

Pre-implementation reflection tool

Before implementing an in-reach rehabilitation service, it is essential to reflect on the local context and priorities. The questions in this tool are designed to guide health services through critical considerations such as hospital size, referral pathways, workforce requirements, patient cohorts, and scope of practice. These questions are not prescriptive. The answers will vary depending on the environment, resources, and community needs. Use this tool to identify gaps, assess readiness, and tailor the implementation process to a unique setting.

Building strong relationships and maintaining flexibility are key to success. Engage stakeholders early, communicate goals clearly, and adapt strategies to fit the culture and workflows of the acute teams. Respect and collaboration will help overcome resistance and ensure the service delivers meaningful outcomes for patients and staff.

1. What is the size and type of hospital or health service?

Why this matters: The scale of the acute service influences the size and scope of the in-reach model. Benchmarking suggests approximately one in-reach package per 45–50 acute beds, but this should be adapted to local demand.

Answer: e.g. number of beds, service type etc

2. What is the current rehabilitation service capability and what are the current referral pathways for rehabilitation?

Why this matters: Understanding existing rehabilitation services and referral processes helps integrate the in-reach model into the continuum of care. Leveraging current systems (e.g., electronic referrals) can streamline workflows and strengthen relationships.

Answer: e.g. existing programs, CSCF level

3. Are there any barriers or delays in referral processes or what gaps in service delivery are you aiming to address?

Why this matters: Identifying gaps and barriers clarifies the purpose of the in-reach service and informs data collection for monitoring success. This ensures that the service addresses real needs and demonstrates value to stakeholders.

Answer: e.g. Workforce, infrastructure, patient flow or outcomes

--

4. Which patient cohorts are most impacted by these gaps?

Why this matters: Knowing which cohorts will benefit most guides workforce planning and stakeholder engagement. It also ensures that the service design reflects the needs of primary referrers and supports effective shared care. Refer to the *In-reach Rehabilitation Model of Care* for details on the condition-specific disciplines that may be supportive for specific caseloads or cohorts.

Answer: *e.g. Neurological, orthopaedic, cardiac, etc.*

5. Do you have governance structures in place for implementation?

Why this matters: Clear governance ensures accountability, alignment with organizational priorities, and sustainability. Consider the existing internal structures within the health service to ensure optimal placement of the in-reach service. Externally, consider participating in the Queensland Rehabilitation Clinical Network and the AROC, In-reach Community of Practice.

Answer: *e.g. Steering committee, sponsor*

6. What resources are available for implementation?

Why this matters: Resource availability determines feasibility and timelines. Identifying gaps early allows for proactive planning and advocacy for funding or staffing solutions. Time limited funding can be utilised for a pilot service to determine feasibility. Pending funding availability, smaller scale services can be established for the pilot period, however noting that historically services have had challenges increasing service size of breadth once established, if working effectively.

Answer: *E.g. Funding, workforce, infrastructure*

7. How will you measure success?

Why this matters: Clear success measures ensure we capture the right clinical and patient-experience outcomes from the start. Use the *in-reach model of care* to guide the core data sets required for baseline operation, along with any supplementary data relevant to your service needs. The evaluation framework outlines how to set up measures from inception. Considering the gaps and barriers identified, determine what information is needed to monitor outcomes and performance. Work with your local business team to plan your costing analysis.

Answer: *e.g. KPIs, patient outcomes, consumer experience*

8. What are the key risks associated with implementing this service?

Why this matters: Each hospital service will present individual risks that will require unique mitigation strategies. It is important to consider potential risks so that mitigation strategies are prioritised and implemented on establishment of the service. Refer to the *In-reach Rehabilitation Model of Care* for generic risks associated and consider any additional risks relevant to the local service context.

Examples: Risk: *Delayed or inconsistent referrals from acute teams, leading to low utilisation of the in-reach service.*

Risk: *Lack of dedicated workspaces, access to equipment or IT systems, slowing down service start.*

Answer:

9. What mitigation strategies can be put in place for each identified risk?

Why this matters: Some risks may not be able to be completely avoided, but it is recommended to have risk mitigation measures in place for the identified risks above. Recommendations for risk mitigation include consideration for change management principles utilising the following [resources](#).

Examples: Mitigation strategy: *Establish clear referrals criteria and workflow co-designed with the acute teams, education sessions given to referrers, attendance at regular ward rounds or MDT meetings, accessible referral via electronic referrals or in-built ieMR options.*

Mitigation strategy: *Conduct an infrastructure readiness audit early, collaborate with facilities/ICT to prioritise access to equipment, device logins and workspace, use of temporary or mobile work set-ups in initial periods, ensure adequate funding embedded into service model of equipment needs including IT.*

Answer:

10. Are there contingency plans for workforce shortages or infrastructure delays?

Why this matters: It is recommended that the in-reach rehabilitation service operates separately to both the acute and rehab service so the workforce is protected from redeployment to acute or rehab services, however this can impact on support pathways for backfill and leave cover. It is encouraged to consider embedding leave coverage in the staff budget to provide the opportunity for short-term contracts to cover extended leave or secondment opportunities. Equally, it is important to establish and maintain relationships with existing allied health, nursing and medical departments that may be involved in the release or supply of staff to fill these gaps and opportunities.

Answer:

11. Who are the key stakeholders to be involved in co-design?

Why this matters: Co-design fosters buy-in and ensures the service meets real needs. Including diverse voices strengthens cultural safety and patient-centred care. Where possible, involve consumers in co-design processes to ensure the service is targeted at the needs of the local demographic, in addition to maintaining the *NSQHS Standard: Partnering with Consumers*. Key stakeholders are likely to include clinical representatives from acute and rehab services e.g. nurse unit managers, ward leads or discipline leads. Representative from senior leadership and executive streams could also be considered including department heads and directors. Depending on needs of your local area, consider including Aboriginal and Torres Strait Islander services or multicultural nurse navigators. Consumer and community representatives can also contribute to provide diverse perspectives and a holistic lens.

Answer:

12. How will you engage these stakeholders throughout planning and implementation?

Why this matters: Engagement should be ongoing, not one-off. Regular communication, workshops, and feedback loops build trust and shared ownership. The nature of this will be specific to the local service and the preference of the key stakeholders.

Answer:

13. Have you considered First Nations representation and consumer voice in local design?

Why this matters: Cultural safety is critical. Including First Nations perspectives ensures care is respectful and responsive to community needs. Considerations should be made for the demographics of the hospital service to inform the decision to include First Nations Support Officers within the in-reach workforce or pathways to build relationships with established services e.g. Liaison Office or First Nations Nurse Navigators.

Answer:

14. How will you build relationships and trust with acute teams?

Why this matters: Building trust with acute teams begins by listening and understanding their priorities. Consider attendance at ward rounds and case conferences to learn their workflows and challenges. Aim to position the in-reach service as a partner that supports their goals, such as improving patient flow and reducing length of stay. Visibility can be maintained by providing regular updates on patient progress and outcomes and demonstrate respect by adapting your processes to complement existing routines rather than disrupt them. Over time, consistent collaboration and transparency will foster mutual trust.

Answer:

15. What strategies will you use to manage resistance and communicate goals clearly?

Why this matters: Resistance is a natural part of change, so proactive communication is essential. Tailor the message to the audience to consider their priorities, e.g. some teams may value efficiency and discharge planning, while other teams may prioritise patient safety and workload balance. Use both data and patient stories to illustrate the benefits of the service. Adjust the level of assertiveness depending on the team's culture and identify influential clinicians who can act as champions for the model. Above all, be transparent about the purpose of the service and invite feedback early and often to build shared ownership.

Answer: