



Public Health
England

Protecting and improving the nation's health

Equality in Public Health England

How we met the public sector equality duty in 2017

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Introduction

Public Health England (PHE) exists to protect and improve the nation's health and reduce health inequalities. To deliver a broad range of products and services, PHE employs over 5,000 staff working from 100 locations. We work with local authorities, the NHS and others to help people live longer, healthier and happier lives and reduce health inequalities.

The equality duty

The equality duty is a general duty on public bodies and others that carry out public functions. It ensures that public bodies consider the needs of all individuals in their day-to-day work in shaping policy, in delivering services, and in relation to their own employees.

The equality duty has 3 aims. It requires public bodies such as PHE to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people who share a protected characteristic and people who do not share it
- foster good relations between people who share a protected characteristic and people who do not share it

The protected characteristics covered by the equality duty are:

- age
- disability
- gender reassignment
- marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
- pregnancy and maternity
- race - this includes ethnic or national origins, colour or nationality
- religion or belief - this includes lack of belief
- sex
- sexual orientation

The general equality duty is supported by 2 specific duties which require public bodies such as PHE to:

- publish information to show their compliance with the equality duty

- set and publish equality objectives, at least every 4 years

Our new objectives for 2017 to 2020 clearly distinguish between those related to staff and to the wider system during the 4-year period. They focus on ensuring that equality considerations are built into any processes, practices and ways of working and that they are implemented as fairly and transparently as possible and kept under continuous review.

We intend to review progress against our objectives on a regular basis, revising them where necessary or updating actions required for effective implementation. We would aim to update and engage senior management and seek their support with the delivery of these revised objectives.

Equality objectives are presented below.

PHE equality duty objectives published in February 2017

Aim 1: Supporting the health system

We aim to promote equality and fairness in all PHE business – the way we design and deliver our functions and products, procure and commission from others, and work with partners, and stakeholders including the public.

Objective 1.1 Research and Intelligence

We will develop and promote use of better intelligence and advocate for better research related to health outcomes and health determinants among groups that share protected characteristics.

Objective 1.2. Advice to the system

We will ensure our advice to the system includes dimensions of equity and equality in line with PHE priorities.

Objective 1.3. Promoting equality through programmes

We will promote equality through all our programmes or functions to ensure they relate to people who share different protected characteristics, advance equality and tackle inequalities.

Aim 2: Engaging and developing PHE staff

We aim to create and maintain a diverse and inclusive working environment that values difference and fosters an inclusive workplace ethos where staff from all backgrounds are treated fairly and equally, and where they can advance their careers.

Objective 2.1: Diversity and staff inclusion

We will develop people managers' understanding of the link between effective diversity and staff inclusion and the future impact on physical and mental health of the actions and behaviours of managers and colleagues.

Objective 2.2: Workforce composition

We will strengthen collection and monitoring information on our staff in reference to their age, gender, ethnicity, sexual orientation, religion/belief and disability.

Objective 2.3: Talent management

We will establish talent management schemes tailored for developing staff from the main 6 protected characteristics.

Objective 2.4 Staff engagement

We will continuously improve staff engagement and inclusiveness as measured by Staff Survey questions.

The health inequalities duty (Health and Social Care Act 2012)

The Health and Social Care Act 2012 introduced specific legal duties on health inequalities for the Secretary of State for Health which PHE must meet on his behalf. The duty requires due regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service. It applies to all PHE public health functions, not just healthcare focused work.

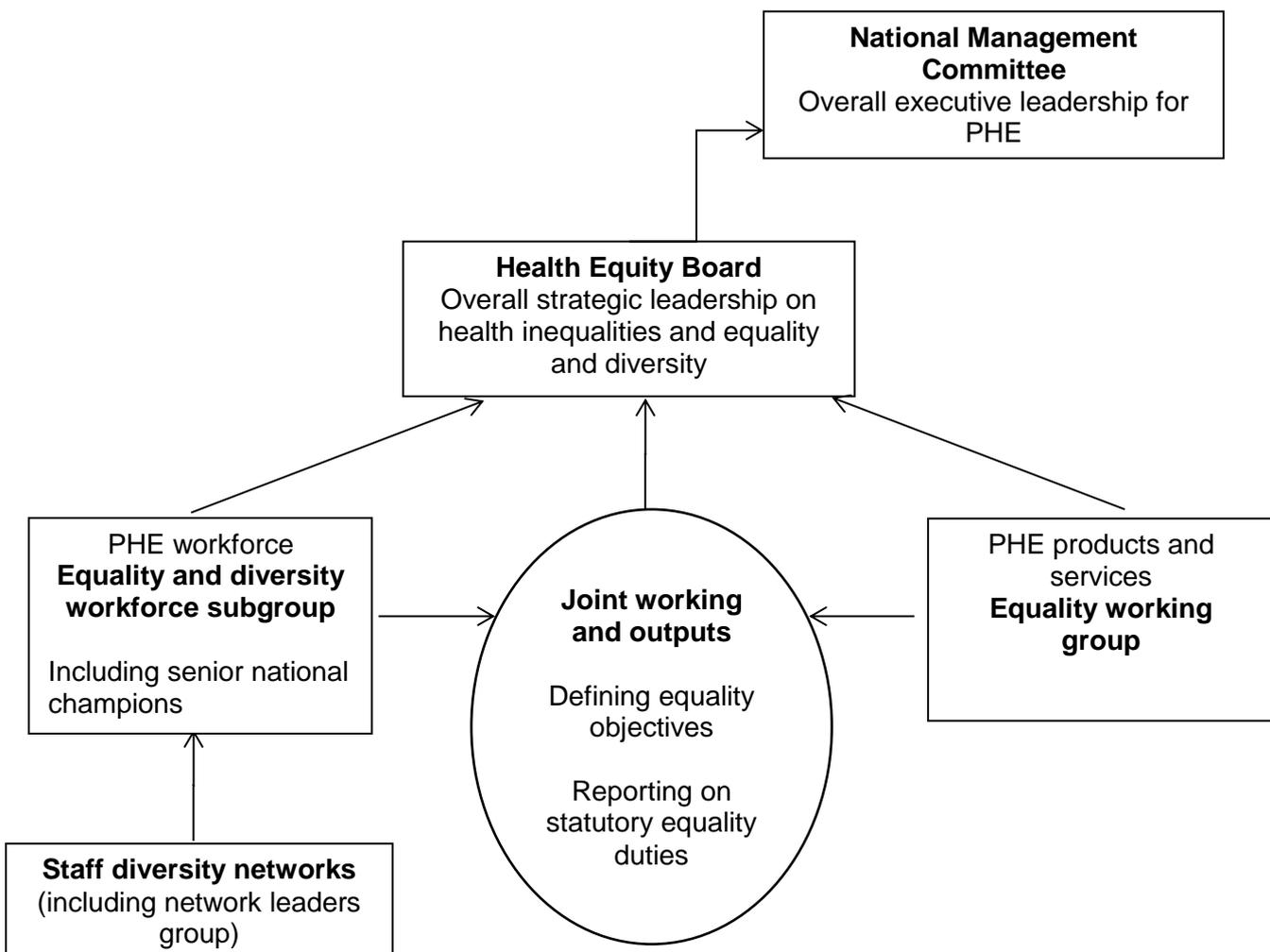
The 2 legal duties are different but have synergies. For example, guidance on the Equality Act 2010 explains that having due regard to the need to advance equality of opportunity involves considering whether there is a need to tackle inequalities suffered by people who share a relevant protected characteristic. PHE has developed a separate Framework for Action on Health Inequalities, which aims to ensure that PHE

supports the health system to reduce health inequalities and fulfils its legal duties related to health inequalities.

Our approach to governance on equality and equity

Our approach to governance on equality and diversity ensures that we have measures in place at all levels of the organisation to consider equality for our workforce and in our service provision. The Health Equity Board provides senior leadership governance for PHE's fulfilment of the equality duty and our legal duties on health inequalities from the Health and Social Care Act 2012. Designated staff across PHE work to provide an operating approach for fulfilment of the duty as shown in Figure 1.

Figure 1: PHE governance on equality and diversity



Contents of this report

This report describes the progress we have made since the publication of **How We Met the Equality Duty in 2016**, highlighting key achievements and activity towards fulfilling our equality objectives. It also provides an outline for focused actions related to our equality objectives in 2017.

This report consists of 3 sections:

1. Workforce equality and diversity – highlighting the characteristics of our staff, and key achievements such as establishment of new staff diversity networks.
2. Actions to fulfil our equality objectives.
3. Next steps.

Actions to fulfil our equality objectives 2017 to 2020

Aim 1: supporting the health system

Background

In PHE we aim to maximise opportunities to become more ambitious in our approach to creating a more diverse, and diversity aware workforce, and promote equality and fairness in the way we design or deliver products and services. In 2017 we published a new set of PHE equality objectives 2017 to 2020, in line with statutory requirements to refresh objectives at least once every 4 years. The new equality objectives have been approved by PHE's Health Equity Board and received final endorsement by the Management Committee.

These objectives clearly distinguish between those related to our staff and to the wider system, and focus on ensuring that equality considerations are built into any processes, practices and ways of working and that they are implemented as fairly and transparently as possible and kept under continuous review.

As equality is at the heart of all our work, our new equality objectives also relate to our priorities and effective delivery of key programmes of work. Each of these objectives have been supported with early stage deliverables shown presented in Appendix 2. This section of the report provides a helpful summary illustrating how PHE met the 'health system related' equality objectives in 2017 and progress on early stage deliverables.

We have worked to continuously refine our delivery planning and corporate reporting approaches and consider how to collect specific information about consideration of the equality duty to inform practical action. As part of our work on the Framework for Action on Health Inequalities we have continued advising and actively engaging with business areas on the activities that they can undertake to focus on equality and diversity.

Objective 1.1 Research and Intelligence

'We will develop and promote use of better intelligence and advocate for better research related to health outcomes and health determinants among groups that share protected characteristics.'

PHE provides the public health system with strong leadership, supporting those responsible for delivery with the high quality evidence, data and tools to make a real difference to the health of communities. We are also committed to building evidence and intelligence health outcomes by protected characteristics.

In 2017, we undertook a range of activity and published evidence and intelligence relating to groups that share protected characteristics. Progress on our early deliverables and additional initiatives is shared below.

Deliverable 1

‘Produce an annual report outlining, as far as possible, health outcomes and health determinants among groups with protected characteristics, and more detailed periodic reports in relation to specific groups where possible’.

Deliverable 2

‘Monitor data and intelligence gaps related to the health of groups that share protected characteristics, taking action to support development of new data or intelligence, or to improve access to existing data’.

The report ‘**Public Health Outcomes Framework (PHOF): Health Equity Report. Focus on Ethnicity**’ was published in June 2017. It presents analysis and commentary on inequalities for 18 indicators from the PHOF. The report supports understanding of inequalities in health for different populations in England, with a particular focus on inequalities between ethnic groups. It presents indicators for selected determinants of health as well as health outcomes, and provides breakdowns of data across a range of factors for example, personal characteristics, including age, sex and ethnic group, in addition to socio-economic status or deprivation. These factors reflect, where possible, the ‘protected characteristics’ defined in the Equality Act 2010.

The **Health Equity Report** contained new analysis of changes in inequality, between ethnic groups, in infant mortality and low birth weight babies; new analysis of sex-specific adult smoking prevalence by ethnic group; and new analysis of admissions to hospital for alcohol specific admissions by ethnic group. It also published, for the first time, mortality for people resident in England by country of birth for all causes combined, cancer, cardiovascular disease and suicide. The report has been welcomed by Race Equality Foundation and viewed 23,000 times online since August 2017.

In addition, in 2017/18, PHE contributed to the Prime Minister’s Race disparity audit which examines how people of different backgrounds are treated across areas, including health, education, employment and the criminal justice system. Analysis of the data collated for the audit helps us to understand and assess differences between

ethnic groups, and to identify those public services where disparities are diminishing and those where work is needed to develop effective strategies to reduce disparities between ethnic groups.

Information on health outcomes by sexual orientation group is still limited. To improve the collection on sexual orientation, PHE has supported the creation of an information standard for sexual orientation monitoring. This information standard will be implemented from 2017/18 onwards. Information standards are used across the health and social care system to help collect and process information. This standard is intended to enable health and social care organisations to monitor sexual orientation in a consistent way. It is classed as a 'fundamental standard', meaning that it applies across all of health and social care. The implementation of this standard is intended to enable policy makers, service commissioners and health and social care providers understand the needs of Lesbian Gay and Bisexual (LGB) populations so that health services can be designed to deliver more targeted forms of care, which best meet the needs of LGB populations and improve outcomes.

Deliverable 3

'Ensure PHE Knowledge Management (KM) Platform includes sections providing knowledge specifically on the reduction of inequalities and impact on specific protected groups'.

The Knowledge Management (KM) Platform has been superseded by plans to develop a Digital Health Intelligence Platform (led by Digital and Knowledge and Intelligence), which will provide a mechanism to combine public health evidence and data with the knowledge needed to interpret it at the local and national level.

The Knowledge and Library Service team have, however, continued to develop resources to help users identify the best available evidence relating to health inequalities, including a Finding the Evidence leaflet and poster, which is available via the KLS online catalogue (OPAC) to anyone with an interest in public health knowledge¹. A new OPAC is in development which will include a special topic area for resources relating to health inequalities.

The leaflet has also been shared with the PHE Knowledge Management in Public Health network via a discussion list. The network comprises an array of public health librarians, information specialists, analysts and PH consultants across England. The poster was used in the Knowledge Zone at the PHE Conference, and is promoted by

¹ See: http://phe.baileysolutions.co.uk/book_details.aspx?source=search

Knowledge and Evidence Specialists in training and presentations throughout PHE and the wider system. It was also disseminated via regular internal communication channels.

Deliverable 4

‘Work with health and related research funders to specify that their funded research should consider its impact on those with protected characteristics, for example, when trialing new interventions’.

In 2017, PHE continued to work with health and related research funders to specify that their funded research consider its impact on those with protected characteristics, for example, when trialing new interventions. We have also supported strategic research and evidence initiatives to fill knowledge gaps and inform public health approaches for specific groups that share protected characteristics.

Further activity

The Health Equity Board continued to monitor progress in reducing inequalities through the Health Equity Dashboard. The dashboard provides evidence on inequalities for PHE priorities and other key health outcomes and wider determinants of health, including information by protected characteristics where available. A report providing analysis and commentary for each of the 18 dashboard indicators has been published in early 2017. It examines inequality for a range of dimensions, but with a particular focus on ethnicity so that indicators are provided by ethnic group where possible.

NHS Health Check Data Extraction 2017

PHE is leading a national data extraction of the NHS Health Checks programme. The extraction, which is being conducted by the General Practice Extraction Service (GPES) at NHS Digital in collaboration with PHE, will expand the knowledge and evidence base by giving information showing variation between areas and different demographic groups. The aim of the initiative is to secure the extraction of approximately 5 million patient records to enable monitoring of the NHS Health Check programme. This will include receiving data on the age, gender, ethnicity, sexuality, mental health, physical disability of people having or invited for an NHS Health Check.

The data which has been collected in 2017 would then be analysed in 2018 to enable the national monitoring of the programmes coverage and health outcomes. It would allow us to undertake a matched comparison between people having and those who have not had an NHS Health Check to understand if there are:

- a. Differences in access by age, gender, ethnicity, sexuality, mental health or physical

disability

- b. Differences in the diagnosis of hypertension, type 2 diabetes, abnormal cholesterol levels by population sub-group (as per point a).
- c. Differences in the referral to behaviour services by population sub group (as per point a).

Availability of data on age, sex, ethnicity and disability will help us to understand current access and outcomes on protected characteristics and inform future action.

Collection of data

We continued work to ensure that protected characteristics are considered in our monitoring systems. For example, The National Drug and Alcohol Treatment Monitoring System (NDTMS) routinely collects data on alcohol and drug treatment service user nationality, ethnicity, age and pregnancy status. The data is collected to inform local areas of any trends or issues in problematic substance use in their areas, as well as to inform national policy making.

Objective 1.2. Advice to the system

'We will ensure our advice to the system includes dimensions of equity and equality in line with PHE priorities'.

We work to embed consideration of equality and diversity throughout our advice to the public health system. We did it through our national programmes in line with PHE priorities and in collaboration with PHE Centres. Progress on our early deliverables is outlined below.

Deliverable 1

All Our Health (AoH) initiative is a call to action to all health and care professionals in England to embed and extend prevention, health protection and promotion of wellbeing and resilience into their practice. It is designed to help individuals make the best choices for their own and their family's health and wellbeing, creating a social movement for health and helping reduce the inequity gap. It is an online framework of evidence, produced by PHE, which brings together priority topics to help address the major factors causing premature death, ill health and health inequalities.

This programme is specifically aimed at ensuring our system partners lead the way on expanding the knowledge and intelligence evidence base with all members of society, but specifically the disadvantaged in society and those people with protected characteristics, such as those with a disability, older people, the young etc. The All our Health resources on gov.uk has received around 9,400 unique views in September

2017 with a total unique views of around 55,000 since April 2017. The achievements of AoH in 2017 include:

- PHE Corporate Business Plan adopted target to reach at least 200,000 health and care professionals so they are embedding and extending prevention in their practice
- Engagement with NHS England to incorporate AoH into the General Practice Nurse action plan (dependent on securing funding)
- Expert advice (for example, blogs) on improving motivational conversations as part of interventions and strengthening lifestyle referrals

Deliverable 2

‘Strengthen capacity in the system by continuing to make evidence and learning on community centred-approaches more accessible as part of efforts to mainstream and translation of evidence into action’.

Connected and Empowered Communities Programme. Community-centred approaches are a vital strategy to close the gap in health inequalities as they engage those experiencing social exclusion and directly address the causes of health inequalities – marginalisation, powerlessness, isolation, stress, resilience. Addressing marginalisation, discrimination and advancing equality of opportunity would help create more engaged and inclusive communities. The following outcomes have been achieved during 2017.

Increased system leadership and collaboration

1. Community-centred and asset-based approaches has been firmly established as a priority. Following the stakeholder scoping exercise PHE made a commitment to a 3-year programme (2017 to 2020) of work to support the system to reduce health inequalities through community-centred and asset-based approaches.
2. Internally, we have engaged all centres and many national teams in the cross-directorate working group on community-centred and asset-based approaches. This is co-ordinating collaborative work across the organisation, for example, publication of the Health Asset Profiles in 2017, testing the asset mapping tool, development of an organisational narrative, presented to Place Board in Dec 2017 and supporting teams to adopt a community and asset narrative, for example, Healthy Ageing, Early years resilience.

Increased knowledge

1. We have helped build research capacity and worked with stakeholders to identify national priorities for research and opportunities to progress these (stakeholder

event and dragon's den March 2017, draft research paper, NIHR (National Institute for Health Research) workshop Dec.

2. We continue to build knowledge and learning through collating and sharing local practice examples of place-based approaches with our centres and also with communities of interest (protected characteristics) via a new initiative with the Voluntary Sector Health and Wellbeing Alliance members.

Improved local practice

1. We worked with Health Education England to produce and launch 2 new ELearning modules in October 2017 that have been completed by 280 staff.

We supported local implementation through delivering national and regional conferences, workshops, events, webinars and networks to improve knowledge and practice amongst local commissioners and providers (for example, 2 national webinars to 175 staff).

Further activity

We worked to further embed equality objectives throughout Criminal Justice programmes of work, recognising that the population who are in contact with the Criminal Justice System experience are not disadvantaged.

Older people in prison's Health Needs Assessment Guide

The over 50's age group are the fastest growing age group in prisons in England. The health and social care needs of this group are often complex and not fully understood, let alone met. In our role to improve and protect the public's health, the PHE have led on the development of a guidance document to support health and social care needs assessments for older people in prisons in England.

The burden of disease experienced by this group is significant and their morbidity and mortality is greater than both their younger prisoner peers and those of the same age living in the community. Social care provision in prisons particularly is very variable and the prison environment is not one that is conducive to 'ageing well'.

The **guide** aims to bring together the understanding of both the health and social care needs of this population in order to support the delivery of both services effectively together.² The health and social care needs assessment guide have drawn together

² The guide is available on gov.uk <https://www.gov.uk/government/publications/health-and-social-care-needs-assessment-of-older-people-in-prison>

data, intelligence and expertise, in partnership with Her Majesty's Prison and Probation Service (HMPPS), Ministry of Justice and NHS England to:

- shape policy development to meet health & social care needs of older people in prison
- advise commissioners of health and social care services
- inform prison reform including the prison reconfiguration and new build programme

PHE continued to provide high quality advice, inclusive of dimensions of equality, through a number of initiatives. These include the development of guides to Commissioning and Delivering Weight Management Services presented in the box below.

Guide to Commissioning and Delivering Tier 2 Adult Weight Management Services

The weight management guides aim to influence the local commissioning and delivery of tier 2 weight management services (WMS) to provide services that work for children, families and adults, and support the interface across the obesity pathway. The guides in part aim to address feedback received from commissioners on barriers to commissioning WMS which was collected in 2015 as part of PHE's National Mapping of WMS.

The **Guide to Commissioning and Delivering Tier 2 Adult Weight Management Services** supports local authorities, clinical commissioning groups, NHS institutions and providers of WMS. PHE will also publish a guide to support tier 2 children and family services.

The guides demonstrate how the design of services, based on the evidence, can benefit users and help people achieve healthier and sustainable behaviours. This includes advice and guidance to the local system on how equality should be considered to address equity of provision and access, to reduce inequalities and ensure that the needs of protected characteristics are considered.

Objective 1. 3. Promoting equality through programmes

'We will promote equality through all our programmes or functions to ensure they relate to people who share different protected characteristics, advance equality and tackle inequalities'.

In 2017, we continued to strengthen focus on embedding and promoting equality in our programmes and functions. Moreover, we refreshed PHE's induction processes ensuring that new staff of all grades and backgrounds are welcomed into our organisation by our most senior leaders, provided with the necessary information and are familiar with our legal duty, Equality Act 2010, and the role they can play.

Deliverable 1

'Improve access to HIV testing in populations most at risk to reduce the proportion of individuals living with undiagnosed HIV'.

The HIV Prevention and Sexual Health Promotion programme aims to improve the sexual health of the country. HIV Prevention England, a consortium led by Terrence Higgins Trust, promotes routine and regular HIV testing in most at risk populations (that is, men who have sex with men and black African communities) across the life course. Campaign activity is focused in National HIV Testing Week (NHTW). In 2016, NHTW successfully reached target audiences including being linked to the delivery over 20,000 self-sampling kits and an external independent evaluation reported very high levels of both reach and cut through³. NHTW 2017 began in November and an evaluation of its impact will be published by early 2018/19.

A report of the first year of activity of the national HIV self-sampling service in England has been made available to Directors of Public Health. An updated report will be published early in the 2018 and will inform service delivery and development at a local level.

Deliverable 2

'Championing better health outcomes for people with learning disabilities'. The achievements in 2017 include:

1. We have disseminated public health messages to the health and social care system widely via a series of monthly webinars covering specific health topics; screening inequalities, substance misuse, pharmacy, hospital admissions and the autism self-assessment framework.
2. We have published an **annual health check audit tool**, aimed at driving up the quality and agreed outcomes of health checks for people with a learning disability.
3. We published a **flu vaccination factsheet for health and social care professionals** giving them information about how they can best support someone with a learning

³ See: <http://uk.kantar.com/business/health/2017/hiv-testing-campaign-engages-target-audiences/>

disability get their flu vaccination and therefore increase uptake, reducing health inequalities.

4. We have worked with NHS digital to support the publication of a second round of data in the **health and care data set**, giving information about how many people with a learning disability experience a range of health conditions and how well these are managed compared to the general population. This provides local and national commissioners with the information they need to inform decisions about meeting the health needs of people with a learning disability.
5. We have published a **guide to making reasonable adjustments to blood tests for people with a learning disability**, to provide health staff, people with a learning disability and those who support them with information to help overcome barriers to getting a blood test when needed.
6. We have collected and reported information from local areas across the country about how well they are supporting the health and care of people with Autism in the latest **Autism Self-Assessment framework exercise**. This allows areas to see how well they are performing compared to other areas and provides information that helps them plan for the future, in consultation with people with autism locally.

Deliverable 3

‘Reduce the rates of smoking among pregnant women at time of delivery’.

Rates of maternal smoking continue to fall nationally (10.8% in Quarter 1 2017/18), but we know that there is significant variation in these rates regionally, by socio-economic status and by the age of the pregnant woman. PHE helps to co-ordinate a range of stakeholders (NHS, Local Government, charities, among others) to maintain focus on this agenda, to identify and cascade good practice, to improve referral pathways into specialist support to quit smoking, and to develop new resources which will help localities to address this issue more effectively.

PHE has provided extensive policy advice around this issue, with smoking in pregnancy being included as one of the key measurables within the government’s newly published Tobacco Control plan. Working closely with NHS England through the Maternity Transformation Programme, PHE leads the Improving Prevention work stream where achieving a smokefree pregnancy is established as a key priority with links across to other relevant parts of the programme, such as safety, workforce and local system transformation. We continue to work with partners to develop training resources and materials for healthcare professionals and stop smoking specialists around smoking in pregnancy, and to help embed carbon monoxide screening. PHE routinely analyses the quarterly smoking at time of delivery data and provides summaries to senior leaders. Data reporting quality around this indicator has improved in 2017, increasing the reliability of the data, with no deterioration in national performance. PHE is currently working with partners to cross-reference smoking at time of delivery data with health

outcomes/health inequalities data to make an even more compelling case for local action.

Future action By PHE in this area includes a pilot of new materials and training resources with healthcare professionals in early 2018, prior to a planned Spring roll-out of these tools. We will continue to work with key national partners around embedding smoking in pregnancy training with all relevant staff, and support the further embedding of carbon monoxide screening at all antennal appointments. Ongoing collaborative work with NHS England through the MTP will include the development of a joint work plan, with to help localities achieve the ambitions within the Tobacco Control Plan for England.

Deliverable 4

‘Reduce inequalities in oral health and oral health services by 2018’.

In 2017, PHE has focused on analysis of the current oral health and oral health service inequalities in England, including protected characteristics, social and geographical considerations. The programme of work considered the importance of protected characteristics as part of the rapid evidence reviews. The work is a collaboration between dental public health and a number of partners including University College London, the British Dental Association, NHS England, Chief Dental Officer office, devolved nations and Department of Health with contributions from health equity and Knowledge and Intelligence teams to specific chapters.

The rapid reviews have proved to be a much more extensive task than originally thought and the publication of the report is planned for 2018.

Further activity

Health and Wellbeing Alliance

The voluntary, community and social enterprise (VCSE) Health and Wellbeing Alliance (HW Alliance) exists to act as a bridge between the VCSE sector, the health and care system, and the people who use it. The Alliance particularly supports objectives of promoting equality through programmes. The Alliance is made up of 21 VCSE Alliance members. Members can reach into a wide range of communities facing significant health inequalities, and are able to represent the collective views of the VCSE sector.

The members have been working with PHE subject leads to support work such as the Prevention Concordat for Better Mental Health and the National Policing and Public Health Consensus statement and national work plan to improve health and wellbeing

and reduce health inequalities through policing. Alliance members are also undertaking a number of projects which were formulated by PHE subject leads, in order to promote equality and reduce inequalities. Some of their products included initiatives to establish Disabled Staff Networks supporting the Workforce Disability Equality Standard and developments of the third sector and employer narrative to support transition into work for young people with mental health problems and people with a learning disability and/or autism.

Health Equity Assessment Tool (HEAT)

Health inequalities are unjust differences in health and wellbeing between different groups of people which are systematic and unavoidable. Health Equity Assessment Tool (HEAT) consists of a series of questions, which are designed to help staff systematically assess health inequalities related to their work programme and identify action that they can take to help reduce inequalities.

In 2017, we continued to promote the use of a revised version of the Health Equity Assessment Tool (HEAT) and commenced the application of the tool to PHE's Antimicrobial Resistance initiatives. Moreover, a number of PHE Centres have used HEAT to inform and shape their business planning processes. For example, PHE South East Children, Young People and Families Workstream used the HEAT tool to assess their programme of work on Children, young people and families, to ensure that the advice, support and guidance they provide to stakeholders was based on the key equality issues and embedded protected characteristics relevant to this area of work. Health Equity Audits (South East). PHE South East has also worked closely with local authorities and other stakeholders to develop national guidance to support local authorities to undertake health equity audits. Learning from these pilots was shared via a national webinar hosted by PHE South East and via the national cardiovascular disease (CVD) prevention conference in 2017.

PHE continues to support a number of local authorities with undertaking HEAs and are also working with one local authority (Kent County Council) to scope a second phase of their HEA to track medium and longer term outcomes to compare those taking up or refusing checks. It is hoped that this will provide learning that can help others understand and demonstrate programme outcomes.

NHS population screening: information for transgender and non-binary people

The aim of the initiative was to ensure screening is offered equally and equitably to all eligible people and does not discriminate against the protected characteristic of gender reassignment. Inequalities can exist because individuals do not know which screening they are eligible for, or are not invited for screening because of the gender they are registered as with their GP.

We developed and published a new national screening leaflet for transgender and non-binary people. It explains who is invited for **breast screening**, **bowel cancer screening**, **cervical screening** and **abdominal aortic aneurysm screening**. It also includes important information about all 4 screening processes and how to access additional support and advice. We developed the leaflet in consultation with **NHS Choices** and representatives of the transgender community, including Michael Toze (transgender conduit), and the National Lesbian Gay Bi-sexual and Trans Partnership. The leaflet is available for local screening providers from **GOV.UK**. The leaflet received excellent feedback from the system.

Investigating the effect of financial incentivisation on NHS Health Check take up

As part of the national NHS Health Checks programme, PHE has conducted a study to understand what effect weighted remuneration of providers has on the take up of NHS Health Checks by patients at high risk of CVD. Population sub groups at high risk of CVD include men, deprived groups, some black and ethnic minority groups and people with mental illness.

The aim of the initiative was to investigate the impact on take up of weighting provider financial remuneration to encourage high risk CVD groups to have an NHS Health Check. The findings for the work will then inform PHEs advice and guidance to commissioners and providers of the NHS Health Check programme. In turn, this will then support the objective of promoting equality.

The study is due to conclude in March 2018. The findings will be published and used to inform PHEs NHS Health Check best practice guidance. A top tips document will also be produced and launched through a webinar to help translate the findings and recommendations from this work into practice.

HITZ programme

Over the last 3 years PHE has supported the Premiership Rugby (PR) HITZ programme, which aims to give vulnerable young people (11 to 19 years) the skills to reach their full potential. Delivered through the PR clubs, HITZ uses an innovative approach using rugby and its role models. Participants come from a range of challenging backgrounds including long-term unemployment, low incomes and dependence on the benefits system, early school-leavers, poor school performance and those with a history of anti-social or risky behaviour including ex-offenders and ex-drug or alcohol abusers.

PHE has supported PR to further develop the existing HITZ programme to encompass healthy eating. The aim is to improve understanding of what constitutes a healthy diet and to increase knowledge of and confidence in food preparation.

Young people from deprived backgrounds are more likely to be overweight and obese. With the diets of young people poor (characterised by low intake of fruit and vegetables and high intakes of sugar and saturated fat), it is crucial to improve diets and teach young people how to feed themselves well for life.

In the last year the HITZ health modules have reached 2,043 14 to 16-year olds and 442 16 to 18-year old learners. Early results from an evaluation indicate that the resources are enhancing learners' understanding of healthy eating.

Prison Smoke Free Programme (South East)

An aim of this programme is to support prisons across the south east to achieve smokefree status by summer 2018. The National Partnership Agreement for Co-commissioning and Delivery of Prison Healthcare in England, (2013), commits NHS England, HMPPS and Public Health England to reduce smoking amongst prisoners and prepare for all prisons to become smoke free. The ambition is that all prisons in England and Wales will be completely smoke free by the summer of 2018. To enable all 3 bodies to do this a regional governance board was set up to enable assurance to the National Smoke Free Delivery Board. Those individuals in a prison setting face significant inequalities in health and therefore ambitions to reduce smoking in this key group are essential in meeting our objectives around equality and equity.

As part of their preparation and implementation of the smoke free project, prisons are required to complete a Smoke Free Equalities Impact Assessment to consider all strands relating to the 9 protected characteristics to ensure equality is considered and evidenced during and post implementation of the Smoke Free Prisons (SFP) Project. PHE played an important role in providing support and guidance to the prison to ensure EIA is adopted as part of the Smoke Free prison programme to inform the developments and improvements.

These assessments ensured that monitoring systems were in place to capture and assess prisoner demographic of non-smoking areas and access to stop smoking services to ensure that all protected characteristics and equality of access is taken into account across the service and the prison.

PHE has also embedded equality considerations in developing resources for pregnant women and their partners. The aim of the project was to develop new high quality easy read versions of **PHE Screening's information booklet about antenatal and newborn screening tests**. The easy read versions are specifically to meet the needs of people with learning disabilities and/or low literacy levels. This is to ensure PHE Screening meets the needs of people covered by the Disability protected characteristic so that they can have equal access to the screening programmes they are eligible for.

PHE published the new **easy read versions of 'Screening tests for you and your baby'** in February 2017. We have also set up a new professional group to look at how we develop high quality national easy read information about the NHS screening programmes.

Aim 2: Engaging and developing PHE staff

Diversity and Staff Inclusion

Diversity and Staff Inclusion is embedded into PHE organisational policies, practices and work areas the organisation including HR Corporate Services, learning and development, recruitment and pay and pensions. A number of initiatives have been developed to drive and further enhance diversity and inclusion in PHE.

Leadership and governance

PHE directors are accountable to Duncan Selbie, CEO, for the subsequent actions taken by their senior management teams in tackling any identified inequalities. Each of PHE Directors has diversity and inclusion focused objective in their individual appraisal objectives.

A new specialist Diversity and Inclusion and Staff Health and Wellbeing Unit, reporting to the CEO, was created in June 2017, to help PHE achieve upper quartile status in these areas, across both public and private sectors, by 2019.

PHE have 7 national executive diversity champions who provide leadership on specific protected characteristics. Over the course of the year, the diversity champions act to provide senior accountability for delivery of the workforce diversity plan and are instrumental in supporting a number of diversity and inclusion activities.

Adopting a new 'grass roots approach' PHE has set up a staff diversity and inclusion forum. The staff diversity and inclusion forum has been created to provide a safe, open and inclusive platform for diversity and inclusion issues within the business. The monthly forum encourages active participation from colleagues all of backgrounds to work collaboratively with each other, executive diversity champions and all staff diversity networks to achieve optimal equality related outcomes for PHE.

Staff diversity networks

PHE is proud to have increased its staff diversity activity, increasing from 3 active staff diversity networks in 2016 to 12 networks in early 2018. The staff diversity networks have played an active part in creating and developing diversity related policies including the new transgender policy. The networks have also facilitated collective learning and development opportunities, holding events attracting high profile internal and external speakers, in addition to engaging positively with their members across PHE. PHE has produced an internal 'role models' booklet which highlights and showcases staff diversity. The booklet was co-created by the staff networks and members of the

Diversity and Inclusion Forum. The booklet has been published internally and feedback has been extremely positive.

Diversity data

Diversity declaration rates are steadily improving although around a third of staff choose not to disclose their religion and /or belief, disability and sexual orientation. Improving organisational diversity declarations remains a key focus for PHE and targeted action through the staff diversity networks is being trialled to communicating the importance of staff disclosing their diversity data.

Diversity dashboard

PHE launched its diversity dashboards in early 2017. The dashboards illustrate the workforce composition of each PHE directorate, disaggregated by grade, gender, ethnicity and age. An overall PHE dashboard presents an entire workforce profile, highlighting protected characteristics including disability, faith and sexual orientation. Dashboards are updated and published at key points during the year. Updates are shared with key stakeholders to initiate challenging conversations, which seek to identify useful next steps to address observable imbalances.

We have developed PHE's diversity dashboards to make them more accessible for colleagues with visual impairments. Improvements to the dashboard include:

- the use of plain text tables alongside infographic charts.
- changes to the colour scheme of the to improve accessibility

We are currently working with the Cabinet Office to support the development of a Civil Service-wide dashboard by April 2018.

Awards and benchmarking

PHE has been recognised nationally for its flexible working, achieving Top 30 Employer status for Working Families 2017. PHE was also awarded a place in the Top 100 Employers Index by Race for Opportunity in 2017.

Race for Opportunity is a national business network of over 180 UK private and public sector organisations across the UK promoting the business case for race and diversity. PHE submitted its fourth Stonewall Workplace Equality Index this year, moving up 67 places to 115 out of 434 organisations who participated. The index demonstrates the extent of an employer's ability to tackle discrimination and provide an open and inclusive environment for lesbian, gay, bisexual and trans people in the workplace. PHE's London Health Protection team was awarded third place in the Civil Service

LGBT (Lesbian, Gay, Bisexual and Trans) Team Impact Index Award in 2017, and the PHE Adult Health and Wellbeing Team was awarded eighth place in the LGBT Impact Awards. Two PHE staff members achieved second and seventh places respectively in the individual LGBT Impact awards.

PHE is a participating member of NHS England's Workforce Race Equality Standard (WRES), sharing organisational best practice and contributing towards the WRES data indicators, which are designed to highlight and tackle areas of inequality. PHE also sits on NHS England's Equality and Diversity Council.

Additionally, PHE co-hosted a conference on creating compassionate workplaces for leaders across different employment sectors with Roffey Park institute in December 2017. PHE has led the development of a compassionate management toolkit along with a number of large private and public sector organisations on behalf of the National Forum for Health and Wellbeing at Work.

A major programme to transform the internal staff health and wellbeing services commenced in the summer of 2017. The aim is for PHE to be in the upper quartile of healthy workplaces by 2019.

Talent management

In 2017, PHE continued to support staff to achieve their potential through targeted mentoring and coaching schemes. We have successfully implemented external and internal mentoring schemes for BAME (British, Black, Asian, Minority Ethnic) and LGBT staff and have created a comprehensive work shadowing scheme to improve social mobility within the organisation.

This year, 8 staff have been successful in obtaining a place on the Race for Opportunity cross-organisational mentoring programme. They will join other private sector and public sector staff in mentoring circles to learn, develop and network with other BAME professionals in an action learning environment.

PHE has also launched the internal mentoring circles for BAME and LGBT staff. Senior lead mentors managed a circle made up of 5 mentees. Following the end of the programme, staff reported an increase in participants' confidence to develop and establish new networking relationships and new skills.

The Raising Aspirations Shadowing Scheme will provide unique experiences to shadow senior members of staff. The scheme will facilitate learning and development opportunities for staff members by encouraging the sharing of perspectives, information and skills between staff members from different cultural and socio-economic backgrounds.

Outreach programme

PHE is committed to tackling health inequalities in England. Employment is beneficial to health and we recognise that some underserved communities face greater barriers to the labour market.

In 2016, PHE initiated a Project SEARCH transition to work programme at its Colindale site. The programme supports young adults, aged between 16 and 25, with learning disabilities and autistic spectrum conditions to gain work-related skills as part of their last year of education. PHE has offered 10 placement opportunities, delivering more than 800 hours of valuable work experience across three rotational work placements, covering roles ranging from site operations and customer service to laboratory work and media production. Four of the students have been appointed to posts within PHE. The second cohort of students commenced in September 2017.

PHE also works with MOSAIC Clubhouse, a Brixton based provider supporting unemployed clients with mental health issues through Transitional Employment Placements (TEP). To date, we have hosted five talented individuals with mental health issues in temporary paid roles across PHE. This positive action employment scheme has provided the hosting teams with additional capacity, as well as providing lived experiences and staff development for a community we recognise is also affected by health inequity.

PHE's involvement in the industry-led Movement to Work Scheme continues. We have provided 29 work experience placements to 18 to 24 year-olds who are not in employment education or training (NEET) and who are seeking opportunities to develop and learn new skills in the workplace that will assist their transition into full-time employment. To date, this scheme has facilitated almost 36,000 placements with a range of employers across the country, achieving 68% progression into positive outcomes. PHE is also liaising with work experience partners who support ex-service personnel who often feel excluded after returning to civilian life.

Recruitment

Whilst Black, Asian and Minority Ethnic (BAME) staff are well represented overall across PHE, they are significantly under-represented at senior grades. PHE is committed to addressing workforce inequality across PHE to create the opportunity for meritocratic appointment to all grades, without barriers to entry. In the next year a focus will also be placed on improving disability-related outcomes. PHE has signed up to be a Disability Confident employer.

Training

PHE has developed recruitment and selection workshops to increase fairness and equality of recruitment. The workshops include unconscious bias training and guidance around job descriptions and panels. The training covers inclusive practice, helping managers to identify and avoid unconscious bias through levelling the playing field for all candidates.

PHE also organises regular corporate induction sessions for all new starters. These events are designed to ensure staff joining PHE gain a clear understanding about the 'One PHE' approach. The induction events include bespoke diversity and inclusion and staff health and wellbeing information. New staff members are introduced to key diversity and inclusion concepts and best practices in addition to internal diverse networking communities.

Policy and procedures

In March 2017, PHE launched a pilot of the Civil Service Workplace Adjustment Passport. Its purpose is to capture an accurate record of an individual's workplace adjustment that could be carried forward with the staff member if they moved to another team or another Civil Service department.

A review of the pilot scheme showed the scheme was welcomed and well received by staff members, who found the workplace adjustment passport a useful document and tool. The review highlighted areas for improvements before recommending the scheme be rolled out across PHE. Further developing the internal passport, PHE has joined with a number of other Civil Service and non-Civil Service organisations to explore best practices to improve the passport for the benefit of staff members.

Staff networks and staff Diversity and Inclusion Forum members have been increasingly proactive in developing and shaping PHE's policies and procedures. An example is the creation of a Transgender policy which included valuable staff member insights.

PHE staff characteristics

This section presents data on protected characteristics among PHE staff. Figures are based on a headcount total of 5,355 members of staff as of 30 November 2017. Statistics are drawn from the PHE Human Resources and Payroll system (also called electronic staff record (ESR)). The next table presents information on the proportion of staff on whom details of a particular protected characteristics are currently held.

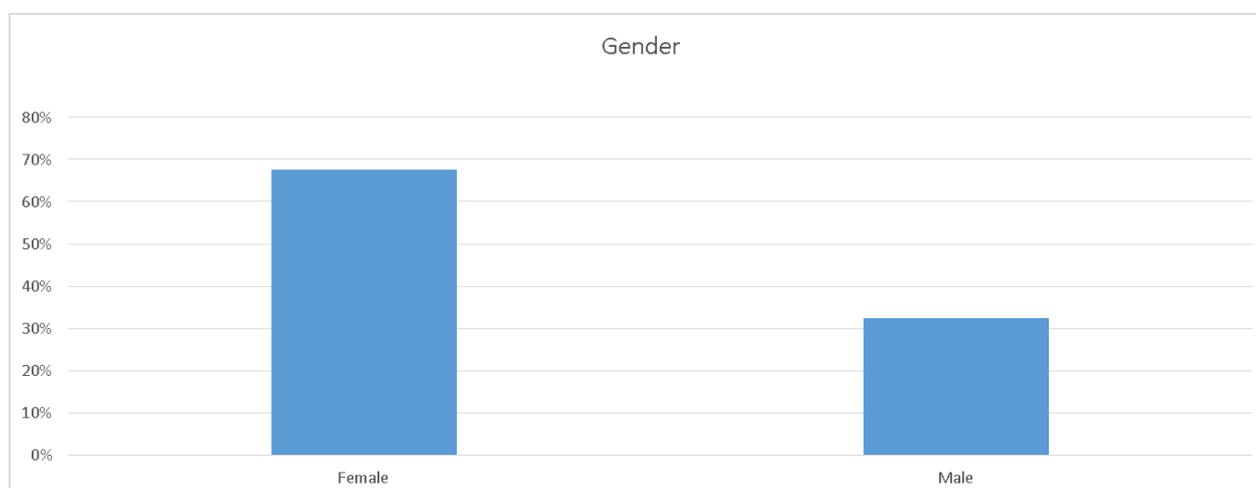
Table 1: Proportion of PHE staff by protected characteristics

Percentage	November 2015	November 2016	November 2017
Gender	100	100	100
Age	100	100	100
Ethnicity	97	96	96
Disability	53	57	62
Religion and Belief	61	65	69
Sexual Orientation	62	66	70
Total	5,324	5,308	5355

Gender

Women make up nearly 70% of the workforce in PHE. This is broadly reflective of the gender make-up of the wider healthcare system (Figure 2).

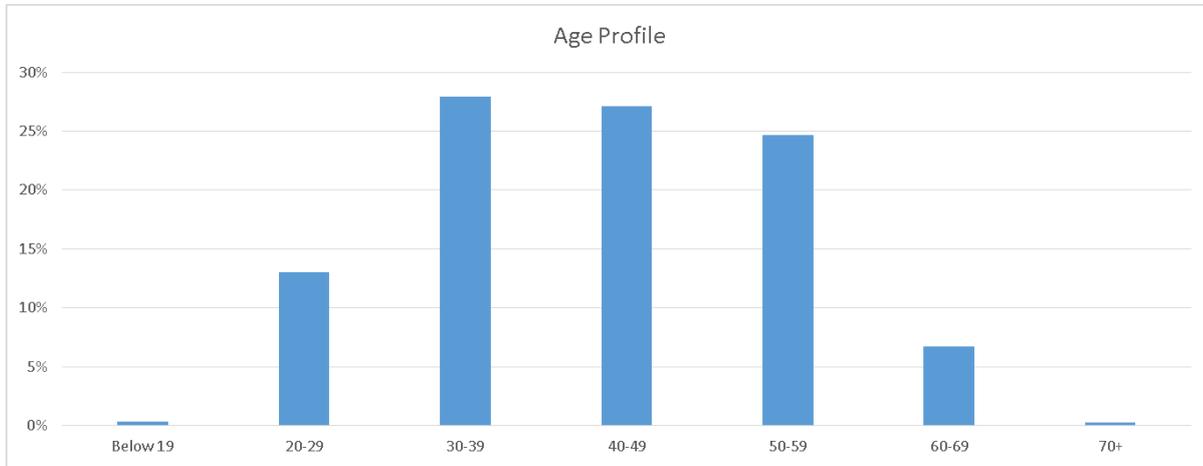
Figure 2. Gender profile of PHE staff, November 2017



Age

The majority of staff in PHE About half of our staff are aged 30 to 49 years, which is typical of the wider healthcare workforce. A quarter of PHE staff (25%) are aged 50 to 59 and 6% are aged 60 to 69 years. There are few younger staff aged under 30 (13%) in the PHE workforce. These patterns will have implications for staff succession and retirement planning (Figure 3)

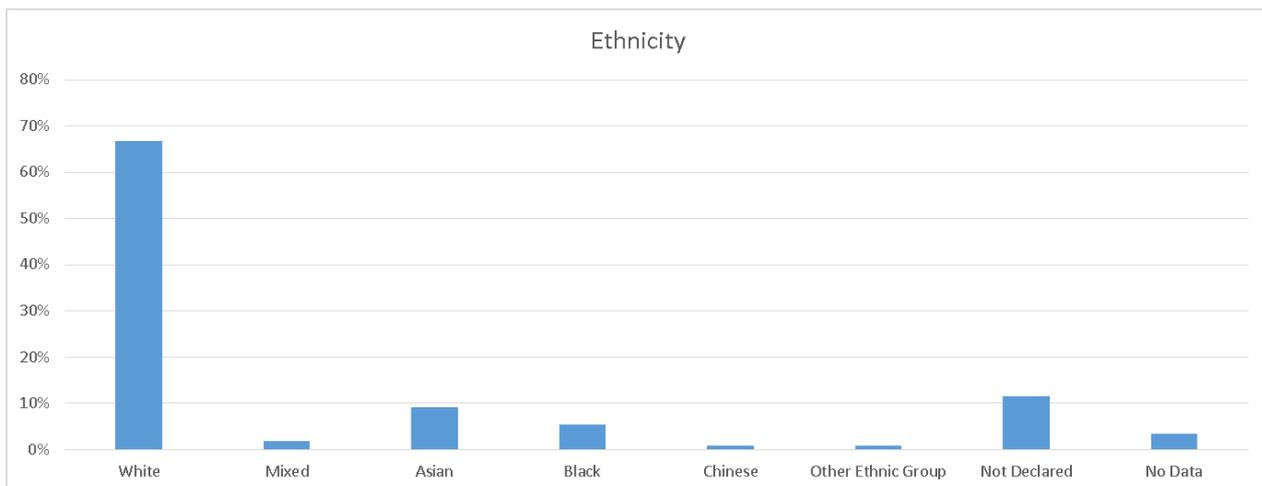
Figure 3: Age profile of PHE staff, November 2017



Ethnicity

Figure 4 shows that 66% of PHE staff describe themselves as white. The next largest ethnic group is Asian/ Asian British (9%), followed by Black/Black British (5%). There are very small proportions of staff who report mixed ethnicities, from Chinese or other ethnic minority backgrounds. These patterns are likely to vary across regions reflecting local population profiles by ethnic group, from which the PHE workforce is drawn. Around 11% of staff members have chosen not to disclose their ethnic group.

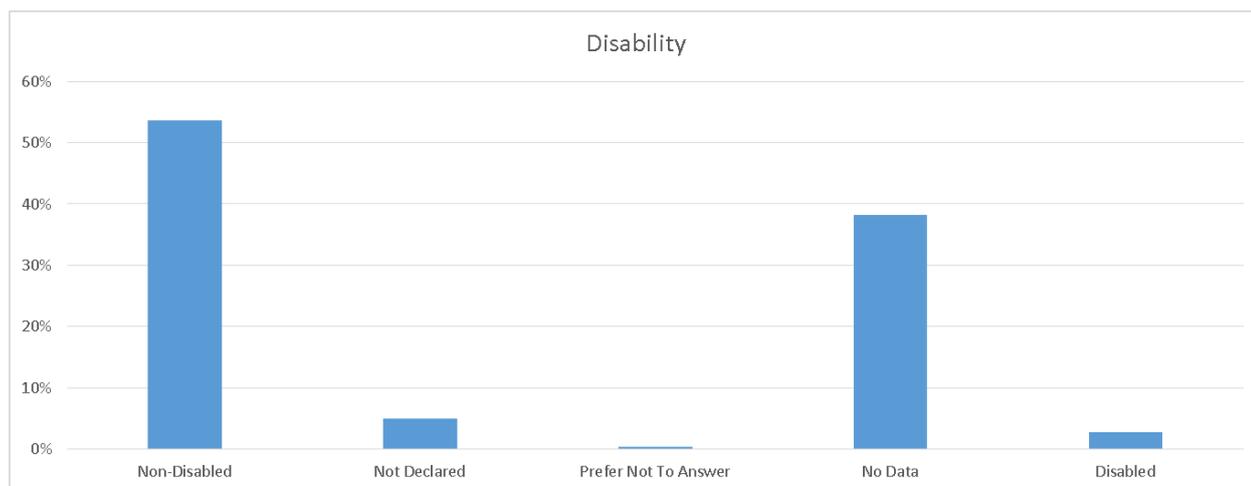
Figure 4: Distribution of PHE staff by ethnic group, November 2017



Disabilities

Records indicate fewer than 3% of all PHE staff have made a positive disability declaration. However, data on whether staff are disabled or not is currently held for 56% of staff and there is a focus for improving disability related information in the coming year.

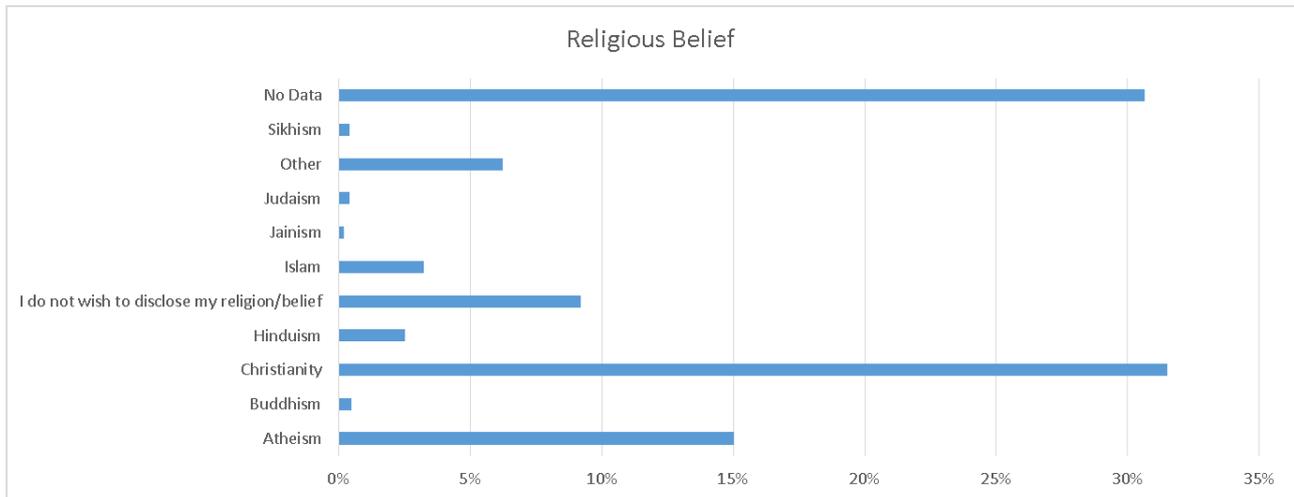
Figure 5: PHE staff by disability status, November 2017



Religion and belief

Data on the religion and belief held by staff is shown in Figure 6. Christianity is the most commonly reported religion among PHE staff (31%); the next largest group is those who report being atheists (15%). There are similar proportions of staff who report that they are Hindu (2%) or Muslim (3%). All other religions are reported by less than 1% of staff, while 9% have chosen not to disclose any religion or belief (not declared or 'prefer not to say').

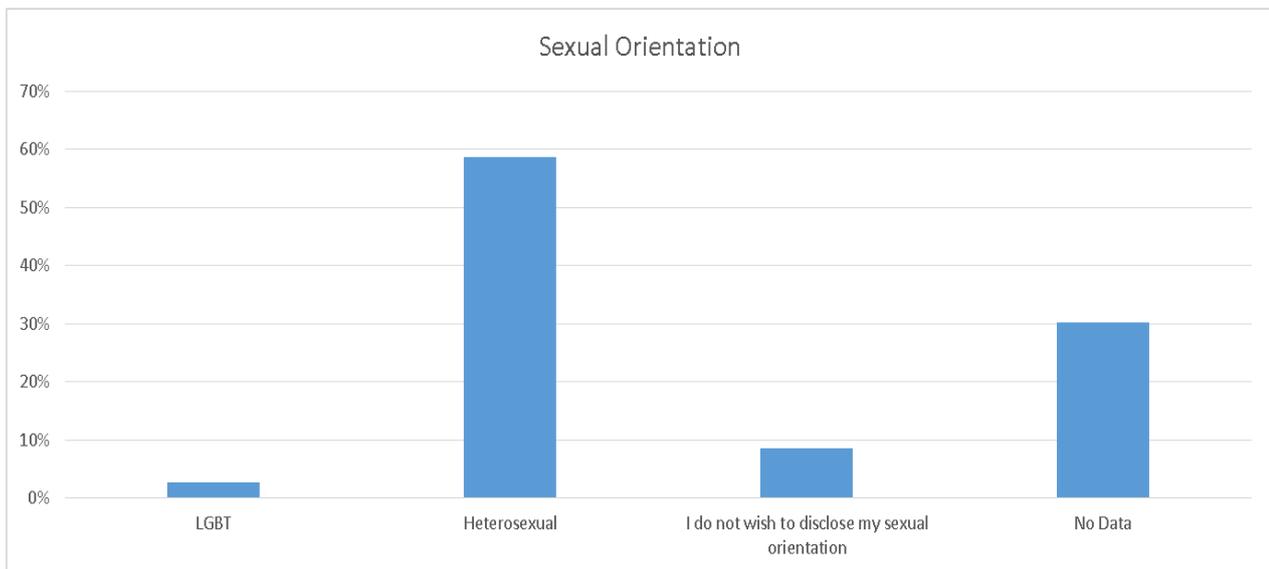
Figure 6: Religion and belief profile reported by PHE staff, November 2017



Sexual orientation

Information about the sexual orientation of PHE staff is available for 69% of the workforce, with 8% of people included in this figure as not wishing to declare their sexual orientation. A majority of staff declare themselves to be heterosexual (58%) with just below 3% of staff reporting being lesbian, gay, bisexual or transsexual.

Figure 7: Sexual orientation reported by PHE staff, November 2017



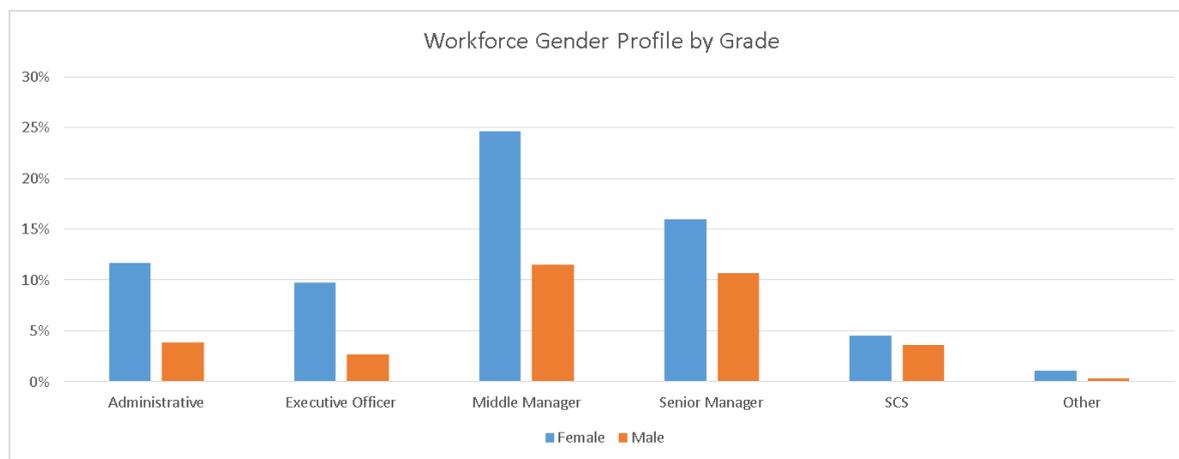
Workforce composition by grade

This section of the report provides information about workforce composition of each PHE directorate by grade and then gender, age and ethnicity as at 17 November 2017.

Gender analysis

There are nearly twice as many women (67%) as men (32%) working within PHE. Figure 8 shows that the gender distribution across the administrative, executive officer and middle manager grade is in proportion to the overall gender PHE workforce composition. Although there is a higher percentage of female staff at senior manager grade, the gender distribution within this grade does not reflect the overall gender PHE workforce composition. Proportionately males are overrepresented at the Senior Civil Service (SCS) grade despite being fewer in terms of numerical headcounts.

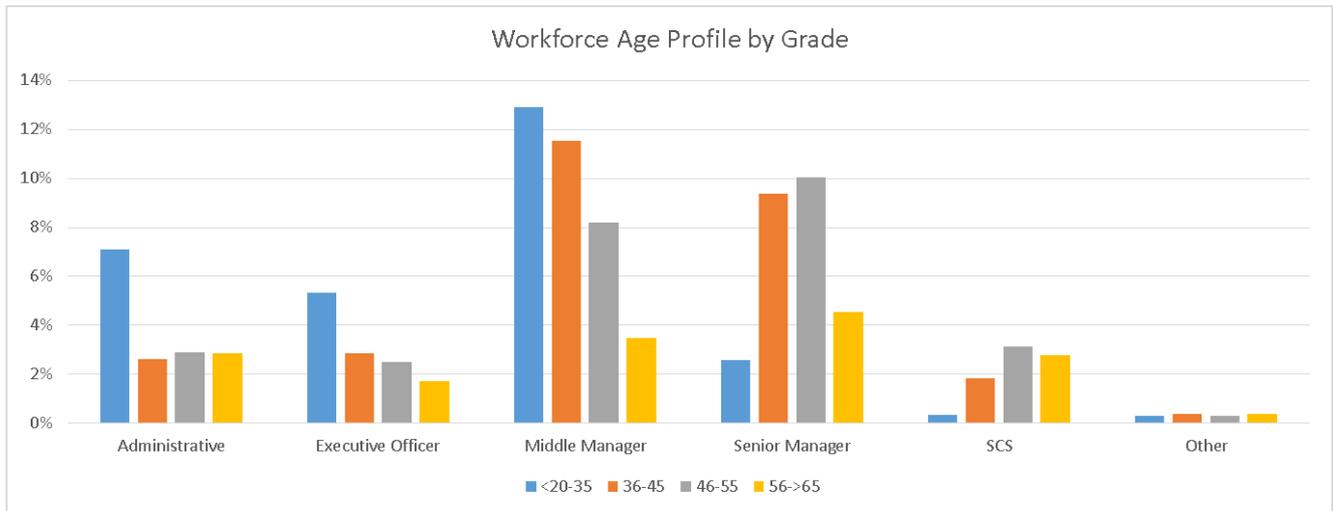
Figure 8: Workforce gender profile by grade



Age analysis

The Figure 9 illustrates that all age groups are represented at all grades at PHE, with the exception of SCS which shows lower membership from younger staff members. Staff aged 46 years and over are mainly represented at middle manager and senior manager grades. Close to 30% of the workforce is represented by staff under 35 in PHE. The largest proportion of staff in middle management roles are under 35 (13%). Within senior manager grades there is a low representation of staff under 35 (2%). The age distribution across the grades may have implications for staff succession and retirement planning.

Figure 9: Workforce age profile by grade



Ethnicity analysis

In Public Health England, 66% of the workforce is White, 18% BAME. Around 11% of people prefer not to disclose their ethnicity. We do not have ethnicity information for 3% of our staff. Figure 10 illustrates that BAME staff are represented at all grades within PHE. The biggest proportion of BAME staff is represented within the middle management grade (6%). There is a lower representation of BAME staff in senior manager grade (2%) and less than 2% of BAME staff are represented within the SCS grade.

Figure 10: Ethnicity workforce profile by grade



Gender pay gap

The DH Pay Gap report published in December identified a gender pay gap of 16% in PHE. For more details, please see table below which provides a breakdown by role and gender. In part, this stems from PHE's formation in April 2013 from over 100 organisations, with many different pay and contractual arrangements inherited by PHE. A range of special permissions granted by the Cabinet Office at the time of PHE's inception also influenced the continuation of the various contract types that influence the current pay gap.

It does not mean that all men are paid 16% more than women for doing the same work rather the difference in average pay between men and women. It reflects the complex make-up of PHE, where women account for two-thirds of the workforce but there are also many more women than men working at lower paid grades. Additionally, there are a significant number of senior and specialist staff on pre PHE legacy terms and of course length of service will influence some salaries. PHE is planning to review its pay strategies and adhering to 'equal pay for equal work' by examining job roles to ensure this is fair and consistent across the organisation. Moreover, PHE will be generating movement of under-represented groups to be more fairly represented at every level in the organisation. The recently launched PHE Gender Balance Staff Network will also play a key role in developing and embedding the action plan.

Table 1. PHE gender pay gap by role and gender

	Female	Male	Salary Difference	% Difference
	Average Full Time Salary			
a. Administrative	19,693.1	19,121.1	(572.0)	(3.0)
b. Executive Officer	25,384.8	24,895.5	(489.3)	(2.0)
c. Middle Manager	34,891.2	35,569.2	678.0	1.9
d. Senior Manager	52,640.8	54,977.3	2,336.6	4.3
e. SCS	86,270.2	90,574.3	4,304.1	4.8
f. Medical	92,335.3	93,901.8	1,566.5	1.7
g. Other Grades	44,018.7	47,920.5	3,901.8	8.1

Next steps

Over the past year, we have undertaken a range of work to improve our capacity to promote diversity and inclusion among our staff, and increase our effectiveness in supporting the wider system to address issues of equality.

In 2017, we refreshed and consulted on our equality objectives for the next period 2017 to 2020, in partnership with Strategic Partners and Equality Forum. Throughout the development phase, we engaged both with PHE staff and a variety of external stakeholders.

Over the next year we will also focus on the following activity:

Actions to support the system

1. We intend to review progress against our objectives on a regular basis, revising them where necessary or updating actions required for effective implementation.
2. We aim to update and engage senior management, Equality Champions and seek their support with the delivery of our objectives.
3. We will continue to work through our corporate business planning and reporting processes to embed a focus on inequality and diversity, and ensure sustainable and distributed ownership across PHE.
4. We will aim to increase our capacity and ability to enable effective delivery at the local level on tackling health inequalities. This will result in the provision of advice, statistics and evidence to local decision makers about the effective actions they can take to improve the health outcomes of people with protected characteristics, as well as reduce health inequalities.
5. We will continue to develop our Framework for PHE Action on inequalities, so that it is well placed to take effective action on those with protected characteristics, in line with the Equality Act 2010. This includes focusing the commitments from the organisation on fewer, prioritised issues and increasing the statistical monitoring of actions.. These changes are intended to achieve more effective national leadership on health equity, as well as distributed leadership across the organisation.

Actions to support workforce equality

Over the next year we will also focus on the following activity.

1. Develop aspirational targets and, where relevant, associated positive action programmes across all directorates.

2. Continuous benchmarking for achieving best practice across all sectors through Race for Opportunity Benchmark, Stonewall Workplace Index, Best Employers for Working Families and reporting against the NHS Workforce Race Equality Standards (WRES) and identify an appropriate benchmark to measure our services for our staff with disabilities.
3. Increase ethnicity, disability and LGBT data declarations made through the ESR system.
4. Improve the diversity dashboard in line with the Civil Service data dashboard
5. Continuously evolve the staff mentoring circles for identified groups.
6. Support the staff diversity networks to grow and expand and to be used effectively as employee resource groups.
7. Roll out nationally the Raising Aspirations Shadowing Scheme.
8. Expand our outreach programmes to reach disadvantaged and underserved communities.

Annex 1: PHE Health Equity Board Members

Name	Job Title/Role	Organisation
Ann Marie Connolly	Deputy Director, Health Equity and Mental Health	PHE
Gregor Henderson	National Lead, Wellbeing and Mental Health	PHE
Ruth Hussey	Advisor to the Board	Independent Consultant
Peter Kelly	Centre Director, North East	PHE
Paul Lincoln	Advisor to the Board,	UK Health Forum
Adrian Masters	National Director of Strategy	PHE
Mala Rao	Advisor to the Board,	Imperial College
Aliko Ahmed,	Centre Director, East of England	PHE
Jabeer Butt	Advisor to the Board, Deputy Chief Executive	Race Equality Foundation
Paul Cosford	Director of Health Protection	PHE
Dominic Harrison	Advisor to the Board, Director of Public Health	Blackburn with Darwen
Paul Johnstone	Regional Director, North of England,	PHE
John Newton	Chief Knowledge Officer	PHE
Ruth Passman	Head of Equality and Health Inequalities	NHS England
Jeremy Taylor	Advisor to the Board	National Voices
Margaret Whitehead	Advisor to the Board	University of Liverpool

Secretariat

Name	Job Title/Role	Organisation
Lina Toleikyte	Public Health Manager, Health Equity and Mental Health Division	PHE
Ravi Jaipaul	Public Health Manager, Health Equity and Mental Health Division	PHE

Annex 2: Our equality objectives 2017 to 2020

Our Aims

Aim 1: Supporting the health system

We aim to promote equality and fairness in all PHE business – the way we design and deliver our functions and products, procure and commission from others, and work with partners, and stakeholders including the public.



Our objectives

Objective 1.1 Research and Intelligence: We will develop and promote use of better intelligence and advocate for better research related to health outcomes and health determinants among groups that share protected characteristics.

Objective 1.2. Advice to the system: We will ensure our advice to the system includes dimensions of equity and equality in line with PHE priorities

Objective 1.3. Promoting equality through programmes: We will promote equality through all our programmes or functions to ensure they relate to people who share different protected characteristics, advance equality and tackle inequalities.



Our outcomes

We will know we have succeeded when:

1. Improvements to our services and advice we provide are underpinned by a robust evidence base, meet the needs of individuals with different protected characteristics and are linked to PHE's seven key priorities.
2. Credible, actionable intelligence and world-class research on the key issues relating to the public's health and inequalities is available to inform local action.

Our Aims

Aim 2: Engaging and developing PHE staff

We aim to create and maintain a diverse and inclusive working environment that values difference and fosters an inclusive workplace ethos where staff from all backgrounds are treated fairly and equally, and where they can advance their careers.



Our objectives

Objective 2.1 Diversity and Staff inclusion: We will develop people managers' understanding of the link between effective diversity and staff inclusion and the future impact on physical and mental health of the actions and behaviours of managers and colleagues.

Objective 2.2 Workforce composition: We will strengthen collection and monitoring information on our staff in reference to their age, gender, ethnicity, sexual orientation, religion/belief and disability.

Objective 2.3 Talent management: We will establish talent management schemes tailored for developing staff from the main six protected characteristics.



Our outcomes

We will know we have succeeded when:

3. Our employment policies and practices, services and ways of working advance the aims of the general duty. All staff are supported to thrive in and progress through PHE.
4. We have identified and progressed action for improvement across our employment policies, practices and ways of working.