Gambling treatment services

Gordon Moody

Date of assessment: 29 and 30 September and 1 October 2025

Background to assessment

We carried out an assessment of support and treatment services delivered by Gordon Moody in Dudley and Redditch on 29 and 30 September and 1 October 2025. This formed part of work agreed between CQC and the Gambling Commission under Schedule 4, paragraph 9 of the Health and Social Care Act 2008, which allows CQC to provide advice and assistance to other public bodies. The Gambling Commission asked CQC to work alongside GambleAware to develop a programme to measure and ensure the availability of high-quality support services within the National Gambling Support Network (NGSN) for people experiencing gambling harm.

Gambling harms treatment services are not regulated under the Health and Social Care Act 2008. As a result, CQC does not have the legal authority to register these services, pursue enforcement, or provide an overall rating following assessments. However, CQC does assess these services who are members of the NGSN to support quality improvement. Our assessments review if services are providing safe, effective, caring, responsive and well led care while meeting the needs of people seeking support for gambling-related harms. CQC will provide recommendations to support improvements where needed.

Gordon Moody is a charity who were set up over 50 years ago to provide support and treatment for those whose lives have been affected by gambling-related harm. They deliver residential support to people who are experiencing these harms and support for affected others, such as partners and family members. Gordon Moody offers 2 treatment programmes; a 3-phase structure including an assessment period (phase 1), a 6-week residential stay (phase 2), and a follow-up phase in the community (phase 3). The second programme, Respite and Counselling (known as R and C), allows individuals to engage in treatment remotely, with the option to attend the residential service for shorter, more flexible periods. This gives people different options of support treatment depending on their personal circumstances. People are supported by a recovery worker as well as a therapist. The service is commissioned to offer free support and treatment.

The NGSN supports people experiencing all levels of gambling harms, with interventions split across a tiered system. Tier 1 interventions provide information and advice; tier 2 treatment includes motivational interviewing and extended brief intervention sessions with clinicians; tier 3 includes

structured treatment such as talking therapy. Tier 4 treatment typically includes residential care for complex cases. Gordon Moody provides treatment for those assessed as needing a tier 4 service.

How we carried out this assessment

Before the assessment, we sent an information request to the provider. We completed our assessment over 3 days, followed up with some remote interviews. During our assessment, we reviewed information about service delivery including policies and procedures, governance documents and case records. We also visited 2 residential sites in operation at the time of the assessment. We spoke with leaders, managers, operational staff and people who were receiving residential treatment. A survey was also sent to people with lived experience to gather their feedback. We also received feedback from other services working with Gordon Moody and the commissioners for the service, GambleAware.

Our view of the service and recommendations

Over the 12 months before this assessment, the provider had reviewed and revised their treatment model to help ensure that the pathway was clear and easy to access and to provide a more timely response for those who needed assessment and treatment. Initial contact following referral was prompt, although data showed that the time for initial assessments was above commissioner's expectations.

The provider was committed to delivering a safe and effective residential service and focused on offering personalised support tailored to individual needs. This included introducing more options such as an alternative to the 6 weeks required in residential treatment. Outcomes were regularly reviewed, and data showed positive outcomes for people using the service throughout their treatment.

We found that partnership working was strong. Overall, there were robust governance processes in place which helped to ensure a safe and effective service as well as underpinning service development. However, some health and safety checks needed strengthening.

We found that staff were knowledgeable about both gambling harms and the people they were working with. They were passionate about making a difference by delivering effective support and treatment. Compliance with mandatory training was good. Therapists had access to monthly clinical supervision to support their work. Staff felt supported by managers and peers; however, we found that managerial supervision was not being carried out in line with the provider's expectation.

People's experience of the service

Overall, we received very positive feedback from people who had used the service. One person told us that 'My recovery to this day is successful because of the support I received from Gordon Moody. They have been instrumental in giving good quality care and advice that I can implement in my daily life so I can stay addiction free. Without this service I would not be here as I joined them at the lowest point in my life'. Another stated that the service was an 'Amazing life-saving place. I wouldn't have been able to recover had it not been for my time in Gordon Moody'. One person told us 'The whole experience went way above what I was expecting. The staff were amazing, the therapy was top level and the accommodation was better than many hotels'. Another stated '3 years ago, Gordon Moody provided me with the hope I desperately needed. Through our sustained work together, that hope has been converted into tangible reality. I have now been gamble-free for 3 years, a milestone

I could not have achieved without the critical availability of Gordon Moody at that time. I owe an immense amount to Gordon Moody and their wonderful, supportive staff'. Another stated, 'I found Gordon Moody excellent and has completely changed my life for the better'.

Several people told us that they felt like more structure and activities would support them in the residential phase (phase 2) of the programme.

The provider received exceptional feedback from stakeholders. One service told us that 'Gordon Moody consistently demonstrates a good understanding of the complex and often hidden needs of people experiencing gambling harms. Their services are highly responsive, holistic in nature and adapting to individual circumstances of those most severely affected by gambling harm'. A theme in the feedback was strong partnership working which benefitted people who used the service and also allowed insight and best practice to be shared. Another stakeholder told us 'the organisation is very responsive and clearly understands the needs of the people using their service. The staff are always ready to discuss any queries and ensure referrals and questions are treated efficiently and ensuring best practice'.

Recommendations

- Ensure all health and safety checks are completed and recorded and that relevant follow-up action is taken.
- Ensure all staff receive formal managerial supervision in line with the provider's requirements.
- Review the initial assessment process to ensure this is completed in line with commissioner's expectations.

Is the service safe?

Safe overall summary

Staff received appropriate safeguarding training and demonstrated a clear understanding of their responsibilities. We found that there were effective risk management processes, including multidisciplinary meetings and evidence of learning from incidents. While regular health and safety checks were established, we identified instances where some checks were either not conducted or potentially not documented in line with the provider's policy or followed up. Staff completed training relevant to their role and therapists had regular clinical supervision. Although staff felt well supported by managers and peers, managerial supervision had not been completed or recorded in line with the provider's expectation for all staff. There were safe recruitment practices in place.

Learning culture

We found that there was an open culture which encouraged staff to report incidents. Incidents and complaints were appropriately investigated and reported to appropriate agencies. There was evidence of learning from incidents and complaints to help improve the service and ensure safety of both staff and people who use the service. For example, following a recent incident an additional audit had been completed with evidence of action being taken across the whole site to prevent future recurrence.

The provider had a clear incident reporting system and there was evidence that incidents were investigated appropriately. Where serious incident reviews had been completed, findings were shared with the relevant governance bodies and learning disseminated through clinical governance meetings, internal safety meetings. All staff also received related learning through bulletins on the electronic recording system.

Safe systems, pathways and transitions

The provider utilised a secure electronic system to maintain the confidentiality and safety of individuals' records. This system also facilitated logging health and safety and other accommodation safety checks, ensuring they were centralised and easily accessible to all staff.

People's safety was a priority and risk assessments were completed to help identify risk and implement plans to help manage risks to help keep people safe. Risk recording that we saw was clear and reviewed regularly. There was an appropriate escalation process in place which included review by a multidisciplinary team.

There were established and effective referral pathways both into the service and with other providers in the NGSN to ensure that people could access support which met their needs.

Safeguarding

Staff we spoke with demonstrated a clear understanding of their safeguarding responsibilities and the appropriate actions to take. They were supported by designated safeguarding leads positioned across all levels of seniority within the organisation. The training was tiered according to role, with more comprehensive training delivered to those in more senior positions. This ensured that the level of training matched individual responsibilities and decision-making authority. Staff could also easily access safeguarding policies and procedures.

We saw some examples of appropriate safeguarding action in response to concerns raised by staff. For example, when staff identified risks around people using the service dependents and their

children. The provider had developed a safeguarding register which helped to ensure clear oversight of all referrals and what action had been taken.

The provider had introduced a section on their website allowing anyone to raise any safeguarding concerns with the aim of enhancing accessibility and ensuring that concerns were identified, recorded and escalated.

Involving people to manage risks

The provider worked with people to understand and manage risks by thinking holistically to ensure that support and coaching supported and met individual needs.

Risk assessments were completed with people who used the service before they entered the residential phase and were also reviewed regularly to ensure they were reflective of current risks. Individualised recovery plans were developed to support people and included both triggers and protective factors. Mandatory drug and alcohol testing was completed before and during residential treatment to ensure people's safety, and alcohol and drug use was not permitted by the service. A vulnerability register helped ensure oversight of any people who needed additional support, such as those with mental health concerns. We also saw evidence of obtaining consent from people who used the service, including where additional levels of observation and support were put in place due to potential risks identified. We found most risks assessments had been completed promptly, such as when it had been identified a person had an allergy and relevant action taken.

Records we reviewed were detailed and reflected people's current needs. This was supported by daily meetings where staff shared information about known and emerging risks helping to keep people safe.

With consent from people who used the service, information was requested from relevant professionals such as a summary from people's GP or mental health worker. This helped to inform risk assessments and ensure staff were aware of key information underpinning the support and treatment delivered.

Safe environments

We found that people received support and treatment in safe environments that met their needs. People's personal items, such as mobile phones were secured safely with appropriate governance. Relevant software was installed on individuals' phones to block access to any form of gambling, helping to ensure their safety when using their phones to contact friends and family. There were also additional checks such as bedroom searches and practice fire drills, and fire evacuation maps on bedrooms doors, to help ensure the safety of both people who used the service and staff.

The provider had either completed or scheduled relevant health and safety checks to ensure that facilities, equipment, and technology were properly maintained, supporting staff in delivering safe and effective support and treatment. These checks included a fire safety audit conducted by an external organisation and a legionella risk assessment. However, we were not assured that all recommendations from these external reviews had sufficient oversight to ensure completion or manage related risks.

While a system for regular health and safety checks was in place, we identified instances where some checks were either not carried out or potentially not documented in line with the provider's policy, for example accommodation key checks.

One building, which could accommodate both male and females, had CCTV installed to help ensure the safety of people within the building and both sites had security staff and support staff at nighttime to support and keep people safe.

A business continuity plan was in place to support the service during unexpected disruptions. It aimed to minimise interruptions to service delivery and ensure the safety of both staff and people who used the service. For example, loss of power to the service.

Staff and people using the service told us that they felt safe in the environments.

Safe and effective staffing

The provider used safe recruitment practices, carrying out thorough pre-employment checks and ensuring that all staff, including agency staff, had enhanced DBS clearance.

In the last 12 months the provider had restructured the treatment pathway and revised the staffing structure. This included the introduction of recovery workers who had a minimum NVQ Level 3 Health and Social Care qualification to help ensure they could understand and meet the needs of people who used the service. Night staff were also trained to a similar level which helped to keep people safe. Therapists were registered with the British Association for Counselling and Psychotherapy (BACP) and had achieved or were working towards level 4 accreditation.

At the time of the assessment there were 4 vacancies with on-going recruitment to fill these posts. We did not find that these vacancies impacted on people who used the service and any gaps in shifts were covered by regular agency staff.

We found that regular clinical supervision was in place for therapists. Although staff reported that they felt well supported by managers and peers, managerial supervision had not been completed or recorded in line with the provider's expectation and we saw significant gaps for some staff. However, there were daily meetings for staff to attend which included an opportunity to discuss and seek help on work matters. Staff could attend a newly-implemented meeting allowing protected time to reflect and learn with support from their peers, helping to improve the quality of support they provided and maintaining their emotional wellbeing. Annual appraisals were also in place to support staff in their role and review performance and competency.

90% of staff were up to date with all mandatory training at the time of the assessment, including training on safeguarding and equality and diversity. Managers were also offered access to a range of development sessions such as coaching skills for managers and strategic thinking and decision-making. Additional training had been delivered when a need was identified to help ensure staff were responsive to people's needs. We heard examples of staff being supported to access additional training if relevant to their role, including formal qualifications such as diplomas and degrees. People who used the service felt that staff had a good understanding of gambling-related harms and supported them. One person stated 'The staff are exceptional at their jobs'.

For staff with lived experience of gambling-related harms, there were processes in place to ensure they were supported if required.

Infection prevention and control

Infection prevention and control (IPC) procedures were established at both residential locations we visited. Regular IPC audits were conducted with follow-up action plans in place. Staff members had completed IPC training to help ensure they understood their responsibilities.

People who used the service were expected to undertake cleaning duties and adhere to house rules. Cleaning was supported by external staff to support in keeping the accommodation clean. The provider also arranged deep cleaning of bedrooms between residential courses.

Medicines optimisation

Although our assessment framework includes medicines optimisation, the provider was not responsible for administering medicines. People who used the service were responsible for taking their own medicines and had lockable storage in their rooms. For controlled drugs (a drug subject to additional legal controls), the provider held these medicines in a designated locked room. We found no apparent risks, but advised the provider to seek specialist advice about on-going storage and recording arrangements to ensure best practice as the service was not subject to any regulatory oversight.

Is the service effective?

Effective overall summary

We found from speaking with staff, feedback and records we reviewed that support and treatment delivered was person centred. There was a clear assessment process in place, although initial assessment times exceeded commissioner's expectations. Interventions were based on individual need and evidence based. Individualised care plans were developed with the person to ensure that they reflected their needs and wishes. There were effective systems in place to monitor the impact of the interventions on people. Data showed that the service was having a positive impact. There was evidence of effective aftercare and on-going support after the residential phase.

Assessing needs

The programme delivered was in 3 phases and phase 1 focused on assessment. People were fully involved in the assessment process and planning their support and agreed what they wanted to achieve which helped to maximise their involvement. Recovery coaches completed the assessment process, and a multidisciplinary meeting reviewed more complex cases to help decide if the residential phase was appropriate and met the person's needs. If treatment was deemed appropriate, then the person would continue to meet with the recovery worker for assessment and further planning including a risk assessment and developing a care plan. The assessment also considered communication styles and whether people could live safely with all people.

Between July and September 2025, 99% of individuals were contacted within 3 days from application, ensuring timely engagement and the opportunity to capture motivation at its peak when booking assessments.

We reviewed data from April 2024 to September 2025 which showed that the time for assessment following initial contact was consistently above the commissioner's expectation. The latest data showed that the time for assessment was 13.1 days, which was above the target of 5 days. While the new model of support aimed to address this, further work was needed to evaluate the reasons for this delay and address it.

The needs of affected others, such as family members and partners, were considered and if required, they could access the affected others support group or individual support.

Delivering evidence-based support and treatment

Some staff members had personal lived experience of addiction, including gambling harms and recovery. This direct experience aligns with the January 2025 guidance from the National Institute for Health and Care Excellence (NICE), which identifies peer support as a central component in addressing gambling-related harms. Peer support fosters understanding, trust, and engagement, and is widely recognised for enhancing recovery outcomes. The guidance highlights the unique value of connecting with others who have faced similar challenges, and this was echoed by many people we spoke with.

During the residential phase (phase 2) of treatment, people received therapeutic support based around cognitive behavioural therapy and motivational interviewing, as well as practical support around housing, work, debt management and their wider health and wellbeing. People who used the service spoke positively about the treatment they received; 1 person told us that they found it 'amazing' and that 'you get all the tools and proper stuff that we need (for) when we get out of here'. Another person stated that 'Staff are knowledgeable and each session we are learning… more

each time and going deeper into things', another person commented that 'the therapists were absolutely amazing and the treatment helped me to think in different ways and to understand my addiction more. I couldn't thank them enough for what they've done for me'. Some people stated that they would welcome more therapy sessions during the residential phase (phase 2) and 1 person commented that they needed to ensure that one-to-one sessions were scheduled with sufficient notice.

How staff, teams and services work together

Feedback we received showed that the provider's staffing team worked effectively with each other but also with other services and stakeholders to support people and ensure clear pathways for support. One stakeholder stated, 'Their willingness to collaborate and share practice has strengthened not only our partnership but the wider treatment and recovery system' and another commented 'Gordon Moody has helped to ensure that pathways into support are robust, safe, and responsive to people's needs'.

The provider's treatment model was updated in August 2024, and staff we spoke with reported that it was now working effectively. They noted a clear distinction between the roles of recovery workers and therapists and their roles in supporting the person who used the service and understood the different phases of the model.

The provider used a secure electronic case recording system coupled with relevant meetings, such as weekly case reviews. The daily team meeting helped to support effective service operation and ensure that staff had access to information they needed to appropriately assess, plan and deliver people's support and treatment.

Supporting people to live healthier lives

Evidence showed that the provider actively supported individuals who used the service in managing their health and wellbeing, helping to enhance their overall quality of life and support their recovery journey. This included organising activities in the local area, such as going to the gym and watching football matches and some were supported with daily living activities such as cooking and washing laundry. One recovery worker told us, 'It's about supporting them to learn new skills'. People were generally positive about the support they received. However, some suggested that access to exercise equipment at 1 site could enhance their wellbeing. Others commented that some further consideration was needed to ensure activities were relevant to them and their interests.

We saw examples of people being supported to access healthcare services in the local area, for example hospital treatment for urgent medical issues and pharmacy services. The provider also conducted regular drug and alcohol testing to support individuals, minimise related harms, and promote a safe environment for all.

Regular contact with people in all 3 phases of treatment who used the service allowed staff to focus on and be aware of any risks which included how to support people if they were struggling or needed further support. One person commented that 'throughout my time with them I have received 5* treatment, from support inside and outside of my residential care. I had a minor lapse when I first left and was able to talk to someone within seconds of reaching out. I now do group chats every week and they make life so much more manageable. I can't thank Gordon Moody more for giving me my life back'.

Monitoring and improving outcomes

The provider used recognised gambling harm and wellness scoring tools including the Problem Gambling Severity Index (PGSI) and CORE outcome measure (CORE-10) tool to monitor outcomes

for people at different stages of their treatment and recovery. Evidence that we reviewed showed that the support and treatment were making a positive impact on people. This reflected the positive feedback we received from people who reported improved outcomes based on the support and treatment they received.

The provider submitted data regularly to commissioners, reporting against a set of key performance indicators to help monitor progress and outcomes.

Weekly clinical audits were carried out to monitor the effectiveness of record keeping around treatment, and case records were reviewed at weekly meetings. Staff received feedback to support improvements to performance and record keeping during these meetings and also in supervision. Records that we reviewed were clear and detailed.

People who used the service were regularly invited to provide feedback, including on completing their treatment, to support ongoing evaluation and improvement of the service. Data provided to us gathered by the provider following treatment showed that all people who responded said life was better compared to before treatment with Gordon Moody, 93% said their loved ones' lives were better compared to before treatment with Gordon Moody, and 79% said they had not gambled since leaving Gordon Moody.

People who used the service told us that they were confident that the treatment they had received supported them to abstain from gambling. One person said that that the treatment they received ‘changed my life, prior to Gordon Moody I was in a destructive cycle harming everyone around me. I was blind to my issues and allowed gambling to ruin my life and push me towards suicide. The support Gordon Moody gave me throughout my time was amazing. Their attitude towards treatment and recovery was consistent and really gave me what I need in life’. Another commented ‘My recovery to this day is successful because of the support I received from Gordon Moody. They have been instrumental in giving good quality care and advice that I can implement in my daily life so I can stay addiction free. Without this service I would not be here’.

Consent to support and treatment

People who used the service told us that staff obtained their consent before providing support and treatment and we observed this was appropriately documented including areas such as methods of communication the provider could use. At the start of residential phase (phase 2), people who used the service signed a contract outlining the terms of their support and treatment, along with agreed guidelines that they should follow to support them.

Is the service caring?

Caring overall summary

We found that staff were hard working and motivated to help improve outcomes for people. People were treated with kindness and respect by staff. Some people who used the service expressed a desire for additional activities or therapy sessions during the residential phase. Accommodation was generally of a high standard and people welcomed this and felt cared for.

Kindness, compassion and dignity

People receiving support and treatment told us they were treated with kindness and compassion. Staff members we engaged with during the assessment demonstrated dedication to delivering effective support and were genuinely motivated to help individuals achieve positive change. Out of 47 responses to our survey, 46 individuals reported being satisfied or highly satisfied with the level of dignity and respect shown to them by staff. Comments included, 'the staff are fantastic', 'Staff are very helpful, they are there emotionally for you when you are feeling low', and 'The staff are friendly, caring and always there when you need them'.

Many people highlighted their treatment, and support was reinforced by some staff's lived experience, which people felt enhanced their ability to fully understand what they were experiencing.

People felt that staff listened to them and communicated with them appropriately and in a way they could understand. One person told us that staff were '100% ready to listen, they are attentive, and you can genuinely tell they care' and another stated that staff will stay even after their shift has ended to ensure that they were listened to and supported. Another person stated that staff 'don't treat us like kids, there is respect and dignity and have house rules to follow and I do feel respected 100%'.

Feedback from stakeholders was very positive about the kindness and compassion of staff. One stakeholder told us 'We regularly see evidence of their staff working with empathy, compassion, and professionalism. Many of their team bring a combination of lived experience and professional expertise into their practice, which helps create safe, supportive and empowering environments for service users'. Another stated that 'All the staff I have met and spoken to and worked alongside demonstrate compassion and empathy, it is evident they want the best for anyone coming into contact with their service, be this clients or professionals.'

Treating people as individuals

The provider adopted a person-centred approach, working with people to understand and respond to their unique needs and preferences. Efforts were made to ensure that communication requirements were met, enabling people to actively participate in their support and treatment. For example, the provider considered the specific needs of neurodiverse individuals and those with dyslexia by implementing tailored strategies. These included providing documentation in advance to allow sufficient time for review and comprehension before group sessions, additional time for completing coursework, completing journals and one-to-one support where needed. One person told us that they struggled to initially speak in a group setting, but they had been supported and could do this now and saw the benefits. Another person told us they were dyslexic and struggled to write notes and listen in the sessions and the provider had implemented strategies to support them, stating 'they help you big time, they are really good'.

Although currently there had not been an identified need, the provider was actively considering how the service could be provided for those that did not have English as their first language. The provider's website was accessible in multiple languages to support the diverse needs of people accessing it.

The personal, cultural, social, and religious needs of people who used the service were actively supported throughout their treatment. For example, individuals were assisted in attending local places of worship and provided with separate food storage as well as their own utensils to meet religious dietary requirements. Multi-faith rooms had been established within both accommodation sites. People who used the service were also given a choice of male or female staff members to ensure they were comfortable during support and treatment. We heard examples of how transgender people were supported to create a safe space to live openly and linked to local support groups.

Graduation ceremonies were in place to celebrate people's achievements at the end of their support and treatment. These were jointly held for the residential sites and previous people who had been through treatment and family members were also encouraged to attend to share the celebration. The provider used graduations to demonstrate the positive outcomes that could be achieved through the support provided.

Independence, choice and control

People who used the service had made the decision to engage with the support and treatment available through the provider. They received information from the provider which helped them to make informed choices about their support and treatment. This included information about restrictions on phone use and remaining on site during their stay, apart from emergencies and planned activities.

Each person's health and wellbeing was reviewed weekly with a staff member. The provider responded to these outcome measures by taking appropriate action, such as increasing therapy sessions when needed, offering tailored support to address specific issues that had emerged such as supporting with debt management or making referrals to other services for additional support.

Some individuals who used the service expressed a desire for additional activities or therapy sessions, noting that they experienced too much unoccupied time. Some also reported that they had not had access to services such as a barber. We discussed this with the provider while on site and were assured that action would be taken; we were told that staff were adapting the support in response to changes to the gender profile of the accommodation.

People who used the service could have contact with their friends and family during the residential phase (phase 2) of the support and treatment. Affected others, such as family members could also attend one-to-one sessions or regular groups specifically to support their needs.

People who had received support and treatment were given the option of attending ongoing groups to support their recovery. One person told us that '2.5 years later I still attend their weekly meetings and they turn up Christmas, New Year, Easter no matter what, even when I was the only person attending the session. I could not have asked for more'. People we spoke with told us that it was easy to re-access support at any point in the future as needed.

Responding to people's immediate needs

Staff we spoke with were aware of the processes if they needed to take immediate action to minimise any discomfort, concern or distress which included appropriate and timely referrals to other services,

for example support for emergency dental treatment. We saw evidence that when immediate action was needed, this was carried out and escalated to a manager and additional support had been given to the person to help ensure their needs were met.

Staff were equipped to respond to immediate needs and ensure safety, with access to first aid kits, defibrillators, and all had mandatory fire safety training. Effective processes were in place for requesting support, including out-of-hours assistance and an on-call manager.

As part of the assessment process (phase 1) people who were due to come receive residential support and treatment were asked about their health and wellbeing and supported to put plans in place, for example arranging to have sufficient medications for the length of the stay and encouraging them to arrange any appointments that may be required such as the dentist before entering the treatment phase to avoid disruptions to their stay.

Both residential sites we visited featured accessible bedrooms designed to support individuals with mobility needs.

Workforce wellbeing and enablement

Staff reported that managers were approachable, actively engaged and supported them. Senior leaders were visible across both sites, and their presence was confirmed by both staff and people using the service, who felt comfortable initiating conversations and discussions with them. Staff generally felt confident that their views would be listened to and taken seriously by management. One member of staff stated that they felt confident in going to managers and that ‘they always make me feel comfortable and no silly question, never the blame game’, and another stated ‘they always have our best interest at heart’. Staff also spoke highly of peer support and how valuable this was.

Staff were provided with appropriate support when needed, including opportunities to observe colleagues performing tasks to support with their development and ensure they felt confident and had access to practical resources such as specialised IT tools that assist them in their roles.

The provider was in the process of starting a peer support group for therapists which would provide a safe space for discussion around service delivery, professional development and wellbeing.

Over the previous 12 months the induction process had been strengthened in response to feedback about previous processes. Newer staff we spoke with were positive about their induction experience. For example, a new staff member told us they were grateful for time they were given on their induction of 4 weeks to watch and shadow other staff to fully learn the role.

Is the service responsive?

Responsive overall summary

Recent changes to the treatment program had helped to ensure that the service was more responsive, including for women. The introduction of recovery workers ensured a more responsive service to meet the needs and well-being of people who used the service. Meetings were effective at supporting service delivery and risk management processes to help keep people safe. There were systems in place for people to share feedback or raise complaints about their support and treatment. People who used the service felt their needs were met. Consistency of recovery worker and therapists through the phases of the programme contributed to the continuity and quality of support and treatment provided. People also appreciated the input of staff with lived experience.

Person-centred support

We observed that people who used the service were placed at the heart of the support and treatment delivered, which was tailored to their unique needs. People were meaningfully involved in identifying and setting personal goals that reflected their priorities and care plans developed. This collaborative approach ensured that the support provided met their needs and helped their recovery. Progress towards goals was routinely monitored and discussed during sessions. The provider had robust systems in place to audit and oversee the quality of care plans, ensuring they remained accurate and responsive to the person's needs. Data for April to September 2025 showed that 100% of people in treatment had a care plan in place.

Staff we spoke with during the assessment described a person-centred approach, with 1 recovery worker describing their role as 'not there to judge them, but to support them in anyway I can'. Staff spoke about building professional relationships and creating space for people to trust them. Feedback we received echoed this and people reported that they felt listened to by staff. One person stated, '(name of therapist) is very knowledgeable, very good and can extract things from me that I didn't know was there. Good relationship with her….can be completely vulnerable with her and that's staying a lot in itself'. Another stated that his worker 'he's approachable…someone I'm comfortable with…and need to be comfortable and feel 110% comfortable with him'. Many people we spoke with told us that the ability to trust staff was fundamental to their recovery.

Stakeholders reported that the service provided was person centred and responsive to individual need. One stakeholder stated that 'the organisation is very responsive and clearly understands the needs of the people using their service', another told us that the providers 'services are highly responsive, holistic in nature and adapting to individual circumstances of those most severely affected by gambling harm'.

Both residential sites provided safe, clean, and well-maintained living spaces and in the main were presented to a very high standard. At one location, new arrivals were welcomed with a thoughtfully prepared basket containing essential toiletries. They also contained a personal note from a person who had previously used the service; this gesture offered encouragement and reassurance, helping individuals feel more at ease during the early stages of their stay. Feedback from people who used the service was very positive about their accommodation. One person described it as "better than a hotel." Each property included private areas for confidential meetings, as well as spacious and inviting communal rooms designed to support group activities and social interaction. The provider informed us that more sofas and chairs would be added as the numbers of people who used the service increased to ensure everyone was comfortable.

Treatment provision, integration, and continuity

We found the provider collaborated effectively with other stakeholders in the network. This included meeting regularly with other stakeholders to review referral pathways and referral rates as well as service changes and consideration for areas such as collaboration on safeguarding processes. Working together helped make sure people were referred to the right support service and moved appropriately between services.

The introduction of 3 clear phases of treatment helped to ensure that people accessing the service understood the aims of each section and the support and treatment given in each. There was consistency of workers throughout all 3 phases which people highlighted as a positive. This helped to ensure that support and treatment was delivered in a way that met assessed needs and was co-ordinated and responsive.

Staff told us about a range of support and treatment options they used to support people, including cognitive behavioural therapy, motivational interviewing, psychodynamic therapies, and creative and art therapies. They highlighted that they were encouraged to use their professional skills and adapt the treatment offered to best meet individual needs. Staff told us that they felt there was a good skill mix within the treatment team which helped to meet people's needs effectively.

We found that the provider demonstrated a commitment to inclusivity and was responsive to the diverse needs of people using the service. They were working hard to ensure further inclusivity and had revised and expanded the treatment pathway to facilitate individual needs being met, such as being unable to be away from home for long periods of time due to personal commitments.

The provider's mental health co-ordinator helped to develop good links with local healthcare and supported staff and people who used the service. This included having contact with community mental health workers to support them in developing how best to support a person and whether the service could safely meet their needs if they entered the residential phase (phase 2).

Providing information

People who used the service received support and advice that was accurate, up-to-date and provided in a way that they could understand, and which meet their communication needs, including the information available on the provider's website. People who used the service were given a detailed handbook in the assessment phase (phase 1) which welcomed them and gave key information, information about the accommodation, what to bring with them, and shared examples of what a care plan would look like and an example timetable helping them to understand what to expect. People told us they met all the other people who would be undergoing treatment at the same time in advance and the staff who would support them which they found reassuring.

The provider had considered how information was presented, such as for those who were neurodiverse or who had specific communication needs. One stakeholder told us that that the provider had presented at a recent event and informed the NGSN network how they were adapting their assessments and paperwork for those people who were neurodiverse and how beneficial this had been.

Listening to and involving people

The provider consistently gathered feedback from individuals using the service across all elements of its delivery. This feedback was used to inform and support ongoing service development and was regularly reviewed during internal meetings.

The provider gathered feedback from people during and at the end of their support and treatment. This included a process group for residents to feedback on their experiences. They also contacted people periodically when they had left the service to ensure they were well supported and could access additional support if needed.

The provider offered an 'affected others' service which delivered remote one-to-one and group sessions to friends and family including information around gambling harms and wellbeing support. People we spoke with told us that the service had supported those close to them who had taken up this support effectively.

The service delivered a fortnightly lived experience question and answer session with input from people who had previously used the service. This helped provide information about ongoing and future support and aimed to help build the confidence of people currently receiving support and treatment.

A clear complaints policy and procedure was in place. Most respondents to our survey indicated they were aware of how to raise concerns. Where complaints were submitted, we saw that they were investigated appropriately, and suitable actions were taken in response.

Equity in access

People could access prompt and free support from Gordon Moody. Data showed that the 99% of people were contacted within 72 hours from application to arrange their first appointment. The provider recognised that for many people with gambling harms engagement at times could fluctuate, and people were not penalised for missed sessions. People could re-engage and were encouraged to seek further support from the provider at any time if needed.

The provider had undertaken a review of the program and the new pathway helped to improve accessibility for a broader range of participants, especially women (although despite continued work by the provider, uptake figures remained low which the provider said was down to barriers such as childcare provision). As part of the review, the residential phase was reduced to 6 weeks, making it more manageable for individuals with personal or professional commitments helping to promote equality, and remove barriers to accessibility. Additionally, the Respite and Counselling programme was restructured to involve shorter stays at the residential site, further supporting those unable to commit to extended periods away from home. A separate women-only course and residential site remained in place to ensure the specific needs of females that used the service were met.

All support offered in phase 1 and 3 was virtual and we were told that this was offered at a range of flexible times to help ensure contact at a suitable time for the person. One person told us that they continued to work during this phase, and the calls were arranged around their work.

Equity in experiences and outcomes

The vast majority of feedback we received during the assessment reflected positively on staff attitudes, and no concerns were raised regarding experiences of discrimination. The provider was also alert to discrimination that could disadvantage different people using their services and this formed part of the assessment process about ensuring people could safely live with others.

Both sites that we visited had accessible rooms to support those with mobility issues and 1 site also had a lift to facilitate movement within the building to help ensure equity in accessing the service.

For people with more complex needs, it was assessed if these could be met safely by the service and people were supported by staff including a mental health co-ordinator and liaison with other agencies if appropriate to ensure a co-ordinated and responsive service was delivered.

Planning for the future

People who used the service told us that discharge planning started in phase 1 to support with future planning. We heard they were given the tools to help support them once they left the residential phase and they were empowered to make informed decisions about their ongoing support, guided by their personal needs and aspirations. During phase 3, the provider introduced people to relapse prevention and support groups. People could continue to access the support groups for as long as needed at the end of their treatment and support, including specific men's and women's groups, and could re-engage if future support was required. The provider also worked closely with NGSN partners to help people access ongoing recovery support services.

Is the service well-led?

Well-led overall summary

There was a strong shared vision across the provider about the focus of the service. Staff reported that it was a good organisation to work for which offered lots of support for staff. Partnership working was strong. The service had a strong management team who had the relevant experience, skills and knowledge to ensure a credible service was delivered. Staff stated managers were visible and approachable and that they felt listened to. There were governance processes in place to support oversight of performance and service delivery. Regular audits supported service delivery with further clinical audits being developed to enhance oversight.

Shared direction and culture

We found that staff shared a common vision to support individuals in their recovery from gambling-related harms and were committed to delivering personalised support and treatment that met each person's needs. Almost all staff we spoke with described the organisational culture as supportive and conducive to learning. Managers were accessible at all levels and promoted a listening culture focusing on trust and understanding.

We found that that there was a culture that encouraged openness, reflection, and mutual support among staff and people told us that they enjoyed working for the provider. One staff member told us 'there is an open-door policy, can share ideas and feel listened to' and that the culture was 'responsive and open and more like a family, very open organisation'. Another person told us that '9/10 feel like I can raise matters with them'.

Capable, compassionate and inclusive leaders

Managers demonstrated a strong understanding of the service and had the skills and experience necessary to navigate the challenges associated with delivering high-quality, effective support and treatment. Their approach was proactive and driven by a passion for service improvement, which was reflected in the development and implementation of a revised treatment pathway and a new model of care.

Most staff we spoke with reported that managers were supportive, approachable, and readily accessible when needed. Regular team meetings provided a structured forum for open communication, shared learning, and mutual support. Staff described feeling listened to and encouraged to raise concerns or seek guidance, contributing to a culture of continuous improvement. We saw evidence of where action had been taken to address concerns which may have impacted on the quality of service being delivered.

Freedom to speak up

All staff had access to appropriate policies, guidance, and clear channels for raising concerns or reporting issues through whistleblowing procedures. Staff described a workplace culture that promoted openness and transparency, where they felt confident and supported to speak up if they had any concerns.

Workforce equality, diversity and inclusion

We found that the provider valued their staff and recognised the unique contributions each individual brought to their role. They were committed to both supporting their team and empowering people on their recovery journey. Reasonable adjustments were made to support staff when needed, for example offering additional guidance and support such as IT packages.

Staff had completed training in equality, diversity and inclusion, which enhanced their understanding and respect for the diverse backgrounds and needs of both the people they supported and their colleagues. This helped to foster an inclusive and respectful working environment. An audit was also completed on culture, diversity and inclusion which underpinned service development.

Governance, management and sustainability

In the 12 months before the assessment, the provider had made significant efforts to strengthen governance processes. The introduction of a new staffing structure had contributed to clearer governance arrangements and accountability. We saw evidence of effective governance systems to monitor performance and support service development, including a performance dashboard to provide managers with a broad overview of service delivery. Many policies and procedures had been reviewed and updated to ensure they could support staff in their roles.

Governance processes were in place to ensure oversight of performance and service delivery. The provider had a proactive approach to monitoring the quality of the service and ensuring continuous improvement. There was a robust audit schedule in place which included annual, monthly and weekly audits, such as review of complaints and accident and near miss data, a drug and alcohol testing audit, culture and environmental audits. The provider had also devised an audit based on the CQC assessment framework. We found that there was evidence of action being taken following audits, for example reviewing elements of the structure of support and treatment pathway.

We found that appropriate systems were in place to identify, record, and monitor risks. Risk registers were used to track both vulnerability-related and operational risks that could affect service delivery. Weekly case reviews were also held and anything of concern could be discussed at the daily team meeting to help ensure that risks were monitored and action taken where required.

Feedback from staff and people who used the service was used to monitor and improve the quality of support and treatment. The provider also submitted required data and notifications to external bodies promptly.

NGSN services are funded by GambleAware, which receives voluntary contributions from gambling operators in line with requirements set by the Gambling Commission. We found no evidence that the provider was influenced by the gambling industry, with staff highlighting the professional and ethical considerations of their work. As a result, the support and treatment offered to individuals was independent, impartial, and grounded in evidence-based practice.

Partnerships and communities

Feedback we received from stakeholders indicated that the provider was a proactive partner in the network which helped to ensure that there were effective pathways in place, that services were joined up and responsive to individual needs. One stakeholder stated that they had a ‘great relationship with Gordon Moody, they regularly attend our regional board meetings providing valuable insights and constructive comments’. Collaboration was also a key theme from the stakeholder feedback we received; one provider told us that ‘Gordon moody are well known providers within the NGSN and continually strive to ensure engagement within partnership working’.

We heard examples of the provider working to develop local partnerships and promote its services with community gambling addiction support, GP surgeries and pharmacies. Engagement staff also considered ways to promote the service on a larger scale. For example, they were working with a television channel on a segment to be broadcast on a popular national television show to highlight the risks of gambling harms and support and treatment options.

Learning, improvement and innovation

The provider clearly demonstrated a proactive approach to service development by identifying where changes to service delivery were needed and implementing them in a structured and thoughtful way. These changes were underpinned by evidence, feedback, and reflective practice. We saw that these changes made had a positive impact on both service quality and outcomes for the people they supported, including through clinical measures and people's feedback.

We heard that the provider engaged with research and collaborated with academic partners including from national universities. This work included research and review of methodologies for evidence-based gambling harm treatment. The provider used this work to inform continuous service improvements.

There was evidence of a culture that supported ongoing learning and development across the organisation. Staff were encouraged to reflect on their practice, share insights, and contribute ideas to help shape service delivery. This collaborative approach helped the provider respond to changing needs and challenges, including those identified through feedback from people who used the service, performance data, and local circumstances.