LEEDS BECKETT UNIVERSITY
SCHOOL OF HEALTH & COMMUNITY STUDIES

Setting up a service for gambling addiction: a formative evaluation of the NHS Northern Gambling Clinic Leeds Hub

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July 2020

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Executive summary

Background

GambleAware recognise the need to increase the national capacity for the treatment of gambling problems. There is a large discrepancy between the numbers currently receiving treatment and the number of people estimated to be in need of treatment for problem gambling, especially for those with more severe addictions. In addition, there is a need for treatment of people with co-morbid mental and physical health conditions, with impaired social functioning and those who may present with more risk, such as risk of suicide.

Leeds was identified as the key location for establishing a service to provide the treatment of gambling problems, with plans to develop problem gambling service provisions including clinics in other urban centres in the north east and north west. As part of the development of this service, Leeds Beckett University were commissioned to undertake a formative evaluation of the NHS Northern Gambling Clinic Leeds Hub (NGSLH).

Model for the new service

The NGSLH was created following the submission of a joint proposal between Leeds and York Partnership Foundation Trust and GamCare. The project began in October 2018 and delivery commencing in September 2019. The model planned would provide care, based on the assessment of need for the full spectrum of people with problem gambling. It was a key assumption that referrals into the service would come from GamCare (via the National Gambling Helpline) along with a direct referral system from other care providers such as GPs and mental health practitioners, self-referral, and from the criminal justice system and wider support services such as housing or debt counsellors.

Aim and objectives

This evaluation aimed to carry out a formative evaluation of the new NGSLH to provide Gamble Aware with insight into the process and experience of the conception, commissioning, and delivery of a new problem gambling treatment service (Northern Gambling Service), which could help to inform the development of future place based services. The objectives were:

- To identify experiences and emerging lessons from the conception, commissioning, and delivery of the new NGSLH.
- Informed by the empirical data, produce a 'how to' guide for the development of similar services in other locations.
- To identify 'what worked well' in the commissioning and delivery of the NGSLH and pitfalls to avoid.

Methodology

A purposive sample of eleven key stakeholders involved in the conception, commissioning, delivery and strategic oversight of the NGSLH were invited to take part in one hour telephone or face-to-face semi structured interviews during February and March 2020 with data collection modifications

made in line with the public sector response to Covid-19. Nine participants took part in the interviews. Documentary data were also received from GambleAware.

Framework analysis was undertaken on both the interview and documentary data with inductive and deductive coding used to identify key themes and insights to capture 'what works' and 'lessons learned' from the implementation of the service.

Key findings

The formative evaluation found:

What worked well

Four key characteristics of the NGSLH were identified by stakeholders as working well in the implementation and running of the service and in achieving high stakeholder satisfaction. These were:

- **Partnership working** - The range of partners involved in the service, and the high level of goodwill and strong desire to deliver the service in Leeds, ensured that issues were able to be worked through.

- **Clinical model** – the range of therapeutic options available to service users worked well, with some stakeholders reporting that the first cohort completing the treatment achieved good outcomes. While no substantial changes had been made to the model - which included engagement strategies, referral and assessment, weekly multidisciplinary team meetings, a range of therapeutic interventions and aftercare - the service was open to making modifications as the evidence base developed.

- **Location of the clinic** – the co-location of the service in a central Leeds City Council building was beneficial as it facilitated ease of access and reduced the stigma attached to approaching more traditional mental health services. It also helped increase awareness of gambling harms within other council services.

- **Operational management and personnel** – strong day to day management allowed the service to operate in a fluid way with good working relationships between the partners. The adoption of digital solutions allowed the service to overcome the operational challenges arising from the response to the Covid-19 pandemic.

Lessons learned

Five areas were identified by stakeholders as issues to improve in the development of any future service. These were:

- **Clarity in the commissioning framework** – The informal approach adopted to the commissioning of the new service had led to a lack of clarity around the role of the partners, and in particular the management of referrals into the service.

- **Agree the pathway and thresholds to support the clinical model** – there was a lack of clarity as to how service users would enter treatment and a risk of unnecessary harms to service users. The management of referrals to the national helpline led to some tensions between the partners.

- **Addressing differences in organisational cultures** – The cultural differences between a statutory organisation, a voluntary sector organisation and council services can lead to issues in the implementation of a joined-up service.

- **Strong project management is essential** – the limitations during the set-up phase of the service contributed to issues experienced with accommodation and financial planning. The recruitment of staff was felt to have taken too long.

- **Agree accommodation needs and the accommodation offer** – the limitations imposed by the physical space in Merrion House has led to issues related to both clinic and office space. In particular, there have been issues relating to IT system access.

Recommendations for place-based services

Table 1 shows the ten recommendations for future place-based service development:

Table 1. Recommendations for future place-based service development.

Area of service development	Recommendations
Strategic Planning: Scoping and Objective Setting	Produce clear service specifications and commissioning processes so that all delivery organisations are clear about expectations and targets. Set clear goals and commissioning objectives where expected activity levels for a service may be difficult to estimate during year one.
Partnership working	Enhance organisational understanding and bridge any cultural differences between partners including the early resolution of tensions between partners.
Clinical model	Ensure an evidence based clinical model is used by all providers with regular refinement in light of emerging evidence of effectiveness. Ensure the referral process is clearly defined and agreed, and best supports service users by directing them to the most appropriate intervention within a service.
Location	Ensure the service is located in a setting which is accessible, maintains service user confidentiality and minimises the

Area of service development	Recommendations
	'stigmatisation' of service users. Ensure that the clinic environment is facilitated by robust IT systems and access.
Operational Management and Infrastructure	Oversee a robust project management approach to mobilisation and operation of the service. Ensure timely recruitment processes are undertaken by providers Ensure providers embrace the use of digital solutions to maximise business continuity in the light of service disruption. This may also attract service users who prefer to engage with the service through digital support.

1. Introduction

1.1 Background

The national rates of gambling disorder are estimated at 0.4% of all adults (Health Survey for England 2018 – Supplementary Analysis on Gambling, NHS Digital, 2019) with approximately 340,000 people experiencing problem gambling, and a further 1.75 million people experiencing some level of harm to health and wellbeing. Research suggests that rates are higher in metropolitan areas, like Leeds, where gambling opportunities are well developed (Kenyon et al., 2016).

Given there are indications that there is a large discrepancy between the numbers currently receiving treatment and the number of people estimated to be in need of treatment for problem gambling, GambleAware recognise the need to increase the national capacity for the treatment of gambling problems, especially for those with more severe addictions. In addition, there is a need for treatment of people with co-morbid mental and physical health conditions, with impaired social functioning and those who may present with more risk, such as risk of suicide.

Until 2019, the majority of treatment services for those affected by gambling harm in Britain was funded via GambleAware and consisted of three main services offering psychosocial interventions ranging from brief information and advice, through counselling and Cognitive Behavioural Therapy (CBT), psychiatric care and residential treatment:

- The largest of the funded providers is **GamCare**, which operates the National Gambling Helpline and a partner network of currently 15 treatment organisations across Great Britain providing counselling.

- **The Gordon Moody Association** offers 12 week residential care for men at centres in Dudley, West Midlands, and Beckenham, Kent and a mixed-mode service for women, combining short-term residential and outpatient therapy.

- **The National Problem Gambling Clinic**, based within the Addictions Service at Central North West London NHS Trust, offers CBT and psychiatric care and is also largely funded by GambleAware.

There was an absence of any other dedicated NHS provision.

Leeds was identified as the key location for establishing this service in the first instance, with plans to develop problem gambling service provisions including clinics in other urban centres in the north east and north west. As part of the development of this service, Leeds Beckett University were commissioned to undertake a formative evaluation of the NHS Northern Gambling Clinic Leeds Hub (NGSLH)[1] to identify any issues, lessons learned, and key successes during the set-up of this gambling treatment service. This would offer insights into how learning could be distilled, and how the model operationalised in Leeds could be transferred elsewhere.

[1] https://www.leedsandyorkpft.nhs.uk/our-services/services-list/northern-gambling-service/

1.2 Aim

This evaluation aimed to carry out a formative evaluation of the new NGSLH to provide Gamble Aware with insight into the process and experience of the conception, commissioning, and delivery of a new problem gambling treatment service (Northern Gambling Service), which could help to inform the development of future place-based services.

1.3 Objectives

- To identify experiences and emerging lessons from the conception, commissioning, and delivery of the new NGSLH.
- Informed by the empirical data, produce a 'How to' guide for the development of similar services in other locations.
- To identify 'What worked well' in the commissioning and delivery of the NGSLH and pitfalls to avoid.

2 Methodology

2.1 Data collection

A purposive sampling approach of key respondents, to encompass those involved in the conception, commissioning, delivery and strategic oversight, was used in the collection of interview data. Individuals were identified following recommendation by GambleAware and liaison with the Clinical Lead of the NHS Northern Gambling Clinic and Leeds Hub who generated the list of key stakeholders.

Initial introductions between the research team and the stakeholders were made by the Clinical Lead, with an email invitation to take part in the interviews, and any reminders, managed by the research team. Eleven individuals were invited to take part in the evaluation between the 20th of February and 27th of March 2020.

Data was collected through a combination of telephone or face-to-face semi-structured interviews at the request of the participant. All interviews were digitally recorded, and field notes taken at the time of the interview. Data was collected from nine participants through eight interviews (one paired-interview). As a result of the unavoidable organisational impacts of the Covid-19 response in the public sector from the 17th of March 2020, one respondent submitted comments in relation to the interview schedule via email. See Appendix 1 for details of the interview schedule.

Documentary data were received from GambleAware which informed the data gathering. The data outlined, in part, the set up and implementation of the service through a business plan and meeting minutes. See Appendix 2 for details of the documentary data received from GambleAware.

The evaluation was given ethical approval through Leeds Beckett University ethics procedures and all the necessary processes – including full participant information, consent and the right to withdraw – were followed to ensure ethical rigour and safeguarding of participants.

2.2 Data analysis

A process of critical listening was undertaken where salient extracts of data were transcribed verbatim and framework analysis, an approach well-used in policy and practice development, to develop the analytic framework. This was done through a combination of inductive and deductive coding of the interview transcripts with key themes and insights emerging from the combined data set. Themes were reviewed internally by members of the evaluation team, with any discrepancies discussed and resolved. These key themes were structured to address the evaluation objectives of capturing experiences and 'lessons learned' from the implementation of the service.

The documentary data was summarised and analysed using the framework structure applied to the interview data.

3 Key findings

3.1 Overview of the service

In October 2018, a joint proposal was submitted to GambleAware describing the NHS Northern Gambling Clinic and Leeds Hub delivered by Leeds and York Partnership NHS Foundation Trust (LYPFT) in partnership with GamCare. The model planned would provide care for the full spectrum of need for treatment of people with gambling problems, and co-morbid conditions who were based in Leeds, and also provide clinics based across the north of England.

The LYPFT provision, the NHS Northern Gambling Service, was established to link in and collaborate with GamCare and the National Gambling Helpline. This identified a care pathway to allow patients to receive the right level of care, from the right provider, according to their needs and in accordance with collaborative multi-disciplinary team discussion on assessment and triage. The Northern Gambling Service would provide care to those with more severe gambling disorders, with co-morbid mental and physical health conditions, with impaired social functioning, and those who may present with more risk.

The joint proposal submitted to GambleAware by LYPFT and GamCare described how referrals into the service would come from GamCare via the National Gambling Helpline, along with a direct referral system from other care providers such as GPs and mental health practitioners, self-referral, from the criminal justice system, and from wider support services such as housing or debt counsellors.

The service was provided across the north of England from major conurbations utilising technology, where appropriate, in order to provide care and reduce travel costs. Once demand had been established within a locality, staff would then be recruited.

The service started delivery in Leeds during September 2019.

3.2 Key mechanisms contributing to success

While not reporting outcomes from service delivery for service users, the evaluation identified key mechanisms or characteristics which were deemed influential for success. These are:

What worked:

- Partnership working
- Clinical model
- Location of the clinic
- Operational management and personnel.

These led to high levels of stakeholder satisfaction with the service.

This section reports the findings about what has been working well in the implementation and running of the service from the stakeholder interviews and documentary data and describes the levels of satisfaction of the stakeholders in relation to the original objectives of the service.

3.2.1 Partnership working

The documentary data from October 2018 detailed the mechanisms for how the full care pathway would be provided by adopting a joined-up approach to the partnership model, delivering the new service involving both LYPFT and GamCare. Though there were some initial problems with clarity around the expectations GambleAware had of both providers, the positive impact of the partnership approach adopted by the stakeholders was reflected on by six stakeholders, particularly in relation to working through issues and finding a way forward:

> *"It was a very useful meeting in terms of clearing the air and it was difficult though people were constructive which was good. It was good because it was the first time all key players were round a table and were communicating directly. So people were able to expose their own basic assumptions and be exposed to other people's basic assumptions, seeing where there was commonality, and seeing where there was ground to close before moving forward." Stakeholder 4.*

The high level of goodwill and a strong desire to deliver the service in Leeds helped ensure the project came to fruition. There was a *'willingness to work together because everyone wants the service'* (Stakeholder 2) and the relationship building between LYPFT and other partners was noted as key to the operational success of the service:

> *"[Clinical Lead] has been at the forefront, kind of the face of the service in many senses...He's ended up developing some of those relationships." Stakeholder 5.*

The range of partners involved with the service was noted as key to its success with the involvement of the NHS essential to establishing gambling as a disorder requiring treatment, GamCare providing connections into the community and delivering education and awareness raising, and Leeds City Council supporting implementation *'behind the scenes'* (Stakeholder 2) across all departments and with the backing of elected members.

3.2.2 Clinical model

The documentary data from October 2018 describes the clinical model adopted by the service. The key characteristics of the model include: engagement strategies, referral and assessment, weekly multidisciplinary team meetings, a range of therapeutic interventions and aftercare. Seven stakeholders talked positively about the care provided through the model, and how the service was agile and dynamic with staff open to making modifications to the model as the evidence base developed:

> *"...It's more or less stayed the same but [the service is] learning as it goes ahead." Stakeholder 8.*

Stakeholders also noted that no substantial changes had been required to the current clinical model to date:

> *"[The service] has got lots of experience with different approaches and models and ways of working so are consciously reflecting on [what is being learned] and whether the model is completely fit." Stakeholder 1.*

The range of therapeutic interventions available to service users was felt to be working very well because *'people who've got gambling addiction need different things and need a range of different interventions and [the service] is well able, right from the off, to deliver that'* (Stakeholder 3). While still in the initial stages of delivery, some stakeholders reported that the first cohort completing treatment achieved good outcomes, and the support provided to the family and those around a problem gambler was highlighted as a particular strength of the current clinical model because *'the families suffer so much* (Stakeholder 9).

3.2.3 Location of the clinic

The documentary data showed that the service planned to have a city centre location and hub and spoke model across the region (data derived from October and November 2018). The city centre location was important to facilitate ease of access to the service given the public transport links and access to car parking. Negotiations with Leeds City Council were ongoing at that point, and by February 2019 a proposal for the accommodation of the service in Merrion House was welcomed by the Project Board.

Four stakeholders reported that the location of the service in Merrion House was a strength of the service, as the central location was ideal for people travelling from across the region into Leeds to access the service. In addition, the location within a busy council facility was also noted as a success of the service, *'the walk-in is brilliant'* (Stakeholder 9), as an individual with concerns about their or another person's gambling behaviour could seek help without the stigma which may be attached to approaching more traditional mental health services:

> *"There are some real advantages...The fact that people aren't coming into a hospital, into a mental health unit, they're coming into the same place where people are talking about their housing benefit or registering the birth of their son. It's a multipurpose council building and I think there is less stigma associated with it than walking into somewhere that says 'here's the gambling clinic'." Stakeholder 3.*

Co-location within a multipurpose council building presents an additional benefit, as it raises the profile of gambling harm with other professional groups or teams. That said, the use of the service was anonymous and *"At no point is their private information shared with [Leeds City Council staff]."* (Stakeholder 6). Though confidentiality and information governance is discussed in the lessons learned below, stakeholders felt that no major issues had been presented by the location of the service:

> *"It's an open plan office... But [the service] haven't had any problems with confidentiality from other teams." Stakeholder 8.*

On a wider level, the co-location of the service in a central Leeds City Council building was felt to be symbolic of what could actually be achieved when partners came together to tackle gambling harm. It was regarded as indicative of how crossing organisational boundaries in formal and informal ways could benefit the delivery of a gambling clinic service.

3.2.4 Operational management and personnel

The documentary data showed that the prioritisation of the recruitment of a project manager was discussed in November 2018, with interim support from LYPFT in place by January 2019 whilst recruitment was ongoing. By October 2019, the Operational Managers of both providers were meeting regularly and the effective day to day running of the service was commented on by four stakeholders. The operational management has been facilitated by recruiting an individual with the set of skills required to manage the project effectively with:

> *"...good people leading the project and developing the processes." (Stakeholder 4).*

This has allowed the service to *'hit the ground running'* (Stakeholder 2) and as the service continues delivery, the Clinical Lead has been able to step away from some of the operational issues and return to a clinical focus while the monthly project meetings allow the service to operate in a fluid way and raise any issues as a result of the good working relationships within the partnership:

> *"[There are] regular meetings with [Operational Leads] to talk about what's going on at the moment. 'Are there any issues that you're facing?' Be that from really minor things about accommodation all the way up to more fundamental things around not getting much traction with this service or that service." Stakeholder 6.*

As the staffing model was fully costed out during the set-up of the service, the budget has not *'caused [the service] too many problems'* (Stakeholder 1) and communications about the launch of the service have been supported by *'Leeds City Council, Gamble Aware and GamCare '* (Stakeholder 7).

The development of an agile working model in the service with the use of digital solutions such as Zoom and Skype have allowed the service to overcome the inevitable operational challenges of working across a number of sites and deliver care through a channel preferred by some service users. In the light of recent events and the need to adapt to the challenges for all health and social care providers presented by the response to Covid-19, this has also helped ensure business continuity.

3.2.5 Stakeholder satisfaction

The documentary data from October 2018 described the two main planning assumptions held by GambleAware in the parameters set for developing the service in Leeds. This included exploring how effective treatment could be delivered locally to more people, and how to deliver regionally based treatment for more complex cases. Five stakeholders reported that they were very satisfied with the development of the service towards the achievement of these objectives.

Though the challenges in developing the clinic in Leeds were acknowledged and are reported later, strong feelings of pride in relation to what had been achieved and the quality of care delivered to those experiencing gambling harms were reported:

> *"I'm very proud to have played a very small part in getting the service up and running here... Delighted that we got to where we are." Stakeholder 2.*

The progress made by the service since the completion of the initial research into the prevalence of gambling harms in Leeds in 2016 was noted by stakeholders. The opening of the clinic in Leeds *'pretty much on schedule'* (Stakeholder 3) was acknowledged as a significant achievement of the project given that this is the first service of its kind outside London.

Stakeholders also reflected that the service is fulfilling an important and under recognised need for the treatment of gambling harm, and provides much needed awareness raising. This consciousness raising was seen to move the issue of gambling harms, and the management of it, higher up the agenda for decision-makers. One stakeholder commented that the willingness of NHS England to commission the service was a *'massive vote of confidence in the team'* (Stakeholder 4), and reflective of the vision and drive of those involved in establishing the service.

3.3 Lessons learned

This section reports what has been less successful in the planning, implementation and delivery of the service from the stakeholder interviews and documentary data, and considers steps that could be taken to prevent the same issues arising in the development of a future service.

3.3.1 Clarity in commissioning

LYPFT had been approached by GambleAware during 2017 to draw up a proposal for a gambling treatment service in Leeds, and the then interim Director of Commissioning also approached GamCare to submit a proposal for a service they would provide in Leeds. Following a stakeholder meeting to discuss the service, GambleAware developed the broad parameters for the hub in Leeds and invited LYPFT and GamCare to submit a joint proposal. Undated documentary data describes these parameters, including planning assumptions, acknowledgement of a need for a monitoring framework to establish impact and value for money, and the need for a team of clinical staff to support more complex cases.

On the appointment of a permanent Director of Commissioning at GambleAware in April 2018, it was reported that working across organisational boundaries had been *'too light touch'* (Stakeholder 4) in the previous requests, and that while each organisation had originally *'thought they would host the service'* (Stakeholder 2) this could be addressed by developing an integrated service. There was, however, *'a general feeling around the table that GambleAware had not been clear in specifying what it wanted'* (Stakeholder 4), and that there had been an overly informal approach to commissioning an ambitious new treatment service prior to April 2018.

The parameters shared with the providers set the terms for the development of a joint proposal, recognising that the service needed to be more ambitious than originally envisaged, and should work across organisational boundaries. This new service would then be the *'crucible to explore different issues'* (Stakeholder 4) and to help develop an understanding of the best way to develop a similar service elsewhere.

However, the commissioning of the treatment service was an issue raised by six stakeholders, who expressed the view that the way the partnership operates was not *'clearly articulated with direction and support from the commissioner'* (Stakeholder 2) particularly in relation to the tiered pathway of care. This led to *'a lot of tension about the NHS coming into this space'* (Stakeholder 1) as there was no clear plan for how the two organisations would be expected to work together. The consequence of this lack of clarity made delivery very challenging. The approach taken by GambleAware was described as *'this is the money available. What is it that you are going to deliver'* (Stakeholder 6), which is in contrast to the more prescriptive procurement processes found in the public sector.

This flexible approach to commissioning was also identified as contributing to the difficulties highlighted by stakeholders around problems in the referral system, as discussed in Section 3.3.2, and the issues arising from accommodation, as discussed below in Section 3.3.5. It was acknowledged by the stakeholders that complications in commissioning may have arisen for a service provided by a public sector organisation to be commissioned by a charity, and that:

> *"Four key organisations having to collaborate is quite a lot of collaboration to be seeking to get under way and formalise within a relatively short period of time'* (Stakeholder 4).

The stakeholders were clear that for future service development, the fluidity of the commissioning approach needs to be balanced more carefully with formal contracting which provides structure and *'a single vision of what is going to be achieved'* (Stakeholder 6) for the providers of the service.

This would also benefit the commissioner and provide an opportunity to monitor the performance of the service as *'[The service is] not told that [it] needs to see X number of patients'* (Stakeholder 3). While there are currently no concerns about the performance of the service, it was noted by the stakeholders that having a target from the commissioner for activity levels in the service could avoid any complacency.

Lessons learned:

The fluidity of the commissioning approach needs to be balanced more carefully with formal contracting which provides structure and a single vision for the providers of the service.

3.3.2 Agree the pathway and thresholds to support the clinical model

The documentary data from October 2018 describes that the two delivery partners agreed to align the assessment and triage of people accessing the service with an agreed treatment pathway established.

Five stakeholders highlighted lessons to be learned from the management of referrals. One issue was the lack of clarity as to where the more complex service users would enter treatment. While those working within the Northern Gambling Service Leeds Hub were clear about the referral criteria described in the joint proposal, several stakeholders felt that the lack of specification in the commissioning of the service left this open to interpretation by GamCare, who were also managing the National Gambling Helpline:

> *"No one has to come to any conclusion how you would specify who a complex client is." Stakeholder 8.*

While no target for the number of referrals managed by NGSLH had been agreed with Gamble Aware ahead of the launch of the service, concerns were raised by a range of stakeholders. The numbers referred to the service from contacts made by potential service users to the National Gambling Helpline have remained very low since September 2019, in relation to the number of calls and referrals made to the National Gambling Helpline. Similar concerns were raised in relation to the lack of referrals from GamCare partners who were in a position to refer more complex service users into the Northern Gambling Service.

This lack of a joined up pathway of care for those experiencing gambling harms was described as *'two organisations doing two different things'* (Stakeholder 1), with the issue raised that there was the risk that service users may get lost between the two services, or not receive the most appropriate care at the right time. There was some reflection on the tension this created between the two providers with the '*clear tensions and disagreements on how the two would operate together'* (Stakeholder 7) noted.

A consequence of the current lack of structure in the commissioning of the treatment service has been a need to:

> *"Build trust with the organisations to increase referrals, to increase the partnership work and ultimately make sure that the service is well known and trusted amongst other service deliverers." Stakeholder 6.*

Stakeholders commented that a lesson learned for any future service was the need for a *'fair and independent referral system, without organisations assisting their best interests'* (Stakeholder 1). This would avoid unnecessary harms to service users placed in the wrong part of the care pathway and ensure the system is clear and transparent for all. However, several stakeholders commented that a clear structure set by the commissioner was central to this as:

> *"This shouldn't be left up to the providers to agree. The commissioner should set this in place as providers might be concerned about losing their commission if they are not able to demonstrate sufficiently high levels of activity." Stakeholder 8.*

Lessons learned:

A clearly defined and agreed referral system is needed to avoid unnecessary harms to service users placed in the wrong part of the care pathway and to ensure the system is clear and transparent for all.

3.3.3 Address any differences in organisational cultures

Evidence suggests that it was clear that cross-organisational working would be a core element of the delivery of the new service. Undated documentary data describes the parameters for the development of a treatment hub in Leeds, with GamCare as lead provider of a national network of organisations delivering treatment outside London. It identified that the new service would need to secure support from a multi-disciplinary team of clinical staff from another provider and would require cross-organisational working.

Seven stakeholders described how differences in culture between a statutory organisation, a voluntary sector organisation and council services can lead to issues in the implementation of a joined-up service, and there may be investment needed to overcome these organisational barriers and develop shared values:

> *"It's always going to be complicated when you've got the NHS, council and a charity partner involved. The NHS are just coming to the realisation that that's something that needs to be done but they do come along a bit with the attitude that they are the NHS and therefore this needs to be done in this manner. Which is fine, but part of working in partnership is that you've all got to give a bit and you've all got to take a bit as well." Stakeholder 6.*

It was noted by some stakeholders that GamCare may have had expectations about continuing to pick up the majority of the treatment population and that the NHS would remain *'on the margins'* (Stakeholder 1). This may have created tensions between the partners if there was the belief GamCare would be resistant to losing their market position, despite the expertise of those working in the Northern Gambling Service with regard to the provision of care for the more complex service users.

There are different positions adopted by the two organisations in relation to working with the gambling industry:

> *"The NHS position themselves to say 'we're not going to work directly with the industry, we want to be seen completely separate and independent from the industry', which is fair enough. Whereas GamCare is a bit more, from the engagement point of view, 'we want to make sure they [name of casino] know we are there' and can actually refer people on to services. We need to talk to them." Stakeholder 2.*

This may need to be managed as while it was noted by the stakeholders that the service *'needs to work with everybody, including the industry'* (Stakeholder 9) in order to change work practices and raise awareness of the damage of gambling harms; however, the research and development of the service requires the NHS to be *'squeaky clean'* (Stakeholder 3) and not subject to any perceived conflicts of interest.

Previously working in a clinical setting may have made it harder for the NHS staff to adjust to the shared spaces and 'hot desking' that is required in Merrion House. A culture shift has been required, which may have been facilitated by the informal relationship building that has naturally developed in the shared workspaces.

A future service may benefit from investing the time needed to cement partner relationships and build trust between the two organisations. Though good personal relationships between key individuals were noted, there needs to be a way to escalate concerns and ensure that formal or informal organisation barriers do not hamper the delivery of the service.

Lessons learned:

Time is needed to cement partner relationships and build trust between partner organisations. There needs to be a way to escalate concerns and ensure that formal or informal organisation barriers do not hamper the delivery of the service.

3.3.4 Strong project management is essential

Documentary data from November 2018 indicated that the need for a project manager to be recruited was a priority and that in January 2019 LYPFT had interim support and was recruiting to the post internally. Stakeholder engagement plans were also in place, developed by LYPFT and Leeds City Council. Other engagement events were planned during April 2019 with a marketing plan developed by LYPFT.

Seven stakeholders discussed limitations with the project management of the mobilisation phase of the implementation of the service. While the current operational management of the service was well regarded, it was felt that the project management of the mobilisation phase had *'not been robust enough'* (Stakeholder 5). Several stakeholders mentioned the absence of a project plan, though it was acknowledged that this may have existed but that it had not been shared with them:

> *"[Names] have taken the lead on getting the service in place and identified what actions needed to be done and at what time but I've not been shared a project plan." Stakeholder 5.*

While there were monthly meetings during the mobilisation phase of the service, the *'fluid approach'* (Stakeholder 6) to the implementation may have contributed to the issues around accommodation that were now being experienced[2]. For example, the confusion arising from a planning assumption held by several stakeholders that it had been agreed that GamCare were delivering their services from community venues, whereas in reality they took one of the two rooms allocated to the service in Merrion House:

> *"[The service] thought that was clear. But it needed to be in an email, or written down, rather than just a verbal agreement." Stakeholder 8.*

As risks and issues may not have been monitored as part of robust project management, as a consequence the service had to operate and try and resolve the problems arising from the inadequate accommodation, rather than acknowledging and mitigating for them beforehand.

Stakeholders also described the impact of the project management on the financial planning for the service. While there were no concerns over the current funding of the service, it was suggested that assumptions were made about financial arrangements rather than fully costed plans put in place:

> *"It was assumed that [Leeds City Council] would pick up accommodation costs. But that was assumed because they are based in [a Leeds City Council] building and that was assumed after the money was given and there was no money for accommodation." Stakeholder 6.*

Though stakeholder engagement plans were in place, there also appeared to be little financial planning for the essential marketing and promotional work that needed to be done to support the launch of the service:

> *"The service was unable to be clear on what costs were available for marketing work at an early stage. If they could have provided a ring fenced budget and clearer idea on what level of referrals they wanted, a marketing campaign [could have been developed] alongside all the PR work." Stakeholder 7.*

The absence of a financial breakdown and spending plan was noted as being in contrast to stakeholder's experiences in other services where these important projections are made in order to facilitate planning. This may be related to the lack of structure in the way the service was commissioned, as discussed in Section 3.3.1. It was noted by the stakeholders that strong project management was essential and *'there needed to be someone who was taking the reins and steering it more systematically'* (Stakeholder 1). Indeed, stakeholders observed that control of the project group seemed to rest with one partner who were not, in fact, leading the project. This may have led to a number of decisions which did not deliver the best outcomes for the service.

For future service development, taking a strong project management approach with appropriate governance, logging and management of risks and issues, and financial planning would be essential. This would also offer the commissioner a way of assuring the service delivery was on schedule and on budget.

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[2] See 3.3.5

Lessons learned:

A strong project management approach with appropriate governance, logging and management of risks and issues, and financial planning is essential.

3.3.4.1 *Improve mobilisation and recruitment*

Stakeholders also highlighted an associated issue arising from the project management of the service. That was the length of time needed to launch the service. The documentary data shows that the service expected a four month lead time to launch the service in Leeds. However, several stakeholders reflected that *'progress with getting the service off the ground was very slow'* (Stakeholder 9). In particular, the recruitment of the mobilisation lead *'took too long'* (Stakeholder 2), and the amount of time needed for mobilisation in terms of the practicalities and relationship building needed could have been better accounted for.

The recruitment to the service was highlighted by some stakeholders:

> *"I was surprised [the service] recruited their full team in one go. If you're building up your patient numbers surely you're not going to need all those people to begin with. Why are you not having a phased approach?" Stakeholder 2.*

Having a core team of clinicians in place while the service built up referral numbers may have increased the speed at which the service could have become operational. In addition, there was other acknowledgement that it can easily be underestimated how long the process of recruitment can take in public sector organisations. However, it should be noted that stakeholders were clear about the importance of recruiting the most highly experienced and specialised staff for the service, and that two weeks of full time staff development and training was planned ahead of the launch to ensure that all staff were fully competent in the specialist management of gambling disorders.

As part of an improved project management approach, any future service should fully scope out the implications of the resource needed to deliver the service and the time required to recruit and train those entering the service.

Lessons learned:

As part of an improved project management approach, full scoping should be done of the implications of the resource needed to deliver the service and the time required for recruitment and training.

3.3.5 Agree the accommodation needs and accommodation offer

The ratio of staff to desks available in Merrion House, combined with the building not opening out of hours, meant that other sites needed to be secured for delivering clinics in the evenings. This was deemed by interviewees to be a challenge to delivery. In February 2019 the proposal for accommodation by Leeds City Council was agreed, and the Operational Manager for the service was asked to refine how the space would be used by the service. The Project Board had further discussions about hardware and connectivity in April 2019.

Seven stakeholders discussed lessons to be learned from the set up of the service in Merrion House. Many described a lack of clarity about what was on offer and the limitations of the physical space on offer from Leeds City Council:

> *"The local authority [was] giving very strong messages 'It's ok, we've got space here, let's just organically grow this." Stakeholder 1.*

There was an expectation that the service would be allocated two rooms for use as clinics, but there was some confusion about the use of clinic space in Merrion House from the launch of their partner service, GamCare who actually took one of these two clinic rooms:

> *"There'd been a misunderstanding about how much of the space that was allocated GamCare would use. [The service] believed that all the clinical space [the service] would use and that [GamCare] would be out in the community hubs." Stakeholder 3.*

The space allocated to the service was described as *'tricky to work in'* (Stakeholder 5) and needed to be *'taken more seriously'* (Stakeholder 1) as the amount of space allocated was not as expected, with only six desks available for up to 14 staff. Maintaining service user confidentiality in the shared work space was challenging for the team, and the model of delivery had to be revised as a result of the limited space available. As a consequence, there are now limited opportunities to grow the service *and* remain co-located with GamCare in Merrion House:

> *"The biggest problem [the service] has got is clinic space...Some sites were agreed, which is nice, but [the service] has one clinic room in Merrion House with other clinics across Leeds city. But it's not just Leeds. People are coming from Hull and Sheffield and further away like Birmingham or Cheshire and they're not going to want to go to Seacroft or Gipton to a council hub. People generally want to come to a city centre. [The service] model was to be in Leeds city centre but that's had to change because there is not enough space at Merrion House. " Stakeholder 8.*

A corresponding lack of articulation of the needs of the service was also highlighted by the stakeholders:

> *"Had [the service] fully assessed what clinic space [the service] needed to be able to run the service and how was that matched against what was being offered?" Stakeholder 5.*

The issues around accommodation could have been raised at an earlier stage and the appropriate choices made ahead of launching the service as *'free accommodation is great, but is it the right thing if it doesn't meet your needs?'* (Stakeholder 5).

Tensions arising from the issues relating to accommodation were noted by the stakeholders, and to prevent these difficulties in any future service, stakeholders suggested that the accommodation should be clarified through formal arrangements, including a lease, and not based on informal or verbal agreements:

> *"It has had to evolve quite flexibly not in a structured way... That's not necessarily always a bad thing but it means that we're all sort of working on different versions of what we think is the outcome...So [the service]has probably not got enough space ...and I think this all does stem back to the flexibility in which the commissioning has been undertaken." Stakeholder 6.*

Lessons learned:

Accommodation should be clarified through formal arrangements, including a lease, and should not be based on informal or verbal agreements.

3.3.5.1 Address IT requirements

Associated with, but also in addition to, the issues around accommodation were those related to IT and interoperability. The documentary data shows that the IT systems were discussed by the Project Board in February 2019 with the suggestion that NHS staff should have access to the systems in Merrion House. However, further discussion was needed around access to telephony, printers and the room booking system within the building.

Four stakeholders reported major difficulties in relation to the IT systems when the service began delivery from Merrion House. These difficulties are still ongoing, and failures of the telephony have resulted in the service *'having to source a mobile phone for the admin staff so that they can accept referrals'* (Stakeholder 5).

Issues relating to interoperability and bringing public sector IT systems together were also described:

> *"They're all nice people and want to work together but you'd never believe the connectivity issues that [the service] had. When you've got two different kinds of public sector firewalls around you, they just don't talk to each other...and despite our best efforts they are not fully resolved." Stakeholder 3.*

The IT problems were felt to come back to the flexible approach to agreeing accommodation requirements and for future services these should be identified and resolved ahead of launch as 'considerable time' had been spent trying to resolve them.

Lessons learned:

Problems with IT should be identified and resolved ahead of the launch of the service.

3.4 Limitations

The findings discussed above should be considered as a snapshot, or cross-sectional view, of the service. As such the issues raised by stakeholders may be influenced by the timing of the data collection and it is not possible to assess the extent to which these issues may be 'teething troubles' that may resolve naturally over time. Nor is it possible to assess the extent to which other issues, which have already been resolved and so were not raised, would be important for commissioners to consider in the future development of a service.

It is also not possible to account for the views of the stakeholders who were not able to take part in the interviews as a result of the unprecedented impacts of the Covid-19 response in the public sector. Valuable insights may have been lost.

These findings only relate to the implementation of the Northern Gambling Service Leeds Hub and do not consider the interdependencies, relationships or perspective of those involved with the establishment of the Leeds Community Gambling Service and GamCare. Nor do they relate to the experiences of establishing the additional clinics operated by LYPFT in Sunderland or Salford as the focus of this evaluation was the treatment centre in Leeds.

4 Conclusions and Recommendations

4.1 Conclusions

This evaluation sought to provide insight into the process and experience of developing the Northern Gambling Service Leeds Hub to support people with gambling disorder and to develop a blueprint for the future roll-out of similar services in the UK.

Drawing on analysis of interview data from nine participants deemed critical in the in the conception, commissioning, delivery and strategic oversight of the service, this formative evaluation noted both key mechanisms facilitating success and 'lessons learned' from the process of implementing the Leeds service.

4.1.1 What worked well

Four areas were identified by stakeholders as working well and which led to high levels of satisfaction with regard to the service achieving its objectives to explore how effective treatment could be delivered locally to more people and how to deliver regionally based treatment for more complex cases. These were:

Partnership working

One of the salient factors contributing to the success of the clinic was partnership working, including the range of partners involved and the shared vision from all constituents to cross organisational boundaries and make the clinic 'work'.

Clinical model

While this evaluation was not concerned with reporting on service user outcomes, the range of therapeutic interventions available to service users was felt to be working very well, with stakeholders reporting some clear successes for those attending the clinic. The high calibre of staff recruited into the service underpins this achievement, particularly in relation to their clinical expertise and experience but also in regard to the skills in the team to manage the day to day running of the service.

Location of the service

The location of the service – being based in the city centre with good transport infrastructure and benefiting from co-location in a council building has strengthened the profile of the service and helped reduce any stigma associated with seeking help. In addition, the presence of a gambling treatment clinic within this shared space undoubtedly raised the agenda of gambling harms within other council teams and services.

Operational management and personnel

Finally, strong day to day management allowed the service to operate in a fluid way with good working relationships between the partners. The adoption of digital solutions allowed the service to overcome the operational challenges arising from the response to the Covid-19 pandemic.

4.1.2 Lessons learned

With regard to the lessons that can be learned from the Leeds service, there were four issues noted as important to avoid replication in any future service.

Clarity

There was a strong sense that clarity was absent from various stages of the commissioning process, particularly in relation to how the partners would work together to provide the service. Further clarity was also required in relation to the referral routes for service users and the pathway of care for those experiencing gambling harms.

Culture

The necessity to understand and bridge organisational cultures is a further lesson that should be noted. Differences in culture between a statutory organisation, a voluntary sector organisation and council services led to issues that could have been mitigated by allowing more time to build organisational resilience and accepting differences in working style and practices.

Project Management

The perceived absence of a robust project management approach seemed to present a missed opportunity for the Leeds service. Taking a formal project management approach with appropriate governance, logging and management of risks and issues, overseeing effective recruitment and training and financial planning would be essential for any future service.

Facilities: Accommodation and IT

Further practical lessons also emerged from this evaluation, including the requirement for sufficient and fit-for purpose accommodation which, at the very minimum, should maintain service user confidentiality. Moreover, having accessible IT systems within the building should not be trivialised or underplayed.

Based on the findings and conclusions the evaluation distils the following ‘blueprint’ for future service delivery.

4.2 Recommendations

This final section draws out recommendations for the development of a gambling clinic derived from empirical evidence from key stakeholders as detailed in Table 1. These form the starting point for a 'blueprint' for service commissioning, design and implementation.

Table 1. Recommendations for future place-based service development.

Area of service development	Recommendations
Strategic Planning: Scoping and Objective Setting	Produce clear service specifications and commissioning processes so that all delivery organisations are clear about expectations and targets. Set clear goals and commissioning objectives where expected activity levels for a service may be difficult to estimate during year one.
Partnership working	Enhance organisational understanding and bridge any cultural differences between partners including the early resolution of tensions between partners.
Clinical model	Ensure an evidence based clinical model is used by all providers with regular refinement in light of emerging evidence of effectiveness. Ensure the referral process is clearly defined and agreed, and best supports service users by directing them to the most appropriate intervention within a service.
Location	Ensure the service is located in a setting which is accessible, maintains service user confidentiality and minimises the 'stigmatisation' of service users. Ensure that the clinic environment is facilitated by robust IT systems and access.
Operational Management and Infrastructure	Oversee a robust project management approach to mobilisation and operation of the service. Ensure timely recruitment processes are undertaken by providers Ensure providers embrace the use of digital solutions to maximise business continuity in the light of service disruption. This may also attract service users who prefer to engage with the service through digital support.

5 Appendix

5.1 Appendix 1: Interview schedule

1. Can you tell me about your role at the Gamble Aware Northern Gambling Service?

2. Can you describe how the project started and what progress has been made?

3. Can you tell me about any issues you have experienced, and what lessons were learned, with regard to:
    a. Recruitment, training and workforce?
    b. Accommodation, estates and planning?
    c. Information Management and Governance?
    d. Finance and costs?

4. Can you tell me what has been working well or what lessons can be learned with regard to partnerships and stakeholders of the Gamble Aware Northern Gambling Service?

5. Can you tell me what has been working well or what lessons can be learned with regard to project management and communications at the Gamble Aware Northern Gambling Service?

6. How do you think the clinical model has changed as the project has developed?
    a. What lessons can be learned from this?

7. Are there any ways in which the service could be improved or modified?

8. Are there aspects of the Gamble Aware Northern Gambling Service which you think are particularly important to sustain long term?

9. Do you have any recommendations for the service?

5.2 Appendix 2: Documentary data received from GambleAware

Gambling service proposal FINAL for submission – October 2018.

GambleAware parameters for developing the Leeds Hub*.

Project meeting for gambling services 3rd October*

Gambling treatment in Leeds meeting notes -14 November 2018

Northern gambling hub meeting notes – 10th January 2019

Gambling hub and clinic meeting agenda – 7th February 2019.

Gambling hub and clinic meeting notes – 7th February 2019.

Leeds Steering Group meeting note – April*

*Exact date of document unknown.

6 References

NHS Digital. (2019). *Health survey for England 2018 – Supplementary analysis on gambling*. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018/health-survey-for-england-2018-supplementary-analysis-on-gambling (Accessed on 9th April 2020).

Kenyon, A. Ormerod, N. Parsons, D., & Wardle, H. (2016). *Problem Gambling in Leeds: Research Report for Leeds City Council.* Leeds Beckett University.