Supporting the implementation of Key Performance Indicators for NGO AOD services in NSW

Summary Report

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Summary

This Summary Report describes findings examining the implementation of NADA Key Performance Indicators (KPIs) in the NSW NGO AOD sector as at December 2024. No funding was made available to facilitate implementation, and this is an important context for all the below findings.

We undertook site visits to 5 residential rehabilitations and 3 outreach and day program services. We spoke with 2 organisations virtually via Microsoft Teams. In total we collected data from 8 organisations, visited 10 services and discussed 16 programs. The data covered small, medium and large organisations, residential and non-residential services, and early adopters and late adopters of the new KPIs. We also held a focus group with seven representatives of AOD treatment funders

The current state of implementation of the new KPIs can be described as haphazard. It is an ongoing iterative process, and while some KPIs have been adopted readily, others have been adapted to suit the funder and/or service provider. Adoption varied by funder, and varied by organisation. The specifications (detailing the definitions and formulae for calculations) do not appear to have gained much traction by participants in this study.

Implementation has been shaped by a lack of dedicated resources, alongside complex and somewhat messy processes that have entailed both a services-led and funder-driven implementation simultaneously. The advantage of mutually proactive implementation (simultaneously by both funders and service providers) is that it shares power between the parties, a key strength of implementation thus far.

The Key Performance Indicator implementation cannot be considered in isolation from all data collection, collation and analysis. Starting at the Client Management System (CMS), we found services to be at various stages of implementation: some well advanced with comprehensive data management systems in place, others just beginning on the journey of establishing data systems.

While many services have innovated and been creative in establishing resources (both funding and human capital) for data management, there is a significant lack of resources across the sector to support the kinds of data management required to achieve full implementation of the KPIs. This includes funding needs, as well as skills and capacity within the workforce.

Finally, and consistent with understanding that data flows commence at the CMS level, there are some major technology gaps. These technology gaps hamper implementation, require substantial resources from services to complete KPI templates, and there is minimal automation (a feature that should be built in across the sector).

A number of potential strategies to support ongoing implementation are provided. Discussions with NADA, services, and funders will identify which of these strategies should be taken forward. All of these strategies will require consultation with the sector to understand if they are viable and relevant interventions for supporting implementation and improving data and reporting systems.

Background and aims

In November 2023 NADA published a finalised set of specifications for the collection of Key Performance Indicators for AOD NGO services. These KPIs provided an opportunity for the multiple treatment funders to adopt them, and for treatment services to collect, collate and report on treatment outcomes, alongside other metrics.

This project seeks to understand the implementation process of these new KPIs alongside taking the opportunity to identify and develop capacity building processes around data collection and analysis in the NGO sector.

The overarching aim of this project is to evaluate the implementation of the KPIs across NSW AOD NGO service providers with a focus on services who have commenced implementation of the new KPIs, and all AOD treatment funders in NSW. The project supports performance measurement as an empowering part of improving services. The more specific aims are to:

- Evaluate and support implementation and scale-up of use of the KPIs within NGO AOD services in NSW
- Evaluate service providers and funders' use of the KPIs, barriers, enablers, risks and strengths
- Review how the data are being used and interpreted, helping services and funders to understand the meaningfulness of data collected for improving outcomes for clients
- Identify the policy, system, and workforce requirements to support full implementation.

This report provides findings from the site visits with treatment organisations, the focus group with funders, and interviews with NADA.

A core contextual feature of this project is the AOD treatment sector's shift to collecting and reporting on outcome measures. Funding for AOD treatment has traditionally been block grants, with a focus on accountability and reporting of the amount of care provided (episodes of care) and to whom. This output-based accountability has been gradually replaced by a focus on outcome-based funding, where funders are concerned with data about health and wellbeing outcomes (rather than solely amount of care received). This has been a major change for the AOD treatment sector in a relatively short period of time.

Policies and strategies that have signified and formalised this shift to outcome measurement have included: at the federal level, the Conceptual Framework for Performance Reporting (Council of Australian Governments, 2011), the *Public Accountability and Performance Reporting* (Council of Australian Governments, 2011) report, and the *Australian Health Performance Framework* (AHPF) (The National Health Information and Performance Principal Committee, 2017). Within NSW this has included the *NSW Health Performance Framework* (NSW Ministry of Health, 2017), the *Human Services Outcome Framework*, and *Value Based Healthcare Framework.*

NADA has taken significant sector leadership in steering this shift from output-based reporting to outcome-based reporting. A major consultative process and Delphi (including service providers and funders) was undertaken by NADA to establish 14 Key Performance Indicators, the majority of which are outcome-focussed, for the NSW NGO sector. In this sense, the sector led and steered the process. The key goal was to have the same outcome-focussed KPIs used by all funders (and with a common set of specifications for those KPIs across multiple funders) alongside NGO treatment services engaged in routine outcome data collection that could not only fulfill funding contract obligations but provide services with outcome data to inform quality improvement activities, reports to Boards and to their communities, and enhance the profile of NGO AOD treatment services in NSW.

Method

Implementation is a complex and challenging process. The environment within which the KPI implementation is occurring is characterised by complex web of multiple organisations providing numerous services based on different models of care and different types of treatment, and an array of funding organisations engaged in competitive tendering processes. Understanding this implementation requires attention to relationships, given the various stakeholders involved and the agendas and forces that are in motion and requires attention to the resources and technologies available.

The first phase of the study was to understand the extent of implementation across the non-government sector. The methods employed to understand these processes included site visits to NSW non-government organisations providing AOD treatment and a focus group with representatives of funding organisations that fund NSW NGO AOD treatment services.

NSW AOD NGO Treatment Organisations

To determine the appropriate sample we needed to cover both residential and non-residential treatment, the size of the organisation (as there is a question about the capacity and capability of services in light of their size), and whether services were early or late adopters. We proposed the following sampling frame, Table 1, resulting in 12 sites.

Table 1: Sampling frame for sites

Sampling frame for site visits				
	Non-residential services		Residential services	
	Early KPI adopter	Late KPI adopter	Early KPI adopter	Late KPI adopter
Small org	1	1	1	1
Medium org	1	1	1	1
Large org	1	1	1	1

The research team engaged with NADA, as the peak alcohol and other drug treatment body in NSW, to collaboratively develop a list of potential organisations and services who met criteria within the sampling frame.

Some organisations provide multiple types of treatment across multiple services. In these instances where an organisation was providing both a residential treatment service and outreach services, we recruited both services for the study but treated them separately. The variable early versus late adopter became a difficult characteristic to identify organisations by yet we sought to ensure a spread of experiences with implementation.

At the end of the phase of this study we had undertaken site visits with 8 organisations, visited 10 services and discussed 16 programs. These 16 programs covered the 12 different sample types in Table 1. We conducted site visits to 5 residential rehabilitations and 3 outreach and day program services. We spoke with 2 organisations virtually via Microsoft Teams.

Site visits

We invited organisations to participate in site visits that we estimated to be 1-2 days. This time was to ensure we as researchers could be flexible and adaptable to the dynamic and changing nature of a service day to day, hour to hour. This time allowed us to be present and responsive to a staff member needing to help a client and needing to postpone or have time for staff to drop in and talk to the researcher when they had a spare moment. The interviews with individual staff during site visits ranged from an hour to two hours. For organisations who did not have capacity to commit to a full day visit we organised an online meeting via Microsoft Teams. These were scheduled for 2 hours.

The site visit data collection followed a semi-structured interview guide, which is provided in Appendix A. Site visits covered data collection systems, data reporting systems, funder relationships, staffing and focussed on understanding the strengths and weaknesses of current approaches to the KPIs and data management.

NSW AOD NGO Treatment Funders

There are five different types of AOD treatment funders in NSW. We invited 1-2 representatives from these funding organisations to attend a 2-hour focus group. For those who were unable to attend on the selected date/time (decided by the majority of participants) we provided alternative times in which one researcher was available to brief representatives on what had been discussed during the main focus group and to provide them an opportunity to add any further comments or perspectives to the conversation. There was one additional session that took place with two representatives from two funding bodies. Chatham House rules were used for these discussions and as such data collected from this activity are attributed to the group not individual funders. Table 2 shows the breakdown of representatives from each funding organisation.

Table 2: Number of representatives who attended focus group from each funding body

Funder	# of representatives
The Commonwealth Department of Health and Aged Care	3 representatives - 1 representative from DoHAC - 2 representatives from Community Grants Hub
The NSW Ministry of Health	1 representative
10 PHNs who commission AOD treatment in NSW	2 representatives
15 LHDs who commission AOD treatment in NSW	0 representatives
The National Indigenous Australians Agency	1 representative

As can be seen, we were unable to engage with LHDs who commission AOD treatment. This was in part due to protocols within the organisation/government about who is expected to be invited to speak in these contexts and the question of whether this protocol would present us with the most relevant staff who could speak directly to this topic.

We designed the focus group to canvas the funder's understanding and perspectives about the uptake of the KPIs by funders, the barriers and facilitators of the KPI implementation, and the benefits of the new KPIs (including how the data are used). In Appendix B we have provided the original questions used to guide this discussion.

Interviews with NADA

After drafting the summary report, we interviewed key representatives from NADA to gain deeper insights into their ongoing efforts to support the sector in implementing the new KPIs. These interviews explored the role of NADA as a major stakeholder in implementation and how they have been involved in promoting and socialising the new KPIs, alongside understanding their practical role in implementation through system and resource supports.

During the interviews, we aimed to understand the systems in place that are designed to support services to implement the new KPIs, the advocacy role NADA has played in promoting the new KPIs, and plans for how NADA could further support the sector in this context. We also explored their work in engaging with the sector and the broader need for standardising treatment measures across the sector (in NSW and nationally).

The information gathered from these interviews provided valuable context that complemented the findings from the other data sources.

This project has ethics approval from the UNSW Human Research Ethics Committee Ethics approval (iRECS6193).

Findings

Before detailing the findings across all aspects of implementation, a few overarching findings set the context for understanding the subsequent detail.

Firstly, all the services involved in this project accepted outcome measures as key performance indicators. In addition, the services are highly committed to data collection, see it as core business, and appreciate the role it plays in service improvements and meeting clients' needs. From the site visits data and discussions with services, we found that while these services had been highly engaged in consultation of the NADA KPIs, there was still a diversity in familiarity with the NADA KPIs. We found discussions for this project to be a process of refamiliarisation, at times this included the researcher emailing or showing a hard copy of the NADA KPI Specifications document to participants and allowing them to work through it.

Secondly, services are collecting substantially more data than is required for reporting. As discussed in more detail later, the distinction between data collected for client management, data collected for organisational purposes including research and evaluation, and data collected for the Key Performance Indicators all overlap. There was not a clear sense of the distinction between KPI data and all other data collected by services. To some extent this is completely understandable (as all data can and may contribute to collation into KPI reporting) but the implication of this is that a project on KPI implementation is also a project on services data management in its entirety.

Thirdly, the 14 KPIs are not perfect. During the course of this phase of the project, we noted comments about the nature of the KPIs themselves. This included that '*complexity [is] not being taken into account'*, recognition that the KPIs are blunt measures, and a sense that some of the KPIs were subjective and could be influenced by the tool used (funders). Despite outcome measures, and the associated KPIs being broadly accepted across these services and funders, there is an ongoing wariness of the capacity of outcome measures to represent the complexity and needs of clients.

The following sections detail: the forces shaping implementation, the extent of adoption and adaptation, and the processes of implementation (data collection, data collation, data analysis and data reporting).

Forces and motivations shaping implementation

There are multiple intersecting forces shaping implementation, from both the service providers and the funders, through to tools produced by NADA and their ongoing advocacy for the sector. The process of introducing new KPIs and the associated specifications originated with NADA and NGO services seeking a solution to a burdensome reporting environment. The motivation for services is to provide better care, demonstrate positive health outcomes, and be accountable for public funds. While the funders share the importance of accountability for public funds, they experience other pressures, including for example, responding to ministers, and needing to be able to say something about the whole system (rather than individual services). In the context of these aligned but also differing needs, implementation has been both bottom-up (led by services) and a top-down (led by funders).

When the services visited were asked whether funders had begun to include the NADA KPIs in contracts and within reporting templates there were mixed responses. Some services had been informed by funders that contracts would start to incorporate some new KPIs over the next iterations of contract variations or renewals. Other services had begun receiving new contracts or variations that included the NADA KPIs as new requirements without consultation. Finally, some services had been proactive and begun incorporating NADA KPIs into internal data systems before any contractual KPI requirements had been introduced by the funders.

The perceptions of these processes differ between services and funders. In a potent example, while one service told us that their contracts had not included the new KPIs (they were expecting them to be introduced in the following year's contract), the funder of this same service told us that they had introduced the new KPIs and template as a trial. We can certainly see across all the data collected that implementation is an iterative process, that varies by funder and by service provider.

A further complexity to this awkward implementation process occurring simultaneously both bottom-up and top-down has been the desire from funders that services 'innovate'. Some funders are expecting services to innovate to find different activities to report on if some of the KPIs outlined in the template are not relevant to them. As one funder noted: "It's still pretty messy and murky for the services, and services have been surprised at their capacity to shape the report".

While funders perceive this to be collaborative, services may feel overwhelmed in this context. Funders are finding the implementation process challenging as the reports they have received vary in terms of the quantity and quality of data that is presented to them. One funder noted this complexity comes from services being given the choice of KPI reporting (given there are some funders who offer this flexibility) and the choice of measurement.

Seeing the KPIs as a menu of options (for both funders and service providers to select from, depending on the nature of the service being funded, the current service capacity for data collection, and the contractual relationship) has perhaps further confounded implementation.

In addition, we noted that funders want reporting to be less burdensome to services and some have implemented this by providing a seemingly non-negotiable template (this was described by one funder as a 'hardening of the process' despite the intention for flexibility). Indeed, the 'template' appears to have resulted in more confusion than expected.

The advantage of mutually proactive implementation (simultaneously by funders, service providers, and NADA) is that it shares the power of implementation between the parties. The risk of a solely top-down implementation process is that it removes the agency of services to influence and direct outcome measurement and KPI reporting. At the same time, a mutually proactive implementation process is unsurprisingly somewhat haphazard and messy.

Adoption and adaptation

In order to assess the degree of adoption and/or adaptation by funders and within the sampled services, we sought to obtain documents that described the reportable data. As it turned out, these documents varied greatly between services. Signed funding contracts that specified the KPIs was one example (one service provided a copy of the contract to the research team). In other cases we obtained multiple data/reporting related documents, including the funding body's KPI template (usually in excel), screenshots of portals for data entry, "activity deliverables" templates, "treatment indicator" templates, and "service provision targets". (A total of 49 data reporting documents were obtained).

The first and most obvious finding from this exercise is that the difference between a "KPI" and 'reportable data' is not clear to many services, nor to us as researchers. It seems that services report significant amounts of data – activity data, output data, outcome data, as well as service development data, and qualitative data. The extent to which some, many, or all of these various reportable data points form a finite list of Key Performance Indicators is not at all clear. While all the 'reportable data' forms part of a contractual obligation between funder and service provider, which elements are used to judge performance, or are attached to financial incentives or penalties, or place a contract at risk, is not known.

If the intention of the KPI Project was to replace existing data reporting with a finite list of (new) KPIs, and re-focus on outcome reporting (rather than activity or output reporting), this has not been achieved to date . Of the seven services that provided reportable data items/examples, all seven were still reporting output or activity data to at least one, if not multiple, funders. Table 3 provides examples of reportable data focussed on activity or output measures.

Table 3: Retention of activity and output data: examples from reportable data (across 7 services sampled)

Example of activity and output data
• Number of clients • Number of occasions of service • Number of episodes of service • Number of unique clients assessed and/or accepted into the program • Number of episodes of service provided to people exiting custodial settings • Number of exit interviews completed

- Number of female clients who commenced the program under the activity within the reporting period
- Number of groups provided
- Number of clients with ONE completed comprehensive assessment in the reporting period
- Percentage of clients offered an opportunity to complete the approved Patient Reported Experience Measure (PREM).

Differentiating what is a “KPI” from other reportable data becomes quite blurred. It is unsurprising that services feel the weight of data reporting (see other sections) in the context where they are reporting not only to multiple funders with different data elements, but reporting extensive output and activity data, as well as now beginning to report on outcome data.

Turning to the more outcome-focussed data, and more specifically the adoption of the NADA KPIs, we examined the various documentation we obtained (funding contracts, data templates, treatment indicators, online portals, and service provision targets) to assess the extent to which the 14 KPIs appeared in some form or other across this extensive suite of ‘reportable data’ items. The top-level findings are summarised in Table 4. As can be seen, we could not definitively categorise the number of funders using each of the KPIs in some form or another. Nonetheless, we observed every KPI appeared in ‘reportable data’ for at minimum one funder or more.[1]

Table 4: Presence of KPIs in reportable data

KPI	**Evident in ‘reportable data’**
KPI 1: Quality of Life	This KPI appears across three different funder templates/reports (NSW Ministry of Health, DoHA, and one PHN)
KPI 2: Severity of Dependence	This KPI appears across two different funder templates/reports (NSW Ministry of Health and DoHA)
KPI 3: AOD use	This KPI appears across multiple funder templates/reports (including NSW Ministry, DoHA, NIAA, PHN, and LHDs)
KPI 4: Mental Health	This KPI appears across multiple funder templates/reports (including NSW Ministry, DoHA, PHN, and LHDs)
KPI 5: Treatment (care) plan	This KPI appears across four different funder templates/reports (NSW Ministry of Health, DoHA, a PHN, and an LHD)
KPI 6: Treatment goals achieved	This KPI appears in at least two funder templates/reports (NIAA and DoHA)
KPI 7: Linked up	This KPI appears in one funder template/report (DoHA)
KPI 8: Culturally safe and inclusive services	This KPI appears in two funder templates/reports (DoHA, a PHN)
KPI 9: Staff Trained in Aboriginal Cultural Competence	This KPI appears in two funder templates/reports (DoHA, a PHN)
KPI 10: Treatment capacity	This KPI appears in at least two funder templates/reports (NSW Ministry and DoHA)
KPI 11: Accreditation	This KPI appears across multiple funder templates/reports (including NSW Ministry, DoHA, PHN, and LHDs)
KPI 12: Professional development	This KPI appears in one funder template/report (DoHA)

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[1] Note that this analysis is not of funding contracts but of reportable data, which may mean that services choose to report the KPI without it being part of their formal contractual obligations to the funder (or listed as a formal KPI in the funding contract).

KPI 13: AODTS-NMDS	This KPI appears consistently across all funders
KPI 14: Audited Financial statement	This KPI appears consistently across all funders

Table note: These data were generated by assessing the presence of the keywords associated with each KPI across the 49 different documents of 'reportable data'

The above analysis suggests that uptake of the NADA KPIs is certainly present, but the extent to which the data elements conform to the NADA definitions and specifications is another matter. The below table (Table 5) provides examples of some of the varied definitions. As can be seen, despite the NADA KPI specifications document providing clear definitions of each KPI (and associated metrics for its collection, covered later under data collation), the ways in which these data elements are being defined and described is highly variable.

Table 5: KPI definitions: Examples comparing definitions between NADA specifications and definitions in use

KPI	**NADA KPI definition**	**Variations in definitions across reportable data**
KPI 3: AOD use	The number and proportion of clients who report a decrease in AOD use. This measure is concerned with principal drug of concern (PDOC) only.	Abstinence reductions in the amount of AOD use per use occasion (quantity) or reducing the number of days of use (frequency) Proportion (%) of individual clients who completed treatment that ceased substance misuse 3 months after exit from residential treatment, in the reporting period Number of clients with AOD use reduction during the reporting period
KPI 4: Mental Health	The number and proportion of clients who report any improvement in mental health.	Number of clients with improved psychological wellbeing during the reporting period
KPI 5: Treatment (care) plan	The number and proportion of clients with a treatment plan for whom an episode of care was closed during the reporting period	Percentage of clients in the reporting period who receive an exit plan upon exit (planned) from the service Number of clients with a completed CARE PLAN in the reporting period
KPI 7: Linked up	The number and proportion of people that report they were linked-up with other services when they leave the program	Effectiveness and Linkages Linked up: clients' perspectives of if and how well they were "linked-up" with other services upon leaving a program to support effective transfer of care. If you are not collecting data, consider an indicator that demonstrates client connection with other services to meet treatment goals and post-treatment support. This could include,

		but is not limited to; external counselling services, group sessions, community housing etc. How does your service manage the transfer of care? (This includes unplanned exits). What feedback / engagement occurs with post-treatment clients? What feedback / engagement occurs with post-treatment stakeholders / services? Discharge summary/transfer of care documentation Percentage of clients in the reporting period who receive an exit plan upon exit (planned) from the service (target-100%)
KPI 8: Culturally safe and inclusive services	The number and proportion of people that report the service was culturally safe and inclusive.	Indicate the # and % of clients that report the service was culturally safe and appropriate Or: Consider an indicator to demonstrate that the service is culturally safe and appropriate to clients. Indicate the # and % of staff trained in Aboriginal and Torres Strait Islander cultural competence Culturally Safe Service is defined by the PMHC-MDS as a service that is: Delivered by an Aboriginal Community Controlled Health Organisation (ACCHO); Delivered by a practitioner that identifies as being of First Nation heritage; or Delivered by a practitioner that has participated in an appropriate cultural awareness training in the previous two (2) years.
KPI 9: Staff Trained in Aboriginal Cultural Competence	The number and proportion of staff trained in Aboriginal and Torres Strait Islander cultural competence.	Provide /offered local based cultural awareness training noting the type training provided/offered to your staff in the last 2 years

One of the important findings discerned from the above is the adoption of the concept of measuring outcomes through the domains covered by the KPIs, yet as is also clear, the ways in which those domains are measured lacks standardisation (i.e. the specifications are not being implemented at this stage). In addition, while the outcome domains as expressed across the 14 KPI's are now included somewhere within reportable data items for the services that were sampled in this project, the extent to which these actually form KPIs in the contractual sense remains unclear. This may reflect the gradual phased implementation, reflecting the current stage of implementation as a 'beginning to collect'.

The rationale for the specifications is that services would only have to use one formula and one set of calculations to deliver the report to a funder or to multiple funders. NADA has supported this by embedding the specifications into NADABase, ensuring that data entered are synthesised using standardised formulae. However, what seems to have happened is that some funders and services have adopted the outcome domains but have not consistently implemented the specifications and their associated formulae. This may be the result of services not relying on NADABase for data analysis and reporting, and a lack of clarity about the role of the specifications document and its ability to make reporting processes more efficient [2]. Moreso, if funders have inconsistently implemented the specifications, services are simultaneously relying on previous data analysis methods or navigating multiple definitions and formulae for reporting. Given this lack of implementation and resulting lack of standardisation in the use of the specifications means that there are no time savings for service providers, no ability to assess benchmarking between services, and no ability to make comment on the broader service system outcomes in a consistent and standardised way yet.

This could suggest that the development of specifications may have been premature and that what was needed was greater understanding that the KPIs would (completely) replace output and activity measures. While general concepts of key performance indicators are being accepted and adopted, the standardisation of these KPIs and the measures required to achieve the goals of broad sector adoption of the NADA KPIs is still in its infancy.

Processes of implementation

The move to outcomes-based reporting has required organisational change within services, including training staff with the right tools, cultural change management of organisations to move away from reporting on output-based funding (measuring the activities services provide, i.e., number of treatment episodes) to collecting outcome data and reporting on performance measures, and investment in ensuring data processes and systems have the capacity to report on outcome measures.

When focusing on services’ capacity and capabilities of reporting on the NADA KPIs we structured our analysis around four key stages of data management: data collection, data collation, data analysis, and reporting to funders (see Figure 1). Below we examine each of these stages of data management and how each stage relies on different staff, skills, resources, and systems.

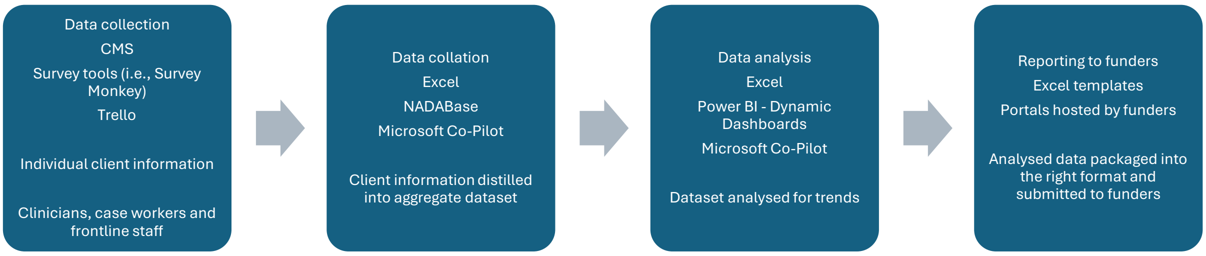

Figure 1: Stages of data management

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[2] MG took the specifications document to each site visit. This led to conversations where participants refamiliarised themselves with the document (noting these services were involved in the consultations that informed the specifications), but services it was unclear whether services’ data systems used these formulae specifically.

Data collection

Data collection starts with the client. Clinicians and case workers collect client information (data) through the process of working with clients to fill out surveys, have one-on-one chats, create treatment plans, all of which is then entered into a Client Management System (CMS). We observed both manual and computer-based systems used to organise and manage clinical care.

The CMS' host a myriad of client related artefacts, for example file notes, client assessment data, referral sheets, K10 results, PREMS, COMS and so on. One service's CMS was described as being able to give case workers a whole picture of what is happening with clients and what needs to happen as it is a "living organism" that is constantly being updated – this helps case workers to make informed decisions about approaches for clients. It means all staff can be across the needs of a client and ensures information isn't "lost" - there is a central space for things to be collected and written up and to overarchingly enable services to provide best care to clients.

Across the 8 services visited each service used a different CMS, two services had in-house electronic systems whereas the others had bought licenses for electronic systems and one was using paper and pen. When speaking with NADA, they noted approximately 30% of members directly enter client information into NADABase (services can use it to track individual client progress). Box 1 shows the different CMS platforms in use by the sampled services.

Box 1: List of CMS platforms used by organisations in this sample

- Mimaso
- RediCase
- 2 internal bespoke systems (anonymised)
- CaseConnect
- Communicare
- Encircle
- Microsoft Dynamics 365
- 1 paper based service (in the process of finding an electronic CMS)

The CMS forms the backbone of data collection (to enable subsequent collation and reporting).
One of the sampled services was in the process of selecting a CMS. They generously shared with us a list of initial features and functions that a CMS and the suppliers would need to be able to provide or aid in designing, see Box 2. This demonstrates the significance of a data system in enabling organisations to collect and collate data, as well as provide clinical services effectively and efficiently.

Box 2: High level selection criteria for Client Management System

1. Able to import files for NADABase
2. Data import/export for flat files
3. Enter data once - use/display many times (we want any field populated in one area to automatically be presented anywhere else it is relevant)
4. Data dictionary available in the system, and can be modified
5. Security - customisable but preferably role-based (both are fully customisable - a bit messy)
6. 'Client Portal' &/or secure data entry available directly by a third party
7. Features to manage waitlist - ability to prioritise a client for assessment based on attributes e.g. pregnant, First Nations, experiencing current DV

8. Report-builder and ability to save report templates (ideal if some KPI measures are already programmed)
9. Manager dashboard - ability to view dashboard based on role
10. Subpoena production - single click file export
11. Usability
12. New fields and forms able to be programed by trained/approved staff
13. Network and hardware requirements
    a. bandwidth recommended
    b. processor speed
14. System uptime and secure backup/restore routine
15. Data privacy and security features
    a. Cybersecurity rating
    a. Where is data hosted & on what platform
    b. Back to back agreements on data privacy and security
16. Structure of provider - Company with appropriate Insurances and staffing to give assurance on services over time
17. HelpDesk availability, Service Level Agreement (SLA) and cost
18. Licensing cost
19. Mature user network, preferably in the sector

During the site visits we spoke to case workers at four services. Some were highly engaged in transforming data collection processes and had helped innovate new forms for client surveys and building excel spreadsheets that meant client information and program information was efficient and easily used for clinical work, alongside being useful for staff who need to export data for reporting. However, for some case workers who felt less comfortable using electronic data systems they noted they would try and use the digital forms but would often revert to using pen and paper with clients and then enter it into the CMS afterwards. This method was often determined by where a client felt most comfortable having a one-on-one, sometimes outside in the sun, and other times in the office. Similarly, some case workers would sit and go through surveys question by question with the client, whereas others were comfortable giving clients the survey for them to fill out alone. In another example, assessment and intake (a key data collection point for services), there are a range of ways in which data are collected and held. Some services use an online application system (that prospective clients complete alone) that is integrated to their electronic CMS. Other services are manually collecting assessment and intake data and manually transferring data across into files and programs. For some they have an electronic client management system that is fully integrated and information collected at assessment and intake creates a client file in which all future information can be entered directly in this profile. However, in these cases there are still components that sit outside of these systems and need to either be manually entered or exported from another system and imported into the core system. For example, one service collects PREMS using SurveyMonkey, which doesn’t directly input into Mimaso, their core client management system.

While some CMSs or databases have been customised for specific services, adding in bespoke features that help improve processes (through grants dedicated to system improvement, data capacity or research, or if services have funds set aside to upgrade these systems), some services have economies of scale that means they have in-house designed databases (these also cover programs in other sectors that services might be involved in – e.g. mental health and/or housing). What is notable however is that no system or database has been completely designed with the AOD treatment sector in mind. One service stated an ongoing issue and focus is “trying to innovate to have a system to meet data collection needs”.

Data quality is a key issue for accurately reporting on KPIs and is a focus for organisations in the data collection phase as it can reduce issues later down the track. Part of improving data quality is having a data management system or CMS that is user-friendly and streamlined. More so, it also involves training frontline staff about how the data they are collecting is flowing into other programs and being translated and packaged into different formats. The ability of the CMS (as an easy and user-friendly system) systematises treatment pathways (i.e., when check-ins are due) and ensures milestones are less likely to be missed or lost. For example, for an organisation to report on KPI #1 there needs to be evidence of measurement tools used iteratively throughout a client's treatment; to report on KPI #5, there needs to be a way for staff to identify where a client has a treatment plan.

Data collation

Data collation is the second phase of data management that contributes to the distillation of clinical data into reportable KPI data. Data collation in the context of KPI reporting is the process of transforming data from a digital CMS or paper-based file into a format ready for reporting. The initial activities involved in this process include data cleaning, such as fixing missing data points, and reformatting. As we observed during the site visits, there are multiple staff involved in this process and it is time-consuming. In the sample involved in this project the positions of those responsible ranged from team leader of a service, project officer, service manager, to CEO (these titles differ across organisations). In some cases they are supported by some data collection staff and IT staff to help with this process. Case workers and clinicians, and other staff involved in data collection, are often called upon to help with missing data points or to help in clarifying contradicting information that causes logic errors in reporting portals. A common example of this was clarifying and re-entering the correct drug use route of administration in the context of primary drug of concern. Other missing data points might be treatment plans that haven't been entered into a client's file, or a survey that was undertaken with a client but hasn't been documented. As summarised under data collection, having a good CMS or data management system makes these processes more automated and easier to maintain and keep record of, which has implications for the data collation process (ie there is less time spent finding missing data or clarifying poor quality data entries).

Other staff involved in this process were IT staff and data analysts (if the service had capacity for these roles). Some services have a data analyst who would clean data before it is provided to the relevant staff. Once downloaded the analyst could work through and delete duplications and transform it into a format easy and accessible for the staff responsible for analysis and reporting (i.e, the team leader or service manager). Having this function in the CMS or data management system where datasets related to a specific service could be automated and downloaded in an accessible format is another example where technology plays a critical role in an organisation's capacity and capability for clinical data to be translated and distilled into a format that enables organisations to report on KPIs. NADA plays a crucial role in the data collation that underpins the capability of services to report on the new KPIs through the availability and functions of NADABase. Services have the flexibility to manually enter individual client data (approximately 30% of these data are directly entered into NADABase) or import it from their client management systems (CMS). The remaining services export datasets from their CMS and import it into NADABase. Data provided by services are then aggregated to create comprehensive service profiles which are fed into producing a NSW sector profile. NADABase allows services to visualise datasets at the service level, providing valuable insights into individual service performance. These sector profiles help NADA, services, and funders understand treatment patterns statewide and allow services to compare their outcomes to the NSW average. NADABase is not a CMS however, so there remain steps between a CMS and NADABase.

Other tools that organisations in this sample were using included a system separate to their CMS specifically for collating and analysing outcome measures. They explained the CMS they use is a "locked system" where they can't easily build in new features and need to request changes to made by the administrator (the key strength of this system is reporting on MDS data). However, in order to collate data on the outcome measures system they use an API (application programming interface) that sends de-identified data from the CMS to the outcome measures program. Another example was one service using Microsoft Co-Pilot for collating data from internal datasets. Given their systems are built using other Microsoft Office programs they can use Microsoft Co-Pilot to search across their systems and pull data together. Importantly, they noted this AI program keeps data within the service's domain and doesn't share data externally or feed into public or open databases.

Despite there being tools available to help with data collation it is a process that requires skilled staff to navigate these technologies and platforms. One service relies heavily on IT support staff from their CMS provider to troubleshoot issues with exporting datasets in the right format to then be uploaded to NADABase. This IT support person is on call at all times – during a demonstration of how to export and upload MDS reports to NADABase a participant directly Teams messaged the IT support to ask a question and got a response within 2 minutes. More so, while many organisations have electronic data management systems, some with automated and integrated form-building, there are still a range of organisations who are manually building excel spreadsheets and/or entering client data one at a time into NADABase in order to collate data for specific services and programs and ensure the right format for reporting.

Data analysis

The third phase of data management for reporting on KPIs is data analysis. Data analysis is an intensive activity that occurs during reporting periods, not in an ongoing fashion across the year (although see below re tools that enable ongoing data analysis). This phase involves analysing the client data to report on proportions, percentages, or other statistics, having selected the right sub-population (eg alcohol only, or those with completed end of treatment data). Data analysis in the context of KPI reporting might be contained to a specific reporting period or specific cohort of clients, and requires the application of various formulae, as provided in the NADA Specifications document. The NADA specifications for each of the 14 KPIs aimed to standardise KPI measures and give organisations a method for analysing data to help with KPI reporting. It became apparent during the site visits that organisations and staff responsible for data analysis were not using these specifications. However, NADABase does apply the specifications formulae. The datasets produced and entered/imported by services to NADABase are processed using the specifications formulae tailored to the new KPIs. This involves aggregating the individual data into summary statistics—like averages, totals, or percentages—that provide a clearer picture of overall trends and outcomes. It is these statistics that are provided in each service's dashboard that services can use when filling out their reporting templates. As of March 2025, NADABase provides dashboards using the KPI specifications that can be used to report on five of the new KPIs: Quality of Life, Severity of Dependence, AOD use, Mental Health, and NSW MDS/AOTDS-NMDS.

The staff involved and responsible for data analysis differ depending on the structure of each organisation. For example, one organisation has an entire dedicated data and research team. They have 4 data and reporting coordinators and a data engineer. Within this team they train case workers and frontline staff and team leaders on what to collect, definitions of data points, cleaning data and analysing data. Another organisation relied on a Nurse Manager and CEO to review data quality and prepare the narrative case studies, and the CEO would run the analyses and calculations required. In one case one team leader is responsible for the data analysis and reporting across three contracts for three programs. On average, across the organisations we visited there were 2-3 people working on data analysis. Usually a combination of team leader, who is managing a team of case workers and who is also reporting directly to a site manager, director or even CEO. A data analyst might be involved, depending on the size of the service, to help with statistical analysis of the data. For organisations who operate a single service, like a residential rehabilitation, the service manager/CEO will also be involved in analysis.

Tools and technologies are being used by some organisations in this data analysis stage. There appeared to be an appetite for dynamic dashboards, such as PowerBI. We noted that a couple of organisations are already using tools such as PowerBI. Others recognised that these kinds of tools were potentially very helpful in generating reports to funders whilst also serving as a quality improvement initiative by way of providing data back to clinical teams. Participants also noted that dynamic interface tools that can produce visualisations of the data can be very useful in demonstrating the impact of a clinical service to stakeholders. NADA also supports a function on NADABase for services to see their data visually represented using PowerBI dashboards. NADA see this tool as a way to support the KPI implementation by making it easier for services to access data that has already been analysed (based on the client information they have uploaded).

Others use excel to create pivot tables and visuals that are both published for all service staff to see and engage with but to help with trends and analysis for reporting back to funders. In one example, a service manager shares data visualisations on team communication platforms at the start of each week. Their intention is to use the data to help easily distil information about the service that might be helpful for the staff. For example the data being shared might display that the majority of clients accessing the service that week use alcohol as their primary drug of concern, or it might show that the majority of clients are under the age of 35. The service manager explained that these data can help staff to shape the conversations they are having with clients or inform what services that might need to provide. The other intention of sharing data in this way so regularly was to increase their staff's comfort and familiarity with data and break down barriers for what data are and how it can be used. They explained data can seem like a nebulous concept for many staff and by presenting it in this way they are able to bridge the gap between the work they are doing one on one with clients and how it can be transformed into something meaningful and informative for the service. Other services explained they wanted to move towards incorporating more dashboards across their organisation and make data summaries more accessible for all staff. They also anticipated that these visualisations and dashboards would be helpful for staff who were preparing funding reports, as these tools could help simplify and streamline data analysis.

However, there were services involved in this study who don't have data platforms and programs that support these tools and technologies (NADABase is a system that could support these services, however it is unclear the extent to which services rely on it). These services are reliant on a data analyst or the team leader/service manager who is responsible for reporting to undertake the analysis. Given the limited resources organisations and services have when it comes to data management, data analysis [to the extent required for funding reports] is under-resourced except during reporting periods. It is during these periods data analysis becomes a resource intensive activity, which has consequences for organisation staff. As one organisation noted they "almost burn out the data analyst during the reporting blocks" as they are working on data cleaning, MDS reporting, pulling together other data for each specific report while also still providing data and IT support to other teams. There is an expectation to carry on business as usual while completing additional time pressure tasks. This organisation went on to explain that given these reporting periods fall at the same time every year there are months (July and January) when these staff are ideally not able to take leave, as they are often one of only few staff in the organisation who have the skills required to manage and analyse data. Limiting staff flexibility like this was a discomfort for the organisation as it is against the ethos for how they want to treat their staff and they recognised it puts a lot of pressure on these employees.

The site visits also revealed how some organisations rely on friends, partners and networks for data analysis (and other aspects as well). Having identified expertise in systems and practices that a service could learn from, one service explained their partnership with a social enterprise comprised of data analysts who help build data capabilities for NGOs and non-for-profits – this group helps with data analysis for the organisation.

Data reporting

The fourth phase of data management for KPI implementation is reporting. This is ensuring data are packaged in the right format that can be returned to funders to meet contractual requirements. There is an overlap with data analysis in terms of staff responsible and the drain on resources.

Services are reliant on the funder portals and systems to submit their reports (unlike the above, where services have choices about the systems they use to collect, collate and analyse the data). How organisations package their data changes depending on the funding body's systems. Some funders provide templates in either a word or excel document that services fill out, others require services to directly input data into a form via a portal. Reporting might look like attaching a completed template to an email or filling out answers and uploading files directly to a portal. The sampled services noted that these templates often change, the portals can be clunky, data might not save properly so things need to be re-entered, or systems are generally slow.

As outlined in the data analysis section, NADA supports the implementation of the new KPIs by providing services with dashboards that eliminate the need for any calculations on their part. These dashboards automatically convert the service data they provide into actionable insights. Built using the KPI specifications published by NADA, these tools facilitate reporting on five key areas: Quality of Life, Severity of Dependence, AOD use, Mental Health, and NSW MDS/AOTDS-NMDS (as of March 2025). The key caveat here is that if funders are asking for different definitions of a KPI in their reporting templates than the specifications used in NADABase then the usefulness of the dashboards to services may be limited.

When interviews turned to the process of reporting to funders many participants started by explaining how intense reporting periods were, how stressful these periods were and were quick to "rant" as they put it. They would apologise and say "don't get me started". However, following this, participants would be open to explaining the process and walking the researcher through the various systems and processes in place to ensure they were reporting on time and reporting quality data. One of the key factors shaping the capacity of services to report on the KPIs is the timeframes and timelines of reporting. To understand this, during site visits we asked the staff responsible for reporting what the time required was to write and submit funding reports. Again, like various aspects of this project, the timeframes for reporting depended on the number of funding contracts a service had. There are different timelines for different funding requirements and reporting periods. Each of these reports usually relies on a different platform or process. A general overview of reporting timelines and reporting frequency is:

- A monthly report of NSW MDS DATS to NADABase
- Quarterly reporting, usually required by PHNs
- Six monthly reporting
- Annual reporting

Box 3 provides an example of the time it takes to report to all funders during a reporting period.

Box 3: Reporting timeframes for a service with 5 grants

Context of this service: Residential rehabilitation, 1x service manager and 1x project officer who are collating, cleaning and analysing data and writing funding reports. Note: Neither has a formal background in data science or analysis but has learnt on the go, learnt to do what is needed to ensure the service functions highly. Additionally there is 1x finance officer who helps with financial reporting requirements.

- Reporting six monthly to 3 funders
- Quarterly reports to 2 funders
- Annual report to 1 funder

To meet all these reporting requirements data cleaning and analysis of trends and changes in the service happen every six months and well as very quarter. Quarterly reports take on average 2-3 days each (3 different funders). Six monthly reports take approximately 3 weeks of the service manager and project officer's time. One of the barriers that slows this process down is staff having to change the format of how data are presented as funders ask for slightly different data outputs (e.g. numbers vs percentages vs averages).

Depending on the time of year and number of funding contracts, services will be required to report to one or a few funders at the same time, or all of their funders at the same time. Staff explained that July/August and January are key reporting periods (this impacts when staff can take leave, staff doing overtime or using personal time to finish reports as services have to maintain their day to day services alongside reporting requirements). For another organisation they explained that reporting creates stress every quarter – (last two weeks of the quarter) – and usually requires team leaders to complete analysis and submit reports outside of work hours. For some programs in this service reporting takes about 2 weeks; this involves reaching out to case workers and marketing and finance teams. This process can be delayed because of the lack of organisation processes/procedures in place that mean information held at an executive or financial level, required for reporting, is not proactively provided to team leaders and often not in the right format. This contributes to reporting processes slowing down and being stressful.

Box 4: Example of reporting on a KPI

The most consistent reporting requirement found in funding contracts and reporting templates is KPI#13 or providing a monthly data extract to the AODTS-NMDS, or more frequently in the contracts provided in this study, providing an extract of the NSW Minimum Dataset (NSW MDS). This is required by the 21st day of each month. Most services comply with this requirement by uploading an extract to NADABase.

The process of reporting requires data to either be entered directly to NADABase or for a file to be uploaded into the NADABase portal. In the sampled services we noted:

- Organisations usually get an IT or data person to export a report that is in the right format for NADABase and then upload via the NADABase portal.
- The process of uploading to NADABase comes with its own challenges where data compliance and cleaning are highlighted.
- Some of the services have used grant funding targeted at updating data capacity to add new fields into their CMS to capture the right data for MDS reporting and building functions into their CMS to ensure the MDS reports can be exported in the right format for NADABase.
- One service noted they are uploading to NADABase in the correct format, but at the funder's request also exporting it separately and sending MDS reports directly to funders (which lead from a conversation about double reporting).
- One funder mentioned that there are some issues around accessing outcome data where if services don't upload MDS to NADABase
- KPI # 13 does not include any outcome data covered in the other KPIs. When uploading to NADABase, the system requires users to upload MDS reports before uploading COMs reports (a point of some annoyance).

Barriers and enablers to implementation

Throughout the above findings, many barriers and enablers have already been identified. Three key barriers are re-iterated here: sector-led and funder-driven; resourcing and capacity; and technology. These are also paralleled in strengths and enablers.

Implementation of the NADA KPI is concurrently sector-led and funder-driven. While this situation is a potential strength, it appears that it has presented challenges to implementation. The sector is highly committed to effective data collection and collation to be positioned to report on outcomes (to their staff, clients, community, and funders). Reporting is seen as core business by the sector, and organisations are committed to the obligations associated with being publicly funded and to improving clinical care in this process. As such, they are seeking to lead in the development of outcome reporting. Some funders are also providing services with the opportunity to select and innovate around KPIs. At the same time, some funders are also imposing reporting requirements, and despite a commitment to a collaborative process, have been perceived to be hardening the rules and processes for reporting. These dual forces appear to have contributed to the complex implementation pattern we have observed. While moving to a more centralised top-down (from funders) or solely bottom-up (from services) might smooth the implementation path, it would remove the desired collaborative relationship between services and funders. Improving the communication and collaborative relationships (reciprocity) between services and funders, such that there is mutual appreciation of each other's context, constraints, and capacities would enhance implementation of the KPI.

The second key barrier is resources and capacity. Again, there are examples where services are well-resourced, highly invested in data management systems, and have developed unique and highly specialised systems to manage their data needs and KPI reporting. These services are champions. Yet these are the exceptions. Most services sampled are not funded to collect, collate and report data in a way that would meet expectations (of funders, of community, or of the services themselves). This work is largely uncounted, invisible and unfunded. The constraints on the proportion of funding available for 'administration' is a key barrier. And the total amount of funding to services is a significant limiting factor. If full implementation of the outcome-based KPIs is to be achieved, significant funding to services to enable this is required. As detailed above, this starts with a CMS system and flows through to resourcing the intensive reporting periods.

There is a sector appetite for data and strong data skills within the sector. Clinicians and case workers recognise the importance of data being central to clinical care and want to learn more about the data they collect and learn more about how data are used in the sector. Addressing this potentially relies on leveraging the key data champions and data analysts who exist in the sector. As one organisation noted you don't need to educate all staff about system builds but what is effective and makes data collection more meaningful is educating staff on the importance of outcome measures and what good data habits allow services to do for clients. Creating more space and time with staff who understand these aspects of the system would help in disseminating data knowledge and improving comfort with using data. There are specific data and research teams across the sector in specific organisations that have great data translation skills (using images and metaphors) to explain data definitions and trends to the whole team.

Resources are not confined to funding alone: capacity in data management and IT skills across the sector and within funder organisations is limited. From the funder side of the equation, we noted high turnover of staff within funder organisations, resulting in poor continuity of data management understanding (and contributing to lower reciprocity between funder and services). While funder expectations (of outcome-focussed KPIs) are growing, they have not been internally resourced to manage this more effectively. From the services point of view, the time and resources to adequately recruit and train staff across the services in data management is a major constraint.

The third barrier (and enabler) is technology. As detailed above, the technology requirements to achieve full KPI implementation are substantial. The introduction of efficient and user-friendly CMSs and data management systems to organisations has been a driver of change not just an enabler of change. The collection, collation and analysis of data has become more efficient than in the past. Organisations are innovating with the technology available to them to improve how they are collecting data and how they are interpreting it. With the right technology and training it means reduced administrative burden on staff and more effective accountability to clients and community.

Some organisations have effective CMS that seamlessly transform client data into reportable data. But this is very rare. NADABase offers a vital service in supporting services to report on 5 KPIs, as services explained they see NADABase as fundamental for reporting on the AODT-NMDS and the NSW MDS (KPI 13). However NADABase is not a CMS, nor does it yet contain the kind of functionality to enable it to produce the KPI reports for services (COMS remains separate to the MDS sections), however as explained above it does provide data analysis that services can use to report on five of the new KPIs. Whether NADA is positioned to make a major investment in NADABase, and whether organisations see this as one of the solutions is a point for further exploration.

Potential strategies for strengthening implementation

In the design of this study, we recognised the opportunity to identify and develop capacity building processes around data collection and analysis in the NGO sector. One of our more specific aims was to support implementation and scale up of the KPI within the NSW NGO treatment context. In response to these aims we have developed a list of potential strategies that could be used to contribute to these aims. Some of these strategies were explicitly suggested by treatment organisations or funders during data collection and engagement, others have been developed by the research team.

Resourcing the sector

NADA has consistently advocated for the implementation of Key Performance Indicators (KPIs) with the broader goal of advocating for a national performance framework. They explained that without an overarching national policy, getting all funders and services to adopt and implement standardised KPIs would be almost impossible. NADA has committed to ongoing consultation with the sector at state and national levels, meeting with funders on an individual basis to ensure alignment and support for the initiative. Additionally, NADA has been presenting on the significance of KPIs at various conferences, sharing insights and fostering discussions around their implementation.

However, there is a need for other resources to be relied upon to support the sector's innovation and to improve treatment standards. Funders have an opportunity to push the initiative forward on a larger scale. Further, funders must commit to removing non-KPI reporting requirements in contracts and reporting templates and ensure they consistently apply the KPIs using the available KPI specifications published by NADA.

In addition, it is the role of funders to recognise that implementation requires resourcing. Resourcing includes investment in technology and data support (as outlined below), as well as investment to support the time required to undertake data management and the time it takes to report to multiple funders.

Investment in technology and data supports

The resources available in the sector shape the experience organisations have when managing data, reporting on KPIs and implementing new KPIs. While all services who participated in this study are meeting their reporting obligations and are engaged in the implementation process of adopting and adapting the new KPIs, it is the difference in technology and resources that enables or impedes a service’s capacity and capability to report efficiently and effectively. Organisations spoke about their own plans and needs to invest in better technology and increase staff skills in managing data, however, organisations also spoke about the resources that would be bettered leveraged at a sector level.

At an organisation level:

- Review and update CMS to ensure it is ‘fit for [its multiple] purposes’
- With a new CMS or electronic data system ensure there is a sandbox that staff can use to become more comfortable with the system and ‘play’ with it to learn features and functionality
- Review CMS to ensure seamless reporting capability (ie transform client data into KPIs automatically)
- Provide training and support to staff

At a sector level:

- Consider an AOD-specific CMS (developed by NADA)
- Review NADABase for its functionality in ensuring KPI data reporting

- Provide a ‘flying squad’ of AOD experienced data analyst – available to help and support services around reporting time. Note that this strategy reflects a desire to be supported so that services can solve their own problems – concerns about ‘outsiders’/people who don’t know the system coming in and trying to fix it
- Provide sector-wide training opportunities, and ‘communities of practice’ where organisations share strategies and solutions
- Identify data champions in the sector. Key to the data landscape is having people who understand data and data systems deeply – this needs to be a key focus of the sector and NADA or to help in providing ‘tech support’ to the sector, ensuring it is “someone who gets both sides”

At the funder level

- A funder provided one-off funding for data capability. This was in response to feedback from service providers that they don’t know where to start or how to improve data reporting. While some funds were provided, there is a need for further funding across the NGO sector for data management
- Appreciating that every organisation is at a different stage, the funding required will differ between organisations. (Some services are so early in their data management systems that the funding that was provided wasn’t enough to help, whereas for services with bigger systems that were more established this funding was put towards maintenance and new features)

Developing reciprocity and empathy from both sides

Given the key findings around the implementation – both services-led and funder-driven - and the advantage of this as a potentially mutually reinforcing, power-sharing arrangement, a greater appreciation of the specific challenges and context for both parties would enhance a sense of working together to implement outcome-focussed KPIs. One organisation explained the importance of having a funder who had prior clinical experience and reporting experience. As a result, the organisation felt they could communicate more effectively with the funder and that the funder did not ask for anything irrelevant when it came to reporting.

Building systems of relief and spaces for reflection

The move to KPIs focussed largely on outcomes measures, as discussed throughout this report, happened quickly and recently and reflects a fundamental accountability shift for treatment organisations and funders. Stakeholders need to recognise the magnitude of this change and find ways to ensure staff feel comfortable and supported in this period. During a site visit with one organisation, two staff in separate discussions introduced the importance of allocating time for reflection – specifically when it comes to client data: what is being collected, what is being measured and why is this meaningful. As they discussed this is core to clinical practice – finding time to reflect and debrief about clients and treatment. The same processes should be used for data.

The strategies outlined above required testing with stakeholders to ensure they are relevant, seen to be useful, and empower the sector prioritising the agency of treatment organisations, whilst meeting funder needs.

Developing ‘Data Maps’

One organisation spoke about the desire to create a ‘data map’ for their service. For them the function of a map would be to identify the types and amount of data that services are collecting. This map is anticipated to assist the organisation at an internal clinical improvement perspective (what gaps are there in the data and how can data be better managed), and from the perspective of what data funders expect. What this map looks like is unclear, however, there are some existing examples of data tools and maps that could be drawn on to help flesh the idea out more clearly.

For example, one service has begun this work at a more conceptual level in which they've produced a data strategy based around four pillars: data needs, data collection, data protection, and data reporting. While the service who discussed this idea spoke about it at a service level, there is opportunity to broaden this to the NGO sector as a whole. Possible elements of a data map might include:

- the flows of data – from an organisation and service perspective it could identify who is collecting data, collating, analysing and producing report. From a funder perspective this could identify similar flows from receiving data through to where data ends up and who sees it along the way.
- the different data management systems and tools that organisations across the sector use
- different KPIs within the sector and link them to examples of policies or decision making

There are different functions a data map could have and whether it has value to the sector needs to be tested with organisations. For it to be a valuable resource it requires collaboration with other stakeholders, i.e., funders who also shape the data landscape and help determine what is meaningful and relevant in terms of data.

This approach could be used to develop a roadmap for the NSW sector; however, it would require clear strategies, roles and responsibilities that would need to be done in consultation with the sector.

Appendix A: Site visit data collection tool

At each site the procedure are as follows:

1. Request and review performance reports (for review prior to site visit dates)
2. Arrange and conduct interview with CEO/Executive Director of organisation concerning the operation of all sites managed by the organisation
3. Send details of site visit arrangements through to site, including rough itinerary for site managers concerning researcher whereabouts and priorities (should be developed in consultation with site managers and include an initial tour of the site); meetings with clinicians, data managers, other management staff.
4. Arrange and hold a meeting with Data Manager/Chief Operating Officer (COO) for a detailed breakdown of their approach to KPI data collection, collation, and storage.
5. Arrange and meet with 2-3 clinical staff to discuss KPIs, data collection.
6. Develop a list of any outstanding issues or documents needed from the site for the study and follow up with site manager.
7. Send a site visit summary to the service delivery provider or site manager within one week of each visit for confirmation and any clarification needed.

For each service we aim to speak to the Service Manager or Chief Operating Officer, the CEO, the Data Manager and 2-3 clinical staff to get an overview of all aspects of the service and understand the service from multiple perspectives. We will not be speaking with clients. The question guide is outlined in the below table. This guide will be used for the first and second round of site visits to all services.

Domain	Questions	Relevant staff
1. Introduction	• Could you describe your organisation and the services you provide?	All staff participating in an interview will be asked this question
2. Staff (who, their skills, and data capabilities)	• How many staff do you employ? • What is the breakdown of staffing roles? • Who is collecting KPI data? • How would you describe the data capabilities of your team? (data literacy) • Is data capability a focus for professional development? • What workforce requirements are necessary to collect, collate and report on the KPIs?	Depending on the service these questions will be directed towards the Service Manager, COO or CEO. The governance structure of the organisations who participate will likely be different, so this will determine who is in the best position to answer these questions.
3. Data collection systems	• What systems/approaches are used to collect data about your clients (paper and pen, CMS, • What CMS do you use?	Depending on the service. If there is a Data Manager this will be the focus for the interview with them. However, for services who do not employ a data manager these questions might be

	• Does the CMS affect the kind or amount of data you report?	best suited for the Service Manager or CEO.
4. Data collection, collation and analysis resources	• Workforce requirements/capacity • What are the arrangements for translating individual client data to KPI summary data? • What performance measures are currently specified in your contract(s)? • How frequently do you report to funders? • What other measures do you collect for your own analysis?	CEO, COO and Data Manager
5. Funder relationship	• How many funders do you report to? • How were the adoption of the new KPIs communicated to you? • Have funders provided any support collecting and collating new data? • How are you selected as a provider (e.g. competitive tendering, other)?	CEO and COO
6. Strengths, weaknesses, issues	• What are your perceptions of the strengths and weaknesses of your data collection systems and resources? • What barriers exist for better data collection (at client, organisational and system levels)? • What are the strengths and weaknesses of your current funding arrangements? • What performance measures do you think are most relevant to your service?	All staff participating in an interview will be asked these questions

Appendix B: Focus Group Question Guide

The following information will be provided at the start of the focus groups:

Please note that the researchers will be reporting all results without attribution to any individual or organisation, however the nature of focus groups means that you will know who said what. We are asking you to observe Chatham House rules for this focus group:

- *Please respect the privacy of your fellow participants.*
- *Broad points from the discussions held in the group can be conveyed to external parties.*
- *Do not to attribute any comments made by individuals within the group, to anyone outside the group.*

Is this OK? And are there any questions?

The following is an outline of the questions that will guide the discussion in the focus groups:
The aim is to understand uptake of the KPIs by funders, and the intended and unintended consequences of the KPI implementation (including how the data are used). All questions are open-ended to encourage discussion and other ideas to emerge.

1. Firstly, let's start with your initial thoughts on standardising KPIs, from the perspective of your funding organisations.
2. How has the introduction of the new KPIs to funding contracts gone so far? We are interested in whether the KPIs have helped or hindered different aspects of your work, e.g., relationships with services, new data plans for your organisations or anything else that they might have affected.
3. How are you currently using this new data, or what are your plans for how this data will be used?
4. What are your goals for AOD treatment data, are there ways you are seeking to leverage it. How?
5. What challenges do expect to experience during this implementation of new KPIs?
6. What challenges do you see the services you fund experiencing during the implementation process?
7. Do you have any other questions or comments you'd like to raise before we finish?