

**International Primary Care Respiratory Group
(a company limited by guarantee)**

Directors' Report and Financial Statements

For the year ended 31 December 2012

Registered Company Number: SC256268

Registered Charity Number: SC035056

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International Primary Care Respiratory Group

Directors' Report and Financial Statements

For the year ended 31 December 2012

Contents	Pages
Directors' Report	2 - 13
Independent Auditor's Report to the Members and Trustees	14 - 15
Statement of Financial Activities and Income and Expenditure Account	16
Balance Sheet	17
Notes to the Financial Statements	18 - 27

Directors and Trustees

Dr John A F Haughney (resigned 25/04/2012)
Dr Anders Østrem (resigned 27/06/2012)
Dr Miguel R Rodriguez (President until 28/04/12, then Immediate Past President)
Dr Ron Tomlins (Treasurer)
Dr Osman Mohammad Yusuf
Dr Niels Chavannes (appointed President 28/04/2012)
Dr Ioanna Tsiligianni
Ms Kristine Whorlow
Dr Jaime B Correia de Sousa (appointed 27/06/2012)

Secretary

Dr Ron Tomlins

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Solicitors

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International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

The directors submit their report and the audited accounts of the charitable company for the year ended 31 December 2012.

Legal and administrative information set out on page 1 forms part of this report. The accounts comply with current statutory requirements, the Memorandum and Articles of Association and the Statement of Recommended Practice – Accounting and Reporting by Charities 2005.

Structure, governance and management

Nature of governing document

International Primary Care Respiratory Group ("IPCRG") is a company limited by guarantee (company number: SC256268) and a registered Scottish charity (charity number: SC035056). The charitable company is governed by its Memorandum and Articles of Association.

Organisational structure

A Board of Directors administers the charity. This comprises a minimum of three and a maximum of eight individuals including:

- ex officio, the President of the Company;
- ex officio, the President Elect of the Company;
- ex officio, the Immediate Past President of the Company;
- ex officio, the Treasurer of the Company; and
- up to four persons co-opted by the Directors

The President, President Elect and Treasurer of the Company are elected by Ordinary Resolution.

It is the charity's policy to seek to appoint directors who have a specific interest in its objectives and whose skills complement those already in place. During 2012 the Board co-opted the maximum four directors as part of its ambition to improve the organisation's sustainability by widening the numbers of people with Board level experience.

Each Ordinary Member of the IPCRG is entitled to appoint one individual as a member of the Senate. The function of the Senate is to advise and assist the Directors and act as ambassadors of the IPCRG.

The Board is advised by sub-committees. During 2012 these sub-committees were Governance, Education, Research and Edinburgh 2012 Organising Committee. An Executive Officer, Siân Williams, is appointed by the directors to manage the day to day operations of the charity with support from a Business Manager, Samantha Louw assisted by an Administrative Assistant, Katie Searles until 3 May 2012 and then Lucy Searles from 1 June 2012.

The IPCRG is a charity working Internationally, registered in Scotland, which is where our Secretariat, legal and financial advice sits. We work closely with several Scottish universities together with academic centres from across the world. Our UK member represents Scottish constituents.

Directors

The directors of the company during the year ended 31 December 2012 were as noted on page 1.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Recruitment and appointment of directors

The Board has decided that succession planning, the development of potential recruits to decision-making and governance roles, recruitment and appointment of directors is a core function of the Board and Chairs of sub-committees. They use the co-option facility to offer people Board experience. The role of the Board is to make recommendations to the members about candidates for the post of President and Treasurer. The directors are appointed as noted above. Any director may be removed by Ordinary Resolution of the members.

Ordinary members

The following organisations were ordinary members in 2012 and have the power to appoint an individual as a member of the Senate and to vote at general meetings:

Australia, National Asthma Council Australia
Bangladesh Lung Foundation - Primary Care Group
Belgian Primary Care Respiratory Group (BPCRG) (Dormant)
Canada, Family Physician Airways Group of Canada
Chile, Grupo de Respiratorio de Atención Primaria (GRAP), Chile
Cyprus, Cyprus Respiratory Group
Denmark, Danish Respiratory Group (Dormant)
Greece, Hellenic Primary Care Respiratory Group until May 2011
Greece, Greek Primary Care Respiratory Group (GPCRG) from May 2011
Ireland, Irish Respiratory Group
Italy, Società Italiana Interdisciplinare per le Cure Primarie (SIICP)
New Zealand, New Zealand Primary Care Respiratory Group
Norway, Lunge i Praksis
Pakistan, IPCRG – Pakistan
Portuguese Association of General Practitioners – respiratory division, GRESP
Spain, Grupo de Respiratorio de Atención Primaria (GRAP)
Sri Lanka, Primary Care Respiratory Group, Sri Lanka
Sweden, Swedish Respiratory Group in Primary Care
The Netherlands, CAHAG
UK, Primary Care Respiratory Group-UK (PCRS-UK)

Related parties and affiliations

The ordinary members of the charitable company are national and international organisations.

Induction and training of directors

Newly appointed directors are introduced to the workings of the Board through their first meetings. They are also provided with an induction pack, drawn from the Office of the Scottish Charity Regulator (OSCR) guidance for charity trustees, which includes:

- What the IPCRG does;
- Its finances and reporting requirements;
- Recent Board papers;
- Organisational structure; and
- Governance policies such as risk management, declaration of interest, sponsorship and endorsement

As an international organisation with directors working in Europe, Australia and Pakistan, face-to-face training is not an option; therefore discussions about the role are maintained by email and telephone contact.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Risk management

The Governance sub-committee regularly assesses the IPCRG's exposure to risk, in particular anything related to its reputation and finance. It makes recommendations to the directors on how best to deal with any identified risk, and reviews systems to manage any exposure.

Objectives and activities

The IPCRG's charitable mission is "to improve public health by carrying out, funding and organising research into the care, treatment and prevention of respiratory illnesses, diseases and problems in a community setting, and to make available the results of such research for the benefit of the public and healthcare professionals." It is the only international primary care respiratory organisation, and the only international primary care organisation with a respiratory research mission. Members believe that the best *place* to diagnose and treat people with respiratory problems is in the communities where they live and work, and the best *way* to do this is through the provision of high quality primary and community care. This requires testing of how best to provide high quality primary care, with the resources available.

The IPCRG is both an organisation of organisations and a global community of interest that enables us to work locally but collaborate globally. Increasingly, it is a global community of practice, and offers demonstration projects that show how primary care can contribute to improved public health. The Board's Strategic Plan was reviewed at the end of 2012. However, for the period Jan-Dec 2012 it continued to consolidate and make the most of what the IPCRG does well, and expand organically, as resources and opportunities allowed, ensuring sustainable growth. It focused on five strategic objectives:

1. *Education:* Create and promote endorsable cross-national educational products and national programmes relevant to members and the contexts in which they work.
2. *Conference:* Build an IPCRG conference programme and style that is an established part of the international respiratory calendar.
3. *Research:* Increase the publicly-available evidence about community respiratory care based on real practice situations including prevention, diagnosis and management of tobacco dependence, chronic obstructive pulmonary disease (COPD), asthma, allergic rhinitis, rhinitis, rhinosinusitis and respiratory infections.
4. *Membership:* Sustain core programmes by building a strong framework of international, national and regional respiratory groups that engage clinicians and researchers in the delivery of quality respiratory care in the community .
5. *Advocacy:* Influence the context in support of primary care roles to deliver respiratory health.

These five strategic priorities were achieved through the application of our Strategic Enablers: our governance arrangements, administration, web development and inclusion of more individuals in our activities.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Achievements and performance 2012

Education

In May 2012 we launched a call for a second round of our flagship E-Quality educational programme. The IPCRG E-Quality initiative seeks to increase educational capability in member and associate member countries: working locally, collaborating globally. With the support of an Education Co-ordinator, we invited proposals offering a total budget of £15,000 for 2012/13 in addition to the sums already committed for E-Quality Round 1 projects that are still running. Project bids needed to meet our evidence-based criteria and applicants were also asked to present to the IPCRG Education Sub-Committee. We received four proposals. Following this selection process two bids were awarded funds to deliver projects in 2012/13. The Board approved use of surplus to fund both projects due to the potential learning to be gained from each, both projects met all our selection criteria and received enthusiastic responses from the members of the Education sub-committee that judged the bids and both projects had senior level commitment and investment from their home countries.

- **Dr Beraki Ghezai and colleagues – Norway/ Eritrea**

This project seeks to develop capacity for diagnosing chronic respiratory disease - by developing knowledge and practice across the whole of Eritrea. The proposal is to introduce the use of diagnostic tools (spirometry) through an educational programme for 6 regional hospital leads (based at the Medical School in Asmara) and to pilot an educational programme for healthcare workers in one region (Mendefera).

- **Dr Sonia Maria Martins and colleagues – San Bernardo, ABC Region, Brazil**

This project seeks to develop knowledge and practice for diagnosis and treatment of asthma and COPD. The proposal is to introduce a multidisciplinary educational programme to facilitate early diagnosis, optimization of therapy, improved control of symptoms, reduced hospitalization, and demand for emergency care; improved quality of life and reduce socio-economic impact.

These complement the programmes from the first round. We have learnt from these that it takes longer than anticipated to build the relationships to ensure proper testing of the projects and that they meet local requirements such as those set by local ethics committees.

- **Dr Sundeep Salvi and Dr Monica Barne, Chest Research Foundation (CRF), Pune, India**

To assess the impact of CRF's one day asthma training programme called CHAMPS (Changing Asthma Management Practices), for GPs currently not prescribing inhaled medicines.

- **Professor James Stout, University Washington in collaboration with Professor Alan J Crockett, University of Southern Australia and Dr Kerry Hancock Adelaide**

Disseminating on-line spirometry training and feedback in Australia based on the Spirometry 360 Train-the-Trainer program. This project has now reported. Valuable information was gathered about the challenges in transferring a programme from one setting to another, and what elements of Spirometry 360 make it unique. Spirometry 360 has also benefited from detailed feedback about the accessibility of its online tools and built them into its new educational software.

We did not continue funding for the Better Breathing Bangladesh project, but instead, made introductions to icddr, the International Centre for Diarrhoeal Disease Research, Bangladesh in Dhaka through the auspices of Richard Smith of United Health. This was specifically to address a fundamental challenge in Bangladesh; namely the credibility of primary care physicians, irrespective of their training or competence. We therefore decided our best contribution to support the continuation of the Bangladesh group was to facilitate strategic alliances with well-known and credible organizations in Bangladesh. This led to the signing of a memorandum of understanding in July. We were delighted to welcome 17 Bangladesh delegates to our conference in 2012, many of whom were graduates of the training we supported.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

We delivered the first stages in an important project on Difficult to Manage Asthma funded by a restricted grant from Novartis. We launched our Desktop Helper at our Edinburgh 2012 conference and during the latter half of 2012 drafted policy recommendations, and links to practical resources including an ideal referral letter, which have been supported by the European Federation of Allergy and Airway Diseases Patients Association (EFA). The work provides practical guidance for primary care on detecting and managing people whose asthma is uncontrolled, and offers guidance about when and who it is appropriate to refer on to specialist services, and to describe what these services should offer.

Respiratory Abstract Review received good reviews from users during 2012. It is now also available in Spanish. This is an online service donated in kind by Teva, and overseen and guided by our Research sub-committee to select, review and summarise monthly up to six respiratory articles most relevant to international primary care. We continue to improve its relevance to global primary care audiences and from 2013 will be using Twitter to offer an even shorter summary to our members.

Biennial conference 2012, Edinburgh

The conference is our major public showcase and a catalyst for the development of a global community of practice. There were 974 participants from 45 countries including 112 allied health professionals. The IPCRG supported 22 participants on its bursary programme. For the first time, we webcast the event to reach a wider audience and this was a great success. Sessions were webcast live in both English and Spanish to separate events held in Chile, Argentina and India, and increased the conference audience by an estimated additional 180. In addition the live webcasts were available to individuals logging in. The feedback we received from participants about the conference was extremely positive. The balance of the programme between research and education was appreciated and the number of abstracts submitted to the conference increased by at least 50 from the last conference. The conference was once again an occasion for networking, learning; showcasing and developing primary care research capability, building friendships and providing fun.

Research

E-faculty

We launched our third round of the E-faculty, our flagship research programme to increase primary care respiratory research capability that has previously run in Vietnam and Romania. We were impressed by the quality and commitment of the four bids that we evaluated before awarding the E-Faculty programme to Chile. This is being run as a collaboration between our Spanish group, GRAP, and our new Chilean group and aims to produce its first research at the 2014 conference.

U-BIOPRED

We continued to provide the primary care input into a major European Union Innovative Medicines Initiative called U-BIOPRED (<http://www.ubiopred.european-lung-foundation.org/index.php?id=16103>). We remain committed to disseminating the findings and have begun to plan collaborations with the European Lung Foundation, European Respiratory Society, the European Federation of Allergy & Airways Diseases Patients' Associations (EFA) Primary Care Respiratory Journal during 2013 and 2014.

ICAAP

The patient concordance study, ICAAP, Improving Care of Asthma Patients in Portugal, will report in 2013.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

UNLOCK

Importantly we made real progress towards our long-term goal of facilitating multi-national real-life research in the primary care management of people with chronic lung disease. Under the auspices of IPCRG, the UNLOCK group (Uncovering and Noting Long-term Outcomes in COPD to enhance Knowledge) planned to answer a number of questions through common analyses of datasets of COPD patient cohorts owned by researchers in a number of countries. The founding group agreed the entry criteria to the group and shared which their diagnostic and follow-up variables their datasets contain. As a result of a restricted grant from Novartis, the first study by Gabe-Thomas and Jones **A comparison of multi-component indices of COPD severity in primary care: an**

UNLOCK study from the IPCRG reported in Edinburgh. Three other studies also commenced, funded by the Novartis grant:

UNLOCK project 2: External validity of COPD studies. Led by Assoc Prof Niels Chavannes.

Description: a cross-sectional description of COPD patients in primary care versus recent large trial populations like UPLIFT and TORCH.

UNLOCK project 3: Health status of COPD patients in clinical practice in three countries in Europe. Led by Dr Ioanna Tsiligianni.

Description: assess the variability of health status (CCQ) in daily clinical practice within each GOLD stage in primary care in three European Countries.

UNLOCK project 4: The GOLD categories v DOSE v ADO. Led by Dr Rupert Jones.

Description: Application of the new GOLD categories based on FEV1 to primary care populations and comparison of findings to the same populations categorised by DOSE and ADO.

We also commissioned a project called Rosetta. This will provide the tools for the UNLOCK group to compare their datasets which use different coding languages.

During 2012 we also agreed to extend UNLOCK into asthma and are committed to fundraising for this in 2013.

FRESH AIR Survey Uganda

IPCRG funded the University of Groningen, Netherlands and University of Makerere, Uganda, through a restricted research grant from Mundipharma to undertake a survey of the causes and scale of chronic lung disease in Masindi district, Uganda. It builds on our FRESH AIR protocol first developed in Vietnam and a subsequent pilot study in Uganda we funded in 2011 from our Research Start Up fund. Despite having to adapt much of the research to fit local circumstances and train a new team, the project has been on time and on budget. We believe it will be an important study of non-communicable disease in low income countries and therefore we also commissioned a TV documentary of the study from a local Ugandan film company using IPCRG reserves.

Primary Care Respiratory Journal

The international input into our journal, the Primary Care Respiratory Journal (PCRJ), published by the UK group PCRS-UK continues to increase; there was a 38% increase in research paper submissions compared to 2011, and these submissions increasingly came from leading research groups around the world. The PCRJ is an open access online peer-reviewed journal also available in hard copy for subscribers. The SCImago 2-year citations per document (calculated in a similar manner to the Thomson's Impact Factor) has moved from 1.98 to 2.61 which places the PCRJ as one of the highest ranked primary care journals in the world and in the top 25-30% of all respiratory journals. Thomson Reuters notified the Editors in 2012 that their application for listing in Web-of-Science and the Journal Citation Reports (JCR) had been successful, and so the PCRJ will receive its first Impact factor in June, which is an important attractor for authors. The IPCRG selects key articles for translation into Spanish and Portuguese, which have been very well received.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Membership: an organisation of organisations and a global community of interest and practice

Our members are primarily national primary care respiratory groups and we continue to implement our 2010 membership policy that sets low barriers to entry to encourage the formation of new member groups around the world. In 2012 we appointed Chile as a new full member. We currently have 19 full members and 28 associate country members including new relationships with colleagues in Brazil, Argentina and India. We currently reach 101,250 primary care professionals worldwide through our members.

We also commissioned an audit of international primary care respiratory authors and began to connect with them in a global community of interest, facilitated by a new web platform, using software developed for knowledge management, called Confluence. Our ambition is to form communities of primary care respiratory practice, offering practical primary care solutions to real-life challenges.

Our associate corporate members in 2012 were Boehringer Ingelheim, Chiesi, Mundipharma, Novartis, Pfizer, Teva and Vitalograph and Pulmonx who shared experience about the development of primary care internationally. We continued to collaborate with our associate members – invited organisations, particularly the European Federation of Allergy & Airways Diseases Patients' Associations (EFA) and World Allergy Organisation on specific projects.

Advocacy

Together with our Greek and Cypriot groups, we supported a meeting under the auspices of the Cyprus Presidency of the Council of the European Union, and hosted by MEPs Mr. Claudiu Ciprian Tănăsescu and Mrs. Sirpa Pietikäinen at the European Parliament in November 2012 on the impact of early diagnosis and control of chronic respiratory diseases on Active and Healthy Ageing. At the time of writing, a work programme arising from that meeting is being confirmed.

We supported the World Health Organization (WHO) Global Action Plan for the prevention and control of non-communicable diseases 2013-2020 Zero Draft that called for; a 25% relative reduction in mortality from non-communicable diseases, including chronic respiratory disease by 2025; 80% availability of affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities and a 30% relative reduction in prevalence of current tobacco use in persons aged 15 years or older. None of these will be possible without a greater acknowledgement of the burden of chronic lung disease, and a better understanding and respect for the value of primary care. We will continue to press for inhaled asthma medicines to be reclassified as "essential". We have also begun discussions with the International Union Against Tuberculosis and Lung Disease (The Union) about publicising its Asthma Drug Facility for low income countries.

We also joined the European COPD Coalition to lobby for greater awareness of COPD, its causes and the role of primary care.

IPCRG Director Niels Chavannes, remained the primary care organisation representative on the Planning Committee of the World Health Organization (WHO) Global Alliance against chronic Respiratory Diseases (GARD) and a second IPCRG Director, Osman Yusuf, continued as Representative of organizations devoted to specific diseases in his capacity as director of The Allergy and Asthma Institute, Pakistan. WHO-GARD advocates for every country to have a national respiratory strategy. Our aim is to ensure that every national respiratory action plan has a clear strategy on primary care. This has been strengthened by the World Health Organization (WHO) Global Action Plan.

As a global community of practice, the IPCRG engages many innovators and early adopters in programmes of research and innovation. However, its value is limited unless it maintains contact and influence with mainstream primary care, where most practitioners do not have a special respiratory interest. Therefore we strengthened our relationship with the global family doctor organisation, WONCA, particularly in Europe, where we were re-confirmed as the Special Interest Group for respiratory care. An IPCRG team of five ran the respiratory programme at WONCA Europe's 2012 conference in Vienna and was confirmed as the leader of the respiratory programme for the combined WONCA Global and WONCA Europe conference in Prague in 2013.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Enabling functions

We implemented our new information, communications and technology strategy in time for launch at the Edinburgh conference in April 2012. In essence it creates the IPCRG "Square" where people can meet, connect and share ideas and resources directly, without having to go through the IPCRG Secretariat. This will facilitate the growth of international communities of practice through application of a new content management system, Atlassian Confluence, designed to be a place online for teams to collaborate and capture knowledge. We appointed a team from the Netherlands to advise us and we continue to learn how best to use the technology and to teach colleagues how to use it.

After a review of our 2012 conference the Board decided that future conferences would be managed differently to reduce the financial and reputational responsibility of the host country. Following substantial research, interviews and analysis, we decided to appoint a professional conference organiser to work with us to deliver the 2014 conference in Athens. The governance structure alongside that arrangement consists of a 2014 Conference Executive Committee, a sub-group of the Board of directors responsible for signing off the budget, sponsorship arrangements and bursary allocation; an internal Conference Team, responsible for developing and performance managing financial and marketing plans, and a Scientific Programme Committee responsible for developing an outstanding scientific programme.

Financial review

We keep our policies and processes under review to ensure they cover our current exposures to risk. We ensured that the 2012 and 2014 biennial conferences and our growing research portfolio had robust risk management plans.

The Board continued to meet monthly by teleconference, which is the directors' preferred way to keep a grip on the charity's activity.

The financial result for the year is shown in the Statement of Financial Activities. After accounting for an unrealised exchange loss of £32,212 (2011: £23,243), the net movements in funds for the year is a deficit of £73,832 (2011: surplus of £173,281). If the detailed profit and loss figures are reviewed, the causes of that movement become apparent. The income for two projects, Difficult to Manage Asthma, funded by a restricted grant from Novartis, and FRESH AIR Survey Uganda, funded by a restricted grant from Mundipharma were received in 2011 but the activity and therefore the expenditure was incurred mainly in 2012, with some still due in 2013.

The IPCRG's principal funding sources are membership subscriptions from associate corporate members, and grants for projects. The level of the subscription is set at the AGM and is revised every three years. Rates were set at Euro 35,000 for pharmaceutical companies and a lower rate for device companies. We had eight associate corporate members in 2012 and we thank them for their subscriptions and engagement with us (listed under membership section above).

The IPCRG budgets to spend no more than its anticipated income in any year. We held to this principle in 2012 and are able to plan for a similar pattern of expenditure in 2013.

We continued to refine our 24-month budgeting cycle, to better reflect the pattern of our income and expenditure, given our biennial conference and to take account of the shifts in charitable activity.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

The first call on any surplus is the IPCRG's reserve fund. We reviewed this in 2012 and agreed that there was no need to increase it further as it has now reached an amount that the Board deems sufficient to cope with any major financial challenge. The second call on any surplus is to initiate or fully fund any high quality and relevant initiatives that might contribute significantly to the charity's mission, such as research endeavours that are unlikely to attract external funding. In 2012 we did not fund any projects but did announce calls for research ideas and educational initiatives that will be funded in 2013. We were delighted to receive 11 research bids, which is a 100% increase in interest from previous calls.

The statement of financial activities describes how our funds were spent.

Reserves

The reserve policy of the IPCRG is to build as quickly as possible a free liquid asset position that would enable the organisation to continue running for several months in the event of a catastrophe or permit the closure of the organization with a minimum loss of reputation. Our risk management strategy identifies our biennial conference as our single most important exposure to financial risk. This is run each time in conjunction with a different national member and each conference is subject to a risk sharing agreement with the host organisation. Therefore the directors established a specific conference reserve which, at the end of 2011, had reached £175,000, which the Board deems sufficient to meet current risk assessments.

Plans for future periods

The IPCRG directors consider that the IPCRG now has a robust track record demonstrating how primary care can detect and improve the lung health of populations and individuals. The IPCRG is now the first point of contact for many policy-makers and organisations wanting to collaborate with, understand or influence the international primary care respiratory community. We are regarded as a thought-leader offering practical solutions in tobacco dependence, asthma, allergic rhinitis, chronic obstructive pulmonary disease and respiratory infection. Our financial security has strengthened as funders' trust in our ability to represent real life and deliver results increases. This gives us a platform to do two things: firstly to focus more on what we want to do, and less on what others want us to do. Secondly, it enables us to extend further into low and middle income countries where there are significant numbers of people at risk of chronic lung disease but less established systems of healthcare delivery, and in particular, rely on a broader primary care, rather than family physician model of first-line care.

Strengths and opportunities

The IPCRG is both an organisation of organisations and also a global community of clinicians passionate about improving the lives of people with, or at risk of, chronic lung disease. It has many collaborations with other multi-national primary care, respiratory and patient organisations. What we offer that is different is the ability to produce high quality research and education grounded in primary care. We can and do demonstrate things that work; "showing through doing." We have done this first in Europe, Australasia, North America, then in Vietnam, Bangladesh, Pakistan, and are now working on demonstration projects in Brazil, Chile, Uganda, Eritrea and India. The United Nation's Declaration on Non-Communicable Disease and the World Health Organisation commitments to national action plans for chronic lung disease and to strengthening primary care gives us opportunities to really make a difference. Our 2014 conference theme is "Multiple morbidities and integrated care" to illustrate and explore how primary care works effectively by supporting the whole person and family and collaborates with professional colleagues in hospitals and other settings. We are also aware of the shortages of trained primary care professionals in many countries and want to test how education, training and also new technology might address these shortages.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Challenges

Our challenges are the business of most of our community, and how we help them to create the time, energy, tools and relationships to develop and share best practice. We want colleagues to use our web platform, which we have designed as a knowledge management system. For example, we are setting up a forum for those interested in the expansion of the FRESH-AIR survey in East Africa and India, forums for colleagues who want to research the value and consequences of mobile health technology and how best to help treat patients with effective quit smoking interventions. We also want to build on our experiences in Bangladesh and Pakistan to reach the other large populations of the world in China, Brazil, India, Russia and Nigeria where primary care may be underdeveloped in the detection and management of chronic diseases including chronic lung disease. We know that the first step here may be to describe the prevalence of chronic lung disease in countries where most citizens and healthcare professionals may think a cough means TB or a smoker's normal experience, or where breathlessness is accepted. Alternatively, the first step may be to demonstrate the value of primary care in countries where family physicians/general practitioners are poorly regarded, or where there is no vocational training, or where family physicians, smoking cessation drugs and inhaled medicines are not reimbursed appropriately. Here our ambition is for increased governmental investment in primary care.

Plans

Over the next three years our priorities are to:

- Promote good clinical respiratory practice
- Actively lead the respiratory health research and education agenda
- Identify and unlock the global potential of our flagship products
- Strengthen our core: membership and communities of interest

Promote good clinical respiratory practice

We will continue to advocate for primary care's role in lung health by showing practical solutions to case-finding and management that include not only general practice but also other primary care approaches. We will also demonstrate the value of primary care in managing multiple morbidities by helping people change behaviours to stop smoking and exposure to indoor smoke, to eat a better diet and to increase physical activity as well as offering safe and effective pharmacological interventions.

Actively lead the respiratory health research and education agenda

We will make progress to answer, or influence others to answer, our prioritised research needs. We will continue to build research and educational capacity in countries with little or no current primary care respiratory research or educational activity including low and middle income countries. We will actively link education and research through implementation studies, feed research findings into education programmes, evaluate education initiatives and feed outcomes of education into new research. We will selectively scale up national projects into larger studies through cross-border collaboration.

Our 3rd Scientific Meeting in Uppsala 2013 will build on the successes of the first two meetings. We aim to attract both experienced and inexperienced international primary care researchers from many countries to share research ideas and the results from their work and to support the next generation of researchers. The meeting will be extended by one day for selected research groups who bid for IPCRG support to develop detailed and costed proposals for research that the IPCRG Research Network itself wishes to lead and deliver and which meet our prioritised research needs statement.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Identify and unlock the global potential of our flagship products

We will expand these flagship products into new clinical and geographical areas:

- **IPCRG conferences** to support the development of primary care communities of interest and practice and to challenge and share best practice.
- **E-Faculty** that increases primary care research capability in respiratory research-naïve countries. In 2014 we will focus on Chile, and also test the proposal for an IPCRG Research Fellow, where the IPCRG supports the living costs of a researcher who works on relevant primary care questions, to spend time as part of the PhD programme away from their host university, working with other primary care respiratory academic centres. The first appointee, Dr Nguyen Nhu Vinh, from Ho Chi Minh Family Medicine Department, who was part of our first E-Faculty programme, will work with the Universities of Heraklion, Southampton and Leiden on a programme on exhaled nitric oxide.
- **E-quality**— that tests what educational interventions make a difference to clinical behavior.
- **FRESH AIR** – “franchising” the survey by providing IPCRG set-up and mentoring support and building a FRESH AIR community by providing mentoring, the FRESH AIR protocol and also some re-usable equipment. This will enable new teams in new countries to measure a population's exposure to smoke, the health impact of that exposure, and to use the survey to develop local commitment and human resources to tackle the problems that are identified.
- **UNLOCK** - expanding IPCRG's research capacity in COPD and also extending to asthma through cross-sectional and longitudinal studies using our community's data: the UNLOCK group provides access to over 22,000 primary care COPD records and potentially 115,000 primary care asthma records.
- **Publications** in multiple languages including desktop helpers, position papers, Respiratory@Glance and translations of key Primary Care Respiratory Journal papers.

Strengthen our core: membership and communities of interest

We will expand our reach beyond the 100,000 clinicians we reach now through supporting membership drives to new primary care groups, corporate members and associates. The Board and Committee Chairs will actively seek new talent for committee and Board positions. We will strengthen the web platform as the hub for communities of interest and practice.

International Primary Care Respiratory Group

Directors' Report

For the year ended 31 December 2012

Statement of Directors' responsibilities

The directors (who are also trustees of International Primary Care Respiratory Group for the purposes of charity law) are responsible for preparing the Directors' Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

Company law requires the directors to prepare financial statements for each financial year which they give a true and fair view of the state of affairs of the charitable company and of the incoming resources and application of resources, including the income and expenditure or deficit of the charitable company for that period. In preparing these financial statements, the directors are required to:

- select suitable accounting policies and then apply them consistently;
- observe methods and principles in the charities SORP;
- make judgements and accounting estimates that are reasonable and prudent;
- state whether applicable UK Accounting standards have been followed, subject to any material departures disclosed and examined in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the company will continue in business.

The directors are responsible for keeping adequate accounting records that are sufficient to show and explain the charitable company's transactions and disclose with reasonable accuracy at any time the financial position of the charitable company and enable them to ensure that the financial statements comply with the Companies Act 2006, the Charities and Trustee Investment (Scotland) Act 2005 and Regulation 8 of the Charities Accounts (Scotland) Regulations 2006 (as amended). They are also responsible for safeguarding the assets of the charitable company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Provision of information to auditors

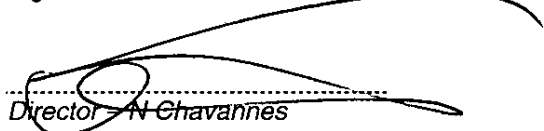
To the knowledge and belief of each of the persons who are directors at the time the report is approved:

- So far as each director is aware, there is no relevant information of which the charitable company's auditors are unaware; and
- He/she has taken all steps that he/she ought to have taken as directors to make himself/herself aware of any relevant audit information and to establish that the charitable company's auditors are aware of the information.

Auditors

The auditors, Scott-Moncrieff, will be proposed for reappointment at the annual general meeting in accordance with section 485 of the Companies Act 2006.

Signed on behalf of the Board of Directors



Director - N Chavannes

28 March 2013

International Primary Care Respiratory Group

Independent Auditor's Report to the Members and Trustees

For the year ended 31 December 2012

We have audited the financial statements of International Primary Care Respiratory Group for the year ended 31 December 2012 which comprise the Statement of Financial Activities, Balance Sheet and related notes. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

This report is made exclusively to the members, as a body, in accordance with Sections 495 and 496 of the Companies Act 2006 and to the charitable company's trustees, as a body, in accordance with section 44 (1) (c) of the Charities and Trustee Investment (Scotland) Act 2005 and Regulation 10 of the Charities Accounts (Scotland) Regulations 2006 (as amended). Our audit work has been undertaken so that we might state to the members and the charitable company's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company and its members and trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of trustees and auditors

As explained more fully in the statement of directors' responsibilities set out on page 13, the trustees (who are also the directors of the charitable company for the purposes of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

We have been appointed as auditor under section 44 (1) (c) of the Charities and Trustee Investment (Scotland) Act 2005 and under the Companies Act 2006 and report in accordance with regulations made under those Acts.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (United Kingdom and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB's) Ethical Standards for Auditors, including "APB Ethical Standard – Provisions Available for Smaller Entities (Revised)", in the circumstances set out in note 16 the financial statements.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the charitable company's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the trustees; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Directors' Report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charitable company's affairs as at 31 December 2012 and of its incoming resources and application of resources, including its income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Companies Act 2006, the Charities and Trustee Investment (Scotland) Act 2005 and regulation 8 of the Charities Accounts (Scotland) Regulations 2006 (as amended).

International Primary Care Respiratory Group

Independent Auditor's Report to the Members and Trustees - continued

For the year ended 31 December 2012

Opinion on other matters prescribed by the Companies Act 2006

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Companies Act 2006 and the Charities Accounts (Scotland) Regulations 2006 (as amended) requires us to report to you if, in our opinion:

- the charitable company has not kept proper and adequate accounting records or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Michael Harkness

Michael Harkness, Senior Statutory Auditor
For and on behalf of Scott-Moncrieff, Statutory Auditor
Chartered Accountants
Eligible to act as an auditor in terms of Section 1212 of the Companies Act 2006
Exchange Place 3
Seample Street
Edinburgh
EH3 8BL

28 March 2013

International Primary Care Respiratory Group

**Statement of Financial Activities and
Income and Expenditure Account**

For the year ended 31 December 2012

	Notes	Unrestricted Funds £	Restricted Funds £	Total 2012 £	Total 2011 £
Incoming resources					
Incoming resources from generated funds:					
<i>Voluntary income:</i>					
- Grants and donations		-	54,115	54,115	196,379
- Membership services	2	192,589	-	192,589	216,449
Incoming resources from charitable activities:					
- Education	3	-	-	-	56,869
Investment income					
- Interest received		553	-	553	1,120
- Share of joint venture income		54,133	-	54,133	-
Total incoming resources		<u>247,275</u>	<u>54,115</u>	<u>301,390</u>	<u>470,817</u>
Resources expended					
Cost of generating funds:					
- Costs of generating voluntary income		6,963	-	6,963	4,166
Charitable activities:					
- Membership services	4a	62,355	-	62,355	49,297
- Education	4a	77,135	117,869	195,004	115,354
- Research	4a	18,580	-	18,580	34,408
Governance costs	4	60,108	-	60,108	71,068
Total resources expended		<u>225,141</u>	<u>117,869</u>	<u>343,010</u>	<u>274,293</u>
Net incoming/(outgoing) resources before other recognised gains and losses		22,134	(63,754)	(41,620)	196,524
Loss on currency conversion		(32,212)	-	(32,212)	(23,243)
Net movements in funds	7	<u>(10,078)</u>	<u>(63,754)</u>	<u>(73,832)</u>	<u>173,281</u>
Total funds brought forward		<u>603,453</u>	<u>189,570</u>	<u>793,023</u>	<u>619,742</u>
Total funds carried forward		<u>593,375</u>	<u>125,816</u>	<u>719,191</u>	<u>793,023</u>

All of the results relate to continuing activities.

There were no recognised gains or losses for the current year or prior year other than those stated above.

The notes on pages 18 to 27 form part of these financial statements

International Primary Care Respiratory Group

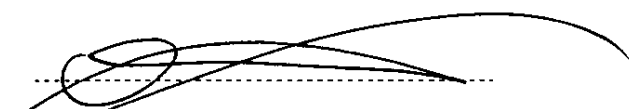
Balance Sheet

As at 31 December 2012

	Notes	2012 £	2011 £
Fixed assets			
Investments	8	50	50
Current assets			
Debtors	9	25,276	49,940
Cash at bank and in hand		702,475	806,774
		<u>727,751</u>	<u>856,714</u>
Current liabilities			
Creditors: Amounts falling due within one year	10	(8,610)	(63,741)
		<u>719,191</u>	<u>793,023</u>
Net assets			
Funds			
Restricted funds	11	125,816	189,570
Unrestricted funds:			
- General reserve	12	276,796	271,112
- Designated funds	12	316,579	332,341
		<u>719,191</u>	<u>793,023</u>

The financial statements were authorised for issue by the directors on
and signed on their behalf by:

..... 28 March 2013


.....
Director – N Chavannes

Company number: SC256268

The notes on pages 18 to 27 form part of these financial statements

International Primary Care Respiratory Group

Notes to the Financial Statements

For the year ended 31 December 2012

1. Accounting policies

(a) Basis of accounting

The financial statements have been prepared in accordance with applicable accounting standards in the United Kingdom, the Companies Act 2006, the Charities and Trustee Investment (Scotland) Act 2005, the Charities Accounts (Scotland) Regulations 2006 and Statement of Recommended Practice - Accounting and Reporting by Charities (SORP 2005).

(b) Incoming resources

- **Voluntary income**
Donations are included in the Statement of Financial Activities in the year in which they are receivable.
- **Membership services**
Annual subscriptions are included in full in the year to which they relate. Subscriptions received in advance are released to the Statement of Financial Activities over the period to which they relate.
- **Conference income**
The company's share of the conference income, in respect of the biennial conference, is included in the Statement of Financial Activities in the year in which the conference is held.
- **Grants receivable**
Income from grants, including capital grants, is included in the incoming resources when it is receivable except where the charity has to fulfil conditions before becoming entitled to it or where the donor has specified that income is to be expended in a future period. In these circumstances income is deferred until those periods.

(c) Resources expended

Resources expended are included in the Statement of Financial Activities on an accruals basis, inclusive of irrecoverable VAT.

Expenditure is directly attributed to the relevant category in the Statement of Financial Activities where practical. Executive Officer and business support fees are allocated across activities based on time incurred in each area.

- Costs of generating funds comprise the costs associated with attracting voluntary income and the costs of trading for fundraising purposes.
- Charitable expenditure comprises direct and support costs incurred by the company in the delivery of its activities and services.

Grants or instalments of grants offered in connection with projects with institutions are charged to the Statement of Financial Activities in the year when the offer is conveyed to the recipient except in those cases where the offer is conditional, such grants being recognised as expenditure when the conditions attached are fulfilled. Grants offered subject to conditions which have not been met at the year end are noted as contingent liabilities, but not accrued as expenditure.

International Primary Care Respiratory Group

Notes to the Financial Statements - continued

For the year ended 31 December 2012

1. Accounting policies - continued

(c) Resources expended - continued

- Governance costs include those costs associated with meeting the constitutional and statutory requirements of the company and include costs linked to the strategic management of the company.

(d) Taxation

The company is recognised by HM Revenue and Customs as a charity and, as a consequence of the tax reliefs available in relation to the current year, income is not liable to taxation. The company is not registered for VAT and accordingly irrecoverable VAT is included within the cost category to which it relates.

(e) Foreign currencies

Assets, liabilities, revenues and costs denominated in foreign currencies are recorded at the rates of exchange ruling at the dates of the transactions; monetary assets and liabilities at the balance sheet date are translated at the year-end rate of exchange. The resulting profits or losses are dealt with in the Statement of Financial Activities.

(f) Funds

Unrestricted funds include incoming resources receivable or generated for the objects of the charity without further specified purpose and are available as general funds. These funds can be used in accordance with the charitable objects at the discretion of the directors.

Designated funds are unrestricted funds earmarked for the directors for specific future purposes or projects.

Restricted funds are to be used for specific purposes as laid down by the donor.

(g) FRS 1 – Cash Flow

The company has taken advantage of the exemption from preparing a cash flow statement as conferred by Financial Reporting Standard No 1 on the grounds that it qualifies as a small company.

(h) Going Concern

The directors consider that the charitable company will continue in existence for the foreseeable future and are therefore of the opinion that it is appropriate to prepare these financial statements on a going concern basis.

(i) Investments

Investments in joint ventures are held as fixed assets are stated at cost less provision for permanent diminution in value.

The company's share of profits of joint ventures is included in the statement of financial activities.

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

2. Membership services

	2012	2011
	£	£
Subscriptions	<u>192,589</u>	<u>216,449</u>

3. Education

	2012	2011
	£	£
Conferences	<u>-</u>	<u>56,689</u>

4. Resources expended

	Charitable activities £	Governance costs £	Total 2012 £	Total 2011 £
Executive officer	30,779	13,648	44,427	45,902
Secretariat	18,427	6,277	24,704	23,984
Website	19,670	-	19,670	6,364
Travel & accommodation	29,738	1,490	31,228	38,561
Executive committee honoraria	-	9,546	9,546	7,590
Project costs	117,869	-	117,869	43,735
Support costs (note b)	59,456	29,147	88,603	103,991
	<u>275,939</u>	<u>60,108</u>	<u>336,047</u>	<u>270,127</u>

a. Charitable expenditure

	Membership services £	Education £	Research £	Total 2012 £	Total 2011 £
Executive officer	9,058	12,588	9,133	30,779	29,323
Secretariat	11,819	5,286	1,322	18,427	17,919
Website	19,190	-	480	19,670	6,364
Travel & accommodation	2,233	25,405	2,100	29,738	16,239
Project costs	-	117,869	-	117,869	43,735
Support costs (note b)	20,055	33,856	5,545	59,456	85,479
	<u>62,355</u>	<u>195,004</u>	<u>18,580</u>	<u>275,939</u>	<u>199,059</u>

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

4. Resources expended - continued

b. Support costs

	Charitable activities £	Governance £	Total 2012 £	Total 2011 £
Treasurer's honoraria	-	-	-	1,518
Professional fees	3,136	6,770	9,906	(3,703)
Audit and accountancy	206	12,124	12,330	17,424
Other support costs (see below)	56,114	10,253	66,367	88,752
	<u>59,456</u>	<u>29,147</u>	<u>88,603</u>	<u>103,991</u>

Other support costs

	Charitable activities £	Governance £	Total 2012 £	Total 2011 £
Fresh Air Uganda	-	-	-	13,779
E-Quality education consultancy	7,382	-	7,382	13,500
E-Quality project costs	11,648	-	11,648	-
Support Better Breathing Bangladesh	-	-	-	10,000
Speaker Bureau expenses	5,827	-	5,827	2,545
Travel, room hire and refreshments for meetings	4,088	1,010	5,098	15,265
Conference expenses	2,509	-	2,509	9,980
Subscriptions	1,587	688	2,275	4,404
Publications	2,400	-	2,400	4,695
Bad debt write off	-	3,000	3,000	-
Administrative assistance	1,867	1,258	3,125	-
Other	18,806	4,297	23,103	14,584
	<u>56,114</u>	<u>10,253</u>	<u>66,367</u>	<u>88,752</u>

5. Staff costs and numbers

The company had no employees during either the current or prior year.

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

6. Directors' emoluments and expenses

John Haughney, previous President, received honoraria totalling £1,339 (2011: £4,452) from the company during the year. At the year end £nil (2011: £nil) was outstanding.

Ron Tomlins, Treasurer, received honoraria totalling £nil (2011: £1,518) from the company during the year. At the year end £nil (2011: £nil) was outstanding.

Miguel Rodriguez, new President, received honoraria totalling £nil (2011: £7,590) from the company during the year. At the year end £nil (2011: £3,753) was outstanding.

Anders Østrem, director, received honoraria totalling £nil (2011: £2,000) from the company during the year. At the year end £nil (2011: £nil) was outstanding.

Osman Mohammad Yusuf, director, received honoraria totalling £1,308 (2011: £2,916) from the company during the year. At the year end £nil (2011: £nil) was outstanding.

Niels Chavannes, director, received honoraria totalling £7,253 (2011: £785) from the company during the year. At the year end £nil (2011: £nil) was outstanding.

Antonio Jamie B Correia de Sousa, director, received honoraria totalling £1,559 (2011: £nil) from the company during the year. At the year end £nil (2011: £nil) was outstanding.

A total of seven (2011: seven) directors were reimbursed travel expenses totalling £16,752 (2011: £16,092) in connection with undertaking the company's charitable activities.

7. Net movement in funds for the year is stated after charging:

	2012	2011
	£	£
Auditor's remuneration		
- audit fees	7,979	7,500
- non-audit fees	4,896	6,960
	<u> </u>	<u> </u>

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

8. Fixed asset investments

IPCRG & PCRS UK 2012 Limited is a 50:50 joint venture agreement between International Primary Care Respiratory Group PCRG and International Primary Care Respiratory Society UK. The purpose of the company is to organise a respiratory care conference in 2012. IPCRG & PCRS UK 2012 Limited has an issued share capital of one hundred with a nominal value of £100.

The total of the charitable company's share of the joint venture IPCRG & PCRS UK 2012 Limited, at 10 December 2012, the most recently available management accounts, was as follows:

	2012 £	2011 £
Investment - cost		
At 1 January 2012	50	1
Additions	-	49
At 31 December 2012	50	50
	21 months to 10 December 2012 £	12 months to 31 March 2011 £
Turnover	280,912	-
Administrative expenses	(211,209)	(14,440)
Share of profit/(loss)	69,703	(14,440)
Share of assets:		
Current assets	30,945	8,178
Share of liabilities:		
Liabilities due within one year	(2,762)	(22,618)
Net assets/(liabilities)	28,183	(14,440)

9. Debtors

	2012 £	2011 £
Trade debtors	-	8,347
Other debtors	-	1,593
Loan to joint venture (note 14)	-	40,000
Accrued income	25,276	-
	25,276	49,940

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

10. Creditors

	2012	2011
	£	£
Trade creditors	120	18,144
Accruals and deferred income	8,490	45,597
	<u>8,610</u>	<u>63,741</u>

Deferred income included in the total above is analysed as:

	£	£
Amounts deferred at 31 December 2011	34,343	29,167
Released to the Statement of Financial Activities in the year	(34,343)	(29,167)
Amounts received in the year relating to future periods	-	34,343
	<u>-</u>	<u>34,343</u>
Amounts deferred at 31 December 2012	<u>-</u>	<u>34,343</u>

11. Restricted funds

	At 31 December 2011	Incoming Resources	Resources Expended	At 31 December 2012
	£	£	£	£
UBIOPRED	17,950	4,629	(1,897)	20,682
UKRRF01	5,195	-	(2,277)	2,918
UKRRF02	965	-	-	965
Inhaler Device Project	6,686	-	-	6,686
Fresh Air Uganda	85,983	-	(65,802)	20,181
GSK Middle East	8,902	-	(96)	8,806
Patient Concordance Study	11,415	-	-	11,415
Difficult Asthma	52,474	-	(40,614)	11,860
UNLOCK	-	49,486	(7,183)	42,303
	<u>189,570</u>	<u>54,115</u>	<u>(117,869)</u>	<u>125,816</u>

UBIOPRED: The IPCRG is one of 41 partners across Europe participating in the U-BIOPRED study led by Dr Peter Sterk (Unbiased BIOMarkers used for PREdicting disease progression and medication efficacy in severe asthma) that has been selected for funding by the European Union Innovative Medicines Initiative. Our role is in Ethics & Safety and Dissemination.

UKRRF01: The IPCRG with financial assistance from Pfizer, funded a study undertaken at Middlesex University: A qualitative analysis of barriers, motivation to quit and tailored interventions for smoking cessation in smokers with and without COPD.

UKRRF02: The IPCRG has funded a study led by Dr Hilary Pinnock: Qualitative exploration and quantitative validation of the Royal College of Physician's three questions for assessment of asthma control (RCP3Qs) when used in the Quality and Outcome Framework indicator pilot 2009/10.

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

11. Restricted funds - continued

Inhaler Device Project: The IPCRG hosted an international meeting on inhaler therapy focusing on real-life solutions to the problems confronting clinicians and patients in choosing and using inhaler devices. This was supported by sponsorship from Mundipharma International Limited and Optimum Patient Care Ltd.

Fresh Air Uganda: The IPCRG has received funds from Mundipharma to enable it to fund University of Groningen and local partners to carry out the FRESH AIR Survey of the prevalence of COPD and its risk factors in Uganda.

GSK Middle East: The IPCRG has received funds from a medical communications agency IMC to support a programme, funded by GlaxoSmithKline, relating to the development of the Middle East and Africa (MEA) Respiratory Institute Educational Programme.

Patient Concordance Study: The IPCRG and European Federation of Allergy and Airways Diseases (EFA), chaired by Martyn Partridge, with financial support from Chiesi Farmaceutici SpA, have been developing tools to support improved relationships between the clinician and patient, and to support self- management, that can be adapted to national health systems.

Difficult Asthma: The IPCRG received funding from Novartis to help provide and produce practical guidance for health care professionals about how to improve their care of patients with difficult to manage asthma.

UNLOCK: The IPCRG received funding from Novartis to enable them to develop a sustainable infrastructure and after project support for the UNLOCK group.

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

12. Unrestricted funds

	At 31 December 2011 £	Incoming resources £	Resources expended £	Transfers £	Loss on currency conversion £	At 31 December 2012 £
General	271,112	224,002	(157,658)	(28,448)	(32,212)	276,796
Designated funds						
Future Conferences	175,000	-	-	-	-	175,000
Conference Bursary	36,000	19,511	(23,525)	4,014	-	36,000
Conference Funds	79,582	2,171	(5,720)		-	76,033
Bring Conferences in House	6,353	1,591	(3,464)	(2,889)	-	1,591
Research	11,439	-		10,000	-	21,439
IPCRG Promotional Materials	340	-	(1,224)	5,000	-	4,116
Translation and Interpretation	5,000	-	(5,000)	-	-	-
Education	1,500	-	(9,100)	10,000	-	2,400
ICT	14,189	-	(19,450)	5,261	-	-
TAKL	2,938	-	-	(2,938)	-	-
	<u>332,341</u>	<u>23,273</u>	<u>(67,483)</u>	<u>28,448</u>	<u>-</u>	<u>316,579</u>
Total unrestricted funds	<u>603,453</u>	<u>247,275</u>	<u>(225,141)</u>	<u>-</u>	<u>(32,212)</u>	<u>593,375</u>

The conference designated funds have been set up to provide a fund for costs relating to potential cancellation costs of future conferences.

The Board agreed to continue with their commitment to a bursary programme, increasing the amount for the next conference and have also agreed to allocate funds to support the delivery of the IPCRG's strategic objectives.

Transfers between designated funds have been made to reallocate surpluses and general funds. These amounts are not repayable to the donor and have been earmarked for spending on the following IPCRG projects:

- Contracting a Professional Conference Organiser (PCO) to work with IPCRG on future conferences
- Pump priming funding for research proposals drafted at our Research Design Day in 2013
- Writing, designing and printing of an annual report
- Translations of articles within the PCRJ
- Continue contracting our E-Quality co-ordinator to run the E-Quality initiative
- Continue contracting our web editor to support the growth of our new web environment

International Primary Care Respiratory Group

Notes to the Financial Statements – continued

For the year ended 31 December 2012

13. Analysis of net assets between funds

	General fund £	Designated funds £	Restricted funds £	Total funds £
Investments	50	-	-	50
Debtors	25,276	-	-	25,276
Cash and bank	260,080	316,579	125,816	702,475
Current liabilities	(8,610)	-	-	(8,610)
Net assets at 31 December 2012	276,796	316,579	125,816	719,191

14. Related party transactions

Control

Throughout the year the charitable company was controlled by the directors, who are also the trustees of the charitable company.

Transactions

During the year IPCRG recharged expenses of £24,509 (2011 - £8,029) to the joint venture, IPCRG & PCRS UK 2012 Limited. At the year end £nil (2011 : £847) was outstanding. During the year IPCRG received £54,133 (2011: £nil) as a share of the joint venture income. At the year end £25,276 (2011: £nil) was outstanding and included within accrued income.

IPCRG granted IPCRG & PCRS UK 2012 Limited an interest free loan of £40,000 in 2011. This was fully repaid during 2012.

Sian Williams, Executive Officer, received professional fees totalling £57,543 (2011: £58,256) from the charitable company during the year for her services. At the year end £nil (2011: £nil) was outstanding.

Directors' emoluments and expenses are disclosed in note 6.

15. Legal status

International Primary Care Respiratory Group is a charitable company limited by guarantee and not having a share capital. The members' liability in the event of winding up is limited by guarantee not exceeding £1 per member.

16. Non-audit services

In common with many other organisations of its size, the charitable company uses its auditors to assist with the preparation of the financial statements.