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# Clinical Audit of Physician Associate Performance in OOH Settings in the United Kingdom

## A Quantitative and Thematic Analysis

CMAPs College of Medical Associate Professionals

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## Abstract

**Background:** Physician Associates (PAs) are playing an increasingly significant role in remote urgent care consultations and out of hours (OOH) settings. Despite a lack of evidence, some organisations have raised concerns about PAs managing undifferentiated patients as well as PAs working in OOH and urgent care settings. This study provides an evidence-based assessment of PA performance in these settings, focusing on safety and effectiveness.

**Methods:** Managing undifferentiated patients is a fundamental aspect of urgent care. This study specifically examines PA performance in handling cases where the presenting complaint does not immediately indicate a clear diagnosis. Remote urgent care and OOH services typically manage a wide range of clinical presentations, from minor, self-limiting conditions to urgent, high acuity cases. The qualitative audit comments indicate that PAs experienced this breadth of complexity during the review period.

A retrospective audit was conducted using data from the Clinical Guardian audit system, analysing performance data from 21 PAs working in remote urgent care and OOH settings. Key metrics examined included pass rates, reflection cases, clinical concerns, and group reviews. Qualitative feedback from clinical consultations audit spreadsheet was compiled and analysed using an assisted thematic analysis to identify areas of strength and areas for improvement.

**Results:** Data from 1,179 PA clinical audits were analysed. The overall pass rate was 98.22%, with 1.70% flagged for reflection cases and 0.08% raising clinical concerns. Comparison of performance using the old and new scoring methods showed that PAs consistently exceeded the organisational average. Thematic analysis highlighted strengths in history taking, red flag recognition, and safety netting, with areas for improvement in documentation and guideline adherence.

**Conclusion:** The audit demonstrates that PAs are safe and effective in managing undifferentiated patients in remote urgent care and OOH settings. These findings support the expansion of PA roles in these areas, offering potential solutions to workforce shortages in high demand environments. As remote, OOH, and urgent care settings continue to evolve, further research into PA contributions will be valuable in shaping future workforce strategies. Understanding how PAs integrate within these models will help refine supervision frameworks and ensure high quality patient care.

**Keywords:** PA, Clinical Audit, Remote OOH, Remote Urgent Care Consultations, Patient Safety, Supervision.

 

## Introduction

In response to the evolving role of PAs, structured guidance has been developed to support their integration into various healthcare settings. Resources such as the Base Scope of Practice and Scope Mapping Tool [1], as well as the Primary and Secondary Care Employers Handbooks [2,3], provide clarity on PA responsibilities and supervision structures. These frameworks aim to standardise expectations and ensure safe, effective practice across diverse clinical environments.

PAs are healthcare professionals trained to perform a wide range of clinical tasks under the supervision of physicians. In recent years, PAs have been increasingly integrated into healthcare teams across the UK, particularly in remote urgent care consultations and OOH settings. These settings involve providing medical care to patients when GP surgeries are closed or when patients need urgent treatment but do not require a visit to the emergency department.

Managing undifferentiated patients, those whose symptoms do not clearly point to a specific diagnosis is a key aspect of urgent care. With an aging population and increasing demand for urgent care services, PAs are seen as an important part of the solution. Their role in addressing workforce shortages and improving access to care has been highlighted in several studies [4].

Previous research on PA performance in acute and emergency settings, including A&E and general practice same day appointments, suggests that PAs can safely manage a range of patient presentations, including undifferentiated cases requiring escalation where necessary [5,6,7]. This study aims to assess whether PAs can safely and effectively manage patients in remote consultations for OOH and urgent care settings, comparing their performance with the organisational average and evaluating the implications of expanding their roles in these settings.

## Methodology

### Study Design and Setting

This retrospective audit utilised data from the Clinical Guardian audit system, which tracks clinician performance in remote urgent care consultations and OOH consultations. The 'organisational average' represents the combined performance of all clinicians including GPs/ACPs/ANPs/ENPs/UCPs/Triage Nurse/PAs who conducted remote urgent care and OOH consultations within the organisation during the study period, this includes 258 active sessional GPs. However, individual GP performance data was not separately audited in this study.

### Data Collection

The data was collected from PAs working in remote urgent care and OOH settings. All PAs at the organisation were invited to participate, the data of those that voluntarily responded, was included in the analysis, except PA 22. The dataset includes structured records documenting pass rates, reflection cases, clinical concerns, and group reviews.

The inclusion criteria were that PAs must have been employed in remote urgent care or OOH settings during the study period, and that their performance data was available for analysis. There were no exclusion criteria applied, as all PAs who responded had their data included.

*Study period*

The audit encompassed each PA's clinically audited consultations from their respective start date of employment through to the latest submission, which varied by individual. The earliest start date among participating PAs was 1 January 2018, and data collection began on 20th January 2025. Because PAs began (and submitted data) at different times, the exact coverage period differs by PA but falls within these overall dates.

*Quantitative Audit Analysis*

This method examined the total number of audits conducted for each PA over their employment period. Performance was assessed using both the old and new scoring methods, classifying cases into structured categories set by the Clinical Guardian system.

*Qualitative Audit Thematic Analysis*

A separate, qualitative analysis was conducted on specific clinical consultations for each PA. Feedback from these individual audits was compiled into a spreadsheet and analysed using AI-assisted thematic coding to identify recurring strengths and areas for improvement. This method focused on the content and quality of decision-making within each consultation, rather than numerical performance trends.

### Data Analysis

Descriptive statistics were used to summarise the performance data, including pass rates (percentage of PAs meeting or exceeding clinical performance benchmarks). The data were compared to the organisational average, and performance outcomes from the old and new scoring methods were analysed.

Separately, qualitative feedback from a selection of clinical consultations was compiled. A smaller subset of consultation audit data was identified for qualitative review, with the intention that it represent a “random” sample. However, because these consultations from the Clinical Guardian System were downloaded and self-submitted by PAs, certain encounters particularly those perceived as noteworthy may have been more likely to be included, introducing potential selection bias. Despite the smaller sample size and possible non-randomness, the qualitative comments were broadly in line with the overall performance patterns indicated by the Clinical Guardian audit’s quantitative scores. As such, while some selection bias may exist, its effect on the core findings appears to be minimal.

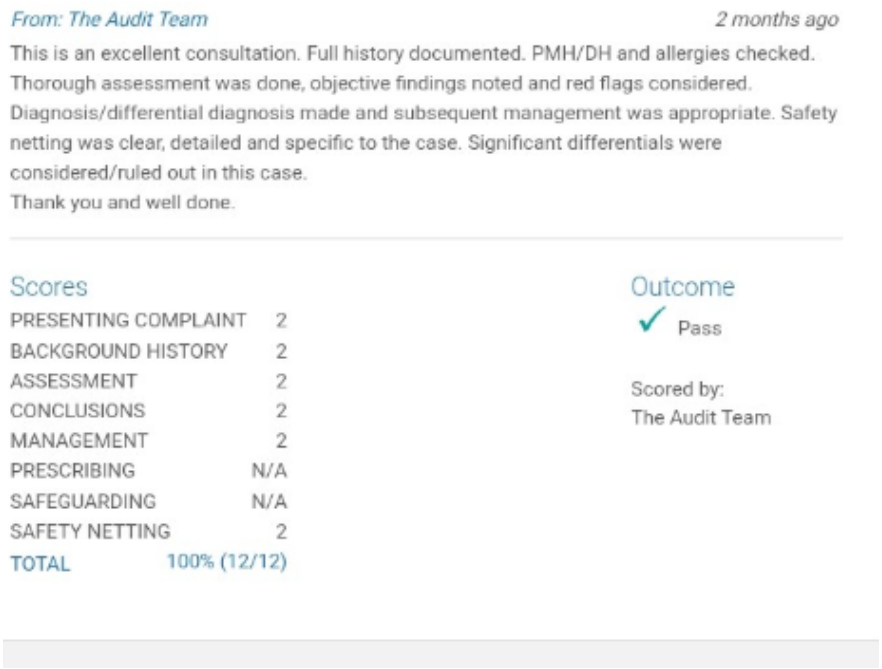


Figure 1: Qualitative feedback: Indvidual case audit for PA2

The qualitative data was compiled for all 21 PAs and each row contained qualitative feedback on a specific PA consultation. Empty rows or duplicated entries were removed, leaving only unique comments for qualitative analysis. After familiarisation with the dataset, an AI based language model (ChatGPT) was used to assist with thematic coding of comments. The model helped identify, consolidate, and label recurring themes (e.g. “Good History Taking,” “Diagnosis and Management,” “Documentation Quality,” “Safety Netting,” etc.). Human review ensured that AI generated themes were accurate, contextually relevant, and reflective of the original content.

The AI generated coding was further refined by comparing individual themes, combining overlapping categories, and ensuring consistency of terminology. Where needed, multiple related subthemes (e.g. red flag identification, antibiotic stewardship) were grouped into larger thematic categories (e.g. Clinical Assessment and Management). This AI assisted approach leverages powerful language model capabilities to systematically process and categorise qualitative data, while still relying on human expertise to interpret and contextualise findings accurately.

## Results

*Overall Performance*

A total of 1,179 PA clinical audits were analysed. The overall pass rate was 98.22%, indicating that PAs were performing well within clinical benchmarks. Only 1.70% of cases were flagged for reflection by auditor. Furthermore, 0.08% of audits raised clinical concerns, reinforcing the safety of PAs in these environments and indicating that while performance was generally strong, the system also served to identify areas warranting closer review and potential improvement.

*Clinical Governance and Audit Process*

The organisation employs Clinical Guardian as part of its clinical governance framework to audit the documentation generated after each patient contact. All clinicians, including PAs, undergo regular auditing, and where relevant, receive feedback aimed at fostering reflective practice.

*Comparison of Scoring Methodology*

Performance was compared against the organisational average, which reflects the combined performance of multiple clinician groups (including GPs and other healthcare professionals). However, individual GP performance data were not separately analysed in this study. This distinction keeps the focus on PA specific performance rather than direct clinician to clinician comparisons.

To improve efficiency and ease of use, the Clinical Guardian system's scoring methodology was revised in January 2022. The "new" scoring method consolidated several categories from the "old" method into a more streamlined and succinct evaluation process. Despite these changes, PAs consistently exceeded the organisational average under both systems:

- Old Scoring Method: Six categories (Excellent, Very Good, Satisfactory, For Reflection, Concern, and Group Review). Among PAs, 16 (100%) exceeded the organisational average, with a median deviation of 14.48%.

- New Scoring Method: Four categories (Pass, For Reflection, Concern, and Group Review). Among PAs, 20 (100%) exceeded the organisational average, with a median deviation of 7.60%.

| Audit Type | Outcome | Total | Percentage | Provider Average Percentage |
|---|---|---|---|---|
| Standard Audit | Excellent | 19 | 55.88 | 27.02 |
| | Very Good | 14 | 41.18 | 29.03 |
| | Satisfactory | 1 | 2.94 | 26.69 |
| | For reflection | 0 | 0.00 | 11.25 |
| | Concern | 0 | 0.00 | 1.69 |
| | Group Review | 0 | 0.00 | 0.00 |

Table1: Clinical Guardian Audit: Old scoring method

| Audit Type | Outcome | Total | Percentage | Provider Average Percentage |
|---|---|---|---|---|
| Standard Audit | Pass | 21 | 100.00 | 92.40 |
| | For reflection | 0 | 0.00 | 6.93 |
| | Concern | 0 | 0.00 | 0.63 |
| | Group Review | 0 | 0.00 | 0.00 |

Table 2: Clinical Guardian Audit: New scoring method

Originally, the old scoring method provided a high level of granularity. In response to clinician feedback and the desire to emphasise patient safety, the organisation and clinical auditors decided to condense the rating system to focus on whether a consultation met safe standards ("Pass"), or if it warranted additional scrutiny ("For Reflection" or "Concern"). Although fewer categories now exist, auditors can still highlight exemplary performance in their narrative comments. This revised structure is intended to reduce negative connotations of ratings such as "Satisfactory" and to encourage safe,

consistent clinical practice without clinicians feeling pressured to strive for “Excellent” in ways that do not necessarily improve patient care.

These results underscore that PAs consistently outperform the organisational average, reinforcing the conclusion that PAs are performing effectively across both the old and new scoring frameworks.


Figure 2: Percentage of maximum score by category

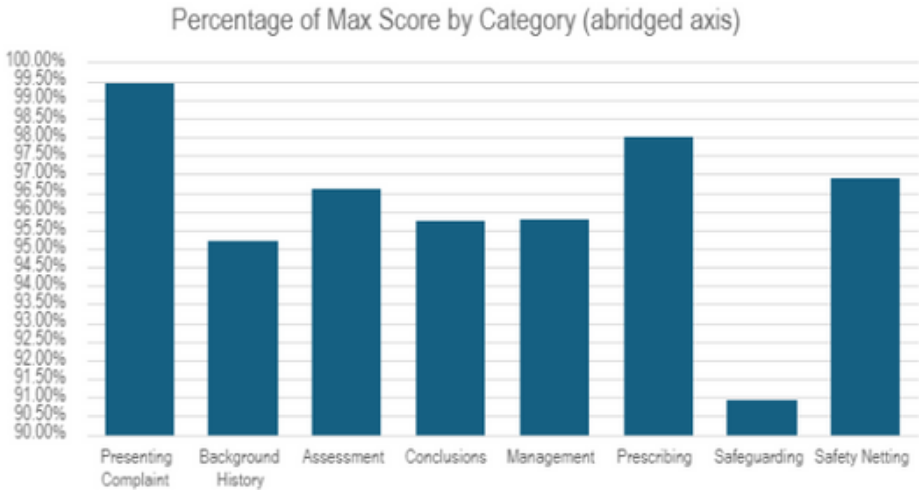


Figure 3: Percentage of maximum score by category (abridged axis)

## Discussion

The audit demonstrates that PAs are safe and effective in managing undifferentiated patients in remote urgent care and OOH settings. The high pass rate (98.22%), minimal clinical concerns (0.08%), and small number of flagged reflection cases (1.70%) indicate that PAs perform safely and competently in high demand environments. The fact that 100% of PAs exceeded the organisational average in both the old and new scoring methods reinforces this conclusion.

Thematic analysis supports these findings, highlighting PA strengths in thorough history taking, appropriate diagnosis and management, and effective safety netting. These skills are crucial in remote and urgent care settings where rapid decision making and efficient care delivery are essential. However, the analysis also identified areas for improvement, particularly in documentation specifics, tailoring safety netting advice, and consistent alignment with clinical guidelines. Addressing these areas could further enhance the quality of care provided by PAs.

## Supervision and Governance

The study highlights the critical role of supervision in ensuring safe and effective PA practice. PAs in this study were supported by supervising GPs and educational supervisors, facilitating the escalation of complex cases where needed. However, in line with established supervision models, not every case requires real-time review, allowing PAs to work autonomously within their scope of practice while still benefiting from structured oversight.

As remote urgent care continues to evolve, refining supervision structures will be essential to maintaining high standards of care and professional support for PAs. **The Primary and Secondary Care Employers Handbooks** (2,3) establish a strong foundation for PA integration across various care settings, including remote and hybrid models. As healthcare delivery continues to evolve, ongoing refinement of these frameworks will ensure that supervision structures remain responsive to the needs of PAs and their multidisciplinary teams. Future investigations should explore how supervision structures impact PA performance across different settings.

To ensure data integrity, all audits were conducted by experienced, skilled clinicians, including GPs, Advanced Clinical Practitioners (ACPs), and 2 PAs from the clinical management team. This rigorous review process strengthens the reliability of the findings and ensures that assessments were objective and aligned with best clinical practices.

The study highlights the critical role of supervision in ensuring safe and effective PA practice. PAs in this study were supported by supervising GPs and educational supervisors, facilitating the escalation of complex cases where needed. This model aligns with findings from other research, which has shown that structured supervision enhances patient safety while allowing PAs to contribute effectively within their scope of practice [8,9].

Given the unique challenges of remote urgent care, further evaluation of how supervision structures operate in nontraditional settings is warranted.  Evaluations of PA integration in different healthcare systems, such as NHS Scotland, can provide valuable insights [10].

The **Primary and Secondary Care Employers Handbooks** [2,3] provide an initial framework, but tailored guidance may be required for virtual or hybrid care models. Future investigations should explore how supervision structures impact PA performance across different settings. The study highlights the critical role of supervision in ensuring safe and effective PA practice. PAs in this study were supported by supervising GPs and educational supervisors, facilitating the escalation of complex cases where needed. This model aligns with findings from other research, which has shown that structured supervision enhances patient safety while allowing PAs to contribute effectively within their scope of practice. Future investigations should explore how supervision structures impact

PA performance across different settings.

## Policy Implications and Recommendations

The development of structured guidance and professional frameworks is essential to ensuring the effective integration of PAs in urgent and OOH care. Documents coproduced by CMAPs and UMAPs, such as the **Base Scope of Practice and Scope Mapping Tool** [1], provide a clear framework for PA practice across various healthcare settings. Additionally, the **Primary Care Employers Handbook** and **Secondary Care Employers Handbook** [2,3] offer practical guidance for organisations employing PAs, ensuring role clarity, appropriate supervision, and professional development opportunities.

Furthermore, the **CMAPs CPD Guidance Framework** due to be published will support continuous learning and development for PAs, ensuring that they remain equipped with the necessary skills to manage undifferentiated patients safely and effectively. Policymakers should consider integrating these resources into workforce planning to enhance PA deployment in high demand clinical settings. These findings support the case for expanding PA roles in OOH and remote urgent care settings.

Given the demonstrated safety and effectiveness of PAs, policymakers should consider revising existing workforce regulations to enable greater flexibility in PA deployment. Further research into optimal supervision models and training frameworks will be essential in supporting the continued integration of PAs into high demand clinical environments.

## Thematic Analysis of Audit Comments

*Note on Structured Language:*
It is worth noting that many of these comments employ a standardised or structured style, which can make them appear very similar. In audit processes, standardised templates or feedback guidelines are often used; this ensures consistency in evaluations but may also lead to recurring phrases or themes across different patient consultations.

### Strengths:

- **Thorough History Taking and Examination:** Multiple entries commend PAs for detailed history taking covering Presenting Complaint (PC), Past Medical History (PMH), Drug History (DH), and checking allergies. The audit often notes that “red flags” or risk factors are proactively considered and documented. In some cases, the PA goes beyond the immediate complaint to address underlying issues (e.g. asthma or repeated UTIs). This thoroughness ensures that major comorbidities and potential complications are not overlooked, which is essential for patient safety.

- **Appropriate Diagnosis and Management Plans:** The reviewed consultations generally demonstrate correct and well-reasoned clinical diagnoses or differentials. Several comments show PAs referencing best practice guidelines (e.g. NICE) regarding stool sampling, medication requests, or fever scores. From requesting medication to arranging urgent face to face assessments, the PAs’ decisions are frequently praised as “appropriate” and “safe”. Timely and accurate decision making minimises risk and leads to better patient outcomes.

- **Effective Safety Netting:** Many consultations receive praise for “clear, detailed, and specific” safety netting, ensuring patients know when and how to seek further help. Some consultations highlight the importance of tailoring safety net advice to the patient’s specific risks (e.g. dehydration for menorrhagia rather than solely focusing on sepsis). Proper safety netting is crucial in settings where immediate follow up is not guaranteed. Providing specific red flags and timelines helps patients (or caregivers) recognise deterioration early.

## Areas for Improvement:

- **Documentation Specifics:** A few comments recommend being more explicit about the main working diagnosis or the range of differentials being considered. The audit highlights the need for clearly stating a timeframe for expected improvement or follow up. Suggestions include documenting how prescription requests via the supervising GP, referrals, or further investigations will be managed, especially if another clinician is responsible for next steps.

- **Tailoring Safety Netting and Communication:** Auditors caution against overly broad or nonspecific instructions that can confuse patients. Safety netting should be focused on the most pressing dangers for the patient's primary complaint rather than listing every potential complication.

- **Alignment with Clinical Guidelines:** Where appropriate, referencing official guidelines (e.g. antibiotic stewardship, requesting delayed prescriptions via supervising GP, stool sampling) improves clarity and justifies management plans.

- **Prescribing requests via supervising GP and Referral Nuances:** In mild or borderline cases, consider requesting delayed prescribing via the supervising GP or alternative management in line with NICE or local guidance. When a referral is necessary, specify urgency and what the patient should do if an appointment is delayed or symptoms worsen.

## Recommendations:

1. Structured Documentation Templates: Although the audit data suggests that a structured approach (e.g. SOAP: Subjective, Objective, Assessment, and Plan) is likely in use, it would be beneficial to review and refine the existing documentation framework to ensure thoroughness and consistency across all aspects of patient encounters. Emphasising clear, standardised headings for each component
2. Targeted Training Sessions: Conduct regular short trainings on best practices for documentation (particularly around differential diagnosis and specifying follow up timelines).
3. Regular Clinical Governance Reviews: Maintain and expand these audits to reinforce strong performance and quickly identify new areas for improvement.
4. Guidelines and Policy Updates: Ensure PAs have easy access to the latest local and national guidelines and understand how to incorporate these into consultations.
5. Tailored SafetyNet Advice: Provide condition specific examples or checklists that clarify how to individualise safety netting instructions effectively.
6. Review and potentially revise current guidelines restricting PA involvement in remote urgent care and OOH settings, allowing for more flexibility in workforce deployment.
7. Conduct further research on supervision models and their impact on PA performance in these settings.

## Limitations

1. Retrospective Nature: The study's retrospective design limits the ability to establish causal relationships.
2. Single Audit System: Reliance on data from a single audit system within one organisation necessitates broader validation across multiple organisations.
3. Lack of Patient Outcome Data: The audit did not include measures of patient outcomes, such as follow up care or patient satisfaction.

## Conclusion

This clinical audit provides strong evidence for the safe and effective integration of PAs in remote urgent care and OOH settings. PAs consistently exceeded organisational averages and demonstrated competence in managing undifferentiated patients. The study also addressed some concerns about PAs managing undifferentiated patients. While areas for improvement were identified, particularly in documentation and tailored communication, the overall findings support the expansion of PA roles in these high demand environments. Implementing the recommended improvements and conducting further research could further optimise PA integration and enhance healthcare delivery, particularly during high demand periods. By focusing on these areas, PAs can continue to enhance the quality of care they provide, ensuring optimal patient outcomes and reinforcing their valuable role within the healthcare team.

## Supplementary Data: PA 22

A further audit series was received after the submission deadline and so are not included in the principal analysis. The results are included here for completeness and transparency. The scores received were comparable (generally marginally better) than the average for the group and so inclusion would not alter the main conclusions and would alter the quantitative performance data by only around 1/10th of a percentage point on each assessment area.

## Declaration of Interest

Mobashar Rashid: Practicing PA in urgent care setting and Acting Co-President of CMAPS
James Pawsey: Practicing PA with previous experience of business change management in emergency care settings.

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