	Community and Wellbeing Scrutiny Committee 16 September 2026
	Report from the Corporate Director of Service Reform and Strategy
	Lead Cabinet Member for Community Safety and Public Health - Cllr Liz Dixon

Childhood Asthma in Brent

Wards Affected:	All
Key or Non-Key Decision:	For information
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
List of Appendices:	Appendix 1: Asthma Data Pack 2026 Appendix 2: Childhood Asthma in Brent LES
Background Papers:	None
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1.0 Executive Summary

1.1 This report provides an overview for the Committee on the prevalence, impact, prevention and management of asthma among children and young people (CYP) in Brent.

1.2 This report includes; the risk factors which contribute to childhood asthma, prevention and early intervention activities, health inequality considerations for vulnerable groups, a comprehensive overview of the asthma services, and engagement with schools and families.

1.3 This report has been prepared by Public Health, NHS partners in West and North London ICB, and Central London Community Healthcare NHS Trust.

2.0 Recommendation(s)

2.1 Members of the Scrutiny Committee are recommended to review and note the progress being made by the NHS and the Council with respect to asthma among children and young people in Brent

3.0 Detail

3.1 Contribution to Borough Plan Priorities & Strategic Context

3.1.1 The **Brent Borough Plan 2023-2027** outlines key strategic priorities aimed at improving health and well-being across the borough. The priority most relevant to this report is: **"A Healthier Brent"**. This priority focuses on reducing health inequalities and improving overall health outcomes for Brent children, and young people. The childhood asthma work stream aligns with this priority.

3.1.2 This report is also relevant to two priorities from the Brent Joint Health and Wellbeing Strategy 2022 – 2027, namely: "Healthy Lives" and "Staying Healthy". Although asthma is not singled out in the strategy, asthma work directly contributes to these commitments through action on:

- Air quality
- Housing conditions
- Access to healthcare
- Self-management of long-term conditions
- Reducing inequalities affecting deprived communities and ethnically diverse populations

3.1.3 The Brent Health Matters CYPs Health Inequalities Programme, established in 2024, identifies childhood asthma as one of three key priorities. Its focus includes asthma education and basic awareness training, community asthma coaches, personalised asthma plans, GP reviews within 48 hours of an A&E attendance, and reducing exposure to air pollution, smoking, damp and mould[1].

4.0 Background

4.1 Definition and Strategic Context

4.1.1 Childhood asthma is an inflammatory condition of the airways in children, where their airways become sensitive and can narrow, swell, and produce excess mucus, leading to symptoms such as wheezing, coughing, shortness of breath, and chest tightness. It can be triggered by viral infections, allergens, air pollution, exercise, cold weather, or tobacco smoke exposure[2].

4.1.2 London has a higher rate of illness and death in children and young people because of asthma compared to other European cities/countries[3]. 1 in 11 children and young people are affected by asthma, which is around 3 in every London classroom.

4.1.3 Although in most children, asthma can be well managed, for some children asthma can have severe impacts. Over 20,000 CYP are admitted to hospital every year in England. Asthma is also one of the top three causes of emergency admission to hospital (3,700 in London in 2023/24). Around 4% of the hospital admissions for asthma are severe episodes which result in a child being admitted to intensive care.

4.1.4 It is very sad that every year, a few children in London die from asthma. This number has ranged from 1 to 10 in recent years[4]. Most asthma deaths are considered preventable through tackling risk factors and providing good asthma management.

4.1.5 The National Child Mortality Database (NCMD) 2024 report, which investigated deaths in children due to asthma and anaphylaxis, recommended a number of areas for service providers and policymakers to focus on These include strengthening the delivery of asthma care, improving identification and follow-up of high-risk children, reducing health inequalities, optimising prescribing and self-management support, improving cross-service communication, and addressing environmental factors such as air pollution, smoking, damp, and mould[5].

4.2 Local Picture

4.2.1 Brent has a relatively young population with high population turnover. There are 149 languages spoken within Brent and 37% of residents do not have English as

[1] Children and Young People's Team | Brent Council
[2] State of Child Health 2026: Asthma | RCPCH
[3] Children and young people's asthma fact sheet - Transformation Partners
[4] Childhood asthma in London 2006 to 2020 - Office for National Statistics
[5] Asthma-and-anaphylaxis.pdf

their first language. The prevalence of diagnosed asthma is slightly higher in Brent compared with northwest London (4.4% vs 4.1% based on August 2026 WSIC[6] data from general practices). Prevalence varies by ethnic group and is highest in children from Black ethnic groups. For disaggregated ethnic groups, children from a Black Caribbean background have a prevalence of 8.7%, Black African background 5.7% and Pakistani background 7.2%.

4.2.2 The childhood asthma admission rate in Brent is 333.8 per 100,000, which is significantly higher than the national rate of 138.8 per 100,000 in England[7], and double the London average[8]. This is based on the latest available comparative data (2024/25). The gap between Brent and London had widened over the past four years to 2024/25. However, WSIC data for Brent shows a decrease of 20% childhood asthma admissions and a decrease of 28% childhood A&E attendances for asthma in 2025/26 compared with the previous year.

4.2.3 Within Brent, asthma admission rates are above average for children from Pakistani and Mixed White & Black Caribbean ethnic groups. The asthma admission rate is highest in Harlesden and lowest in Kilburn.

4.2.4 WSIC data also shows that 29% of CYP diagnosed with asthma live in the 20% most deprived neighbourhoods (Index of Multiple Deprivation deciles 1–2), demonstrating the disproportionate impact of asthma on disadvantaged communities and the importance of targeting support to those at greatest risk.

4.2.5 The proportion of asthma patients with a completed annual asthma review has increased steadily over the past five years, showing that initiatives to increase asthma management have improved over time. During the asthma review, the child's GP asks about asthma symptoms, triggers, use of inhaler and other relevant aspects of their asthma.

4.2.6 Inhaled corticosteroid prescribing (also known as a "preventer" inhaler) has also increased over time. While prescribing of short-acting beta-2 agonists (SABAs) which have a rapid onset of action has increased over the past two years, multiple SABA prescriptions have decreased. This decrease shows that treatment of children's asthma is moving more towards the preventative end.

4.3 **Risk Factors, Environmental Factors, and Wider Determinants**

4.3.1 Risk factors for childhood asthma include multiple deprivation, housing (overcrowding, damp and mould), air pollution, exposure to household smoking, vaping, lower respiratory tract infections, low immunisation uptake, and premature births.

4.3.2 The 2025 Income Deprivation Affecting Children Index shows one in three Brent LSOAs (small areas) in Brent are in the most deprived 10% in the country and 13 are in the most deprived 1%. Brent is the fifth most deprived local authority in

[6] WSIC = Whole Systems Integrated Care NHS data resource for northwest London

[7] *OHID, based on NHS England and Office for National Statistics data*

[8] 2024/25 Hospital Episode Statistics

England on the 2025 IDACI, with almost 60% of children living in income deprived households[9].

4.3.3 At borough level, air pollution (NO2) levels are similar in Brent compared to London; however, there are known hotspots in Brent where NO2 levels are non-compliant with regulations (2024 and 2025 data).[10]

4.3.4 Damp is more prevalent in the social housing sector compared with owner-occupied and private rented housing, although under-recording may be a particular issue in privately rented homes. Around 7-8% of social rented homes in Brent had damp (2023 and 2024 data)[11], presenting an opportunity to help tackle asthma through housing improvements and other initiatives targeted at social housing tenants. Brent has higher levels of overcrowding than the London average. It is in the top three most overcrowded boroughs in London.

4.3.5 Other health factors can exacerbate asthma, including lower respiratory tract infections (some of which may be preventable by immunisation) and premature birth. Lower respiratory tract infection rates are higher in Brent compared with London. Coverage of child vaccinations that could reduce respiratory infections, including flu and MMR, is lower in Brent than nationally.

4.3.6 Over the past ten years, the premature birth rate has consistently been higher in Brent compared with London and time trends show the rate has increased over the past five years.

4.3.7 More details on prevalence and risk factors can be found in the asthma data pack in Appendix 1.

4.4 Prevention, Early Intervention and Partnership Working

4.4.1 Children and families have more contact with primary care than any other part of the healthcare system, therefore primary care plays a central coordinating role in the management of childhood asthma. Primary care is responsible for diagnosing asthma, reviewing and optimising treatment, educating families and preventing inequalities in access or quality of care for children.

4.4.2 **Childhood Asthma Local Enhanced Service (LES)**. Brent identified childhood asthma as a primary care priority due to low diagnosis rates and poor disease control. In 2024, only 2.3% of children and young people in Brent had a recorded asthma diagnosis, compared with 4.1% across North West London and 6.8% nationally, suggesting significant under-diagnosis.

[9] https://data.brent.gov.uk/download/2j30l/hf4/Report%20-%20Deprivation%20in%20Brent%20v1.0.pdf
[10] Air quality monitoring and reports | Brent Council
[11] LG Inform Plus: English Housing Survey modelled estimate

4.4.3 To address this, Brent introduced a Childhood Asthma Local Enhanced Service (LES) which combined proactive case finding with enhanced reviews for higher-risk children aged 5 to 17 years. The programme used practice data to identify children who may have undiagnosed asthma and provided targeted reviews focused on inhaler technique, preventative treatment, personalised asthma action plans, and environmental risk factors such as smoking exposure and damp housing. Delivery was supported through Tier 3 (clinical assessment and management) training for practices, asthma Community Coaches working with families and communities, and monthly performance data to help practices monitor and improve outcomes.

4.4.4 The Childhood Asthma LES was associated with significant improvements in diagnosis and asthma management. New diagnoses increased by 56.5%, from 294 in 2024/25 to 460 in 2025/26, with Brent's diagnosis rate rising from 0.48% to 0.78%, compared with 0.45% across North West London (NWL). Adjusted analysis showed Brent children were 1.74 times more likely to receive a new asthma diagnosis than matched peers elsewhere in NWL, indicating a substantial increase in diagnostic activity.

4.4.5 Outcomes also improved, with oral prednisolone (a corticosteroid) prescribing falling from 3.6% to 0.6% of asthma-related prescribing and high salbutamol inhaler prescribing reducing from 8.3% to 4.0% – this reflects better asthma control and fewer exacerbations. Hospital admissions fell by 12.4%, from 266 to 233, suggesting a positive trend, although this reduction was not significantly greater than that seen across NWL. For more information on the LES, see appendix 2.

4.5 Health Inequalities and Vulnerable Groups

4.5.1 To support primary care in prevention and early detection and intervention, Brent has commissioned additional unique services such as the Brent Health Matters Children and Young People Asthma programme to help address health inequalities.

4.5.2 **The Brent Health Matters Children and Young People (BHM CYP) Asthma Programme.** The Brent Health Matters (BHM) CYP Asthma Programme supports local and West and North London ICB priorities by reducing inequalities, improving asthma management and enabling earlier access to evidence-based care.

4.5.3 The team is made up of specialist nurses, healthcare assistants, link workers and community coaches. They aim to reduce inequalities through community outreach events where they deliver culturally appropriate asthma education and myth-busting and signposting. They also train up asthma community coaches

and wider workforce among partner organisations. Families can access the programme via referrals and signposting from GPs and other healthcare professionals, self-referral, and outreach events.

4.5.4 Asthma Community Coaches Programme
This programme trains trusted community members to provide culturally appropriate asthma education and free spacer packs. Developed in response to resident feedback, it helps overcome barriers to asthma information, equipment and support. To date, 88 coaches have been trained, with training for 33 more coaches planned by September 2026.

4.5.5 Training increased confidence in supporting families by 76% and asthma, inhaler and spacer knowledge by 73%; 32 spacer packs have also been distributed. Feedback indicates improved awareness, asthma management and understanding of care plans among families. Spacers help ensure effective delivery of the asthma medication to the lungs and knowledge of proper inhalation technique and other aspects of symptom management help prevent complications and hospital admission.

4.5.6 Multilingual Resources and Health Literacy
The BHM CYP asthma programme has co-produced accessible asthma resources for use across GP practices, hospitals and community settings. Materials include training booklets with practical information about asthma management, symptom recognition, trigger avoidance, and how to access support. Symptom diaries and spacer guidance are provided in six languages, “48 Hours” leaflets in eight languages, and five awareness videos in seven languages. A damp and mould resource has also been developed. There are videos on Dry Powder Inhalers (DPI), MART (maintenance and reliever therapy) and AIR (anti-inflammatory reliever) therapies due by September 2026.

4.5.7 To further address inequalities in asthma diagnosis and management, a FeNO machine (which measures the amount of nitric oxide breath to check for swelling and inflammation in airways) was purchased in August 2026, and this will support community-based asthma assessments from September 2026. It aims to support earlier and more accurate diagnosis, strengthen monitoring and medication adherence, and enable asthma health checks at community events.

4.6 **Community Engagement**

4.6.1 The BHM CYP Asthma programme’s community engagement has reached families beyond healthcare settings, promoting asthma awareness, medication adherence and correct inhaler use. #AskAboutAsthma is an NHS England London-wide campaign which promotes four key actions to improve outcomes

for children and young people with asthma: personalised asthma action plans, correct inhaler technique, annual asthma reviews, and air quality awareness.

4.6.2 Thirty families engaged at the Clean Air Community Fun Day in June 2026, receiving tailored advice and signposting. Ongoing activity promotes community coach training and asthma support, with a dedicated event planned for the September #AskAboutAsthma Week 2026.

4.6.3 In Brent, the campaign supports local priorities to reduce inequalities, improve diagnosis, and strengthen self-management. It also brings together schools, primary care, community organisations and healthcare providers to improve asthma outcomes and reduce avoidable emergency attendances. The 2026 campaign provides an opportunity to showcase local improvements and track progress against asthma quality improvement goals.

4.7 **Brent Asthma Nurse Specialist Service**

4.7.1 Overview of the Service

The Brent Asthma Nurse Specialist (ANS) service provides a specialist, nurse-led community respiratory service for children and young people with asthma across Brent. The service works across primary care, community services, schools and acute settings to improve asthma control, reduce avoidable emergency attendances and admissions, and support children and families to self-manage their condition.

4.7.2 The service is commissioned by the ICB and provided by Central London Community Healthcare (CLCH) NHS Trust. It is a single 0.9 WTE post. CLCH is currently exploring alternative delivery models through the children's community nursing teams that would provide year-round cover. The Service is an extension of the Children's Community Nursing Service, which has been a part of CLCH's community children's services in Brent for several years.

4.7.3 The role provides specialist assessment, asthma reviews, education, inhaler technique support, personalised asthma action plans and telephone advice. The service also plays a key role in workforce development through education and training delivered to GPs, school nurses, schools and other professionals managing children with asthma, and supporting parents to attend primary care reviews within 48-hours of A&E attendance. The service also participates in public health events to promote the availability of the specialist service and provide information on asthma management and inhaler technique.

4.7.4 Activity and Performance

Over the last 12 months the Asthma Nurse Specialist service has undergone a comprehensive review of its operating model, referral pathways, governance arrangements and performance. By September 2025, the associated Quality Improvement project had delivered a 66% increase in referrals compared with the previous four-month average, demonstrating the positive impact of pathway redesign and proactive case identification.

4.7.5 The service has also transformed how referrals are received. Previously, referral criteria required two A&E attendances before a child could access specialist support. This threshold has now been removed and, since January 2026, the service has proactively treated all North NWL and A&E notifications as referrals. Parent self-referrals are also now accepted, further improving accessibility and reducing barriers to support.

4.8 **0-19 services following A&E attendance**

4.8.1 In addition to the Asthma Nurse Specialist service, CYP with asthma are supported by universal 0-19 services, including health visiting and school nursing, commissioned by Public Health.

4.8.2 For children under 5 years of age, the health visiting service receives a notification when a child has attended A&E for asthma or preschool wheeze. Parents are then contacted by the health visiting service to confirm if care plans are in place, confirm any medication, and provide advice and signposting as required, for example to the Asthma Nurse Specialist or GP.

4.8.3 For school-aged CYP, the School Nursing Service contacts parents following A&E attendance and alerts the named School Nurse for further follow-up, including telephone contact with families and review of the CYP in school if required. Also, the School Nurse will liaise with the school's welfare officer to ensure the child has an up-to-date care plan in school. The School Nurse will encourage parents to contact their GP for an appointment if a 48-hour review is not already arranged.

4.9 **Brent-Specific Lessons Learned from Asthma Deaths and Serious Incidents**

4.9.1 Within CLCH, the After-Action Review (AAR) following the death of a young person with autism and asthma identified important learning across health, education and social care systems. Whilst the child had an asthma care plan, annual reviews and access to school-based support, opportunities to identify escalating risk were missed. The review highlighted that the mother's needs were not known, recorded or shared between agencies, resulting in assumptions about her understanding of asthma management and treatment.

4.9.2 Communication between professionals was inconsistent, and there was limited professional curiosity when concerns emerged regarding inhaler use, repeated A&E attendances and missed reviews.

4.9.3 Key actions following the review focused on strengthening systems and reducing reliance on individual judgement. These included introducing EMIS alerts to record parental learning needs, implementing a mandatory asthma review crib sheet, embedding escalation processes when inhaler use increases, ensuring school nurses attend regular safeguarding meetings, and improving communication pathways with primary care and acute providers. All actions were completed by July 2026.

4.10 Schools and Educational Settings

4.10.1 **Asthma Friendly Schools Programme.** An asthma-friendly school is an educational setting which chooses to undertake specialist training and accreditation to work with local health services to create a safe, healthy environment for students with asthma in school.

4.10.2 To become a certified Asthma Friendly School, a school must work with its allocated School Nurse to complete an annual audit, which is then officially accredited by the Brent Asthma Specialist Nurse. Once accredited, the school is issued an official certificate and logo. Status is maintained through annual audit and renewal of accreditation.

4.10.3 The programme delivery is supported by a partnership of services – School Nursing, commissioned by Public Health and the Asthma Nurse Specialist. Brent began implementing the Asthma Friendly Schools programme in 2024. Currently, there are 23 primary schools (42.6%) and 2 secondary schools (12.5%) that have achieved Asthma Friendly School status. A further 27 primary (50%) and 8 secondary schools (50%) as well as one alternative provision are actively working towards accreditation.

4.10.4 Core Requirements for Schools

- **Asthma Register:** Maintains an up-to-date list of all pupils diagnosed with asthma.
- **Action Plans**: Keeps a personal asthma action plan for each child alongside an emergency protocol.
- **Named Lead**: Assigns a specific staff member responsible for coordinating asthma care and linking with school nurses.
- **Staff Training**: Trains school staff to recognise symptoms and respond to asthma attacks safely via completion of foundational and whole-school training, reaching at least 85% staff awareness.

- **Inhaler Access**: Allows students quick, unhindered access to their reliever inhalers and houses spare emergency school inhaler kits.

4.10.5 Environmental and Attendance Standards

- **Trigger Reduction:** Minimises indoor triggers such as dust, mould and dampness, and enforces smoke-free and vape-free school gates.
- **Monitoring Absence:** Identifies students missing school or sitting out of sports due to poorly controlled asthma and escalates concerns to healthcare professionals.

5.0 Performance, Challenges and Future Priorities

5.1.1 There are several additional actions underway to further improve outcomes for CYP with asthma. We have seen a lot of progress in the efforts to improve outcomes in asthma prevention and management for Brent children. Moving forward, we are keen to continue focus on early identification and strengthening the delivery of asthma care for Brent children, including regular reviews, action plans, medicines optimisation, and follow-up for high-risk children.

5.1.2 Childhood Asthma Local Enhanced Service (LES): The recommended focus for 2026/27 for the childhood asthma LES include:

- Maximise completion of asthma high-risk reviews.
- Increase coverage of personalised asthma action plans.
- Review prescribing patterns, particularly SABA overuse.
- Strengthen links with housing, smoking cessation and social prescribing services.
- Monitor outcomes relating to exacerbations, oral steroid use and unplanned care utilisation.

5.1.3 Asthma Nurse Specialist Service: Following the service review, a detailed improvement programme is being implemented to further strengthen the quality, accessibility and effectiveness of the service. Key actions include:

- Enhanced professional development for the Asthma Nurse Specialist role, including independent prescribing capability to enable timely medication adjustment without requiring GP appointments.
- Development of promotional materials, posters and patient information leaflets to increase awareness of the service across GP practices
- Increased use of digital appointment reminders to reduce DNA rates and improve patient engagement.
- Development of a formal Standard Operating Procedure (SOP), including clear escalation pathways for repeated non-attendance and safeguarding concerns.
- Continued use of Cerner A&E attendance notifications as a primary referral source to support early intervention.
- Removal of restrictive referral criteria and introduction of parent self-referral pathways.

- Rescheduling clinic sessions to later in the day and after school hours to improve accessibility for school-aged children and reduce educational disruption.
- Strengthened clinical governance arrangements through direct clinical supervision from the Divisional Director of Nursing.
- Regular multidisciplinary discussions and specialist respiratory supervision with Dr Wolfgang Muller and colleagues at North West London hospitals support the management of children with complex asthma needs within the borough.

5.2 Asthma Friendly Schools: Potential future uptake: 7 primary schools (13%) and 5 secondary schools (31%), with the addition of 1 unit, are not currently interested in accreditation; however, they have expressed a potential interest in participating in the future. There are also 7 primary schools (13%) and 2 secondary schools (12.5%) that have declined to participate.

6.0 Stakeholder and ward member consultation and engagement

6.1 There was no direct stakeholder or ward member consultation or engagement leading up to the development of this report. However, the services provided do work closely with communities and stakeholders and have been shaped by feedback from local residents.

7.0 Financial Considerations

7.1 The funding for the various interventions and programmes is individually, and sometimes jointly from the North West London ICB (now the West & North London ICB) and the public health grant.

8.0 Legal Considerations

8.1 These are covered in the body of the report.

9.0 Equity, Diversity & Inclusion (EDI) Considerations

9.1 Children from some ethnic minority communities and those living in more deprived areas in Brent experience a disproportionate burden of childhood asthma, resulting in poorer outcomes and greater use of urgent care services. These inequalities vary across ethnic groups and neighbourhoods, highlighting the need for targeted support for populations at greater risk.

9.2 The BHM CYP Asthma Programme addresses some of these inequalities through co-produced, culturally appropriate resources available in multiple languages across healthcare and community settings. By improving access to information, reducing language barriers, and addressing wider determinants of health such as damp and mould, the programme aims to make asthma support more inclusive and accessible for Brent's diverse population.

10.0 Climate Change and Environmental Considerations

10.1 These are covered in the body of the report.

11.0 Human Resources/Property Considerations (if appropriate)

11.1 There were no human resources or property considerations included in this report

12.0 Communication Considerations

12.1 These are covered in the body of the report.

Report sign off:

Rachel Crossley
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