Gambling treatment services

NECA

Date of assessment visit: 3 and 4 June 2025

Background to assessment

We carried out an assessment of treatment and support services delivered by NECA in the Northeast of England and Yorkshire and Humber region on 3 and 4 June 2025. This forms part of work initiated by 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.

NECA is a charity based in the Northeast of England delivering education around gambling harms. They also support and provide treatment for tier 1 to 3A treatment for addiction and gambling harms (tier 1 interventions provide information and advice, tier 2 includes motivational interviewing and extended brief intervention sessions with clinicians and tier 3 includes structured treatment such as therapy). They also deliver treatment only in the Yorkshire and Humber region. They are commissioned by GambleAware to provide support and treatment as part of the NGSN.

The NGSN delivers for people at all levels of gambling harms, with interventions split across a tiered system. Tier 4 treatment typically includes residential care for complex cases, while Tier 3 includes structured treatment such as therapy. Tier 2 treatment includes motivational interviewing and extended brief intervention sessions with clinicians, and Tier 1 interventions provide information and advice, such as through the National Gambling Helpline

How we carried out this assessment

Before the assessment, we sent a provider information request. We completed our assessment over 2 days at the provider's office in Sunderland with some further interviews being conducted online. During our assessment, we reviewed information about service delivery including policies and procedures, governance documentation and case records. We spoke with leaders, managers, operational staff and HR staff. A survey was also sent to people using or who had recently used the service. In addition, we spoke with 2 groups of people who used services. We also received feedback from other services working with NECA and the commissioners for the service, GambleAware.

Our view of the service and recommendations:

NECA is a well-established organisation and has been delivering services for over 50 years and gambling services for over 25 years. The service was well led and there was a clear vision about what the provider wanted to achieve, how to do this and we found that staff reflected these values. They were committed to providing a responsive and inclusive service. There were robust governance processes in place which helped to ensure a safe and effective service as well as underpinning service development.

Partnership working was strong. There were effective relationships with a wide range of organisations such as NHS services, other third sector organisations, local authorities and the Police and Crime Commissioner (PCC) helping to increase awareness of gambling harm and promote a coordinated response. This also included the establishment of 'champions' in organisations. These were staff employed by the organisation who received training to help to increase awareness of gambling related harms and also support early identification for both people who used their services but also staff they employed.

We found that there were effective referral processes in place. Assessments were timely and reviewed regularly. We found there to be a clear focus on ensuring that all support delivered was person centred and met the needs of each person. Data showed that there were good outcomes for people who used the service during and at the end of their treatment and support. At the time of the assessment there was no waiting time to access the service.

Staff we spoke with during the assessment were knowledgeable about both gambling harms and the people they were working with. They were passionate about supporting them.

People's experience of the service

We received overwhelmingly positive feedback about the provider and staff from people who used the service. This included their interactions with them, their level of knowledge about gambling harms and the timeliness of treatment. One person stated that it was an "Excellent service from gifted caring people that truly appreciate and care and want to help people like me overcome this awful addiction and help to find ways to make that happen" and that "they listen without judging and that makes them priceless and trustworthy". Another told us that "If it wasn't for (worker) and the team at NECA I don't know where I would be today".

One stakeholder told us that that they had found the provider to be "very responsive" when we have asked for their specialist expertise to help inform the support they provided.

We have not made any recommendations to the provider.

Is the service safe?

Safe overall summary

In summary we found that the provider had appropriate systems and processes in place to help keep people who used the service and staff safe. Effective risk management processes were in place including weekly oversight by a manager helping to keep people safe. Staff completed training relevant to their role and had regular supervision. All staff we spoke with felt extremely well supported by managers and peers. There were safe recruitment practices in place.

Learning Culture

We found that there was a positive culture of safety based on openness and a willingness to learn and continually improve the service.

The provider had robust processes in place to ensure continuous improvement across all aspects of the service. We saw that action had been taken to improve the service as a result of feedback, such as ensuring staff continuity from first point of contact with a person who used the service.

The provider had appropriate processes in place for managing and supporting staff with significant incidents. In the 12 months before the assessment there were no reportable accidents or incidents. However, staff we spoke with were aware of the escalation process and were supported by appropriate policies should they be required to take action following any incident. There were processes in place to ensure investigation of any incident which included how any learning would be disseminated across the service.

All staff had undertaken training around duty of candour to help ensure they understood this, why it was important and how to follow good practice guidelines.

Safe systems, pathways and transitions

The provider ensured that there was continuity of support for people who used the service. This included continuity of a staff member from first point of contact with the service helping build a therapeutic relationship.

With consent from the person who used the service, the provider liaised and shared information with relevant partners to manage risks at all stages of service users' support and treatment. For example, informing a GP or liaising with a mental health service.

At any point in contact with the service, the provider could make referrals to appropriate other services to help ensure that all the persons needs were being met. For example, if a person started to report physical or mental health concerns then there were pathways in place to ensure timely referrals. People could also access weekly support groups as part of their journey and some people we spoke with stated that they had been attending groups for around 2 years.

Staff used a secure electronic recording system to manage clinical records. We found that records were clear and detailed. The provider was part of an active working group across the NGSN looking at the recording system to help improve the system and ensure it met provider needs.

Safeguarding

Staff we spoke with understood their safeguarding responsibilities and had received appropriate training. All staff had level 3 training in safeguarding adults and children, and managers were trained

to level 4. Staff also received training from the relevant local authority in the area in which they worked, which helped ensure they were aware of local thresholds and referral processes.

Staff were supported by an appropriate range of policies for both safeguarding adults and children. Safeguarding incidents were reviewed regularly by managers and any learning was shared with staff.

We saw examples of appropriate safeguarding action in response to concerns raised by staff. In any cases where there were safeguarding concerns, these were reviewed weekly by a manager to ensure that appropriate action had been taken and to help manage any risks. We also heard examples of staff involvement in multidisciplinary meetings to manage safeguarding concerns, for example with local authorities, healthcare professionals and the police.

Involving people to manage risks

Potential risks to and from people who used the service were assessed at the initial contact stage and reviewed at various points during their contact with the provider to help ensure they were reflective of the presenting issues. Risk assessments were reviewed by a manager to help manage the risk and to ensure they were of a good standard.

For people who used the service who presented with additional needs such as physical or mental health concerns, staff completed a risk management plan to help put in safeguards to keep the person safe. They could also refer on to other services such as local charities who supported people who were at risk of suicide and NHS services. We saw examples of staff taking quick and effective actions to address significant risks around self-harm and put in place measures to keep people safe.

Consideration was given to risk that a person may present after each intervention and reflected in clinical records and appropriate action taken.

Safe environments

Regular health and safety checks were in place for the building we visited, including regular fire safety checks and drills for staff. The provider had a dedicated estates team and approved contractors who had completed risk assessments and audits. These included regular PAT testing for electrical equipment, pest control measures, gas safety certification and monthly checks on first aid boxes training. This helped to ensure that equipment and facilities were safe places to deliver support. For buildings which the provider did not own, a risk assessment was carried out to ensure that it met their standards and was safe for both staff and people who used the service.

The provider ensured that staff had undertaken training in key areas such as fire safety, fire wardens, health and safety and wellbeing to help ensure that staff were supported in their roles. There was also training for all staff on lone working, and procedures in place to help ensure that staff were kept safe and could access help if needed.

A business continuity plan was in place which set out contingency planning processes for emergencies, including about the premises, staffing and the use of technology should this be needed.

Safe and effective staffing

At the time of our assessment, the provider had 3 vacancies and an active recruitment process was in place to fill these posts. However, we found that this was not affecting service delivery or capacity. The provider had safe recruitment practices including pre-employment checks and enhanced DBS clearance for all staff working with people who used the service.

The service provided support to people during normal working hours from Monday to Friday, with some out-of-hours appointments available to support people flexibly, and some groups accessible in the evenings to help people fit this around their other commitments.

Staff we spoke with had a range of relevant background experience in other sectors, for example social work, nursing and working within the criminal justice system and many had worked for the provider for numerous years.

We found that staff were up to date with mandatory training which helped to ensure that they had the appropriate knowledge and skills to deliver safe and effective treatment and understand the needs of the people they supported. This included training on mental health awareness, communication skills and delivering person-centred care. The provider monitored training delivery to make sure it was appropriate and consistent. People who used the service felt that staff had in-depth knowledge and understanding and could support them and provide effective treatment.

Staff told us that the provider supported their development but it was often difficult to find external training directly relevant to their professional development in the gambling harms sector because it was a 'niche' area. We heard examples of staff identifying and completing training to help meet the needs of specific groups of people they worked with, for example around autism and ADHD.

Staff received regular supervision, including peer and management supervision. Staff told us that they felt extremely well supported and that managers were both accessible and proactive in supporting them.

Over the last 4 months the provider had started to have joint team meetings for both regions to help further integrate the two teams.

There were arrangements in place for staff who were lone working, this included emergency procedures and although the staff we spoke with had not had to use them they were aware of the process to follow.

Infection prevention and control

Staff had completed mandatory training in infection prevention and control measures. This included looking at measures needed such as hand hygiene as well as managing the environment.

Medicines Optimisation

Our assessment framework covers medicines optimisation; however, this provider was not responsible for medicines management. Staff told us that if people reported issues or concerns about their medication, they would signpost them to or contact relevant physical or mental health professionals, with peoples' consent.

Is the service effective?

Effective overall summary

In summary we found that 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. Evidence showed that people who used the provider's services consistently experienced positive outcomes. Consent was obtained at relevant times during people's support and treatment.

Assessing needs

Regular assessments were undertaken by staff which helped to ensure that interventions delivered both met current need and maximised their effectiveness. Assessments were based on national guidance helping to ensure best practice. The assessments that we reviewed were detailed and reviewed regularly to ensure that they were responsive. They also considered the person's health and wellbeing, and communication needs, to enable them to receive treatment and support that had the best possible outcomes.

Assessments were undertaken very quickly. Data for October to December 2024 showed that it was less than a day before initial contact was made and the assessment considered what support or treatment was needed. If treatment was needed, on average this started within 5 days of initial contact with the service; this was much less than the target of 9 days given by commissioners for the service.

It was evident from speaking with staff, feedback from our survey, people we spoke with and records we reviewed that support and treatment delivered was person centred. One staff member described the approach as delivering 'client-driven therapy. Plans are flexible, no fit all approach as every client has a different story'. People who used the service that we spoke with also confirmed this.

Established processes were in place for referring people to other services that could support their needs if indicated during their assessment. This included partner organisations that could further support people with specific needs such as healthcare partners and advice services such as supporting people with homelessness. There were also established pathways into the service for those who may be more at risk of gambling harm such as those on some prescribed medications or those with specific health conditions.

Delivering evidence-based support and treatment

All people who used the service received a triage or assessment to help to determine the most appropriate intervention and support to meet their needs.

Assessments were based on current national guidance to help ensure that they were meeting current standards and maximising the opportunity for the person using the service. People received treatment and support that was evidence-based and in line with national guidelines. This ranged from lower level extended brief interventions, signposting and harm minimisation strategies to more intensive treatment interventions.

Interventions were based on evidence-informed models of care. People who needed treatment received around 6-10 sessions one to one with a practitioner. Staff told us that the length of treatment was set to reflect best practice in addiction interventions and help to ensure positive outcomes, but this could be flexible to meet individual need. Where lower-level support needs were identified, people received shorter, focused support, for example gambling advice and guidance,

self-help tools, or signposting to other support services. People could access the service again at any point in the future should they need this.

The provider also worked closely with regional GPs to increase their awareness about gambling harm. This included work with social prescribers and ensuring they all had information on gambling related harms and services to support them in their work as well. They were also piloting a project with another provider and the Royal College of GPs (RCGP) to help GP practices become accredited and to promote gambling screening in line with NICE guidelines.

How staff, teams and services work together

The provider coordinated effectively with other services to ensure good outcomes for people requiring support and treatment for gambling harms and their wider impact. This included NHS and network partners who they had arrangements in place with to both refer people to and accept referrals from for support, along with a significant number of wider support services in the region.

The provider ensured that people who used the service had plans for transitions to other services or for discharge, and that they had relevant support in place. This included having contact with the provider at set intervals for the first 12 months after treatment. Events had been held to share information with people about options for support once treatment had ended, including services who offered peer support from people with lived experience.

We saw evidence of the provider working with partners in the region to develop referral pathways, for example with local authorities, universities and local businesses in the region.

Staff that we spoke with during the inspection told us that the team worked effectively together at all levels to provide good support for the people they worked with. This included having regular team meetings to ensure that key information was shared. Electronic clinical record keeping allowed secure sharing of information between staff.

Supporting people to live healthier lives

We saw evidence of the provider referring service users to relevant support services when health risks emerged or their health deteriorated, for example sharing information with GPs and community mental health teams. They also referred people for help to services which supported wider health and wellbeing needs. The provider has also held pop-up stalls to help promote the services at places such as local foodbanks.

The provider had established effective links with a range of stakeholders in the community to help increase people's knowledge about gambling harm and to support early identification of people needing support and treatment. 'Champions' helped to reduce stigma, increase awareness, and supporting early identification and referral into the service. At the time of this assessment there were 128 Champions recruited across 83 organisations, these included NHS services, universities, local authorities and charities including those supporting people with homelessness.

Monitoring and improving outcomes

The provider used recognised gambling harm and wellness scoring tools. This included the Problem Gambling Severity Index (PGSI) and CORE outcome measure (CORE-10) tool to monitor outcomes for service users at different stages of therapeutic intervention. Data showed that people receiving support from the provider consistently experienced positive outcomes both in reducing their gambling related harm but also improvements in their mental wellbeing by the end of their treatment.

The provider monitored scoring tool outcomes during treatment and used this to inform decisions about service users' support, for example extending treatment sessions, referring to healthcare

partners for additional support or referring them to NGSN partners for more intensive treatment. There was also oversight and support around clinical tools used by the clinical director.

The provider submitted regular data to the commissioner around service delivery and reported against a range of performance indicators. Recent information shared with us was positive. For example, developing pathways with external organisations.

Consent to support and treatment

Staff considered and understood how to manage consent and concerns around capacity. Staff gained people's consent in initial discussions, and this was documented in their records. A consent and confidentiality agreement set out what people using the service could expect in terms of how information would be shared.

Staff gained people's consent when sharing information about their treatment with other professionals, for example GPs or mental health teams. Again, this was documented clearly in people's records.

Staff received training around the Mental Capacity Act and Deprivation of Liberty Safeguards (safeguards for people who lack capacity to make decisions about their care) as part of their mandatory training to support them in their roles.

Is the service caring?

Caring overall summary

In summary we found that staff were hard working and motivated to help improve the outcomes for people that they were working with. People were very positive about the staff they were working with and told us that they were all treated with kindness and respect. Management cared about their staff and supported them in their roles.

Kindness, compassion and dignity

All the staff we spoke with during our assessment demonstrated a caring and compassionate approach towards the people that they were working with and were motivated to support them. We found that staff were non-judgmental in their approach and focused on individual needs.

We received excellent feedback from people who used the service who told us that they were treated with kindness and compassion by the provider. One person told us “My support worker always calls me on time and treats me with the upmost respect. She always makes me feel comfortable and at ease”. Another person highlighted that their worker was “very supportive and understanding and giving me everything I was looking for”. A theme from the feedback we received was that people felt that they could trust staff and that they were treated with dignity and respect. One person stated their worker “has been absolutely amazing she’s got me through some of the hardest days of my life and I owe her so much I just want to thank her for everything, she really has made a difference to my life, she’s so caring and listened and helped me with all my problems. You (NECA) are very lucky to have her”.

We saw evidence that people were assured that their information was treated confidentially (unless they were at risk of serious harm) and staff respected their privacy by working to the methods of communication requested by the person using the service.

One stakeholder who shared feedback about the provider stated that “We have found NECA to be very responsive” and that “we have always found NECA to be understanding and empathetic regarding our requests for their specialist expertise”.

Treating people as individuals

There was a strong ethos from the provider about working with a person as an individual and ensuring their needs were met. This was supported by a range of policies and procedures. Staff had received training which included communication skills, working with autistic people and equality, diversity and human rights which helped to ensure that individual needs were prioritised and reflected in the treatment and support delivered.

The provider delivered support that met specific cultural needs. For example, working with Investing in People and Culture to reach into Czech and Roma communities through mentoring, interpreting and bespoke materials to delivering on-going support groups for affected others.

There was access to an interpretation service where required and staff we spoke with demonstrated an understanding around cultural and religious needs for these communities.

Independence, choice and control

People who used the service choose to engage with the provider and told us support was offered in a way that met their needs, for example through a mixture of face-to-face and remote sessions to fit

around other aspects of their life. The provider did not penalise people who had failed to attend interventions and continued to try and re-engage with them as appropriate while respecting their choice.

The provider was able to access interpreters for service users who spoke other languages, and written materials were also available in a range of languages.

Responding to people's immediate needs

The provider quickly assessed people's immediate needs during their initial contact with the service and could signpost or refer people to other services that could support them, for example physical or mental health professionals.

Whilst accessing interventions, staff monitored people's psychological distress using the CORE-10 psychological assessment tool at the end of each session to ensure responsive action was taken such as escalation to support to meet individual needs if required.

Workforce wellbeing and enablement

Staff we spoke with during the assessment all felt the provider prioritised staff wellbeing. There was an open culture and staff felt supported by both managers and peers. One person told us that it was the best place they had worked due to the culture. Staff felt well supported in their roles, noting that managers had an open-door policy and communicated effectively and regularly with all staff.

Staff told us they received regular supervision and attended regular all staff meetings to support them in their roles. They also said the provider was responsive to providing additional training and support.

Staff that we spoke with stated that current caseloads were manageable and that before any new cases were allocated, these were discussed to ensure that this was manageable and staff felt supported by managers if they felt unable to take on new cases.

Is the service responsive?

Response overall summary

In summary we found that the provider understood the diverse health and care needs of people and local communities. This included helping to ensure equity in access which was underpinned by strong partnership work across the community. There were systems in place to enable people to share feedback or raise complaints about their treatment and support and evidence that appropriate action had been taken as a result.

Person-centred support

We found that the treatment and support delivered was person centred and focused on meeting each person's needs and preferences. People receiving treatment had an individualised care plan in place. This was co-produced to ensure it reflected the person's needs, their goals and how they could best be supported. Care plans were reviewed regularly to ensure that represented the current needs of the person. One staff member told us that the service provided "client-driven therapy, plans are flexible, no fit all approach as every client has a different story'.

People who used the services confirmed that support and treatment met their needs. One person who attended a group felt that the staff member "gave direction but listened to what we needed".

We heard examples of how staff provided person-centred support to meet people's specific needs. For example, staff sent screening tools to a person with autism in advance of their meetings to support better communication and understanding.

People who used the service were given a choice of whether they would like remote support or face to face. Where people chose face to face, sessions were held in the providers' offices, but also in a number of places, such as confidential rooms in banks. Confidential spaces were available across the region to ensure that they best supported people and facilitated access in their local areas.

Care provision, integration, and continuity

There were clear referral pathways in place helping to support people in accessing the service. People could access support via the national helpline, self-referral or being referred by other professionals. The provider had developed a range of promotional materials as part of a strategy to increase awareness of their services to the general population. These included the use of QR codes including the use of advertised QR codes, meaning people could self-refer decreasing the fear of any judgment.

The provider offered a range of provision from education to treatment. Staff used the assessment process to determine what support would best meet a person's needs. Data showed that there were minimal waiting times for both assessment and treatment ensuring people had timely access. We also found that the changing needs of people using the service were reviewed regularly and that referrals to appropriate services had been made to support them with additional needs.

People who were accessing treatment worked with the same practitioner to help ensure continuity and build professional relationships. This started from the first point of contact with the service.

We found that the provider was focused on being inclusive as well as responsive to the different needs of people who used the service. They had developed specialist programmes to ensure that all needs were met.

Providing information

The provider had information available about the service as well as wider information on general health and wellbeing which were in both paper form and on their website. Information was available in different languages and the provider had worked with leaders in communities to ensure resources were culturally appropriate. Staff could access translation services as needed.

People who used the service received an appropriate resource pack. These included practical advice and information tailored to people who used the service including affected others, such as family members. There was signposting to other relevant support groups as well as pocket guides on topics such as 'Dealing with worry' and 'Living with Someone's Alcohol and Drug Use or Gambling'.

People could also access information outside of working hours on the providers website. This included a dedicated crisis support section with emergency contact details as well as general self-help and wellbeing information.

Listening to and involving people

Complaints processes were in place for people who used the service and these were well advertised including on posters and leaflets. People were informed about the complaints policy and how to raise concerns should they need to at the start of their support. Information provided was clear to help ensure that it was accessible for all people using the service. In the previous 12 months to this assessment, there had been one complaint and we saw that this had been investigated and that positive action had been taken because of this and that the complainant was happy with the action.

People were regularly asked for feedback and this included looking at the delivery of the interventions, as well as how accessible the service was and the impact of the intervention. Focus groups were also held to capture feedback as well as 'roundtable' events where both stakeholders and people who used the service discussed provision and co-produced improvements or solutions.

People who were affected by another person's gambling, for example partners and parents, were also able to access support through the provider. This included a weekly group meeting which had been running for over 2 years. We spoke with people who were accessing this and they were all very complimentary about the supported provided.

Equity in access

People could access free support from NECA without delay. There were very short timescales between initial contact with the service, assessment for support needs and to treatment if needed. People were not penalised if they did not attend any sessions and practitioners tried to reengage with people to continue to offer support.

Support was delivered both remotely or face to face depending on geography and the wishes and needs of the person who used the service. We found that staff considered individual needs when planning how they would access support and treatment.

Information was provided both in the resource pack and also online about where people could access support when the service was closed.

Equity in experiences and outcomes

The provider had clear systems in place to ensure all people had access to support and treatment outside of the service as needed. People who used the service told us that staff considered their preferences during their support and treatment.

Staff had access to a policy setting out expectations around equality and diversity within the organisation and received regular training around this. Feedback we received during this assessment was all positive about staff attitudes and we did not receive any information about any discrimination they had experienced.

Planning for the future

The provider had good discharge processes in place which focused on recovery and ensuring all peoples' needs had been met. People who used the service could access a range of aftercare to help support them in their journey. This included ongoing group sessions around relapse prevention, and events which informed people about other services such as peer support from people with lived experience.

The provider contacted people at 3, 6 and 12 months after completing their treatment to enable them to discuss their progress and support them if new or additional needs had arisen. People were able to re-enter the service at any point to access further support and treatment helping to support them in their journey.

People who used the service told us that they felt listened to and supported. One person stated, "Brilliant service, (worker) is really helping me in my journey".

Is the service well-led?

Well-led overall summary

In summary we found that there was a strong shared vision across the provider. 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 very approachable and that they felt listened to by them. There were established and effective governance processes in place and good oversight of performance and service delivery.

Shared direction and culture

The provider had a clear vision to work effectively with local communities and stakeholders to increase awareness, educate, promote early identification and provide effective support and treatment. Staff that we spoke with during the assessment were clear about the provider's vision and values and described providing support which displayed these values. Feedback from people who used the service was positive and reflected that staff displayed the provider's values when supporting them.

Staff we spoke with during the assessment described the culture as 'open' and 'non-blaming', and all felt that they had exceptional support from both managers and colleagues. One person stated that managers were "really responsive, I don't feel isolated even though we work remotely…always feel at ease if you need to contact someone for support. Makes you feel supported." Another staff member told us that there was an "open culture and if a person makes a mistake, we are not afraid to be open" and that managers "will share things with the team about things that work and don't work." There were regular team meetings and supervision for staff which helped to facilitate an open culture with a focus on learning and improvement for the service.

Capable, compassionate and inclusive leaders

The service had a strong management team who had the relevant skills, knowledge and capability to ensure a credible service was delivered and that risks identified were well managed. Managers that we spoke with understood the service they were leading and the challenges in delivering a high quality and sustainable service. They highlighted challenges such as the difference between the 2 regions in terms of the impact of only delivering treatment rather than engagement and treatment in the Yorkshire and Humber region.

Staff told us that leaders in the organisation were approachable and visible and gave staff the relevant direction and support.

We heard that the provider's clinical director delivered effective support to the wider staff team, attending team meetings and providing advice around comorbidities NICE guidelines, trends, and promoting engagement with local healthcare services including GPs.

Freedom to speak up

Staff described an 'open' and 'transparent' culture within the organisation. Those that we spoke with told us they knew how to raise concerns and said they would be confident to do so and felt they would be listened to by managers. Staff were supported by appropriate policies and procedures.

Workforce equality, diversity and inclusion

Staff that we spoke with told us they were treated with respect by all managers and colleagues. The provider had diversity and equality policies and procedure in place which set out guidance for staff

around working with and supporting people from different backgrounds and those with protected characteristics. Staff completed training in equality, diversity and human rights as part of their mandatory training to support them in their work and help ensure equality.

Governance, management and sustainability

There were established governance processes in place and oversight of performance and service delivery. The provider had a proactive approach to monitoring the quality of the service and ensuring continuous improvement. This was through analysis of data, feedback from people who used the service, reflective practice and structured governance processes. Monthly data meetings supported the performance of the service. This included reviewing referral patterns, outcome measures and access issues, and additional scrutiny such as emerging trends. Each month in depth reviews were completed on 10% of treatment records to ensure that support, treatment and recording of this was of a high standard and meeting the needs of people who used the service. Feedback was shared with staff individually when improvements were needed, and themes were shared more widely for group discussion.

Systems were in place to identify, record and monitor risks. The provider had a corporate risk register in place to record and monitor ongoing and potential risks to service delivery. In addition, there was a risk register where cases which were identified as medium risk or above would be reviewed weekly by a manager to help ensure that risks were being well managed and the appropriate action had been taken.

We sampled a range of policies and procedures which supported service delivery. These were all regularly reviewed with a section clearly showing if changes had been made to help staff follow any recent changes.

NGSN services are funded by GambleAware, and this funding includes voluntary financial contributions from gambling operators as legally required by the Gambling Commission. We found that the provider delivered treatment and support that was independent and free from any influence from the gambling industry.

Partnerships and communities

There was evidence of strong and well-established partnership work with both the public and private sectors. This helped to educate, increase awareness, support early identification and help ensure all people were more informed and aware of gambling-related harms. For example, the work completed with the PCC had resulted in changes to the police screening process with specific gambling harm questions now being asked. Training had also been completed with Victim Support, and police staff and at the time of the assessment to educate, identify and refer into the service. The provider had a strong focus on community engagement and developing links with various regional partners. Through increased engagement, they had developed effective links which had increased referrals from partners for both brief and therapeutic interventions. The provider had also developed a network of community champions in the region including large businesses. We heard examples of how champions had helped to reducing stigma, increasing awareness, and supported early identification.

Stakeholders that gave us feedback described strong partnership working. One organisation stated, “We have always found NECA to be very willing to work in partnership with (name of service) and we value the good working relationship we have with them”.

Learning, improvement and innovation

The provider had a strong focus on service development to ensure that people in local communities and the region could access appropriate support for the gambling harm and wider wellbeing needs. The provider had also engaged with many partners across areas such as local healthcare, education and homelessness services to deliver training and support and promote a better understanding of gambling harms and established gambling harm ‘champions’.

The provider had been innovative in their approach to ensure they were as inclusive as possible. For example, they had recently created a podcast which was about to be published helping to reach and educate a wider audience about gambling harms and the use of QR codes to access referral pathways.

Staff had received training around models of care, which included cognitive behavioural therapy (CBT) and motivational interviewing skills to help support their work. People we spoke with felt that staff were knowledgeable and one person told us that “(worker) has the skills and knowledge to help us and keeps us updated on the latest developments”.

The provider had also introduced regular policy awareness training which used an online question-based format. These questions were tailored to specific organisational policies and are designed to raise awareness, reinforce key content, and assess staff knowledge which helped to ensure they were embedded into day-to-day practice.