Comparing evolving Australian urgent care clinic models to other established Western models

John W Adie, Nigel Barr, Nicole Masters, Michelle Murphy, Ben Adie

Background
Quality, safety and operational excellence are essential to the success of urgent care clinic (UCC) models. This is part two of a survey study that explores operational and service delivery challenges and insights from the perspective of doctors working within the UCC setting.

Objective
To explore a range of operational practices of UCCs in Australia.

Methods
A convenience sample of doctors working in UCCs since 1 July 2023 were invited to participate in an online survey. This was advertised through The Royal Australian College of General Practitioners (RACGP), The Royal New Zealand College of Urgent Care (RNZCUC), corporate general practices, UCC peer groups and LinkedIn.

Results
To identify 11 key operational themes, 52 responses were analysed. Themes included clinic location, opening hours, imaging options, availability of radiology services, referral sources, staffing models (including doctors and nurse practitioners), practitioner-to-nurse ratio, Schedule 8 medication storage, onsite services and equipment, triage process and a surge management plan.

Discussion
Findings were compared with practices in other Western countries. This study highlights the potential for national standards to address unwarranted variation in health care delivery in Australian UCCs.

SINCE 2019, AUSTRALIA HAS SEEN a significant investment in general practitioner (GP)-led urgent care clinic (UCC) models for the management of non-life-threatening urgent conditions (NLTUCs).[1] UCCs manage predominantly minor illnesses and injuries.[2–4] Infections are defined as patient presentations with International Statistical Classification of Diseases (ICD)-10 A00–B99 categories and infections from other ICD-10 groups, while injuries correspond to patient presentations with ICD-10 S00–T88 categories.[5] In Australia, the largest model is the federally funded Medicare UCC model, with 137 UCCs in total planned to be open across all states and territories by the end of the 2025–26 financial year.[6] In addition, there are state funded Priority Primary Care Centres (Victoria) (n = 11), Urgent Care Services (New South Wales) (n = 10), Priority Care Centres (South Australia) (n = 5) and St John Urgent Care (Western Australia) (n = 6), alongside a number of privately operated services.[1,7,8]

Ensuring quality, safety and operational excellence is essential to the success of UCCs. This study represents the second part of a national survey study of doctors working in Australian UCCs. The first paper[7] focused on concerns raised by doctors related to capacity, accreditation standard, qualifications and experience of doctors and nurse practitioners (NPs), training, funding and public education. This paper focuses on operational issues and compares practice in Australia with other Western UCC models.

Many Western countries have well established UCC models from which Australia can draw insight. These include the US,[3] New Zealand (NZ), and the UK.[9] Common features of these international models include extended opening hours, walk-in availability, onsite radiology services, as well as standards for accreditation, and, certification, often overseen by independent regulatory bodies.[9] Each of these international models reflect differing priorities and approaches for delivering urgent care, providing a basis for comparative analysis and policy development in the Australian context.

UCC models provide patients presenting with NLTUCs an alternative option to presenting to an emergency department (ED) when presentation to a GP is not available. However, there are differences as to how this is achieved. In the US, most UCCs are hospital owned or in joint ventures with hospitals (52%), and most are community based, either in a shopping centre, a retail strip mall (46%) or freestanding (29%).[10] England's model of UCCs are increasingly expected to be co-located with EDs.[4] In Australia, many UCCs are co-located with integrated primary care centres (IPCCs).[1]

International models have an UCC standard,[11–13] vocational training and vocational registration,[11,14,15] whereas Australian models do not. UCC standards guide UCC practice for operational issues such as opening hours, requirements for imaging, referral pathways and staffing, including the role of NPs and paramedics, as part of an appropriate multidisciplinary workforce supporting a senior clinical leader.[11,12,14] Comparison of evolving Australian UCC models with established Western UCC networks could help inform the development of specific UCC standards and vocational training in Australia.

Objective

This survey explores a range of operational practices of UCCs in Australia to demonstrate inconsistencies of practice and encourage the formation of a UCC standard in Australia.

Methods

This project was explored using survey methods chosen to gain lived experience insights from doctors working in UCCs, particularly as no aggregated databases of services currently exist. The methods have been described previously.[7] Doctors were chosen for two reasons; first, the authors could leverage existing special interest groups to promote participant numbers, and second, the research was exploratory to determine breadth of models and not to quantify the proportion of each.

Questionnaire design

The survey instrument was custom designed because no validated questionnaires were identified that were able to be used in this study. The basis for this questionnaire included literature reviews in a PhD thesis,[16] known UCC models from Western countries,[17] and issues identified in UCCs by the authors. The 22 items in the survey included categorical and open-ended questions that identified emergent or a priori items (Table 1). From the 22 items, 18 themes were identified. The initial 12 items and corresponding eight themes related more to performance of medical doctors who work in UCCs and have been discussed in a previous article.[7] In addition to the item and theme of location, repeated from the previous article, 10 further items and themes will be discussed. Participants were recruited using convenience sampling through a professional body membership database, and the survey was administered through Qualtrics.[7,18] The first paper explored eight themes. These related to 'perceptions of medical doctors working in Australian UCCs with the goal of formulating solutions to concerns raised by participants'.[7]

Questionnaire review

The survey was piloted by three GPs with experience. One was also a public health physician and senior federal government health sector bureaucrat. Changes to the survey were based on their feedback, which included suggestions on content, face validity and functionality. The survey was presented and disseminated to members of The Royal Australian College of General Practitioners (RACGP) 'Urgent and emergency presentations to primary care' (UEPPC) Specific Interest Group (SIG) on 17 October 2023.

Sampling

The method used to sample medical doctors with expertise in UCC models

Table 1. Variable groups and question details in 'Doctor-led Urgent Care Models in Australia'[A]

Item	Variable groups	Details
1	Location (state or territory) of employment	1 question, categorical, 9 options
2	Opening hours of UCC	3 questions, open-ended
3	Imaging options	1 question, categorical, 5 options plus comments (multiple options allowed)
4	Availability of radiology including X-ray, ultrasound scan and CT scan – weekdays, weekends and public holidays	9 questions, open-ended
5	Referral sources	1 question, categorical, 11 options plus comments (multiple options allowed)
6	Numbers of doctors and nurse practitioners working – weekdays, weekends and public holidays	3 questions, open-ended
7	Practitioner (doctor/nurse practitioner) to nurse ratio aimed for over 7 days	1 question, categorical, 11 options
8	Schedule 8 medication storage	1 question, categorical, 4 options plus comments (multiple options allowed)
9	Onsite clinics or equipment	1 question, categorical, 7 options (multiple options allowed)
10	Triage process	1 question, categorical, 5 options plus comments (multiple options allowed)
11	Surge plan	1 question, categorical, 5 options plus comments (multiple options allowed)

[A]A copy of the questionnaire, with answers, can be obtained by contacting the authors.

CT scan, computed tomography scan; UCC, urgent care clinic.

Table 2. Themes and details of responses for 'Doctor-led Urgent Care Models in Australia'

Item	Theme	Type of question	No. responses
1	Location	Categorical	49
2	Opening hours of UCC – weekdays, weekends and public holidays	Open-ended	50, 49, 49
3	Imaging options	Categorical	114
4	Availability of radiology – X-ray, ultrasound scan and CT scan	Open-ended	31, 24, 20 (weekdays); 29, 18, 17 (weekends); 24, 13, 12 (public holidays)
5	Referral sources	Categorical	240
6	Doctors and NPs working weekdays, weekends and public holidays	Open-ended	80, 80, 76
7	Practitioner (doctor and NP) to nurse ratio	Categorical	49
8	Schedule 8 medication storage	Categorical	52
9	Onsite services and equipment	Categorical	73
10	Triage process	Categorical	54
11	Surge plan	Categorical	61

CT scan, computed tomography scan; NP, nurse practitioner; UCC, urgent care clinic.

was anonymous convenience sampling of doctors who had worked in UCC models in Australia since 1 July 2023, when the first Medicare UCCs opened. This online survey was administered through Qualtrics[18] and the invitation to doctors to participate was done in six ways: (a) RACGP UEPPC SIG newsletters (emailed every 4 months); (b) Royal New Zealand College of Urgent Care (RNZCUC) 'Australian Faculty' newsletters (emailed every 4 months); (c) emails sent to medical doctors working in two corporate general practices with UCCs; (d) emails sent to two UCC peer review groups; (e) emails sent to Primary Health Networks (PHNs) related to the overseeing of UCCs; and (f) a LinkedIn invitation sent on 26 April 2024. Doctors could participate in the study between 2 September 2023 and 5 June 2024, after which the study was closed because no further results had been received for 30 days and successive attempts at advertising the study were resulting in few extra survey completions. At the time of the study there were 50 federal UCCs opened or opening, with a further 27 promised. In 2025, a further 50 UCCs were committed to bringing the total number to 137 UCCs.[6] There were also state funded and private UCCs operational where doctors working in these settings could participate in the study.

Data analysis

Descriptive analysis was performed on the numerical data. For textual data, thematic analysis was used to discover themes within the data.[18]

Ethics

Ethics approval was provided by The University of the Sunshine Coast Human Research Ethics Committee (A232000).

Results

The online survey had a total of 52 doctors who completed it. In this second paper, 11 new themes arose from three open-ended and eight closed questions (Table 1). The themes deemed to be operational issues are the basis of this study. Response rates to each question varied, with lower response rates for the categorical questions than the questions that were open-ended (Table 2). The numerical data was summarised and displayed as descriptive statistics (Tables 1–5). The items listed are the survey questions. Themes were then developed from the textual responses to the items using thematic analysis[19] to explore the perceptions of the participants. Each of the 11 themes are presented below.

Location

The six states worked in by respondents were Queensland (n = 14, 29%), Tasmania (n = 9, 18%), New South Wales (n = 8, 16%), Victoria or South Australia (both n = 7, 14%), and Western Australia (n = 3, 6%). Most participants worked in state (47%) and federal government funded (41%) UCCs. Some (9%) worked in private UCCs. One UCC was both federally and state funded (1%), others did not know.

Opening hours

There were 20 different opening hours of UCCs on weekdays, weekends and public holidays (Table 3). The most common opening hours were 8 am to 8 pm (40% on weekdays, 40.8% on weekends and 32.7% on public holidays). The next most common was 8 am to 10 pm (14% on weekdays, 12.2% on weekends and 12.2% on public holidays). Two UCCs were open 24 hours per day, one was closed weekends, and four were closed on public holidays.

Table 3. Opening hours of urgent care clinics weekdays, weekends and public holidays

	Hours open	Weekdays	Weekends	Public holidays
1	8.00 am – 4.00 pm		1	1
2	8.00 am – 6.00 pm	3	2	2
3	8.00 am – 5.30 pm	1		
4	8.00 am – 7.00 pm	3	2	2
5	8.00 am – 8.00 pm	20	20	16
6	8.00 am – 10.00 pm	7	6	6
7	8.00 am – 11.00 pm	1	1	1
8	8.00 am – 12.00 am	2	1	1
9	9.00 am – 4.00 pm		1	
10	9.00 am – 5.00 pm	1		
11	9.00 am – 6.00 pm		1	1
12	9.00 am – 10.00 pm	1		
13	10.00 am – 4.00 pm		1	2
14	10.00 am – 6.00 pm	1		
15	10.00 am – 8.00 pm	1		
16	10.00 am – 12.00 am		2	2
17	12.00 pm – 8.00 pm		1	
18	2.00 pm – 8.00 pm	4	4	4
19	2.00 pm – 8.30 pm	1	1	1
20	24 hours per day	2	2	3
	Closed		1	4
	Unable to understand answer	2	2	3
	Total	50	49	49

Availability of radiology

Data were obtained for the modalities of X-ray, ultrasound scan (USS) and computed tomography (CT) scan on weekdays, weekends and public holidays. This garnered 36 patterns of availability (Table 4). Some radiology was provided off-site by private providers and the local public hospital. Some UCCs had doctors who were proficient in point-of-care USS (n = 20, 18%) which was a required skillset of doctors working in 3% of responses (n = 3, 2.6%). The most common weekday opening times for X-ray were: 8 am to 5 pm (n = 4, 13.3%), for USS 9 am to 5 pm (n = 2, 12.5%), and CT scan either 8 am to 5 pm (n = 3, 15%) or 8 am to 6 pm (n = 3, 15%). All clinics had some availability for X-ray on weekdays, whereas some clinics did not have USS or CT scan modalities available on weekends and public holidays.

Referral sources to the UCC

There were fifteen referral sources (Table 5). The most common referral source was self-referral by patients walking into the UCC. The following six next most common referral sources (with 15 or more responses) in descending order were: other GPs; Ambulance Service; EDs; healthdirect;[20] public health unit; and Workcover from local businesses.

Doctors and nurse practitioners working

While 100% of respondents (n = 49) had doctors working in the UCCs during the week and weekends and 98% (n = 47) on public holidays, fewer UCCs had NPs working during the same times (n = 30, 61%, n = 30, 61% and n = 28, 58% respectively).

Practitioner-to-nurse ratio

Most UCCs (n = 35, 71%) had a ratio of one practitioner (doctor or NP) to one nurse, some (n = 10, 20%) had a ratio of two to one over the 7-day week.

Schedule 8 medication storage

While most UCCs (n = 38, 73%) stored Schedule 8 (S8) medications onsite, others had storage in an on-site pharmacy (n = 7, 13%), and some did not store S8 medications onsite (n = 6, 12%).

Onsite services and equipment

Some (n = 32, 44%) respondents reported having a slit lamp at their clinic, some (n = 18, 25%) had a portable blood analysis system (eg an I-stat machine), few (n = 8, 11%) had a GP-led fracture clinic and few (n = 3, 4%) had a specialist led fracture clinic.

Triage process

In the UCCs most respondents worked at, some (n = 39, 72%) had all patients triaged by a nurse. Some (n = 10, 19%) had reception identify patients who required triage assessment by asking patients to read a poster and depending on outcome of certain identifiers, referred to the nurse for triage. Few respondents (n = 2, 4%) had an online check-in that identified patients who require triage assessment and referred the patients to the nurse for triage, and few had no formal triage (n = 2, 4%).

Surge plan

Surge planning occurred where the number and complexity of patients presenting to the UCC were more than what the GP working in the UCC considered safe to manage.

Table 4. Imaging hours

	Hours	X-ray weekdays	USS weekdays	CT scan weekdays	X-ray weekends	USS weekends	CT scan weekends	X-ray public holidays	USS public holidays	CT scan public holidays	Total
1	8.00 am – 4.00 pm	1		2							3
2	8.00 am – 12.00 pm				2	1	2				5
3	8.00 am – 2.00 pm							1			1
4	8.00 am – 2.00 pm + call in				1	1	1	2	1		6
5	8.00 am – 4.00 pm		2			1	1				4
6	8.00 am – 5.00 pm	4	2	3							9
7	8.00 am – 6.00 pm	3	2	3	2	1	1	3	1	1	17
8	8.00 am – 6.00 pm + call in	1	1	1						1	4
9	8.00 am – 8.00 pm	1									1
10	8.00 am – 10.00 pm	2	1	1	2	1	1	1			9
11	8.30 am – 5.00 pm	1	2	1							4
12	8.30 am – 8.00 pm	1			1						2
13	9.00 am – 1.00 pm		1	1	1	1	1	1	1	1	8
14	9.00 am – 2.00 pm				1	1	1				3
15	9.30 am – 4.30 pm										
16	9.00 am – 5.00 pm	2	3	1				1			7
17	9.00 am – 12.00 pm, 1.00 pm – 8.00 pm	1									1
18	9.00 am – 1.00 pm, 3.00 pm – 8.00 pm				1						1
19	9.00 am – 5.00 pm				1						1
20	9.00 am – 5.00 pm 9 days per fortnight		1								1
21	9.00 am – 8.00 pm	2									2
22	9.00 am – 10.00 pm				1						1
23	9.30 am – 4.30 pm	1			1			1			3
24	10.00 am – 2.00 pm		1			1	1		1		4
25	10.00 am – 5.00 pm		1	1						1	3
26	10.00 am – 6.00 pm				1			1			2
27	10.00 am – 8.00 pm				1		1				2
28	10.00 am – 10.00 pm	2		1							3
29	12.00 pm – 4.00 pm				1	1	1				3

Table continued on the next page

Table 4. Imaging hours (cont'd)

	Hours	X-ray weekdays	USS weekdays	CT scan weekdays	X-ray weekends	USS weekends	CT scan weekends	X-ray public holidays	USS public holidays	CT scan public holidays	Total
30	2.00 pm – 5.00 pm		2	1							3
31	2.00 pm – 8.00 pm	2			1			2			5
32	Offsite 2.00 pm – 8.00 pm				1			1			2
33	2.00 pm – 8.30 pm	1									1
34	Offsite 8.00 am – 5.00 pm	1									1
35	Offsite 8.00 am – 12.00 pm				1						1
36	Offsite 2.00 pm – 8.00 pm										
	Closed				2	6	2	7	8	6	31
	Unable to understand answer	4	5	4	4	3	4	3	1	2	30
	Total	30	24	20	26	18	17	24	13	12	184

CT scan, computed tomography scan; USS, ultrasound scan.

The most common surge plan involved the triage nurse attending to patients who cannot be seen by the UCC doctor and advising next steps. These steps could include refer to local ED, refer to local GP, or referral to 'healthdirect' (n = 27, 44%). Patients presenting with life-threatening conditions would still be managed even though the UCC was at capacity. This was followed by UCC staff either calling a doctor who was not on call to see if they could work at the UCC (cold calling any doctor) and closing the door of the clinic (n = 10, 16% each), or calling in an on-call doctor (n = 5, 8%). Three (5%) respondents had no surge plan at their clinics and one each (2%) responded that there was no surge issue or that they would see all who wait.

Discussion

This analysis found 11 important themes: clinic location, opening hours, imaging options, availability of radiology services, referral sources, staffing models (including doctors and nurse practitioners), practitioner-to-nurse ratio, Schedule 8 medication storage, onsite services and equipment, triage process and a surge management plan. These themes will be discussed under four headings: (1) Provision of UCC services; (2) Referral sources; (3) Triage; and (4) Surge demand.

Provision of UCC services, radiology, slit lamp, I-stat machine and onsite fracture clinic

There were 20 differing UCC opening hours identified from weekdays, weekends and public holidays (Table 3). This was comparable to the US, where 70% of UCCs open 8 am or earlier and 95% closed after 7 pm.[21] A report of UCCs in the US found 67% open every day, 18% are closed on weekends, and 11% are open Monday to Saturday.[3] UCCs in England and NZ are required to open from at least 8 am to 8 pm, 7 days per week.[11,12] Access to radiology was usually less than the opening hours of the UCCs.

The wide range of 36 different opening hours for radiology modalities was inconsistent with UCC models in some Western countries. Opening hours for radiology services depended on the day of the week and type of imaging (Table 4), which was predominantly X-ray, but also included USS and CT scan. UCCs in England and NZ are only required to have X-ray onsite.[8,9] In England, the requirement for access to X-ray facilities and clinicians able to analyse and interpret results is throughout opening hours.[12] In NZ, the requirement for access to X-ray facilities on site is for a minimum of 6 hours per day weekdays, 3 hours per weekend or to operate an on-call service for at least 6 hours per weekend.[22] UCCs in the US provide X-ray in some form in at least 85% of clinics, but only 5% provide advanced radiology services.[10] Our survey also found greater access to radiology modalities such as USS and CT scan compared to the US, England and NZ. In addition to radiology services, some clinics had access to other equipment and clinics.

Access to medical assessment devices like slit lamps, I-stat portable blood analysis systems, and fracture clinics varied between respondents. In comparison to international literature, the availability of slit lamps, portable blood analysis systems and access to fracture clinics in this study was more than

described for UCCs in the US.[10] A US report found few UCCs had access to a slit lamp (1%, compared with 44% in our convenience sample), few provided onsite blood analysis systems (2%, compared with 25% in our convenience sample), and few provided fracture care (2%, compared with 15% in our convenience sample).[10] All UCCs in NZ have fracture clinics and slit lamps.[23]

Referral sources

Unlike other Western countries, federal and state government funded UCCs in Australia have a wide range of referral sources to the UCC, but a limited scope of occupational health or telehealth services. The Medicare UCC design principles include that Medicare UCCs will:

> *... Support people to connect to pathways of care through integration with the broader health system: ensuring connectivity to hospital and ambulatory services and other supports and services, streamlining access to urgent care.*[24]

Although this study identified fifteen referral sources, compared to the US and NZ, there is less emphasis on occupational health and telehealth services.

In the US, UCCs offer occupational health services such as 'pre-placement physicals, drug screening, post-injury testing, annual employment physicals, flu immunisations, and workforce health education' and telehealth.[3] The top reason US UCC providers gave for continuing telehealth post COVID was not because of profitability, but that patients expected it, and to keep the UCC competitive.[10] In NZ, 31% of patient presentations are for accidents (including those that occur in work and for which the UCC can claim for under the national insurance scheme)[23] compared to a study from Southeast Queensland that found 20% of patient presentations were for accidents.[9] The difference could be that the NZ government have a national insurance scheme for accidents called the Accident Compensation Corporation (ACC),[25] which includes initial and ongoing management of occupational injuries, which are able to be managed at UCCs.[25] Expanding the offering of services provided by Australian UCCs to include occupational health and telehealth services could allow Australian UCCs to better serve patients. The next relevant finding from this survey study was how patients are initially dealt with when they arrive.

Table 5. Referral sources

	Referral source	No. responses
1	Self (walk-in)	47
2	Other general practitioner	41
3	Ambulance service	35
4	Emergency department	34
5	healthdirect	22
6	Public health unit	16
7	Workcover from local business	15
8	School	9
9	Residential aged care facility	7
10	Consultant referral line	6
11	Pharmacy	3
12	Nurse-on-Call	2
13	Kindergarten	1
14	Local specialist	1
15	Community nursing, disability care providers, other various community providers	1

Triage

Self-referred or walk-in patients are the most common source of presentations to UCCs in this study. This is consistent with the federal and state community awareness campaigns that promote UCCs as available for walk-ins, bulk-billed, and with extended hours, simultaneously re-directing patients with NLTUC away from EDs experiencing unprecedented growth.[26] Walk-in patients are clinically undifferentiated when they arrive at the UCC and studies from Australia, the US and NZ find some patients presenting to UCCs will be high acuity.[27] Timely recognition of patient acuity by a trained professional is required to maintain quality of care and improve health outcomes.[28]

Most UCCs in our study had a nurse to triage all patients. However, some hybrid models had reception staff or the patient using images or words to self-identify the need for referral to the nurse for triage. Others had no formal triage. This is inconsistent with international UCC standards and the Australian Federal Medicare and State Funded UCC guidance.[29,30] There is unequivocal evidence that sorting undifferentiated patients to identify life-threatening conditions such as stroke and acute coronary syndrome will allow for prioritisation of care and contribute to health outcomes.[31] This theme highlights the importance of the adoption of evidence-based tools, education, implementation, and evaluation of clinicians performing triage in Australian UCCs, which may also contribute to patient outcomes.[28] This survey did not delve into specific triage tools utilised in Australian UCCs.

The use of the Australasian Triage Scale (ATS), endorsed by the Australasian College of Emergency Medicine[32,33] aligns the patient triage category with those across Australian EDs. The Urgent Care Association (UCA) requires triage to be performed by a nurse and emphasises that triage is not within the scope of a medical assistant.[10] RNZCUC requires UCCs to internally audit 50 triage entries

every 6 months to verify triage has occurred.[11] The last point of discussion relates to triage and occurs when the UCC is at capacity.

Surge demand

Responses to surges in demand varied across the sites where the surveyed doctors work from. These included every patient being triaged by a nurse, closing the door, and having the ability to call a doctor in.

The UCC walk-in model, like EDs, is designed to manage unscheduled and unplanned NLTUCs. This will inevitably lead to unpredictable presentation volumes during opening hours and the probability for surge in demand. The current fixed staffing ratio over operating hours (one doctor and one nurse) in 71% of UCCs where doctors were surveyed, will lead to patients waiting much longer for care during a surge in demand. In undifferentiated patients this wait time may be detrimental to their health outcomes.[31,34] Health services need to have a framework to safely and consistently provide a rapid response to surges.[34] This includes a clarity on metrics to recognise a surge, clear actions to expand capacity on-site (ie increase staffing), and setting clinical goals (ie standard of care remains, but level of service for the individual may change).[34] Coordinating responses to surges in demand, like in other countries, could improve wait times for patients.

In England, the National Health Service plans to expand and improve links in healthcare outside hospitals to better support patients with services at home (this includes virtual wards).[35] Australian providers have developed and piloted unpublished tools that have been shared with Primary Health Networks and government in relation to the safe clinical treatment times recommended in the ATS.[36] The tools take into consideration the number of new patients arriving, the number of doctors on-site and the estimated clinical treatment time. The treatment time is estimated in a graded escalation matrix that activates workflow changes, provides scripts for staff to manage patient expectations and undertake activities to increase capacity in the clinic during times of surge.

Having UCC standards like the US, England and NZ[4,11,37] could ensure standardisation of services like access to radiology, equipment like slit lamps and I-stat on-site portable blood analysis systems and onsite fracture clinics. The standards could also give further guidance for triage and management of UCCs when in surge demand, and protocols for surge demand. This could occur under the National Safety and Quality Primary and Community Healthcare Standards.[38]

Limitations

There were several limitations in this study. First, that this study utilised convenience sampling. While this limits the generalisability of the data, the purpose of the study was to explore the range of models rather than quantify them, and the outcomes demonstrate a need for a central repository for industry data. Second, only 52 responses were received, which also limits the generalisability of the results. While this is a limitation, the purpose of the study was to explore the diversity of service models. Finally, the study was biased towards state (47% of participants) and federal government (41% of participants) funded UCCs.

Conclusion

This paper is part two of a survey study of 52 doctors working in UCCs in six Australian states since 1 July 2023. Part one focused on the themes of capacity, accreditation standard, qualification and experience of doctors and NPs, training, funding and public education. This paper focused on themes related to operational issues. These include clinic location, opening hours, imaging options, availability of radiology services, referral sources, staffing models (including doctors and nurse practitioners), practitioner-to-nurse ratio, Schedule 8 medication storage, onsite services and equipment, triage process and a surge management plan. This paper also compares the evolving models in Australia with other Western UCC models to inform development of a UCC model that can better serve Australian patients, providers and our healthcare system. The introduction of UCC standards will address unwarranted variation in the provision of health care in Australian UCCs.

Authors

John W Adie PhD, FACRRM, FRACGP, FRNZCUC, FRNZGP, BMin, MBChB, BHB, PGDip Community Emergency Medicine, Obs/Med Gyn and Paed, Associate Professor of Urgent Care, School of Health, University of the Sunshine Coast, Sunshine Coast, Qld; Training and Education lead, ForHealth, Leichardt, NSW; Specific Interest Group Chair, Urgent and emergent presentations to primary care, RACGP, Brisbane, Qld; Australian Convenor, RNZCUC, Auckland; Australasian Agent, Emergency Medicine Special Interest Group, World Organization of Family Doctors (WONCA), Brussels

Nigel Barr PhD, Grad Cert Prof Learn, Adv Dip MICA Paramedic Studies, Dip HealthSc (Ambulance Officer), Grad Dip AdvClinNurs (ICU), BNurs, Discipline Lead and Associate Professor, Paramedicine, School of Health, University of the Sunshine Coast, Sunshine Coast, Qld; Program Coordinator Paramedicine, Bachelor of Medicine, University of the Sunshine Coast, Sunshine Coast, Qld

Nicole Masters PhD, BSc (Hons), Grad Cert Prof Learn, Associate Dean, Learning and Teaching, School of Health, University of the Sunshine Coast, Sunshine Coast, Qld; Associate Professor in Bioscience, School of Health, University of the Sunshine Coast, Sunshine Coast, Qld; Member, Centre for Bioinnovation, Sunshine Coast, Qld

Michelle Murphy Master of Emergency Health, Bachelor of Nursing, Bachelor of Health Science (Paramedicine), Grad Cert Public Policy, National Manager, Integrated Care Pathways and Partnerships, ForHealth, Sydney, NSW; Advocacy and Government Relationship Lead, Australasian College of Paramedicine, Sydney, NSW; Adjunct Associate Professor, Paramedicine, School of Health, University of the Sunshine Coast, Sunshine Coast, Qld

Ben Adie Bachelor of Business and Bachelor of Laws, Commercial Operations Analyst, Brisbane, Qld

Competing interests: JWA works part time as an Associate Professor of Urgent Care at the University of the Sunshine Coast. In his role at the university, he has taught seminars in conjunction with ForHealth where he is the Urgent Care Clinic Training and Education Lead. He has received honorariums when teaching fracture management and upskilling doctors to better manage emergency presentations to primary care; MM works as National Manager Integrated Care Pathways and Partnerships with ForHealth. She collates relevant data across the network that is part of the delivery of urgent care education workshops. She is the Advocacy and Government Relations Lead for the Australasian College of Paramedicine.

Funding: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

Correspondence to:
jadie@usc.edu.au

References

1. Australian Government Services Australia. Medicare Urgent Care Clinics and other urgent care initiatives 2024. Updated March 2024. Available at https://hpe.servicesaustralia.gov.au/INFO/UCC/UCCINFO7.pdf [Accessed 2 February 2025].
2. DOHAC. Evaluation of the Medicare Urgent Care Clinics: Interim Evaluation Report 1. 28 January 2025.
3. Urgent Care Association. Urgent Care Industry White Paper - The Essential Nature of Urgent Care in the Healthcare Ecosystem Post-COVID-19. UCA; 2023.

4. NHS England. Urgent treatment centres. Available at www.england.nhs.uk/urgent-emergency-care/urgent-treatment-centres [Accessed 9 September 2024].
5. Adie JW, Graham W, O'Donnell R, Wallis M. Patient presentations to an after-hours general practice, an urgent care clinic and an emergency department on Sundays: A comparative, observational study. J Health Organ Manag 2023;(ahead-of-print):96–115. doi: 10.1108/JHOM-08-2021-0308.
6. The Hon Mark Butler. Strengthening Medicare: 50 more Medicare Urgent Care Clinics. Commonwealth of Australia, 2025. Updated 2 March 2025. Available at www.health.gov.au/ministers/the-hon-mark-butler-mp/media/strengthening-medicare-50-more-medicare-urgent-care-clinics [Accessed 24 May 2025].
7. Adie J, Barr N, Masters N, Murphy M, Adie B. Concerns identified by medical doctors working in urgent care clinic models in Australia. Aust J Gen Pract 2025;54(9):603–10. doi: 10.31128/AJGP-08-24-7394.
8. John S. When it's urgent, but not an emergency, 2025. Available at https://stjohnhealth.com.au/walk-in-urgent-care [Accessed 1 February 2025].
9. Adie JW, Graham W, O'Donnell R, Wallis M. Patient presentations to an after-hours general practice, an urgent care clinic and an emergency department on Sundays: A comparative, observational study. J Health Organ Manag 2023(ahead-of-print):96–115. doi: 10.1108/JHOM-08-2021-0308.
10. UCA. UCA Benchmarking Report Operations 2022. Available at https://urgentcareassociation.org/wp-content/uploads/2023/04/Benchmarking-Operations-10.12.22.pdf [Accessed 9 September 2024].
11. RNZCUC. Urgent Care Standard 2015. Royal New Zealand College of Urgent Care, 2015.
12. NHS England. Urgent treatment centres – Principles and standards. 2023.
13. National Urgent Care Centre Accreditation. National Urgent Care Centre Accreditation, n.d. Available at http://ucaccreditation.org [Accessed 27 February 2025].
14. Urgent Care Association. Certification 2025. Available at https://urgentcareassociation.org/quality/certification [Accessed 27 February 2025].
15. Royal College of Surgeons of Edinburgh. Fellowship in Immediate Medical Care 2021. Available at https://fphc.rcsed.ac.uk/examinations/fellowship-in-immediate-medical-care [Accessed 11 August 2021].
16. Adie J. Management of patients with non-life-threatening urgent conditions in the community: A case study in South-East Queensland [Thesis by publication]. University of the Sunshine Coast, 2022.
17. Adie J, Graham W, Bromfield K, Maiden B, Klaer S, Wallis M. Urgent care in the community: An observational study. J Health Organ Manag 2021;(ahead-of-print):949–63. doi: 10.1108/JHOM-09-2020-0364.
18. Qualtrics. qualtrics XM 2024 [updated]. Available at www.qualtrics.com/en-au/?utm_source=bing&utm_medium=ppc&utm_campaign=ANZ-EN%7CSRC%7CBRD%7CQualtrics&utm_keyword=qualtrics&MatchType=e&adid=&utm_content=&adgroupid=1233652262894040&campaignid=398440091&AdGroup=Brand%20Name%20-%20Qualtrics&BidMatchType=be&Target=&targetid=kwd-77103444158116:loc-4050&Device=c&devicemodel=&loc_phsyical_ms=123944&Placement=&querystring=qualtrics&network=o&adposition=&GCLID=&msclkid=411300999aa51c55ec72663a8d14d0d&utm_term=qualtrics [Accessed 26 July 2024].
19. Krippendorff K. Content analysis: An introduction to its methodology. 4th edn. SAGE Publications, Inc, 2019.
20. healthdirect. Service finder [updated]. Available at www.healthdirect.gov.au/australian-health-services [Accessed 2 February 2025].
21. Urgent Care Association of America. Urgent Care Association of America Urgent Care Industry Information Kit, 2013; p. 1–4.
22. RNZCUC. What is urgent care? 2020–2021. Available at https://rnzcuc.org.nz/about/what-is-uc [Accessed 27 February 2025].
23. RNZCUC. Urgent Care in New Zealand in 2022. 2023.
24. Australian Government Department of Health and Aged Care. Medicare Urgent Care Clinics Onboarding Pack. June 2024 Version 2. 2024.
25. New Zealand Government. Available at www.acc.co.nz/#:~:text=Everyone%20in%20New%20Zealand%20is%20covered%20by%20our%20no-fault%20scheme [Accessed 27 February 2025].
26. Adie J, Graham W, Wallis M. Entry Points to the Health System: A review of the emerging community models for management of non-life threatening urgent conditions relevant to Australia. Asia Pacific Journal of Health Management 2017;12(2):9–16. doi: 10.24083/apjhm.v12i2.71.
27. Siegfried I, Jacobs J, Olympia RP. Adult emergency department referrals from urgent care centers. Am J Emerg Med 2019;37(10):1949–54. doi: 10.1016/j.ajem.2019.01.029.
28. Varndell W, Hodge A, Fry M. Triage in Australian emergency departments: Results of a New South Wales survey. Australas Emerg Care 2019;22(2):81–86. doi: 10.1016/j.auec.2019.01.003.
29. Australian Government Department of Health and Aged Care. Operational Guidance for Urgent Care Clinic. 2022.
30. Government of South Australia SA Health. Priority Care Centres, 2025. Available at www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/community+and+specialised+services/priority+care+centres/priority+care+centres [Accessed 1 February 2025].
31. Bhaumik S, Hannun M, Dymond C, et al. Prehospital triage tools across the world: A scoping review of the published literature. Scand J Trauma Resusc Emerg Med 2022;30(1):32. doi: 10.1186/s13049-022-01019-z.
32. Ebrahimi M, Heydari A, Mazlom R, Mirhaghi A. The reliability of the Australasian Triage Scale: A meta-analysis. World J Emerg Med 2015;6(2):94–99. doi: 10.5847/wjem.j.1920-8642.2015.02.002.
33. Forero RN, Nugus P. Australasian College for Emergency Medicine (ACEM) Literature Review on the Australasian Triage Scale (ATS). 2011.
34. Bradt DA, Aitken P, FitzGerald G, Swift R, O'Reilly G, Bartley B. Emergency department surge capacity: Recommendations of the Australasian Surge Strategy Working Group. Acad Emerg Med 2009;16(12):1350–58. doi: 10.1111/j.1553-2712.2009.00501.x.
35. NHS England. Delivery plan for recovering urgent and emergency services. In: Care DoHS, editor. 2023.
36. ACEM. Guidelines on the Implementation of the Australasian Triage Scale in Emergency Departments. 2023.
37. Urgent Care Association. 2024 Accreditation Standards Manual, 2024. Available at https://urgentcareassociation.org/shop/roles/for-clinicians/2024-accreditation-standards-manual [Accessed 27 February 2025].
38. Australian Commission on Safety and Quality in Healthcare. National Safety and Quality Primary and Community Healthcare Standards – Guide for Healthcare Services. 2024.

correspondence **ajgp@racgp.org.au**