Prim Care Respir J 2013; **22**(3): 353-359

Primary Care RESPIRATORY JOURNAL
www.thepcrj.org

DISCUSSION PAPER

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

***Kevin Gruffydd-Jones[1], Iain Small[2], Monica Fletcher[3], Tricia Bryant[4]**

[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

Originally received 2nd January 2013; resubmitted 4th April 2013; revised 6th April 2013; accepted 12th April 2013; online 23rd August 2013

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.

K Gruffydd-Jones *et al*. *Prim Care Respir J* 2013; **22**(3): 353-359
http://dx.doi.org/10.4104/pcrj.2013.00065

Keywords asthma, COPD, management, primary care, quality, standards

The full version of this paper, with online appendices, is available online at www.thepcrj.org

Background

Against a global background of rising healthcare demands and constrained healthcare funding, it is imperative that the quality of healthcare provision is not diluted. In the UK the provision of high-quality medical care has become a pivotal part of government health policy via the Quality, Improvement, Productivity and Prevention (QIPP) agenda[1] and the National Health Service (NHS) Outcomes Framework 2010.[2] The Department of Health (DH) Outcomes Strategy for People with COPD and Asthma[3] and its companion document[4] outline the aspirations for high-quality care in chronic obstructive pulmonary disease (COPD) and asthma. There is, however, evidence of suboptimal care including substantial variation in standards in COPD care across England,[5] variation in the quality of primary care spirometry,[6] and deficiencies in the assessment of the acute asthma attack.[7]

With this background in mind, a meeting of respiratory-interested patient and health professional organisations led by the Primary Care Respiratory Society-UK (PCRS-UK) met in 2009 to discuss how to raise the quality of primary respiratory care. The decision was made to develop a Quality Award which would set out the standards that best define high-quality primary respiratory care and reward practices that met these standards (Box 1).

Development process

The Award design was devised and the development of the Award overseen by a multidisciplinary steering group composed of members from respiratory-interested health professionals and patient organisations (see Appendix 1, available online at www.thepcrj.org).

*** Corresponding author:** Dr Kevin Gruffydd-Jones, Box Surgery, Box, Wiltshire SN13 8NA, UK.
Tel: +44 (0)1225 742361 E-mail: Kevin.Gruffydd-Jones@gp-J83013.nhs.uk

Box 1. Aim of the PCRS-UK Practice Quality Award

To set out the standards that best define high quality respiratory care in primary care, providing:

- Recognition of practices delivering a high standard of respiratory care
- A quality assurance mark for patients, commissioning groups and the wider NHS
- A developmental framework that can be used at practice, locality and national levels to promote, support and reward quality respiratory care in the primary care setting

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
  - Prevention
  - Early and accurate diagnosis
  - Acute care
  - Chronic care
- Organisational
  - Equipment
- The Practice Team
  - Practice learning needs
  - 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 Model[15] (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.

Figure 1. Quality standards

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,[1,2] lung cancer,[1,2] asthma.[1,3] 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 prevention of 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.
2a 2b	The practice must • Complete and submit the results of a survey of a sample of smokers with a long-term condition (see page 31) • 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/intends 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 immmunisation 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 immunisation rates, how these 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 workplaces, particularly for manual working groups, pregnant women and hard to reach communities. 2008. http://www.nice.org.uk/nicemedia/live/11925/39596/39596.pdf [accessed 11/11/2010]

(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) clinical guideline 101. 2010. http://guidance.nice.org.uk/CG101 [accessed 11/12/2010]

(3) Piipari R, Jaakkola JJK, Jaakkola N, Jaakkola MS. Smoking and asthma in adults. *Eur Respir J* 2004;**24**:734–9.

(4) World Health Organization. Influenza (seasonal). Fact sheet 211 (2009). Available from: http://www.who.int/mediacentre/factsheets/fs211/en/ [accessed 1/4/2010]

Other resources

A smoke-free future: a comprehensive tobacco control strategy for England. Tobacco Dependency Clinical Strategy, Feb 2010. http://webarchive.nationalarchives.gov.uk/20100509080731/http://dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 [accessed 08/08/2013]

National Institute for Health and Clinical Excellence: Brief interventions and referral for smoking cessation. Public Health Guidance 1. March 2006. http://publications.nice.org.uk/brief-interventions-and-referral-for-smoking-cessation-ph1 [accessed 08/08/2013]

NICE guidance on brief interventions for smoking. http://guidance.nice.org.uk/PH1 [accessed 16/11/2010]

Department of Health. The Green Book. Immunisation chapter. 2010. http://www.dh.gov.uk/en/Publichealth/Immunisation/Greenbook/index.htm

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

Tackling the Smoking Epidemic - IPCRG International guidance on smoking cessation in primary care. https://www.theipcrg.org/display/RESSMO/Tackling+the+Smoking+Epidemic+-+IPCRG+International+guidance+on+smoking+cessation+in+primary+care [last accessed 08/08/2013]

London Respiratory Team smoking cessation materials. http://www.networks.nhs.uk/nhs-networks/london-respiratory-network/key-documents/stop-smoking-as-treatment-for-respiratory-disease-1 [accessed 08/08/2013]

Training Module for Brief Intervention http://www.networks.nhs.uk/nhs-networks/london-respiratory-network/key-documents/stop-smoking-as-treatment-for-respiratory-disease-1

Training module for clinical and non-clinical staff on smoking cessation http://www.nhshealth.org.uk/StopSmoking/elearning/

The Green Book - http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131000.pdf

Module A: Clinical Care - Early and accurate diagnosis

Standard 2	The practice will demonstrate evidence of a system for early and accurate diagnosis of respiratory disease
Rationale	There is significant under-diagnosis of COPD in the community and practices should be able to demonstrate that they provide COPD screening at suitable opportunities. Early and accurate diagnosis of respiratory disease is vital for appropriate and successful interventions. The ability to investigate appropriately and interpret the information leads to accurate diagnoses and relevant successful treatments. Practices will be able to provide evidence, reflecting current national guidance, on how asthma and COPD are diagnosed. Evidence of spirometry should demonstrate that it meets current diagnostic standards and interpretation of spirometry should be in keeping with ATS/ERS standards.

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

Evidence	Case finding
4	The practice will describe (maximum one side A4) the systems available for case finding in COPD and a reflective paragraph on the successes/challenges of case finding in COPD.
Evidence	**Diagnosis**
5a (asthma) 5b (COPD)	i. The practice will provide its policy for the diagnosis of asthma and COPD and include evidence of the appropriate use of spirometry in the diagnostic process.
6a	ii. The practice will demonstrate that its diagnosis policy is effective by providing an example of a patient journey or case study on the diagnosis of asthma **OR** COPD.
6b	iii. The practice must include a reflective narrative including an action plan for maintaining or improving the standards of diagnosis of respiratory conditions in the practice including identification of misdiagnosed or undiagnosed patients[1]
7	iv. The practice will provide an audit of its spirometry practice using the audit template provided (see page 32) including reflection and action plan. Practices should be able to demonstrate that 90% of patients diagnosed with COPD have had their diagnosis confirmed by spirometry (with legitimate exceptions taken into account – details must be provided). An electronic version of this audit is available which provides an automated report of the results of the audit against the audit criteria shown on page 9 and allows practices to compare their own results with other practices. To access the online audit facility please contact the award administrator for a username and password (tricia@pcrs-uk.org). The electronic audit can be accessed at http://www.guideline-audit.com/pcrsuk_copd_dx/instructions.php and includes detailed instructions.

Further information and references

(1) "Invisible Lives Key Findings: A Summary" http://www.lunguk.org/Resources/British%20Lung%20Foundation/Migrated%20Resources/Documents/I/Invisible%20Lives%20report.pdf

National Institute for Health and Clinical Excellence. Guideline CG101. Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care 2010. http://publications.nice.org.uk/chronic-obstructive-pulmonary-disease-cg101 [accessed 08/08/2013]

National Institute for Health and Clinical Excellence. Quality Standards - Chronic obstructive pulmonary disease (COPD) (QS10) http://guidance.nice.org.uk/QS10 [accessed 08/08/2013]

Quality Standard for asthma (QS25) http://publications.nice.org.uk/quality-standard-for-asthma-qs25 [accessed 08/08/2013]

British Thoracic Society and Scottish Intercollegiate Guideline Network. British Guideline on the management of asthma. 2012 http://www.sign.ac.uk/guidelines/fulltext/101/ [accessed 08/08/2013]

Department of Health COPD Consultation document. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_116716 [accessed 17/11/2010]

A Guide to Quality Assured Diagnostic Spirometry. Primary Care Commissioning. 2013 http://www.pcc-cic.org.uk/article/guide-quality-assured-diagnostic-spirometry [accessed 08/08/2013]

ATS/ERS spirometry standards: Miller MR, Hankinson J, Brusasco V, Burgos F, Casaburi R, Coates A, *et al.* Standardisation of spirometry. *Eur Respir J* 2005;**26**:319–38. http://www.thoracic.org/statements/resources/pfet/PFT2.pdf [accessed 11/11/2010].

Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes SGT, 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.

The PCRS-UK has a wide range of tools and resources ranging from nurse patient group directions, nurse protocols and checklists, a series of well respected PCRS-UK opinion sheets and other supported materials. You can access all these materials by using our Quick Retrieval Tool

Figure 1. Quality standards continued

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 (2 parts, all must be completed)

Evidence	Identification of high-risk patients
8a (asthma) 8b (COPD)	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) and include a reflective paragraph on the appropriateness/ completeness of the data recording systems.
9	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. protocol) and reflect on the effectiveness of these processes. If the practice does not have a process for identifying high-risk patients they should include reflective narrative including an action plan on how they plan to address this which includes information on how a locum GP, who does not know your patients, would be able to identify high-risk patients.
10	3. The practice will provide evidence of audit (either COPD or asthma) including a reflective narrative and action plan which considers the adequacy and appropriateness of the identification and management policies of high risk patients.

Evidence	Regular review
11a (asthma) 11b (COPD) 12a (asthma) 12b (COPD) 13	1. The practice will provide copies of its protocol(s) for the management of asthma **AND** COPD. 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 that local/national guidance is implemented. 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
14	4. Using data in 1–3 above, evaluate how regular review is undertaken in the practice (maximum one A4 sheet of paper)

Further information

National Institute for Health and Clinical Excellence. Guideline CG101. Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care 2010. http://publications.nice.org.uk/chronic-obstructive-pulmonary-disease-cg101 [accessed 08/08/2013]

National Institute for Health and Clinical Excellence. Quality Standards - Chronic obstructive pulmonary disease (COPD) (QS10) http://guidance.nice.org.uk/QS10 [accessed 08/08/2013]

Quality Standard for asthma (QS25) http://publications.nice.org.uk/quality-standard-for-asthma-qs25 [accessed 08/08/2013]

British Thoracic Society and Scottish Intercollegiate Guideline Network. British Guideline on the management of asthma. 2012 http://www.sign.ac.uk/guidelines/fulltext/101/ [accessed 08/08/2013]

PCRS-UK primary care resources on the diagnosis and management of asthma and COPD can be located via the resources menu of PCRS-UK website and include our Quick Guides:- http://www.pcrs-uk.org/downloads/resources/asthma_quick_guide.pdf [accessed 08/08/2013]

http://www.pcrs-uk.org/downloads/resources/copd_guidelinebooklet_final.pdf [accessed 08/08/2013]

Revalidation Guidelines for GP's .Royal College of General Practitioners http://www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx(accessed July 2013)

Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes SGT, 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

The PCRS-UK has a wide range of tools and resources ranging from nurse patient group directions, nurse protocols and checklists, a series of well respected PCRS-UK opinion sheets and other supported materials. You can access all these materials via the resources menu of the website and using our **search resources** feature option located in the top right of all PCRS-UK web pages.

Module A: Clinical Care - Acute respiratory care

Standard 4	Practices can demonstrate an effective system for the recognition, assessment and immediate management of patients with acute respiratory problems
Rationale	Patients with respiratory disorders can often present to primary care centres when in crisis. It is essential practice to have systems in place to recognise, assess and manage acute respiratory problems promptly. By having protocols, systems and equipment in place to deal with acute respiratory problems, the practice will be able to deliver prompt, safe and effective management of patients. These protocols should link all team members – from reception staff to doctors – to recognise respiratory distress early. The practice will submit evidence to demonstrate safe, effective and appropriate systems for the identification and management of acute respiratory conditions (including adult and child anaphylaxis) in accordance with national guidance.

Evidence required to support application

Evidence	Practice systems
15a. anaphylaxis 15b. child acute 15c. adult acute	1. The practice must include practice protocols for the management of anaphylaxis **AND** acute respiratory conditions (adult **AND** child) and information on how the protocols are implemented in practice
16.	2. The practice will provide a significant event analysis of either anaphylaxis **OR** an acute respiratory condition

References

(1) National Institute for Health and Clinical Excellence. Guideline CG101. Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care 2010. http://publications.nice.org.uk/chronic-obstructive-pulmonary-disease-cg101 [accessed 08/08/2013]

(2) British Thoracic Society and Scottish Intercollegiate Guideline Network. British Guideline on the management of asthma. 2012 http://www.sign.ac.uk/guidelines/fulltext/101/ [accessed 08/08/2013]

(3) http://www.sign.ac.uk/guidelines/fulltext/101/index.html [accessed 17/11/2010]

Further information

National Institute for Health and Clinical Excellence. Quality Standards - Chronic obstructive pulmonary disease (COPD) (QS10) http://guidance.nice.org.uk/QS10 [accessed 08/08/2013]

Quality Standard for asthma (QS25) http://publications.nice.org.uk/quality-standard-for-asthma-qs25 [accessed 08/08/2013]

http://www.rcn.org.uk/development/publications [accessed 17/11/2010]

PCRS-UK website http://www.pcrs-uk.org/ [accessed 17/11/2010]

RCGP QPA case study definition http://www.rcgp.org.uk/revalidation-and-cpd/practice-accreditation-and-quality-practice-award.aspx(accessedJuly 2013)

The PCRS-UK has a wide range of tools and resources ranging from nurse patient group directions, nurse protocols and checklists, a series of well respected PCRS-UK opinion sheets and other supported materials. You can access all these materials via the resources menu of the website and using our **search resources** feature option located in the top right of all PCRS-UK web pages.

Figure 1. Quality standards continued

Module B: Organisational - 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. c) Infection control policy 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 this equipment)

Further information

Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes SGT, 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

Steve Holmes, Shepton Mallet, UK and Sarah-Jane Peffers, Bristol, UK. Opinion Sheet 28. The use of pulse oximetry in primary care. April 2009 http://www.pcrs-uk.org/downloads/resources/os28_pulse_oximetry.pdf

Module C: Practice Team - Teamwork

Standard 6	The practice works in an effective comprehensive multidisciplinary way to meet the needs of patients with respiratory conditions. The practice supports its staff to fulfil their role, and works across organisational boundaries for the benefit of patients and staff.
Rationale	It is a widely understood concept that united we stand and divided we fall. An effective respiratory team communicates well, listens to each other, works together as a cohesive group for a common objective, learns from and offers support to each other. In this Award the practice will submit evidence of multidisciplinary leadership (to include a named GP and nurse) which demonstrates how the system of care within and without the practice is led and will also submit evidence of clinical leadership within the practice which demonstrates how that leadership impacts on the practice team. The practice will also submit evidence of how it engages with multidisciplinary teams in the coordination and management of patients with complex respiratory needs. The practice will be able to demonstrate that it can meet the needs of the practice population with respiratory conditions including any patient involvement. Key components of an effective approach to teamwork are: • Identifying a clinical lead with responsibility for respiratory care within the practice • A practice training plan based on the needs of both patients and staff, reflecting the particular challenges and working practices of the practice and area • Effective interaction with other health and social care providers • Contingency planning

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?
18b	2. How do you communicate within the team? Please provide details and give an example as an appendix to the document e.g. practice minutes.
18c	3. Provide an example of where practice has changed through teamwork. For example, consider how you responded to a change in respiratory national guidance (maximum length one side A4).
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 nurse to deliver effective respiratory care in primary care with helpful guides for three levels of experience: minimum, medium and maximum. McArthur Ruth. http://www.pcrs-uk.org/downloads/nurses/skillsleveldoc_rev2010.pdf [accessed 08/08/2013]

Figure 1. Quality standards continued

Module C: Practice Team - Education and training

Standard 7	People with respiratory disease should have access to an effective coordinated service provided by appropriately skilled healthcare professionals
Rationale	Quality care depends not only on the skills and talents of individuals but on their ability to work within a flexible team. This should be supported by protected time and resources to allow individual and team development in order to promote a high quality service for respiratory patients and their carers. Within this context, professionals need to be clear about their identified roles and responsibilities and these should be underpinned by appropriate education. The practice will demonstrate evidence of a mechanism to show that there is appropriate **significant event analyses** relating to care for people with respiratory conditions when they occur. These may be linked to palliative care, hospital admissions, late diagnoses. The practice will provide evidence of a strategy to ensure appropriate, relevant and ongoing training and professional development for all those involved in respiratory care, ensuring that all aspects of disease management are covered within the practice including competency to perform and interpret necessary diagnostic testing, e.g. spirometry.

Evidence required to support application (3 parts, all must be completed)	
Evidence	**Development/learning plan**
21	The practice has a current practice development plan, updated in the last 12 months, and educational activity record which provides information on training and education requirements, continuing professional development and the dissemination of relevant and appropriate guidance for the management of respiratory conditions. The practice will complete the education plan - **Form PCD1** (see **Appendix 14**)
Evidence	**Significant event analyses**
22	The practice will provide a significant event analysis on an aspect of respiratory care and demonstrate team discussion and learning from the analysis including details of who participated, what was discussed, what actions were implemented and information on review dates and follow-up.
Evidence	**Continuing professional development**
23	i. The practice will provide a reflective document (maximum size one side A4) outlining:- • How are ongoing development needs of the team met? • How is education disseminated to the practice team? • How have you assessed that the education plan (form PCD1) fulfils the needs of the population? • How is risk assessment covered in the education plan e.g. lifting and carrying, resuscitation, arranging cover for colleagues or during holiday periods etc? • How is equipment-specific training dealt with and achieved to a satisfactory level?
24	ii. The practice will provide a document (maximum two pages A4) which outlines the learning experiences of participating in this Quality Award including the following:- • What work did the team need to implement in order to participate in the Award? • What were the learning experiences of the Award for the practice team? • What new processes, actions will the practice be introducing as a result of participating in this Award? • What, if any, training requirements have been identified as a result of participating in this Award? • What have been the benefits to the practice of participating in this Award?
Further information	

Revalidation Guidelines for GP's. Royal College of General Practitioners
http://www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx(accessed July 2013)

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[16] 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 improvements.[17] Surprisingly, there has only been limited evaluation of the UK Royal College of General Practitioners QPA which mainly focused on general practice organisation.[4] A postal questionnaire sent to practices that had completed the QPA stated that there was an improvement in practice teamwork.[18] In view of this limited evidence, it is important that this Respiratory Practice Award is properly evaluated when it is rolled out beyond the pilot stage.

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

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).

Handling editor Mike Thomas

Acknowledgements In addition to all the work of the development committees, we would like to thank Inez Gentiles and Anne Smith for their hard work and commitment to this project.

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, Mundipharma/NAPP, and Merck Sharp and Dohme. He is co-chair of the Quality Award Group. IS is Chair of the Primary Care Respiratory Society Care-UK and co-chair of the Quality Award Development Group. He is a trustee of Asthma UK. MF has spoken for and acted as consultant for Almirall, Mundipharma/NAPP, and Novartis. TB is Director of Red Hot Irons Ltd. Red Hot Irons Ltd is contracted to provide the PCRS-UK Quality Award project management and operations services for the Primary Care Respiratory Society UK.

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.

Funding The Quality Award development process and pilot process was kindly funded by unconditional educational grants from the following organisations: Allen & Hanbury's (Respiratory Division of Glaxo Smith Kline), AstraZeneca UK Ltd, Boehringer Ingelheim Ltd, Chiesi Ltd, MSD UK, Napp Pharmaceuticals, Pfizer Ltd, Teva Ltd.

References

1. Department of Health. Quality Innovation, Productivity and Prevention (QIPP). www.dh.gov.uk/health/category/policy-ara/quality/qipp
2. Department of Health. NHS Outcome Framework 2011 to 2012. November 2010. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944
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/_db/_documents/COPD_report1_200607272728.pdf
6. Levy M, Quanjer PH, Booker R, 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/pcrj.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**:303-13. 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/13029/49425/49425.pdf
9. National Institute for Health and Clinical Excellence. Chronic Obstructive Pulmonary Disease (COPD) Quality Standard (QS10). http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp
10. Healthcare Improvement Scotland. British Guideline on the Management of Asthma. May 2009 (revised 2012) http://www.brit-thoracic.org.uk/Portals/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, *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, Huijsman 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/mzl071
18. McLean T, Atkins E, McLean K. Quality Award and teamworking: 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

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 McKevitt, 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