Royal Papworth Hospital
NHS Foundation Trust

NHS Equality Delivery System 2022

EDS22 Report 2025-2026

Royal Papworth Hospital NHS Foundation Trust

04th March 2026

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Equality Delivery System for the NHS

EDS Reporting

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. EDS reviews should be carried out annually with the result of the review published on organisation websites by 28th February (or the following working day). Most reviews can be completed in-year; although it is recognised that flexibility may be required. Any justification for late publication must be provided and signed off at Board level.

The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.

During COVID-19, reporting of the EDS was suspended, and a review was undertaken by NHS England to incorporate system changes and take account of the new system architecture. Through collaboration, co-production and taking into account the impact of COVID-19, the EDS was updated.

This is the first report undertaken by RPH under the new system, we have learnt a lot from doing this and have identified a number if improvements in future years of doing this.

NHS England has requested that Trusts use their reporting template, this template is completed using a nationally prescribed format and starts from page 4 to page 37.

Trusts including RPH are required to refer to a rating and score card that can be found on page 5 of this document, providing information on how to score and weight evidence produced for the eleven outcomes across the three EDS domains, leading to

an overall EDS rating for the organisation. The definitions column provides a benchmark for evidence submitted.

Within the annual cycle of EDS evidence and insight-based reviews it is recommended that:

• Domain 1 – reviews (Commissioned or provided services) should take place during the summer months (quarter 2 of the financial year).

• Domain 2- reviews (Workforce health and well-being) should take place during the spring and/or summer months (quarters 1 and 2 of the financial year).

• Domain 3 – reviews (Inclusive leadership) should take place during the Autumn months (quarter 3 of the financial year).

Name of Organisation		**Royal Papworth Hospital (RPH)**		**Organisation Board Sponsor/Lead**	
				Director of Workforce and OD Chief Nursing Officer Acting Deputy Director of Workforce and OD	
Name of Integrated Care System		Cambridgeshire and Peterborough ICS			
EDS Lead	Acting Assistant Director of OD Berin Krenek, Health Inequalities Specialist		**At what level has this been completed**		
				***List organisations**	
EDS engagement date(s)	Domain 2 Review date: 13 November 2025 Domain 3 Peer Review date: 17 December 2025		**Individual organisation**	Royal Papworth Hospital NHS Foundation Trust	
			Partnership* (two or more organisations)	Cambridgeshire and Peterborough NHS Foundation Trust North-West Anglia Foundation Trust	
			Integrated Care System-wide*	Cambridgeshire and Peterborough ICS	
Date completed	04/03/2026		**Month and year published**	June 2026	
Date authorised	02/07/2026		**Revision date**	Feb 2027	

EDS Rating and Score Card

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services (Period November 2024 - November 2025)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Respiratory Support and Sleep Service** Our services are accessed through GP referral or via the "Refer a Patient" online platform for GDH referrals. We operate clear referral pathways supported by our dedicated bookings teams, with oversight from the Operations team to manage and review waiting lists fairly and consistently. We have a strong understanding of the patient population we serve, which includes individuals with progressive respiratory conditions who often require repeated, long-term support. Recognising that travel to hospital can be a significant barrier, we have developed a Hospital at Home service, enabling care to be provided closer to or within the patient's home, where appropriate. We also work in partnership with community respiratory teams to extend provision across localities. In addition, the RSSC ANP team are leading the HoHo trial, which explores whether patients can be safely initiated on NIV in their own homes — reflecting our	2	Review of 1 undertaken by: Berin Krenek

		commitment to innovation, inclusivity, and equitable service design. Accessibility and equity are central to our model. We consider the impact of disability, ethnicity, and socio-economic factors on an individual basis, adapting care accordingly. An example includes our response to a longstanding barrier: Car Park 2 lift dimensions do not accommodate bariatric wheelchairs. In response, we have published the lift specifications online and established a process where patients can arrange parking directly outside the hospital through Estates support. For patients with language needs, we provide an on-demand interpreting service via ward-based iPads, ensuring every patient can fully understand and participate in their care. Patients are actively involved in shaping information and pathways — for example, updates have been made to the tracheostomy tube log and resources for learning tracheostomy care and cough assist, following feedback and incident review. Patient feedback is sought routinely via surveys during inpatient or day-case admissions and contributes to our monthly Friends & Family Test reports. Results are shared transparently through a “You Said,		

		We Did" process. We recognise that participation rates remain challenging, given that many patients are on long-term pathways and may feel they have already shared their views. To address this, we have introduced QR codes in patient rooms, alongside paper options, to make giving feedback simpler and more accessible. Our services continue to evolve through this cycle of patient engagement, evidence-based practice, and innovation, ensuring that care remains equitable, inclusive, and responsive to the needs of our local communities. **Diabetes Service** The diabetes service is predominantly inpatient, with referrals from wards across the hospital. Occasionally, handovers are received from other hospitals when ongoing diabetes care is needed. The team monitors transplant patients for new-onset steroid-induced diabetes. Transitions occur via handover between DSNs at different hospitals, or to GPs on discharge. Notes may be added to e-discharge letters or separate letters sent. DSNs may support patients post-discharge with insulin adjustment before handing care back to the GP. Patient Experience The process relies on communication between		

		clinicians rather than a formal SOP. Patients may receive telephone follow-up or be seen at transplant clinic before full GP handover.		
	1B: Individual patients (service users) health needs are met	**Respiratory Support and Sleep Service** Transitions are identified through referral and managed by our dedicated Transitional Co-ordinator Lead. We have clear processes in place, supported by clinical leadership from one of the Consultants and Advanced Nurse Practitioner, with oversight from the Trust Transitional Care Steering Group. This ensures a structured and consistent approach to patient transfers across services. Patient Experience Multi-professional liaison is central to safe transition. We hold regular MDTs with Addenbrooke's Hospital, where both clinical teams and patients are involved in planning their onward pathway. This ensures patients are fully informed, supported, and prepared as they move between services. Continuous Improvement We are currently developing our own transition guidelines to strengthen consistency and quality. Once published, these will be evaluated through structured service user feedback to measure success and highlight further improvements. While formal evaluation is not yet complete, informal patient and professional feedback	2	

		has been positive, particularly regarding the support of the Transitional Co-ordinator role. All patients admitted to our service undergo a structured assessment using the Roper, Logan and Tierney model of nursing, ensuring care is framed around the individual's activities of daily living. On admission, assessments are completed electronically via Lorenzo, where an individualised care plan is created and tailored to the patient's identified needs. These plans are live documents that are reviewed and updated every shift, with additional updates for patients requiring complex interventions (e.g., tracheostomy patients, whose plans are updated at least three times daily). To support safe and comprehensive assessment, we also use nationally recognised assessment tools such as MUST (nutrition), Braden (pressure ulcer risk), and other ward-based competencies. Where needs are identified, patients are promptly referred to additional services such as dietetics, tissue viability, or social care. This approach ensures that every patient receives care that is both individualised and continuously evaluated. Patients have reported consistently positive experiences of the quality and responsiveness of their care,		

		with almost 100% recommending the service through the Friends & Family Test. Recent feedback has prompted improvements in the way we communicate with patients: for example, letters have been redesigned to provide more informative content. We also display a “You Said, We Did” board, which demonstrates how patient and staff feedback directly influences service improvements. Continuous Improvement Our care planning and evaluation processes are dynamic and responsive. By embedding feedback cycles alongside professional competencies, we ensure that staff have the skills and tools to assess needs accurately, escalate concerns, and adapt plans of care appropriately. Patient surveys and incident reporting continue to feed into service development. By linking national tools (MUST, Braden) with local innovation (improved patient communication and feedback cycles), we can evidence that individual health needs are not only assessed but met in ways that are appropriate, effective, and person-centred. **Diabetes Service** The service has not previously collected diabetes-specific feedback but is currently developing a patient satisfaction questionnaire. Patients are asked to		

		complete the Friends & Family Test on discharge, but participation rates are unknown. The Service Patients are assessed face-to-face on wards following internal referral. DSNs aim to see patients within 24 hours, involving family where appropriate. A care plan is agreed and documented in Lorenzo, with ward and medical teams informed. All DSNs hold specialist training, including a diabetes module; some have advanced assessment training.		
	1C: When patients (service users) use the service, they are free from harm	**Respiratory Support and Sleep Service** Patient safety is a priority. All mistakes, harm or near misses are reported via DATIX, investigated, and themed. Findings are shared through the Quality & Risk Management Group, Harm Free Care Panel, and Thoracic & Ambulatory Meeting Group. A Transitional Co-ordinator Lead manages referrals, with daily board rounds and weekly MDT meetings ensuring safe, well-planned care. Any patient admitted with existing skin damage has a DATIX completed and a referral to the Tissue Viability Nurse (TVN) and Safeguarding if required. The ward scorecard monitors VTE compliance, pressure ulcers, complaints, and infection control audits.	2	

		Patients consistently report feeling safe and well cared for, with almost 100% recommending the service in the FFT. Patient stories highlight high satisfaction and trust. Incident data show low numbers of falls and pressure ulcers, mainly categorised as low harm. Our openness in sharing outcomes and learning contributes to patient reassurance. Learning from incidents is shared in morning briefs and via the ward newsletter. Localised training is delivered where needed. The Trust's safeguarding policies and standards on acceptable behaviour are actively promoted, and any concerns about mistreatment or abuse are promptly addressed and reported sensitively. We continue to embed a culture of openness, transparency, and learning to strengthen safety for all patient **Diabetes Service** The Service Safety incidents are reported on DATIX. The service contributes to the National Diabetes Inpatient Harms Audit, monitoring DKA, HHS, foot ulcers, and severe hypoglycaemia. Patient Experience Feedback indicates some staff lack confidence in diabetes care, leading to disagreements between patients and staff		

		(e.g. insulin doses). Patients report this as frustrating. Learning from DATIX informs education sessions, including ward teaching, workshops, and new doctor inductions. The team is working to implement the Cambridge Diabetes Education Programme (CDEP). Abuse would be escalated via DATIX and DN090. The Service The team has a limited role in screening and vaccination. Health promotion is focused on healthy eating and reinforcing the importance of annual diabetes reviews and retinal screening. Patient Experience Health promotion is delivered face-to-face, with leaflets as backup. The team adapts materials, e.g. picture charts for non-readers or posters for patients with learning disabilities. Continuous Improvement Signposting includes referral to DESMOND and retinal screening for new diagnoses. Health promotion is not specifically embedded in the pathway but is delivered opportunistically. The Service All inpatients can be referred. Referrals come from across the hospital. Patient Experience Barriers include lack of non-English leaflets, but translation services are used. Adaptations include picture resources and flexible		

		education over multiple sessions, with relatives encouraged to attend. Continuous Improvement No patients have been denied access. Accessibility is assumed through the referral process, but there is no formal evaluation.		
	1D: Patients (service users) report positive experiences of the service	**Respiratory Support and Sleep Service** Positive feedback is captured through the "Laudit" system, which allows staff or patients to submit comments anonymously or named. These are shared via email. Patients also frequently send thank-you cards, which are shared with the whole team. Concerns or complaints can be raised directly with the nurse in charge/ward sister, through PALS, or via patient surveys. Where possible, concerns are resolved locally to ensure a quick response. Feedback is shared at ward handover, team meetings, and business meetings, keeping staff informed and engaged. Continuous Improvement learning and improvements are tracked through the "You Said, We Did" process, with actions recorded in the monthly Matrons' report, which is widely shared. Day to day, staff rely on visibility on the ward and direct conversations with patients to ensure care experiences remain positive.	1	

		Complaints can be raised through feedback forms or via PALS. At present, there are no active complaints within the service. The team seeks to resolve concerns quickly and locally where possible. If a patient or relative raises an issue, staff listen, identify the concern, investigate, and provide feedback. Where needed, escalation is made to the Matron, Head of Nursing, or Clinical Lead. The PALS team provides support for patients, relatives, and staff throughout the process. Learning from complaints is shared within the team and, where required, an action plan is developed to prevent recurrence. This ensures complaints are treated as an opportunity to improve care and maintain patient trust. **Diabetes Service** The team does not have a structured system for capturing positive feedback, though it is welcomed. Patient Experience Concerns are resolved locally where possible, with escalation to PALS if needed. Outcomes are documented in EMR and shared in team meetings. The team does not currently measure patient experience. Plans are in place to implement a patient satisfaction questionnaire to		

		address this. The Service The team is aware of PALS and DN195 but reports limited knowledge of the complaints process. No current complaints exist. Patient Experience Complaints are managed by the team lead, with PALS involvement as needed. Patients would be kept informed of progress. Continuous Improvement Complaints are rare, but any raised issues are used to work towards a positive outcome. This process is not formally captured.		
Domain 1: Commissioned or provided services overall rating			7	

Domain 2: Workforce health and well-being (Period November 2024 – November 2025)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	The organisation monitors the health of staff with protected characteristics. The organisation promotes self-management of conditions to all staff. The organisation uses sickness and absence data to support staff to self-manage long term conditions and to reduce negative impacts of the working environment. The organisation provides support to staff who have protected characteristics for all mentioned conditions. The organisation promotes work-life balance and healthy lifestyles. The organisation signposts to national and VSCE support.	1	Review of Domain 2 undertaken by: Lorraine Wilde Liz Taylor Ellie Abraham

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	The Trust has engaged Brap (joint authors of the Too Hot to Handle report into racism in the NHS) to deliver training to the Workforce Division. Senior leaders took part in a recent workshop designed to generate ideas and discussion to tackle bullying and harassment at the Trust. The findings are contributing to a bespoke 3-hour workshop as part of the developmental Line Manager Series. Within the same series, the Inclusive Working Relationships module explores micro-aggressions, incivility, and everyday discrimination. Members of staff are encouraged to speak up and to be an active bystander, and there are a number of well-advertised members of staff to speak up to. The Trust has signed the NHS Sexual Safety Charter and delivers respectful Relationship training to staff. Zero tolerance is a principle held by the Trust and framed as safety and inclusion. Staff are signposted to organisations which can help them and this work is being expanded.	2	

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	The organisation supports union representatives to be independent and impartial. Freedom to Speak Up champions are embedded, supported by the Trusts Freedom to Speak Up Guardian. Relevant staff networks are active, accessible and staff led. Equality impact assessments are applied when amending or creating policy and procedures for reporting abuse, harassment, bullying and physical violence. Support is provided for staff outside of their line management structure.	2	
	2D: Staff recommend the organisation as a place to work and receive treatment	In the 2024 NHS Staff Survey (published in 2025) the relevant results were as follows. 91% of staff would recommend the Trust as a place to receive care. 71% of staff would recommend the Trust as a place to work.	2	
Domain 2: Workforce health and well-being overall rating			7	

Domain 3: Inclusive leadership (Period November 2024 – November 2025)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Evidence provided at the peer review scored 2: Equality is a standing agenda item in all Board meetings, and the review group saw evidence that health inequalities is an item where reports concern patients and staff. The review panel was presented with evidence of internal visual communications detailing inclusion events attended by Board members and staff networks. Senior staff made themselves available and engaging in dialogue with underserved groups. Minutes of staff network meetings showed Executive members in attendance and contributing to the meetings. Each network has more than one senior sponsor. Board members hold services to account through governance structures including EDI Steering Group and the Health Inequalities Group, both of which report into committees of the Board.	2	Review of Domain 3 undertaken by peers in the ICS: CPFT Jo Wallis Dean Culvert Sue Rampal Ali Kassim NWAFT Hyacinta Zozulokova Joanna David Daniel Clifford Samantha Hemraj Maneesha Joseph

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Evidence was provided to demonstrate equality and health inequalities are standing agenda items in some board meetings. Equality Impact Assessments are completed and are built into the document control process. Decisions are made with consideration of equality and health inequality impacts. Interventions and actions are monitored through the EDI Steering Group and Health Inequalities Group and report into the Board. Executives attend the staff networks to complete the feedback loop.	2	

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Evidence was provided to show levers are in place to manage performance and monitor progress with input from staff networks and oversight by EDI Steering Committee and, through the Workforce Committee, to the Board. Action planning is based on organisational data and monitored for year-on-year improvements. WRES, WDES, Gender Pay Gap actions are monitored and made publicly available. Staff holding roles at AfC bands 7 and above are partially reflective of local population depending on the measures used. Targeted and funded, positive action development programme underway to address lack of parity.	3	
Domain 3: Inclusive leadership overall rating			7	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): As above	**Independent Evaluator(s)/Peer Reviewer(s):** Following submission of additional evidence, Hyacinta Zozulokova and Jo Wallis confirmed gradings above.

EDS Organisation Rating (overall rating): **21 Developing**

Organisation name(s): Royal Papworth Hospital NHS Foundation Trust

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Head of Equality, Diversity & Inclusion Health Inequalities Specialist	March 2026 - March 2027
EDS Sponsor	**Authorisation date**

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**RSSC** Ensure the service is accessible and equitable for all patients **Diabetes** Ensure patients requiring diabetes specialist input are identified and referred promptly.	Introduce a simple annual review of access (including virtual clinics, Hospital at Home and transport barriers) using patient feedback and referral data to identify any inequalities. Review ward referral patterns and develop a short guide for clinical teams explaining when and how to refer to the diabetes specialist nurses.	Mar 2027

	1B: Individual patients (service users) health needs are met	**RSSC -** Ensure all patients receive individualised care based on structured assessment **Diabetes -** Ensure education and care plans meet the needs of patients with different literacy or learning needs.	**RSSC** - Undertake periodic audits of electronic care plans to confirm assessments and referrals to specialist services **Diabetes** - Ensure education and care plans meet the needs of patients with different literacy or learning needs.	Mar 2027
	1C: When patients (service users) use the service, they are free from harm	**RSSC and Diabetes** Continue improving patient safety through monitoring and shared learning.	Review DATIX incident themes quarterly and deliver targeted training or safety reminders where patterns are identified.	Mar 2027
	1D: Patients (service users) report positive experiences of the service	**RSSC and Diabetes** Increase opportunities for patients to share their experiences of the service. .	Encourage completion of the Friends and Family Test during admission and discharge. **Diabetes** - Implement the planned diabetes patient satisfaction questionnaire	Mar 2027

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To pro-actively support staff with long term health conditions to manage their health and well-being.	Monitoring and reporting of protected characteristics in relation to sick leave for the mentioned conditions.	February 2027
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Continue to make the Trust a safer place for staff, free from harm.	Roll out and evaluate Line Manager Series including module on Bullying and Harassment and Inclusive Working Relationships. Make progress on sexual safety charter.	October 2026 Dec 2026
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Improve information signposting to independent support.	Update staff intranet and brief for FTSUGs.	October 2026
	2D: Staff recommend the organisation as a place to work and receive treatment	Improvement in recommendation to work here to above 85%.	Embed and evaluate existing programmes to improve employee experience.	February 2027

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Visibility inclusive leadership.	Board members and senior staff to continue to support staff networks,	Ongoing
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Embed health inequalities considerations into relevant Board and Committee Reports.	Health Inequalities to be a standing item in Board and Committee reports.	October 2026
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Capture the views and experiences of staff who are leaving or thinking of leaving the organisation.	Look at using Exit interviews in equality assessments. Consider other methods of capturing qualitative data.	Decision on method by October 2026.