Design a way into care

Start with people who need primary care and cannot reach it. Build one practical change around their experience. Use aggregate counts and planning details. Leave names and personal medical information off this sheet.

1. Define the access gap

Who is seeking care, and where do people first encounter the barrier? Compare travel, waiting time or availability with a published source or local baseline. A clinic list misses people who have never made it through the door.

Who is missing, what blocks access, and what evidence supports that judgment?

2. Design one change together

The advanced practice nurse convenes the Covenant Table. Name the local clinical lead, the colleague available for private psychological or psychosocial support, and the specialist who can advise remotely. Agree with residents and community health workers on one decision they can make. Specify consent, supervision, referral and a backup when the connection fails.

One change, the decision residents can change, who can commit resources, and who responds

Clinical and specialist roles, private support, referral and backup arrangements

Measure who gains access

Choose a local deadline and comparison before the pilot begins. A booking, an answered call and a completed clinical assessment tell you three different things. Track what people actually receive.

3. Define access and timeliness

For first access, count each eligible person seeking a first assessment in the observation period, including people outside the clinic roster. Count how many complete an assessment by the agreed deadline. Separately, for follow-up, count each eligible person once at the first return due. Exclude people with no return due from that calculation.

Eligibility, deadline, comparison and counts for first access and for follow-up

How will you find requests outside the clinic and verify each completed assessment?

4. Account for people missing from the record

Count a transfer as timely only when the receiving clinician confirms completion by the deadline. Separate late, missed and unknown outcomes. Keep unknown outcomes in the relevant denominator. For each measure, show a second estimate assuming everyone with an unknown outcome completed care on time.

Counts on time, late, missed or unknown and how the second estimate changes the result

Whose needs remain unseen, and how can residents check the count?

Decide what can last

Better access should mean something to the people doing the travelling and to the team that stays open. Agree on a review date, a person responsible for the decision and a way to report back to residents.

5. Count the work and cost

Compare patient travel, waits and access to psychological support among people who wanted it. Count paid outreach, clinical coverage, specialist time, interpretation, private space and connectivity. Track the wait for other patients and separate startup costs from recurring costs per completed first assessment.

Changes in travel, waits, requested support and workload shifted to other people

Startup and recurring costs, funding sources and who covers the next shift

6. Set a decision rule

Set a meaningful access gain, an acceptable cost and a burden that would require a change. Name the group that can continue, revise or stop the service. Record the strength of the comparison and other possible explanations before attributing an improvement to the pilot.

Threshold for continuing, revising or stopping and the evidence still needed

Who decides with residents, and when and how will they hear the result?