Public Health England

Protecting and improving the nation's health

Equality in Public Health England
How we met the public sector equality duty in 2015

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Published February 2016
PHE publications gateway number: 2015679

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Introduction

Public Health England (PHE) exists to protect and improve the nation's health and reduce health inequalities. To deliver a broad range of products and services, we employ over 5,600 staff working from 100 locations. We work with local authorities, the NHS and others to help people live longer, healthier and happier lives and reduce health inequalities.

The equality duty

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

The equality duty has 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 general equality duty is supported by two specific duties that require public bodies such as PHE to:

- publish information to show their compliance with the equality duty
- set and publish equality objectives, at least every four years

Our seven equality objectives are shown in Box 1.

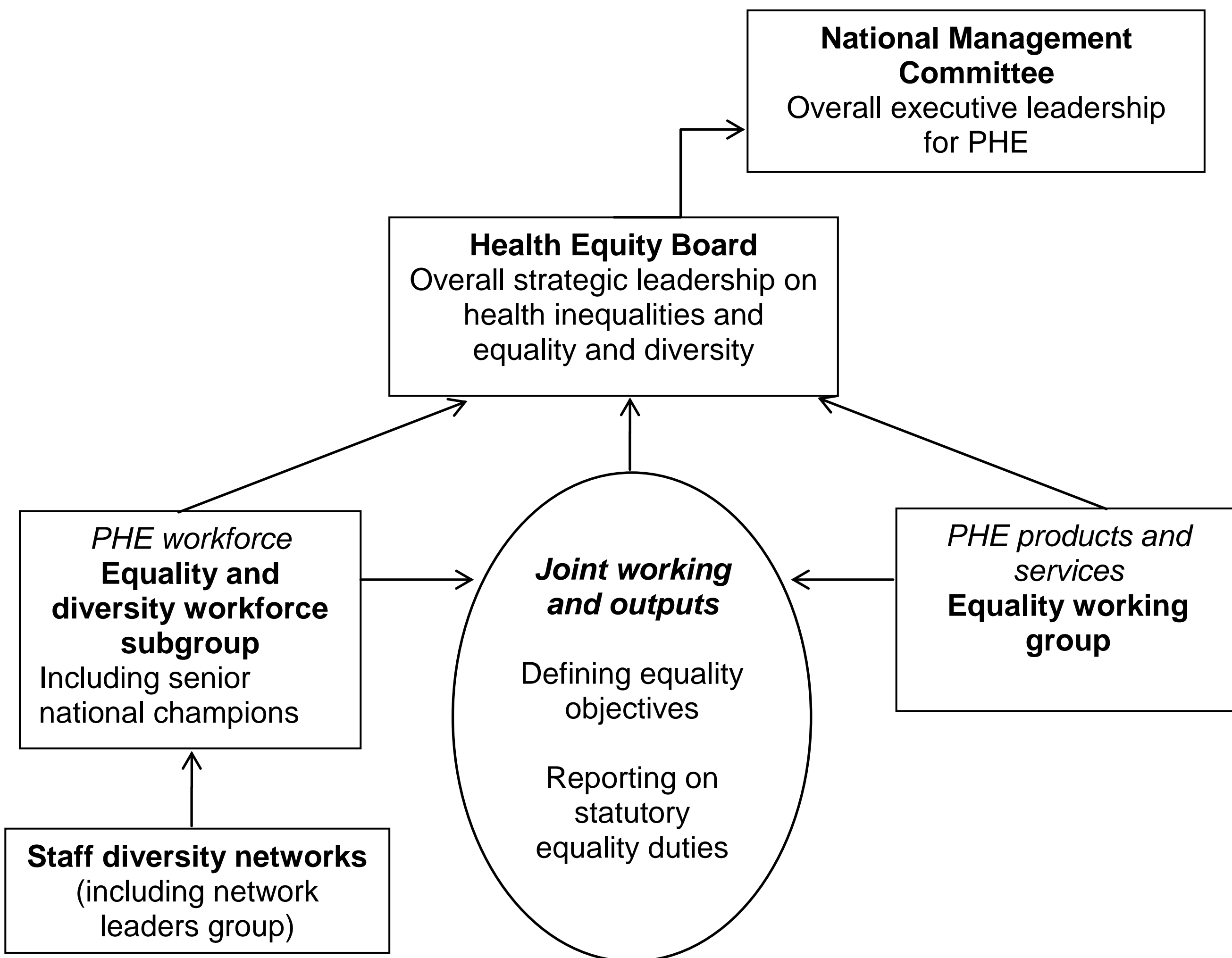
Box 1: PHE equality objectives published in January 2014

1. PHE will ensure that the public sector equality duty is embedded and reflected in our corporate priorities and is an integral part of any future priority setting for our organisation.
2. We will build and develop our relationships with stakeholders and the public, including those that represent groups with protected characteristics, to improve our functions and services, and consult with them about our priorities.
3. We will ensure that our advice (including to local authorities, NHS England and government) includes dimensions of health equity and equality and diversity in accordance with the Equality Act 2010.
4. As an expert organisation, we will build on our strengths in knowledge and intelligence, improve the information we hold and collect from our system partners and lead the way on expanding the knowledge and intelligence evidence base on people with protected characteristics.
5. We will improve accessibility and ease of understanding of the information and advice we produce. We will seek to improve the accessibility of the information that we provide to the public and stakeholders.
6. We will improve our internal business processes so that equality and diversity is an integral part of everything we do. Our drive to increase value, efficiency and productivity will always consider the needs of people with protected characteristics, internally in PHE and in our externally facing functions.
7. We will ensure we have a motivated and engaged workforce who live our behaviours of respect for each other.

Our approach to governance on equality and equity

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

Figure 1: PHE governance on equality and diversity



How we show that we are compliant with the equality duty

This report describes the progress we have made since the publication of 'How We Met the Equality Duty in 2014', highlighting key achievements and activity towards fulfilling our equality objectives. It also provides an outline for focused actions related to our equality objectives in 2016.

This report consists of three sections:

- workforce equality and diversity – highlighting the characteristics of our staff, and key achievements such as establishment of new staff diversity networks
- actions to fulfil our equality objectives
- next steps

Workforce equality and diversity

Diverse and Talented Workforce programme

We established a comprehensive Equality and Diversity Workforce Action plan in 2014. The activities set out in this plan contribute to our wider Diverse and Talented Workforce Programme. We have a dedicated team, led by a Head of Diversity and Staff Inclusion which delivers the programme.

Leadership and governance

We have demonstrated our commitment to creating a diverse and talented workforce by ensuring we provide clear leadership and accountability for delivering this aim. PHE's Equality and Diversity Workforce subgroup oversees delivery of actions related to workforce equality issues. This group reports to our Health Equity Board (Figure 1). We have six National Executive diversity champions – who respectively provide leadership on specific protected characteristics. Over the course of the year, our champions have acted to provide senior accountability for delivery of the workforce diversity plan and have been instrumental in supporting a number of activities. Executive diversity champions have an equality and diversity objective in their performance framework.

We have also expanded the role of head of diversity and staff inclusion to incorporate recruitment and learning and development functions. This will enable us to further integrate our activity to promote diversity and inclusion with other HR functions, for example by expanding mandatory and management training to include diversity confidence, unconscious bias, and inclusive management.

Staff diversity networks

We have continued to support the establishment and work of staff diversity networks throughout 2015. We now have three active staff diversity networks – Black and Minority Ethnic (BAME); Disability; and Lesbian, Gay, Bisexual and Transgender (LGBT), which have undertaken a range of activity (Box 2). Executive diversity champions and staff network leads have worked in partnership to tailor their respective networks.

Box 2: Activity by PHE staff diversity networks

1. both the Disability and BAME staff networks ran initial brainstorming sessions respectively over this summer. As a result the networks have an action plan of activity planned for 2016, including the re-establishment of a chair for the BAME Network, interviewer training for members and the publishing of case studies featuring community role models
2. the PHE Rainbow Alliance (PHERA) network that represents lesbian, gay, bisexual and trans-gender staff has continued to grow in both membership and activity. This year the group has successfully facilitated a number of seminars across PHE on LBGT health with support from the LGBT executive champion Professor Kevin Fenton
3. PHE has worked with staff across a variety of religions and beliefs to publish a faith calendar to raise awareness of festivals and key dates and encourage supporting activity. This has included tips for Ramadan on the organisation's intranet and a food share to celebrate Eid

Talent management

In 2014-15, we successfully participated in cross-organisational mentoring circles for BAME staff, organised by Race for Opportunity. A further 13 BAME staff were selected for the 2015-16 programme. Individuals will join a mentoring circle together with nine other private and public sector firms to learn, develop and network with other BAME professionals in an action learning environment. Staff from the previous cohort reported an increase in their confidence to develop, established new networking relationships, developed new skills and most critically advanced in their career. We launched internal mentoring circles for BAME staff and have identified senior lead mentors for the mentoring circle.

We are currently building an Emerging Leaders Programme that will ultimately seek to identify talented individuals who would not otherwise be sponsored through innovative recruitment and selection methods, and a comprehensive and interactive learning experience for helping untapped talent to reach their individual potential. The programme will have targets around engagement of staff who share certain protected characteristics.

Recruitment

PHE recognises that it is essential to attract a diverse, talented workforce to serve the nation in our mission to protect and improve health and reduce health inequalities. In 2015, we have piloted initiatives bespoke to different parts of the business to promote

an inclusive recruitment and selection processes and have taken a number of actions to minimise disadvantages that particular groups may face in employment.

We are working with international organization, Project Search, to co-ordinate a rolling work placement programme with onsite training for up to eight young people with learning disabilities. Along with our public sector peers, we have started to form the strategy for meeting government targets on recruitment and redeployment of apprentices as 2.3% of our workforce. An Apprentice Programme Board has been established that includes representation from workforce planning leads from each PHE directorate to carry out the work. PHE's involvement in the government Movement to Work scheme has developed progressively in providing work experience opportunities for 18 to 24-year-old young people not in employment, education or training (NEET) with meaningful work placements that will assist their transition into full-time employment.

External benchmarking

PHE took part in Stonewall's Workplace Index for 2014/15. The Index demonstrates the extent of an employer's ability to tackle discrimination and provide an open and inclusive environment for lesbian, gay and bisexual people in the workplace. PHE ranked 217 out of 397 organisations. This was the first time we had taken part in the bench marking exercise and following these findings, we have taken forward a number of actions including:

- the launch of an LGBT Allies programme that engages non-LGBT staff in fostering good relations and raising awareness
- facilitation of a series of seminars on LGBT health
- an Action Plan for gay, bisexual and other men who have sex with men
- taking part in the Business in the Community Race for Opportunity benchmarking exercise as a means of comparing ourselves with public sector peers and the private sector (results available in 2016)

Training

Bespoke diversity confidence training has been delivered to a variety of teams across the organisation including all HR advisors, three directorate senior management teams and the National Leadership team. The learning and development function is currently creating comprehensive training on recruitment and selection and for people managers, which will have inclusive management practice and addressing unconscious bias at the core.

Policy and procedures

We are launching a Reasonable Adjustment Passport in 2016 to allow the disability staff networks to pilot test the initiative so that we can guarantee quality on roll out. The initiative will seek to provide a single point of reference for employee, manager and HR for individual and tailored reasonable adjustments. The virtual document will follow the employee, regardless of changes in role or line manager. We also intend to collect meaningful data on staff disability through supporting communications.

Diversity scorecard

We have piloted a Diversity Scorecard in one directorate of PHE. The final scorecard will be provided to deputy directors (heads of divisions) and, will inform the 2016 appraisal process with their directors. Where the diversity scorecard indicates poorer outcomes or experiences for certain groups, this will inform development of diversity initiatives.

PHE staff characteristics

This section presents data on protected characteristics among PHE staff. Figures are based on a headcount total of 5,324 members of staff as of 30 November 2015 and are drawn from the PHE HR and payroll system.

Data quality

During the formation of PHE in early 2013, the transition team collected 75% of data relating to staff that were transferring into PHE. There were concerns about data protection and competing priorities during the transition. In line with equality protocol established in March 2012 by the Integrated Programme office at the Department of Health, it was agreed that a ‘people tracker’ would be used to collect data on four protected characteristics for consistency across sender organisations – gender, age, disability and ethnicity. Information on other protected characteristics, for example religion and belief, or sexual orientation, is therefore has lower rates of completion and is less robust.

To address this issue, in 2015, we implemented an electronic staff record (ESR) self-service facility to improve the quality of our workforce data by protected characteristics. The launch was successful in increasing the quantity of diversity data that we hold. Table 1 presents information on the proportion of staff on whom details of a particular protected characteristics are currently held. We have seen a slight increase in the declaration of sexual orientation and religion/belief. In 2016, we plan to focus on increasing the ethnicity and disability data that ESR holds for our staff.

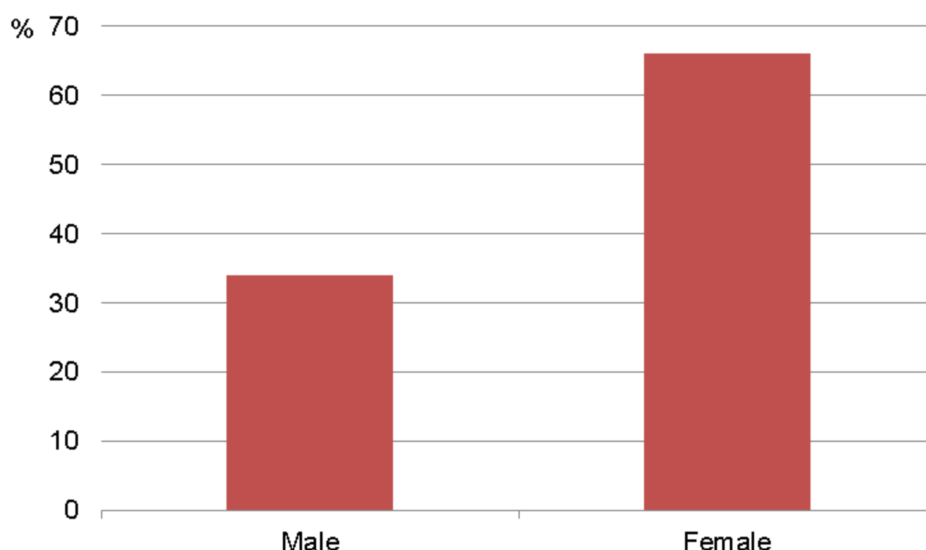
Table 1: Proportion of PHE staff for whom data are held on protected characteristics

Protected characteristic	% of staff on whom information is held	
	November 2014	November 2015
Gender	100	100
Age	100	100
Ethnic group	97	97
Disability	49	53
Religion and belief	58	61
Sexual orientation	59	62
Base	*5,692*	*5,324*

Gender

There are nearly twice as many women (66%) as men (34%) in the PHE workforce. This reflects the gender make-up of the wider healthcare system (Figure 2).

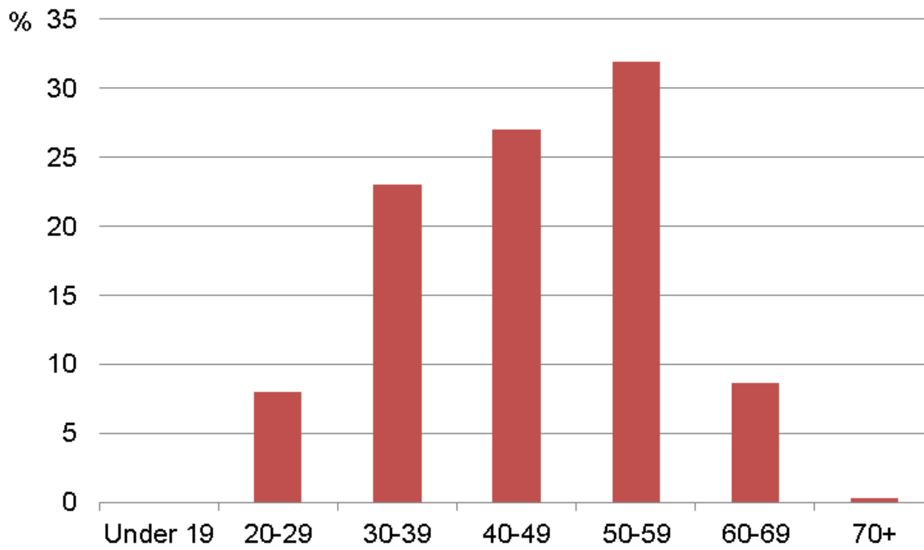
Figure 2. Gender profile of PHE staff, November 2015



Age

About half of our staff are aged 30 to 49 years, which is typical of the wider healthcare workforce. A large minority of staff in PHE are aged over 50: a third of PHE staff (32%) are aged 50 to 59 and almost 9% are aged 60 to 69 years. There are few younger staff aged under 30 (8%) in the PHE workforce. These patterns will have implications for staff succession and retirement planning. (Figure 3).

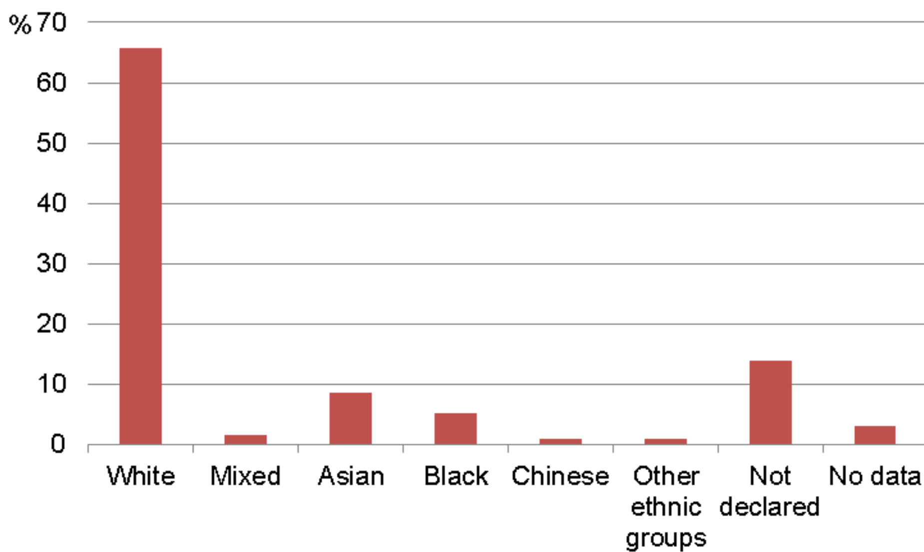
Figure 3: Age profile of PHE staff, November 2015



Ethnicity

Figure 4 shows that 66% of PHE staff describe themselves as white.[1] The next largest ethnic group is Asian/Asian British (9%), followed by Black/Black British[2] (5%). There are very small proportions of staff who report Mixed ethnicities, or being Chinese and from other ethnic groups. These patterns are likely to vary across regions reflecting local population profiles by ethnic group, from which the PHE workforce is drawn. About one in seven in PHE (14%) have chosen not to disclose their ethnic group.

Figure 4: Distribution of PHE staff by ethnic group, November 2015



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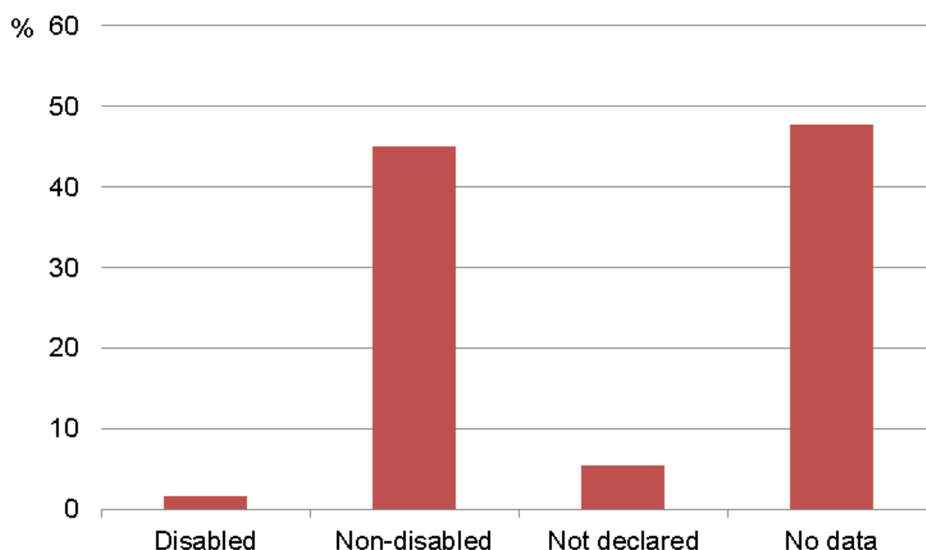
1 This includes British, Irish, Greek, Turkish Cypriot and European

2 This includes Caribbean, African, Black British

Disabilities

Records indicate that 1.5% of all PHE staff are disabled (Figure 5). This rate is lower compared with the Department of Health, where 7% of staff in 2013 declared themselves as having a disability. However, data on whether staff are disabled or not is currently held for 53% of staff and this is a focus for improved data in the coming year.

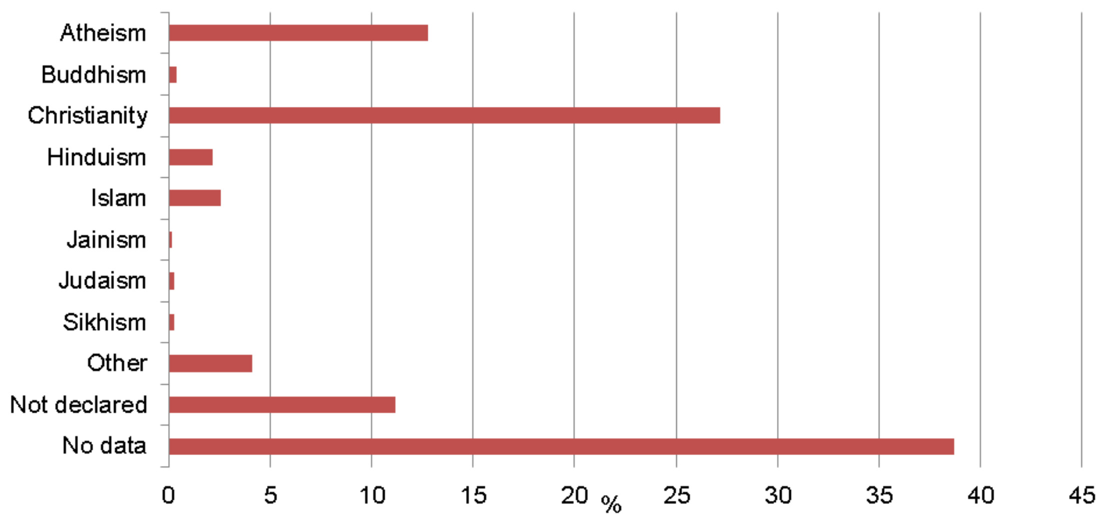
Figure 5: PHE staff by disability status, November 2015



Religion and belief

Data on the religion of belief held by staff is shown in Figure 6. This information was not captured by the transition team for people transferring into PHE in 2013 so there is a high percentage of staff (39%) on whom no data is currently held. Christianity is the most commonly reported religion among PHE staff (27%); the next largest group is those who report being atheists (13%). There are similar proportions of staff who report that they are Hindu (2%) or Muslim (3%). All other religions are reported by less than 1% per cent of staff, while 11% have chosen not to disclose any religion or belief (not declared or 'prefer not to say').

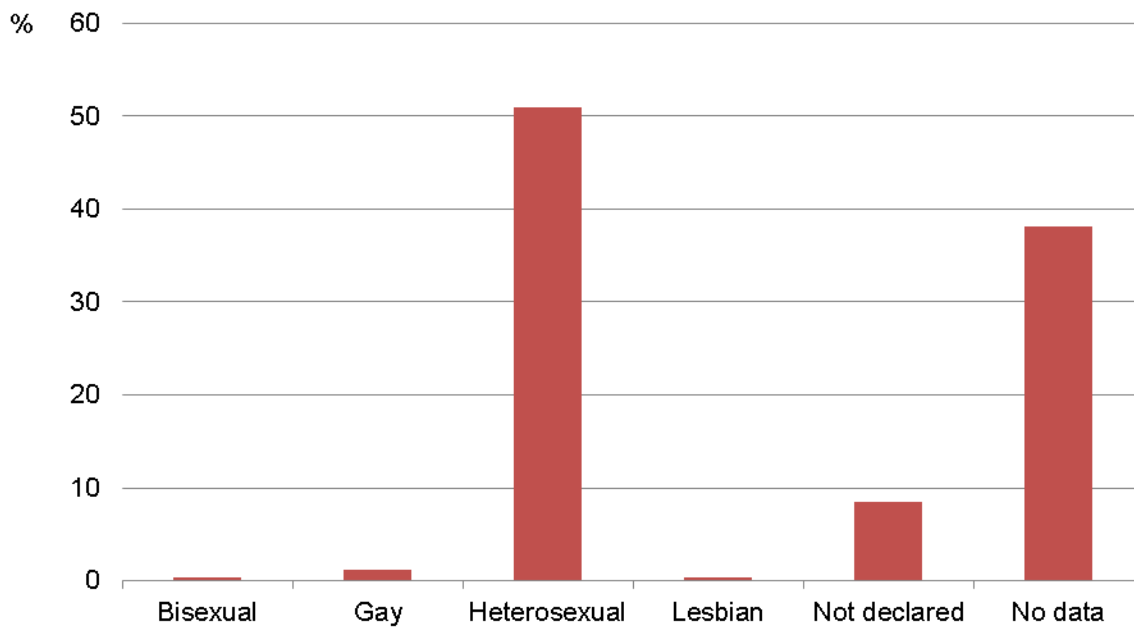
Figure 6: Religion and belief profile reported by PHE staff, November 2015



Sexual orientation

Information about the sexual orientation of PHE staff is available for 62% of the workforce, as information this characteristic was not captured when staff transferred into PHE in 2013. Considering all staff, including those where information on sexual orientation is not held, a slight majority declare being heterosexual (51%). Almost 2% of staff report being lesbian, gay or bisexual. A small proportion of staff (8%) have chosen not to disclose their sexual orientation (not declared) (Figure 7).

Figure 7: Sexual orientation reported by PHE staff, November 2015



Actions to fulfil our equality objectives

Embed equality and diversity in corporate priorities and make it integral to future priorities (objective 1)

One of our key achievements in 2015 was development of a new Framework for PHE action on health inequalities. This document for PHE staff explains our role in promoting equality and diversity and reducing health inequalities and the governance arrangements, including the role of Health Equity Board (Box 3). It describes the general activities staff can take to make progress on equality and reducing health inequalities, such as using our Health Equity Assessment Tool (Box 4). At the heart of the framework for action is a set of specific commitments that business areas will undertake in 2016-17.

Box 3: The Health Equity Board's work in 2015

The Health Equity Board was established in January 2014 including senior leaders across all PHE directorates alongside a number of external advisors. The Health Equity Board provides overall governance for PHE's fulfilment of the equality duty and our legal duties on health inequalities from the Health and Social Care Act 2013. The Board:

- provides leadership to ensure that PHE can provide advice on health inequalities and the social determinants of health to government and the wider system
- acts on behalf of the National Management Committee and PHE Advisory Board to ensure that PHE meets and reports on its legal duties on health inequalities and equality and diversity
- monitors progress on health inequalities and equalities
- identifies delivery and strategic risks related to health inequalities and equalities and recommend mitigating actions and contingency arrangements, and escalating issues to other governance boards as necessary

In 2015, the Board met three times – in March, July and November. The Board monitored progress on reporting and assurance of legal duties, considering both reports of delivery monitoring data, and the design of the organisation's Health Equity Dashboard.

The Board discussed the equity and equality aspects of a range of strategic developments including public sector priorities after the general election and devolution in Greater Manchester. The Board received updates from the Workforce Equality Subgroup at each meeting.

Box 4: The Heath Equity Assessment Tool

We introduced a Health Equity Assessments Tool in 2013/14 to support PHE's work promoting equality and diversity and reducing health inequalities. It is designed to help staff consider the requirements of both the Equality Act 2010, and our legal duty of health inequalities (Health and Social Care Act 2010) and so embed such considerations throughout the organisation's activity. The tool currently consists of four questions:

- what health inequalities or discrimination of protected groups exist in relation to your work?
- how might your work affect health inequalities and have regard to the needs of protected groups?
- how will you monitor and evaluation the effect of your work on health inequalities and protected groups?
- what are the next steps?

In 2015, we assessed use of the tool and have continued to promote its use across the organisation. We have learnt more about the application of the tool in practice, and have worked to identify areas where we could refine the tool.

The health system is now coalescing to focus on prevention of ill-health. This focus was described in the 'NHS Five Year Forward View'. We set out complementary public health priorities for the nation in 'From evidence into action: opportunities to protect and improve the nation's health', which include obesity, smoking, alcohol, ensuring a better start in life, reducing dementia risk and robustly tackling tuberculosis and antimicrobial resistance. These seven priorities are by no means our only areas of interest, but they are areas that we have identified as issues where we can most effectively focus our efforts. In 2015, we worked to marshal the evidence on groups who share protected characteristics around some of our priorities, including smoking, obesity and dementia. For example, we published a systematic review on the prevalence of dementia by protected characteristics.

Build relationships with stakeholders and the public (objective 2)

PHE recognises that our effectiveness as an organisation is influenced by the quality of our relationships with partners and stakeholders, including communities and the general public.

We are continuing to work with the cross sector 'Strategic Partners Programme' which enables PHE, alongside the Department of Health and NHS England, to work closely

with 22 voluntary and community organisations and networks from across the breadth and depth of the health and social care sector. The partnership supports PHE to hear from, and communicate with, diverse groups and communities that are often underrepresented in policy and programme development. This is facilitated through regular 'working days' where programme leads engage partners for their input and views, as well as through direct relationships and partnerships between our teams and key strategic partner organisations.

The programme also enables the partners to lead specific projects supporting work on the public health agenda on behalf of the communities they represent. Examples include work to promote faith settings as 'friendly places' to discuss mental health and wellbeing, and improving prevention of dementia in BAME older people. Through our ongoing engagement with the Strategic Partner Programme we develop more robust policies and programmes that reflect the needs of a wider range of people and communities.

We also continue the work of our Equality Forum. The Equality Forum has a diverse membership drawn from People's Panel (this compromises 1,400 members of the public who were recruited through a national random sample survey) members who have self-reported specific protected characteristics. In addition, the forum includes representatives from a range of user-led and community organisations that work with people who share specific protected characteristics, as well as groups who are at risk of worse health outcomes PHE staff.

For example, the forum hosted a seminar in July 2015 on the issue of young people's health and wellbeing. The seminar involved young people and young people's representative groups and aimed to identify lessons for PHE's work. The forum provides updates on its activities to the Health Equity Board.

We published our 'Guide to community-centred approaches to health and wellbeing'[3] in February 2015. We know that communities, both place-based and where people share a common identity or affinity have a vital contribution to make to health and wellbeing. The guide presents some of the practical, evidence-based options that can be used to improve community health and wellbeing.

In October 2015, we held a National Physical Activity Day focused on disability. Over 350 cross-sector leaders from national and local levels attended the conference for the National physical activity framework, 'Everybody Active Every Day', one year on. Our focus on disability at the event encouraged stakeholders to prioritise disabled people in their work and to understand that access to opportunities, rather than opportunities

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3 South, J. (2015). Health and wellbeing: a guide to community-centred approaches. Full report. Public Health England. Available at: https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

themselves is a primary reason for inequalities in physical activity for disabled people. The event included keynote speakers, workshops and a range of all ability activities and taster sessions. For example, the conference was opened with an instructability session led by a disabled instructor.

Ensure our advice includes equality and diversity considerations or dimensions (objective 3)

We work to embed consideration of equality and diversity throughout our advice to the public health system. For example, our 'Alcohol, drugs and tobacco joint strategic needs assessment support packs' support planning and commissioning cycles for alcohol and drug treatment and prevention and tobacco control. The packs provide areas with bespoke data and good practice prompts to support local areas assess local need and plan to meet it, including meeting the needs of the groups that share protected characteristics (see www.nta.nhs.uk/healthcare-JSNA.aspx).

In partnership with the Royal College of Nursing, we produced Suicide Prevention Toolkits for Lesbian, Gay and Bisexual, and Trans young people. The practical toolkits were produced to support people working with lesbian, gay, bisexual and trans young people to address the higher suicide rates in this population. The two toolkits (LGB and T) are available online.[4,5]

Through our PHE centres, we have worked to provide local authorities with advice on understanding internal migration (particularly onward migration of international migrants) and local population needs.

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4 Guerra, L. (2015). Preventing suicide among lesbian, gay and bisexual young people. A toolkit for nurses Public Health England. Available at: https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

5 Dockety, C. and Guerra, L. (2015). Preventing suicide among trans young people. A toolkit for nurses Public Health England. Available at: https://www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

Box 5: NHS Health Check Health Equity Audit Guidance

PHE South East Centre has played a lead role in the development of the NHS Health Check Health Equity Audit Guidance. The guidance was developed in response to local authority requests for a resource to support them with the audit process. A task and finish group was established in June 2015, involving representatives from PHE centres and Regions, local authorities and PHE national teams working on Health Equity and NHS Health Checks teams. This group has produced draft guidance for local authorities, which has been consulted on.
A review of existing HEAs undertaken by local authorities indicated that most focus on inequity in the offers and take up of NHS Health Checks.

A key feature of the guidance is that it promotes a broader approach to analysing inequity across the entire NHS Health Checks pathway, including inequity in outcomes, whilst at the same time supporting a pragmatic approach to scoping audits to reflect local requirements. The guidance will also support local authorities in generating recommendations to address any inequities identified, with links to a wider range of information, case studies and resources.

The resource will be piloted in a small number of local authorities in 2016, with support from PHE centres before publication on the NHS Health Check website.

Build knowledge and intelligence (objective 4)

In 2015, we undertook a range of activity and published evidence and intelligence relating to groups that share protected characteristics. We have a dedicated health intelligence network on learning disability which has published specific reports related to health inequalities experienced by people with learning disabilities.[6] The network also publishes updates on its work in an easy to read format.[7]

PHE continues to update and develop its tool to display indicators for the Public Health Outcomes Framework, providing information to aid understanding of how well public health is being improved and protected. Breakdowns of indicators by dimensions of inequality have been added, where data are available. From the tool's homepage,

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6 Emerson, E. (2015). The determinants of health inequities experienced by children with learning disabilities. Public Health England report. Available at: www.ihal.org.uk/gsf.php5?f=313900
7 The Learning Disabilities Public Health Observatory. What we have been doing in the last six months: April – September 2015. Available at http://www.improvinghealthandlives.org.uk/publications/313912/An_update_on_IHaL

(under Recent Updates) there is now clearer signposting to indicators available by specific protected characteristics (see www.phoutcomes.info).

To enable the Health Equity Board to regularly review progress in reducing inequalities within England, a health equity dashboard has been developed to provide the board with recent evidence on inequalities for PHE priorities and other key health outcomes and wider determinants of health, including information by protected characteristics where available. The dashboard will be further developed in 2016 with the intention of making it publicly available.

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

We are committed to building evidence and intelligence health outcomes by protected characteristics in order to understand the health and wellbeing needs of different population groups. A critical requirement for assessing the health outcomes of the LGB population is to have robust estimates of the size of the population in different sexual orientation groups. As there has been no systematic approach to quantifying the size of the LGB population in England, PHE has commissioned work to provide such estimates, which will be reported in 2016.

Box 6: Meeting the health needs of migrant populations

A new project in the East of England has been initiated to provide health professionals with the latest data on the incidence of infectious diseases in migrant populations along with information on migration trends and characteristics. Some evidence within the East of England recently suggested that there are unmet health needs in this population particularly around late presentation and inappropriate use of services. The project includes the following objectives:

- to map the migrant population within the East of England and how this has changed over time
- to describe the characteristics of the migrant population within the East of England
- to estimate the incidence of infection (STIs, HIV and TB) within the migrant population within the East of England
- to undertake a comparison of the burden of infectious diseases in the migrant population versus UK-born residents

We also support strategic research and evidence initiatives to fill knowledge gaps and inform public health approaches for specific groups that share protected characteristics. For example, to support our programme on health and work, we have supported an Ageing Well at Work Call to Action. This is an EU-funded project led by the Greater Manchester Public Health Network that explored practice across partner EU countries and nationally to develop a system-wide approach to enable ageing well in the workplace. It supports people to remain in work and continue to receive the health and wellbeing benefits of paid and voluntary work.

In addition to supporting Manchester's work as an Age Friendly City, the Call to Action report outlines key opportunities to address this agenda in local areas across the country.

In addition, we commissioned an evidence review on health and work in Chinese businesses to address a knowledge deficit about workplace health in the context of ethnic minority businesses. Led by academics from the Institute for Health and Human Development (IHHD), University of East London, the project consisted of a review of available research and qualitative research with Chinese businesses.

Improve accessibility and ease of understanding of our information (objective 5)

We work actively to improve the quality and accessibility of our information for professionals and the public. In 2015, we introduced checks on accessible and inclusive language through a new publication standard assurance process. We have also developed guidance for staff on producing easy to read information.

Some of our work has focused on improving the inclusive and accessible information that can influence the behaviour of members of the general public and professionals alike - this is the case for one project which has focused specifically on capacity to support the health and wellbeing of Black and Minority Ethnic men who have sex with men (BME MSM) (Box 5).

Box 5: Health and wellbeing of Black and Minority Ethnic men who have sex with men project

This collaboration with the MAC Foundation took an innovative approach to develop a range of resources to address the multiple sources of discrimination and associated health inequalities among BME MSM.

It has brought together partners from across the public health system to address three key issues for this minority within a minority group: sexual health and HIV; mental health and wellbeing; and drugs, alcohol and tobacco use.

Project components include: three structured learning sets; an e-learning module developed with the RCGP; a photo image bank; and pilot behaviour change interventions.

Improve business processes to focus on equality and diversity (objective 6)

We have worked to continuously refine our delivery planning and corporate reporting approaches and consider how to collect specific information about consideration of the equality duty to inform practical action.

Our work in developing a framework for PHE action on health inequalities has brought renewed focus to ensuring that PHE considers both equality and equity issues in our services and products. We have provided clear advice to business areas on the activities that they can undertake to focus on equality and diversity.

We have developed our staff diversity scorecard to support senior managers with thinking about equality and diversity in their teams. We have likewise a diverse network of engagement agents who provide a conduit between teams across PHE and help to shape our operating approach.

We also draw on the expertise in our organisation to promote equality for our staff. For example, our Children, Young People and Families team has been developing policy and support for women returning to work following maternity leave with a particular focus on supporting women to maintain breastfeeding.

Ensure we have a motivated and engaged workforce who live our behaviours and respect each other (objective 7)

We have undertaken a range of activity to engage and motivate our staff and promote inclusive behaviours. Earlier in this report we set out the activity of our staff diversity networks. In addition, in 2015, our staff engagement team has worked to gather grass roots staff opinion to influence and help shape our new behaviours, ensuring that staff have a real say in how we go about doing what we do. These behaviours will be core to how we deliver future recruitment, induction, appraisal, performance management, the annual staff survey and learning and development.

The staff engagement team is responsible for supporting and developing our network of 100 engagement agents, who come from a wider range of levels and backgrounds across the organisation. They work closely alongside our network of 150 health and wellbeing champions to ensure there is seamless support for our staff. We ensure that all our organisational development interventions are accessible and promote diversity and inclusion; for example our ccorporate induction has a dedicated session on these issues.

To strengthen management capability across the organisation, we also delivered a bespoke one-day training offer to all managers which provided tools and techniques to improve their own skills, particularly around feedback, team development and inclusivity.

We have improved internal communication through Team Talk, a monthly organisation-wide set of conversations at all levels on contemporary key topics. For example, this included an item of ESR self-service, and the benefits of updating personal details on protected characteristics. In response to feedback from staff, we refreshed our induction processes ensuring that new staff of all grades and backgrounds are welcomed into our organisation by our most senior leaders and provided with the necessary information to enable them to succeed in their role.

PHE undertook an organisational change programme in 2015, Securing our Future. We are reviewing job descriptions in our centres and regions to bring them up to date, ensure they adequately incorporate equality and diversity considerations, and ensure staff are paid the same rate for the same role across the country.

Next steps

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

Our equality objectives were set in 2013 and we are required to set equality objectives every four years. We will begin the process of consulting on our equality objectives for the next period, in partnership with strategic partners.

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

Workforce equality:

- increase the ethnicity and disability data that ESR holds for our staff
- roll out our staff diversity scorecard across the business
  - establish mentoring circles for senior women and LGBT staff will be launched in 2016, building on our mentoring circulate model for BAME staff
  - formally launch the gender network for staff. It will seek to examine gender issues across the spectrum, including trans, identity and non-binary definition of gender

For our products and services:

- establish a work plan for our equality and diversity working group to with some areas of strategic focus that will support the entire organisation to take meaningful action to address equality through our products and services
- identify how best to monitor and drive focus equality and diversity through our corporate business planning and reporting processes that results in impactful action

Appendix: Our seven equality objectives

Equality objective 1: We will ensure that the public sector equality duty is embedded and reflected in our corporate priorities and is an integral part of any future priority setting for our organisation.

Equality objective 2: We will build and develop our relationships with stakeholders and the public, including those that represent groups with protected characteristics, to improve our functions and services, and consult with them about our priorities.

Equality objective 3: We will ensure that our advice (including to local authorities, NHS England and government) includes dimensions of health equity and equality and diversity in accordance with the Equality Act 2010.

Equality objective 4: As an expert organisation, we will build on our strengths in knowledge and intelligence, improve the information we hold and collect from our system partners and lead the way on expanding the knowledge and intelligence evidence base on people with protected characteristics.

Equality objective 5: We will improve accessibility and ease of understanding of the information and advice we produce. We will seek to improve the accessibility of the information that we provide to the public and stakeholders.

Equality objective 6: We will improve our internal business processes so that equality and diversity is an integral part of everything we do. Our drive to increase value, efficiency and productivity will always consider the needs of people with protected characteristics, internally in PHE and in our externally facing functions.

Equality objective 7: We will ensure we have a motivated and engaged workforce who live our behaviours of respect for each other.