What GPs Need To Know To Carry Out a Practice / Clinical Audit

This is a brief guide to help GP colleagues undertake clinical audit. There are suggestions for clinical audits. Keeping your audit short, simple, and easily completed is the key to success.

You might find ideas from these examples that could work in your practice.

My favourite audits are the audit award winning assessment of bone health in cancer, and the last two audits in this guide.

Consider submitting your completed audit to the ICGP annual audit prize, and/or ICGP-Medisec Quality and Safety in Practice award. It's a great showcase to disseminate quality improvement, and the prizes are very generous.

1. **Introduction**
2. **Five stages of successful clinical audit**
3. **Documenting your audit, and audit caveats**
4. **Audit data collection and audit report templates**
5. **Resources and references**

Introduction

Audit is simply about improving patient care. Clinical audit is '*a clinically led, quality improvement process to improve patient care through systematic review of care against explicit criteria and…improve care when standards are not met.*'(1)

Clinical audit "is *the single most important method...to ensure the quality of the service…an essential component of professional practice…should be at the heart of clinical practice*"(1) Clinical audit is fundamental to fostering a culture of patient safety and continuously improving clinical care. Audit enables us to measure quality of current care, to identify, implement and document quality improvement. The Medical Council recommends clinicians spend one hour or more, per month, undertaking audit (2). Give protected time for your audit.

Key barriers to clinical audit are time, resources, perceived deficit of audit skills, with audit perceived as tedious and onerous (1). Clinicians undertaking audit need to feel safe and supported within a culture of quality improvement (1). "Clinical Audit Guides" are a series of excellent, short video clips (just 2-5min duration), which also include audit suggestions for locums and doctors not in active clinical practice (3).

Audit is good for doctors, and good for our patients

- Enhance clinical care: "*pick up bad stuff & identify good stuff*"
- 'Make your life easier' Audit can reduce your workload (see examples below)
- Enhance your diagnostic skills
- Delegate the data collection to others ("share the learning"!)
- Increase practice income

Five Stages of Successful Clinical Audit

Five stages of Audit

Stage 1 Plan your audit

Stage 2 Identify Criteria & Standard

Stage 3 Measure current practice/collect data

Stage 4 Make improvements

Stage 5 Sustain & disseminate improvements

CELEBRATE YOUR SUCCESS!

Planning: Choosing an audit topic is the most important step. This needs discussion and agreement within your practice. If you don't have GP colleagues within your practice, you could consider engaging with local GP colleagues in a multi-practice audit or simply use the examples in this document to get a head start. A worthwhile topic should be an interesting/ common/important clinical issue and easy to complete! Try to identify an issue with acknowledged potential for improving care. Embarking on an audit without consensus is fraught, as colleagues are less likely to engage and actively participate. Teamwork makes the dream work! Agree the topic, share current practice data, agree & implement change, measure again, share data, sustain change. Consider a very quick pilot survey.

Identify criteria & set a standard: A criterion is what you will assess, such as "All adults should have smoking status documented". Identify evidence based criteria (4). The standard is the target compliance of your practice "We will document smoking status of XX % of adults": which is a substantial improvement on our current practice. The standard should be SMART (Specific, Measurable, Achievable, Relevant, Timely).

A criterion may be "All patients taking methotrexate should have 4-6 blood tests in 13/12". Your practice audit standard might be "XX % of our patients on methotrexate have 4-6 blood tests in 13/12".

A criterion might be "All adults with asthma have an annual asthma review" and your audit standard might be "XX % of our adult patients with asthma have a documented annual asthma review". Audit standards are rarely quoted in guidelines so be pragmatic. Ask yourself "*Is 90% compliance achievable or is 70% compliance good enough?*" Undertaking a 'quick pilot' survey of 3-5 patients may identify your current standard and what is feasible.

Remember "Done is better than perfect".

Measure current practice: collect data: A word of warning: Collect only relevant data: for most audits a small amount of data on 10 patients is sufficient (4)! Your time is precious and don't collect irrelevant data (age, gender, past history etc). Delegate, delegate, delegate: audit data can be collected by your practice nurse, medical student or admin team.

Analyse your data to identify excellence, areas for improvement and barriers to quality care. Share initial and later data with ALL relevant stakeholders to stimulate and sustain quality improvement. See Audit data collection templates below.

Make improvements: Change is the essence of successful audit. Change is tough, and usually the most difficult part of audit (4)!! Your clinical quality improvements should be SMART. Identify what needs to change, and how this change will happen in your practice.

Remember: No change means zero gains.

Sustain & disseminate improvements: A second data collection is essential to "*Complete the cycle: close the audit loop*". Failure to collect a second tranche of data spells doom for your audit, wasting everyone's time, energy and goodwill. Share both data sets with stakeholders to quantify the quality improvements achieved and identify further potential improvements. Disseminate and celebrate your success! Ensure you upload your audit to your PCS ePortfolio.

Documenting Your Audit and Some Caveats

The audit report should be concise, ideally a single A4 page. Consider using the template below. Always upload your audit for CPD. Your report might follow the 'five stages of audit':

1. Planning your audit: a very brief outline of your project, and why it's relevant to your practice, where improvement is possible. Include role of the practice team.
2. Document criteria & the target standard
3. Measure current practice/collect data: Document the data collected (simply 'copy & paste' the eXcel spreadsheet). Remember to remove any patient identifiers in your final report.
4. Make improvements: Very briefly outline what you did to improve care.
5. Sustain improvements Document data collected after you made the change.

Caveats with your audit: A note of caution

- Clinical audit should not examine the work of other clinicians without their knowledge, consent and ideally their involvement. This is especially relevant for GP group practices, and multi-practice audits.
- Data protection is key: comply with GDPR, MCI and other relevant guidance. In general, GP clinical audit does not require informed patient consent. It is prudent to consider informing patients (via website, practice leaflet) that "*as part of normal care processes, personal data will be used for audit and quality improvement*" (4).
- Patient confidentiality and anonymisation of data: Audit design should ensure personal health data is confidential. **When sharing audit data, patient identity should be irrevocably anonymised** (4).

Key points to successful audit in your practice

- Keep audit simple and interesting: it's not rocket science
- Close the audit loop: unclosed loops are an abomination
- Consider a pilot audit of 3-5 cases
- Avoid excessive data collection like the plague: 10 patients should suffice: "Less is more"
- Tell EVERYONE about your audit (especially the Medical Council and your mother!)
- Respect confidentiality: No names: use computer patient id number
- A dose of realism: "*Is 100% achievable or is 80% compliance good enough?*"

  "*Done is better than perfect*"

Audit Data Collection and Audit Report Templates

Below you will find a selection of audit templates that may be helpful in deciding which audit is most appropriate for you in your regular clinical practice.

Audit Report Template (Sample)

This template is designed to avoid and minimise repetitive work in your audit. It is easily adapted to your specific audit. Black type is template, red to be inserted by GP

Title of Audit	Audit of patients **stabilised** on Methotrexate (Mtx) in XXX Practice		
Names of participating GPs and practice nurses	Dr A, B and C Nurse A and B		
Brief outline of background to this audit	Suboptimal management of patients taking methotrexate is a common cause of serious patient harm.		
Objective(s) of this audit (brief)	1. To assess the current standard of care across the broad range of criteria 2. To improve the care and sustain the improvements		
Number of patients audited	10 patients		
Criteria assessed (Hint: simply copy and paste criteria from the audit data collection templates)		Initial Results (Cycle 1) **(compliance**)	"Re-Audit" (Cycle 2) **(compliance)**
Patients with 4-6 blood tests in previous 13/12		4/10	8/10
Dose; Specify Day of week?		5/10	9/10
Dose; specify 2.5mg?		3/10	9/10
Clinical record: Summary highlight Immunocompromised?		2/10	5/10
Flu vax in current season?		5/10	8/10
Pneumococcal Vax up to date?		4/10	8/10
Documented Patient education re s/s toxicity?		2/10	5/10
Documented Patient education: Weekly dosing?		3/10	7/10
Other criteria included here as necessary			

Conclusions	1. Audit highlighted areas of suboptimal Mtx management
Recommendations for improvement	1. Amend and 'free-text' Mtx prescriptions to specify day of week, dose, and s/s of toxicity/sepsis 2. Improve vax status of pnts on Mtx.
Audit Action Plan (The plan should be very **SMART**)	1. **GPs** agree and draft template 'Methotrexate prescription free text', **by 1/10/2019** 2. **Nurse** 'cut and paste' template into each patients Mtx prescription **by 31/11/19** 3. **Manager** to insert 'Pop-up reminder' to have relevant vax with next blood test, **by 1/10/19**
Comments/suggestions	
Date & signature of author(s)	
"Re-audit date" (if appropriate)	
Date Uploaded to ICGP ePortfolio	

Selection of Audit Templates Involving Data Collection

Below, you will find a few very short audit data collection templates that are manageable in just about every GP practice type followed by some more interesting and engaging audits. You may modify these draft data collection templates to suit your specific practice.

Audit: Patient smoking habits and cessation advice

This audit can easily be amended to audit alcohol intake.

Patient ID	**Patient 1**	**Patient 2**	**Patient 10**
Smoking documented	Yes / No	Yes / No	Yes / No
Smoking cessation advice offered	Yes / No	Yes / No	Yes / No

Audit: chronic disease co-morbidities

Assess patients with Type 1 diabetes for other auto-immune disorders. This audit can easily be amended to screen for co-morbidities in coeliac (B12, TFT, bone density).

Patient ID	**Patient 1**	**Patient 2**	**Patient 10**
TFT check in past 3y	Yes / No	Yes / No	Yes / No
Vitamin B12 check in past 3y?	Yes / No	Yes / No	Yes / No
Coeliac check in past 5y?	Yes / No	Yes / No	Yes / No

Audit: Vitamin B12 injections

Assess whether patients get Vitamin B12 monthly or every three months

Patient ID	**Patient 1**	**Patient 2-10**
Vit B12 'cytamen' monthly	Yes/no	Yes/no
Vit B12 'neocytamen' every 3 months	Yes/no	Yes/no

Audit: Flu vaccination of patients: "Vaccine Given/Offered"

This audit can include pneumococcal vaccine, pertussis in pregnancy, and vaccination of immunocompromised people. This audit will improve quality of care, and practice income. This audit also highlights the clinical and medicolegal importance of documenting when a vaccine is offered and declined. See HSE immunisation guidelines.

Patient ID	Patient 1	Patient 2-10
Vax offered/given: People >65y	Yes / No	Yes / No
Vax offered/given: People with diabetes (and other chronic illnesses)	Yes / No	Yes / No
Vax offered/given: Pregnant women	Yes / No	Yes / No

Audit: Patient waiting times

This audit assesses "patient waiting times", an important issue for patients.

Criterion: "*Patients should wait no longer than 20 minutes from time of consultation*".

Consider undertaking this for each clinician, for a typical full day. Your admin team can undertake all the data collection retrospectively from your IT system.

If clinicians are routinely 'running behind', consider how you might address this (start surgery punctually, longer appointments, 'catch-up' slots, avoid interruptions, etc).

Patient ID	Patient 1	Patient 2-10
First patient called <5min of appointment time	Yes / No	Yes / No
Patient waiting time (minutes from time of appointment to time clinical file opened)		
Comment/extenuating circumstances.		

Audit of Potentially Toxic Medication: Making Lithium safer

Check Lithium level and renal function every 3 months, Thyroid Function Tests (TFT) every 6 months. Suboptimal monitoring of lithium therapy is well documented: only one third of patients meeting all recommended standards. Serious patient harm may readily result from Lithium toxicity.

Patient ID	Patient 1	Patient 2-10
Lithium level in past 13/12 (Standard is 4 tests)		
Renal function in past 13/12 (Standard is 4 tests)		
TFT in past 13/12 (Standard is 2 tests)		

Audit: Recording common absolute/relative contra-indications to Combined Oral Contraceptive Pill (COCP)

Audit whether your clinical records document common absolute/relative contra-indications. This audit tool does not assess all medical contra-indications to COCP. The full list is available from FSRH.

Patient ID	Patient 1	Patient 2-10
COCP prescribed <6 weeks postpartum	Yes / No	Yes / No
Current smoking status documented	Yes / No	Yes / No
Current BP	Yes / No	Yes / No
Personal or family history of VTE documented	Yes / No	Yes / No
Current migraine status documented	Yes / No	Yes / No
Current BMI documented	Yes / No	Yes / No

Audit: Quality of care in Type 2 Diabetes Mellitis (T2DM)

This audit may help identify those patients where improvement is feasible. See ICGP for Quality in Practice guide. Evidence suggests that **footcare and ACR/eGFR** are the most commonly neglected parameters.

Patient ID	**Patient 1**	**Patient 2-10**
HbA1c: (circle current)	≤53 54-58 59+	≤ 53 54-58 59+
SBP to target (120-139)	Yes / No	Yes / No
DBP to target (70-79)		
ECG in past 13/12	Yes / No	Yes / No
Referred Retinopathy screening programme	Yes / No	Yes / No
Prescribed Statin	Yes / No	Yes / No
Flu vax up to date	Yes / No	Yes / No
Pneumovax up to date	Yes / No	Yes / No
ACR& eGFR in past year	Yes / No	Yes / No
Smoking status recorded	Yes / No	Yes / No
Foot check: Skin & nails	Yes / No	Yes / No
Foot check: Vibration sense in big toe	Yes / No	Yes / No
Foot check: 10g monofilament	Yes / No	Yes / No
Foot check: Circulation: pulses, CRT, warm-cold	Yes / No	Yes / No
BMI documented?	Yes / No	Yes / No

Audit: Management of Cardiovascular Disease

Audit whether your management is compliant with current guidelines (See recent ICGP guidelines on the management of hypertension for exact figures) See ICGP cardiovascular guidelines.

Patient ID (choose patient age to maximal clinical benefit)	**Patient 1**	**Patient 2-10**
Smoking status documented	Yes / No	Yes / No
Lipids documented	Yes / No	Yes / No
HbA1c in past 3y	Yes / No	Yes / No
BMI in past 3y documented	Yes / No	Yes / No
Family history documented	Yes / No	Yes / No
Systolic BP <140 (in past 3y)	Yes / No	Yes / No
Diastolic BP 70-89 (in past 3y)	Yes / No	Yes / No
24hour ABPM offered/undertaken if high BP	Yes / No	Yes / No
CKD: Urine ACR & eGFR if high BP	Yes / No	Yes / No
>65y: Screen for Atrial Fib (Pulse check/ECG)	Yes / No	Yes / No

Audit: Managing Direct Oral Anti-Coagulants (DOACs) in Atrial Fibrillation

Audit whether your management is compliant with current guidance.

Patient ID	**Patient 1**	**Patient 2-10**
Indication for DOAC clearly documented	Yes / No	Yes / No
Duration of DOAC therapy clearly documented	Yes / No	Yes / No
Patients taking reduced DOAC dose have indication clearly documented	Yes / No	Yes / No
DOAC (<75y age): Annual: Hb, renal, liver function	Yes / No	Yes / No
DOAC (>/= 75y age): Every 6/12:	Yes / No	Yes / No
DOAC (if eGFR <60): Every 3/12	Yes / No	Yes / No
Patients taking both DOAC and anti-platelet have indication for dual therapy clearly recorded	Yes / No	Yes / No
Patients on a DOAC have a creatinine clearance calculated using the Cockcroft Gault formula	Yes / No	Yes / No

Audit: Management of Asthma in adults

Audit whether your management is compliant with current guidelines (See recent ICGP guidelines on the management of asthma) See ICGP asthma audit proforma.

Patient ID	**Patient 1**	**Patient 2-10**
ICD 10 coded for asthma	Yes / No	Yes / No
Formal asthma review in past year	Yes / No	Yes / No
Written 'self-management plan'	Yes / No	Yes / No
PEFR in past year documented		
Predicted PEFR documented		
Smoking status documented		
Inhaler technique assessed in past year	Yes / No	Yes / No
If moderate/severe asthma: offered flu vax		
Prescribed LABA but not ICS?		
Number of Salbutamol mdi prescribed in past year: (Target: Aim for 1-2 per year)		
Asthma review patient with >1 salbutamol mdi per month	Yes / No	Yes / No
Review within 5 working days of patient presenting to GP/OOH/A&E with acute asthma attack	Yes/No	Yes/No
Referred to respiratory physician (if needed A&E referral or hospital admission) (NA: not applicable)	Yes/No/NA	Yes/No/NA
Prescribed 'Ventolin syrup'	Yes/No	Yes/No
Prescribed 'nebules' for home nebuliser?	Yes/No	Yes/No
GP completed formal asthma education in past 3y? (ICGP Quick Reference guide, or equivalent https://elearning.asthma.ie/enrol/index.php?id=3	Yes / No	Yes / No

Audit of Chronic Obstructive Pulmonary Disease (COPD)

Patient ID	**Patient 1**	**Patient 2-10**
ICD 10 coded for COPD	Yes / No	Yes / No
Formal COPD in past year	Yes / No	Yes / No
Written self-management plan reviewed	Yes / No	Yes / No
mMRC dysponea scale	Yes / No	Yes / No
FEV1; Most recent recorded	Yes / No	Yes / No
Smoking status/advice documented	Yes / No	Yes / No
Inhaler technique/compliance checked	Yes / No	Yes / No
Flu vax up to date ("yes' if offered & declined)	Yes / No	Yes / No
Pneumovax up to date ("yes' if offered & declined)	Yes / No	Yes / No
Record number COPD exacerbations & hosp admissions in past yr	Yes / No	Yes / No

Audit: Clinical Records in GP Out of Hours (GP OOH)

GP OOH has unique clinical risks, and is considered a high risk (5). Consider an audit of your clinical records in OOH (6). The audit assesses **eight** parameters, each of which gets a score of 0,1,2 (criterion fully met, partially met, wholly absent). This audit can be simply amended for OOH telephone consultations (the sole omitted parameter is physical examination).

Patient ID	**Patient 1**	**Patient 2-10**
Elicits presenting complaint	0 1 2	0 1 2
Past medical History	0 1 2	0 1 2
Current Medication & allergies	0 1 2	0 1 2
Examination	0 1 2	0 1 2
Diagnosis	0 1 2	0 1 2
Management	0 1 2	0 1 2
Prescribing	0 1 2	0 1 2
Safety net & follow up	0 1 2	0 1 2
Total Score (range 0-16) **		

* *Score of </= 8 much scope for improvement, 9-12 satisfactory, 13-16 good.

Audit: Rapid cycle analysis preferred antibiotics audit tool

This is an excellent rapid cycle audit, to support meaningful improvement in your prescribing of antibiotics. The audit tool spreadsheet is available for download here. A medical student undertook the data collection in my practice. We provided personalised feedback to each GP. Identify areas for Quality improvement.

Patient ID	**Patient 1**	**Patient 2**	**Patient 10**
Antibiotic name			
Diagnosis			
Patient's age			
Dose			
Duration			
Preferred:	Yes--No	Yes--No	Yes--No
Justified	Yes--No	Yes--No	Yes--No
Correct	Yes--No	Yes--No	Yes--No
Comment			

Audit: Chronic Kidney Disease (CKD)

ICGP QSIP winner 2019 Dr Richard Murray & William Murray (Medical student)

Patients with CKD are an under-diagnosed and highly vulnerable cohort, with much cardiovascular risk, significant morbidity and mortality. For every 100 patients with moderate-severe CKD: there are 7 deaths, 38 unplanned admissions, 7 acute kidney and 6 cardiovascular events per annum. The majority of these patients are managed solely by GPs.

This excellent audit actively identified and managed people with CKD: Identify patients with eGFR and Code for CKD, optimise CKD risk factors, and address patient education.

The ICGP has an excellent Quick Reference Guide for CKD

Patient ID	**Patient 1**	**Patient 2-10**
Coded CKD (eGFR <45)	Yes/no	Yes/no
All information on one screen *	Yes/No	Yes/No
Patient aware of CKD diagnosis	Yes/No	Yes/No
Patient took 'OTC' NSAID in past year	Yes/no	Yes/no
Patient aware may need to adjust medication in acute illness	Yes/No	Yes/No
Urinalysis for blood, ACR	Yes/No	Yes/No
Blood tests: Hb, HbA1c, eGFR	Yes/No	Yes/No

*Opening screen of patient file identified patient as having CKD, and showed most recent BP, Lipids, BMI, Hb, Smoking status, current medication.

Audit of Potentially Toxic Medication: Making Methotrexate Safer (7)

Sub-optimal management of Methotrexate is a common cause of serious patient harm including death and litigation in GP (7). Some practices undertake excessive blood monitoring, and compliance with guidelines may actually reduce your workload.

(*Caution: This audit is for patients stabilised on Methotrexate: different blood testing applies to patients recently initiated or dose changes*). The ICGP has a recently updated detailed guide on audit of Methotrexate.

Patient ID	**Patient 1**	**Patient 2-10**
Number of blood tests in the previous 13 months (ideal 4-6)		
Dose; Specify Day of week?	Yes/No	Yes/No
Dose; specify 2.5mg?	Yes/No	Yes/No
Clinical record: Summary highlight Immunocompromised?	Yes/no	Yes/no
Flu vax in current season?	Yes/No	Yes/No
Pneumococcal Vax up to date?	Yes/No	Yes/No
Patient education re s/s toxicity?***	Yes/No	Yes/No
Patient education: Weekly dosing? ***	Yes/No	Yes/No

***Consider 'Freetexting' safety advice on your prescription: It's a verifiable record, will auto-populate every subsequent prescription, and the patient's pharmacist will re-iterate the safety advice with every dispensing.

Acknowledgements

I am very grateful to my colleagues for their support, comments and encouragement, especially Dr Tony Cox, Dr Helen McVeigh (PhD), Drs Peter Cronin, Diarmuid Mulcahy, and the GP clinical leads Nuala O'Connor, Dermot Nolan, Mark O'Kelly, Joe Gallagher.

Errors in this document are entirely my responsibility. Constructive feedback to help improve this document is actively sought and always welcome.

Resources and References

Resources

ICGP has an excellent Short Guide to Audit as well as template audits on coeliac disease, heart failure, atrial fibrillation, monitoring of DOACs, immunisation of people with diabetes, and management of asthma, to name a few (5).

The ICGP annual audit prize winners have undertaken excellent audits. You might plagiarise and simply replicate these audits in your practice.

Please share your completed audit: submit to the ICGP annual audit prize, or ICGP-Medisec Quality and Safety in Practice award.

Professor Paul Bowie has "*Ideas for Audit*" a very concise and excellent resource. http://www.appraisal.nes.scot.nhs.uk/media/145815/Audit-Booklet.rtf

References

1. Department of Health. Building a Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance. Dublin: The Stationery Office; 2008; Available at: https://health.gov.ie/blog/publications/building-a-culture-of-patient-safety-report-of-the-commission-on-patient-safety-and-quality-assurance/. Accessed 03/09, 2019.

2. Medical Council. Guide to Professional Conduct and Ethics for Registered Medical Practitioners (Amended) 8th Edition 2019. Dublin: Medical Council of Ireland; 2019; Available at: https://medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-and-Ethics-for-Registered-Medical-Practitioners-Amended-.pdf. Accessed 03/09, 2019.

3. Medical Council. Clinical Audit Guides. 2019; Available at: https://www.medicalcouncil.ie/news-and-publications/videos/clinical-audit-guides. Accessed 03/09, 2019.

4. HSE. A Practical Guide to Clinical Audit. Dublin: Health Service Executive; 2013; Available at: https://www.hse.ie/eng/about/who/qid/measurementquality/clinical-audit/practicalguideclaudit2013.pdf. Accessed 03/09, 2019.

5. Price J. Out of Hours, but not without risks. Medical Protection Practice Matters Sept (2), 2013 ; Available at: https://www.medicalprotection.org/ireland/practice-matters/issue-2---september-2013/out-of-hours-but-not-without-risks. Accessed 03/09, 2019.

6. RCGP, RCPCH, The College of Emergency Medicine. Urgent and Emergency Care Clinical Audit Toolkit. 2010; Available at: https://heeoe.hee.nhs.uk/sites/default/files/urgentcaretoolkit.pdf. Accessed 03/09, 2019.

7 Quinlan D, Ryan P. Making methotrexate safer. Medical Protection Casebook Jan 2013; Available at: https://www.medicalprotection.org/ireland/casebook/casebook-january-2013/making-methotrexate-safer. Accessed 03/09, 2019.

Glossary of Terms

A&E	Accident & Emergency (also called emergency Department (ED))
ACR	Albumin to Creatine Ratio
CKD	Chronic Kidney Disease
COCP	Combined Oral Contraceptive Pill
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
DOAC	Direct Oral Anti-Coagulant
eGFR	estimated Glomerular Filtration Rate
FSRH	Faculty of Sexual and Reproductive Health
GDPR	General Data Protection Regulation
ICD	International Classification of Diseases
ICS	Inhaled CorticoSteroid
LABA	Long Acting Beta Agonist
OOH	Out of Hours
PCS	Professional Competence Scheme
PEFR	Peak Expiratory Flow Rate
T2DM	Type 2 Diabetes Mellitis
TFT	Thyroid Function Tests