Evaluation of the Effectiveness of the National Gambling Support Network – Scoping Report

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1 Contents, Figures, Glossary

Contents

Figures

Glossary

Table 1.1: Glossary

Term	Definition
GA	GambleAware
NGSN	National Gambling Support Network
NGTS	National Gambling Treatment Service
CA	Contribution Analysis
DRF	Data Reporting Framework
ToC	Theory of Change
PSM	Participatory Systems Mapping
KPIs	Key Performance Indicators
OHID	Office for Health Improvement and Disparities
EJP	Economically Justifiable Price
PCGS	Primary Care Gambling Service
PGSI	Problem Gambling Severity Index
YTD	Year to date
TRTCO	Treatment Commissioner
Q&P	Quality and Performance
CRM	Customer Relationship Management
LE	Lived Experience
ALERTS	GambleAware commissioned Lived Experience group
GRHPG	Gambling Related Harms Provider Group
HRQoL	Health-related quality of life
QALYs	Quality-adjusted life years
ICER	Incremental cost-effectiveness ratio
NMB	Net monetary benefit
NHB	Net health benefit
NIESR	National Institute of Economic and Social Research
NICE	National Institute for Health and Care Excellence
DSA	Deterministic sensitivity analysis

2 Purpose and scope of the report

GambleAware commissioned IFF Research, in consortium with York Health Economics Consortium (YHEC), CECAN Ltd and Dr Sharon Collard, to evaluate the effectiveness of the National Gambling Support Network (NGSN). This report summarises the scoping stage of the evaluation, including implications for the evaluation objectives and design. The aim of the scoping stage was to develop a Theory of Change and systems map for the NGSN, and to refine the initial proposal for evaluating the NGSN.

Overview of the NGSN

Commissioned by GambleAware, The National Gambling Support Network (NGSN) is a network of 13 voluntary sector organisations, that takes a public health and 'regional-first' approach to the prevention of gambling harms.[1] The NGSN provides free, confidential and personalised support across Great Britain for anyone experiencing problems from gambling, as well as those affected by someone else's gambling.

The NGSN accounts for the majority of treatment and support delivered for people affected by gambling harms across Great Britain (GB). The NGSN has developed a particular emphasis on early intervention to prevent the escalation of harms associated with gambling, in addition to providing the necessary treatment and support for those experiencing harms. There are also other forms of support available for those affected by gambling harms: the NHS provides treatment through a network of 15 specialist clinics in England; and there are also other non-NGSN voluntary sector providers, such as lived experience-led groups.

NGSN context

The NGSN was redesigned and recommissioned in 2023, replacing the previous National Gambling Treatment Service (NGTS). The transformation was designed to meet the growing and changing needs of those at risk of gambling harms in Great Britain, by rolling out a regional-first approach that facilitates additional focus on early intervention, as part of a public health approach. As well as supporting integration across voluntary and statutory organisations, this approach enabled delivery of more targeted support across the life journey model for those affected by gambling harms.

Two other policy changes in the gambling harms support landscape will have significant impact on the way that the NGSN will operate in the future, and motivated the need for an evaluation.

Firstly, the 2023 White Paper on gambling reform[2] proposed the introduction of a new statutory levy on gambling operators to fund gambling harms research, prevention and treatment. This will replace the previous voluntary funding system. The Government has confirmed that as part of these changes, the NHS will become the sole commissioner of treatment for gambling harms.

[1] The network expanded from 11 members to 13 on 1st Oct 2024 with the addition of Epic Restart, who will become operational as NGSN members in Jan 2025. They have not been considered in scope for the evaluation activities, therefore this ToC is based on the activities of the 11 existing providers.
[2] https://www.gov.uk/government/publications/high-stakes-gambling-reform-for-the-digital-age

Secondly, updated 2023 NICE Guidelines[3] provided evidence-based recommendations for the care of those affected by gambling harms, which will shape the support provided by the NGSN and the NHS.

These policy changes introduced uncertainty for the NGSN providers and other third-sector support providers. Compounding this, there is considerable need for effective support and treatment for adults affected by gambling harms, with an estimated 1.6 million adults in England alone who are in need of some form of support[4]. Therefore, there is a need to support the NGSN by evaluating and evidencing the delivery of an integrated, high-quality, and cost-effective system between the third sector and NHS, as the NHS specialist clinics start to develop, to ensure people are accessing effective support at the right time.

The evaluation will inform actions that need to be taken to reach this goal, by assessing the overall effectiveness of the NGSN, providing evidence of its strengths and identifying areas of improvement. Ultimately, this aims to build credibility and a shared understanding of the role of the NGSN in future, supporting future partnership with the NHS, and supporting a smooth transition between GambleAware and NHS as the new treatment commissioner.

3 Evaluation objectives and approach

Initial evaluation objectives

The table below summarises the initial evaluation aims and objectives, at the start of the scoping stage. The rest of the document expands on what was learned during the scoping stage and what that means for the evaluation design and delivery.

Table 3.1 Summary of Initial Evaluation Objectives and Research Questions

Nº	Initial evaluation objectives	Initial research questions
1	Develop a Theory of Change for the NGSN system	a) What are the main inputs and activities of the NGSN system, and the benefits those are expected to lead to for system users? b) What are the assumptions underlying this theory of change?
2	Assess the operational effectiveness of the NGSN system	a) What is the NGSN governance structure and how effective is it? b) What are the factors affecting the NGSN system's ability to reduce harm among people experiencing harm from gambling at the regional and national level, and their causal relationship? c) Are GambleAware's principles embedded in the NGSN system?
3	Assess the clinical effectiveness of the NGSN system	a) Who does the NGSN support (and not), regionally and nationally? b) How does eligibility criteria for support access vary across the NGSN, regionally and nationally?

[3] https://www.nice.org.uk/guidance/gid-ng10210/documents/draft-guideline
[4] https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology

Nº	Initial evaluation objectives	Initial research questions
		c) What different tiers of provision are provided by different providers and what proportion of clients experience those different tiers? d) What are the common referral pathways through the NGSN and what factors influence those pathways, including between Helpline and treatment provision? e) Whether/how NGSN system contributes to system and individual-level outcomes as captured in the outcomes framework? f) What are the specialist knowledge/skills in the NGSN? g) How do GambleAware and NGSN providers understand community needs, identify gaps in support and address those gaps?
4	Assess the economic effectiveness of the NGSN system	a) What are the NGSN operating costs? b) What are the cost/ health benefit ratios, both regionally and nationally?
5	Generate and disseminate learning to GambleAware and NGSN system users	N/A

Evaluation approach

Contribution Analysis

The evaluation will adopt a theory-based approach, drawing on a theory of change model and contribution analysis. The theory of change model was developed to set out how the NGSN's operations are expected to affect change in the short, medium and long term by mapping the expected inputs, activities, outputs, outcomes and impacts. IFF developed a Theory of change with GambleAware and NGSN providers. Further detail on how the Theory of Change was developed can be found in Section 6.

Contribution analysis will then be used to explain and test the validity of agreed components in the theory of change model. A series of contribution claims will be developed to articulate how these agreed components leads to change, while recognising the importance of other influencing factors. The contribution claims are simply subsets of the theory of change model that isolate the relevant inputs, activities, and outputs related to specific outcomes and impacts.

The contribution analysis will then test the validity of the contribution claims (meaning, the extent to which they had been met) using a range of evidence from different strands of research, data collection and analyses.

A Three-Phase Approach

The evaluation is being carried out across three phases:

- **Phase 1: Scoping** took place between June and December 2024. Details on the purpose of the scoping stage, activities undertaken and outputs can be found in Section 4.

- **Phase 2: Mainstage** will take place between January and September 2025. This will involve an online survey with provider staff, four provider case studies and the development of an Economic Model based on the protocol agreed at scoping stage (see the appendix). Phase 2 findings will be delivered in an interim report, organised according to the evaluation objectives and research questions.

- **Phase 3: Final Outputs** will be developed between September and November 2025. This phase will involve the final CA workshops with key stakeholders to test and validate evaluation findings. This will ensure that the insights that we generate are robust, ahead of producing the final written report.

4 Scoping stage objectives and approach

Objectives

The objectives of the scoping stage were to develop a Theory of Change and systems map for the NGSN, to inform the evaluation design, and to refine the initial evaluation objectives, research questions and approach for evaluating the NGSN.

Approach

The evaluation conducted the following activities to build on our understanding of the NGSN, and to use that to inform and refine the evaluation scope and approach.

Table 4.1 Scoping stage objectives and approach

Method	Aim/Description	Sample / sources[5]
Qualitative scoping interviews	We captured the views of 17 stakeholders across 11 60-minute remote interviews, to inform development of the Theory of Change and plans for assessing the operational, clinical and cost effectiveness of the NGSN.	Nine GA staff[6], eight provider representatives[7], two DCMS representatives, and one MLS evaluator[8] [9]
Lived Experience workshop	We hosted a virtual group discussion to explore the role of lived experience within the NGSN, and inform development of the Participatory Systems Map and Theory of Change.	Seven members of GambleAware's Lived Experience Council
Participatory Systems Mapping (PSM) workshop	We hosted a two-and-a-half-hour in-person workshop to brainstorm factors that affect the NGSN system's ability to reduce harm among people experiencing harm from gambling. Results informed the development of draft Participatory Systems Maps.	Two GA staff, and eight provider representatives

[5] GA informed NHSE of the evaluation and decided not to invite them to take part in scoping stage research activities because of other strategic priorities at the time, and NHSE availability.
[6] GA staff included those in leadership, quality and performance, provider management, and data roles.
[7] Providers represented included the Primary Care Gambling Service (PCGS), Betknowmore, Beacons Counselling Trust, GamCare and Gordon Moody.
[8] Evaluator was a representative from the Tavistock Institute of Health, who are concurrently evaluating GambleAware's Mobilising Local Systems (MLS) funding programme.
[9] Representatives from the Gambling Commission were also invited to participate in a scoping discussion, but declined to take part.

Participatory Systems Mapping (PSM) supplementary mapping interviews	We also gathered input from additional stakeholders who were unable to attend the in-person workshop, across three virtual follow up sessions.	Two GA staff, and two PCGS representatives
Participatory Systems Mapping (PSM) validation workshop	The draft participatory systems maps were presented to stakeholders in a one-and-a-half-hour online session, to gather additional evidence to produce a single map.	One GA staff member, and 7 provider representatives
Theory of Change workshop	We created a draft Theory of Change based on the document review, scoping discussions and lived experience workshop. We then hosted an online workshop with 13 stakeholders to test and refine the draft.	Six GA staff, and 7 provider representatives
Secondary data mapping[10]	We reviewed secondary data relating to the clinical effectiveness and cost effectiveness of the NGSN, to assess whether datasets would be usable for subsequent phases of the evaluation, and inform the development of an economic protocol.	• GambleAware's Data Reporting Framework (DRF), • The Annual GB Treatment and Support Survey carried out by YouGov, the National Statistic on Gambling commissioned by the Gambling Commission, • GambleAware's PDC KPI reports, • the Public Health England report on gambling harms, • the National Gambling Treatment Service and GamCare National Helpline Service Development Plan, • GamCare Trustees' Annual Report and Financial Statements, • NHS Digital admissions episodes, • Office for Health Improvement and Disparities data, • Office for National Statistics population data.

[10] Theseus is the NGSN CRM which is accessed by NGSN providers and where they enter appointments, treatment, case notes etc. At the moment it is managed by GamCare (commissioned by GA) and GamCare provide performance reporting to GA (and access to dashboards for reporting but GA or providers do not have the actual data). GA are in the process of building a data warehouse so they will manage the CRM and have access to the anonymised data in Theseus for the purposes of reporting in the future. This means this provider-level data is unavailable for this evaluation.

Document review	We conducted a review and synthesis of various documents to begin assessing the operational, clinical effectiveness and cost-effectiveness of the NGSN.	44 documents: 28 relating to service and treatment delivery, and 16 relating to NGSN governance.

Further detail on the approach for the Participatory Systems Mapping (PSM) and economic protocol is listed below.

- **Participatory Systems Mapping (PSM):** PSM was proposed for use in the scoping phase to explore and capture the complexity of systems of interest and use this to inform the overall evaluation design and delivery. The method engages stakeholders in exploring the complexity of the system they work in. It promotes a shared understanding of the context which the evaluation is operating in and, through making complexity explicit, it is intended to make it easier to identify what is important and where efforts should be focused. By using PSM, CECAN Ltd aimed to explore the factors affecting the operational effectiveness of NGSN. The systems map is a visual representation of the factors that affect the NGSN system's ability to reduce harm among people experiencing harm from gambling at the regional and national level, and their causal relationships.

- **Economic protocol:** The aim of the economic protocol is to outline the objectives, modelling approach, assumptions, and limitations of the cost-effectiveness evaluation. Multiple non-systematic targeted literature searches were conducted to identify the current evidence surrounding gambling harms and the NGSN. The aim of the searches was to:

    - Understand the resource use within the NGSN treatment pathway.

    - Extract information on previous economic evaluations into gambling and the type of modelling used.

    - Extract potential inputs to be used in the economic model, including transition probabilities, costs, resource use, and utilities.

The full eligibility criteria and search strategies can be found in the full protocol. These searches were also complimented by a review of documents provided by the NGSN, to support the conceptualisation of the modelling approach.

Outputs

Findings from scoping stage activities were used to inform the development of three key outputs which will be further tested and refined in coming phases of the evaluation:

- **Participatory Systems Map** – a visual representation of factors influencing the NGSN system's ability to reduce harm among people experiencing harm from gambling, and the causal relationships between these factors.

- **Theory of Change** – a model representing our understanding of the inputs and activities of the NGSN, and how these are intended to achieve short to medium term outcomes and long-term impacts.

- **Economic Protocol** – summary of objectives, modelling approach, assumptions and limitations of the cost-effectiveness evaluation.

5 Theory of Change

What is a Theory of Change?

A theory of change captures our understanding of the NGSN, illustrates the mechanisms for change and how activities are to be translated into impacts.

More specifically, it depicts the physical inputs and activities of the programme, the short to medium term outcomes that should be achieved through these processes, and the long-term impacts that should eventually be realised through the programme.

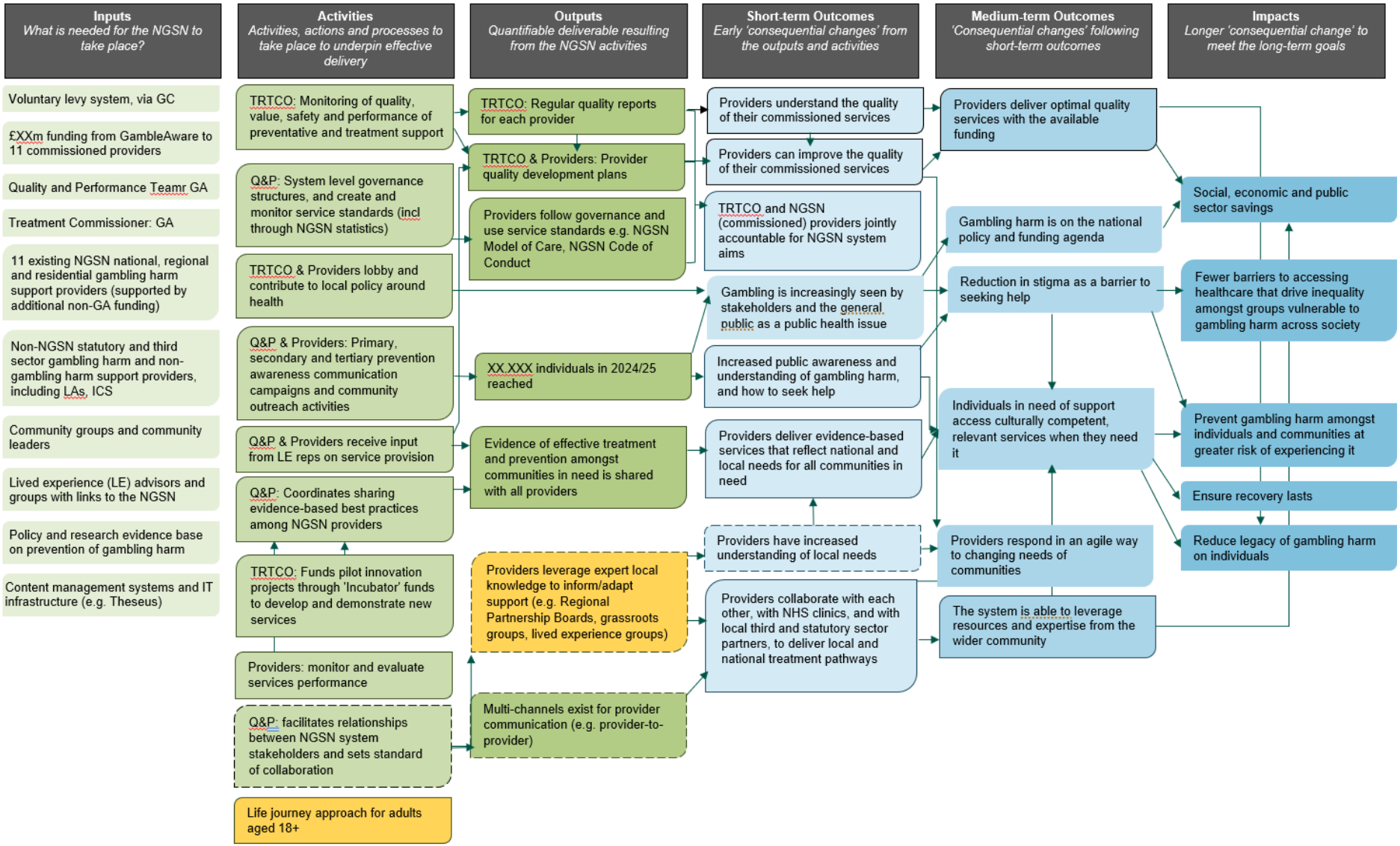
Purpose of the Theory of Change

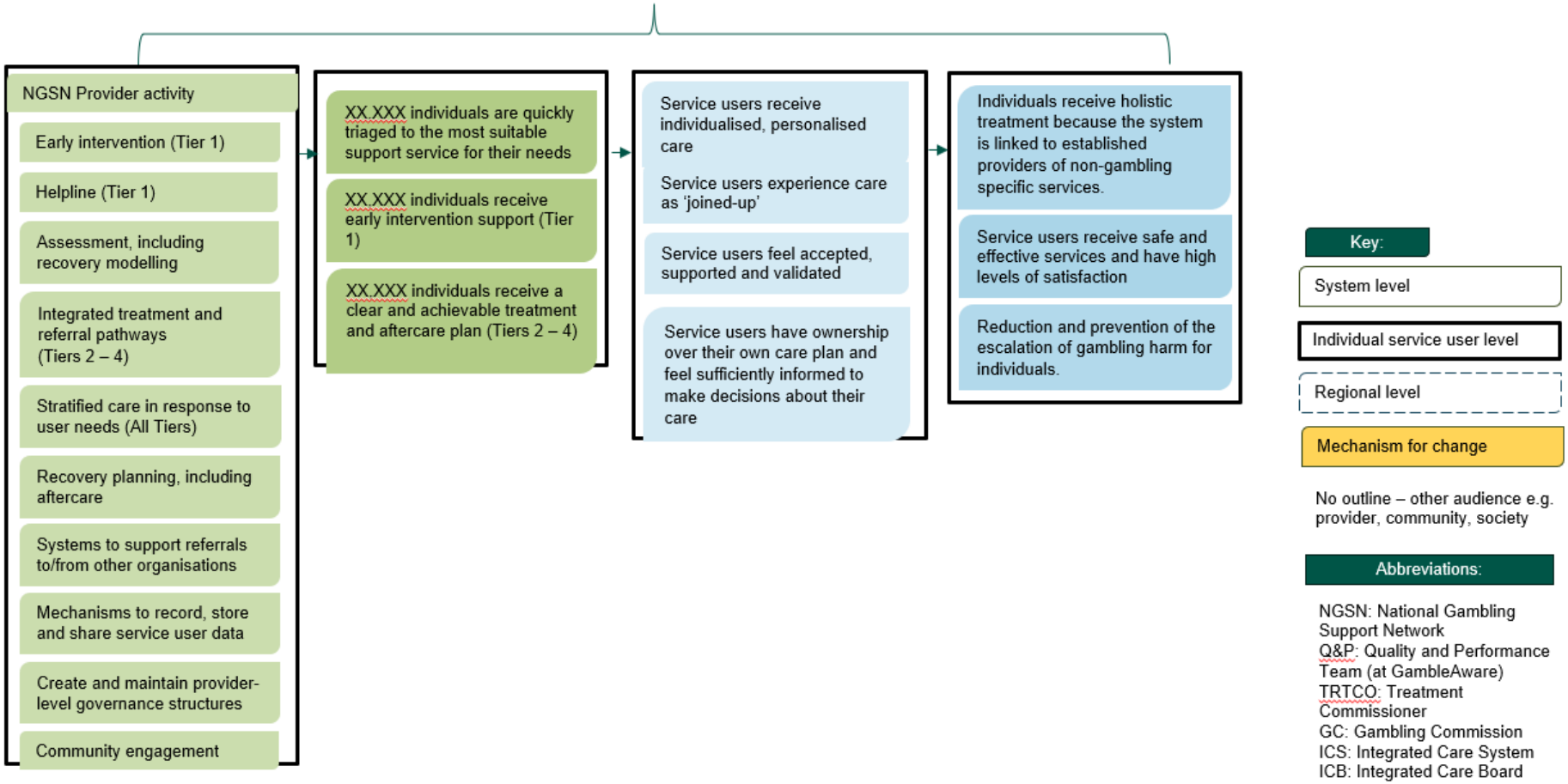
Developing a ToC was a key aim of the scoping phase as its own deliverable and to inform the design of the remaining phases of evaluation. It has been used to identify contribution claims linking causal pathways that explain how outcomes materialise. We will test these contribution claims through contribution analysis in the next phase. It is intended that the ToC will also be helpful for those involved in the design and delivery of the NGSN by helping them to understand their delivery model more clearly, identify any potential gaps or opportunities, identify any changes that need to be made, and understand the causal pathways that should lead to positive outcomes.

NGSN Theory of Change

The final ToC for the NGSN is shown overleaf in Figure 5.1. The ToC was developed by IFF, in collaboration with GambleAware and some NGSN providers, and informed by key documents and scoping interviews. The next section will explain each of the ToC elements in greater detail.

Figure 5.1 NGSN Theory of Change




NGSN Provider activity
Early intervention (Tier 1)
Helpline (Tier 1)
Assessment, including recovery modelling
Integrated treatment and referral pathways (Tiers 2 – 4)
Stratified care in response to user needs (All Tiers)
Recovery planning, including aftercare
Systems to support referrals to/from other organisations
Mechanisms to record, store and share service user data
Create and maintain provider-level governance structures
Community engagement
XX,XXX individuals are quickly triaged to the most suitable support service for their needs
XX,XXX individuals receive early intervention support (Tier 1)
XX,XXX individuals receive a clear and achievable treatment and aftercare plan (Tiers 2 – 4)
Service users receive individualised, personalised care
Service users experience care as 'joined-up'
Service users feel accepted, supported and validated
Service users have ownership over their own care plan and feel sufficiently informed to make decisions about their care
Individuals receive holistic treatment because the system is linked to established providers of non-gambling specific services.
Service users receive safe and effective services and have high levels of satisfaction
Reduction and prevention of the escalation of gambling harm for individuals.
Key:
System level
Individual service user level
Regional level
Mechanism for change
No outline – other audience e.g. provider, community, society
Abbreviations:
NGSN: National Gambling Support Network
Q&P: Quality and Performance Team (at GambleAware)
TRTCO: Treatment Commissioner
GC: Gambling Commission
ICS: Integrated Care System
ICB: Integrated Care Board
LE: Lived Experience

Context and Problem Statement

Commissioned by GambleAware, The National Gambling Support Service (NGSN) is a network of 13 voluntary sector organisations, that takes a public health and 'regional-first' approach to the prevention of gambling harms.[1] The NGSN provides free, confidential and personalised support across Great Britain for anyone experiencing problems from gambling, as well as those affected by someone else's gambling.

The NGSN accounts for the majority of treatment and support delivered for people affected by gambling harms. However, it is not the only form of support. The NHS also provides treatment through a network of specialist clinics, and this network has grown to include 15 specialist clinics across England. There are also other non-NGSN voluntary sector providers (e.g. lived experience led groups). The NGSN has developed a particular emphasis on early intervention and its primary goal is to prevent the escalation of harms associated with gambling, in addition to providing the necessary treatment and support.

The NGSN was redesigned and recommissioned in 2023, replacing the previous National Gambling Treatment Service (NGTS). This process was informed by research conducted by GambleAware indicating that of those who reported experiencing harm from gambling, a small group of people who would benefit from treatment and support services in Great Britain were accessing them. The new service model prioritises a holistic, joined-up approach to service provision at a regional level.

In October 2023, following the publication of the April 2023 gambling white paper, the Government announced that the NHS would become the main commissioner of gambling harm treatment services, funded by a statutory level on gambling companies. It is anticipated that this transition will be fully implemented by 2026/27. Until then, GambleAware remain the commissioner of treatment and support, ensuring there is long-term investment in preventing and treating gambling harms. However, because of this decision, the immediate priorities identified as part of the NGSN redesign and recommissioning process in 2022/23 have been revised with successful transition to the new system a key objective. For GambleAware the foremost priority is to ensure the NGSN becomes a fully integrated service, working with the wider statutory and voluntary sector to ensure safe, high-quality, holistic support for NGSN users.

NGSN Structure and GambleAware

The NGSN aims to achieve the intended outcomes (summarised in the Theory of Change) for users through activity conducted across systems, regions and individuals. Providers work directly with service users, therefore most outcomes that are specified at an *individual* level occur because of provider-led activities and outputs. However, the activities that providers undertake and the way that these are delivered, are guided by *system* level activities and outputs. Therefore, the system level outcomes continuously feed into the way in which individual outcomes manifest. Furthermore, the NGSN intends to take a locally-focused, regional-first approach to service delivery, and as such, the individual outcomes should also be shaped by *regional* activities.

As of October 2024, GambleAware hold multiple roles within the NGSN system as the strategic lead commissioner, including as current Treatment Commissioner (TRTCO) and lead for Quality and

[1] The network expanded from 11 members to 13 on 1st Oct 2024 with the addition of Epic and Reframe, who will become operational as NGSN members in Jan 2025. They have not been considered in scope for the evaluation activities, therefore this ToC is based on the activities of the 11 existing providers.

Performance (Q&P). GambleAware wish to ensure the transition to the NHS as the new TRTCO is as smooth as possible.

GambleAware's organisational quality principles underpin the delivery of the NGSN:

- Achieving health and well-being with the public, service users and professionals as equal partners (person-centred, efficient)
- Ensuring the direction of individuals into appropriate care pathways and services, making most effective use of skills and resources (timely, efficient and effective)
- Doing only what is needed – do no less, do no harm (safe and efficient)
- Reducing inappropriate variation in access and outcomes (equitable, effective and efficient).

Assumptions

The assumptions underlying the NGSN Theory of Change are grouped into four key themes:

Public and societal need for support

- Gambling related harms may impact on multiple aspects of both an individual's life (including (but not limited to) their relationships, finances, employment, health) and wider communities/society
- Individuals who engage with support want to reduce the level of harm they are experiencing
- There is demand for support amongst those who have experienced gambling related harm, which can be addressed by NGSN services, and is not already provided elsewhere

Availability of resources

- There are sufficient resources and funds to meet needs on a local and national level
- There is sufficient clarity and certainty about the future of funding to allow service providers to plan and develop services on a long-term timeframe
- There exists a sufficient network of non-gambling support services for NGSN providers to receive referrals from, and refer individuals onto
- There is capacity amongst staff in third-party organisations to collaborate locally to achieve the NGSN's aims

Trust and motivation

- There is a base level of trust by the public in the work of the CQC and the efficacy of gambling treatment services
- There is trust between providers and the Treatment Commissioner, and the Quality and Performance team that all parties will act in the best interests of service users
- Individuals and organisations who are part of, or working with the NGSN have the motivation to achieve the aims of the NGSN
- Third-party organisations (other support organisations, public services etc.) trust in the NGSN's ability to reduce the experience of harm from gambling

Knowledge and understanding

- NGSN staff have the skills, knowledge and capability to deliver a high-quality service
- Third-party organisations have the skills, knowledge and capability to support the delivery of holistic support to individuals who have experienced gambling related harm
- The nuances of gambling support are understood by all parties, so services need to be designed and delivered based on the needs of individuals and communities who have/are

experiencing gambling related harm (i.e. as opposed to being considered as a variation of existing addiction provision, gambling harm services must be approached from the ground up.)

Inputs

The NGSN is built on 11 existing NGSN gambling harm support providers.

The 11 providers are (as of September 2024):

- National providers: National Gambling Helpline (GamCare), Betknowmore, the Primary Care Gambling Service (Hurley Group)
- Residential providers: Gordon Moody, Adferiad
- Regional providers: ARA, Aquarius, GamCare, Beacon Counselling Trust, Breakeven, NECA, RCA Trust

The NGSN providers do not exist exclusively in relation to the NGSN. Some, if not all, carry out other activities, including gambling-harm related work and wider support for other health issues, such as alcohol or drug dependency, and secure separate funding for this. Further to this, the NGSN system level activities are generally fulfilled by individuals in wider job roles, as opposed to providers having dedicated roles dedicated solely to servicing the system. Whilst those working for the National Gambling Helpline play a key role in referral into the system, the helpline is a support mechanism in its own right, providing brief interventions and immediate support for those in distress, as well as helping people find structured support through the NGSN.

The NGSN's place-based approach builds on existing provision and infrastructure at local levels across England, Scotland and Wales, for example Integrated Care Systems (ICS), which are partnerships that bring together NHS organisations, local authorities and other parties to take collective responsibility for planning services, improving health, and reducing inequalities across geographical areas. At a local level, delivery of the NGSN differs because of the strength and availability of these pre-existing partnerships and services. Informal structures such as faith groups, sport groups and parenting organisations provide pathways into communities and allow NGSN members to build relationships with underserved populations. Community leaders (e.g. religious leaders, sport team coaches) have a key influence over members of their communities and can act as 'gatekeepers' to engagement.

Lived Experience (LE) input into the NGSN comes from via two routes:

1) input from ALERTs, a GambleAware commissioned Lived Experience group and

2) LE representatives that engage with providers on a local/regional level.

ALERTs engage both strategically and routinely on service delivery; for example, they were consulted on the development of the Model of Care that all NGSN providers adhere to, and on a monthly basis ALERTs provide feedback via a report to both providers and GambleAware about a provider's engagement with LE. At a regional level, most (however not all) providers also have input from other representatives with Lived Experience – this contact takes place directly between providers and representatives and is not centralised or overseen by GambleAware. All LE consultation by providers is on the basis of an 'expectation' of consultation as part of the commissioning of the NGSN.

The design and operation of the NGSN is informed by policy and research evidence base on prevention of gambling harm. This includes GA's Commissioning Intentions paper, GA's Organisational Strategy, research and evidence provided by GA and providers, the 2023 white paper

on the reform of gambling regulation and subsequent announcement that the NHS will become the main commissioner of treatment for gambling harms.

Network activities and associated outcomes

This section offers an overview of the intended activities of the NGSN and the outcomes they are designed to achieve.

System level

Governance and quality

GambleAware, as the current NGSN Treatment Commissioner (TRTCO), undertakes monitoring of the quality, value, safety and performance of preventative and treatment support. This includes collection of data and evidence that enables the NGSN to demonstrate reliable improvement outcomes and reliable recovery outcomes. The requirement for monitoring, and the types of monitoring performed, both at a system level and by individual providers, is informed by system level governance standards, which ensures providers are held to consistent standards across the network. Standards also ensure a uniform approach to delivery and quality of services across the network, which supports a joined-up user experience. From this work GA as current TRTCO creates regular quality reports for each provider, the purpose of which is to help providers understand their areas of strength and weakness in delivery of their commissioned services.

Based on these reports, and input from representatives of those with lived experience (LE, as detailed above), GA as current TRTCO and NGSN providers work together to produce quality development plans. Providers are required to specify how they will improve service delivery if required. This regular process means services are consistently reviewed and improved upon, so the service is responsive to user needs.

Over time, the expectation is that TRTCO and NGSN (commissioned) providers are held jointly accountable for NGSN system aims. This is facilitated through several forums, for example the Gambling Related Harms Provider Group (GRHPG) and NGSN briefing meetings, in addition to the quality monitoring and reporting previously referenced. With all parties having clear roles and remits, lines of responsibility and accountability should also be clear. Ultimately, this process of understanding, action planning and accountability is intended to facilitate the continuous improvement to service delivery to support longer-term optimal delivery.

The NGSN aims to help to alleviate the burden of gambling harms reduction on other services across the UK through the reduction of longer-term consequences of gambling harm. In theory, in the absence of influence of external factors beyond the NGSN, activity should result in social, economic and public sector savings and a reduction of the legacy of gambling harm on individuals. Gambling harm has both monetisable and non-monetisable costs to society in terms of employment, criminality, homelessness, healthcare service use, social service use etc, therefore reduction of gambling harm has consequences for many other dimensions of public need. Successful and sustained prevention, treatment and recovery will ultimately reduce the longer-term impacts of gambling harm on both individuals who gamble and those affected by someone else's gambling.

Communications

GambleAware and individual NGSN providers carry out primary, secondary and tertiary prevention awareness communication campaigns and outreach activities amongst the public. This is in line with

public health approaches to tackling gambling harm.[2] For example, GambleAware run national communications campaigns advertising the NGSN, and providers run regional outreach activities, such as Beacon Counselling Trust's "Breaking the Sharam" project, which is aimed at people from a South Asian background in the North West. Providers undertake outreach activities with a range of different audiences, for example other support organisations, as well as community members (e.g. through attending workplaces) to raise awareness of gambling harms and support. The outreach undertaken by providers will be driven by their understanding of regional needs and gaps, so activities will vary be locality. While providers primarily undertake secondary and tertiary prevention activities, GA's NGSN communications activities are primary only.

GA as current TRTCO and NGSN providers also lobby and contribute to local policy around health, for example, through responding to consultations, engaging with MPs, issuing Press Release statements in response to major developments. Lobbying and communications activities undertaken by GA and providers contribute towards a growth in understanding and recognition of gambling as a public health issue. It is hoped that this activity will be influential within the policy space, so that gambling harms are recognised as a public health issue and given parity, both as a policy and funding priority, with issues such as smoking.

This activity is designed to support a reduction in stigma as a barrier to seeking help. However, whilst the NGSN is working to achieve these outcomes, external factors will naturally also have influence. The wider context in which the NGSN operates, including the direction of political opinions and wider societal attitudes will shape perspectives on gambling as a public health issue and the extent of experience of stigma.

One of the intended ultimate impacts of this activity is that there will be fewer barriers to accessing healthcare that drive inequality amongst groups vulnerable to gambling harm across society. For example, research shows that minoritised groups such as ethnic and religious minorities may be more vulnerable to gambling harm. There are commonalities between groups vulnerable to gambling harm, and those underserved in other aspects of public life. Reduction in one dimension is intended to support equality in other dimensions through the avoidance of the costs of gambling harm referenced above.

Learning and collaboration

GA commissions research into the effectiveness of treatment and support, and shares insights and recommendations directly with NGSN providers. Learnings from providers' own monitoring and evaluation feeds into this evidence. More widely, GA as TRTCO funds pilot innovation projects through 'incubator' funds to develop and demonstrate new services. This includes, for example, the Improving Outcomes Fund which aims to reduce the inequalities which exist relating to gambling harm for women and people from minority religious and ethnic minority communities.

Best practice is then shared between the TRTCO and providers in specific workstreams with the providers such as Model of Care, Data Working Group, and Risk and Safeguarding. Furthermore, the Quality and Performance team (Q&P), facilitates relationships between NGSN system stakeholders and sets standards of collaboration, for example, through funding projects such as 'Mobilising Local Systems', providing resource to local areas to support the building of relationships.

[2] What is known about population level programs designed to address gambling-related harm: rapid review of the evidence | Harm Reduction Journal | Full Text

An important feature of the NGSN is the ability of providers to leverage expert local knowledge to inform/adapt support (e.g. Regional Partnership Boards, grassroots groups, lived experience groups). This is a "mechanism for change" of the NGSN; an explanation of how the NGSN is able to achieve its desired outcomes. Local knowledge is gathered and integrated into the NGSN through multiple forums and relationships, formal and informal. Regional Partnership Boards are an example of a formal structure. These groups, aligned broadly with NHS Regions, and led by an NGSN provider from the respective region, bring together representatives from local and national systems, for example local authorities, police and crime commissioners, and other voluntary sector stakeholders to ensure a holistic approach to supporting people experiencing gambling harm.

As a result of these collaboration and communication activities, providers and the NGSN develop an evidence-based understanding of what works for which communities, that is, how can services be delivered in a culturally competent manner to ensure inclusivity and equity of treatment access and outcomes. Working with stakeholders also positively influences their perceptions of the NGSN and motivates them to have 'buy-in' to the aims and objectives of the NGSN. The understanding and goodwill that is fostered promotes further collaboration between services to achieve a result which is beneficial for the end user in delivering holistic treatment.

This allows NGSN services to be tailored to reflect national and local needs amongst all populations, including the needs of underserved communities within regions/localities by putting in place services in place that speak to and include those groups. As services are evidence-based, this ensures funding is spent appropriately on activities that have demonstrable improvements in outcomes for individuals. Furthermore, collaboration enables the delivery of local and national treatment pathways, providing holistic care. This is supported by the 'life journey approach' to care that the NGSN takes refers to the fact that the NGSN aims to provide support 'touchpoints' for every life stage of adulthood.[3] This is a "mechanism for change", that is, an explanation of a key feature through which the NGSN achieves its aims.

Provider level

The delivery of support by individual providers underpins the whole NGSN system. Key features of provider activity include:

The NGSN approach to assessment involving recovery modelling so that individuals do not require escalation into acute support. The NGSN takes an early intervention perspective to achieve recovery before treatment.

At a system level, a stratified care model is employed. This means that service users are assigned to different levels of care right from the start of their treatment based on their assessment, rather than being 'stepped up' through the tiers. As part of this model, regular assessments are made during a service user's journey to ensure clinically safe delivery of treatment and support, and to service users are moved between treatment tiers as needed.

Maintaining mechanisms to record, store and share service user data. Regional providers and the National Gambling Helpline use the same Customer Relationship Management system (CRM), Theseus, which supports data sharing between a subset of NGSN organisations. User data is necessary to understand who is (and is not) currently having their needs met by the service.

[3] NGSN providers are not contractually obligated to offer services to people aged under 18 (although some do also undertake work with families or youth).

These activities support outcomes for both individuals and the wider system, enabling individuals to receive safe and effective individualised personalised care, through culturally competent, relevant services when they need them.

System level learning and collaboration activities, and provider activities are intended to ultimately prevent gambling harm amongst individuals and communities at greater risk of experiencing it, and to ensure recovery lasts. Early intervention and prevention before treatment are part of the NGSN philosophy. Through prevention activities, the need for treatment can be reduced, as individuals will not have experiences that prompt the need for treatment. The NGSN model of care also includes recovery before treatment and aftercare. If services are effective, appropriate to the needs of individuals and their communities, available and accessible, then the NGSN will be able to support sustained recovery from harm.

6 Participatory Systems Map

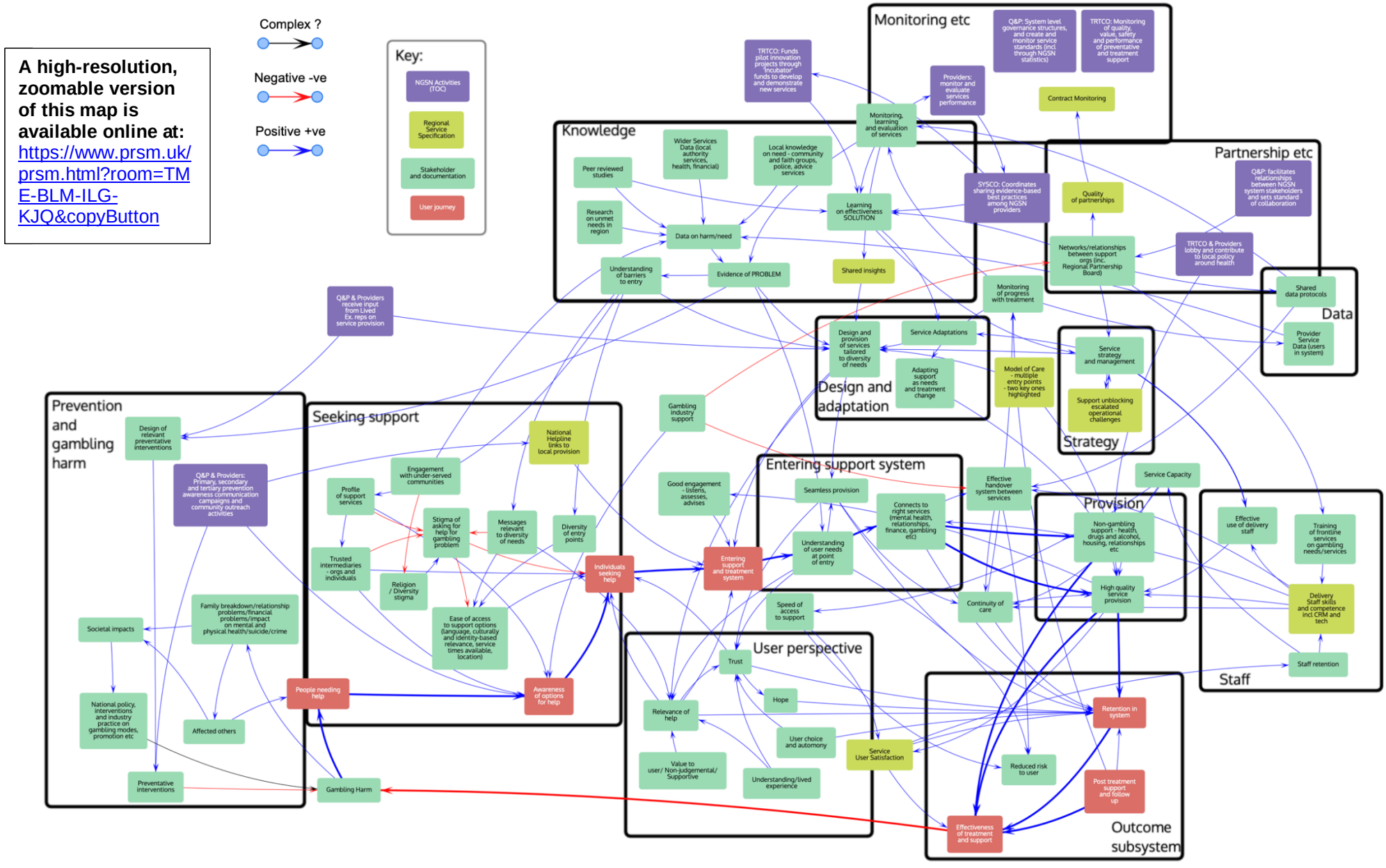
The participatory systems map is overleaf, and can also be viewed at: https://www.prsm.uk/prsm.html?room=TME-BLM-ILG-KJQ&copyButton, which allows a more dynamic exploration of the detail of the map by zooming in and out. The online map is read only, but a copy can be created which can be edited, developed or used for further analysis of factors of interest.

In the following sections, we give a description of the overall structure of the map, then present insights and analysis from it and then conclusions and recommendations from the systems mapping, including for the mainstage evaluation.

Participatory Systems Map

Figure 6.1 The systems driving NGSN's ability to reduce harm among target groups

A high-resolution, zoomable version of this map is available online at: https://www.prsm.uk/prsm.html?room=TME-BLM-ILG-KJQ&copyButton



Reading the maps – factors, links and colours

Systems maps are formed of individual factors (or nodes) and links between the factors. Factors are generally things that can go up or down, either qualitatively (better or worse) or quantitatively. For example, although hard to quantify, 'Trust' as a factor can increase or decrease. Less abstract and more easily measurable examples are, 'Staff retention' or 'Individuals seeking help' which can increase or decrease.

The different factors and links on the map are colour coded as follows:

- Green – factors identified by stakeholders in mapping process,
- Lime green – factors derived from the Regional Service Specification,
- Purple with white text - factors derived from theory of change developed in this evaluation,
- Red with white text – factors representing the service user 'pipeline' and largely derived from stakeholder workshop.

Factors are connected by links (arrows) indicating a causal mechanism between them. The direction of arrows indicates the direction of causality. The colour codes for links are:

- Blue arrows indicate a positive relationship between the two connected factors, i.e. if the first factor increases then then the second one the arrow points to increases, and vice versa.
- Red arrows indicate a negative relationship between two connected factors, i.e. if the first factor increases then the second one the arrow points to decreases, and vice versa.
- Black arrows indicate connections considered to be either uncertain, variable or complex, for example, sometimes positive and sometimes negative contingent on other circumstances, or requiring a threshold to be met.

It is important to note that positive and negative causal relationships do not necessarily mean one factor makes the other better or worse. A positive causal link can result in something getting worse and a negative causal link can result in something getting better.

To help the user 'read' the map it has been grouped into sections, or subsystems, with boxes around factors related to certain aspects of the system. These are not definitive categorisations but are intended to ease the user into the map without it being overwhelming. Thirteen subsystems are labelled on the map. These are listed below with a brief description of what each subsystem represents:

- Monitoring etc – factors related to the monitoring of system for reduction in gambling harms, monitoring and evaluation of service performance,
- Knowledge – factors related to knowledge and evidence of gambling problems and effectiveness of support and treatment,
- Partnership etc – factors related to the development of partnerships in the NGSN and in service delivery,
- Design and adaptation – factors related to the design and adaptation of support and treatment services in response to contextual changes and evolving nature of need,
- Strategy – factors related to the service strategy development,
- Prevention and gambling harm – factors related to prevention (as opposed to support and treatment) and generation of gambling harms,
- Seeking support – factors related to the user journey from an awareness of need for help to actually seeking help,
- Entering support system – factors related to effective entry of user into the gambling support and treatment system,
- Provision – factors related to the provision of gambling support and treatment services,
- Staff – factors related to the staffing of gambling support and treatment services,

- User perspective – factors related to the users of support and treatment services and lived experience,
- Outcome subsystem – factors related to outcomes of support and treatment system.

The purple boxes with white text are the NGSN activities represented in the Theory of Change (ToC) developed in this evaluation (version 4) and these can be seen to act on the delivery system both directly and mediated through other factors.

Understanding and describing the map

The map represents a large complex system with multiple elements. Orientation and 'reading' of big complex maps can be challenging as there are so many pathways and relationships that can be followed and explored. The analysis section later in this report isolates areas and mechanisms of particular interest. First, we describe the broad structure of the map and main groupings of factors that form the map to provide an introduction to it.

The broad shape of the map is that the heart of service provision is found at the centre of the map within the boxes labelled *Entering support system* and *Provision*. The map then shows an *Outcome subsystem* below *Provision.* On the left appear the factors related to people coming into the system of provision: a section on *Seeking support* and, to some extent determining that, factors around *Prevention and gambling harm.* Above the central *Provision* area of the map can be found several groupings of factors that affect provision more broadly, *Design and adaptation* and *Strategy*. Also, to the right there are some factors linked to *Staff* and at the bottom of the map to the left of the *Outcome subsystem*, are factors related to the *User perspective*.

Analysis of map

The map captures a large and complex system which is formed of nested subsystems as described above. Looked at as a whole it can be overwhelming and the density of connections between the factors can obscures important mechanisms which are clearer when filtered versions of the map are viewed.

The nodes related to the support and treatment pathway are highlighted in the map to help show the key mechanism of reducing gambling harm. However, while the user journey through treatment and support can be followed, wider factors in the system can significantly affect this effectiveness of the pathway.

In the analysis phase we have therefore sought to identify key nodes relevant to delivery of reduction in gambling harm and create filtered versions of the map to show these mechanisms and how they flow through the map. We have selected factors to look at that the map along with the qualitative information we have collected suggests are important in relation to NGSN operational effectiveness.

These were presented above in the Scoping stage findings in section 5.2 with extracts of the map and an explanatory narrative focused on the following five factors on the map:

1. *Awareness of options for help,*
2. *Design and provision of services tailored to diversity of needs,*

3. *Retention in the system*[1]*,*
4. *Monitoring evaluation and learning of services,*
5. *Networks/relationships between support orgs (inc. Regional Partnership Board)*.

Conclusions from scoping stage

With stakeholders, we have mapped the system driving the NGSN's ability to reduce gambling harm among its target group. The map shows a large and complex system and captures the diverse factors driving improvement in harm reduction.

It should be noted that the systems map was generated relatively quickly and with a small and incomplete group of stakeholders[2]. As such, it is not to be considered a definitive or complete representation of the system. In spite of these caveats the following overall conclusions can be drawn from the work.

Reducing gambling harms requires good quality support services and adequate awareness raising of these services with potential users

Support and treatment service providers are a critical element in reducing gambling harm. As such, this mapping exercise has had a significant focus on the provider support and treatment system and user experience within it. We have represented the service user journey as a pipeline on the map. Two key elements appear on this pipeline. Firstly, entry into the pipeline, which is affected by user awareness and support service profile. Secondly, retention of service users in the system once entered and this is affected by, understanding of user needs and quality of service design and delivery. Those falling out of the system will not receive the treatment or support they need. These are key elements that lead to a reduction in gambling harm. Raising awareness of support and treatment services is an important mechanism for increasing the numbers of people receiving support and treatment to address gambling harms and one that stakeholders thought more attention could be given to.

The NGSN is a formed of a nested set of systems: success and failures in one part can propagate through the system

Reduction of gambling harm is a nested system. Frontline delivery is supported by wider subsystems both within the service provider, for example, management and strategy functions and by the wider organisations in the NGSN and beyond. While individual providers can operate as standalone organisations, their effectiveness can be enhanced by the support provided by the wider system - for example, by capturing and sharing learning, setting standards to allow interaction across organisational boundaries and sharing of data. Around the provider service providers delivery are subsystems of management, monitoring, evaluation and learning and strategy systems. Around these are wider support subsystems provided by NGSN and other support services in healthcare and local authorities.

[1] NB The factor *Retention in system* refers to the retention of service users in the support and treatment system not staff retention by providers.
[2] Full details of the participatory systems mapping process and limitations are given in the report included in the appendices.

The mechanisms by which value is added by NGSN activity can be seen in the system map through the roles NGSN plays in service commissioning, standard setting, facilitation of provider interactions, monitoring, learning and evaluation. It has also been seen how weaknesses in providers, for example, not collecting data, or NGSN activity, for example, not providing appropriate leadership or provision of spaces for exchange of lessons from practice, can propagate through the system because of the causal linkages between factors identified in the mapping. If the NGSN functions are not performed effectively it has the potential to create a burden on the system in terms of resource use demanded without the value added of more effective delivery.

7 Contribution Analysis

What is contribution analysis?

Contribution analysis is an approach to evaluation used to assess the extent to which a program, intervention, or policy has contributed to observed outcomes. Contribution analysis enables us to explore and test the validity of parts the NGSN Theory of Change.

The analysis approach involves developing a number of 'contribution claims' which articulate how components in the NGSN Theory of Change are expected to lead to change, while recognising the importance of other influencing factors.

The contribution claims are subsets of the theory in the NGSN Theory of Change that isolate the systems' relevant inputs, activities and outputs and the anticipated relationship to specific outcomes. Claims are an explanation of behaviour: a hypothesis of what we believe will bring about the intended NGSN outcomes.

The contribution analysis will test the validity of the contribution claims (meaning, the extent to which they have been met) using a range of evidence from different strands of research, data collection and analyses that we will conduct in phases 2 and 3.

Contribution analysis is a solutions-focused analysis approach: our intention is to identify the limiting and enabling factors that facilitate change. In doing so, we will learn identify opportunities for improvement, and learn from best practice in aspect/areas that are working well. In evaluating each claim, we look at the extent to which it is met, how consistently, and the level of completeness.

Development of the contribution claims

The contribution claims that we will focus on in the next phase of the evaluation have been agreed in consultation with GambleAware. As part of the analysis of the scoping stage findings, we have reviewed the Theory of Change to assess the aspects that have been highlighted as priorities for further investigation. Our understanding of the priorities has been informed by feedback during the development of the Theory of Change, areas indicated by the PSM process, knowledge gathered through the document review, and input from GambleAware stakeholders.

The evaluation resources permit analysis of up to four claims, so initially IFF drafted options of two chains, each with four claims for GambleAware's review. Following feedback from GambleAware we have prioritised the aspects of the Theory of Change that will provide the most valuable insight to stakeholders. These insight relate to four claims, but divided between the two chains, with three claims for one chain, and one claim for the other chain.

We note that as we are examining three claims for chain 1, and one claim for chain 2, it is likely that the evidence we collect for chain 1 will be more substantial, robust and rigorous than for chain 2. This is because we will be able to build a more compelling and comprehensive contribution narrative by interrogating multiple related claims for chain 1. Whilst the evidence collected for chain 2 will be more limited, the importance of the individual claim to our overall understanding of the NGSN justifies its inclusion as a standalone claim.

NGSN contribution claims

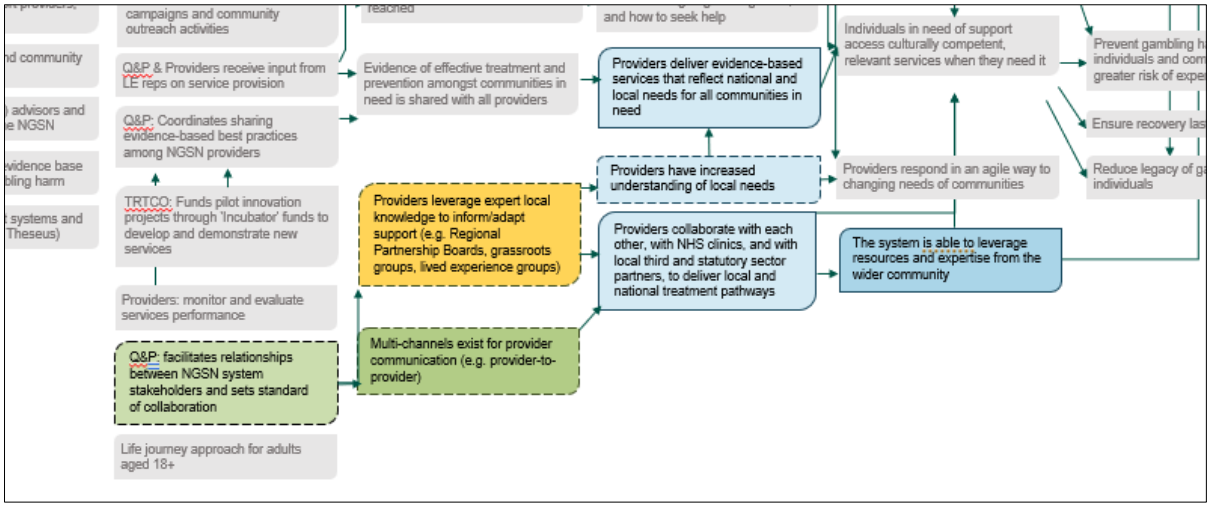
We will assess four claims which relate to two logic chains in the NGSN Theory of Change.

Chain 1: Theory of change: Provision of local treatment pathways that allow individuals to access relevant services

We will focus on this aspect of the ToC because we consider regional and local delivery to be a key facet of the NGSN, which has been emphasised by both GambleAware during the scoping depths, and providers during the development of the PSM.

The relevant aspects of the ToC are shown below:

Figure 7.1 Chain 1: Provision of local treatment pathways that allow individuals to access relevant services



The claims we will interrogate for this chain, and the reasons for doing so are:

- *Claim 1: Providers gather evidence to understand the gambling treatment support needs for tiers 2 and 3, in their local area.*
  Rationale: This step is part of "leveraging expert local knowledge" contributing to providers having an "increased understanding of local needs". We have honed in on tiers 2 and 3 because tier 4 is not delivered locally, and tier 1 activities have a much boarder preventative reach so we consider these activities to be less relevant to the development of treatment pathways.

- *Claim 2: All providers have tailored the treatment and support services they provide based on evidence of need.*
  Rationale: This step is necessary to link "increased understanding of local needs" with the "delivery of evidence-based services that reflect local needs"

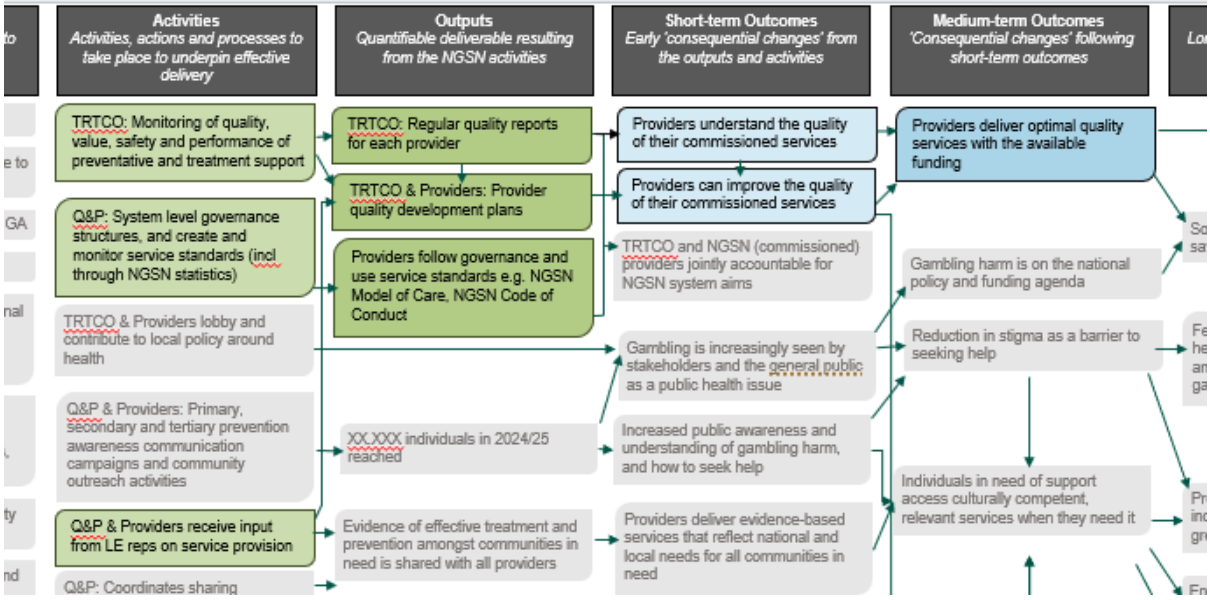
- *Claim 3: Providers have treatment pathways with mechanisms of referral for individuals with local non-gambling specific services.*
  Rationale: This is an indicator of the extent to which local treatment pathways are 1) holistic and 2) embedded in the communities, to help us to understand the nature of "collaboration with third sector partners" and whether/how this contributes to "the system leveraging local resources"

Chain 2: Theory of change: Provision of optimal quality services

A key feature of the NGSN is the strength of having a network of partners delivering to the same standards and being quality assured by GA as current TRTCO in this respect. Demonstrating how the NGSN ensure quality services provides evidence to the future treatment commissioner of the value of the network.

The relevant aspects of the ToC are shown below:

Figure 7.2 Chain 2: Provision of optimal quality services



The claim we will interrogate for this chain, and the reason for doing so are:

- *Claim 4: Providers regularly review their services in line with the quality assurance framework, and implement changes to improve the quality of their services where possible.* Rationale: To deliver optimal quality services, providers need to both conduct reviews of services and be able to implement changes which evidence that they are taking action to improve services. If there are barriers to providers being able to implement changes, it is important to uncover these.

8 Scoping stage findings

This section discusses the scoping stage findings, and their implications on the evaluation scope and design. It is structured by the evaluation objectives and the associated research questions.

Table 8.1 Summary of Initial Evaluation Objectives and Research Questions

Nº	Initial evaluation objectives	Initial research questions
1	Develop a Theory of Change for the NGSN system	c) What are the main inputs and activities of the NGSN system, and the benefits those are expected to lead to for system users? d) What are the assumptions underlying this theory of change?
2	Assess the operational effectiveness of the NGSN system	d) What is the NGSN governance structure and how effective is it? e) What are the factors affecting the NGSN system's ability to reduce harm among people experiencing harm from gambling at the regional and national level, and their causal relationship?

Nº	Initial evaluation objectives	Initial research questions
		f) Are GambleAware's principles embedded in the NGSN system?
3	Assess the clinical effectiveness of the NGSN system	h) Who does the NGSN support (and not), regionally and nationally? i) How does eligibility criteria for support access vary across the NGSN, regionally and nationally? j) What different tiers of provision are provided by different providers and what proportion of clients experience those different tiers? k) What are the common referral pathways through the NGSN and what factors influence those pathways, including between Helpline and treatment provision? l) Whether/how NGSN system contributes to system and individual-level outcomes as captured in the outcomes framework? m) What are the specialist knowledge/skills in the NGSN? n) How do GambleAware and NGSN providers understand community needs, identify gaps in support and address those gaps?
4	Assess the economic effectiveness of the NGSN system	c) What are the NGSN operating costs? d) What are the cost/ health benefit ratios, both regionally and nationally?
5	Generate and disseminate learning to GambleAware and NGSN system users	N/A

1. Develop a Theory of Change for the NGSN system

a) What are the main inputs and activities of the NGSN system, and the benefits those are expected to lead to for system users?

Summary

The Theory of Change (ToC) developed by IFF with GA and providers for the NGSN sets out the intended inputs, activities and outcomes of the network. The visual illustration and description can be found in Chapter 5

.

Implications

In the second phase of our evaluation, we will 'test' components of the ToC agreed with GA to understand what contributes to network outcomes (the 'contribution claims').

b) What are the assumptions underlying this Theory of Change?

Summary

During the development of the Theory of Change, we identified key assumptions we grouped into four themes. They were:

- The existence of a public and societal need for support
- The availability of resources
- Sufficient levels of trust and motivation
- Sufficient levels of knowledge and understanding

There are further details about the assumptions underpinning the Theory of Change in Chapter 6.

Implications

In the second phase we will assess whether these assumptions hold true, if there is evidence from the Phase 2 activities that the assumptions are not valid, and/or if there are different assumptions.

2. Assess the operational effectiveness of the NGSN system.

a) What is the NGSN governance structure and how effective is it?

Summary

Through a combination of the document review and scoping interviews we were able to gain a clear idea of the NGSN governance structure, and some early indications of its effectiveness, although it will be in the next phase that we are able to gain a more comprehensive idea of provider perceptions of its effectiveness.

GambleAware have contractual relationships with service providers, which set out clear policies and procedures, as well as provider-specific KPIs to report against in monitoring performance. GambleAware also have service level agreements, confidentiality agreements and clear rules on governance and accountability with each provider. Providers have a two-tier governance model; they have their own governance structure but are also governed by GambleAware's overarching policies and care models to create an integrated system.

GambleAware is ultimately accountable for performance of the NGSN, but providers are accountable for day-to-day service performance. Provider performance is monitored by GambleAware through quarterly reporting, serious incident reporting and audit reviews, based on KPIs that are pre-agreed with GambleAware for each provider. GambleAware also have a quality review process which provides them with assurance of the extent to which providers are delivering against quality indicators. In this quality review process, providers are assessed against the 6 quality indicators embedded in their contracts – that the services they provide are safe, effective, person-centred,

timely, efficient and equitable. Actions plans are developed for each provider on areas where improvement is needed and a holistic, system-wide approach is taken. The action plans are monitored and supported via the Senior System Commissioner at a regional level and the Head of Quality and Performance at a national level.

Implications

To better reflect the scope of data sources that we will have available to us in Phase 2, we suggest adapting the question wording to *"What is the NGSN governance structure and what are provider perceptions of its effectiveness?"*. The case studies and provider survey will allow us to assess provider perceptions of the effectiveness of the NGSN governance structure, but we won't have the data available for the evaluation to verify its effectiveness independently of this – which is why we recommend adapting the question so it is centred on provider perceptions.

b) What are the factors affecting the NGSN system's ability to reduce harm among people experiencing harm from gambling at the regional and national level, and their causal relationships?

This research question was explored through the participatory systems mapping exercise. It should be noted that the systems map was generated relatively quickly and with a small and incomplete group of stakeholders[3]. As such, it is not to be considered a definitive or complete representation of the system. In spite, of these caveats the following findings were drawn from the work.

Five factors were identified: awareness of options for help, design and provision of services tailored to diversity of needs, retention in system, monitoring evaluation and learning of services and finally networks/relationships between support organisations (including Regional Partnership Board).

1. Awareness of options for help

Summary

Awareness of options for help is a key early step on the pipeline of support and treatment to those experiencing gambling harms. As such, it is a significant factor affecting uptake of service and meeting of need. Increasing awareness raising activity flows through the pipeline of support and treatment. It was identified in the systems mapping workshops as a necessary activity for reducing gambling harm. However, in workshops and discussions with stakeholders the role of profile raising of support and treatment services received less attention than those related to service provision and delivery. This is reflected in the relatively few NGSN and provider nodes upstream of, i.e. that affect, *'Awareness of options for help'* (Figure 8.2) and the relative lack of detail in these. Workshop participants acknowledged the importance of awareness-raising activity. However the combination of time available in workshops to conduct the mapping combined with the stakeholders present, who were better placed to map the activity 'behind the door' of treatment services rather than activities 'to get people to the door' meant less time was given to mapping awareness-raising activity. We are not able to draw conclusions from these inputs, i.e. the mapping and stakeholder comments in workshops, on whether the split of resources between awareness raising activity and service delivery is appropriate. However, we note that awareness-raising activity may have significant potential to reduce gambling harm through the increase it could generate in the numbers of people seeking support and treatment.

[3] Full details of the participatory systems mapping process and limitations are given in the report included in the appendices.

Implications

The PSM map could be used as a prompt in the mainstage evaluation for discussions about how well developed and resourced different parts of the map are relative to one another, either through consideration of links between key nodes and/or the different subsystems[4]. For example, is the split of resources between raising awareness of support and treatment options vs providing good quality support and treatment when people access it appropriate? We will cover this directly in the mainstage in the case study interviews with provider leadership.

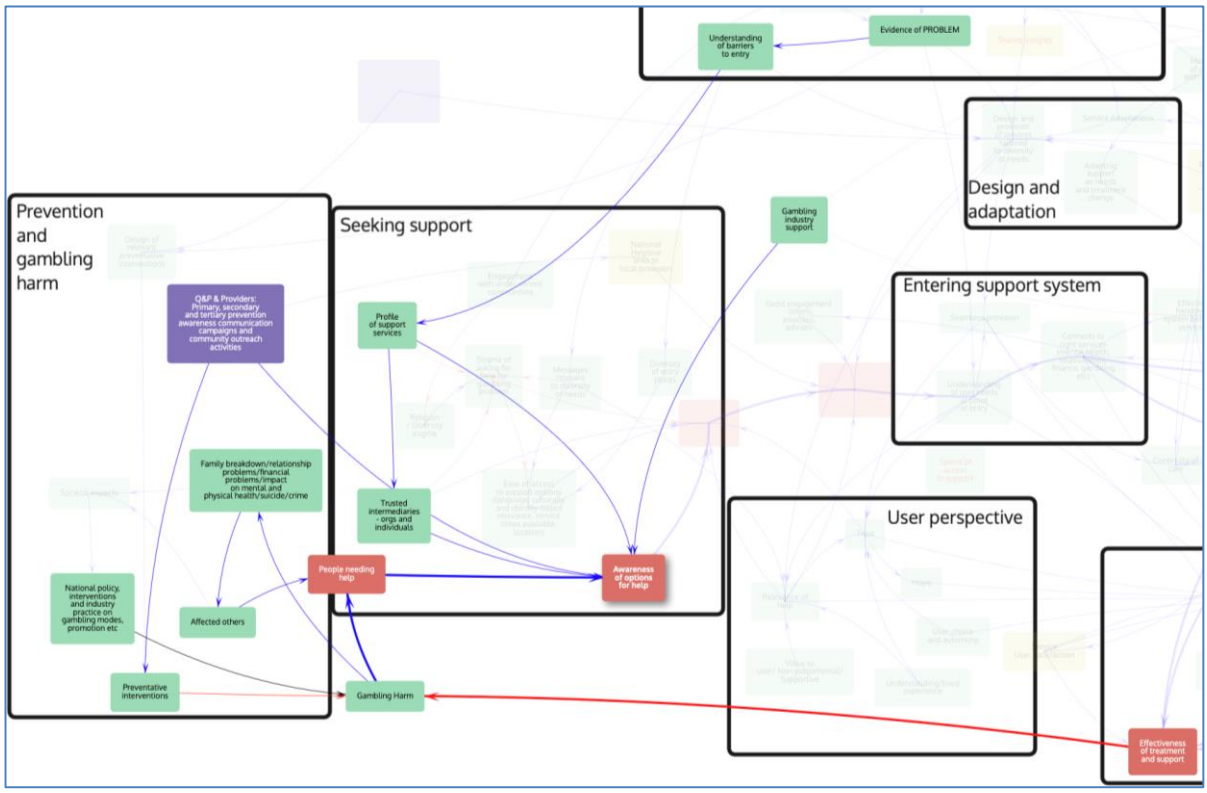


Figure 8.2 Awareness of options for help - upstream factors

2. Design and provision of services tailored to diversity of needs

Summary

As would be expected the *Design and Provision of services tailored to diversity of needs* flows downstream into the service provision-related subsystems of the map. Services tailored to need are more likely to engage and retain people accessing them and vice versa. However, looking upstream from this node the importance of NGSN activities can be seen (Figure 8.3) in addition to the feedback from the service providers own management of delivery. Knowledge and evidence are an important additional input into *Design and Provision of services tailored to diversity of needs.* The subsystems of knowledge; monitoring, evaluation and learning; partnership; data and strategy all feature as feeding into the design and provision. These are notably multiple factors from the NGSN Theory of Change and Regional Service Specification activities. The effectiveness of these activities conducted across the Network will affect the quality of provider service design.

[4] Note that in this scenario the maps are not intended to be a perfect representation of all elements of the NGSN system but more as a tool to stimulate discussion

Implications

The PSM map indicates that learning and sharing of good practice can impact positively on design and provision of service tailored to need and this is function best conducted at the network rather than provider level. The effectiveness of the processes for firstly, generating learning and insight from the individual providers and secondly the processes and formats for sharing this across the Network could be explored to understand if this is working well and how it could be improved to drive innovation and better meeting of need. We will explore this further in the case study interviews with provider leadership.

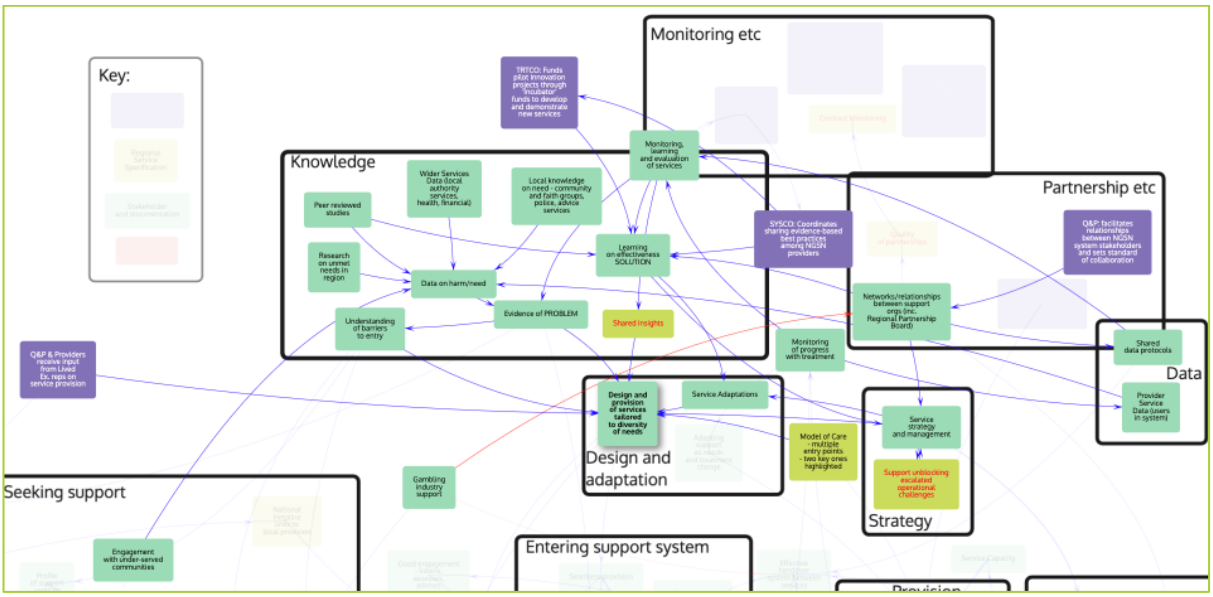


Figure 8.3 Design and Provision of services tailored to diversity of needs - upstream nodes

3. Retention in system

Summary

Retention in system, which refers to retention of service users in the support and treatment system rather than staff retention, was a key factor highlighted by stakeholders in the first workshop. Successful support and treatment requires those seeking help to stay in the system – users can't be helped if they leave and they will leave if their needs are not being met. Factors upstream of *retention in system* relate to user perspectives and good quality services. One interpretation of 'Retention in system' can, we would suggest, therefore be seen as a proxy measure for system quality and relevance seen from a user perspective. Additionally, *retention in the system* relates to the importance of post-treatment support and follow up to effective treatment and reduction in gambling harm.

The figures below illustrate these points. Figure 8.4 shows the importance of user perspective and service delivery one step upstream from *retention in system*, i.e. factors with direct impact. 8.5 then shows, everything one, two and three factors upstream of *retention in system*, illustrating the less direct support of factors in the knowledge, design and adaptation, strategy and data subsystems. Again, as noted in the previous section, while NGSN activities don't directly affect *Retention in system* they are represented in important upstream factors that affect support and treatment delivery in strategic terms. If the support to service providers from NGSN represented by these links is not reaching them it may have consequences for effective delivery.

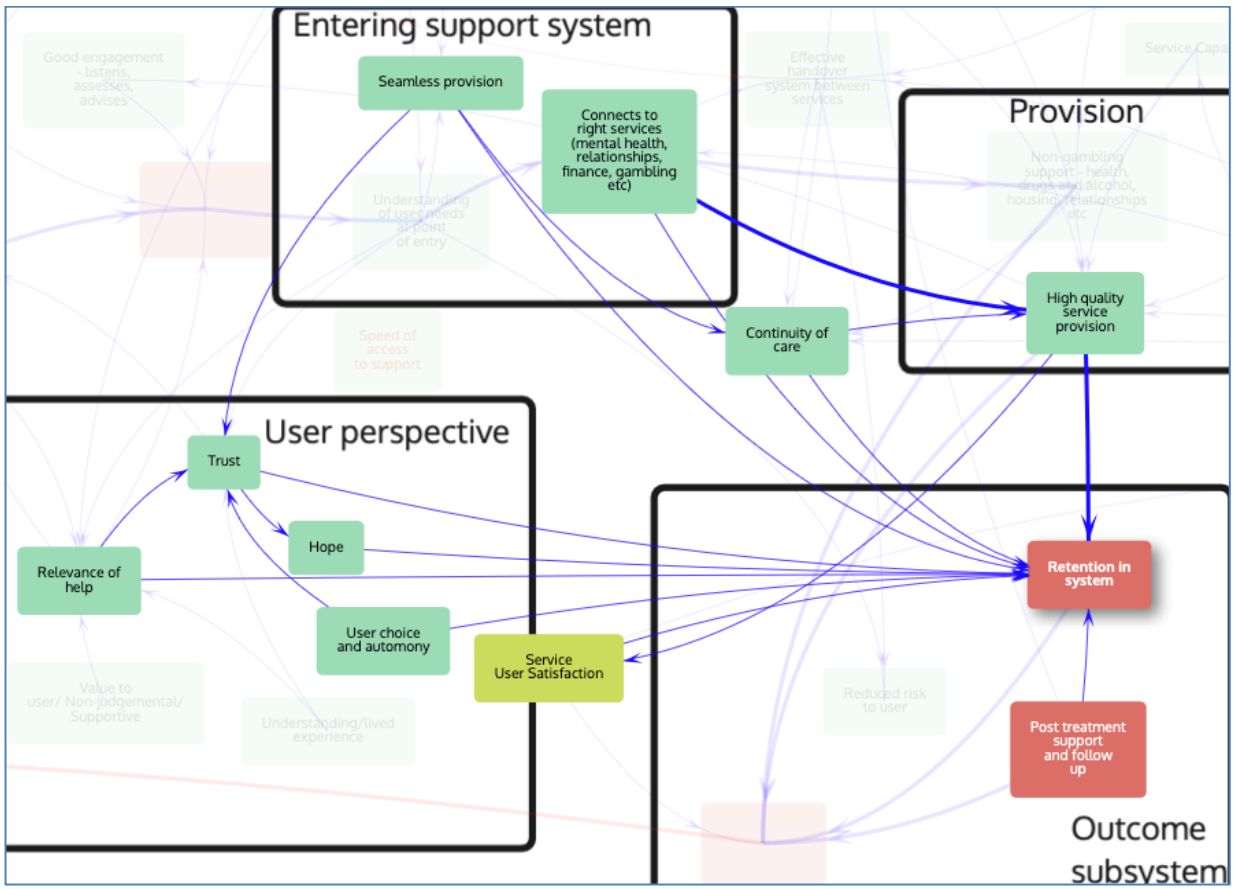


Figure 8.4 Retention in system - factors one link upstream

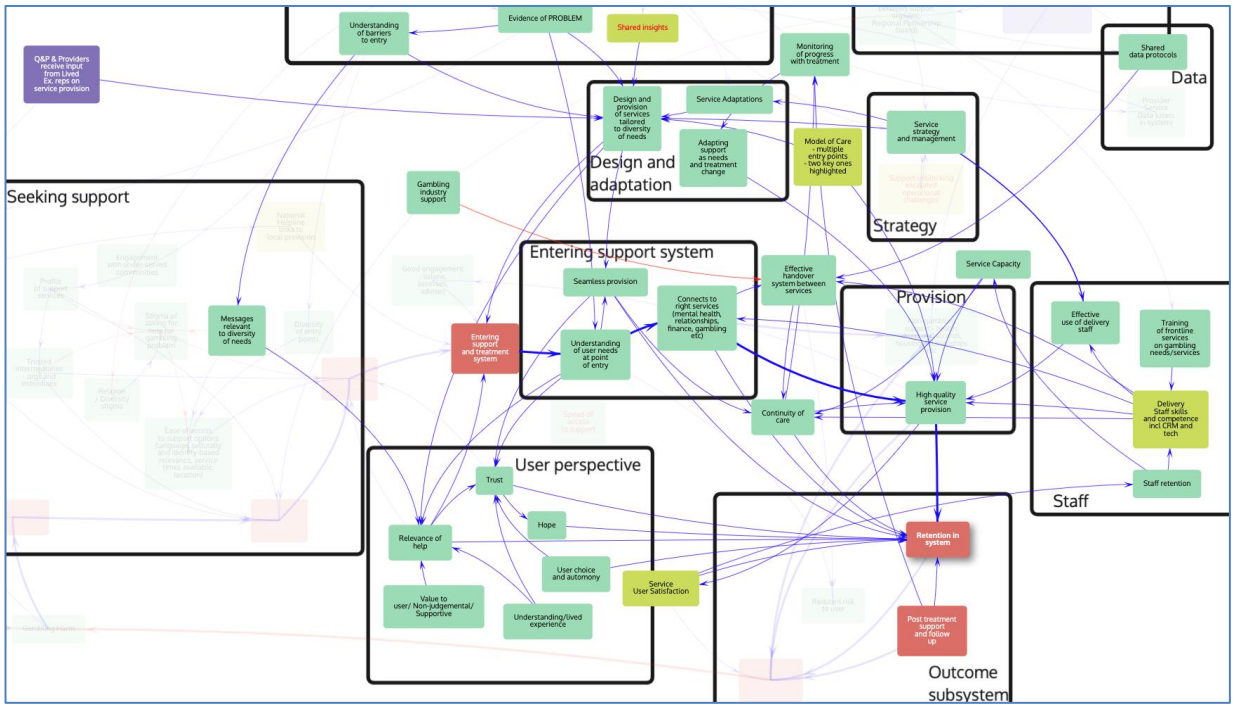


Figure 8.5 Retention in system - factors one, two and three links upstream

Implications

Retention in system is affected by multiple factors which will impact on service users on their journey from accessing services, through treatment and support and on to post treatment follow ups. The mapping has identified factors which affect retention in system but has not identified either which are the most important of these or the points at which service users are prone to drop out of support and treatment. The mainstage evaluation could explore the progression through these stages in more detail to identify strengths and weaknesses of retention in the system and hence effectiveness of treatment and support. We will be exploring referral pathways through the NGSN in the case study groups with frontline practitioners, and as part of this we can look at the effectiveness of retention in the system in more detail.

4. Monitoring evaluation and learning of services

Summary

Monitoring evaluation and learning of services is a factor on the map that has significant reach across the whole system for reduction of gambling harm. However, the factor is not one that is strongly directly connected into the wider system when factors one link away from it are considered (Figure 8.6).

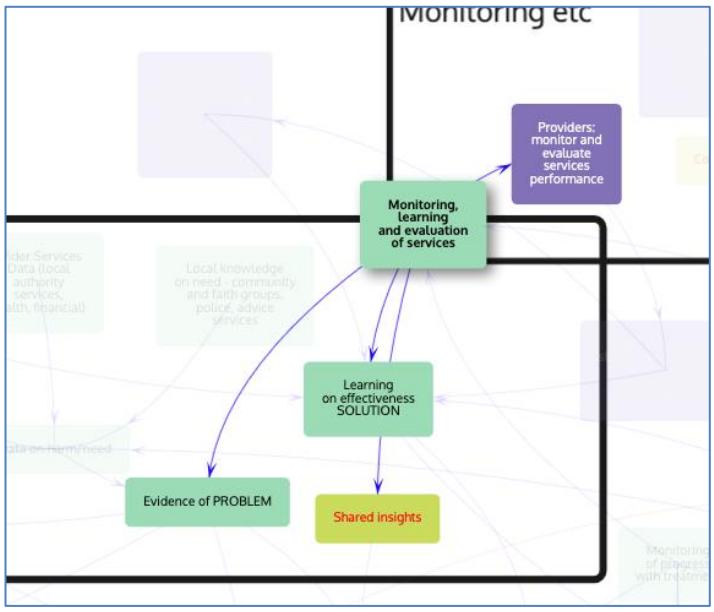


Figure 8.6 Monitoring evaluation and learning of services - factors one link downstream

However, its reach when factors two or three links downstream are considered is significant with figure 8.7 showing factors one and two links downstream and figure 8.8 showing factors one, two and three links downstream. While *monitoring learning and evaluation of services* has relatively few direct links, i.e. one link downstream, when steps further downstream are considered the reach of the factor is across the system is more significant. Areas of the map reached three links downstream include the subsystems of *Knowledge, Prevention and gambling harm, Seeking support, Design and adaptation, Strategy, Entering support system, Staff, Outcome and User Perspective.*

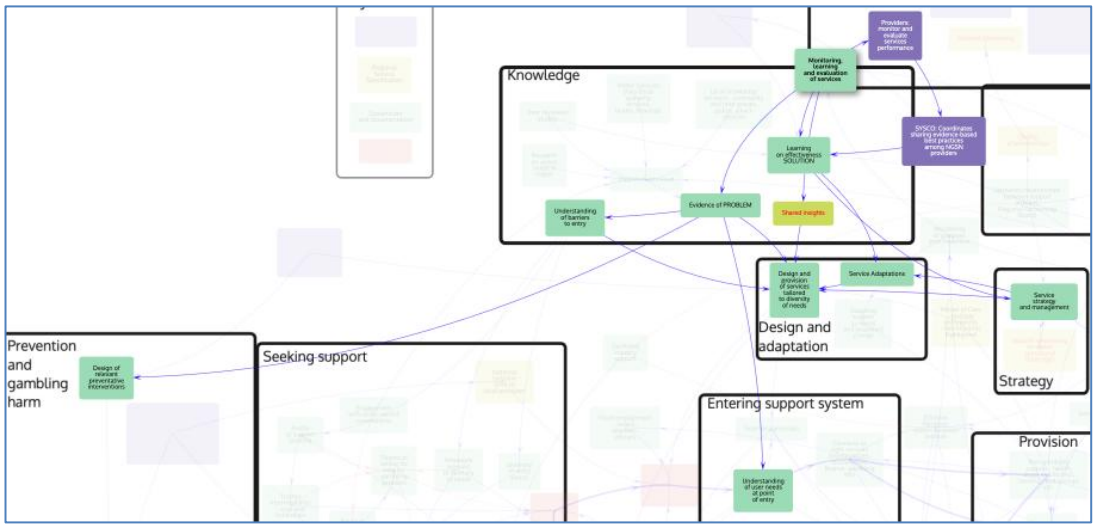


Figure 8.7 Monitoring evaluation and learning of services - factors one and two links downstream

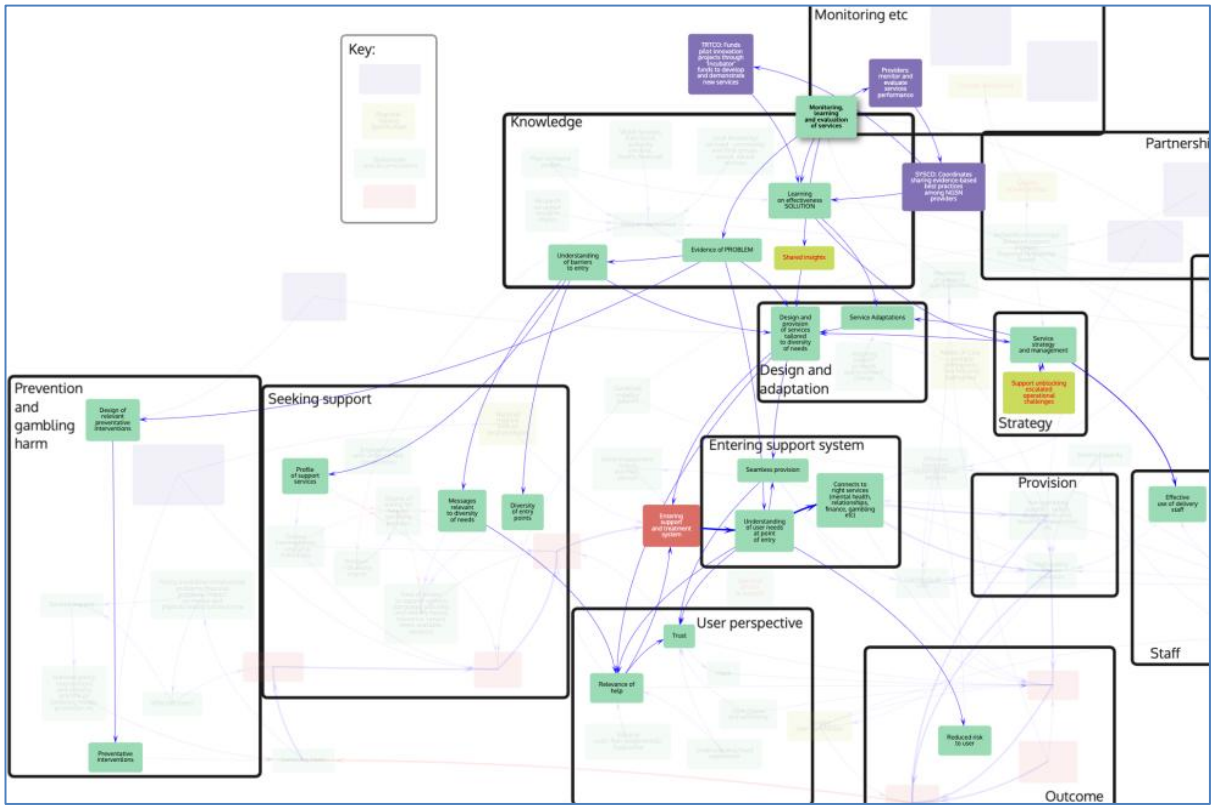


Figure 8.8 Monitoring evaluation and learning of services - factors one, two and three links downstream

Given the importance and reach downstream of the factor *Monitoring, learning and evaluation of services,* the factors that affect it upstream are important to examine. One link upstream are *Monitoring of progress with treatment* and *Shared data protocols* as shown in Figure 8.9.

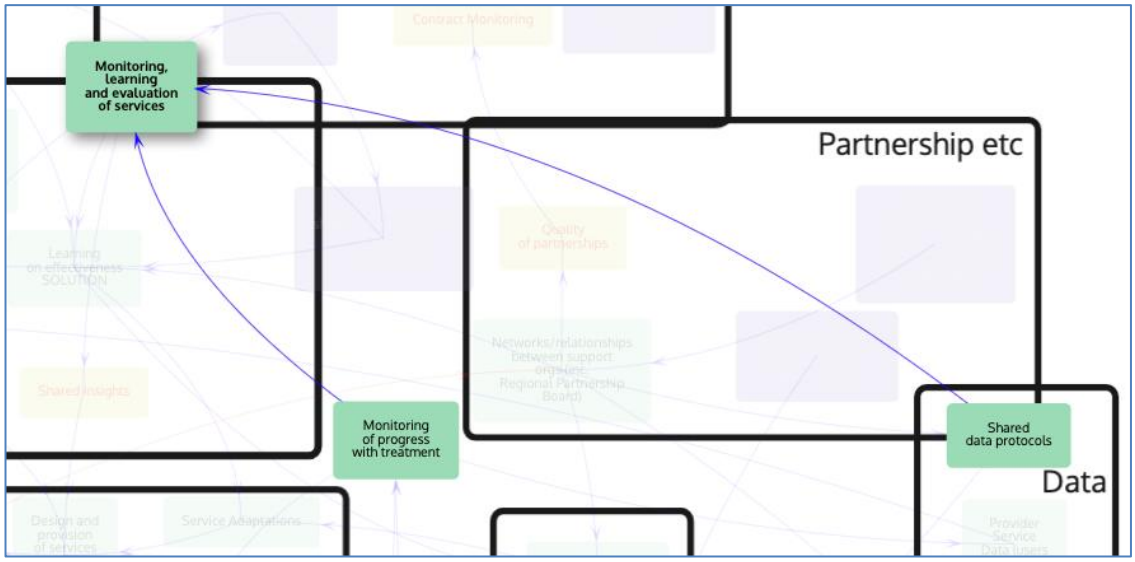


Figure 8.9 Monitoring, learning and evaluation of services - factors one link upstream

Looking further (Figure 8.10) upstream shows the importance of factors in service delivery and also the importance of training from NGSN to enable providers to use systems and capture data. The potential for both positive and negative flows through the system should be noted. For example, service providers not collecting or sharing data, or data collection and sharing systems not working across providers will flow through the system negatively affecting *monitoring, learning and evaluation of services*. Service user data flows through monitoring and evaluation processes to impact service design, strategy and profile. The converse is also true: a lack of service user data will limit these wider processes.

Monitoring, learning and evaluation of services is dependent on actors across the system working together to agree data protocols, collect (good quality) data, create value and insight from this data and then feedback learning to users so they can adapt their activities and also understand that their data collection has value to them. The value emerges from the sum of the parts and feedbacks – positive and negative – between different parts of the system.

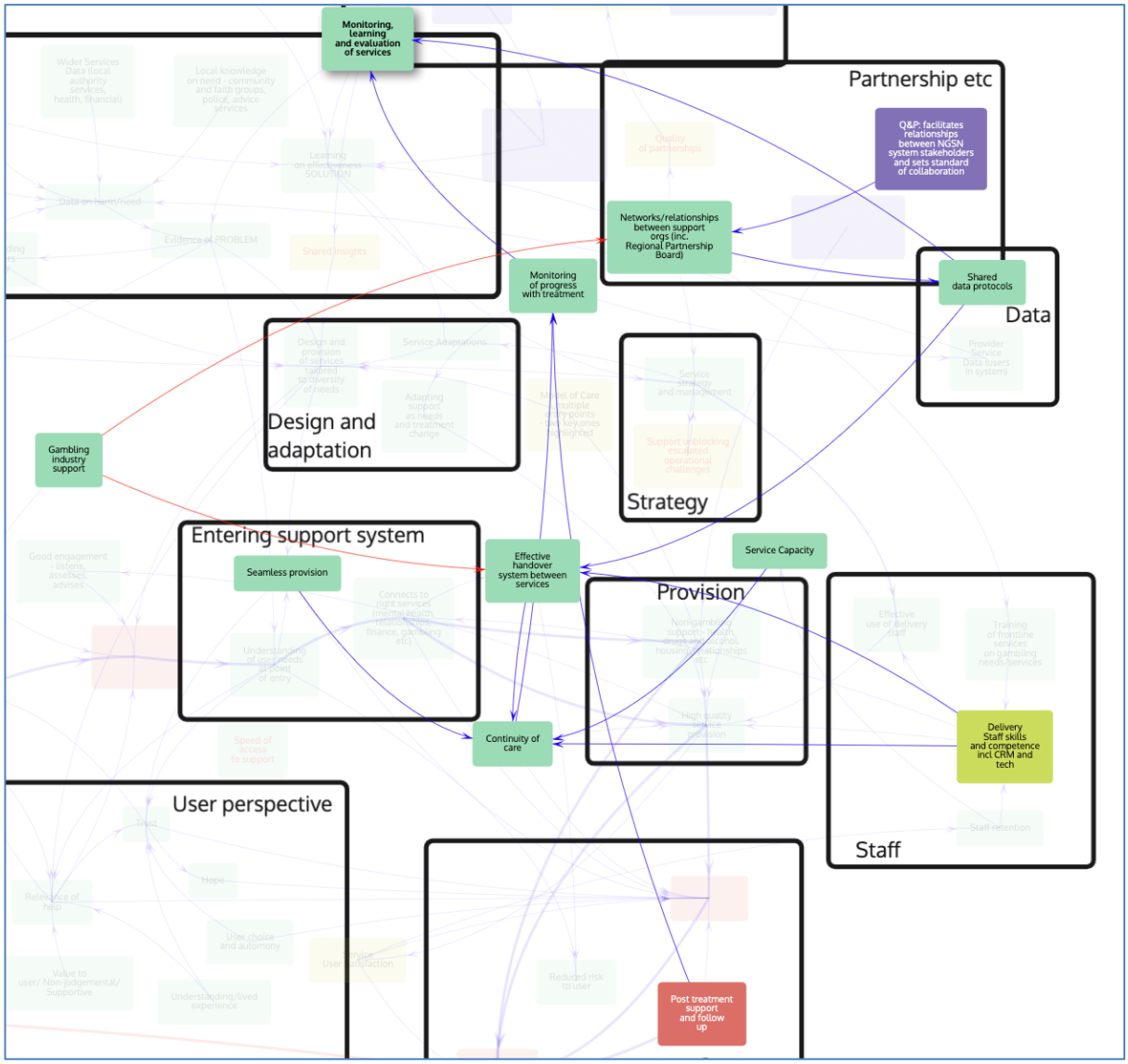


Figure 8.10 Monitoring, learning and evaluation of services - factors one, two and three links upstream

Implications

Monitoring, evaluation and learning has significant reach downstream across the system. It is affected by upstream factors such as shared data protocols, monitoring progress and treatment. These upstream factors require coordination across the network and inputs from all network members if monitoring, evaluation and learning are to be successfully delivered. We intend to explore the effectiveness of network coordination in this area and alignment of network members on the importance and focus on monitoring, evaluation and learning and use of shared system for it in the next phase of the evaluation through the case study interviews with provider leadership.

5. Networks/relationships between support organisations (including Regional Partnership Board)

Summary

Networks/relationships between support orgs (inc. Regional Partnership Board) is an important factor that has downstream links into subsystems including *Knowledge, Monitoring etc, Design and adaptation, Strategy, Entering support system, Provision* and *Staff* (Figure 8.11). The lack of connections from *Networks/relationships between support organisations* to the subsystems of *Seeking support* and *Prevention and gambling harm* is notable and worthy of further exploration. This

may be an artefact of the emphasis of the mapping activity on support and treatment provision a reflection in reality of a lack of connections *from the Networks/relationships between support orgs*. As noted earlier, raising awareness and increasing the numbers of people seeking support and treatment is a potentially important factor in reducing gambling harm and the *network/relationships* factor could be a way of ensuring expertise on reasons for seeking support and barriers/enablers of it are linked and used in awareness-raising activities.

Through its downstream links *Networks/relationships between support orgs* has the potential to significantly affect operational effectiveness. It reaches into subsystems of *Design and adaptation*, *Strategy* and *Staff* at two links downstream and into *Service provision* at three links downstream. Good networks and relationships will flow through positively to these areas and vice versa. Different types and networks and relationships were highlighted by participants both for network for coordination and management and that allow less formal and hierarchical support and reflection. Networks build operational effectiveness by bringing together different partners *within* regions (health, local authority, community) and *between* regions. The former is the role of the provider and the latter NGSN. The importance of spaces that allow members of the NGSN to come together to reflect on support and treatment cases and practice and explore resolution of these challenges with their peers was highlighted.

Upstream, *Networks/relationships between support orgs* is only affected by *Q&P: facilitates relationships between NGSN system stakeholders and sets standard of collaboration*[5] positively, and *Gambling industry support* negatively (figure 8.12). The latter's negative link was identified in workshops as being due to the unwillingness of some stakeholders to work in processes supported by voluntary gambling industry contributions[6]. As such the nature of collaboration spaces and relationships facilitated by NGSN is an important factor affecting operational effectiveness.

Implications

The mainstage evaluation could explore:

- the effectiveness of convening and management of networks of providers with regional partners and service users seeking support from gambling harm, and for preventing gambling harm.
- the nature and effectiveness of convening and management of collaboration, shared working and meeting spaces for NGSN providers and the wider system stakeholders.

In the mainstage evaluation, we intend to focus attention on provider views of the effectiveness of convening and management of collaboration spaces for NGSN providers and the wider system stakeholders in the case study interviews with provider leadership.

[5] 'Q&P' refers to the Quality and Performance Team at GambleAware.
[6] This was not fully explored in the workshops but the context to it is provided in the February 2022 letter from NHS England to GambleAware available at: https://www.england.nhs.uk/wp-content/uploads/2022/02/letter-to-gambleaware-from-claire-murdoch.pdf

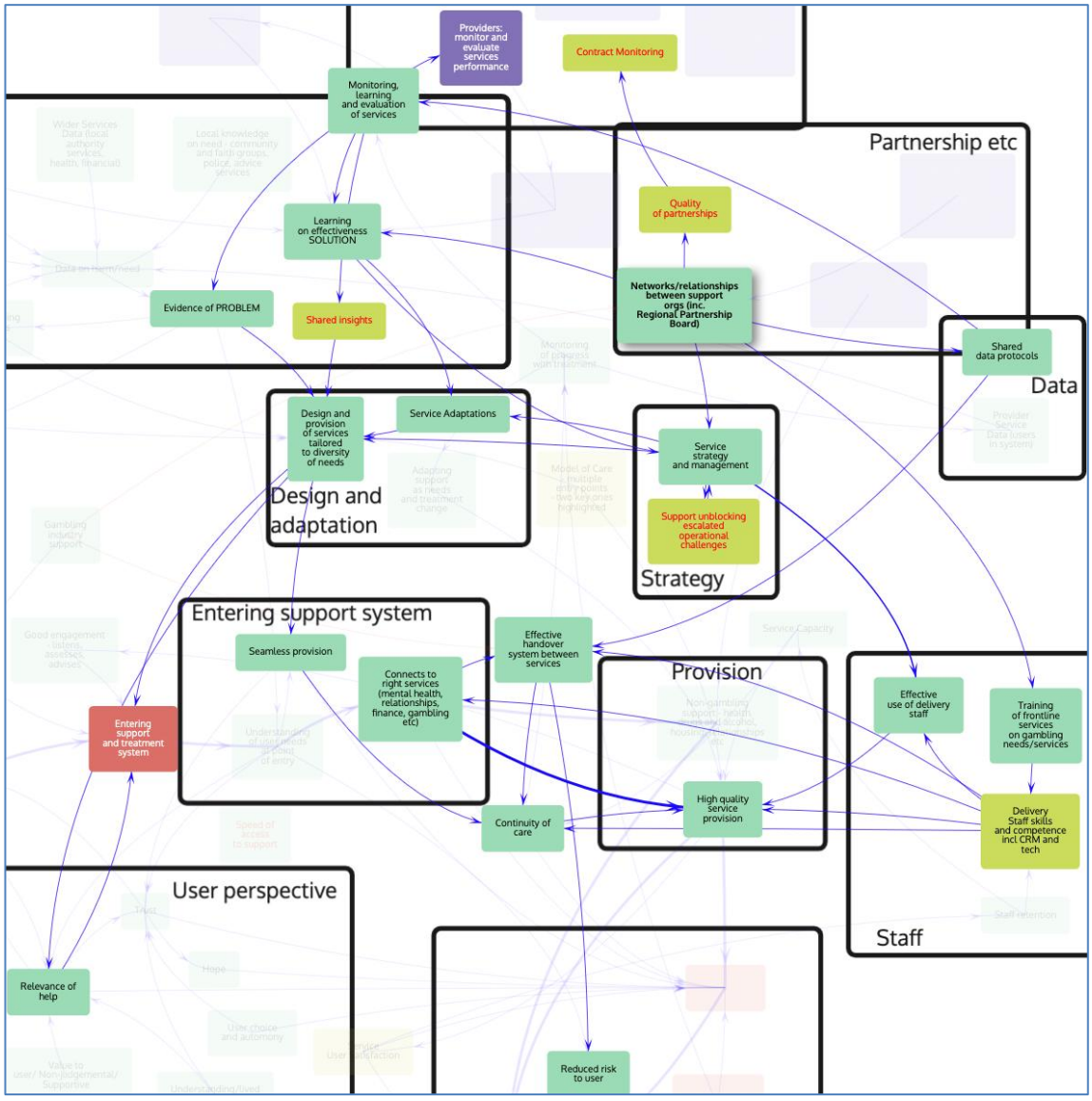


Figure 8.11 Networks/relationships between support organisations (including Regional Partnership Board) – factors one, two or three links downstream

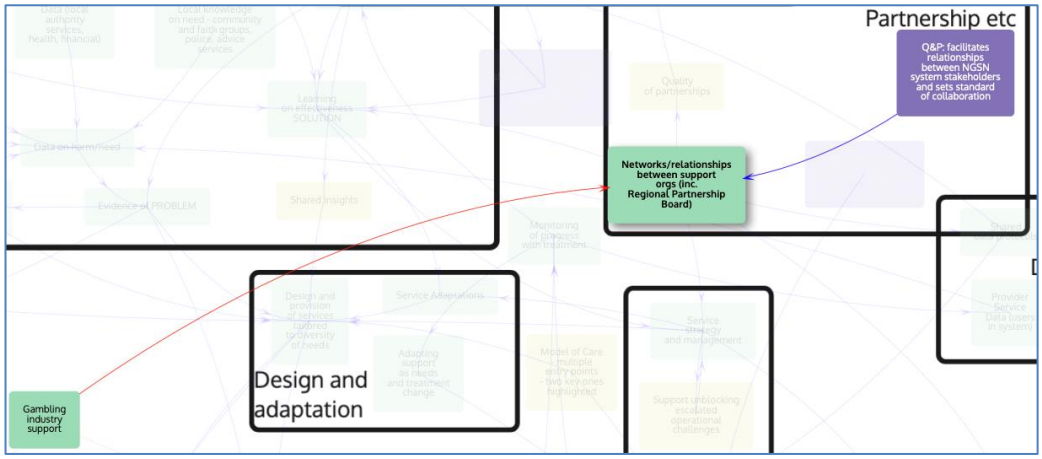


Figure 8.12 Networks/relationships between support orgs (inc. Regional Partnership Board) - upstream factors (all)

c) Are GambleAware's principles embedded in the NGSN system?

Summary

The PSM stakeholder workshop and follow-up sessions indicated that the guiding principles of the Model of Care are embedded in the NGSN system, however further work is needed to establish this in Phase 2.

The principles of the Model of Care are:

1. Harnessing the lens of lived experience
2. We are person-centred
3. We promote self-determination
4. Advancement through innovation, research, organisational learning and information gathering
5. We are safe, caring, compassionate, well-led and responsive to our service user needs

The first three principles, which are all related to NGSN user experience, are all expressed in multiple factors on the map. The fact that we were able to highlight a user pathway through the system is indicative that the user is a central feature of the system and is evidence these principles are embedded in the NGSN system. In the workshop discussions, user experience of the system, the importance of harnessing lived experience and self-determination all featured prominently in discussion and were raised unprompted by participants, again providing evidence that these principles are embedded in the NGSN.

Principle 4 is similarly represented in the map, this time through subsystems of *Knowledge, Monitoring* and *Partnership*. While the map shows that a system with factors related to innovation, research, organisational learning and information gathering is present, further evidence is needed in Phase 2 to evaluate the centrality and importance of these factors to the system as a whole.

Principle 5 combines multiple dimensions in relation to service user needs. For 'safe, caring, compassionate and responsive' the commentary above in relation to principles 1 to 3 applies. In relation to 'well-led', factors related to management and strategy are capture on the map. Again, the map shows *how* these factors can affect the NGSN outcomes related to reduction of harm but not *how well developed* they are. Their presence on the map and the evidence from workshop discussions, follow-up interviews and documentary evidence indicate at least a degree of embedding of the principle, but further work is required to evaluate this more fully.

Implications

Since we already have some evidence that the principles of the Model of Care are embedded in the system, we suggest than in Phase 2 we interrogate the *extent* to which they are embedded in the system. So, we propose changing the question wording to *"To what extent are provider practices informed by the NGSN Model of Care principles?"* This also explicitly recognises the fact that it is the Model of Care principles that we are interested in, which reflects GambleAware's vision for the system.

3. Assess the clinical effectiveness of the NGSN system

a) Who does the NGSN support (and not) regionally and nationally?

Summary

The documents reviewed captured whom the NGSN supports nationally[7], and those that NGSN is currently not supporting but could be. We have a less clear picture of who the NGSN providers support regionally, but believe that the analysis of Data Reporting Framework (DRF) data in Phase 2 will help to shed more light on this.

Data is available about the demographic profile of those receiving NGSN support in published reports and the DRF. Modelling of various data sources by the NHS and Health Economics Unit published in 2023 found that those receiving Tiers 3 and 4 support from the NGSN had the following characteristics[8]:

- **Gender:** Male (69%), Female (30%)
- **Age:** 25-34 year olds (39%); 35-44 year olds (27%); 45-54 year olds (15%)
- **Ethnicity:** White (80%); Asian (5%); Black (3%)
- **Country**: England (88%); Scotland (4%); Wales (4%)
- **Work status**: Employed (63%); Unemployed (21%)

It also shows that most people receiving Tiers 3 and 4 treatment from NGSN providers had a high PGSI score:

- PGSI 8+ (62%)
- 'Affected other' (14%)
- PGSI 3-7 (5%); 0 (1%); 1-2 (1%).

Quarterly KPI reports providers submit to GA indicate the profile of those receiving Tier 1 support from the National Gambling Helpline. The reports show that those calling the helpline in the 2023-24 YTD were predominantly white (86%), male (68%) 26-35 years old (36%) or 36-45 years old (25%). There is no demographic data available about those accessing other forms of Tier 1 support, such as live chat.[9]

While there is some data available on those who are experiencing gambling harms but are currently not supported by the NGSN, the picture is less clear. The 2023 Annual Treatment and Support survey says that "*Demand for treatment and support has continued to rise, with 23% of those with a PGSI score of 1+ saying they would like some form of treatment or support for cutting down on their gambling, up from 19% in 2022*." However, the demand for gambling support among some groups is not currently being met by the NGSN. Across people who gamble, demand for any treatment/support/advice is substantially higher for ethnic minorities than it is for those from a white background (19% vs 4%), yet we know that people from ethnic minority backgrounds are under-represented in NGSN support services relative to demand. [10]

[7] In this question, when we refer to clients that the NGSN supports 'nationally', we mean people that the NGSN supports at a national level (so across providers, not split by region)
[8] Modelling gambling harm across Great Britain - Health Economics Unit
[9] PDC Data Q4 Template Updated KPIs 2024 - GambleAware
[10] Annual GB Treatment and Support Survey 2023

Previous GambleAware research found that minority ethnic communities were disproportionately impacted by gambling harms and had a higher demand for treatment and support, but that substantial numbers seemed to be accessing treatment and support other than through the (then) National Gambling Treatment Service.[11]

Modelling of various data sources by the NHS and Health Economics Unit published in 2023 found that "If we model the population experiencing gambling harm, we estimate that the treated NGSN users (tier 3 and 4, only) equate to 0.07% of the wider GB population in need. This indicates that there is a substantial gap in support and treatment."[12]

Implications

We believe that the range of sources we have available to us means that we will be able to answer this question comprehensively in Phase 2. Although we have a less clear idea of the regional picture, analysis of the DRF data will help to build this understanding. As such, we do not recommend changes to this research question.

However, unless we are able to access disaggregated data on use of Tier 1 support we will be limited in the extent to which we can answer this for Tier 1 users. It is also worth noting that issues with the quality and consistency of the DRF data mean that we need to caveat findings that are drawn from this source.

In order to be able to answer this question for Tier 1 support more fully, we would need to have either:

- A respondent-level data file for Tier 1 support across the NGSN, containing key demographic variables
- Aggregated data for Tier 1 support across the NGSN (e.g. data tables) with key demographic variables as cross breaks
- Provider respondent-level data files for Tier 1 support, containing key demographic variables
- Provider aggregated data for Tier 1 support across the NGSN (e.g. data tables) with key demographic variables as cross breaks.

In terms of timescale, we would need to receive any respondent-level data files by 20th February 2025, and any aggregated data files by 28th March 2025. This is because we need to allow time for respondent-level data files to be processed before they can be used for analysis.

b) How does eligibility criteria for support access vary across the NGSN, regionally and nationally?

Summary

The document review details the national and regional eligibility criteria across the NGSN. In principle, eligibility criteria should be consistent across regions of the UK, however through our work so far we have not yet ascertained whether this is the case in practice.

[11] https://www.gambleaware.org/news/gambling-among-adults-black-asian-and-minority-ethnic-communities
[12] Modelling gambling harm across Great Britain - Health Economics Unit

Across providers, there are two overarching criteria for NGSN Tier 3 and 4 support: (1) that people are aged 18 or over and (2) that they live in England, Wales or Scotland. In contrast, for Tier 1 and 2 support from the helpline, there appears to be no age restriction, as the service specification states that *"the provider will at all times work to ensure that users are able to access the Helpline irrespective of their age, cultural, physical or other needs."*[13]

Although the primary focus of Tier 1 and 2 support is adults, some providers do offer services and interventions for young people. GamCare, for example, deliver youth-specific services, including education, prevention, and tailored support for individuals under 18 experiencing gambling-related harms.

While not all providers have dedicated pathways for young people, those who do often integrate early interventions, awareness programs, and brief support tailored to young people.

For regional services, GambleAware's Regional Service Specification sets out the follow criteria:

- **Acceptance criteria**: "*Service users experiencing gambling harms, as a person who gambles or an affected other located in the region. Service users must be over 18 years of age."*
- **Exclusion criteria**: "*Those not located in the region will be referred to their local service provider; Those who are actively suicidal; Those who are detained under the Mental Health Act; Those who are in an inpatient/residential unit; Those under the age of 18*."

Linked to this, a stakeholder interviewed during the scoping stage emphasised that gambling harms needs to be the main issue for the user, above other clinical needs. If there are other mental or physical health concerns, then the provider will assess which need is greater before referring them on to another service if needed.

Implications

Since eligibility criteria is clearly documented, this question is relatively straightforward to address. However, to achieve a better depth of insight we suggest expanding the scope of the question to *"What are provider perceptions of the factors that impact whether eligible clients are able to access NGSN* support?"

We believe this new question wording allows us to explore the more pertinent question of whether all who are eligible to access support through the NGSN are able to do so. Although eligibility criteria is consistent in principle, this does not mean that all who are eligible are accessing the support. If this is the case, we would like to explore provider perceptions of the factors that impact whether eligible clients are able to access NGSN support. However, it should be noted that although this reframed question is more pertinent, the insights we generate will likely be at a higher-level, due to the broad nature of the question.

c) What different tiers of provisions are provided by different providers and what proportion of clients experience those different tiers?

[13] NGSN Risk Management best practice guide (2024)

Summary

Scoping interviews, document review and secondary data mapping have not captured a clear picture of support tiers offered across the NGSN. However, secondary analysis of DRF data for each provider should enable us to report the proportion of clients that experience different support tiers.

Most providers provide support at Tiers 1-3, and do not provide Tier 4 support themselves but will refer users to Tier 4 residential treatment support if needed.

Stakeholders interviewed felt most providers provided Tier 3 support. Tier 4 residential treatment is provided by two NGSN providers, Gordon Moody and Adferiad Recovery, or NHS specialist clinics. As well as proving Tier 4 services, NHS clinics also provider Tier 2 and 3 support.

It is less clear what proportion of clients experience the different tiers. There are ongoing data collection challenges with Tier 1 support; although we have had access to quarterly provider KPI figures which report helpline volumes, we are not able to triangulate this data with other data sources to assess what proportion of clients are receiving Tier 1 support.

There are other data sources that can give us an indication of the proportion of clients that receive Tiers 2, 3 and 4 support. The GambleAware Annual Statistics from the National Support Network 2023/2024 report states that, of the 10,754 clients receiving NGSN support between April 2023 and March 2024, 31% received Tier 2 treatment only, 36% received Tier 3 treatment only, 5% received Tier 4 treatment only, and 28% received Tier 2 as well as Tier 3 or 4 treatment[14].

Modelling conducted by the NHS and Health Economics Unit in relation to demand and capacity for Tier 3 and 4 provision showed that, for referrals ending 1 April 2021 or later, Tier 3 accounted for 93% of total people treated, at 68% of total cost; needing 62% of total staff); while Tier 4 accounted for 7% of total people treated; at 32% of total cost; needing 38% of total staff.[15]

Implications

We believe the first part of this question will be straightforward to address for Tiers 2-4, however ongoing data collection challenges with Tier 1 data mean that we may not be able to include figures for Tier 1 support. In order to ensure we are able to answer the second part of the question fully, we suggesting amending the wording to make it clear we will look at this split by each provider, rather than the NGSN as a whole. The proposed new wording is *"What different tiers of provisions are provided by different providers and what proportion of each provider's clients access each support tier?"* The reason for this is that integrating data from different providers together into one dataset to give a view of the support tiers offered across the NGSN as a whole will likely prove problematic, due to differences in the way data is recorded – so we will do this on a provider-by-provider basis.

d) **What are the common referral pathways through the NGSN and what factors influence those pathways, including Helpline and treatment provision?**

Summary

[14] Annual Statistics from the National Support Network (Great Britain) 2023/2024 (2024)
[15] Modelling gambling harm across Great Britain - Health Economics Unit (2023)

Quality standards and service specifications for different elements of the NGSN all emphasise the importance of effective referral pathways. However, there are some data deficits that make it difficult in practice to understand or assess client pathways, as well as concerns about the impact of tensions in working relationships between NGSN and NHS providers on client pathways. We are able to gather information on the source of referrals into the NGSN, and there is also regional data that indicates the proportion of clients engaging in aftercare. In the YTD 2023-34, 9% of NGSN clients engaged in aftercare, which is significantly lower than the 83% that were contact for a follow-up post treatment, indicating the challenge faced in getting clients to engage in aftercare support[16].

However, although we have an indication of routes into the system and the proportion receiving aftercare, aftercare service provision is limited, meaning that detailed data gathering on aftercare is naturally limited as a result. Challenges with data gathering of user treatment journeys has been noted in previous research. For example, in its 2024 report on the current gambling treatment system in England, OHID noted that "*There is a lack of clarity about referral pathways to gambling treatment and inadequate links with wider services, which is a problem particularly for service users with complex needs."* The same report noted *"There is no standardised or co-ordinated approach across NHS and third sector providers to collect uniform metrics on service provision and service user treatment journeys."*[17]

Referrals into the NGSN come from a range of sources – drug and alcohol services, the NGSN website and the Helpline. Several documents suggest that the Helpline is the most common route into treatment (accounting for at least half of referrals), followed by self-referral (20-30% of referrals).[18] The DRF also shows that just over half (51%) of referrals come from the Helpline, with self-referral (19%) being the second most common referral source. The proportion of clients self-referring into the NGSN has increased in recent years.

While there is a common recognition of the importance of aftercare and a service design blueprint that maps out how aftercare should look, the current provision of aftercare across the system is insufficient. In general, pathways out the NGSN are not as well defined as pathways in.

Implications

Although our document review, scoping interviews and secondary data mapping suggest that it won't be possible to establish common pathways through the NGSN, we will be able to establish referral pathways into the network through analysis of the DRF, the provider survey and case studies.

Through our case studies we will also be able to map out example of referrals pathways, however we may not be able to make firm conclusions about how commonly these occur across all providers.

So, we propose reshaping the question into two more refined questions: *"i) What are referral sources for NGSN providers?* and *ii) What are examples of referral pathways through the NGSN and what factors influence those pathways?"*

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[16] PDC Data Q4 Template Updated KPIs 2024 - GambleAware
[17] Modelling gambling harm across Great Britain - Health Economics Unit (2023)
[18] Gambling treatment: Assessing the current system in England (2024), Office for Health Improvements and Disparities, Modelling gambling harm across Great Britain - Health Economics Unit (2023), Annual Statistics from the National Gambling Treatment Service Great Britain 2022/23 (2023)

e) Whether and how NGSN system contributes to system and individual-level outcomes as captured in the outcomes framework?

Summary

From the document review there are strong indications that the NGSN system contributes to positive individual-level outcomes. However, there is a large amount of missing and poor-quality data related to individual-level clinical outcomes in the DRF, meaning that even when we conduct a full analysis in Phase 2, it is likely that we will have to caveat any conclusions we draw about individual-level outcomes from the DRF.

Evidence shows that NGSN treatment leads to a reduction in PGSI and CORE-10 scores. For example, data from The GambleAware Annual Statistics from the National Support Network 2023/2024 report shows that improvements in PGSI score were seen in 95% of people who completed treatment and 62% of those who dropped out. Improvements in CORE-10 score were seen in 88% of clients who completed treatment compared with 68% who dropped out.[19]

In addition to this, OHID's analysis of people in England who received treatment in 2021-22 showed that, for treatment episodes that had a recorded exit reason, 92% of people who completed scheduled treatment recorded an improvement in their PGSI score compared to only 62% showing improvement among those who had an unscheduled or unplanned exit.[20]

However, the completeness of existing datasets is an issue when trying to monitor individual-level outcomes after treatment with other data sources. In the DRF, while there are PGSI and CORE10 scores recorded at an appointment level, much of this data is missing - PGSI scores are missing in 49% of appointments. CORE10 scores are missing in 38% of all appointments. However, it should be noted that PGSI and CORE10 scores are only routinely taken in first and last appointments, which explains some of the missing data here.

There is a perception among some providers that the performance data submitted through quarterly KPI reports and the DRF may be incomplete. This can result in pushback from providers, as the dataset, which does not always include all users going through the system, is being used to assess their performance. Some GambleAware staff members noted that providers occasionally question the accuracy of data submitted through formal reporting channels, which complicates the process of scrutinising performance. GambleAware have taken steps to resolve this and improve data accuracy.

Implications

During Phase 2, we will conduct analysis of DRF data to assess what outcomes are possible based on the evidence available. We will also use contribution analysis to assess contributing factors to agreed logic chains in in the Theory of Change. These claims are listed out in section 8 of this report.

Issues with poor quality and missing data in the DRF will mean we will have to caveat findings drawn from this source.

It should be noted that not all of the missing data in the DRF is problematic. For example, providers are instructed to record the PGSI and CORE-10 scores only at the first appointment and on discharge, which means that intervening appointments will not have PGSI and CORE-10 scores

[19] Annual Statistics from the National Support Network (Great Britain) 2023/2024
[20] Gambling treatment: Assessing the current system in England (2024), Office for Health Improvements and Disparities

associated with them. However, there is still some variance among providers and many final appointments do not have PGSI or CORE-10 scores. In addition to this, there is a large amount of cleaning that is required to make the DRF data files usable (e.g. making variable labels consistent), and the DRF files will need to be restructured so it there is one row for each person, rather than one row for each event. We will need to create rules in order to clean the files – for example, in some cases, missing data is coded as '99' but in other places missing data is empty with nothing to signify it. In instances like this, that we would need to create rules of thumb to even out inconsistencies in the way providers have recorded data. We will run these rules past GambleAware before we process the DRF data files.

f) What are specialist knowledge/skills in the NGSN?

Summary

While there is documentation available on the knowledge and skills that staff working in the NGSN are expected to have, during the scoping phase we were not able to compare these guidelines to the specialist skills staff exhibit on the ground.[21]

The NGSN Quality Standards states that providers are obliged to "*ensure staff have appropriate qualifications, skills, knowledge and experience and are adequately trained to fulfil their specific roles in care and treatment*."[22] There is also an NGSN Competency Framework which lays out competencies and skills that staff at NGSN providers must be able to demonstrate.[23]

Although in principle all providers in the NGSN should be providing the same level of minimum standards, there are indications that this is not the case. OHID's analysis of the current system of gambling treatment in England found that minimum qualifications of staff differed across providers, particularly in the third sector. A recent quality review of regional services also noted "significant differences across the regions in the training and development of frontline practitioners."[24]

Implications

We believe we will be able to answer this question fully in Phase 2, through a combination of the provider survey and case studies. As such, there is no need to change the scope of the question.

g) How does GA and NGSN providers understand community needs, identify gaps in support and address those issues?

Summary

The regional service specification describes three main ways in which NGSN regional providers are expected to identify and address unmet needs in their communities: community champions, local awareness raising and diverse and varied support networks for people *"including groups that people*

[21] https://www.gambleaware.org/sites/default/files/2021-05/Gambling_Competency_Framework.pdf
[22] NGSN Quality Standards, quality reviews of providers, GambleAware (No date)
[23] Gambling Competency Framework, GambleAware (2021)
[24] Gambling treatment: Assessing the current system in England (2024), Office for Health Improvements and Disparities

identify with, for example specific genders, cultures, identities and backgrounds, designed to meet local needs." [25]

One provider interviewed during scoping said they have a network of social prescribers who are keyed into the local area, and aware of settings where they are more likely to come into contact with people experiencing gambling harms, such as debt advisory services and food banks. Another provider partnered with a local council to run groups every Thursday which allowed people to have conversations about gambling in a safe space.

However, there are also indications that more work was needed for NGSN providers to identify gaps in support available. For example, those from ethnic minority backgrounds and LGBTQ+ people were reported to be underrepresented in NGSN support programmes, and aftercare support plans. So, while there are undoubtedly many effective initiatives in place that help to understand community needs and identify gaps in support, it there is still much more that could be done to make sure that more people experiencing gambling harms are able to access support.

Implications

We are confident we will be able to answer this question in Phase 2, using the case studies and second document review to build on the information we have uncovered during the scoping phase. The availability of relevant information means there is no need to amend or change this research question.

4. Assess the economic effectiveness of the NGSN system.

a) What are the NGSN operating costs?

Summary

Operating costs for the NGSN were identified and calculated from the documents provided by the NGSN. We have attempted to stratify costs by treatment tier based on financial dashboard data and published economic evidence. There were some limitations to this method as cost of resources were not reported for Tier 1 or Tier 4. Tier 4 costs were calculated by dividing total budget by the number of applicants reported by Gordon Moody 2023. For Tiers 1, 2, and 3, two methods were used. The first method assumed that all three Tiers had the same costs, taken from the GambleAware Finance Dashboard Data total budget. The second method assumed that Tier 2 was the average cost of Tier 1, 2, and 3; Tier 3 was micro-costed using resource use; Tier 1 cost was scaled down by the same difference between Tier 2 and Tier 3..The results of these calculations can be found in the full economic protocol.

Implications

There is no implication for the next phase of the evaluation, as these cost estimates were completed as part of the scoping phase. It is important to note that because the cost of resources was not reported for Tier 1 or Tier 4, assumptions have had to be made to calculate these costs, as outlined above.

b) What are the cost/health benefit ratios, both regionally and nationally?

[25] GambleAware Regional Service Specification (No date)

Summary

The cost/health benefit ratios will be calculated using the economic model in Phase 2 and 3. The NGSN has provided data on operating costs and client volumes for the various regions. Therefore, we will be able to use the model to estimate the benefits from treatment, primarily based on national data, and estimate the cost-effectiveness using the framework outlined in the economic protocol. We will be able to explore this both regionally and nationally, as we can use the model to estimate the economically justifiable price (EJP). This means that for defined levels of effectiveness, we can determine what the maximum operating costs will be to still be cost-effective. This can be compared with different regional providers, to see the operational costs relative to the EJP.

One limitation of the available data relates to Tier 1. At the time of writing, we have limited data on the effectiveness of Tier 1 interventions, as well as the true cost of delivering these services – which will have implications for the way we are able to calculate cost/health benefit ratios in the next phase. We can also contextualise these figures by using published literature on early interventions to support people experiencing problem gambling. Even with limited evidence, we can deliver a useful analysis to consider the potential impact of Tier 1 interventions.

As part of the Phase 2 and Phase 3 reports, we will also deliver recommendations for future evidence generation. This will help to support future evaluations by identifying evidence gaps, as well as solutions to fill these evidence gaps. Outlining plans for future evidence generation will support future evaluations, to provide a more certain estimate of cost/health benefit ratios.

Implications

The lack of available data on Tier 1 interventions means we need to adjust our original approach. We propose capturing this by conducting exploratory analysis to determine the relationship between operating costs and effectiveness. Using this method, we will be able to identify the EJP for different levels of theoretical effectiveness for Tier 1 interventions.

9 Implications for the evaluation approach

The proposed scope of the evaluation remains largely unchanged. We do, however, propose some refinements to our research questions and approach (detailed in Table 8.1 overleaf). We require GA's agreement with these refinements.

Summary of changes to research questions

Table 9.1 Summary of changes to research questions

Evaluation objectives	Original research questions	Original approach	Proposed changes
1. Develop a Theory of Change for the NGSN system.	a) What are the main inputs and activities of the NGSN system, and the benefits those are expected to lead to for system users?	Scoping: All scoping activities plus ToC development Mainstage: Test agreed elements of ToC for CA Final outputs: Update ToC at evaluation end.	No changes proposed.
	b) What are the assumptions underlying this theory of change?	As above	
2. Assess the operational effectiveness of the NGSN system.	a) What is the NGSN governance structure and how effective is it?	Scoping: Discussions, document review Mainstage: Document review, case studies	We suggest changing this question to *"What is the NGSN governance structure and what are provider perceptions of its effectiveness?"* We have adapted this research question to better reflect the scope of the data sources we will have available to us at Phase 2; primarily, case study discussions with providers and the survey of providers.
	b) What are the factors affecting the NGSN system's ability to reduce harm among people experiencing harm from gambling at the regional and national level, and their causal relationships?	Scoping: PSM and ToC development activities Mainstage: Case studies, survey	No changes required. The PSM and ToC development undertaken in the scoping stage provides a strong foundation for further interrogation of relevant factors during Phase 2.
	c) Are GambleAware's principles embedded in the NGSN system?	Scoping: Document review, discussions Mainstage: Case studies, survey	We suggest changing this question to *"To what extent are provider practices informed by the NGSN Model of Care principles?"* This better reflects GambleAware's vision for the system and these principles are the most salient to examine.

3. Assess the clinical effectiveness of the NGSN system.	a) Who does the NGSN support (and not) regionally and nationally?	Scoping: Discussions, document review Mainstage: DRF analysis, document review	No changes required. However, unless GambleAware can facilitate access to disaggregated data on use of Tier 1 support (e.g. helpline data), we will be limited in the extent to which we can answer this for Tier 1 users.
	b) How does eligibility criteria for support access vary across the NGSN, regionally and nationally?	Scoping: Discussions, document review Mainstage: Case studies	From our scoping activities, this question is straightforward to address, as eligibility criteria are clearly documented. Therefore, to achieve a better depth of insight we suggest we expand the scope of this question to address *"What are provider perceptions of the factors that impact whether eligible clients are able to access NGSN support?"*
	c) What different tiers of provisions are provided by different providers and what proportion of clients experience those different tiers?	Scoping: Discussions, document review Mainstage: DRF analysis, document review	From our scoping activities we are confident we can address this question for Tiers 2 – 4; there is greater uncertainty around figures for Tier 1 support. We suggest we slightly amend this question to clearly specify that we will be able to look at provision by each provider: *"What different tiers of provisions are provided by different providers and what proportion of each provider's clients experience each tier?"*
	d) What are the common referral pathways through the NGSN and what factors influence those pathways, including Helpline and treatment provision?	Scoping: Discussions, document review Mainstage: Survey, case studies, document review	We suggest we split this question in two slightly refined questions: *"i) What are referral sources for NGSN providers?* *ii) What are examples of referral pathways through the NGSN and what factors influence those pathways?"* Our scoping activity suggests that it won't be possible to establish common pathways, because pathways are not sufficiently documented. Instead, will be able to establish referral sources though analysis of DRF data, the provider survey and our case studies. Through our case studies we will be able to extract examples of referral pathways though the NGSN (and the factors influencing them), but we will not be able to confidently draw conclusions about how commonly these occur.
	e) Whether and how NGNS system contributes to system and individual-level outcomes	Scoping: Data mapping Mainstage: survey, case studies, document review,	Following agreement of the contribution claims with GambleAware, for the second phase, the scope of this question will be focused on assessing the evidence for the following claims:

	as captured in the outcomes framework?	contribution analysis workshops Final outputs: Contribution analysis and workshops	*Claim 1: Providers gather evidence to understand the gambling treatment support needs for tiers 2 and 3, in their local area.* *Claim 2: All providers have tailored the treatment and support services they provide based on evidence of need* *Claim 3: Providers have treatment pathways with mechanisms of referral for individuals with local non-gambling specific services* *Claim 4: Providers regularly review their services in line with the quality assurance framework, and implement changes to improve the quality of their services where possible*
	f) What are specialist knowledge/skills in the NGSN?	Scoping: Data mapping Mainstage: Survey, document review	No changes required. We are confident we will be able to answer this question through our Phase 2 activities, although we recommend also gathering evidence to answer this question through the case studies.
	g) How does GA and NGSN providers understand community needs, identify gaps in support and address those issues?	Scoping: Discussions Mainstage: Case studies, survey	No changes required. We are confident we will be able to answer this question through our Phase 2 activities, including the contribution analysis.
4. Assess the economic effectiveness of the NGSN system.	a) What are the NGSN operating costs?	Scoping: Scope economic model's design and data inputs Mainstage: Build and populate model	Cost estimates completed during scoping stage so no changes proposed. No changes proposed, with the exception that in relation to Tier 1 support this estimate will have limitations, due to data availability.
	b) What are the cost/health benefit ratios, both regionally and nationally?	As above	

Evaluation framework

The evaluation framework reflects the proposed refinement to research questions discussed above, and how we will answer each. The purpose of an evaluation framework is to identify how each of research questions will be addressed through the evaluation. This provides a roadmap of how the evaluation will assess the effectiveness of the NGSN and determines the best method or methods to gathering the required data.

There are a number of assumptions to note when reviewing the considering the evaluation framework:

- The document review in Phase 2 will cover 25 x 20 page documents (or equivalent)
- We will engage 4 NGSN providers as case studies, and for each undertake:
    - 1 x 60 minute paired depth with leadership
    - 1 x 90 focus group with frontline staff
- Secondary data analysis will be carried out on the most recent complete year's (or financial year's) data available (typically 23/24)
- The provider survey will be up to 15 minutes in length, circulated by provider leadership and cascaded through their organisation

Economic protocol for assessing the economic effectiveness of the NGSN system

Modelling Approach

The primary objective of the proposed economic modelling will be to evaluate the cost-effectiveness of the NGSN services. This will be undertaken from an NHS and personal social services (PSS) perspective, while a wider societal perspective will be used in scenario analysis.

Decision Problem

The key elements of the modelling approach are summarised in 8.3. The population considered in the model will be aligned with the population accessing NGSN services currently, utilising data on treatment outcomes. The comparator arm of the model will capture standard of care when not accessing NGSN services, which may include access to other NHS services, private services, or people not accessing any support services.

The primary anticipated benefit of the NGSN is reducing the number of people who experience gambling harms, either those who gamble or affected others. Reducing gambling harms is likely to lead to reduced healthcare resource use, improvements in health-related quality of life (HRQoL), and reductions in societal costs.

Similar to other mental health related economic modelling, a short time horizon is appropriate[1]. This is because of the potential of experiencing a recurrence of gambling harms, which may lead to future treatments, of which the outcomes are highly uncertain. This also makes the benefits and likelihood of sustained improvements difficult to measure in an economically meaningful way. Hence, only one treatment period with the NGSN will be captured in the model, not necessarily capturing multiple treatment rounds if there is a recurrence of gambling harms in the future. In the base case, all costs will be from the UK NHS and personal social services, given the NHS will become the treatment commissioner of the services. As a result, the opportunity cost of funding gambling services will fall on the NHS. However, scenario analysis will be conducted, capturing a wider societal perspective as well, given the varied potential impacts of reducing gambling harms.

Table 9.2 Decision problem

Model element	Description
Population	People who experience gambling harms: either those who gamble or those affected by gambling. Subgroup analysis: applied by treatment tier and baseline PGSI score.
Intervention	National Gambling Support Network
Comparator	Standard of care
Outcomes	Per-person costs and quality-adjusted life years (QALYs), incremental cost-effectiveness ratio (ICER), net monetary benefit (NMB), net health benefit (NHB).
Perspective	NHS and PSS
Model design	Markov model
Discount rate	3.5% for costs and health benefits.[2]
Threshold	£20,000 per QALY.[3]
Time horizon	2 years in base case, flexibility to capture up to 5 years.

[1] Donker T, Blankers M, Hedman E, Ljotsson B, Petrie K, Christensen H. Economic evaluations of Internet interventions for mental health: a systematic review. Psychol Med. 2015.45(16):3357-76. doi: 10.1017/S0033291715001427
Le LK, Esturas AC, Mihalopoulos C, Chiotelis O, Bucholc J, Chatterton ML, et al. Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. PLoS Med. 2021.18(5):e1003606. doi: 10.1371/journal.pmed.1003606
[2] NICE. NICE health technology evaluations: the manual 2022. Available from: https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741.
[3] NICE. NICE health technology evaluations: the manual 2022. Available from: https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741.

Cost-Effectiveness Model

Model structure

Based on previous experience of modelling a range of mental health interventions, the available evidence, and previous economic analysis on gambling harms, we propose that a Markov model would be a suitable structure to address the decision problem. Markov models use health states to represent all possible consequences of an intervention of interest. These are mutually exclusive and exhaustive and so each individual represented in the model can be in one and only one of these states at any given time.

Individuals move ('transition') between health states as their condition changes over time. A schematic of the model is shown in Figure 8.4 for people who gamble, and Figure 8.5 for the affected others subgroup. Time itself is considered in discrete time periods called 'cycles', which will be one-month long, and movements from one health state to another (in the subsequent time period) are represented as 'transition probabilities'. Time spent in each health state for a single model cycle (and transitions between states) is associated with a cost and a health outcome. Costs and health outcomes are aggregated for a modelled cohort of people over successive cycles to provide a summary of the cohort experience, which can be compared with the aggregate experience of the comparator cohort.

The health states included in this model will be determined by an individual's PGSI score for those who gamble. Health states will include no risk, low risk, moderate risk or people experiencing problem gambling, as well as a death health state. For affected others, an exploratory analysis will be used, due to limited economic evidence surrounding CORE-10 scores. The Patient Health Questionnaire-9 (PHQ-9) is a depression screening tool that uses a scale to determine the severity of a patient's depression. The scoring system allocates individuals into a severity group, and can be linked to economic outcomes:

0-4: None/minimal.

5-9: Mild depression.

10-14: Moderate depression.

15-19: Moderately severe depression.

20-27: Severe depression.

As an assumption, PHQ-9 scores can be mapped to CORE-10 scores. Therefore, PHQ-9 will be used as a proxy for CORE-10 scores, in the absence of evidence that links CORE-10 to economic outcomes. This assumption was discussed with clinicians available to the NGSN, and confirmed to be appropriate, given the evidence gaps encountered.

The time horizon of the model will be set to two years in the base case and will be adjustable between one and five years through scenario analysis. The base case is set to two years as we cannot be confident in the outcomes associated with the risk of relapse. People seeking multiple rounds of treatments are likely to have different outcomes, so could be considered to be a different population. Mental health models across a range of literature tend to have shorter-time horizons for this reason, to reduce the uncertainty within the quantified estimate. A two-year time horizon was considered adequate to capture longer-term costs and effects of treatment, without significant extrapolation over the course of a person's life, during which there may be recurrences in risky gambling behaviours.

This is consistent with previous literature. Half-cycle correction will be applied to account for the fact that people may move health state or die at any point in the cycle.

Figure 9.2 Model schematic – people who gamble

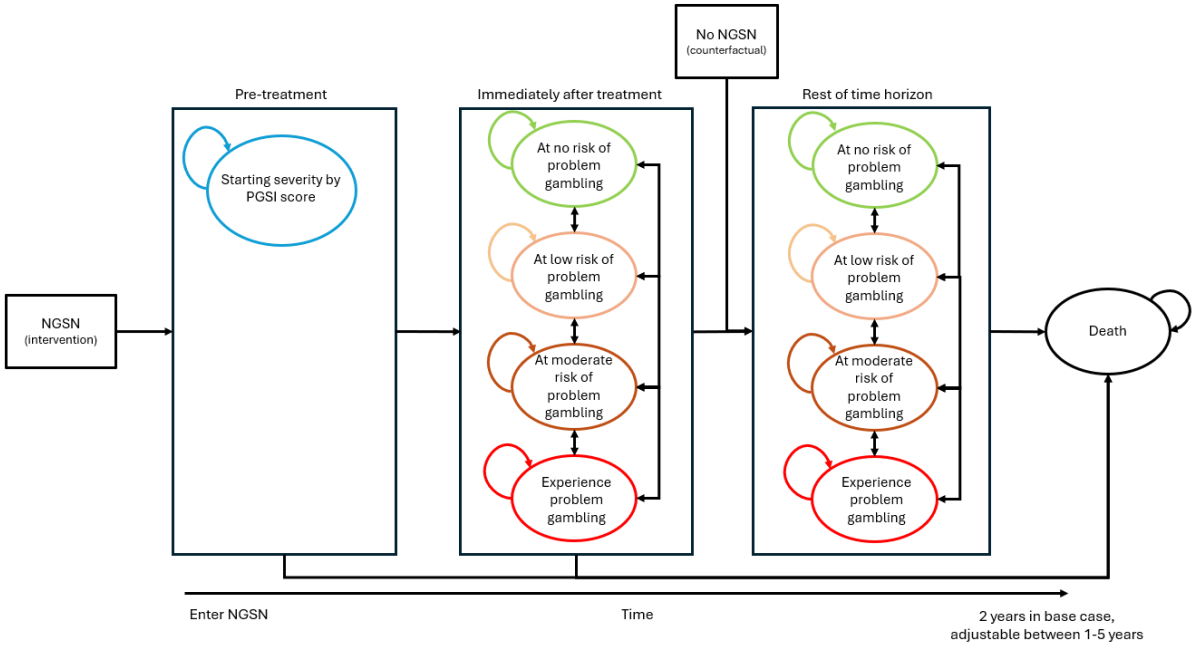
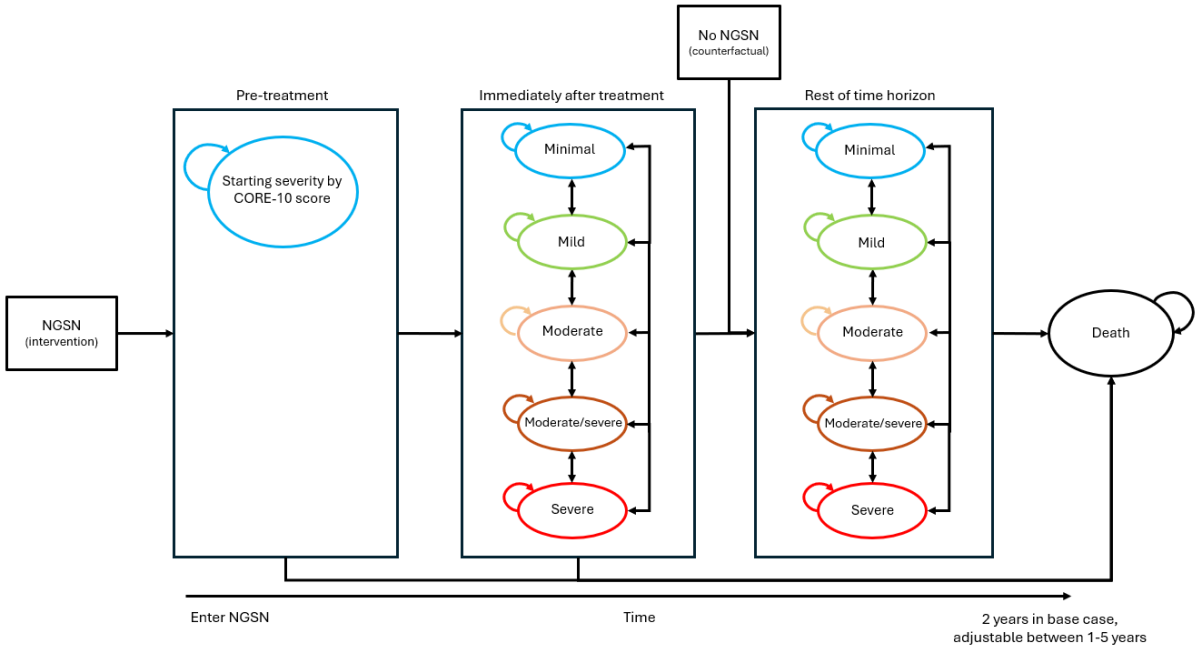


Figure 9.3 Model schematic – affected others subgroup



No data were identified to link the impact of Tier 1 interventions to any intermediate or useful economic outcomes. We acknowledge that Tier 1 interventions, particularly early interventions and the helpline, represent an important value proposition for the NGSN, supporting effective delivery of services. Therefore, despite no available effectiveness data, we propose to run a threshold analysis for Tier 1 interventions. This will be conducted by applying relative risks to the likelihood of recurrence (PGSI progression), to determine how much impact is required for Tier 1 interventions to be cost-effective. Hence, we can then back-calculate the effectiveness required from Tier 1 interventions to be considered good value for money within this threshold analysis. A scenario will also be included to consider the impact that Tier 1 interventions may have on access to future support. This is described below in the Model Outputs section.

We believe this is the optimal approach for capturing the economic impact of the NGSN because:

- PGSI is the metric with the most available data linking to economic outcomes. The NGSN captures treatment outcomes for PGSI and Core-10. Hence, these two metrics can be used to capture the potential economic benefits associated with the NGSN. These outcomes can be used as the engine of the model, where the treatment effect will be captured by potentially seeing improved scores in the intervention arm. However, Core-10 has very little evidence to map scores onto key economic outcomes, such as healthcare resource use. Therefore, using Core-10 would not capture the potential economic benefits of the NGSN and using PHQ-9 as a proxy will allow the quantification of economic outcomes linked to affected others.

- A Markov model allows for extrapolation of the available evidence using transition probabilities. The benefits associated with the NGSN will continue beyond when the treatment is finished, as a proportion of people will recover, and may stay recovered into the future. We expect that more people will have lower PGSI scores in the NGSN intervention arm of the model than in the comparator arm.

The relative risks estimated in threshold analysis will then be calibrated with quantitative and qualitative evaluations, looking at early intervention for gambling.[4] This analysis will be run for different PGSI baseline scores, as defined in Figure 8.4. As part of Phase 2 and 3 of this project, we will also provide future recommendations for how to collect data to identify the true impact of Tier 1 interventions.

Assumptions and limitations

Table 9.3 details a summary of the key modelling assumptions and their likely impact on the results.

[4] Yakovenko I, Quigley L, Hemmelgarn BR, Hodgins DC, Ronksley P. The efficacy of motivational interviewing for disordered gambling: Systematic review and meta-analysis. Addictive Behaviors. 2015.43:72-82. doi: https://doi.org/10.1016/j.addbeh.2014.12.011

Table 9.3 Key modelling assumptions

Assumption	Justification	Likely impact on results
Affected others included in the model using PHQ-9 as a proxy for CORE-10 scores.	This is due to limited data on costs and health outcomes linked to CORE-10 score. This exploratory analysis was discussed with clinical experts to validate the assumptions used.	This may result in an under- or over-estimation of the impact on affected others through use of the services. It is difficult to estimate the direction of the bias for this assumption. Various sensitivity analysis will be run to provide a range of estimates, given this assumption.
PGSI is the most appropriate measure to track treatment benefit for the economic analysis of those who are gambling.	Previous literature has highlighted that PGSI is the most common measure within economic analysis. Furthermore, there is a substantial range of literature stratifying costs and health outcomes by PGSI. We acknowledge that PGSI may be limited to capture true effectiveness. However, at this time, we believe this is the most appropriate measure of benefit for the economic analysis.	If PGSI is less sensitive to improvements in wellbeing that may stem from intervention, then the model may underestimate the true treatment effect. We believe that future evidence should look to stratify economic outcomes by alternative metrics, such as PHQ-9, CORE-10 or GAD-7. Further detail will be provided in Phase 2 and 3 on future evidence generation.
Alcohol and substance misuse are not included in the model.	In the literature, correlation rather than causation between these behaviours has been found, suggesting a shared causal factor.	This may underestimate the impact of services to support people at risk from gambling. However, it is preferable to make a more conservative estimate than to potentially overestimate the true impact.
Impact of aftercare is not included in the model.	Insufficient evidence base for aftercare and the impact it may have on recurrent gambling in the literature.	This is a limitation, as the model will underestimate the continued benefits of aftercare. As above, it is preferable to make a more conservative estimate in the absence of evidence.
The age of T1 clients is the same as T3-T4.	Absence of data for Tier 1 in the DRF.	This assumption will have limited impact to the model results as the model does not have a lifetime time horizon.

Model parameters

A complete list of proposed model parameters of the economic modelling can be found in the full protocol. This includes data sources and values to be used, for model settings, population, clinical parameters, resource use, costs, utilities, and mortality.

Treatment tier allocation for Tiers 2, 3 and 4 will be informed by the DRF data, which reports which tiered treatment is accessed by an individual. Pre-treatment and post-treatment PGSI scores and CORE-10 scores for Tiers 2, 3 and 4 are to be provided by GambleAware. For the intervention, PGSI movements from baseline to post-treatment are to be provided by GambleAware, as their Annual Statistics publication includes evidence demonstrating the movement of clients between PGSI severity levels. Dashboard data has indicated that PGSI is also collected by Tier 2 treatments, hence, we expect this can be provided by GambleAware.

The modelled cohort will incur ongoing resource use and costs, depending on which health state they occupy. Annual GP appointments by PGSI score are taken from the NICE evidence review.[5] The annual number of hospital admissions per person for the general population was calculated using NHS Digital Hospital Admitted Patient Care Activity and ONS population data for England. Odds ratios (OR) for hospital admissions based on PGSI score are estimated by the National Institute of Economic and Social Research (NIESR) within their report looking into the fiscal costs and benefits of problem gambling.[6]

The Office for Health Improvement and Disparities (OHID) provided an estimate of the number of people experiencing problem gambling who are in prison and the impact of gambling on unemployment benefits claimed. Prevalence of homelessness was estimated using a prediction of the number of people without a home in England, sourced from Shelter in 2023 in relation to the population of England.[7] NIESR estimated how much more likely it was for a person experiencing problem gambling to be without a home, which was used to calculate the prevalence of homelessness in a population with a PGSI score of 8+.

We have provided two options for costing the treatment tiers. The first option assumes the same cost for Tiers 1, 2 and 3 as this is calculated from the total financial budget data provided by GambleAware. An alternative option for costing the 3 tiers has been provided, using the same costing method for Tier 2 but alternative methods for Tiers 1 and 3. The cost for Tier 3 has been estimated using the same approach as the Health Economics Unit report, by a granular resource use method. Costs were inflated to the 2022/23 cost year. The cost of Tier 1 was downscaled by the same proportion that Tier 3 is upscaled by.

Suggested utility values to be used in the economic model come from a variety of sources, including values used in the economic model as part of NICE guidelines.[8] The valuation of health states should be based on public preferences elicited using a choice-based method (such as the time trade-off or standard gamble), in a representative sample of the UK population. NICE recommends the EQ-5D as the preferred measure of health-related quality of life (HRQoL) in adults for use in cost-utility analysis. However, none of the utility values found through literature searching were based on EQ-5D ratings. The utilities determined by Moayeri 2020 were elicited through the UK short form-36 (SF-36) health

[5] NICE. Harmful gambling: identification, assessment and management. Evidence Review F. 2023. Available from: https://www.nice.org.uk/guidance/gid-ng10210/documents/evidence-review-9
[6] National Institute of Economic and Social Research. The Fiscal Costs and Benefits of Problem Gambling: Towards Better Estimates. 2023. Available from: https://www.niesr.ac.uk/wp-content/uploads/2023/04/The-Fiscal-Costs-and-Benefits-of-Problem-Gambling-1.pdf?ver=pnPnslUqVRP9I60kYjEy
[7] Shelter. At least 309,000 people homeless in England today. 2023. [cited 9th September 2024 Available from: https://england.shelter.org.uk/media/press_release/at_least_309000_people_homeless_in_england_today.
[8] NICE. Harmful gambling: identification, assessment and management. Evidence Review F. 2023. Available from: https://www.nice.org.uk/guidance/gid-ng10210/documents/evidence-review-9.

questionnaire. These values were directly relevant to the UK population and were therefore deemed appropriate for the economic analysis.[9]

Model Outputs

The economic model will be designed to estimate the cost-effectiveness (i.e. cost per QALY) of the NGSN compared with standard of care. The primary outcome from the model will be the incremental cost-effectiveness ratio (ICER), presented as an incremental cost per QALY. These results will be compared against pre-established cost-effectiveness thresholds to understand whether the NGSN is likely to be an efficient use of healthcare resources from a UK perspective. Cost breakdowns, QALY breakdowns, and health state occupancy will also be included.

Sensitivity Analysis

Following the setup and running of the analysis, the model will test the 'uncertainty' of the results, based on the input values used, through deterministic sensitivity analysis (DSA). The main output from the DSA will be a tornado diagram, which will summarise the impact of changes to each parameter on the model results. For all varied parameters, a range of values, based on confidence intervals where available, will be applied around the point estimate that has been applied in the base-case analysis, to investigate the impact of changes in each parameter on the overall model results.

A range of scenarios and subgroup analyses will also be conducted, as follows:

- Separate analysis of different treatment tiers, as well as baseline PGSI scores.
- Exploratory threshold analysis will be conducted on the required treatment impact of Tier 1 interventions to be cost-effective, at different PGSI scores. A scenario will be included to consider the impact that Tier 1 interventions may have on access to future support. Clinical advice will be sought to inform the likelihood that Tier 1 interventions may have an impact on the rates of access to Tier 3 and Tier 4 services.
- The base-case analysis will use NICE guidelines for economic evaluation, reflecting an NHS perspective on the analysis. A scenario analysis will be undertaken using the HM Treasury guidelines instead. This will involve altering the discount rate from 3.5% to 1.5%, and the willingness-to-pay threshold from £20,000 per QALY gained to £70,000 per QALY gained.

Quality Assurance

Once the model has been developed, a thorough verification will be conducted to confirm the internal validity of the model. This will focus on checking the formulae to ensure that they are correct and appropriately applied and will be undertaken by a member of YHEC staff completely independent of the model development up to this point. This will use a standard checklist that includes a range of tests, including sense checks, for instance, changing certain inputs to zero and checking that the observed effect is as expected. Other, model-specific, checks will also be incorporated as part of the verification process. Once the model has been reviewed by the NGSN, YHEC will provide an updated

[9] Moayeri F. A reference set of Health State Utility Values for gambling problem behaviour, a survey of the Australian general population: implications for future healthcare evaluations. Expert Rev Pharmacoecon Outcomes Res. 2020.20(1):115-24. doi: 10.1080/14737167.2019.1610397

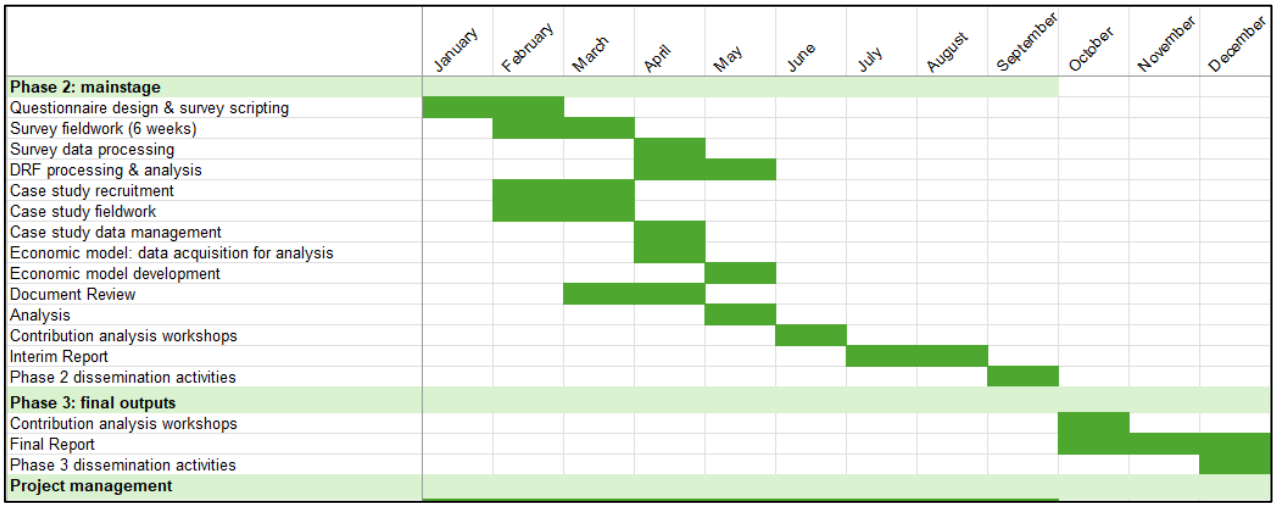
model, including all recommended changes, highlighting any areas where changes were not possible (e.g. due to limited data).

10 Outputs and timings

Updated timings

There are no substantial changes to the project timing from the proposal version, with just slightly amended timings for the survey as shown below. This change does not impact on our overall reporting timescales.

Figure 10.1 Evaluation timetable



Key outputs

Table 10.1 Key Phase 2 Outputs

Nº	Output	Description	Sources	Timings
1	Provider survey toplines	Topline figures (data shown at a total level) for each survey question, based on interim survey data. Note that the data will not be tabulated at this stage.	Provider survey data	• Delivered 28th March

		Excel format – total responses will be shown for each survey question. Data will not be cut by sub-groups for the toplines.		
3	Economic model	A core Excel-based economic model, fully annotated and referenced, and technical report detailing the model structure, inputs, results, discussion and limitations of the analysis.	Economic protocol, document review	• Model draft delivery: 18th April • Model finalised: 16th May
4	Contribution analysis workshops (x2)	The purpose of these workshops is to test and validate the emerging contribution story and to explore any additional evidence or alternative explanations for the contribution claims. Each workshop will last up to 90 mins – one will be with NGSN stakeholders and the other will be with the Lived Experience group.	Contribution claims, Theory of Change	• 2nd – 20th June
5	Interim report	Report detailing the findings from all work so far across the first two project phases. It will be structured around our evaluation objectives and research questions, and including conclusions and recommendations structured by stakeholder audiences. It will include participatory systems map results from scoping, and economic model results, including context to the decision problem and model conceptualisation, base case results, results from sensitivity analysis, and results for subgroups and key scenarios to highlight important uncertainties. 40 pages, Word document.	Provider survey, provider case studies, document review, economic model, DRF data, PSM, economic model	• Draft 1 delivery: 25th July • Draft 2 delivery: 12th August • Final report delivery: 3rd Sep

6	Dissemination webinar	Webinar to disseminate the findings of the interim report to stakeholders. We anticipate the length of the webinar will be 60 mins and that it will be hosted on either Teams or Zoom.	Interim report	• 8th – 19th September
7	Final report	We will bring together the evaluation findings, evidence and recommendations. We anticipate the report covering: policy and system context; evaluation approach, including limitations/considerations; thematically organised chapters, organised around objectives and clearly distinguishing between audiences, and what is working well/less well for audiences; conclusions and considerations for policy, practice and research. Our costs assume two rounds of collated, substantive feedback and we assumed the peer reviewer would contribute at round two. 40 pages, Word document. We will also include a 3-5 page executive summary and technical appendix,	Provider survey, provider case studies, document review, economic model, DRF data, PSM, economic model, contribution analysis workshops,	• Draft 1 delivery: 31st October • Draft 2 delivery: 21st November • Final report delivery: 10th December
8	Dissemination activities	Exact activities to be agreed, but we have budgeted fo: • 60 min webinar hosted on Zoom on Teams • Social media posts x 3 based on webinar themes • Email bulletin on webinar	Final report	• 5th – 16th Jan 2026

11 Appendix

- The full economic protocol is available here 

- The full PSM map and narrative is available here 

- Detail of the development of the contribution claims is available here 

- The document review is available here