

Corporate Gaslighting

Race, Recruitment and Denial in the NHS

2021-2022 Data Set

(includes some data sets from 2023-24 and 2024-25)

*An independent study of the likelihood of job-offer from application
by ethnicity, across the 18 NHS Acute Trusts in London*

Sheila Cunliffe FCIPD

Founder & Director

Citou Consulting

September 2025 (Reviewed September 2026)

“Gaslighting: A colloquialism for a specific type of manipulation where the manipulator is successful in having the target (a person or a group of people) question their own reality, memory or perceptions.”

Contents

Introduction	4
Executive Summary	4
The Process	6
How the Trusts Responded	7
A note about South West London ICB	7
A Note about Imperial	9
Issues with other trusts.....	9
Impact on the Research Programme.....	10
Individual Trust Responses	10
WRES Data compared with Corporate Gaslighting Data.....	11
Comparison Table – WRES Data and Corporate Gaslighting Data	13
Cross-London Analysis of Key Groups.....	15
Annual Spend on Overseas Recruitment of B5 Nurses.....	20
The Wider Evidence Base.....	21
Further Reading	22
Conclusions	23
Why this research is important	23
Volume of Applicants.....	23
Recommendations	24
1. Measure the whole recruitment process, not its final stage	24
2. Report ethnicity in the categories people actually belong to	24
3. Report on the whole workforce, not a single cohort	24
4. Bring international recruitment inside the same record	25
5. Make the data obtainable without recourse to the Information Commissioner	25
6. Give boards the report they need, and hold them to what it shows	25
Priorities for Action	27
NHS England	27
NHS London and the Integrated Care Boards.....	27

Acute trust boards.....	27
Other Issues of Concern	29
Acknowledgements.....	30
A note about the Author.....	30
Appendix 1 - What obligations do trusts have to understand and act on this data?	31
Public Sector Equality Duty.....	31
Trust Contract with NHS England.....	31
Appendix 2 – Freedom of Information Request, June 2022.....	32
Appendix 3 – GRC Decision Notice, October 2024	34
Appendix 4 – GRC Evidence Statement (RK)	35

Introduction

This research follows on from a very similar piece of work conducted by the author in 2021 which looked at race and recruitment for the year 1/4/20 to 31/3/21 in the 18 Acute NHS trusts in London.

Executive Summary

In June 2022 a Freedom of Information request was sent to all eighteen acute NHS trusts in London, asking how many people applied, were shortlisted and were offered a post, by ethnicity, across fourteen staff groups. It followed similar research published in October 2021. No trust replied within the statutory twenty working days. Obtaining the data took three years, complaints to the Information Commissioner and an appeal heard by the General Regulatory Chamber. One trust, Imperial, never provided anything beyond its overseas nurse recruitment figures.

The measure the NHS relies on looks at the wrong stage of the process.

WRES Indicator 2 — the recruitment measure every trust must report to NHS England — records the likelihood of appointment from shortlisting. Measured that way, the data in this report gives a cross-London ratio of 1.41 between White and BAME applicants: the same average figure WRES itself reports for those trusts. Measured from application, the point at which a candidate actually enters the process, the same data for the same trusts gives 2.59. The disparity almost doubles, and all of that additional disparity falls at a stage no trust is required to report.

The disparity runs across almost the whole workforce.

In seven of the eight staff groups analysed, White applicants were more likely to be offered a post than applicants of every other ethnicity. The widest gaps are in nursing. Band 5 registered nursing is by far the largest category in this data, with almost 87,000 applications across seventeen trusts; in it, Black applicants were offered posts at less than a quarter the rate of White applicants.

Two ethnicity categories conceal more than they show.

WRES compares BAME with White. One trust in this report has a BAME-to-White ratio of 4.60 which, once broken down, is offering posts to White applicants 7.49 times more often than to Black applicants.

Where a like-for-like comparison with 2021 is possible, outcomes have got worse.

Band 5 registered nursing is the only category directly comparable with the earlier research. Since 2020-21 the ratio has worsened for Black applicants from 2.4 to 4.4, for Mixed applicants from 1.4 to 3.0 and for Other applicants from 1.7 to 3.7. None of the four non-White groups improved.

Trusts are rejecting home applicants while paying to recruit overseas.

Twelve London trusts spent more than £22 million in a single year recruiting Band 5 nurses from abroad, while offering posts to between 0.8% and 16.41% of home applicants for the same roles.

The data trusts hold is not yet reliable enough to govern by.

Applicants whose ethnicity was not recorded had the highest offer rate of any group in four of the eight categories examined. Four trusts returned figures for SAS doctors on an apparently different definition from the other eleven. One trust needed individual guidance to produce a standard report from a recruitment system it had used for years.

The recommendations that follow ask for almost no data the NHS does not already hold. They ask for what is already recorded to be reported at the stage where the loss occurs, in categories specific enough to act on, and put in front of the people accountable for it.

The Process

The data in this report has been gathered via a Freedom of Information request sent to each of the 18 acute NHS trusts in London. The statutory timeframe for FoI request handling is that a response to the request must be provided within 20 working days. Following which, an Internal Review request must also be responded to within 20 working days.

For reasons set out in the 'How the Trusts Responded' section below, the data in this report has taken over 3 years to obtain and this report is, therefore, being published as a data set a considerable time after most of the data was provided. Public bodies can use sections of the FoI Act to delay or refuse to provide information. In this case, the following three sections of the act are of relevance:

Section 12	This section states that a public authority does not have to comply with a request for information if the authority estimates that the cost of complying with the request would exceed the appropriate limit. At the time of this request the limit was 18 hours or £450
Section 22	This exemption applies if, at the time the request is received, the public authority is preparing the material requested, intends for it to be published, and it is reasonable not to disclose it until then. The authority does not have to have an identified publication date. This exemption is qualified by the public interest test. The ICO confirmed that public bodies can delay response by 6-12 months when this exemption is applied.
Section 40	This exemption covers the personal data of third parties (anyone other than the requester) where complying with the request would breach any of the principles in the UK GDPR. In this case, Trusts using S40 claimed that the ethnicity of individuals would be identifiable through the public availability of this reporting. This provision is qualified by the public interest test.
Public Interest Test	When considering whether public bodies should disclose information, they need to weigh the public interest in disclosure against the public interest in maintaining the exemption. For example, in applying any of the above sections of the FoI Act, they must bear in mind that the principle behind the Act is to release information unless there is a good reason not to. To justify withholding information, the public interest in maintaining the exemption would have to outweigh the public interest in disclosure. Therefore, in choosing to apply one of the above sections the public body must not only be able to justify the technicality of the exception used but also be able to show that withholding the information is allowable on a public interest basis.

The Request

On 23 June 2022 a Freedom of Information request was made to the 18 acute NHS Trusts in London (Appendix 2). According to the statutory timeframes above, responses should have been received by 25 July and any internal reviews lodged dealt with by the end of August 2022.

No Trust responded within the statutory timeframe. By the end of Summer 2022 14 of the 18 trusts had responded. Unless otherwise specified on Page 9, the data in this report is from April 2021 to March 2022.

How the Trusts Responded

Trust		Trust	
Barking, Havering & Redbridge		Kings	
Barts		Kingston	
Chelsea & Westminster		Lewisham & Greenwich	
Croydon		London North West	
Epsom & St Helier		North Middlesex	
Guy's & St Thomas'		Royal Free	
Hillingdon		St George's	
Homerton		UCLH	
Imperial		Whittington	

	Provided the data	Provided the data with redactions or omissions	Provided the data using different ethnicity categories leading to more significant redaction	Provided the data after ICO complaints and successful GRC appeals.	Only provided overseas nurse data
--	-------------------	--	--	--	-----------------------------------

A note about South West London ICB

All four acute Trusts in South West London ICB refused to provide a response to this data request.

Croydon were generally unresponsive to the request, including follow-up emails and requests for Internal Review.

Kingston, St George's, and Epsom & St Helier all use a joint recruitment hub hosted by Kingston. These three trusts refused to provide the information requested stating to the ICO that:

"Following consultation with the Information Governance team at Kingston Hospital NHS Foundation (KHFT), ... it was advised that St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust should provide the same response given by KHFT and apply a Section 22 exemption."

After waiting 12 months for the S22 exemption to expire, the data was once again requested from the trusts who then responded by providing their WRES data which was not what was requested.

Formal complaints regarding Kingston, St George's and Epsom & St Helier were made to the ICO on the basis that they had relied on a S22 exemption and subsequently had not published the data requested as required by that section of the act. In addition, the three trusts appeared to have not retained the data needed to respond to the request. A complaint was also lodged with the ICO regarding Croydon's lack of response.

The trusts subsequently withdrew their reliance on a S22 exemption and cited S12 of the Act, saying that it would take hundreds if not thousands of hours to produce the data. No evidence of this timeframe was provided by the trusts to justify the statement and the ICO did not contact trusts who they knew had produced the data to ascertain whether this was correct. Despite argument and evidence to the contrary being submitted by the researcher, the ICO issued a decision notice in favour of the trusts using a S12 exemption.

The ICO Decision Notices on all four cases were then appealed to the General Regulatory Chamber (Information). The ICO asked the GRC to invite the four trusts to be joined to the case. None of the trusts accepted the GRC invitation. The GRC tribunal hearing in front of a Judge and two Tribunal Members, was held in September 2024. A representative of the ICO did not attend the hearing. I am grateful to Roger Kline, ex Director of WRES at NHSE for his provision of an evidence statement for the tribunal hearing (see Appendix 4).

The GRC found in favour of the appellant and against the ICO stating that:

"Section 22: Three of the Trusts originally cited S22 as an exemption and (later) changed the basis of their refusal to S12. Considering that the data was held for only 400 days this was an egregious position for those Trusts to take" ... "this impacted on the credibility of the Trusts"

Section 12: The Tribunal did not agree that the requested information was exempt from disclosure under S12. Neither the Trust nor the Commissioner could rely on that section and to that extent the Commissioner's decision was wrong"

The GRC issued a substituted decision notice stating that:

"The third parties shall within 35 days of being sent this Decision, respond to the Appellant's Part One request for information as detailed below without reliance upon Section 12 of the Freedom of Information Act 2000."

Following the GRC decision in October 2024 the full data was received from Kingston in November 2024. St George's and Epsom & St Helier both provided the data but chose to redact it, citing exemption under S40 of the Act. After initially being advised by the GRC that the next step was to lodge a Contempt of Court application, and doing so, the researcher was then informed that a further complaint should be made to the ICO regarding the appropriateness of relying on S40 to redact the data.

The ICO accepted the complaint and, after a four-month wait, allocated a case manager who contacted both trusts by phone. The unredacted data was then provided. St George's provided the data on 17 July 2025 and Epsom and St Helier on 24 July 2025.

The ICO declined the researcher's request to confirm the content of their conversation with the trusts or issue a Decision Notice regarding the two appeals against the use of a S40 exemption. Their reasoning was that the trusts had now provided the data. The ICO stated that they ask *"public authorities to consider changing their response and informally resolving a complaint. If it subsequently does so, it would be inappropriate to then penalise that authority."* In the view of the researcher, this approach is not helpful when public authorities such as Epsom & St Helier and St George's incorrectly apply multiple consecutive exemptions under the FoI Act resulting in the data being provided after 3 years rather than the statutory 20 days.

Croydon appeared to have issues within their Freedom of Information team and did not appear to have sufficient knowledge or experience to use the correct standard reporting in the Trac recruitment system to provide the requested data. Croydon initially responded to the GRC decision on 14 April 2025 by providing data which they later admitted they knew was almost certainly incorrect. The researcher worked with them to obtain reliable data in the correct format, and this was provided on 19 June 2025.

A Note about Imperial

Imperial did not provide any data other than the overseas nurse recruitment information despite repeated contact, a complaint to the ICO and a Decision Notice from them on 2 November 2022 (ref IC-196040-T1J2) requiring the trust to provide the data within 35 days. Due to the amount of work needed in relation to the four trusts in SW London ICB no further action was taken.

Issues with other trusts

UCLH refused to provide the data in the format requested, breaking two categories down at a lower level. The trust also relied on S40 of the FoI act, redacting their data when numbers were equal to or less than 4. As the trust had set out Chinese ethnicity separately from the Asian category and had applied a redaction this led to the higher-level Asian category becoming redacted when the two were totalled. UCLH also split the Unknown category into two categories which also resulted in small enough numbers to cause redaction when totalled.

In relying on S40 to redact the data, the trust acknowledged that a member of the public would not be able to ascertain the ethnicity of an individual from the data requested, but that their own staff, who had access to the Trac recruitment system, would be able to identify individuals.

An Internal Review of the trust decision was requested, the outcome of which was a continued refusal to provide the data in unredacted form and according to categories requested. Unfortunately, the 28 calendar days deadline for appeal to the ICO was missed.

It is noted that UCLH have recently been issued with an Enforcement Notice by the ICO which can be found here: <https://ico.org.uk/action-weve-taken/foi-regulatory-action/2025/06/university-college-london-hospitals-nhs-foundation-trust/>

Guy's and St Thomas' redacted their data when the numbers were less than or equal to 5¹ and did not respond to an Internal Review request.

It is noted that GST have recently been issued with a practice recommendation from the ICO which can be found here: <https://ico.org.uk/action-weve-taken/foi-regulatory-action/2025/07/guys-and-st-thomas-nhs-foundation-trust/>

Whittington redacted their data when the numbers were less than or equal to 5.

Barts initially cited a S12 exemption but, following an Internal Review request, they withdrew their reliance on S12 and provided the data for some categories. There were a significant number of categories where Barts said they were unable to respond as they did not hold the data requested.

Impact on the Research Programme

Following publication of the first Corporate Gaslighting report in October 2021, the intention was to undertake this research on an annual basis. Having had no response from Croydon and S22 responses from the three other trusts in SW London ICB, the intention was amended to undertaking the research on a biennial basis to accommodate their delayed response.

By January 2024 it became clear that the statutory process to address public authorities who did not wish to provide the data was exceptionally slow. The process of ICO complaints, a GRC hearing, possible Contempt of Court applications to the GRC and then, in the case of St George's and Epsom & St Helier, further ICO complaints to ensure the data was provided in unredacted form enabled the four trusts in SW London ICB to not fully respond until three years after the initial request.

Given the statutory timeframe for response to FoI requests is 20 working days with an additional 20 working days for an Internal Review if requested, it is easy to see how, when public authorities do not wish to provide data, they can weaponise consecutive exemption reasons in the FoI Act to frustrate the process.

Individual Trust Responses

The data for each individual trust and by professional group and ethnicity, with the numbers who Applied, and were Shortlisted and Offered is set out in a separate trust data tables document available at Citou.com/research-and-resources. The detailed likelihood of Shortlist

¹ GST did not state the precise number below which data was redacted. The commonly used number is less than or equal to 5

and Offer from Application is also set out in this document. A summary table for all trusts is also available.

Unless otherwise stated in the table on page 9 the data in this report is for the period April 2021 to March 2022.

WRES Data compared with Corporate Gaslighting Data

All AfC Staff 2021-22 (unless indicated)

WRES looks at the likelihood of offer from shortlist for AfC recruitment.

WRES compares two categories of ethnicity:

- BAME
- White

WRES reporting and action planning was introduced in April 2015 (see Appendix 4).

Although the categories within the report have evolved in that time, the basic premise of comparing BAME and White staff likelihood of offer from shortlist has not.

WRES does not break the BAME category into Asian, Black, Mixed, and Other categories and, as a result, fails to examine the stark differences in likelihood of offer between candidates of different BAME heritage. These, often significant, differences are set out in the data tables in this report.

In addition, in measuring likelihood of offer from interview, WRES fails to examine the differential likelihood of BAME and White candidates at shortlisting stage. These differences are set out in the data tables in this report.

The above WRES approach eventuates in the experience of applicants of individual Asian, Black, Mixed, and Other heritage being un-quantified. In turn, this results in wholly inadequate and largely ineffective Trust Board reporting which significantly impacts trust action planning in relation to WRES.

As an example: the table below sets out the figures for Epsom & St Helier University Hospitals NHS Trust, for all Agenda for Change roles, for the period November 2023 to November 2024. From these we can see that there is an All AfC BAME to White likelihood of offer from shortlist ratio of 1.45 and offer from application of 4.60. However, looking in detail at the data shows that the likelihood when broken down into Asian, Black, Mixed, Other, White and Unknown varies considerably with Black Candidates being more significantly less likely to be offered the role from either shortlist or application than is suggested by the BAME to White comparison. In this case, White applicants are 1.86 times more likely than Black applicants to be offered from shortlist and 7.49 times more likely to be offered from application.

Ethnicity	% Likelihood of offer from shortlist	% Likelihood of offer from application
Asian	14.02	1.79
Black	9.79	0.87
Mixed	12.64	1.69
Other	15.81	2.95
White	18.21	6.52
Unknown	20.62	4.45

Comparison Table – WRES Data and Corporate Gaslighting Data

DNP = Did not provide **UTC = Unable to calculate due to data redaction**

	2022 WRES REPORT DATA (Looks at likelihood of Offer from Shortlist)			CORPORATE GASLIGHTING DATA All data from 2021-22 unless otherwise stated			
	BAME	WHITE	Offer from shortlist likelihood ratio White & BAME	Offer from Application BAME	Offer from Application WHITE	Offer from shortlist likelihood ratio White & BAME	Offer from application likelihood ratio White & BAME
Barking, Havering and Redbridge	15%	28%	1.96	6.53%	13.12%	1.54	2.01
Barts	23%	34%	1.50	3.67%	10.75%	1.69	2.93
Chelsea and Westminster	9%	15%	1.72	3.26%	9.11%	1.61	2.80
Croydon (6/24-5/25)	4%	6%	1.43	2.11%	6.36%	1.4	3.02
Epsom & St Helier (11/23- 11/24)	3%	3%	1.04	1.42%	6.52%	1.45	4.60
Guy's & St Thomas'	17%	27%	1.61	UTC	10.04%	UTC	UTC
Hillingdon	21%	31%	1.51	2.49%	9.12%	1.36	3.66
Homerton	16%	22%	1.39	2.46%	4.92%	1.43	2.00
Imperial	11%	17%	1.55	DNP	DNP	DNP	DNP
Kings	4%	5%	1.34	1.31%	3.18%	1.75	2.43
Kingston (11/23-11/24)	20%	27%	1.38	1.73%	8.10%	1.54	4.69
Lewisham & Greenwich	16%	23%	1.39	5.12%	11.89%	1.38	2.32
London North West	3%	5%	1.33	2.36%	3.88%	1.15	1.65
North Middlesex	37%	43%	1.17	4.20%	5.21%	1.31	1.24
Royal Free (24-25)	27%	35%	1.26	12.04%	19.65%	1.23	1.63
St George's (11/23-11/24)	24%	30%	1.25	0.82%	1.03%	0.88	1.26
UCLH	19%	29%	1.53	UTC	9.5%	UTC	UTC
Whittington	21%	30%	1.42	UTC	5.02%	UTC	UTC

A closer look at the disparity ratios in the table above illustrates why the WRES methodology critiqued throughout this report understates the problem it purports to measure. Measured the way WRES measures it — likelihood of offer from shortlist, White against BAME — this report's own data gives a cross-London average of 1.41 across the fourteen trusts for which it can be calculated, the same as the WRES figure of 1.41 for those same fourteen trusts. This rate rises to 1.43 across all eighteen, ranging from 1.04 (Epsom & St Helier) to 1.96 (Barking, Havering and Redbridge). The two measures agree: what WRES reports is, in this example, accurate as far as it goes. Measured instead across the whole recruitment funnel, from application rather than from shortlist, the same data for the same fourteen trusts gives an average of 2.59, ranging from 1.24 (North Middlesex) to 4.69 (Kingston). The disparity almost doubles the moment the application stage is brought into the measurement — the stage WRES does not measure, and the stage at which the great majority of BAME applicants are lost.

In other words, a White applicant to a London acute trust is, on average, nearly two and a half times more likely to be offered a post than a BAME applicant — not the roughly 1.4 times suggested by the metric trusts are contractually required to report to NHS England. The difference lies in where the measurement begins, not in how ethnicity is grouped.

The two-category BAME/White split conceals a second problem. In the worked example above, a trust whose headline BAME-to-White ratio is 4.60 turns out, once the data is broken down, to be offering posts to White applicants 7.49 times more often than to Black applicants. The eight tables in the next section set out those differences for each staff group across London. They are not visible in anything trusts are currently required to report.

This is consistent with NHS England's own most recent national analysis, which found that at 80% of NHS trusts White staff were significantly more likely than Black and minority ethnic staff to be appointed from shortlisting (NHS England, 2025; full citation under 'Further Reading', page below). This report's data indicates that the London picture, examined at application stage and by individual ethnicity, is markedly worse than that national headline figure suggests.

Cross-London Analysis of Key Groups

The below data shows the Cross-London average % likelihood of offer for key professional groups. It also compares the offer rates with those from our 2021 research and highlights whether there has been an improvement or deterioration. Throughout this section the Offer Ratio is the number of times an applicant of White ethnicity is more, or less, likely to be offered a post than an applicant of Asian, Black, Mixed, Other or Unknown ethnicity; a ratio above 1.0 means White applicants were more likely to be offered.

A summary of all likelihood of offer % by trust is available in the Summary document which accompanies this report. A copy of the full data set by trust is also available. These documents can be downloaded at citou.com/research-and-resources.

	Base Number		Increase/Deterioration		Decrease/Improvement
--	-------------	--	------------------------	--	----------------------

Agenda for Change – bands 1-8b²

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio ³ White applicants of each ethnicity	Offer Ratio Increase or Decrease from 20-21	2020-21 Report Cross-London Average	2020-21 Offer Ratio White applicants of each ethnicity
Asian	17	4.0	2.0	0.1	3.3	1.9
Black	17	3.2	2.6	0.7	3.4	1.9
Mixed	17	4.4	1.9	0.3	3.9	1.6
Other	17	4.1	2.0	0.7	4.8	1.3
White	17	8.1	1.0	0.0	6.3	1.0
Unknown	16	11.3	0.7		DNC	

Agenda for Change – band 8c and above

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio White applicants of each other ethnicity	Offer Ratio Increase or Decrease from 20-21	2020-21 Report Cross-London Average	2020-21 Offer Ratio White applicants of each other ethnicity
Asian	16	2.5	3.2	0.6	2.9	2.6
Black	15	2.8	2.8	1.3	4.8	1.5
Mixed	15	3.9	2.0	-0.7	2.8	2.7
Other	15	6.3	1.3	-14.0	0.5	15.3
White	17	7.9	1.0	0.0	7.5	1.0
Unknown	16	16.0	0.5		DNC	

Note: percentages in the band 8c and above table rest on very small applicant numbers at most trusts. The 2020-21 comparison for the Other category — a cross-London average of 0.5%, giving a ratio of 15.3 — produces the largest single movement anywhere in this report and should not be read as a real change in outcomes.

² 2021 figure is for all AfC

³ Offer Ratio is the number of times an applicant of White ethnicity is more/less likely to be offered than an applicant of A,B,M,O,U ethnicity.

Registered Nurses at Band 5

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio White applicants of each other ethnicity	Offer Ratio Increase or Decrease from 20-21	2020-21 Report Cross-London Average	2020-21 Offer Ratio White applicants of each other ethnicity
Asian	17	11.0	1.2	0.0	11.3	1.2
Black	17	2.9	4.4	2.0	5.9	2.4
Mixed	16	4.2	3.0	1.6	9.9	1.4
Other	16	3.5	3.7	2.0	8.3	1.7
White	17	12.7	1.0	0.0	13.9	1.0
Unknown	16	21.9	0.6		DNC	

Registered Nursing at Band 8c and above⁴

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio White applicants of each other ethnicity	Offer Ratio Increase or Decrease from 20-21	2020-21 Report Cross-London Average	2020-21 Offer Ratio White applicants of each other ethnicity
Asian	14	2.6	4.8	2.3	7.7	2.5
Black	14	17.6	0.7	-1.0	11.0	1.7
Mixed	12	4.2	2.9	1.4	13.2	1.5
Other	10	5.0	2.5	0.4	9.0	2.1
White	13	12.3	1.0	0.0	19.2	1.0
Unknown	9	13.0	0.9		DNC	

Registered Midwives at Band 6⁵

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio White applicants of each other ethnicity
Asian	14	11.9	2.3
Black	14	12.3	2.2
Mixed	12	22.2	1.2
Other	12	11.5	2.3
White	15	26.8	1.0
Unknown	10	14.5	1.8

⁴ 2021 figure is for 8a and above. Percentages in this category rest on very small applicant numbers — single figures at most trusts — and should be treated as indicative only.

⁵ Not collected in 2021

All Allied Health Professionals⁶

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio White applicants of each other ethnicity
Asian	17	3.5	3.6
Black	17	3.2	3.9
Mixed	16	4.9	2.6
Other	15	5.8	2.2
White	17	12.7	1.0
Unknown	15	9.3	1.4

All SAS Roles⁷

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio White applicants of each other ethnicity	Offer Ratio Increase or Decrease from 20-21	2020-21 Report Cross-London Average	2020-21 Offer Ratio White applicants of each other ethnicity
Asian	15	9.9	2.0	-2.7	1.66	4.7
Black	14	8.7	2.3	-4.9	1.09	7.2
Mixed	14	18.9	1.1	-3.3	1.78	4.4
Other	14	19.2	1.0	-3.7	1.67	4.7
White	14	20.0	1.0	0.0	7.84	1.0
Unknown	13	8.6	2.3		DNC	

All Medical Consultant Roles⁸

	Number of useable data points	Cross-London Acute Trust Average of Likelihood Percentages	Offer Ratio White applicants of each other ethnicity	Offer Ratio Increase or Decrease from 20-21	2020-21 Report Cross-London Average	2020-21 Offer Ratio White applicants of each other ethnicity
Asian	15	17.1	1.4	-0.2	14.0	1.6
Black	15	15.4	1.5	-0.1	13.6	1.6
Mixed	15	14.7	1.6	-0.4	10.9	2.0
Other	15	11.0	2.2	-0.3	8.6	2.5
White	15	23.9	1.0	0.0	22.0	1.0
Unknown	14	26.7	0.9		DNC	

⁶ Not collected in 2021

⁷ 2021 figure is for All Medical

⁸ 2021 figure is for All Permanent Consultants

Read across the detailed tables above, three patterns stand out. First, in seven of the eight categories, and for every non-White ethnicity, the Offer Ratio exceeds 1.0 — White applicants are more likely to be offered a post than every other group, across almost every part of the workforce examined. Some of these gaps are stark: in Registered Nursing at Band 8c and above, Asian applicants are offered at little more than a fifth the rate of White applicants (ratio 4.8); in Registered Nurses at Band 5 — by far the highest-volume category in this report (see ‘Volume of Applicants’, below) — Black applicants are offered at less than a quarter the rate (ratio 4.4). The single exception to the pattern falls in the same senior nursing category, where Black applicants were more likely than White applicants to be offered a post (ratio 0.7). That category rests on fourteen useable trust data points and on single-figure applicant numbers at most trusts and should not be read as evidence of a different pattern at senior nursing level.

Second, where a genuine like-for-like comparison with the 2021 report is possible, the trend is one of deterioration rather than improvement. Registered Nurses at Band 5 is the only category in which the 2021 comparison is drawn from the same staff group, and it is also by far the largest in this data set. In it, the Offer Ratio has worsened for Black applicants from 2.4 to 4.4, for Mixed applicants from 1.4 to 3.0 and for Other applicants from 1.7 to 3.7, while for Asian applicants it is unchanged at 1.2: three of the four non-White groups worse, one unchanged, none improved. Taken across all six categories for which a 2020-21 figure is given, twelve of the twenty-four ethnicity/category combinations show the ratio worsening, eleven show it is improving, and one is unchanged — but sixteen of those twenty-four rest on a 2021 comparator drawn from a different staff group, as the footnotes to the tables above record, and should be read with that in mind. None of this is the picture of consistent progress that repeated Board and NHS England commitments to anti-racist practice would suggest.

Third, some of the largest apparent year-on-year improvements need to be read with care. All SAS Roles appears to show ratios falling by more than half since 2021 — from 4.7 to 2.0 for Asian applicants, 7.2 to 2.3 for Black, 4.4 to 1.1 for Mixed and 4.7 to 1.0 for Other — but the table’s own footnote records that the 2021 comparison figure was drawn from ‘All Medical’ staff generally, not the SAS grade specifically. Nor is the SAS data securely comparable between trusts: as the Data Anomalies note to the accompanying data tables records, Barts, King’s, Hillingdon and Guy’s & St Thomas’ returned SAS applicant numbers one to two orders of magnitude above the other eleven trusts, which points to a wider definition of the grade, and those four trusts remain within the cross-London SAS average. Registered Nursing at Band 8c and above and All Medical Consultant Roles carry similar footnoted caveats about a change in the comparison group, while Registered Midwives at Band 6 and All Allied Health Professionals were not measured at all in 2021. Apparent improvement in these categories may therefore reflect a change in what was measured rather than a change in outcomes for applicants.

A fourth pattern is worth noting. Applicants whose ethnicity is not recorded have the highest offer rate of any group in four of the eight categories — Agenda for Change bands 1-8b (11.3% against 8.1% for White applicants), bands 8c and above (16.0% against 7.9%), Registered Nurses at Band 5 (21.9% against 12.7%) and All Medical Consultant Roles (26.7% against 23.9%). In bands 1-8b the Unknown rate is some 40% higher than the White rate. Whatever the explanation — recording practice, internal or already-known candidates, or routes that bypass the standard process — it bears directly on the quality of the records from which trusts compile their WRES returns: at the point where ethnicity is not recorded at all, applicants fare better than any group whose ethnicity is.

Annual Spend on Overseas Recruitment of B5 Nurses

In a climate where NHS trusts had significant vacancy rates, the NHSE Capital Nurse programme had set aside a considerable budget to recruit B5 nurses from overseas. The high application and low offer numbers in this report, along with the below data provided as part of the FoI request for this research, appear to be in stark contrast to each other. All data below is from 2021-22 unless otherwise stated in the above table.

DNP = Did not provide

UTC = Unable to calculate due to data redaction

RTP= Refused to provide

	NHSE Funding	Additional Trust Expenditure	Total Expenditure	Number Recruited via overseas recruitment campaigns	Overseas Recruitment - Cost per Recruit	% of B5 Nursing applicants to UK adverts who were offered (detailed data tables below)
Barking, Havering and Redbridge	1,339,176	3,027,440	4,366,616	260	16,795	6.9%
Barts	222,300 ⁹	RTP ¹⁰	UTC	165	UTC	2.8%
Chelsea and Westminster	287,000	1,340,000	1,627,000	135	12,052	12.3%
Croydon	DNP					2.0%
Epsom & St Helier	488,000	1,949,000	2,437,000	253	9,632	1.2%
Guy's & St Thomas'	DNP					UTC
Hillingdon	390,000	2,302,040	2,692,040	130	20,708	1.4%
Homerton	No Recruitment					2.6%
Imperial	286,825	1,572,552	1,859,377	130	14,303	DNP
Kings	1,050,000	835,830	1,885,830	306	6,163	1.4%
Kingston	0	971,767	971,767	78	12,459	2.6%
Lewisham and Greenwich	362,261	1,135,199	1,497,460	59	25,381	3.7%
London North West	280,703	1,050,251	1,330,954	189	7,042	3.1%
North Middlesex	0	490,200	490,200	57	8,600	5.2%
Royal Free	61,394	2,471,027	2,532,421	318	7,964	16.41%
St George's	DNP					0.8%
UCLH	DNP					11.1%
Whittington	337,812	338,076	675,888	69	9,795	UTC
TOTAL/AVERAGE	4,883,171	17,483,382	22,366,553	1,984	11,273	4.9%

⁹ Not included in the TOTAL/AVERAGE figure

¹⁰ Barts refused to provide data on trust expenditure on the grounds of commercial sensitivity

This pattern is not unique to London, nor to this data set. In September 2024, Roger Kline — the original architect of WRES and a contributor to this research (see Appendix 4) — warned that WRES Indicator 2 has appeared static nationally (at a likelihood ratio of around 1.59) largely because the shortlisting data for internationally recruited staff, drawn from overwhelmingly BAME applicant pools overseas, is often never entered into the same TRAC recruitment records used to calculate the indicator. Where it is included, he documented cases where an apparently improving ratio (0.59) became a markedly worse one (1.40) once the omitted data was restored (Kline, 2024; full citation under ‘Further Reading’, below). The pattern in this report’s own overseas recruitment table — the twelve London trusts that disclosed their expenditure spending, between them, over £22 million in a single year recruiting Band 5 nurses from overseas while rejecting the great majority of home applicants to the same roles, with four further trusts and the trust-funded element at a fifth not disclosed — is precisely the phenomenon Kline describes: heavy, high-cost overseas recruitment can mask, and even flatter, the scale of the domestic recruitment disparities documented throughout this report.

The Wider Evidence Base

The findings in this report do not stand alone. They sit within a substantial and long-running body of research documenting racial inequality in NHS recruitment, career progression and governance — much of it produced or commissioned by the NHS’s own regulators and professional bodies.

Ten years before this report, Roger Kline’s ‘The Snowy White Peaks of the NHS’ (2014) found that London’s NHS boards did not reflect the ethnic diversity of the workforce or population they served, and argued that this absence of BAME representation at governance level was itself a barrier to addressing exactly the kind of recruitment disparity documented in this report. The Race Equality Foundation’s 2022 follow-up briefing, ‘Beyond the Snowy White Peaks of the NHS?’, found that progress on board diversity had remained slow eight years on — a finding this report’s own observations about Board oversight (see ‘Other Issues of Concern’, below) echo at trust level.

The General Medical Council’s 2019 ‘Fair to Refer?’ report, led by Dr Doyin Atewologun and Roger Kline, found that BAME doctors are referred to fitness-to-practise proceedings by their employers at more than double the rate of White doctors, and identified organisational cultures — isolated working, blame-focused management, weak induction for overseas-trained staff — as root causes, rather than the conduct of individual doctors. The parallel with this report’s recruitment data is direct: the same trusts, and often the same workforce groups, show both a lower likelihood of being offered a post in the first place and a higher likelihood of adverse treatment once employed.

The British Medical Association's twin 2022 reports, 'Racism in Medicine' and 'Delivering Racial Equality in Medicine', found that 76% of ethnic minority doctors surveyed had experienced racism at work in the preceding two years at a time when ethnic minority doctors made up 41.9% of the medical workforce, and called for far greater regulatory and employer accountability — including scrutiny of recruitment and progression data by ethnicity, precisely the kind of scrutiny the current WRES methodology does not provide (see page 9).

Taken together with NHS England's own 2025 finding (reporting 2024 data) that White staff were more likely than BAME staff to be appointed from shortlisting at 80% of trusts nationally, the picture is consistent and long-standing. This report's London-specific, application-stage, ethnicity-disaggregated data does not reveal a new problem so much as it reveals, in much sharper detail, the scale of one that has been documented, acknowledged and left largely unaddressed for over a decade.

Further Reading

- Kline, R. (2014) The Snowy White Peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. Middlesex University.
- Race Equality Foundation (2022) Beyond the Snowy White Peaks of the NHS? Better Health Briefing 39.
- Atewologun, D., Kline, R. and Ochieng, M. (2019) Fair to Refer? Reducing Disproportionality in Fitness to Practise Concerns Reported to the GMC. General Medical Council.
- British Medical Association (2022) Delivering Racial Equality in Medicine; Racism in Medicine survey report. 15 June 2022.
- NHS England (2025) NHS Workforce Race Equality Standard 2024 Data Analysis Report for NHS Trusts. 25 June 2025.
- Kline, R. (2024) WRES 2 data and international recruitment: a serious problem? 15 September 2024.

Conclusions

Why this research is important

In health and social care, data drives the personalisation and optimisation of clinical treatment plans. By analysing data from various sources, healthcare professionals can make more informed decisions, improve treatment effectiveness, and enhance patient outcomes. This approach is currently enabling the sector to move away from generic care towards individualised and more proactive treatment strategies.

It is, therefore, difficult to understand why support services within the NHS shy away from data driven service development. In many cases, they continue to do what they have always done and expect the result to be different. Evidence suggests that where NHS managers have used data to do things differently, the results can be dramatic improvement within a relatively short period of time.¹¹

What the data in this report shows is that, across the board, irrespective of whatever interventions have been made at corporate or team level, significant racism in recruitment continues to demonstrate that the NHS is institutionally racist. It also demonstrates that commitments to anti-racist practice by NHS England and by individual Trust Boards has failed to result in the significant change identified and promised for many years.

Volume of Applicants

Although volume of applicants compared with number of candidates offered the role is not at the heart of this research, it is a significant byproduct of the FoI request. It is evident from this research that all trusts have large volumes of applicants in many recruitment categories and are making very few offers.

Most significant is the number of applicants and offers made in the recruitment of Band 5 Registered Nurses. B5 is the starting band for RNs and covers roles which should be suitable for any qualified and registered nurse. Roles which require specialist skills and experience would be graded at Band 6.

The table on page 13 primarily concerns the cost of overseas nurse recruitment but also sets out data on the percentage of applicants offered Band 5 RN roles via general advertisement. The highest offer rate calculable is Royal Free at 16.41% of applicants, the lowest calculable is 0.8% at St George's.¹² Significant cost is allocated to overseas recruitment of B5 Nurses by both NHS England and by individual trusts. In these circumstances, it is difficult to understand why so many qualified and registered applicants are being rejected.

¹¹ See 'Implementing Batch Recruitment to Improve Nursing Offer Rate and Diversity' at Citou.com/research-and-resources

¹² It is important to note that the Trac recruitment system used by all 18 trusts in this research allows the use of 'Killer Questions' which prevent progression to application if a potential candidate is not a qualified Registered Nurse.

Recommendations

The findings in this report are not new. They sit alongside a decade of research — Roger Kline’s ‘The Snowy White Peaks of the NHS’ (2014), the General Medical Council’s ‘Fair to Refer?’ (2019), the British Medical Association’s ‘Racism in Medicine’ (2022), and NHS England’s own finding that at 80% of trusts White staff were more likely than Black and minority ethnic staff to be appointed from shortlisting. What this report adds is precision about where in the recruitment process the loss occurs, and how much of it the current reporting requirement does not see.

That is where the recommendations below begin. Almost none of them asks for data that is not already held. They ask for what is already recorded to be reported at the stage where it matters, in categories specific enough to act on, and for the people accountable to be shown it.

1. Measure the whole recruitment process, not its final stage

WRES Indicator 2 measures the likelihood of appointment from shortlisting. Measured that way, the data in this report gives a cross-London ratio of 1.41 — the same figure WRES itself reports for those trusts. The metric is doing what it was designed to do. Measured from application, the point at which a candidate actually enters the process, the same data for the same trusts gives 2.59. The disparity almost doubles, and all of that additional disparity occurs at a stage no trust is required to report.

We recommend that NHS England adds an application-to-shortlist measure to WRES Indicator 2 and to the Technical Guidance that accompanies it. The data is already held in Trac; no trust would need to collect anything new.

2. Report ethnicity in the categories people actually belong to

WRES compares two categories, BAME and White. The example set out earlier in this report shows a trust with an BAME-to-White ratio of 4.60 which, once broken down, is offering posts to White applicants 7.49 times more often than to Black applicants. An aggregated figure cannot direct action, because it does not say who is being lost.

We recommend reporting against the six ethnicity categories used in the 2021 Census, as this research does. Where numbers are too small to report safely, that should be stated rather than absorbed into an aggregate.

3. Report on the whole workforce, not a single cohort

WRES reporting covers one cohort of Agenda for Change staff. This research requested fourteen staff groups and found White applicants more likely to be offered a post in seven of the eight key groups analysed, with the widest gaps in Band 5 nursing, senior nursing and the medical grades. None of those groups is separately visible in a WRES return.

We recommend that reporting is extended to registered nursing and midwifery by band, the allied health professions, non-consultant and consultant grades, and bank recruitment.

4. Bring international recruitment inside the same record

Roger Kline's 2024 analysis found that WRES Indicator 2 has appeared static nationally in part because shortlisting data for internationally recruited staff, drawn from overwhelmingly BAME applicant pools, is often never entered into the Trac records from which the indicator is calculated. Where the omitted data was restored, an apparently improving ratio of 0.59 became 1.40.

This report's own overseas recruitment data shows why that matters in London. Twelve trusts spent over £22 million in a single year recruiting Band 5 nurses from overseas, while offering posts to between 0.8% and 16.41% of home applicants for the same roles.

We recommend that recruitment by every route, including international campaigns and agency appointments, is recorded in the same system and included in the same return.

5. Make the data obtainable without recourse to the Information Commissioner

It took three years, complaints to the Information Commissioner and a hearing before the General Regulatory Chamber to obtain data from four London trusts — data those trusts are contractually required to compile each year. One of them needed individual guidance to produce a standard report from a recruitment system it had used for years. Whatever else that demonstrates, it is not the behaviour of organisations confident in what their own data shows.

We recommend that NHS London and the Integrated Care Boards publish application-stage recruitment data for every London trust annually, so that comparison between trusts does not depend on the Freedom of Information Act; and that WRES submissions are capable of verification against source records on request.

6. Give boards the report they need, and hold them to what it shows

Boards cannot act on what they are not shown. A board receiving only a WRES return sees one cohort, two ethnicity categories, and the last stage of the process.

Band 5 registered nursing should be the first priority. It carries the largest number of applicants in this data set; it is the only category with a clean comparison to our 2021 research; and on that comparison three of the four non-White groups have worsened while none has improved. Boards should also ask why applicants whose ethnicity is not recorded have the highest offer rate of any group in four of the eight categories examined. That is a question about the reliability of the board's own data, and it is one the board is entitled to have answered.

We recommend that trust boards receive, at least twice a year, offer rates from application by the six ethnicity categories and by staff group, with the shortlisting stage reported separately; and that they see the Freedom of Information refusals and exemptions applied in their name.

7. Make the evidence count in regulation

In our 2021 report we recommended that demonstrable evidence of anti-racist practice should form part of the Care Quality Commission's Well-Led assessment. That has not happened. In December 2022 the CQC rated Kingston 'Good' for Well-Led, despite the data that trust had provided for the previous report showing 418 Black applicants for medical roles in 2020-21 with no offers made, against 317 White applicants and 50 offers in the same period.

We repeat the recommendation. Application-stage recruitment data, and the action a board has taken on it, should be evidence considered in Well-Led assessment.

Taken together these recommendations ask for something modest in technical terms and considerable in effect: that the NHS looks at the whole of its own recruitment process, in enough detail to see who is being lost, and puts the answer in front of the people accountable for it. The accompanying page, 'Priorities for Action', sets out what each of NHS England, NHS London and individual trust boards would need to do

Priorities for Action

The findings in this report point to one structural conclusion: the NHS measures recruitment equality at the wrong stage of the process, reports it in categories too broad to act on, and does so for only part of its workforce. The actions below follow from that.

NHS England

1. **Measure from application, not from shortlist.** WRES Indicator 2 is accurate for what it measures — this report's own shortlist-stage ratio is 1.41, the same as the WRES figure for the same trusts. Measured from application it is 2.59. Adding an application-to-shortlist indicator to the WRES technical guidance would make visible the stage at which the great majority of BAME applicants are lost.
2. **Report the six census ethnicity categories, not two.** A single BAME-to-White ratio of 4.60 at one trust in this report conceals a Black-to-White ratio of 7.49. Aggregate reporting cannot support targeted action.
3. **Extend the reported cohort beyond Agenda for Change bands 1-8b** to registered nursing and midwifery by band, the allied health professions, SAS and consultant grades, and bank recruitment — the groups in which this report finds the widest gaps.
4. **Require international recruitment to be recorded in the same system.** Kline (2024) documented a reported ratio of 0.59 becoming 1.40 once omitted overseas data was restored. Until this is mandatory, WRES Indicator 2 understates disparity nationally.
5. **Make the return auditable.** Four London trusts took three years, an ICO complaint and a tribunal hearing to produce data they are contractually required to hold. WRES submissions should be capable of verification against source records on request.

NHS London and the Integrated Care Boards

6. **Publish application-stage recruitment data for every London trust annually,** broken down as above, so that comparison between trusts does not depend on Freedom of Information requests.
7. **Apply the same expectation to shared recruitment hubs.** Three trusts using a single hub issued one co-ordinated refusal to this request. Shared infrastructure should produce shared, comparable data.
8. **Set overseas recruitment spend against domestic offer rates.** Twelve London trusts spent over £22 million in a single year recruiting Band 5 nurses from overseas, while offering posts to between 0.8% and 16.41% of home applicants for the same roles.

Acute trust boards

9. **Ask for the right report:** offer rates from application, by the six ethnicity categories, by staff group, at least twice a year, with the shortlisting stage shown separately.
10. **Start with Band 5 nursing.** It is the highest-volume category in this report and the only one with a clean comparison to 2021; on that comparison three of the four non-White groups have worsened and none has improved.

11. **Ask why unrecorded ethnicity outperforms every recorded group**, as it does in four of the eight categories examined. That is a question about the integrity of the board's own data.
12. **See what has been refused in the board's name.** Freedom of Information refusals, and the exemptions applied on the trust's behalf, should come to the board.
13. **Put the evidence into Well-Led.** Application-stage data, and the action taken on it, belong in CQC assessment.

None of this requires a new data collection. It requires reporting what is already recorded, at the stage where the loss occurs, in categories specific enough to act on.

Other Issues of Concern

*“If there is junk in your attic, you may not have put it there,
but it’s your job to clear it up”*

John Amaechi

The data in this report raises many other questions such as the role of Boards in monitoring the effectiveness of trust anti-racism work and holding the organisation to account for lack of progress. In turn, the important role of Board highlights, the lack of diversity of knowledge and experience in this area and any significant improvement following the NHSE commitment to ensure greater Board diversity.

However, in addressing the issue of racism in recruitment, the most significant question appears to be that of allyship.

It is difficult to understand how, on either an individual or organisational level, boards (and senior managers) whose trust data is contained in this report can claim to be anti-racist allies.

It is difficult to understand how the boards of the three trusts in South West London ICB felt it was appropriate for their Directors to jointly agree they would refuse to provide data for this study. Instead, to maintain their position, they chose to cite unsustainable exemptions which were overturned on two (Kingston) or three (E&SH, and St George’s) occasions by the ICO/GRC. The other trust in SW London (Croydon) failed to respond, was included in the GRC tribunal case, and subsequently needed 1:1 guidance in how to produce the reporting from the Trac system they had been using for many years.

If the NHS is to provide excellent care to a diverse population it needs to recruit the best talent possible and that means appointment and promotion based on suitability for the role and without bias.

This report follows on from the original ‘Corporate Gaslighting – Race Recruitment and Denial in the NHS’ report, published in October 2021, and forms part of an ongoing programme of research. The more recent data included in this report gives no indication of improvement: across the five trusts whose data relates to 2023-25 — Croydon, Epsom & St Helier, Kingston, Royal Free and St George’s — the White-to-BAME likelihood of offer from application averages 3.0, against 2.6 across London as a whole, though individual trusts within that group range from 1.26 to 4.69. Future rounds of this research will repeat most of the professional categories covered here, allowing a clearer picture to emerge of whether meaningful improvement occurs over time.

Eliminating racism in the NHS is the responsibility of us all. The attic is well overdue for a clear-up. Let’s get on with it!

Acknowledgements

My thanks to the following for their help and encouragement in the production and peer review of this report:

- Daniel Collard (RMN), Former NHS England EDI manager and Senior Programme Manager Workforce Equality, Temporary Staffing Strategy and National Workforce Insight;
- Roger Kline, Consultant on Workforce Culture, Research Fellow at Middlesex Business School, and ex Director of NHS England Workforce Race Equality Strategy;
- Surash Surash, Neurosurgeon and Former Consultant Neurosurgeon at Neurolex Consulting Ltd;
- Amanda Whitlock, Mental Health and Wellbeing Consultant

A note about the Author

Sheila Cunliffe is an executive-level People, OD and EDI professional with over 35 years of experience in the Health, Education, Public and Not for Profit Sectors. She is the Founder and Director of Citou Consulting.

Sheila began her independent research into racism in recruitment in the 18 Acute NHS Trusts in London in 2021 having done similar research in-house whilst working for individual trusts.

Sheila's first research report 'Corporate Gaslighting - Race Recruitment and Denial in the NHS' was published in October 2021. The report and associated media coverage can be found at:

citou.com/research-and-resources

Sheila intends to continue this research, with a further report examining whether meaningful change has occurred since 2020.

All Sheila's work on this research is carried out on a pro-bono basis.

Appendix 1 - What obligations do trusts have to understand and act on this data?

Public Sector Equality Duty

Each trust has a statutory obligation through the Public Sector Equality Duty requiring them to consider, and keep reviewing, how they are promoting equality in recruitment, promotion and performance management of employees to:

- put an end to unlawful behaviour that is banned by the Equality Act 2010, including discrimination, harassment and victimisation
- advance equal opportunities between people who have a protected characteristic and those who do not
- foster good relations between people who have a protected characteristic and those who do not

As highlighted on Page 9 of this document, the robustness of WRES reporting on level of offer from shortlist rather than application; by only two categories of ethnicity (BAME and White); and for one cohort of all staff recruited on AfC contracts is highly questionable in the context of compliance with and the ability to take action on the above aspects of the Public Sector Equality Duty.

Trust Contract with NHS England

Each NHS Trust has a contractual obligation with NHS England which states that they:

- Must produce annual WRES Reporting for NHS England and for their own Board
- Must produce an annual WRES Action Plan setting out how key issues will be addressed and improvements made.

As mentioned in Roger Kline's Witness Statement to the GRC Tribunal hearing (Appendix 4), in the almost ten years since WRES was introduced, there has been a small amount of expansion of the measures and a greater emphasis on monitoring progress. However, the recruitment data trusts are required to report has stayed the same – a single cohort of AfC staff, two categories of ethnicity, and the measurement of offer from shortlist rather than application.

In our 2021 report¹³, we suggested that demonstrable evidence of trusts being anti-racist organisations (eg through the provision of the type of data contained in this report) should be part of CQC Well-Led assessment. To date, this is not the case. For example, in December 2022 the CQC rated Kingston as 'Good' for Well Led despite the data they provided for our previous report showing that they had 418 Black applicants for medical roles in 2020-21 with 0 offers being made (compared with 317 White applicants receiving 50 offers in the same period).

¹³ See [Citou.com/research-and-resources](https://citou.com/research-and-resources)

Appendix 2 – Freedom of Information Request, June 2022

Under the Freedom of Information Act, please provide me with the following:

Part One

Numbers of Job Applicants, Applicants Shortlisted for Interview, and Applicants Offered a position after interview, by ethnicity and for the following groups of staff, for the period 1 April 2021 to 31 March 2022 (or, if not available, the most recent 12-month period – in which case please state which period the data is for):

1. All AfC Roles at bands 1 – 8b
2. All AfC Roles at 8c and above

3. All Registered Nursing Roles at Band 5
4. All Registered Nursing Roles at Band 8c and above

5. All Registered Midwives at Band 5
6. All Registered Midwives at Band 6

7. All Allied Health Professionals
8. All Occupational Therapists
9. All Physiotherapists
10. All Dietitians
11. All Radiographers

12. All SAS Roles
13. All Medical Consultant Roles

14. All Band 5 Bank Registered Nurse recruitment

Please supply the numbers of candidates (not the %) for the following Ethnicity Descriptors:

- Asian (including Chinese)
- Black
- Mixed (including Arab)
- Other
- White
- Unknown (including do not wish to say)

The above categories mirror the 2021 Census categories, please refer to the attached document setting out these category descriptors if further guidance is needed. If you use Trac please ensure that the Vietnamese, Japanese, Filipino, and Malaysian descriptors are included in the Asian

category. Please note in particular that Chinese is listed as Other on Trac & should be re-classified as Asian in line with the 2021 census categories.

This request is part of a larger research project. In order to avoid transcription errors the format of the data should be sent as an Excel file in the following format:

Ethnicity	Number of Applicants	Number Shortlisted for Interview	Number Offered the Position
Asian			
Black			
Mixed			
Other			
White			
Unknown			

Part 2

Please provide the level of expenditure in the 2021-22 financial year on the recruitment of overseas nurses. To minimise transcription errors, please use the following format and attach as an Excel file.

Number of Nurses Recruited in 21-22	Funding allocated to the trust for this purpose by NHSEI	Cost to the trust (excluding NHSEI funding) of overseas nurse recruitment. This should include all associated expenses such as trust staff costs, Agency costs, flights, accommodation, etc.	Total Cost

I understand that under the Act I am entitled to a response within 20 working days of your receipt of this request.

If you require any clarification, please contact me as soon as possible. If my request is denied in whole or in part, I ask that you justify all deletions by reference to specific exemptions of the act.

Please acknowledge receipt of this request, and I look forward to receiving the information in the near future.

Appendix 3 – GRC Decision Notice, October 2024



Neutral citation number: [2024] UKFTT 00879 (GRC)

Case References: EA/2023/0532 EA/2024/0014 FT/EA/2024/0103 FT/EA/2024/0092

First-tier Tribunal
(General Regulatory Chamber)
Information Rights

Heard by Cloud Video Platform
Heard on: 26th September 2024
Decision given on: 17 October 2024

Before

JUDGE L MOAN
TRIBUNAL MEMBER J MURPHY
TRIBUNAL MEMBER P TAYLOR

Between

SHEILA MARGARET ROBINSON CUNLIFFE

Appellant

and

INFORMATION COMMISSIONER

Respondent

Representation:

For the Appellant: In person

For the Respondent: Did not attend

Decision:

1. The Appeal is Allowed.
2. The Respondent shall provide a copy of this Decision to the four respective NHS Trusts (the third parties) who made the original decisions not to provide the requested information.

Substituted Decision Notice: The third parties shall within 35 days of being sent this Decision, respond to the Appellant's Part One requests for information as detailed below without reliance upon section 12 of the Freedom of Information Act 2000.

Appendix 4 – GRC Evidence Statement (RK)

Roger Kline's email and Evidence Statement to the GRC Hearing (submitted April 2024)

Sheila Cunliffe

From: Roger Kline [REDACTED]
Sent: 01 April 2024 19:26
To: [REDACTED]
Cc: Roger Kline
Subject: Evidence statement
Attachments: Evidence statement.doc.final.docx; Evidence statement.doc.final.pdf
Importance: High

Sheila

You have asked me if were able, in my capacity as the designer of the NHS Workforce Race equality Standard and as the first joint national director for that programme (2015-2017), to advise on how onerous it might be for NHS trusts to provide the disaggregated data you have requested.

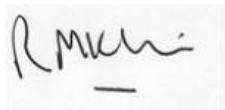
I am surprised that provision of the data you have requested is onerous requiring many hundreds or more hours to manually process the data.

It is a contractual requirement that NHS providers – all NHS Trusts fall into this category – are required to collect and collate such data in order to meet the requirement of the NHS Standard Contract.

If there are known shortcomings in local ESR or TRAC data (the two data sources) then I would expect that to have been reported in their annual WRES submission and in their accompanying Board report if it was sufficient to compromise their annual submission. I have examined many hundreds of such reports and in recent years I cannot recall any such serious qualification being made – though obviously I have not seen all such reports.

Whilst no workforce data system is perfect, there is no reason why any shortcomings would be sufficiently significant to be an obstacle to the provision of the data you request. In my considered opinion such data can and should be made available to you and it is in the public interest that such data is made available.

Yours sincerely



Roger Kline OBE FRSA

Evidence statement

1. I, Roger Kline am a Research Fellow at Middlesex University Business School.
2. I have been asked to advise on the requirement for NHS Trusts to collect and publish workforce race equality data.
3. I was asked in 2014 by the then Chief Executive of NHS England, Sir Simon Stevens, to create a standard for collecting data on the ethnicity of staff employed by the NHS organisations who provide services to the NHS which are regulated by the NHS Standard contract.
4. I subsequently created the Workforce Race Equality Standard which at the time had nine metrics. It has since been expended slightly. I also drafted the Technical Guidance which sets out the requirements for data submission on an annual basis.
5. From 2015-17 I was joint director of the Workforce Race Equality Standard head office team tasked with implementing this standard.
6. The NHS England web site (accessed 28th March 2024) states
<https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/>

"Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the [NHS standard contract](#).

The [NHS Equality and Diversity Council](#) announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

This is important because studies show that a motivated, included and valued workforce helps deliver high-quality patient care, increased patient satisfaction and better patient safety.

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the WRES was mandated through the NHS standard contract, starting in [2015/16](#). From 2017, independent healthcare providers are required to publish their WRES data.

The [first WRES report](#), was published in June 2016, followed by the [2016 WRES report](#) on 19 April 2017. In the first two years, there have been improvements in some trusts, although a number of organisations still have a long way to go. The [2017](#) and [2018](#) WRES data reports showed a trend of continued improvement in a number of areas, but there is still much work to do in some trusts, sectors and parts of the NHS.

The [2023 WRES data report](#) compares data from previous years to assess trends. NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

7. The requirement to provide data is assisted by Technical Guidance which can be found at <https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-technical-guidance/>
8. The Full-length NHS Standard Contract 2022/23 (Particulars, Service Conditions, General Conditions) can be found here: <https://www.england.nhs.uk/publication/full-length-nhs-standard-contract-2022-23-particulars-service-conditions-general-conditions/> It states:

The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care,

9. I would be surprised to hear that some NHS Trusts are suggesting that the data they hold is not sufficiently accurate and the TRAC system is so poor that it will take hundreds to thousands of hours for them to manually collate the data requested by Sheila Cunliffe since the data required will already have been collated and submitted to NHS England as a condition of the NHS Standard Contract. The submission to NHS England will have been approved by each local NHS Trust Board. The submission will be entirely drawn from two sources – workforce data collected by TRAC or ESR (metrics 104) – and data drawn from the NHS national staff survey (metrics 5-8) together with a manual report on the ethnicity of the Trust Board.

The only two shortcomings in the data collected (which would be reported to NHS England) are the proportion of staff who have not self-declared their ethnicity (normally 5% or less) and the shortcomings some Trusts (a small minority) struggle with on metric 4 on “non mandatory training”.

10. There should be no significant shortcomings in the data collection for the two metrics the data request relates to:

WRES Indicator 1 - compare the data for white and BME staff: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

WRES Indicator 2 - compare the data for white and BME staff: Relative likelihood of staff being appointed from shortlisting across all posts This indicator will be based on year-end data

11. The aggregated data on these two metrics is reported in the 2023 Workforce Race Equality Standard report. It contains no qualifications regarding the quality or comprehensiveness of the data.

The data which I understand has been requested would need to exist in order to for a Trust to be able to collate and submit this data collection.

This data submission, often supplemented by other data on ethnicity, is additionally, published annually by every NHS Trust.

Public Sector Equality Duty

The Public Sector Equality Duty, or “the duty”, which applies in Great Britain (England, Scotland and Wales), requires public authorities to have due regard to certain equality considerations when exercising their functions, like making decisions. The Government states: <https://www.gov.uk/government/publications/public-sector-equality-duty-guidance-for-public-authorities/public-sector-equality-duty-guidance-for-public-authorities> that:

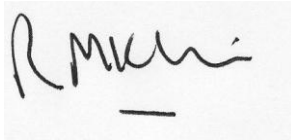
The duty is a statutory duty on listed public authorities and other bodies carrying out public functions. It ensures that those organisations consider how their functions will affect people with different protected characteristics. These functions include their policies, programmes, and services. The duty supports good decision-making by helping decision-makers understand how their activities affect different people. It also requires public bodies to monitor the actual impact of the things they do

The general duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- *eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct prohibited by the act*
- *advance equality of opportunity between people who share and people who do not share a relevant protected characteristic*
- *foster good relations between people who share and people who do not share a relevant protected characteristic*

Decision-makers must consider what information they have and what further information may be needed to give proper consideration. The duty asks decision-makers to stop and check the evidence. In equality terms, can you confidently describe the people affected by your decision? Do you know what they think about the subject? Is there data on the demographics of people impacted by your policies or practices? If not, do you know how to get it? Do not forget to assess the equality impact on the people who may have to implement your decision, such as staff or suppliers

NHS Trusts would expect to have sufficient, accurate information on the ethnicity of their workforce to enable them to meet the provisions of the Public Sector Equality Duty and indeed, all would accept that is the case, and accordingly confirm their compliance with this requirement in their published annual Trust Equality Report.



Roger Kline. OBE, FRSA

March 30th, 2024