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

QUARTER 4 2025-2026

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

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

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

Quarterly Summary of Published CQC Reports

This update includes inspection reports published between January and March 2026 (inclusive). These are included at **Appendix 1** and contain the results of all inspections of services based in the Borough (irrespective of whether they are commissioned by the Council).

During this quarter, **8** inspection results were published. Please note: there is a time lag between dates of the inspection and the publication of the report. In addition, where concerns are identified by the CQC, re-inspections may take place soon after the initial report is published. When the outcomes are made available within the same quarter, the result of the most recent report is included in this update.

The main outcomes from the reports are as follows:

- 2 Adult Services were reported on (2 rated 'Good')
- 4 Primary Medical Care Services were reported on (2 rated 'Good'; 1 rated 'Requires Improvement'; 1 not rated)
- 2 Hospital / Other Health Care Services were reported on (1 rated 'Good'; 1 rated 'Requires Improvement')

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

PAMMS Assessment Reports

SBC are utilising the Provider Assessment and Market Management Solutions (PAMMS) in the quality assurance process. PAMMS is an online assessment tool developed in collaboration with Directors of Adult Social Services (ADASS) East and regional Local Authorities. It is designed to assist in assessing the quality of care delivered by providers. The PAMMS assessment consists of

a series of questions over a number of domains and quality standards that forms a risk-based scoring system to ensure equality of approach. The PAMMS key areas are:

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

Following the PAMMS assessment, the key areas are scored either 'Excellent', 'Good', 'Requires Improvement' or 'Poor', and an overall rating is assigned to the assessment using these headings. **Appendix 2** shows **12** reports published between January and March 2026 (inclusive), the overall outcomes of which can be summarised as follows:

- 12 rated 'Good'

APPENDIX 1

ADULT SERVICES

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

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

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

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

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

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

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

Supporting Evidence and Supplementary Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRIMARY MEDICAL CARE SERVICES

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

Further Information

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

CQC view of the service

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

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

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

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

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

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

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

People's experience of this service

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

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

Further Information

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

CQC view of the service

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

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

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

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

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

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

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

People's experience of this service

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

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

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

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

Further Information

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

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

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

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

Further Information

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

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

CQC view of the service

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

People's experience of this service

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

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

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

HOSPITAL AND COMMUNITY HEALTH SERVICES
(including mental health care)

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

Further Information

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

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

CQC view of the service

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

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

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

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

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

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

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

Further Information

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

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

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

This was the first inspection for this service.

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

APPENDIX 2

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

Provider Name	**St. Martin's Care Limited**	
Service Name	**Woodside Grange Care Home**	
Category of Care	**Residential / Nursing / Dementia**	
Address	Tedder Avenue, Thornaby, Stockton-on-Tees TS17 9JP	
Ward	**Stainsby Hill**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**9th December 2025**	
Date Assessment Published	**1st January 2026**	
Date Previous Assessment Published	**10th March 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the areas identified as requiring improvement. Progress will be monitored by the Quality Assurance & Compliance (QuAC) Officer through contractual visits.

Level of Quality Assurance & Contract Compliance Monitoring

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

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

Provider Name	**Akari Care Limited**	
Service Name	**Wellburn House**	
Category of Care	**Residential Care**	
Address	Wellburn Road, Fairfield, Stockton-on-Tees TS19 7PP	
Ward	**Fairfield**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Requires Improvement**
Date of Inspection	**12th & 13th January 2026**	
Date Assessment Published	**19th January 2026**	
Date Previous Assessment Published	**17th February 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas of improvement were identified in this assessment.

Level of Quality Assurance & Contract Compliance Monitoring

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

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

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

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

Professionals visiting during the assessment provided positive feedback.

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

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

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

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

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

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

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

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

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

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

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

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

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

Staff visibility during the assessment was strong, with team members present throughout the home and engaging actively with residents. Call bells were heard infrequently, and when they did ring, responses were prompt. Staff files contained the required recruitment documents, but some checklists were incomplete due to documents being stored on online portals. Advice was provided to update the checklists to reflect this. Reference verification was not evidenced, as this was handled by the organisational recruitment team. Only minor recommendations were made.
Plans and Actions to Address Concerns and Improve Quality and Compliance
The provider will complete an Action Plan for all questions assessed as 'Requires Improvement' and the Quality Assurance and Compliance (QuAC) Officer will monitor this for progress through contractual visits.
Level of Quality Assurance & Contract Compliance Monitoring
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
The provider has a good relationship with the QuAC Officer and responds to requests for information in a timely manner.
Engagement and Support from Transformation Managers
The home has demonstrated some initial engagement with the initiatives and opportunities offered, including Council-led activities and Provider Forums, reflecting an awareness of the support available and a willingness to engage where capacity allows. While participation to date has been limited, this appears to be influenced by competing operational pressures rather than a lack of commitment to engaging. The Transformation Team will continue to build positive relationships with the home, clearly communicate the benefits of involvement, and offer tailored support to encourage greater participation.

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

Provider Name	**Stockton Care Limited**	
Service Name	**Cherry Tree Care Centre**	
Category of Care	**Residential / Residential Dementia**	
Address	South Road, Norton, Stockton-on-Tees TS20 2TB	
Ward	**Norton South**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**26th – 28th January 2026**	
Date Assessment Published	**6th February 2026**	
Date Previous Assessment Published	**27th February 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

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

Level of Quality Assurance & Contract Compliance Monitoring

Level 2 – Moderate Concerns (Supportive Monitoring)

Level of Engagement with the Authority

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

Engagement and Support from Transformation Managers

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

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

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

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

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

Level of Quality Assurance & Contract Compliance Monitoring

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

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

Provider Name	**Willow View Care Limited**	
Service Name	**Willow View Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	1 Norton Court, Norton Road, Stockton-on-Tees TS20 2BL	
Ward	**Norton South**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Requires Improvement**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**9th – 13th February 2026**	
Date Assessment Published	**26th February 2026**	
Date Previous Assessment Published	**10th March 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

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

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

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

Engagement and Support from Transformation Managers

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

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

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

Provider Name	**Vestra Homecare Limited**	
Service Name	**Vestra Homecare Hartlepool**	
Category of Care	**Homecare Agency**	
Address	Unit 19, Hartlepool Enterprise Centre, Brougham Terrace, Hartlepool TS24 8EY	
Ward	**n/a**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**n/a**
Involvement & Information	**Good**	**n/a**
Personalised Care / Support	**Good**	**n/a**
Safeguarding & Safety	**Good**	**n/a**
Suitability of Staffing	**Good**	**n/a**
Quality of Management	**Good**	**n/a**
Date of Inspection	**9th – 11th February 2026**	
Date Assessment Published	**10th March 2026**	
Date Previous Assessment Published	**n/a**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

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

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

The provider engages well with the QuAC Officer, responding to requests for information and submitting performance data in a timely manner.

Engagement and Support from Transformation Managers

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

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

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

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas were identified that were 'Requires Improvement'.

Level of Quality Assurance & Contract Compliance Monitoring

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

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

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

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

The manager began work immediately to address areas of improvement noted, some of which are noted within the report. A formal Action Plan will be created and progress monitored and signed off by the Quality Assurance and Compliance (QuAC) Officer.

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

Both the provider and manager engage well with the Local Authority.

Engagement and Support from Transformation Managers

Parkside Court continues to maintain a positive and constructive relationship with the Transformation Team. The management team participates actively in the quarterly Housing with Care meetings, engaging alongside other care providers, housing colleagues, QuAC Officers and the strategy team. They have hosted one-to-one sessions to share their approach to managing the scheme and have made effective use of opportunities offered by the Transformation Team, including collaboration with North Tees education teams to support resident wellbeing. We anticipate continued productive engagement with the manager and wider team over the coming months.

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

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

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

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

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

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the areas identified for improvement to ensure full compliance and improve quality. Progress towards meeting the Action Plan will be monitored by the Quality Assurance & Compliance (QuAC) Officer.

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

The manager engages well with the QuAC Officer, is responsive to requests, and submits performance information in a timely manner.

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

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

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

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

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

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

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

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

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

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

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

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

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

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the areas identified for improvement to ensure full compliance and improve quality. Progress towards meeting the Action Plan will be monitored by the Quality Assurance & Compliance (QuAC) Officer.

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

The manager engages well with the QuAC Officer, is responsive to requests, and submits performance information in a timely manner.

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