

Australasian College  
for Emergency Medicine

# Position Statement

Impact of Urgent Care Centres on EDs in Australia

## 1. Introduction

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Timely access to community-based healthcare is a fundamental tenet of healthcare in Australia. ACEM supports any successful initiatives that improve access to primary healthcare.

Urgent Care Centres (UCCs) are being developed in the Australian context to increase access to primary healthcare, with a government stated intent they will reduce pressure on Emergency Departments (EDs). Urgent care can take many different forms; however, the primary model being implemented across Australia is after hours General Practice (GP) services (AHGP). Different models, that may expand beyond primary care are also being investigated and implemented by state and territory governments. Whilst UCCs provide additional options, and positive patient experience for low-acuity patients; current evidence shows little impact on emergency department (ED) pressures.

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## 1.1 Impact of Urgent Care Centres on ED Presentations

Reviews of international literature assessing the impact of introducing AHGP care and UCCs found increased primary care utilisation but mixed results with respect to ED utilisation. In the Australian context, there is limited evidence of the impact of these services at a systemic level; including contributing to reduced ED attendances when services are implemented at scale.

One review examining UCCs, urgent treatment clinics and AHGP found that walk-in clinics caused an 8% reduction in ED presentations, while GP Cooperatives caused a 13% reduction (Crawford 2017). A second review determined that patients who had access to AHGP care were 1.9% less likely to attend the ED (Hong 2020). A systematic review of primary care service interventions to reduce ED presentations (Ismail 2013) found a negligible effect on ED attendance for all interventions, with limited data on patient outcomes and cost-effectiveness.

A recent UK study of emergency specialists (RCEM, 2020) found that 36% of respondents indicated that UCCs had been successful in reducing ED attendances, while 29% indicated that their workload had reduced. Of concern, 30.8% indicated increased workforce pressure with staff leaving ED roles to provide care in UCCs. In addition, there remained a degree of scepticism amongst ED staff regarding all the potential benefits of UCCs with respect to reducing pressure on EDs.

The evaluation of the Kids Care Centre (KCC)/UCC pilot in New South Wales (NSW) found no evidence that the models of care were any better or worse than other existing models for streamlining and treating non-urgent, non-complex patients within NSW public hospital EDs. The evaluation also found sufficient evidence to indicate that several other models of ED streaming and treatment may produce superior outcomes for ED performance and patient outcomes with the same types of patients treated in UCCs (Aspex, 2014).

Further Australian evidence is limited to site specific analyses, with one study of an AHGP service in regional New South Wales finding a daily reduction of 7.04 patients in total for non-urgent presentations to the ED, representing a total of 8.2% reduction in total presentations (Buckley, 2017). Another study of AHGP in regional NSW demonstrated that patient satisfaction was high with 99% responding they would use the clinic again; 76% of patients classifying their visit as essential and 60% reporting they would have gone to the ED had the service not been operational (Payne, 2017).

## 2. Purpose and Scope

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This position statement has been developed to highlight key opportunities and challenges for emergency care in the implementation of Urgent Care Centres (UCCs) in the Australian context. Due to the rapid pace of change and variable models being proposed by different governments this statement will continue to be updated as more information becomes available.

Aotearoa New Zealand has a well-established network of UCCs. This statement does not apply in that context.

Where patient acuity and complexity have been quantified in this document (for example, 'low acuity' or 'high complexity') this measurement refers to how the presentation would be viewed in an emergency care setting.

## 3. Definitions

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### 3.1 Urgent Care Centre

The term urgent care centre refers to a broad range of services that typically seek to treat patients who require urgent attention for conditions that are low-acuity, not life threatening nor are likely to lead to severe morbidity. They are usually conceived to be a step between primary care (typically General Practice) and hospital-based ED.

### 3.2 Medicare Urgent Care Centre

The Australian Government is developing a network of federally funded Medicare Urgent Care Centres (MUCCs). The services will be based out of GP clinics or community health centres and will provide bulk-billing service.

## 4. ACEM Position

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The Australasian College for Emergency Medicine (ACEM; the College) cautiously supports the introduction of UCCs, where the intention is to improve timely access for urgent low-acuity primary care needs. There is potential for UCCs to provide benefit to patients; enabling timely access to out-of-hours GP care, urgent GP access when a patient is unable to secure a primary healthcare appointment, and reduced wait-times for urgent treatment or medical assessment and testing.

ED pressures, overcrowding and ambulance ramping are phenomena that occur when patients are waiting for admission to a hospital in-patient ward and remain in the ED for an extended period of time due to lack of available in-patient beds. This results in hospital access block. These patients represent a different group of patients to those that can be managed in UCCs. UCCs may lead to reductions in low acuity presentations to EDs but will not have significant impact on these main drivers of ED pressure.

ACEM calls for greater action to manage hospital access block that will address ED pressures in a constructive and sustainable way.

Emergency physicians have a unique role within health services – to provide expert generalist acute care for patients between the community and inpatient hospital system. Therefore, emergency physicians are well placed to collaborate and provide guidance at all stages of UCC service planning, implementation, and integration.

## 5. Principles for the Implementation of Urgent Care Centres

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### 5.1 Access to Care for Patients

Improving timely and affordable access to primary care has benefits to patients. Primary care in Australia is currently under-resourced and in the absence of large-scale Medicare and primary health reform to support longitudinal care, patients may benefit from an additional access point for urgent episodic low acuity care. This includes low acuity patients who are currently attending the ED for urgent episodic care.

### 5.2 Causes of ED Pressure

The predominant cause of ED overcrowding and ambulance ramping is hospital access block. Ambulance ramping occurs when the ED does not have capacity to accept new patients arriving via ambulance, and complete transfer of clinical care to the ED. Access block is where patients experience excessive wait-times in the ED due to lack of capacity in the hospital. UCCs will not manage these patients as they are too ill for community-based treatment and require hospital admission to receive definitive care.

Lower acuity patients are often managed through ED 'fast-track' or ambulatory models of care and are separately streamed from patients requiring admission. UCCs may assist in reducing the volume of these types of patients in waiting rooms and ambulatory treatment areas but this is a different problem to access block. The benefit of this to EDs is that it may reduce patient numbers allowing staff to monitor waiting patients more effectively for deterioration, thereby improving the safety of the service.

### 5.3 Australasian Triage Scale and UCCs

It is not appropriate to use the Australian Triage Scale (ATS) categories (ACEM, 2012) as a proxy to identify patients who should be seen in UCCs.

Often, patients determined as lower acuity via the ATS have been referred directly to the ED by their primary care provider due to complexity, need for same-day investigations or difficulty in accessing urgent hospital-based outpatient services in a timely manner. Therefore, further work is required to clearly define acuity and types of patients that can or should be seen across the different health services within the healthcare system, including UCCs.

### 5.4 Workforce

Australia is experiencing a shortage of a range of healthcare workforce, which will present a challenge for

staffing UCCs, and result in increasing workforce pressures elsewhere in the health system. These workforce shortages will be particularly challenging in regional and rural areas.

UCCs sit at the intersection of primary and acute care, and there are opportunities for GPs, emergency specialists, nurse practitioners and other appropriately trained speciality nurses to contribute to the workforce. The operation of UCCs should be medical-led and will require a mix of clinical skills that appropriately address the range of treatment needs for a low-acuity patient.

There may be opportunities for additional roles such as advanced care physiotherapists and paramedics, who could contribute to clinical and management roles in UCC models that take a multidisciplinary approach to care.

## **5.5 Scope of Practice**

There will be overlap between UCCs, primary care and EDs, which requires a carefully defined scope of practice for UCCs to facilitate timely connections to definitive, ongoing and follow-up care.

UCCs must be able to operate independently across the scope of low-acuity patient needs. UCCs should have sufficient diagnostic capability to mitigate diagnostic delay and patients requiring ED transfer. If they are not appropriately equipped to manage this patient group, there is significant risk they will increase ED workload and delay patient care.

UCCs must also have established mechanisms for referral to appropriate specialist review services and to a patient's regular primary care provider.

All UCCs must have advanced life support capabilities.

## **5.6 Governance**

Clinical governance structures should include expertise from primary and acute care settings to ensure UCCs are enabling access to intended patient groups for episodic low-acuity urgent care; are not contributing to duplication of service in primary or tertiary care; and are integrated into the broader health system. These governance structures should also be enabled from the outset of model development and throughout evaluation processes.

## **5.7 System Integration**

UCCs must be integrated into primary and tertiary care services, and other related existing community-based services to ensure continuity of care and expedient referrals and linkages between services. Clear clinical pathways should be co-developed with EDs and hospital networks, so patients requiring further specialist review can be referred, booked, and consulted efficiently. This should also include referral to a UCC from an ED for episodic follow-up care. There should also be linkages and appropriate information sharing with primary care providers and GPs managing the ongoing care of patients that have accessed UCC services.

## **5.8 Hours of Operation**

UCCs should have extended hours of operation and reflect the busiest periods for low-acuity presentations to the local EDs.

## **5.9 Community Engagement**

UCCs will act as an additional healthcare access point for low acuity, low complexity urgent health problems either from illness or injury. Communication about what services UCCs can provide must be prioritised, to support patients to attend the service that is right for them, to reduce confusion, and ensure patients can utilise health services in the most effective way.

## **5.10 Monitoring Implementation**

As UCCs represent a significant innovation and investment in the health system, a robust system for defining and measuring outcomes is required. Evaluation must be prioritised from the outset of implementation and closely monitored on an ongoing basis. Intended and unintended consequences must be monitored. Evaluations should also be fit for purpose, measuring intended outcomes based on site specific local need.

There are a range of domains that require monitoring. The following should be prioritised:

- Quality and patient safety within UCCs
- Patient perspectives of care at UCCs
- Characteristics of patients attending UCCs, including patients who would not have sought care if a UCC was not accessible
- Trends regarding access to primary care GPs
- Impact on ED attendances and performance measures
- Quality of interface between primary care, UCCs, community services, EDs and other speciality services
- Proportion of services provided considered low quality care
- Costs of UCC care
- Workforce availability and changes in health system workforce (particularly GP and EDs)
- Community understanding of role of UCCs

## 6. References

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## Document review

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Timeframe for review: every three (3) years, or earlier if required.  
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## Revision history

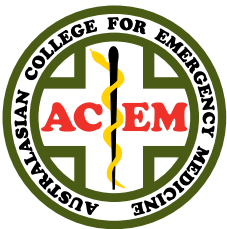
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1.0	Jul 2023	Approved by the Council of Advocacy, Practice and Partnerships

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