



Public Health
England

How we met our public sector equality duties (April to December 2013)

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

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Introduction

Public Health England's role as an expert public health agency

Public Health England works transparently, proactively providing government, local government, the NHS, MPs, industry, public health professionals and the public with evidence-based professional, scientific and delivery expertise and advice.

We ensure there are effective arrangements in place nationally and locally for preparing, planning and responding to health protection concerns and emergencies, including the future impact of climate change. We provide specialist health protection, epidemiology and microbiology services across England.

Improvement in the public's health has to be led from within communities, rather than directed centrally. This is why every upper tier and unitary local authority now has a legal duty to improve the public's health. Local health and wellbeing boards bring together key local partners (including NHS clinical commissioning groups who have a duty to address health inequalities) to agree local priorities.

We support local authorities, and through them clinical commissioning groups, by providing evidence and knowledge on local health needs, alongside practical and professional advice on what to do to improve health, and by taking action nationally where it makes sense to do so. Public Health England (PHE) in turn is the public health adviser to NHS England.

We work in partnership with the Chief Medical Officer for England and with colleagues in Scotland, Wales and Northern Ireland to protect and improve the public's health, as well as internationally through a wide-ranging global health programme.

What is the Equality Duty?

The Equality Duty is a 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.¹

¹ See also Government Equality Office: Equality Act 2010: Public sector equality duty. What do I need to know? A quick start guide for public sector organisations. April 2011.

The Equality Duty has three 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 principles of equality and diversity are fundamental to PHE's vision and values. As a new organisation, we are committed to building an explicit commitment to equality and diversity into everything we do—whether this is delivering services or producing guidance and advice for our partners in the NHS or local and central government, and as an employer of nearly 5,300 staff.

In May 2013, we published our equality analysis of how equalities considerations have informed the design and transition of PHE, and how equalities work can be embedded into the future work of PHE.²

How do we show that we are compliant with the Equality Duty?

The Equality Duty is supported by two **specific duties**³ which require public bodies such as PHE to:

- publish information to show their compliance with the Equality Duty

² <https://www.gov.uk/government/publications/equality-analysis-public-health-england>.

³ See also Government Equality Office: Equality Act 2010: Specific duties to support the equality duty. What do I need to know? A quick start guide for public sector organisations. October 2011.

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

This report sets out how we have responded to the first of these specific duties since April 2013 when we were established as a new national public health agency for England. It contains information about how we have thought about the three aims of the Equality Duty in conducting our work between April and December 2013. In going forward, we will update and improve on this information, and publish it, at least annually.

Alongside this report, we have published our equality objectives from April 2013, which we hope tell a story about how we have, and will be, embedding equality and diversity thinking into our work now and in the future.

There are two parts to this report. One contains information relating to our staff who share protected characteristics; the other contains information about how we have thought about people who share protected characteristics and who are affected by our principal functions.

Our staff

The equality and diversity figures in this section are based on a headcount total of 5,256 members of staff on 30 November 2013 and are drawn from our human resources and payroll system.

Data Quality

During the formation of PHE, the transition team collected 75% of data relating to staff who were transferring to the organisation. There were concerns about data protection and competing priorities during the transition. In line with the equality protocol established in March 2012 by the integrated programme office at the Department of Health (DH), it was agreed for consistency that the people tracker, which was designed to capture staff affected by the health and social care reform, would collect data across four of the people characteristics only. Therefore, data was only collected by sender organisations on four of the equality strands—gender, age, disability and ethnicity.

During our first year of operation, consideration has been given to improving data collection and analysis of the information we have about our staff. Plans are currently being implemented with a view to further improving the quality of PHE's workforce data (see Next Steps below). Table A below presents an analysis of the quality of the data we currently hold relating to protected characteristics.

Table A: Quality of data held for Public Health England staff

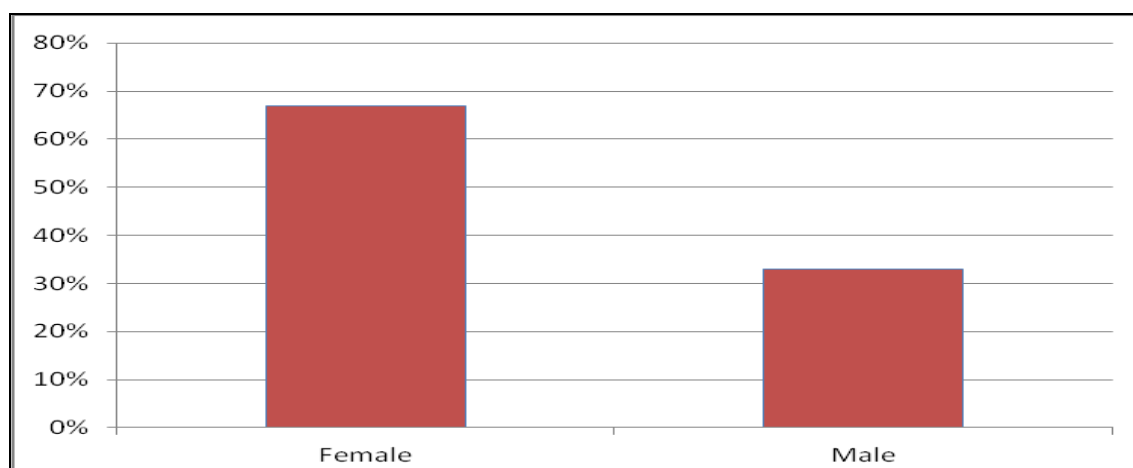
Characteristic	% of staff with data
Gender	100%
Age	100%
Ethnic Origin	97%
Disability	41%
Religious Belief	55%
Sexual Orientation	55%

Analysis of Data

Gender

There are twice as many women (67%) as men (33%) in the PHE workforce. This reflects the gender make-up of the healthcare system from which staff have been inherited (see graph A).

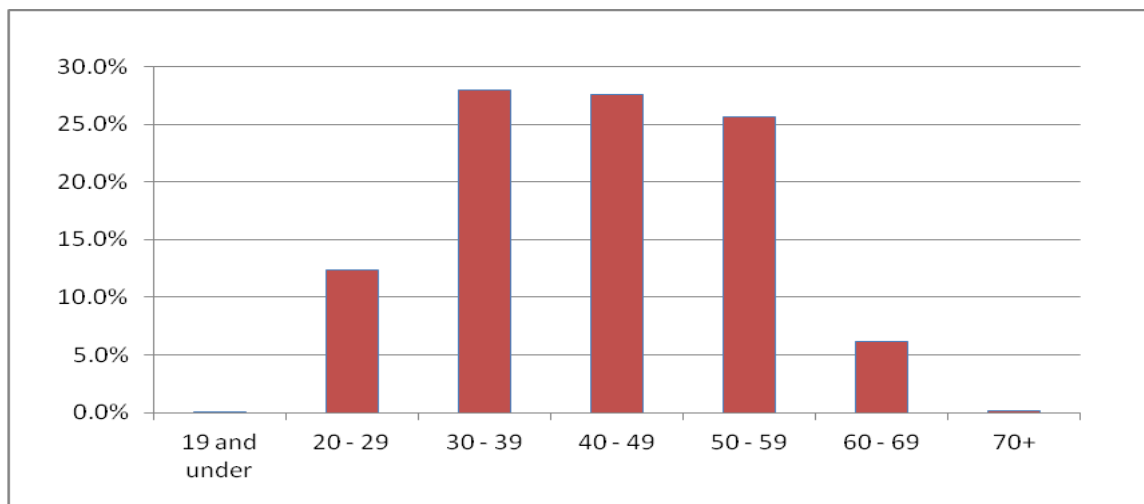
Graph A: Gender profile for Public Health England



Age

The majority of the workforce (56%) is between 30 and 49 years old, which is typical of the wider healthcare system. A third of the workforce (32%) is between 50 and 69 years old. This will have implications for staff succession and retirement planning. Just 12% of staff are aged 19 to 29 years old, 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).

Graph B: Age profile for Public Health England



Ethnicity

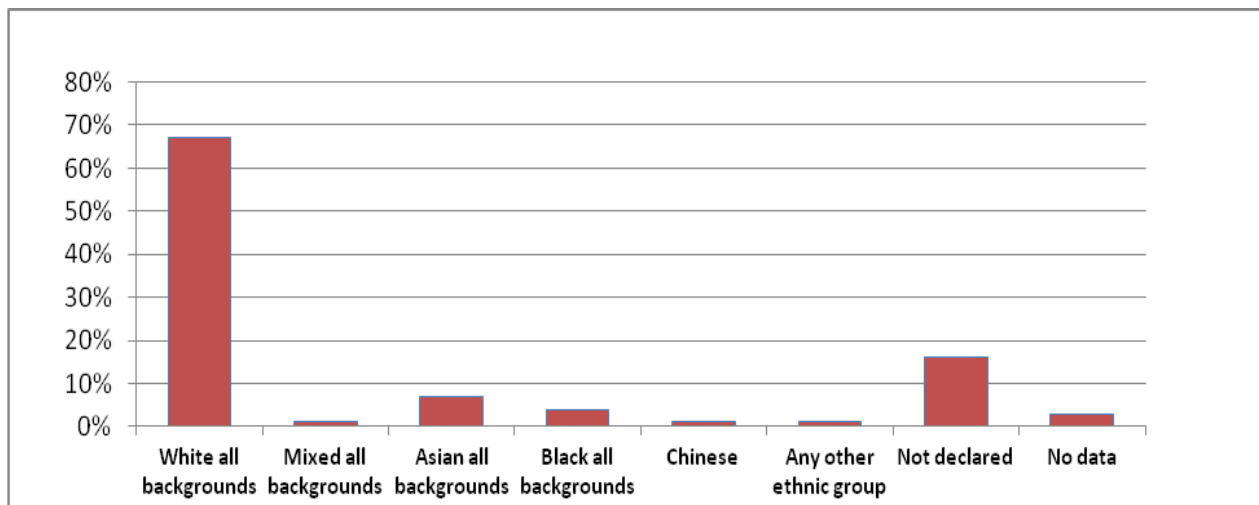
Sixty-seven per cent of staff describe themselves as white.⁴ The next largest ethnic group is Asian/Asian British (7%), followed by black/black British⁵ (4%). There are small proportions (1%) of mixed background, Chinese and other ethnic groups. Sixteen per cent of staff have chosen not to disclose their ethnic origin (not declared).

There are likely to be large regional variations in the ethnic origin of staff due to local population differences in England. Local data will need to be analysed in order to draw any meaningful conclusions (see graph C).

⁴ This includes British, Irish, Greek, Turkish Cypriot and European.

⁵ This includes Caribbean, African, Black British.

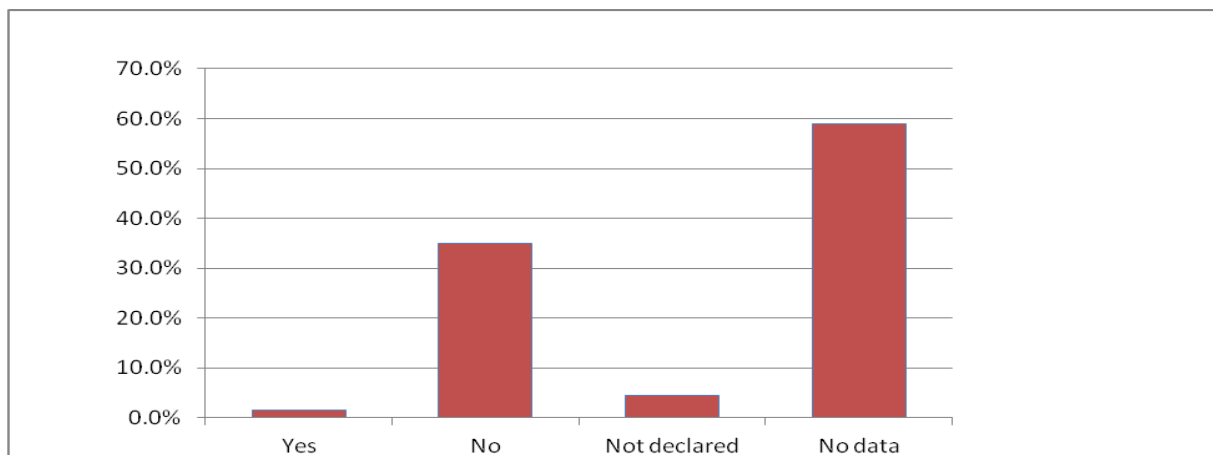
Graph C: Ethnicity profile for Public Health England



Disabilities

One and a half per cent of staff state that they have a disability. This is low compared 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. There is a high proportion of staff (59%) where no data is currently held (see graph D).

Graph D: Disability profile for Public Health England

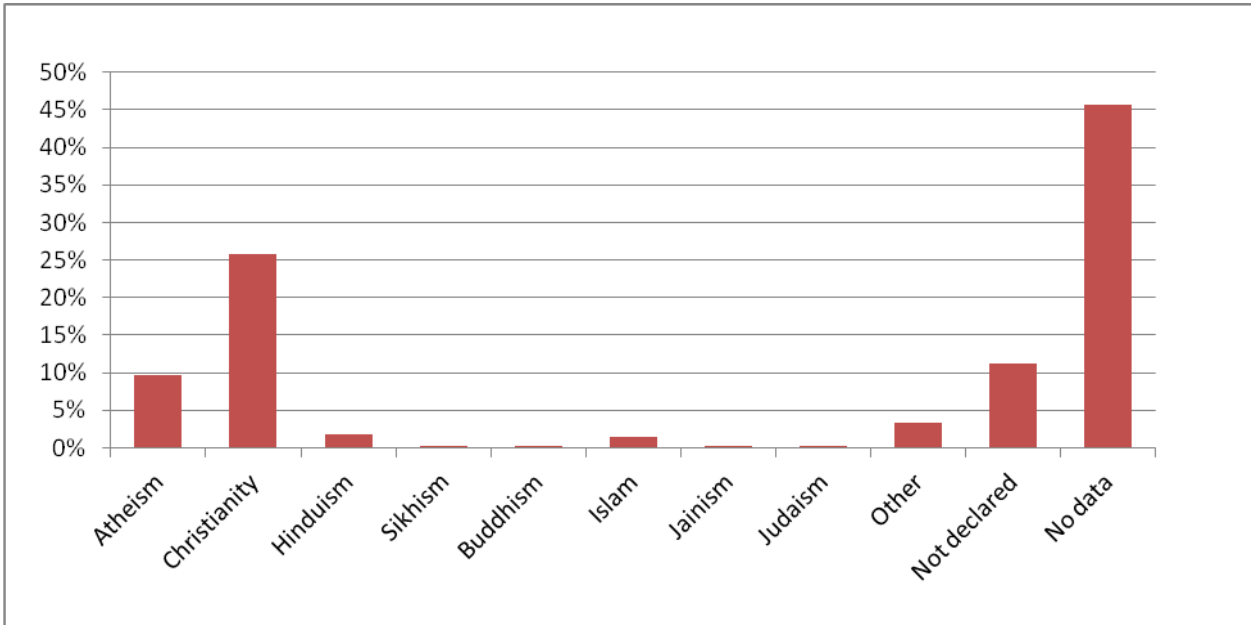


Religion & belief

Data for this characteristic was not captured by the transition team for staff transferring into PHE. Therefore, there is a high percentage of staff (45%) where no data is currently held. Of the data held, 11% of staff have chosen not to disclose (not declared) any religion or belief and a similar amount have disclosed atheism.

Christianity has been stated as the religion for a larger group of staff (26%). All other religions fall into ranges from 0.3% to 3% (see graph E).

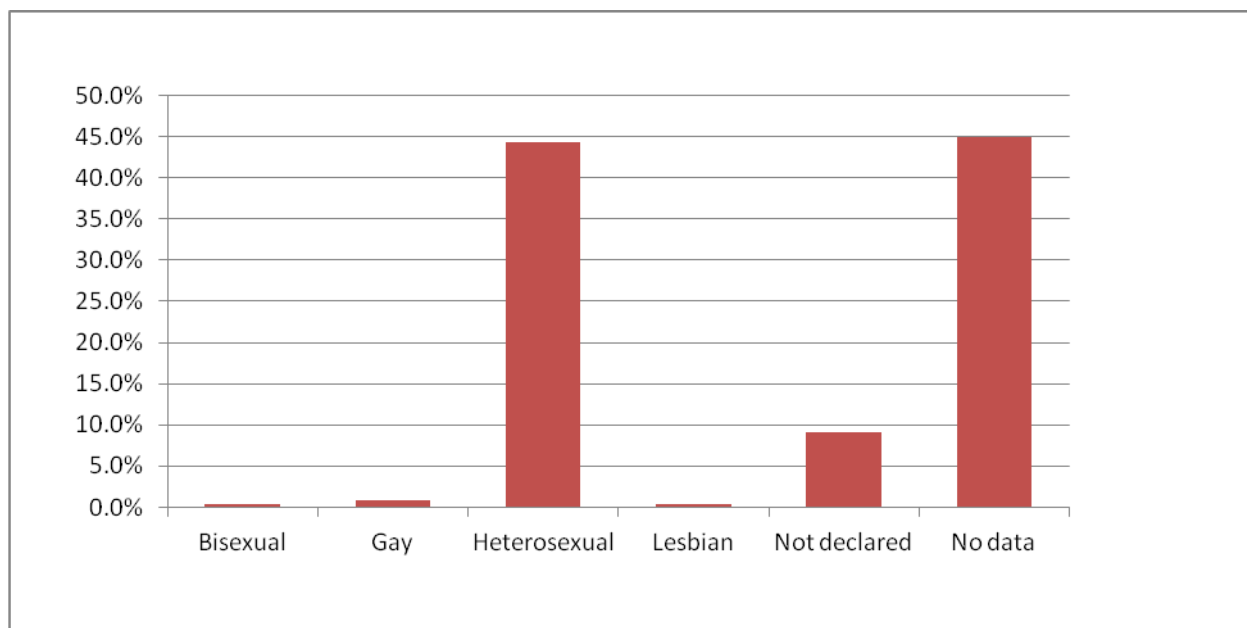
Graph E: Religion & belief profile for Public Health England



Sexual orientation

Data for this characteristic was not captured by the transition team for staff transferring into PHE. Therefore, there is a high percentage of staff (45%) where no data is currently held. Of the data held, a high proportion of staff declare themselves as heterosexual (44%). **Staff in the lesbian, gay, bisexual and transgender (LGBT) group range from 0.4% to 1%. A small proportion of staff (11%) have chosen not to disclose (not declared) this characteristic (see graph F).**

Graph F: Sexual orientation profile for Public Health England



Next steps

PHE will undertake a staff equality and diversity data verification exercise in 2014 to improve the quality of the workforce data held in respect of protected characteristics. The aim is to better understand the profile of our workforce and how different policies and practices may affect specific groups of staff.

In 2014/15, we also plan to capture and publish equality and diversity information, in relation to:

- recruitment activity
- staff progression
- access to learning and development opportunities
- pay grades analysed against protected characteristics

This information will be analysed in comparison to appropriate benchmarks in order to draw conclusions and develop action plans.

Specifically relating to learning and development, PHE can generate equality and diversity monitoring reports for staff learning and development via existing systems. However, during 2014, we will develop and improve our workforce information—gathering capabilities generally and more specifically to support professional workforce development activities. PHE’s approach to learning and development has primarily been delivered through the Civil Service Learning on-line modules. We intend to offer a range of learning and development options to harness the diverse needs of our workforce.

PHE implemented an interim recruitment strategy for 2013. The strategy was to ensure equity and transparency in recruiting to the significant number of vacant posts. We also began scoping the implementation of an apprenticeship programme for disabled staff. This work will continue and develop in 2014.

Finally, we will use the information obtained from the Civil Service staff survey to inform the development of equality and diversity action plans.

How we thought about equality and diversity in delivering our functions

In April 2013, we published our priorities for 2013/14.⁶ We described how we would focus on a number of key areas and continue to work with our partners over the course of 2013 to develop a longer-term plan for demonstrable improvements in the public's health. We also delivered many principal functions. We:

- maintained a 24/7 health protection service to protect the country from infectious disease and environmental hazards
- generated, synthesised and applied knowledge, evidence and professional advice to promote effective interventions by local authorities, the NHS and other partners
- supported nationwide programmes to support healthy lifestyles, behavioural change, prevention, early diagnosis and intervention
- nurtured the development of the public health system and its professional workforce
- reported health outcomes and progress across the Public Health Outcomes Framework
- delivered core business processes
- developed an engagement and public involvement strategy

This document gives examples of how we began to integrate our equality objectives and considered equality and diversity information in delivering these groups of functions. We will continue to embed our commitment to equality and diversity within our annual plans and longer-term thinking.

Our corporate programmes for 2013/14

During 2013, we developed a process by which all the activities that sit within PHE's seven corporate programmes (as described in *Our Priorities for 2013/14*) considered issues relating to health equity, equalities and diversity on a monthly basis. We put in place a system to report this to PHE's National Executive and Department of Health.

⁶ Public Health England: *Our priorities for 2013/14*, April 2013.

A health protection service to protect the country from infectious disease and environmental threats

Health protection advice

Port health

We are supporting professionals working with migrant populations through the National Travel Health Network and Centre (NaTHNaC) and aided by the Migrant Health Guide (a substantial web-based information and advice service for professionals working with migrant populations). For more details, see <http://www.hpa.org.uk/MigrantHealthGuide/>

Field epidemiology

Our field epidemiology function monitors infections and other health protection issues across England. We make sure that all our data collection methods are robust, picking up important characteristics where it is necessary and not asking for data when it is not required. We ensure that questions are fair and appropriate, thus ensuring that misleading results are not generated.

Data collection is maximised through the use of the most appropriate media (paper, electronic, interviews) and interpreters or translation services are used in outbreak investigations as necessary. We collect data to facilitate inclusion. Results are carefully considered to ensure that appropriate reporting occurs to facilitate correct interpretation of analyses and avoiding unfounded assumptions about health outcomes.

Surveillance

This concerns the surveillance of tuberculosis (TB), HIV, healthcare-associated infections and antimicrobial resistance. The collection of data that enables analyses of disease burden by groups with protected characteristics is a standard element of many of our infectious disease surveillance systems.

For example, national tuberculosis surveillance data includes information that would allow the characteristics of individuals to be collected in a manner that supports an understanding of the variation of the burden of disease and inequalities in the distribution of disease. Reporting of data involves careful consideration of protected characteristics while preserving important public health messages. In addition, TB National Knowledge Service guidance and information materials have been developed and evaluated in collaboration with stakeholders such as AdFam, Homeless Link, and TB Alert. They include information resources for staff and managers working in hostels

for the homeless, for prison staff and inmates, and translated resources for patients attending TB services. For details:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/NationalKnowledgeServiceTB/ResourcesDevelopedByNKSTB/>.

Immunisations

Our immunisation team contributes to Equality Impact Assessments for vaccine policy decisions made and published by the Department of Health.

Sexual health

Many of our sexual health outputs highlight the disproportionate disease burden experienced by groups with protected characteristics, with outputs produced specifically for many of those groups. See:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIVAndSTIs/PreventionGroups/>.

Global health / international

We produce specific guidance for the Muslim community in relation to the Hajj pilgrimage. This includes engagement with leaders in the community.

Chlamydia Screening Programme

The National Chlamydia Screening Programme (NCSP) is a universal, sexually transmitted infection control programme (<http://www.chlamydia-screening.nhs.uk/>). It is NCSP policy that chlamydia screening be available and accessible for all young people in any local authority in England. This includes being able to access services in a range of settings. The NCSP supports local monitoring of equality of delivery through the Chlamydia Testing Activity Dataset, which includes data on ethnicity as well as age and sex (<http://www.hpa.org.uk/sexualhealth/ctad>). Services are encouraged to review their data to ensure that local provision reflects need. The NCSP provides information materials for young people in a variety of languages for use by local providers to ensure that barriers to uptake are minimised.

The NCSP is mindful of the sexual health needs of men who have sex with men (MSM) as well as the lesbian, gay, bisexual, and transgender (LGBT) community. This is reflected in the standards document produced by the NCSP. Screening is offered to all irrespective of gender or sexual orientation. Specific guidance is provided by the NCSP on what is best practice for testing in MSM, a high-risk group for sexually transmitted infections.

Emergency preparedness, outbreaks and surveillance

Equality and diversity issues are considered in all our emergency response plans and we have specific pieces of work focussing on these issues within our microbial risk assessment team and their decontamination projects. Questionnaires and surveys that are completed following the delivery of training by our teams also cover equality and diversity.

Chemical, radiation and environmental hazards

PHE develops advice and guidance based on sound review of the scientific evidence. This advice and guidance is aimed at all those with responsibilities for protecting the public from hazards (such as PHE and governmental, health service and other statutory organisations). In some cases, it is also aimed directly at the public.

Factors that make some persons more susceptible to adverse health effects from exposure to radiation or chemicals include age, gender and illnesses that make sufferers particularly susceptible. Individual differences are accounted for when advice and exposure guidelines are set by the use of additional protection factors, compared to the 'average' individual, and/or by explicit consideration of the most vulnerable in the population, for example through:

- the use of a factor of 10 added to public exposure guidelines to account for individual differences
- specific consideration of 'representative individuals' in certain exposure situations (for example, on the basis of habitual food consumption pattern)
- setting emergency reference levels for stable iodine prophylaxis at levels which protect infants and children, who are the most vulnerable in the population

Wherever practicable, we consult stakeholders on our advice and guidance during development. The main barriers to giving advice or setting standards applicable for everyone are:

- lack of information on the effects of risk/exposures on particular subgroups, or situations where there is only information available for animals and not humans
- lack of information about the levels of risk/exposure in different population groups
- imprecision and uncertainty in the models used to estimate risk from quantified or semi quantified exposures

Sustainability, climate change and extreme events

The adverse health effects of climate change may differentially affect vulnerable populations, who may also find it more difficult to alter their lifestyles to adapt to changed conditions. PHE's research and advice takes account of a range of medical and social vulnerabilities to ensure that everyone can be protected from adverse health effects.

Key publications produced by PHE since April 2013

- The National Chlamydia Screening Programme published *Equity of Access* in 2012. Its 2013 audit report *internet-based chlamydia testing* made recommendations regarding the accessibility for users with visual impairments and where to find information in different languages
<http://www.chlamydia-screening.nhs.uk/ps/standards.asp>
- *HIV in the United Kingdom: 2013* contains information in relation to the protected characteristics, including HIV test uptake by gender, male sexual orientation, and age group
<http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/1311HIVintheUk2013report/>
- *Surveillance of influenza and other respiratory viruses, including novel respiratory viruses, in the UK: Winter 2012-13; the Flu plan, Winter 2013 to 2014; and a survey user guide for general practices and area team immunisation leads and influenza coordinators called Seasonal influenza vaccine uptake data collection: GP patients 'All practices' survey (England)*. All three reports include information about patients in at-risk groups, such as children and pregnant women
http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317139320524, <https://www.gov.uk/government/publications/flu-plan-winter-2013-to-2014> and <https://www.gov.uk/government/publications/seasonal-influenza-vaccine-uptake-data-collection-guidance-gp-patients-all-practices-survey-england-2013-to-2014>
- Annual reports on hepatitis C and tuberculosis in the UK 2013 analyse infection levels in the UK and give information relating to protected characteristics such as ethnicity and age
<http://www.hpa.org.uk/Publications/InfectiousDiseases/BloodBorneInfections/HepatitisCInTheUK/1307HepatitisCintheUK2013report/> and <http://www.hpa.org.uk/Publications/InfectiousDiseases/Tuberculosis/1308TBintheUK2013report/>
- The Gonococcal Resistance to Antimicrobials Surveillance Programme monitors trends and drifts in susceptibility to antimicrobial agents used for treating gonorrhoea in England and Wales. The latest report contains information relating to protected characteristics such as gender, sexual

orientation and age

<http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/GRASPREports/1310GRASP2012/>

- The 2013 Heatwave and Cold Weather Plans for England aim to protect the population from heat or cold related harm to health
<https://www.gov.uk/government/publications/heatwave-plan-for-england-2013> and <https://www.gov.uk/government/publications/cold-weather-plan-for-england-2013> for the plans as well as their respective equality analyses

Health and wellbeing functions to support healthy lifestyles, behavioural change, prevention, early diagnosis and intervention

The health equity assessment tool

PHE's health equity team is developing a health equity assessment tool. This tool will help colleagues to include a regard for health equity and the protected characteristics as an integral part of their work programmes. It asks PHE colleagues to consider issues of discrimination and health equity in relation to the topic area in which they work, how their work will impact on health equity and protected groups, and what they can do to ensure that their work promotes equality. This tool was piloted and evaluated in the second half of 2013. Training and resources are being developed and it is hoped that the tool will be rolled out across our corporate programmes in 2014.

PHE London's sexual and reproductive health team used the draft tool to develop a comprehensive equality and inequality assessment of various options for HIV prevention commissioning, which was presented to the Leaders' Committee of London councils. See *Health Equity Assessment of options for the future commissioning of HIV Prevention Services in London, A report for the Association of Directors of Public Health*, which can be found here: <http://bit.ly/1cNWU8X>.

PHE's programmes team used the draft tool to help scope future work on dementia. This identified the need for improved understanding of how people's experience of dementia varies across the protected characteristics, which is informing our planning for 2014/15.

Health equity

In addition to embedding a regard for health equity throughout PHE, the health equity team pursues a specific programme of work dedicated to reducing health inequalities through action on the social determinants of health. As well as considering the social gradient in health in relation to socioeconomic inequalities, this programme of work considers key protected characteristics such as inequalities in health according to

ethnicity. For example, we have commissioned a project from the Institute of Health Equity on producing advice to local authorities on addressing health inequalities at a local level. This will include where possible, consideration of the protected characteristics. At the start of 2014, we are also running a 'National Conversation', which will bring together citizens to discuss issues of health equity. This, and ongoing work on the project, will ensure that there is good representation of local communities, including protected groups.

Social marketing

National marketing programmes identify the scale of action required and target it in relation to geographical distribution and level of disadvantage, for example, by focusing on areas of high smoking prevalence. We will review the response data to ensure that the profile of those who engage with in this work are representative of the target audience. In doing so, we pilot most activity locally, before scaling up.

Further information is available in the 2013/14 Public Health England Marketing Plan: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/186957/PHE_Marketing_Plan_2013-14_1651.pdf.

Screening

The UK National Screening Committee (UK NSC), which is part of PHE, has an extensive online equality portal at <http://www.screening.nhs.uk/equality> which provides resources and advice to help local screening services target the barriers to screening experienced by hard-to-reach populations. The resources are designed for anyone involved in screening, primary care, community groups and service users.

The UK NSC provides accessible, plain English information about screening to help people make the right choices. This includes information on the screening websites and leaflets that PHE develops to give free of charge to providers. PHE's core information is translated into 18 languages.

During the process of making screening policy recommendations, extensive consultations are held with external partners and stakeholders in order to ensure that the impact of recommendations on target populations have been fully considered. National screening service specifications also emphasise the need to ensure that there is equitable access to screening. These specifications form the basis of the agreement between NHS commissioners and the service providers.

We are committed to providing healthcare staff with freely accessible, flexible, training resources to develop their knowledge and skill in order to facilitate informed choices with users across the whole screening pathway.

Smoking

The key activity is to increase life expectancy and healthy life expectancy by reducing smoking prevalence and its consequences. PHE recognises that there are people within protected groups who are far more vulnerable to the damaging effects of smoke than those people who do not share a protected characteristic. We are committed to ensuring that the services they receive reflect that need. We are developing plans for targeted support to vulnerable groups and working with the Care Quality Commission to support greater cessation opportunities for those people suffering from mental ill-health. We are also working with NHS England to develop a plan for improving support for smoking cessation in pregnancy.

Drugs and alcohol

Key methods for collecting data about the equality aspects of alcohol and drug treatment are the National Drug Treatment Monitoring System (NDTMS) and the Treatment Outcomes Profile (TOP). Responding to the diverse needs of all sections of the treatment population is integral to the success of alcohol and drug treatment. NDTMS data provides local commissioners and alcohol and drug treatment providers with accurate figures on race, ethnicity and gender. TOP data is validated with explicit reference to gender, ethnicity, drug of choice, age and treatment modality.

Our 2013/14 business plan includes the following actions, each of which has an impact on equality or improves our understanding of the inequalities that exist:

1. An independent review of recovery from drug misuse has been commissioned with the aim of producing an objective assessment of recovery rates in England. The review will be led by Dr Tom McLellan, and independent expert who is CEO of the Treatment Research Institute, Philadelphia. The work will provide an academic, evidenced, international view of the proportion of people likely to recover and over what time scales. It will inform our understanding of the different needs of groups within the treatment population, and the most appropriate responses to them.
2. PHE's mutual aid action plan will support the local development of specialist peer support and recovery services for specific cohorts: women, parents, young people, and older people.
3. We are developing an information forum, which will allow treatment services and commissioners to share intelligence on trends in health harms from drugs, with particular relevance for LGBT communities.
4. We will promote and share effective practice in keeping children safe from the impact of adult drug and alcohol misuse and the inter-generational transfer of dependence.

5. We will provide data tools to help local areas contribute to improved outcomes for those children and young people who are most vulnerable, such as those who are 'looked after' or at risk of sexual exploitation.
6. Looking at the needs of people living with a disability, we will support local areas to ensure that the drug and alcohol treatment and recovery needs of the most complex clients are met, including appropriate support for co-existing physical and mental health issues.
7. A drug recovery priority to be delivered by PHE is to: 'Improve recovery rates from drug dependency, recognising this as the core purpose of drug treatment'. A key barrier to improving recovery rates is a specific cohort of entrenched heroin users, many in treatment for a long time, often in poor health, and lacking recovery resources, for example, employment skills, job history, stable housing, family support and a positive social network. Lasting recovery is often harder to achieve for this group. Action will involve the provision of case studies, benchmarking toolkits and evidence-based practice guidance to local authorities and drug treatment services to ensure interventions are effectively targeted.

In addition to the national work described above, we support local alcohol and drug treatment services in addressing health inequalities and have regard to the protected characteristics. In order to support treatment providers and local alcohol and drugs commissioners to take due regard of inequalities, we produced a guide to assist local services to assess their current compliance with the Equality Act 2010. It is intended to complement, rather than replace, local equality analyses and impact assessments. The checklist was derived from a number of sources and maintains links with the approach used by the National Treatment Agency (the functions of which were absorbed by PHE) in conjunction with the University of Central Lancashire in the Diversity Assessment Package (DAP), first published in 2006.

This checklist is in four main parts (<http://www.nta.nhs.uk/checklist.aspx>):

1. Part 1 aims to ensure that organisations are aware of the definitional changes inherent in the Equality Act 2010
2. Part 2 focuses on whether internal governance arrangements are in place
3. Part 3 examines the corporate governance arrangements required for adherence to the Act
4. Part 4 provides some analysis for agencies to assess the impact of equality on the delivery of services for drug users

Some publications since April 2013:

- *Drug treatment in England 2012-13* provides statistics for people in drug treatment such as age: <http://www.nta.nhs.uk/uploads/adultstats2012-13.pdf>

- A support pack for joint strategic needs assessments, *Good practice in planning for alcohol and drugs prevention, treatment and recovery*, refers to the Equality Act in its commissioning principles for adult alcohol and drugs prevention, treatment and recovery
<http://www.nta.nhs.uk/uploads/goodpracticeinplanningforalcoholanddrugspreventionandtreatmentandrecovery%5B0%5D.pdf>

Mental health and wellbeing

We are developing a national programme on mental health in public health that supports *No Health Without Mental Health*⁷, prioritising the promotion of mental wellbeing, the prevention of mental health problems and the prevention of suicide, along with improving the health and wellbeing of those living with and recovering from mental illness. In 2013, PHE became a signatory to the Public Health Responsibility Deal and pledged its support for the Time to Change anti-stigma and discrimination campaign. This demonstrates PHE's commitment to lead by example—supporting managers to recognise and respond to mental health difficulties and apply practical guidance to make reasonable workplace adjustments for employees with mental illness.

We are also addressing health inequalities across our programme of work. For example:

- **intelligence**—the new national Mental Health Intelligence Network will develop tools to help identify and address health inequalities
- **workforce**—work to develop a confident, competent and committed public mental health workforce will include mental health inequalities as a competency for all public health professionals and prioritise the development of public health workforces who most often work with the most vulnerable people and who are subject to the widest health inequalities
- **evidence**—we will publish knowledge summaries on mental health and wellbeing primarily for local authorities. They will cover issues relating to equality and health inequalities. We will support local work to help identify inequalities arising from poor mental health and wellbeing and offer a range of interventions to improve some of the key determinants of health.
- **reducing premature mortality**—we hosted a national conference in September 2013 highlighting the physical health and premature mortality experienced by people living with mental health problems. We began work to

⁷ No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages. See <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

improve access to public health preventative services such as immunisation, screening, smoking cessation and NHS Health Checks. We are also working with national partners, for example NHS England and the Care Quality Commission, to reduce the inequality in physical health of people with mental health problems.

Children, young people and families

Data relating to child health outcomes shows that infant mortality, obesity, childhood accidents and teenage pregnancy are more likely to affect children and young people from disadvantaged backgrounds. The National Child Measurement Programme (NCMP) reveals, for example, that the prevalence of obesity in the most deprived children is double that of the least deprived. Tackling inequalities is a priority across each of the stages of the life-course and is reflected through specific objectives. For example, one objective is to reduce injury rates for the poorest households at a faster pace.

Many groups across the children, young people and families life-course face disadvantage. In particular, data shows how the 65,000 children and young people who are looked after by the state have very poor health outcomes. Improving the health and wellbeing of vulnerable groups—including looked-after children and young people in the justice system—is therefore a priority. It will be reflected in the Adolescent Health Framework being developed by PHE.

Analysis of data has highlighted a need to focus on populations that share protected characteristics. Children who have a disability are a priority group. Children with poor mental health and those whose parents suffer from mental illness are at increased risk of poorer health outcomes. In relation to ethnicity, figures from the Office for National Statistics show that the rate of infant deaths due to congenital abnormalities is twice as high in Pakistani communities compared to the UK average. Further, the NCMP shows substantial differences in obesity prevalence and trends between different ethnic groups.

During 2013 we used regional events to provide local authorities with an overview of data trends, highlighting the inequalities that exist and promoting practice to address these inequalities. For example, we showed how some local areas are using NCMP data to focus action on tackling child obesity in the groups most at need. To reinforce this message, we provided guidance for local areas on how to use data to inform action. At four regional events on school health, we promoted nationally-led work to improve the health and wellbeing of young carers and give young people better access to services provided by school nurses.

Further examples of work to promote equality and address inequalities include:

- support for projects to help women to stop smoking in pregnancy, with emphasis on the higher prevalence of smoking in deprived areas and communities
- the family nurse partnership illustrates the importance of targeted approaches where those in greatest need receive enhanced services
- work on adolescent health and, in particular, the needs of disabled young people and ethnicity
- to improve the health and wellbeing of children, we are developing a strategic framework to help schools and colleges contribute to this aim. In the use of data, we give consideration to protected populations in terms of how we present the findings from research, our communications, the case studies we highlight; and the way that information is presented on the Children and Maternal Health Intelligence Network hub
<http://www.chimat.org.uk/default.aspx>
- the Start4Life campaign encourages women to have healthy pregnancies and advises new parents on ways to keep children healthy and active. We provide information via weekly e-mail and text messages tailored to the stage of pregnancy or the child's age. Pregnant women in lower socioeconomic groups are less likely to seek out health information during pregnancy, leading to health inequalities for children from these groups. Start4Life targets these groups through media and healthcare professionals
- Together with the Troubled Families programme, we are supporting efforts to improve the life chances and outcomes of troubled families

NHS Health Checks

The *NHS Health Check implementation review and action plan* was published in 2013 (<https://www.gov.uk/government/publications/nhs-health-check-implementation-review-and-action-plan>). PHE works with local authorities on the commissioning of services that recognise the needs of all people, including those who share protected characteristics. We have developed a variety of resources and products to support providers in ensuring equality of access to the information and support available through the programme.

We also work with local authority NHS Health Check programme teams to test behavioural insight and marketing interventions on uptake, with a focus on at-risk groups. The NHS Health Check Expert and Scientific and Clinical Advisory Panel will outline future priority work in this area as part of the programme's wider research and evaluation strategy and develop work on effective communication of risk with service users.

To share new learning with commissioners and providers, we have worked with NHS Improving Quality to develop case studies that describe innovative and effective approaches to reducing health inequalities through the NHS Health Check programme.

Health and Wellbeing Framework for England

A Health and Wellbeing Framework for England is expected to be published in summer 2014. Health equity, equality and diversity will be central to the framework, making it useful resource for people working to improve public health and health outcomes. The framework will include a menu of recommended interventions that aim to address health inequalities, including those with protected characteristics.

PHE's knowledge and intelligence functions

As an expert organisation, PHE is continually building its knowledge and intelligence so as to provide the best information and advice. This includes expanding the knowledge and intelligence evidence base on people with protected characteristics. Activities in 2013 involved the following areas.

Knowledge strategy

PHE concluded a consultation on its *Knowledge Strategy: harnessing the power of information to improve the public's health* in 2013. The strategy describes the approach we will take to improve data collection and generation, information synthesis and analysis, and knowledge preparation and dissemination, to improve and protect health and reduce inequalities. To take account of equality and diversity issues, the strategy proposes a number of changes that will result in improvement to data quality; development of tools and communication channels to effect evidence-based action and two-way communication; and adoption of common standards which could be used, for instance, to mandate collection of protected characteristics and identify where equality and diversity issues exist.

Disease registration and data collection

PHE continues to improve the quality of data held by the National Cancer Registration Service (NCRS), including improvements to data on protected characteristics such as ethnicity. Quality of ethnicity coding and sexual orientation recorded by the NCRS relies upon data feeds from acute providers and is expected to improve as the cancer outcomes and services dataset are rolled out across the NHS. In addition, specific

relevant questions are included within the patient reported outcomes surveys and the results from these are incorporated into NCRS.

PHE continues to collect information on equalities characteristics through the National Drug Treatment Monitoring System, including age, sex, ethnicity, sexual orientation, pregnancy and mental health information.

PHE responded to the integrated household survey consultation on reducing the frequency of the question on sexual orientation by advocating that this important question was kept in the survey. Results of this consultation have been published⁸ and the question will remain for the next year.

Knowledge and intelligence teams

PHE's Knowledge and Intelligence Teams (KITs) provide a range of products and publications, the majority of which include indicators of the health of the population broken down by age and gender. In addition, many products and publications provide further breakdowns by other protected characteristics at national or local level.

Key national publications since April 2013

- *Health Profiles* aim to help local government and health services identify problems in their areas and decide how to tackle them. They provide a snapshot of the overall health of the local population, including some information on protected characteristics such as age and ethnicity, and highlight potential problems through comparison with other areas and with the national average
- The *NHS Atlas of Variation* series, co-published with NHS England, is intended to support local decision-making to increase the value which a population receives from the resources spent on their healthcare. A series of themed atlases focus on specific conditions or populations in more depth, for example on children and young people
<http://www.rightcare.nhs.uk/index.php/nhs-atlas/>.
- Co-produced with NHS England, our *Commissioning for Value* packs are a resource for clinical commissioning groups (CCGs), providing data for CCGs on the health of their populations, including data on protected characteristics such as mental health, maternity services and teenage pregnancy
<http://www.rightcare.nhs.uk/index.php/commissioning-for-value/>
- The Improving Health and Lives: Learning Disabilities Observatory published various reports about people with learning disabilities. They included an

⁸ <http://www.ons.gov.uk/ons/about-ons/get-involved/consultations/consultations/integrated-household-survey-questionnaire-content-review---2014/index.html>

annual report called *People with Learning Disabilities in England 2012*; information about annual health checks (*Health checks for people with learning disabilities in England*); Learning Disability Profiles; and a report which signposts professionals, support workers and family carers to numerous resources that can be used to enable people with learning disabilities maintain quality of life and access dementia services

<http://www.improvinghealthandlives.org.uk/>

- The Child and Material Health Intelligence network publishes information and intelligence to improve decision-making for high quality, cost effective services; for example through access to a data, information and intelligence and a range of online tools designed to support decision-making, and through a knowledge hub relating to all aspects of children's, young people's and maternal health <http://www.chimat.org.uk/>
- PHE's Obesity Knowledge and Intelligence team published a report that examined the evidence linking obesity and disability among adults. It also explored inequalities in relation to obesity and disability and highlighted implications for health and social care http://www.noo.org.uk/NOO_pub/briefing_papers
- *What we know now 2013: New information collated by the National End of Life Care Intelligence Network* describes how there may be inequalities in care related to age, ethnicity, culture, sexuality or place of death http://www.endoflifecare-intelligence.org.uk/resources/publications/what_we_know_now_2013.
- The national information standard, which specifies the core record content to support the provision of high-quality coordinated care at the end of life, was revised in 2013. PHE developed *End of life care co-ordination implementation guidance* to support local decision-making. It provides commissioners, health and social care organisations and IT system suppliers with the information needed to support implementation of a core data set for end of life care http://www.endoflifecare-intelligence.org.uk/resources/publications/implementation_guidance.

Regional publications since April 2013

KITs also produce regional and local reports that cover elements of the protected characteristics to illustrate health patterns and investigate health inequalities locally. See www.apho.org.uk. Some specific examples are:

- The *North West Mental Wellbeing Survey 2012/13* <http://www.nwph.net/nwpho/>
- The London KIT and the London Health Improvement Board conducted a joint initiative to analyse breastfeeding data, examine local evidence and share

local breastfeeding practice in London

<http://www.lho.org.uk/viewResource.aspx?id=18210>

- The Northern and Yorkshire KIT studied the patient experience among equality groups, a project that arose from work in West Yorkshire on the Equality Delivery System

Publication of health outcomes and progress across the Public Health Outcomes Framework

The government's Public Health Outcomes Framework (PHOF) *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help us to understand how well public health is being improved and protected. The equality analysis published alongside it, *Healthy Lives, Healthy People: Transparency in Outcomes*⁹, outlines how the framework can be used by public health professionals, local authorities, third sector organisations and individuals in the drive for equality. Data for the framework are published by PHE.

Key activities in 2013

The PHOF focuses the whole system on achieving positive health outcomes for the population, including those with protected characteristics, and reducing inequalities in health. Most indicators in the framework have the potential to impact on inequalities. We hope that it will be possible for all indicators to be disaggregated by equalities characteristic in order to support work locally to reduce health inequalities.

Our PHOF data tool presents data for indicators at England and upper tier local authority levels. It is updated regularly. Three updates to the indicators in the PHOF were produced in 2013. See www.phoutcomes.info.

Several indicators within the framework focus on protected characteristics:

- 1.06i—adults with a learning disability who live in stable and appropriate accommodation
- 1.06i—adults in contact with secondary mental health services who live in stable and appropriate accommodation
- 1.08i—gap in the employment rate between those with a long-term health condition and the overall employment rate

⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216164/dh_132374.pdf

- 1.08ii—gap in the employment rate between those with a learning disability and the overall employment rate

As well as breaking down some of the local authority level indicators by gender or age, we presented data by equalities characteristic for a small number of indicators at national level. These indicators are:

- 1.03—pupil absence by ethnicity
- 1.03 - Pupil absence by gender;
- 1.06i—adults with a learning disability who live in stable and appropriate accommodation by gender
- 1.17—fuel poverty by age, gender, ethnicity and disability
- 1.18i—social isolation of adult social care users by age, gender, ethnicity, disability and religion
- 2.06i—excess weight in 4–5 year olds by ethnicity
- 2.06ii—excess weight in 10–11 year olds by ethnicity
- 3.02i—chlamydia diagnoses by gender

With partners, we also published *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document*, a resource for all those commissioning and delivering healthcare services in order to support the delivery of an equitable public health system. See <http://www.lgf.org.uk/phof>.

Development of the public health system and its professional workforce

Our health equity assessment tool described above is being piloted against the key priority actions agreed for our corporate programme of ‘promoting place-based public health systems’. This includes implementing the Public Health Workforce Strategy¹⁰ (published in May 2013) and developing PHE’s workforce. This will have an impact on work to develop a minimum workforce set to inform local and national planning of the public health workforce to enable a cost-effective focus on training and development. The application of the tool will also impact on work to develop a Public Health Skills Passport aimed at developing all levels of the public health workforce across the system. In the short term, the passport will be tested with the public health practitioner workforce in different locations. In the medium term, it will be expanded to include other levels of the public health workforce. The passport will provide an effective method to show skill sets and development, leading to a strengthened cohort of public health workers at all levels. When used in workforce development, it will promote a

¹⁰

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197403/2900899_28781_Healthy_lives_v0.8.pdf

better understanding of health inequalities and show how development activities reduce disadvantage to those groups in the health workforce who share protected characteristics.

We are working with Health Education England (HEE) and public health standard setting bodies for public health in relation to public health workforce planning, commissioning of specialist public health training programmes and the education and training of other staff groups who have a role in public health such as scientists and nurses. This includes active engagement in HEE's newly established governance and advisory structures including the Public Health, Nursing and Scientific Advisory Groups and the Values Based Recruitment Advisory Group. These newly created advisory mechanisms will embrace the application of equality and diversity within the workforce. PHE's contribution to these decision-making mechanisms provides an opportunity to ensure that regard to the reduction of health inequalities is included in training commissioned by, or co-delivered by, partners.

PHE workforce development leads are working with other partners to develop and implement the indicators set out in the Education Outcomes Framework for the healthcare workforce.¹¹ This links education and learning to improvements in patient care and outcomes.

Equality and diversity is embedded in PHE's learning and professional development policy. The policy applies to all employees and affirms that learning and professional development is an integral part of every employee's job. It recognises that all employees should have fair and equitable access to development opportunities and that the manner in which employee development is delivered supports diversity across the organisation. We have a direct role in providing some public health education activities such as specialist training, and can ensure that there is a focus on reducing health inequalities.

Finally, PHE on behalf of the Secretary of State has a joint responsibility to appoint Directors of Public Health to posts in local authorities. Guidance issued by the Local Government Association, the Faculty of Public Health and PHE stipulates that recruitment and selection must be robust, transparent and appropriate, in line with statutory requirements. See:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249814/DsPH_in_LG_guidance_on_appointments.pdf

¹¹ Education outcomes framework for healthcare workforce. <https://www.gov.uk/government/publications/education-outcomes-framework-for-healthcare-workforce>

Our business processes

PHE tender documentation refers to the Equality Act 2010. This is in line with European Union procurement regulations. Our standard terms and conditions refer to equality and diversity.

We are mindful of guidance, frameworks and policies developed by the UK government and Cabinet Office to further equality and eliminate discrimination. These are cascaded to our local procurement teams. Equality and diversity is an important aspect within the procurement process and appropriate consideration is undertaken to ensure tender documentation meets requirements. For example, we apply guidance developed some years ago by the NHS called “Mosaic” which contains advice on how to consider equality and diversity as part of the procurement processes.

Engagement and public involvement

Public involvement

PHE is committed to involving the public in its work. We want to listen to people’s views, take them into account when delivering services and engage them in our work. PHE’s public involvement strategy affects everyone working for the organisation. As PHE matures, the strategy will be embedded in all that we do. Everyone with responsibility for developing programmes and services is expected to take personal and professional responsibility for ensuring a public involvement component to their work. The strategy sets out the principles to inform the involvement process.

A key part of our public engagement work is the ‘People’s Panel’, which is a large group of almost 1,000 people across England, forming the largest consumer panel of its kind in the country. The People’s Panel was established as an innovative way to engage with the public about health priorities, information and services. Membership was drawn from two national random survey samples, giving a unique and valuable insight into public health issues that the public feels are important and how they understand and respond to health information. The membership will be refreshed in 2014.

PHE’s Equality Forum ensures that we support and consider equality and diversity in the way that we work. The forum has a diverse membership. Some members, drawn from the People’s Panel, have self-identified as having a characteristic protected by the Equality Act 2010. Others come from a range of user-led and community organisations representing and mediating for people with protected characteristics, those who are at risk of worse health outcomes on the health inequality gradient and/or those often socially excluded or marginalised. The forum also includes members from PHE staff groups. The Equality Forum works with other PHE

engagement agents to support and promote equality, diversity and health equity across the organisation's corporate and public-facing activities.

Since PHE was established in April 2013, the Equality Forum has supported our mainstream activities by running two seminars. The first looked at the double discrimination and impact of living with a mental health problems and being a member of a marginalised community or group (*Mental Health, Marginal Communities and Wellbeing: The Public Health Challenge*, July 2013). The second seminar, entitled *Sex, Drugs and Roll Ups: Risky behaviour and public health*, explored risky behaviours among marginalised groups, specifically their increased use, consumption and exposure to drugs, alcohol, tobacco and sexually transmitted infections (November 2013).

The Equality Forum was consulted in the development of PHE's equality objectives published alongside this document, and will continue to support their implementation and review as a critical friend.

Stakeholder engagement

PHE recognises the critical role that all stakeholders, including those with protected characteristics, have in delivering services that meet their needs. To this end, we are embedding high-quality engagement and involvement with stakeholders across the organisation and establishing stakeholder forums to develop and co-produce our work.

PHE uses qualitative and quantitative surveys to seek feedback from stakeholders on how well we involve and engage with them. A programme of quantitative research, developed and delivered with IPSOS Mori, has begun. This annual survey is aimed at a broad range of stakeholders, including local authority leaders, senior public health leaders and external stakeholders from academia, business, the voluntary sector and others. The results will give a better understanding of our partners' views on PHE's performance and inform our priorities in 2014/15.

Strategic partners

Along with DH and NHS England, Public Health England helps to convene the Strategic Partner Programme. This brings together 21 voluntary and community sector organisations and coalitions of organisations, helping them to work more effectively with health, social care and public health organisations. Through their membership, the strategic partners are able to reach people and communities across the protected characteristics and provide extensive depth of reach to particularly vulnerable groups and communities.

Innovation Excellence and Strategic Development Fund

We are helping to assess and offer support to voluntary sector funding through the DH's Innovation, Excellence and Strategic Development (IESD) fund. In 2013, the IESD fund had a specific theme that focussed on public health (theme 3). We assisted DH colleagues in shortlisting and selecting proposals that promote better public health.