# BROMLEY CHILDREN AND YOUNG PERSON JOINT STRATEGIC NEEDS ASSESSMENT 2026

## Introduction &

## Section 1:

## Demography


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# Table of Contents

**Introduction .....5**

Acknowledgements .....6

**Section 1**

The Population of Bromley: Demography .....7

a) Current Picture & Projections .....7

b) Ethnicity of children and young people in Bromley .....15

Integrated Neighbourhood Team profile for CYP .....17

Summary of health, development and wellbeing outcomes .....19

a) Local Context .....19

b) Key inequalities and areas for attention .....22

Key findings from Section 1 .....22

Glossary and abbreviations .....23

Appendices..... ...24

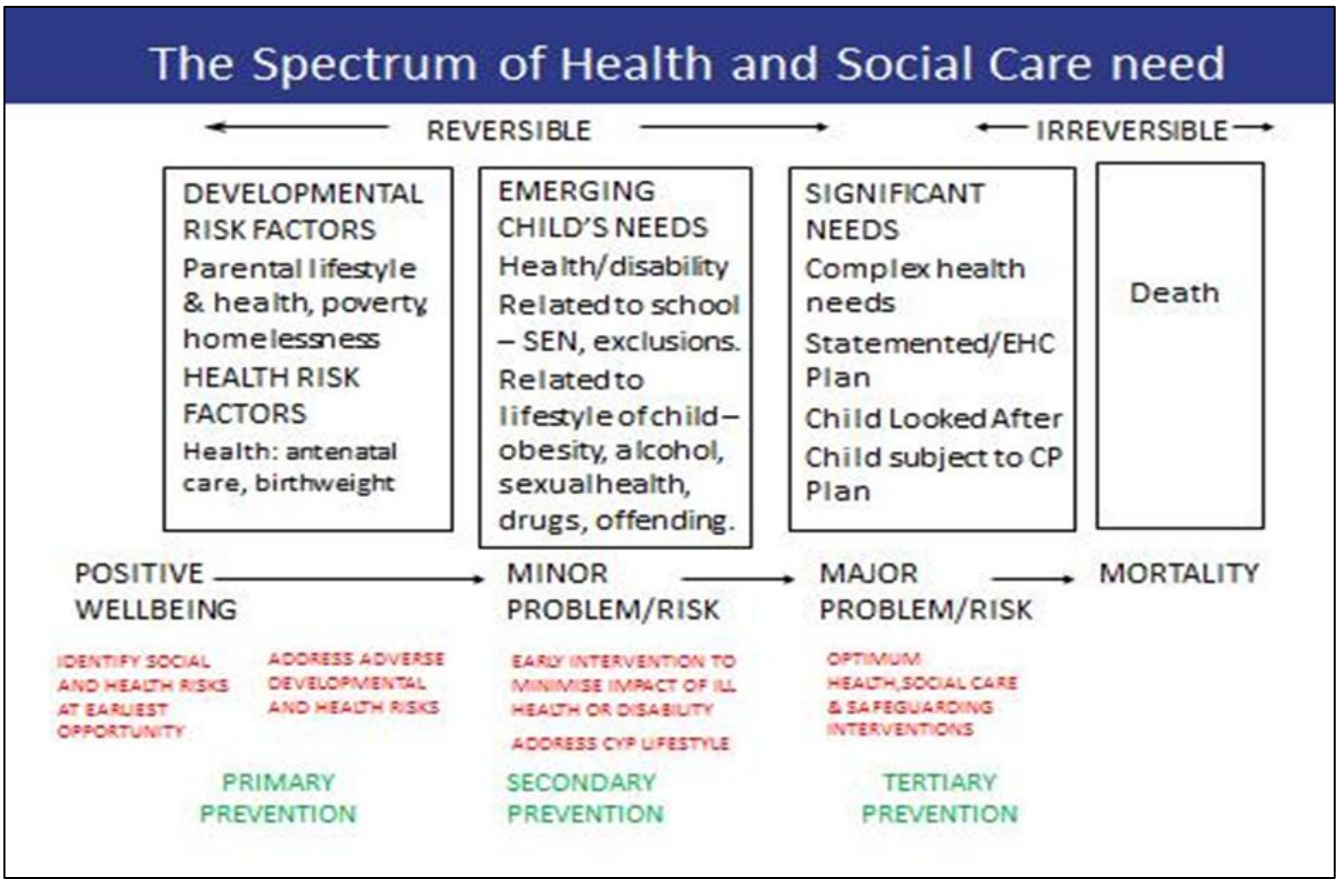
References ..... ....28

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# Introduction

This is the fourth update of the Children's Joint Strategic Needs Assessment for Bromley. The conceptual framework underlying the structure of the report is below in Figure 1.0. The reports include a demographic summary in Section 1, developmental risk factors in Section 2, emerging needs of the child in Section 3, and significant child needs and child death in Section 4.

**Figure 1.0 Conceptual framework for the Children's JSNA**




The significance of this framework is the opportunity for prevention. This may be primary prevention to stop problems arising in the first place (good examples are vaccination campaigns or parenting programmes). If a health or social need has been identified at an early stage, then secondary prevention can minimise the impact of that need on the development of the child. Tertiary prevention aims to manage significant and established needs in the best way to optimise the development and outcomes for that child.

This JSNA only sets out identified needs. Service use information is only used where it helps to paint a picture of needs. This document is not a review of services and does not make recommendations. The information used to inform this JSNA is generally published data although some data comes direct from LBB services, GPs, local hospitals and Bromley Police. This JSNA also benefits from a survey of year 10 pupils in Bromley in early 2026. The survey provides

substantial local evidence; however, results reflect participating schools and pupils present on the day. Statistical significance is reported only for specified comparisons.

**Acknowledgements**

This JSNA would not have been possible without the help of many people who provided me with local data and intelligence. Thanks go to:

Deborah Back, Family Nurse Partnership Supervisor, Bromley Healthcare

Dr Ibidun Fakoya, Senior Research Fellow, Department of Women & Children's Health, King's College London

Kokui Binns, Intelligence and Operations Lead, EIFS, LBB

Rachel Dunley, Head of Service, Early Intervention and Family Support, LBB

Dr Mark Essop, GP, One Bromley

Betty McDonald, Head of Service, Bromley Youth Justice Service, LBB

Sophia Obee, Senior Education Welfare Officer, LBB

Finola O'Driscoll, Senior Strategist, Public Health, LBB

Jamie O'Malley, Domestic Abuse Strategic Lead Officer, LBB

Nilesh Parmar, Performance Officer, Strategy and Performance team, ECHS, LBB

Tom Price, Operational Reporting Manager, King's College Hospital

Kate Greenlees, Digital Midwife, King's College Hospital

Dr David Regis, Research Manager, School Health Education Unit

Joanna Ryan, Senior IT Clinical Trainer, One Bromley

Edwin Sear, Bromley Police

Rob Vale, Head of Service, Community Safety, Environmental and Domestic Regulation, LBB

Mohammed Abdillahi, Performance and Information Officer, ECHS, LBB

# 1. The Population of Bromley: Demography

## a) Current Picture & Projections

According to the Office for National Statistics (ONS), the total mid-2025 population estimate for Bromley is 336,048, of which approximately 23% (76,036) are children aged 0-18 years[1]. Children and young people population projections provided by the Greater London Authority (GLA) are shown in Table 1 below. The age groups roughly correspond to pre-school, primary school and secondary school age groups. The child population is projected to decline to 61,987 in 2036, driven mainly by a 15.2% fall among 11-18-year-olds.

### Table 1: Children's Population Projections 2026 to 2036

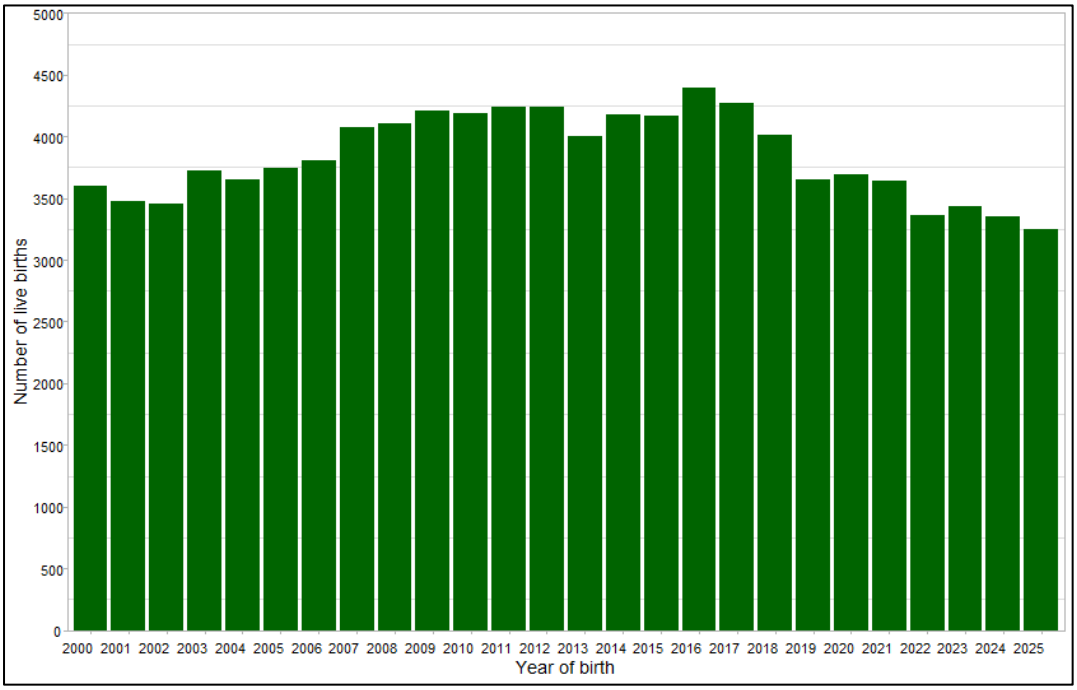
| Age | 2026 | 2031 | 2036 |
|---|---|---|---|
| 0-4 | 17,142 | 16,133 | 15,449 |
| 5-10 | 22,943 | 20,287 | 18,921 |
| 11-18 | 32,554 | 31,179 | 27,617 |
| Total | 72,639 | 67,599 | 61,987 |

**Source: GLA 2024-based housing-led population projections, 2026**

Some health and education services are provided to children who live outside the borough but attend health or education settings within the borough. Data on populations attending school in Bromley are also included in this description of the demography of children in Bromley.

The number of live births in Bromley increased overall from 3,599 occurrences in 2000 to a peak of 4,393 occurrences in 2016. Birth numbers remained above 4,000 occurrences between 2007 and 2018, with particularly high levels recorded in 2009 to 2017. However, since 2016 there has been a marked decline, falling to 3,250 births in 2025, indicating a sustained reduction in the number of live births in Bromley over recent years.

## Figure 1.1 Number of live birth occurrences in Bromley

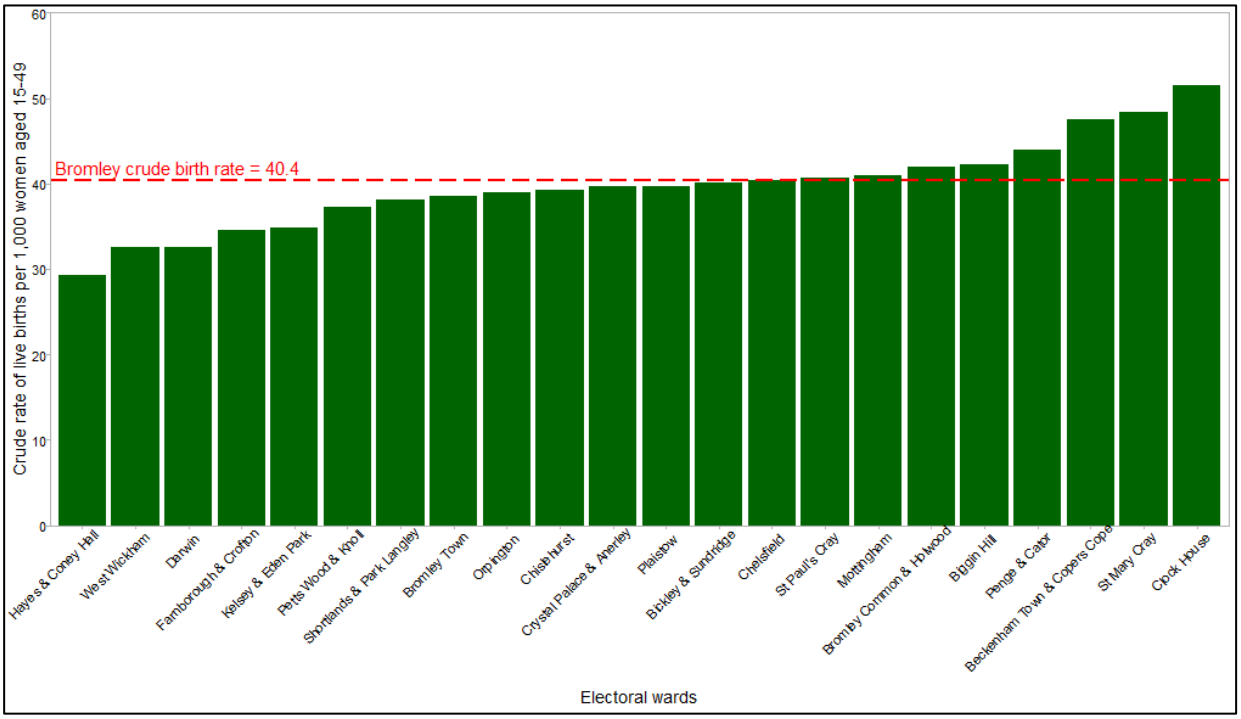



**Source: Civil Registration Births Data, 2026**

*Note that these figures are provisional at the time of publication and more births may get registered at later points in time.*

Birth rates vary between wards and are unevenly distributed. The highest rate is in Clock House with 51.6 births per 1,000 women of child-bearing age, well above Bromley's rate of 40.4 births per 1000 women of child-bearing age, and the lowest in Hayes and Coney Hall, with 29.3 births per 1,000 women of child-bearing age.

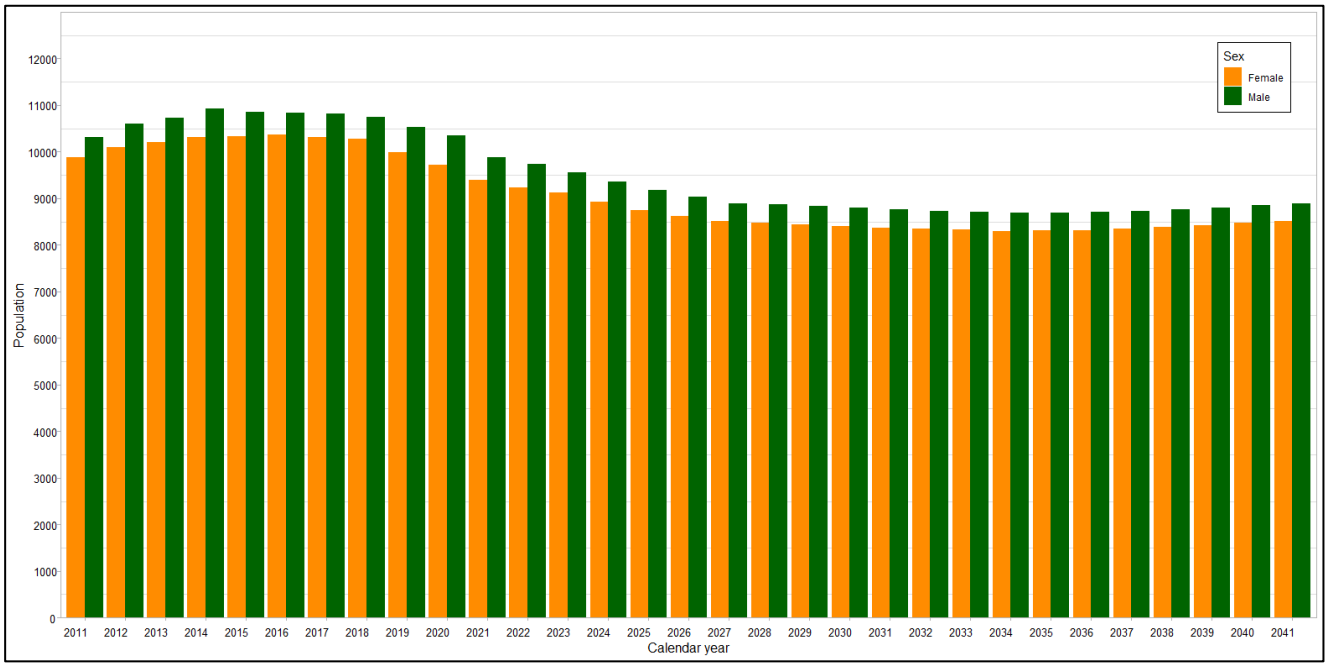
## Figure 1.2 Birth rate by ward, Bromley, 2024




**Source: Civil Registration Births Data and NOMIS 2024**

The population projections for children aged 0-4 years in Bromley are projected to decline steadily until the mid-2030s, before stabilising at a lower level through 2041, with females remaining slightly higher than males across all years.

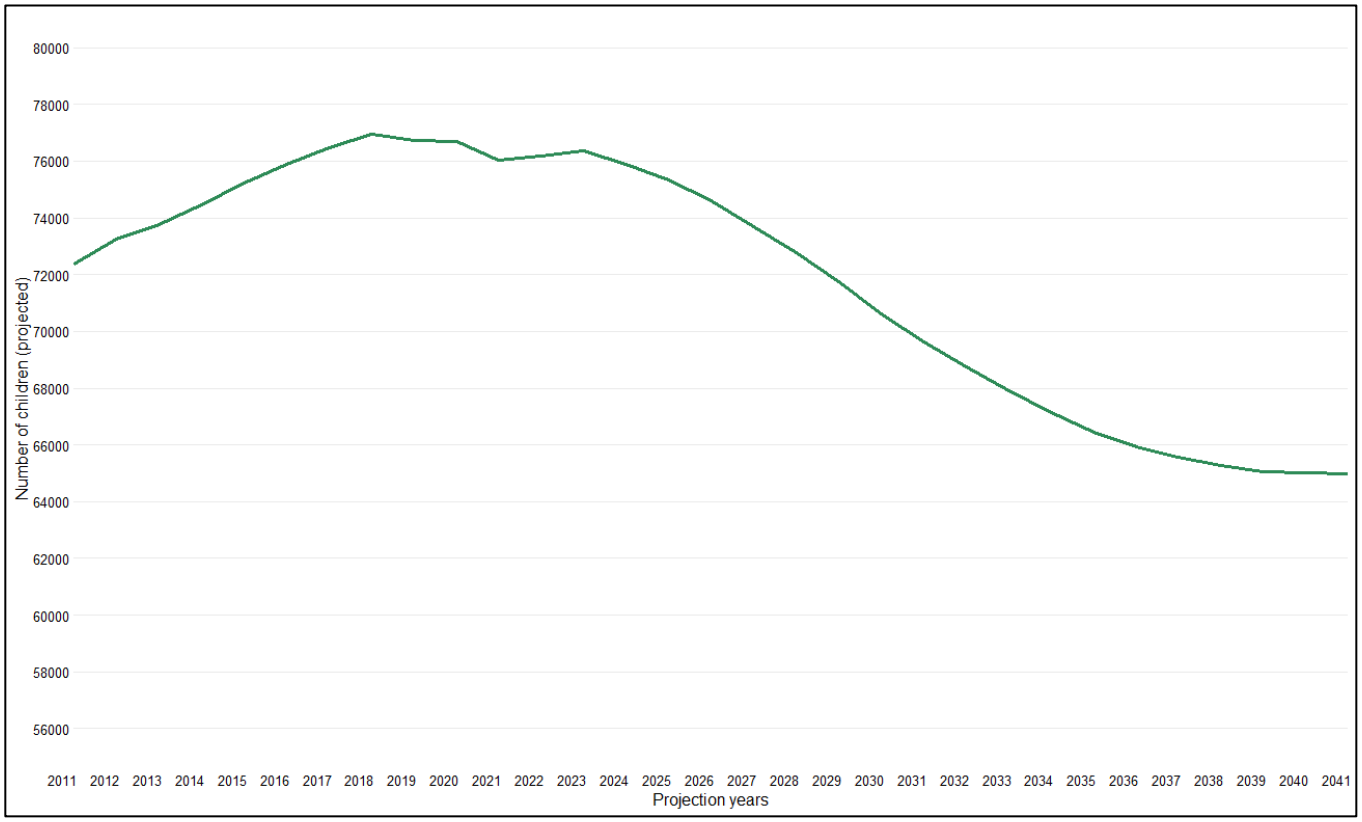
## Figure 1.3 Population Projections Bromley Children aged 0 to 4 years




**Source: GLA Demography 2022-based Population Projections, November 2025**

Figure 1.4 shows the projected change in the population of 0-18-year-olds between 2011 to 2041. This shows that the population has decreased slightly since 2011 and is projected to fall further over the next 16 years from 75,321 in 2025 to 64,977 in 2041, a decrease of 13.7%.

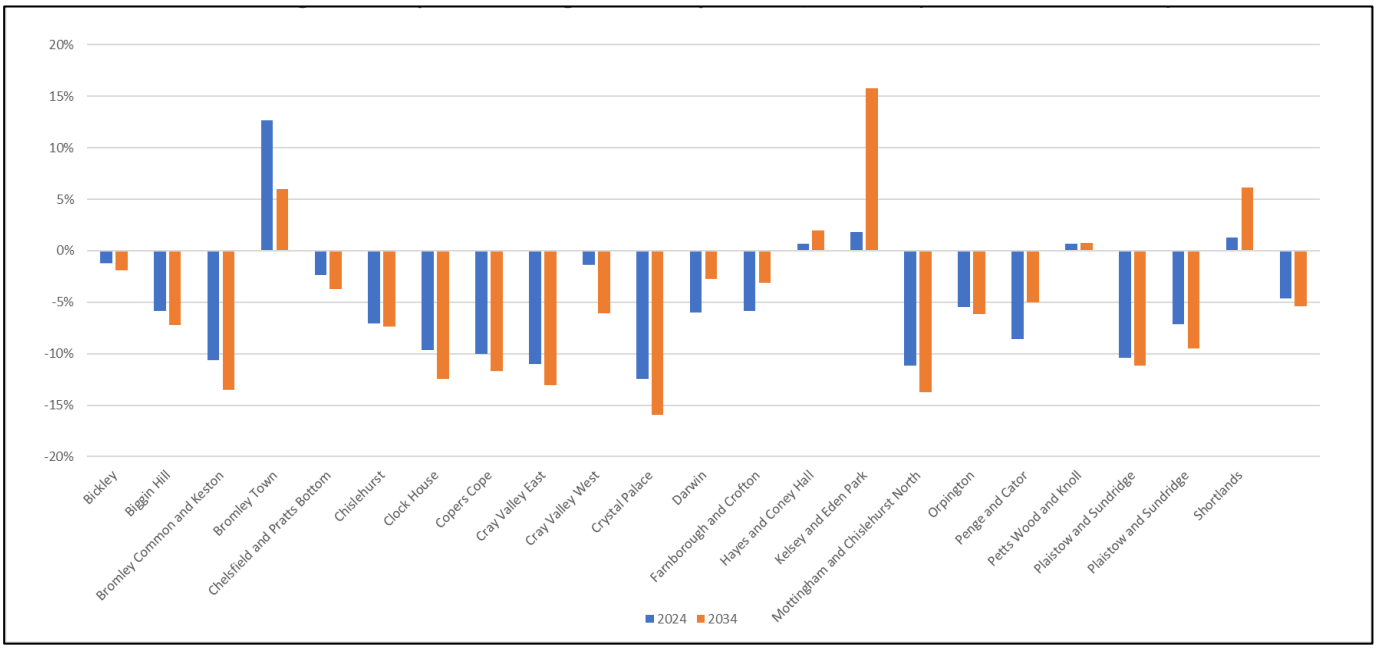
**Figure 1.4: Population projections to 2041 for children in Bromley aged 0-18**




**Source: GLA Demography 2022-based Population Projections, November 2025**

A few wards are expected to see a rise in the proportion of young children aged 0-4 years, but most will see a reduction in the number of young children.

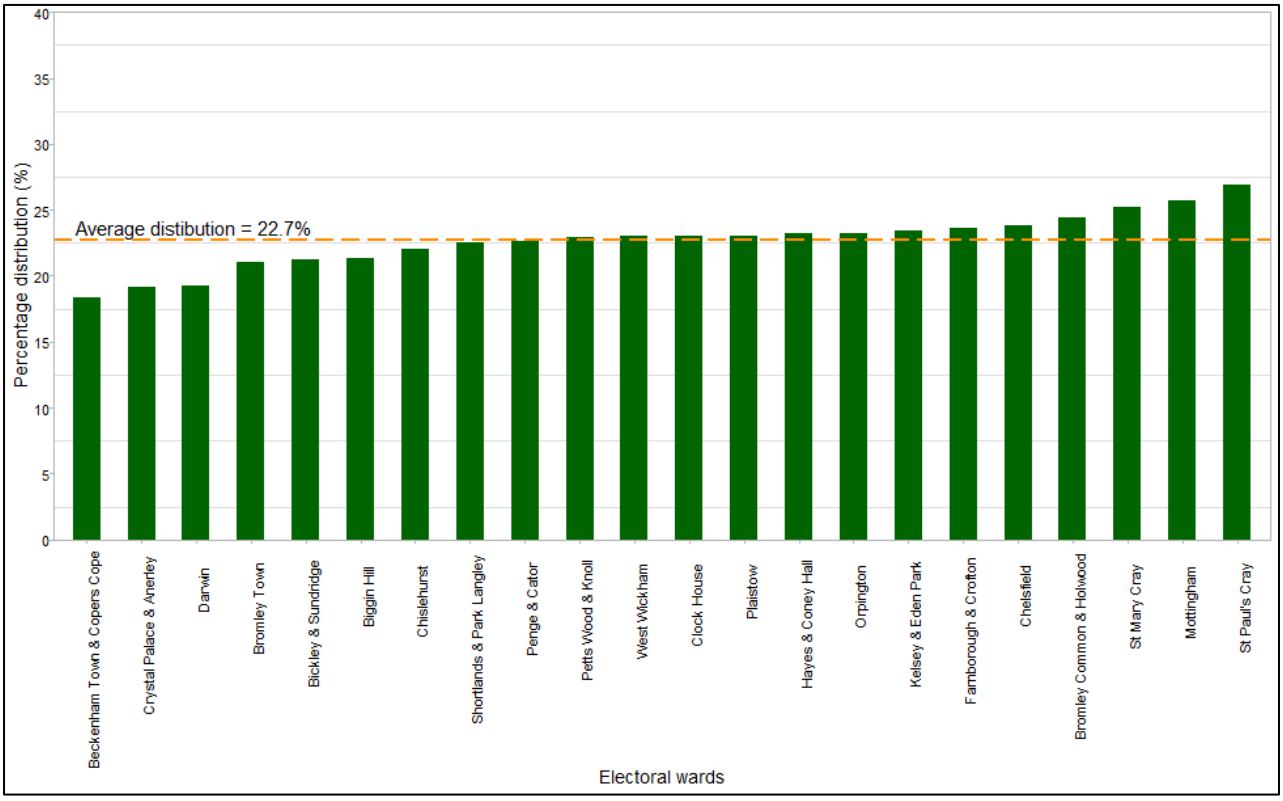
**Figure 1.5 Percentage Ward Population change in Bromley: Persons, 0-4 Years, (2024 to 2029 and 2034)**




**Source: GLA 2021 based ward-level population projections, 2024**

Figure 1.6 illustrates the uneven distribution of children and young people aged 0-19 across Bromley's wards in 2026, with proportions ranging above and below the borough average of 22.7%. St Paul's Cray has the highest concentration of children and young people, while Beckenham Town & Copers Cope has the lowest, highlighting notable spatial variation in the child population. These differences suggest that some wards have younger, more family-oriented populations and are likely to experience greater demand for services such as early years provision, school places, and youth support, whereas wards with fewer children may have older demographic profiles and face different service pressures.

**Figure 1.6 Percentage Distribution of 0-19 Year Olds by Ward in Bromley, 2026**

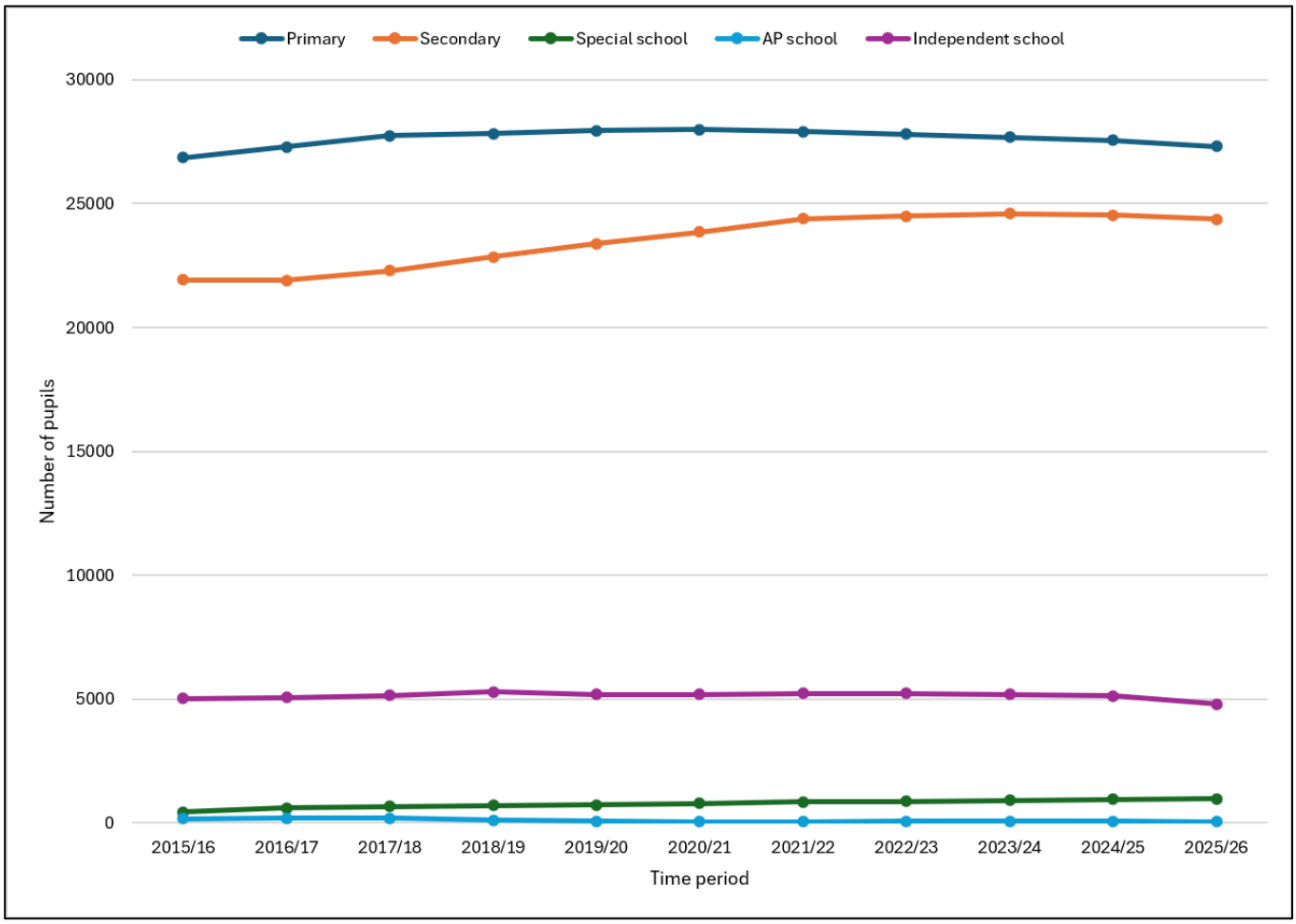



**Source: GLA 2021-based Identified Capacity 10-year migration. Borough and ward projection, 2026**

Between 2015/16 and 2025/26, the number of state-funded school pupils in Bromley rose overall from 54,398 to a peak of 58,449 in 2022/23, before falling to 57,500 in 2025/26 (Figure 1.7). The pattern differs by school type: primary rolls peaked earlier, at 27,999 in 2020/21, and have since declined to 27,314, consistent with falling births and a smaller younger child population.

Secondary rolls increased more strongly over the period, from 21,923 in 2015/16 to a peak of 24,599 in 2023/24, before beginning to fall slightly to 24,379 by 2025/26. Special school rolls increased substantially, more than doubling from 431 to 959, consistent with increased recorded use of specialist provision, while alternative provision numbers fluctuated and remained comparatively small. Overall, the figure suggests that Bromley is moving from a period of rising school rolls to one of gradual decline, but with continuing pressure in secondary and specialist provision.

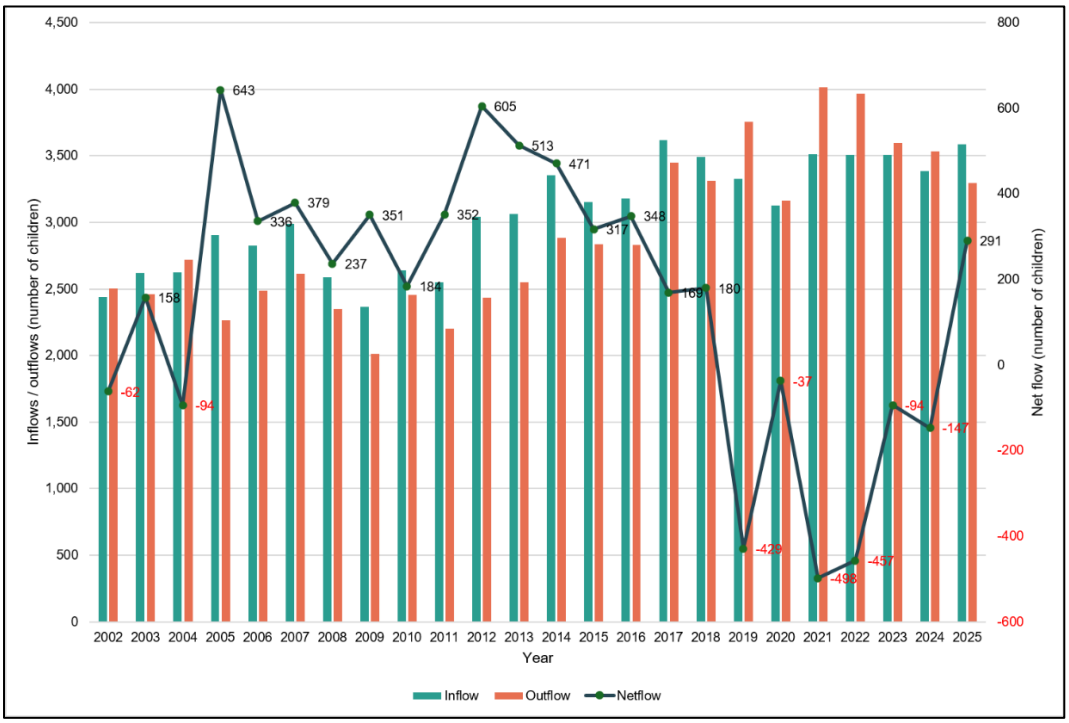
**Figure 1.7: Number of state-funded school pupils in Bromley by school type, 2015 to 2026**




**Source: Department for Education, 2026[2]**

Figure 1.8 estimates annual internal migration among children aged 0-15. Inflow is the number moving into Bromley from elsewhere in the UK, outflow is the number leaving Bromley, and net flow is inflow minus outflow. A positive net flow means Bromley gained children through migration; a negative value means it lost children. Between 2002 and 2018, Bromley generally recorded net gains, but experienced net losses from 2019 to 2024. In 2025, 3,585 children moved in and 3,294 moved out, giving a net gain of 291.

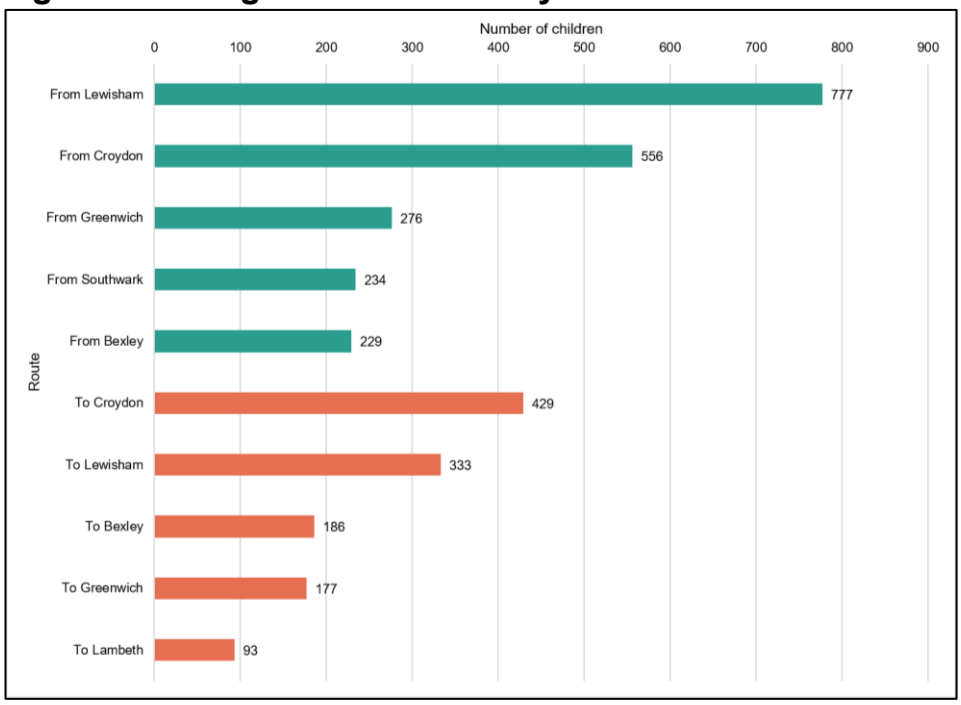
**Figure 1.8: Annual internal migration among children aged 0-15 years, Bromley, 2002 - 2025**




**Source: GLA, Internal migration flows - school-age children, 2026**

Figure 1.9 shows where children moved from or to in 2025. Lewisham was the largest source of inflows (777), followed by Croydon (556), while Croydon was the largest destination for outflows (429), followed by Lewisham (333). Greenwich, Bexley and Southwark were also important connections, indicating that children's migration largely reflects movement within Bromley's neighbouring London area.

## Figure 1.9: Largest local authority routes to and from Bromley, 2025

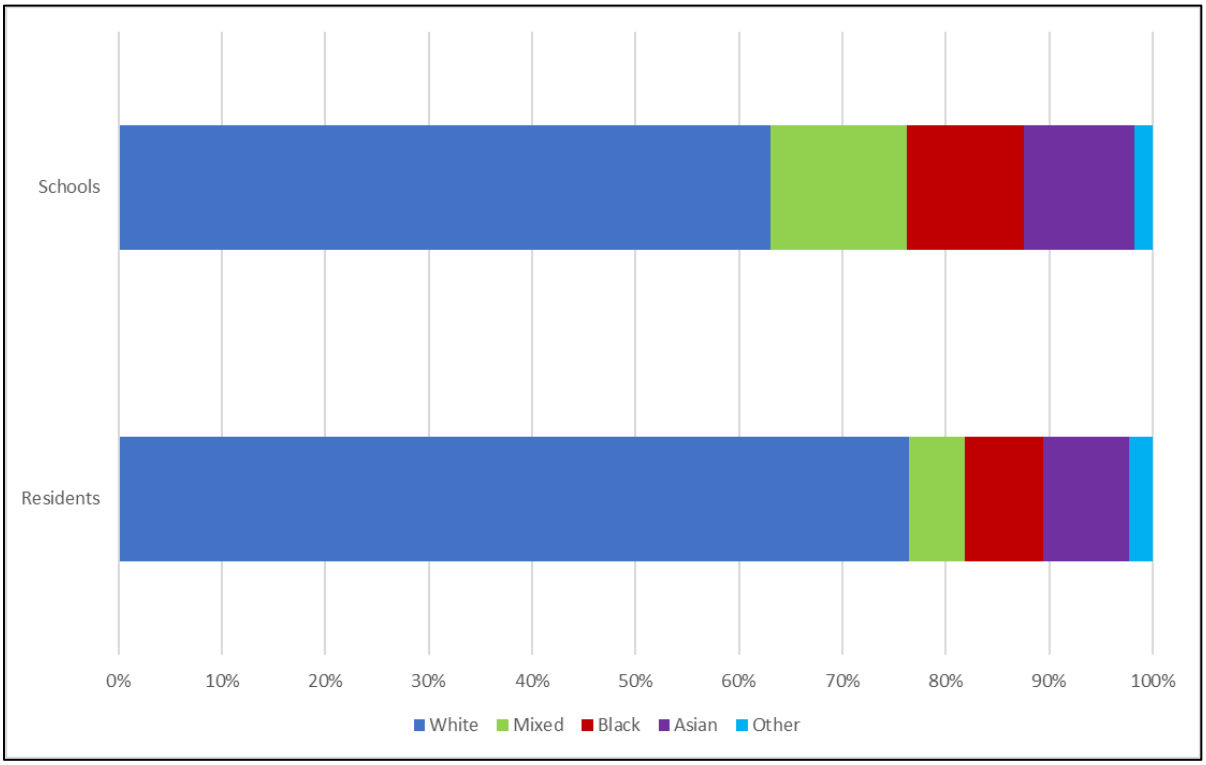



**Source: GLA, Internal migration flows - school-age children, 2026**

## b) Ethnicity of pupils in Bromley schools

In Bromley schools, 62% of pupils are white, 13% are mixed ethnicity, 11% are black and 11% are Asian.

## Figure 1.10: Ethnicity of Bromley residents and pupils in Bromley schools (2023/24)



**Source: ECHS data and Census 2021**

This data is different to the ethnicity of the resident population which has a higher proportion of white children (77%) and lower proportion of mixed ethnicity (8%).

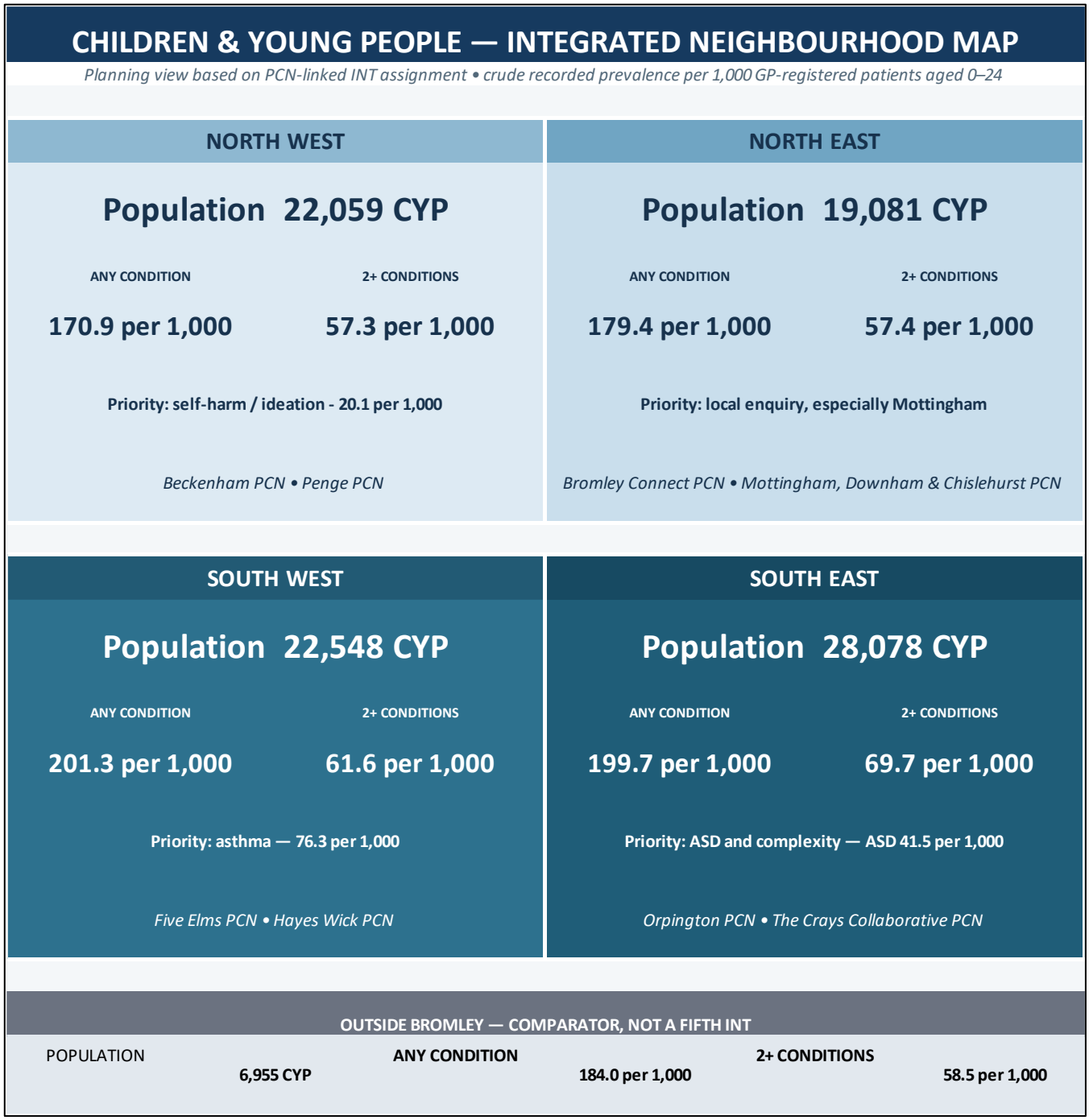
The latest available GLA ethnic group population projections indicate that the Black African population is expected to experience the greatest proportional increase among ethnic minority groups in Bromley, with the population projected to increase by 16.6% between 2021 and 2026 and by 29.5% between 2021 and 2031. These projections are based on the GLA's 2016-based ethnic group projections, which remain the most recent ethnicity-specific projections available[3].

## 2. Integrated Neighbourhood Team profile for Children and Young People (CYP)

The analysis includes **98,721 GP-registered patients aged 0-24** assigned to an Integrated Neighbourhood Team (INT), which were grouped by Primary Care Network (PCN)-linked INT.

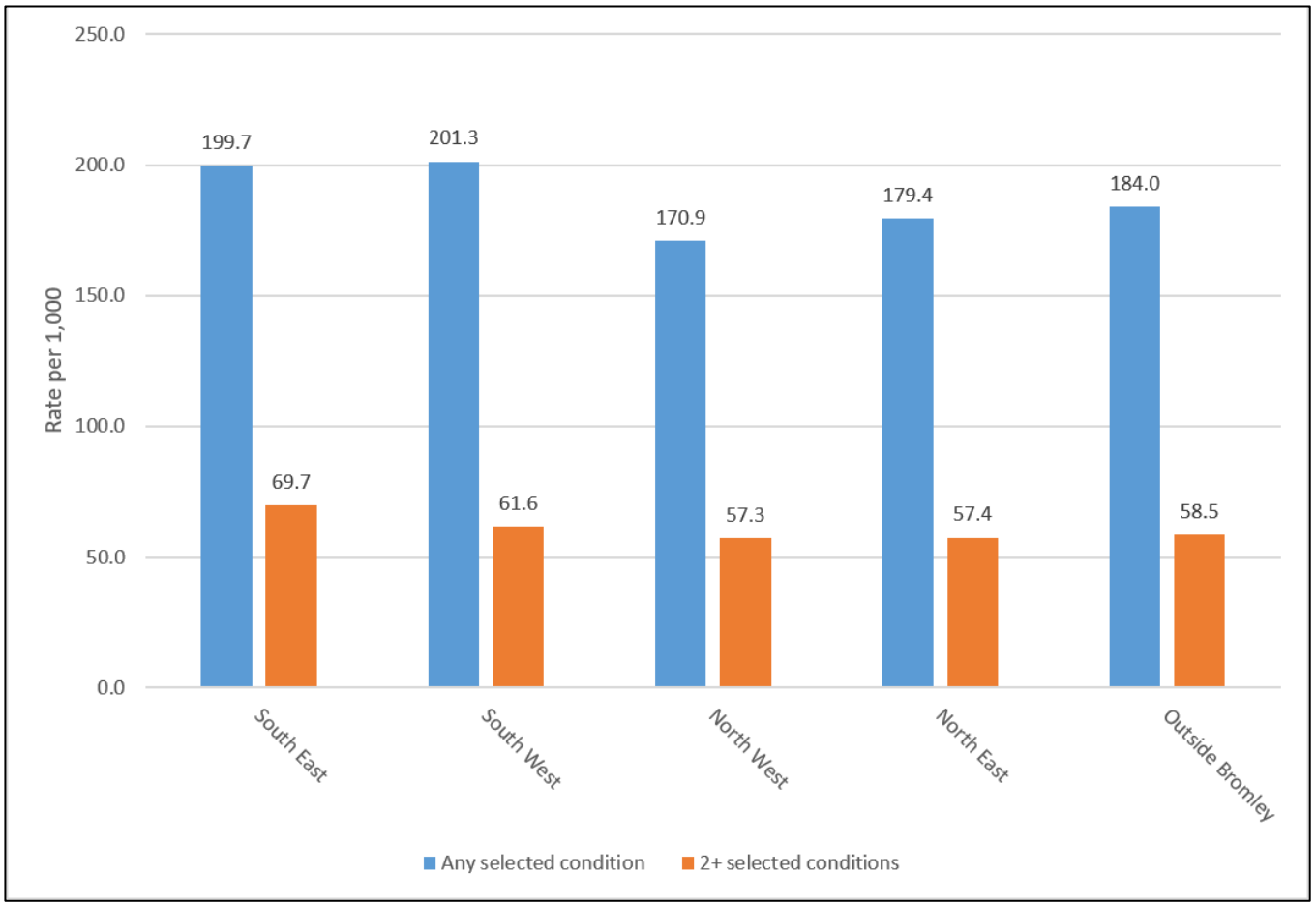
Southeast of Bromley has the largest cohort (28,078; 28.4%), followed by Southwest (22,548), Northwest (22,059) and Northeast (19,081). A further 6,955 patients registered outside Bromley are shown separately as a comparator.

**Figure 1.11: Population and recorded condition burden by Integrated Neighbourhood Team, per 1,000 GP-registered patients aged 0-24, in Bromley**




**Source: Bromley GP data, 2026**

**Figure 1.12: Recorded prevalence of any selected condition and multiple conditions by Integrated Neighbourhood Team, in Bromley**




**Source: Bromley GP data, 2026**

Recorded condition burden varies across the neighbourhood teams (Figure 1.12). Southwest has the highest prevalence of any selected condition at 201.3 per 1,000, closely followed by Southeast at 199.7. Southeast has the highest recorded multi-condition burden at 69.7 per 1,000, compared with 61.6 in Southwest, 57.4 in Northeast and 57.3 in Northwest. Recorded prevalence varies geographically. These crude rates may reflect underlying need, clinical coding and service access and should support local enquiry rather than performance ranking.

# 3. Summary of health, development and wellbeing outcomes

This section provides an overview of the health, development and wellbeing outcomes for children and young people across the life course, together with selected family and environmental determinants. Bromley performs better than England on many measures, including early development, healthy weight, physical activity, school attendance, child poverty and several hospital admission indicators. However, important inequalities and areas for further attention have been identified, particularly poorer school-readiness outcomes among children eligible for free school meals, social, emotional and mental health needs, the persistence of excess weight from Reception to Year 6, low birth weight and road casualties. The thematic chapters examine these issues in greater detail.

## a) Local context

Overall, Bromley compares favourably with England on several measures. In the early years, 89% of infants receive a 6-8-week review, 83% of children achieve a good level of development at age 2-2½, and 73% achieve a good level of development at age 5. Each of these proportions is above the corresponding England figure (Figure 1.13).

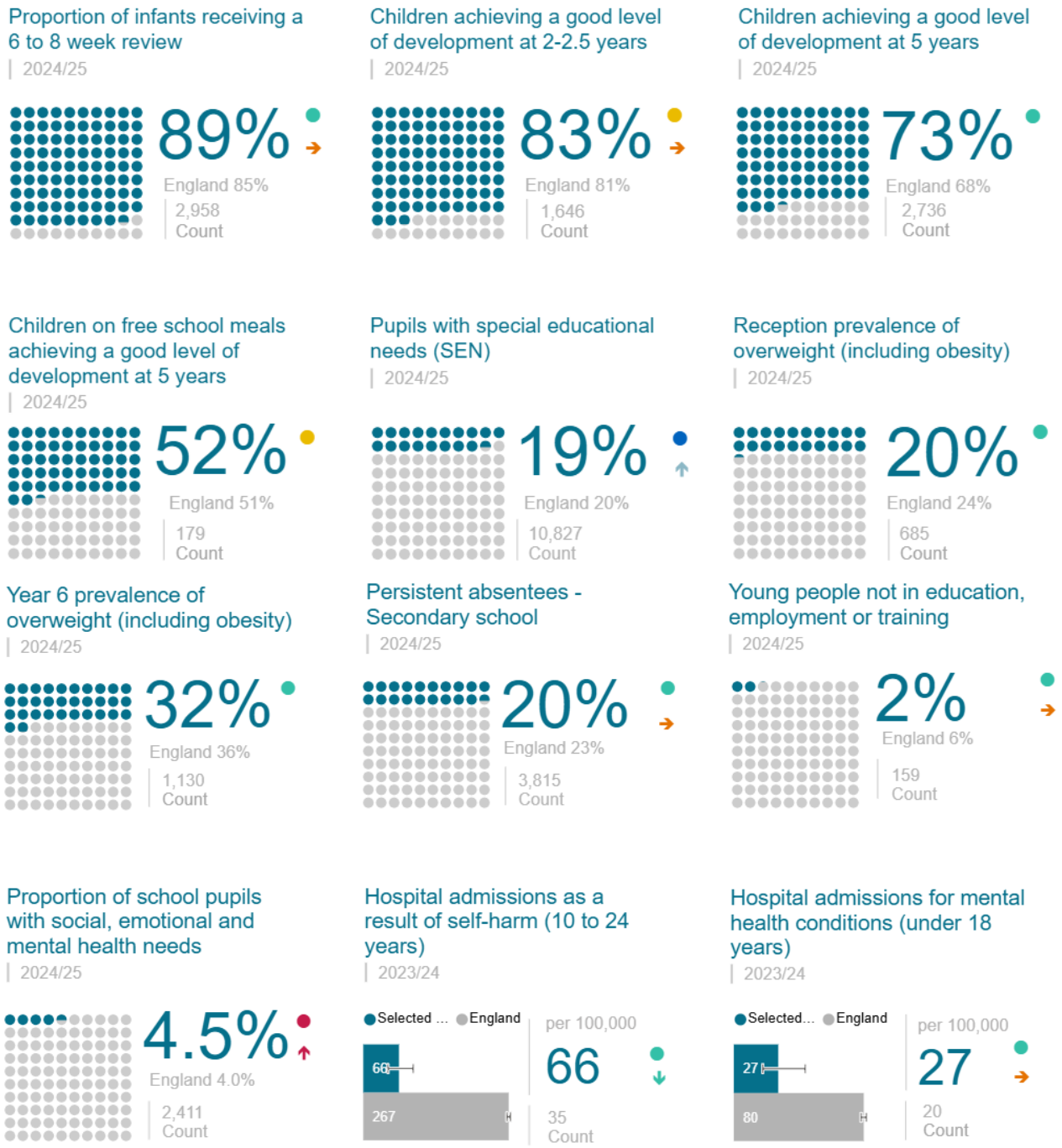
Educational participation indicators are also comparatively favourable. Persistent absence in secondary schools is 20%, below the England figure of 23%, while 2% of young people are not in education, employment or training, compared with 6% nationally. Nineteen per cent of pupils have special educational needs, close to the England figure of 20%.

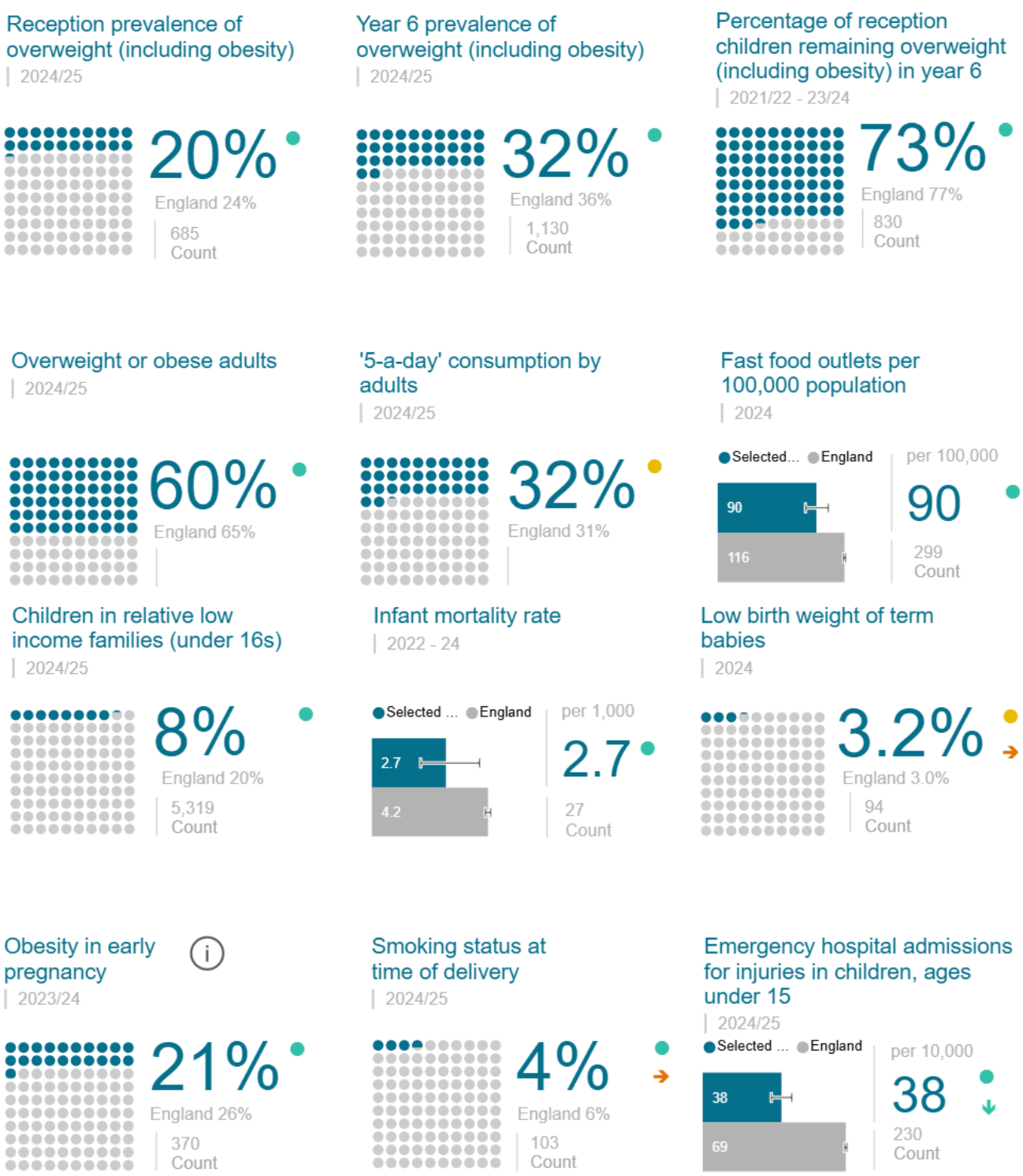
Healthy weight and physical activity outcomes are generally better than the national average. Twenty per cent of Reception children and 32% of Year 6 children are overweight, including obesity, compared with 24% and 36% respectively in England. Fifty-two per cent of children and young people are physically active, above the England figure of 49%.

The wider environment is mixed: fast-food outlet density is lower than nationally, while the proportion of adults reporting five portions of fruit and vegetables a day is broadly similar to England. Local survey evidence from Healthwatch Bromley found that 49% of children surveyed in Bromley reported consuming at least five portions of fruit and vegetables per day. However, this should be interpreted cautiously as it is not a current population-level estimate[4]. More recent nationally representative data from the National Diet and Nutrition Survey (2019-2023), a UK benchmark for 11-18-year-olds, indicate substantially lower consumption among older children, with only 9% of 11-18-year-olds meeting the 5-a-day recommendation and an average intake of 2.8 portions per day[5].

Several measures of health service use and safety are also favourable. Hospital admission rates for self-harm among people aged 10-24, mental health conditions among those aged under 18, and injuries among children aged under 15 are lower than the England comparators. Maternal and infant indicators show lower infant mortality, lower obesity in early pregnancy and lower smoking at delivery than England. Low birth weight among term babies, at 3.2%, is slightly above the national figure of 3.0%.

## Figure 1.13 Headline indicators for children, young people and families






**Source: Health of the Region Explorer Power BI Tool, OHID, May 2026**

*Note: Values are shown against England benchmarks; reporting periods vary by indicator.*

## b) Key inequalities and areas for attention

The favourable overall picture masks differences between groups and several continuing challenges. At age 5, 52% of children eligible for free school meals achieve a good level of development, compared with 73% of children overall, indicating a substantial socioeconomic gap in school readiness. Although excess weight prevalence is below the national average, 73% of children who are overweight in Reception remain overweight in Year 6, suggesting that early excess weight often persists.

In addition, 4.5% of school pupils are identified as having social, emotional and mental health needs, above the England figure of 4.0%. Low birth weight among term babies is also slightly higher than nationally, at 3.2% compared with 3.0%, and the rate of people killed or seriously injured on roads is above the England comparator.

**Key findings from Section 1**

Bromley's child population is projected to decline substantially, with those aged 0-18 falling from 72,639 in 2026 to 67,599 in 2031 and 61,987 by 2036.

- State-funded school rolls peaked in 2022/23 and have begun to fall. Primary rolls are already declining, secondary rolls are starting to level off, and special school rolls have more than doubled since 2015/16, indicating continuing pressure on specialist provision.
- After net losses of children aged 0-15 between 2019 and 2024, Bromley recorded a small net migration gain in 2025. Most movement was with neighbouring boroughs, particularly Lewisham, Croydon, Greenwich and Bexley.
- Pupils attending Bromley schools are more ethnically diverse than the resident child population, and the Black African population is projected to experience the largest proportional growth.
- Among GP-registered patients aged 0-24, the Southeast Integrated Neighbourhood Team has the largest cohort and the highest recorded multi-condition burden, while Southwest has the highest prevalence of any selected condition. These crude rates may reflect need, coding and access and should support local enquiry rather than performance ranking.
- Bromley performs better than England on many early development, healthy weight, physical activity, school attendance, child poverty, hospital admission, maternal and infant health indicators.
- Important inequalities and areas for attention remain: school readiness is substantially lower among children eligible for free school meals; excess weight often persists from Reception to Year 6; social, emotional and mental health needs are above the England figure; and low birth weight and serious road casualties are also comparatively high.

# 4. Glossary and abbreviations

| | |
|---|---|
| CYP | Children and Young People |
| DfE | Department for Education |
| ECHS | Education, Care and Health Services |
| FSM | Free-School-Meals |
| GLA | Greater London Authority |
| GP | General Practitioner |
| INT | Integrated Neighbourhood Team |
| JSNA | Joint Strategic Needs Assessment |
| LBB | London Borough of Bromley |
| NOMIS | ONS-supported service for official labour-market and Census statistics |
| OHID | Office of Health Improvement and Disparities |
| ONS | Office for National Statistics |
| PCN | Primary Care Network |
| SEMH | Social, Emotional and Mental Health Needs |
| SHEU | Schools Health Education Unit |

# 5. Appendices

## Appendix 1: Methodology

### a) Purpose and scope

This section describes the methods used to compile and interpret the demographic, primary care, education, health and wellbeing evidence presented in Section 1 of the Bromley Children and Young People's Joint Strategic Needs Assessment 2026. The assessment describes identified population need and inequalities. It is not an evaluation of services and does not make recommendations about individual providers.

The analysis covers several related but distinct populations: children and young people usually resident in Bromley; pupils attending Bromley schools, some of whom may live outside the borough; people registered with participating general practices, including some patients' resident outside Bromley; and participants in local surveys. Results from these populations are not treated as directly interchangeable.

### b) Data sources

Evidence was drawn from accredited official statistics, national administrative datasets, Greater London Authority demographic datasets, local administrative records and local survey evidence. The principal sources were:

- Office for National Statistics mid-year population estimates, births data and Census 2021;
- Greater London Authority housing-led population projections and internal migration estimates;
- Department for Education school census statistics and local Education, Care and Health Services data;
- Office for Health Improvement and Disparities public health profiles and the Health of the Region Explorer;
- National Diet and Nutrition Survey data;
- NOMIS Census and population datasets;
- Bromley civil registration births data;
- Bromley general practice data grouped by Primary Care Network-linked Integrated Neighbourhood Team;
- the 2026 School Health Education Unit survey of Year 10 pupils in participating Bromley schools; and
- other local intelligence supplied by London Borough of Bromley services and partner organisations.

The most recent source available when the analysis was undertaken was used wherever practicable. Each figure or table identifies its principal source. Reporting periods differ between indicators because national and local datasets are updated on different schedules.

### c) Population estimates and projections

The resident population was described using Office for National Statistics mid-year population estimates. These are annual estimates of usual residents and are subject to statistical uncertainty, particularly for smaller areas and detailed age groups.

Future population change was assessed using the Greater London Authority 2024-based housing-led population projections. The central variant was used unless otherwise stated. These

projections incorporate assumptions about fertility, mortality, migration and expected housing supply. The corrected files published by the Greater London Authority on 28 August 2026 were used. Projections are scenarios rather than forecasts and should not be interpreted as precise predictions.

Borough-level estimates were preferred for strategic totals. Ward-level results were interpreted more cautiously because small-area projections are more sensitive to modelling assumptions, boundary definitions and the choice of geography. Where ward and Middle-layer Super Output Area outputs differ, this may reflect the modifiable areal unit problem rather than an error.
Age groups vary according to the purpose and structure of each source. The report therefore identifies whether an estimate relates to ages 0-4, 5-10, 11-18, 0-18, 0-19, 0-15 or 0-24. The term “Children and young people” is not assumed to have one uniform age definition across all datasets.

### d) Births and fertility analysis

Birth trends were assessed using civil registration and Office for National Statistics data. Birth occurrences relate to births taking place in a specified area, while birth registrations relate to births registered to mothers usually resident in an area. These measures are not interchangeable.
The ward birth rate was calculated as the number of live births divided by the estimated number of women of childbearing age in the relevant ward, multiplied by 1,000. The reference year, age range used to define women of childbearing age and source of the denominator should be retained with the published figure. Provisional figures may be revised when late registrations are received.

### e) Internal migration analysis

Internal migration estimates relate to moves within the United Kingdom involving children aged 0-15. Inflow is the estimated number of children moving into Bromley from another UK local authority, outflow is the estimated number leaving Bromley for another UK local authority, and net flow is inflow minus outflow.
The year labelled 2025 refers to the year ending mid-2025. The estimates do not include international migration and should not be interpreted as total population change. Small differences between releases may arise from revisions to the underlying Office for National Statistics estimates.

### f) Integrated Neighbourhood Team analysis

The primary care analysis included 98,721 GP-registered patients aged 0-24 who could be assigned to a Primary Care Network-linked Integrated Neighbourhood Team. Patients registered outside Bromley were retained as a separate comparator where shown.
Recorded conditions were identified using the clinical-code lists agreed for the extract. “Any selected condition” means at least one recorded condition from the specified list, while “multiple conditions” means more than one selected condition recorded for the same patient. Detailed code lists, extraction date and data-processing specification should be retained in the supporting analytical file.

Crude prevalence was calculated as:

Recorded patients meeting the definition ÷ all included registered patients in the relevant group × 1,000.

The analysis is descriptive and the rates have not been adjusted for differences in age, sex, deprivation or ethnicity unless explicitly stated. Recorded prevalence may be affected by true population need, registration patterns, access to diagnosis, consultation behaviour, data completeness and variation in clinical coding. The findings should support local enquiry and service planning and should not be used to rank Integrated Neighbourhood Teams or general practices.

## g) Public health indicators

Headline indicators were selected to provide a concise life-course overview of child development, education, healthy weight, physical activity, maternal and infant health, hospital activity, safety and wider determinants. Most indicators were obtained from the Office for Health Improvement and Disparities Child and Maternal Health profile or the Health of the Region Explorer.

Each indicator retains the definition, numerator, denominator, age range and reporting period used by the source. Values from different periods were presented together for overview purposes but were not interpreted as if they related to one common year. England values were used as contextual comparators and do not by themselves determine whether a local difference is statistically significant.

## h) Quality assurance

Where a source was revised during production, the latest corrected version available at the publication cut-off was used. Any figures updated after the cut-off should be considered for the next JSNA refresh.

## i) Interpretation and limitations

Findings from different sources should be triangulated rather than interpreted in isolation. Resident, school-attending, GP-registered and survey populations overlap but are not identical. Differences between them may reflect population movement, service boundaries, registration patterns, data quality and coverage as well as genuine need.

Administrative data are collected primarily for operational rather than research purposes and may contain missing, delayed or inconsistently coded information. Recorded activity is not the same as prevalence or unmet need. Higher recorded prevalence may indicate greater underlying need, better identification, improved access or more complete coding.

Small-area results are more susceptible to random variation and disclosure constraints. Counts based on small numbers should be suppressed or grouped in accordance with the relevant information-governance rules. No identifiable patient- or pupil-level information is presented in this report.

Associations described in the report are not assumed to be causal. Conclusions about inequality, access or service pressure should be supported by the consistency of findings across multiple

sources and, where relevant, by further analysis using appropriate population denominators and adjustment for demographic differences.

## j) Data protection and information governance

Local patient-, pupil- and service-level datasets were processed for population-health intelligence purposes under the information-governance arrangements of the supplying organisations. Analysis was undertaken using the minimum information required, and published outputs are aggregated. Small counts and potentially disclosive combinations should be suppressed or otherwise protected in accordance with the applicable data-sharing agreement and organisational disclosure-control policy.

## 6. References

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