

Insights Report - Primary Care Access Evaluation

NOVEMBER 2023 – REPORT 3

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Overview of insights reports

Purpose

The purpose of the insights reports is to provide early insights during implementation of the Primary Care Access project (PCA) and to inform continuous quality improvement (CQI) activities, and PCA service development.

The reports will provide reflections on implementation, trends and early outcomes which will be drawn from available program and service monitoring data and evaluation data. Refer to the PCA Evaluation plan for an overview of proposed evaluation data sources.

Each insight report will have a key focus topic, which is determined in consultation with HNC PCA and The George Institute for Global Health (TGI). The reports will also identify areas for future inquiry and suggest recommendations for program implementation and evaluation going forward.

Audience

The reports will be prepared by the TGI and presented to Healthy North Coast (HNC). The reports are intended to provide updates on the program, and inform and guide discussion with the below program stakeholders:

- PCA Reference Group
- Amplar Health and Pharmaceutical Society of Australia
- Local Aboriginal Community Controlled Health Organisations
- Participating GPs and Pharmacies
- Stakeholders of HNC – e.g. Urgent Care Providers, LHDs, policy makers
- Primary healthcare sector
- Healthdirect Australia
- Primary healthcare funders including Commonwealth and State Governments

Reporting timelines

Insights reports will be prepared at 6-monthly intervals during the evaluation period. The reporting will be timed to coincide with the quarterly meetings of the Evaluation and data working group and PCA Reference group. Reports will be submitted in advance of these meetings to enable reflection and discussion.

Insights Report 3 – Nov 2023

Focus of this insights report

This focus of this report is to provide an overview of urgent care services/clinics in Australia and to summarise key learnings and considerations from existing models internationally to help understand the potential impacts for primary care access and the delivery of NCHC.

The information will provide a high-level overview of the topic for PCA project and is not intended as a comprehensive policy briefing.

The report covers and overview of:

- the policy setting for urgent care in Australia
- the proposed government funded urgent care services (State) and urgent care clinics (Federal) in Australia and in Northern NSW, highlighting variations in mode of delivery (as of November 2023).
- the potential impact of
 - urgent care services on primary care – including NCHC and emergency services
 - centralised access via a digital front door
 - opportunities and threats for NCHC

Methods and data sources

This report draws on information gathered through a rapid document review which included both peer-reviewed journal articles and grey literature sources.

- **Peer reviewed literature** was rapidly searched to identify any key studies evaluating urgent care models in international settings, alongside systematic reviews of the evidence for these models, and any discussion pieces relating to urgent care in Australia. At the time of the review there were no published evaluations of these models in the Australian setting due to their emerging nature.
- **Grey literature sources** were searched to fill information gaps in the context of the emerging models in Australia. These sources included government reports/releases, websites, and information provided from HNC PHN Urgent Care Commissioning team in relation to proposed local UCC/UCS in the region.

The information was current as at the 30 November 2023.

1. Overview - Policy setting for urgent care in Australia

Increasing demand for health care

Rapidly increasing demand for emergency department (ED) services as compared to capacity is one of the major challenges for Australia's health system. In 2020-21 and 2021-2022, over 8.8 million people presented at EDs across Australia, the highest number ever recorded.[1] Between 2019–20 and 2020–21, despite restrictions due to the ongoing COVID-19 pandemic, there was a 6.9% increase in the number of presentations, relative to a 3.2% annual growth in the five years prior to the commencement of the COVID-19 pandemic.[2]

Growing numbers of people are presenting to EDs with conditions that could potentially be managed by a primary care provider.[3] Last year, one third of all ED presentations were potentially able to be managed in another health setting.[3] The pressure on hospitals with increased waiting times and time spent in EDs[1], provides a compelling justification to develop alternative models of care in the community for urgent care services.

What is urgent care?

Urgent care refers to medical care for urgent conditions that are not considered life-threatening.[4] The implementation of such services has potential to reduce health system costs, improve performance of the acute care system and most importantly improve patient experience.[5]

This problem of low acuity ED presentations that are manageable in primary care is one that is recognised by both Australian Federal and State Governments with different models of care delivered across the years.

Table 1 provides a brief overview in the delivery and functions of several different models of urgent care including after-hours GPs, urgent care clinics, urgent care services in comparison to traditional emergency department care. This table was adapted from findings presented by Adie et al. (2021) [6] and supplemented with new information gathered in this review.

Table 1: Overview of the delivery and functions of urgent care models

	After Hours-GP*	UCC*	UCS	ED*
Opening hours*	0800-1200	0800-2000 (recommended) 0900-1630 (Adie et al)	0800-2000 (NSW Health)	24 hrs
Weekend	Yes	Yes	Yes	Yes
Walk In	Variable	Yes	Yes	Yes
Booking	Variable	Variable	Variable	Not available
Triage Line	Not available	Not available	Some	Not available
Staff*	One doctor, one nurse, one reception	One doctor, one nurse, one reception		Emergency physicians, GPs, medical officers, nurse practitioners, registered nurses, allied health, social workers
Qualification of lead clinicians*	FRACGP	FRNZCUC, FRACGP	FRNZCUC, FRACGP	FACEM
Radiology onsite*	Not available on site	Available	Available	X-ray, ultrasound, CT-Scan
Pathology on site*	Available	Available	Available	Available
Short stay unit*	Not available	Not available	Variable	Available
Acute medical and surgical beds*	Not available	Not available	Not available	Not available
Other relevant services*	General practice	General practice	General practice	Non-GP specialty services
Ambulance referrals*	Not encouraged	Not encouraged	Not encouraged	Yes
Integration with the GPs and health system	Yes	In some practices	In some practices	No
Focus on equity groups[#]	N/A	Yes (Goal)	Not reported	Not reported

*Adapted from Adie et al.[6]; [#]Aboriginal and Torres Strait Islander people, young people and people living in targeted geographic areas; Note: Generalisations were undertaken and there is variability across practices.

2. Overview –Urgent care services in Australia

What are the different models of urgent care?

This section will provide an overview of the objectives and scope of various urgent care models in Australia, with a specific focus on the proposed Urgent Care Clinics (funded by Federal Government) and Urgent Care Services/Priority Care Centres (funded by NSW State Government) as well as services delivered in other jurisdictions. It will also provide a brief overview of the role of Healthdirect in supporting urgent care.

► Medicare Urgent Care Clinics (UCCs)

Urgent care clinics are medical clinics equipped and staffed to treat urgent but non-life-threatening illnesses and injuries. They were designed similar to the New Zealand model to “reduce pressure on hospitals and emergency departments, allowing them to focus on higher urgency and life-threatening conditions” and funded by the Federal Government to “complement existing state run initiatives”.^[7] In the 2023-24 May Budget, the Australian Government announced \$358.5 million worth of funding over five years for “Medicare Urgent Care Clinics”, with 58 UCCs established by the end of 2023. At the time of reporting, 33 are currently in operation.^[7]

The Medicare UCCs are fully bulk billed and are recruited from existing GP clinics, community health centres and Aboriginal Community Controlled Health Services. They are expected to open for extended hours, 7 days a week and offer walk-in care though there is variation across currently operating practices on their hours of operation. Some of them provide a booking service via phone or online. Nurse-led triage (like in the ED) is done on the spot upon presentation.

For current list of Urgent Care Clinics operating visit <https://www.health.gov.au/our-work/medicare-urgent-care-clinics/find-a-medicare-urgent-care-clinic-near-you>

► NSW Urgent Care Services (UCSs)

In NSW, urgent care is defined as medical attention that is required within 2-12 hours for a non-life-threatening illness or injury. An Urgent Care Service is a health service that provides short-term, one-off episodes of care for urgent but non-life-threatening health care needs and is not an emergency department. ^[8] One such site in Western Sydney presented this in lay terms as “They aren’t like your usual GP and they’re not emergency departments. They are something in between”.^[4]

The NSW government has committed \$124 million in funding over two years to deliver 25 Urgent Care Services in NSW by mid-2025.

► Other examples of state-level Urgent Care Service models

In Victoria, “Priority Primary Care Centres” (PPCCs) are intended to fulfil a similar function to NSW UCCs. These are staffed by GPs in partnership with nearby EDs. Existing GP clinics within 5km (metro) and 10km (regional) of target EDs were selected and designed as PPCCs. Patients without a Medicare card are able to access PPCCs free of charge.^[9]

In South Australia, UCS (called Priority Care Centres) have been established in 5 sites in Adelaide (Marion, Elizabeth, Para Hills West, Hindmarsh, and Mount Barker). They are led by GPs and supported by South Australia Health hospital trained nurses.^[10]

In Western Australia, a different model called the GP Urgent Care Network was implemented through an 18-month pilot program in September 2019. The Network included more than 125 GP practices across the State. These practices were to be supported through a comprehensive advertising campaign aimed to raise awareness of the types of conditions that the GP Urgent Care Clinic Network can treat, and through upskilling of GPs to manage UC conditions. The entry point is online and via booking via Healthdirect with the possibility of same day appointments. All GP Urgent Care Clinics in the pilot were to have access to pathology and radiology services. They will also include fully equipped treatment rooms to apply sutures, plastering and conduct minor procedures.^[11] While this pilot was established in 2019, our rapid review of the literature did not identify an evaluation of this pilot or what was learnt from its’ implementation. The WA government

had also previously funded St John’s to deliver Urgent Care Services in a small number of practices. [12]

► Proposed models for Urgent Care in the north coast NSW region

The following information was provided by HNC Urgent Care Commissioning teams and is current as of November 2023. The information is limited as these services are still in infancy at planning and operationalisation stages. Figure 1 provides a brief overview of planned UCS and UCC in the Healthy North Coast region.



Figure 1: Overview of proposed urgent care facilities in Healthy North Coast region

There will be two Medicare Urgent Care clinics commissioned by HNC/Commonwealth. They will each be located in larger towns (Coffs Harbour and Lismore) across both of the Local Health District catchments. These locations were identified through a needs assessment and scoping of the local health service landscape. These services will be co-located at existing GP clinic locations and offer extended opening hours, including evenings and weekends. The services will start operations by the end of 2023.

In addition, two state funded UCSs are planned for the region, with one being delivered by each LHD. Information into the proposed models is currently limited. Mid North Coast LHD is proposing an expansion of their current virtual care services with linkages to local services. Northern NSW LHD is proposing a paramedic outreach service which will be located in Tweed Heads.

How will Healthdirect be used to support the delivery of, and access to, urgent care clinics and services?

Healthdirect offers support to reach UCSs through their phone service and website.

The Healthdirect helpline is available to call for free, 24 hours a day, 7 days a week on 1800 022 222. Callers speak with a registered nurse who asks questions about their condition and then if suitable will guide the patients to UCSs, including support in booking an appointment at a local UCS in certain areas.[8]

All Medicare UCCs are listed in the Healthdirect website, even if they don’t have an online booking option. In NSW, Tasmania, Victoria and WA users are able to use a step-by-step process to search for their closest UCCs.[13]

3. Impact assessment

This section summarises key studies from peer reviewed literature and evaluations reporting on urgent care services, including local and international models. It will highlight important learnings and considerations of the potential impacts, opportunities and threats that urgent care services can have for the health system.

Possible impacts of urgent care services on access to health services

► Primary care services

There is limited evidence assessing the impact of urgent care models on primary care. Most studies have focused on understanding the impact of urgent care models on reducing demand on EDs.

There is potential for urgent care services to improve some functions of primary care access, for example by increasing access to the first point of contact, due to the proposed extended hours and (in Australia) bulk billing availability. This would be particularly important in contexts where out of pocket costs and/or timing of service delivery (e.g. after hours) are known barriers to access. Some have postulated that the availability of these new services could stimulate overall demand for healthcare rather than contribute to demand reduction.[14]

The HNC PCA baseline theory of change hypothesised that if demand on usual GP practices is reduced through appropriate triage by NCHC, then available appointments would be able to be redirected toward usual care and unplanned care, thus increasing access to primary care for those with immediate needs. However, there was a risk identified, that without a new influx of GP workforce and/or task shifting to nurses/ other providers, the capacity to deliver primary care services in the region would not change.

It is also expected that demand for urgent care services will fluctuate in the region due to seasonal illness, influx of holiday makers, and service operating hours, and thus there may be challenges in maintaining an optimal balance between supply and demand.

► Emergency Departments

There are several ways in which urgent care service may influence ED use. Urgent care services may offer patients another place to go before they reach EDs. For example, an evaluation of a GP after-hours access program in the Lower Hunter region of NSW from 2015, reported that 61 per cent of respondents said they would have attended an ED if the service had not been available.[15]

In other settings, urgent/rapid care services have served as a place to divert and outwardly refer from EDs. In July and September of 2020, Northern Adelaide Priority Care Centres received 20 per cent of category 4 and 5 ED presentations, which had been referred from the Northern Adelaide Local Health Network ED.[16] In Northern Sydney, rapid care pathways for elderly people with low acuity conditions have been developed as part of the NSW Health Collaborative Commissioning policy. Modelling of these pathways predicts that a 10-125% reduction in ED presentations for this population in Northern Sydney could be achievable from these new services.[17] Since these are relatively new services in Australia, the longer term impacts and influences of these services on primary care is not yet known, and a long term view should be taken to observe any changes in patient and system behaviour, such as supply and demand, and understand the sustainability and impact of these services.

In New Zealand urgent care centres have been implemented since the 1980s, and these models informed the development of Australia's UCC model. Thus, these centres can provide insights into the potential impacts of longer established services, compared to those in early implementation phases. New Zealand has one of the lowest rates of ED presentations in the world, and throughout the country, ED presentations appear to be significantly lower in areas where urgent care centres are available.[18] New Zealand's urgent care centres are staffed by medical staff who are trained in urgent care to treat minor illnesses, injuries and infections.[18] In addition to the training, New Zealand urgent care centres are governed as a medical speciality, with a clinical branch in its own medical college.[18]

Possible impacts of centralisation of access

Digital support services, such as NCHC or Healthdirect, can offer a centralised access point for patients seeking care and act as a 'a digital front door'. The rapid review of literature identified several evaluations of similar service designs which have sought to assess impacts of centralised access on health system efficiencies and effectiveness, and acceptability for patients and health care providers.

► System efficiencies and effectiveness

Two services that provide centralisation of access to urgent care services are the United Kingdom's digital and telephone triage services, NHS 111 (pre-2020) and NHS 111 First (2020 onwards). The main differentiator between the two services is the availability of an online urgent care triage and assessment system in the latter (111 First). 111 First offers direct booking for patients needing ED or urgent care into same-day arrival time slots.[19] Whereas, NHS 111 pre-2020 is a 24 hours 7 days a week telephone service for non-emergency health problems, operated by trained non-clinical call handlers with clinical support from nurse advisors, using NHS Pathways software to triage calls to different services and home care.[19]

One before-after study in England observing attendances at NHS111 with 4 pilot sites with 3 control sites reported that after the first year of operation, NHS 111 did not deliver the expected system benefits of a reduction in calls to the ambulance service (999) or diversion of patients to urgent rather than emergency care. They reported there was a potential that the service had unintended consequences of increasing overall demand for urgent care.[19]

Inaccuracies in triage particularly when undertaken by non-clinical call handlers has been previously reported. A study of NHS111 reviewed the accuracy of triage by non-clinical call handlers using a digital pathways tool for calls identified with 'urgent' outcomes, finding that of the 12% of these calls needed to be upgraded after clinician triage, and 74% of calls were downgraded. Notably, 92% (n = 33 394) of calls classified at primary triage as needing clinical attention within 1 hour were downgraded.[20] Additionally, if a triage line is to be effective, callers need to follow the recommended advice. A further study also of the NHS 111 service [21] found that 11% (n = 289,748) of patients attended the ED when they had been advised to self-care or seek primary care. Of those who presented at ED, a considerable number were further classed as meeting urgent needs (88%, n = 255,931); and a substantial minority (37%, 106,207) were subsequently admitted to hospital. Furthermore, the study identified that a significant proportion of patients who were sent an ambulance or told to attend ED were later classified as non-urgent upon attending ED (9%, n = 42,372). These studies taken together suggest that this service model based on non-clinical call handlers supported by algorithms may possibly present an inefficiency for resource allocation.

► Patient Experience

A study of NHS 111 reported that half of the population surveyed had previously heard of the service, with 9% having used it in the past 9 months[22, 23] Another study found that prior to calling, 22% reported contacting other health care services [24] and the service did not meet call answering time targets[25]. Most callers (89%) reported being more confident with receiving urgent care advice from the service than their own GPs [24].

► Provider Experiences

The roll out of NHS 111 in the UK entailed significant human resource substitution from nurses to non-clinical staff in the UK. Providers had mixed views about the service. [25] Some providers feel the system used by the service ('NHS Pathways') which guides the decision making is risk adverse.[19] Urgent Care clinicians also reported that they had infrequently used the NHS 111 call summary information because it was regarded as limited, in a format that is difficult to access, or they don't trust it. UCC clinicians voiced concerns about who is making decisions on NHS 111 (non-clinicians, as compared to clinicians) and this fostered tension between these groups.[26]

Some providers have expressed views that NHS 111 First (that includes an online triage and direct booking function) created an erroneous perception among patients that by booking via the line they would be seen immediately at the service upon presentation rather than needing to undergo local triage processes at the recommended service.[26]

Opportunities and Threats for NCHC

An assessment of the literature has identified several opportunities and threats for NCHC which may arise following introduction of urgent care services. Tables 2 and 3 present a summary of key opportunities and threats i) for patients as the end users of these service and ii) following the introduction of urgent care facilities.

Table 2: Summary of key findings from literature on opportunities and threats for patients and end-users of NCHC

Patient, end-users	Opportunity/Threat
Patients may face confusion about too many healthcare choices.[27] Additionally different levels of 'urgency' are not well understood by patients.[28]	Threat
Patients may face anxiety about waiting for care without knowing/understanding why, since not all users confident to ask about next steps in care, and could divert to UC or ED instead of waiting for recommended lower tiered care.[28]	Threat
Patients will have improved ease and access to primary care appointments and enhanced information about any delays.[29]	Opportunity Opportunity for NCHC brokerage model
Patients 'gaming the system' to reach appointments faster. The literature also identified there should be consideration of a balance those seeking a quicker appointments when their GP has a longer wait, and also those who do not have access to a regular GP and require non immediate care but may still be considered urgent.[19, 27]	Threat Opportunity for NCHC brokerage to introduce and help patients engage with new GP services
Communication and transfer of patient information to and from other services has been suboptimal and UCCs have not been systematically designed to interface with other services to support patient flow.[30] Patients may have frustration with different medical records and having to repeat key information such as medications, allergies, to different providers at each point of contact, (i.e. GP, hospital, UC).[28]	Threat Opportunity for NCHC warm transfer or use e-referrals
Contributing to inequities and priority groups being left behind. Currently no Medicare UCCs have been established within or partnering with Aboriginal Health Services. Services locations may not have been designed to prioritise HNC target groups or younger populations, priority SA3, or Aboriginal and Torres Strait Islander people. Lower population density in some areas may make UCCs/UCSs unviable due to low through put.	Threat Opportunity for NCHC brokerage model
Patient expectations of fees charged for services at UC centres. Emerging findings from Australian services has identified that patients are being charged out of pocket costs for 'non-urgent' presentations to urgent care services but had expected the service to bulk bill. Additionally patients might expect similar of out of pocket costs for ED or UC.[31]	Threat for UC Opportunity for NCHC brokerage model

Table 3: Summary of key findings from literature on opportunities and threats for NCHC following introduction of UC facilities

Introduction of UC facilities	Opportunity/Threat
UCs can improve patient flow, and appropriate escalation of care by providing another avenue for patients to reach care for acute needs.[30]	Opportunity
UCs will offer dedicated staff with sufficient knowledge, skills and confidence to manage UC workloads. However, the literature suggests that some staff may lack confidence and/or skills to meet UC needs. For example, common paediatric scenarios have been found to challenge UCC providers – acutely ill, minor TBI, uncooperative children.[32] Other studies found GPs had to adjust their skills to suit UC, with more presentations of trauma and the acutely unwell.[33]	Threats for over referral to ED and also consumer confidence and trust in NCHC recommendation to attend UC instead of ED
Adequate staffing levels of UCs would ensure patients can be seen appropriately and in a timely way. Some studies identified that UCs found it hard to balance workload presented from referrals from the urgent care line and walk ins[26], and that staffing level needs to be increased during peak periods to improve UC outcomes.[34]	Opportunity for integration Opportunity for NCHC and PCA referral, consumer confidence Opportunity to explore feasibility of 2-way referral and communication between NCHC and UCCs/UCSs
UC clinicians may disagree with the appropriateness of referrals coming from NCHC or Healthdirect, as observed in NHS111.[26] The literature identified in some UCs that GP/Nurse practitioner relationships took time to develop and to overcome historical hierarchy/culture. Eventually, GPs felt Nurse Practitioner provided safe and effective care.[33]	Threat to provider trust and local integration of NCHC and other services

4. Insights

Throughout this report, insights have been presented as learnings identified in the literature. In this section questions and considerations are posed for the HNC PCA Reference group, and service implementers to reflect on.

What are the priorities for integration and collaboration?

- How might UCSs influence the use of the current urgent brokerage model and NCHC services? e.g. areas with UCSs close by, patient walk-ins, and among priority groups
- Can UCSs be informed about the NCHC service and brokerage offerings to support escalation/de-escalation of patients, e.g. when patients present for same day appointments but are not eligible for ‘urgent care’ or bulk billed appointments
- How can services collaborate to improve and support effective communication about patients transferred to and from other services? i.e. UC literature suggests this has been suboptimal
- How can monitoring of NCHC triage outcomes and referral patterns be used to support UCSs in planning for staffing/peak periods?

How could the NCHC bottom-up service model design and access for priority groups be impacted?

- The purpose of UCSs is to divert patients from ED, but are not necessarily intended to improve overall PC access. How can PCA project leverage these goals while still prioritising the intended functions of PCA?
- PCA priority groups (under 35’s, Aboriginal people, priority LGAs) are not explicitly mentioned across all policy and guidance documents for UCS and UCC. How can PCA continue to prioritise and support these populations?
- How does the proposed UCS and UCC sites align with coverage for SA3, and populations of young people and Aboriginal and Torres Strait Islander people?

What operational changes for NCHC could be adopted within the service scope?

- How could NCHC integrate with UC to support current service gaps identified so far? E.g. Out of hours/weekends, locations and availability of brokerage?

Concluding comments

This report has gathered information from the peer reviewed and grey literature to provide an overview of urgent care and centralised digital access services. It has highlighted some key learnings and consideration from evaluations of current models in Australia and internationally to inform possible impacts, opportunities and threats for the HNC PCA project.

Information should be interpreted with an understanding that the policy landscape and implementation of urgent care services is rapidly evolving. This was a rapid, but not comprehensive review, with information current as of November 2023.

The report is intended to inform discussion and continuous quality improvement activities within the PCA project. Reflections and any comments on the data or other topics can be explored in future insights reports and evaluation activities.

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