**ORGANISATIONAL DEVELOPMENT PROCEDURE**

***Note\****

*This procedure template has been developed to meet the needs of a diverse range of services and includes items for consideration in policy and procedure.*

***Not all content will be relevant to your service.******Organisations are encouraged to edit, add and delete content to ensure relevancy.***

*NADA does not accept legal responsibility for the correctness of this procedure as it applies to your organisation. If you are unsure about legislative responsibilities for your specific service, you are encouraged to seek out a legal review of Policy Toolkit documents.*

*All notes (like this one) should be considered and deleted before finalising the procedure, and the contents list should be updated as changes are made and when content is finalised. See the NADA Policy Toolkit User Guide for more editing tips.*

*Links to websites and resources provided by organisations other than NADA are listed at the end of this template.*

*\*Please delete note before finalising this procedure*

***Note\****

*To update the contents list when all content has been finalised, right click on the contents list and select ‘update field’, an option box will appear, select ‘Update entire table’ and ‘Ok’.*

*To use the contents list to skip to relevant text, use Ctrl and click to select the relevant page number.*

*\*Please delete note before finalising this procedure.*

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SECTION 1: SCOPE  
This document sets out the procedural aspects of the Organisational Development Policy and should be read in conjunction with it.   
  
The procedure includes guidance on: client data collection and management, quality improvement work, partnerships and external relationships, and research and evidence-based practice. For guidance on policy development, see the Policy and Procedure Development Policy.

# SECTION 2: ORGANISATION VALUES AND STRATEGIC GOALS

Organisational values and strategic goals underpin all elements of **[insert organisation name]**’s work.

This section provides guidance on the organisation’s goals and values which are at the forefront of service delivery, operations, organisational development and quality improvement.

Full detail of the organisation’s goals are outlined in the Governance Policy (NADA template available) and the Strategic Plan.

***Note\****

*This section should be developed in line with your organisation’s strategic plan. The items that have been included in this section of the template below are based on common values which are considered best practice across alcohol and other drug and community services. These can be edited or added to, based on your organisation’s goals and values.*

*\*Please delete note before finalising this procedure.*

## **2.1** **Inclusivity and respect for diversity**

**[Insert organisation name]** respects and values the diversity of staff, clients and the community, and promotes inclusive practice in its organisational development work.   
For further information on diversity and inclusion responsibilities in relation to staff, including professional development and legislative responsibilities, see the Diversity, Inclusion and Anti-Discrimination Policy and Procedure.

## **2.2** **Consumer participation**

**[Insert organisation name]** is committed to supporting consumer participation and recognises the benefit consumers bring to the organisation in ensuring that the services and programs are appropriate, accessible and responsive to client needs. **[Insert organisation name]** encourages consumer participation in quality improvement, organisation development and delivery of services. For further guidance on consumer participation, refer to the Consumer Engagement Policy.

# SECTION 3: QUALITY IMPROVEMENT

**[Insert organisation name]** is committed to continually improving the quality of its services and organisational management in order to fully realise its strategic outcomes, and be inclusive and responsive to clients, staff, students, volunteers, stakeholders and the wider community.

The aim of the organisation’s quality improvement (QI) systems is to ensure that its activities within and outside the organisation, are of a consistently high quality.

Reflective of the organisation’s commitment to continuous improvement, **[insert organisation name]** is engaged in an external review and accreditation cycle with the **[insert name of quality improvement provider, e.g. Australian Council on Health Care Standards (ACHS)]** against its **[insert type of standards].**

In striving for best practice, **[insert organisation name]:**

* Approaches QI activities with a cyclical model which includes the elements of monitoring, assessment, action, evaluation and feedback
* Provides resources and support to staff, Board members and stakeholders to engage in its QI program
* Considers quality improvement fundamental to the way business is carried out and embeds QI in the organisation’s philosophy and practice
* Encourages evidence-based and innovative work practices, with staff recognised for best practice and innovative ideas.

Section 3 of this procedure ensures:

* That the organisation is recognised for its continuous improvement practices and quality services, as evidenced by formal accreditation and other external recognition.
* Quality improvement permeates all areas of business, with all staff and Board members seeking to improve the quality of their own activities and areas of responsibility, as well as the quality of the organisation as a whole.
* Staff and Board members are aware of and practice continuous QI.

The quality improvement process and system are coordinated and led by the **[insert allocated position],** though all staff and Board members are responsible for understanding, implementing and maintaining QI systems as appropriate to their role and responsibilities.

This section outlines the organisation’s QI program details, responsibilities, communication and implementation.

***Note\****

*Useful tools and QI support are also available from the NSW Agency for Clinical Innovation website.*

*\*Please delete note before finalising this procedure.*

## **3.1** **[Insert organisation name]’s quality improvement program**

* The organisation’s QI program is structured around the **[insert name of quality improvement provider, e.g. Australian Council on Health Care Standards (ACHS)]** against its **[insert type of standards].**
* The organisation’s QI program considers the goals and outcomes, identified in the Strategic Plan, so that all activity contributes to planned achievements.
* A QI Action Plan, led by the **[insert allocated position]**, provides all staff and Board members with guidance on scheduled improvement activities, scheduled policy reviews, improvement activities completed, timeframes and responsibilities.
* The QI Action Plan is reviewed, updated and redistributed to staff at least **[insert time period, e.g. twice per year, monthly]**.
* Improvement activities are usually undertaken by small teams of two or three staff to support workload issues, for multi-disciplinary input, and to further build team bonds.

## **3.2** **Quality improvement program leadership**

* The organisation’s Board is responsible for demonstrating a culture of QI through Board practices and operations, as well as through identifying and supporting organisational performance and outcomes.
* The organisation’s CEO/Manager and **[insert allocated position, e.g. QI program leader]** leads the development of a QI culture by: identifying, initiating and undertaking improvement activities; orientating new staff to the organisation’s QI program; supporting staff to undertake improvement activities with resources, training and flexibility; and committing to QI over the full program cycle.
* The organisation’s CEO/Manager identifies a **[insert allocated position, e.g. QI program leader]** whose responsibility includes: managing the relationship with the external QI program provider; coordinating, reviewing and documenting QI activities; preparing the organisation for QI program events (such as external review); and reporting to the Board and staff on progress and outcomes.
* The **[insert allocated position, e.g. QI program leader]** is not responsible for all QI activity; rather, they lead the broader QI program, with all staff and Board members responsible for participating in QI implementation.

## **3.3** **Staff and Board responsibilities**

* Staff and Board members are responsible for leading and/or contributing to a culture of QI through all work practices
* Supervisors are responsible for ensuring all new staff understand and participate in the organisation’s QI program.

### **3.3.1** **Quality improvement activities undertaken by the Board include:**

* Review and endorse all organisational policies.
* Understand and endorse financial expenditure for QI program membership and implementation costs.
* Lead the development, implementation and review of Board governance, including related policies and planning.
* Undertake and respond to annual Board performance assessments.

### **3.3.2** **Quality improvement activities undertaken by staff include:**

* Identify and respond to areas for improvement in self and organisational practice.
* Lead and participate in the review and update of organisational policies, procedures and supporting documents.
* Develop and implement systems/processes that support quality service delivery to clients and stakeholders.
* Develop and implement systems/processes that support quality organisational management in the areas of planning and resources, human resources, communications, EEO, WHS, finances, risk, information, technology, compliance and reporting.

## **3.4** **Quality improvement program orientation**

* Participation in the organisation’s QI program is a requirement of all staff and is an accountability in all position descriptions and performance and development reviews.
* All staff orientation processes include the introduction and explanation of QI and how it is implemented in the organisation. This is usually provided by the **[insert allocated position, e.g. QI program leader]** and/or the staff’s supervisor.
* As required, the organisation supports staff in formal QI training and incorporates this into staff professional development plans.
* Staff who are new to formal QI programs and processes may gain understanding and support by participating in teams that are undertaking quality improvement activities.

## **3.5** **QI program communication**

* The **[insert allocated position, e.g. QI program leader]** is responsible for leading the communication of program progress and outcomes to staff and Board members.
* QI program implementation is a standing agenda item at the organisation’s staff meeting. All staff are responsible for identifying improvement activities and reporting on scheduled activity progress at the staff meeting.

***Note\****

*Other communication methods utilised by the QI program activities could include monthly QI program email updates that are developed by the QI program leader and distributed to all staff. These updates allow communication on activity due, changes/updates on the organisation’s QI program, and items of interest relating to QI.*

*Contact NADA for more information on QI-related support that NADA can provide your organisation.*

*\*Please delete note before finalising this procedure.*

## **3.6** **Implementing quality improvement activities**

**[Insert organisation name]** undertakes QI activities based on the quality cycle detailed below. A structured Quality Improvement Action Plan outlines the specific tasks to be undertaken by staff during a quality cycle.

The organisation’s goals and outcomes identified in the strategic plan should be considered in all stages of the quality cycle.

### **3.6.1** **Monitoring**

**[Insert organisation name]** routinely collects information on its services to identify progress, achievements, outcomes and areas of potential improvement. This information is collected through a variety of mechanisms, including: analysis of data sets, surveys, interviews, literature reviews, audits, informal feedback, observations and policy/record/system reviews.

### **3.6.2** **Assessment**

Analysing information from the monitoring stage can provide an assessment of the current situation and identify the best approach to take for improvement. Individual assessment activities and resulting recommendations should be shared with relevant staff through staff or team meeting presentations, group discussions or other mechanisms to communicate findings and reach an agreed approach for subsequent improvement activities.

### **3.6.3** **Action**

Through the assessment phase, QI actions should be decided upon and/or prioritised. If the activity requires financial resources, an adequate budget should be identified before the activity commences. Similarly, if the activity requires significant time/human resources, discussions should take place with management prior to its commencement.

Suitable and practical solutions should take into account the current available evidence, as well as the needs of the organisation, staff, clients and stakeholders that might be affected. Actions may range from procedure documentation or policy development to system redesign or creation, e.g. electronic filing, human resources system.

### **3.6.4** **Evaluation**

Once the action has been taken, individuals involved should evaluate the results of that action to ensure the required result was achieved. Key questions to ask in evaluating an activity include:

* Did the action achieve the desired result or outcome?
* Is there any further action to be taken in this area?

Evaluation information should be collected in a similar way to monitoring information (see 4.6.1) or refer to the NADA Program Management Policy for more information on evaluation types.

### **3.6.5** **Feedback**

All individuals involved in, or affected by, quality improvement actions/activities should be aware of changes made to the organisation and the results of these activities (both internal and external stakeholders). Communication at all stages is critical to achieving sustainable results and facilitating organisational change.

## **3.7** **Documentation and record-keeping**

All scheduled and completed quality improvement activities are to be documented in the organisation’s Quality Improvement Action Plan by the **[insert allocated position, e.g. QI program leader]**.

Organisational changes made as part of the review and update of operational policies are to be summarised on the first page of the updated version of each policy under ‘Changes on previous version’. For more information on policy development and implementation, refer to Section 3 of this policy.

Organisation changes made as part of the developing new systems or reviewing and updating existing systems are documented capturing the following elements:

* Current situation (refer to 4.6.1)
* Description of the activity undertaken, e.g. staff survey, file audit
* Identified best practice
* Recommendations for improvement.

The organisation’s Quality Improvement Program Activity Report provided by **[insert name of quality improvement provider, e.g. Australian Council on Health Care Standards (ACHS)]** may be used to document organisational development activities.

Documenting system changes provides evidence of continuous improvement, supports QI program reporting to the external body, and allows for reflective learning.

## **3.8** **Accreditation**

Accreditation standards and the accreditation cycle supports **[insert organisation name]** to establish and maintain quality improvement processes, meet minimum requirements of operations and service delivery, and provide a level of assurance to service users and funders about service safety and quality. Accreditation provides a framework for **[insert organisation name**] to build a culture of continuous quality improvement and to guide performance improvement.

The NGO AOD performance indicator specifications for AOD-Core 2: Organisation, accreditation and clinical governance, requires **[insert organisation name**] to hold current accreditation.

**[Insert organisation name]** holds current **[insert name of Accreditation Standard]** with **[insert name of certifying body].**

Commencing **[insert date XX/XX/20XX]**, **[insert organisation name**] reports on the AOD-Core 2 performance indicator every six (6) months, no later than the 21st day of the month following each six-month period of collection.

***Note\****

*Fact sheets on NGO AOD performance indicator specifications for the  ‘AOD-Core 2: Organisation accreditation and clinical governance’ are available on the NSW Health website.*

*NSW Health-approved Organisation Accreditation Standards include:*

*- QIC Health and Community Service Standards by Quality Innovation Performance (QIP)*

*- Australian Service Excellence Standards (ASES) by the Department for Communities and Social Inclusion, Government of South Australia*

*- Evaluation and Quality Improvement Program (EQuIP) by the Australian Council on Healthcare Standards (ACHS)*

*- National Standards for Mental Health Services by the Australian Commission on Safety and Quality in Health Care (Note: stand-along accreditation to these services is only acceptable for dedicated mental health service organisations and those recognised as mental health and AOD 'dual diagnosis' service organisations).*

*For more information and support on Accreditation and QI contact NADA or visit the NADA website.*

*\*Please delete note before finalising this procedure.*

# SECTION 4: CLIENT DATA COLLECTION AND MANAGEMENT

**[Insert organisation name]** has a commitment to the ethical collection and reporting of client data for the purposes of increasing service responsiveness and improving the quality of treatment interventions.

All client data collected is preceded by gaining informed consent as outlined in the Service and Program Operations and Client Clinical Management Procedures. Clients should be informed as to what information is collected, by whom, how it will be used and their rights in relation to it.

Staff engaging with Indigenous data[[1]](#footnote-1) should be guided by, and work to promote, Indigenous Data Sovereignty[[2]](#footnote-2) in their work.

***\*Note*** *Resources providing information on ways to promote and respect Indigenous Data Sovereignty include:*

*- Maiam nayri Wingara’s 2018 ‘Indigenous Data Sovereignty Principles Communique’ (see references and resources section)*

*-E-learning and other resources on the Lowitja Institute website:* [*https://www.lowitja.org.au/*](https://www.lowitja.org.au/) *You may be interested in moving these resources to the body of the text if useful for staff.*

*\*Please delete this note before finalising this procedure.*

De-identified client related data will be forwarded to government-endorsed national and state agencies, as per contractual funding requirements. For more information, please refer to the Data Dictionary and Collection Guidelines for the NSW Minimum Data Set for Drug and Alcohol Treatment Services(NSW Health 2015).

Client information is provided and reported in different ways, including:

* Quantitative descriptive client data, as provided through National Minimum Data Set and NSW Minimum Data Set via Intake and Assessment forms (see the NADA Client Clinical Management Procedure for more detail)
* Qualitative descriptive client data that might be gathered as case studies or direct feedback quotes from interviews or client feedback forms
* Client outcome measurement data, on both the individual and across the organisation
* **[Insert other client information].**

**[Insert organisation]** aligns data items on its administrative forms as closely as possible to national and state data collection items to promote quality, consistency and continuity of state and national data.

## **4.1** **National Minimum Data Set (NMDS) and NSW Minimum Data Set (MDS)**

All government and non-government drug and alcohol agencies receiving NSW Ministry of Health funding to provide specialised drug and alcohol services must collect and report data to the NSW MDS DATS from 1 July 2015. Compliance with this policy directive is mandatory.

The National and NSW MDS consists of a range of items that describe administrative, social, demographic, drug-related and service-related information. This client information is collected and provided to health departments at both the State and Commonwealth levels.

**[Insert organisation name]** uses the **[insert name of system, e.g. NADAbase, TED, MACSIMS, MIMASO, etc.]** system to collect N/MDS data. Data is submitted to the relevant government departments on a **[insert time frame, e.g. monthly for N/MDS]** basis via **[insert system name]**. For more information on the NSW MDS and the relevant submission guidelines, refer to the NSW Health Data Dictionary and the Collection Requirements for the NSW MDS for Drug and Alcohol Treatment Services (2015).

For support around collecting gender and sexuality data, refer to the ACON and NADA e-learning resource, ‘[Asking the question: recommended gender and sexuality indicators’.](https://nada.org.au/uncategorized/asking-the-question-recommended-gender-sexuality-indicators/)

## **4.2** **Client Outcome Data**

Client outcome data is designed to detect change in an individual that is attributable to an intervention or interventions. Data on outcomes is generally obtained by collecting standard measures over a period of time, commonly at treatment entry, some midpoint, at exit and at a follow-up point. Outcome data can inform treatment interventions with individuals, and can also provide data on organisations and the AOD sector, thereby improving reporting and enabling advocacy for appropriate resources.

Client outcome data collection and reporting has become the standard by which alcohol and other drug treatment effectiveness is measured in the NGO Alcohol and other Drug Treatment sector, and **[insert organisation]** is committed to its implementation across all current and future services.

**[Insert organisation name]** routinely collects client outcome data via **[NADAbase, TED, Communicare, Other – delete all those that do not apply].** Client outcome data is reported in a variety of ways, including:

* Client review meetings
* Annual reports
* Tender and grant submissions
* Government/funding reporting
* Conference presentations.

***Note\****

*A number of client data collection and management resources and tools are available, including the NADAbase N/MDS and COMS. Contact NADA or visit the NADA website for NADAbase support and training.*

*Further information on client data and client outcome data collection can be found on the NSW Health website.*

*\*Please delete note before finalising this procedure.*

# SECTION 5: PARTNERSHIPS AND EXTERNAL RELATIONSHIPS

**[Insert organisation name]** recognises the value of partnerships and external relationships in providing quality services and outcomes for clients and the broader drug and alcohol sector. **[Insert organisation name]** develops relationships with a range of external individuals, groups and affiliated organisations to support **[insert organisation name]** working towards its goals.

The purpose of this section is to provide guidance in identifying, developing and maintaining relationships with external parties to ensure a consistent approach to more effectively meet their strategic objectives.

To provide quality and coordinated services, the organisation:

* Considers that partnerships and external relationships contribute to the organisation’s business.
* Ensures that staff are supported to invest time and effort in the development and maintenance of external relationships.
* Respects and values differing perspectives and priorities held by individuals, groups and organisations, while focusing on the agreed and common purpose of the relationship.
* Considers the development of both formal and informal relationships as adding value to the organisation and its clients.

This section ensures that:

* All external relationships contribute to the fulfilment of the organisation’s operation and goals.
* **[Insert organisation name]** maintains a range of relationships, both formal and informal, that benefit the organisation, its clients and the relevant sectors.
* Formal partnerships and relationships are governed by an agreed set of specifications.

**[Insert organisation name]** engages in a range of relationships, both informal and formal, with external parties. It is important to recognise that relationships change over time, as do the expectations of those involved in the relationship. Therefore, regular review of the purpose of the relationship and how the relationship functions ensures that time and effort invested is productive and rewarding.

## **5.1** **Types of relationships**

### **5.1.1** **Funding relationships**

Funding relationships are entered into for the purpose of receiving grants and/or to provide a specified service in support of its mission. Funding relationships are formalised through an agreed set of specifications, such as a funding contract. All funding relationships will be approved and signed by the CEO/Manager.

As part of the funding contract, the organisation commits to achieving outcomes in the agreement’s performance indicators which are reported against as stipulated.

### **5.1.2** **Membership relationships**

**[Insert organisation name]** enters into membership relationships with (or ‘joins’) professional bodies for the purpose of access to information, resources and the opportunity to contribute to policy that impact on the sectors of which it is a part. Entering into a membership relationship, does not endorse the organisation or the views of the body.

The organisation will enter into a membership relationship once approved by the CEO/Manager, an appropriate budget is identified, and the relevant application process is completed.

### **5.1.3** **Contractual relationships**

Contractual relationships with individuals, groups or organisations are entered into as a process for purchasing a product or service that supports the organisation’s activities to fulfil its strategic objectives.

Contractual relationships must be demonstrated through a purchaser/provider contract. The consultant contract clearly identifies:

* Involved parties and their responsibilities
* Product/service to be provided
* Timeframe for delivery
* Payment schedule
* Dispute resolution procedures.

The CEO/Manager and **[insert allocated positions]** are responsible for identifying and leading contractual relationships as delegated. The CEO/Manager is responsible for sign-off on all contractual relationships.

Contractual relationships are considered legally binding and are to be given due consideration as to the obligations and expectations before entering into such relationships.

When needs are identified, and contractual relationships are considered, staff members must:

* Identify the product or service that is required to support the implementation of an activity
* Identify an appropriate program/project budget
* Research the product or service that is required. Consult with staff, clients and if relevant, external stakeholders that have experience in the area. Discuss the product or service that is required with other staff for input.
* Seek endorsement from CEO/Manager to enter into a contractual relationship
* Prepare a consultant briefing paper, which outlines the aims, timeframes, deliverables and the budget of the project/task. The document is guided by the organisation’s Consultant Briefing Paper (NADA template available).
* Identify and engage the appropriate consultant(s) through:
* the organisation’s Consultant list
* recommendations from other staff, Board or partners
* information learned from a commercial advertisement.
* Prepare consultant contract. This document is guided by the organisation’s Consultant Contract (NADA template available).
* Consultant and CEO/Manager sign and agree to the terms and conditions outlined in the consultant contract.
* Release payment as per schedule in consultant contract.
* Consultant to deliver product as per consultant contract (allowing for amendments to service if appropriate and as detailed in the consultant contract).
* Discuss the consultant experience with the consultant as an evaluative process.
* Discuss the consultant experience with other staff as an evaluative process.
* Update the consultant list as required.

### **5.1.4** **Partnerships**

**[Insert organisation name]** enters into external partnerships as a way of working with other organisations. Partnerships may take the form of joint project ventures, strategic alliances, advisory group membership, forums or collaborative activities. **[Insert organisation name]** may enter into a specific type of relationship with an external party and have a partnership with the same external party for a different purpose.

Refer to the organisation’s Partnership Engagement Checklist (NADA template available) to further advance partnership opportunities.

***Note\****

*A number of partnership resources and tools are available across the community service and government sector, including resources from NADA, the Council of Social Service of NSW (NCOSS), the Victorian Council of Social Services (VCOSS), Victoria State Government, and the Mental Health Coordinating Council.*

*\*Please delete note before finalising this procedure.*

## **5.2** **Formal and informal external relationships**

External working relationships may be informal or may be formalised through an agreement or contract.

Where the organisation enters into a funding relationship and is awarded a grant to provide a specified service or product, there will be a formal agreement, such as a funding and performance agreement in place.

Where funds are exchanged for services, a formal agreement such as a consultant contract may be required.

Partnerships may be informal associations or formalised through agreements called ‘Memorandum of Understanding’, ‘Working Agreement’, or ‘Intention to Collaborate’. The common theme of these types of agreements is that they identify:

* Background information
* All parties involved and relevant contact officers
* The agreed-upon participation
* Purpose and outcomes of the agreement
* Dispute resolution procedures
* Length of the association.

Refer to the organisation’s Memorandum of Understanding/Working Agreement/Intention to Collaborate (NADA templates available) to see further partnership details.

Participating in, and hosting, advisory/steering/working groups may also be considered a formal relationship demonstrated through ‘Terms of Reference’ (TOR). Where **[insert organisation name]** hosts an advisory/steering/reference/working group, terms of reference (TOR) will be established which outline background information, membership, role of the group, and meeting processes.

Refer to the organisation’s Terms of Reference (NADA template available) for more information.

# SECTION 6: RESEARCH AND EVIDENCE-BASED PRACTICE

**[Insert organisation name]** is committed to the application of research and evidence-based practice, which is the integration of experience, judgment and expertise with the best available external evidence from systematic research[[3]](#footnote-3). [Insert organisation name] is committed to evidence-based practice in all areas of operations, and views this procedure section as essential to its continuous quality improvement and organisational development.

In striving for best practice, **[insert organisation name]:**

* Critically evaluates its processes and procedures to ensure that all aspects of business are guided by current research and evidence-based practice.
* Engages and consults with its staff, membership, key stakeholders and relevant experts to guide its operations and future planning.
* Compares its performance with similar organisations through benchmarking and other processes.

This section ensures that:

* All levels of operations at the organisation are guided by current research and evidence-based practice.
* Research and consultation are conducted, wherever applicable.
* Staff are supported and encouraged to engage in professional development.
* Processes and procedures are regularly reviewed and evaluated to inform future practice and planning.
* Staff are aware of, and have access to, information and services that contribute to building the evidence base for work being conducted within the organisation.

For information on project evaluation for organisational development purposes, refer to the Project Management Policy.

## **6.1** **Research**

**[Insert organisation name]** conducts research and analysis, by formal and informal means, to guide work practices. The following is a list of resources used in conducting research:

**[Insert/delete examples as they apply to your organisation]**

* Internal policies and procedures
* Government policies, guidelines and other resources
* Literature reviews
* Consultation (see Section 5.3 for more detail)
* Library (e.g. ADF Library, NSW Health Drug and Alcohol Library)
* Email updates (e.g. NDARC Connections Newsletter, NCOSS News, Turning Point Spotlight)
* Subscriptions to journals, magazines or expert bodies (e.g. D&A Review, ADF, APSAD)
* Newspapers and journal articles
* Online resources (e.g. Healthinfonet, AOD Knowledge Centre, NDARC)
* Internal project evaluations
* Forums/conferences
* Meetings (internal and external)
* Internal communication (e.g. newsletters)
* Verbal discussions (with colleagues, sector contacts, networking at events, etc.)

Where research is conducted with people with lived and/or living experience of accessing AOD services, they are compensated in accordance with the Consumer Engagement Policy.

## **6.2** **Literature reviews**

A literature review is conducted for projects at **[insert organisation name]** which are new or are under review. This is carried out by **[insert allocated staff member, e.g. program manager]** or an external consultant. The purpose of the literature review is to examine all current and relevant research on a particular topic. The literature review will usually also identify relevant projects that have been undertaken both locally and internationally.

## **6.3** **Consultation**

The following consultation methods are used to inform decision-making at **[insert organisation name]**. The results of consultations are collated, analysed and communicated to clients, staff and involved stakeholders. The organisation consults with people with lived and/or living experience of accessing AOD services, staff, the Board and stakeholders in many levels of decision-making to inform work practices.

### **6.3.1** **Clients – current and past**

Client needs and feedback are instrumental to inform the planning process and services of the organisation. The following mechanisms are used to consult with clients and members:

* Questionnaires and surveys (hard copy or online, e.g. SurveyMonkey)
* Forums and workshops
* Telephone contact and email
* Face-to-face interviews/meetings
* Site visits
* Focus groups.

For more information on ensuring client contribution to organisational development, see the Consumer Engagement Policy.

### **6.3.2** **Staff, Board Members and Stakeholders**

The organisation consults with staff, Board members and stakeholders, based on their expertise and experience in areas relevant to program development, organisational development and quality improvement. Many of the above mechanisms are also used to engage with stakeholders.

The organisation’s Board will contain a representative with research expertise, when available. Board members will provide advice on research, where appropriate.

### **6.3.3** **Advisory groups and committees**

In addition to having diverse representation on project advisory groups and steering committees, the organisation represents clients on external groups and committees. These meetings provide a valuable resource for consulting with key stakeholders, experts and funding bodies.

### **6.3.4** **Consultants**

**[Insert organisation name]** may utilise the expertise of consultants in the sector to conduct work such as:

* Project scoping
* Literature reviews
* Project evaluations
* Resource production
* Final reports.

Further information about working with consultants, partners and stakeholders can be found in the Partnerships and External Relationships Section of this procedure.

## **6.4** **Referencing and plagiarism**

It is important that all sources of information used in **[insert organisation name]** material are correctly referenced to avoid breaches of copyright and claims of plagiarism. Any sources used (e.g. books, journals and websites) should be acknowledged as a matter of courtesy, to secure the author’s credibility, to inform readers, and for copyright compliance.

The preferred referencing system is the author-date system, which is widely accepted and most commonly used within the drug and alcohol sector. Refer to the Communications Procedure (NADA template available) for more information and see Section 6 for the Monash University citing and reference website.

# SECTION 7: REFERENCES, RESOURCES AND WEBSITES

## **7.1 References and resources**[[4]](#footnote-4)

* Australian Commission on Safety and Quality in Health Care (ACSQHC)
* **Australian Charter on Healthcare Rights,** including posters<https://www.safetyandquality.gov.au/our-work/partnering-consumers/australian-charter-healthcare-rights>
* **National Standards for Mental Health Services**[www.safetyandquality.gov.au/our-work/mental-health/national-standards-in-mental-health](http://www.safetyandquality.gov.au/our-work/mental-health/national-standards-in-mental-health)
* Australian Council on Healthcare Standards (ACHS) – **Evaluation and Quality Improvement Program (EQuIP)**  
  <https://www.achs.org.au/our-services/accreditation-and-standards/accreditation-programs/equip6>
* Clinical Excellence Commission, NSW Government – **QI tools** <https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools>
* Council of Social Service of NSW (NCOSS) – **Formalising Partnerships Resource Kit (2008)**

[www.ncoss.org.au/resources/080801-formalising-partnerships-resource-kit.pdf](http://www.ncoss.org.au/resources/080801-formalising-partnerships-resource-kit.pdf)

* Council of Social Service of Victoria (VCOSS) – **Partnership Practice Guides (2008)**

https://vcoss.org.au/wp-content/uploads/2018/05/VCOSS-Guide-1-Preparing-to-Partner.pdf

* Department of Human Services, SA – **Australian Service Excellence Standards (ASES)** <https://dhs.sa.gov.au/services/community-services/australian-service-excellence-standards>
* Lowitja Institute- **Indigenous Data Sovereignty resources**

https://www.lowitja.org.au/

* Monash University – **Citing and referencing webpage**<https://guides.lib.monash.edu/citing-referencing>
* Maiam nayri Wingara 2018, ‘Indigenous Data Sovereignty Communique’, Indigenous Data Sovereignty Summit, 20 June 2018, Canberra, ACT, viewed 30 May 2024,

<https://static1.squarespace.com/static/5b3043afb40b9d20411f3512/t/63ed934fe861fa061ebb9202/1676514134724/Communique-Indigenous-Data-Sovereignty-Summit.pdf>

* Mental Health Commission of Western Australia, *Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025***,** https://www.mhc.wa.gov.au/media/2532/170876-menheac-engagement-framework-web.pdf
* NSW Health:
* ​​​**AOD-Core 2: Organisation accreditation and clinical governance**  
  www.health.nsw.gov.au/aod/Pages/core2-acg.aspx
* **Data Dictionary & Collection Guidelines for the NSW Minimum Data Set for Drug and Alcohol Treatment Services (2015)**

www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2015\_014.pdf

* **NSW Minimum Data Set (MDS) for drug and alcohol treatment services:**

www.health.nsw.gov.au/aod/Pages/minimum-data-set.aspx

* **PREMs Factsheet**

www.health.nsw.gov.au/aod/Factsheets/prems.pdf

* Quality Innovation Performance (QIP) – **QIC Health and Community Service Standards**

www.qip.com.au/standards/qic-health-and-community-services-standards/

* Reconciliation NSW – **Reconciliation Action Plans**

www.nswreconciliation.org.au/reconciliation-action-plans/

## **7.2 Useful Websites**[[5]](#footnote-5)

* **Australian Council on Healthcare Standards (ACHS)** –Corporate Member Services www.achs.org.au  
  X
* **Quality Innovation Performance (QIP)**

www.qip.com.au/  
X

* **National Archives of Australia: Information Management**

https://www.naa.gov.au/information-management  
X

* **National Centre for Education and Training on Addiction (NCETA)**

www.nceta.flinders.edu.au  
X

* **National Drug and Alcohol Research Centre (NDARC)**

www.ndarc.med.unsw.edu.au  
X

* **National Drug Research Institute (NDRI)**

ndri.curtin.edu.au  
X

* **NSW Users and AIDS Association (NUAA)**

www.nuaa.org.au/  
X

* **Centre of Research Excellence Indigenous Health and Alcohol**<https://gathering.edu.au/>
* Alcohol and other drugs knowledge Centre, **Australian Indigenous HealthInfoNet**  
  https://aodknowledgecentre.ecu.edu.au/key-resources/publications/

1. ‘Indigenous Data’ refers to information or knowledge, in any format or medium, which is about and may affect Indigenous peoples both collectively and individually’ (Maiam nayri Wingara Aboriginal and Torres Strait Islander Data Sovereignty Collective [Maiam nayri Wingara] 2018).  [↑](#footnote-ref-1)
2. Indigenous Data Sovereignty refers to, ‘the right of Indigenous people to exercise ownership over Indigenous Data. Ownership of data can be expressed through the creation, collection, access, analysis, interpretation, management, dissemination and reuse of Indigenous Data’ (Maiam nayri Wingara 2018). [↑](#footnote-ref-2)
3. Davies, P.T. (1999) 'What is Evidence-Based Education?', *British Journal of Educational Studies*, vol. 47, no. 2, pp. 108-121. [↑](#footnote-ref-3)
4. Hyperlinks checked and available - April 2023 [↑](#footnote-ref-4)
5. Hyperlinks checked and available – April 2023 [↑](#footnote-ref-5)