

Implementation process guide

This process guide forms part of the broader suite of tools within the *In-reach rehabilitation toolkit*, designed to support services in planning, implementing, and refining in-reach rehabilitation models of care. As with all components of the toolkit, this guide is intended to be practical, adaptable, and responsive to local contexts.

The accompanying implementation checklist is intentionally non-linear. Rather than outlining a fixed set of sequential steps, it is organised into implementation domains that reflect the dynamic and iterative nature of service development. Activities within these domains often occur concurrently, may be revisited multiple times, and may commence at different stages depending on service maturity, funding opportunities, workforce availability, and organisational readiness. Services are encouraged to move flexibly between domains, using the checklist as a guide rather than a prescriptive pathway. This approach is illustrated in [Image 1](#), with each domain described in detail below.

Domain	Tasks:
Strategic planning	<ul style="list-style-type: none"> • Complete the <i>Pre-implementation reflection tool</i> to assess readiness and establish local context factors (e.g. referrals pathways). • Establish a governance structure (project sponsor, steering committee, project management office) and define reporting lines. It is recommended that this occurs through rehab departments or divisions to ensure maintenance of specialist rehab focus. Project sponsorship or service funding is specific to individual Hospital and Health Services (HHSs) and may be dependent on time specific opportunities. • Identify key stakeholders for co-design and schedule initial engagement sessions. This will likely include key referrers from acute service, sub-acute or rehab representative and consumers to ensure co-design considerations included. • The <i>In-reach Rehabilitation Model of Care</i> can provide guidance for service design and delivery and can be used as a reference or basis for establishing service plans. • Building strong relationships is essential when introducing a new service. Priority should be given to engaging and establishing connections with key identified stakeholders
Stakeholder engagement	<ul style="list-style-type: none"> • Map and engage key stakeholders (clinicians, consumers, Primary Health Networks (PHNs), community) including site relevant referrers. This can be managed with the following Queensland Health template. It may be useful to establish a working group to ensure regular scheduled discussions and a feedback process. • Consider engagement or liaison with additional relevant local stakeholders e.g. Directors of rehabilitation services or allied health disciplines to inform staffing decisions and service design. • Develop change management plan (communications, training) including communication strategies and training schedules. Refer to the Organisational Change Management Guidelines for resources and templates to support implementation. • Utilise key contact directory to contact existing in-reach services for further support or networking

Business case & funding	<ul style="list-style-type: none"> • Develop a business case using local HHS templates. This can reference or include details from the <i>In-reach Rehabilitation Toolkit</i> resources. Priorities for the business case will be dependent on local contexts and outcomes of the <i>Pre-implementation reflection tool</i>. Cost-benefit analysis and projected outcomes can be challenging given limited availability of data and challenges with projection of existing services to different service contexts. The <i>Current state analysis</i> resource may be supportive in evidence of the impact of existing services. • Once funding approval has been confirmed, allocate budget for staffing, equipment, and technology integration. It is important to account for hidden or indirect costs that may impact the budget, including recurring expenses such as patient consumables. • It is important that the budget allows for annual changes to staffing HP banding as adequate funds will be necessary to staff more senior bands within HP levels e.g. HP3.7, depending on the clinical experience of staff, and to allow for their continued progression through banding as per the respective Queensland Health Enterprise Bargaining Agreements.
Policy, standards & accreditation	<ul style="list-style-type: none"> • Review relevant Queensland Health directives and ensure compliance with Clinical Services Capability Framework (CSCF) requirements. • Map accreditation requirements with the National Safety and Quality Health Service (NSQHS) and integrate them into project timelines. Refer to the <i>In-reach Rehabilitation Toolkit</i> resources that outline alignment with these standards and with the Queensland Department of Health Strategic Plan 2025-2029. Consider additional alignment strategies for local HHS strategic plans. • Identify applicable clinical guidelines and embed them into protocols. These are likely to be specific to key clinical capabilities that are relevant for local context e.g. Stroke. • Ensure compliance with any local policies or standards unique to the HHS.
Detailed development	<ul style="list-style-type: none"> • Finalise the service model (scope, referral criteria, governance structure). The <i>In-reach Rehabilitation Model of Care document</i> can support this process. • Create a detailed project plan with milestones, risk register, and benefit register. • Draft a functional design brief for clinical spaces, equipment, and IT systems. • Establish data collection and workflow processes (refer to workflow resources, Australasian Rehabilitation Outcomes Centre (AROC) reporting.) Pre-made templates and guides are available in the <i>In-reach Rehabilitation Toolkit</i>.
Service establishment	<ul style="list-style-type: none"> • Recruit and credential the workforce; ensure orientation and competency checks. • Configure IT systems for referral pathways and data capture. • Conduct pilot testing with a small cohort and apply Plan-Do-Study-Act cycles for improvement. • Document workflows and escalation pathways for operational clarity.
Service launch	<ul style="list-style-type: none"> • Execute a go-live strategy including staff training and stakeholder communication. • Commence service launch – consider graded increase of patient packages to

	<p>ensure adequate time for onboarding.</p> <ul style="list-style-type: none"> Advertising/communication may be necessary to ensure key referrers and acute services aware of service and capacity.
Evaluation	<ul style="list-style-type: none"> Monitor performance metrics (e.g. Functional Independence Measure, Goal Attainment Scale or Patient Reported Outcome Measures) and consumer experience using the evaluation framework. Schedule evaluation checkpoints at 3-, 6-, and 12-months post-launch. Ensure evaluation checkpoints are consistent with expected reporting timeframes with service sponsors or executive teams. Contribute to AROC In-reach Pathway 2 dataset to maintain benchmarking processes with similar services. AROC in-reach membership will include invitation to the AROC In-reach Community of Practice.
Maintenance & sustainability	<ul style="list-style-type: none"> Transition governance to operational teams and embed reporting into routine structures. Reporting schedules will be dependent on funding schedules and executive expectations. Regardless of reporting schedules, regular review of service outcomes is recommended to monitor service performance and goal attainment. Ensure awareness of HHS NSQHS accreditation reviews to ensure service compliance. Embed continuous quality improvement processes and update protocols as needed. Consider participation in in-reach rehabilitation communities of practice to ensure maintenance and contribution to best practice.

Image 1 – Implementation process

