Bradford Teaching Hospitals NHS Foundation Trust – Health Inequalities Statement 2025/26

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) serves a population of around 667,000 people across Bradford and the surrounding area. Bradford is one of the most deprived areas in England, and the health of its residents reflects that. Healthy life expectancy varies by up to 23 years between the most and least deprived parts of the district. Almost half of our population lives in the most deprived 20% of postcodes. Reducing health inequalities is central to our purpose and how we work.

This statement sets out how BTHFT has collected, analysed and published information on health inequalities in 2025/26, in line with NHS England's Statement on Information on Health Inequalities (November 2025). It describes our understanding of the population we serve, the inequalities in access, experience and outcomes we have identified, and the actions we have taken in response. Population health data is drawn from the Bradford District Joint Strategic Needs Assessment (JSNA) (November 2025) and the Bradford District and Craven Health and Care Partnership strategy (September 2025).

Our Approach to Health Inequalities and Health Equity

Reducing health inequalities is one of the five strategic objectives set out in BTHFT's corporate strategy 'Our Patients, Our People, Our Place and Our Partners' (2022-2027) - *to collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals*.

Health inequalities are also identified as a Board Assurance Framework (BAF) strategic risk: if the Trust fails to address health inequalities, then this will contribute to a widening of the gap in health outcomes, access and experiences across Bradford District and Craven.

Progress is reported through quarterly reports to committees and the Board of Directors. The Board receives updates twice a year, presented by the Director of Strategy and Transformation who is the Executive Lead for Health Inequalities. The Equality and Diversity Council, chaired by the Chief Executive, provides strategic oversight of how equality, diversity and inclusion work connects with population health inequalities. Our approach is aligned with the Core20PLUS5 framework, the West Yorkshire Integrated Care Board's ten big ambitions for reducing population health inequalities, and the NHS 10 Year Health Plan.

The Trust's EDI Strategy 2023-2025 contains a dedicated chapter on health equity and health inequalities and sets out five objectives –

- Addressing health inequalities as a priority – focused on ensuring we embed health inequalities as an ethos into everything we do
- Data analysis and utilisation – to implement data driven approaches
- Fulfilling our role as an anchor organisation – utilising the anchor principles as part of our approach in addressing health inequalities and influencing the wider determinants
- Providing care based on our population profiles – to understand our population and cater our care to their needs
- Collaborating with other organisations – work with our partners to reduce health inequalities

A Board Development session in Autumn 2024 provided long-term focus for the work programme and continues to guide priorities:

- Undertake projects with scalability in mind - start small and expand
- Develop capability within the organisation to address health inequalities
- Reframe health inequalities with a focus on improving health equity
- Focus where we can have the greatest influence

The Health Equity and Health Inequalities programme was one of the 10 priority initiatives approved by the Board in March 2025 for the 2025/26 financial year and set out in the Trust's Strategic Framework. The priority initiatives are the high profile, organisation-wide programmes designed to deliver a step change in achievement of the strategic objectives. The aim of this programme is to improve equity of access, outcomes and experience for our services and take action to reduce health inequalities across the wider population. Each CSU and corporate department described their plans for improving health equity/addressing health inequalities during 2025/26 on strategy posters displayed across the Trust.

Core20PLUS5 Framework

BTHFT uses the Core20PLUS5 framework as the primary structure for its approach, adapted to Bradford's specific population context:

- Core20: the most deprived 20% of the national population by Index of Multiple Deprivation. In Bradford, this represents a disproportionately large share of residents: 46.9% of the Bradford and District population live in Core20 postcodes.

- PLUS groups identified locally: Asian/Pakistani communities (32.1% of Bradford District's population, the 2nd highest proportion of Pakistani-heritage residents in England); Gypsy, Roma and Traveller communities (1.8% identify as Roma per Census 2021); people with learning disabilities; and inclusion health groups including the homeless and asylum seekers.

Understanding our population

Bradford District, the core local authority area we serve, has a resident population of 563,605 (ONS mid-year 2024 estimate). This is distinct from the Bradford District and Craven Health and Care Partnership's wider footprint, which covers a GP-registered population of approximately 670,000, stretching from Bradford city centre through Keighley and the Aire Valley to Ilkley, Skipton and Craven. The table below describes the Bradford District population we primarily serve with the Health and Care Partnership's population figures being used where data relates to the wider partnership area.

Current population profile

Bradford District is the fifth largest metropolitan borough in England by population with a young and economically deprived population that is significantly different from the national profile. Table 1 demonstrates.

Table 1 Population Profile

Demographic/characteristic	Bradford figure	Comparison
Total population (Bradford District)	563,605	Mid-year 2024 estimates (ONS). 5th largest metropolitan borough after Birmingham, Leeds, Sheffield and Manchester.
Population density	1,538 per km²	Highest in West Yorkshire; significantly above regional (368) and England (450) averages.
Median age	36.9 years	Well below England average (40.2) and Yorkshire and Humber average (40.3). Bradford has a distinctly young population.
Under-15 population	20.8%	Higher than Yorkshire and Humber (17.2%) and England (17.2%). Joint 3rd lowest median age in the region.
Gender split	50.9% female / 49.1% male	Closely mirrors England (51%/49%).
Deprivation rank (IMD 2025)	12th most deprived (of 296 LAs)	Worsening: was 13th in 2019, 19th in 2015. 115 LSOAs (11 more than 2019) fall in the most deprived 10% nationally.
% in relative poverty (working age)	22%	157,000 people live in the 10% most deprived wards in England. In Bradford East and West, half of under-15s live in relative poverty.
Asian/Asian British/Welsh ethnicity	32.1%	Up from 26.8% in 2011. The largest proportional increase of any ethnic group. Bradford has the 2nd highest proportion of Pakistani-heritage residents in England.
White ethnicity	61.1%	Down from 67.4% in 2011. England average is 81%. Over 150 languages spoken across the district.
Muslim residents	30.5%	Up from 24.7% in 2011.
Gypsy/Roma/Traveller	1.8% Roma	Per 2021 Census. A significant locally identified PLUS group.
Long-term illness/disability (day-to-day limited a lot)	8.0%	Higher than England average (7.3%).
Private rented housing	23.1%	Up from 19.6% in 2011. 62% owner-occupied.
Employment rate (16-64)	69.7%	24.9% economically inactive. 4.8% of adults with learning disability in paid employment.
Life expectancy at birth (male)	76.6 years	Source: Bradford Council / ONS.
Life expectancy at birth (female)	81.1 years	Source: Bradford Council / ONS.

Source: Bradford District JSNA Demographics Slide Set, November 2025; ONS mid-year 2024 population estimates; Census 2021

Population projections

BTHFT's planning assumptions are extracted from the Bradford District and Craven Health and Care Partnership (HCP) strategy (September 2025), which uses ONS projections and predictive modelling to map potential population changes by 2040. The projections indicate a population that is stable in size but changing in age structure and health complexity in ways that will significantly affect demand for Trust services.

Overall population trajectory

Bradford District's population is projected to grow from 563,605 to approximately 570,100 by 2032 (3.1%) and 588,541 by 2049 (6.4%). The median age will rise from 36 to 39 years by 2032 as Bradford's currently young population ages. Growth is concentrated in older age groups, shifting in ways that will substantially increase demand for acute, community and palliative care services. Table 2 below demonstrates.

Table 2 – Overall population trajectory

Population group	Projected change by 2040	Implications for health inequalities
0-19 year olds	-16%	Falling CYP population. Prevention and early intervention must maximise health outcomes for this still large and disproportionately deprived population.
Working age adults (20-64)	+6%	Moderate growth; continued burden of MSK, diabetes, mental health and substance use disorders.
People aged 65+	+27%	Significant increase. This is the highest healthcare use group and will require expanded community and intermediate care capacity.
People aged 85+	+53%	The fastest-growing segment; frailty, dementia estimated to increase 38% and palliative care demand 29%
People with long-term conditions	+9%	If trends continue, the healthy population will fall 2.2% while LTCs rise.
Largest local population changes	Keighley +5.8%, Craven +7.6%, Shipley +5.1%	Rural and peri-urban growth will require new models of community care, especially in Craven (older, further ageing population).

Source: Bradford District and Craven HCP 'Our Plans for Health, Care and Wellbeing', September 2025; City of Bradford Metropolitan District Council Intelligence Bulletin

Projected long-term conditions

The HCP strategy identifies the following projected increases in major conditions by 2040, which directly inform our health inequalities priorities -

- Diabetes: 49% increase (already around 55,000 people living with diabetes in Bradford District and Craven, with prevalence in some areas twice that of others linked to deprivation)
- Heart failure: 92% increase (deaths from circulatory diseases already contribute at least half of the life expectancy gap in the district)
- Chronic pain: 32% increase
- Frailty and dementia: 29% increase
- Palliative care need: 38% increase

Health inequalities in Bradford

Population health data from the Bradford JSNA and HCP strategy, triangulated against BTHFT's own activity data, shows the scale of inequality within our catchment population. The evidence below informs the clinical priorities and operational focus set out in section 5.

Life expectancy gap

Life expectancy varies by 10 years for men and 8 years for women across wards in Bradford District and Craven. Healthy life expectancy gaps are even more stark. Women in parts of central Bradford can expect just 49 years of healthy life compared to 72 years in Wharfedale, a difference of 23 years. For men, healthy life expectancy varies from 51 to 71 years, a 20-year gap.

Source: Bradford District and Craven HCP Strategy, September 2025.

Other health inequalities experienced by the Bradford population include –

- Preventable mortality is significantly higher than the England average in 17 of Bradford's 30 council wards
- Smoking rates vary from 8% to 24% across the 13 Community Partnership areas (overall 18%)
- Two thirds of adults are overweight or obese; obesity rates for children are above the national average
- Asthma admissions in 0-9 year olds: 279.1 per 100,000 (Bradford) vs 172.7 (England).

Data quality

Actions to improve ethnicity recording

The Trust has undertaken a baseline review of ethnicity recording completeness across all patient records on its Electronic Patient Record system. Current data shows that 72% of patients have an ethnicity recorded, with 23% coded as not known and 5% as not stated. This positions the Trust broadly in line with the national outpatient average published by NHS England in its October 2025 Ethnicity Recording Improvement Plan, though it falls below the completeness levels seen in inpatient and emergency care settings nationally.

Work is now in development to address this. A health equity dashboard is being designed using the suite of indicators set out in Appendix 3 of the NHS England Statement on Information on Health Inequalities. The dashboard will allow clinical services to filter indicators, enabling teams to see their own recording performance in context and identify gaps. Ethnicity

completeness will be a prominent metric within this. Structured conversations with clinical services are planned, covering the relationship between ethnicity data quality, DNA rates, and the Trust's wider recovery position.

Staff-facing improvement on recording this activity is also planned. Short informational videos will be developed to explain to staff why asking patients about ethnicity matters and how to do so in a way that reflects patient choice. This draws directly on the NHS England Improvement Plan's recognition that staff confidence and capability are central barriers to recording quality. Elements will also be incorporated into the Trust's lunch and learn webinars and targeted workshops with clinical teams are under consideration where data indicates recording rates are particularly low.

Processing data and linking to population groups

The Trust analyses its data to examine patterns of access and demand across patient groups, using demographic variables including age, sex, deprivation index, and ethnicity where recorded. DNA rates have been examined by demographic group to understand patterns across services and this analysis informs the conversations planned with clinical teams specifically on the disparities between core20 and non-core20 patients.

Where ethnicity data is missing or incomplete, the Trust draws on deprivation-based data primarily using Index of Multiple Deprivation to identify groups likely to be experiencing inequalities even when protected characteristic data is not available. This approach has limitations and the Trust does not treat it as a substitute for accurate ethnicity recording but it provides a working basis for inequalities analysis in the interim.

Gaps in data quality and assurance

Assurance on steps to address gaps will operate through the health equity dashboard once it is live which will make recording completeness visible at service level and create a mechanism for holding teams to account through regular review. Where services have lower than the trust average stats on ethnicity recording, we will work with services by exploring the optimal options on a service-by-service basis. This may include workshops where needed which will be documented and tracked to provide evidence of progress. The lunch and learn programme and informational video content will form part of the broader assurance narrative around staff awareness and capability, in line with the domains for improvement set out in the NHS England Ethnicity Recording Improvement Plan.

The Trust also notes the NHS England finding that staff training in isolation will not improve recording quality and that process changes are required alongside it. Reporting to the relevant committee will provide ongoing oversight of progress against ethnicity recording improvements.

Understanding inequalities in access, experience and outcomes

BTHFT has collected and analysed data across the Core20PLUS5 clinical areas, using the population profile as its baseline. Data is disaggregated at a minimum by deprivation, ethnicity, age and sex, in line with NHS Health Inequalities Statement requirements.

Understanding our data and inequalities

Health inequalities across a range of population groups and clinical domains

Health inequalities have been identified as a significant but context-specific driver of trends in performance, productivity, and resource utilisation across several population groups and clinical domains. Analysis of hospital data demonstrates that differences associated with deprivation, ethnicity, and age influence patterns of service demand, attendance, and outcomes. However, targeted interventions and service redesign have mitigated some of these disparities, indicating that inequalities are an important-but not sole-factor shaping system performance.

Firstly, deprivation has been a key determinant of variation in elective care access and utilisation. Bradford District and Craven has relatively high deprivation levels, with 46.9% of the population living in CORE20 (most deprived) postcodes. Following the pandemic, patients from these areas experienced slightly longer waiting times and were almost twice as likely to miss appointments, affecting elective productivity and efficient use of clinical capacity. These inequalities were addressed through targeted actions, such as improving access and introducing initiatives like free bus travel for patients in inner-city primary care networks. Non-attendance rates have decreased and waiting times are now broadly comparable by urgency and treatment type, demonstrating how addressing inequalities can improve operational performance and activity levels. We are continuing work to reduce the number of missed appointments for core20 patients. See Measurement Framework: '% waiting 18 weeks or less for elective treatment' and '% waiting over 52 weeks for elective treatment' tables, disaggregated by Core20, ethnicity, learning difficulty, gender and age.

Secondly, inequalities also affect patterns of emergency demand, particularly among younger populations. In the under-18 population, 55.6% live in CORE20 areas and 45.8% are from BAME backgrounds, and both groups show higher-than-expected emergency attendances compared with their share of the population. For deprived communities, higher emergency department (ED) attendances suggest unmet need or differences in access to community care. This increases pressure on hospital services and influences resource utilisation in urgent care pathways. See Measurement Framework: 'Mean Time in ED' and 'Ambulance Rates' tables, disaggregated by Core20, ethnicity and age.

Overall, the evidence suggests that health inequalities substantially shape trends in healthcare demand, operational performance, and resource utilisation, particularly through higher service use among deprived populations and certain ethnic groups. However, the Trust's analysis and targeted interventions show that these impacts can be reduced through focused service improvements, partnership working, and targeted population-health initiatives. Consequently, health inequalities are both a driver of variation and a key focus for improving system efficiency, productivity, and equitable access to care. The Measurement Framework section provides the supporting data tables for the analysis described above, covering elective care and urgent and emergency care disaggregated by Core20, ethnicity, learning difficulty, gender and age.

Health inequalities and routine data

Routine performance data is systematically analysed to identify potential health inequalities by breaking down activity and outcomes across deprivation, ethnicity, age, and population characteristics. This approach enables the organisation to understand whether different population groups experience variation in access to care, waiting times, or clinical outcomes, and to identify where targeted interventions may be required.

A key method of analysis involves examining hospital activity data-particularly elective care and urgent and emergency care-against demographic indicators such as the Index of Multiple Deprivation (IMD), ethnicity, and age cohorts. Routine performance data is therefore compared with these population baselines to determine whether specific groups are over- or under-represented in-service use. This is demonstrated in the Measurement Framework section - elective care tables covering 18-week and 52-week waits and waiting list size, and urgent and emergency care tables covering mean time in ED and ambulance rates, each disaggregated by Core20, ethnicity, learning difficulty, gender and age.

In addition, system collaboration and service-level intelligence contribute to understanding the drivers behind inequalities. For instance, patterns of emergency department use among deprived populations have been explored with primary care and community groups to determine whether they reflect unmet need or limitations in access to services outside hospital. Similarly, a Learning Disability (LD) flag was implemented within Cerner to identify patients with learning disabilities more effectively and services were encouraged, to prioritise patients identified with an LD flag. This has resulted in significant improvement in RTT performance for patients with learning difficulties.

Overall, routine performance data-broken down by deprivation, ethnicity, age, and other demographic factors-provides structured evidence base for identifying inequalities in access, utilisation, and outcomes. When combined with more detailed local analysis and insights from clinical teams and system partners, this approach enables a deeper understanding of the drivers of inequality, including barriers to access, patterns of health need, and differences in patient experience, and informs targeted actions to improve equity in care delivery.

Analysis of A&E attenders and the inequalities they face

Analysis to identify frequent attenders at A&E is undertaken through routine review of urgent and emergency care activity data, with a focus on demographic and socioeconomic characteristics such as deprivation, ethnicity, and age. By linking emergency department (ED) attendance and hospital admission data with population demographics, the Trust can identify groups that attend more frequently than expected and explore the inequalities that may be contributing to these patterns.

To better understand frequent attendance patterns, the Trust also analyses admission rates relative to ED attendance. For patients living in the most deprived areas, higher admission numbers largely reflect higher attendance at the emergency department, suggesting that these communities may rely more heavily on hospital-based urgent care. Contributing factors may include unmet health needs, barriers to accessing community or primary care services, or geographic proximity to the emergency department at Bradford Royal Infirmary. See Measurement Framework: ‘Mean Time in ED’ tables by Core20 and age, and ‘Ambulance Rates’ tables by Core20 and age.

Core 20 metrics showing a more favourable trend, as 62% of attendances fall within the Core 20 cohort, this is related to improvement in overall performance for emergency department (ED). Mean time in ED for patients for patients of white ethnicity remains comparatively high, largely because 71% of attendances among patients aged over 65 are White, a group that also demonstrates a higher admission rate. In contrast, the position for patients under 18 appears more positive due to their lower admission rates, with 67% of under-18 attendances coming from BAME groups. Additionally, a large proportion of attendances among patients under 65 are classified as Type 3 and Type 5. This suggests that improved community-based provision for these patients may help reduce presentations to the Emergency Department (ED).

This quantitative analysis is complemented by collaboration with primary care and community partners within the Bradford District and Craven Health and Care Partnership. These discussions help triangulate routine performance data with local insights to determine whether high attendance reflects unmet need, gaps in preventative care, or barriers to accessing services outside hospital.

The findings from this analysis are being used to inform targeted and proactive interventions, including work through the Trust's acute care programme and broader system partnership initiatives aimed at strengthening community-based services and supporting care closer to home. By identifying frequent attenders and understanding the inequalities they face, the Trust and its partners can better design support that reduces avoidable emergency department use while improving access to appropriate care.

Intersectionality considerations

Bradford's position as the 12th most deprived local authority in England, with 46.9% of its population living in Core20 postcodes, means that multimorbidity is a significant issue. Residents in the most deprived areas face a combination of unhealthy housing and limited access to primary care and higher rates of smoking, poor nutrition and physical inactivity. These are established features of life in deprived communities rather than individual choices, and they drive the elevated rates of chronic conditions that BTHFT sees in its patient population.

The HCP strategy's projections of a 49% increase in diabetes, a 92% increase in heart failure and a 32% increase in chronic pain by 2040 reflect this burden accumulating over time. Patients from the most deprived areas are more likely to arrive at BTHFT services with multiple long-term conditions, at a later stage of disease progression.

Barriers to early diagnosis mean conditions are harder to manage by the time they reach secondary care. Poverty, stress and social isolation add further complexity that standard care pathways are not always designed to address. This pattern is visible in urgent and emergency care demand, where one in six hospital admissions relate to conditions that timely community intervention could have prevented as noted within the Bradford District and Craven Partnership strategy 2025.

This evidence informs BTHFT's prioritisation of Core20PLUS5 clinical areas, its investment in the Make Every Contact Count (MECC) project, and its community outreach work. It also explains why the Trust's anchor institution role, its Born in Bradford and BIHR research components and its direct engagement with deprived communities are central to addressing unequal health outcomes across the local population.

Patient and community engagement

EXCEL Programme – patient and workforce engagement

The EXCEL programme focuses on urgent care and conducted structured engagement with patients, community groups and staff during 2025/26 to understand lived experience of services specifically focusing on the Emergency Department. Engagement reached approximately 500 community members and patients across 42 sessions with patient and community groups, including roadshow events and a local patient feedback survey. A further 24 face-to-face staff engagement sessions were held with 147 or more colleagues, alongside three dedicated EDI staff sessions.

Analysis of findings identified the following connecting themes from patient and community feedback:

- Overcrowding and pressure in the Emergency Department, driven in large part by patients with non-urgent conditions who report being unable to access primary care in a timely manner
- Long waits which were a key source of dissatisfaction
- Poor communication, patients and families uncertain about what was happening, how long they would wait, and who to approach with concerns
- System and pathway challenges for patients, and for staff navigating referral pathways and system partner responsibilities

Community engagement work

The Trust has carried out a programme of targeted outreach into specific communities during 2024/25 and into 2025/26, working with community organisations and voluntary sector partners to reach groups that do not consistently engage with NHS services through conventional routes.

Homeless community

Trust staff visited services supporting homeless people in Bradford to hear directly about their experiences of attending the Emergency Department. Participants described stigma and social judgment when accessing the department, including feeling looked down upon by other patients and at times by staff. These accounts align with a broader finding from the EXCEL programme around inequalities in how patients with additional needs are received in the acute setting.

Black and minority ethnic women's groups

Through outreach to a Dominican women's group, the Trust gathered accounts of experiences of racial bias during hospital care, including perceptions that staff attention and responsiveness differed according to the ethnicity of the patient. One participant, who had experienced this when supporting a family member on a ward, subsequently became a Trust governor in order to advocate for change.

Cancer screening engagement

In partnership with the West Bowling Youth Initiative, Trust staff conducted sessions with members of the local Asian community to understand barriers to cancer screening attendance. Sessions were run separately with women and men, with a questionnaire used to capture responses. Findings confirmed that appointment letters were frequently overlooked, with many participants treating screening as optional rather than urgent and some saying they simply

forgot. A community contact in Bradford East raised the potential of a mobile cancer unit model, through which the Trust would come to the community rather than expecting patients to travel to the Bradford Royal Infirmary. Both approaches point to the value of embedded, community-based outreach in addressing the low cancer screening take-up rates that the Trust has identified as a priority.

Accessibility walk rounds

The Trust has worked with groups representing partially sighted people and neurodiverse individuals to carry out walkthroughs of Trust sites.

A visit to the ENT & Eye outpatient department at the BRI with partially sighted participants identified significant navigation difficulties:

- the reception area is not visible from the entrance
- the route requires several turns through a busy corridor, and physical guides in the waiting area were found to be a hazard rather than an aid for people using white canes
- Strip lighting and glare from the reception screen further reduced visibility for those with partial sight

A follow-up visit to the Eccleshill site with a neurodiverse group using a built environment accessibility toolkit is underway. These visits have directly informed a programme of physical improvements.

Romani and gypsy, traveller community engagement

The Trust has worked with a community interest company run by a member of the local Romani community to understand barriers to healthcare access for gypsy, Roma and traveller service users.

A patient representative recently filmed their patient story for the Trust Board. The patient story highlighted specific barriers that would not have been visible through routine feedback:

- written signage in the department carried meanings unfamiliar to some community members
- the expectation that patients access secondary care only via a GP referral was a source of confusion for people from countries where direct hospital attendance is the norm.

White working-class communities

As part of the wider Listen In programme, the Trust has also engaged with white British working-class communities, recognising that this group can feel excluded from engagement activity. Findings mirrored national evidence on this population: health needs are real and significant, but a culture of self-reliance and limited trust in formal services can make engagement harder to sustain without community-based entry points.

Listen In: community voice events

The Bradford District and Craven Health and Care Partnership's Listen In programme has conducted a series of community engagement cycles. Some of these are directly relevant to BTHFT's health inequalities priorities. Key themes emerging from recent reports are summarised below.

Mental health access and stigma emerged as a consistent concern across every community group consulted. LGBTQ+ people reported delays of months to access mental health services. White British working-class men described stigma and a culture of self-reliance as major barriers and community groups provide an important bridge into support.

Children and young people and their families highlighted unsustainable pressure on CAMHS and long waits for neurodevelopmental assessments. These themes align with both the EXCEL findings and the Trust's own community outreach which found mental health presentations in the Emergency Department to be increasing and becoming more complex.

Culturally responsive care, accessibility for patients with additional needs, and digital exclusion were further consistent themes across the Listen In reports, directly reinforcing the priorities identified through EXCEL and the Trust's health equity programme.

Digital inclusion and the Bradford Digital Inclusion Index

The Bradford Digital Inclusion Index (BDII), produced by Yemetech in partnership with Bradford Metropolitan District Council, provides a ward-level assessment of digital exclusion across the district using four composite measures –

- digital accessibility (broadband speed and public internet access points)
- affordability (income deprivation and social grade),
- digital ability (household composition and English proficiency),
- and behaviour and motivation (digital propensity and internet user profile).

The BDII's geographic analysis is directly relevant to the Trust's patient population. Areas scoring in the lowest ranges on affordability and digital ability are concentrated in the inner-city wards immediately surrounding Bradford Royal Infirmary, including Manningham, Toller, City Ward, Little Horton, Bowling and Barkerend, and Clayton. These are among the wards with the highest proportion of the Trust's patient attendances as well as experiencing high levels of deprivation. On behaviour and motivation, large parts of inner Bradford score in the lowest range, meaning that even where physical connectivity exists, low digital engagement and confidence remain significant barriers to service access.

The index highlights the area of Girlington, a ward adjacent to BRI, which is classified as 'At Risk' on the composite digital inclusion score. It has a high proportion of ethnic minority residents, deprived households, and residents with no or low digital skills. The BDII framework identifies community centres, mosques and language services as the most relevant assets through which digital inclusion interventions can be routed in such areas, reflecting the Trust's own experience that community-based entry points are more effective than direct outreach for these populations.

For the Trust, the BDII evidence reinforces three practical implications. First, digital-first service navigation models must be accompanied by non-digital alternatives and active community support, particularly for patients in inner-city areas. Second, outreach on appointment-keeping, screening and preventive care should factor in low digital engagement as a structural barrier rather than an individual failing. Third, the Trust's partnerships with community organisations are central to its digital inclusion, providing the trusted access points through which digitally excluded residents are most likely to engage with health services.

In combination, this set of engagement evidence points to a consistent set of priorities –

- reducing waits and demand pressure in urgent care,
- improving communication and information during care,
- ensuring services are physically and culturally accessible to patients with additional needs,
- and strengthening community-based pathways that can support people before they reach the Emergency Department.

Applying this intelligence systematically ensures that a digital inclusion lens is embedded across key programmes of work, whether initiatives are driven directly by the local digital programme or sit within broader transformation workstreams. By grounding design decisions in BDII insights and lived-experience data, programmes can proactively identify where digital exclusion risks are highest and tailor interventions accordingly - whether that means adapting digital pathways, strengthening non-digital routes, or partnering with trusted community assets. This approach ensures that digital transformation within the Trust is not pursued in isolation but is continually shaped by an understanding of local digital barriers, enabling more equitable access, improved patient journeys, and greater coherence between digitally led, clinical, operational and community-based programmes of work.

EDS22 Community Engagement Event

In February 2026, BTHFT took part in a District wide community engagement event convened as part of the NHS Equality Delivery System (EDS22) (Equalities Framework). The event was attended by community representatives, VCSE partners and service users from across Bradford and Craven, the event was structured to gather community and patient perspectives on Domain 1 of the EDS22 framework which covers access, outcomes, safety and patient experience for commissioned and provided services.

BTHFT presented evidence on three services assessed under Domain 1 for 2025/26: the Maternity – Labour Ward, the Home Enteral Feeding Dietetic Service, and Mental Health provision within the Emergency Department. Presentations covered how each service supports equitable access, meets the needs of diverse patient groups with additional needs, patient safety, and patient experience and mechanisms for patient feedback.

Community members reviewed the evidence presented and scored each service against the four Domain 1 outcome measures, with additional qualitative feedback gathered through table discussions and feedback forms. Feedback highlighted the importance of flexible and personalised care, clear communication with patients who have additional language or accessibility needs and joined-up support for patients with mental health needs presenting in an acute setting. The event findings will inform BTHFT's EDS22 scoring and improvement planning for 2026/27.

Research as a tool to understand and address inequalities

BTHFT and the Bradford Institute for Health Research (BIHR), based at BTHFT's Bradford Royal Infirmary site, use research as a core mechanism for understanding and addressing health inequalities. Research priorities directly relevant to local health inequalities include –

- Europe's first clinical trial using injections to treat asthma, relevant to Bradford's elevated asthma rates in children (279.1 per 100,000 for 0-9 year olds vs 172.7 nationally).
- A study examining whether better blood pressure management can reduce falls risk in older adults, relevant to the projected 27% increase in the 65+ population.

- The Born in Bradford longitudinal cohort study, tracking the health of over 40,000 Bradford residents from birth and providing foundational evidence on inequalities in early childhood health, air quality, mental health and multiple long-term conditions.
- Born in Bradford Age of Wonder research found a marked increase in reported depression in young people post-pandemic. Mental health disorders are the leading condition for young people under 20 in the district alongside maternal/neonatal disorders.
- BTHFT was awarded nearly £7m to establish one of 20 new Commercial Research Delivery Centres, acting as a regional hub for clinical trials. This creates opportunities for Bradford's diverse and deprived communities to access cutting-edge treatments.

Actions taken to reduce health inequalities

This section describes BTHFT's key programmes and initiatives during 2025/26. It draws on reporting to the Board of Directors in March and September and the Trust's EDI Strategy 2023-2025.

Governance and approach

Health equity has been embedded into the Trust's corporate induction giving over 600 new starters an overview of the Bradford population and inequalities experienced by our residents. Actions are also underway to include training sessions within the Preceptorship programme, allowing newly qualified nurses and practitioners to deepen their understanding of the population and their role in tackling inequalities.

The Health Equity Oversight Group (HEOG) was established in August 2025 to embed health inequalities work across the Trust. It is chaired by the Director of Strategy and Transformation and membership spans clinical, operational, digital, research and strategic functions as well as partners including the Reducing Inequalities Alliance. This breadth reflects the Trust's approach that reducing health inequalities is a partnership and organisation-wide responsibility.

In August 2025, the HEOG carried out the NHS Providers health inequalities self-assessment for a second time to assess the Trust’s progress in its approach to addressing health inequalities. The outcome of the self-assessment provided areas to improve which were included in the work plan for 2025/26. The results can be seen in table 3 below –

Table 3 – NHS Providers Health Inequalities self-assessment findings

Domain	Ratings	Change
Building Public Health capacity and capability	2024/25 rating – Emerging 2025/26 rating - Developing	Improved
Data, insight, evidence and evaluation	2024/25 rating – Maturing 2025/26 rating - Maturing	No change
Strategic leadership & accountability	2024/25 rating – Developing 2025/26 rating - Maturing	Improved
System Partnerships	2024/25 rating – Maturing 2025/26 rating - Maturing	No change

Service improvements addressing inequalities

The following specific service improvements were focused on with an aim to impact health inequalities:

- **Maternity services.** Maternity services have embedded multiple health equity initiatives into their work. These include providing patients with food bags (working with the Bradford Metropolitan Food bank), a winter coat rail where coats donated are made available to patients, freephone taxi access and prepaid SIM cards for those struggling with mobile phone access. Dignity packs, containing essential toiletries, are also made available to patients.
- Our **Make Every Contact Count (MECC)** project, launched in early 2025, trains clinical staff to use opportunistic contacts to support patients in making behaviour change with a focus on prevention. Changes are relevant to health inequalities priorities including smoking cessation, increasing physical activity and managing alcohol intake. There is also a specific focus on the South Asian population, specifically Pakistani males, who experience higher instances of stroke. The aim is to identify instances of hypertension/high blood pressure through targeted conversations. MECC has been rolled out to the Phlebotomy and Adult Outpatient Departments.
- **Reduction in DNA rates** and aiming for parity in Core20 and non-Core20 populations. A DNA dashboard has been created to inform Clinical Service Units of disparities. Our data shows that the Core20 population experience higher DNA rates compared to the non-Core20 cohort therefore there is a need for our CSUs to utilise this data locally.
- BTHFT is also an active participant in the **Making Improvements Shaping Services for Meaningful Equity (MISSME)** programme. The focus of this regional programme is on reducing missed appointments at renal clinics. At BTHFT, the focus is on transplant clinics to understand reasons for DNAs and which interventions will be most effective. Service users will be involved in designing interventions to ensure patient voices are heard.
- As part of our work to support digital inclusion and provide digital access to local residents, we have been developing a service that **opens our hospital Library Service to public users**. A dedicated service (starting in April 2026) will give residents, especially in Girlington as mentioned in the digital inclusion section, a place to access the internet, receive support to draft NHS job applications, support users to

use the NHS App and for patients to obtain help in arranging/rearranging the appointments digitally. BTHFT is also working closely with a community organisation, Yorkshire Women's Forum, who are aiming to provide a similar digital access service expanding the locations from which digital support is available. This supports our work and the population as we shift to a digital landscape.

- **Language access.** The Trust's adoption of the CardMedic language translation app to support communication with non-English speaking patients across services continues to address language barriers. This supplements an established interpreting service. Bradford's population speaks over 150 languages and language barriers are a documented driver of unequal access and experience.
- **Culturally responsive care**. The Trust's Ramadan fast-pack campaign, supporting Muslim staff and patients during Ramadan, gained national recognition. Visiting hours were extended during Ramadan and Eid. These initiatives are particularly important given that 30.5% of the Bradford population identify as Muslim.
- **Technology to reduce inequalities**. Virtual clinics have been expanded, although the Trust recognises that digital access barriers in Bradford mean virtual pathways must be accompanied by non-digital alternatives, particularly for older patients and those in deprived areas.
- **Health on the High Street**. BTHFT is exploring ways to reduce health inequalities by providing outpatient services from a more easily accessible city centre location.

Anchor Institution Role

As an anchor institution in Bradford, BTHFT has an obligation to support the health, social and economic development of the community. We do this through a range of activities covering recruitment, employment, staff support and development, procurement, sustainability, how we use our buildings, how we design our services to meet the needs of the local population, and how we work in partnership with other anchor institutions across Bradford District and Craven. In 2025 we carried out a self-assessment of how well we are meeting our duties as an anchor institution and developed an action plan to help us to develop this role in the coming year.

Following an internal workshop in January 2026, four priorities for the year were agreed: maximising the opportunity offered by the development of the health on the high street programme; connecting with the University of Bradford to deliver joint projects at scale; exploring links with Green Champions; and working on requests for more work experience across the Trust. We will report to the Trust Board on progress on these areas, and more generally on the action plan twice a year.

Publishing Information on Health Inequalities

In line with Section 4 Appendix 2 of the NHSE Statement, BTHFT has published information on health inequalities through the following channels during 2025/26 -

- This annual report section, which forms part of BTHFT's public Annual Report and Accounts 2025/26 and constitutes the Trust's formal statement of information on health inequalities as required by the NHS Health Inequalities Statement
- Board of Directors public papers: a health inequalities update is presented to the Board as a standing agenda item at every March and September meeting, led by the Director of Strategy and Transformation. These papers are published publicly on the BTHFT website. The September 2025 and March 2026 Board updates are cited as evidence sources for this report.
- Quality Account 2024/25, published June 2025, which includes BTHFT's progress against 'Understanding and tackling health inequalities' as a named quality priority, and identifies reducing health inequalities in maternity and neonatal services as a priority for 2025/26

Self-Assessment Against NHSE Key Lines of Enquiry (KLOEs)

The NHSE Statement (November 2025) introduced Key Lines of Enquiry to support NHS bodies in assessing compliance. Our self-assessment is set out in table 4 below.

Table 4 – NHSE KLOEs Self-Assessment

Key Line of Enquiry	Evidence / Narrative
Do we understand our population's health needs, including for Core20PLUS groups?	Yes. Population profile grounded in Bradford JSNA (Nov 2025) and BDCHCP Strategy (Sep 2025). Core20PLUS groups identified: Pakistani/Asian communities (32.1%), Gypsy/Roma/Traveller, people with learning disabilities, people with multiple LTCs, digital exclusion groups, LGBTQ+ communities.
Are we disaggregating data at a minimum by deprivation, ethnicity, age and sex?	Yes. DNA rates and waiting times are analysed by IMD, ethnicity, age and sex.
Are we identifying and addressing unwarranted variation in access and outcomes?	Yes. Trust-wide Health Equity and Health Inequalities programme.
Are we improving data quality, including reducing 'unknown/not stated' fields?	Yes. Plans are underway to further improve ethnicity recording across the Trust.
Are we using health inequalities information to inform action and evaluate impact?	Yes. Overseen by Health Equity Oversight Group. Quality Committee monitors progress.
Are we publishing information on health inequalities in our annual report and board papers?	Yes. This annual report section fulfils the NHSE Statement requirement. Board health inequalities papers published publicly at March and September Board meetings.

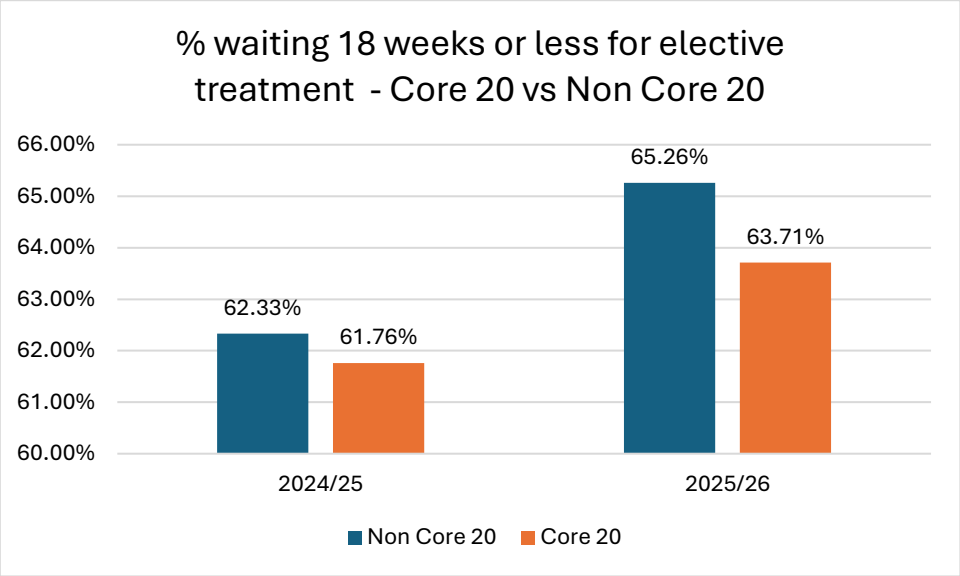
Measurement framework

Operational priorities

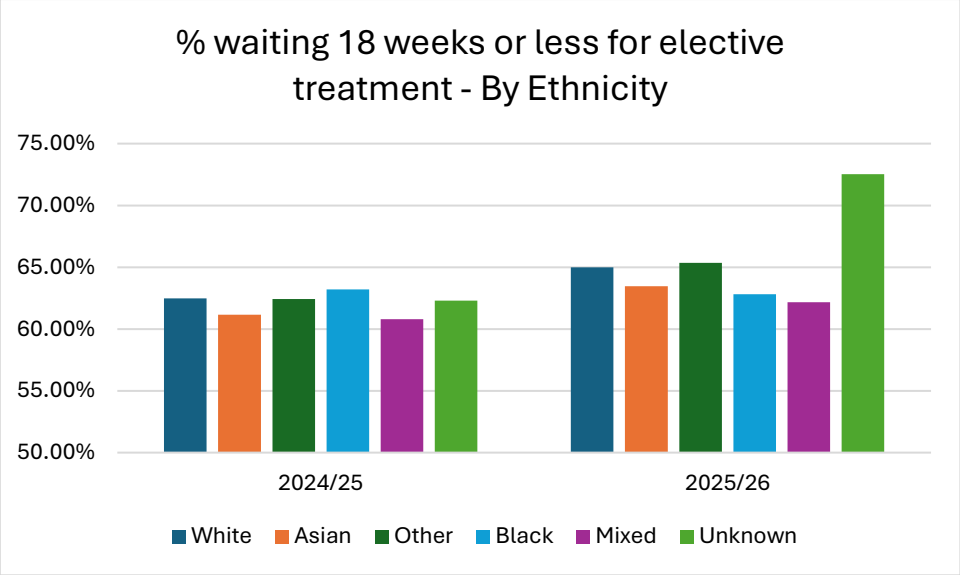
Elective care and community services Core measures

Inequalities in percentage of people waiting 18 weeks or less for elective treatment*

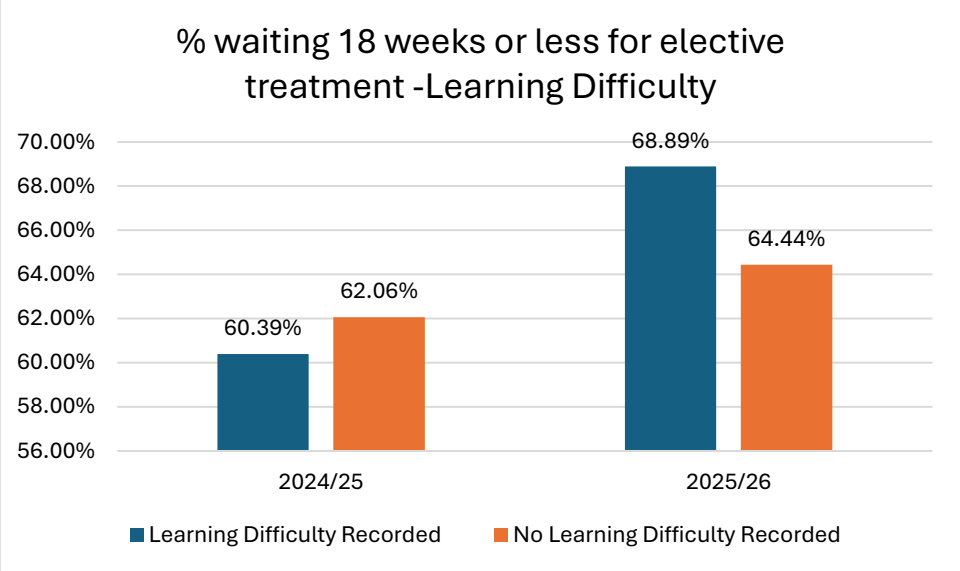
% waiting 18 weeks or less for elective treatment - Core 20 vs Non-Core 20	2024/25	2025/26
Non Core 20	62.33%	65.26%
Core 20	61.76%	63.71%



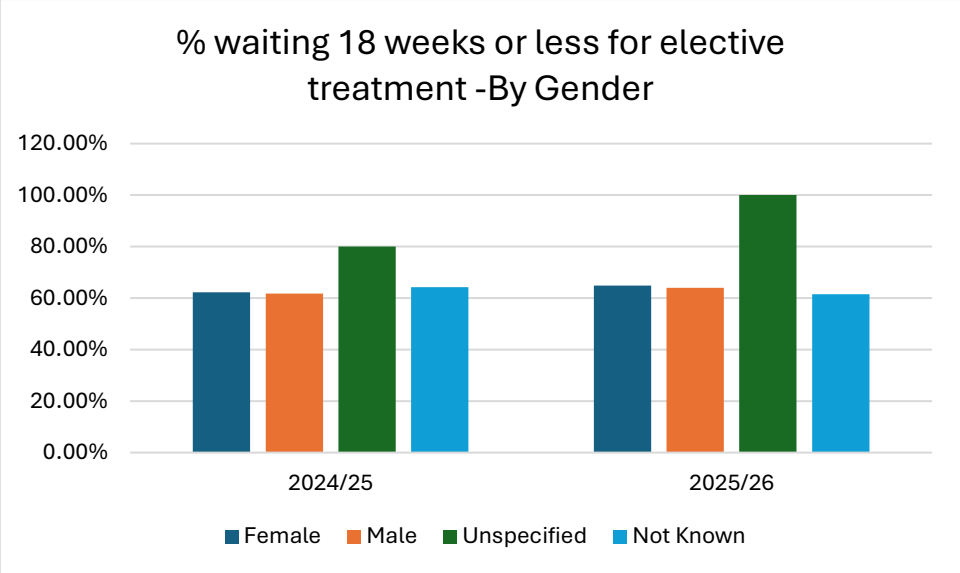
% waiting 18 weeks or less for elective treatment -By Ethnicity	2024/25	2025/26
White	62.48%	64.99%
Asian	61.15%	63.47%
Other	62.43%	65.35%
Black	63.20%	62.81%
Mixed	60.80%	62.16%
Unknown	62.30%	72.53%



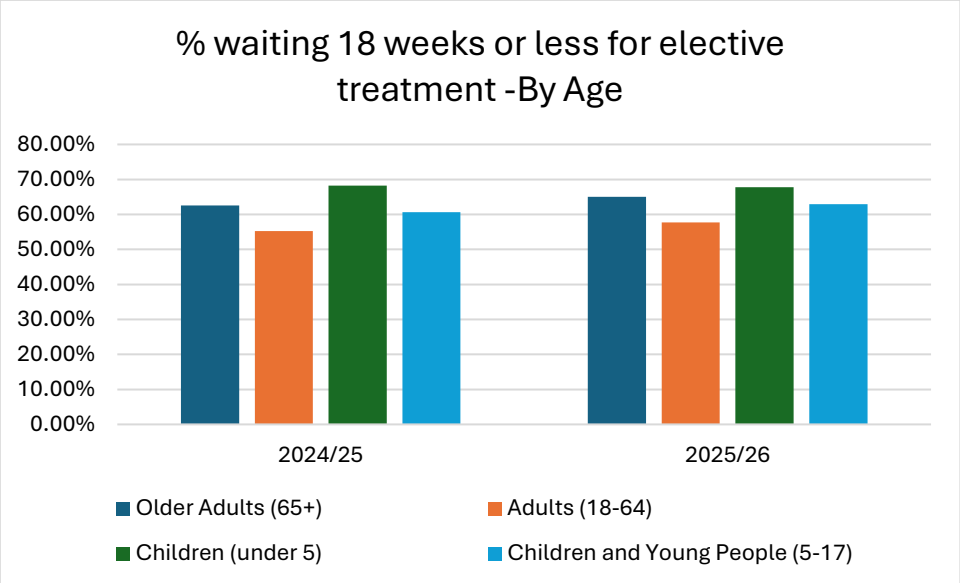
% waiting 18 weeks or less for elective treatment -Learning Difficulty	2024/25	2025/26
Learning Difficulty Recorded	60.39%	68.89%
No Learning Difficulty Recorded	62.06%	64.44%



% waiting 18 weeks or less for elective treatment -By Gender	2024/25	2025/26
Female	62.26%	64.87%
Male	61.78%	63.99%
Unspecified	80.00%	100.00%
Not Known	64.25%	61.54%

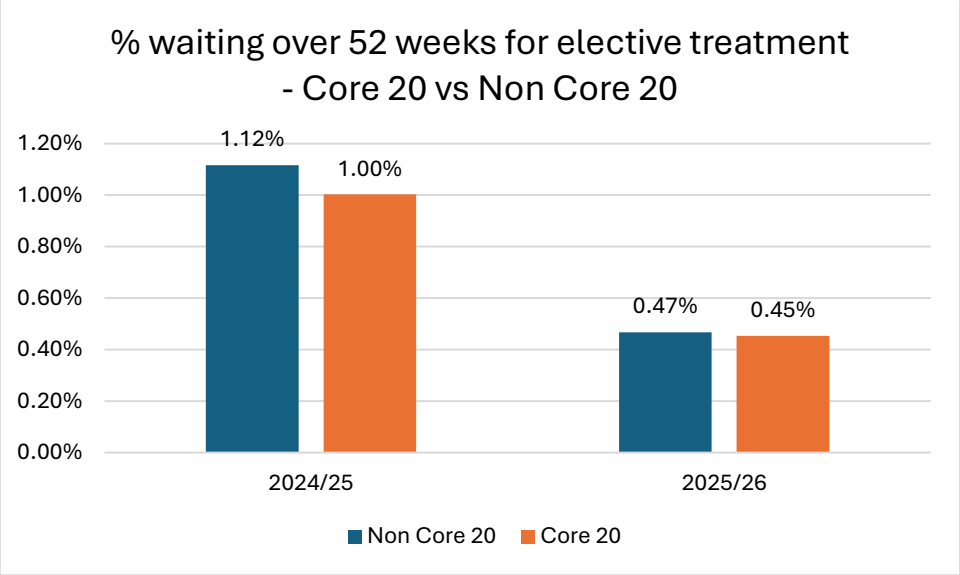


% waiting 18 weeks or less for elective treatment -By Age	2024/25	2025/26
Older Adults (65+)	62.53%	65.00%
Adults (18-64)	55.28%	57.70%
Children and Young People (5-17)	60.60%	62.96%
Children (under 5)	68.23%	67.74%

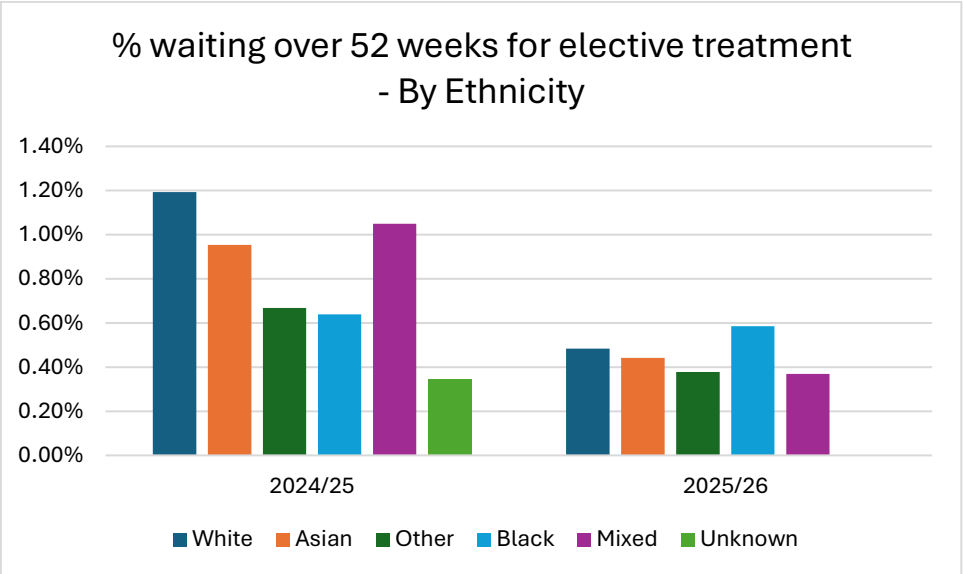


Inequalities in percentage of people waiting over 52 weeks for elective treatment**

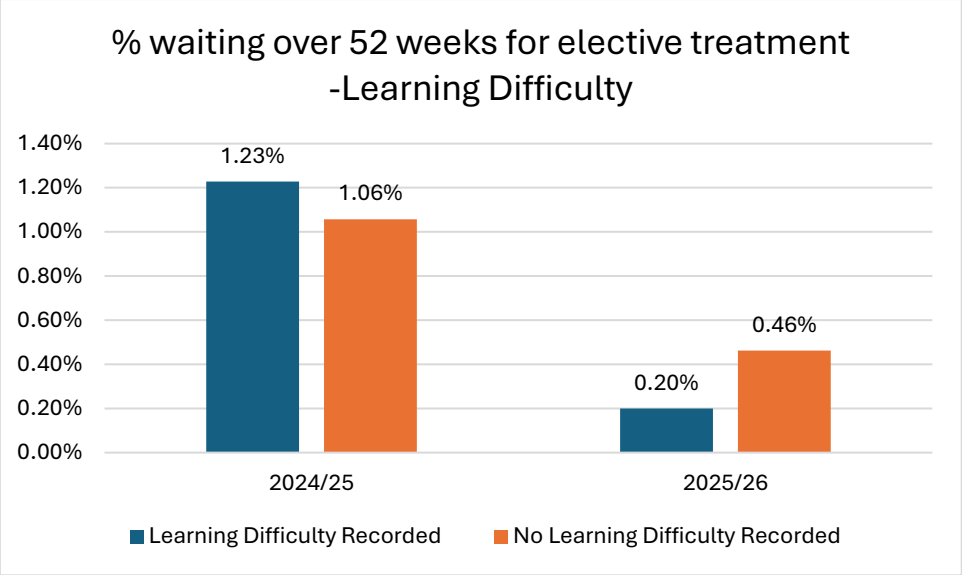
% waiting over 52 weeks for elective treatment - Core 20 vs Non-Core 20	2024/25	2025/26
Non Core 20	1.12%	0.47%
Core 20	1.00%	0.45%



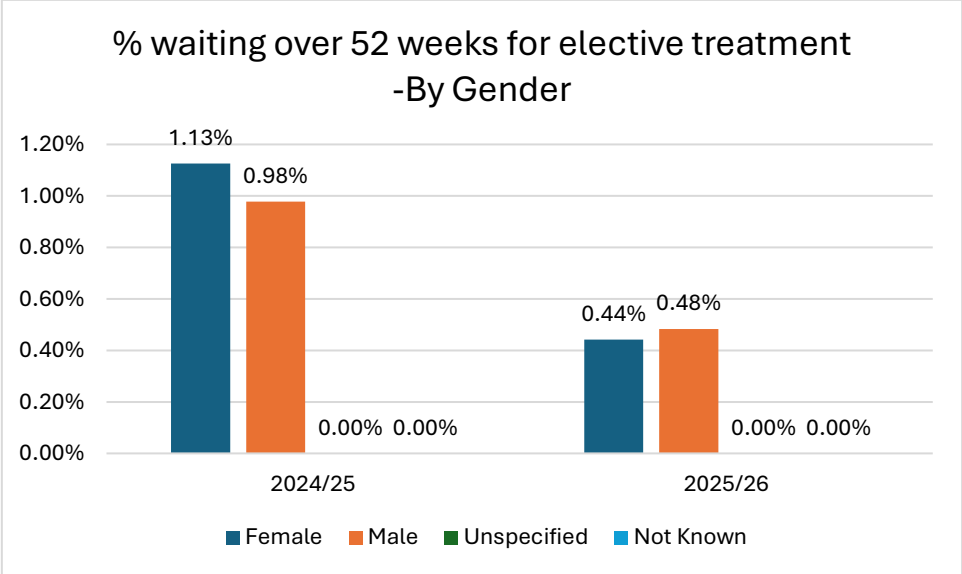
% waiting over 52 weeks for elective treatment -By Ethnicity	2024/25	2025/26
White	1.19%	0.48%
Asian	0.95%	0.44%
Other	0.67%	0.38%
Black	0.64%	0.59%
Mixed	1.05%	0.37%
Unknown	0.35%	0.00%



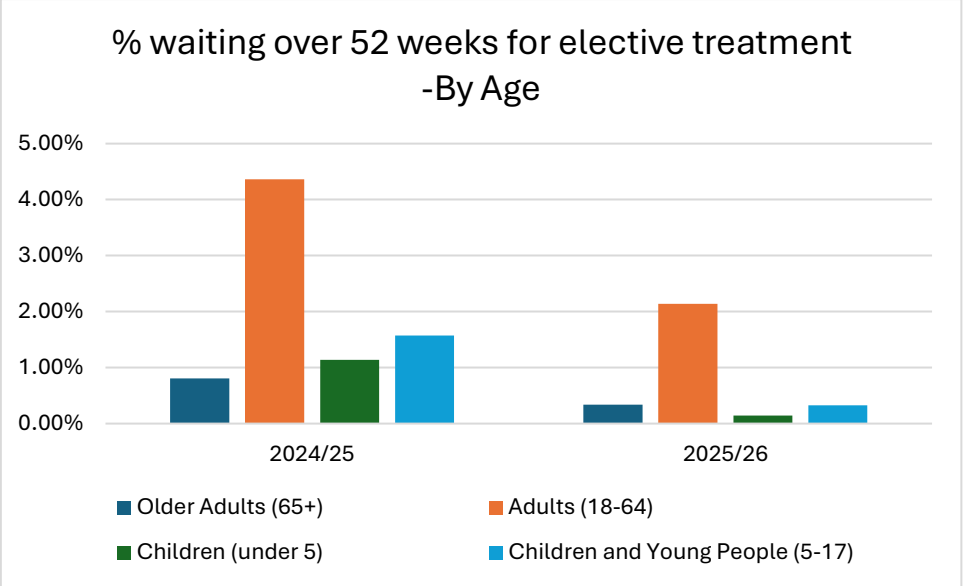
% waiting over 52 weeks for elective treatment -Learning Difficulty	2024/25	2025/26
Learning Difficulty Recorded	1.23%	0.20%
No Learning Difficulty Recorded	1.06%	0.46%



% waiting over 52 weeks for elective treatment -By Gender	2024/25	2025/26
Female	1.13%	0.44%
Male	0.98%	0.48%
Unspecified	0.00%	0.00%
Not Known	0.00%	0.00%

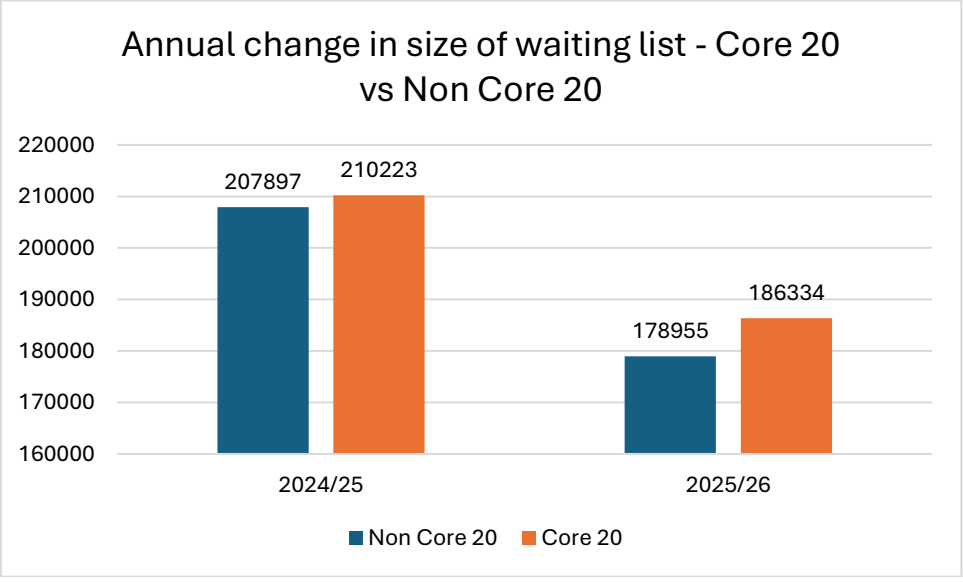


% waiting over 52 weeks for elective treatment -By Age	2024/25	2025/26
Older Adults (65+)	0.81%	0.34%
Adults (18-64)	4.36%	2.14%
Children and Young People (5-17)	1.57%	0.32%
Children (under 5)	1.14%	0.14%



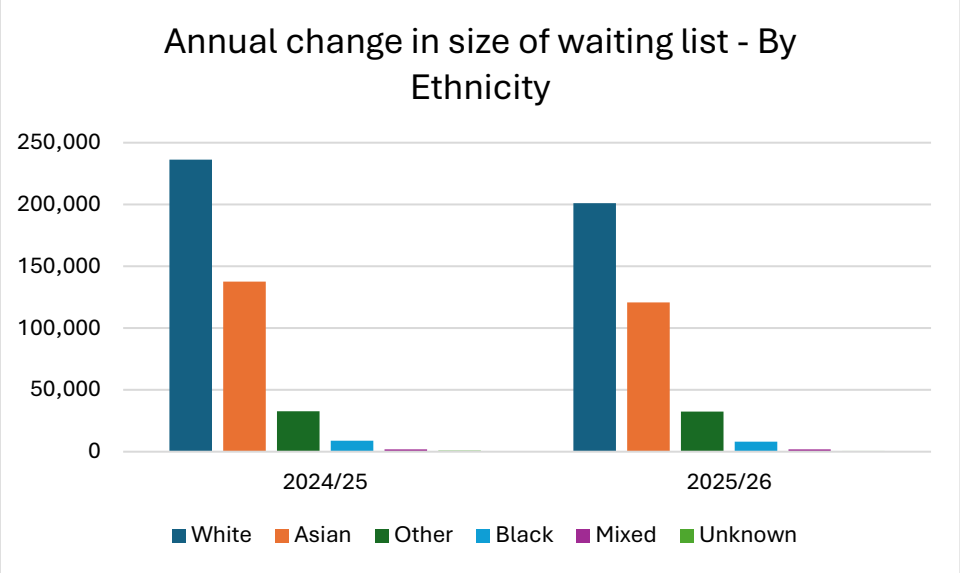
Inequalities in annual change in size of waiting list - this data is based on combining RTT WL size at the end of each month for the whole year.

Annual change in size of waiting list - Core 20 vs Non-Core 20	2024/25	2025/26
Non Core 20	207897	178955
Core 20	210223	186334

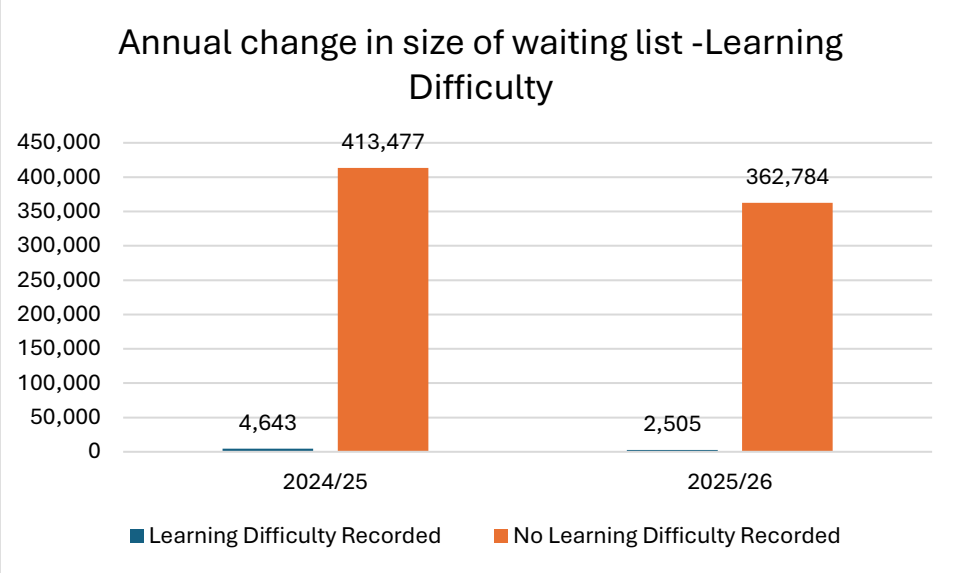


Annual change in size of waiting list -By Ethnicity	2024/25	2025/26
White	236,223	201,164
Asian	137,611	120,889
Other	32,668	32,524
Black	8,756	8,204
Mixed	2,000	1,900

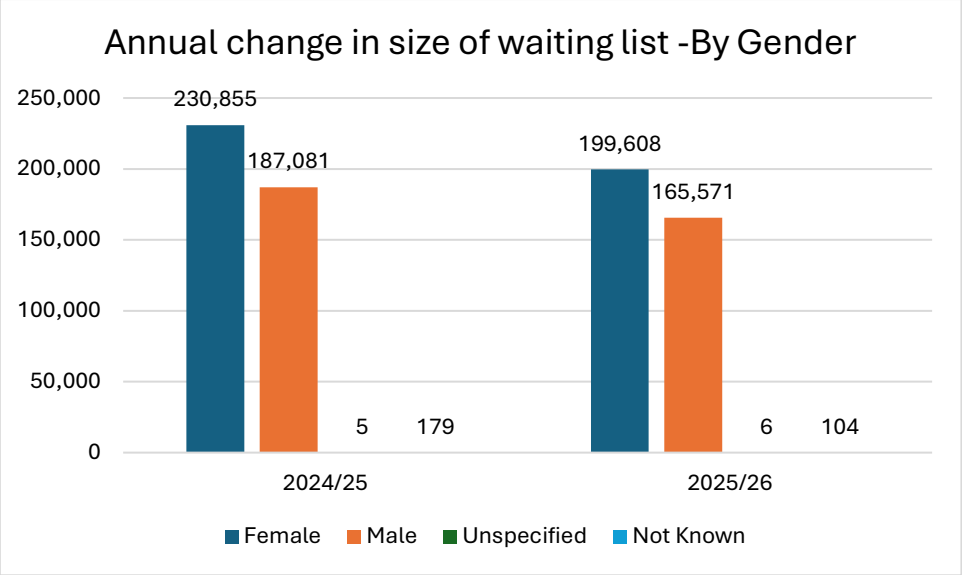
Unknown	862	608



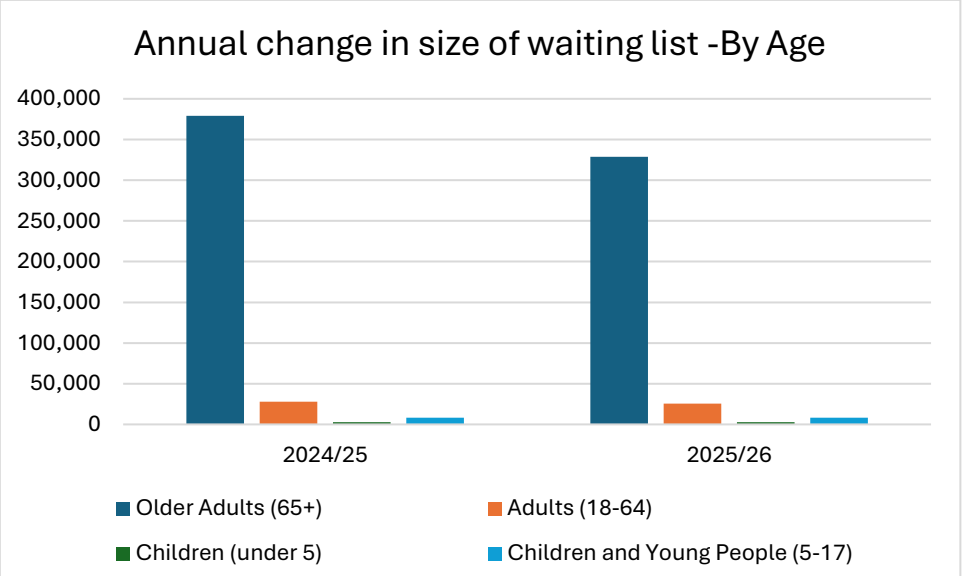
Annual change in size of waiting list - Learning Difficulty	2024/25	2025/26
Learning Difficulty Recorded	4,643	2,505
No Learning Difficulty Recorded	413,477	362,784



Annual change in size of waiting list -By Gender	2024/25	2025/26
Female	230,855	199,608
Male	187,081	165,571
Unspecified	5	6
Not Known	179	104

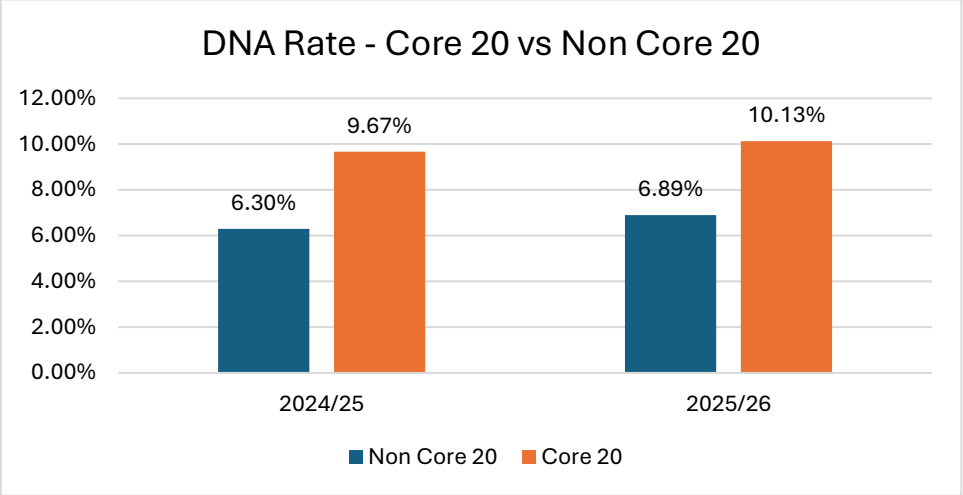


Annual change in size of waiting list -By Age	2024/25	2025/26
Older Adults (65+)	379,291	328,632
Adults (18-64)	27,699	25,523
Children and Young People (5-17)	8,407	8,329
Children (under 5)	2,723	2,805

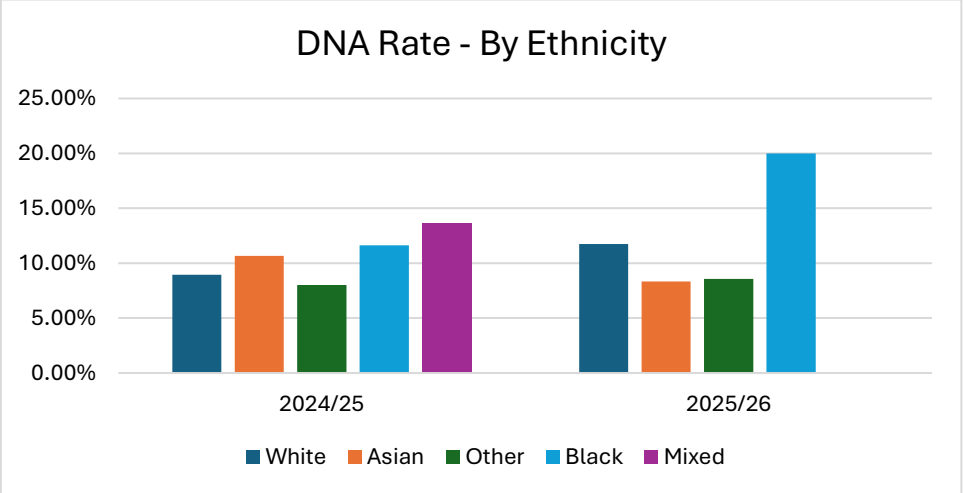


Supporting measures
Inequalities in rates of did not attends/was not brought across elective services

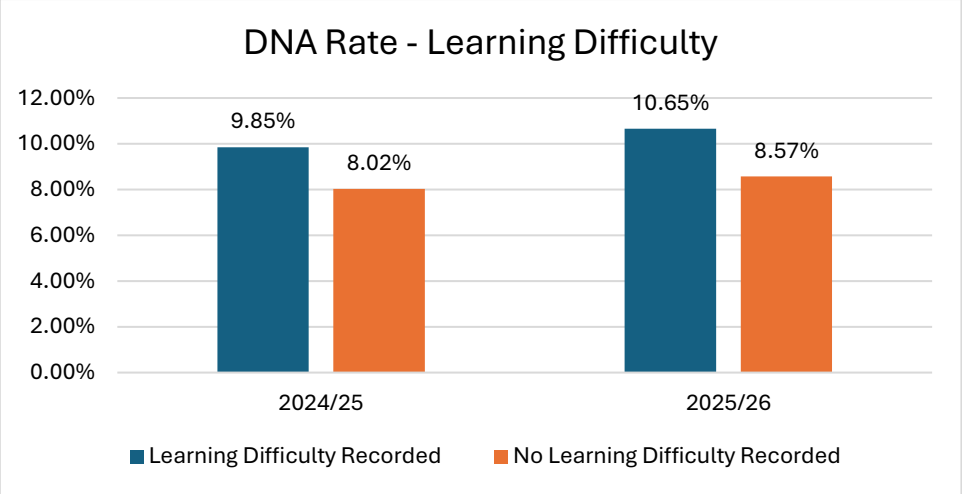
DNA Rate - Core 20 vs Non-Core 20	2024/25	2025/26
Non-Core 20	6.30%	6.89%
Core 20	9.67%	10.13%



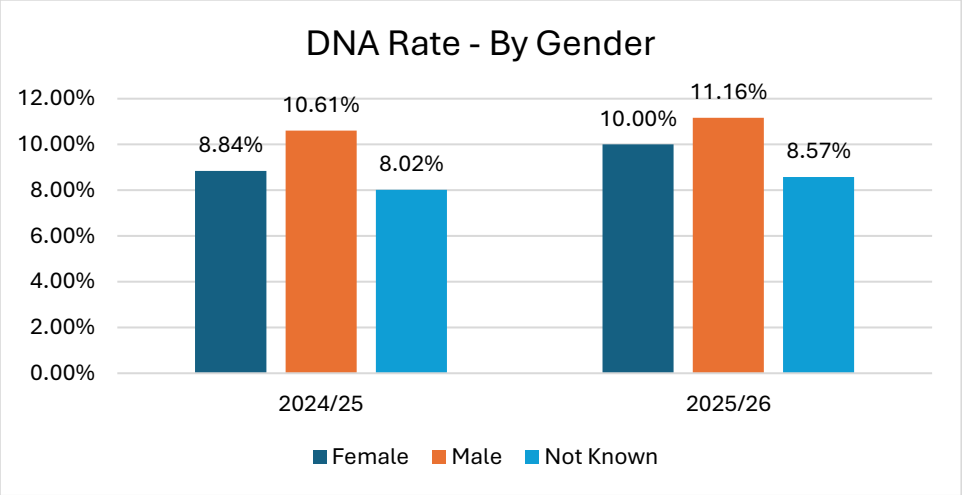
DNA Rate -By Ethnicity	2024/25	2025/26
White	8.96%	11.73%
Asian	10.66%	8.33%
Other	8.02%	8.58%
Black	11.63%	20.00%
Mixed	13.59%	0.00%



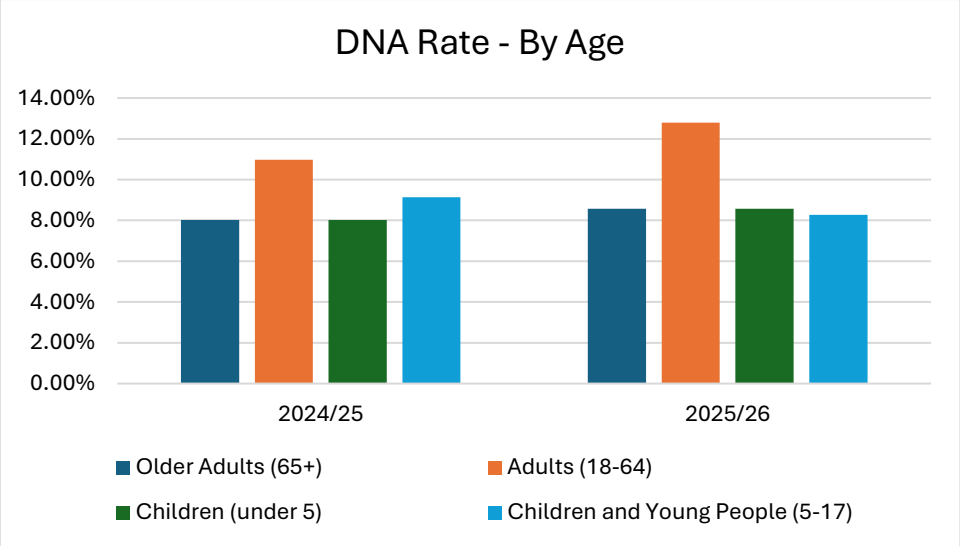
DNA Rate -Learning Difficulty	2024/25	2025/26
Learning Difficulty Recorded	9.85%	10.65%
No Learning Difficulty Recorded	8.02%	8.57%



DNA Rate -By Gender	2024/25	2025/26
Female	8.84%	10.00%
Male	10.61%	11.16%
Not Known	8.02%	8.57%

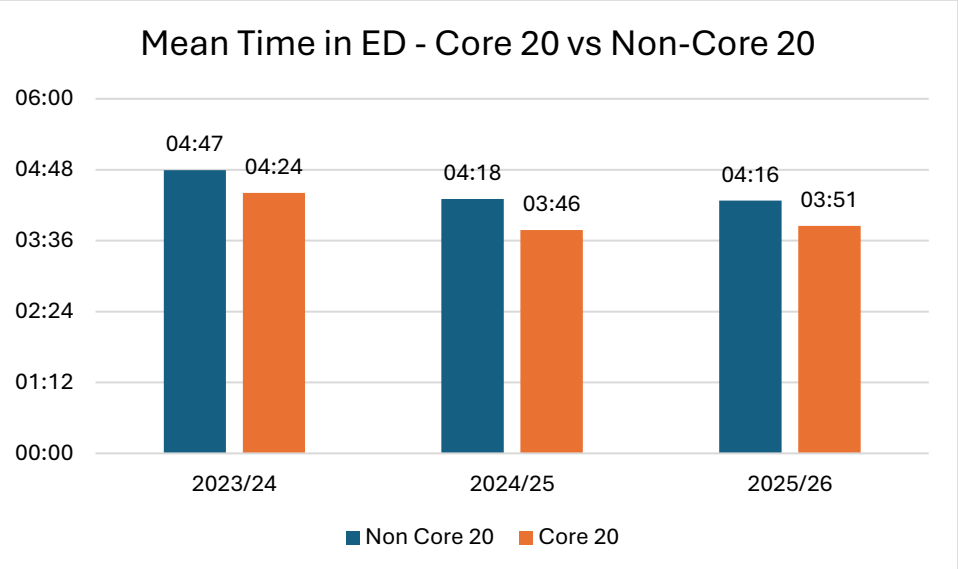


DNA Rate -By Age	2024/25	2025/26
Older Adults (65+)	8.02%	8.57%
Adults (18-64)	10.98%	12.80%
Children and Young People (5-17)	9.14%	8.28%
Children (under 5)	8.02%	8.57%

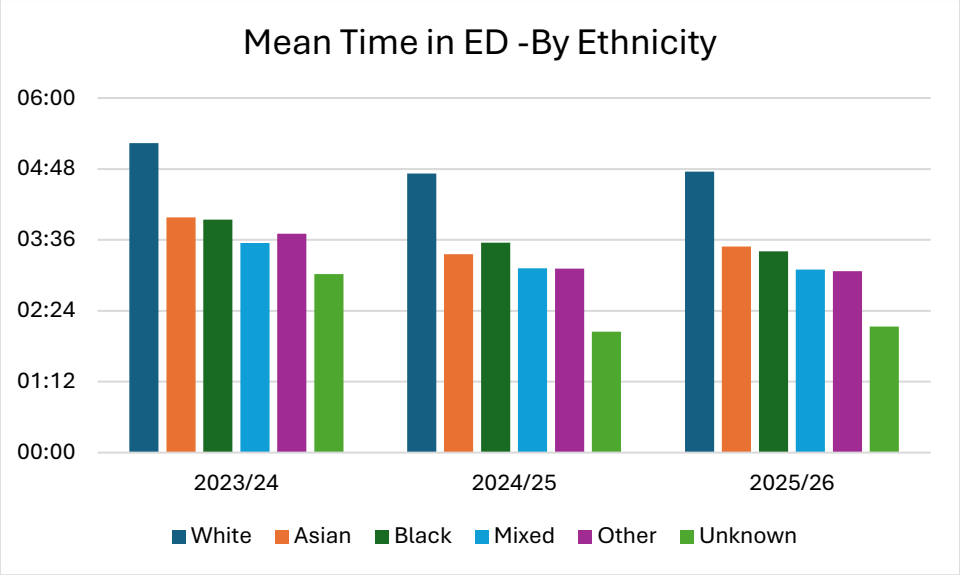


Urgent and emergency care
Core measures
NOTE: 2025/26 data is up to the end of February 2026.
inequalities in mean time in emergency department

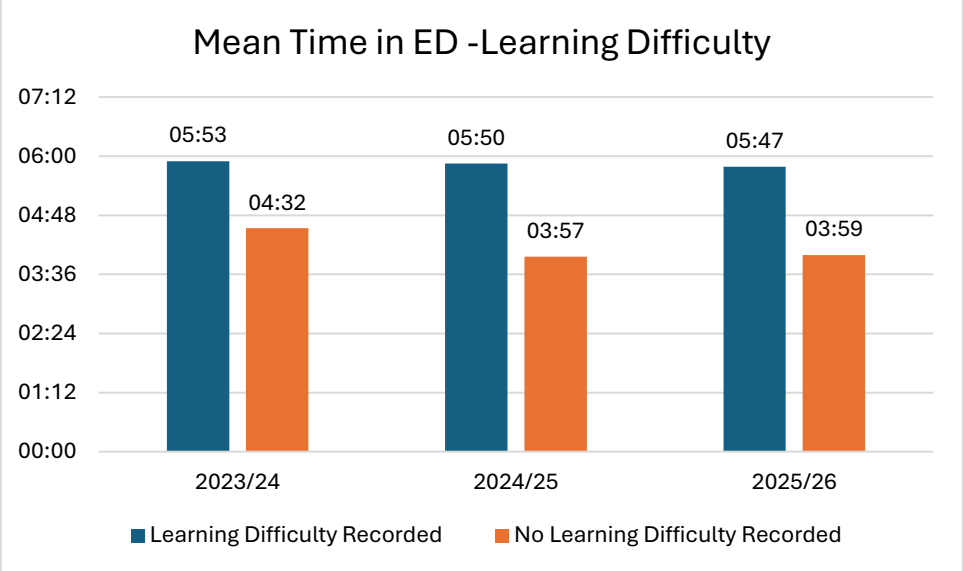
Mean Time in ED - Core 20 vs Non-Core 20	2023/24	2024/25	2025/26
Non Core 20	04:47	04:18	04:16
Core 20	04:24	03:46	03:51



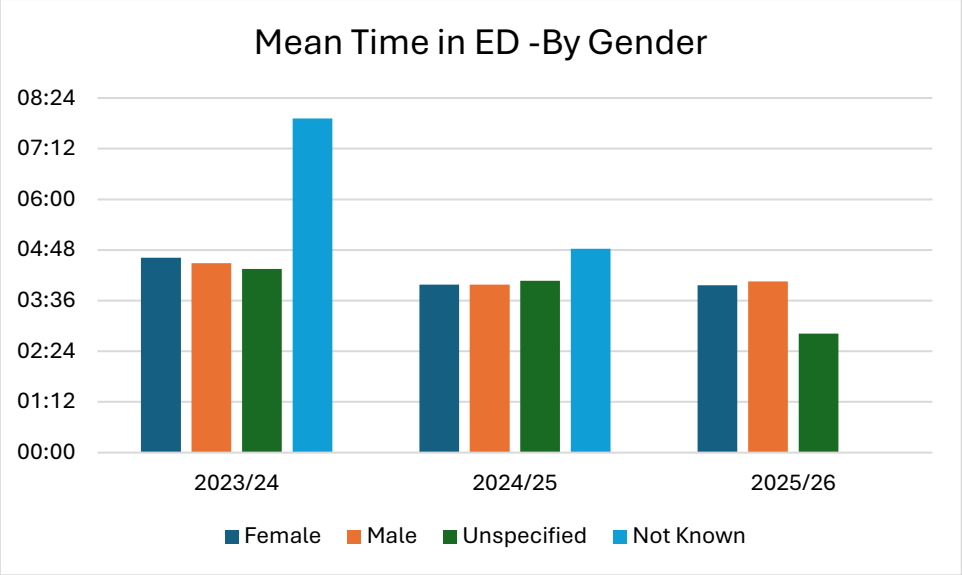
Mean Time in ED -By Ethnicity	2023/24	2024/25	2025/26
White	05:14	04:43	04:45
Asian	03:58	03:21	03:29
Black	03:56	03:33	03:24
Mixed	03:32	03:07	03:05
Other	03:42	03:06	03:04
Unknown	03:01	02:02	02:07



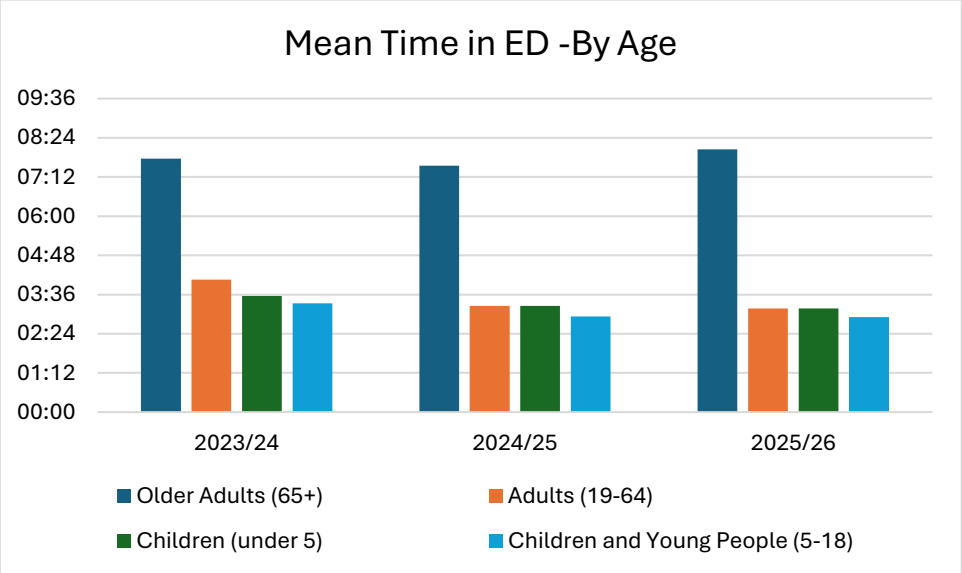
Mean Time in ED -Learning Difficulty	2023/24	2024/25	2025/26
Learning Difficulty Recorded	05:53	05:50	05:47
No Learning Difficulty Recorded	04:32	03:57	03:59



Mean Time in ED -By Gender	2023/24	2024/25	2025/26
Female	04:36	03:58	03:58
Male	04:29	03:58	04:03
Unspecified	04:20	04:04	02:49
Not Known	07:54	04:49	

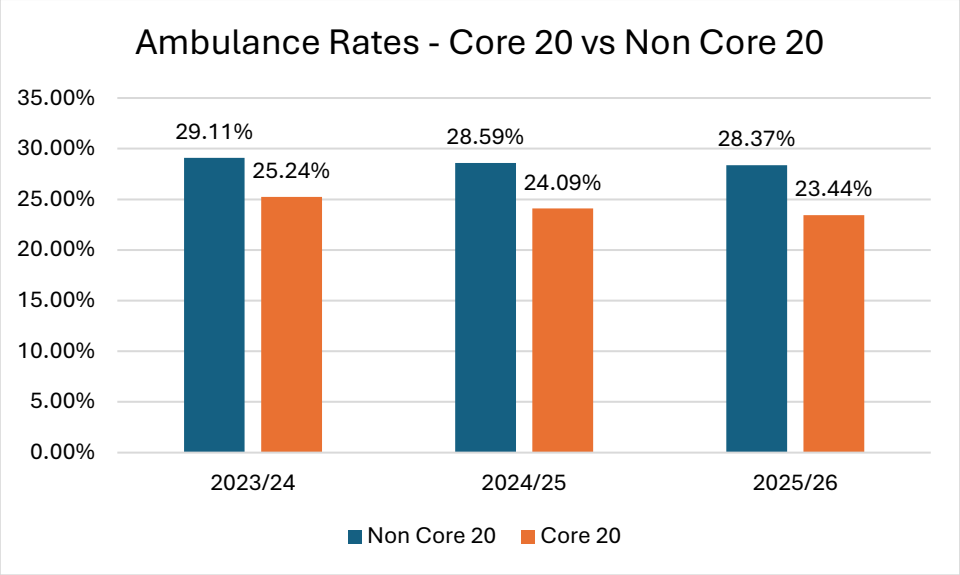


Mean Time in ED -By Age	2023/24	2024/25	2025/26
Older Adults (65+)	07:45	07:32	08:02
Adults (19-64)	04:03	03:15	03:10
Children and Young People (5-18)	03:20	02:55	02:54
Children (under 5)	03:33	03:14	03:10

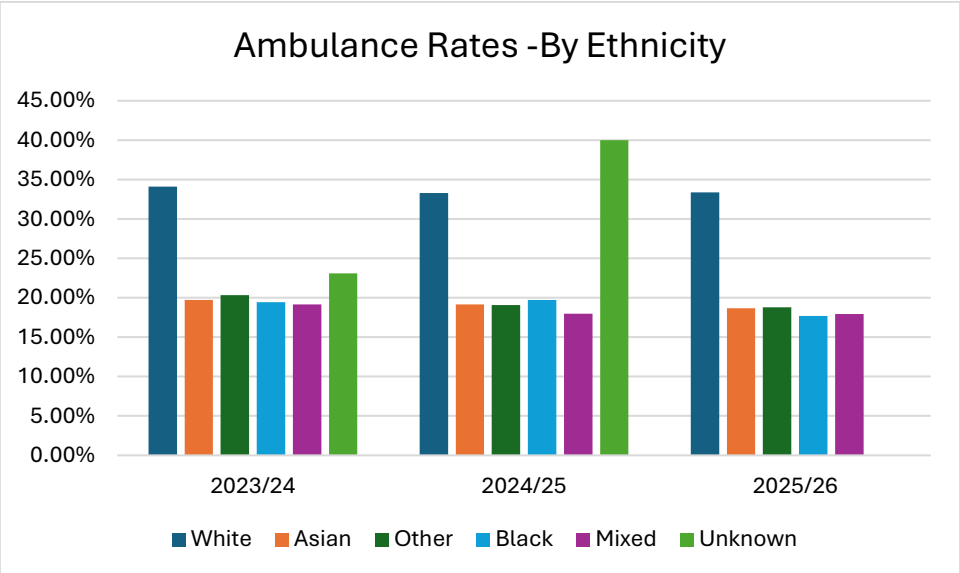


Supporting measures
inequalities in rates of ambulance calls across different patient groups - the calculations are based on how many ED attendances came via ambulance compared to all attendances in each cohort.

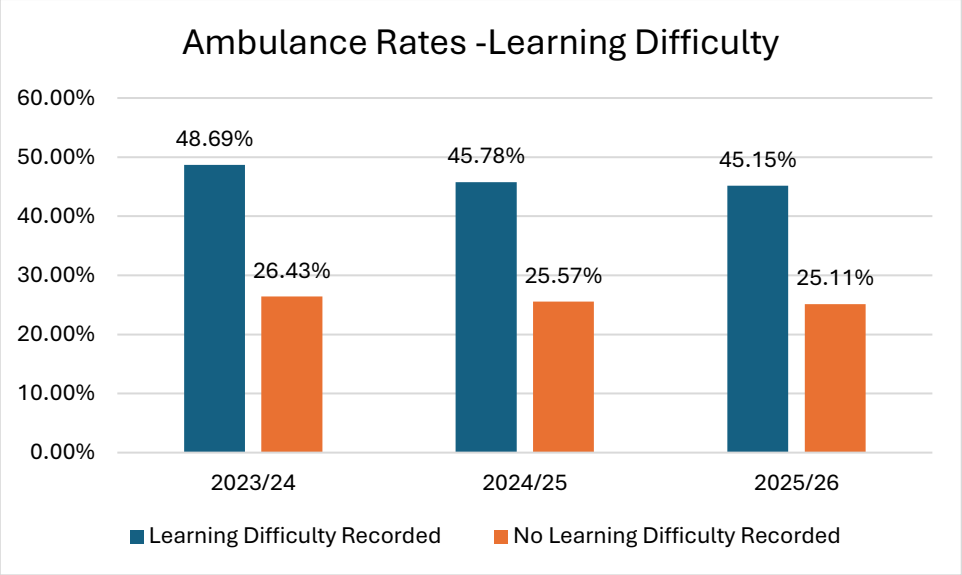
Ambulance Rates - Core 20 vs Non Core 20	2023/24	2024/25	2025/26
Non Core 20	29.11%	28.59%	28.37%
Core 20	25.24%	24.09%	23.44%



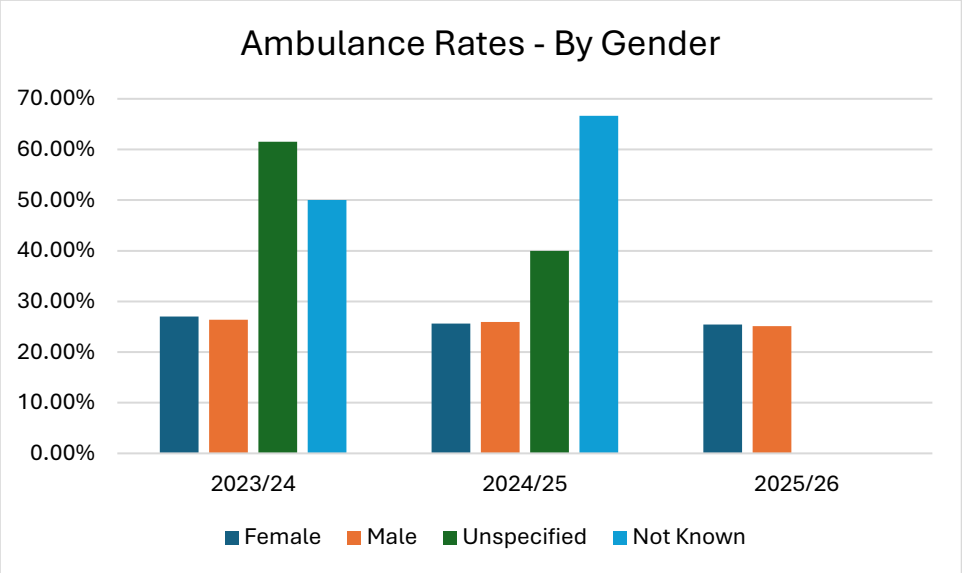
Ambulance Rates -By Ethnicity	2023/24	2024/25	2025/26
White	34.09%	33.28%	33.37%
Asian	19.73%	19.14%	18.66%
Other	20.32%	19.08%	18.80%
Black	19.42%	19.72%	17.69%
Mixed	19.14%	17.97%	17.93%
Unknown	23.08%	40.00%	0.00%



Ambulance Rates -Learning Difficulty	2023/24	2024/25	2025/26
Learning Difficulty Recorded	48.69%	45.78%	45.15%
No Learning Difficulty Recorded	26.43%	25.57%	25.11%



Ambulance Rates -By Gender	2023/24	2024/25	2025/26
Female	27.04%	25.63%	25.46%
Male	26.38%	25.97%	25.12%
Unspecified	61.54%	40.00%	0.00%
Not Known	50.00%	66.67%	



Ambulance Rates -By Age	2023/24	2024/25	2025/26
Older Adults (65+)	58.15%	55.91%	55.16%
Adults (19-64)	22.23%	21.49%	21.56%
Children and Young People (5-18)	10.58%	10.16%	9.08%
Children (under 5)	21.07%	19.46%	17.43%