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NHS trusts should be openly sharing their data on ethnicity and recruitment

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Data on recruitment success by ethnicity are an important barometer of how inclusive, or discriminatory, NHS trusts are. As such, hospitals should be sharing this information freely and using it to make improvements, argues Sheila Cunliffe

Earlier this year, I decided to assemble a cross-London dataset on ethnicity and recruitment in the NHS to see what it showed about the likelihood of a successful job application according to ethnicity. I undertook this as a piece of independent research but hadn't anticipated how difficult it would be to get hold of these data.

Data on ethnicity and recruitment are not on NHS organisations' websites—in fact, they are not routinely published in any form. So, as a first step, I submitted individual freedom of information (FOI) requests to all 18 NHS acute trusts in London to ask for access to this information. Mindful of the pressures created by covid-19, I made sure that the request I made could be fulfilled in approximately five hours.

I've responded to many FOI requests during my more than 30 year career across the NHS and the wider public sector, but this is the first time I have made one. My experience of answering FOI requests is that the FOI team are usually tenacious: they will write to you repeatedly until you respond to the request or give a very good reason as to why you are unable to supply the data within the 20 working day statutory limit.

Three months on from the FOI request (and eight weeks after the statutory FOI deadline for response), I finally had all but one set of data (from a trust who were still insisting on redacting the core data to a level which made it unusable). Yet arriving even at this point had been an unexpected struggle. Another two trusts told me that they had "accidentally" released the full data and would redact it if I made a similar request in the future. The rationale given by these three trusts for redacting the data was that it might breach individual anonymity. But, when specifically asked, none of them were able to explain how this could happen given the volume of job offers.

With two trusts, the team handling FOI requests did not respond to my messages, and some weeks after the statutory deadline for response, I had to contact the chief executive's office to ensure the team communicated with me. The team at another hospital only responded once the director of communications was alerted to the problem after I had reached out to the trust via Twitter.

The fact that trusts did not respond, redacted their responses, or returned data that were different from what had been requested sent a clear message to me. It said to me that trusts thought this issue was so unimportant they did not see the need to respond as requested, or appropriately, or at all.

I have to admit that the process of getting these data was frustrating, annoying, and at times emotionally taxing. I am in the privileged position of not having to undertake this research. I could just ignore this issue, give up on trying to access the data, and decide it's someone else's problem. But it really isn't someone else's problem. Racism in the NHS is a problem for us all. Skin colour remains an impediment to recruitment success, equal pay, and career progression. And it's time we all stood up, acknowledged the impact that this lack of equity has on staff and on patients, and did something about it.

A first step would be to stop doing things we have done previously that haven't worked. We can use data on recruitment, pay, formal disciplinary, etc to identify key areas for improvement and evaluate the actions we take to assess their impact. We can then repeat what works, discard what doesn't, and look for new solutions to try and evaluate.

At the moment, data driven approaches to identifying equality, diversity, and inclusion priorities get little traction in the NHS. I'm mystified by this when the NHS's whole service delivery model is based on research driven treatment and when data collection is vital to pinpointing our failures, evaluating the effectiveness of what we are doing, and informing our commissioning of appropriate future work. Yet when it comes to diversity and inclusion, we end up doing the same things that haven't worked for decades, over and over again, without evaluating the application of those processes and initiatives to find out whether they are delivering the results they should.

It is time that NHS England and NHS Improvement (NHSE/I) and the Care Quality Commission (CQC) stepped up and stopped tolerating racism in the NHS. What is needed is challenge, in a meaningful, helpful way that ensures we bring about real change.

Data on ethnicity (and other characteristics) and recruitment, pay, formal disciplinary, etc are easily obtainable from trust recruitment and electronic staff record systems, and should be fully assessed as part of the "well led" rating in CQC inspections. NHSE/I and the CQC need to be clear with trusts that evidence of racism or any other kind of discrimination is not acceptable, must be urgently addressed, and will be proactively monitored. I would even suggest that, where there is evidence of racism, and a trust is considered "unsatisfactory" in this area, the CQC should have an equality, diversity, and inclusion version of special measures to address this. In such cases, NHSE/I could proactively use experts in this area to ensure that trusts rapidly improve.

My challenge to individual NHS trusts is to ask, "If you are not taking demonstrably effective action on this now, when will you?" It's not enough to include nice words that speak of equality in your corporate trust documents without making them a reality. What staff and patients urgently need is effective change and an inclusive environment where we can all thrive at work.

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