The Primary Care Respiratory Society-UK Quality Award: development and piloting of quality standards for primary care respiratory medicine

*Kevin Gruffydd-Jones¹, Iain Small², Monica Fletcher³, Tricia Bryant⁴

¹ Box Surgery, Box, Wiltshire, UK
² Peterhead Health Centre, Peterhead, Grampian, UK
³ Education for Health, The Athenaeum, 10 Church Street, Warwick, UK
⁴ PCRS-UK, Smithy House, Waterbeck, Lockerbie, UK

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Abstract

In an attempt to improve the standards of primary respiratory care in the UK, the Primary Care Respiratory Society-UK (PCRS-UK), in conjunction with other leading respiratory-interested health professional and patient groups, has devised a General Practice Quality Award for Respiratory Medicine. The Award is divided into three modules separated into a total of seven clinical standards (in parentheses): ‘Clinical’ (prevention, early and accurate diagnosis, acute care, chronic care); ‘Organisational’ (equipment); and ‘The Practice Team’ (practice learning needs, educational strategy). Assessment is by submission of a written portfolio of 37 pieces of evidence including audit, reflective learning, patient feedback, and significant event analyses. The Award was piloted in five respiratory-interested practices across the UK. The practices reported improvements in practice organisation, practice teamwork, improved process measures such as improvement in quality of spirometry, and improved patient access to patient services. All practices in the UK are being invited to apply for the Award in 2013. It is hoped that it will provide a framework and stimulus for provision of high-quality primary respiratory care, not only in the UK, but also some aspects of the Award may be applicable on a wider international scale.

Keywords asthma, COPD, management, primary care, quality, standards
The Quality Standards were initially developed by a multidisciplinary Module Development Group (see Appendix 2, available online at www.thepcrj.org). This group drew upon national respiratory guidelines to produce an initial set of standards and evidence requirements.3,8–13 This initial set was modified by a larger group using the following criteria: whether the standards were truly evidence-based; were practical and deliverable; were generalisable across a UK primary care population; and whether they were evaluable. The number of items of evidence was further reduced after consultation with seven primary care practices varying in size, geography, and socio-economics across the spectrum of UK general practice using the same criteria.

**Design and scope of the Award**

The Award has been partly based on the generic Royal College of General Practitioners Quality Practice Award (QPA)14 which assesses quality of care across a wide range of disease areas managed in general practice. QPA involves submission of a written portfolio of evidence across several modules, concentrating mainly on practice organisation.

The PCRS-UK Award is divided into three modules: ‘Clinical’, ‘Organisation’, and ‘The Practice Team’. These are subdivided into seven standards as shown in Box 2.

**Box 2. Modules and Standards of the Quality Award**

| • Clinical          | • Organisational         |
|---------------------|--------------------------|
|   o Prevention       |   o Equipment             |
|   o Early and accurate diagnosis |   o The Practice Team  |
|   o Acute care       |   o Practice learning needs |
|   o Chronic care     |   o Educational strategy  |

The clinical standards are mainly centred on the disease areas of asthma and COPD, but examples of good practice in other areas of respiratory medicine can be submitted. The format of the standards has been modelled on that used by Health Improvement Scotland in their Asthma and COPD Services Clinical Standards.12,13 Each standard has a headline statement (e.g. “People listed on the asthma and COPD registers are offered regular structured review of their condition”), followed by the rationale for the statement and finally the evidence required to meet that standard. The full quality standards are shown in Figure 1.

Practices are asked to submit 37 pieces of written evidence within a 6-month period to the PCRS-UK assessors comprising audits, protocols, significant event analyses, patient case histories, and examples of reflective learning. Assessment of the written portfolio is carried out by two trained independent assessors drawn from the stakeholder organisations. A practice is required to provide all the evidence that it meets these standards in order to gain the PCRS-UK Quality Award.

**Piloting of the Award**

The Award was initially piloted in 2011 in five respiratory-interested practices in England and Scotland to establish whether working for the Award was feasible and to iron out any practical problems.

All phase 1 pilot practices successfully gained the Award. The practices reported that working for the Award had led to numerous improvements in practice organisation, varying from updating outdated protocols to actively involving all members of the practice team rather than respiratory care being carried out by one or two individuals.

As a result of the audit, there were significant improvements in some practices in the quality of spirometry, increased influenza vaccination uptake, and improved review of patients after hospital admission for acute COPD and asthma. The improvements were largely confined to process outcomes such as improved quality of care rather than outcome measures such as reduction in hospital admissions and exacerbations which were not recorded in this pilot phase. However, examples of tangible benefits from patients included improved access to surgery appointments for school children with asthma and improved access to smoking cessation services.

We also analysed qualitative feedback from these practices. Although practices acknowledged the need for extra time to complete the Award, feedback has been positive with comments such as “It has given us the opportunity to take time to really look at our respiratory service in detail … and we’re doing a good job” and “It was a motivating process and helped us engage the whole team”.

The experience and feedback of the five pilot practices demonstrated that the PCRS-UK Quality Award is an important developmental opportunity for the whole practice and does drive improvements in care, even in high performing practices.

Following this initial pilot phase, minor adjustments to the original evidence requirements (such as examples of patient feedback questionnaires, suggested surveys and audits, and a more detailed practice profile) were made to the Award, which is being tested further in pilot phase 2.

**Discussion**

Improvement in the quality of provision of healthcare has been a major priority in the UK and many healthcare systems throughout the world. The development and implementation of a Quality Award was seen by the stakeholder organisations as a method of incorporating the key elements of quality care improvement using Wagner’s Chronic Care Model15 (improved organisation, improved health professional clinical care using education, and peer review) into a quality improvement method award that would be achievable in a wide range of primary care practices and raise standards of care.
Module A: Clinical Care - Prevention

Standard 1  
The practice can demonstrate a health promotion policy for the prevention of respiratory disease in all patient groups

Rationale  
Smoking is known to be a major cause of respiratory illness – COPD,1 lung cancer,2 asthma.3 Smoking cessation advice to all patient groups offered in primary care is an effective intervention in helping smokers to quit.

Vaccination programmes to prevent respiratory infection in vulnerable groups offer effective protection against respiratory infection and prevent complications.4

All practices participating in the PCRS-UK Quality Award will be able to demonstrate appropriate activity surrounding the process of smoking prevention, smoking cessation and vaccination programmes.

Evidence required to support application (2 parts, both must be completed)

Evidence Smoking prevention and cessation

1  
The practice must be able to demonstrate a robust smoking cessation policy utilised in the practice which, at a minimum:
   • asks all patients who are smokers if they are ready to quit
   • ensures those patients expressing an interest in quitting are referred to an appropriate smoking cessation service.

The practice must

2a  
Complete and submit the results of a survey of a sample of smokers with a long-term condition (see page 31)

2b  
Provide a reflective narrative on what it has learned about the success, or otherwise, of its policy for smoking cessation and any changes the practice has made/endeavoured to make as a result of the survey

Evidence Vaccination

3a  
The practice will submit the results of its most recent influenza vaccination data and be able to demonstrate that it can achieve its immunisation targets for influenza vaccination in all vulnerable groups, according to local/regional or national standards.

3b  
The practice will reflect on the success of its influenza vaccination programme, what can be improved and what actions will be taken if it has failed to achieve the desired target influenza vaccination standards.

References

1  
National Institute for Health and Clinical Excellence (NICE). Smoking cessation services in primary care: pharmacies, local authorities and local NHS bodies (National service framework for schools, pregnant women and hard to reach communities). 2009. http://www.nice.org.uk/CG112 [accessed 18/11/2010]

2  
National Clinical Guideline Centre. Chronic obstructive pulmonary disease: management of chronic obstructive pulmonary disease in adults in primary and secondary care. National Institute for Health and Clinical Excellence (NICE). 2004. http://guidance.gov.uk/CG253?image=pdf&title=COPD_Confirmed [accessed 18/11/2010]

3  
Patient Info & Audits M. Smoking and asthma in adults. Eur Respir J 2010; 35:734–9.

4  
World Health Organization. Influenza season. Fact sheet N 191 2009. Available from: http://www.who.int/mediacentre/factsheets/fs116/en/ [accessed 18/4/2010]

Further information and resources

1  
“Invisible Lives Key Findings: A Summary” http://www.lunguk.org/Resources/British%20Lung%20Foundation/Migrated%20Resources/Documents/I/Invisible%20Lives%20report.pdf [accessed 08/08/2013]

2  
PCRS-UK Smoking cessation opinion sheet – See http://www.pcrs-uk.org/downloads/resources/os17_smoking_cess.pdf [accessed 08/08/2013]

3  
“Tackling the Smoking Epidemic - IPCRG International guidance on smoking cessation in primary care”. Available from: http://www.thoracic.org/statements/resources/pfet/PFT2.pdf [accessed 11/11/2010].

Further information and references

1  
ATS/ERS spirometry standards: Miller MR, Hankinson J, Brusasco V, et al. Standardisation of spirometry. Eur Respir J 2005; 26:319–38. http://www.ersjournals.com/doi/abs/10.1183/09031936.05.00076205?journalCode=ersj

2  
National Institute for Health and Clinical Excellence: Chronic obstructive pulmonary disease (COPD) (QS9) http://guidance.nice.org.uk/QS9 [accessed 08/08/2013]

3  
National Institute for Health and Clinical Excellence: Asthma (QS8) http://guidance.nice.org.uk/QS8 [accessed 08/08/2013]

4  
“Smoking is known to be a major cause of respiratory illness – COPD, lung cancer, asthma. Smoking cessation advice to all patient groups offered in primary care is an effective intervention in helping smokers to quit.” Tackling the Smoking Epidemic - IPCRG International guidance on smoking cessation in primary care. Available from: http://www.thoracic.org/statements/resources/pfet/PFT2.pdf [accessed 11/11/2010].

5  
All practices participating in the PCRS-UK Quality Award will be able to demonstrate appropriate activity surrounding the process of smoking prevention, smoking cessation and vaccination programmes.

6  
A practice must submit the results of its most recent influenza vaccination data and be able to demonstrate that it can achieve its immunisation targets for influenza vaccination in all vulnerable groups, according to local/regional or national standards.

7  
The practice will reflect on the success of its influenza vaccination programme, what can be improved and what actions will be taken if it has failed to achieve the desired target influenza vaccination standards.
Module A: Clinical Care - Chronic respiratory care

**Standard 3** People listed on the COPD and asthma registers are offered regular structured review of their condition.

**Rationale** Proactive structured review for asthma and COPD is associated with an improvement in clinical outcomes such as reduced exacerbation rates, reduced hospitalisations and improved symptom control. A structured review offers the opportunity to:

- a) Assess the impact of the disease, identify any co-morbidities and review therapeutic interventions upon the patient.
- b) Review and adjust pharmacological and non-pharmacological therapy including the need for specialist respiratory referral.
- c) Promote patient self-management and empowerment.

Practices will demonstrate how they proactively review their patients with stable asthma and COPD. Practices will demonstrate (in asthma and COPD) the process by which they identify patients at high risk of significant disease impact.

**Evidence required to support application**

| Evidence | Identification of high-risk patients |
|----------|-------------------------------------|
| 8a (asthma) | The practice will provide evidence of the frequency of review of patients with asthma and COPD (for low- and high-risk patients) in accordance with national guidance by submitting copies of asthma and COPD templates or other data recording systems. | 1. The practice will provide evidence of the frequency of review of patients with asthma and COPD (for low- and high-risk patients) in accordance with national guidance by submitting copies of asthma and COPD templates or other data recording systems. |
| 8b (COPD) | 2. The practice will outline the process for identifying high-risk patients and evidence of the systems in place to manage these patients (e.g., protocols) and reflect on the effectiveness of these processes. | 2. The practice will outline the process for identifying high-risk patients and evidence of the systems in place to manage these patients (e.g., protocols) and reflect on the effectiveness of these processes. |

**Further information**

National Institute for Health and Clinical Excellence. Guidelines CG101. Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care. 2010. [Accessed 08/08/2013]

British Thoracic Society and Scottish Intercollegiate Guidelines Network. British Guideline on the management of asthma. 2012. [Accessed 17/11/2010]

Revalidation on Guidelines for GPs. Royal College of General Practitioners. [Accessed 17/11/2010]

National Institute for Health and Clinical Excellence. Quality Standard for asthma (QS25). [Accessed 17/11/2010]

Further information

1. The practice will provide evidence of its protocol(s) for the management of asthma AND COPD. The practice will provide evidence of patient action plans or self-management plans for both asthma AND COPD, including a description of educational materials used.

2. The practice will provide evidence of patient action plans or self-management plans for both asthma AND COPD, including a description of educational materials used.

3. The practice will provide evidence of how disease is effectively managed, including the regular checking of inhaler device technique. Practices will be able to demonstrate evidence of local/national guidance on inhaler use. Mechanisms by which the practice can demonstrate this must include at least one audit on asthma or COPD including a reflective paragraph showing evidence of your action plan to address any issues raised in the audit.

4. Using data in 1-3 above, evaluate how regular review is undertaken in the practice (maximum one A4 sheet of paper).
Figure 1. Quality standards continued

Module B: Organisation - Equipment

Standard 5 Practices have access to – and the ability to use effectively – the equipment necessary to assess, diagnose, review and treat patients with respiratory conditions.

Rationale Patients with respiratory conditions such as asthma and COPD present to clinicians in primary care. The ability to establish or exclude a diagnosis, to review and treat such patients within a primary care setting is a mark of a quality service and requires the appropriate equipment to be in place, in good working condition and used by appropriately trained staff.

Practices participating in the Award will be required to submit details of the key components of an effective equipment policy including:

a) Identifying equipment necessary to meet the needs of clinicians and patients within the frame work of other local services.

b) Calibration or verification/maintenance policies and procedures.

Evidence required to support application

| Evidence | Equipment register |
|----------|--------------------|
| 17       | Practices will complete Form ER1 (see Appendix 13) in full provided by PCRS-UK in the event that practices do not have available all of the equipment listed in form ER1 they must be able to provide a detailed explanation and clear rationale for why they do not carry the equipment. |

Further information

Levy ML, Quanjer PH, Bookman R, Cooper BG, Holmes SG, Small I. Diagnostic spirometry in primary care: proposed standards for general practice compliance with American Thoracic Society and European Respiratory Society recommendations. Prim Care Respir J 2009; 18: 313–17.

Evidence required to support application (3 parts, all must be completed)

| Evidence | Teamwork |
|----------|----------|
| 18a      | 1. The practice must submit a document outlining the following information (maximum length two sides of A4 for points 1–3 below excluding appendix):
|          | a. Who are the team members?
|          | b. What are the roles within the team and who fulfils them?
|          | c. How do you implement change of practice within the team? |

| Evidence | Interaction with other providers |
|----------|--------------------------------|
| 19a      | 1. The practice will provide a case study on end-of-life care. |
| 19b      | 2. The practice will provide a document (maximum one side A4) which illustrates engagement with the multi-disciplinary team in the above case study including details of:
|          | a. Who did you engage with?
|          | b. How did you communicate with the team outside of regular hours?
|          | c. How did you change care and implement changes? |

| Evidence | Patient experience/involvement |
|----------|--------------------------------|
| 20       | 1. The practice will undertake a survey of a random sample of at least 20 patients with respiratory disease using the template provided (see Appendix 6). The practice will provide a reflective paragraph on the outcome of the results of the questionnaire and provide an action plan. |

Further information

The document aims to outline the standards and skills required from the individual primary care nurses to deliver effective respiratory care in primary care. For more information, visit: www.pcrs-uk.org/downloads/resources/doc_rev2010.pdf [accessed 08/08/2013].
Improvements. Surprisingly, there has only been limited evaluation of the Respiratory Practice Award which has been adopted by many healthcare organisations in the Netherlands and Germany. However, a systematic review of performance based on this model showed only weak evidence of sustainability. 

Although quality awards have been used to improve healthcare for several years, the evidence base for their efficacy is not large. The European Foundation for Quality Management has devised a model of healthcare quality improvement and Quality Award which has been adopted by many healthcare organisations in the Netherlands and Germany. However, a systematic review of performance based on this model showed only weak evidence of sustainability. 

The development of the PCRS-UK Quality Award involved the successful co-operation of respiratory-interested multi-professional and patient groups. During the iterative process the initial number of pieces of evidence required was reduced to minimise practice workload, and an important section added to include patient experience and practice feedback. The feedback from the pilot practices suggested that there was a significant amount of work involved in collating the evidence needed for the Award. However, the impact of this increased workload could be greatly reduced by sharing the evidence submission with other members of the primary healthcare team. In return, there were tangible gains with regard to improved teamwork, patient access, and raised process standards (see “Piloting of the Award” section). This should be tempered by the fact that the pilot 1 practices were already respiratory-interested organisations. In addition, questions remain about long-term sustainability of the Award – for example, will improvements be maintained if key personnel leave the practice and will short-term process improvements translate into longer-term outcome benefits such as reduced patient admissions or improved patient quality of life?

It is planned to make the fully functional PCRS-UK Quality Award available to all general practices in the UK in 2013. As the Award is rolled out to a wider range of practices, there is a need to train more assessors. This is being met by training both lay and health professional assessors. A major challenge will be to encourage practices to apply for the Award. One possibility is to encourage groups of practices (e.g. Clinical Commissioning Groups in England) to apply for the Award to meet the UK Government's QIPP agenda using national or local financial incentives. Another possibility is to make individual modules available either as a precursor to carrying out the whole Award or as a quality improvement tool in its own right. Although developed for the UK, the standards would fit with most developed healthcare systems that rely on primary care for the diagnosis, treatment, and management of long-term conditions. It is acknowledged that some of the individual pieces of evidence might need to be changed to reflect local practice, although significant event analyses, reflection
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on multidisciplinary working, and completed audits are universally applicable.

Conclusions
The PCRS-UK Quality Award has been developed in conjunction with major professional and patient respiratory organisations in the UK. It offers a possible tool to provide a developmental framework that can be used at the practice, locality, and national level to promote high-quality respiratory medicine in primary care.

Further details of the Award can be found on the PCRS-UK website (http://www.pcrs-uk.org/pcrs-uk-quality-award).

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Conflicts of interest KG-J has acted as consultant for and spoken on behalf of the Department of Health, GlaxoSmithKline, AstraZeneca, Almirall, Chiesi, Novartis, Boehringer Ingelheim, MundipharmaNAPP, and Merck Sharp and Dohme. He is co-chair of the Quality Award Group. IS is Chair of the Primary Care Respiratory Society UK. AstraZeneca Ltd, MSD UK, Napp Pharmaceuticals, Pfizer Ltd, Teva Ltd.

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Contributorship Kevin Gruffydd-Jones is the principal author of this article, with significant contributions regarding methodology and input into the discussion from the other authors.

References
1. Department of Health. Quality Innovation, Productivity and Prevention (QIPP). www.dh.gov.uk/health/category/policy/quality/qipp
2. Department of Health. NHS Outcome Framework 2011 to 2012. November 2010. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129444
3. Department of Health. An Outcomes Strategy for People with Asthma and COPD. 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127974
4. Department of Health. An Outcomes Strategy for COPD and Asthma. NHS Companion Document 2012. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134000
5. Healthcare Commission. Clearing the Air: National Study of Chronic Obstructive Pulmonary Disease. 2006. http://archive.cqc.org.uk/dh/documents/COPD_report1_2006072727272727. pdf
6. Levy M, Quanjer PH, Cooper BG, Holmes S, Small I. Diagnostic spirometry in primary care: proposed standards for general practice compliant with American Thoracic Society and European Respiratory Society recommendations. Prim Care Respir J 2009;18(3):130-47. http://dx.doi.org/10.4104/prcj.2009.00054
7. Harrison B, Stephenson P, Mohan G, Nasser S. An ongoing confidential enquiry into asthma deaths in the Eastern Region of the United Kingdom 2001-2003. Prim Care Respir J 2005;14(3):103-13. http://dx.doi.org/10.1016/j.pcrj.2005.08.004
8. National Clinical Guideline Centre. Chronic Obstructive Pulmonary Disease: Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care. http://www.nice.org.uk/nicemedia/live/13209/49425/49425.pdf
9. National Institute for Health and Clinical Excellence. Chronic Obstructive Pulmonary Disease (COPD) Quality Standard (QS10). http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivemulmonarydisease/copdqualitystandard.jsp
10. Healthcare Improvement Scotland. British Guideline on the Management of Asthma. May 2009 (revised 2012) http://www.brit-thoracic.org.uk/Portal/0/Guidelines/AsthmaGuidelines/sign101%20Jan%202012.pdf
11. Department of Health. An Outcomes Strategy for People with Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127974
12. Healthcare Improvement Scotland. Asthma Services for Children and Young People Clinical Standards. 2007. http://www.healthcareimprovementscotland.org/previous_resources/standards/asthma_services_for_children_a.aspx
13. Healthcare Improvement Scotland. Chronic Obstructive Pulmonary Disease (COPD) Services - Clinical Standards and Evaluation. http://www.healthcareimprovementscotland.org/default.aspx?page=11931
14. Royal College of General Practitioners. Quality Practice Award (QPA). http://www.rcgp.org.uk/professional_development/team_quality/qpa.aspx
15. Wagner EH, Glasgow RE, Davis C, Trejo J, Scallan C, et al. Quality improvement in chronic illness care: a collaborative approach. Jt Comm J Qual Improv 2001;27:63-80.
16. Nabitz U, Klazinga N, Walburg J. The EFQM excellence model: European and Dutch experiences with the EFQM approach in health care. European Foundation for Quality Management. Int J Qual Health Care 2000;12(3):191-201. http://dx.doi.org/10.1093/intqhc/12.3.191
17. Minkman M, Ahaus K, Huisman R. Performance improvement based on integrated quality management models: what evidence do we have? A systematic literature review. Int J Qual Health Care 2007;19(2):90-104. http://dx.doi.org/10.1093/intqhc/mzm071
18. McLean T, Atkins E, McLean K. Quality Award and teamwork: the perceptions of primary health care team members in Scotland. J Interprof Care 2005;19(2):149-55. http://dx.doi.org/10.1080/13561820400024084

Available online at http://www.thepcj.org
Appendix 1. Original Steering Committee and stakeholder organisations involved in developing the Quality Award

Iain Small, Primary Care Respiratory Society-UK (PCRS-UK) (Co-Chair)

Kevin Gruffydd-Jones, PCRS-UK and Royal College of General Practitioners (RCGP) (Co-Chair)

Dr John Warwick, RCGP

Dr John O Kelly, Northern Ireland RCGP

Dr Steve Holmes, PCRS-UK

Dr Mark Hopkin, GP

Dr Tarek Bahkt, GP

Dr Raj Ramachandram, PCRS-UK

Dr Richard Russell, British Thoracic Society (BTS)

Dr Sheila Edwards, BTS

Dr Mike Morgan, BTS

Carol Stonham, PCRS-UK

Stephanie Wolfe, PCRS-UK

Bronwen Thomson, PCRS-UK

Monica Fletcher, Education for Health

Gill Hall, Respiratory Education UK

Dame Helena Shovelton, British Lung Foundation (BLF)

Kate Leach, BLF

Annette Duck, Association Respiratory Nurse Specialists (ARNS)

Simon Selo, Asthma UK

Neil Churchill, Asthma UK

Current Quality Award Development Group

Dr Noel Baxter, PCRS-UK

Monica Fletcher, Education for Health

Kevin Gruffydd-Jones, PCRS-UK

Gill Hall, Respiratory Education UK

Steve Holmes, PCRS-UK

Mark Hopkin, PCRS-UK

Matt Kearney, Department of Health

Chris Loveridge, Education for Health

Mike McKeivitt, BLF

Richard Russell, BTS

Simon Selo, Asthma UK

Iain Small, PCRS-UK

Carol Stonham, PCRS-UK

John Warwick, RCGP
Appendix 2. Module Development Group

Kevin Gruffydd-Jones, PCRS-UK (Co-Chair Quality Award Development Group) and Royal College of General Practitioners (RCGP)

Iain Small, Primary Care Respiratory Society-UK (PCRS-UK) (Co-Chair Quality Award Development Group)

Mark Hopkin, GP, Stourbridge

Tarek Bakht, GP, Bolton

Steve Holmes, PCRS-UK Education Committee Chair and GP

Erica Haines, Specialist respiratory nurse, Buckinghamshire