Enclosure/16/11/06d

Public Health England

Protecting and improving the nation's health

Equality in Public Health England

How we met the public sector equality duty in 2016

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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Introduction

Public Health England (PHE) exists to protect and improve the nation's health and reduce health inequalities. To deliver a broad range of products and services, PHE employs over 5,308 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 Public Health England (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 which require public bodies such as PHE to:

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

Our seven equality objectives are shown in Box 1.

Box 1: PHE equality objectives published in January 2014

1. Public Health England 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 Public Health England 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.

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

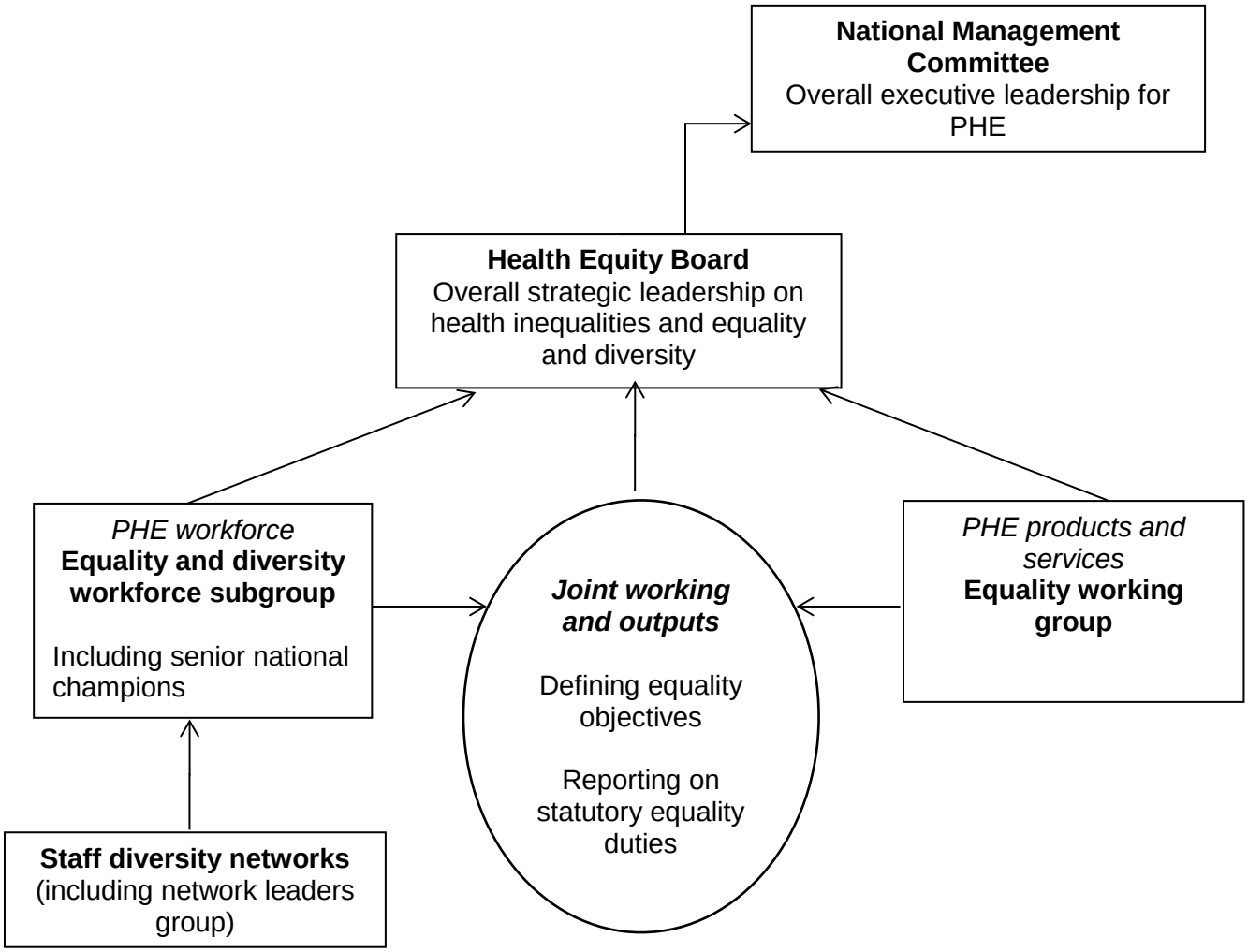
The Health and Social Care Act 2012 introduced specific legal duties on health inequalities for the Secretary of State for Health which PHE must meet on his behalf. The duty requires due regard to the need to reduce inequalities between the people of England with respect to the benefits that they can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

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

Our approach to governance on equality and equity

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

Figure 1: PHE governance on equality and diversity



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 2015,* 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

Diversity and Staff Inclusion

Diversity and Staff Inclusion is fully embedded into HR Corporate Services and incorporates diversity and staff inclusion, learning and development and recruitment and pay and pensions.

Leadership and governance

PHE directors are accountable to Duncan Selbie, CEO, for the subsequent actions taken by their senior management teams in tackling the identified inequalities via the equality and diversity focused objective stipulated within their individual appraisal objectives.

PHE demonstrated its commitment to creating a diverse and talented workforce by ensuring providing strong leadership and accountability for delivering this aim. PHE's Diverse and Talented Programme board oversees the delivery of actions related to workforce equality issues and reports to the Health Equity Board.

In addition to this 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 and are accountable for ensuring that.

Diversity data

It has become clear that there is a high percentage of staff that chose not to disclose their religion and /or belief, disability and sexual orientation. We established a staff facing declaration campaign which communicates the importance of staff disclosing this personal information and encouraging them to do so through a multifaceted communications campaign. This includes videos from the executive diversity champions and illustrative infographics.

Benchmarking

PHE submitted their third completed survey to the Stonewall Workplace Index this year. 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. In 2015/16 PHE ranked 128, jumping 89 places from 2014/15

This year PHE were achieved a bronze ranking for the 2015 completion if the Race for Opportunity benchmark. The benchmark is a tool that helps organisations evaluate their performance, including peer comparisons, and inform evidence-based decision-making around workplace diversity.

Although PHE is not formally required to report against NHS England's Workforce Race Equality Standard (WRES), the DTW programme is equipped to report on most of the WRES indicators, taking into account differences between Civil Service and NHS workforce information systems and their reporting mechanisms.

On 4 October, PHE was invited to present to the NHS England Workforce Race Equality Standard (WRES) Board, chaired by Sir Keith Pearson from Health Education England. The purpose was to illustrate PHE's ongoing commitment and subsequent work in making diversity and inclusion 'core business'. We provided the interactive diversity dashboard (which now contains recruitment attrition data) and the WRES Board is keen for PHE to share our work across the NHS and its ALBs.

Staff diversity networks

PHE is proud to have three active staff diversity networks – Black and Minority Ethnic (BAME), Disability, and Lesbian, Gay, Bisexual and Transgender (LGBT). The PHE Faith Network formally launched this summer the network seeks to support and celebrate all beliefs across PHE by providing spaces and workplace guidance for all staff. This year we developed a flexible working champion's network across PHE and we will be launching the gender balance network 2016/17.

Talent management

In 2016, PHE continued to support staff to achieve their potential through targeted mentoring, coaching and innovative trainee management programmes.

This year seventeen individuals have been successful in obtaining a place on the Race for Opportunity cross organisational mentoring programme. They will join the mentoring circle together with other private sector and public sector firms to learn, develop and network with other BAME professionals in an action learning environment. PHE has also launched the internal mentoring circles for BAME staff within PHE. Four senior lead mentors managed a circle made up of five mentees. Following the end of the programme staff reported an increase in their confidence to develop, established new networking relationships, developed new skills and within one circle three of the participants advanced within their career.

Outreach programme

PHE has a commitment to tackling health inequalities in England. Employment is beneficial to health and some groups within society face grater barriers to and are a s a result underrepresented within the labour market

This year PHE signed up to the Project SEARCH programme, which is a work experience scheme for young adults with learning disabilities. PHE have offered 11 young adults, aged between 16-23 with learning disabilities or on the autism spectrum, 800 hours of valuable work experience across three rotational work placements, across a multitude of disciplines from front of house to the laboratories at our Colindale site.

PHE are working with MOSAIC Clubhouse, Brixton to provide their unemployed clients with mental health issues Transitional Employment Placements (TEP).To date we have recruited three talented individuals with mental health issues into temporary paid roles across PHE. This positive action employment scheme has not only provided the welcoming teams with invaluable resource, but has raised awareness amongst staff around mental health issues and how we can recruit from a wider pool of talent.

PHE’s involvement in the government Movement to Work scheme continues to develop to date we have provided over 50 work experience placement to 18 -24 year olds who are not in employment education or training (NEET) who are seeking opportunities to develop and learn new skills in the workplace that will assist their transition into full-time employment. To date the programme has had almost 36,000 placements across the country with 68% moving into employment.

PHE will be launching a work placement programme for wounded, injured or sick (WIS) military personnel. The aim of the initiative is to provide the individuals with opportunities to rebuild their self-esteem and self-confidence so they are better able to re-join the labour market. PHE will be working with a

number of colleagues from across the Civil Service and the Career Transition Partnership.

Recruitment

Whilst Black, Asian and Minority Ethnic (BAME) staff are well represented overall across PHE and individual contracts, they are significantly under-represented at senior grades. PHE is committed to addressing workforce inequality across PHE to create the opportunity for meritocratic appointment to all grades, without barriers to entry. This year the HR directorate will be piloted several positive action initiatives over the next few months which will seek to 'level the playing field' for BAME talent at both the recruitment and development stage.

Training

Increased the fairness and equality of recruitment through unconscious bias training at recruitment and selection workshops and bespoke guidance around job descriptions and panels. The training invaluably covers inclusive practice; helping managers to identify and avoid unconscious bias through levelling the playing field for all candidates.

PHE have revamped their people management seminars in order to weave diversity and inclusion throughout the day, which is mandatory for all PHE staff with line management responsibility.

The aim of the seminars is to introduce new PHE people managers to the key skills and behaviours expected of all people managers.

We have identified a number of 'golden threads' which will run throughout the seminar:

- Engagement (and link to staff survey and engage for success key engagement factors)
- The People Charter
- Diversity and inclusion
- PHE Operating Model
- 'One PHE'

The seminars include a specific on inclusive leadership and challenges managers to identify those competencies within themselves.

Throughout the year the DTW team facilitated a number of bespoke diversity confidence training workshops at national conferences and workshops to stakeholders.

Policy and procedures

In summer 2016, HR benefited from the expertise of external celebrated consultant who led a large consultation piece with PHE staff in order to inform the emerging reasonable adjustment implementation plan. The internal findings suggested that staff would prefer a mainstream approach which would seek to collect, monitor and implement adjustments for all, incorporating accessibility, religious, care and technological needs. We have therefore decided to pilot the Civil Service Workplace Adjustment Passport.

Diversity scorecard

The Diverse and Talented Workforce (DTW) function launched the diversity dashboards across PHE in April 2016. The dashboards illustrate the workforce composition of each PHE directorate, disaggregated by grade and then gender, ethnicity and age. An overall PHE dashboard shows us what the entire workforce looks like by disability, faith and sexual orientation.

Both dashboards are published quarterly and distributed to respective directorate SMTs to provoke challenging conversations, which seek to identify useful next steps.

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 2016 and are drawn from the PHE Human Resources and Payroll system.

Table 1 presents information on the proportion of staff on whom details of a particular protected characteristics are currently held.

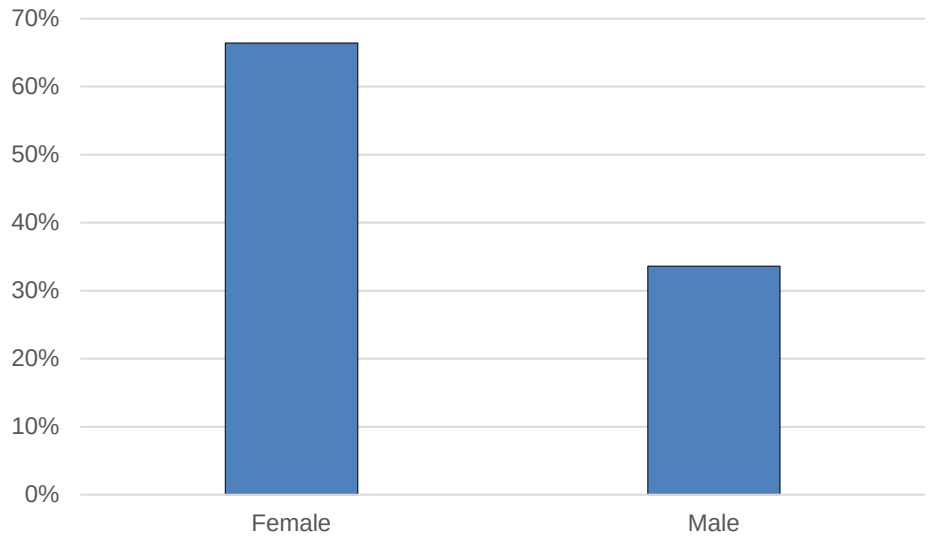
Table: Proportion of PHE staff whom data are held on protected characteristics

Protected characteristics is held	**% of staff on whom information**		
	November 2014	November 2015	November 2016
Gender	100	100	100
Age	100	100	100
Ethnic group	97	97	96
Disability	49	53	57
Religion and Belief	58	61	65
Sexual Orientation	59	62	66
Base	5,692	5,324	5,308

Gender

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

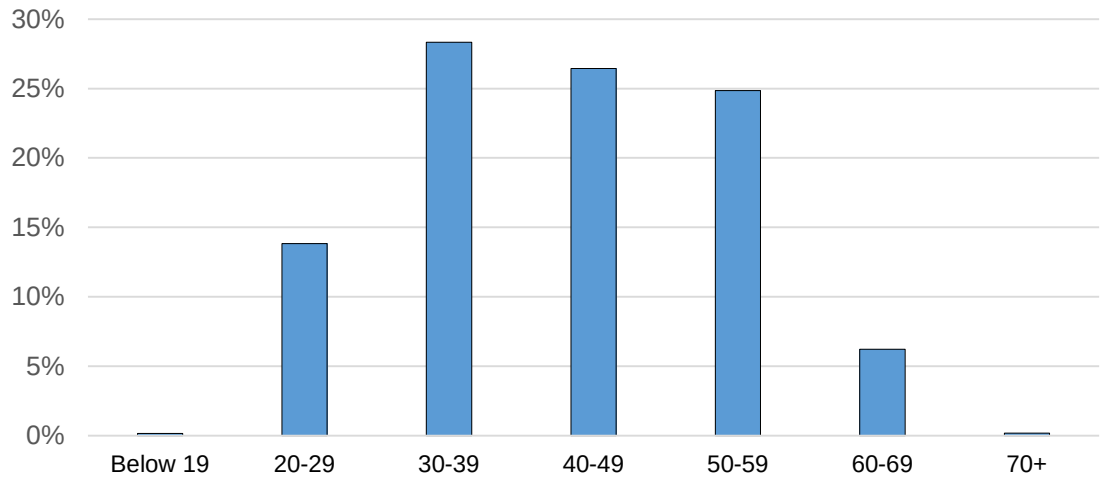
Figure 2. Gender profile of PHE staff, November 2016



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 quarter of PHE staff (25%) are aged 50 to 59 and 6% are aged 60- 69 years. There are few younger staff aged under 30 (14%) in the PHE workforce. These patterns will have implications for staff succession and retirement planning (Figure 3)

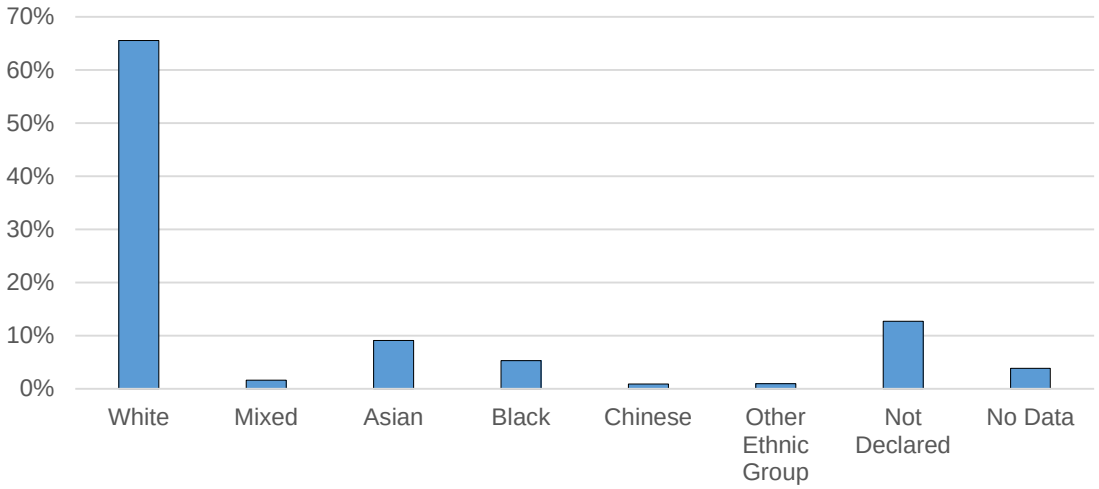
Figure 3: Age profile of PHE staff, November 2016



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 (13%) have chosen not to disclose their ethnic group.

Figure 4: Distribution of PHE staff by ethnic group, November 2016



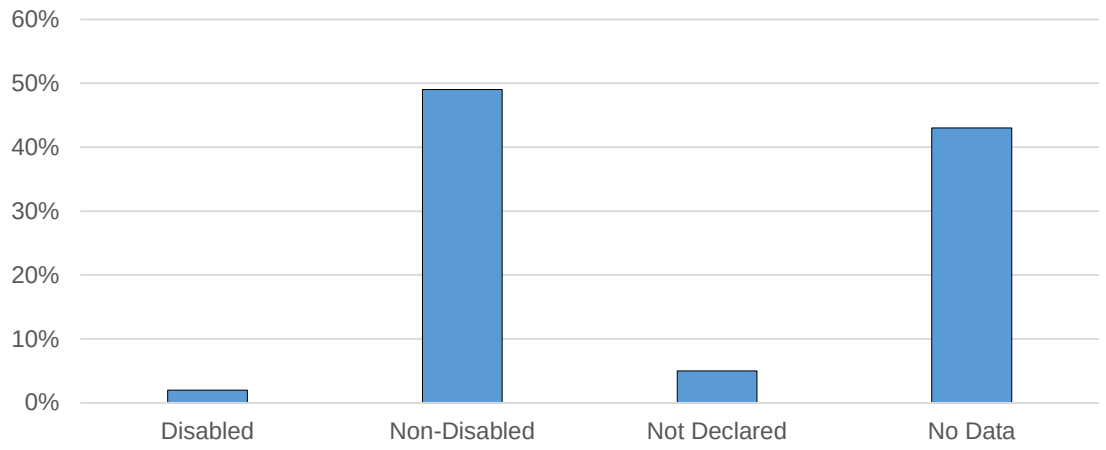
[1] This includes British , Irish , Greek, Turkish Cypriot and European

[2] This includes Caribbean, African, Black British

Disabilities

Records indicate that 2% of all PHE staff are disabled (Figure 5). This rate is lower compared with the Department of Health, where 6% of staff in 2015 declared themselves as having a disability. However, data on whether staff are disabled or not is currently held for 43% of staff and there is a focus for improved data in the coming year.

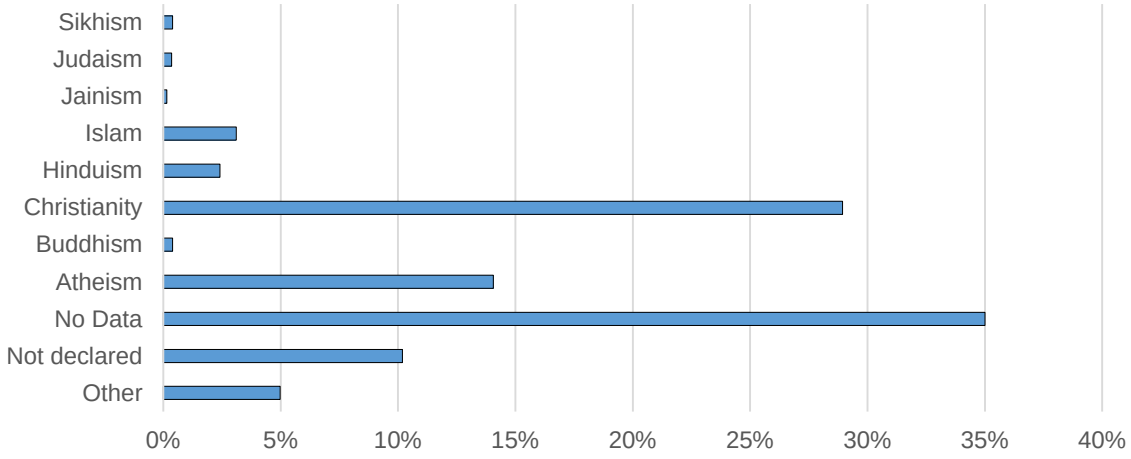
Figure 5: PHE staff by disability status, November 2016



Religion and belief

Data on the religion and belief held by staff is shown in Figure 6. This information was not captured by the transition team for people transferring into PGHE in 2013 so there is a high percentage of staff (35%) on whom no data is currently held. Christianity is the most commonly reported religion among PHE staff (29%); the next largest group is those who report being atheists (14%). There are similar proportions of staff who report that they are Hindu (2%) or Muslim (3%). All other religions are reported by less than 1% of staff, while 10% have chosen not to disclose any religion or belief (not declared or 'prefer not to say').

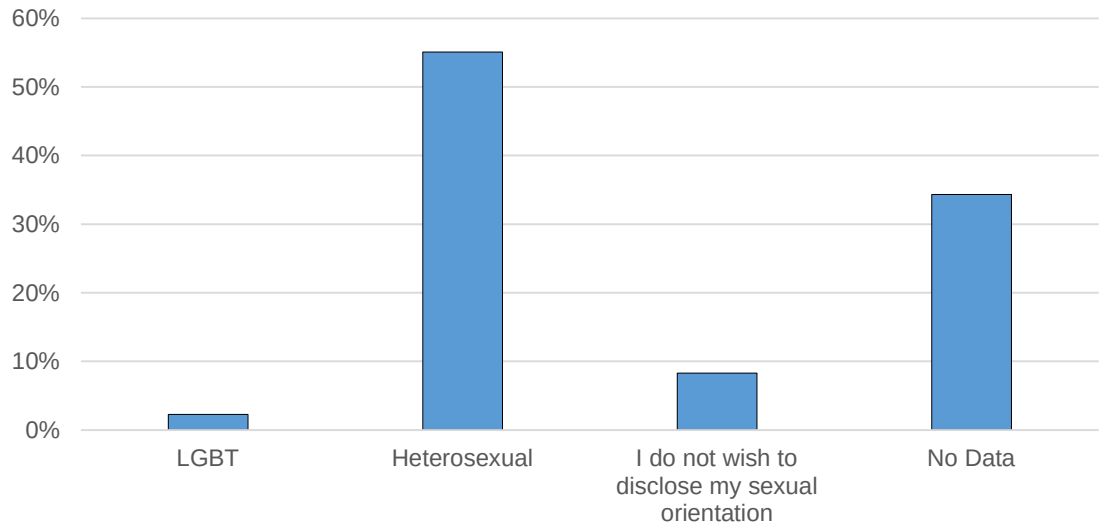
Figure 6: Religion and belief profile reported by PHE staff, November 2015



Sexual orientation

Information about the sexual orientation of PHE staff is available for 66% of the workforce, as information on 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 (55%). 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 2016



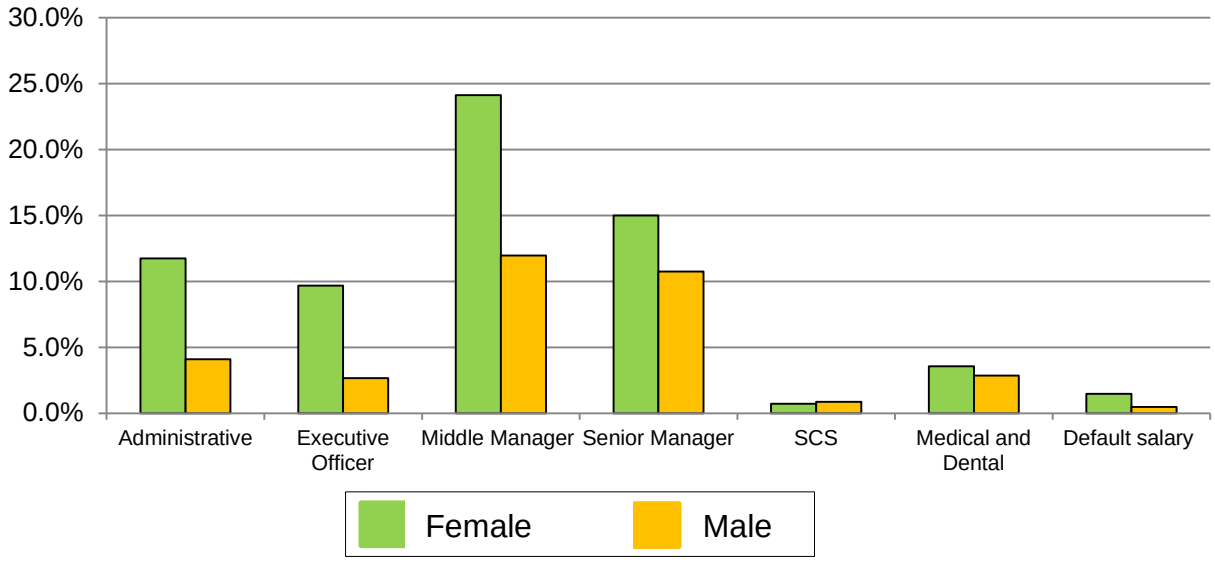
Workforce composition by grade

This section of the report provides information about workforce composition of each PHE directorate by grade and then gender, age and ethnicity as at 17 November 2016.

Gender analysis

There are nearly twice as many women (66%) as men (34%) working within PHE. Figure 8 shows that the gender distribution across the administrative, executive officer and middle manager grade is in proportion to the overall gender PHE workforce composition. Although there is a higher percentage of female staff at senior manager grade, the gender distribution within this grade does not reflect the overall gender PHE workforce composition. A greater proportion of PHE staff at SCS grade are male (0.9%) in comparison to females (0.7%).

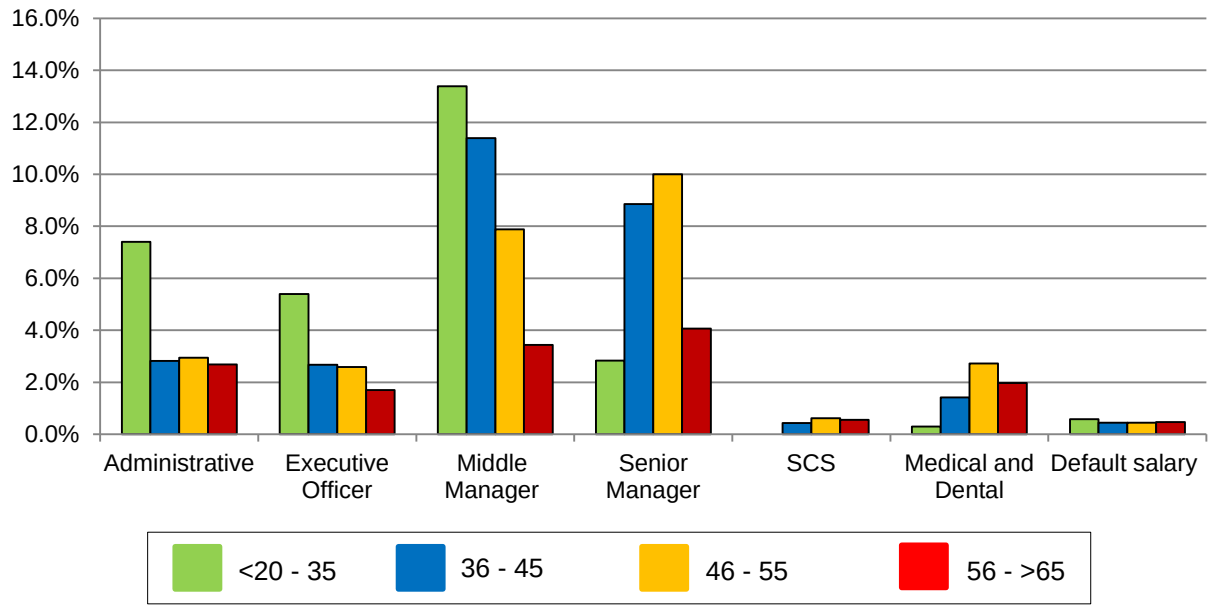
Figure 8: Workforce gender profile by grade



Age analysis

The Figure 9 illustrates that all age groups are represented at all grades at PHE, with the exception of the SCS grade. Staff aged 46 years and over are mainly represented at middle manager and senior manager grades. 30% of the workforce is represented by staff under 35 in PHE. Biggest proportion of staff in middle management roles are under 35 (13.4%). Within senior manager grades there is a low representation of staff under 35 (2.8%). The age distribution across the grades may have implications for staff succession and retirement planning.

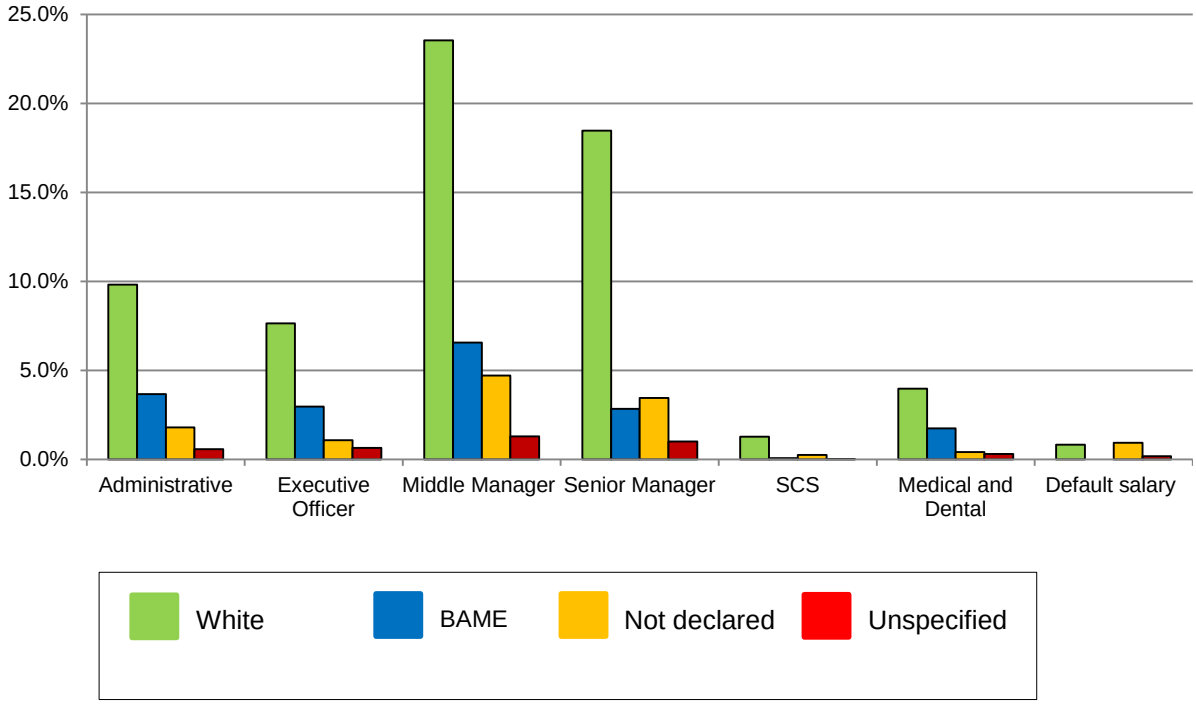
Figure 9: Workforce age profile by grade



Ethnicity analysis

In Public Health England, 66% of the workforce is White, 17% BAME and 14% prefer not to disclose their ethnicity. We do not have ethnicity information for 3% of our staff. Figure 10 illustrates that BAME staff are represented at all grades within PHE. The biggest proportion of BAME staff is represented within the middle management grade (6%). There is a lower representation of BAME staff in senior manager grade (2.6%) and less than 1% of BAME staff representation within the SCS grade.

Figure 10: Ethnicity workforce profile by grade



Actions to fulfil our equality objectives

Objective 1: Embed equality and diversity in corporate priorities and make it integral to future priorities

Key accomplishments:

- New equality objectives for 2017-2020
- New external advisors to the Health Equity Board
- Revised Health Equity Assessment Tool (HEAT)

In PHE we aim to maximise opportunities to become more ambitious in our approach to creating a more diverse, and diversity aware workforce, and promote equality and fairness in the way we design or deliver services. One of our key achievements in 2016 was development of the new set of PHE equality objectives 2017-2020, in line with a statutory requirements to refresh objectives at least once every four years.

Health Equity Unit worked closely with Human Resources and Organisation and Workforce Development colleagues to produce a new set of equality objectives. They clearly distinguish between those related to our staff and to the wider system, and focus on ensuring that equality considerations are built into any processes, practices and ways of working and that they are implemented as fairly and transparently as possible and kept under continuous review. The publication is due in February 2017.

This document reflects developments of the Health Equity Board which are outlined in Box 1 below.

Box 1: The Health Equity Board's work in 2016

The Health Equity Board chaired by the National Director Professor Kevin Fenton 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 HEB is now well established in its assurance role and agreed to extend its membership to include additional external advisors to the Board (full membership is available in **Annex 1**). They are:

- Professor Ruth Hussey, former Chief Medical Officer for Wales and Honorary Life Member of the Liverpool Medical Students Society.

- Paul Lincoln, CEO, UK Health Forum
- Jeremy Taylor, CEO, National Voices
- Professor Mala Rao OBE, Professor & Senior Clinical Fellow, Imperial College London & Honorary Consultant Public Health England

The Board met three times, in March, July and November 2016, with an additional teleconference in September to discuss the refresh of PHE equality objectives for the next four years. Members discussed health equity across a range of topics, such as community-centred and asset based approaches to health and well-being, the national TB programme and PHE's role in supporting devolution programmes in reducing health inequalities and promoting inclusion. In July, the Board discussed the importance of Inclusion Health and the needs of vulnerable and excluded groups, and received reports on health and homelessness. Further work is underway to scope this area in more detail to identify where the HEB could add value.

The Board received regular updates on the Health Equity Dashboard, which has developed substantially since its design in 2015 to monitor the fulfillment of PHE's statutory duties, to have due regard to reduce inequalities, and its role in promoting equality and diversity. The dashboard now incorporates a selection of PHOF indicators, such as slope indices of inequality, mental health by working status, inequalities in the PHE priority areas, and inequalities in the social determinants of health. Where available the indicators are analysed by protected characteristics. Work is underway to launch a local version of the dashboard. Health Equity Dashboard annual report is under way and planned to be published in early 2017. The report will take a particular focus on ethnicity, and additional data on ethnicity has been sourced where possible.

Regular reports were also received from the Diverse and Talented Workforce programme on the diversity profile of the organisation and the progress of its projects on the recruitment of talented individuals with mental health difficulties and providing work placements for young people with learning disabilities.

In 2016 a revision of the Health Equity Assessment Tool (HEAT) has been undertaken in collaboration and partnership with colleagues across PHE.

Box 2: The Heath Equity Assessment Tool (HEAT)

The tool 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. For example, the tool actively encourages staff to advance equality of opportunity and consider those who share protected characteristics and those who do not share it when developing new guidance or evidence reviews. The tool has five stages – Prepare, Assess, Refine, Apply, and Review – but it can be used flexibly. It is important that a senior leader sponsors the assessment and is involved at the review stage so it is thoroughly embedded in a team's work. We have run workshops to promote the use of the tool and support colleagues in its application. The tool will be open to refinement and adjustment as we evaluate its effectiveness.

We continue to focus our work on prevention of ill-health and on key public health priorities for the nation as described 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 TB and antimicrobial resistance. A significant progress has been made in a number of these areas and some of them are referenced in the section below.

Objective 2: Build relationships with stakeholders and the public

Key accomplishments:

- Strategic Partners Programme 'working days', successfully engaging with 22 voluntary and community organisations
- Children and Young People Takeover Day (workshops)
- Targeted health promotion initiatives with Muslim communities in West Midlands

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 PHE 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 on mental health support for BAME prisoners examines a place based approach to mental health within prisons, and work to increase our understanding of how childhood obesity impacts specific groups of children. Through its ongoing engagement with the Strategic Partner Programme PHE develops more robust policies and programmes which reflect the needs of a wider range of people and communities. For instance, Strategic Partners recently advised PHE on draft Health Equity (HEA) Guidance for NHS Health Check programme.

Box 3: Targeted health promotion amongst South Asian communities (West Midlands)

PHE West Midlands (WM) played a key role in engaging members of South Asian and Muslim communities in awareness-raising and opportunistic testing campaigns for Hepatitis. The centre worked in conjunction with the HepC Trust and Birmingham City Council to staff stalls offering HepC Testing, blood pressure and BMI checks. There was an incredibly high level of interest and attendance from the community, enhanced by the mosque management and Imam providing pre-event publicity and announcements at Friday prayers.

As a result of this initiative, the mosque management expressed an interest in developing further relationships with PHE and the HepC Trust to address a variety of health concerns amongst neighbouring mosques for awareness raising and testing for their congregations.

This has led to PHE partnering with Birmingham Public Health and local Mosques and Muslim community organisations to map local assets in two deprived wards in Birmingham with a high South Asian population. The intention is to determine what local people feel about their health and the role faith place based health promotion activities may play in tackling health inequalities.

We also continue the work of our Equality Forum. The Equality Forum has a diverse membership drawn from People’s Panel (compromises 1,600 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. Members of the forum have helped to contribute to the development of an inclusive model of engagement with older children and young people. This follows a successful children and young people's Takeover Day in which the Board asked PHE colleagues to explore ways of involving children and young people in our work like that of the People's Panel. Workshops have been run with young people to help inform proposals to go to the Board for a pilot project to be initiated in the spring of 2017.

Objective 3: Ensure our advice includes equality and diversity considerations or dimensions

Key accomplishments:

- Strong collaboration with PHE Centres to fully embed equality and diversity
- Physical activity and sedentary behaviour in girls aged 8-10 years – research project established

We work to embed consideration of equality and diversity throughout our advice to the public health system. 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.

Box 4: Physical activity and sedentary behaviour in girls aged 8-10 years – research project

Data indicates **girls'** participation in physical activity starts to decline between the ages of **8-10 years** coinciding with research from the Government Equality Office on **'***the tipping point for confidence and attitudes in 7-8 year old girls'.*

PHE commissioned research in order to better understand the correlates of physical inactivity and sedentary behaviour amongst this cohort and to identify the components of interventions in schools that may help address this issue.

The project included the following components:

- a literature review to identify correlates and determinants of physical activity and sedentary behaviour in 8-10 year old girls
- the development of school-based interventions seeking to translate into practice key defining features of effective practice highlighted through the

literature review

- implementation of activities in 7 schools over an 8-week period
- independent evaluation of the school-based activities
- development of a practical toolkit for schools to assist in the planning and delivery of activities to promote physical activity and reduce sedentary behaviour amongst girls aged 8-10 years

It is anticipated that these outputs would inform local delivery of objectives within the Child Obesity Plan, specifically an aspiration for 30 minutes of the recommended 60 minutes of daily physical activity to be met within school time. The practical ideas set out in the toolkit would help primary schools to consider actions to enhance physical activity offer to help achieve this aspiration and give particular consideration to the needs of girls.

Objective 4: Build knowledge and intelligence

Key accomplishments:

- National data extraction exercise of the NHS Health Checks programme
- Monitoring and delivery of the HPV vaccine to MSM pilot
- Enhanced Health Equity Dashboard, including new indicators

In 2016, we undertook a range of activity and published evidence and intelligence relating to groups that share protected characteristics.

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. Many indicators are provided with breakdowns by dimensions of inequality, and these are signposted from the tool's home page (under Recent Updates). A new development in 2016 has been the addition of trend data for many of these dimensions of inequality, with charts illustrating how patterns of inequality have changed in recent years. For example, in November 2016, the tool introduced four new indicators which included the average number of portions of fruit and vegetables consumed by 15 year olds, the proportion of children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review and adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison.

The Health Equity Board continued to monitor progress in reducing inequalities through the Health Equity Dashboard, which was updated three times in 2016. The dashboard provides evidence on inequalities for PHE priorities and other key health outcomes and wider determinants of health, including information by protected characteristics where available. A report providing analysis and commentary for each of the 18 dashboard indicators has recently been completed and will be published in early 2017. It examines inequality for a range of dimensions, but with a particular focus on ethnicity and indicators are provided by ethnic group where possible.

Box 5: Development of a Weight Management Commissioning Toolkit

The aim of the Weight Management Commissioning Toolkit (WMCT) is to influence the local commissioning and delivery of tier 2 and tier 3 weight management services (WMS) to provide services that work for children, families and adults, and support the interface across the obesity pathway. The WMCT in part aims to address feedback received from commissioners on barriers to commissioning WMS which was collected in 2015 as part of PHE's National Mapping of WMS.

To inform the evidence base and support the translation of evidence into practice, and access to effective services, we:

- commissioned 2 evidence reviews to understand "what works" in WMS for children, families and adults, due to be published towards the end of the year
- commissioned in-depth insights to illustrate user journeys and worked with commissioners and providers to understand barriers and facilitators to WMS, to determine how to improve services

Going Forward:

- a WMCT Working Group made up of local and national stakeholders will provide ongoing review, act as a critical friend and ensure the developing toolkit is best placed to meet the needs of users, commissioners and providers of WMS
- the WMCT will be finalised taking consideration the protected characteristics, in particular age and sex, and published in 2017 covering; tier 2 and tier 3 adults; and tier 2 and tier 3 children and family services for use by local authorities, clinical commissioning groups, NHS institutions and providers of WMS.

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. Following the advice from the Joint Committee on vaccination and immunisation, PHE has commenced monitoring the delivery of the HPV vaccine to men who have sex with men (MSM) in 2016 through a small number of invited clinics as part of the HPV MSM pilot. The purpose of the HPV MSM pilot is to help evaluate whether it is operationally possible and cost effective to deliver such a programme through GUM and HIV clinics. The results of the pilot will inform the potential roll out of a national programme that will benefit the whole MSM population. PHE will also carry out an evaluation to determine whether the programme is equitable by comparing uptake in large urban centres versus rural centres.

Box 6: NHS Health Check Data Extraction

Public Health England is leading a national data extraction of the NHS Health Checks programme. Until now, PHE only has a national record of offers and uptake of the NHS Health Check by local authority. The extraction, which is being conducted by the General Practice Extraction Service (GPES) at NHS Digital in collaboration with PHE, will expand the knowledge and evidence base by giving information showing variation between areas and different demographic groups.

Public Health England is leading a national data extraction of the NHS Health Checks programme. The data extraction will involve GPES extracting identifiable patient level data and, following the extraction, pseudonymised patient level data will be disseminated to PHE. Extracting patient level data will allow a more in-depth analysis of the data compared to aggregate level indicators, for example of variation in take up and/or outcomes between and within different local areas and between demographic groups.

As a result, PHE will be able to evaluate both the quality of the NHS Health Check programme and better understand differences in local implementation of the NHS Health Checks programme. The information from the extraction will give PHE and health care planners, commissioners and providers opportunities to improve delivery, identify areas for improvement, better target inequalities and reduce variation across the programme. Given the scale of the programme, this

extract will provide the largest dataset of its kind in the world (8.79 million checks offered, 4.2 million received, and counting).

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

We also support strategic research and evidence initiatives to fill knowledge gaps and inform public health approaches for specific groups that share protected characteristics.

Objective 5: Improve accessibility and ease of understanding of our information

Key accomplishments:

- national HIV Prevention Programme for Most At-Risk Populations
- Health and Work infographics
- tackling tuberculosis in under-served populations: a resource for TB Control Boards and their partners

We work actively to improve the quality and accessibility of our information for professionals and the public. PHE introduced checks on accessible and inclusive language through a new publication standard assurance process.

Some of our work has focused on raising awareness of how health and work transect to improve understanding and support by statutory services and employers to improve the health and working lives of individuals. We worked with the Work Foundation to produce a selection of twelve Health and Work infographics which are intended to help public health practitioners, local authorities and policy makers to make the case and inform planning on embedding health, work and worklessness within and across these issues.

PHE has also made a significant progress towards implementation and delivery of NHS England and PHE Collaborative TB Strategy for England, 2015-2020. The TB Strategy was launched by NHS England and PHE in 2015 in response to the high rates of TB in England compared to most other Western European countries and the USA. There are marked inequalities in the ethnic, geographical and socioeconomic distribution of TB cases.

Box 7: NHS England and PHE collaborative TB strategy for England 2015-2020

Improving accessibility to services and ease of understanding of information lies is at the heart of this national strategy. The work is being implemented and delivered across England by a national team in collaboration with seven regional TB Control Boards supported by several 'task and finish' groups set up specifically to focus on diagnostics, MDR-TB/drug resistance, under-served populations (USPs), workforce and the LTBI testing and treatment programme.

The TB Control Boards and 'task and finish' groups include strong partnership working by PHE with NHS England, NHS, CCGs, Local Authorities and non-statutory organisations including those that represent and include TB patients. Equity lies at the very heart of this programme, for example the action plan for England includes tackling TB in under-served populations from specific ethnic groups where TB is highly prevalent and improving testing and treatment of new migrants for latent TB infection.

The focus since the launch of the strategy has been on:

- implementing LTBI testing and treatment among migrants through CCG based LTBI testing and treatment programmes supported by £10m from NHSE in 2015/16 and 2016/17. This includes a LTBI toolkit Advocacy, guidance and publications - The Truth about TB to support access, testing and treatment for new entrant LTBI testing and treatment programmes
- updating and enhancing information and awareness resources for TB patients, communities and health care professionals to reduce diagnostic delay through awareness raising and improving accessibility of services
- maintaining the quality of TB treatment and care services to ensure continued high treatment completion including a national TB service specification for use by TB services and commissioners

Equity lies at the very heart of this programme

For further information please see following the documents:
NHS England and PHE Collaborative TB Strategy for England, 2015 - 2020
Tuberculosis in England (2016)

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 most at-risk populations for HIV (eg black African people and with gay men/men who have sex with men (MSM) (Box 8).

Box 8: National HIV Prevention Programme for Most At-Risk Populations

PHE is delighted to be working in partnership with NHS England on this major new edition of the national HIV programme. The nationally co-ordinated programme of HIV prevention work with UK-based black African people and with gay men/men who have sex with men (MSM). It brings together campaigns, online services, local work and policy work. It works closely with black African, gay, and faith communities, NHS clinics, local authorities and national organisations. (www.hivpreventionengland.org.uk).

The programme aims to:

- increase HIV testing to reduce undiagnosed and late diagnoses
- promote of condom use as a safer sex strategy
- promote other evidence-based safer-sex and biomedical HIV prevention interventions
- raise awareness of the role of sexually transmitted infections (STIs) in the context of HIV acquisition and transmission
- reduce levels of HIV related stigma within affected communities and more widely.

Lessons learnt:

- Local Activation. The national programme helps fund local efforts. This is better done through close collaboration with local authorities and commissioners to help complement and amplify locally-funded strategies.
- sector development. It is important to integrate sector development into the structures of the programme to increase knowledge, skills and innovation within HIV prevention in England.
- system leadership for better awareness. Customisation of messages should include not only community members but also service providers including: clinicians, faith communities, local authorities and commissioners, GPs and primary care.

Objective 6: Improve business processes to focus on equality and diversity

Key accomplishments:

- framework for PHE action on health inequalities embedded in business areas
- PHE maternity and return to work policy reviewed

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

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 breast feeding.

Box 9: PHE maternity and return to work policy

PHE is committed to supporting mothers to continue to breastfeed for as long as they want to, including after they return to work. PHE publishes information for parents and employers on the law regarding breastfeeding when returning to work or study and tips on how to continue to breastfeed in its Start4Life leaflets and via the Start4Life Information Service for Parents.

The Children, Young People and Families team has been working with HR and Facilities to ensure PHE corporate processes embed best practice relating to gender and pregnancy and maternity so that the organisation delivers on its ambition of being a model employer for equality and diversity. In particular we focused on developing a policy on supporting women who wish to continue to breast feed on after returning to work.

A review of a range of workforce policies is currently underway and updated wording has been drafted for inclusion in PHE's revised Maternity Guidance for Expectant Mothers and Workplace Managers.

Facilities have also agreed to ensure that quiet places which comply with best practice for breastfeeding, expressing breastmilk and safe storage are provided on all PHE premises.

Once the policies have updated, we will work with staff side representatives and other key partners across PHE to disseminate the new guidance and ensure that PHE employees are able to take full advantage of the facilities available to them to continue to breastfeed.

Objective 7: Ensure we have a motivated and engaged workforce who live our behaviours and respect each

Key accomplishments:

- successful involvement of staff in shaping the PHE People Charter Framework
- refreshed PHE staff induction process, incorporating sessions on equality and health inequalities duties

Earlier in this report we set out the activity of our staff diversity networks. In addition, in 2016, 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 *People Charter Framework, How we work together to achieve more* sets out the core values and behaviours that define 'how' we are expected to approach our work and interactions with others and sits alongside 'what' we do as outlined in our remit letter, our mission and purpose and our operating plan. The framework details the behaviours and attitudes required by all staff and it supports the delivery of our operating plan and development of our culture.

We have responded to feedback from staff and updated PHE's induction processes ensuring that new staff of all grades and backgrounds are welcomed into our organisation by our most senior leaders, provided with the necessary information and are familiar with our legal duty and the role they can play.

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 began this important process of refreshing and consulting on our equality objectives for the next period 2017-2020, in partnership with Strategic Partners and Equality Forum. Throughout the development phase, we engaged both with PHE staff and a variety of external stakeholders.

The views and feedback from engagement with PHE workforce and the external engagement has been taken into account to inform the development of the final set of objectives and convey ambition whilst remaining achievable and measurable. The new equality objectives have been approved by PHE's Health Equity Board and received final endorsement by the Management Committee. The progress on the new set of objectives will be reported annually through the PHE Equality duty report available on our website from 2018.

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

Workforce equality

PHE HR and workforce teams have identified a number of areas for development over the course of the year. They include:

- continuous benchmarking for achieving best practice across all sectors through Race for Opportunity Benchmark, Stonewall Workplace Index and quarterly reporting against NHS Workforce Race Equality Standards (WRES)
- launch of internal mentoring circles for identified targeted groups, including senior women and isolated LGBT staff
- review of childcare provision across all 74 PHE sites
- launch of diversity confidence in leadership communication campaign, in partnership with executive diversity champions and NED representation. We will further develop confidence training, bespoke advice and guidance and communication programmes to support diversity of faith groups

- campaign launched with identified universities to include diversity and staff inclusion and staff health and wellbeing modules in every undergraduate and postgraduate course in the UK.

For our products and services

- in 2015, we have set out a structured framework for action across PHE to reduce health inequalities. It established a clear direction for enabling the organisation to fulfil its legal duties related to health inequalities and equalities, including elimination of discrimination and promotion of inclusion. In 2017, we aim to review the framework for PHE action on health inequalities which takes into account the importance of protected characteristics in line with Equality Act 2010. The review of the framework will provide an opportunity to review progress made to date, and most importantly ways to strengthen PHE's support to the health system to reduce health inequalities and fulfil its legal duties related to health inequalities
- we will identify how best to monitor and drive focus equality and diversity through our corporate business planning and reporting processes that results in impactful action

Annex 1: PHE Health Equity Board Members

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

Secretariat

Name	Job Title/Role	Organisation
Donna Carr,	Head of Health Equity Unit, Health Equity and Mental Health Division,	PHE
Chloe Johnson	Public Health Manager,	PHE

	Health Equity and Mental Health Division	
Lina Toleikyte	Public Health Manager, Health Equity and Mental Health Division	PHE
Claire Laurent	Public Health Manager, Health Equity and Mental Health Division	PHE

Annex 2: Our seven equality objectives

Equality objective 1: Public Health England 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 Public Health England 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.