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Access to Urgent Care Among Individuals Experiencing Health Inequalities: A Scoping Review and Recommendations

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We would like to thank all the local VCFSE organisations who generously responded to our requests for additional information and insight. Your contributions provided valuable local context that has enriched the depth and relevance of this report.

Executive Summary

Background:
People experiencing health inequalities often face substantial barriers in accessing urgent care. Urgent care services include NHS 111, urgent treatment centres (UTCs), GP out-of-hours, urgent dental and sexual health services, and pharmacies. Health inequalities include individuals who experience physical and mental disabilities, learning disabilities, sensory differences (deafness or blindness), individuals in the LGBTQIA+ and Transgender community, non-English speakers, individuals experiencing homelessness, digital exclusion, rural populations, and individuals with alcohol or substance abuse. Barriers to urgent care can result in poorer health outcomes, inappropriate use of urgent and emergency services, and increased strain on health and social care systems.

Objective:
This report aimed to examine how individuals experiencing health inequalities access urgent care services, and strategies that may help to increase access with a particular focus on the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector.

Methodology:
A scoping review was conducted using academic databases (e.g., MEDLINE, CINAHL, Scopus) and grey literature sources (e.g., Healthwatch, National Voices, NHS England, The King's Fund). A total of 16 peer-reviewed papers and 16 grey literature reports were included. Data extraction and thematic analysis identified key themes and potential recommendations for increasing urgent care access among those experiencing health inequalities.

Key Findings:
- **Barriers to access:** Individuals with health inequalities face challenges accessing urgent care including digital exclusion, low health literacy, geographical isolation, language barriers, rigid or fragmented systems, and a lack of reasonable adjustments.
- **Health inequalities and utilisation patterns:** Many groups, including frail older adults, people with substance use disorders, those with dementia, and low-income communities, are more likely to use emergency departments rather than urgent care due to poor access to timely and appropriate urgent care.

Issues identified with current urgent care models:
- **Fragmented and poorly coordinated services**: Urgent care is often disconnected from primary and community services, leading to poor record sharing, patient navigation, triage challenges, and inappropriate emergency department use.
- **Inflexible models that do not meet diverse needs**: One-size-fits-all approaches fail to accommodate individual patient needs, especially for those facing language, communication, cultural, or socioeconomic barriers.
- **Limited local adaptation**: Services are not always informed by local data, resulting in gaps for populations that are underserved.
- **Digital access inequities**: While digital tools can improve access, they often result in digital exclusions for older adults, non-English speakers, and people with poor digital literacy.
- **Lack of preventative planning**: Patients often lack the tools and support to manage their own health, particularly those with chronic conditions or frequent urgent care users.
- **Low health literacy and public awareness**: Many patients and carers are unclear about when and how to use urgent care appropriately, due to limited education and public awareness on which services are appropriate to their care needs.

Conclusion :
The literature reinforces both anecdotal insights and evidence gathered from individuals and groups supporting those affected by health inequalities. Implementing the below recommendations could help improve access to urgent care and reduce pressure on emergency services.

Access to Urgent Care for People Facing Health Inequalities

Background

People experiencing health inequalities often face substantial barriers when access urgent care services, such as:

- NHS 111
- Urgent Treatment Centres (UTCs)
- GP out-of-hours
- Urgent dental and sexual health services

Barriers to Urgent care can result in:

- Poorer health outcomes
- Inappropriate use of emergency services
- Increased strain on health and social care systems

Examples of Health inequalities:

- People with physical, mental, or neurological health conditions
- People with learning disabilities
- People with sensory impairments
- Pregnant people
- LGBTQIA+ and Transgender people
- Neurodivergent people
- Non-English speakers
- People with alcohol or substance use disorders
- People experiencing homelessness
- People living in rural or remote areas
- Unpaid or family carers
- People facing transport barriers or digital exclusion

Objectives

This report aimed to examine:

- How individuals experiencing health inequalities access urgent care services
- Strategies that may help to increase access

Methods

A scoping review was conducted using academic databases

- MEDLINE, CINAHL, Scopus

Grey literature sources

- Healthwatch, National Voices, NHS England, The King's Fund

16 peer-reviewed studies **16** grey literature reports

Key Findings

Barriers to access:

- Digital exclusion
- Low health literacy
- Geographical isolation
- Language barriers
- Rigid or fragmented systems
- Lack of reasonable adjustments

Health inequalities and utilisation patterns:

Populations such as frail older adults, people with substance use disorders, those with dementia, and low-income communities, are more likely to use emergency departments rather than urgent care due to poor access to timely and appropriate urgent care.

Executive Summary

Issues identified with current urgent care models	
 **Fragmented and poorly coordinated services** Urgent care is often disconnected from primary and community services, leading to poor record sharing, patient navigation, triage challenges, and inappropriate emergency department use.	 **Inflexible models that do not meet diverse needs** One-size-fits-all approaches fail to accommodate individual patient needs, especially for those facing language, cultural, or socioeconomic barriers.
 **Limited local adaptation** Services are not always informed by local data, resulting in gaps for populations that are underserved.	 **Digital exclusion** While digital tools can improve access, they often result in digital exclusions for older adults, non-English speakers, and people with poor digital literacy.
 **Lack of preventative planning** Patients often lack the tools and support to manage their own health, particularly those with chronic conditions or frequent urgent care users.	 **Low health literacy and public awareness** Many patients and carers are unclear about when and how to use urgent care appropriately, due to limited education and public information on which services are appropriate to their care needs.

Conclusions

This review identifies persistent barriers to urgent care access for people experiencing health inequalities. Promising interventions, particularly from the VCFSE sector, highlight the need for urgent care pathways to become more inclusive, integrated, and locally co-designed. By embedding person-centred approaches and tailoring services to diverse population needs, Urgent and Emergency Care systems could ensure timely, appropriate urgent care access for all.

Recommendations

Based on the scoping review and grey literature, the following recommendations are noted to improve equitable access to urgent care for individuals experiencing health inequalities:

1. Improve system navigation, triage, and coordination

- Enhance integration between urgent care, primary care, and social care through improved care pathways and record-sharing.
- Expand the use of care navigators, community link workers, and front-of-house triage staff.
- Develop simplified, multilingual service navigation tools and support tools to guide service users.
- Use multiple public education strategies to signpost to appropriate services.
- Utilise VCFSE organisations as alternative options for accessing urgent care.

2. Address digital exclusion and promote inclusive innovation

- Provide training, devices, and translation tools to support digital access for underserved groups.
- Design digital platforms (e.g., NHS 111 online, virtual consultations) with user-testing from marginalised populations to prevent digital exclusions.
- Promote awareness of digital access options in underserved communities.

3. Address geographical and spatial access issues by embedding local population needs into service design

- Use local population data and VCFSE insight to map access gaps and tailor urgent care services accordingly.
- Commission community-informed models, such as mobile clinics or targeted outreach for specific groups (e.g. people with dementia, those experiencing homelessness).

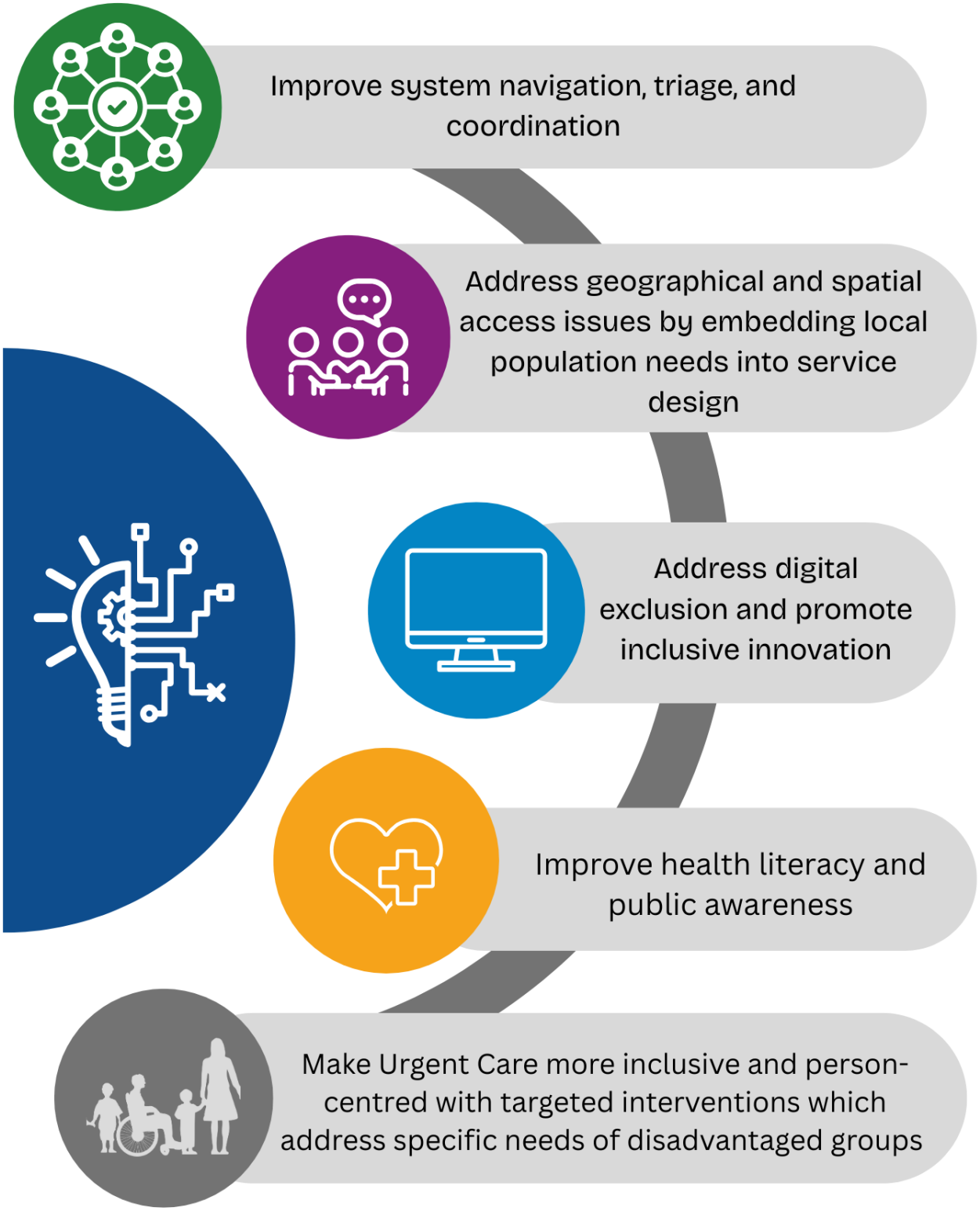
4. Improve health literacy and public awareness

- Launch culturally relevant public education campaigns on urgent vs emergency care, NHS 111, and self-care. Ensure these public education campaigns are consistent across the NHS.
- Provide training for health professionals and carers to support patient understanding, particularly for people with low literacy, learning disabilities, or cognitive impairments.

5. Make Urgent Care more inclusive and person-centred with targeted interventions which address specific needs of disadvantaged groups

- Embed reasonable adjustment and communication support in all urgent care settings.
- Ensure services accommodate language, cultural, and sensory needs, particularly during out-of-hours care.
- Improve training of staff in reasonable adjustments and communication accommodations.
- Ensure “flags” on patient records can be used to identify patient needs and requirements, for example encourage the use of strategies such as health passports.

Recommendations



Introduction

Background

Urgent care refers to healthcare services for minor illnesses or injuries that need attention quickly but are not life threatening. This includes illnesses and injuries that require attention within hours to prevent deterioration but do not require emergency services or hospital care. In the UK, this includes NHS 111 (phone or online), urgent treatment centres (UTCs), GP out-of-hours appointments, walk-in clinics, urgent dental and sexual health services, and pharmacies. These services are intended to provide accessible, efficient alternatives to emergency departments (EDs), helping to manage demand across the urgent and emergency care (UEC) system.

However, health inequalities often prevent equal access to urgent care. These health inequalities include age/frailty, poverty, mental and physical disability, ethnicity, migration status, homelessness, rural isolation, language barriers, or digital exclusion/access issues. Individuals with such health inequalities often encounter disproportionate barriers to timely, appropriate care. This can result in delays in seeking help, an increased reliance on emergency services, worse clinical outcomes, and reduced trust in healthcare systems (Turner *et al*., 2022; Kings Fund, 2022; Dooley *et al*., 2020).

Research suggests that there are several barriers to accessing urgent care including digital exclusion, low health literacy, poor communication from providers, lack of transport, fragmented service design, and structural inequalities (National Voices, 2024; Healthwatch, 2020). Additionally, individuals with complex or chronic needs, such as older adults living with frailty or people with substance use issues, often rely on emergency services due to gaps in access to community-based urgent care (Phelps *et al*., 2022; Chen *et al*., 2015; Booth *et al*., 2019). Furthermore, patients with sensory impairments, language needs or lower digital literacy skills often face barriers with navigating urgent care options, particularly out of hours or digital services (National Voices, 2024; Healthwatch, 2020). Geographic disparities further compound challenges to accessing urgent care. In particular, access to UTCs, GP out-of-hours services, or urgent dental care is inconsistent across regions, with rural populations often facing longer travel distances and fewer local options (Baier *et al.*, 2020; Hedden *et al.*, 2019). Structural and system-level issues, such as fragmented care pathways, inappropriate triage systems, and poor coordination between urgent, primary, and community care, create additional access barriers for underserved populations (Kings Fund, 2024; NHS England HIU Programme, 2024).

The Voluntary, Community, Faith and Social Enterprise (VCFSE) sector plays a critical role in bridging these gaps to urgent care access. Community-based organisations often provide trusted, culturally sensitive support to marginalised groups and have piloted innovative models that have shown some improvement to urgent care access (Booth *et al*., 2019; National Voices, 2024). These interventions show promise for reducing health inequalities and informing system redesign, however there is a lack of research investigating how individuals with health inequalities are accessing urgent care and what can be done to improve access to urgent care amongst these groups. In order to address healthcare access challenges in regard to individuals with health inequalities, it is essential to identify how these individuals are accessing urgent care. Additionally, in line with national NHS policy priorities, such as Core20PLUS5 and the UEC Recovery Plan, there is a growing recognition of the need to understand and replicate models that work for those most at risk of being left behind by current urgent care provision. As such, this report highlights key barriers, enablers, and

recommendations for improving access to urgent care for individuals experiencing health inequalities, with a particular focus on the evidence and perspectives emerging from the VCFSE sector.

Aim

To scope literature and grey research on how service users experiencing health inequalities access urgent care, with a particular focus on work carried out by VCFSE (Voluntary, Community Faith and Social Enterprise) colleagues.

Research Questions

- What research or evidence exists from VCFSE sectors on urgent care access for service users with health inequalities?
- What are the barriers and enablers to access to urgent care?
- How do various health inequalities intersect with access to different types of urgent care (e.g., GP, UTC, dentist)?
- What types of interventions or innovations have VCFSE organisations proposed or tested to increase access to urgent care.

Methods

Scoping review strategy

For this scoping review we followed the PRISMA-ScR (Tricco *et al.* . 2018) guidelines to ensure transparency. The search strategy was developed collaboratively by the research team using PCC format (Joanna Briggs Institute, 2020; - Please see Tables 1-3 for more details). Several terms for urgent care and health inequalities were used. Searches were run in the electronic databases MEDLINE, CINAHL, and the Social Science database and were run from inception to the 17th of July 2025. The search included grey literature, evaluations, and academic papers. See Table 4 for the full search strategy.

Table 1: Population, Concept, and Context information

PCC	
Element	**Description**
Population/Problem	- People with physical, mental, neurological health conditions - Learning disabilities - Sensory impairments (deafness, blindness) - Pregnant people - Transgender individuals - Neurodivergent individuals - non-English speakers - People with alcohol or substance use issues - People experiencing homelessness - Rural populations - Full-time carers - Those with transport issues or digital exclusion
Concept	Access to and experiences of urgent care services, including: - NHS 111 (phone/online) - Urgent care centres, walk-in clinics, minor injury units - GP urgent/out-of-hours appointments - Urgent dental and sexual health care - Pharmacy consultations
Context	UK and global healthcare systems with a focus on VCFSE (Voluntary, Community, Faith and Social Enterprise) sector research and community-led initiatives.

Table 2: Inclusion and Exclusion parameters

Inclusion/Exclusion Parameters		
PCC	**Inclusion Criteria**	**Exclusion Criteria**
Population/Problem	Service users experiencing health inequalities (e.g., mental/physical health conditions, neurodivergent, transgender, sensory impairments, homelessness, substance use, rural, carers, non-English speakers)	Populations without health inequalities
Concept	Research on access to urgent care (NHS 111, GP's, dental, sexual health, pharmacies, UTCs)	Research not on urgent care access (e.g. emergency care or routine care)
Context	NHS, VCFSE, UK (potentially global) Both peer-reviewed literature and grey literature (evaluations, reports, organisational documents)	NA
Publication period	Last 10 years	Older than 10 years

Table 3: Leading terms derived from the PCC tool

Leading terms derived through using PCC tool			
	Population Problem	**Concept**	**Context**
Research question's terms	**Health inequalities**	**Urgent care**	**NHS or VSFCE**
Alternative terms	Vulnerable populations, underserved groups, marginalised communities, disabled persons, neurodivergent, homeless, substance use, non-English speakers, rural populations, carers, pregnant people, transgender individuals, sensory impairments (deaf, blind)	UTCs, walk-in centres, minor injury units, NHS 111, out-of-hours GP, urgent dental care, urgent sexual health services, pharmacy consultations, rapid access care	Third sector, community organisations, charity sector, voluntary sector, civil society, community-led services, non-profit organisations, grassroots organisations

Data extraction

Data extraction was carried out using guidelines outlined in Pollock *et al.* (2023). Relevant data included the aim, data type, methodology, population, how service users are accessing urgent care, recommendations of how can improve access to urgent care, and conclusions. The results of the data extraction can be seen in Table 5.

Synthesis

A thematic analysis approach was used to synthesise the data. A thematic framework was established by revisiting the aims of the study while also identifying any emerging themes using the framework developed by the National Centre for Social Research (Ritche and Spencer, 2002). Prominent themes were identified; from this process several sub-themes also emerged within the overarching themes. Differences in coding were resolved by consensus among the research team.

Table 4. Search strategy for MEDLINE

Via Ovid, search date 18.06.25, records identified 1833
Database: Ovid Medline(R) and Epub Ahead of Print, In-Process, In-Data-Review and Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to present>
1 exp Health Status Disparities/ 2. (“health inequality*” or neurodivergent or transgender or “disabled person*”or homeless or "learning disab*" or "sensory impairment*" or deaf* or blind* or pregnancy or carer* or rural or "substance use" or “Substance-Related Disorders" or "non-English" or "marginalised communit*" or "vulnerable population*" or “underserved population*” or “language barrier*” or carer or digital exclusions).ti,ab. 3. 1 OR 2 4. exp Urgent Care/ 5. ("walk-in centre*" or "minor injury unit*" or "NHS 111" or "out-of-hours GP" or "urgent dental care" or "sexual health service*" or "pharmacy consultation*" or "rapid access care" or "urgent care").ti,ab. 6. 4 OR 5 7. (Access or barriers or use or utilisation or “service engagement” or “healthcare access” or “navigating services” or “access to services” or “service uptake”).ti,ab. 8. 3 and 6 and 7 9. limit 8 to (English language and yr="2015 -Current") **Filters:** Last 10 years, English Language **Study types:** Reviews, evaluations, qualitative studies, reports

Grey literature strategy

This review incorporated grey literature to complement academic sources and ensure inclusion of lived experience, voluntary sector insights, and service-level perspectives often underrepresented in peer-reviewed literature.

Sources Consulted
A targeted list of organisations and platforms was compiled to identify high-quality grey literature relevant to health inequalities, community voice, and access to care. These included:

- **Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector organisations**:
    - National Voices
    - The King's Fund
    - Healthwatch
    - Centre for Mental Health
    - Homeless Link
    - Clinks (criminal justice sector)
    - Mencap, Scope, RNIB, RNID
    - LGBT Foundation
    - Refugee Council
    - Regional VCFSE networks

- **Statutory and system-level sources**:
    - NHS England
    - Local Integrated Care Systems (ICS) and Integrated Care Boards (ICB) websites
    - Community Health Partnerships publications
    - Conferences

Methods of Identification
The following methods were employed to identify and retrieve relevant documents:

- **Google Advanced Search** combining relevant keywords (e.g. "urgent care", "health inequality" and "access to care") with file type pdf to target downloadable grey literature
- **Direct from organisational websites and databases**, including specific charity and think tank repositories to locate annual reports and strategy documents from key VCFSE providers
- **Direct outreach** to select organisations and networks for recent or unpublished material

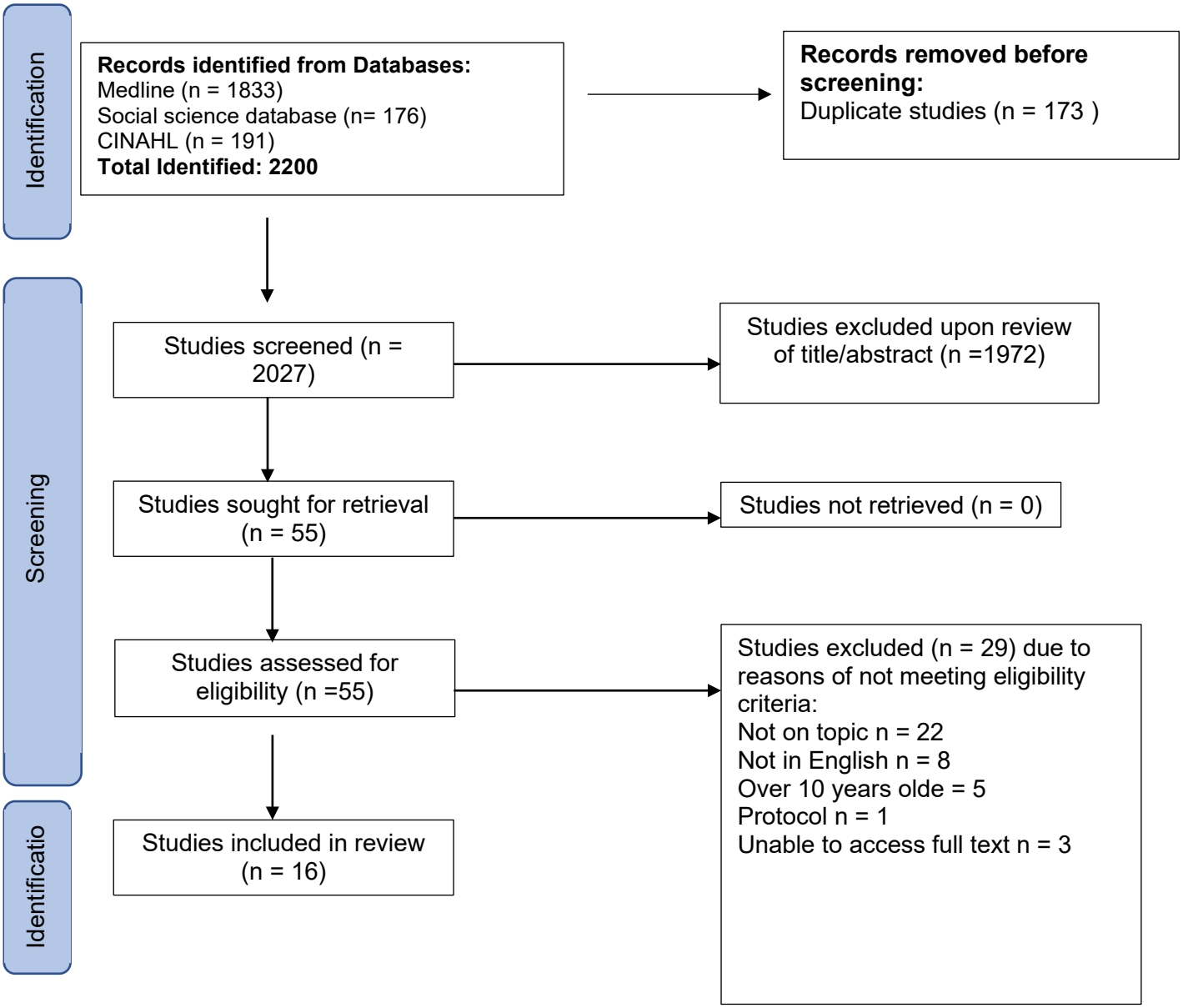
Inclusion Criteria
Grey literature was included based on the following criteria:

- Provided insight into VCFSE perspectives, community voice, or inequalities in access to urgent care.
- Published within the last 10 years.

Findings

A total of 2200 results were identified from the electronic databases. Following removal of duplicate studies, 2027 studies were excluded based on title and abstract screening (see Figure 1). A total of 55 studies remained for full review of which 16 were relevant to the aims of the scoping review and fit within the inclusion criteria of the search.

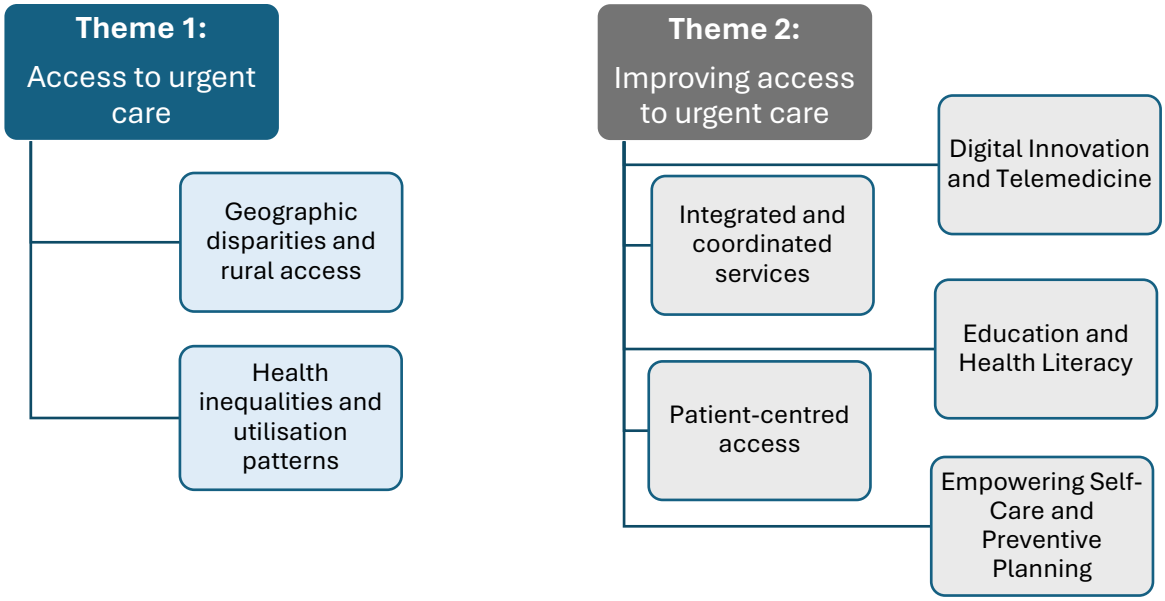
Figure 1: PRISMA 2020 Flow diagram



Thematic analysis

The following themes were identified from the review of the study findings:

Figure 2: Identified themes from scoping review



*Please note the numbers in superscript relate to the respective paper number in the Table 5. Full data extraction results can be seen in Appendix a.

Theme 1: Access to urgent care

1.1 Geographic disparities and rural access

Not all communities have access to adequate urgent care such as UTCs or similar urgent care models. For example, rural populations often face substantial barriers in accessing urgent care services[1, 2, 7]. Individuals in rural areas are more likely to consult their nearest physician, suggesting out of hours primary care is more important in rural than urban areas[1, 2, 7]. Additionally, regional inequities in healthcare infrastructure such as travel distance, transportation issues, and lack of local UTCs contribute to unequal health outcomes and increase reliance on emergency departments. Mapping and addressing these disparities are essential to achieving equitable care delivery [1, 2, 7]. Paper 2 provides an example of a spatial measure of access by looking at physician density, distance to nearest physician, and perceived spatial access. Improving access in rural regions requires tailored strategies that take into account local healthcare infrastructure and workforce shortages.

1.2 health inequalities and utilisation patterns

The research revealed that different groups access healthcare differently. For example, certain groups disproportionately rely on emergency care rather than using urgent care. These include the elderly, drug users, younger adults, people with low income, individuals with limited education, and individuals who have other co-morbidities[6]. The research suggested that frail older adults and people with complex conditions often use emergency care due to accessibility challenges or because their health needs are not met by standard urgent care services[3, 4, 9]. People from low-income likely access emergency care rather than urgent care due a lack of local urgent care providers[6]. Individuals with limited education tend to access inappropriate care due to a lack of awareness of appropriate health

services or a misunderstanding of their health care needs due to poor health literacy[6]. Drug users often receive fewer outpatient or inpatient services which leads to increased emergency department use[3]. UCCs are particularly important for underserved populations however they are not available to all.

Theme 2: Improving access to urgent care

2.1 Integrated and coordinated services

One of the main suggestions for increasing access to urgent care is improving the integration, coordination, and communication between urgent care, primary care, and community services [4, 5, 6, 7, 9, 10, 11, 12, 13, 15]. The research suggests that this can be done by improving triage services, and integrating care pathways through the use of care navigators, community outreach, integration of UTCs, and regular follow-up for vulnerable groups. Improved integration and coordination of care can help reduce inappropriate urgent care use, ED overcrowding, and improve patient outcomes [4, 5, 10,11, 12, 13, 15]. Paper 7 provides examples of specific approaches that have been used in previous research, this includes using a patient navigator programme which was aimed to work with providers, nurses, social workers and care managers to support patients to best understand, access and utilise the health-care system, along with family members and Hospital EDs linked to local primary care providers. Additionally, they noted that front of A&E GPs can work in helping refer people to relevant services which is important for individuals who have difficulty navigating primary care, such as migrants or those whose first language is not English. Paper 15 suggests that the Nurse Practitioner role is also essential to providing integrated and coordinated urgent care.

2.2 Patient-centred access

One strategy that emerged from the literature in regard to improving access to urgent care for individuals with health inequalities was to ensure urgent care is patient centred[5,7,13]. Healthcare access is highly individualised, people use urgent care differently based on their context, needs, and perceptions. This means a one-size-fits-all model is inadequate. Additionally, barriers to accessing urgent care may differ between different groups, thus there is a need for a nuanced understanding of these diverse populations [7]. Effective urgent care systems must account for patient preferences, local demand, and barriers to access, including accessible language support, improving health literacy, and consideration of socio-economic factors[5,7,13]. Paper 7 describes the importance of person-centred approaches such as using migrant support programmes for those from ethnic minorities or those whose first language is not English.

2.3 Targeted, Locally Informed Urgent Care Services

Furthermore, the literature suggests that services must be planned around local population needs. This includes using demographic and service use data to design targeted interventions for groups that are underserved by urgent care or at higher risk of using emergency care inappropriately[1, 2, 5, 7].

2.4 Digital Innovation and Telemedicine

The literature also suggested that is important that urgent care considers alternatives to physical access, such as the use of telemedicine and online triage, particularly for rural or mobility-restricted populations, as well as groups which require additional language support [8, 11, 14, 16]. Paper 8 and 14 provide evaluations of digital approaches to urgent care which have shown some success, with paper 8 showing positive results of a digital and online symptom checker for urgent health problems, and paper 14 demonstrating that a web portal designed such that any patient-provider encounter that could occur in person could be delivered through a synchronous online portal also showed some initial success. However, digital exclusion remains a concern, in particular digital services are more likely to be used by younger or highly educated people[8]. To ensure digital solutions are equitable, investment in infrastructure, digital literacy support, education, and translation services are needed [16].

2.5 Empowering Self-Care and Preventive Planning

Additionally, the literature suggests that urgent care reform should focus on proactive care planning

and self-management support. Improving patients' ability to manage their health through education, coaching, and appropriate follow-up can prevent crises and reduce unnecessary urgent care use[3, 4, 9, 10, 11]. Paper 3 and 11 suggests that this is particularly important for patient groups that have co-morbidities, long term physical health conditions such as diabetes, and are frequent users of emergency services such as people affected by alcohol or substance abuse.

2.6 Education and Health Literacy

In addition to empowering patient self-care, educational interventions are also essential to improving patient healthcare navigation and ensuring the appropriate use of healthcare services [5, 6, 9, 11, 12]. This could include carrying out public health initiatives and wider advertising activities of when urgent vs emergency care is more appropriate as well as improving the populations health literacy to ensure a wider audience reach. These educational interventions need to be aimed at not just patients but also healthcare providers, and carers. Paper 7 suggests that using a case management approach to assist patients with barriers to finding non-emergent care and educating patients could be a potential way of achieving this. Additionally, paper 9 suggests that caregiver education and dementia specialists, could both mitigate avoidable urgent care use and patients experience of health care.

Table 5. Study information for included papers

N	Title	Authors	Year	Country
1	Trends in Providing Out-of-Office, Urgent After-Hours, and On-Call Care in British Columbia	Hedden *et al.*	2019	Canada
2	Capturing modelled and perceived spatial access to ambulatory health care services in rural and urban areas in Germany	Baier *et al.*	2020	Germany
3	Health service utilization of heroin abusers: A retrospective cohort study	Chen *et al.*	2015	Taiwan
4	What are the goals of care for older people living with frailty when they access urgent care? Are those goals attained? A qualitative view of patient and carer perspectives	Phelps *et al.*	2022	England
5	The Role of Urgent Care Clinics in Alleviating Emergency Department Congestion: A Systematic Review of Patient Outcomes and Resource Utilization	Abullah *et al.*	2025	SAU
6	Code Not-So-Blue: Burden and Predictors of Nonurgent Visits to the Surgical Emergency Room in Peshawar, Pakistan	Khan *et al.*	2025	Pakistan
7	Interventions to manage use of the emergency and urgent care system by people from vulnerable groups: a mapping review. Health Services and Delivery Research	Booth, *et al.*	2019	UK
8	Digital and online symptom checkers and assessment services for urgent care to inform a new digital platform: a systematic review	Chambers *et al.*	2019	UK
9	Urgent care for patients with dementia: a scoping review of associated factors and stakeholder experiences.	Dooley *et al.* .	2020	UK
10	Dermatology urgent care model reduces costs and healthcare utilization for psychodermatology patients - a retrospective chart review	Jonhson *et al.*	2022	USA
11	'Well, who do I phone?' Preparing for urgent care: a challenge for patients and service providers alike'	Coates *et al.*	2015	UK
12	Community partnerships within a novel dental school urgent care center: Student perceptions	Crivello *et al.*	2020	USA
13	Babies, children and young people's experience of healthcare	NICE	2021	UK
14	Advancing health equity and access using telemedicine: a geospatial assessment	Khairat *et al.*	2019	USA
15	Nurse practitioner led model of after-hours emergency care in an Australian rural urgent care Centre: health service stakeholder perceptions	Wilson, *et al.*	2021	Australia
16	Patient and Visit Characteristics of Families Accessing Paediatric Urgent Care Telemedicine During the COVID-19 Pandemic	Solo-Josephson *et al.*	2022	USA

Specific examples from Paper 7 (Booth *et al.* 2019):

Paper 7 provided examples of interventions which have been used to manage the use of the emergency and urgent care systems by vulnerable groups. However, it should be noted that a lot of the samples included in this paper were that of frequent users of the emergency department (ED) and not necessarily specific to individuals with health inequalities or urgent care.

Nine different intervention types were reported that were delivered across the emergency and urgent care system. These included: care navigators, care planning, case finding, case management, care planning, front of accident and emergency general practice/front-door streaming model, migrant support programme, outreach services and teams, rapid access doctor/paramedic/urgent visiting services and urgent care clinics. Relevant papers from Paper 7 are presented below in Table 6.

Table 6. Examples of interventions provided in Paper 7

Authors	Country	Population	Description of the intervention	Outcomes
Shnowske *et al.* (2018)	USA	Aged > 18 years, assigned a care guide as identified as having recurrent visits for non-emergent complaints	Case management via a care guide who assisted patients with barriers to finding non-emergent care, such as identifying primary care, scheduling appointments, educating patients and helping with financial management of medical care	Care guide initiation does reduce ED use by at least 40% for non-emergent and chronic complaints
Bodenman n *et al.* (2017	Switzerla nd	Frequent users (five or more visits in the previous 12-month period) aged > 18 years	Case management in addition to emergency care at 1, 3 and 5 months. Interdisciplinary mobile team	Intervention group made 19% fewer visits
Edwards *et al.* (2015)	UK	Frequent ambulance callers, mostly with multiple and complex reasons for calling and who required multiple interventional strategies	Case management intervention	Significant reduction in median call volume observed as a result of the individualised case management programme. The programme found that these callers had complex unmet medical, mental health, social and personal care needs
Fiesseler *et al.* (2015)	USA	'Patients at high risk for drug seeking behaviour	Care plan initiated by an ED staff member. Primary care physician contacted and if agreed an ED care plan was put in place. The plan directed patients to visit the ED for new or recurring symptoms but outlined that they would be screened on arrival and if there was no new disease there would be no opioid administration	Mean ED visits declined
Garbers and Peretz (2016)	USA	Patients without a primary care provider, without insurance or who had visited the ED more than once in the preceding 12 months	Patient navigator programme aimed to work with providers, nurses, social workers and care managers to support patients to best understand, access and utilise the health-care system, along with family members	Mean ED visits declined
Kim *et al.* (2015)	USA	Low income/uninsured	Hospital EDs linked to local primary care providers. ED staff referred patients to clinics. Describes a number of sites that implemented similar models. 'Navigators' in hospitals and clinics	ED visits declined
Rathlev *et al.* (2016)	USA	Patients with opioid use disorder and high-frequency ED use	Care plan instituted and added to the electronic health record	Did not alter number of ED visits

Grey literature findings

To complement the findings of the scoping review, relevant grey literature was identified and summarised. Sources included policy reports, briefings, and publications from key VCFSE organisations, think tanks, and statutory bodies (e.g. National Voices, The King's Fund, NHS

England). These sources offered valuable perspectives on community needs, lived experience, and service-level responses to health inequalities.

The results of the grey literature broadly echoes the main themes identified in the scoping review. The grey literature emphasised access barriers, systemic inequities, and the need for more inclusive, community-informed approaches. A summary of the grey literature focus, populations of interest, key findings, and recommendations are provided in the table below.

Table 7. Grey literature findings

Reference	Focus	Population(s)	Key findings	Recommendations
National Voices (2024)	Workshop to consider the experiences of diverse patient groups when they access Urgent Primary Care when their GP surgery is closed.	Children and young people People experiencing mental health crisis Frail and older people People at end of life People with special access requirements.	Identified several key access challenges: 1) Lack of awareness and understanding – people do not know what service to access, particularly for immigrant population. 2) Communication and accessibility issues – urgent care more inaccessible than regular daytime services due to digital exclusions and failing to meet additional communication needs 3) inconsistent services across the country – particularly in rural areas. 4) lack of shared records across regular daytime and out of hours services – patients must repeat information, flags are not on patient records etc. 5) lack of integration within the wider healthcare system – gaps between urgent primary care and VCFSE, secondary care and primary care. 6) Rigid systems that do not respond to complexity – reliance on scripts, particularly NHS 111 means ill-equipped to deal with complex issues.	Implementing the Accessible Information Standard and the Reasonable Adjustment flag across all services. Ensuring that patients' access to public and private transport is considered when making referrals. Training staff in a) active listening and person-centred support. b) supporting people who may be more vulnerable. Improving communication by a) using a range of formats to convey when and how services can be accessed. b) using a range of tools – e.g. leaflets, texts, voice notes – to give people "take away" information. Reconfiguring services: offering more direct routes back into services; creating more effective pathways by joining up NHS, social care and VCFSE out-of-hours support through better signposting and understanding of what is available, to who and when; sharing records; moving away from scripted interactions; Move towards seven-day services to remove the dividing line between out-of-hours and regular primary care services.
NHS England High Intensity Use Programme	High intensity use and health inequalities in urgent care.	Frequent users, deprived communities.	HIU services reduce ED use and support integration. HIU services are locally funded and are largely delivered in the community via VCFSE organisations.	Expand HIU coverage across ICSs and partner with VCFSE sector.
The Kings Fund 2022	Health inequalities in emergency medicine.	Individuals with health inequalities.	Individuals with health inequalities are more likely to use A&E.	Need to improve signposting to other appropriate services, provide holistic support, and consider population/contextual factors.

The Kings Fund 2024	Tackling health inequalities.	Individuals with health inequalities (not specific to UC).	Barriers to accessing health care include: - Discrimination and racism. - Not being treated with empathy or feeling genuinely listened to. - Lack of communication from services - feeling of powerlessness - Practical barriers, e.g., travel costs. - Shame and stigma. - Services not being flexible, holistic or inclusive enough. - Lack of trust and engagement due to negative experiences in the past.	Tackling health inequalities and improving access to health care requires: - Integrating health systems. - Tackling the wider determinants of health. - Tackling racism and discrimination in the NHS and cultivating a culture of compassion. - Focusing on prevention. - Actively supporting local VCFSE organisations.
Healthwatch 2020	Different outcomes, Different access to care the views & experiences of people who are likely to experience health and care inequalities in Buckinghamshire, Oxfordshire, Reading, West Berkshire & Wokingham Borough.	People experiencing health and care inequalities (not specific to UC).	Individuals with health and care inequalities face the following barriers to accessing care: - Administrative barriers e.g., letters difficult to understand - Geographical barriers. - Access thresholds that leave patients/service users without help. - System barriers – integration of services.	Services must be personalised to people's individual needs. Services must consider: Communication - each service must be able to communicate effectively and respectively with everyone. Training is needed on respectful listening, support for communication needs, consideration of staff attitudes, awareness and knowledge. Access - each service must be able to adapt to meet the needs of all service users. Services should use patient, carer, and family feedback to inform service design.
National Audit Office 2023	Access to unplanned or urgent care.	Not specific to individuals with health inequalities - more general.	Demand for urgent care is increasing. There has been increased use of urgent care in general practices, community pharmacists, and calls to NHS 111.	Patients access to services for urgent care has worsened - there needs to be improvements in transferring patients from one service to another.
Turner *et al.* 2022	Socioeconomic inequality in access to timely and appropriate care in emergency departments.	Data from all major EDs in England during 2016/17.	Patients from deprived areas face longer wait times, less complex ED care, and are less likely to be admitted to inpatient care, more likely to reattend ED, and experience unconscious bias from physicians.	No recommendations provided.
RCEM Learning Herrieven (2025)	Health Inequalities in the ED.	Individuals with health inequalities.	People living in more deprived areas are 2.5 times more likely to go to the ED with preventable emergency admissions and are more likely to report negative experiences of primary care, primarily a lack of access to GPs. Black patients are least likely to use online services to access Primary Care. Individuals with learning disability are not accessing urgent/emergency care due to lack of reasonable adjustments in those settings.	No recommendations provided.

Scottish Government 2021	Redesign of urgent care: equality impact assessment.	Individuals with health inequalities.	The Scottish Government is undertaking a system redesign of urgent care. The aim of this redesign is to provide an accessible, efficient, effective and safe urgent care service for the public ensuring patients receive the right care, in the right place, at the right time, first time. As part of this redesign they introduced: 1 New clinical pathways to reduce waiting rime 2 Provided alternative, accessible and innovative solutions to A&E for urgent care needs using technology, including a Telephone and Digital First approach via NHS 24 on 111. 3 Delivered a safe and robust process for scheduling attendances to our A&E and Acute Assessment Units. 4 Provided equitable access by delivering effective, accessible and inclusive communication and public messaging to improve access to urgent care services with a particular focus on seldom heard groups. Through a scoping exercise they found: - Women are more likely to use NHS 111 - Women with children under 5 are more likely to access urgent care - NHS 111 is used more by young people - Older age groups are more likely to attend ED - UC is more likely to be used by people from deprived backgrounds (rather than ED) - There are data gaps on disability and race - Digital models risk excluding certain groups e.g., individuals from socioeconomically disadvantaged backgrounds, older people, disabled people, and non-English speakers. - Transport and geography remain major barriers. People in rural or remote areas may be unable to access care if directed to facilities outside their local area, especially during out-of-hours periods. - Poor communication about changes led to confusion and increased anxiety. There was a lack of accessible information (e.g., Easy Read formats, multiple languages).	Understanding the patient experience is fundamental to the redesign of urgent care. To do this it is essential that healthcare systems: - Understand the needs of all citizens and key stakeholders. - Explore the impact of the Redesign of Urgent Care on all parts of the system. - Identify if patients are receiving right care first time. Recommendations: - Implement targeted communication strategies that use multiple languages, formats (texts, leaflets, voice notes), and trusted community channels. - Introduce reasonable adjustment flags in systems so that staff are immediately aware of specific access needs. - Provide basic mobile devices and digital literacy support, particularly to people experiencing homelessness or digital exclusion. - Collaborate with VCFSE organisations and use community spaces (e.g., libraries, shelters, faith venues) as access points for urgent care support. - Address transport inequalities by factoring local infrastructure and cost into care pathway planning. - Recognise and mitigate the intersectional barriers faced by people with overlapping vulnerabilities (e.g. non-English speakers with disabilities).
NHS report Holmes (2023)	Inclusive recovery and tackling inequalities in urgent and emergency care.	People in deprived areas in the UK.	A&E attendances are twice as high in the most deprived areas.	Implement a long-term UEC strategy focused on improving population health and reducing inequalities. Address workforce shortages. NHS trusts should work closely with system partners to reduce demand by tackling root causes like poor health in deprived communities.

European Commission Beaten *et al.* (2018)	Inequalities in access to healthcare across Europe	Vulnerable groups in 35 European countries including low-income populations, rural residents, Roma, migrants, women.	Inequities stem from issues like inadequate funding, fragmented coverage, high user charges, and rural service unavailability. Vulnerable populations face the greatest access barriers. Inequities are not linked to health system model (e.g., whether NHS or private) but to specific organisation mechanisms.	Invest in integrated primary care, especially in rural areas. Incentivise health professionals to work in underserved areas. Proactively target vulnerable groups (e.g. Roma, migrants) via health campaigns and cultural mediators. Run info campaigns to raise awareness of healthcare rights among minorities and marginalised groups.
AHRQ Health Equity Summit Jindal *et al.* . (2023)	Addressing inequities in healthcare access through a health equity lens.	Racial/ethnic minorities, economically/socially/geographically disadvantaged groups in the U.S.	Health care inequities persist across various disadvantaged groups. Root causes include systemic oppression, marginalisation, and racism. Access issues must be understood through a health equity framework.	**Approachability**: Build trust through anti-racist toolkits, community-engaged research, and improving health literacy. **Acceptability**: Adapt services to better meet diverse cultural/social needs; diversify the health workforce and implement anti-racist education tools. Fund research and training for co-production and novel info dissemination strategies.
Healthwatch Suffolk 2023	Access to health and care for d/Deaf and hard of hearing people.	147 Deaf and hard of hearing people in Suffolk – not specific to urgent care but healthcare more generally.	The NHS Accessible Information Standard is not being met consistently. 33 individuals said they don't need any support from services to receive information, treatment or care. 58 people felt they needed various forms of support to access health and social care services. Records are not being shared, and needs are not always being flagged. Relevant quotes: "I felt frustrated, stressed, and incredulous that, in this day and age of 'inclusivity and diversity', that hearing loss and deafness awareness and accessibility is so badly lacking or non-existent." "Greater awareness of hidden disabilities is needed, and staff actively asking about communication needs." "They have access to my medical records and must be able to flag that I am hard of hearing. Yet, I must go through the same explanation every time."	Healthcare services need to ask people about their specific communication needs. Deaf awareness training. Update records and flag needs to staff. Provide a range of contact methods. Visible and accessible information.
Healthwatch Suffolk 2022	Experiences of accessible health and social care in Suffolk	Suffolk residents including individuals with communication needs and older adults.	Within Suffolk individuals are less likely than those nationally to have been refused information in alternative formats. One in six (16%) Suffolk residents said they struggle to understand, or don't understand, most of the information given by services, whereas nationally this is	No recommendations provided.

			one in four. Over one in four (29%) had been refused support to understand healthcare information. Staff attitudes were the main factor influencing whether individuals felt confident asking for support Suffolk people reported more difficulties with accessing their GP, dentist, and mental health services due to communication difficulties than the national survey respondents.	
Healthwatch Suffolk 2021	Digital Health & Care – a report on local experiences in Suffolk and North East Essex.	Surveys with 517 individuals in Suffolk and North East Essex. Not specific to urgent care.	Digital exclusions identified were poor signal, affordability, lack of digital skill, do not want to use, no access to devices, worries about security and lack of confidence. Barriers to using digital services included disability/health conditions, lack of equipment, lack of computer skills, knowledge of what services are available, digital not offered by all health services, and complicated systems.	Face-to-face contact is important for individuals with digital exclusions – important to have choice of which method of access they would like. Digital systems need to be made more accessible and user friendly.
Healthwatch Essex 2021	Co-designing accessibility to health services in Mid and South Essex.	Individuals with learning disabilities.	Need for personalised care, flags on records, capacity and willingness of staff to accommodate for the needs of learning disability patients is often low, unclear how to access certain services.	Need to work with patients' groups to develop personalised and targeted interventions. There is a need to improve record sharing and simplify flags of patients' needs. This needs to be standardised. Training courses aimed at promoting holistic understanding of patient.

Feedback from local services

As part of the grey literature scope, we also reached out to local service providers to gather additional, practice-based insights and to assess the extent to which local perspectives align with findings from the published literature. In particular, we engaged with a local VCFSE-sector organisation who shared insights from a recent Patient Advisory Group meeting which focused on individuals with health inequalities and urgent care access. Participants of the group included individuals with learning disabilities, long term conditions, carers, and individuals who did not speak English as a first language. The meeting highlighted the need for long term interventions that are co-produced with relevant local advocates. The following themes from the literature were supported from the responses at the local level meeting.

Integrated and coordinated services

Consistent with findings in the academic and grey literature, poor coordination inadequate sharing of patient information between services was identified as a significant barrier. As one individual noted:

> *"What astonishes me is that every single one of us has information about who we are and what we struggle with generally is on our record somewhere. But we are forever explaining ourselves, retelling our story, having to explain ourselves in situations which are quite frankly quite traumatic."*

Patient-Centred Access

Furthermore, several individuals noted several barriers related to a lack of person-centred care, in particular rigid, inflexible systems that fail to accommodate complex needs. The NHS 111 service was described as overly rigid, with insufficient adaptability for patients requiring urgent or compassionate response:

> *"When I've rung 111, they ask too many questions."*
>
> *"So, families who've got children with severe learning disabilities and challenging behaviour... the range of questions, the disbelief, when in the background you can hear the child clearly self-injuring, is really challenging for our families."*

Additionally, several individuals noted that urgent care facilities often do not account for reasonable adjustments and accessible facilities. In general, it was noted that the NHS accessible information standard is not being used consistently.

> *"My main issue is when I go to wherever I need to, I don't always know how accessible the building is because there isn't that information available online."*
>
> *"I walk into the hospital building and I'm very light-sensitive, I'm autistic, and I struggle massively in these buildings."*

Poor communication and staff attitudes were cited as further barriers to accessing urgent care:

> *"You're infantilised, you're spoken to like a child, not respected in the same way."*
>
> *"I phoned up one day... I could barely speak... and was told quite bluntly by the doctor, 'Well, if you can't get down to see me, there's nothing I can do for you.' And it was awful."*

Language was also a key barrier, particularly for migrant communities:

> *"We are representing many communities where the language is really a barrier and we are running the ESOL English for health courses, where we are trying to explain NHS 111 and pharmacy and urgent NHS dentist as well."*

Digital Innovation

Digital tools and communication strategies offer opportunities to enhance access, but concerns remain regarding digital exclusion. While some groups benefit from online information sharing, improving digital communications was highlighted as a priority at the local level:

> *"We can access excellent social media posts that we can forward out but we're not meeting the needs of those that aren't digitally connected."*
>
> *"I think we could do a lot around improving communications."*

Education and Health Literacy

Individuals repeatedly emphasised the lack of awareness around available urgent care services and how to use them appropriately. We were informed that at the meeting there was a general lack of knowledge among participants about urgent treatment centres, in particular what they offer, or even where they are located. Thus, highlighting a significant gap in public-facing education and signposting about appropriate services. The group emphasised that education needs to be consistent, with regular messaging to ensure individuals are aware of which service they should be accessing:

> *"People need the awareness of where to go and for what and then they can make better decisions. Because otherwise, we get what we have, and people go to the wrong service. And think of the cost of that daily."*

Discussion and implications

This review demonstrates that individuals with health inequalities often experience persistent barriers to urgent care access. These barriers are multifaceted, complex, structural, and systematic. Frequently mentioned barriers include: Inconsistent geographical provision of urgent care, particularly in rural areas where individuals have limited access to urgent care; digital exclusions, particularly for older adults, non-English speakers, and lower socio-economic groups; failure to meet language and communication needs, particularly for individuals with learning disabilities, communication difficulties, and non-English speakers; limited health literacy resulting in individuals being unsure of which service is appropriate for their needs; and poor integration between services resulting in fragmented care.

Additionally, the evidence suggests that different populations access urgent care differently. For example, older populations living with frailty, people with substance use disorders, individuals experiencing homelessness, people with low income, those with cognitive or sensory impairments, and people from minoritised or non-English speaking backgrounds, are far more likely to access emergency care rather than urgent care even when urgent care would be more appropriate. This results in increased reliance on emergency departments, delayed interventions, and missed opportunities for prevention and early support. Conversely, the literature suggests that urgent care, in particular GP services, are used more by rural populations (due to a lack of local emergency services), individuals from deprived backgrounds, and women.

The evidence highlights that inappropriate emergency care use may be due to a lack of timely, accessible, and appropriate urgent care services. Additionally, poor health literacy and a lack of awareness of appropriate health care systems also plays a predominant role in individuals not attending urgent care. Communication issues, a lack of reasonable adjustments, and poor integration between services further compound these challenges. Although not limited to urgent care, results also revealed that discrimination and racism was seen as an inhibitor to accessing healthcare. These challenges to accessing urgent care were highlighted in both the academic scoping review and the grey literature, highlighting the urgent need for targeted interventions to address these barriers and promote equitable access to urgent care for individuals with health inequalities.

While national strategies increasingly recognise the need to address health inequalities, the findings indicate that current urgent care models are often not adequately configured to meet the diverse needs of these populations. Fragmented pathways limited out-of-hours access, and a digital-first approach, without appropriate safeguards, can further marginalise those already at risk of poor health outcomes. The literature highlighted a range of strategies to improve access to urgent care for populations experiencing health inequalities. Key strategies include better integration between urgent, primary, and community care, potentially supported by care navigators and coordinated pathways. A person-centred approach is essential, recognising the diverse needs and barriers faced by different groups. Services should be informed by local data to target underserved populations effectively. While digital tools offer potential benefits, they must be designed with avoiding digital exclusions in mind. Additionally, improving the populations health literacy through patient education and increased awareness of available services is important in helping reduce avoidable urgent care and improve system navigation.

The review identified several promising interventions, particularly within the VCFSE sector. These include community-based triage and navigation, targeted outreach programmes, and digitally supported care with accessibility features. While effective, these models are often locally driven, inconsistently implemented, and not routinely embedded in wider system design. Nevertheless, the review highlights that there is the potential to create urgent care delivery models that are inclusive, informed by local population needs, have improved system navigation and coordination amongst different healthcare sectors, and embed reasonable adjustments. Such urgent care models would

have the potential to reduce inequity in accessing urgent care within populations who experience health inequalities.

It is important to note that across both the peer-reviewed and grey literature, there was considerable variation in how urgent care was defined and operationalised, with many studies conflating urgent and emergency services or focusing primarily on emergency department use. This inconsistency presents a methodological challenge and suggests a significant evidence gap. Without clearer definitions and dedicated research into the use and accessibility of urgent care services, efforts to improve equity of accessibility in this area may be hindered.

Summary and Recommendations

Below are the specific recommendations to increasing urgent care access for individuals with health inequalities based on findings from the literature. Please note that the order of the recommendations is in line with the prevalence of which the recommendation was noted in the review of the literature and grey reports.

1. Triage, Navigation, integration, coordination, and System Design

Key Issues:

- Confusion about available services.
- Inadequate discharge communication and care coordination.

What's Working:

- Walk-in and urgent care centres improve satisfaction.
- Structured triage reduces ED demand.

Recommendations:

- Develop and evaluate "front-door" UC models.
- Improve navigation tools and transitions of care.
- Improve integration and communication between UC, primary and community services.
- Utilise VCFSE organisations as alternative options for accessing urgent care.
- Improve the sharing of records between different services.
- Improve education around the right systems to use according to needs/symptoms.
- Use multiple public education strategies and tools to increase awareness around signposting to different types of care and services available.

2. Health Literacy and Empowerment

Key Issues:

- Low health literacy and poor self-management lead to increased use of UCs.
- Common among caregivers and those with chronic illnesses.

What's Working:

- Education and care coordination reduce in appropriate ED visits in targeted populations (e.g., diabetes, dementia).

Recommendations:

- Provide tailored education and self-management support.
- Support caregivers and patients with complex needs.
- Identify the root cause of poor health in deprived communities to develop interventions that tackle access challenges.

3. Targeted interventions which address specific needs of disadvantaged group

Key Issues:

- High inappropriate emergency care use among people with low income, frailty, dementia, co-morbidities, alcohol/substance abuse, and rural residents.

What's Working:

- Targeted, community-based clinics designed around specific needs.

Recommendations:

- Develop person centred and context-specific interventions.

- Address social determinants and provide support to prevent inappropriate emergency care use such as improving care pathways, triaging, health literacy and education.
- Train staff on how to achieve reasonable adjustments, communication needs, staff attitudes, and awareness of needs of different populations.
- Develop and evaluate more mitigation strategies that support equal access.
- Ensure “flags” are used to highlight the needs and considerations needed for certain patients.
- Proactively target vulnerable groups by health campaigns and cultural mediators such as community groups.

4. Digital Access & Virtual Care (VC)

Key Issues:
- VC may increase inequities (access, transport, language barriers).
- Rural and older populations face digital access issues.

What’s Working:
- High satisfaction among rural and educated users.
- VC reduces travel and in-person waiting times.

Recommendations:
- Bridge the digital divide with translation, support, and training.
- Promote awareness of VC options in underserved communities.

5. Geographic and spatial access and understanding local needs

Key Issues:
- Rural areas face long travel distances and urgent care options.
- Urban/rural differences in service availability.

What’s Working:
- Rural physicians are more likely to offer after-hours care

Recommendations:
- Tailor spatial planning to rural vs. urban needs.
- Support alternative urgent care provision in underserved areas.
- It is important that changes to urgent care are co-developed with the local population and consider the needs of the local population.

Conclusions

This review highlights persistent barriers to accessing urgent care for individuals’ with health inequalities. Despite national priorities to reduce health inequalities, current urgent care models are often fragmented, difficult to navigate, and insufficiently responsive to population diversity. However, this review identified promising interventions, particularly from the VCFSE sector, which could increase access to urgent care. Improving access will require urgent care models to shift towards co-designed, locally informed services that prioritise inclusivity, service integration, and are person-centred to meet the needs of diverse populations to ensure everyone can access the right care, in the right place, at the right time.

References

- Alaqil, N.A.N. et al. (2025) The role of urgent care clinics in alleviating emergency department congestion: a systematic review of patient outcomes and resource utilization. Cureus, 17(4).
- Baier, N. et al. (2020) Capturing modelled and perceived spatial access to ambulatory health care services in rural and urban areas in Germany. Social Science & Medicine, 265, p.113328.
- Bodenmann, P. et al. (2017) Case management may reduce emergency department frequent use in a universal health coverage system: a randomised controlled trial. Journal of General Internal Medicine, 32, pp.508–515.
- Booth, A. et al. (2019) Interventions to manage use of the emergency and urgent care system by people from vulnerable groups: a mapping review. Health and Social Care Delivery Research, 7(33), pp.1–46.
- Chambers, D. et al. (2019) Digital and online symptom checkers and assessment services for urgent care to inform a new digital platform: a systematic review. Health Services and Delivery Research, 7(29), pp.1–88.
- Chen, I.M. et al. (2015) Health service utilization of heroin abusers: a retrospective cohort study. Addictive Behaviors, 45, pp.281–286.
- Coates, V.E. et al. (2015) 'Well, who do I phone?' Preparing for urgent care: a challenge for patients and service providers alike. Journal of Clinical Nursing, 24(15–16), pp.2152–2163.
- Crivello, B.J. et al. (2021) Community partnerships within a novel dental school urgent care center: student perceptions. Journal of Dental Education, 85(8), pp.1396–1403.
- Dooley, J. et al. (2020) Urgent care for patients with dementia: a scoping review of associated factors and stakeholder experiences. BMJ Open, 10(9), p.e037673.
- Edwards, M.J. et al. (2015) Frequent callers to the ambulance service: patient profiling and impact of case management on patient utilisation of the ambulance service. Emergency Medicine Journal, 32, pp.392–396.
- European Commission (2018) Inequalities in access to healthcare across Europe. Available at: https://www.ygeiamou.gr/wp-content/uploads/2023/04/KE-03-18-334-EN-N.pdf [Accessed 28 July 2025].
- Fiesseler, F. et al. (2015) Care plans reduce ED visits in those with drug-seeking behavior. American Journal of Emergency Medicine, 33, pp.1799–1801.
- Garbers, S. and Peretz, P. (2016) Urban patient navigator program associated with decreased emergency department use, and increased primary care use, among vulnerable patients. Journal of Community Medicine & Health Education, 6, p.440.
- Healthwatch Bucks, Oxfordshire, Reading, West Berkshire & Wokingham (2021) Different outcomes, different access to care. Available at: https://nds.healthwatch.co.uk/reports-library/different-outcomes-different-access-care [Accessed 28 July 2025].
- Healthwatch Suffolk (2021) *Digital health and care: exploring experiences and accessibility* [PDF]. Healthwatch Suffolk. Available at: https://healthwatchsuffolk.co.uk/wp-content/uploads/2021/05/Digital-Health-and-Care-Final-Copy-1.pdf (Accessed: 29 July 2025) healthwatchsuffolk.co.uk.
- Healthwatch Suffolk (2022.) *Your Care, Your Way: people's experiences of accessible information and support* [online]. Healthwatch Suffolk. Available at: https://healthwatchsuffolk.co.uk/your-care-your-way/ (Accessed: 29 July 2025) healthwatchsuffolk.co.uk+11healthwatchsuffolk.co.uk+11healthwatchsuffolk.co.uk+1

1.
- Healthwatch Suffolk (2023) *Access to health and care for d/Deaf and hard of hearing people: a 'Your Care Your Way' campaign survey* [PDF], August 21 2023. Healthwatch Suffolk. Available at: https://healthwatchsuffolk.co.uk/wp-content/uploads/2023/08/dDeaf-report_FNL_HWS-2023V2.pdf (Accessed: 29 July 2025).
- Healthwatch Suffolk (2025) *On the Virtual Ward: carers' experiences of the virtual ward service* [PDF], February 2025. Healthwatch Suffolk. Available at: https://healthwatchsuffolk.co.uk/wp-content/uploads/2025/02/Virtual-ward_February-2025-Updated.pdf (Accessed: 29 July 2025) healthwatchsuffolk.co.uk.
- Hedden, L. et al. (2019) Trends in providing out-of-office, urgent after-hours, and on-call care in British Columbia. The Annals of Family Medicine, 17(2), pp.116–124.
- Holmes, L. (2023) Inclusive recovery and tackling inequalities in urgent and emergency care. BMJ, 380, p.p502. Available at: https://www.bmj.com/content/380/bmj.p502 [Accessed 28 July 2025].
- Jindal, S. et al. (2023) Addressing inequities in healthcare access through a health equity lens. Health Services Research. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.14202 [Accessed 28 July 2025].
- Joanna Briggs Institute (2020) JBI manual for evidence synthesis. Chapter 11: scoping reviews. Available at: https://synthesismanual.jbi.global [Accessed July 2025].
- Johnson, J. et al. (2022) Dermatology urgent care model reduces costs and healthcare utilization for psychodermatology patients - a retrospective chart review. Dermatology Online Journal, 28(5). doi: 10.5070/D328559260.
- Khairat, S. et al. (2019) Advancing health equity and access using telemedicine: a geospatial assessment. Journal of the American Medical Informatics Association, 26(8–9), pp.796–805.
- Khan, M.A. et al. (2025) Code Not-So-Blue: Burden and predictors of non-urgent visits to the surgical emergency room in Peshawar, Pakistan. Cureus, 17(4).
- Kim, T.Y., Mortensen, K. and Eldridge, B. (2015) Linking uninsured patients treated in the emergency department to primary care shows some promise in Maryland. Health Affairs, 34, pp.796–804.
- National Audit Office (2023) Access to unplanned or urgent care. Available at: https://www.nao.org.uk/reports/access-to-unplanned-or-urgent-care/ [Accessed 28 July 2025].
- National Voices (2024) Experiences of urgent primary care services. Available at: https://www.nationalvoices.org.uk/publication/experiences-of-urgent-primary-care-services/ [Accessed 28 July 2025].
- NHS England (n.d.) High Intensity Use programme. Available at: https://www.england.nhs.uk/high-intensity-use-programme/ [Accessed 28 July 2025].
- NICE guideline NG204 (2021) Babies, children and young people's experience of healthcare.
- Phelps, K. et al. (2022) What are the goals of care for older people living with frailty when they access urgent care? Are those goals attained? A qualitative view of patient and carer perspectives. International Emergency Nursing, 63, p.101189.
- Pollock, D. et al. (2023) Recommendations for the extraction, analysis, and presentation of results in scoping reviews. JBI Evidence Synthesis, 21(3), pp.520–532.
- Rathlev, N. et al. (2016) Randomized controlled trial of electronic care plan alerts and resource utilization by high frequency emergency department users with opioid use disorder. Western Journal of Emergency Medicine, 17, pp.28–34.
- RCEM Learning (2025) Health inequalities in the ED. Available at:

https://www.rcemlearning.co.uk/foamed/health-inequalities-in-the-ed/ [Accessed 28 July 2025].
- Ritchie, J. and Spencer, L. (2002) Qualitative data analysis for applied policy research. In: Bryman, A. and Burgess, R. (eds.) Analyzing qualitative data. London: Routledge, pp.173–194. National Centre for Social Research.
- Scottish Government (2021) Redesign of urgent care: equality impact assessment. Available at: https://www.gov.scot/publications/redesign-urgent-care-equality-impact-assessment/pages/3/ [Accessed 28 July 2025].
- Shnowske, K. et al. (2018) Care guide use for repeated non-emergent complaints and its effect on emergency department visit frequency. American Journal of Emergency Medicine, 36, pp.1697–1698.
- Solo-Josephson, P., Murren-Boezem, J. and Zettler-Greeley, C.M. (2022) Patient and visit characteristics of families accessing pediatric urgent care telemedicine during the COVID-19 pandemic. Telemedicine and e-Health, 28(4), pp.558–565.
- The King's Fund (2022) Health inequalities: what is happening in emergency medicine. Available at: https://www.kingsfund.org.uk/insight-and-analysis/blogs/health-inequalities-what-happening-emergency-medicine [Accessed 28 July 2025].
- The King's Fund (2024) Tackling health inequalities. Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/tackling-health-inequalities-seven-priorities-nhs [Accessed 28 July 2025].
- Tricco, A.C. et al. (2018) PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Annals of Internal Medicine, 169(7), pp.467–473. doi: 10.7326/M18-0850.
- Turner, J. et al. (2022) Socioeconomic inequality in access to timely and appropriate care in emergency departments. Health Policy, 126(2), pp.xxx–xxx. Available at: https://www.sciencedirect.com/science/article/pii/S0167629622000844 [Accessed 28 July 2025].
- Wilson, E. et al. (2021) Nurse practitioner led model of after-hours emergency care in an Australian rural urgent care centre: health service stakeholder perceptions. BMC Health Services Research, 21(1), p.819.

Appendix A

Full data extraction results

N	Aim	Data type	Methods	Pop.	How are service users accessing urgent care	How can improve access to UC - strategies used or suggestions	Conclusion	Strengths	Limitations
1	Providing care in alternative (non-office) locations and outside office hours are important elements of access and comprehensiveness of primary care We examined the trends in and determinants of the services provided in a cohort of primary care physicians in British Columbia, Canada.	Mixed	Longitudinal mixed-effects models	Rural, urban, and metropolitan areas	Physicians located in rural areas were more likely to provide care at all alternative locations and after hours. The proportion of physicians who provided care in alternative locations and after hours declined significantly during the period, in rural, urban, and metropolitan practices. Declines ranged from 5% for long-term care facility visits to 22% for after-hours care. Female physicians, and those in the oldest age category, had lower odds of providing care at alternative locations and for urgent after-hours care. Compared with those practicing in metropolitan centers, physicians working in rural areas had significantly higher odds of providing care both in alternative locations and after hours.	Jurisdictions where providing these services are not mandated, and where similar workforce demographic shifts are occurring, may experience similar accessibility challenges.	Care provided in non-office locations and after office hours declined significantly during the study period. Jurisdictions where providing these services are not mandated, and where similar workforce demographic shifts are occurring, may experience similar accessibility challenges.	Mixed methods design and longitudinal	The review period was 2007-2012 and therefore over 10 years ago
2	To evaluate the association between different spatial measures of access (i.e. physician density, distance to the nearest provider, and measures based on floating catchment area methods) and measures of perceived spatial access to ambulatory health care in rural and urban areas in Germany.	Qualitative	Surveys	Rural and urban areas	The distance. four different methods to measure spatial access to ambulatory health care services: physician density (of the respective type),distance to nearest physician, FCA and distance-weighted 2SFCA method. We measured physician density by the number of physicians per 100,000 inhabitants within the district of the patients. We calculated the distance to the nearest physician via open street map data using the geocoded addresses of the respondents as departure points and the address of the nearest physician as the destination to the nearest physician is associated with perceived spatial access to GPs only in rural areas but not in urban areas. Respondents in rural areas were	Ensuring spatial access to health care is an essential prerequisite for achieving the goal of universal access to health care.	In rural areas, respondents tend to consult their nearest physician in contrast to urban areas where they have a greater choice of providers. These differences suggest that the patient perspective could be integrated in needs-based planning by using different measures of spatial access in different types of areas.	Used tested scales	Only focused on two areas in Germany

					generally less satisfied with their access to ambulatory health care services than respondents in urban areas.				
3	This study aimed to determine the patterns of medical service utilization among heroin users and to identify the factors associated with the frequency of utilization.	Mixed	Retrospective/prospective cohort study of 789 heroin-using adults i	Outpatient and emergency care	In conclusion, our study demonstrated that heroin users received fewer outpatient or inpatient services, but utilized costly emergency service more than the general population. Health service utilization was mostly due to infectious diseases, orthopaedic problems, and gastroenterological disorders, with the main reasons being infectious disease and accidental injury, and the major correlates being HIV status and educational levels.	Integrated outpatient services	Our findings suggest that integrated outpatient services may help to enhance medical service accessibility and adherence, and also imply the necessity of putting more effort into promoting health management and safe behaviours in heroin users, particularly the lower-educated addicts.	Mixed methods	The review period was 2008 and therefore over 10 years ago
4	This qualitative study examined the views of older people living with frailty and their families in relation to specific episodes of urgent care, what they wanted to achieve and whether those goals were attained.	Qualitative	Interviews	Hospital	Forty participants were interviewed either alone or jointly (24 patients and 16 carers), describing episodes of urgent care which started in ED for 28 patients.	There is a need for improved communication across the whole pathway of care, with patients being able to feel involved at every stage and more person-centred care.	Older people living with frailty have heterogeneous urgent care goals which require individual ascertainment. Identifying these goals of care early could result in improved attainment through person-centred care.	In-depth interviews	Small sample
5	Systematic review	Qualitative	Literature review	UCCS	The findings indicate that UCCs significantly reduce ED visits, particularly for non-urgent cases, leading to shorter wait times and improved resource allocation. UCCs also enhance healthcare accessibility for underserved populations and are associated with higher patient satisfaction. Cost-effectiveness analyses suggest that UCCs lower overall healthcare expenditures by reducing unnecessary ED visits. However, challenges such as workforce redistribution and regional disparities in UCC effectiveness remain.	Integrating UCCs into healthcare systems reduces ED congestion, improves operational efficiency, lowers costs, and enhances patient satisfaction. Educational interventions and clearer triage guidelines are essential to improve patient healthcare navigation and ensure the appropriate use of healthcare services. light the need for tailored approaches that account for local healthcare demands and population-specific needs. Specialty urgent care clinics, such as oncology-specific UCCs and triage eye clinics, further demonstrate the value of targeted healthcare delivery models.	The findings from this review highlight the critical role of urgent care clinics (UCCs) in alleviating emergency department congestion and improving healthcare efficiency.	Rigorous literature review	The included studies exhibit substantial variability in their methodologies, sample sizes, different groups of patients, and geographic focus, introducing heterogeneity that may

									affect the consistency of the findings and limit their applicability across different healthcare systems.
6	Non-urgent visits to surgical emergency rooms (SERs) are an unnecessary burden on emergency health services, especially in low-resource settings. The aim of this study was to quantify the burden and determine predictors of non-urgent surgical ER visits in a tertiary care setting.	Quan	This is a prospective analysis of the non-urgent visits in our SER over a 15-day period. We included patients of all ages and genders who presented to the SER at the time of data collection.	Non emergency visits in surgical emergency room	Non-urgent visits accounted for 147 (35%) of all visits and were associated with younger age, female sex, rural residence, low income, and limited education (p<0.001). Most non-urgent cases were triage referred (110 (74.8%), p=0.012). Diabetes mellitus (DM) and obesity were more common in urgent cases (p<0.05). Independent predictors of non-urgent visits included female sex (adjusted odds ratio (aOR): 1.50, 95% CI (1.10 - 2.05), p = 0.020), rural residence (aOR: 1.30, 95% CI (1.02 - 1.65), p < 0.040), low income (aOR: 1.40, 95% CI (1.05 - 1.88), p = 0.030), and chronic kidney disease (CKD) (aOR: 1.80, 95% CI (1.10 - 3.20), p =0.040).	should focus on improving the triage protocols, access to primary care, patient education, and public health initiatives.	Our study identified the common predictors of non-urgent SER visits in our settings, such as younger age, rural residence, poor socioeconomic status, and lower education level. Combined efforts should focus on improving the triage protocols, access to primary care, patient education, and public health initiatives. Further research should also assess the effectiveness of urgent care clinics and telemedicine in reducing non-urgent ER presentation		Cross sectional study and potentially selection bias
7	Our objective was to identify what interventions exist to manage use of the emergency and urgent care system by people from a prespecified list of vulnerable groups. We aimed to describe the characteristics of these interventions and examine service delivery outcomes (for patients and the health service)	Qualitative	Mapping review to assess the quantity and nature of the published research evidence relating to seven vulnerable groups	Vulnerable groups		We identified nine different types of interventions: care navigators, care planning case finding, case management, front of accident and emergency general practice/front-door streaming model, migrant support programme, outreach services and teams, rapid access doctor/paramedic/urgent visiting services and urgent care. Few interventions had been targeted at vulnerable populations; instead, they represented general population interventions or were targeted at frequent attenders (who may or may not be from vulnerable groups).	The review identified a limited number of intervention types that may be useful in addressing the needs of specific vulnerable populations, with little evidence specifically relating to these groups. The evidence highlights that vulnerable populations encompass different subgroups with potentially differing needs, and also that interventions seem particularly context sensitive. This indicates a	In-depth qualitative data	Resources did not allow exhaustive identification of all UK initiatives; the examples cited are indicative

	resulting from these interventions						need for a greater understanding of potential drivers for varying groups in specific localities.		
8	This review focuses on digital and online symptom checkers for urgent health problems. This systematic review was commissioned to provide NHS England with an independent review of previous research in this area to inform strategic decision-making and service design.	Quantitative	Focused searches of seven bibliographic databases	General population	The studies showed that younger and more highly educated people are more likely to use these services. Study participants generally expressed high levels of satisfaction with digital and online triage services, albeit in uncontrolled studies.	Digital symptom checkers	Major uncertainties surround the probable impact of digital 111 services on most outcomes. It will be important to monitor and evaluate the services using all available data sources and by commissioning high-quality research.	In-depth data	Not exclusive to vulnerable groups
9	This review explored the factors associated with urgent care use in dementia and the experiences of people with dementia, informal carers and professionals.	Qualitative	Scoping review	People with dementia	Specific factors that influenced use of urgent care included: (1) common age-related conditions occurring alongside dementia, (2) dementia as a diagnosis increasing or decreasing urgent care use, (3) informal and professional carers, (4) patient characteristics such as older age or behavioural symptoms and (5) the presence or absence of community support services. Included studies reported three crucial components of urgent care situations: (1) knowledge of the patient and dementia as a condition, (2) inadequate non-emergency health and social care support and (3) informal carer education and stress.	Improved and increased community support for non-urgent situations, such as integrated care, caregiver education and dementia specialists, will both mitigate avoidable urgent care use and improve the experience of those in crisis. Advanced care planning, care coordinators Inadequate health and social care support leads to accessing urgent care.	The scoping review highlighted a wider variety of sometimes competing factors that were associated with urgent care situations	Large number of studies	does not include a formal quality appraisal process
10	To determine whether a dermatology urgent care model can reduce healthcare utilization among patients with psychiatric dermatoses	Quan	retrospective chart review of patients seen in dermatology urgent care	People with psychiatric dermatoses	Patient factors may include lack of insight into their condition, low trust of medical providers, inconsistent follow up, and suboptimal medication adherence. Provider factors may include lack of training in the management of psychiatric patients and resultant low comfort. Patients with psychiatric dermatoses are often high utilizers of healthcare,	urgent care model in which a twice-weekly clinic is staffed by a single dermatologist with no specialized or additional training in psychiatric dermatoses. Patients were regularly scheduled for follow-up every four weeks. During acute flares, patients were instructed to reach out to the provider for guidance using MyChart, and responded to accordingly within	Urgent care models in dermatology may reduce overuse of healthcare and emergency services among patients with psychiatric dermatoses	relatively large sample	Just one hospital

					including emergency services, thus there is a need for more effective care models	24-48 business hours. Herein, we demonstrate that our model, by allowing patients to regularly connect with a trusted provider and receive care during acute crises, can substantially reduce overall healthcare utilization and costs associated with emergency department care.			
11	To investigate factors influencing patients' self-management of urgent diabetes problems that precipitated unscheduled hospital care.	Qualitative	descriptive investigation, across two contrasting sites. Semi-structured interviews	People with diabetes, rural vs urban	Recently treated in ED	Education plays an important role in assisting individuals to self manage their diabetes on a daily basis, but urgent, unexpected health problems proved challenging for both patients and health service providers. A greater focus on empowering patients with core self-management skills is required to enhance ability to successfully manage unexpected diabetes complications, coupled with enhanced primary care resources, particularly out of hours.	Although there will be some occasions when hospital admission is indeed the required course of action, this study indicates that both educational interventions and health service provision needs to be improved to achieve optimal management of urgent problems within a community setting. It is suggested that, interventions to enhance problem solving abilities are warranted.		
12	A mixed-methods, cross-sectional study design was used to survey third-year and fourth-year students at a Midwest dental school in spring 2020 about their experiences providing patient care in the school's internal urgent care center.	Mixed	The aim of the current study was to investigate student perceptions of a novel dental school urgent care clinic model.	NA - students at the school	Available to underserved populations	A.T. Still University's Missouri School of Dentistry & Oral Health (ATSU-MOSDOH) was established in 2013 as part of an initiative to train community-minded dentists to improve access to care in rural and low-income areas of Missouri. This innovative program has a strong public health focus with emphasis on person-centred care.	This collaborative school-based urgent care clinic model incorporating community partnerships provided transformative learning experiences, positively impacted student perceptions of their learning, and influenced future practice behaviours related to urgent dental care.	Mixed methods	Not exclusive to vulnerable groups
13	Review	Qualitative	To examine Babies, children and young people's experience of healthcare	People over 18 but responding on behalf of child or young person		Health education, instilling confidence in healthcare professionals, providing accessible healthcare services - accessible language, alternatives to physical appointments, promotion of primary healthcare services			

14	We studied a total of 5343 patient activation records and 2195 unique encounters collected from a VUC during the first 4 quarters of operation. Zip codes served as the analysis unit and geospatial analysis and informatics quantified the results.	Quan	This article evaluates the reach and context of a virtual urgent care (VUC) program on health equity and accessibility with a focus on the rural underserved population.	rural underserved populations	Telehealth services provide a timely solution for rural communities facing many challenges in accessing health care	The web portal was designed such that any patient-provider encounter that could occur in person could be delivered through the synchronous online portal. VUC services were advertised through digital methods. Patients are asked to register (an activation) an account and submit demographics and medical history information through a secure healthcare system–branded website. To manage patient's expectations, a comprehensive list of nonemergency medical conditions is provided upon registration. Prior to an on-demand appointment (an encounter), the patient chooses either video conference or phone call to interact with a physician. During the appointment, the online doctor reviews the patient's medical history and symptoms to aid in diagnosis. If medication is needed, the doctor can send an electronic prescription to the pharmacy of the patients' choice.	The study concluded that patients facing inequities from rural areas were enabled better healthcare access by utilizing the VUC.	Large sample size	Reachability was defined in this research as the occurrence of at least 1 encounter within a zip code, which may introduce unweighted bias between zip codes with varying numbers of encounters.
15	The aim of this study was to explore the views of staff and stakeholders of a rural health service in relation to the implementation of an after-hours nurse practitioner model of health care delivery in its Urgent Care Centre.	Qualitative	Semi-structured interviews	Rural	NPs have completed additional training and have the necessary clinical skills and competencies to lead the provision of emergency health care in rural UCCs autonomously. During this period, a person who presented to the UCC was triaged by the RN, who then contacted the NP. The NP was responsible for the assessment, requesting any diagnostic procedures, initiating any intervention and deciding on whether the person required admission to the hospital for ongoing care, transfer to another health service or for discharge to their home with follow-up outpatient health care services.	NP-led model. to develop and implement a communication plan that raises awareness in rural communities of the NP role in the afterhours UCCs; and to provide education and documentation that clarifies the delineation of roles and responsibilities of clinical staff to help dispel challenges in adapting to change of after-hours urgent care works for rural population	This study suggests that the nurse practitioner-led model is valued by rural health practitioners and could reduce the burden of excessive after-hour on-call duties for rural GPs while improving access to quality health care for community members. As pressure on rural urgent care centres further intensifies with the presence of the COVID-19 pandemic, serious consideration of the nurse practitioner-led model is recommended as a desirable and effective alternative.	in-depth qual	perceptions of health service staff and stakeholders of one rural health service.
16	We examined changes in	Quan	Retrospective, cross-	General populati	Access to virtual paediatric urgent care is low in rural patients, low	Need for implementation of mitigation strategies that support equal access	Researchers, health care providers, and	Large sample size	limited to one

	paediatric telemedicine utilization as related to social determinants of health and characteristics of families accessing care.		sectional comparison of completed visits for parent-initiated, urgent care telemedicine services received by a paediatric health care system	on access to paediatric medicine	economic, and Hispanic patients	and use of virtual healthcare amongst diverse populations e.g. language and translation-based services	policymakers should examine the implementation of varying mitigation strategies that support equal access and use of virtual health care among an increasingly diverse, post-COVID-19 paediatric patient population.		paediatric platform during the pandemic.