

FINAL DRAFT

Childhood Asthma Review Final Report

Report of: Health Overview and Scrutiny Committee

Date: 16 July 2003

This Review was commissioned by the Health Overview and Scrutiny Committee at its meeting on 18 February 2003. The review was initially led by the then Chairman, Councillor Roger Avins; when he left the Committee in May it was progressed to completion by the Vice Chairman, Councillor Denise Carr. The Review was supported throughout by Caroline Farrar, Principal Policy Officer.

1 Aim and Objectives of the Review

Asthma has a significant impact on children's health; nationally 5% of GP consultations for children relate to asthma. Evidence suggests that the long-term future for children with persistent uncontrolled asthma is relatively poor, with most continuing to experience symptoms into adulthood, and that prevention, early intervention and effective long-term management are important in both improving children's lives and their health in the long-term.

Given this, the aims of the review were:

- to identify the factors causing childhood asthma, the impact it has on children's lives and its implications for health in adulthood;
- to identify how the experience and long-term future of children with asthma can be improved through improved prevention, diagnosis, education, management and treatment (noting that diagnosis and treatment are mainly clinical governance matters).

2 Conducting the Review

There were five main types of evidence gathered during the review.

- Background information on the condition was compiled from web-based searches of relevant literature and from local information available from the Council and Richmond and Twickenham Primary Care Trust.
- Visits were made to a number of relevant services (listed below).
- A questionnaire was sent to all schools in the borough, including fee-paying schools, about their management and experience of childhood asthma.
- Interviews were held with 7 parents and one primary school pupil who responded to advertisements to give evidence to the review, and a meeting was held with a number of secondary school pupils who were willing to talk about their experiences.
- Evidence was heard by the whole Health Overview and Scrutiny Committee in 'select committee' style (witnesses listed below).

The visits made to services were:

Orleans Park School (Cllrs Carr, Coombs & Head)	9 April 2003
Barnes Primary School (Cllrs Carr & Avins)	6 May 2003
Hampton Junior School (Cllrs Carr & Avins)	9 May 2003

A GP group practice in Twickenham (Cllrs Dance & Parsons)	21 May 2003
Children's Community Nursing Team (Cllr Carr)	28 May 2003
School Nursing Service (Cllr Carr)	4 June 2003
Healthy Schools Coordinator (telephone discussion)	5 June 2003
Kingston Hospital NHS Trust (Paediatric Consultant) (Cllrs Carr & Parsons)	18 June 2003

The witnesses heard by the Committee at its meeting on 4 June 2003 were:

Brian Holder	Teddington Society
Carol Rapley	Transport Planning Manager, LBRuT
John Coates	Special Project Officer, LBRuT
Angela Rowan	Health Development Officer, LBRuT
Houda Al Sharifi	Director of Public Health, Richmond and Twickenham PCT.

Written information on the Council's guidance to schools on managing medication was submitted by the Council's Health and Safety Unit (Personnel Department).

3 About Asthma

3.1 What is asthma?

Asthma is a condition that affects the airways. Children with asthma have airways that are almost always red and inflamed. These airways can react badly when someone with asthma has a cold or other viral infection or comes into contact with an asthma trigger.

An asthma trigger is anything that irritates the airways and causes the symptoms of asthma to appear. There are many of these and not everyone will react to the same triggers, but common ones include colds and viral infections, house-dust mites, pollen, cigarette smoke, chemical fumes, furry or feathery pets, exercise, air pollution, laughter and stress.

When someone's asthma is triggered, the airway lining starts to swell, it secretes mucus and the muscles that surround the airway start to get tighter; this makes the tubes very narrow and it is hard to breathe in and out normally. Asthma symptoms appear, including coughing, wheezing, a tight chest and shortness of breath. This is called an asthma attack.

There is no clear evidence about what causes asthma, but there are factors which make it more likely that a child will develop the condition:

- asthma often runs in families. If one or both parents have an allergic condition such as asthma, hay fever or eczema, their child is more likely to develop asthma.
- many aspects of modern lifestyles, such as changes in housing and diet and a more hygienic environment, may have contributed to the rise in asthma over the last few decades.
- smoking during pregnancy increases the chance of a child developing asthma.
- environmental pollution can make asthma symptoms worse but has not been proven to actually cause asthma.

3.2 Prevalence, national and local figures

The prevalence of asthma has apparently increased in recent years and approximately one in eight children are currently living with the condition (compared with one in 13 adults). However there is some evidence to suggest that the apparent increase in childhood asthma diagnoses is not due to an actual rise in asthma and respiratory symptoms, but is due to the

condition being more broadly defined and more readily recognised by GPs and other health professionals. Whichever is true, the numbers of children with asthma make it an issue for all schools and services for children.

Figures on the prevalence of asthma specifically in the borough are difficult to obtain, along with other morbidity data. However the question is not whether the problem is worse in this area than in others, as it is clear that there are significant numbers of children in the borough living with the condition. The key questions are rather is asthma being properly diagnosed, treated, managed and controlled for those living with the condition, and are children with asthma and their parents receiving the support they need. The prevalence data presented in this section should be understood in this context.

Asthma is a significant childhood illness. Nationally 5% of GP consultations for children relate to asthma. Respiratory disease is the most commonly reported long-term illness in children, accounting for over 40% of all long-term illnesses. Over 80% of long-term respiratory illnesses (and nearly a third of all long-term illnesses) in childhood are due to doctor-diagnosed asthma. Respiratory disease is a leading cause of hospital admissions in children, accounting for 14% of all admissions for childhood complaints or illnesses; around 15% of these admissions are due to doctor-diagnosed asthma.

Both wheeze and diagnosed asthma are more common in boys than in girls. [NB Wheeze is a symptom of asthma but is also a symptom of other respiratory illnesses.] The prevalence of diagnosed asthma declines in young adulthood, but the rate of decline is higher in males than in females leading to a higher prevalence of diagnosed asthma in women in adult life than in men.

From 1994-98 the prevalence of treated asthma (as opposed to doctor-diagnosed asthma rates, which are higher) in England and Wales in children aged 0-4 has ranged from 9.7% to 10.36% in males and 6.25% to 6.77% in females. For the 5-15 age group the rates have been from 12.8% to 13.2% for males, and 10% to 10.57% for females. Regionally prevalence in the South Thames region is generally slightly lower than the national average, except in the female 0-4 age range.

The registered Richmond and Twickenham PCT population is approximately 196,022. Based on national rates, a Primary Care Trust of 100,000 people (including 20,000 children) could expect each year, on average:

- almost 4000 children who are diagnosed with asthma (just under 20%);
- over half of these children to visit their GP for treatment at least once;
- around 60 emergency hospital admissions for childhood asthma.

Figures from Kingston Hospital were obtained for the year March 2002 to February 2003 on asthma-related admissions of children from the Richmond and Twickenham Primary Care Trust area (roughly comparable with the borough). There were 132 admissions in the 12 month period, of which 4 were planned, booked or transferred, 123 through Accident and Emergency and 5 through urgent GP referral. Figures from West Middlesex Hospital were less usefully broken down but showed 16 admissions from April 2002 to mid-March 2003.

3.3 Asthma Diagnosis

Accurate diagnosis of asthma in young children is very important but also very challenging, as there is currently no specific clinical test for childhood asthma and early signs and symptoms do not give a definite indication. To reach an accurate diagnosis, a doctor needs to know the child well, look for typical signs and symptoms (including testing for lung function and allergy) and monitor progress over time. Doctors may rely on response to treatment as their primary aid to diagnosis, particularly in very young children.

In older children a peak flow meter can be used to assess lung function to aid diagnosis and monitoring. This is a simple device which measures lung capacity by the patient blowing as hard as possible in a short, sharp blow into it.

Asthma symptoms vary in severity; some children experience an occasional cough or wheeze, while for others the symptoms will be much more severe. Asthma can usually be managed effectively by avoiding known triggers and taking the correct medication, although some children will have to take time off school or have disturbed sleep due to asthma symptoms.

3.4 Asthma Treatment

Treatment of asthma is governed by NHS clinical governance protocols and the review did not therefore focus heavily on treatment issues. However, it was appropriate to collect children's and parents' experience of and views on prescribing and how their views have been taken into account in the process. Information from the National Asthma Campaign indicates that there are often issues for children around their acceptance of inhaler medication; for example inhalers that fit less obviously into trouser pockets are more likely to be carried and used than those that do not. These need to be considered as issues in prescribing by GPs, as well as cost and efficacy.

There are three types of asthma medication: preventer inhalers, reliever inhalers and steroid tablets.

Preventer inhalers are usually brown, maroon or orange and are taken twice every day, usually first thing in the morning and last thing at night. Preventers reduce the inflammation and irritability in the airways so that an attack is less likely to happen when in contact with a trigger. They work over a period of time so they are taken every day even if the asthma appears to be under control.

Reliever inhalers are usually blue. These are taken immediately symptoms appear to quickly relax the muscles around the airways. As the muscles relax, the airways open wider and it gets easier to breathe again. Children with asthma need to keep their relievers with them, or close at hand at all times, as asthma attacks cannot be predicted and may happen at any time. Reliever medication is extremely safe and effective and has few side effects; even in the event of a severe attack and continued use of the reliever, it is not possible for a child to overdose on this. However if a child is using their reliever inhaler more than once a day or three or four times a week, their asthma is not under control and their treatment needs to be reviewed by their GP or nurse.

Steroid tablets are used on a short term basis to bring severe symptoms under control and in an emergency. It is very unusual for them to be prescribed on a long term basis in children.

Spacers make metered dose inhalers easier to use and more effective, allowing more of the medication to be breathed straight down into the lungs where it is needed most. The device is like a plastic tube which is wider in the middle and narrower at either end. The inhaler is sprayed into one end and breathed in through the other. Because of the coordination needed, children under twelve often find it difficult to use spray inhalers properly without a spacer and will often need to carry one around.

Use of an inhaler is a not a straightforward matter that can be taken for granted, particularly in treating children. A recent review of the evidence (Effective Health Care Bulletin, 'Inhaler devices for the treatment of asthma and COPD', Volume 8 Number 1, 2003) found that even with teaching only 63% of patients were using the correct technique when using the most

commonly prescribed inhalers, and concluded that all patients should receive appropriate instruction and guidance on effective technique when prescribed inhaler devices and this should be regularly reinforced.

3.5 Avoiding Asthma Triggers

Avoiding triggers is an effective way of managing asthma, although it can take time to identify what these are.

Colds and viral infections are very common triggers and difficult to avoid, but regular use of the preventer inhaler, a healthy diet with fresh fruit and vegetables and flu injections for people with severe asthma can help.

House-dust mites are tiny insects (about 0.3mm long) and are transparent, so they can only be seen with a microscope. They live in the dust that builds up around the house, in carpets, bedding, beds, soft furnishings and soft toys. Up to 85% of people with allergic asthma are sensitive to house-dust mite and their droppings. The numbers of house-dust mites in a home can be reduced significantly by using barrier covers on beds and bedding, hot washing bedding weekly, regular vacuuming, damp dusting surfaces daily, reducing the number of carpets, rugs and soft furnishings, washing curtains regularly or replacing them with blinds and reducing humidity levels.

Cigarette smoke is an irritant to people with asthma, who should not smoke and should avoid smoky environments.

Furry and feathery pets should be avoided around children with asthma, but if there is a pet the problem can be controlled by keeping the pet out of areas like the lounge and bedroom and using a vacuum cleaner with a filter.

Exercise is a common trigger for asthma, affecting about 80% of people with the condition, but overall exercise is good for everyone including people with asthma. Proper use of asthma medications can help to avoid this problem.

Pollen can trigger asthma symptoms in some people. It can be avoided by not spending too much time outdoors on hot, dry days, avoiding long grass and keeping car windows closed.

Poor air quality, including car exhaust fumes and ground level ozone, can irritate the airways. This is difficult to avoid, but people can keep informed about air quality through the Air Pollution Bulletin Service and on the Council's web site. Avoiding outdoor exercise on days of high pollution, especially hot summer days, may help.

Other triggers include the weather, mould, emotion, food allergies and medicines.

3.6 Reviewing and monitoring

Following an initial diagnosis, asthma needs to be monitored continually to determine the minimum level of medication that offers effective symptom control. Once the symptoms are under control, regular assessment and monitoring are needed to ensure that this remains the case as the child grows and changes.

Asthma is not straightforward and parents and children need to be involved in decisions about their care and to receive education and support on lifestyle change and trigger avoidance to enable them to manage the condition effectively.

3.7 Impact

Asthma is a serious condition, but if it is treated, managed and controlled effectively it need not limit life, opportunities or long-term prospects. The aim of this review is to look at whether this is happening effectively in the area, and make recommendations to improve children's experience and long-term prospects.

There is evidence that uncontrolled asthma leading to regular attacks persisting from early childhood into adulthood may be associated with irreversible and progressive damage to the airways. The conclusion of this evidence is that asthma needs to be properly managed and controlled in children to prevent lung function deterioration leading to chronic illness in later life.

3.8 Schools

The National Asthma Campaign's good practice guidance on asthma in schools states that schools should:

- have an asthma policy;
- ensure that children have immediate access to their inhalers at all times in accordance with Department of Health guidance, and should be allowed to carry them when responsible enough and able to do so;
- ensure that children with asthma participate fully in all aspects of school life including PE;
- keep records of children with asthma and their medication;
- ensure that the school environment is favourable to children with asthma by removing triggers such as furry and feathery animals, strong fumes and tobacco smoke;
- ensure that other children understand asthma;
- ensure that all staff who come into contact with children with asthma know what to do in the event of an asthma attack;
- work in partnership with all interested parties including all school staff, parents, governors, doctors and nurses and children to ensure they fully support an asthma policy so it is implemented and maintained successfully.

Also, that:

- the LEA should provide indemnity for those teachers who are trained to administer asthma medication at school and that teachers know that such indemnity does exist;
- the PCT should ensure that the most appropriately qualified local health professionals are available to train school staff on the management of asthma at school.

4 Findings and Recommendations

These findings and recommendations are set out under four broad categories, with some areas of overlap inevitable:

- asthma and schools;
- asthma and health services;
- asthma and the environment;
- health inequalities and asthma.

Observations relating very specifically to any particular service visited during the review will be given separately to that service, as the aim of the review is to identify those issues relevant across the borough.

4.1 Asthma and Schools – Findings and Recommendations

Schools appear to take asthma seriously and all those responding to the School Asthma Questionnaire have established procedures for dealing with both regular medication and emergencies. Interviews with parents of children with asthma showed that, overall, they had no major concerns about how the schools managed their children's asthma. However, management of asthma in schools appears to vary widely. Few borough primary schools fully meet Department of Health and National Asthma Campaign guidance to ensure immediate access to inhalers. Similarly the Council's guidance on medication in schools, produced following consultation with schools, advises that primary school children should be encouraged to take responsibility for their own medication. A delay in getting an inhaler of even a few minutes could be dangerous to a child (and can certainly be distressing), and an asthma attack cannot always be predicted. In one of the schools visited the inhalers were quite disorganised in the cupboard in which they were kept and not clearly labelled, which could lead to delay in an emergency. This demonstrates the potential problems with this approach to managing inhalers in schools.

Again because even a small delay in accessing and using an inhaler properly could be dangerous, the National Asthma Campaign recommends that all staff in schools who are in regular contact with children with asthma are trained to deal with an attack. This is not the case in many schools, with many relying on their first aiders to help in an emergency. However it is recognised that there may be problems in requiring teachers to carry out this role and some may be unwilling to act in this capacity.

Approximately one in eight children has a diagnosis of asthma and inhalers are now commonly found in schools. It would be useful to those children who have asthma for other pupils to have an understanding of their condition, but currently only around half the schools which responded to the questionnaire do anything to educate and inform other pupils.

Recommendation 1: All schools adopt a school asthma policy which meets Department of Health and National Asthma Campaign guidance, including immediate access to inhalers, training for staff, proper emergency procedures and education and information for other children.

Recommendation 2: The Council's planned new Health and Safety guidance on the management of medication in schools requires that immediate access to inhalers is facilitated. Where possible all children should be encouraged to take responsibility for their own medication with the agreement of a parent, but where this is not possible inhalers should be kept in an accessible place in the classroom.

Recommendation 3: Where schools hold inhalers (including spare inhalers) for children, good practice in storage and labelling must be followed.

Recommendation 4: The Council's Health and Safety Unit includes a check on storage of medication during monitoring of school health and safety procedures.

Pupils at Orleans Park Secondary School were not confident that all teachers were aware of their condition, as asthma can vary quite widely and what is appropriate for one child may not be appropriate for another. One pupil suggested that those with medical conditions carry an

identity card which would explain to teachers about their condition, including the severity of their symptoms and any precautions they may need to take.

Recommendation 5: Secondary schools consider the potential benefits and feasibility of introducing a medical identity card scheme, as suggested by pupils at Orleans Park School.

Welfare Assistants appear to carry much of the burden of managing medication in schools. There are occasional training days where they meet other school staff, but no formal networks for discussing problems and sharing good practice.

Recommendation 6: The LEA and schools consider whether there is benefit in developing a network or shared professional development day for school Welfare Assistants where good practice can be shared.

Uncontrolled asthma can cause significant absences from school, which in turn may affect educational attainment. Parents, pupils and the School Nursing Service all gave evidence of significant school absences to the review. However, the schools visited had no mechanism for recording reasons for absence and accordingly this information could not be supplied by the Local Education Authority.

Recommendation 7: Schools and the LEA work together to improve the information they collect on sickness absence to include a reason.

Although the Local Education Authority supports a local Healthy Schools Scheme and it is a Community Plan objective to support all schools to achieve the national Healthy Schools Standard, there appears to be no officer in the LEA leading on broader health matters. Asthma is one of many health issues affecting schools that is not covered by the Healthy Schools Scheme. The only input the scheme has in this area is that participating schools must have an overall policy on managing medical needs in school. Neither could Education Welfare assist. This left the review in the position of having no-one from the LEA able to assist with evidence for this review.

Recommendation 8: The LEA ensures that a strategic lead on health matters in schools is given by a senior officer.

Schools appear to expect that input and training on issues such as asthma will be driven by the School Nurse, whereas the School Nursing Service appeared to expect schools to ask for advice on particular issues rather than having a programme of activity.

Recommendation 9: The School Nursing Service develops a regular programme of training and support for schools on asthma, to support their implementation of the National Asthma Campaign guidance.

4.2 Asthma and Health Services – Findings and Recommendations

The finding of most concern to the Committee in this review is that not all children with asthma and their parents receive appropriate advice, support and education about managing their condition from their GP practice. Asthma is a condition which requires a high level of

understanding and insight from the patient (and/or a parent in the case of a child) in order to manage it effectively. There needs to be understanding of the different types of inhalers, when to take which and why, what to do if symptoms worsen, teaching on how to use an inhaler, help and advice on removing and reducing triggers and regular monitoring to achieve the optimum medication level. As reported above (section 3.4, Asthma Treatment), studies have shown that even with teaching only 63% of all patients (including adults) could correctly use an inhaler. However both children and parents giving evidence to this review reported a lack of adequate monitoring, education, support and advice in managing their asthma. Several parents said that they had found a way through and now knew what to do, but without the help of their GP. Several reported simply being prescribed an inhaler with no instruction on what to do and no follow-up. People's experience appears to depend to some extent on which GP the child is registered with and whether there is a Practice Nurse with an interest in asthma; the GP practice visited in Twickenham as part of the review appeared to provide very comprehensive services to its patients on asthma management. Similarly, if the child is sufficiently ill and receives a referral to the Children's Community Nursing Team the family is likely to receive comprehensive input and support.

Recommendation 10: The PCT undertakes development work with GPs on asthma management, including work to maximise the number of asthma-trained practice nurses.

Recommendation 11: All children diagnosed with asthma in the borough should receive a written management plan setting out the details of their treatment and other steps that should be taken to control their asthma (an asthma action plan).

Overall the appropriate services to support children with asthma in the borough appear to be in place, including acute services and community nursing. Those parents who had used the services provided by Kingston Hospital were very positive about these, and a visit confirmed the view that this was a comprehensive service that appeared to meet its patients' needs. Written management plans and printed information were particularly appreciated by parents. However liaison between the services did not always appear to be working well, in particular the interface between primary care (GPs, Practice Nurses, Health Visitors etc) and hospital settings.

Recommendation 12: The PCT to work with GPs and acute providers on interface issues, including the need for a written management plan (an asthma action plan).

Both children and parents reported a lack of useful printed information about asthma. This meant that they had no way of checking the information that had been given to them verbally and they had no references to follow-up for any more general queries. Although it is recognised that printed materials and other resources such as videos can never be a substitute for one-to-one advice from a qualified healthcare professional, they should be available as part of the overall management of the regime.

Recommendation 13: Printed material appropriate for children of all ages (such as that already developed by the National Asthma Campaign) to be made available by the PCT to all healthcare settings in the borough, with a translation facility for those who need it. Printed material also signposts patients to the National Asthma Campaign.

Awareness of the services offered by the Children's Community Nursing Team appears to be low among GPs and other health professionals who are more likely to see children on a regular basis. However it is accepted that it would not be appropriate to promote this small, specialist service to the general public.

Recommendation 14: The PCT to support the Children's Community Nursing team with promoting its services among GPs and other primary care professionals.

The PCT has offered a further recommendation to assist in reducing the impact of flu on children with asthma.

Recommendation 15: The PCT to support health professionals to offer and deliver flu (influenza) vaccination to those children with asthma over six months in age as per government guidelines.

4.3 Asthma and the Environment

It was never within the remit of this review to judge the impact of pollution on asthma, to replicate large-scale international research or to investigate whether perceived high levels of and increases in asthma diagnoses may be, in whole or in part, due to poor air quality. Nevertheless there has been some public interest in this aspect of asthma.

The best evidence available to the Committee is that asthma is not caused by environmental pollution, but that air pollution may be one of many triggers which can aggravate the airways and worsen an attack. However air pollution is not the most common nor the most important asthma trigger. Moreover, air quality monitoring within the borough currently indicates that levels of pollutants are significantly below the levels which would endanger health, as these are currently understood.

The amount of impact that the Committee can have on air quality is likely to be small. The Council's Air Quality Action Plan is seeking to bring pollution hot spot areas within Government limits. For the best improvement, some of the action will be long term and is being carried out on a London-wide basis, while other improvements require national or even European Union action. It is much easier to control other factors and asthma triggers than air pollution, but the issue must nevertheless be considered alongside those above.

Recommendation 16: The Council continues to support measures to reduce congestion including encouraging use of less polluting forms of transport such as cycling and walking.

Recommendation 17: Air quality monitoring to be targeted at schools, in conjunction with a coordinated programme to address children and parents on the issues of travel choice.

Recommendation 18: As the Council has designated the whole of the borough an Air Quality Management Area, better environmental impact modelling of proposed traffic schemes should take into account the impact of total traffic rather than the increase in traffic.

Smoking is also an irritant to children with asthma. Ahead of any possible future change in the law on smoking in public places, we can only encourage cafes, pubs and restaurants to take measures to reduce this problem.

Recommendation 19: The Council's Food without Fumes scheme is promoted and expanded as much as possible.

Recommendation 20: To reduce the number of children living in smoking households, the PCT will encourage health professionals to offer smoking advice to those living under the same roof as a child with asthma.

4.4 Health Inequalities and Asthma

There is clear evidence that asthma is a health inequalities issue. Although there are no significant differences in the prevalence of diagnosed asthma between different social groups, the implications of childhood asthma for those living on low incomes are heightened. They are more likely to be exposed to several of the known triggers and are less likely to be able to counteract them:

- poor housing is more likely to be damp and therefore more prone to colonisation by moulds, giving rise to higher levels of mould spores;
- smoking rates are higher in deprived communities;
- living on a low income brings a high level of stress associated with unemployment and lack of money;
- the cost of effective house dust mite treatments, a high performance vacuum cleaner and protective covers for bedding are likely to be prohibitive;
- a diet high in minerals and vitamins is difficult to achieve;
- families are less likely to be able to research information and advice for themselves if it is not provided by health professionals;
- school absences due to asthma could affect educational attainment, reinforcing the cycle of deprivation.

It has been difficult to obtain data on the impact of the condition among children in the borough, and consequently impossible to back up these findings from national and international research with local experience.

Recommendation 21: The PCT, Council and other agencies work together to undertake research to establish the need for services to tackle health inequalities in childhood asthma.

Recommendation 22: Contingent upon the outcome of Recommendation 21, the Council and PCT work together to establish a system of support for families on low incomes to manage childhood asthma, possibly including grants and/or targeted services.

The PCT has offered a further recommendation as follows, as there is evidence that smoking during pregnancy increases the chance of a child developing asthma, and that breastfeeding decreases the chance.

Recommendation 23: The PCT to take steps to promote breastfeeding and to take action to reduce the number of women smoking during pregnancy and the first few weeks of a baby's life.

There was evidence that asthma, and particularly severe asthma, caused significant stress to families, affecting parents and siblings as well as the child themselves. At least two parents

said they thought that a parent support group might help. However, the National Asthma Campaign no longer runs local groups and this is not the responsibility of the PCT or Council.

Recommendation 24: Richmond CVS considers whether it might be appropriate to assist in setting up a parent support group. Alternatively, individual GP practices could consider this option to support children and families.

5 Evaluation and Monitoring

It is recommended that the Committee revisits this report in early 2004 to monitor progress on its recommendations.

6 References and Further Reading

'Starting as we mean to go on' – An audit of children's asthma in the UK', National Asthma Campaign Asthma Audit 2002, May 2002.

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'Out in the open – a true picture of asthma in the United Kingdom today', National Asthma Campaign Asthma Audit 2001, September 2001.

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'Exercise and Asthma', National Asthma Campaign website, July 2000.

'Peak practice', National Asthma Campaign website, April 2000.

'Asthma at school', National Asthma Campaign, 1999.

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'Prevalence of treated asthma per 1000 patients', Key Health Statistics from General Practice, 1998.

'Sleepless nights, anxious days – a National Asthma Campaign report into the experiences of parents of children with asthma', National Asthma Campaign, 2002.

'Asthma and Outdoor Air Pollution', Committee on the Medical Aspects of Air Pollutants, Department of Health, 2000.

'Public Health Profile', Richmond and Twickenham Primary Care Trust, Public Health, Sept 2002.

'Inhaler devices for the management of asthma and COPD', Effective Health Care Bulletin Volume 8 Number 1, NHS Centre for Reviews and Dissemination (University of York), 2003

NB Anonymised notes of visits to services and witness interviews, and an analysis of the schools' questionnaire results can be made available on request.