Public Health England

Protecting and improving the nation's health

Equality in Public Health England

How we met the public sector equality duty in 2018

About Public Health England

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

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Contents

Introduction

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

The equality duty

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

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

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

The protected characteristics covered by the equality duty are:

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

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

- publish information to show their compliance with the equality duty
- set and publish equality objectives, at least every 4 years

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

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

Equality objectives are presented below.

PHE equality duty objectives published in February 2017

Aim 1: Supporting the health system

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

Objective 1.1 Research and intelligence

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

Objective 1.2. Advice to the system

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

Objective 1. 3. Promoting equality through programmes

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

Aim 2: Engaging and developing PHE staff

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

Objective 2.1: Diversity and staff inclusion

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

Objective 2.2: Workforce composition

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

Objective 2.3: Talent management

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

Objective 2.4 Staff engagement

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

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

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

The 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. PHE has developed a separate Framework for Action on Health Inequalities, which aims to ensure that PHE supports the health system to reduce health inequalities and fulfils its legal duties related to health inequalities.

Contents of this report

This report describes the progress we have made since the publication of How We Met the Equality Duty in 2017, highlighting key achievements and activity towards fulfilling our equality objectives.

Actions to fulfil our equality objectives 2017 to 2020

Aim 1: supporting the health system

Background

In PHE we aim to maximise opportunities to become more ambitious in our approach to creating a more diverse, and diversity aware workforce, and promote equality and fairness in the way we design or deliver products and services. In 2017 we published a new set of PHE equality objectives 2017 to 2020, in line with statutory requirements to refresh objectives at least once every 4 years.

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

As equality is at the heart of all our work, the equality objectives also relate to our priorities and effective delivery of key programmes of work.

Objective 1.1 Research and intelligence

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

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

In 2018, we undertook a range of activity and published evidence and intelligence relating to groups that share protected characteristics. Progress on our early deliverables and additional initiatives is shared below.

Deliverable 1

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

PHE’s Health Profile for England 2018 report gives a comprehensive picture of the health of the population. It includes a chapter on health inequalities which reports indicators such as life expectancy and healthy life expectancy by level of deprivation and sex. It also reports outcomes by other protected characteristics such as childhood excess weight and common mental health disorders by ethnic group, and smoking prevalence by sexual orientation. Other chapters present inequalities in the health of children and in the wider determinants of health. Many outcomes are reported by level of deprivation or other indicators of socioeconomic status, and some are reported by protected characteristics, such as employment by ethnic group and disability status, and loneliness by sex and age.

The Health Profile for England was accompanied by the launch of PHE’s Health Equity Dashboard, an interactive tool developed to present evidence for the key indicators being used by PHE to monitor progress in reducing inequalities. The dashboard includes outcomes by deprivation and selected protected characteristics, such as smoking prevalence by sexual orientation, childhood excess weight by ethnic group and employment rates for people with a long-term health condition.

Deliverable 2

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

The following are some examples of work by PHE in 2018 to provide data and intelligence to help understanding of inequalities in health outcomes for different populations in England, including groups that share protected characteristics.
During 2018, PHE supplied data to the government’s Race Disparity Audit, providing key indicators presented in the Ethnicity Facts and Figures website.

A recent national report on women’s health and risk factors in early pregnancy, included breakdowns where possible of all key factors by age, ethnicity and deprivation of area of residence of the mother. This is being updated this year and in the long term we will develop indicators to monitor these, including consideration of inequalities and variation.

In a similar way, we have done some initial work to look at inequalities in early childhood development, looking at the domains of early development by sex and by

deprivation of residence. Again, the long-term plan includes indicator development to allow us to routinely monitor these. New digital standards for child health are being developed, and we have an advisory role. We have taken the opportunity to include more background information on protected characteristics and vulnerable groups.

We currently provide inequality breakdowns at national level for the following older people related indicators in the Public Health Outcomes Framework:

- health related quality of life for older people (ethnicity, gender, religion/belief, sexual orientation, area deprivation)
- hip fractures in older people (gender, area deprivation)
- excess winter deaths in older people (gender, area deprivation)
- preventable sight loss - age related macular degeneration (area deprivation)
- estimated dementia diagnosis rate in older people (area deprivation)

Many other indicators in the Public Health Outcomes Framework are provided with breakdowns by dimensions of inequality, and these are signposted from the tool's home page (under Recent Updates).

PHE is in the process of developing a new tool – the Productive Healthy Ageing Profile - to replace the current Older People's Health & Wellbeing Profile, with the first version to be released early April 2019.

Unlike the current tool, the new tool will display inequality breakdowns and we intend to develop further indicator inequality breakdowns over time.

Deliverable 3

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

An online resource, "Finding the evidence: health inequalities, equality and diversity" has been produced to help professionals across the public health landscape search for the best available evidence on inequalities, equality and diversity. This includes details of UK and international information sources, research support and learning resources as well as guidance on searching the literature to identify current and relevant evidence on reducing inequalities and assessing impact on specific protected groups.

Deliverable 4

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

In 2018, PHE continued to work with health and related research funders to specify that their funded research consider its impact on those with protected characteristics, for example, when trialling new interventions. We have also supported strategic research and evidence initiatives to fill knowledge gaps and inform public health approaches for specific groups that share protected characteristics.

Objective 1.2. Advice to the system

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

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

Deliverable 1

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

This programme is specifically aimed at ensuring our system partners lead the way on expanding the knowledge and intelligence evidence base with all members of society, but specifically the disadvantaged in society and those people with protected characteristics, such as those with a disability, older people, the young etc. In 2018, the All Our Health resources had 189,537 unique views and social shares. The achievements of All Our Health in 2018 include:

Establishing a partnership with Health Education England to develop a suite of interactive e-learning resources to further engage health and care professionals with the All Our Health content.

Formed relationships with 25 academic institutions to embed All Our Health within the curricula for health and care professionals.

Promotion of the All Our Health framework through a new animation, articles, journals, blogs, lecturing, professional event attendance and planning for an All Our Health WeLearn to use social media to increase engagement with health and care professionals.

Deliverable 2

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

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

The aim of the programme in 2018-2019 is to work as One PHE together with national and local partners to deliver a nationwide community centred and asset-based approaches programme.

The objectives are:

i. Leadership across the system – provide a clear mandate and coordination across sectors and between national with local
ii. Evidence & knowledge translation – improve intelligence & evaluation, build the evidence base & dissemination
iii. Implementation support – build good practice and commissioning; integrate community-centred approaches into public health
iv. Capacity building – build capability in community-centred approaches across the public health and wider workforce

During 2018 the work programme on community-centred approaches became embedded into PHE's health inequalities team. All of the work is now explicitly aiming to reduce health inequalities and key projects and products are aligned. The cross-directorate working group has been strengthened to engage all parts of the organisation in adopting community-centred approaches to reduce health inequalities.

The programme has continued to support delivery of evidence-based practice in community-centred approaches through providing leadership and improving knowledge and skills. A new narrative on reducing health inequalities through community-centred approaches was disseminated through PHE's Health Matters. This has helped to engage a wide range of organisations and professionals in adopting a shared approach and the launch webinar successfully involved a record number of participants. PHE's annual conference further engaged leaders and practitioners from the statutory, voluntary and community sectors in sharing and stimulating best practice through a number of workshops and discussions.

Examples of approaches that improve outcomes for people experiencing inequalities/ with protected characteristics have been expanded in our collection of Practice Examples available through PHE's online knowledge and library service. Examples of local work demonstrate the benefits of community-centred approaches to people's health and wellbeing. Outcomes include reducing social isolation amongst older people, improving maternity services for refugees and asylum seekers, increasing physical activity amongst girls and improving inclusion and participation of people with mental health problems.

The next stage of work recognises that health inequalities won't be reduced unless this work is done at scale. Research has been undertaken to understand the principles and requirements of whole system approaches to community-centred public health.

Objective 1. 3. Promoting equality through programmes

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

In 2018, we continued to strengthen focus on embedding and promoting equality in our programmes and functions, with examples given in this report. Moreover, we refreshed PHE's induction processes ensuring that new staff of all grades and backgrounds are welcomed into our organisation by our most senior leaders, provided with the necessary information and are aware of the role they can play.

Deliverable 1
'Improve access to HIV testing in populations most at risk to reduce the proportion of individuals living with undiagnosed HIV'.

The national HIV Prevention and Sexual Health Promotion programmes aim to improve the sexual health of the country. HIV Prevention England, a consortium led by Terrence Higgins Trust, promotes routine and regular HIV testing in most at risk populations (that is, men who have sex with men and black African communities) across the life course.

Campaign activity is focused in National HIV Testing Week (NHTW). Since 2016, NHTW successfully reached target audiences including being linked to the delivery over 80,000 self-sampling kits and an external independent evaluation reported very high levels of both reach and cut through[1]. NHTW 2018 began in November and an evaluation of its impact will be published by early 2019/20.

Complete data on the activity of the national HIV self-sampling service in England is currently available to all local authorities signed up to the service. This data includes uptake on the service as well as reactive results organised by ethnicity, gender (including transgender), sexual orientation, and age. A complete report of the first two years of the service has been published in 2018 to better inform local impact of the service.[2]

Deliverable 2

'Championing better health outcomes for people with learning disabilities'. The achievements in 2018 include:

- we have updated our learning disability profile which covers a range of data about the health and care of people with learning disabilities in England
- we have run monthly webinars on a range of topics relating to health and care of people with learning disabilities
- we hosted a conference co-chaired by a self-advocate as well as a series of face to face events for people with learning disabilities and those who support them exploring important health and care issues
- we have worked to improve the evidence base about paid employment and the health of people with learning disabilities. We published an analysis of employment rates and two secondary analyses about the impact on health and quality of work.
- we have added to our collection of guides about how reasonable adjustments can be made to improve access to health care for people with learning disabilities
- reports about the self-reported behaviours of young people with moderate learning disabilities were published looking specifically at:
- sexual activity and sexual health
- mental health
- sport and exercise
- smoking, alcohol and drug use
- we published guidance about flu vaccinations for people with learning disabilities for health and social care professionals

[1] See: http://uk.kantar.com/business/health/2017/hiv-testing-campaign-engages-target-audiences/
[2] See: https://www.gov.uk/government/publications/national-hiv-self-sampling-service

- we have collected and will report information from local areas across the country about how well they are meeting the needs of autistic people
- we have analysed and will publish data about the prescribing of psychotropic medication to people with learning disabilities, autism or both to support NHS England's STOMP campaign, which aims to reduce over-medication

Deliverable 3
'Reduce the rates of smoking among pregnant women at time of delivery'.

Rates of maternal smoking, as measured by smoking at time of delivery, have plateaued somewhat in recent years and currently sit at just under 11% (10.5%, Q2 2018/19) . There are also significant variations, geographical, by socio-economic status and by the age of the pregnant woman. PHE helps to co-ordinate a range of stakeholders (NHS, Local Government, charities, among others) to maintain focus on this agenda, to identify and cascade good practice, to improve referral pathways into specialist support to quit smoking, and to develop new resources which will help localities to address this issue more effectively.

The Tobacco Control Plan for England (July 2017) set an ambitious target of reducing smoking amongst pregnant women to 6% or less by the end of 2022. The Secretary of State has also set an ambition to reduce the rate of stillbirths, neonatal and maternal deaths and brain injuries by 50% in England by 2025 (with a 20% reduction by 2020).

Sustained system-wide action is required to address the issue of smoking during pregnancy and there are programmes of work underway at national, regional and local level, all based on NICE guidance. The Tobacco Control Plan for England and the Delivery Plan, commit to a range of actions for Government agencies and other partners. A joint action plan has been produced, led by PHE and incorporating activity underway for NHS England, NHS Improvement, Health Education England and PHE. Increasing the number of women having a smokefree pregnancy is a key priority for the NHS Maternity Transformation Programme and PHE lead the *Improving Prevention & Population Health* work stream working across the MTP to embed actions to increase the number of smokefree pregnancies. The NHS Long Term Plan also includes action to improve the provision of stop smoking support for pregnant women and their partners. PHE and NHS England will be working collaboratively to develop a plan for piloting and rolling out this programme.

We continue to work with partners to develop training resources and materials for healthcare professionals working with pregnant women, particularly around raising the issue of smoking, assessing exposure to Carbon Monoxide and having brief meaningful conversations.
Ongoing and future work that PHE is engaged in includes working with NHS England to pilot action on new pathways for expectant mothers and partners, as stated in the Long

Term Plan, supporting implementation of the Saving babies lives care bundle, which includes an element on smokefree pregnancy and developing/cascading new training opportunities. Over the next year, PHE plan to produce an over-arching prevention pathway, spanning the preconception period and pregnancy, bringing together the evidence and support for action on smoking and other risk factors to support professionals working with parents. Work also continues with the Smoking in Pregnancy Challenge Group, this year with a focus on support for Local Maternity Systems, local smokefree champions and new resources for Health Visitors and other early years practitioners working with pregnant women and families.

Deliverable 4

Reducing inequalities in oral health: Evidence into Action

PHE aims to publish analyses a report outlining inequalities in oral health in adults and children and in availability, access and outcomes of oral healthcare service in England. The report explores inequalities by socio-economic position, protected characteristic and other vulnerable groups. The report will inform equality impact assessments and provide a baseline against which the impact of oral healthcare reform may be measured.

We plan to publish the report in 2019 and it will also inform the work of our Adult Oral Health Oversight Group which will lead our work with key stakeholders to reduce inequalities in oral health of adults.

A rapid review of barriers to urgent dental care

A rapid review of barriers to urgent dental care was completed and is due to be published in March 2019. The review considered access and need to urgent dental services for vulnerable groups and people with protected characteristics.

The evidence was used to inform the development of an NHS England commissioning standard for urgent dental care, which was co-written by PHE. The commissioning standard includes reference to people with protective characteristics and vulnerable groups who are likely to have greater need for urgent dental care to ensure they have equitable access to urgent dental services.

The work has been accepted for publication in the British Dental Journal.

Commissioning better oral health for vulnerable older people

PHE has produced resources to support commissioners to improve the oral health of vulnerable older people. This includes an evidence-informed toolkit for local authorities:

Commissioning better oral health for vulnerable older people

This toolkit is designed to support commissioners improve the oral health of vulnerable older people in all settings. It gives an overview of the impact of oral diseases in vulnerable older people, the evidence on what works to improve oral health in this group and advice to commission services to improve oral health. The toolkit is supported by a rapid review of the evidence and a resource compendium.

The rapid review provides evidence on which targeted oral health improvement programmes local authorities could commission in addition to integrating oral health improvement and mouth care. This work will inform the work of our Adult Oral Health Oversight Group which will lead our work with key stakeholders to reduce inequalities in oral health of adults.

The report of the 2016/17 survey of oral health of 5-year-olds focused on the large inequalities between deprivation groups, ethnic groups, and geographic location. https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2017

Publication of a report using dental epidemiological data to identify higher risk local authorities and trends of improvement or deterioration to inform focused action where it is most needed.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/707179/Local_authority_area_variation_in_the_oral_health_of_five-year-olds.pdf

The water fluoridation health monitoring report for England specifically looked at the impact on inequalities of this health promotion intervention. It showed the improvement in oral health in fluoridated areas reduced inequalities in deprived areas.

https://www.gov.uk/government/publications/water-fluoridation-health-monitoring-report-for-england-2018

Aim 2: Engaging and developing PHE staff

Diversity and Staff Inclusion

Diversity and Staff Inclusion is embedded into PHE organisational policies, practices and work areas the organisation including HR Corporate Services, learning and

development, recruitment and pay and pensions. A number of initiatives have been developed to drive and further enhance diversity and inclusion in PHE.

Leadership and governance

PHE directors are accountable to Duncan Selbie, CEO, for the subsequent actions taken by their senior management teams in tackling any identified inequalities. PHE has national executive diversity champions who provide leadership on specific protected characteristics. Over the course of the year, the diversity champions act to provide senior accountability for delivery of the workforce diversity plan and are instrumental in supporting a number of diversity and inclusion activities.

PHE has set up a staff diversity and inclusion forum that aims to meet monthly. The staff diversity and inclusion forum has been created to provide a safe, open and inclusive platform for diversity and inclusion issues within the business.

Staff diversity networks

PHE is proud to have increased its staff diversity activity. The staff diversity networks have played an active part in creating and developing our culture and have facilitated collective learning and development opportunities, holding events attracting high profile internal and external speakers, in addition to engaging positively with their members across PHE.

Diversity data

Diversity declaration rates are steadily improving although around a quarter of staff choose not to disclose their religion and /or belief, disability and sexual orientation. Improving organisational diversity declarations remains a key focus for PHE in the coming year.

Diversity dashboard

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

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

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

Awards and benchmarking

PHE gained Disability Confident Leader status in 2018 with support from the Disability Staff Network.

PHE has been recognised nationally for its flexible working, achieving Top 30 Employer status for Working Families 2017. PHE was also awarded a place in the Top 100 Employers Index by Race for Opportunity in 2018.

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

Talent management

In 2018, PHE continued to support staff to achieve their potential through targeted mentoring and coaching schemes. We have successfully implemented external and internal mentoring schemes for BAME (Black, Asian, Minority Ethnic) staff and this year 10 staff have been successful in obtaining a place on the Race for Opportunity cross-organisational mentoring programme. They will join other private sector and public sector staff in mentoring circles to learn, develop and network with other BAME professionals in an action learning environment.

PHE will be exploring how to develop mentoring circles with colleagues in the Department of Health and Social Care and the Medicines and Healthcare Products Regulatory Agency. We will also consider whether we are able to introduce a reverse mentoring scheme.

Outreach programme

In 2016, PHE initiated a Project SEARCH transition to work programme at its Colindale site. The programme supports young adults, aged between 16 and 25, with learning disabilities and autistic spectrum conditions to gain work-related skills as part of their last year of education. PHE has offered placement opportunities to provide valuable work experience across three rotational work placements, covering roles ranging from site operations and customer service to laboratory work and media production. Four of the students have been appointed to posts within PHE. The third cohort of students commenced in September 2018.

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

PHE's involvement in the industry-led Movement to Work Scheme continues as does our work with Ambitious About Autism.

Recruitment

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

Training

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

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

Policy and procedures

In November 2018, PHE relaunched its Workplace Adjustment Passport together with 31 guides aimed at helping managers and staff identify reasonable adjustments for psychological and physical health conditions.

The passport captures an accurate record of an individual's workplace adjustment that could be carried forward with the staff member if they moved to another team or another Civil Service department.

PHE staff characteristics

This section presents data on protected characteristics among PHE staff. Figures are based on a headcount total of 5,428 members of staff as of 30 November 2018. Statistics are drawn from the PHE Human Resources and Payroll system (also called electronic staff record (ESR)). The next table presents information on the proportion of staff on whom details of a particular protected characteristic are currently held.

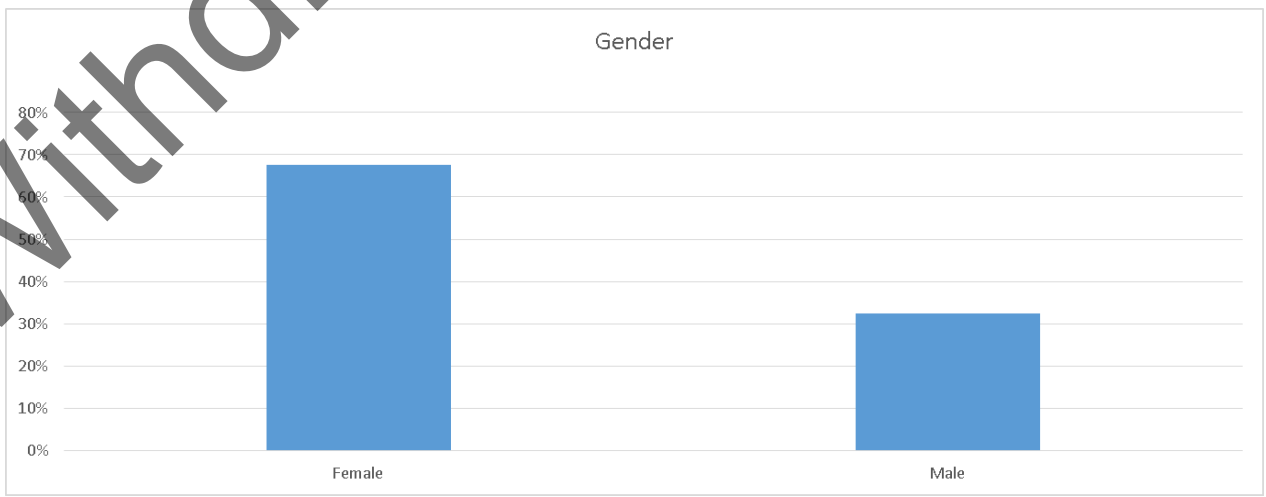
Table 1: Proportion of PHE staff declaring a protected characteristic

Percentage	November 2015	November 2016	November 2017	November 2018
Gender	100	100	100	100
Age	100	100	100	100
Ethnicity	97	96	96	97
Disability	53	57	62	64
Religion and Belief	61	65	69	72
Sexual Orientation	62	66	70	73
Total	5,324	5,308	5,355	5,428

Gender

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

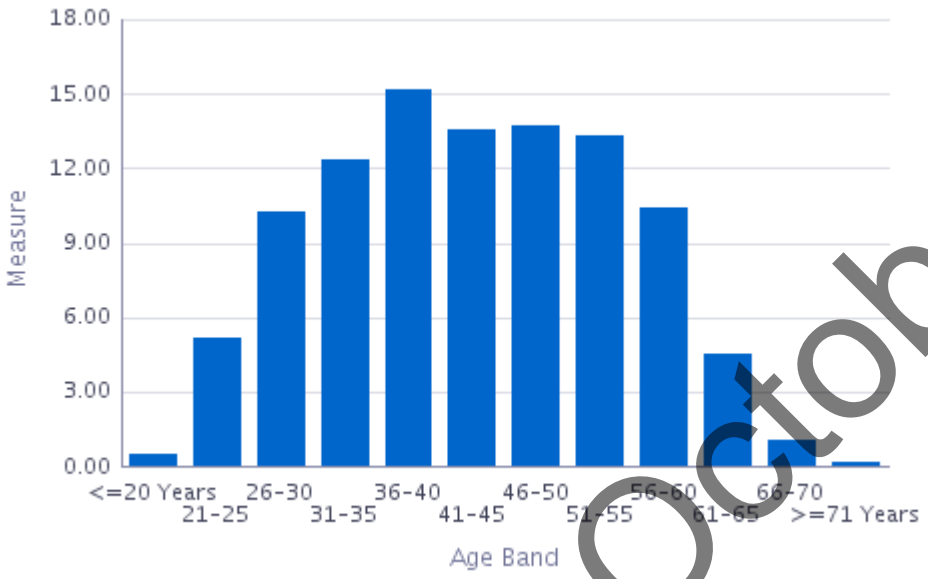
Figure 2. Gender profile of PHE staff, November 2018



Age

About half of our staff are aged 30 to 49 years, which is typical of the wider healthcare workforce. A quarter of PHE staff (24%) are aged 50 to 59 and 6% are aged over 60 years. There are few younger staff aged under 30 (16%) in the PHE workforce.

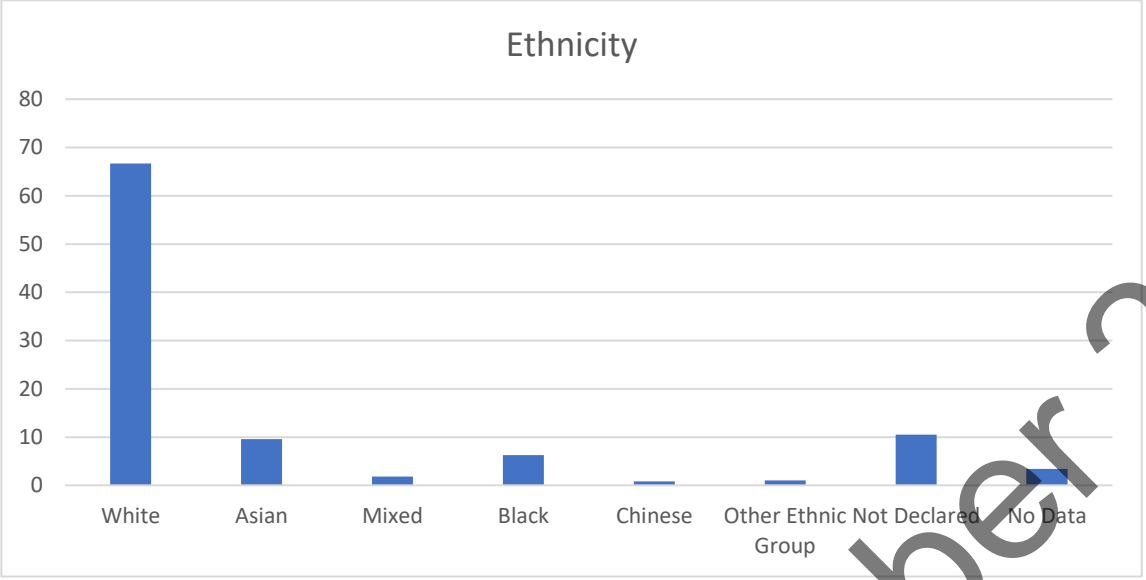
Figure 3: Age profile of PHE staff, November 2018



Ethnicity

Figure 4 shows that 67% of PHE staff describe themselves as white. The next largest ethnic group is Asian/ Asian British (10%), followed by Black/Black British (6%). There are very small proportions of staff who report mixed ethnicities, from Chinese or other ethnic minority backgrounds. These patterns are likely to vary across regions reflecting local population profiles by ethnic group, from which the PHE workforce is drawn. Around 11% of staff members have chosen not to disclose their ethnic group.

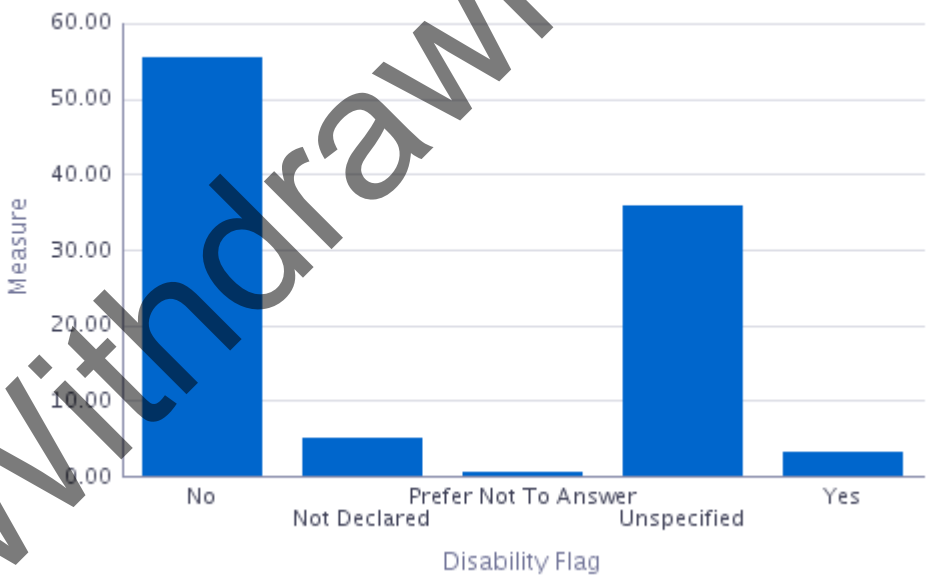
Figure 4: Distribution of PHE staff by ethnic group, November 2018



Disabilities

Around 3% of all PHE staff have made a positive disability declaration. Work is underway with the Disability Staff Network to explore how we improve disability-related information in the coming year.

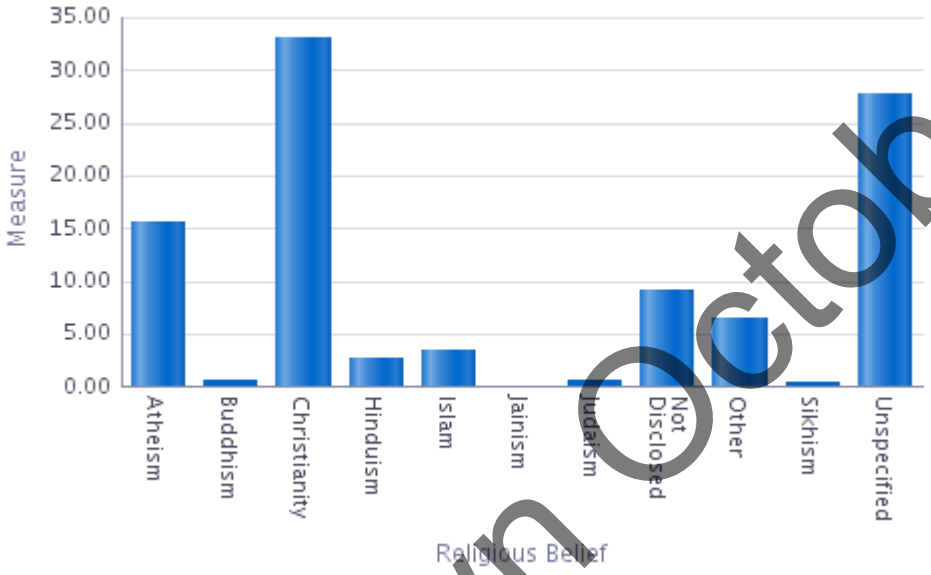
Figure 5: PHE staff by disability status, November 2018



Religion and belief

Data on the religion and belief held by staff is shown in Figure 6. Christianity is the most commonly reported religion among PHE staff (33%); the next largest group is those who report being atheists (16%). There are similar proportions of staff who report that they are Hindu (3%) or Muslim (4%). All other religions are reported by less than 1% of staff, while 9% have chosen not to disclose any religion or belief (not declared or 'prefer not to say').

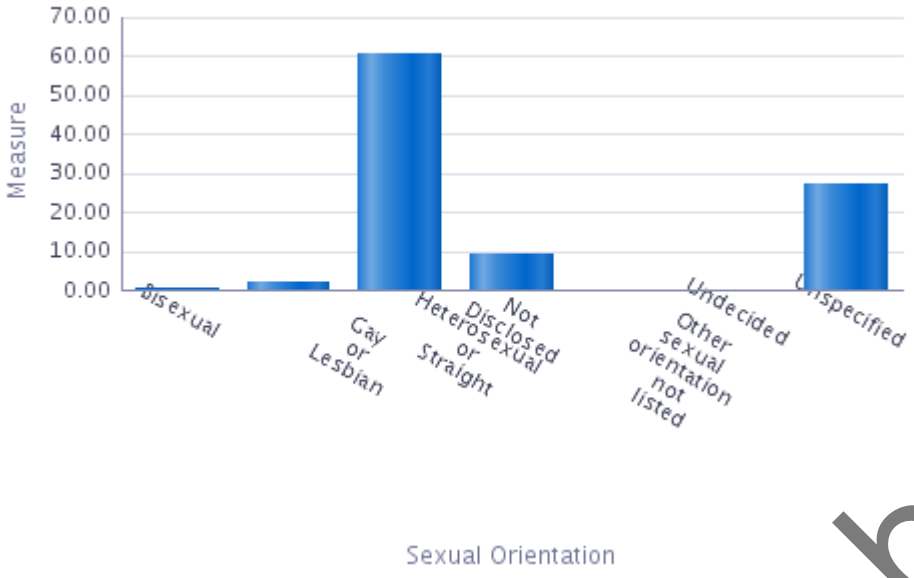
Figure 6: Religion and belief profile reported by PHE staff, November 2018



Sexual orientation

Information about the sexual orientation of PHE staff is available for 73% of the workforce, with 9% of people included in this figure not wishing to declare their sexual orientation. A majority of staff declare themselves to be heterosexual (61%) with just below 3% of staff reporting being lesbian, gay, bisexual or transsexual.

Figure 7: Sexual orientation reported by PHE staff, November 2018



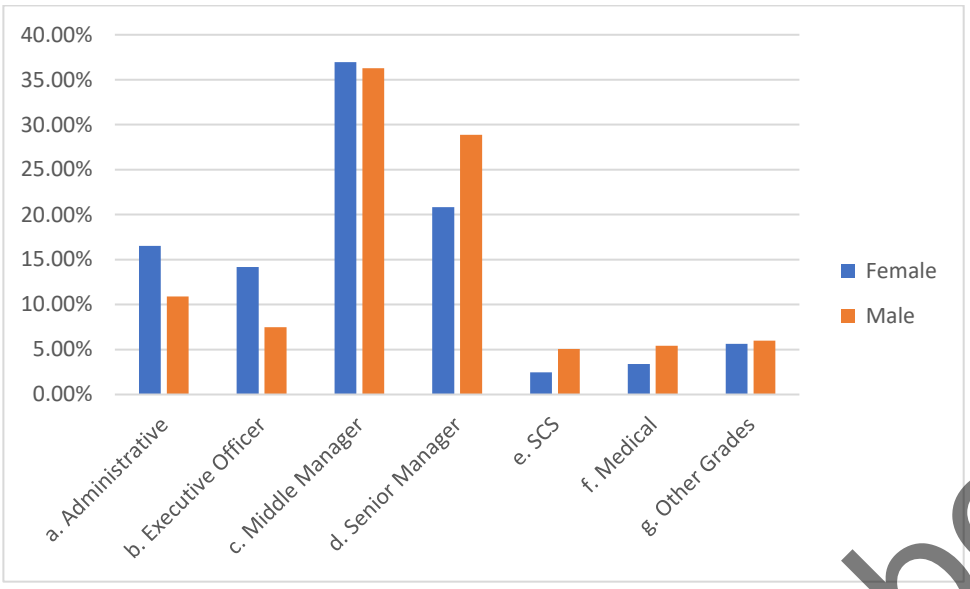
Workforce composition by grade

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 2018.

Gender analysis

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

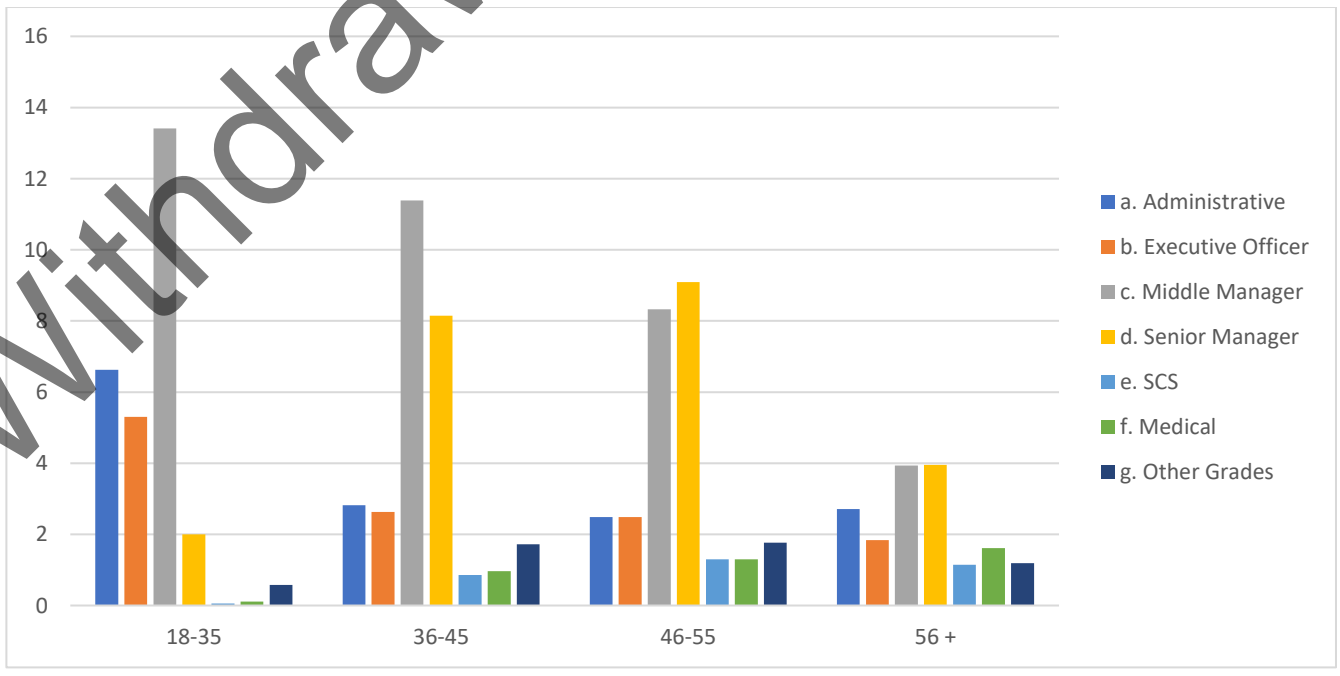
Figure 8: Workforce gender profile by grade



Age analysis

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

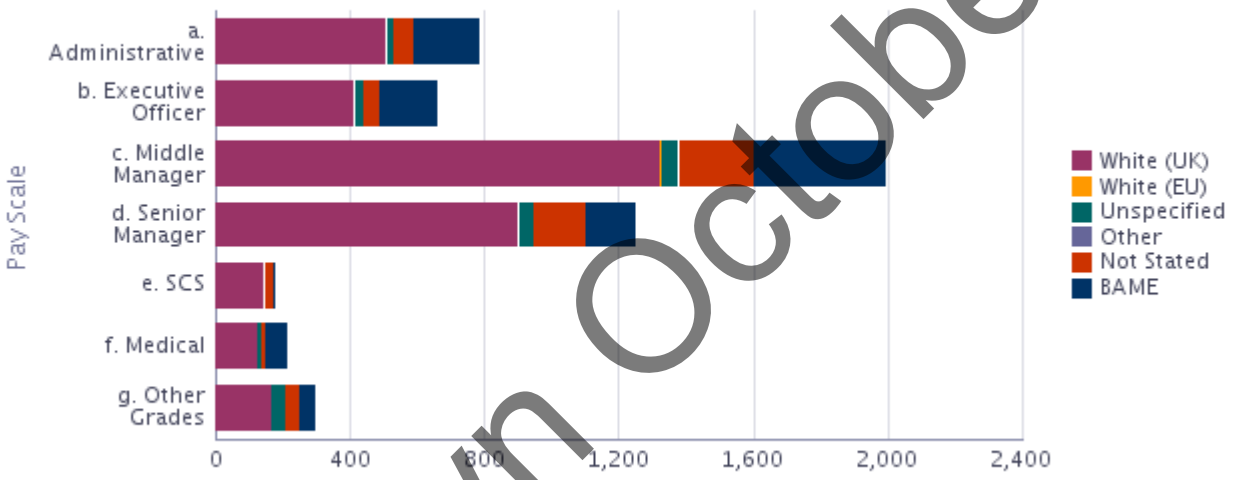
Figure 9: Workforce age profile by grade



Ethnicity analysis

In Public Health England, 67% of the workforce is White, 18% BAME. Around 11% of people prefer not to disclose their ethnicity. We do not have ethnicity information for 3% of our staff. Figure 10 illustrates that BAME staff are represented at all grades within PHE. The biggest proportion of BAME staff is represented within the middle management grade (7%). There is a lower representation of BAME staff in senior manager grade (16% of BAME staff are in senior grades compared to 30% of white staff) and less than 1% of BAME staff are employed at SCS grade compared to 2% of white staff.

Figure 10: Ethnicity workforce profile by grade



Gender pay gap

The Department of Health and Social Care Pay Gap report published in December 2018 identified a mean gender pay gap of 14.7% in PHE.

It does not mean that all men are paid 14.7% more than women for doing the same work rather the difference in average pay between men and women across all grades. It reflects the complex make-up of PHE, where women account for two-thirds of the workforce but there are also many more women than men working at lower paid grades. Additionally, there are a significant number of senior and specialist staff on pre PHE legacy terms and length of service will influence some salaries.

PHE has undertaken an analysis of the Gender Pay Gap and has looked at several factors that might have an influence such as grade, geographical location and terms and conditions. PHE has developed a strategy in response that puts in place targeted interventions, such as promoting pathways to progression within the organisation.

Next steps

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

In 2019 we will continue to build on this work and over the next year we will also focus on the following activity:

Actions to support the system

1. We will keep our deliverables under review as we move towards refreshing them in 2020.
2. We aim to update and engage senior management, Equality Champions and seek their support with the delivery of our objectives.
3. We will continue to work through our corporate business planning and reporting processes to embed a focus on inequality and diversity, and ensure sustainable and distributed ownership across PHE.
4. We will aim to increase our capacity and ability to enable effective delivery at the local level on tackling health inequalities. This will result in the provision of advice, statistics and evidence to local decision makers about the effective actions they can take to improve the health outcomes of people with protected characteristics, as well as reduce health inequalities.

Actions to support workforce equality

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

1. Continuous benchmarking for achieving best practice, working with colleagues in the Department of Health and Social Care and Medicines and Healthcare Products Regulatory Agency to understand what we can achieve together
2. Continue to increase ethnicity, disability and LGBT data declarations made through the ESR system.
3. Continue to provide work experience opportunities for individuals from under-represented groups and/or disadvantaged backgrounds
4. Implement our plans for taking action on the Gender Pay Gap
5. Continue to update and monitor the diversity dashboard
6. Evolve the staff mentoring circles for identified groups.
7. Support the staff diversity networks to grow and expand and to be used effectively as employee resource groups.