REPORT from the GAMING COMMISSION
on DRUG AND ALCOHOL RECOVERY PbR PILOTS

Summary

1. The Gaming Commission (GC) was set up in August 2011 to identify gaming opportunities within the Drug & Alcohol (D&A) Recovery PbR pilot schemes, and to recommend how these might be eradicated or minimised.

2. This report is based on the outcome of three meetings of relevant professionals using their first-hand knowledge of commissioning and service provision, and taking into consideration the evidence from other policy sectors and the findings of a report on the D&A Recovery PbR by the Policy Innovation Research Unit (PIRU).

3. Gaming is defined as the deliberate manipulation of the system, outside of the agreed rules, for financial gain, and unethical behaviour to maximise income.

4. General issues that could impact on gaming were identified:
   - The complexity associated with having multiple outcomes and multiple severity groups is unprecedented and will increase opportunities for gaming or for the accidental introduction of perverse incentives.
   - Tariff weighting: if this is not considered carefully, providers may be incentivised to “park” or “fast-track” clients in order to maximise payments.
   - Pressures to game the system will tend to increase if external factors mean it is more difficult to achieve the PbR outcomes.
   - Outcome weighting systems, if too simple, may be too “blunt” to incentivise the required outcomes, while if too complex may reduce transparency and encourage gaming.
   - Tying a high proportion of income to performance is more likely to have perverse consequences when the outcome is not fully under the control of the provider.

5. Specific risks and gaming opportunities were identified as falling into three key areas:
   - the assessment of clients, and particularly the role of Local Area Single Assessment and Referral System (or LASARS);
   - the weighting and timing of payments for different PbR outcomes; and
   - misrepresenting or inflating success to obtain outcome payments that are not really merited or deserved.

Many of these gaming risks can be reduced or eliminated through effective setting of tariff weightings and payment structures.

6. Effective system design should be considered the primary opportunity for minimising and eradicating ‘gaming’, and ‘policing’ the behaviour of providers as a secondary strategy. However, given the complexity and speed of implementation of the pilots there are many ‘unknowns’ in the design process so monitoring processes will be of particular importance and flexibility should built into the systems.

7. In order to monitor and identify if gaming is occurring and to deter it, actions of three main types were identified:
   - Monitoring data to detect change from previous years (e.g. in the distribution of “complexity groups in an area’s treatment population). Triangulation with other sources of evidence or using data from other comparable areas may be helpful for confirming anomalies.
   - Auditing processes will be essential. Robust auditing of assessments and outcomes will be important everywhere but particularly where there are non-independent LASARS.
   - Involvement of service users in systematic, independent assessment of their views and experiences of the services provided.
1. Introduction

The Department of Health is leading on a cross-departmental project to explore how Payment by Results (PbR) can incentivise delivery of recovery outcomes for adults with drug or alcohol problems, with pilots being developed in eight areas. Underpinning the pilots is the principle that providers will no longer be paid on the basis of activity but on the outcomes they support service users to achieve. The pilots are being developed by a national co-design group, but with significant scope for local variation.

1.1 Role and remit of the PbR for Recovery Gaming Commission

The Gaming Commission (GC) was set up in August 2011 as a sub-group of the Co-design group. Most of its members were not directly involved in the Co-design group. This was partly because it was necessary to ensure there was no conflict of interest and, in particular, that GC members were not involved in the pilots in any way. It brought together policy specialists (including those involved in the design of other PbR schemes across Government) together with a group of people with operational experience of service provision – as commissioners, providers and service users. The co-chairs of the GC – from DrugScope and the UK Drug Policy Commission respectively - were independent from Government.¹

The GC’s ‘main responsibilities’ were identified as:

- To examine the agreed models, outcome definitions and metrics of the Drug and Alcohol Recovery PbR pilots and consider opportunities for:
  - deterring access to treatment for those least likely to achieve outcomes;
  - ‘parking’ or delivering minimal treatment to clients least likely to achieve outcomes;
  - securing unwarranted payments;
  - other ways of ‘gaming’ the system.
- To recommend how these opportunities could be eradicated or minimised.

While the main focus of the discussions of the GC were on the implications for the commissioners of the services in the pilot areas, the findings will also be of value in informing the design of the evaluation of the pilots.

1.2 The approach taken

The Commission had a tight time scale for deliberating on these issues, which meant that some of the information for modelling some aspects of the system was not available in time to be considered. As a result the conclusions have had to be quite broad-brush in nature. It also means that the issues identified below are unlikely to be a complete list of all possible gaming opportunities but nevertheless provide an indication of some critical points in the system to which particular attention should be paid.

This report is informed by the deliberations at three meetings on 22 September, 19 October and 15 November 2011. The first meeting introduced the PbR approach being taken in the pilots and the issue of gaming. The second, and longest, meeting considered the proposed models in more details and what was known about the outcomes against which payments would be made and then brainstormed the various gaming opportunities. The final meeting reviewed the gaming opportunities and discussed how these might be identified and/or mitigated against.

The report also takes into account the conclusions of a report produced by the Policy Innovation Research Unit (PIRU) on 10 November 2011. The PIRU was asked to consider key design aspects of the PbR pilots, and a number of its findings support the conclusions of the Gaming Commission. The GC also considered evidence from other policy sectors – for example, at our first meeting, Dr Maria Hudson presented on the findings from the evaluation of the DWP’s PbR-based ‘Pathways to Work’ initiative which she led at the Policy Studies Institute.

1.3 A note on the Commission’s assumptions about provider motivation

For the purposes of its deliberations the GC has found it helpful to assume that providers and commissioners will act in a self-interested way to maximise their income and/or minimise their

¹ The Terms of Reference of the Gaming Commission, including a list of its membership, are provided as Appendix 1 of this document.
expenditure. In reality, we know that the commissioners and service providers involved in the PbR pilots are motivated by a desire to achieve the best possible outcomes for service users, families and communities.

1.4 The purposes of this report
The GC intends that this report should inform the development of Drug and Alcohol Recovery PbR by:
- providing an analysis of gaming issues relevant to the development of the Drug and Alcohol Recovery PbR schemes;
- providing guidance to the eight pilot areas and to other commissioners involved in the design of PbR systems (now and in the future) on minimising or eradicating opportunities for gaming through effective system design and other safeguards;
- informing the monitoring, auditing and evaluation of the PbR pilots by highlighting where gaming is most likely to occur, and identifying some of the early warning signs.

1.5 What is gaming?
The Audit Commission (AC) (2005) report ‘Early lessons from payment by results’ identified gaming as a significant risk for payment by results approaches to the delivery of public services.

In line with the AC, the GC agreed the following definition of gaming:

- The deliberate manipulation of the system, outside of the agreed rules, for financial gain, and in particular:
  - Deliberately manipulating complexity ratings;
  - Securing unwarranted payments;
  - Deliberately inflating successes.
- Unethical behaviour to maximise income, and in particular:
  - Cherry-picking/creaming clients most likely to achieve outcomes; and
  - Parking clients who can achieve initial outcomes but are unlikely to achieve abstinence.

The GC also discussed the risks that both commissioners and service users could also ‘play the system’.

2 Identifying gaming opportunities and developing responses
The GC identified a number of points within the PBR process at which it concluded that there were significant opportunities for different forms of gaming. (See figures 1 & 2 below). It concluded that the principal risks of gaming could be captured by focusing on three key issues:

1. Gaming opportunities associated with the assessment of clients, and particularly the role of Local Area Single Assessment and Referral Services (or LASARS);
2. Gaming opportunities associated with the weighting and timing of payments for different PbR outcomes; and
3. Gaming opportunities for misrepresenting or inflating success to obtain outcome payments that are not really merited or deserved.

These three themes are considered in more detail below (see pages 5-9).
Figure 1 The Basic Model

- LASARS
  - Assessment & tariff-setting
  - Referral to provider
  - Confirmation of outcomes to trigger payments
  - Advocacy

- Prime provider
- Free from drug(s)
- Reduced offending
- Improved H&WB

- Provider Framework

Figure 2 Gaming Opportunities

- Access denied
- Complexity exaggerated
- ARS
  - Assessment falsified
  - Contingent
  - Cherry-picked
  - Waiting list created

- TOP falsified
- Creamed

- Relapse
- Sustained recovery
2.1 General issues relating to gaming

The Gaming Commission also highlighted some general issues that could impact on the risks of gaming:

1. Setting tariffs for multiple outcomes and groups. Perhaps the key concern is that if the tariff weightings are not carefully calibrated some service users will be ‘parked’ in treatment with little pro-active support once any applicable ‘interim outcomes’ have been achieved (it was noted that the risk of ‘parking’ will tend to increase as the treatment journey progresses and the range of available outcomes remaining for a particular service user contracts). Equally, there were concerns that service users could be fast-tracked through and out of the treatment system prematurely in an attempt to maximise payments for treatment success (it was noted that if this payment is sufficiently high providers could calculate that in business terms they should fast-track exit even while expecting a significant rate of representation).

2. Strategies for survival. The pressures to game the system will tend to increase if external factors mean it is more difficult to achieve the PbR outcomes. Qualitative evidence from the evaluation of the DWP’s Pathways to Work initiative concluded that the tendency to ‘park’ clients who were considered further from entering the labour market increased during the 2009 recession. Where external factors create additional pressures for drug and alcohol services, an element of ‘gaming’ could act as a kind of ‘buffer’ – i.e. as an adaptive strategy to sustain the provision of services in a more difficult environment.

3. Complexity and transparency. Some members of the GC suggested that there would be more opportunities for gaming the more ‘complex’ the PbR arrangements. Intuitively, this seems right, although it is perhaps the lack of transparency that is a consequence of greater complexity that is the key issue. On the other hand, it could be argued that a ‘complex’ tariff and outcome weighting system is required to produce a sufficiently sophisticated incentive structure to minimise ‘parking and ‘creaming’.

4. Benevolent gaming. The GC noted that while ‘gaming’ is identified with ‘unethical’ behaviour it can also have positive motivations. For example, a provider may be incentivised to game the system because they believe this is a necessary strategy for maintaining investment in a service for vulnerable clients. In practical terms, this means that effective system design should be considered the primary opportunity for minimising and eradicating ‘gaming’, and ‘policing’ the behaviour of providers as a secondary strategy (prevention is better than cure).

5. Gaming and flexibility. The GC concluded that there may even be an argument for tolerating a degree of ‘gaming’ in PbR systems, as a mechanism for service providers to manage unintended problems with system design and to maintain activity and business viability. It may be helpful for practical reasons to give further consideration to the possibility of distinguishing between gaming as an adaptive strategy for managing problems and more destructive or fraudulent forms of gaming, and to design and develop calibrated responses in the light of this distinction.

6. Level of provider control over outcome. We note that the PIRU concluded that ‘tying a high proportion of income to performance is more likely to have perverse consequences when the outcome is not fully under the control of the provider’. The GC expressed concerns about the achievability of the non-representation outcome where service users were unable to access the ‘recovery capital’ for social reintegration and sustained recovery (including housing, meaningful activity, pathways to employment and family support). This may be a particular concern in the current financial climate.

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2 It is, of course, difficult to say with precision what forms and levels of gaming could be potentially benevolent for (or, at least, permissible within) PbR systems or how this would work in practical terms.
2.2 LASARs and the assessment of clients

**Background and general points**

Some service users are less likely to achieve PbR outcomes than others, and will require a greater investment of resource from providers if they are to do so. All else being equal, there is an incentive for providers to focus disproportionately on those clients who they believe will achieve PbR outcomes and/or are ‘closest’ to achieving them. To counter the tendency to ‘park’ some service users, PbR schemes have: (i) developed payments for achievement of ‘interim’ outcomes, and (ii) introduced higher payments for achieving outcomes with clients with more complex and entrenched problems.

The introduction of differential tariffs brings its own risks for gaming into the system. From a business point of view, providers would prefer service users to be placed on high tariffs (so that they get the highest possible payments for achieving fixed outcomes), while commissioners have an interest in placing them on lower tariffs (to minimise the payments they make to providers and to manage budgets). The amounts that are paid to service providers for achieving PbR outcomes will depend on the assessments of client need and complexity carried out by LASARS. There is a rational incentive for both providers and commissioners to try to influence the assessment process.

The LASARS will also have a key role in verifying outcomes, and therefore the process for releasing payments to providers, and in making referrals.

**Risks and opportunities**

The GC considered the opportunities associated with LASARS and the assessment process and highlighted the following issues and concerns:

- there is a particular risk of gaming where LASARS are non-independent, particularly in PbR pilots where the LASARS function lies with the service provider (e.g., pressure on the LASARS to uprate tariffs and agree ‘false’ or unverified outcomes);
- in their role as referrers, LASARS would also have scope to manipulate complexity ratings to advantage or disadvantage particular providers (e.g., by referring less complex clients to a favoured provider);
- even where the LASARS function is not managed by the provider, there was a concern that where LASARS are co-located with services, then this could reduce independence and increase the risks of gaming (although it was acknowledged that from a practical point of view, co-location could be positive for service users, providing a ‘one stop shop’);
- service users could have an incentive to ‘play the system’ and/or to collude with LASARS in gaming activities (e.g., service users may see an advantage in assessments that exaggerate complexity as this may result in access to other and more intensive support);
- conversely, where LASARS are managed by commissioners there is a risk that assessment and referral decisions could be shaped by budgetary considerations (e.g. under-estimating complexity where budgets are stretched to reduce liability for outcome payments).

The GC notes that the PIRU report on the PbR pilots focussed on the role of LASARS in its discussion of gaming issues, specifically noting that:

- ‘The PbR system places considerable onus on having independent LASARS, yet at least two of the pilot sites have LASARS that will not be independent of the providers, increasing the potential for the abuse of the system’;
- ‘Even independent LASARS may be influenced by providers and refer clients accordingly (e.g., “easy” clients to struggling providers, “difficult” clients to over-performing providers’). It was suggested in the Gaming Commission that there will be particular challenges in allocating payments fairly and appropriately where two or more providers are working with clients with different levels of complexity).
We note that time scales for developing the PbR pilots and resource considerations have resulted in different approaches to LASARS provision being taken in different areas, and have been a factor in decisions to place the LASARS with service providers in two areas. **However, the GC concludes that there are significantly greater risks of gaming where LASARS are not independent, and further consideration needs to be given to how these services are monitored and these risks are minimised.**

**Responses and solutions**

The GC considered what sorts of monitoring and auditing could establish whether gaming was influencing assessment and referral decisions, it concluded that:

- It would be important to establish relevant base-line data, including for ‘case mix’ and for numbers of referrals to particular providers and it was suggested that if there was extensive gaming on assessment and referral this should produce a clear ‘spike’ in data trends over a relatively short time period (say, two or three months);
- It will be helpful to use available data to produce a ‘bell curve’ to show the distribution of complexity across local treatment populations. Any subsequent shift in the bell curve would suggest inflation (or deflation) in complexity ratings at assessment, to facilitate the detection of any potential ‘drift’ in assessments over time. This would also provide an indication of variability and hence the size of any shift in assessments that would be necessary to reliably indicate a change;
- There should be provision for regular and robust auditing of LASARS (particularly non-independent LASARS, and those co-located in provider services), with provision for service user involvement in the auditing process (one possibility was that service users could be required to sign off LASARS assessments to indicate their agreement);
- Service users should be involved through on-going systematic and independent assessment of client satisfaction, and could also act as ‘mystery shoppers’ at LASARS, as a way of identifying poor or fraudulent practice.

The GC identified three practical recommendations for minimising and/or eradicating this form of gaming:

- Generally, we consider it particularly high risk from a gaming perspective for the LASARS service to be managed by service providers or commissioners, and we would recommend particularly close monitoring of PbR pilots that have non-independent LASARS, and further consideration of any additional safeguards that could be introduced in these areas;
- The contract setting between commissioners and LASARS will be critical in addressing the gaming issues identified by the GC and PIRU. There should be a clear statement of the standards expected of LASARS and service providers in their respective contracts, which could include a specific section on gaming based on the definition provided by the Audit Commission and developed by the GC;
- Reinforcing the significance of robust contract setting, we would like to see a clear statement going forward of the responsibility of Public Health England and local Directors of Public Health for ensuring that all PbR commissioning and contracting in their locality is based on good practice. We also feel it is important that there is some consideration of the relationship of the new Healthwatch arrangements with respect to the pilots.

2.3 **Weighting and timing of payments**

**Background**

The Drug and Alcohol Recovery PbR pilots are unprecedented in the range of outcomes that they incorporate – including both ‘interim’ and ‘final’ outcomes. If they are to incentivise service providers to deliver a more recovery-orientated approach it is important that they encourage and support a balanced approach across the different outcome domains. It would, for example, be contrary to the intentions of the PbR pilots if the outcome weightings were set in a way that enabled services to
develop viable business models which did not require a pro-active approach to achieving outcomes in the ‘free from drugs of dependence’ domain.

There are also issues about the timing of payments. If some payments are made immediately while others can only be verified after a year or more, how will this affect the behaviour of providers? What are the potentials for gaming where the potential payments associated with working with a particular service user depend on the time when they present or re-present to services?

These issues were also highlighted by the PIRU in its discussion of gaming and related issues. The PIRU concluded that data lags, particularly for measurement of long-term outcomes, expose providers (especially smaller providers) to cash flow risks, and could lead to pilot sites loading payments onto initial outcomes, which could undermine the overall aim of incentivising sustained recovery (although the GC would also note the importance of including payments for ‘interim’ outcomes in view of the strong evidence base that ‘full’ recovery may not be achievable in the short or medium term for significant numbers of service users, including many of those with the most entrenched and complex needs).

**Risks and opportunities**

The GC highlighted the following issues and concerns on the weighting and timing of payments:

- If long-term outcomes are not sufficiently weighted, then there is a risk that service providers will adopt business strategies that focus on securing payments for what are perceived as ‘safer’ interim outcomes and lose the recovery focus;

- An extreme version of this scenario envisaged weightings set in such a way that service providers could rely on a combination of funding not tied to outcomes (in areas where payment will not be based entirely on PbR outcomes) plus attachment fees;

- This sort of approach could incentivise services to seek to engage ‘easy to treat’ clients in large numbers (described by one participant as ‘ambulance chasing’);

- Where a very high reward attaches to ‘planned exit’ and ‘non-representation’ there could be an incentive to push service users forwards too quickly to maximise the ‘pool’ who could potentially attract the high non-representation payment;

- Where service users attempt to represent to services within 12 months of a planned exit there will be an incentive for providers to prevent them re-entering treatment until they secure the final payment for outcome 1 (particularly where the service user attempts to re-present close to the 12 month deadline);

- The GC considered the potential for the creation of ‘representation clinics’ that would hold service users out of the PbR treatment services until after the 12 month deadline, perhaps providing some treatment and condition management or involving GPs who don’t report to NDTMS. However, it was also noted that some form of representation clinic aimed at providing crisis support to prevent lapse turning into relapse might be a wholly appropriate intervention;

- There was a discussion in the GC about the extent to which service users representing to services would qualify for a second attachment fee or another payment for re-achieving outcomes that had been achieved during a previous treatment episode, and the risks that this could create an incentive to encourage drop out and representation in some circumstances, to secure a second attachment fee or second payment for an outcome;

- Service providers could deliberately postpone those interventions that they have the most control over (for example, they can determine when Hepatitis B vaccination is offered and provided), as a form of insurance to help to manage financial ‘pinch points’.
Responses and solutions

It was noted that many of these gaming risks should be reduced or eliminated through effective setting of tariff weightings and payment structures – e.g. by ensuring the rewards for longer-term outcomes are sufficient to incentivise a recovery-orientated approach. Others argued that too high a weighting for these outcomes would penalise providers disproportionately, particularly where longer-term outcomes may be partly outside the direct control of the service provider (as they require access to other services and resources), and could make the PbR system non-viable. This may be a particular concern during this period of fiscal constraint.

Specific recommendations from the GC included:

- By establishing base-lines and monitoring treatment length, presentation and re-presentation rates it should be possible to identify patterns that could indicate a possibility of gaming. This needs to include consideration of different sub-groups within the overall population as some may be differentially affected;
- To ensure against premature discharge of clients to maximise opportunities for outcome payments it would be possible to incorporate independent validation of discharge decisions into contracts with service providers (this could be a role for independent LASARS);
- Encourage the development by commissioners and service providers of post-exit ‘clinics’ and other forms of support (for example, engagement with mutual aid) that sustain treatment gains, support sustained recovery and reduce the risks of representation (this depends on distinguishing between ‘treatment exit’ and ‘recovery exit’) i.e. a concrete example of the non-representation outcome providing a strong incentive to support the recovery agenda;
- It may be possible to monitor ePACT data on prescribing trends in primary care to identify if GPs are picking up ‘failures’ that ought really to be considered as representations;
- It was noted that professionals involved in assessment and referral processes should be prevented by their professional ethics from gaming, and relevant codes of ethics could be developed to highlight gaming issues.

2.4 Inflating outcomes to achieve payments that are not deserved

Background

Perhaps the most obvious opportunities for gaming are to manipulate outcomes data in various ways in order to attract payments – for example, where an outcome payment depends on self-reporting by service users there is a clear incentive to influence this process.

This issue was highlighted in the PIRU paper on PbR, which noted, in particular, that the reliance on self-reported outcomes through TOP ‘provided opportunities for fraudulent reporting both by providers alone, and in collaboration with service users’ – and that this was a particular issue for the health and well-being domain.

Risks and opportunities

The GC highlighted the following issues and concerns on misrepresentation of outcomes:

- Clients will not be recorded as representing to treatment where they are entering the system with different attributers, and it would be possible in principle to conceal re-representations through small variations in attribution data (for example, use of different initials) – it was also pointed out that a certain amount of variation in attribution data will occur anyway (for example, as a result of mistakes or name changes) with implications for the pilots;

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3 A service which allows real time on-line analysis of the previous sixty months prescribing data held on NHS Prescription Services’ Prescribing Database.
• There are a range of issues around outcomes that are measured using TOP data, given that TOP is based on self-report (for example, there are various ways in which service users might be steered or incentivised to improve how they rate themselves on the TOPS ‘quality of life’ scale);

• Where a service user is misusing a range of substances, there may be an incentive for the treatment provider to limit the number recorded on first presentation. This could be done either to allow a subsequent treatment episode to address other substances, increasing overall payments, or to reduce the likelihood of continued usage of substances not seen as a problem by the client preventing successful treatment payments;

• Service providers could seek to represent treatment drop outs as planned exits;

• Service users could be prescribed drugs (for example, benzodiazepines) as a replacement for a presenting substance.

Responses and solutions

The solutions that were discussed by the GC were broadly the same as those identified in the previous section concerning weighting and tariffs – particularly the need for robust auditing and monitoring NDTMS data to identify any significant deviations in outcomes (for example, if there is a marked inflation in overall quality of life ratings through TOP compared with TOP data prior to the introduction of PbR).

Additionally, in order to look at the impact of the pilot and to pick up on unintended consequences (such as less recovery-focused treatment) it is important that things such as the number of times an individual is seen and what interventions they are getting and the change in use of other services are also considered. This is probably most easily considered by the evaluators.

2.5 Issues not addressed by the GC

The GC did not discuss the offending outcome in detail, in part because pilot areas are adopting cohort approaches and modelling data was not available. We note, however, that work in the Ministry of Justice on the development of payment by results approaches in prisons and to resettlement will be relevant. Nor was the GC able to test the specific potential for gaming based on proposed outcome and tariff weightings, as this information was not available from the pilot sites.

3 Concluding remarks

While movements to PbR will inevitably involve a process of discovery, these PbR pilots are ambitious and are markedly different from any of the other PbR pilots being undertaken, both in terms of complexity and the timescale associated with their development and introduction. As a result, there is greater potential for gaming alongside other risks to commissioners, providers and clients. Therefore it is vital that there is a high level of investment in both monitoring and evaluation so that critical signs are identified early before crises develop. This needs to extend beyond the evaluation (as the timing of this will inevitably introduce a time lag) and probably goes beyond what the pilot sites can realistically be expected to fund and undertake alone.

Given the short timescale within which the GC operated and the limitations of the information available about the PbR models at that time, it is unlikely that all the potential gaming opportunities have been identified and it was not possible to provide any indication of which are most likely or would be most problematic. Nevertheless, the deliberations have highlighted a number of critical potential gaming threats and some actions that might help mitigate these.

Some general issues relating to gaming were highlighted as particularly pertinent to this PbR model. Firstly, the complexity associated with having multiple outcomes and multiple severity groups is unprecedented and will increase opportunities for gaming or for the accidental introduction of perverse

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4 For example see Gary Sturgess and Lauren Cumming (2010) Payment by Outcome: A Commissioner’s Toolkit.
2020 Public Services Trust
incentives. Secondly, it was noted that ‘gaming’ need not necessarily be harmful, some strategies that could be viewed as gaming may be necessary for provider survival, while others could be seen as effectively increasing efficiency. The danger arises if the outcomes focused on or most heavily incentivised are not properly aligned with the overall outcome required (for example, if it effectively incentivises solely methadone-prescribing without accompanying recovery-focused activities). There is similarly a risk when the outcome does not take account of contextual factors such that achievement of the key outcome is effectively beyond the service provider’s control, as might be the case for the sustained recovery (representation) outcome in areas which are particularly hardly hit by the financial problems where access to the necessary ‘recovery capital’, such as employment and housing, may be limited.

Specific gaming opportunities were identified as occurring associated with three main areas:

- **LASARS and the assessment of clients;** in particular, the GC concluded that there are significantly greater risks of gaming where LASARS are not independent and hence particular attention must be paid to monitoring such services.

- **Weighting and timing of payments for different outcomes;** the considerable time lags associated with some outcome payments may pose particular cash flow risks for providers and have a big impact on where activity is focused, but compensating for this by weighting these outcomes more heavily may impact on provider viability or lead to other perverse practices (eg delaying appropriate representations).

- **Misrepresenting or inflating success;** the greater importance of particular outcome measures may automatically lead to changes in reporting but, particularly for self-reported outcome measures, there is scope for influencing what is recorded as well as outright fabrication.

In order to monitor and identify if gaming is occurring and to deter it, actions of three main types were identified:

a) **Monitoring data** from NDTMS in detail (beyond just the outcomes achieved and looking at different sub-groups of clients) to detect change from previous years. However, some change is inevitable, as the data will have become more important and also there are likely to be on-going changes in the types of individuals presenting to services. Triangulation with other sources of evidence or using data from other comparable areas may be helpful for confirming anomalies.

b) **Auditing processes** will be essential. Robust auditing of assessments and outcomes will be important everywhere but particularly where there are non-independent LASARS.

c) **Involvement of service users** in systematic, independent assessment of their views and experiences of the services provided. The importance of the patient ‘voice’ in improving the quality of services is well evidenced and it is important that in the delivery of the PbR pilots and the inevitable complexity of monitoring the range of outcomes the perspective of the individual service user does not get lost. Their experiences may also be one of the quickest ways of identifying emerging problems with the system.

It is important in the pilot phase that these processes are set up from the start and information monitored frequently and regularly. Given the radical nature of this PbR model and the short time scale involved in developing the models it is important that any potential problems are identified early and that there is flexibility built in to permit changes to be introduced if necessary. If gaming does occur a range of adjustments may be required. As Sturgess and Cumming (2010) indicate “Adjusting the mix of performance measures so they accurately reflect the primary outcome sought; using measures appropriately, assessing impact and interposing discretion where necessary; changing the intensity and diversity of incentives; and segmenting the population differently ... are among the tools commissioners can use to reduce harmful gaming”. Whatever action is considered, the contracting process needs to permit change and a good commissioner-provider relationship will facilitate this.
Appendix 1
Payment by Results for Recovery
Gaming Commission - Terms of Reference

Background
The Department of Health is leading a cross-departmental project to explore how Payment by Results (PbR) can incentivise delivery of recovery outcomes for adults who are drug or alcohol dependent. Under the pilots, providers will no longer be paid on the basis of activity but on the outcomes they support individuals to achieve on their recovery journey. The aim is to test whether such an approach can help more people to break the cycle of dependence and achieve long term recovery.

The nationally-agreed outcome definitions and metrics are nearing final sign-off, and pilot sites are starting to think about how they will weight each outcome and take into account the complexity of each client to arrive at the price to be paid for each outcome.

Purpose of Gaming Commission
The Audit Commission report “Early lessons from payment by results”\(^5\) identifies gaming as a key risk arising from payment by results, where gaming is described as the deliberate manipulation of the system by providers, outside of the agreed rules, for financial gain.

With this in mind, the Gaming Commission brings together a group of people with operational experience of service provision as commissioners, providers and service users, to explore the possible gaming opportunities presented by the PbR models under development, and to propose recommendations as to how such opportunities can be minimised.

Main responsibilities
• to examine the agreed models (i.e. configuration of LASARS, prime and framework providers), outcome definitions and metrics of the Drug and Alcohol Recovery PbR system and consider the opportunities for:
  o deterring access to treatment for those least likely to achieve outcomes;
  o “parking” or delivering minimal treatment to clients least likely to achieve outcomes;
  o securing unwarranted payments
  o other ways of ‘gaming’ the system
• to recommend how these opportunities can be eradicated or minimised through local weighting and pricing mechanisms, through independent assessment and audit mechanisms, or by any other means

Membership
The core membership is drawn from:

- The cross-government project team representing the following central government departments:
  o Department of Health
  o Ministry of Justice
  o Home Office
  o National Treatment Agency
- Commissioners from non-pilot areas

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\(^5\) Early lessons from payment by results. Audit Commission, 2005
- Providers (with no direct interest in pilot site service provision)
- Provider representation organisations
- Service users

The full list of members is shown in the Annex below

**Reporting Structure**

The Gaming Commission will report to the Co-design Group, which in turn reports to the Officials Steering Group providing updates on progress and seeking steers where needed.

**Meetings**

The Gaming Commission is likely to meet for a maximum of three to four meetings.

Agenda and papers will be circulated at least three days before the meeting. Minutes and action points will be circulated within 10 working days after the date of each meeting.

Full minutes will not be posted on the DH D&A PbR web page, as they are likely to contain information on how best to defraud the PbR Recovery system. However, major decisions and action points will be published.

**Quoracy**

The meeting will be deemed quorate if there is representation from at least half the core members.
## Annex: Membership of the Gaming Commission

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dr Marcus Roberts</td>
<td>Director of Policy</td>
<td>DrugScope</td>
</tr>
<tr>
<td>2.</td>
<td>Dr Nicola Singleton</td>
<td>Director of Policy &amp; Research</td>
<td>UK Drug Policy Commission</td>
</tr>
<tr>
<td>3.</td>
<td>Andy Wooldridge</td>
<td>Manager</td>
<td>Hungerford Drugs Project, Turning Point</td>
</tr>
<tr>
<td>4.</td>
<td>Richard Phillips</td>
<td>Director</td>
<td>Smart Recovery</td>
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<tr>
<td>5.</td>
<td>Andy Stopher</td>
<td>Manager</td>
<td>C&amp;l MH Trust</td>
</tr>
<tr>
<td>6.</td>
<td>Anne McKay</td>
<td>Commissioner</td>
<td>Worcestershire (PbR already in place)</td>
</tr>
<tr>
<td>7.</td>
<td>Ben Hughes</td>
<td>Commissioner</td>
<td>Essex</td>
</tr>
<tr>
<td>8.</td>
<td>Jason Gough</td>
<td>Service User</td>
<td>Patient Opinion (Sheffield)</td>
</tr>
<tr>
<td>9.</td>
<td>Lucinda Owen</td>
<td>Service User</td>
<td>London</td>
</tr>
<tr>
<td>10.</td>
<td>Ian Sherwood</td>
<td>Deputy Regional Manager</td>
<td>NTA SW Team</td>
</tr>
<tr>
<td>11.</td>
<td>Claire Pennell</td>
<td>Deputy Regional Manager</td>
<td>NTA West Midlands</td>
</tr>
<tr>
<td>12.</td>
<td>Bernie Casey</td>
<td>Deputy Regional Manager</td>
<td>NTA London &amp; SE</td>
</tr>
<tr>
<td>13.</td>
<td>Dr Mark Prunty</td>
<td>Addictions Psychiatrist</td>
<td>DH</td>
</tr>
<tr>
<td>14.</td>
<td>Katie Hill</td>
<td>Head of Policy and Communication</td>
<td>eATA</td>
</tr>
<tr>
<td>15.</td>
<td>Clive Pritchard</td>
<td>Health Improvement Analytical Team</td>
<td>DH</td>
</tr>
<tr>
<td>16.</td>
<td>Dr Maria Hudson</td>
<td>Employment and Social Policy</td>
<td>Hudson Research Limited</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Researcher and Analyst</td>
<td></td>
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<tr>
<td></td>
<td><strong>Officials:</strong></td>
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<tr>
<td>17.</td>
<td>Nic Garcia</td>
<td>Policy Advisor</td>
<td>DH</td>
</tr>
<tr>
<td>18.</td>
<td>Clive Henn</td>
<td>Senior Alcohol Advisor</td>
<td>DH</td>
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<tr>
<td>19.</td>
<td>Mike Jones</td>
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<td>DWP</td>
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<td>20.</td>
<td>Michael Wheatley</td>
<td>PbR Custody Commissioning</td>
<td>NOMS</td>
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<td>21.</td>
<td>Jack Feintuck</td>
<td>Payment by results - sentencing &amp;</td>
<td>MoJ</td>
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<td></td>
<td></td>
<td>Rehabilitation Directorate</td>
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<tr>
<td>22.</td>
<td>Daniel Northam-Jones</td>
<td></td>
<td>Cabinet Office</td>
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<tr>
<td>23.</td>
<td>Jon Knight</td>
<td>Head of Analysis</td>
<td>NTA</td>
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<tr>
<td>24.</td>
<td>Megan Jones</td>
<td>Programme Manager</td>
<td>NTA</td>
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