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Public Health England equality analysis

An analysis of how equalities considerations have informed the design and transition of Public Health England (PHE), and how equalities work can be embedded into the future work of PHE.

Key messages

One of the primary aims of PHE is to reduce health inequalities. This paper examines how we have taken equalities considerations into account when designing PHE and when moving the workforce over from sender organisations. The design of PHE's new elements has been influenced by a desire to make equalities thinking central to the organisation. As an executive agency of the Department of Health, it is recognised that PHE must work alongside the department's and wider government's objectives to deliver this agenda. In its first year of operation, PHE will build upon work already done by sender organisations on promoting equality and preventing health inequalities. The Strategy and Human Resources directorates will lead this process, supported by an equalities lead from each directorate. PHE will establish links with organisations across the healthcare system to promote collaborative working on equality and health inequalities. Promoting equality and reducing health inequalities is the collective responsibility of all in PHE.

Establishing PHE

'One of the primary aims of PHE is to reduce health inequalities so I am pleased to introduce this analysis of how equality initiatives and activities have informed the structural and functional design of the new organisation. I am particularly grateful for the work that has taken place in the various sender organisations, which we can embrace in PHE. Within this analysis you will see examples of how equality and diversity has informed the services that will come together to form PHE. I am confident that we can build on this work to help us achieve our equality ambitions.

To make this a reality, we are determined to promote equality in all the services we provide and to eliminate any institutional inequalities in everything we do. We are also committed to ensuring that our staff are treated fairly and with dignity and are given the opportunity to develop to their fullest potential.'

Duncan Selbie – Chief Executive, PHE

PHE was established from 1 April 2013 as an authoritative national voice and expert service provider for public health. Its overall mission is to protect and improve the health and wellbeing of the population and to reduce inequalities in health and wellbeing outcomes. The Equality Act 2010 requires PHE to ensure that interventions and services are designed and

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implemented in ways that meet the needs of different groups in society, advancing equality of opportunity between protected groups and others.

This analysis demonstrates how the structural and functional design of PHE and the workforce transfer processes have been informed by these considerations. It will inform the process by which PHE sets organisational equality objectives and by which PHE ensures that equality and health inequalities considerations are reflected in the planning and delivery of PHE's business priorities.

Although a new organisation, many of PHE's staff and functions are being transferred directly across from sender organisations into PHE's directorates. The following analysis focuses principally on the Health and Wellbeing and Chief Knowledge Officer's directorates, as they have been newly designed for April 2013. The analysis also acknowledges the already existing practices on equality and diversity that we have invited from sender organisations.

Background

Equality is concerned with treating everyone fairly and with dignity and respect, ensuring that individuals have equal chances in life regardless of their personal characteristics or background. National legislation focuses on nine protected characteristics – age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and marriage or civil partnership[1]. As a public body, PHE has a duty to promote equality by considering how it will:

- eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and people who do not
- encourage and develop good relations between people who share a protected characteristic and those who do not, including promoting understanding and tackling prejudice

PHE is required to publish information annually demonstrating how it has met these duties. It must also set and publish specific measurable equality objectives every four years in a way that is easy for people to access.

For more information please refer to the Equality Act 2010, Part 11, Chapter 1 the Public Sector Equality Duty[2].

[1] For marriage and civil partnership, only the duty to eliminate discrimination, harassment and victimisation applies.
[2] Link to the Public Sector Equality Duty: http://www.legislation.gov.uk/ukpga/2010/15/section/149

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Health inequalities are systematic and avoidable disparities in the health outcomes of population groups. They are seen in different geographic as well as socio-economic and demographic communities and can become further entrenched when these categories overlap. The Marmot Review[3], *Fair Society, Healthy Lives*, argues that avoidable health inequalities arise because of inequalities in society and the conditions in which we are born, grow, live, work and age. The recommendations of the report have informed the design of PHE in general, and the Health and Wellbeing directorate in particular.

There is confluence and some imbalance between equality and inequality issues; however, one of the underpinning principles of the **Public Health Outcomes Framework** is the need to reduce inequalities in health outcomes. The framework contains an inbuilt push towards greater equality in health and care. It includes measures that specifically focus on variation between different areas and a commitment to publish all measures broken down by inequalities and equalities breakdowns where feasible. This inbuilt push reflects the new duties that the Health and Social Care Act 2012 places on the Secretary of State (and by extension PHE) to have regard to the need to reduce health inequalities in access to healthcare services and health outcomes[4].

Fair Society. Healthy Lives – The Marmot Review 2010

The Marmot Review proposes an evidence based strategy to address the social determinants of health, the conditions in which people live and work and which can lead to health inequalities. It draws attention to the evidence that most people in England aren't living as long as the best off in society and spend longer in ill-health.

The detailed report contains many important findings, some of which are summarised below:

- *people living in the poorest neighbourhoods in England will die younger and spend more of their lives with disability than people living in richer areas*
- *health inequalities arise from an interaction of factors (eg. housing, income, education, social isolation, disability) which are strongly affected by one's economic and social status*
- *there is a social gradient in health inequalities. The lower one's social and economic status, the poorer one's health is likely to be*
- *to reduce the steepness of the social gradient in health, actions must be universal, but proportionate to the level of disadvantage. This is called proportionate universalism*
- *health inequalities are largely preventable*
- *economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals*

Based on the evidence assembled, the report also sets out several recommendations, grouped into six policy objectives, which are summarised below:

- *give every child the best start in life*
- *enable all children, young people and adults to maximise their capabilities and have control over their lives*
- *create fair employment and good work for all*
- *ensure a healthy standard of living for all*
- *create and develop healthy and sustainable places and communities*
- *strengthen the role and impact of ill-health prevention*

[3] Marmot, M. (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010), www.marmotreview.org.*
[4] The Secretary of State must also report annually on how effectively they have carried out these duties.

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Stakeholder views

Prior to the establishment of PHE, the Department of Health conducted several **equality impact assessments** to analyse the proposed reorganisation of the health system. They concluded that the overall impact of the new public health provisions would be positive for equality groups given the clear focus[5] on reducing health inequalities. The burden of poor health is not spread equally across society; older people, people with disabilities and people from minority ethnic backgrounds can all be more likely to experience preventable health problems.

> ***We welcome the Coalition Government's strategy for public health, Healthy Lives, Healthy People. We particularly welcome the attention paid to taking a life course approach to public health, the focus on social determinants of health inequalities, and the linkages made between health, wellbeing and mental health.***
>
> Afiya Trust and ROTA

DH also launched **several public consultations and workshops** to inform the design of the new public health system. Many equalities groups[6] endorsed the vision of *Healthy Lives, Healthy People*, the focus on professor Michael Marmot's report *Fair Society, Healthy Lives*, and the corresponding focus on the wider determinants of health. They also identified issues that we could give further consideration to:

- the importance of the voluntary, community and social enterprise sector in understanding and engaging with disadvantaged and hard-to-reach groups
- the needs of minority groups, particularly excluded or marginalised communities, that may be overlooked at population level or not captured in routine data
- ensuring that resource allocation and outcome measurements do not overlook low volume groups, particularly those that have high inequalities but which are too small to contribute to overarching outcomes
- the impact of the current economic situation on disadvantaged groups, particularly with regards to wider determinants of health
- PHE's role in identifying progress against wider determinants of health with non-health system organisations
- the importance of PHE's independence from government in highlighting concerns over wider determinants of health, such as low income

PHE is committed to listening to feedback, and to working in dialogue with organisations from the voluntary, community and social enterprise (VCSE) sectors. This will allow PHE to capitalise on the expert knowledge held within those organisations and will encourage representation of the viewpoints of the most marginalised groups.

[4] The new public health system unifies accountability for public health under the Secretary of State, gives a clear statutory duty to the Secretary of State to reduce health inequalities, and establishes PHE as a new organisation with a clear remit to tackle health inequalities.

[5] Equalities groups responding to the consultation included Mencap, Age UK, Men's Health Forum, Zacchaeus Trust, Catch 22 and Stonewall.

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Setting up PHE's workforce

During the transition PHE has collected data relating to 3,968 staff (75%). These are staff who have transferred in through job matching or competitive slot-in. We are still awaiting data on 1,300 other staff who have transferred where data is incomplete or there are outstanding queries on their status. There have been difficulties in obtaining data due to concerns about data protection and competing priorities during the transition.

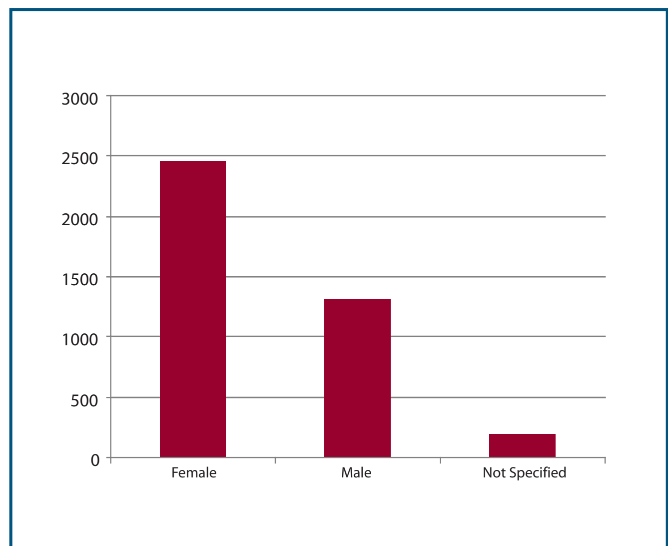
In line with equity protocol established in March 2012 by the Integrated Programme Office at the Department of Health, it was agreed for consistency that the people tracker would collect data across four of the people characteristics only. Therefore, data has been collected by sender organisations on four of the equality strands – gender, age, disability and ethnicity. The following analysis relates to data as at 31 January 2013.

As PHE enters its first year of operation, consideration will be given to improving data collection and analysis, with a view to collecting comprehensive workforce data (see Next Steps).

Gender

There are almost twice as many women as men in the PHE workforce. This reflects the gender make-up of the wider health care system from which staff have been inherited. (See graph A)

Graph A: gender profile



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Age

The age profile shows that the majority of the workforce (55 %) is aged 30 years to 49 years which is typical of the wider health care system. There are 1,175 staff (30%) who are between 50 and 69 years old. This should be noted as it will have implications for staff succession and retirement planning. There are few younger staff (11%) aged 19-29 years old in the PHE workforce, which means that there are fewer staff available to move into more senior roles as they become vacant. This should be noted in terms of future workforce and leadership planning. (See graph B)

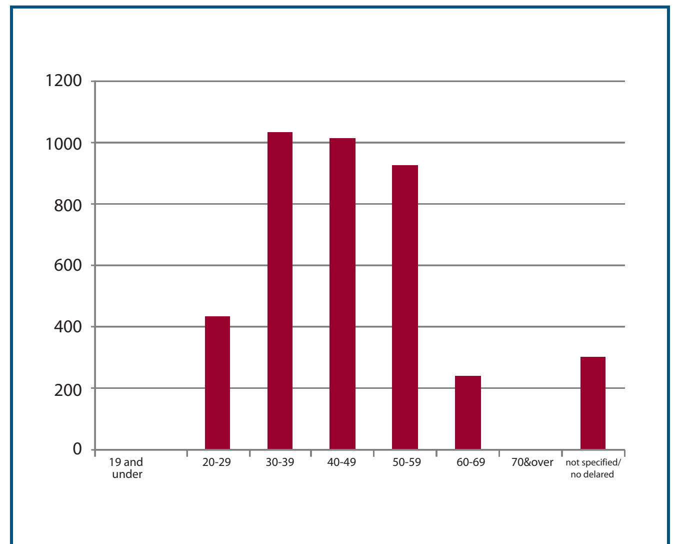
Disabilities

One per cent of staff state that they have a disability. This is low in comparison with the Department of Health, where 7% of staff declare themselves as having a disability. However, it is common for answers to this category to have a low response rate from staff; a high proportion of staff (73%) completing the questionnaire did not respond to this question (see graph C).

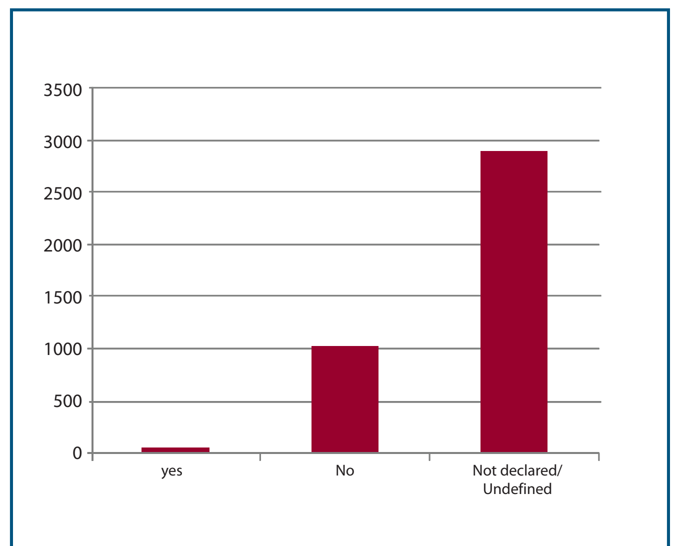
Ethnicity

Sixty-six per cent of transferring staff describe themselves as white[7]. The next largest ethnic group is Asian/Asian British (7%), followed by black[8] (3%). There are very small proportions (1%) of mixed, Chinese and other ethnic groups. PHE is a national organisation but there are likely to be large regional differences in this category. Local data would need to be collated in order to decide where and how to redress under-representation of minority ethnic groups (see graph D).

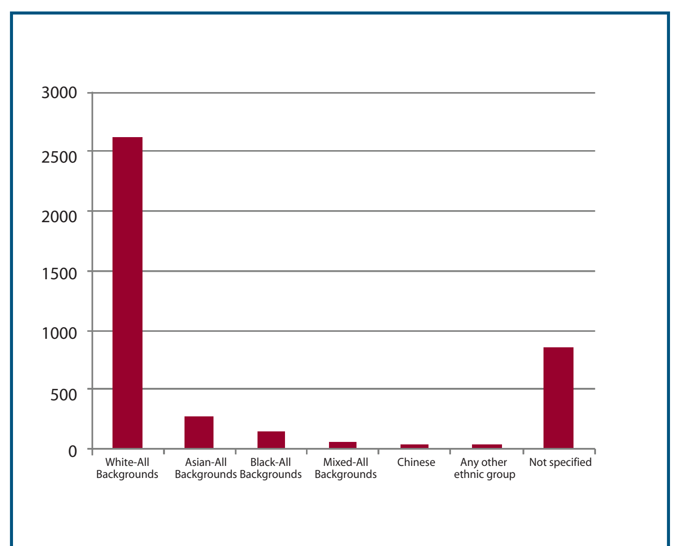
Graph B: age profile



Graph C: disability profile



Graph D: Ethnicity profile



[7] This includes British, Irish, Greek, Turkish Cypriot and European.
[8] This includes Caribbean, African, Nigerian, Black British.

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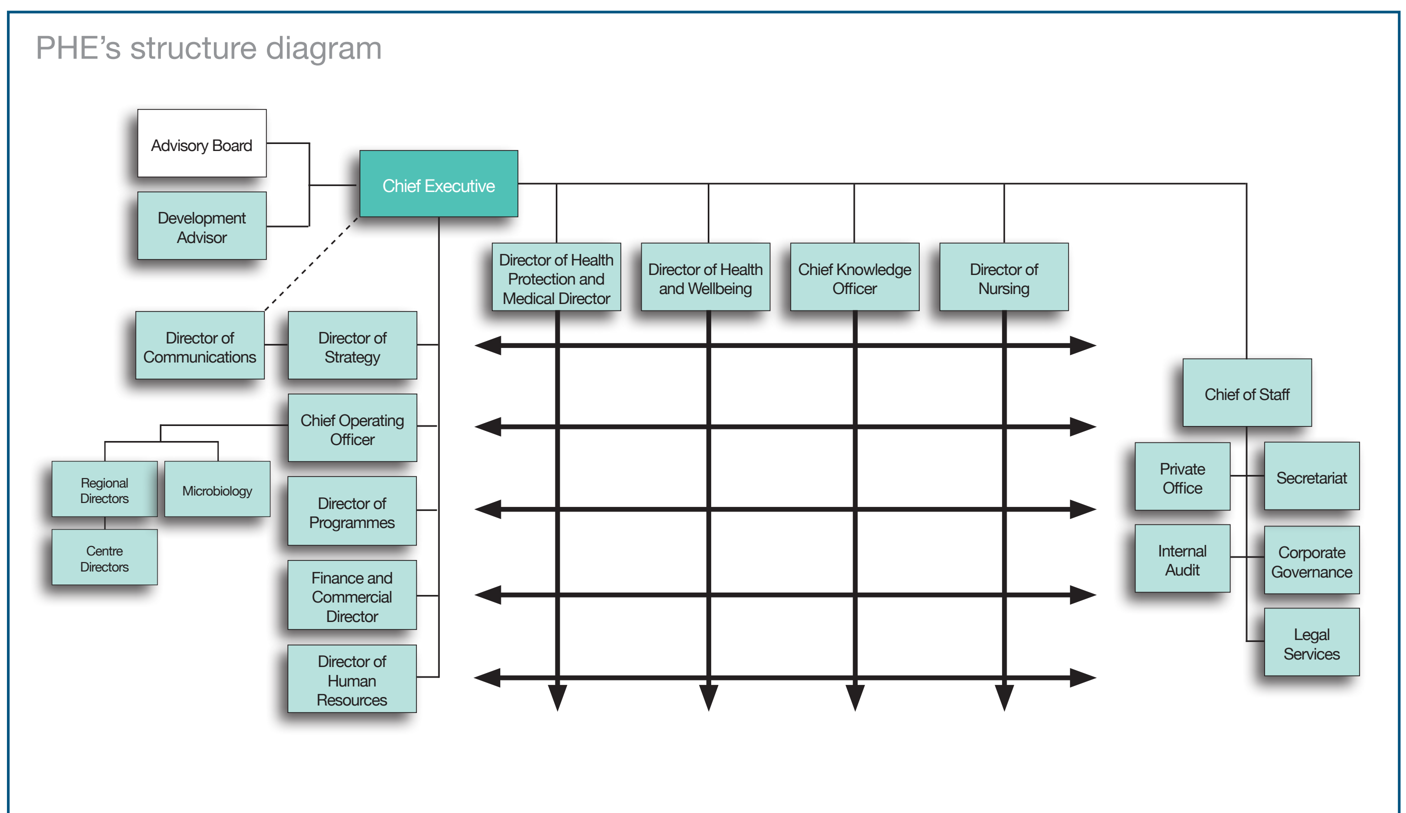
Designing PHE's structure

Each of PHE's new directorates will have a nominated equalities lead appointed by spring 2013. This ensures that equalities considerations can be embedded across the organisation and within each directorate. Each directorate has a role to play in addressing health inequalities and will continue to deliver on their existing commitments.

PHE's structure diagram



The **Chief Executive's Office** is responsible for a number of corporate functions. Managed by the chief of staff, it comprises the chief executive's private office, corporate governance, the internal audit function, legal services teams and the PHE secretariat.

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The **Health Protection directorate** delivers health protection services to leading international standards. It will utilise the expertise within the VCSE sector to identify and protect against health threats that affect disadvantaged groups. PHE inherits several well-established programmes, and will build upon the work done by the Health Protection Agency (HPA) on equalities and inequalities previously (see Figure 1 for an example).

Figure 1

The HPA's work on improving vaccine-preventable disease outcomes for protected groups included:

- *investigating measles outbreaks in minority communities e.g Traveller and Orthodox Jewish communities and finding ways to ensure increased vaccine coverage without stigmatising these communities*
- *developing culturally sensitive communication materials in association with the Irish traveller movement*
- *corresponding with the Board of Deputies of British Jews and developing a PhD proposal to look at vaccine uptake and coverage in the Orthodox Jewish Community*
- *analysing pertussis deaths and cases in children under 3 months by deprivation*
- *producing travel leaflets and information on typhoid for the South East Asian community*
- *submitting for publication a paper on vaccine coverage by ethnicity*

Moving into PHE, we will take care to ensure that inherited programmes of work like this are built upon and developed.

The **Operations directorate** oversees the delivery of services at the regions and centres, working in partnership with local government to reduce health inequalities. As the local arm of PHE it encourages the integrated working of all public health disciplines. The newly designed elements of the Operations directorate relate to the local delivery of the Health and Wellbeing functions and are addressed in the analysis below.

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The **Strategy directorate** leads the development of PHE's objectives, and the strategy to deliver them. It ensures that equalities considerations are at the forefront of PHE's thinking and that they are built into all elements of PHE's business. The Directorate also includes the communications, public accountability and parliamentary accountability functions (see Figure 2 for an example).

Figure 2

The communications team at the HPA set up an equality forum for consultation and engagement with people from hard-to-reach communities many of whom are drawn from the protected status groups. It is intended that this forum continue operating as we move into PHE. Representation on the forum includes the staff support groups for the protected statuses.

The **Programmes directorate** is newly established and will lead PHE's cross-cutting programmes from initiation through to commissioning or implementation. The design of the Directorate is still being developed post April 2013.

The **Finance and Commercial Services directorate** provides finance and corporate services for PHE and ensures that it operates within its financial envelope. Business processes in PHE support the organisation in giving due regard to equalities issues.

The **Human Resources directorate** provides human resources services and leads on organisational development of the new organisation. It is responsible for ensuring that the workforce is equitable and that the development of the workforce is carried out with due regard to equalities issues.

The **Nursing directorate provides** leadership and advice on public health nursing issues within PHE and across the nursing and midwifery professions and, in partnership with the Medical directorate, will ensure robust clinical governance and quality systems are developed and implemented within PHE.

The **Chief Knowledge Officer's directorate** delivers a national knowledge and inteligence service, encompassing research, statistics and know how, that supports the practice of public health.

The **Health and Wellbeing directorate** delivers a health and wellbeing service to support local authorities and the NHS in tackling health inequalities and delivering improvements in the public's health.

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The Health and Wellbeing directorate

The Health and Wellbeing directorate supports local authorities and the NHS to deliver improvements and reduce inequalities in health and wellbeing outcomes. It leads in the use of evidence-based practice to target the major causes of morbidity and mortality across the life course. It focuses on wider determinants of health (eg healthy places, sustainable environments), health risk behaviours (eg reducing smoking, poor diet and nutrition, lack of physical exercise) and protective or preventative factors (promoting good mental health and wellbeing). It promotes parity of esteem between mental health and physical health.

The directorate inherits several teams that are moving directly across from sender organisations. The new design of the directorate also includes newly created teams for children, young people and families, mental health and wellbeing, social determinants and health inequalities and healthcare service improvement. These teams will sit within six divisions. A key design element is the new health equity and impact division, which will house the social determinants of health, healthy places, accident, injury and violence, and sustainable development teams. The division will work in a matrix style to ensure a major focus on health inequalities and the social determinants of health within and throughout the directorate and PHE.

The design of the directorate draws on the findings of various papers: *The Marmot Review, Tackling Health Inequalities Programme for Action, National Support Team for Health Inequalities*. The directorate will prioritise partnerships with academic institutions including the Health Equity Unit at UCL, which is led by professor Michael Marmot. The intention is that in time it will support innovative partnerships, research and training programmes.

The division of partnership, performance and planning will work with health equity and impact to monitor health inequalities work.

This new provision is aimed at addressing equality and inequality issues in recognition that:

- there are many factors that influence an individual's health ranging from social factors (socio-economic, cultural and environmental) to individual lifestyle factors and that there is often an interplay between these factors
- integrated approaches are needed, which take account of the interplay between factors
- there should be parity of esteem given to addressing mental health alongside physical health
- prevention should be embedded across healthcare pathways;
- members of groups marginalized because of socioeconomic status, race or ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these experience the worst health outcomes. These groups also tend to have less access

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to the conditions that support health (eg healthy food, good housing and education, safe neighbourhoods and access to health services).

The newly created teams and the overall design of the directorate provides a framework for providing an integrated focus on the wider determinants of health, both in relation to protected characteristics and to those characteristics that are not covered by the Equality Act 2010, but which contribute to health inequalities.

The Chief Knowledge Officer's directorate

The Chief Knowledge Officer's directorate delivers a national knowledge and intelligence service, encompassing research, statistics and know-how, that supports the practice of public health and drives improvements in the public's health. It provides leadership and support to those who wish to make use of evidence to improve the health of their local populations and to assist in PHE's goal of transforming health in England. Its main aim is to ensure that decisions that PHE and the wider health and care sector make about the health of the population are based on the best information available and will deliver the best outcomes.

The Chief Knowledge Officer's directorate has six divisions: disease registration, knowledge and intelligence, drug treatment monitoring, National Cancer Intelligence Network, research and development, business and planning. It brings together organisations with specialist expertise and many years' experience in the use of public health data and knowledge. These functions are delivered through teams distributed across England. Through the creation of a national co-ordinated function, expertise on inequalities can be prioritised and shared across the network to bring consistency and to focus on the populations with the highest needs. The network of teams based around the country ensures that all parts of England receive an effective knowledge and intelligence service with comprehensive coverage of the population across England. By creating a national service ensures that expertise and resources are available to all users of the services of the Chief Knowledge Officer's directorate without regard to location. By locating staff across England they can also provide a responsive service which can be targeted to populations in greatest need.

The teams will work alongside partners and colleagues in other PHE Directorates to promote a collaborative approach to improving and protecting the public's health.

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Work programmes of the Chief Knowledge Officer's and Health and Wellbeing directorate

Data

The way in which knowledge and intelligence is gathered and used in the new system has been designed to take account of equalities dimensions and of the potential to reduce health inequalities.

The Chief Knowledge Officer's directorate gathers information from various sources in order to provide data on the state of public health, and on the effectiveness of public health interventions. Information will be disaggregated to identify and highlight health inequalities and to enable the needs of specific groups to be understood in more depth. It is expected that an inequalities dimension will be considered as an element of every activity of the Chief Knowledge Officer's directorate.

The Health and Wellbeing directorate will work with the Chief Knowledge Officer's directorate to analyse available data sets by equality characteristics and will use this evidence to inform priorities within the directorate. It will also work with colleagues in the Chief Knowledge Officer's directorate to promote access to evidence and intelligence in a way which advances equality, eg making available evidence and intelligence that has been disaggregated by equality characteristics.

PHE will identify gaps in the evidence base in relation to protected characteristics, and will influence action to address these gaps. Improving the collection and dissemination of public health information will give a better understanding of the health outcomes experienced by different groups. This will be used to promote better targeting of effective interventions.

PHE will use evidence to highlight the needs of populations with protected characteristics, and will promote effective practice in relation to these needs. PHE will also ensure that health improvement strategies promote fair allocation of resources, and that they target groups with higher risk or higher need. They will support local systems to identify priorities for action in line with these needs.

PHE will have a role in conducting and commissioning data collection. In developing its strategy for data collection, PHE will take account of the potential to enhance the quality of data available on different equalities groups and on health inequalities. This will enable commissioners and providers to target their services at those groups who would benefit most.

In partnership with NICE, the directorate will apply economic evaluation techniques to identify the most effective and cost-efficient public health interventions. The service has been designed to ensure that the impact on equalities and health inequalities is taken into account when evaluating possible interventions.

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Communication and dissemination

Much of the work to address public health challenges will take place outside of PHE, within local authorities, the NHS and broader society. PHE's role in disseminating and communicating information to influence the wider system has been designed to ensure that professionals are provided with information that allows them to take account of equalities and inequalities in service planning, commissioning and assessment. For example, the Chief Knowledge Officer's directorate will highlight differences in health status between population groups in a local area, informing how local commissioners will design their services to most effectively target those with the greatest need.

Via PHE's website, PHE's Knowledge and Intelligence function will provide information about local services and the quality of those services so that equalities groups and those experiencing inequalities are able to access it easily. This will help them hold local commissioners and providers to account.

PHE will work closely with NHS, local authority and social care colleagues in providing healthy-living advice to the public. PHE has been designed to consider how public health communications can reach all groups within the population. Particular attention will be paid to those population groups who experience poor access to advice generally and/or who experience inequalities in health in comparison with other groups. PHE will work with the NHS England to identify opportunities through a new 'customer service platform' which will replace NHS Choices and NHS Direct. It will be a way for the public to engage with the NHS using a wide range of channels, including telephone, web, apps and social media. This will include health improvement advice provided to the public, including to those with greatest need.

The strategies used by social marketing teams, and the communication of information both to the public and to PHE's customers, will take account of the needs of populations with protected characteristics, eg information and services need to be culturally and linguistically sensitive if they are to produce more equal outcomes for black and minority ethnic communities and other groups and services need to be accessible to people with disabilities.

Role of voluntary sector

In acknowledgement of the importance of voluntary and community organisations to deliver services to the most vulnerable and hard-to-reach groups, PHE will help to improve the capacity of these groups. The role of community support is critical for those who are disproportionately affected by health inequalities[9].

[9] *'Tackling Health Inequalities: A Programme for Action' DH, 2003* highlights particular groups who are vulnerable to experiencing health inequalities. These include: people from ethnic minorities, older people, those with mental health problems, the homeless, prisoners, asylum seekers and refugees, young people form black and minority ethnic backgrounds, looked after children.

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For example, black and minority ethnic groups are more likely to live in the poorest 20% of local authority areas and have problems accessing services that tend to be of poorer quality and not responsive to their needs. It is vital to engage with these groups if the life expectancy target is to be achieved

Governance

The Strategy directorate will coordinate the equalities agenda across the organisation and will establish an **equality and diversity strategy group**. This group will have an equalities lead from each directorate, who will be responsible for progress against the equalities objectives within their directorate. They will report to the National Executive, who will assure PHE's compliance with its duties under national equalities and health inequalities legislation.

The Human Resources directorate will be responsible for ensuring the equality of the PHE workforce. An **equality and diversity employment group** will be established and chaired by the deputy director of human resources. Membership will include representatives from each of the recognised trade unions for PHE, the heads of human resources for the directorates, and a representative from the Department of Health human resources team. This group will report to the equality and diversity strategy group. In addition a staff support sub-group will be established, based on existing staff support groups previously set up by the HPA. This sub-group will report to the equality and diversity employment group and a representative of the sub-group will be a member of the equality and diversity employment group.

With human resources support and management, individual staff will be responsible for adhering to the behaviours and values of the organisation, and as such equalities considerations will be embedded in all staff objectives. These values are to: work together, not undermine each other; speak well of each other, in public and in private; consistently spend our time on what we say we care about; behave well, especially when things go wrong; and keep our promises, small or large.

Next steps

As an executive agency of the Department of Health, PHE recognises that it must work alongside the department and the wider government objectives to deliver this agenda. As PHE enters its first year of operation, it will build on work carried out previously within sender organisations. The Strategy directorate will oversee a process of integrating the equalities schemes that already exist in the sender organisations, making best use of existing assets, skills and knowledge. PHE will note the points emerging from the consultation and commit to continued engagement with stakeholders, and to building on their recommendations.

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Equalities duties should be undertaken as an intrinsic part of the approach taken to work, analogous to the requirement to achieve a balanced budget. They should be embedded within the processes of the organisation. The Strategy directorate will lead PHE in establishing a set of clearly defined organisational equalities objectives. These will be published in the autumn and will help PHE fulfil its obligations under the Equality Act 2010. These objectives will be used to ensure that actions across the organisation are part of a coherent strategy, and a process will be agreed to enable this. For example, this process might involve a series of questions that are automatically asked whenever taking a decision, the answers to which can then be used to measure against major decisions that are taken in terms of how each decision supported or impacted upon the equalities aims. As part of the business planning process, PHE will also consider how and when it will undertake an equality analysis of its functions and services, and how these will be reported upon. It will agree the methods it will use to demonstrate performance through evidence and outcomes.

In order to ensure that equalities considerations are embedded across the organisation, each directorate will appoint an equalities lead by spring 2013. This lead will attend a newly established cross-directorate equality and diversity strategy group that meets quarterly. This group will be supported by the equality and diversity employment group, which will have the specific remit of workforce related equality issues and will have representation from each of the recognised trade unions for PHE, the heads of human resources for the directorates, and a representative from the Department of Health human resources team.

In year one PHE, through the equality and diversity strategy and employment groups, will:

a) as a priority consider the different models for setting up this agenda, taking learning from mechanisms that have worked previously in other sender organisations
b) consider commitments made previously by the sender organisations, for example the HPA committed to enrolling in the Stonewall Diversity Champions Scheme and to considering the implementation of the National Living Wage initiative
c) work to establish further support for staff through development of a staff support sub-group to focus on specific protected characteristics, previously developed by the HPA. A small budget provision within the human resources budget will be made to support the staff groups and this budget will be managed by the deputy director of human resources
d) agree a detailed plan for the collection of workforce data post April 2013, encouraging staff to fill in details and set up appropriate reporting arrangements based on all the protected characteristics. It will use this data to establish a workforce baseline, and agree when this baseline will be refreshed and from this will agree targets and benchmarks for the protected characteristic strands. It will examine areas of under-representation and consider how to redress these. This may include the use of positive action in the form of, management and leadership programmes. It may also include the development of succession planning and talent management approaches

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e) consider the equality standards it may use to monitor its progress, such as the Two Ticks symbol, which identifies those employers who have agreed to meet five commitments regarding the recruitment, employment, retention and career development of disabled people

Further objectives for year one will be considered by both the equality and diversity strategy and employment groups in line with the PHE business planning process.

PHE is working with UCL's health equity team, establishing links to enable cross-organisational working and to allow PHE to keep up-to-date on the latest developments and thinking on health inequalities. PHE will further work to establish relationships with equalities leads in organisations within the wider health system to ensure a collaborative system-wide approach, in line with the outcomes framework. It will consider opportunities to align itself with national programmes to promote equality in health, such as Race for Health and Delivering Equality in Mental Health.

PHE will also have a key role in helping to shape the work of local action on health and health inequalities. We will do that through our role as an exemplar organisation and through: i) stakeholder engagement; ii) production of high quality data and analysis; iii) through delivery of high quality products and tools that will inform the work of local authorities and other stakeholders on how best to address inequalities issues for its communities; and iv) through creating learning networks and increasing capacity and capability in the system to systematically address the causes and impact of inequalities.

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