Actions to Address Concerns and Improve Quality and Compliance

An action plan is to be created by the provider to address areas of improvement. This will be reviewed by the Quality Assurance and Compliance (QuAC) Officer with contract 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 level of engagement with the Local Authority, and responds timely to emails and submissions. All levels of management communicate well with the Quality Assurance and Compliance (QuAC) Team and provide regular updates, when needed, on the home’s ongoing improvement plans.

Engagement and Support from Transformation Managers

Green Lodge engage with the Transformation Team initiatives, with the leadership team having completed the last cohort of the Well-Led Programme, and the Activity Co-ordinator accessing the activities network and events in the community. The Transformation Team will work with the home to identify new opportunities and leadership support.

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| Current CQC Assessment - Date / Overall Rating | 30/09/2020 | Good |
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|--|---|------------------------------|
| Provider Name | Bondcare Wellington Limited | |
| Service Name | Allington House | |
| Category of Care | Residential / Residential Dementia | |
| Address | Marsh House Avenue, Billingham, Stockton-on-Tees TS23 3ET | |
| Ward | Billingham North | |
| | New PAMMS Rating | Previous PAMMS Rating |
| Overall Rating | Good | Requires Improvement |
| Involvement & Information | Good | Good |
| Personalised Care / Support | Good | Requires Improvement |
| Safeguarding & Safety | Good | Requires Improvement |
| Suitability of Staffing | Good | Good |
| Quality of Management | Good | Good |
| Date of Inspection | 6th – 8th October 2025 | |
| Date Assessment Published | 29th October 2025 | |
| Date Previous Assessment Published | 3rd February 2025 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>Allington House used an electronic care planning system (Person Centred Software) that enabled the development of highly personalised care plans. Each resident's plan included an 'About Me' section, outlining preferences, key relationships, communication styles, and specific needs. Real-time updates were logged throughout the day. Visual indicators – amber for overdue tasks and green for completed ones – helped ensure timely care delivery. Although the system did not support resident or family signatures, their input was captured through monthly reviews and designated sections such as 'Supported to write this section' or 'Care need discussed with person or legitimate representative'.</p> <p>During the assessment, staff were consistently observed engaging positively with residents, demonstrating dignity, respect and kindness. Staff promoted independence by knocking before entering rooms and maintaining friendly, courteous interactions. These practices reflected a strong commitment to resident wellbeing, with individuals appearing well cared for and supported.</p> <p>Each resident's room featured a coloured dot system at the entrance, indicating the presence of key documentation such as DoLS (Deprivation of Liberty Safeguards), DNAR (Do Not Attempt Resuscitation), or EHCP (Emergency Health Care Plan). Monthly reviews of care plans and risk assessments were evident, and daily records were consistently maintained across essential areas, including nutrition, mobility, toileting, meals, mattress checks, and hygiene.</p> <p>Residents had access to food and drinks outside standard mealtimes. A snack trolley offered fruit, biscuits, tea and coffee between meals, while refreshment stations with crisps and biscuits were available throughout the home. Jugs of juice were also accessible in residents' rooms. During the food standards inspection on 29 September 2025, the home achieved a 5-star rating.</p> | | |

The manager conducted thorough audits, with actions recorded in the Service Improvement Plan overseen by the regional manager. Fire safety checks – including alarms, detectors, lighting and equipment – were up-to-date. The latest fire risk assessment was completed in October 2024 and was due for renewal in October 2025. Fire drills were documented.

A comprehensive maintenance matrix was maintained, covering Fire Risk Assessments, PAT testing (Portable Appliance Testing), Gas Safety Certificates, Fixed Wiring Certificates, Legionella assessments, and water temperature checks. Mattress inspections and window restrictor checks were also recorded.

Staff-resident interactions indicated a secure and calm environment, with strong relationships evident. Staff demonstrated clear knowledge of safeguarding procedures, whistleblowing policies, and external reporting channels.

Medication management was robust. The medication room was clean and secure, with Controlled Drugs stored in locked cupboards and trolleys. The home used paper MAR charts (Medication Administration Records), verified by two staff members upon receipt. Administration records were complete, and discrepancies were addressed through regular audits.

Risk assessments and safe working systems were documented, covering areas such as oxygen storage and bath hoist usage. Clear signage supported navigation throughout the premises. Dementia-friendly design features included coloured handrails, distinctive bedroom doors, and clear bathroom signage. The manager was liaising with the Local Authority to implement the Stockton Dementia Friendly Care Home Guide (as required by contract).

Staff files confirmed completion of all employment checks, including DBS (Disclosure and Barring Service) and right-to-work documentation. A structured 12-week induction programme was in place, followed by a probation review. Training aligned with the Skills for Care Certificate, with refresher sessions for NVQ3-qualified staff.

All staff received supervision and appraisal within the past year, with additional supervisions scheduled for the current month. The manager had been advised to ensure bi-monthly supervisions were maintained (in line with the Local Authority contract).

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| 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 and open relationship with the Quality Assurance & Compliance (QuAC) Officer and responds to requests for information in a timely manner. | | |
| Engagement and Support from Transformation Managers | | |
| Allington House engages with a vast range of opportunities and initiatives available through the Transformation Team, including the Well-Led Programme, Activity Co-ordinator Network, training sessions, research projects through NIHR, and Provider Forums. The leadership team and wider staff team are keen to link with peer networks across the Borough and are open to working collaboratively. | | |
| Current CQC Assessment - Date / Overall Rating | 12/09/2019 | Good |

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|---|--|------------------------------|
| Provider Name | SSL Healthcare Ltd | |
| Service Name | The White House Care Home | |
| Category of Care | Residential | |
| Address | 76a Darlington Road, Hartburn, Stockton-on-Tees TS18 5ET | |
| Ward | Hartburn | |
| | New PAMMS Rating | Previous PAMMS Rating |
| Overall Rating | Excellent | Good |
| Involvement & Information | Good | Good |
| Personalised Care / Support | Excellent | Excellent |
| Safeguarding & Safety | Good | Good |
| Suitability of Staffing | Excellent | Good |
| Quality of Management | Good | Good |
| Date of Inspection | 7th October 2025 | |
| Date Assessment Published | 3rd November 2025 | |
| Date Previous Assessment Published | 7th August 2024 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>Care plans were seen to be personalised and contained pertinent personal information, including any advanced decisions. Mental capacity assessments were in place and decision-specific (i.e. accommodation, health, medication, finances), with Deprivation of Liberty authorisations in place for those residents who required them. Care plans identified residents likes / dislikes, hobbies, activities, social preferences, goals / actions, and promoted independence / maintaining of skills. Care plans evidenced residents were supported to access health and social care services when required. Care plans were paper-based – the home plans to move to electronic care planning system in the near future.</p> <p>Relevant risk assessments were in place to ensure the health and wellbeing of residents was maintained, such as Malnutrition Universal Screening Tool (MUST), Waterlow, and Personal Emergency Evacuation Plans (PEEPs). Care plans and risk assessments were reviewed at least monthly.</p> <p>Observations confirmed residents were placed at the centre of their care and were provided information and time to make their own decisions. Staff interactions with residents ensured their promoted dignity and respect, seeking appropriate consent prior to offering care and support, being patient with residents, and providing them with information and time to make their own choices and decisions. Residents appeared to have good relationships with the staff team, who knew residents well.</p> <p>The home had a key worker system in place; the key worker provides a monthly update to a key family member each month for each resident. Family members were also able to provide feedback on the plans.</p> <p>The home had two Activity Co-ordinators. The home was ambitious in their activity provision and undertook a range of activities outside of the home in the local community and further afield, including holidays to the Lake District, etc. The manager and deputy were creative in their</p> | | |

approach and undertook video risk assessments of places they intended to visit to ensure the activity was accessible. The home was also actively involved in several research projects and supported education sessions and placements from a local college.

On the whole, medication management, including the storing and administration of medication, was good, though staff competency assessments were found to be annually (the SBC contract required they were completed six-monthly). This was identified as an area requiring improvement and will be followed up in an Action Plan.

Discussion with staff confirmed they had the required knowledge for the role and had received appropriate induction, training and support. Staffing levels within the home were good, including a range of roles. Staff were visible around the home and call bells were answered promptly.

Safer recruitment practice was followed; references were requested and verbally verified, gaps in employment recorded and explored, and Disclosure and Barring checks and Right to Work checks were in place. Staff supervisions were found to take place regularly and were seen to be themed around pertinent topics encountered within the home. All staff had an annual appraisal. At the time of the assessment, overall staff training compliance was 94.8%.

The home was safe and secure to prevent unauthorised access, with double-entry, key-coded doors; visitors were required to sign in and out of the home. The home environment was homely and welcoming. The home was found to be clean and tidy, with furniture and furnishings in a good condition. The home had completed the Dementia Care Home Accreditation. Bathrooms had clear signage, were clean, and followed infection control guidelines. Local Authority Infection Prevention & Control (IPC) Audit was last completed in July 2024; the audit for 2025 was due to be received this month. The external grounds were also well maintained, with a drive to the front of the home and an enclosed garden to the rear which residents were able to access freely.

Access to areas which posed a risk to residents was seen to have appropriate controlled access such as kitchen and laundry rooms. The kitchen area was clean and tidy, with suitable equipment in place. The most recent Food Safety Inspection was conducted on 26 February 2025 and the home maintained its rating of 5/5. The laundry room was well organised. Cleaning records and risk assessments were seen to be in place.

Service Certification and Lifting Operations & Lifting Equipment Regulations (LOLER) testing were seen to be in date, including Gas Safety, Fixed wiring, and Portable Appliance Testing (PAT). Appropriate fire safety arrangements were in place, including fire risk assessment and monthly checks on extinguishers, emergency lighting, door closers, etc., and weekly fire alarm checks were conducted and regular fire drills.

The manager had a range of audits in place such as employment, health and safety, accidents, medication, etc., and identified actions were transferred onto an Action Plan which identified person responsible, a target date, update of actions, and sign off.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan for the one individual question identified as 'Requires Improvement' and the Quality Assurance & Compliance (QuAC) Officer will monitor this progress through contract visits.

Level of Quality Assurance & Contract Compliance Monitoring

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

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| Level of Engagement with the Authority | | |
| The provider has a positive relationship with the QuAC Officer; monthly reporting is received in a timely manner. | | |
| Engagement and Support from Transformation Managers | | |
| The White House Care Home engage to a very high level with the Transformation Team opportunities and initiatives, including peer networking, Provider Forums, training and development, research projects, Patient and Public Involvement (PPI) research meetings with residents and researchers, and the Activity Co-ordinator network. | | |
| Current CQC Assessment - Date / Overall Rating | 18/12/2019 | Outstanding |

| | | |
|--|--|------------------------------|
| Provider Name | T.L. Care Limited | |
| Service Name | The Beeches Care Home | |
| Category of Care | Residential / Residential Dementia | |
| Address | Green Lane, Newtown, Stockton-on-Tees TS19 0FH | |
| Ward | Newtown | |
| | 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 | 1st October 2025 | |
| Date Assessment Published | 5th November 2025 | |
| Date Previous Assessment Published | 16th January 2025 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>Staff were observed to support residents in a non-discriminatory manner, promoting dignity and respect by asking for consent before providing care and support, knocking on bedroom doors before entering, using people's names when talking to them, and offering choices. Residents spoken with confirmed that their privacy and dignity was maintained at all times and spoke highly of the staff.</p> <p>Care plans were not signed by the residents as an electronic care planning system was used. Responses to the question around involvement in care planning on the recent questionnaires evidenced that some residents did not feel involved enough. One commented '<i>I know that I have a care plan, but I haven't seen it</i>'. All care plans, risk assessments and PEEPs were reviewed monthly, and there was evidence of cross-referencing of needs across all. Care plans viewed were seen to be reflective of the current needs of the resident.</p> <p>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 as independent as possible with eating and drinking, offering specialist equipment and discrete support as necessary. A recent questionnaire around the mealtime experience had been completed, and the menu had been revised in line with suggestions made. The last Food Standard Agency visit was 26 March 2025 and the home retained its five-star rating.</p> <p>The observed medication rounds were conducted to a high standard. The trolley was cleaned prior to use, and excellent 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 overall approach was calm, thorough and unhurried. All staff administering held the level 3 qualification in medication and received regular training updates around medication. Twice-yearly medication competencies were conducted, together with an annual topical competency. Staff spoken with</p> | | |

confirmed that they were confident in managing medication because of the training and support they received.

Resident's dependency levels were reviewed monthly or upon a change of need. These levels fed into a dependency tool to assist the manager in producing the staff rota. The provider allowed managerial discretion to be able to override the dependency tool if they felt additional staffing was required – this then went to the regional manager for agreement. Rotas were checked and staffing levels reflected the staffing requirements as per the dependency tool.

All new staff completed an induction programme which covered the layout of the home, fire procedures, infection control, and competencies specific to the role. Two induction booklets were signed by the employee and the person supporting with the induction – this was evidenced on all staff files viewed. The modules contained in the induction programme were in line with the Skills for Care 'care certificate'. There was a lack of evidence in the staff files to support that regular 1:1 supervisions and an annual appraisal were taking place (it is a contractual requirement that staff receive six supervision meetings a year, together with an annual appraisal, to support performance management).

Risk assessments were in place where specific needs were identified for a resident and equipment required. Documented checks of wheelchairs, mattresses and profiling beds were conducted. The atmosphere was seen to be appropriate for those residents living with dementia, with orientation points throughout the unit. The home was currently working towards accreditation with the living well with dementia team.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the areas identified as 'Requires 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 has a positive relationship with the QuAC Officer, maintaining honest and open communications and responding to requests for information in a timely manner.

Engagement and Support from Transformation Managers

The care home engages very well with the Transformation Team opportunities and initiatives. Although the manager had completed a version of the Well-Led Programme in a differed Local Authority area, he engaged with the Stockton cohort, too. The Activity Co-ordinator engages to a high level, having completed the Level 2 Activity Provision for Wellbeing qualification, and attends all networking, workshops, training, and activities. The care home is also engaging in research opportunities.

Current CQC Assessment - Date / Overall Rating

24/09/2025

Good

| | | |
|---|--|------------------------------|
| Provider Name | Mrs J Stead | |
| Service Name | Chestnut Lodge Nursing Home | |
| Category of Care | Nursing / Residential | |
| Address | 302 Norton Road, Norton, Stockton-on-Tees TS20 2PU | |
| 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 | 10th & 11th November 2025 | |
| Date Assessment Published | 24th November 2025 | |
| Date Previous Assessment Published | 5th November 2024 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>Care plans were seen to be person-centred and written from the resident's perspective. Care plans included residents' desired outcomes, their strengths, actions for staff, and gave detail on resident preferences on how they liked to be cared for. Good detail was seen of what residents liked to talk about and how they liked staff to interact with them. Family involvement was seen across care plans, and families spoken with backed up this inclusion. Information around the home was in an accessible format.</p> <p>Interactions observed around the home were good. Resident choices were respected; staff supported with residents who had capacity to make unwise decisions. Feedback from families spoken with was exemplary. Staff gave constant reassurance to residents, explained what they were doing clearly, and always asked for consent. Residents in the home at this time were largely non-verbal, and the staff showed a good array of knowledge of how to read verbal cues to communicate effectively.</p> <p>Care plans were reviewed monthly, though review notes were limited, with the majority having no note or a basic note. The home had a specific 'monthly review' plan following previous feedback, though this was again either not completed or completed as a basic summary of the resident rather than a summary of the month. Daily notes were recorded often and varied with needs. Overall, daily notes were personalised, person-centred and contained good detail on the level of support offered and given.</p> <p>Residents' had two allocated keyworkers, as per contractual requirements, which they named buddies: one carer and one nurse. Families were aware of the buddy system, and this was clearly identifiable in bedrooms, with a poster listing their responsibilities.</p> <p>Staff had a good knowledge of resident preferences for food and drinks, and kitchen staff particularly knew without needing to reference care plans. Portion size was good, and menus were balanced. Food hygiene and infection control practices were good. The home's current</p> | | |

food hygiene rating was 5. Staff were observed as bare below the elbow, hair tied back, and using the correct colour-coded Personal Protective Equipment (PPE). Hand hygiene was good, with correct use of gloves. Appropriate waste management processes were followed. The home had an allocated Infection Prevention and Control (IPC) Champion, as per contractual requirements.

Medication rounds observed were good; staff were knowledgeable of resident preferences and needs, and spoke to them with respect. Good hand hygiene was observed, and the trolley was cleaned before and during use. Medications were in blister packs stored in a locked medication trolley which was secured to the wall in the office. Controlled drugs were stored in an appropriate locked cupboard, and the count book was signed by two members of staff, with regular audits and stock-checks. Medication administration records were completed to a good standard; correct codes were used, no missed entries, crossing out, or overwriting were seen, and all had a good standard of front covers in place. Regular manager audits took place, actioned accordingly. Staff competencies were completed six-monthly, in line with the contract requirements.

All staff confirmed they had received training on the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), and safeguarding, and were able to explain their purpose, and gave good examples of how they put them into practice for the residents in the home. Staff were all very knowledgeable on the correct processes to follow if they had concerns to be raised.

The premises were seen to be secured and safe. Corridors were free of clutter, there was no inappropriate storage, external doors were alarmed, and windows had restrictors. An audit was in place monthly to monitor environment risks. The home had recently undertaken dementia-friendly consultation and commenced the Dementia Friends accreditation; the home was in the process of adapting communal spaces to meet these needs. Fire risk assessments were in place and seen to be reviewed annually. There were some decor updates that needed to be made for the overall presentation of the home; however, the home was clean and tidy throughout with no evidence of malodours.

A comprehensive induction process was in place, which utilised the Care Certificate. Staff confirmed they had supervisions and appraisals; on review of the supervisions matrix and paperwork, these were not taking place regularly and were not compliant with contractual requirements. No staff reported concerns with staffing levels, and when the rota was viewed against the dependency tool, staffing was appropriately split.

A range of audits and servicing certificates were in place and in date, and the manager also undertook a range of weekly and monthly audits. Maintenance, domestic and kitchen audits took place daily and were recorded, with no gaps seen. Cleaning sheets were on display around the home which were coloured in once completed; one per room and for each communal space, and included daily, weekly and monthly tasks.

An open-door policy for the manager and nursing staff was utilised by families, and families advised that any concerns they did raise were handled timely. Families gave good feedback on communication by management and staff. Staff also reported feeling highly supported by the management structure. Annual surveys were taken for residents, families and staff.

Plans and Actions to Address Concerns and Improve Quality and Compliance

A small Action Plan is to be created by the provider to address the few areas that were found that require improvement – this will be assessed by the Quality Assurance and Compliance (QuAC) Officer through contractual visits.

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|---|-------------------|-----------------------------|
| 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, is responsive to emails, and is always on time with submissions. | | |
| Engagement and Support from Transformation Managers | | |
| Chestnut Lodge engage with the Transformation Team in a number of ways, including the Well Led Programme, training opportunities, Provider Forum, and Leadership Networks. The staff team are always open to conversations about opportunities and look to how they can participate in the initiatives suggested to them. | | |
| Current CQC Assessment - Date / Overall Rating | 09/03/2023 | Requires Improvement |

| | | |
|--|--|------------------------------|
| Provider Name | The Poplars (Thornaby) Limited | |
| Service Name | The Poplars Care Home | |
| Category of Care | Residential / Nursing / Dementia | |
| Address | 375 Thornaby Road, Thornaby, Stockton-on-Tees TS17 8QN | |
| Ward | Village | |
| | New PAMMS Rating | Previous PAMMS Rating |
| Overall Rating | Good | 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 | 12th November 2025 | |
| Date Assessment Published | 3rd December 2025 | |
| Date Previous Assessment Published | 30th January 2025 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>There had been a change in management since the last assessment; the current manager had been in post approximately 6 months.</p> <p>The home used an electronic care planning system. Care plans were found to be person-centred, and included personal and pertinent details and other important information such as risks to be aware of, information you should know, equipment needed, a medical and care summary, along with key contact information such as family members, social worker and GP. Mental Capacity Assessments were seen to be in place and Deprivation of Liberty Safeguards (DoLS) authorisations for those residents who were deemed to lack capacity, with details such as expiry date / date to renew recorded in relevant care plans. Documentation was seen to be in place for any advanced decisions such as DNACPR and Emergency Hospital Care Plans (EHCP), with detail recorded in care plans and on residents' profiles. All residents had allocated key workers as per the Council's contractual requirement.</p> <p>Resident and family members / representatives were provided with a service-user guide on admission to the home which contained details of how to raise concerns and / or make a complaint, and further information was observed to be on display in the home. Evidence was seen of resident / family / representative involvement in care plans and reviews. Care plans were seen to promote independence, detailing what residents could do for themselves and what they required support with.</p> <p>Appropriate assessments were used to ensure residents needs were met and their welfare protected, such as Malnutrition Universal Screening Tool (MUST), Waterlow, pain, continence, dependency, falls, mobility, Personal Emergency Evacuation Plans (PEEP), etc. All care plans and assessments were reviewed at least monthly. Daily notes contained a good level of detail. Care plans were seen to include dietary requirements or restrictions, although some 'likes' and 'dislikes' recorded information was quite limited.</p> | | |

Feedback from residents spoken to was positive, who advised they felt safe and were well looked after. Residents provided positive feedback regarding the activities and food in the home.

Staff had the required knowledge and confirmed they received sufficient training for the job role. Staff rotas were reviewed against the dependency tool and evidenced sufficient staffing, however, a visiting family member advised they did not feel there was enough staff available in the home. During the assessment, staff were generally seen to be visible throughout the home, however, there were times when staff were observed in the lounge with residents, due to the layout of the home reducing staff visibility for residents. Safer recruitment practises were followed within the home; on commencement of employment, all staff received an induction, mandatory training and competency assessments. Training was seen to be monitored and refreshed regularly; at the time of the assessment, training compliance was 94%. Regular supervision was in place for staff, however, annual appraisals were overdue – the manager was aware of this and had plans in place to complete.

At the time of the assessment, substantial work was underway on replacing a number of doors and door frames as required due to fire regulations. The home was under an Enforcement Notice; this had been reviewed and reduced to an Action Plan. The home was observed to be clean and tidy, however, due to the repairs, required redecoration – the manager had identified a number of improvements they would like to make.

The home was split over two floors and part of the top floor was a dementia unit with key-coded access. Appropriate dementia signage was seen to be in place on some toilets / bathrooms but not on others. The manager was currently working towards the dementia care home guide. Some issues were observed in bathrooms; one bathroom had equipment stored in it preventing use, and a shower chair was seen to be rusting – these were raised with the manager to address.

Appropriate waste disposal arrangements were in place; foot-operated bin not seen to be overflowing. Bedrooms were seen to be personalised. Areas which posed a risk to residents such as laundry, kitchen, sluice were seen to have appropriate key-code restrictions in place. COSHH data sheets were in place. The most recent Food Standards inspection was 25/09/2024 and the home maintained the 5-star rating. Infection control audits were carried out; the IPC nurse had visited the home, and the manager was in the process of arranging a visit to undertake the LA IPC audit.

Staff were observed to administer medication in a safe and person-centred way, and good hand hygiene followed. Medication was stored securely, with room and fridge temperature checks in place, however, improvements were found in relation to medication records, handwritten Medication Administration Records (MAR) were missing details such as strength and special instructions, and a PRN protocol viewed had not been reviewed within the required timescale.

The manager had a range of methods to gather information about the quality of services delivered such as comments and complaints, accidents and incidents recordings, audits, staff, resident / relative meetings audits, surveys, suggestions, etc. The manager analysed feedback and created an Action Plan for the negative comments received.

A range of monthly audits were seen to be in place such as Health and Safety Management, Food Hygiene Practices, Fire Safety – Staff, Fire Safety – Environment, Care Plans, Service Use, Dignity, Medication, Kitchen & Dining, and Domestic & Laundry. Further quality improvements and policy quarterly audits were in place. Actions identified in audits were transferred onto an Action Plan. Appropriate maintenance checks were seen to be in place, including fire system checks, water temperature checks, etc., with management oversight.

| Plans and Actions to Address Concerns and Improve Quality and Compliance | | |
|--|-------------------|-------------|
| <p>The provider will complete an Action Plan to address the areas identified for improvement to ensure full compliance and improve quality. Progress towards meeting the Action Plan will be monitored by the Quality Assurance and Compliance (QuAC) Officer.</p> | | |
| Level of Quality Assurance & Contract Compliance Monitoring | | |
| <p>Level 1 – No Concerns / Minor Concerns (Standard Monitoring)</p> | | |
| Level of Engagement with the Authority | | |
| <p>The manager engages well with the QuAC Officer, is responsive to requests, and submits performance information in a timely manner.</p> | | |
| Engagement and Support from Transformation Managers | | |
| <p>The manager at The Poplars is relatively new to the role but has demonstrated strong engagement and commitment. He regularly attends Care Home Provider Forums, actively collaborates with partners and stakeholders, and responds promptly to communication from the Transformation Team. Plans are in place for the Transformation Team to visit the home and provide an overview of the resources and support available in Stockton to strengthen the sector. The manager has been very receptive to this approach, and we look forward to building a positive and productive relationship with the home in the coming months.</p> | | |
| Current CQC Assessment - Date / Overall Rating | 16/05/2023 | Good |

| | | |
|---|--|------------------------------|
| Provider Name | Care UK Community Partnerships Ltd | |
| Service Name | Hadrian Park | |
| Category of Care | Residential / Residential Dementia | |
| Address | Marsh House Avenue, Billingham, Stockton-on-Tees TS23 3DF | |
| Ward | Billingham East | |
| | New PAMMS Rating | Previous PAMMS Rating |
| Overall Rating | Good | Good |
| Involvement & Information | Good | Good |
| Personalised Care / Support | Good | Requires Improvement |
| Safeguarding & Safety | Good | Good |
| Suitability of Staffing | Good | Good |
| Quality of Management | Good | Good |
| Date of Inspection | 24th & 25th November 2025 | |
| Date Assessment Published | 4th December 2025 | |
| Date Previous Assessment Published | 24th January 2025 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>Care plans were person-centred and included comprehensive details about each individual's life history and preferences. Pre-assessment documentation was noted to have been accurately transposed into care plans, ensuring continuity of information. Needs-specific assessments were regularly reviewed, and the findings were integrated into care plans. Personal Emergency Evacuation Plans (PEEPs) were in place and maintained accurately. Monitoring forms and welfare checks were implemented where required, particularly following incidents such as falls, demonstrating an ongoing commitment to resident safety and wellbeing. Care and support plans were reviewed at least monthly and contained up-to-date information, and daily notes accurately reflected the individual's current presentation and interventions from external professionals. Person-centred care was reinforced through the 'Resident of the Day' initiative.</p> <p>Families and pets frequently visited, and residents were supported to access activities both inside and outside of the home. The home used its Facebook page and the Relish app to share updates and personalised information with relatives, including newsletters and photographs of residents' daily activities. A diverse range of activities was offered daily, including arts and crafts, quizzes, pampering sessions, and outings. Residents' requests were accommodated where possible, such as a recent beach trip arranged in response to a wish tree request.</p> <p>Observations during the assessment confirmed a culture of dignity, respect and kindness throughout the home, and resident engagement was actively promoted. Friendly conversations were frequently noted, reflective of the warm and supportive environment. Residents were observed receiving food and beverages outside standard mealtimes, with snack trolleys and stations offering a variety of options including fortified juices, fresh fruit and pastries. Domestic fridges and kettles were available in dining areas, providing residents with additional autonomy. The home maintained a calm atmosphere, and positive relationships between staff and residents were evident. The home was clean and tidy and received a 'Very Good (5)' rating in its August 2025 food hygiene inspection.</p> | | |

Staff demonstrated clear knowledge of safeguarding principles, whistleblowing policies, and reporting procedures, including awareness of external agencies. A review of staff files confirmed that all essential employment checks, including DBS certification and right-to-work documentation, were completed and recorded. All staff completed a structured 12-week induction programme that included shadowing and the completion of an induction booklet, followed by a probation review signed off by management. Training was aligned with Skills for Care standards (as per SBC contract), including the Care Certificate for new employees and refresher training for those holding NVQ3 qualifications. A supervision and appraisal matrix was in place, evidencing annual appraisals and bi-monthly supervisions (as per SBC contract), with only a small number of missing entries.

Monthly EMAR checklists and medication audits showed compliance scores of 76% in September and 71% in October. Additionally, the NECS Medication Optimisation Team conducted a review in September 2025, resulting in a score of 75.5% and an associated Action Plan that was currently being implemented. MAR charts and patch application records were completed appropriately on the electronic system, though there were some issues around medication labels which required attention. Otherwise, medication was stored appropriately, with clean and tidy medication rooms and trolleys. Controlled drugs were securely stored, and records were properly maintained. Room and fridge temperatures were consistently monitored and recorded within the required limits. Competency assessments were conducted every six months in line with contractual requirements. Three staff members involved in medication administration had not yet achieved the contractually required Level 3 medication qualification, and the manager was addressing this.

Safety and compliance measures were found to be satisfactory. Fire escapes and corridors were free from obstruction, and keypad security systems were in place where restricted entry was required. The Lifting Operations & Lifting Equipment Regs (LOLER) testing certificate was valid, and staff were seen using moving and handling equipment correctly, promoting dignity and respect throughout. Equipment servicing and maintenance checks were completed regularly and within the required timeframes, and were tracked via a new electronic system, which scheduled checks at set intervals and provided compliance dashboards. Orientation points and signage were visible throughout. The home had a dementia-friendly environment, particularly on the Chesters Suite where those with advanced dementia resided, and the Dementia Friendly Guide had been completed as per contract.

Quality assurance processes were robust, with feedback collected through multiple channels, including QR codes, surveys and meetings. Actions taken were communicated via 'You Said, We Did' boards and other documented formats. Monthly random audits were conducted alongside eight-weekly appraisals by the Care UK Quality Manager, and case studies were used to support learning. All incidents, accidents, near misses and complaints were thoroughly investigated, with outcomes and lessons learned shared transparently.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will draft and complete a small Action Plan to address any recommendations made, as well as the one area identified to require improvement, and the Quality Assurance and Compliance (QuAC) Officer will monitor progress against this to ensure the expected standard has been achieved.

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

The managers at Hadrian Park are responsive and engage well the QuAC Officer.

| Engagement and Support from Transformation Managers | | |
|--|-------------------|-------------|
| <p>Hadrian Park engage fully with the Transformation Team. Both the manager and the deputy have completed the Well-Led Programme, as have some of the wider staff team. They attend all networking, Provider Forums, Activity Co-ordinator Networks, research meetings, and events and activities in the community. They work collaboratively with other care homes across Stockton.</p> | | |
| Current CQC Assessment - Date / Overall Rating | 15/06/2023 | Good |

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|---|---|------------------------------|
| Provider Name | Bondcare (Ambassador) Limited | |
| Service Name | Elton Hall Care Home | |
| Category of Care | Residential / Residential Dementia / Functional Mental Health Unit | |
| Address | Elton Village, Elton, Stockton-on-Tees TS21 1AG | |
| Ward | Eaglescliffe West | |
| | 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 | 8th December 2025 | |
| Date Assessment Published | 17th December 2025 | |
| Date Previous Assessment Published | 21st March 2025 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>The home used an electronic care planning system (PCS) that enabled highly personalised care plans. Each resident's profile included a photograph, room number, and a clear summary of their risks, care needs, medical history, preferences, required equipment, and key contacts.</p> <p>An 'About Me' section was included for every resident, capturing personal preferences, significant relationships, communication needs, and individual do's and don'ts. Care updates were logged in real-time throughout the day, with visual indicators amber for overdue tasks and green for completed ones.</p> <p>Care plans incorporated Deprivation of Liberty Safeguards (DoLS) and capacity assessments. Each DoLS plan records application and expiry dates, with status displayed prominently on the homepage. While initial gaps in identifying residents subject to DoLS were noted, these were promptly corrected during the assessment.</p> <p>Staff interactions consistently demonstrated dignity and respect. Observations confirmed that team members encouraged independence, knocked before entering rooms, introduced themselves, and prioritised residents' wellbeing.</p> <p>A varied activity programme, led by three Activity Co-ordinators, ensured daily engagement. Recent activities included a church service, Christmas show, arts and crafts, movie afternoons, bingo, shopping trips, and one-to-one sessions. Residents were actively involved, and photographs of these events were displayed throughout the home.</p> <p>Risk assessments were embedded within care plans, and Personal Emergency Evacuation Plans (PEEPs) were maintained in both electronic and printed formats, reviewed monthly. Malnutrition Universal Screening Tool (MUST) assessments were monitored consistently. Daily charts tracked mobility, toileting, meals, mattress checks, and hygiene, with</p> | | |

accurate, live updates recorded via PCS. Food and fluid intake was logged daily, and a health passport could be generated from the system.

The manager conducted regular audits, recording actions in a Service Improvement Plan monitored by the regional manager. Key Performance Indicator (KPI) data was reviewed to identify trends and address issues. Fire safety compliance was strong, with checks on alarms, detectors, emergency lighting, and equipment. A full fire risk assessment was completed in October 2025, and drill records were maintained. A compliance matrix ensured all safety documentation (Fire Risk Assessments, Portable Appliance Testing (PAT) testing, gas and electrical certificates, Legionella monitoring, and water temperature checks) are up-to-date. Additional audits covered bed rails, mattresses and window restrictors.

The home maintained a calm, secure environment, with positive staff-resident relationships. Staff demonstrated clear knowledge of safeguarding, whistleblowing, and escalation procedures. The building blended historical character with modernisation, supported by a phased refurbishment plan. Bathrooms had been upgraded, and while some areas showed age, all spaces remained clean, organised, and clutter-free. The home achieved a 5-star food hygiene rating in March 2025.

Infection control was overseen by a dedicated champion who monitored hand hygiene, conducted observations, and attended network meetings and training. The medication room was clean, organised and secure, with Controlled Drugs stored in locked cupboards and medication trolleys secured when not in use.

Dementia-friendly design features such as colour-coded handrails, distinctive bedroom doors, and clear bathroom signage were evident. The manager adhered to the Stockton Dementia Friendly Care Home Guide and met Local Authority standards.

Medication policies were current and included guidance on home remedies and covert administration (last reviewed in August 2025). Staff competencies aligned with the Council's contract requirements, with six-monthly assessments. Care plans showed evidence of supporting residents with annual health checks and medication reviews. Medication labelling was generally clear, with only minor exceptions noted.

Medication administration was recorded on paper Medication Admin Record (MAR) charts. Staff verified charts against medication labels upon receipt, with a second team member confirming accuracy. Observations confirmed records were complete and free from gaps. Discrepancies were addressed promptly through audit processes. Regular audits covered MAR chart reviews and controlled drug counts, with findings and corrective actions documented.

Staffing levels were appropriate, with team members visible and responsive, and call bells were answered promptly. Interactions reflected a calm atmosphere and positive relationships.

A review of staff files confirmed all mandatory checks, including DBS certification, employment history, references, contracts, health checks, and right-to-work documentation. New staff completed shadow shifts and a structured induction within 12 weeks, following Skills for Care standards. Induction booklets were signed by mentors and managers. NVQ Level 3 staff followed the same process. Medication competencies were reviewed every six months. All staff had received supervision and appraisal within the past year, with bi-monthly supervision sessions in line with Local Authority requirements.

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas were identified that were 'Requires Improvement'.

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| 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 and Compliance (QuAC) Officer, and responds to requests for information in a timely manner. | | |
| Engagement and Support from Transformation Managers | | |
| Elton Hall engages well with the Transformation Team, and have participated in Provider Forums, the Activity Co-ordinator Network, and other opportunities offered, as well as communicating with the Transformation Managers around training and requests for information. We will continue to promote further innovative opportunities such as research and more collaborative working. | | |
| Current CQC Assessment - Date / Overall Rating | 07/12/2019 | Good |

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| Provider Name | T.L. Care Limited | |
| Service Name | Mandale Care Home | |
| Category of Care | Residential / Residential Dementia | |
| Address | 136 Acklam Road, Thornaby, Stockton-on-Tees TS17 7JR | |
| 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 | 17th & 18th November 2025 | |
| Date Assessment Published | 23rd December 2025 | |
| Date Previous Assessment Published | 27th February 2025 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>The Home used an electronic care planning system, with management completing the initial care plan based on information gathered during a thorough pre-admission assessment. The care plans reviewed included detailed front pages containing a concise overview, key risks, a medical summary, essential contacts, and information regarding POA and DNAR decisions. The documentation was consistent throughout, and there was clear evidence of regular reviews being undertaken to ensure that each care plan accurately reflected the resident's current needs, abilities, and preferences.</p> <p>Care plans referenced the Deprivation of Liberty Safeguards (DoLS) and the resident's capacity. Each DoLS care plan included the application and expiry dates, and the DoLS status was clearly displayed on the main homepage. 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.</p> <p>Residents who were spoken with reported feeling well supported, treated fairly, and respected by all staff. This was consistent with observations, which showed staff interacting respectfully, addressing individuals according to their preferences, and seeking consent before carrying out any task. Staff were also consistently observed knocking on residents' doors and waiting for a response before entering.</p> <p>Residents were offered three main meals each day and were observed to receive a balanced and nutritious diet. Morning and afternoon snack trolleys were available, providing a wide selection of drinks and snacks, including tea, coffee, juice, cakes, biscuits, and fresh fruit. Residents were asked about their preferred mealtime locations, and staff supported and accommodated their choices. The home had its last food hygiene inspection on 11 February 2025 and received a five-star (very good) rating.</p> | | |

Residents spoken with confirmed they felt satisfied with the support they received around medication and felt sufficiently involved with decisions made. Staff were observed asking residents if they required PRN medication and clearly knew how they preferred to take their medication. Staff administering held the level 3 qualification in medication and received regular training updates around medication. Twice-yearly medication competencies were carried out together with an annual topical competency. Staff spoken with confirmed that they were confident in managing medication because of the training and support they received.

Staff spoken with confirmed that they received regular supervision sessions and an annual appraisal. Staff said that supervisions were supportive and gave them the opportunity to discuss areas of improvement and career progression. A staff training matrix was maintained to show all mandatory and specialist training for staff, when this training was completed, and when updates were required. Training was a mixture of online courses, workbooks and face-to-face training sessions. The home used an online training platform 'Your Hippo'; overall compliance for mandatory training at the time of the assessment was 96%.

The atmosphere was seen to be appropriate for those residents living with dementia, with orientation points throughout the unit. The home was awarded a dementia-friendly certificate on 12 May 2025.

Monthly audits were completed by the Manager in accordance with the annual schedule and appeared to be thorough and effective. The quality assurance process was further strengthened by additional audits conducted during visits from the Regional Manager and Quality Assurance Manager. All service-related documentation and safety checks were stored in a dedicated file, which included a summary sheet highlighting certificate renewal dates. Compliance was monitored by the Manager through routine health and safety audits. All required certificates were available and up-to-date.

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| Plans and Actions to Address Concerns and Improve Quality and Compliance | | |
| The provider will complete an Action Plan to address the areas identified as 'Requires 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 has a positive relationship with the QuAC Officer, maintaining honest and open communications and responding to requests for information in a timely manner. | | |
| Engagement and Support from Transformation Managers | | |
| The care home engage to a high level with initiatives, opportunities and training from the Transformation Team. The Manager has completed the Well-Led Programme, and the home attends the Provider Forums, Leadership Networks, Activity Co-ordinator Networks, and engages with training opportunities, workshops, and research in care homes projects. | | |
| Current CQC Assessment - Date / Overall Rating | 31/07/2025 | Requires Improvement |

| | | |
|--|--|------------------------------|
| Provider Name | St Philips Care Limited | |
| Service Name | The Maple Care Home | |
| Category of Care | Residential / Residential Dementia | |
| Address | Dover Road, Stockton-on-Tees TS19 0JS | |
| Ward | Newtown | |
| | 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 | 13th & 14th November 2025 | |
| Date Assessment Published | 26th December 2025 | |
| Date Previous Assessment Published | 10th September 2024 | |
| PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns) | | |
| <p>The home used an electronic care planning system. Management created the initial care plans based on information gathered during a comprehensive pre-admission assessment. The care plans reviewed featured detailed front pages, including a concise overview, identified risks, a medical summary, key contacts, and information regarding Power of Attorney (POA) and Do Not Attempt Resuscitation (DNAR) status. Care plans were designed to promote independence by clearly outlining the tasks residents could manage themselves and those requiring support. Reviews of care plans demonstrated changes in the level of need and support in response to residents' declining health.</p> <p>Staff could confidently explain how they respected the privacy and dignity of residents. Staff could give examples of how they respected resident choice, and the choices they offered them. Staff spoken with were aware of, and support, equal opportunities and diversity; they received copies of the policies during induction and had also completed training. Staff understood the need to always be respectful to residents and maintain their privacy and dignity. Staff spoke of knocking on residents' doors before entering their room, always seeking consent, and allowing choice and independence.</p> <p>During the assessment, staff consistently demonstrated respectful, person-centred care practices. Consent was obtained from residents both before and throughout the delivery of care. Staff knocked prior to entering rooms and allowed sufficient time for residents to respond. They displayed patience and attentiveness, showing strong skills in interpreting non-verbal clues. Staff were able to explain how they supported residents who were non-verbal or unable to provide verbal consent. Throughout care interactions, staff communicated clearly, explaining each step of the process and seeking ongoing consent.</p> <p>Staff were observed discussing meal choices available that day with the residents and a pictorial menu was also available to help those who found visual information useful. Portion sizes were good, and more was offered to the resident if required. Staff were observed to give choices of</p> | | |

drinks and snacks from the trollies, morning and afternoon. The menus evidenced a good level of seasonal dishes, with a wide range of choice across the week. Staff were observed wearing suitable PPE in relation to food hygiene. Food was seen to be covered when being transported. The Maple had its last food hygiene inspection on 1 October 2025 and received a five-star (very good) rating.

The observed medication rounds were conducted to a high standard. The trolley was cleaned prior to use, and excellent 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. Support with eye drops and topical medication was also observed. The overall approach was calm, thorough, and unhurried. All staff administering medication held the level 3 qualification in medication and received regular training updates. Twice-yearly, medication competencies were carried out, together with an annual topical competency, which were due at the end of November and beginning of December.

Appraisals had been carried out the beginning of 2025, but supervisions had not been conducted in the first half of the year. Supervisions had been carried out over the last three months, but were still not at the required contractual level for the previous 12-month period.

Regular departmental and general staff meetings had been put in place by the new Manager. These were advertised in advance, an agenda displayed for discussion points to be added, and minutes circulated following the meeting. Only one residents meeting had been held; these need to be scheduled on a regular basis and advertised so that visitors and representative can attend and contribute.

The provider had put in place the necessary tools to allow individuals to voice their concerns. A current Safeguarding Policy was displayed in the home, the Complaints Policy was also displayed and included in the Service-Users Guide. Both the Whistleblowing and Safeguarding Policies were contained in the Staff Handbook and discussion with staff confirmed their knowledge. The home displayed the Quality Assurance report, compiled using survey feedback, in the foyer of the home to show how they had acted on comments. Management had an open-door policy and staff spoken with confirmed that they had opportunity to voice any concerns and would be happy to do so if necessary.

The building appeared well maintained and was very homely. No visual hazards were apparent during the days of the PAMMS assessment, exits were clear of obstruction, and flooring was in good repair. External doors were secured, and visitors were asked to produce suitable identification and sign in and out. The home incorporated dementia-friendly design features, such as coloured bedroom doors, clear bathroom signage, and an orientation board displaying the season, month, day, and current weather. The home received its dementia-friendly award on 12 May 2025.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the areas identified as ‘Requires 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 has a positive relationship with the QuAC Officer, maintaining honest and open communications and responding to requests for information in a timely manner. | | |
| Engagement and Support from Transformation Managers | | |
| The home engages on some level with the Transformation Team – the Activity Co-ordinators attend all networking and activities in the community, and the Manager attends the Provider Forums. The Transformation Team will work with the care home to identify new opportunities that they can participate in to sustain the quality within the home. | | |
| Current CQC Assessment - Date / Overall Rating | 05/10/2022 | Requires Improvement |