Public Health England

Annual Report and Accounts 2013/14

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

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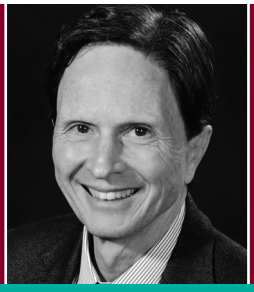


Professor
David L Heymann
CHAIRMAN

Chairman's report

In its first year, Public Health England has taken seriously its role to provide professional, scientific and delivery expertise to partners across the public health system and the population as a whole. It has combined and integrated the broad range of specialities and functions inherited from its predecessor bodies and adopted a new operating model that recognises the importance of working with, and through, its partners.

During the year, PHE collaborated with many organisations to achieve its goals of protecting and improving health, promoting health and wellbeing, and reducing inequalities in health. The extent of these partnerships – with local government, the NHS, the voluntary and community sector, universities, industry and partners overseas – can be seen throughout this annual report.

In particular, PHE has listened to local authorities about what guidance and support they need in order to fulfil their new duty to improve the health of local populations, and has geared up to provide this. A clear sign that this is a priority for PHE was given by the Chief Executive, who criss-crossed the country meeting leaders of the local public health system to build solid working relationships. These efforts are reflected in the first annual independent survey of stakeholder perceptions showing that PHE is well-regarded by its partners.

Public health encompasses not just the immediate threats to health from infectious disease and environmental hazards, but also the longer-term, determinants of health and wellbeing such as lifestyle, diet, smoking and mental health. A further component is reducing the inequalities in health that often correlate with socioeconomic factors. PHE has embraced the breadth of this work and has made organisational adjustments in order to deliver effective services and guidance.

PHE is first and foremost an evidence-led organisation that produces or sources evidence using its world-class scientific, public health and medical expertise. Freedom to follow the evidence when publishing information and advice was one of the founding principles of PHE. This was set out early on in the Framework Agreement with the Department of Health.

PHE has upheld this principle throughout its first year; it works in partnership with the Department of Health, and other government departments, but prizes its operational independence and has not hesitated to speak to the evidence, for example on plain packaging and minimum unit pricing.

As well as building relationships with our partners, it has been a year of internal change as PHE has shouldered its new responsibilities and set its priorities. The Board has worked with PHE's National Executive to develop a strong strategic direction for PHE and lay the groundwork for the new approach to protecting and improving the nation's health.

As with any transition, uncertainty and change has been an additional pressure for staff, who are the lifeblood of the organisation. Notwithstanding these challenges, the commitment of staff has been exemplary, and ensured that PHE's world-leading services have continued without loss of quality or impediment. Indeed, the organisation has made significant advances in many fields, one example being the web-based tools by which PHE disseminates information about public health in ways that make it relevant and useful to local decision-makers.

PHE is still finding its feet, but has completed its first year with uninterrupted professionalism and competence. New ways of working are being tested and lines of communication are being reviewed and refined to ensure a strong local presence and authoritative national voice. It will take time to realise the full benefits of PHE and the local public health system, but we can move forward to the next stage of development from a position of confidence and strength.

Duncan Selbie
CHIEF EXECUTIVE

Chief Executive's foreword

Smoking, alcohol, drug misuse, high blood pressure, obesity, poor diet and insufficient exercise remain the major causes of preventable illness and premature death. Infectious diseases are a persistent threat to health with the emergence of new infections and the resurgence of old ones, such as tuberculosis. Acute chemical, radiation and environmental incidents, including extreme weather events, are an additional, ever-present threat.

PHE is uniquely equipped to tackle these challenges. For the first time, health protection and health improvement have been united in one organisation with the potential to exploit the knowledge and expertise to maximum advantage in addressing the health challenges facing the nation.

We will build on the capabilities we inherited in infectious disease, screening and vaccination, disease registration, surveillance, translational research, environmental hazards and emergency preparedness and response.

Alongside health protection comes the contribution we can make to improving health and wellbeing by promoting healthier choices, supporting action to reduce inequalities and making the case for prevention and early intervention.

Local authorities have taken on their new responsibilities for improving the health of their people with great enthusiasm. This change recognises that efforts to improve people's health are better led from within communities than directed nationally. We support local authorities, the NHS and other partners by providing evidence about local health needs as well as practical and professional advice.

This report summarises the progress we made in our first year, which included working with the NHS to vaccinate the population against 16 diseases and screen for 26 conditions; supporting local authorities in commissioning NHS Health Check programmes that gave 1.3 million adults an individual assessment of the risks to their health, and handling more than 9,000 health protection issues, including outbreaks of infection and chemical, radiation and environmental incidents.

I am proud of the significant work and effort of our staff. This summary of the year can't hope to do justice to the remarkable work of so many, but I hope you will find it an interesting read.

Our priorities for the coming year are set out in our business plan, which you can find at www.gov.uk/phe.

1 Operating review

Public Health England at a glance

PHE is the expert national public health agency that fulfils the Secretary of State's statutory duty to protect health and address inequalities, and executes his power to promote the health and wellbeing of the nation. The annual remit letter from the Minister for Public Health sets out her requirements of PHE.

PHE has four core functions:

- protecting the public's health from infectious diseases and other hazards to health
- improving the public's health and wellbeing and reducing health inequalities
- improving population health through sustainable health and care services
- building the capability and capacity of the public health system

We deliver these through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services.

PHE has operational autonomy. Our freedoms are set out in the PHE Code of Conduct for staff and the Framework Agreement, which make clear that PHE must speak to the evidence and its professional judgement. The overwhelming majority of our staff are scientists, researchers and public health professionals.

PHE aims to work transparently, proactively providing government, local government, the NHS, MPs, business, public health professionals and the public with evidence-based professional, scientific and delivery expertise and advice.

PHE provides specialist health protection, epidemiology and microbiology services across England. We lead for the UK on the International Health Regulations, and this extends to playing our part in protecting the UK from international health hazards, most obviously from communicable diseases.

PHE supports local authorities in their duty to improve the public's health, and through them clinical commissioning groups, by providing evidence and knowledge of local health needs, alongside practical and professional advice on what to do to improve health and reduce inequalities, and by taking action nationally where it makes sense to do so. PHE in turn is the public health adviser to NHS England.

PHE enables the system to be held to account for its performance, for example by publishing public health outcomes data and highlighting variation in performance. PHE actively promotes the public's health, using the evidence as a challenge to local and national action and in providing the public with the information they need to take responsibility for their health.

Ultimately, we will be judged on the improvements secured in the public's health through the Public Health Outcomes Framework. We will work with the NHS to make our health system the most transparent in the world.

Our values

We know our effectiveness depends on how we behave so we will:

- consistently spend our time on what we say we care about
- work together, not undermine each other
- speak well of each other, in public and in private
- behave well, especially when things go wrong
- keep our promises, small and large
- speak with candour and courage

Priorities for 2013/14

Our Priorities 2013/14, published early in April 2013, set out five high-level priorities for our first year:

1. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol.
2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia.
3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics.
4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme.
5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives.

Supporting local leadership for healthy communities

PHE exists to serve the public through the public health system, led locally by elected members, who have responsibility for the public's health alongside inward investment, creating jobs, decent housing and resilient communities. Upper tier authorities have a duty to improve the health of their local people; county councils work in partnership with district councils, which are responsible for housing, leisure, planning and environmental health.

In our first year we established 15 local centres, each aligned with a number of local authorities and co-terminous with government regions. Each works with our national and regional specialist teams to deliver an integrated and tailored service, supporting the local system to deliver their priorities.

Each of our centres, in agreement with local partners, has developed a prospectus that sets out how PHE will support the local system in making a positive difference to the health and wellbeing of their people.



Some of our achievements in 2013/14

We **successfully managed the transition to PHE** and were fully operational in our new form, with all functions transferred safely on 1 April 2013, with no "dip" in delivery.

We published a **ground-breaking UK analysis** of the Global Burden of Disease setting out the causes of ill health and mortality in the UK and the underlying risk factors that drive them.

We handled 9,000 **health protection issues**, including outbreaks of infection and chemical, radiation and environmental incidents.

We launched the **world's largest single database of cancer**. The cancer registry provides clinical information on the 350,000 cancers diagnosed each year in England and includes 11 million historical cancer records.

Working with NHS England, we introduced **three new immunisation programmes** – to protect babies against rotavirus, children against influenza, and people aged over 70 from shingles.

Thirteen partnerships between PHE and universities won £47.5 million in Department of Health funding to set up **health protection research units**. These will focus on public health priority areas ranging from immunisation to radiation hazards. Funding will run for five years from April 2014.

We published the **first NHS Atlas of Variation in Diagnostic Services**, showing significant differences in how health conditions are identified and monitored.

Fifty per cent more smokers tried to quit during our **Stoptober campaign** than during other months of the year, according to a University College London study that said the campaign was cost-effective, saving 10,000 years of life. Stoptober was one of 20 public health awareness campaigns run by PHE.

Our **Longer Lives** website, which won first place in the "disrupting" category at the international 2014 Interaction Awards, allows local authorities to compare their mortality rates for the four most common causes of death.

The **NHS Abdominal Aortic Aneurysm Screening Programme** for all 65-year-old men was rolled out nationally on time and on budget. Early detection through the screening programme will prevent around 2,000 deaths a year.

The **NHS Health Check** programme, which seeks to reduce premature death and ill health from heart disease, stroke, kidney disease and diabetes, and raise awareness about dementia, is now being delivered in every local authority across England.

We generated over £180 million through our work, including through the **manufacture and clinical trials of life-saving medicines and vaccines**, supporting wider UK economic growth, exports and life sciences.

We launched an emergency **MMR catch-up campaign** with NHS England to vaccinate unprotected children against measles, mumps and rubella. Seventy cases of measles were confirmed in the first three months (January to March) of 2014 compared to 673 in the same period of 2013.

During the **winter's floods and storms**, we provided expert health protection advice and support alongside colleagues in local government, the Environment Agency and the emergency services, and assisted in the recovery process.

Programmes of work

This section reviews progress made by PHE's five main priority programmes during 2013/14.

1. Longer, healthier lives

Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol.

NHS Health Check: This is a world-leading programme to help people live healthier lives by taking an active approach to identifying the risks to health of individual adults as they get older. Fifteen million adults in England, aged 40 to 74, are offered an NHS Health Check every five years to determine their risk of developing disease and, where a risk is identified, to support them in managing the risk through lifestyle changes or, where necessary, medical treatment.

The programme aims to prevent some of our biggest causes of premature death and disability, such as heart disease, strokes, kidney disease and diabetes. It provides an opportunity to discuss dementia with those aged 65 to 74, being the most feared condition in this age group, and includes an alcohol risk assessment.

Modelling by the Department of Health suggests the programme is cost effective, with the potential each year to prevent 1,600 heart attacks and save 650 lives; prevent 4,000 people from developing diabetes and identify 20,000 cases of diabetes or kidney disease at an earlier stage.

PHE underpins the NHS Health Check programme with leadership, advice and support for local authorities, who are responsible for delivering the programme locally as one of five public health services they are mandated to provide.

During 2013/14, the number of people receiving an NHS Health Check increased by 9.5% compared to the previous year. More than 2.8 million people were offered an NHS Health Check, with 49% taking up the offer. This is the largest number of checks since the programme started in 2009.

Achievements: To support local authorities in implementing the programme, PHE:

- strengthened the governance and scientific oversight of the programme by establishing a national advisory committee and an expert scientific and clinical advisory panel
- reviewed implementation to date, setting out priority actions and highlighting the need for a greater focus on quality, consistency, programme governance, and research and evaluation
- published guidance on information governance and data flows to help commissioners and providers of the service manage the transfer of patient data
- established a quality assurance working group, along with national quality metrics, to help local commissioners and providers focus on quality and consistency

Smoking: Tobacco is the number one cause of premature death, killing more than 80,000 people each year. PHE activity aims to cut overall smoking prevalence and, in particular, reduce the number of new smokers and prevalence among 11 to 15 year-olds and expectant mothers.

Achievements: PHE ran three high-impact campaigns to encourage smokers to quit and highlight the dangers to children of inhaling second-hand smoke. Stoptober, which has won eight industry awards, attracted 1.3 million visits to its website and 500,000 support tools were ordered. The Health Harms campaign showed dirty blood affecting the lungs, heart and brain. It prompted 600,000 web visits and 100,000 requests for support products. The harm caused to children by second-hand smoke in cars and homes was emphasised in a third campaign that achieved high rates of public recognition (see Figure 1). PHE also:

- secured funding for the National Centre for Smoking Cessation to provide training and support for stop smoking services
- encouraged local authorities to maintain investment in stop smoking services alongside broader tobacco control measures
- managed the transfer of local stop smoking services data from mandatory to voluntary collection, initiating changes to the data collection form, eg to capture information on the use of electronic cigarettes
- submitted evidence in support of plain cigarette packets to the independent review on standardised packaging of tobacco products
- worked through PHE centres to develop a toolkit to help local authorities engage with shisha users

Figure 1: TV advertising for PHE's Smokefree Homes and Cars campaign in 2013

Public Health Outcomes Framework and the Longer Lives website: PHE makes data available in accessible, relevant and meaningful ways so that local authorities, with NHS partners and others, can take action to improve health outcomes and reduce inequalities. In particular, it publishes information on premature mortality and other indicators in the Public Health Outcomes Framework (PHOF) for each local authority in England.

Achievements: PHE launched the interactive website Longer Lives to make PHOF data about premature mortality widely accessible. The website, which won an international design award, provides information about premature mortality (deaths under 75) for all English local authorities. It covers the four most common causes of death – cancer, heart disease and stroke, lung disease and liver disease. Comparisons can be made with mortality rates in areas with similar socioeconomic profiles and with national averages. The evidence helps local areas address their most pressing health problems. Councils have used the data to promote the long-term benefits of leading a healthy life. Longer Lives 2 is planned as a result of user feedback and suggestions for improvement and additional information.

The PHOF sets out key health indicators and desired outcomes for local authorities to work towards, with benchmarks for comparison against national averages. Quarterly updates of the PHOF data tool took place during the year. Baselines for new indicators were added, for example the overarching indicators on healthy life expectancy and gaps in life expectancy between communities. Definitions for the majority of indicators were finalised. A user survey was carried out and user engagement events were planned.

Integration of care: PHE works to enable better integration of care, promote prevention and early intervention, and support local innovations that offer alternatives to hospital-based care.

Achievements: To achieve better integration of health and care services, PHE:

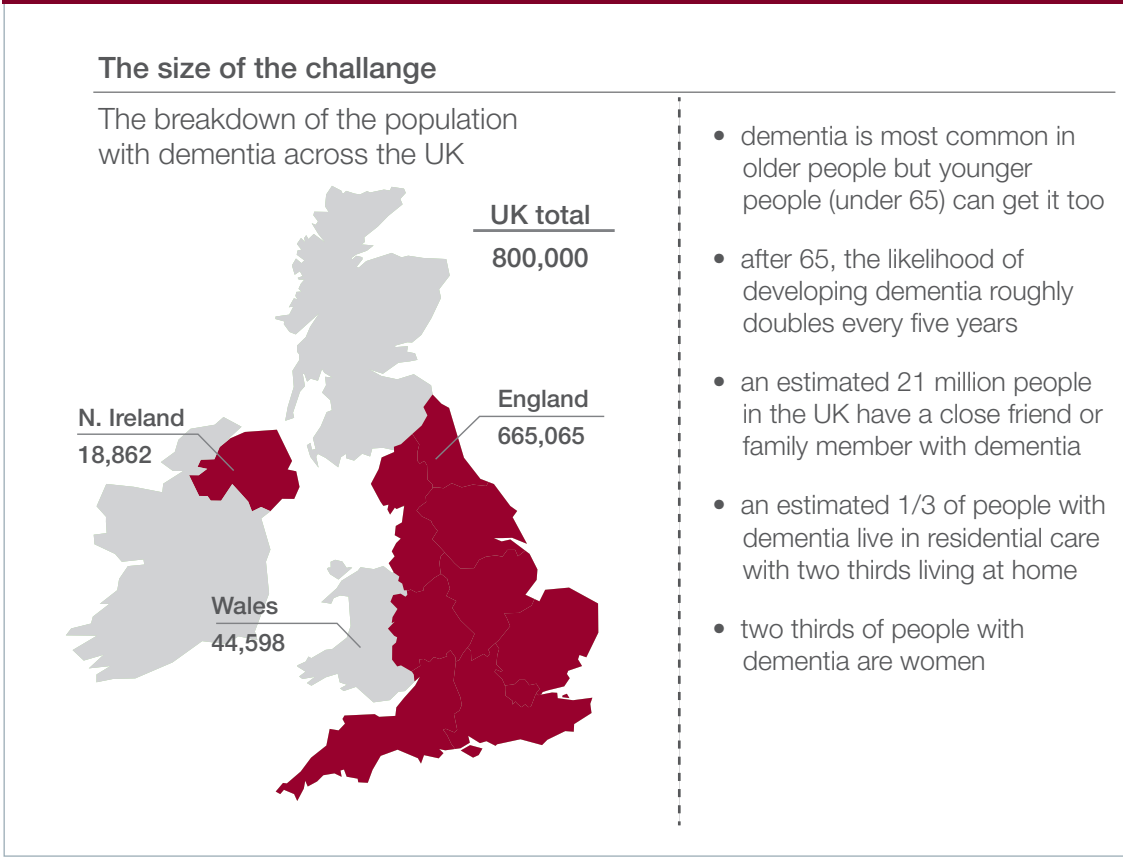
- worked with local authorities, directors of public health, NHS England and the Local Government Association (LGA) to determine how best to support local areas in designing and implementing their integration plans
- worked with NHS England and the LGA to determine how the Better Care Fund could be used to encourage local areas to integrate services, ensuring a focus on prevention and public health
- promoted the case for integration from a public health perspective by publishing evidence, rationale and examples of integration and setting out areas for future focus
- helped to broaden the definition of integration beyond acute care to include the public's health and wider determinants, demonstrating the importance of public health in realising transformational change across health and care services

2. Reducing disease and disability

Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia.

Dementia: Around 665,000 people in England have dementia (see Figure 2) and this number is set to double in the next 30 years. Some of the risk factors for dementia are the same as for heart disease and cancers, such as smoking, inactivity and poor diet. PHE is working with the NHS, local government, Alzheimer's Society and others to develop a co-ordinated national approach to reducing dementia risk, and helping people with dementia to live well.

Figure 2: Dementia in the UK



Achievements: PHE developed the Dementia Friends social marketing campaign, in partnership with Alzheimer's Society, to change attitudes to dementia and foster dementia-friendly behaviour in communities. The campaign aims to make people more aware, confident, accommodating and understanding of people with dementia. In addition, PHE:

- commissioned the UK Health Forum (UKHF) to explore ways to integrate the prevention aspects of dementia policy and practice with other non-communicable diseases
- held an expert summit with UKHF to inform the development of an integrated prevention agenda for dementia, and joined 58 othe organisations and experts in signing the Blackfriars Consensus Statement on dementia risk reduction
- worked with partners to develop a model of best practice to help commissioners deliver high-quality, post-diagnosis support to people with dementia and their carers

Mental health and wellbeing: Mental health problems, including depression and anxiety, are major causes of long-term disability. PHE is developing a mental health programme to promote good mental health, prevent mental health problems and suicide, and improve the wellbeing of those living with and recovering from mental illness.

Achievements: PHE has:

- raised awareness of mental health and wellbeing through marketing campaigns. *How Healthy Behaviour Supports Children's Wellbeing* was published as part of the Change4Life's back-to-school campaign in 2013
- produced summaries of evidence to help local areas commission evidence-based interventions that improve mental health and wellbeing
- with the NHS, developed an action plan to improve the physical health of people living with mental health problems and reduce premature mortality. This will increase access to interventions such as smoking cessation projects, physical health checks and other public health programmes
- developed a National Mental Health Intelligence Network (MHIN) in partnership with NHS England to bring together authoritative information, research and best practice about mental health
- developed an initial public health workforce plan to build capacity, capability and leadership in wellbeing and mental health, giving strategic direction for developing the competence of public health specialists and the wider workforce

Drug recovery: Rates of recovery among problem drug users were improving, but reached a plateau in 2012/13. To help people overcome drug dependency, PHE supports local authorities in the commissioning of recovery services – providing information, expertise and best practice.

Achievements: PHE has:

- prioritised 54 local authority areas for intensive diagnostic and support work to improve recovery and representation rates. Early signs indicate that focused support can help localities deliver better outcomes
- trained local areas and drug recovery providers to use PHE's recovery diagnostic toolkit, which provides bespoke analysis of those in treatment and can help to improve outcomes
- conducted a review of recovery progress, led by PHE's independent drug recovery adviser

- published annual drug treatment statistics, including the report *Drug Treatment in England 2012-13*
- worked to increase the number of areas that foster effective links between treatment services and mutual aid groups

Alcohol: More than one in five adults in England, or nine million people, regularly drink alcohol at levels that could damage their health and more than 20,000 people die from alcohol-related causes each year.

Achievements: During its first year, PHE:

- provided tools and data to allow local areas to measure alcohol-related harm and plan evidence-based responses to alcohol misuse
- supported the Home Office programme to establish 18 Local Alcohol Action Areas in England that will explore new ways of tackling alcohol-related harm
- helped to implement the alcohol risk assessment in the NHS Health Check for people aged 40 to 74
- made clear our professional assessment that the introduction of a minimum unit price would reduce alcohol-related harm, particularly in relation to those most at risk

HIV, sexual and reproductive health: PHE aims to reduce the prevalence of HIV and improve sexual and reproductive health by working with partners to deliver more effective services and raise awareness about the risks of sexually transmitted infections.

Achievements:

- PHE published summaries of evidence to help local areas increase chlamydia diagnoses in 15 to 24 year-olds and reduce the number of people presenting with HIV at a late stage
- to help local authorities sustain the reduction in under-18 conception rates, PHE published data summaries of local authority progress and ward atlases to inform targeted prevention
- a draft strategic framework was developed to improve HIV prevention and sexual health among men who have sex with men (MSM), with the goal of reversing the upward trend of HIV infections in MSM by 2020
- to support local authorities, a framework was developed to integrate sexual health information and data. This will allow performance to be measured on a wider range of metrics and facilitate integrated HIV and sexual health commissioning

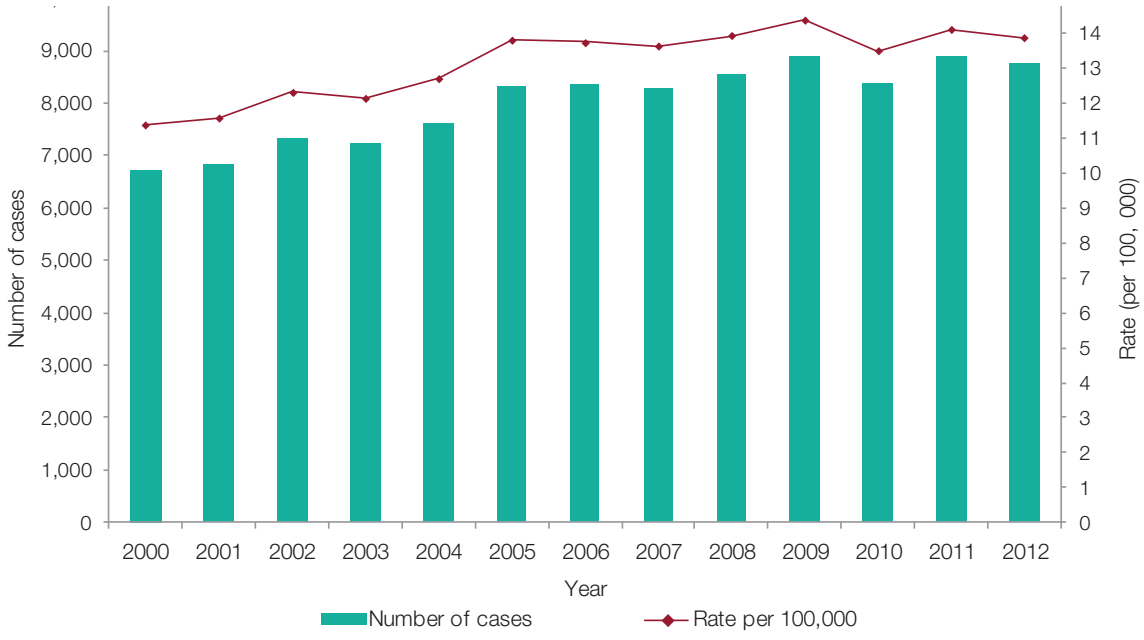

3. Protecting health

Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics.

Tuberculosis: Despite considerable efforts to improve TB prevention, treatment and control, the incidence of TB in the UK remains high compared to most other Western European countries, with 8,751 cases reported in 2012, an incidence of 13.9 per 100,000 population (see Figure 3). To reduce the incidence of tuberculosis, PHE is leading the development of a collaborative tuberculosis strategy – bringing together best practice in clinical care, social support and public health. PHE will develop national indicators to monitor the success of TB control activities.

Achievements: PHE established a National TB Oversight Group (including local clinicians, directors of public health, NHS England, the British Thoracic Society, TB Alert, the National Institute for Health and Care Excellence and local government) to develop a collaborative TB strategy and strengthen TB control. The strategy will have clear lines of accountability, prioritising high burden areas and under-served populations. PHE will conduct local service reviews, identify evidence-based interventions and monitor achievements against national standards.

Figure 3: Tuberculosis case reports and rates in the UK, 2000 to 2012



Source: Enhanced Tuberculosis Surveillance (ETS), Enhanced Surveillance of Mycobacterial Infections (ESMI), Office for National Statistics (ONS). Data as at July 2013. Prepared by TB Section, Centre for Infectious Disease Surveillance and Control, Public Health England.

In addition:

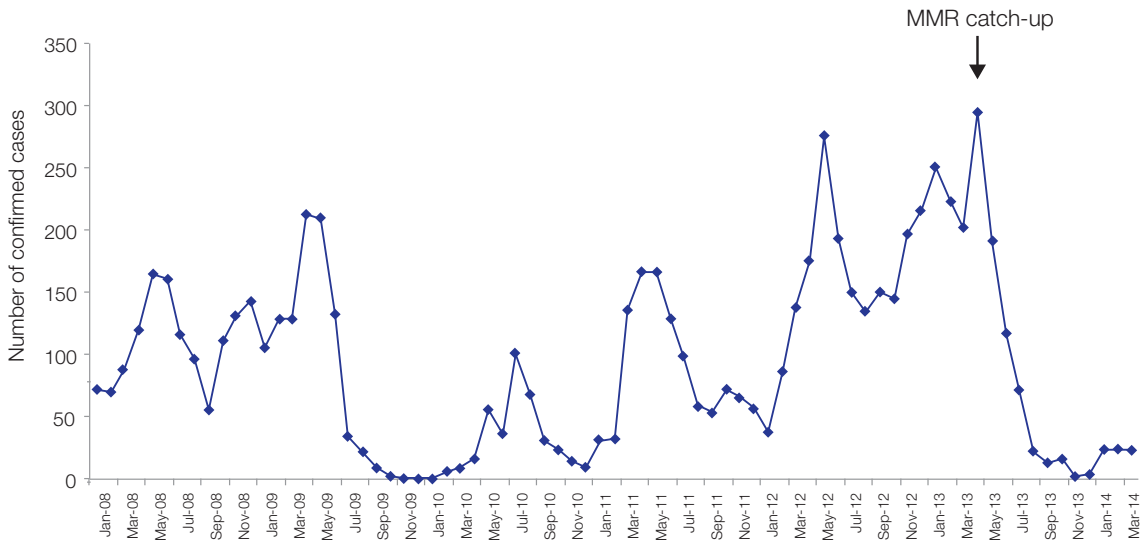
- the London TB Control Board developed indicators to underpin TB health profile reports for local authorities and clinical commissioning groups about TB issues in their catchment
- an evaluation of the National Tuberculosis Strain Typing Service (which assists in the rapid identification and control of TB cases) outlined ways to improve the service and these measures are now being acted on
- PHE worked with the Home Office to introduce pre-entry TB screening for immigrants from countries with high rates of TB

Vaccination: The UK has one of the best immunisation programmes in the world and is at the forefront of introducing new vaccines to prevent disease and save lives. PHE ensures high coverage of safe, cost-effective vaccines by monitoring the uptake and impact of vaccines, providing advice and guidance, and contributing expertise and analysis to inform national policy.

Achievements: During the year, PHE delivered an MMR catch-up programme to reverse an increase in cases of measles and worked with partners to introduce three new vaccine programmes to protect babies against rotavirus, children against influenza, and people aged over 70 from shingles:

- the MMR catch-up programme was launched in April 2013 to vaccinate unprotected children against measles, mumps and rubella. PHE epidemiologists worked with local screening and immunisation teams to target those children who were unprotected or not fully protected against measles, through schools, GPs and other community settings. Only 70 cases of measles were confirmed in the first three months of 2014, compared to 673 in the same period of 2013
- vaccination of pensioners aged 70 and 79 against shingles began in September. By the end of April, around 55% of the target population had received the vaccine
- roll-out of a universal childhood influenza vaccine programme commenced in September, using a highly effective nasal vaccine. This programme has the potential to interrupt transmission of seasonal influenza and dramatically reduce cases in all age groups. Vaccination of children aged 2-3 years started in primary care and PHE co-ordinated primary school pilots in seven areas, using a range of providers
- uptake of seasonal flu vaccine in England is among the highest in Europe
- vaccination of pregnant women against whooping cough (pertussis) led to a dramatic fall in the number of whooping cough cases in babies, preventing deaths and hospitalisations of infants
- universal vaccination of infants against rotavirus infection began in July with the aim of reducing hospital admissions and consultations for gastroenteritis. Early indications suggest that the number of confirmed rotavirus infections is around 70% lower than in previous seasons. In previous years, rotavirus in children under five in England and Wales led to 90,000-133,000 GP consultations, 30,000 accident and emergency department attendances and 14,000 hospital admissions

Figure 4: Confirmed measles by month, January 2008 to March 2014, England



Screening: Screening programmes save many lives through the early detection of a range of serious diseases. PHE helps to provide world-leading, population-wide screening programmes for 26 conditions.

Achievements: During the year, PHE:

- piloted a new bowel scope screening mechanism, flexible sigmoidoscopy, for men and women at age 55, and rolled this out to 37% of screening centres in England
- expanded the breast screening programme so that women over 30 with a confirmed hereditary cancer gene are entitled to annual screening with MRI when they are younger and adding in mammography for those aged 40 or over
- piloted a screening programme to test women for high-risk papillomavirus, resulting in a more targeted approach to cervical screening, allowing most women to be screened less often
- completed the roll-out of the NHS Abdominal Aortic Aneurysm Screening Programme in England on budget and on time
- evaluated the cost and clinical benefit of extending the NHS Newborn Blood Spot Screening Programme (NBSSP) to cover several rare conditions
- announced research into the use of innovative genetic techniques to improve the screening for Down's syndrome
- established regional quality assurance teams to ensure the quality and safety of local services of services provided by the NHS
- provided online training to more than 6,700 professionals. Many maternity units adopted PHE's antenatal and newborn e-learning module as mandatory training

Screening saves lives and reduces the burden of disease. In 2013/14:

More than five million women were screened for breast or cervical cancer, saving around 6,000 lives per year.

Two million men and women were screened for bowel cancer, saving an estimated 2,000 lives.

More than 200,000 men were screened for abdominal aortic aneurysm, diagnosing more than 3,000 for surveillance or treatment.

All pregnant women (more than 700,000) were offered screening for a variety of infections and genetic and congenital abnormalities. This programme means that almost all pregnant women living with HIV are diagnosed by the time they give birth. As a result, about 1 in 200 of their babies is born with HIV infection compared with 1 in 50 in 2000/01, a four-fold reduction in the transmission rate.

Parents of all newborn babies were offered screening for their infants. During the year, 3,000 babies with genetic or metabolic diseases were identified and treated to prevent life-threatening or life-shortening diseases.

Some 1,200 children were identified as having a hearing loss, the diagnosis of which will help them reach their education and social potential.

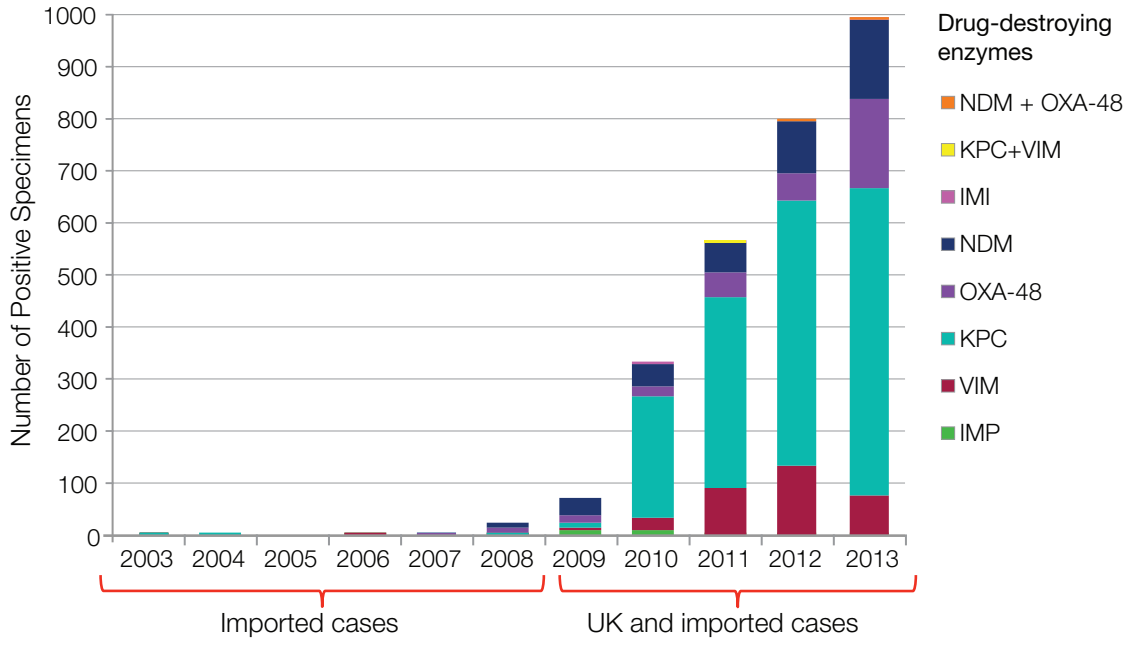
A total of 1.9 million people with diabetes were screened, including some 4,000 who went on to have laser treatment to prevent further sight impairment and blindness. This programme has contributed to the fact that diabetes is no longer the leading cause of blindness in working age adults.

Antimicrobial resistance: One of the biggest threats to healthcare and our ability to treat infections is the increase in bacteria that are resistant to antibiotics. Bacterial strains that are resistant to carbapenem antibiotics, which have been the 'last resort' medication for treating severe infections in hospitals, are a major concern. Finding new antibiotics to counter the rise of antimicrobial resistance (AMR) is increasingly difficult. The Chief Medical Officer has warned that without urgent action to reduce antibiotic use and control AMR, people may in a few decades start dying from operations and ailments that can today be treated easily.

Mandatory surveillance showed that rates of meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* infection continued to decline in 2013/14. Bacteraemia rates for meticillin-sensitive *Staphylococcus aureus* and *Escherichia coli* remained relatively stable.

Rates of infections caused by Gram-negative bacteria continue to remain high and increasing numbers of carbapenem-resistant Enterobacteriaceae, including those that produce carbapenemases, were reported (see Figure 5).

Figure 5: Numbers of carbapenem-resistant Enterobacteriaceae (gut bacteria) confirmed by PHE's national Reference Unit to produce carbapenem-destroying enzymes



Carbapenemases are enzymes that destroy carbapenem antibiotics, resulting in drug resistance; these enzymes are made by Enterobacteriaceae strains. Between 2003 and 2013 primary resistant strains in the UK were *Klebsiella* species (79%), *Escherichia coli* (12%), *Enterobacter* species (7%), and 2% other.

Achievements: PHE co-ordinated action to implement the government's *UK 5 Year Antimicrobial Resistance Strategy 2013 to 2018* across health and social care and also:

- established a new national programme to measure and monitor antimicrobial use and resistance in hospitals and primary care
- provided expert advice and support about the prevention and control of healthcare-associated infections
- published a toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae in hospitals
- updated clinical guidance on the management and treatment of *Clostridium difficile* infection
- published antimicrobial prescribing and stewardship competencies for independent prescribers, in collaboration with the scientific committee on Antimicrobial Resistance and Healthcare Associated Infections
- supported the implementation of the TARGET toolkit—an information resource for clinicians and commissioners about safe, effective and prudent antibiotic prescribing
- established two research units in collaboration with Imperial College London and Oxford University

Genomics: PHE is leading the implementation of whole genome sequencing (WGS) of pathogens to improve the diagnosis and management of infectious diseases and deliver the infectious diseases aspects of the government-led 100,000 Genomes Project. This work aims to transform the diagnosis and management of patients with key infectious diseases and tackle antimicrobial resistance. It will accelerate the adoption of genomic technologies in services, thereby enabling more rapid detection of antimicrobial resistance and better identification and control of disease outbreaks.

Achievements: PHE is leading the development of proposals to implement WGS in the priority areas of TB, hepatitis C and HIV. PHE also developed and validated WGS capability to support outbreak investigations, surveillance and emergency response.

PHE worked with Health Education England to identify and meet the needs of our specialist workforce, including bioinformaticians, microbiologists, epidemiologists and other public health professionals. Training courses and tools were developed, including an e-learning module that provides introductory training in genomics.

Surveillance: PHE's world-leading surveillance services provide robust evidence to inform public health decisions and actions. A national surveillance strategy is being developed to bring together the full range of PHE surveillance and intelligence capabilities. The goal is to provide access to consolidated data about all aspects of public health including infectious diseases, acute and chronic diseases, environmental and behavioural risk factors, and other health determinants.

Achievements: PHE provided timely and accurate public health surveillance data, produced according to defined standards, to local and national government, the NHS and others. It also:

- developed surveillance outputs for use in the production of indicators for the Public Health Outcomes Framework
- upgraded international alerting and response protocols and systems in line with EU legislation
- made progress in reviewing all PHE surveillance outputs to ensure that current systems meet the needs of users and to identify gaps

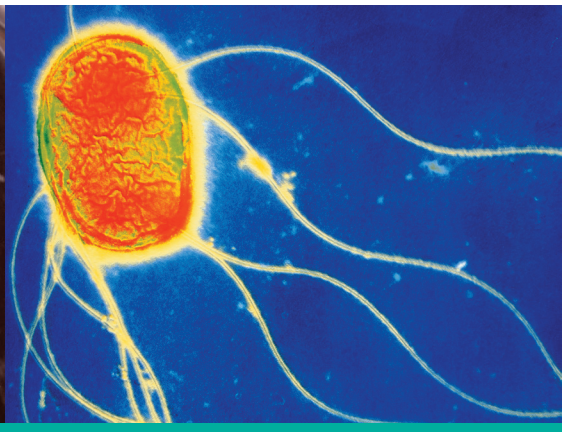
Outbreaks of food poisoning

Many outbreaks of food poisoning were detected and investigated by PHE during 2013/14, including 11 outbreaks of salmonellosis, nine of vero cytotoxin-producing *Escherichia coli* (VTEC) infection and three of listeriosis.

Watercress was the probable cause of an outbreak of VTEC O157 that affected 17 people directly. Whole genome sequencing showed that the organism had not been seen in the UK before, suggesting that the watercress may have been contaminated with foreign source material. Four other outbreaks, involving novel food vehicles, were identified through PHE surveillance and response:

- an outbreak of *Salmonella* Goldcoast involving whelks
- an outbreak of *Salmonella* Agona, *E. coli* and shigella in which 413 people fell ill after eating coconut chutney containing contaminated curry leaves
- two outbreaks of listeriosis involving crab meat





4. Children, young people and families

Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme.

A healthy start for under 5s: The early years are critical in shaping health and wellbeing throughout life. Evidence shows that providing support to a family in the early years of a child's life has life-long benefit. This is particularly true for disadvantaged families and children with complex needs and behaviours. PHE supports local areas in the provision of services for children under five, including health visiting, school nursing and family nurse partnerships.

PHE commissioned a rapid review of the Healthy Child Programme – an early intervention programme provided by health visitors to ensure that children under five have a healthy start in life. This will assist local authorities when they start to commission health visiting services from October 2015.

Early intervention: PHE worked with the Early Intervention Foundation (EIF) to help build evidence that can support a shift in resources towards early interventions to improve the life chances and outcomes for children, young people and families. This will help PHE centres, directors of public health and local authorities make the case for investing in early intervention that has demonstrable impact.

Partner the Troubled Families Programme: Many troubled families have significant health issues – domestic violence, substance misuse and mental ill health are prevalent either individually or together – and many families receive regular, high-cost, high-intensity health services.

PHE worked with the Troubled Families Programme to improve the life chances of troubled families. In particular, PHE led work with the Department of Health and NHS England to develop proposals to recognise that a key part of improving the lives of troubled families is health related. PHE also worked with local areas to find out how health services can be made more responsive to troubled families and how to realise the benefits of early intervention, public health and prevention.

Childhood obesity: The prevalence of childhood obesity doubles between the ages of 4–5 and 10–11 (from 9.3% to 18.9%), according to the National Child Measurement Programme. There are signs that these rates are stabilising, with a possible downward trend for 4–5 year-olds. However, wide socioeconomic inequalities persist. Children from the most deprived areas are twice as likely to be obese as children from the least deprived areas (24.2% versus 13% for 10-11 year olds).

Achievements: During the year, PHE:

- delivered the Get Going This Summer and the Smart Restart Change4Life campaigns
- provided National Child Measurement Programme guidance; resources; briefings for councillors and councils; IT tools to help local councils deliver their statutory duty to measure children's height and weight, and assistance with letters of advice to parents and carers
- worked with the LGA to establish a peer-challenge process for childhood obesity, where a team of peers from various organisations reviews a council's approach and recommends improvements
- published briefing papers to help practitioners and policy makers

Figure 6: Prevalence of excess weight among children

One in five children in Reception is overweight or obese (boys 23.2%, girls 21.2%)

One in three children in Year 6 is overweight or obese (boys 34.8%, girls 31.8%)

Child overweight (including obesity)/ excess weight: BMI ≥ 85th centile of the UK90 growth reference

National Child Measurement Programme data 2012/13 school year. Health and Social Care Information Centre. www.hscic.gov.uk/ncmp. Figure produced by PHE.

Physical activity is important to healthy weight and wellbeing in children. Figures for 2012 show that as children get older, the proportion who meet the minimum daily activity guideline of 60 minutes falls. This is worse for girls than boys. Among 13-15 year olds, 14% of boys met this target compared with 8% of girls.

PHE worked with agencies such as Natural England, Play England and the Youth Sport Trust to support schools and local areas. The Change4life School Sports Clubs are an important part of this work.

Adult obesity: Two-thirds of men (67%) and over half (57%) of women are obese or overweight, according to Health Survey for England data for 2012. Obesity has a significant impact on health and is a major cause of long-term disease leading to early death. Problems caused by people being overweight and obese cost the NHS over £5 billion a year.

Achievements: During the year, PHE:

- helped NHS England to deliver the obesity care pathway
- trained local commissioners to evaluate the impact of weight management, diet and physical activity interventions
- published new local authority level data on excess weight in adults, allowing councils to monitor local trends
- supported local action by developing evidence-based summaries, briefings and toolkits

5. Health at work

Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives.

Adults in employment spend, on average, more than a third of their waking hours in the workplace. Improving health at work is therefore important – for staff and employers. Benefits include increased productivity and improved staff retention, safety and customer service. Priorities in 2013/14 were to:

- help employers establish a business case for improving the health of their workers, adopt evidence-based interventions and sign up to the Department of Health's Public Health Responsibility Deal (PHRD)
- encourage wider adoption of the PHRD commitment on mental wellbeing in the workplace so that working practices support people with mental health needs and promote good mental health for all staff
- develop PHE's employment practices so they support a healthy and productive workforce and act as an exemplar of the PHRD's aspirations

Achievements: New national standards for the Workplace Wellbeing Charter (WWC), which provides guidance for employers on how to improve workplace health, were launched in spring 2014. To underpin the charter, PHE worked with partners to develop guidance for businesses on specific topics, such as healthy eating and physical activity.

The PHRD pledge on mental wellbeing in the workplace was signed by 74 public and private sector organisations. PHE supported the Council for Work and Health's work on the future of occupational health medicine; helped the Department for Work and Pensions and the Department of Health to develop the Health and Work service; and worked with the City Mental Health Alliance to develop metrics for measuring mental wellbeing in the workplace and commissioned a report on metrics for productivity.

PHE commissioned reports on workplace health, including:

- mapping the academic landscape of workplace health (University of Durham)
- pre-burnout interventions in the workplace (Leeds Metropolitan University)
- the impact of the office environment on employee health (Roberston Cooper, Manchester)

In addition, PHE supported the Manchester Academic Partnership in developing an active ageing strategy for England. The project will focus on initiatives to reduce the number of people who fall out of work due to poor health and help people to remain active in their local communities.

Unique capabilities

PHE combines and integrates the widest range of specialities and functions of perhaps any public health organisation in the world.

Knowledge, know-how and data

PHE provides high-quality data, evidence, knowledge and experience to inform public health practitioners, policy makers, commissioners and the public so that decisions about health are based on the best information. Experts working for PHE have long experience of collecting, analysing and managing data. Some examples of work in 2013/14 are set out below.

The NHS Atlas of Variation in Diagnostic Services – the latest in the Atlas series produced by NHS Right Care and PHE – was published. It provides 69 maps of diagnostics use across England, covering imaging, endoscopy, physiological diagnostics, pathology and genetics. The Atlas used a wide range of data sources and extensive clinical input – integrating statistics, research and experience in the form of case studies. It shows significant differences in how health conditions are identified and monitored, such as:

- big variations in the speed of response to stroke, with some patients waiting 24 hours for a brain scan
- delays in CT scans for some trauma patients
- very large local variations in many specialised tests, including those for sleep disorders, thyroid, rheumatoid arthritis, allergies and vitamin D

The National Cardiovascular Intelligence Network (covering diabetes, heart, stroke and renal diseases) and the National Mental Health Intelligence Network were established. The networks operate across other organisations – including the NHS, charities and research bodies—to collect information and data that can be used to improve quality of care and treatment outcomes.

PHE has three pre-existing intelligence networks covering end of life care, child and maternal health, and cancer. The cancer network has significantly improved information about where and how patients are diagnosed and when treatments are most effective.

A single national cancer registry for England was created by importing 11 million records from the former regional registries into a new system run by PHE's National Cancer Registration Service. The unified dataset provides almost immediate access to information covering all tumours diagnosed in England's population. PHE can now monitor cancer treatment and outcomes for the whole population. In future, with genomic analyses, cancer specialists will be able to deliver very specific targeted therapies to individual patients.

The health protection and surveillance data that PHE holds has unique value to research and intelligence communities. An Office for Data Release was set up to describe the data and provide a managed service to authenticate and respond to external requests.

Specialist and reference microbiology

PHE microbiologists work to prevent the spread of infections by undertaking laboratory diagnosis and characterisation of pathogens, susceptibility testing and typing; providing microbiological surveillance data and supporting outbreak investigations. They provide services for the NHS and, in the cases of food, water and environmental samples, to local authorities and other partners.

Capabilities include:

- world-class centres of expertise with cutting-edge technologies that provide the most rapid and robust analytical information about biological agents
- specialist diagnostics for low incidence, high-risk infections, including antimicrobial resistance issues
- the detection of epidemiological shifts, newly-emerging pathogens and antimicrobial resistance through horizon scanning and specialist investigative science
- monitoring of routine surveillance programmes to identify the cause of exceedances
- a portfolio of tests and investigative algorithms to sustain the quality of public health microbiology from all providers
- research and development to advance microbiological science and services

Examples of work: PHE's National Collection of Type Cultures was awarded £734,500 by the Wellcome Trust to extend the information available about 3,000 bacteria and viruses that have caused human infection. Not only will this add genomic and proteomic data to that already available relating to the history, original geographical location and characteristics of the organisms, but also it will present the data electronically in a valuable, user-friendly way to the global scientific community. This project actively supports a better understanding of infectious diseases.

Specialist investigation and control of outbreaks

PHE has singular expertise in responding to and controlling outbreaks of infectious disease and other environmental hazards, including chemical and radiological incidents. Specialist support for the NHS and other partners at a local level is available 24/7 while national experts are available to brief government and other agencies. They also contribute to global health security – co-operation that is increasingly important to meet international disease threats.

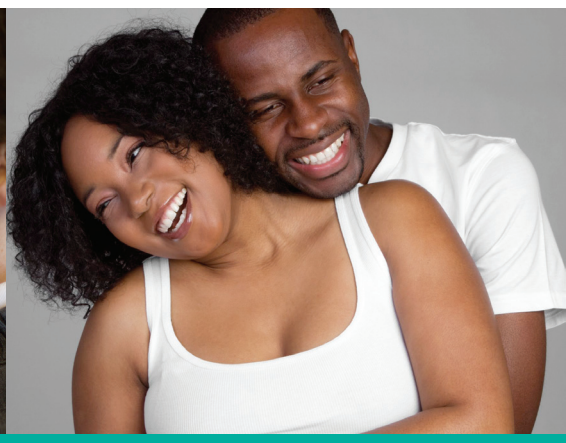
Examples of work: During the year, PHE:

- set up a specialist field epidemiology service to identify and control the source of outbreaks of infection. Field epidemiologists undertook 48 investigations to identify the source of significant outbreaks in 2013/14, supported the response to numerous others and contributed to surveillance activity in response to the severe floods in early 2014
- established a joint oversight group with the Food Standards Agency to ensure effective collaboration on food safety and health protection
- developed a capability to use whole genome sequencing techniques during the investigation of outbreaks, allowing more timely and effective control
- undertook joint projects to improve the response to protracted chemical fires
- published operational guidance for managing outbreaks of communicable disease in consultation with four partner bodies
- established a multi-agency group to agree roles, responsibilities and revised arrangements for personal emergency radiation monitoring, following the restructuring of the health system

Response to outbreaks and incidents

More than 9,000 health protection issues, including outbreaks of infection and chemical, radiation and environmental incidents, were handled by PHE in 2013/14. Among the outbreaks of infectious disease, at least nine incidents required national co-ordination. They included the response to an increase in infections caused by bacteria resistant to carbapenem antibiotics; a hepatitis C look-back exercise that involved co-ordination with Scotland, Wales and Northern Ireland; and evaluation of the MMR catch-up vaccination programme. PHE responded to 837 acute chemical, radiation and environmental incidents. Our staff provided advice about managing chemical spills, worked with partners to protect the public from large waste fires and developed national arrangements for responding to potential natural events, such as solar flares and volcanic eruptions.





Emergency preparedness, resilience and response

PHE provides effective and sustained responses to health emergencies and risks, including disease outbreaks, incidents involving potential exposures to chemicals and radiation, terrorist threats, natural disasters and other mass casualty events. The emergency preparedness, resilience and response (EPRR) function includes monitoring and support for international crises. PHE's emergency response procedures are integrated with those of the NHS, other agencies and government departments.

Examples of work: During the year, PHE:

- provided specialist medical entomology and mathematical modelling expertise to reassess the risk to the UK from emerging vector-borne disease threats
- used specialist high-performance computing facilities to model the potential impact of biological, chemical and radiation threats outlined in the National Risk Assessment and help to optimise mitigation strategies
- provided specialist epidemiological and behavioural science advice, and mathematical modelling to support cross-government planning to mitigate the deliberate release of a biological, chemical or radiological agent
- provided epidemiological and mathematical modelling support to local and national teams for Legionnaires' and similar disease outbreaks, including desktop tools to help detect clusters of Legionnaires' disease
- developed the National Incident and Emergency Response plans and Concept of Operations
- maintained the National Incident Co-ordination Centre in London
- trained PHE and NHS staff in emergency preparedness, resilience and response
- designed and conducted four regional tabletop exercises to test EPRR management arrangements in the new health system

International activities

PHE sent staff to support emergencies such as the Philippines typhoon and the Ebola virus outbreak in West Africa, and planned to send staff to Trinidad (supporting the Caribbean Public Health Association as well as the UK overseas territories in the region), Kenya (working with International Rescue Committee and the Kenya Ministry of Health) and WHO Geneva (currently supporting development of the new WHO antimicrobial resistance action plan).

PHE also provided support, in partnership with the International Association of National Public Health Institutes, to countries such as Uganda around establishment of a national public health institute; and, in Sierra Leone, around building microbiological capacity and undertaking a national oral health survey.

Global health

PHE provides expertise on global health protection, encourages international collaboration and contributes to global health security. Experts work with the WHO, the European Centre for Disease Prevention and Control (ECDC), the US Centers for Disease Control and Prevention (CDC), public health agencies in Asia and the Middle East and less obvious partners such as the police, military and intelligence sectors. PHE also hosts the WHO Collaborating Centre for Mass Gatherings and High Visibility/High Consequence Events.

Examples of work: PHE shared the expertise and experience gained from the London 2012 Olympic and Paralympic Games with countries holding similar mass gatherings, helping them to strengthen their public health capacity and capability. This work included advising Brazil on the FIFA World Cup 2014 and the Rio Olympics 2016; Scotland on the Glasgow 2014 Commonwealth Games; and Russia on the Sochi Winter Olympics 2014.

PHE responded to international issues such as the emerging respiratory infections MERS CoV in the Middle East and H7N9 in China, providing expert advice and support.

Environmental Hazards

PHE has unique expertise in health hazards resulting from exposure to chemicals and poisons, ionising and non-ionising radiations, environmental noise, ultrasound and infrasound, extreme weather events, and the potential risks to health from climate change. Specialists provide evidence-based advice about the impact on public health, assist in the response to local, national and international incidents, and collaborate in high-profile research projects. PHE commissions the National Poisons Information Service to provide advice to clinicians.

Examples of work:

- during the floods of early 2014, PHE gave advice about the potential health effects, before, during and after the flood
- maintained and developed UK radiation epidemiological databases, which provide an important contribution to the international assessment and understanding of radiation exposure health risks
- reviewed scientific evidence about the risk to health from emissions during the shale gas extraction lifecycle
- published a methodology and estimated values for the mortality attributable to air pollution at a local authority level
- published the Heatwave Plan for England and the Cold Weather Plan for England
- measured radon concentrations in schools in radon-prone areas to inform local actions to reduce radiation health risks

- set up new research programmes on the causes of asthma, the public health impacts of noise and the beneficial effects of natural light
- worked with university partners to set up research units on the Health Impact of Environmental Hazards, Environmental Change and Health, and Chemical and Radiation Threats and Hazards

Research and development

PHE's research expertise is very broad in scope owing to the diverse capabilities of its predecessor organisations. Research ranges from the DNA sequence analyses of dangerous pathogens to modelling the effects of climate change.

PHE works collaboratively with universities and public health partners to translate evidence from research into practical applications that improve public health. We have several WHO accredited national laboratories, including those for influenza, poliovirus and measles as well as world-class reference laboratories. In addition, we have internationally recognised expertise in biological models for testing new drugs and vaccines. Uniquely, PHE is licensed to produce vaccines and anti-cancer drugs (biopharmaceuticals) on behalf of government and commerce.

During the year, PHE developed its research and academic strategy, informed by discussions with partners. The strategy will be launched in autumn 2014.

Manufacturing capabilities

PHE has unique capabilities in the development and manufacture of biopharmaceutical products. Most of these activities are performed for third party commercial partners such as biotechnology/pharmaceutical companies in Europe and the US. However, translational development services are also provided to the UK pharma industry and to the US and French governments on a commercial basis.

Examples of work:

- worldwide sales of Erwinase, an enzyme used in the treatment of certain kinds of childhood leukaemia, reached record levels
- major capital refurbishment of facilities, including approval for a new freeze-drier and a 3,000-litre fermenter
- audits by the US Food and Drug Administration, the Medicines and Healthcare products Regulatory Agency and several customers were completed successfully

Sustainability report

PHE became operational on 1 April 2013 and therefore 2013/14 is classed as the baseline year relative to the Greening Government Commitment initiative. In order to take account of the available historical data for the bodies that came together to form PHE, calculated data for 2012/13 is presented. This is based on actual data for the estate of the former Health Protection Agency (HPA) and data derived for the remainder of the PHE estate using government formulae for utility usage. This information is provided for comparison purposes only and will not form part of PHE's baseline data.

PHE agreed a number of carbon related reduction targets for its estate. These include utility use, business travel, water consumption and total waste. Monitoring processes were put in place to allow PHE to evaluate and develop reduction strategies to meet these targets. A more detailed analysis will be included in PHE's annual sustainability report, which will be published later in 2014.

Greenhouse gas emissions

PHE set a target to reduce carbon emissions by 3% annually for the period to March 2020, compared to the baseline year of 2013/14, to meet its obligations under the Greening Government Commitment. Initial analysis indicates that PHE's total carbon emissions for 2013/14 were 26,161 tCO_2e; this includes the organisation's reportable and non-reportable sites. (Non-reportable sites are those offices and/or laboratories that are being reported separately by the landlord). Estimated emissions for the previous year were 24,096 tCO_2e. The variance is mostly due to changes in the nature of the PHE estate and an increase in operational activities over the year.

PHE introduced a number of strategies to help reduce its carbon burden from these impacts. We aim to engage staff through a mandatory e-learning training programme on sustainable development, which includes a module on carbon management. This training ensures that staff are aware of the need to minimise their carbon footprint and act in a sustainable manner, taking into account their impact on the environment.

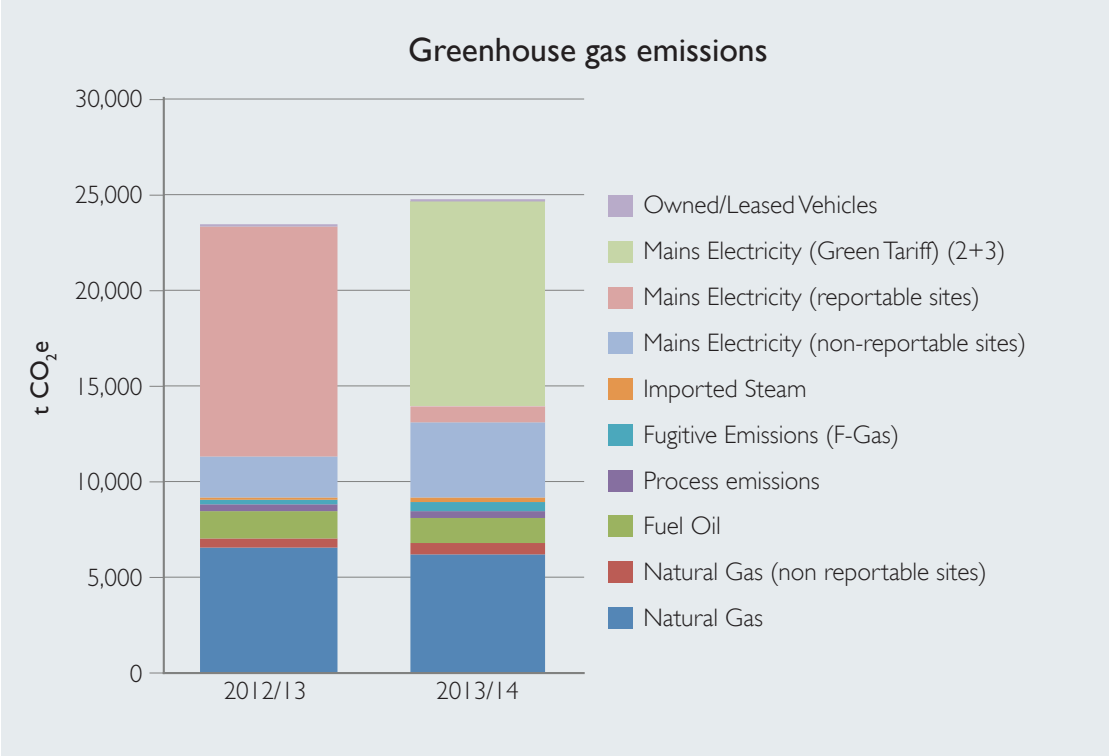
PHE continues to strengthen its commitment to its green procurement initiatives by utilising the government approved 'CAESER' software tool with our suppliers, including SMEs. This software tool has helped to ensure a robust approach to sustainability through the supply chain. PHE continues to embed sustainability into contracts, which has helped to highlight risks to the organisation arising from its procurement activities.

PHE is fully committed to sustainable development in all its activities. A Sustainable Development Management Plan, which includes a section on carbon reduction, helps to set out our aims for future work in this area, ensuring that its operations become more sustainable. A number of capital projects intended to improve the efficiency of future energy usage were started at PHE-owned sites. Sub-metering of utility supplies was introduced in many areas so that greater local control could be achieved.

GREENHOUSE GAS EMISSIONS		2012/13	2013/14
SCOPE 1+ 2			
Non-Financial Indicators (tCO_2e)	Natural Gas	6,521	6,229
	Natural Gas (non reportable sites)	453	577
	Fuel Oil	1,480	1,290
	Process emissions	296	342
	Fugitive Emissions (F-Gas)	253	504
	Imported Steam	166	161
	Mains Electricity (non-reportable sites)	2,110	3,924
	Mains Electricity (reportable sites)	11,955	847
	Mains Electricity (Green Tariff) (2 + 3)	N/A	10,723
	Owned/Leased Vehicles	52	92
Related Energy Consumption (kWh)	Natural Gas	48,841,887	34,087,464
	Natural Gas (non reportable sites)	2,445,438	3,133,382
	Fuel Oil	5,272,190	4,747,646
	Process emissions*	1,608,696	1,858,695
	Imported Steam	907,778	874,444
	Electricity (non reportable sites)	4,107,217	7,790,559
	Electricity (reportable sites non Green Tariff)	31,351,452	2,075,589
	Electricity (Green Tariff)	N/A	22,174,537
Related Consumption (kgs)	**Fugitive Emissions (F-Gas)**	**335,000**	**504,038**
Related Scope 1 travel (kms)	**Owned/Leased Vehicles**	**259,181**	**433,108**
Financial Indicators (£)	Natural Gas	1,481,428	1,353,637
	Fuel Oil	356,223	326,155
	Owned/Lease Vehicles (Fuel/i-expenses)	18,293	18,551
	Fugitive Emissions (F-Gas)	64,287	32,682**
	Imported Steam	68,589	70,124
	Mains Electricity (reportable)	2,272,659	2,576,149
Total Gross Emissions Scope 1 + 2		**20,723**	**20,188**
Total Gross Emissions from Non-Reportable Sites Scope 1 + 2		**2,563**	**4,501**

* Process emissions from Porton incinerator waste (kWh * 0.184 conversion factor).
** F-Gas costs from PHE campus sites are absorbed as part of the service contract.

PHE owns six of the locations from which it operates and has a direct relationship with the utility provider at a further four. The organisation also has shared facilities embedded in government-owned property (including hospitals) and in other tenanted accommodation. There is no direct relationship with the utility provider in these premises and no sub-metering has been undertaken. To avoid double-accounting relating to carbon emissions from these properties, they have been identified separately for reporting purposes. PHE has no properties within SSSI or AONB boundaries.



Water consumption

PHE set a target to reduce its water consumption by 2% annually for the period to March 2020, compared to its baseline year of 2013/14. The reportable usage of water for the estate was 172,757m^3, with a further estimated 17,318m^3 being used by its non-reportable sites.

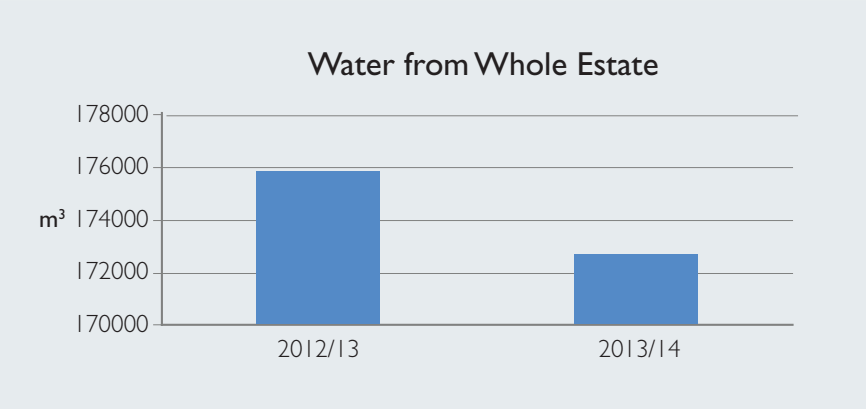
WATER		2012/13	2013/14
SCOPE 3 (Water)			
Non-Financial Indicators (m^3)	Water from Office Estate (Reportable)	83	684
	Water from Office Estate (Non-reportable)*	3,936	6,971
	Water from Whole Estate (Reportable)	175,824	172,757
	Water from Whole Estate (Non- Reportable)*	10,613	17,318
Financial Indicators (£)	**Water supply costs****	**159,738**	**169,947**

* Estimated usage
** Water costs from owned sites

A number of projects were identified to reduce the organisation's water consumption. Several of PHE's sites have a mixture of office and non-office facilities; it was therefore not possible to split the two categories into any viable dataset.

The financial cost shown in the table relates to the water that was directly supplied to those sites that were within the reporting boundary.

In terms of water consumption, PHE's major impacts on the environment were from its main campus sites, which house a large number of laboratories. The water supply to PHE's campus sites was monitored and measured, and therefore the

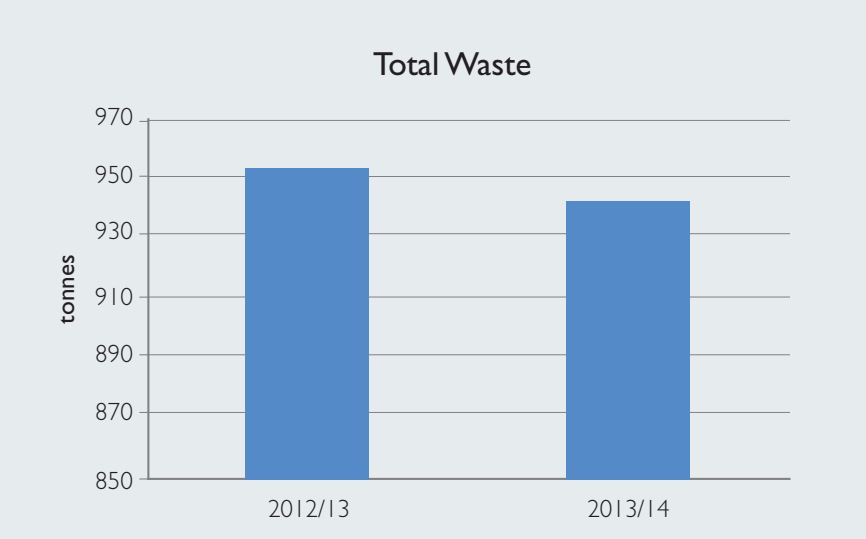


pattern of daily usage was known. Senior managers used this information to refine strategies that will help towards meeting future water reduction targets. Water that was consumed at offices and laboratories embedded in tenanted accommodation was estimated using a recognised benchmarking algorithm.

Waste

PHE set a total waste reduction target of 2% annually for the period to March 2020, compared to its baseline year of 2013/14. Preliminary analysis indicated a 25% reduction of waste going to landfill over the year; a more detailed analysis will be included in PHE's annual sustainability report. PHE's total waste figure for 2013/14 was 941 tonnes, compared to the estimated figure for 2012/13 of 948 tonnes. PHE introduced a rigorous programme to reduce, wherever practicable, its total waste, especially to landfill. The trend was positive, with a number of projects being implemented to divert waste from landfill to other waste streams, principally to energy from waste. This markedly reduced the landfill disposal, with significant social, financial and environmental benefits for the organisation. In addition, the need to increase PHE's level of recycling was emphasised, which is also reflected in the figures above.

Due to the nature of the work carried out at some of our sites, a significant quantity of hazardous waste is produced. Management controls were in place to manage this. The majority of this waste was sent for incineration, in compliance with government guidelines.



WASTE	2012/13	2013/14
SCOPE 3 (Waste)		
Non-Financial Indicators (tonnes)		
Waste recycled externally (non-ICT equipment)	331	254
Waste reused externally (non-ICT equipment)	1	0
Waste recycled externally (ICT equipment)	8	8
Waste reused externally (ICT equipment)	4	8
Waste composted or sent to anaerobic digestion	22	17
Waste incinerated with energy recovery	217	252
Waste incinerated without energy recovery (Clinical waste)	287	329
Total ICT waste	12	15
Total waste not to landfill	870	867
Total waste sent to landfill	60	45
Total landfill waste deemed hazardous (incl. Clinical waste)	18	29
Total waste	**948**	**941**
Financial Indicators (£)		
Waste recycled externally (non-ICT equipment)	53,263	55,939
Waste reused externally (non-ICT equipment)	705	0
Waste recycled externally (ICT equipment)	3,874	7,504
Waste reused externally (ICT equipment)	0*	0*
Waste composted or sent to anaerobic digestion	2,823	2,175
Waste incinerated with energy recovery	58,378	50,957
Waste incinerated without energy recovery (Clinical waste)	178,292	446,758
Total waste sent to landfill	34,112	9,761
Total waste	**349,087**	**617,691**
Total landfill waste deemed hazardous (incl. Clinical waste)	17,640	44,598
* Data not available		

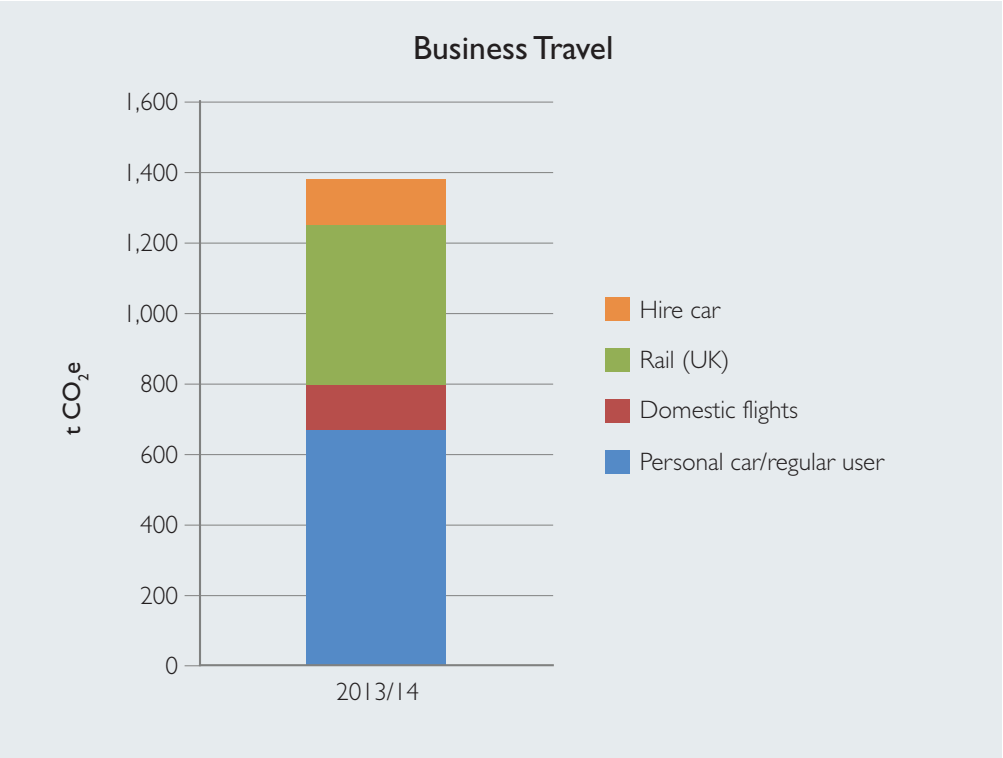
As part of initiatives to reduce waste at all locations (covering both offices and laboratories), contractors working at PHE sites were informed of the requirement to reduce their waste wherever possible. This is in line with PHE's waste policy and the associated management arrangements.

A third-party provider is engaged to recycle and, wherever possible, reuse all redundant ICT equipment. More than 15 tonnes of ICT waste was processed in this manner in 2013/14. This approach continues to be an effective method of disposal for this waste stream, and is in line with government policy.

Business travel

PHE adopted a no first-class travel policy from day one and emphasised public transport over any other. The only exception is on grounds of a reasonable adjustment for a disability. It set a target to reduce business travel by at least 2% annually for the period to March 2020, compared to its baseline year of 2013/14. Staff are encouraged

to minimise journeys by using alternatives (such as teleconferencing) wherever possible and when they must travel, to use more sustainable modes of transport. A reduction in PHE's business travel would not only improve local air quality, but also support PHE's plan to reduce carbon and benefit the organisation financially. Travel data relate only to in-year travel; of the 12 'sender bodies' which came together to form PHE, only the former HPA had historical data relating to business travel emissions and it was not possible to estimate travel for other bodies during 2012/13.



Data for travel by bus, taxi and underground are not represented due to their low carbon values.

Steps were taken to ensure all members of staff recognise the benefits of travelling in a more sustainable manner. During 2013/14, PHE staff made 440 domestic flights. While it is not always practicable because of time constraints to take other means of transport, PHE will be reducing this. PHE focused on sustainable business travel for NHS Sustainability Day and a number of other local initiatives were introduced to monitor business travel more closely.

General

Other measures to improve reporting and knowledge of the social, environmental and financial impacts of PHE's operations included:

- playing an active role in the development of the NHS, Public Health and Social Care sustainable development strategy, which was co-launched by the chief executives of PHE and NHS England in January 2014

- continuing work on PHE's commitment to the National Adaptation Programme, delivering evidence-based health advice to the debate on adapting to climate change
- introducing a programme to reduce paper usage, which involved moving to closed-loop recycling for sourcing paper, multi-function devices for printing across the business, and signage and better communication about minimising printing

BUSINESS TRAVEL		2013/14
SCOPE 3		
Non-Financial Indicators (tCO_2e)	Personal Car/Regular User	681
	Domestic Flights	120
	Rail (UK)	458
	Taxi	5
	Bus/Coach/PTR	4
	Hire Car	122
	Underground	1
	Total	1,392
Related Scope 3 travel (kms)	Personal Car/Regular User	3,580,880
	Domestic Flights	366,392
	Rail (UK)	9,346,189
	Taxi*	36,830
	Bus/Coach*/PTR	39,822
	Hire Car*	641,065
	Underground*	7,962
	Total	14,019,140
Financial Indicators (£)	Personal Car/Regular User	1,022,687
	Domestic Flights	66,494
	Rail (UK)	2,970,871
	Taxi	79,901
	Bus/Coach/PTR	19,739
	Hire Car	87,639
	Underground	45,625
	Total	4,292,956
Other business travel (kms)	Short Haul International Average	1,918,087
	Long Haul International Average	4,370,326
	Rail - Eurostar	113,679
Total	Total Gross Emissions Scope 3 Business Travel	1,391
	Total Financial Cost Scope 3 Business Travel	**4,292,956**
	Total Other Financial Cost	**497,078**

* Figures calculated using own conversion table

Corporate information

Reducing health inequalities and the Equality Act 2010

PHE is committed to integrating equality and diversity into all of its work. PHE is a member of the Stonewall Diversity Champions Programme and, through this, part of a network of more than 600 organisations committed to developing inclusive workplace cultures.

PHE is embedding a commitment to how health inequalities can be reduced into all of its programmes. As part of this, a Health Equity Assessment Tool was developed to help PHE staff consider the impact of their work on health inequalities and equality and diversity.

PHE aims to ensure that the whole public health system has access to the best knowledge resources to inform their priorities, including the best intelligence systems for targeting interventions where there is greatest need. PHE has developed several tools to facilitate this, including:

- the Public Health Outcomes Framework data tool, which provides data for local authorities, including differences between communities in life expectancy and healthy life expectancy, and helps to identify inequalities and areas of greatest need. PHE is seeking to disaggregate indicators by equalities characteristics (including gender) and by socioeconomic analysis in order to support work locally to reduce health inequalities
- information for local authorities on the causes of death that contribute most to the life expectancy gap in their areas
- local authority and neighbourhood health profiles on health outcomes and wider determinants of health, which are designed to help local government and health services make decisions to improve people's health and reduce health inequalities. This supports local joint strategic needs assessments and health and wellbeing strategies

As part of complying with the Equality Act, PHE published equality objectives and information on how it met the equality duty in January 2014. This was based on an earlier analysis that set out how equalities considerations informed the transition process and how they would be embedded into PHE's forward work programme.

Staff support groups were established to provide a point of contact for, and support to, their members and contribute to policies and other organisational issues. Groups include: Black and Minority Ethnic (BME) Network for Equality and Diversity; lesbian, gay, bisexual and transgender; employees with disabilities; and women.

The PHE Equality Forum helps to ensure that the organisation supports and considers equality and diversity in its work. Membership is drawn from members

of PHE People's Panel who have identified themselves as having a characteristic protected by the Equality Act 2010, as well as a range of user-led and community organisations representing and mediating for people with protected characteristics, those who are at risk of worse health outcomes on the health inequality gradient and/or those often socially excluded, and PHE's own staff groups. The forum supports and promotes equality, diversity and health equity across PHE's corporate and public-facing activities.

PHE has held a number of public-facing equality and diversity events, topics for which have included mental health issues in marginalised and protected status communities, and good practice to reduce risk-taking behaviour.

Health and safety

PHE's health and safety policy aims to protect its staff and others from harm and to reduce the risk to their health, safety and wellbeing as far as possible. PHE undertakes a wide range of activity with a variety of different risks. A number of specific policies are in place to cover higher risk areas, for example, working with biological agents, hazardous activities and fire. PHE has a strategy for health and safety and a management system to ensure the highest standards are achieved with the aim to continuously improve. Each year, a number of priorities are set and an annual health and safety plan is put in place, along with a number of key performance indicators. Delivery is overseen by the Health and Safety Steering Group, the membership of which includes staff side representatives.

PHE has in place general controls to protect staff from harm as part of good risk management, which includes the suitable and sufficient assessment of its activities and putting in place control measures to prevent and reduce risks. PHE's health and safety policy is supported by a *My Safety: My Health* handbook for all staff and a *Laboratory Precautions* handbook for those who work with biological agents. These cover a number of specific areas and risks and are complemented by additional and specific information and guidance.

National Executive members are responsible for ensuring that the necessary management arrangements are in place within their directorates to ensure that all aspects of health, safety and welfare are adequately controlled. All controls must be in line with the relevant policies, procedures and guidance. Any changes to the health and safety system are fully consulted on with employees through a network of safety representatives and advocates.

Staff engagement

A number of initiatives were introduced in PHE's first year of operation, including:

- "Going Live" events in the run up to PHE's establishment to help staff from the large number of sender bodies understand its role, values and priorities
- establishment of the PHE Senior Leadership Forum and a number of all-staff events at different locations around the country
- a range of staff-facing communications, including the Chief Executive's Friday Message, *PHE News* and *PHE Inbox*, as well as the development of the PHEnet intranet

- the establishment of a cadre of engagement agents, staff volunteers who helped to communicate with colleagues across PHE and at all levels of the workforce, helping to ensure everyone was supported and had the information they needed
- the first annual PHE staff survey, the feedback from which will help us form and shape the organisation

The Chief Executive established a Staff Partnership Forum as a focus for negotiation and consultation with recognised trade unions across PHE, enabling discussion on significant issues which have a substantial effect on staff, for example:

- staffing implications of strategic planning decisions
- operational decisions, especially those likely to affect job prospects or job security of particular groups or occupations
- the working environment, including staff facilities
- HR policies and procedures

The forum also negotiates agreements between PHE and the recognised trade unions, with the exception of pay, including other terms and conditions of employment within the delegated authority of PHE, and facilities arrangements for accredited employee representatives.

Organisational development

In preparing PHE's organisational development strategy, there was a focus on key areas in 2013/14:

- system leadership: PHE worked with colleagues from across local and national government, the NHS and the social care system to create a development offer for systems leaders. PHE supported key systems leaders in 25 communities in making progress on a particular public health priority that would improve health and wellbeing outcomes for local communities, for example, improving levels of physical activity in Coventry and reducing female genital mutilation in Hackney, which at the same time improved their leadership skills. Several hundred leaders were involved in this work during the course of the year
- talent management: working with colleagues at the Local Government Association and Association of Directors of Public Health, PHE initiated a programme to develop talented leaders at all levels throughout the public health system
- leadership development: in partnership with DH and the Leadership Centre, PHE developed two new leadership programmes, Skills for Systems Leadership and Leadership for Change. A second cohort of aspirant directors of public health participated in the programme PHE developed with DH and which is sponsored by the Society of Local Authority Chief Executives (SOLACE). A total of 65 people have participated, with a quarter having secured a director of public health role to date
- high-performing teams: PHE supported several of its centre and regional teams with staff development events. PHE also supported half of its embedded public health commissioning teams as they developed new ways of working with NHS England colleagues

Sickness absence

During 2013/14, the total number of whole time equivalent (WTE) days lost to sickness absence was 55,025 days, an average of 6.6 working days per employee WTE per year; and a sickness absence rate of 4.38%.

Public involvement

PHE's 15 centres are the front door of the organisation and responsible for assuring that the services and expertise provided is focused on local needs. Each centre director is a partner in the local public health system, which includes the voluntary and community sector, and their unique role is to provide a range of services and expert advice that is tailored to the needs, wishes and aspirations of local government, clinical commissioning groups and the local NHS.

They provide leadership and support on health protection, health improvement and healthcare public health. This includes supporting local government in its leadership of the place-based public health system; supporting local authority directors of public health across the range of their responsibilities enabling them to access specialised advice and support when required; working with NHS England to support it in its role as a direct commissioner of key services, including specialist services and national public health programmes; and providing leadership in responding to emergencies where specialist public health expertise is necessary.

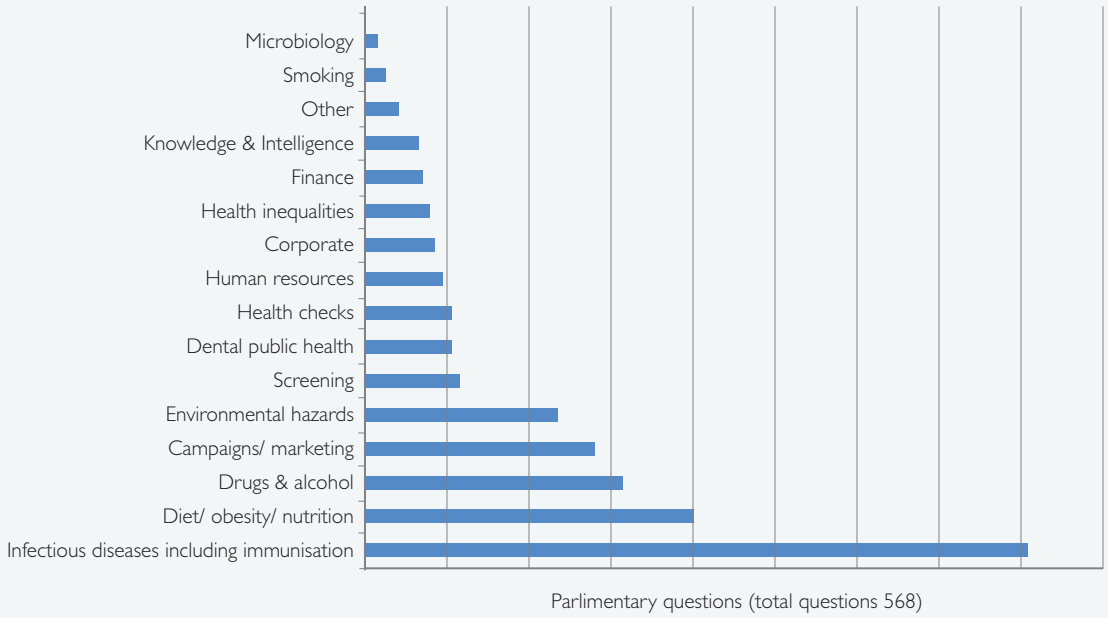
More generally, PHE has other mechanisms in place including public consultations, voluntary and community sector engagement and the People's Panel, which is the largest consumer panel of its kind in England, comprising almost 1,000 members. The panel was established as an innovative way to engage with the public about health priorities, information and services. Membership is drawn from two national random survey samples, giving a unique and valuable insight into public health issues that the public feels are important and how they understand and respond to health information. During the year, discussion groups were held to test and improve the quality of public health advice and information in the following areas:

- a review of flooding advice on the website and in health factsheets
- consumer testing of the National Travel Health Network and Centre's website for travellers and health professionals
- evaluation of antenatal screening publications
- feedback on proposals to offer teenagers and young people repeat testing for chlamydia

PHE recognises the potential of social media as a means of communicating effectively with the public, including in providing important information on emergency preparedness and response. PHE has developed its presence on Twitter, with more than 24,000 followers, and more than 3,000 people see content posted on PHE's Facebook page each week.

Parliamentary questions

During 2013/14, PHE responded to 568 parliamentary questions. These were on a wide range of subjects, the relative proportions of which are shown below:



Statutory information requests

During 2013/14, PHE received 530 information access requests, the majority of which were under the Freedom of Information Act 2000, others being under the Environmental Information Regulations 2004 and Data Protection Act 1998.

Enquiries through www.gov.uk/phe

PHE received over 3,000 online enquiries from the public and stakeholders.

Complaints

PHE is committed to providing a high-quality service to everyone it deals with. In order to do this, PHE needs the public and stakeholders to provide comments about its service and to say when it gets things wrong. PHE wants to help resolve complaints as quickly as possible and has therefore published a complaints procedure (available at: www.gov.uk/government/organisations/public-health-england/about/complaints-procedure#complaints-procedure). A total of 41 complaints were handled during the year.

Duncan Selbie
Chief Executive
13 June 2014

2 Directors' reports

Governance statement

Introduction

PHE is as an executive agency of the Department of Health (DH). Our primary duty is to protect the public from infectious diseases and other environmental hazards and our second is to improve the health of the people and reduce health inequalities. PHE has operational autonomy and carries out the functions set out in the Framework Agreement between DH and PHE (www.gov.uk/government/publications/framework-agreement-between-the-department-of-health-and-public-health-england). This focuses on:

- how DH and PHE work in partnership to serve the public
- how DH and PHE discharge their accountability responsibilities effectively

Establishment of PHE and management of transition

I was appointed as Chief Executive Designate of PHE in July 2012 in advance of its establishment on 1 April 2013, when I formally took up post as its Chief Executive. I was supported up until this time by a PHE transition team whose objective was to deliver a new public health system with strong local and national leadership capable of achieving the expected benefits set out in the Public Health Outcomes Framework. The transition programme covered the design of PHE, people transition, policy development and infrastructure arrangements. Among other things, it involved:

- the transfer of more than 5,000 staff from over 100 sender organisations to PHE on 1 April 2013 in accordance with the PHE People Transition Policy
- the transfer of functions and staff from a wide range of sender bodies including the Health Protection Agency (HPA), the National Treatment Agency for Substance Misuse (NTA), the NHS, public health observatories, the National Cancer Intelligence Network, DH and others
- settling PHE's organisational design, including the function and establishment of its four regions and 15 centres
- adoption of the PHE Code of Conduct that incorporates both the Civil Service Code, which also applies to our staff, and our professional responsibilities
- the development and implementation of over 40 key corporate policies for PHE staff
- tracking of over 1,000 programme level milestones and many more at project level
- budgetary transfers, including negotiations with DH in order to ensure that PHE had robust baseline funding
- a quality handover process from sender bodies to receive formally any clinical and quality risks, including health and safety, as at the date of transfer

Following appointments to PHE's senior team in the autumn of 2012, a process which involved the Civil Service Commissioners and the Cabinet Office, I established the PHE National Executive in shadow form in January 2013 to assist in the final stages of transition. This helped to ensure the smooth transfer and ongoing effectiveness of key health protection functions and public health information campaigns.

Role of the Chief Executive

As Chief Executive and Accounting Officer, I am responsible for:

- the leadership and management of PHE
- safeguarding the public funds and assets for which I have charge
- ensuring propriety, regularity, value for money and feasibility in the handling of those funds
- ensuring that PHE is run on the basis of the standards (in terms of governance, decision-making and financial management) set out in Managing Public Money, including seeking and assuring all relevant financial approvals
- together with DH, accounting to Parliament and the public for PHE's financial performance and the delivery of its objectives
- accounting to the DH Permanent Secretary, who is the Principal Accounting Officer (PAO) for the whole of the DH's budget, providing a line of sight from DH to PHE. The responsibilities of the PAO and my relationship with them are set out in paragraphs 4.2 and 4.3 of the Framework Agreement
- reporting to the PAO on a frequency agreed between us on performance against PHE's objectives, which includes formal quarterly accountability meetings chaired by the DH Senior Departmental Sponsor

Role of the PHE Board

I am supported by a Board that provides me with strategic advice on the running of PHE and assurance on the effectiveness of PHE's corporate governance arrangements. Its terms of reference are available at www.gov.uk/phe.

The Board comprises a non-executive Chairman, at least three, but no more than seven, non-executive members appointed by the Secretary of State, and up to two associate non-executive members appointed by the Board, who are non-voting. I am the sole executive member of the Board and relevant members of the National Executive attend by standing invitation. The Board advises me on:

- the development of PHE's business plan
- PHE's financial and performance objectives and progress on meeting them
- ensuring that PHE maintains independence, and the highest professional and scientific standards in preparing and publishing its advice to the public and government, and commands the confidence of the professional and scientific communities related to public health
- issues and policies, both within the public health system and from other government departments, which could impact on the strategic direction of PHE

The Board is responsible for ensuring that effective arrangements are in place to provide assurance on risk management, governance and internal controls. The Board supports me in my role as Accounting Officer in ensuring that PHE exercises

proper stewardship of public funds, including compliance with the principles laid out in *Managing Public Money*, and ensuring that total capital and revenue resource utilised in a financial year does not exceed the amount specified by the Secretary of State.

The initial round of appointments to the Board was made in May 2013 and the final round was completed in March 2014. The Board, which meets in public, met five times during the 2013/14 financial year. Each meeting considered one of the following public health priorities: obesity, tobacco, research, global health and alcohol. External subject matter experts were invited to contribute to the Board's deliberations and their recommendations were captured in a "watch list", which was reviewed and acted on by the National Executive as appropriate with progress reported to the Board on a regular basis. The Board also received regular reports on PHE's financial performance from the Finance and Commercial Director and from the Chairman of the Audit and Risk Committee on the issues considered by it.

Role of the Board Secretary

The Board Secretary is responsible for:

- advising the Board on all corporate governance matters
- ensuring that Board procedures are followed
- ensuring good information flow between the Board, its committees and the National Executive
- facilitating induction programmes for non-executive directors

Board effectiveness

On joining the Board, non-executive members are provided with written terms of appointment, including details of how their performance will be appraised. Members also receive an induction programme comprising briefings by the National Executive, a briefing from the Board Secretary on the Board's responsibilities and procedures, and visits to PHE sites. The Board has met informally on several occasions during the year to discuss and develop its role as set out in its terms of reference.

The Board and National Executive have met jointly to discuss and agree how best the Board can assure and add value to the delivery of the organisation's objectives.

Objectives for the Chairman are set and assessed by the Senior Departmental Sponsor. The Chairman sets and assesses performance against objectives for individual Board members. The Board will undertake the first annual review of its effectiveness in 2014/15 as part of ensuring that it adds the most value to the organisation.

Register of interests

Board members are required to notify and register with the Board Secretary any issues on which they might have had a conflict of interest. Declarations of interest are invited at each and every Board meeting. A register of members' interests is maintained, and is publicly available at www.gov.uk/phe.

Standards

The Board and the National Executive are committed to the highest standards of corporate governance and follow the best practice provisions of the Corporate Governance in Central Government Departments: Code of Good Practice 2011 issued by HM Treasury. A full assessment of compliance with the Code will be undertaken by October 2014.

PHE Audit and Risk Committee

The Board has established an Audit and Risk Committee, chaired by an independent non-executive member with significant experience of financial leadership at board level. The primary role of the committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. It is the responsibility of the National Executive to agree and implement this.

The Audit and Risk Committee provides independent monitoring and scrutiny of the processes implemented in relation to governance, risk and internal control. Its work focuses on the framework of risks, controls and related assurances that underpin the delivery of PHE's objectives. The Audit and Risk Committee has a crucial function in reviewing PHE's external reporting disclosures in relation to finance and internal control, including the Annual Report and Accounts, this governance statement and other required declarations.

The Audit and Risk Committee's membership is drawn exclusively from independent non-executive members of PHE's Board and externally co-opted members. It is supported by the work programmes of internal and external audit, which ensures independence from executive and operational management. At the invitation of the committee Chairman, I, the Chief of Staff, Finance and Commercial Director, Head of Internal Audit, the external auditor (National Audit Office) and a representative of PHE's sponsor team in DH attend their meetings. The Board Secretary also attends and acts as secretary to the committee. The committee met on four occasions in the 2013/14 financial year.

The Chairman of the Audit and Risk Committee reports key issues to the PHE Board after each meeting. He also prepared and submitted an annual report on the committee's work to the Board, which was informed by a review of the committee's effectiveness to which the NAO contributed. In addition, the minutes of the Audit and Risk Committee are made publicly available as part of the papers for Board meetings.

Areas for particular focus for the committee in 2013/14 included:

- the statutory audit of the final accounts for the two largest sender bodies, the HPA and NTA, as well as tracking and monitoring outstanding audit recommendations that were carried forward into PHE
- considering and approving the inaugural internal audit plan for PHE, monitoring of its completion, and review of internal audit reports
- the development of the system of risk management
- considering PHE's Annual Report and Accounts, including reviewing the accounts, annual report and this governance statement prior to submission for audit, together with any issues arising from the audit of the accounts
- considering the accountability arrangements established to support the Accounting Officer, in particular, those relating to the public health grant to local government

- reviewing potential shared HR and Finance shared service arrangements;
- a governance report at each meeting collating information on incidents, public information access requests, parliamentary questions, complaints, clinical governance, health and safety and information governance, which provided insight into critical perspectives of PHE infrastructure

During 2013/14, the internal auditors undertook over 20 reviews as part of the plan approved by the Audit and Risk Committee. These reviews covered key business risks, with a particular focus on PHE as a new organisation.

PHE Board and Audit and Risk Committee attendance in 2013/14

	Attendance at meetings in 2013/14	
	Board	Audit and Risk Committee
David Heymann	5/5 *	
Rosie Glazebrook[1]	1/1	
George Griffin	5/5	
Sian Griffiths[2]	2/2	
Martin Hindle	5/5	3/4
Poppy Jaman[3]	1/1	
Paul Lincoln	5/5	
Derek Myers	3/5	4/4 *
Richard Parish	5/5	
Duncan Selbie	5/5	1/4

*Indicates chairman of Board or committee
[1]Rosie Glazebrook was appointed on 26 March 2014
[2]Sian Griffiths was appointed on 1 January 2014
[3]Poppy Jaman was appointed on 26 March 2014

The Board Secretary, Chief of Staff and Finance and Commercial Director attended all Board and Audit and Risk Committee meetings held in the year. The Board also received regular updates from the following members of the National Executive on their respective areas of responsibility: Deputy Chief Executive and Chief Operating Officer, Director for Health Protection and Medical Director, Director of Health and Wellbeing, Chief Knowledge Officer and Director of Nursing and Midwifery.

PHE National Executive

As Chief Executive, I am responsible for determining PHE's management arrangements. In advance of PHE's establishment on 1 April 2013, I established the PHE National Executive in shadow form to support me in delivering PHE's objectives by implementing a robust system of internal control and driving forward an agenda to deliver them.

The National Executive was formally established on 1 April 2013 and is the key decision-making body in PHE and helps mobilise internal resources to deliver its role. Its membership comprises the national and regional directors. It focuses on how PHE contributes to the national and local public health systems and identifying and solving problems and challenges facing PHE in its work with partners. Its overarching remit is to constantly improve how PHE delivers its duties.

The National Executive has considered and agreed a wide range of public health strategies, for example, on public health surveillance, research, annual health checks, and tuberculosis. It has also received regular reports on financial performance, health and safety and adverse incidents. The attendance of members of the National Executive at meetings during 2013/14 was as follows:

	Attendance at National Executive meetings in 2013/14
Duncan Selbie (Chief Executive)	20/33
Richard Gleave (Deputy Chief Executive and Chief Operating Officer)	28/33
Viv Bennett (Director of Nursing and Midwifery)	21/33
Lis Birrane (Director of Communications)	28/33
Michael Brodie (Finance and Commercial Director)	28/33
Paul Cosford (Director for Health Protection and Medical Director)	24/33
Yvonne Doyle (Regional Director – London)	26/33
Kevin Fenton (Director of Health and Wellbeing)	21/33
Jenny Harries (Regional Director – South of England)	26/33
Paul Johnstone (Regional Director – North of England)	24/33
Christine McCartney (Director of Microbiology)[1]	12/14
Jonathan Marron (Director of Strategy)	23/33
Stephen Morris (Development Adviser)	23/33
John Newton (Chief Knowledge Officer)	26/33
Rashmi Shukla (Regional Director – Midlands and East of England)	27/33
Alex Sienkiewicz (Chief of Staff)	27/33
Tony Vickers-Byrne (Director of Human Resources)	28/33
Sally Warren (Director of Programmes)	24/33

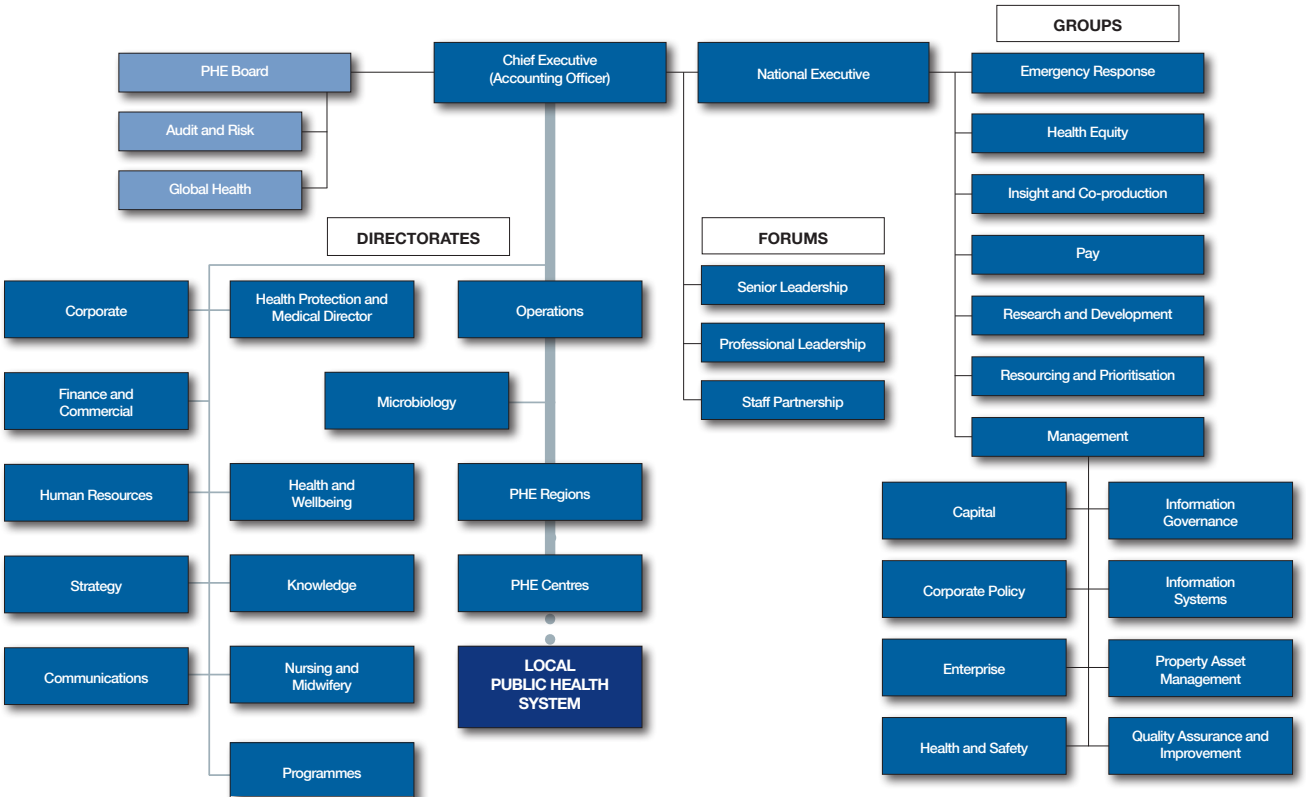
1 Joined the National Executive in October 2013

From March 2014, the National Executive has been supported by a smaller Management Committee, which provides dedicated support to me in the exercise of my role as PHE's Accounting Officer. The focus of the committee is on overseeing the delivery of PHE's responsibilities under the Framework Agreement and PHE's governance, the arrangements for which are set out on the following page.

PHE Pay Committee

The Pay Committee is a sub-committee of the National Executive and has delegated authority to deal with the following matters:

- application of the performance-related pay (PRP) process
- application of the pay remit process and implementation of the agreed pay remit
- approval of any premature retirement application on the grounds of 'the interests of the efficiency of the service
- approval of the annual PHE remuneration report
- any case which PHE is required to submit to DH or HM Treasury
- making recommendations to the National Executive on any aspect of pay policy
- considering any other relevant pay-related cases which require approval at corporate level
- approval of any professional services business cases for appointment of off-payroll fixed term contractors prior to seeking external approval as required



The committee does not deal with matters concerning its own pay; rather they are considered and decided by me as Chief Executive with the support of the recently established Remuneration Committee of the Board and in the context of DH and government-wide recruitment controls.

Performance of PHE

The DH Senior Departmental Sponsor chairs quarterly accountability and partnership meetings attended by me and other PHE and DH directors. The focus of the meeting is on strategic issues and any issues of delivery that the sponsor wishes to bring to this meeting, including compliance with the Framework Agreement. Each quarter DH reviews:

- PHE's contribution against the department's strategic objectives, and progress against the PHE business plan
- performance against the PHE performance scorecard, which includes key metrics of overall system performance alongside delivery of PHE's key actions and internal performance metrics on people, finance and governance
- PHE's financial performance, governance and risk management arrangements
- the relationship between the department and PHE, and any other key issues identified in delivery of the department's strategic objectives

Other processes in place include:

- a formal meeting between me, the Chairman and the lead Minister for Public Health which takes place at least quarterly, and with the Secretary of State at least annually
- the Minister for Public Health chairing an annual accountability meeting to review the performance and strategic development of PHE, discuss the annual report and inform the next set of objectives

- the Permanent Secretary's annual appraisal of my performance, taking account of feedback from PHE's Board
- Select Committee hearings; the first annual accountability meeting with the Health Committee was held in November 2013 and their subsequent report and recommendations were published in February 2014
- regular contact between DH's sponsor team and PHE

Our Priorities 2013/14 and corporate programmes

Our Priorities 2013/14, published in April 2013, set out the progress I wanted to see in our first year by focusing on a small number of key actions with the greatest potential to make a difference to health and wellbeing in England. The Director of Programmes established five corporate programme boards to structure the organisation's work across these high-level priorities in a matrix fashion. Each of the boards was accountable for the delivery of up to four high-level priorities, and responsibility for delivery of these priority programmes was shared across multiple directorates.

The corporate programme boards were chaired by a member of the National Executive and therefore supported a matrix management approach to delivery. Regional directors, who are also members of the National Executive, were appointed as vice-chairs to ensure that local issues identified by PHE centres were able to influence national programmes. Membership comprised staff from across PHE and a range of partners and topic experts, for example, from DH, NHS England, the Local Government Association and the voluntary and community sector.

Corporate programme boards were accountable to the National Executive and monthly reports on progress were discussed at National Executive meetings. Progress was also reported to DH as part of the quarterly PHE scorecard. The governance of PHE high-level priorities has been reviewed throughout the course of the year and a revised structure has been established in 2014/15 to structure work across the PHE business plan. The outcomes of the programmes and future work are set out elsewhere in the annual report.

PHE Science Hub Programme

The PHE Science Hub, formerly Chrysalis, is a key programme inherited from the HPA. Initially focused on the re-provision of the microbiology laboratories at Porton Down, it now focuses on bringing together into a central integrated centre many of the epidemiology and laboratory services at Porton Down, Colindale and the Whitechapel TB Reference Laboratories. The programme reflects our wider remit; its goal is to provide up-to-date facilities and enhanced services that will improve and protect the public's health, be an internationally recognised centre of excellence and offer first class training facilities and programmes for employees.

The Science Hub is a major change programme not just in terms of buildings but also in how they will enable PHE and its staff to operate. The scale of the building, operating and staff model put together have been designated as a "major project" by the government and therefore part of the quarterly Major Projects Authority (MPA) reporting system. Following an independent review by an experienced public sector capital programme professional, we refreshed the programme board that oversees its development and implementation early in the financial year. This is chaired by the Deputy Chief Executive and Chief Operating Officer, the senior responsible owner

(SRO) for the programme, and reports to the National Executive. Its membership includes a non-executive member of PHE's Board, who is also a member of PHE's Audit and Risk Committee. The programme is underpinned by detailed project plans and milestones, and regular and focused staff engagement in line with MPA and other best practice requirements.

PHE refreshed the strategic case for the programme through engagement with internal and external stakeholders to ensure that it reflected the range of PHE's responsibilities, included stakeholder perspectives in the detail of the design of the preferred option and generated the benefit criteria by which options would be compared in order that they reflected the best evidence on the benefits of co-location.

The SRO, with the support of DH as the sponsoring department, requested a Programme Assurance Review by the MPA in advance of the formal Gateway 2 Review, which is due in the summer of 2014. The Delivery Confidence Assessment at the time of the MPA's subsequent report of December 2013 was "amber" and its recommendations have been acted on and overseen by the programme board in advance of the submission of the Outline Business Case to DH, Cabinet Office and HM Treasury in July.

Quality assurance

PHE has considered the recommendations in Sir Nicholas Macpherson's review of quality assurance of government models. PHE is increasing the scope and scale of its modelling work as we seek to build a better quantitative understanding of the drivers of health and the possible future burden of ill health. We are therefore developing quality assurance processes in line with the review's recommendations. These principles are being tested in the latest work on health modelling for the Health and Wellbeing Framework and will be developed further in future iterations. As part of this, PHE:

- has identified an SRO for this modelling exercise
- has established a modelling sub-group with identified internal expertise as part of the quality assurance process to work with suppliers, test assumptions and modelled outputs and consult with external content experts
- is working within its risk management framework on the robustness, suitability and applicability of the models
- is seeking to develop in-house modelling capability to enhance the quality assurance process

PHE will ensure that all models are regarded as information assets recorded in its information management and risk system.

Internal control

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of PHE's policies, aims and objectives, which are set out in the Framework Agreement and *Our Priorities 2013/14*. In doing so, I must safeguard the public funds and assets in accordance with the responsibilities assigned to me in *Managing Public Money* and the Accounts Direction from DH of 10 February 2013.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of PHE's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised
- manage risks effectively, efficiently and economically

The system of internal control has been in place for the year ended 31 March 2014 and up to the date of approval of the Annual Report and Accounts, and accords with HM Treasury guidance.

Risk and control framework

As Chief Executive, I am accountable for the overall risk management activity in the organisation. In discharging these responsibilities, I am assisted by the following members of the National Executive:

- the Deputy Chief Executive and Chief Operating Officer, who has delegated responsibility for managing operational risk, and assists me in the day-to-day running of the organisation, including through chairing the National Executive and its Resourcing and Prioritisation Group
- the Finance and Commercial Director, who has delegated responsibility for managing financial risk and assists me in ensuring that the organisation's resources are managed efficiently, economically and effectively
- the Director for Health Protection and Medical Director, who has delegated responsibility for:
  - managing PHE's emergency response function
  - with the Director of Nursing and Midwifery, managing the strategic development and implementation of safety and quality governance, for reporting this to the Board and National Executive through its Quality Assurance and Improvement Group, and for the assessment and reporting of clinical risk
  - medical revalidation, supported by PHE's Responsible Officer and their team. The Director for Health Protection and Medical Director is also PHE's Caldicott Guardian
- the Chief of Staff, who has delegated responsibility for managing the development and implementation of strategic and corporate risk management and, from 1 January 2014, health and safety, in particular, that appropriate health and safety policies and procedures relevant to PHE's operation are in place together with governance and assurance systems to facilitate compliance with relevant legislation
- the Chief Knowledge Officer, who as the organisation's senior information risk owner (SIRO), has delegated responsibility for the organisation's information governance arrangements and advising me of any serious control weaknesses concerning information risk and governance. The Chief Knowledge Officer also has delegated responsibility for the governance of research activity carried out by PHE

As a new organisation, the risk framework and procedures were developed, implemented and reviewed during the year. The system of internal control has been developed in response to internal audit's review of risk management and an external review in this area by an independent expert.

The National Executive is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. High-level risk assessments were carried out in conjunction with the development of corporate programmes and PHE strategy, and were reviewed and communicated. National Executive members were responsible for risk management within their areas of responsibility. This included promoting risk awareness and supporting staff in managing risk. Corporate risk leads in each directorate were identified and responsible for informing and advising their director on risk management issues such as how best to implement risk management policies and procedures.

The Audit and Risk Committee, under the chairmanship of a non-executive member of the Board, provided an independent perspective of the strategic processes for risk management, and provided constructive challenge to the National Executive on its responsibility for risk, controls and associated assurance.

The system of internal control was based on an ongoing process designed to identify and prioritise the risks to the achievement of PHE's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system was in place up to the year ended 31 March 2014, and accorded with HM Treasury guidance.

Capacity to handle risk

A range of risk management training is provided to managers and there are policies in place that describe the roles and responsibilities in relation to the identification, management and control of risk. All relevant risk policies are available to staff through the PHE intranet (PHENet).

PHE's risk management policy and procedure set out responsibilities at all levels including senior-level leadership for the risk management process. In support of this, an information risk management policy clarifies specific roles and responsibilities, as do health and safety policies.

PHE aimed to minimise adverse outcomes such as harm, loss or damage to the organisation, its people or property, or those who received its services, through adequate supervision and training, appropriate delegation, continuous review of processes and the environment, and the sharing of lessons learnt and best practice.

An electronic incident management and investigation system was used to manage adverse incidents, with lessons-learnt reports being shared through email, PHE Inbox and PHE's intranet. To improve the quality of adverse incident investigations and action plans, a number of managers were trained in root cause analysis.

PHE's primary duty is to protect the public from infectious diseases and other environmental hazards and on this we remain at all times alert and ready. We have worked hard throughout the transition process and beyond to ensure that we are

able to provide effective public health emergency preparedness, resilience and response in the UK, including providing support to local and national resilience partners and to international crises as part of our role in disaster risk reduction.

PHE's generic emergency preparedness, resilience and response (EPRR) arrangements are set out in its National Incident Response Plan (NIRP). This describes the mechanisms by which PHE discharges the duties delegated by the Secretary of State for Health to its staff that are responsible for emergency planning, resilience and response, such that they operate as if PHE itself were a category 1 responder under the Civil Contingencies Act 2004. In this plan, incidents are assessed as being one of five levels. Level 1 and Level 2 are a major part of the normal acute activity of PHE centres supported by the relevant specialist service of PHE as required. Incidents that are assessed as Level 3-5 are considered to need national co-ordination and/or control and leadership, with the extent of national involvement determined on a case-by-case basis. If national co-ordination is required, a National Incident Co-ordination Centre (NICC) is opened.

These arrangements are overseen by PHE's EPPR Oversight Group, chaired by the Director for Health Protection and Medical Director, and are exercised on a regular basis. They were put into action in response to the flooding in the south of England in January and February 2014, when the maximum response level reached during these floods was Level 3 with the NICC supporting local response teams established in affected PHE centres. PHE's strategic objectives in this incident were to:

- provide technical and specialist advice, particularly with regard to microbiological and chemical hazards and mental health impacts. This was provided to national and local partners including the Cabinet Office Briefing Rooms (COBR), DH and ministers, NHS England, the Environment Agency, local multi-agency strategic co-ordinating groups and local government
- raise public awareness of the potential risks and consequences during and after a flooding event, and to provide public and professional guidance and reassurance as appropriate
- monitor the impact on health through real-time syndromic and other surveillance, particularly in relation to gastrointestinal disease
- maintain business continuity through the provision of mutual aid from unaffected areas as appropriate

The response to this Level 3 incident was regarded as successful, both within PHE and by external partners. The feedback from the debrief process has been considered by PHE and key stakeholders to inform further development of plans, training programmes and other preparedness activities for future emergencies.

Our second duty is to improve the health of the people and reduce health inequalities. We also have wider responsibilities under the Equality Act 2010. PHE established a Health Equity Board in August 2013, whose remit was subsequently extended to include issues of equality and diversity. Reporting to the National Executive twice a year, it leads a programme of work on reducing health inequalities, and provides leadership across the organisation to ensure that PHE acts with regard to the need to reduce discrimination and promote equality of opportunity. In addition, the Health Equity Board:

- receives regular reports on the progress of all the corporate programme boards in identifying and addressing health inequalities
- ensures the development of capacity and capability for promoting health equity across PHE and across the wider public health system
- is informed by and engages with a wide range of individuals and organisations including national and international academics, implementation leaders and networks, NHS England and DH

PHE's health and safety function, part of the Corporate directorate, works with colleagues across the organisation to ensure compliance with relevant legislation. In particular, it works closely with Microbiology, part of the Operations directorate, which conducts activities considered by the Health and Safety Executive to be "high hazard"; some staff work with the most dangerous pathogens (which, in some cases, have no therapeutic response), while others with radioactive material. PHE's arrangements to mitigate health and safety risk include the work of the Health and Safety Steering Group, chaired by the Chief of Staff, which implemented and reviewed PHE's health and safety strategy, improvement plans, arrangements and performance to ensure that they were appropriate.

PHE has developed and implemented a business continuity plan in order to be able to respond to any disruption to business and to recover time-critical functions where necessary. PHE has completed a self-assessment against the key areas of ISO 22301 Societal Security – Business Continuity Management Systems and has rated its arrangements as adequate. Further work will be carried out in 2014/15 to ensure appropriate levels of staff training and awareness and to test the arrangements in place.

PHE completed an assessment against the requirements of the revised Cabinet Office Security Policy Framework and overall compliance was acceptable.

In October 2013, PHE undertook an evaluation against the requirements of the Cabinet Office Fraud and Error capacity assessment. There were no areas identified where PHE's actions to manage risk of fraud or losses from financial error were determined to be weak; PHE's assessment was that the capacity to manage the risk of financial fraud was appropriate.

Capturing and responding to risk information

A strategic risk register was developed over the course of the year with input from the National Executive and the Board, including through a facilitated seminar in March 2014. This is presented to DH as part of the quarterly accountability meeting.

Directorates and corporate programmes have identified, monitored and managed risks, which feed into top-level risk information as appropriate. Operational risk registers were maintained at sub-directorate level for priority programmes and key projects. Where a risk could not be managed at a particular level within the organisation, it was escalated upwards. A bottom-up approach was in place whereby risks were reported via risk registers, orally during staff and management meetings, or through written reports. These mechanisms helped to ensure that the appropriate filtering and delegation of risk management was in place and that the system was embedded throughout the PHE.

Assessment of the adequacy of controls is a key part of PHE's systematic approach that attempts to limit risk to an acceptable residual level, rather than obviate risk altogether. The risk management team develops PHE's approach to risk management, identifies cross-cutting operational risks, and provides support to adverse incident management and investigation. It also reviews directorate and corporate programme risk registers and provides feedback to improve the quality of risk information.

PHE introduced an adverse incident and serious untoward incident management policy and procedure to provide a formal mechanism for reporting and learning from incidents. An electronic incident management and investigation system enabled management to report and track key issues. Adverse incident and other risk performance data was presented to the National Executive on a monthly basis. PHE also published reports on major events and these were used to share lessons learnt for both the PHE and its partners.

PHE works with a variety of stakeholders through partnerships and other arrangements. Partnership risks were identified through a number of forums, in particular, through PHE centres and regions and the corporate programmes. Our success or otherwise depends on being a valued and effective partner, especially given the scale of change in both the health and care sector. PHE has therefore engaged closely with local government, the NHS, government agencies and the voluntary and community sector to test its impact and effectiveness. As part of this, we commissioned Ipsos MORI to undertake the first annual stakeholder research exercise to assess how PHE is perceived externally and how well stakeholder relationships are developing. This report, which is available at www.gov.uk/phe, has provided baseline metrics against which PHE's future progress can be benchmarked.

The Quality Assurance and Improvement Group helps to ensure that robust clinical and health protection governance systems operate in PHE through implementation of the clinical governance framework, which for 2013/14 was that developed and implemented by the HPA and adopted by PHE on its establishment. This aims to ensure continuous improvement in the quality of PHE clinical services and of services that safeguard the health of the public. Clinical incident information is reviewed at each meeting to identify any changes in the pattern of incidents and enable earlier investigation. In addition, the lead Consultant in Public Health Strategy carries out weekly reviews.

Information governance

The flow of patient identifiable data (PID) between PHE and partners in the health and care sector is essential to the delivery of our national public health functions. An information risk management policy framework was established by PHE's Chief Knowledge Officer, PHE's SIRO, to ensure that all such data is adequately safeguarded. PHE's performance against information governance requirements remains an ongoing organisational priority. A PHE information asset register was developed and populated to include process maps, dependencies, and system specific risk assessments. This helps PHE to govern information risks and improve

risk and assurance information. PHE's adverse incident and serious untoward incident management policy and procedures provided a framework for the management of incidents involving personal data.

PHE measures its performance in this area using the DH/NHS Information Governance Toolkit (IGT). Our first annual IGT assessment highlighted that although there are robust practice and procedures in place in areas handling PID such as the National Cancer Registry and National Drug Treatment Monitoring System, significant work is required across the organisation as a whole to ensure consistency of standards and approach. This is a priority for early on in the 2014/15 financial year.

There were no incidents in the reporting period that fell under the criteria for reporting data loss to the Information Commissioner's Office (ICO). However, there was one incident concerning a data controller other than PHE that was reported to the ICO and which is under investigation by them. This concerned the loss of records of tests carried out by PHE staff working from an NHS provider's premises. An envelope containing patient reports was damaged in a Royal Mail sorting office in Manchester releasing some or all of the contents. Patients were notified of the event via telephone and letter by the data controller. PHE staff dispatched the reports according to local policy but Royal Mail's process and management of damaged items did not appear to have been initiated or followed. In response, the data controller and PHE have strengthened operational procedures and controls and implemented a more detailed data sharing agreement.

During the year, PHE handled a qualifying disclosure under the Public Interest Disclosure Act 1998 with respect to PID handling in one of its directorates. On investigation, the concerns were found to be unsubstantiated but, in the interests of transparency, a copy of the investigation report was sent to the ICO.

Principal risks facing PHE during 2013/14

Pandemic influenza

Pandemic influenza is one of the top risks in the National Risk Register. PHE continues to maintain a stockpile of antivirals for pandemic flu preparedness in line with DH policy for continuing to be prepared for a more severe influenza pandemic. Future stockpile decisions, will, as they have done in the past, take account of the latest scientific evidence and international comparisons, including the Cochrane Review. PHE has concluded that their recent review does not provide a reason to change current advice in relation to the use of these drugs. The market value and value in use of the antivirals remains unchanged so there has been no bearing on the valuation of the antiviral stockpile. Any future changes in pandemic flu policy and the impact on stockpiles will be agreed through the governance arrangements in place with DH.

Ring-fenced public health grant

From 1 April 2013, primary responsibility for public health in specific localities transferred to local government. This involved the transfer of funding of £2.66bn from former NHS primary care trusts and strategic health authorities to local authorities. The funding flow for the ring-fenced grant is via PHE and I am therefore the Accounting Officer for this spend.

PHE developed and implemented an assurance process that demonstrates how, as Accounting Officer, I can be assured of the regularity of spend by local authorities so that I can assert as part of PHE's Annual Accounts that the funding has been used on the purposes intended by Parliament. This sets out the sources of assurance that are in place across the system which help to ensure that the grant is utilised appropriately and includes:

- the grant conditions governing the use of the public health grant
- the financial reporting arrangements agreed with the Department for Communities and Local Government, requiring an annual budget and outturn to be reported across 18 categories of public health spend
- summary quarterly returns from each local authority to PHE
- local authority member-led scrutiny processes
- sector-led improvement
- public accountability and Freedom of Information/Parliamentary Question processes
- local authority internal and external audit arrangements
- joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs) providing clarity on priorities
- the role of directors of public health and their relationship with PHE centres and regions
- annual assurances signed by each local authority chief executive (or designated by the chief executive to s.151 officers or finance directors)

Assurance statements from all 152 upper-tier local authorities confirming compliance with grant conditions were received and reviewed by PHE as part of this process. The combination of assurances set out above has led me to conclude that the ring-fenced public health grant has been used appropriately.

Appointment of directors of public health

As PHE's Chief Executive, I am jointly responsible with local authority chief executives for the appointment of directors of public health. The vacancy rate early in the financial year, which at one point was as high as one-third, represented a significant risk to local government's ability to fulfil their new statutory duties to improve the health of their population. This was perhaps inevitable given the numbers who left during the transition of their posts from primary care trusts, by whom they were employed, to local government, either because of their age or they were allowed to do so.

This risk was effectively mitigated by ensuring that there was at least an interim director of public health in each of the local authorities that had a vacancy and the vacancy rate in March 2014 had reduced to 17%. I expect that by March 2015 that this will have reduced to 10%, which is as stable as it is ever likely to be.

Terms and conditions of PHE staff

The establishment of an organisation of the scale and complexity of PHE in a short timescale brought with it many challenges, not least of which was that the majority of staff in sender bodies were previously employed on NHS terms and conditions whereas PHE is part of the Civil Service.

We were not able to offer an equivalent pension to these staff as part of their transfer to PHE and this has meant that thousands of staff are employed on legacy terms and conditions. Creating a new forward-looking organisation when facing the resultant widespread variation in pay, often for the same job, has been challenging. This inequity has been reflected in the feedback we received in the first annual staff survey on how they felt about working for PHE. We will therefore continue to work closely with Cabinet Office colleagues to address this.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the internal auditors and the National Executive members who have responsibility for the development and maintenance of the internal control framework, together with comments made by the external auditors in their management letter and reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit and Risk Committee, National Executive and Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. Looking forward, future reviews will be informed by a documented set of returns from each National Executive member providing assurance on the internal controls in place in their respective areas of the business.

The Board, Audit and Risk Committee, National Executive and Management Committee and its sub-committees meet regularly and, as part of their consideration, keep arrangements for internal control under review through discussion and approval of policies and practice. The Audit and Risk Committee has provided the Board with an independent and objective review of financial and corporate governance, and internal financial control within PHE. The Board and National Executive receive a monthly report from the Finance and Commercial Director on financial performance and the steps taken to mitigate risks to delivery of the year-end financial control total. A report is also made to each meeting of the Audit and Risk Committee.

The National Executive has maintained strategic oversight and review of internal control and risk management through regular reports by directors on their areas of responsibility and through specific papers for discussion. The Audit and Risk Committee, which meets on a quarterly basis, has considered:

- individual internal audit reports and management responses
- the internal auditors' annual report and opinion on the adequacy of our internal control system
- National Audit Office audit reports and recommendations
- regular integrated governance reports and updates on the development of PHE's Strategic Risk Register

The internal audit and independent reviews of risk management have helped to identify the areas we need to develop in 2014/15 to develop a risk management approach aligned to our strategic goals and on which a PHE-wide Assurance Framework can be developed such that it can, in its own right, provide reasonable assurance that there is a sufficiently effective system of internal control in place.

Several external agencies and other assessors measure and report on PHE's performance against statutory and legislative requirements or best practice. They examine many potentially high-risk areas, for example, the Care Quality Commission undertook in February 2014 an inspection of our compliance with several of the national standards that apply to PHE by way of a service level agreement with them. The CQC found that PHE complied with all of the standards inspected. All significant external scrutiny reports are also reported to the appropriate committee for monitoring.

In response to an internal audit review of statutory and legislative compliance requirements, PHE's secretariat has conducted an in-depth review of the direct and indirect statutory and other legislative duties that apply to PHE in order to ensure that the relevant parts of the organisation are aware of the relevant requirements, are suitably resourced to carry them out and can provide appropriate assurance that they are being exercised in an appropriate way.

The PHE Board received reports from the Chairman of the Audit and Risk Committee concerning risk, control and governance, and associated assurance together with an annual report on its work.

Internal audit provides an independent, objective assurance and consulting service designed to add value and improve PHE's operations. Its work is based on an agreed audit plan, which is carried out in accordance with government internal audit standards. This helps to ensure that the work undertaken by internal audit provided a reasonable indication of the controls in operation across the whole of PHE. Findings from work carried out during the year were presented to the Audit and Risk Committee.

There was a small number of audits in which a "weak" level of assurance was provided, including on IT outages, risk management and the clinical governance framework. In the case of the latter, I take assurance from the fact that the clinical governance framework from the HPA, the largest sender body, was adopted by PHE on its establishment as the baseline framework and that a clinical governance framework tailored to PHE has recently been adopted. Action plans are in place to address each of the recommendations in a timely period and progress will be reviewed by internal audit as part of follow-up audits in the 2014/15 financial year.

Audit actions identified as outstanding from sender bodies were carried forward into PHE. New audit recommendations were tracked and monitored by the committee until resolved. In several review areas, it was recognised that systems, which would be judged “weak” in a developed organisation, were judged “satisfactory” in the first year of operation where the progress of controls towards a steady state was deemed appropriate.

The Head of Internal Audit has provided me with reasonable assurance that PHE has had adequate and effective systems of control, governance and risk management in place for the 2013/14 financial year but more remains to be done, which will be the focus of the Management Committee’s work programme in 2014/15.

Conclusion

I am satisfied that, overall, there have been adequate and effective governance, risk and control systems during the financial year 2013/14, the first year of PHE’s operation. These systems will need to be further developed and embedded across the organisation in its second year of operation, which the Board, Audit and Risk Committee and Management Committee will monitor and oversee.

Duncan Selbie
Chief Executive
13 June 2014



Remuneration report

This report details the policy on the appointment, appraisal and remuneration of members of the PHE Board and the National Executive for the year ended 31 March 2014. The report has been prepared in consultation with PHE's Pay Committee, and is based upon the provisions contained within the *Government Financial Reporting Manual 2013/14*.

Accountability

As a sub-committee of the National Executive, the Pay Committee is accountable to the National Executive.

Role of the Pay Committee

The terms of reference define the scope of the committee and those elements relevant to executive pay are as follows:

1) The application of the performance-related pay process.
2) The approval of any premature retirement application on the grounds of 'the interests of the efficiency of the service'.
3) Approval of the annual PHE Remuneration Report.
4) Any case which PHE is required to submit to the Department of Health (DH) or HM Treasury, and specifically for individual cases for:
   (a) any redundancy package with a capitalised cost of more than £100,000
   (b) compensation in lieu of notice of £50,000 or more
   (c) ex gratia payments to a member of PHE's staff of £20,000 or more and all special severance payments (defined as any payment in excess of, or outside of statutory or contractual entitlements) including compromise agreements.
5) Making recommendations to the National Executive on any aspect of pay policy.

The committee does not deal with matters concerning its own pay; rather issues concerning its members' pay are considered and decided by the Chief Executive.

Committee membership

The Pay Committee consists of four members of the National Executive. The members for 2013/14 were:

Members of the Pay Committee

Tony Vickers-Byrne (Director of Human Resources, Chair)
Michael Brodie (Finance and Commercial Director)
Richard Gleave (Deputy Chief Executive and Chief Operating Officer)
Alex Sienkiewicz (Chief of Staff)

All four members served on the committee throughout the year.

Appointment and appraisal of non-executive Board members

Non-executive Board members are appointed by the Secretary of State for Health for a defined term. In addition, the Board's terms of reference provide that it may appoint up to two associate non-executive members. The performance of non-executive Board members was assessed by PHE's Chairman through an annual appraisal process. The appraisal process for the Chairman was conducted by PHE's Senior Departmental Sponsor, the DH Director General of Public Health.

Remuneration of non-executive Board members

The table below lists all non-executive persons who served on PHE's Board during the year ended 31 March 2014. The date of their appointment is accompanied by the total remuneration due to each individual during their tenure in post in 2013/14.

Total remuneration due to each individual during their tenure in post in 2013/14	Date of appointment	Total salary, fees and allowances
		Year ended 31 March 2014
		£'000
Professor David Heymann (Chairman)	1 April 2013	35 - 40
Rosie Glazebrook	26 March 2014	0 - 5
Professor George Griffin	1 June 2013	5 -10
Professor Sian Griffiths (Associate)	1 January 2014	0 - 5
Poppy Jarman	26 March 2014	0 - 5
Martin Hindle	1 June 2013	5 - 10
Derek Myers**	1 June 2013	10 - 15
Professor Richard Parish	1 June 2013	5 - 10
Paul Lincoln* (Associate)	1 June 2013	5 - 10

*Paul Lincoln waived his remuneration and his entitlement was paid to his employing organisation, the UK Health Forum, to offset its cost for his time spent on PHE matters.

**The remuneration of Derek Myers reflects his position as Chairman of the PHE Audit and Risk Committee, to which he was appointed specifically by the Secretary of State for Health.

Appointment and appraisal of National Executive members

PHE adheres to the provisions of the Constitutional Reform and Governance Act 2010, which requires that Civil Service appointments are made on merit on the basis of fair and open competition. The recruitment principles published by the Civil Service Commission specify the circumstances when appointments may be made otherwise. The members of the National Executive hold employment contracts that are open-ended with notice periods of three months—except for the Chief Executive who is employed on an initial three-year contact with a six-month notice period.

Early termination by PHE, other than for misconduct, would result in the individual receiving compensation in accordance with Civil Service or NHS terms and conditions. Compensation for loss of office would be agreed by the Pay Committee, with reference to DH and HM Treasury guidelines.

Given that this was PHE's first year of operation, the Chief Executive undertook an appraisal interview with each member of the National Executive to agree objectives for 2013/14. Performance was assessed against these objectives in May 2014 and a set of core management skills and leadership qualities in future years. The Chief Executive's appraisal was conducted by the DH Permanent Secretary, taking into account feedback from the PHE Board.

REMUNERATION OF NATIONAL EXECUTIVE MEMBERS

	Date commenced, reappointed or extended	Expiry date of current contract	Notice period	Total salary, fees and allowances	Bonus payments	Pension benefits	Total remuneration
				Year ended 31 March 2014			
				£000	£000	£	£
Duncan Selbie[1] (Chief Executive)	1 April 2013	30 June 2015	6 months	185 - 190		43,145	229,046
Viv Bennett[3]	1 April 2013			105 - 110		41,292	147,192
Lis Birrane[8]	1 April 2013		3 months	100 - 105	10 - 15	23,015	134,177
Michael Brodie[4,9]	24 June 2013		3 months	105 - 110		8,934	116,656
Dr Paul Cosford[2,6]	1 April 2013		3 months	160 - 165		66,184	229,294
Dr Yvonne Doyle[2]	1 April 2013		3 months	165 - 170		43,529	213,231
Professor Kevin Fenton[2]	1 April 2013		3 months	175 - 180		27,053	203,053
Richard Gleave	1 April 2013		3 months	130 - 135		26,152	158,652
Dr Jenny Harries	1 April 2013		3 months	125 - 130		84,596	209,596
Professor Paul Johnstone[2]	1 April 2013		3 months	180 - 185		51,553	232,481
Jonathan Marron	1 April 2013		3 months	110 - 115		26,476	139,476
Dr Christine McCartney[9,10]	1 October 2013	31 March 2014	3 months	55 - 60		-	58,512
Stephen Morris[5]	1 April 2013			120 - 125		30,398	152,198
Professor John Newton[2]	1 April 2013		3 months	165 - 170		27,474	193,155
Dr Rashmi Shukla[2,7]	1 April 2013		3 months	165 - 170		48,582	216,575
Alex Sienkiewicz[5]	1 April 2013			115 – 120		49,979	164,979
Tony Vickers-Byrne[8]	1 April 2013		3 months	100 - 105	10 - 15	48,582	160,082
Sally Warren[8]	1 April 2013		3 months	80 - 85	10 - 15	34,457	131,857

1. Duncan Selbie was appointed by the Department of Health (DH) as Chief Executive Designate of Public Health England in April 2012, a role he undertook between 1 July 2012 and 31 March 2013 prior to formally assuming his role as Chief Executive of PHE on its establishment on 1 April 2013. His salary during this nine-month period was paid by DH. As part of ensuring a smooth transfer of functions, and by agreement with DH, Mr Selbie was appointed by the Health Protection Agency as its Acting Chief Executive for the period 1 February to 31 March 2013. His salary during this two-month period, which continued to be paid by DH, was £30,800. There was no cost to the HPA for this appointment.
2. The remuneration of these members of the National Executive included a clinical excellence award.
3. Seconded from the Department of Health on a part time basis at no cost to PHE.
4. Seconded to PHE for two days per week from 1 April to 23 June 2013 on non-remunerated basis from the NHS Business Services Authority.
5. Seconded from Brighton and Sussex University Hospitals NHS Trust on a full time basis.
6. Dr Cosford's remuneration includes a one off payment of £4,388 in recognition of his role as Acting Chief Executive (15 October 2012 to 31 January 2013) and Deputy Chief Executive (1 February to 31 March 2013) of the Health Protection Agency.
7. Dr Shukla's remuneration includes a one off payment of £2,545 in payment for untaken annual leave for the leave year 2012/13 while Dr Shukla was employed at the Department of Health.
8. The bonus payments relate to performance with predecessor organisations not PHE.
9. The full year equivalent salary in respect of Michael Brodie was £140,000 and in respect of Dr McCartney was £117,024.
10. Dr McCartney is not a pension scheme member.

Remuneration of National Executive members

The table on the previous page lists all persons who served on the National Executive during the year ended 31 March 2014. A summary of their employment contract is accompanied by the total remuneration due to each individual during their tenure in post in 2013/14.

Compensation for loss of office

No payment of compensation for loss of office was made to any member of the Board or National Executive during the year ended 31 March 2014.

Remuneration policy

Non-executive Board members

Non-executive Board members' remuneration is not performance related, and was determined by the Secretary of State for Health. The remuneration package is subject to an annual review by the relevant authority.

Members of the National Executive

The policy for remunerating members of the National Executive was determined by the DH in agreement with the Cabinet Office as part of the process for making permanent appointments. Their terms and conditions are either Senior Civil Service or NHS (if their posts are designated within the clinical ring fence). For those within the clinical ring fence, the terms and conditions applicable are either NHS Medical and Dental or NHS Very Senior Manager. Posts that are included within the clinical ring fence are those that meet the criteria agreed with the Cabinet Office as follows:

- a clinical qualification and professional registration is essential for the role*
- the role would have a career pathway that included training, which would have been in a publicly-funded health service
- the role would have a career pathway where any further likely promotion or professional development would remain in a publicly-funded health service
- the role has regular patient or population contact

* For the purposes of public health specialist roles, any posts meeting the Faculty of Public Health's requirements of a public health consultant/specialist will be considered clinical. For microbiology specialist roles, any posts meeting the Royal College of Pathologists' requirements for a consultant level post will be considered in the same way.

Some performance-related bonuses were paid to members of the National Executive relating to activities with predecessor organisations. In future years, performance-related payments will be available to those employed on Senior Civil Service or Very Senior Manager terms and conditions. Their remuneration package consists of a salary and pension contributions. In determining the package, the DH and Cabinet Office had regard to pay and employment policies elsewhere within the Civil Service and NHS as well as the need to recruit, retain and motivate suitably able and qualified people to exercise their different responsibilities.

The salaries of National Executive members are reviewed annually, having regard to the relevant terms and conditions applicable. For the financial year 2013/14, some members of the National Executive, employed on legacy terms and conditions, received cost-of-living increases in line with agreements reached prior to transfer to PHE.

Payments to a third party for services of National Executive members

The amount paid to Brighton and Sussex University Hospitals NHS Trust for the services of Stephen Morris and Alex Sienkiewicz were £153,430 and £147,762, respectively.

Salary, fees and allowances

Salary, fees and allowances cover both pensionable and non-pensionable amounts, and include any allowances or other payments to the extent they are subject to UK taxation. They do not include amounts that are simply a reimbursement of expenses directly incurred in the performance of the individual's duties. Expenses paid to Board members and National Executive members were published quarterly on the PHE website.

Benefits in kind

During the year ended 31 March 2014, no benefits in kind were made available to any non-executive Board member or any National Executive member.

Pension entitlements

The remuneration of non-executive Board members is not pensionable. Members of the National Executive were members of the Civil Service or NHS pension schemes. Details of both pension schemes, including benefits payable, are included in the Notes to the Financial Statements. The pension entitlements of National Executive members who were in post at 31 March 2014 are shown in the table on the following page.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially-assessed, capitalised value of the pension scheme benefits accrued by a scheme member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefit in another scheme or arrangement that the individual has transferred to the Civil Service or NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

PENSION ENTITLEMENTS OF NATIONAL EXECUTIVE MEMBERS

	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2014	Lump sum at age 60 related to accrued pension at 31 March 2014	Cash Equivalent Transfer Value at 1 April 2013	Cash Equivalent Transfer Value at 31 March 2014	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension	Total pension entitlement at 31 March 2014
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	To nearest £1,000	To nearest £1,000	To nearest £1,000	To nearest £1,000	To nearest £5,000
Chief Executive									
Duncan Selbie[1]	2.5 - 5.0	0.0 - 2.5	110.0 - 115.0	0.0 - 5.0	1,563	1,696	29	-	110.0 - 115.0
Executive directors									
Viv Bennett	2.5 - 5.0	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	17	52	26	-	0.0 - 5.0
Lis Birrane[2]	0.0 - 2.5	2.5 - 5.0	10.0 - 15.0	35.0 - 40.0	249	283	29	-	10.0 - 15.0
Michael Brodie[1]	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	-	9	-	-	0.0 - 5.0
Dr Paul Cosford[1]	2.5 - 5.0	7.5 - 10.0	50.0 - 55.0	150.0 -155.0	824	918	76	-	50.0 - 55.0
Dr Yvonne Doyle[2]	0.0 - 2.5	5.0 - 7.5	40.0 - 45.0	125.0 -130.0	835	918	64	-	40.0 - 45.0
Professor Kevin Fenton[1]	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	11	34	8	-	0.0 - 5.0
Richard Gleave[1]	0.0 - 2.5	0.0 - 2.5	10.0 - 15.0	0.0 - 5.0	150	191	15	-	10.0 - 15.0
Dr Jenny Harries[1]	2.5 - 5.0	10.0 - 12.5	30.0 - 35.0	90.0 - 95.0	549	655	93	-	30.0 - 35.0
Professor Paul Johnstone[1]	2.5 - 5.0	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	-	31	31	-	0.0 - 5.0
Jonathan Marron[1]	0.0 - 2.5	0.0 - -2.5	15.0 - 20.0	50.0 - 55.0	213	246	11	-	15.0 - 20.0
Dr Christine McCartney[3]	-	-	-	-	-	-	-	-	-
Stephen Morris	0.0 - 2.5	2.5 - 5.0	40.0 - 45.0	120.0 -125.0	749	813	48		40.0 - 45.0
Professor John Newton[1]	0.0 - 2.5	2.5 - 5.0	50.0 - 55.0	160.0 -165.0	1,181	1,272	64	-	50.0 - 55.0
Alex Sienkiewicz	0.0 - 2.5	5.0 - 7.5	5.0 - 10.0	25.0 - 30.0	85	116	30		5.0 - 10.0
Dr Rashmi Shukla[1]	0.0 - 2.5	0.0 - 2.5	0.0 - 5.0	0.0 - 5.0	-	40	40	-	0.0 - 5.0
Tony Vickers-Byrne[2]	0.0 - 2.5	0.0 - 2.5	35.0 - 40.0	110.0 - 115.0	706	752	30	-	35.0 - 40.0
Sally Warren[1]	0.0 - 2.5	5.0 - 7.5	15.0 - 20.0	45.0 - 50.0	146	174	14	-	15.0 - 20.0

1. New member to PHE.
2. Continuity of membership from predecessor body.
3. Not a pension scheme member.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement), and uses common market valuation factors for the start and end of the period.

Comparison of median pay to highest earning director's remuneration

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in PHE in the financial year 2013/14 was £185,000 to £190,000. This was 5.1 times the median remuneration of the workforce, which was £36,163.

In 2013/14, remuneration across the PHE workforce ranged from £14,653 to £208,000. Three employees received remuneration in excess of the highest-paid director (ie more than £185,000 to £190,000).

The table below shows a comparison between the median workforce remuneration and the remuneration of the highest-paid director. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

COMPARISON OF MEDIAN PAY TO HIGHEST EARNER'S REMUNERATION

	Year ended 31 March 2014
Highest earning director's total remuneration	£185,000 to £190,000
Median total remuneration*	£36,163
Ratio of median remuneration and remuneration of highest earning employee	5.1

*The calculation of the median salary is based on the total remuneration of staff employed at 31 March 2014 and uses basic salary plus recurrent allowances. The calculation excludes staff who had periods of unpaid maternity or sick leave. The remuneration for part-time staff has been adjusted to the appropriate full-time equivalent figure.

Auditable and non-auditable elements of this report

The tables in this remuneration report, as well as the details of amounts payable to third parties for the services of senior managers, have been subject to audit and are referred to in the Certificate and Report of the Comptroller and Auditor General to the House of Commons. The auditor's opinion is included within the Auditor's Report on page 79.

Duncan Selbie
Accounting Officer
13 June 2014

Financial review

Accounts direction

The financial statements contained within this first Annual Report and Accounts relate to the financial year 1 April 2013 to 31 March 2014. They were prepared in accordance with the Accounts Direction given by HM Treasury under section 7(2) of the Government Resources and Accounts Act 2000.

Accounts preparation and overview

PHE's accounts consist of primary statements (which provide summary information) and accompanying notes. The primary statements comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity. The accounts were compiled according to the standards set out in the *Government Financial Reporting Manual* issued by HM Treasury (FReM), which is adapted from International Financial Reporting Standards (IFRS), to give a true and fair view of the state of affairs.

As a result of the Health and Social Care Act 2012, the activities and financial positions from a number of functions transferred into PHE on a going concern basis and are reflected in the opening position. During the year, financial performance was reported in three operating segments. These are:

- distribution of public health grants to local authorities in England made on behalf of the Department of Health (DH)
- activities carried out on behalf of DH in the oversight and reporting of immunisation and countermeasures (vaccines)
- our operating expenditure – the costs of running PHE and its programmes of activity

PHE's funding regime

Funding for revenue and capital expenditure is received through the parliamentary supply process as grant-in-aid (GIA), and allocated within the main DH estimate. PHE also receives significant additional income from additional services provided to customers, grant-funded bodies and the devolved administrations.

Funding in 2013/14

For 2013/14, the funding provided by the DH for our three operating segments was as follows:

- local authority grants: ring-fenced programme revenue within a limit of £2,662m
- vaccines: ring-fenced programme revenue within a limit of £412m
- operating activities: non ring-fenced admin and programme revenue within a limit of £405m

Financial performance

In 2013/14, PHE achieved all of its financial targets by managing resources in line with the budgets set and voted through the parliamentary supply process.

Through the year, the timing and delivery of planned activity was reviewed and re-phased in line with health priorities and recruitment to the many posts which were vacant at transition, leading to minor overspends and underspends in certain areas. Overall, however, financial performance was broadly in line with that originally planned, so that at the end of the financial year, PHE had a net underspend of £7m (0.2%) against a net expenditure budget of £3,503.3m, supported by £180.3m of operational income from a variety of sources such as research grants, commercial services and contract income. Vaccine sales of £51.2m have been made to other government agencies in the year. These sales are a transfer of stock and not reported within the analysis of operational income, however, the financial statements recognise both the sales and the cost of sales at £51.2m.

PHE is operating in a challenging economic climate but considers that it is well-placed to continue to manage resources and deliverables in line with anticipated future funding settlements. Expenditure will be reviewed as part of efficient management of the organisation, including a strategic review to be performed in the first half of 2014/15. The operating expenditure of PHE will, in any event, continue to be largely funded by GIA from DH. A commercial strategy has been developed to support the organisation in continuing to deliver income at sustainable levels, recognising that at least some of this is driven by market demand.

Overall results

Net expenditure for 2013/14 totalled £3,498.3m. The table below provides a summary of our financial performance for the year showing a high level breakdown of our income and expenditure against budget for the year.

2013/14 (£m)	Full year		
	Budget	Actual	Variance
External operational income:			
Operating activities	170.6	169.8	(0.8)
Vaccines	10.5	10.5	-
Total operational income	**181.1**	**180.3**	**(0.8)**
Expenditure:			
Pay	300.3	285.5	14.8
Non-pay	287.3	294.5	(7.2)
Local authority grants	2,661.8	2,662.9	(1.1)
Vaccines	412.3	412.3	-
Depreciation	24.7	23.4	1.3
Total expenditure	**3,686.4**	**3,678.6**	**7.8**
Net expenditure	**3,505.3**	**3,498.3**	**7.0**

The financial performance information above forms the basis of the Statement of Comprehensive Net Expenditure, which also includes the following material adjustments:

- net gain on revaluation of property, plant, equipment and intangible assets of £0.8m
- a one-off gain of £826.4m due to assets being transferred into PHE from DH

Operational income

An important part of PHE's work is the provision of products and services to national and local government, the NHS, industry, universities and research foundations, throughout the UK and worldwide.

Any income generated from PHE's products and services supports our public health work, offsets the cost to taxpayers, and serves to maximise PHE's impact on public health.

In 2013/14, PHE generated operational income of £180.3m from supplies and services to third parties, which is broken down below:

	Budget	Actual	Variance
	£m	£m	£m
NHS laboratory contracts	44.5	43.8	(0.7)
Research grants	34.5	30.8	(3.7)
Commercial services	30.0	26.3	(3.7)
Products and royalties	60.3	62.8	2.5
Other	11.8	16.6	4.8
External operational income	**181.1**	**180.3**	**(0.8)**

Public health grants

PHE provides a public health grant (£2.66bn in 2013/14) to local authorities to support every upper tier and unitary local authority to fulfil its duty to improve the public's health. The Chief Executive of PHE is the Accounting Officer for the grant. Local authorities are required to discharge a small number of mandated services, but are otherwise free to set their own priorities, working with local partners, through health and wellbeing boards. PHE supports local authorities by providing evidence and knowledge on local health needs and by taking action nationally where it makes sense to do so.

Immunisation and countermeasures (vaccines)

On 1 April 2013, PHE inherited from DH the responsibility for overall vaccine procurement, distribution and inventory control. Vaccines that relate to 'emergency stocks' are capitalised rather than charged as revenue expenditure, however, the administration costs are accounted for within PHE's budget and in-year funding is variable and dependent on the priorities set by the department/ministers. For 2013/14, the combined expenditure and capital budget was set at £423m.

Relationships with suppliers

PHE is committed to the Better Payment Practice Code. Its policy is to pay 90% of all suppliers with 10 days of receipt of a valid invoice. PHE systems record the invoice date rather than the date of receipt, so payment will have been faster than the recorded statistics.

In 2013/14, 70% of supplier bills were paid within five days and 95% within 30 days. No interest payments were made to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998.

Payment period in days	0 to 5	6 to 10	11 to 30	Over 30	Total
	£000s	£000s	£000s	£000s	£000s
Value of invoices	**208,015**	**51,504**	**69,888**	**36,518**	**365,925**
	57%	14%	19%	10%	100%
Number of invoices	**70,908**	**11,333**	**13,799**	**5,432**	**9,652**
	70%	11%	14%	5%	100%

Full monthly statistics on PHE's prompt payment data can be seen at www.gov.uk/phe.

Exposure to liquidity and credit risk

Since PHE's net revenue resource requirements are mainly financed by government GIA, the organisation is not exposed to significant liquidity risks. In addition, most of PHE's partners and customers are other public sector bodies, which means there is no deemed credit risk. However, PHE has procedures in place to regularly review credit levels. For those organisations that are not public sector bodies, PHE has policies and procedures in place to ensure credit risk is kept to a minimum.

Pensions costs for current staff

The treatment of pensions liabilities and relevant scheme details are set out in note 3.2 to the financial statements and in the Remuneration Report.

Efficiency measures and delivering value for money

PHE participates fully in the efficiency measures announced by the government in May 2010 and the transparency rules introduced during 2010/11. Expenditure and procurement controls are embedded throughout PHE's business-as-usual processes and complement operational management.

Back office review

PHE is committed to continuously improve understanding of the organisation's costs and develop more efficient ways of working. As part of a programme called 'making it easier to do business', the organisational business processes have been reviewed and streamlined. PHE is committed to delivering its back office services to best practice benchmark standards.

Hosted services

In 2013/14, as part of value for money considerations, PHE provided a hosted service to the Medicines and Healthcare products Regulatory Authority in respect

of transactional accounting. The income and expenditure entries as processed through the hosted service do not form part of PHE accounts. The income received by PHE for the provision of the hosted service was £305,000. This arrangement will continue through 2014/15.

Future developments

It is anticipated that the government spending review process will continue the drive to reduce public spending, with plans for significant reductions in funding in 2014/15 and 2015/16. Like all public services, we are facing significant financial challenges in the short term. We are in the process of undertaking a strategic review of all our functions with a view to ensuring that PHE remains fit for purpose for the future and 'right sized' to deliver against our challenging public health agenda. As well as reviewing all our functions we will continue to look at how we can deliver our services more efficiently through, for example, smarter procurement.

Going concern basis

PHE came into operation on 1 April 2013. Based on normal business planning and control procedures, and with the continuing financial support of government, the Board has reasonable expectation that PHE has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Board adopts the going concern basis for preparing the financial statements.

Audit services and costs

The Comptroller and Auditor General is head of the National Audit Office (NAO) and is appointed as the external auditor of PHE under section 7 of the Government Resources and Accounts Act 2000. The auditor's remuneration was £210,000 for 2013/14. This is a notional fee. In addition, NAO provided audit services in respect of the provision of EU grant funds at a cost to PHE of £3,600. The internal audit function has been provided by DH internal auditors under a non-statutory engagement to provide an independent review of the systems and financial activities and transactions supporting these annual accounts.

Disclosure of relevant audit information

During the audit of these financial statements my staff and I have co-operated fully with the Comptroller and Auditor General. I have taken all feasible steps to ensure that I am fully aware of all information pertinent to the audit and to ensure that this information is notified and made available to the organisation's auditors. Consequently, as far as I am aware, there is no relevant audit information that has not been available to the auditors.

Duncan Selbie
Accounting Officer
13 June 2014

3 Accounts

Statement of Accounting Officer's responsibilities

Under Accounts Direction, given by HM Treasury in accordance with section 7(2) of the Government Resources and Accounts Act 2000, Public Health England (PHE) shall prepare accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of PHE and of its net expenditure, application of resources, changes in taxpayers' equity and the cash flow statement for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *Government Financial Reporting Manual* and in particular to:

- observe the Accounts Direction given by HM Treasury, including the relevant accounting and disclosure requirements
- apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *Government Financial Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis

The Accounting Officer for the Department of Health has appointed the Chief Executive as the Accounting Officer for PHE. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding PHE's assets, are set out *Managing Public Money* published by HM Treasury.

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements of Public Health England for the year ended 31 March 2014 under the Government Resources and Accounts Act 2000. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

RESPECTIVE RESPONSIBILITIES OF THE ACCOUNTING OFFICER AND AUDITOR

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Government Resources and Accounts Act 2000. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

SCOPE OF THE AUDIT OF THE FINANCIAL STATEMENTS

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to Public Health England's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by Public Health England, and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Strategic Report and Directors' Reports to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

OPINION ON REGULARITY

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

OPINION ON FINANCIAL STATEMENTS

In my opinion:

- the financial statements give a true and fair view of the state of Public Health England's affairs as at 31 March 2014 and of the net operating cost for the year then ended; and
- the financial statements have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder.

OPINION ON OTHER MATTERS

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000; and
- the information given in the Financial Review, Corporate Information and the Sustainability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

MATTERS ON WHICH I REPORT BY EXCEPTION

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my reporting have not been received from branches not visted by my staff; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

REPORT

I have no observations to make on these financial statements.
Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
London SW1W 9SP
25 June 2014

Statement of comprehensive net expenditure

FOR THE PERIOD ENDED 31 MARCH 2014

Administration Costs	Note	2013/14 Staff Costs	2013/14 Other Costs	2013/14 Income
		£000	£000	£000
Staff costs	3	119,661	-	-
Administrative costs	4	-	78,938	-
Operating income	6	-	-	(57,996)
Non-operating income				(333)
Total		**119,661**	**78,938**	**(58,329)**
Programme costs				
Staff costs	3	165,793	-	-
Programme costs	5	-	3,365,446	-
Operating income	6	-	-	(173,228)
Total		**165,793**	**3,365,446**	**(173,228)**
Total costs		**285,454**	**3,444,384**	**(231,557)**
Net operating cost				**3,498,281**
Gain on transfer by absorption	1.30			(826,393)
Total net costs				**2,671,888**

Other comprehensive expenditure

FOR THE PERIOD ENDED 31 MARCH 2014

	Note	2013/14 £000
Total net costs for the year ended 31 March 2014		2,671,888
Items that will not be reclassified to net operating costs:		
Net (gain) on revaluation of property, plant and equipment	7	(837)
Total comprehensive expenditure for the year ended 31 March 2014		**2,671,051**

Statement of financial position

FOR THE PERIOD ENDED 31 MARCH 2014

	Note	2013/14
		£000
Non current assets:		
Property, plant and equipment	7	927,591
Intangible assets	8	6,411
Financial assets	12	92
Total non current assets		**934,094**
Current assets:		
Trade and other receivables	12	44,163
Inventories	11	131,719
Cash and cash equivalents	13	129,430
Total current assets		**305,312**
Total assets		**1,239,406**
Current liabilities		
Trade and other payables	14	(123,308)
Provisions	15	(6,722)
Total current liabilities		**(130,030)**
Non current assets plus net current assets		**1,109,376**
Non current liabilities		
Provisions	15	(2,597)
Other payables	14	-
Total non current liabilities		**(2,597)**
Assets less liabilities		**1,106,779**
Taxpayer's equity		
General fund		1,073,167
Revaluation reserve		33,612
Total taxpayer's equity		**1,106,779**

The notes on pages 85 to 116 form part of these accounts
The financial statements on pages 81 to 84 were signed by:

Duncan Selbie
Accounting Officer
13 June 2014

Statement of cash flows

FOR THE PERIOD ENDED 31 MARCH 2014

Cash flows from operating activities	**Note**	**2013/14**
		£000
Net operating cost		(3,498,281)
Adjustments for non cash transactions		
Auditor remuneration	4	210
Loss on de-recognition of property, plant and equipment	4/5	76,846
Loss on disposal of asset held for sale	5	65
Reclassification of stockpiled goods	7	157
Amortisation and depreciation	4/5	23,375
Provision for impairments	4	29
Loss on disposal of inventories	11	(48)
Revaluation of assets written off to the statement of comprehensive net expenditure	7	50
Impairment of revaluation reserve	10	1,008
Transfers relating to modified and absorption accounting	1.30	122,768
(Increase) in trade and other receivables		(44,163)
(Increase) in inventories		(131,719)
Increase in trade payables		123,308
Expenditure charged to provisions	15	(188)
Increase in provisions	15	9,507
Net cash outflow from operating activities		**(3,317,076)**
Cash flows from investing activities		
Purchase of property, plant and equipment	7	(126,684)
Purchase of intangible assets	8	(2,800)
Increase in non-current financial assets		(92)
Net cash outflow from investing activities		**(129,576)**
Cash flows from financing activities		
Net parliamentary funding		3,576,082
Net cash inflow from financing activities		**3,576,082**
Net increase in cash and cash equivalents in the period		**129,430**
Cash and cash equivalents at the beginning of the period	13	-
Cash and cash equivalents at the end of the period	13	**129,430**

Statement of changes in taxpayers' equity

FOR THE PERIOD ENDED 31 MARCH 2014

	Note	General fund £'000	Revaluation reserve £'000	Total £'000
Balance at 1 April 2013		-	-	-
Transfers under modified absorption accounting	1.30	193,084	2,957	196,041
Transfers under absorption accounting	1.30	(32,475)	32,475	-
Net parliamentary funding		3,576,082	-	3,576,082
Net parliamentary funding – legacy items paid by Department of Health		4,537	-	4,537
Non cash charges: auditor's remuneration		210	-	210
Impairment of revaluation reserve	10	-	1,008	1,008
Net gain on revaluation of property, plant and equipment	7	-	837	837
Release of revaluation reserve in respect of de-recognised assets		3,617	(3,617)	-
Loss on disposal of inventory		-	(48)	(48)
Total net operating costs for the year		(2,671,888)	-	(2,671,888)
Balance at 31 March 2014		**1,073,167**	**33,612**	**1,106,779**

Notes to the financial statements

1 STATEMENT OF ACCOUNTING POLICIES

1.1 Statement of accounting policies

PHE is required, by its Accounts Direction given by HM Treasury, to prepare financial statements that present a true and fair view of its results for the year.

The financial statements have been prepared in accordance with the *Government Financial Reporting Manual* (FReM) 2013/14 issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of PHE for the purpose of giving a true and fair view has been selected. The particular policies adopted by PHE are described below. They have been applied consistently in dealing with items considered material to the accounts.

PHE prepares primary statements as required by IFRS and the Companies Act (a statement of comprehensive net expenditure, a statement of financial position, a statement of changes in taxpayer's equity and a statement of cash flows).

1.2 Operating segments

In accordance with IFRS 8, PHE's activities are considered to fall within three distinct segments: the payment of ring-fenced public health grants to local authorities, expenditure on vaccines and emergency countermeasures and operating expenditure relating to (mainstream) activity. Details of income and expenditure and assets and liabilities of each of the segments are shown in note 2 and are disclosed in more detail within the relevant notes to the accounts.

1.3 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation to fair value of property, plant and equipment, intangible assets, certain financial assets and financial liabilities and stockpiled goods.

1.4 Going concern

PHE exists as an executive agency established within the Department of Health and PHE's annual report and accounts are produced on a going concern basis.

1.5 Short-term employment benefit costs

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

Annual leave that has been earned but not taken at the year-end is recognised in the financial statements.

1.6 Retirement benefit costs

Past and present employees are covered by one of three defined benefit schemes:

The Principal Civil Service Pension Scheme
The NHS Pension Scheme
The UKAEA Combined Pension Scheme

PHE recognises the expected cost of these elements on a systematic and rational basis over the period during which it benefits from employees' service by payments to the scheme of amounts calculated on an accruing basis. Liability for future benefits is a charge on the schemes. In respect of the defined contribution scheme, PHE recognises the contributions payable for the year.

Full details can be found at note 3.

1.7 Administration and programme costs

The statement of comprehensive net expenditure is analysed between administration and programme costs, as defined by HM Treasury. Programme costs are defined as 'front-line' service delivery; administration costs are those that are not programme costs.

1.8 Grants payable

Grants made by PHE (including public health grants made to local authorities) are recognised as expenditure in the period in which they are paid.

Public health grants are ring-fenced grants to local authorities (upper tier and unitary local authorities) in England, intended to enable relevant local authorities to discharge their new public health responsibilities.

If there are funds left over at the end of the financial year, local authorities can carry these over into the next financial year as part of a public health reserve. All conditions that apply to the use of the grant will continue to apply to any funds carried over.

1.9 Audit costs

PHE is audited by the Comptroller and Auditor General. No cash charge is made for this service but a notional charge reflecting the cost of audit is included in expenditure. This notional charge covers the audit costs in respect of PHE's annual report and accounts.

1.10 Value added tax (VAT)

PHE is registered for VAT. VAT is charged on invoices for business contracts relating to products, services and research activities. PHE recovers part of its input VAT proportionate to its business activities in relation to total income. Expenditure is shown net of recoverable VAT. Non-recoverable VAT is charged to the most appropriate expenditure or capitalised if it relates to a non-current asset.

1.11 Corporation tax

PHE is not liable to pay corporation tax.

1.12 Income

Operating income comprises fees and charges for goods and services provided and is recognised when the service is rendered and the stage of completion of the transaction at the end of the reporting period can be measured reliably, and it is probable that economic benefit associated with the transaction will flow to PHE. Income is measured at fair value of the consideration receivable.

Non-operating income includes the proceeds from the sale of investments and non-current assets.

Income is deferred where it is received for a specific activity, which is to be delivered in the following financial year.

Net parliamentary funding received for revenue purposes from the Department of Health is treated as a contribution from a controlling party rather than as operating income and is, therefore, credited directly to the general reserve as it is received.

1.13 Non-current assets: property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, PHE
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- collectively, a number of items have a total cost of at least £5,000 where the items are purchased together and will be used for the same common operational purpose and not distributed to various operational or geographical activities and each item is assessed as having a similar useful life so that they are all likely to have simultaneous disposal dates and are under single managerial control

Where an asset includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful economic lives.

Valuation of property, plant and equipment

All property, plant and equipment is measured initially at cost representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner

intended by management. It is classified under assets under construction, until the point at which the asset is brought into use. All assets are measured subsequently at fair value.

The fair value of freehold land and buildings is determined by an independent valuation carried out every five years in accordance with guidance issued by the Royal Institute of Chartered Surveyors. A valuation was last undertaken on 31 March 2013. Valuation is on an open market (existing use) basis except for buildings of a specialised nature, where a market value is not readily obtainable, which are valued on a depreciated replacement cost basis. In the years when no valuation occurs, land and buildings are reviewed to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Other property, plant and equipment are valued at depreciated replacement cost, which is used as a proxy for fair value. The depreciated replacement cost is calculated by applying, annually, the producer price indices published by the Office for National Statistics (ONS). ONS have advised that these are the most appropriate indices for this purpose.

IT equipment that is held for operational use is valued at depreciated historic cost as a proxy for fair value. This is in accordance with FReM requirements as these assets have short lives, or low values, or both. Transport equipment, furniture and fittings and plant and machinery that is held for operational use are valued at modified historic cost as a proxy for fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is only recognised as an impairment charged to the revaluation reserve when it does not result from a loss in the economic value or service potential to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported in the statement of changes in taxpayers' equity.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Assets under construction

Assets in the course of construction are carried at cost, less any impairment loss. Cost includes professional fees. Assets are re-valued and depreciation commences when they are brought into use.

1.14 Non-current assets: intangible assets

Intangible non-current assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of PHE's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, PHE, where the cost of the asset can be measured reliably; and where the cost is at least £5,000. Intangible non-current assets in PHE comprise software and websites.

Following initial recognition, intangible assets are carried on the statement of financial position at cost, net of amortisation and impairment, or depreciated replacement cost where materially different. Amortisation is calculated on a straight-line basis over the useful life of the asset. Useful lives are determined on an individual asset basis in accordance with the asset's anticipated economic life.

1.15 Research and development

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Development expenditure is capitalised to the extent that it results in the creation of an asset and only if, all of the following have been demonstrated from the date when the criteria for recognition are initially met:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to reliably measure the expenditure attributable to the intangible asset during its development. The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred

Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

1.16 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, stockpiled goods and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated remaining useful lives.

The estimated useful life of an asset is determined on an individual asset basis by the period over which PHE expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year-end, with the effect of any changes recognised on a prospective basis.

Expected useful lives are as follows:

Asset category	Expected useful life
Freehold buildings	Up to 80 years
Freehold land	Not depreciated
Leasehold land	Over the lease term
Fixtures and fittings	Up to 20 years
Plant and equipment	5 to 20 years
Vehicles	7 years
Information technology equipment	3 to 5 years
Software licences	The life of the licence or 3 years
Website	Up to 3 years
Assets under construction	Not depreciated
Stockpiled goods	Not depreciated

At each financial year-end, PHE determines whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is an indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset being impaired and, thereafter, to expenditure.

1.17 Grants received for capital purchases

Capital grants receivable from non-government bodies for the purchase of specific capital assets are recognised as income as they are received provided no conditions are attached. Where there are conditions attached to the grant, the income is transferred to deferred income until those conditions are met.

1.18 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is satisfied once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale is highly probable

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the statement of comprehensive net expenditure. On disposal, the balance for the asset in the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that are to be scrapped or demolished do not qualify for recognition as held for sale. Instead, such an asset is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.19 Leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Lease premiums paid for leasehold property are shown as financial assets (leasehold premium prepayments) in the statement of financial position. The prepayments are released annually to operating costs over the life of the relevant leases.

PHE does not enter into finance leases.

1.20 Inventories and stockpiled goods

Inventories are valued at the lower of cost (or net current replacement cost if materially different) and net realisable value. Stockpiled goods are held at fair value. Where necessary, provision is made for obsolete, slow moving and defective inventories.

For inventories held for resale, net realisable value is based on estimated selling price less further costs expected to be incurred to completion. Work in progress is valued at cost, less the cost of work invoiced on incomplete contracts and less foreseeable losses. Cost means direct costs plus production overheads.

Internally generated stock is classified as an inventory when it has passed quality testing.

Inventories and stockpiled goods held by PHE are held at last price paid as a proxy for the lower of cost and net realisable value and fair value, respectively. This is considered to be a reasonable approximation due to the high turnover of stocks. PHE undertakes an annual review of the difference between the last price paid for stockpiled goods and fair value. Where the difference is found to be material, the stockpiled goods are re-valued to fair value.

Strategic goods held for use in national emergencies (stockpiled goods) are held as non-current assets within property, plant and equipment. These stocks are maintained at minimum capability levels by replenishment to offset write-offs and so are not depreciated, as agreed with HM Treasury.

1.21 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and which are readily convertible to known amounts of cash with insignificant risk of change in value. PHE does not hold cash equivalents.

In the statement of cash flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of cash management.

Cash, bank and overdraft balances are recorded at current values. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, 'interest receivable' and ' interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.22 Provisions

Provisions are recognised when:

- PHE has a present legal or constructive obligation as a result of a past event
- it is probable that PHE will be required to settle the obligation and
- a reliable estimate can be made of the amount of the obligation

The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Provisions are reviewed annually as at the date of the statement of financial position and are adjusted to reflect the latest best estimate of the present obligation concerned. These adjustments are reflected in the statement of comprehensive net expenditure for the year.

1.23 Contingent liabilities and contingent assets

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of PHE

  or

- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of PHE. A contingent asset is disclosed where an inflow of economic benefits is probable.

In addition to contingent liabilities disclosed in accordance with IAS 37, PHE discloses for parliamentary reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to Parliament in accordance with the requirements of *Managing Public Money.*

Where the time value of money is material, contingent liabilities that are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to Parliament is separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to Parliament.

1.24 Financial instruments

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Investments, comprising unlisted investments, are carried at historic cost in the statement of financial position because a readily ascertainable market value cannot be obtained.

Trade and other receivables are measured at amortised cost. This is assumed to equal the invoiced amount, as the impact of discounting is not material. Accrued amounts not invoiced are measured at the estimated fair value of the goods or services rendered. Trade and other receivables are tested annually for impairment and the difference between the carrying amount and the impaired value is written off to operating costs. The carrying value of loans and receivables on the statement of financial position is net of a provision for impairment.

Cash and cash equivalents are shown at fair value, which is either the sterling balance or the sterling equivalent of foreign currency balances as at the statement of financial position date.

Trade and other payables are measured at the invoiced amount, which is equivalent to fair value. Goods or services received but not yet invoiced are accrued at estimated fair value. Contractual provisions are measured in accordance with note 1.22.

1.25 Financial assets

Financial assets are recognised on the statement of financial position when PHE becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

At the statement of financial position date, PHE assesses whether any financial assets are impaired. Financial assets are impaired, and impairment losses recognised, if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of comprehensive net expenditure.

1.26 Financial liabilities

Financial liabilities are recognised in the statement of financial position when PHE becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are initially recognised at fair value.

1.27 Foreign exchange

The functional and presentational currency of PHE is pounds sterling.

Transactions denominated in foreign currencies are translated into sterling at the exchange rate ruling on the date the transaction takes place. Balances denominated in foreign currencies are translated into sterling at the exchange rate ruling as at the statement of financial position date. Exchange rate gains and losses are recognised in the statement of comprehensive net expenditure in the period in which they arise.

1.28 Assets belonging to third parties

Assets belonging to third parties that are under PHE's control, but which were funded by and remain in the ownership of third parties, are not recognised in the accounts since PHE has no beneficial interest in them. These amounts are disclosed in note 22.

Assets purchased by third parties from grants awarded by PHE are not disclosed in the accounts. The expenditure on such grants is charged to revenue in PHE's accounts because PHE has no beneficial interest in the assets, which are owned by the third parties.

1.29 Losses and special payments

Losses and special payments are items that the Department of Health would not have contemplated when it agreed funds for PHE. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled. Further information can be found on the HM Treasury website: www.hm-treasury.gov.uk. Losses and special payments are disclosed in note 20 and are charged to the relevant functional headings.

1.30 Transfer of functions

As at 1 April 2013, PHE was formed from the functions of the Health Protection Agency (except for those functions relating to the National Institute for Biological Standards and Control), the National Treatment Agency and a number of other sender functions including Strategic Health Authorities and Primary Care Trusts. As public sector bodies are deemed to operate under common control, business reconfigurations are outside the scope of IFRS 3 Business Combinations and the FReM 2013/14 requires the use of absorption accounting for such transfers, where the transfer is within a departmental group.

The FReM requires absorption accounting for transfers of functions below department level within a departmental group. However, HM Treasury has agreed a departure from FReM for 2013/14 for the Department of Health Group in respect of balances that transfer from sender functions which have closed and require successor bodies to apply a modified version of "absorption accounting" such that the gain arising on receipt of an asset (or loss arising on the transfer of a liability) is recognised in reserves rather than in current year income and expenditure. The FReM does not require retrospective adoption of the absorption accounting policy. Consequently, prior year transactions have not been included.

Where only part of a sender function has transferred, the gain or loss resulting is recognised in the statement of comprehensive net expenditure, and is disclosed separately from operating costs.

1.31 Accounting for the costs of the Carbon Reduction Commitment Energy Efficiency Scheme

PHE participates in the Carbon Reduction Commitment Energy Efficiency Scheme, which is in its introductory phase until April 2014. PHE is required to purchase and surrender allowances, currently retrospectively, on the basis of emissions, ie for carbon dioxide produced as energy is used. A liability and an expense are recognised, measured at the best estimate of the allowances for the energy usage in 2013/14.

1.32 Accounting standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013/14. The application of the Standards as revised would not have a material impact on the accounts in 2013/14, were they applied in that year:

IFRS 13 – Fair Value Measurement
IAS 17 (replacement) - Leases
IAS 18 (replacement) – Revenue Recognition and Liabilities Recognition
IFRS 9 – Financial Instruments

1.33 Significant accounting policies and material judgements

Estimates and the underlying assumptions are reviewed on a regular basis by PHE's senior management. There are no judgments or estimates made or used by management that have a significant impact on the financial statements.

Notes to the financial statements

2 STATEMENT OF OPERATING COST BY OPERATING SEGMENT

PHE income/expenditure is derived/incurred from three distinct sources which are primarily and substantially related to its regulatory functions related to the improvement of public health and reduction of preventable deaths. These are:

a) The payment of ring-fenced public health (PH) grants to local authorities
b) The oversight of expenditure on vaccines and emergency countermeasures (vaccines)
c) Operational activities as funded through parliamentary supply.

PHE reports against these three distinct reporting segments as defined within the scope of IFRS 8 (Segmental Reporting) under paragraph 12 (aggregation criteria). PHE management consider that all operational activities as per point (1) above are inter-related and contiguous, and fall within the objectives of improving public health and reducing preventable deaths.

	2013/14			
	Operations	Public health grants	Vaccine programme	Total
	£000	£000	£000	£000
Gross expenditure	603,450	2,662,900	463,488	3,729,838
Income	(169,869)	-	(61,688)	(231,557)
Net operating cost	**433,581**	**2,662,900**	**401,800**	**3,498,281**

The major sources of operational income are as follows:

	2013/14
	£000
NHS laboratory contracts	43,800
Research grants	30,840
Commercial services	26,300
Products and royalties	62,761
Other	67,856
External operational income	**231,557**

Operations
Operational activities are undertaken by PHE, and are funded through parliamentary supply.

Public health grants
Public health grants are ring-fenced grants to local authorities (upper tier and unitary local authorities) in England, intended to enable relevant local authorities to discharge their new public health responsibilities.

Vaccine programme
The vaccine programme represents the costs of maintaining stockpiled goods held for use in national emergencies.

2.1 Reconciliation between operating segments and statement of comprehensive net expenditure

	Operations	Public health grants	Vaccines programme	Total
	£000	£000	£000	£000
Total net expenditure per statement of operating cost by segment	433,581	2,662,900	401,800	3,498,281
Reconciling items				
Gain on transfer by absorption	(826,393)	-	-	(826,393)
Total net expenditure per statement of comprehensive net expenditure	**(392,812)**	**2,662,900**	**401,800**	**2,671,888**

3 STAFF NUMBERS AND RELATED COSTS

Staff costs comprise:

	2013/14		
	Permanently employed staff	Other staff	Total
	£000	£000	£000
Wages and salaries	215,554	23,572	239,126
Social security costs	18,550	-	18,550
Other pension costs	28,470	-	28,470
Subtotal	**262,574**	**23,572**	**286,146**
Redundancy and other department costs	2,050	-	2,050
Less recoveries in respect of outward secondments	(1,728)	-	(1,728)
Less recoveries in respect of staff engaged on capital projects	(738)	(276)	(1,014)
Total net costs	**262,158**	**23,296**	**285,454**

Other staff comprises staff engaged on the objectives of PHE (for example, short term contract staff, agency/temporary staff, locally engaged staff overseas and inward secondments) where PHE is paying the whole or the majority of their costs.

Notes to the financial statements Continued

Average number of persons employed

The average number of whole time equivalent persons employed during the year was as follows:

	2013/14		
	Permanently employed staff	Others	Total
Directly employed	4,801	-	4,801
Other	-	390	390
Staff engaged on capital projects	-	5	5
Total	**4,801**	**395**	**5,196**

3.1 Reporting of civil service and other compensation schemes - exit packages

Exit package cost band	Number of redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	22	-	22
£10,000 - £25,000	8	-	8
£25,000 - £50,000	19	-	19
£50,000 - £100,000	9	-	9
£100,000 - £150,000	2	-	2
£150,000 - £200,000	-	-	-
Total number of exit packages	**60**	**-**	**60**
Total resource cost (£000)	2,050	-	2,050

Redundancy and other departure costs have been paid in accordance with the provisions of the Civil Service Compensation Scheme, a statutory scheme made under the Superannuation Act 1972. Exit costs are accounted for in full in the year of departure. Where PHE has agreed early retirements, the additional costs are met by PHE and not by the Civil Service pension scheme. Ill health retirements are met by the pension scheme and are not included in the table.

3.2 Pensions

a) Pension scheme participation

At the start of the year, the majority of PHE's employees were covered by three pension schemes: the Principal Civil Service Pension Scheme, the National Health Service Pension Scheme and the United Kingdom Atomic Energy Authority Combined Pension Scheme. All employees covered by the United Kingdom Atomic Energy Authority Combined Pension Scheme transferred to the Principal Civil Pension Scheme tranferred to the Principal Civil Service Pension Scheme on 1 October 2013.

A few employees have exercised other options available as a result of the Social Security Act 1986. The pension schemes available to PHE employees are defined benefit schemes, all of which prepare separate scheme statements, which are readily available to the public. Details of the major pension schemes are provided below.

b) The Principal Civil Service Pension Scheme (PCSPS)

The PCSPS is an unfunded, multi-employer, defined benefit scheme but PHE is unable to identify its share of the underlying assets and liabilities. A full actuarial valuation was carried out as at 31 March 2007. Details can be found in the resource accounts of the Cabinet Office: Civil Superannuation (www.civilservice-pensions.gov.uk).

For 2013/14, employers contributions were payable to the PCSPS at one of six rates in the range 1.5% to 8.25% of pensionable pay, based on salary bands. The scheme's actuary reviews employer contributions every four years following a full scheme valuation. The salary bands and contribution rates were revised for 2011/12 and will remain unchanged until 2014/15. The contribution rates reflect benefits as they are accrued, not when the costs are actually incurred, and reflect past experience of the scheme.

The contribution rates are as follows:

Full time pay range	Classic scheme	Premium, nuvos and classic plus schemes
Up to £15,000	1.50%	3.50%
£15,001 - £21,000	2.70%	4.70%
£21,001 - £30,000	3.88%	5.88%
£30,001 - £50,000	4.67%	6.67%
£50,001 - £60,000	5.46%	7.46%
Over £60,000	6.25%	8.25%

Further details about the Civil Service pension arrangements can be found at: www.civilservice-pensions.gov.uk.

Notes to the financial statements Continued

c) The NHS Pension Scheme (NHSPS)

The NHSPS is an unfunded, multi-employer, defined benefit scheme, the provisions of which are contained in the NHS Pension Scheme Regulations (SI 1995 No. 300). The scheme is notionally funded: payment liabilities are underwritten by the Exchequer. PHE is unable to identify its share of the underlying assets and liabilities. Scheme accounts are prepared annually by the NHS Business Services Authority and are examined by the Comptroller and Auditor General. The Government Actuary's Department (GAD) values the NHSPS every four years, and those quadrennial reports are published. The scheme has a money purchase Additional Voluntary Contribution (AVC) arrangement which is available to employees to enhance their pension benefits.

Between valuations the GAD provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the scheme is contained in the *Report of the Actuary*, which forms part of the *NHS Pension scheme & NHS Compensation for Premature Retirement Scheme Resource Accounts*, published annually. These accounts can be viewed on the NHS Pensions website at www.nhsbsa.nhs.uk. Copies can also be obtained from The Stationery Office.

Under NHSPS regulations, PHE and participating employees are required to pay contributions, as specified by the Secretary of State for Health. These contributions are used to defray the costs of providing the NHSPS benefits. Employer contributions are charged to operating costs as they become due. Employer contributions are 14% of pensionable pay in all cases.

Employee contribution rates are based on pensionable pay scaled to the full year, full-time equivalent for part-time employees, as follows:

	2013/14 Annual pensionable pay	2 13/14 Employee contribution
Tier 1	up to £15,278 .99	5.00%
Tier 2	£15,279 - £21,175.99	5.30%
Tier 3	£21,176 - £26,557.99	6.80%
Tier 4	£26,558 - £48,982.99	9.00%
Tier 5	£48,983 - £69,931.99	11.30%
Tier 6	£69,932 - £110,273.99	12.30%
Tier 7	£110,274 and over	13.30%

Contributions for new members of the NHS Pension scheme are based on their pensionable pay at the time of joining the scheme.

The *Government Financial Reporting Manual 2013/14* requires the scheme to be accounted for as defined contribution in nature.

d) The United Kingdom Atomic Energy Authority Combined Pension Scheme (UKAEA CPS)

The UKAEA CPS was set up as a statutory body with effect from 1 July 1997 as a result of merging the previous UKAEA Principal Non-Industrial Superannuation Scheme (PNISS) and the UKAEA Industrial Superannuation Scheme (ISS). The scheme is managed by the UKAEA. It is a multi-employer scheme which provides defined benefits to its members. PHE is unable to identify its share of the underlying assets and liabilities.

All employees in the scheme transferred to the PCSPS on 1 October 2014, up until that point employees were required to pay contributions of 5% of pensionable pay. The employer's contribution amounted to 17.3% of pensionable pay in all cases. Employer contributions are charged to operating costs as they become due.

In common with other public sector schemes the UKAEA CPS does not have many of the attributes of normal pension schemes. All contributions are paid to (and benefits paid by) HM Government via the Consolidated Fund. Any surplus of contributions made in excess of benefits paid out in any year is surrendered to the Consolidated Fund and any liabilities are met from the Consolidated Fund via the annual Parliamentary vote. Government does not maintain a separate fund and the scheme valuations are based on a theoretical calculation as to how a typical UK pension scheme would have invested the historical surplus of contributions over payments. There is no actual fund.

The *Government Financial Reporting Manual 2013/14* requires the scheme to be accounted for as defined contribution in nature.

e) Employer contributions

PHE has accounted for its employer contributions to these schemes as if they were defined contribution schemes. PHE's contributions were as follows:

	2013/14 £'000
The PCSPS	4,816
The NHSPS	22,936
The UKAEA CPS	718
Total contributions	**28,470**

f) Retirements due to ill health

During 2013/14, there were four early retirements from PHE on the grounds of ill health; the total additional accrued pension liabilities on the year amounted to £314,158.

Notes to the financial statements Continued

4 OTHER ADMINISTRATIVE COSTS

	2013/14 £000
Accommodation	12,712
Auditor remuneration	4
Bank charges	59
Education, training and conferences	2,008
Foreign exchange losses	129
Hospitality	23
Insurance	21
Laboratory consumables and services	9,699
Legal fees	54
Rentals under operating leases	617
Research & Development	67
Supplies and services	34,288
Travel and subsistence	3,227
Voluntary sector grants	524
Non cash items:	
Auditor remuneration	210
Charge of provision for impairments:	29
Depreciation	13,328
Amortisation	1,641
Loss on de-recognition of property, plant and equipment and intangible assets	298
Total	**78,938**

During the year, PHE purchased no non-audit services from its auditor, the National Audit Office (NAO). NAO undertook an audit of a European Union grant which is separate to the statutory remit. The amount of this was £3,600.

5 PROGRAMME COSTS

		2013/14 £000
Accommodation		13,591
Education, training and conferences		2,390
European Union grant expenditure		230
Hospitality		46
Insurance		206
Inventories written down	11	12,656
Inventories consumed	11	323,009
Laboratory consumables and services		36,363
Legal fees		126
Loss on disposal of asset held for sale		65
Public Health grants		2,662,919
Rentals under operating leases		14,392
Research & development		1,563
Supplies and services		185,993
Travel and subsistence		5,868
Voluntary sector grants		14,508
Non cash items:		
Depreciation		6,352
Amortisation		2,054
Loss on de-recognition of property, plant and equipment and intangible assets		76,548
Revaluation of fixtures and fittings	7	50
Provision provided for in year	15	5,509
Impairment	10	1,008
Total		**3,365,446**

Notes to the financial statements Continued

Significant administration and programme expenditure items include:

Accommodation costs
Total accommodation costs include property maintenance costs paid directly by PHE and property rent, rates and utilities in respect of accommodation occupied by PHE.

Laboratory consumables and services
Total laboratory consumables include all items used for testing, including sub-contracted work.

Public health grants
Public health grants are ring-fenced grants to local authorities (upper tier and unitary local authorities) in England, intended to enable relevant local authorities to discharge their new public health responsibilities. If there are any funds left over at the end of the financial year, local authorities can carry these over into the next financial year as part of a public health reserve. All the conditions that apply to the use of the grant will continue to apply to any funds carried over.

Supplies and services
Supplies and services includes all expenditure on a number of items including recruitment, office consumables, professional fees, subcontracted and outsourced services, social marketing, information technology and software.

Voluntary sector grants
Grants made under section 31 of the Local Government Act 2003, were granted in year to fund projects relating to Drugs and Alcohol Recovery Centres in line with PHE's remit for health and wellbeing as per the agreed framework. Grants made under section 64 of the Health Services and Public Health Act 1968 were made to voluntary sector organisations with charitable status for in year projects for the benefit of public health in England in accordance with the framework agreement.

Non cash items comprise:

Auditor remuneration
The audit fees reflect the notional cost of the National Audit Office's fees for undertaking the audit of the statutory accounts.

Depreciation, amortisation, loss on de-recognition of property, plant and equipment and intangible assets.
Freehold land, assets under construction or development, stockpiled goods and assets held for sale are not depreciated/amortised. Otherwise, depreciation or amortisation, as appropriate, is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated remaining useful lives. When assets are disposed of, any remaining net book value is charged against expenditure as a loss on disposal.

Provisions
This represents the costs provided for in the year relating to the provisions contained within note 15.

Impairment of revaluation reserve (note 10)
The impairment of the revaluation reserve relates to the negative reserves on land, building and fixtures and fittings inherited from the Health Protection Agency. It has been agreed with the National Audit Office that these amounts represent a prior year adjustment, although as it is not material it has been presented as a cost in this financial year.

6 INCOME

6a Operating income

	2013/14 Administration £000	2013/14 Programme £000	Total £000
Laboratory and other services	54,435	16,977	71,412
Grants from the United Kingdom government	85	1,905	1,990
Grants from the European Union	90	3,535	3,625
Products and royalties	903	61,887	62,790
Research and related contracts and grants	962	24,263	25,225
Education and training	446	1,182	1,628
Other operating income	1,075	63,479	64,554
Total	**57,996**	**173,228**	**231,224**

6b Non-operating income

	2013/14 Administration £000	2013/14 Programme £000	Total £000
Proceeds from sale of investment	333	-	333
	333	**-**	**333**

6c Fees and charges

An analysis of the services for which a fee is charged where the full cost is over £1 million or is otherwise material in the context of the financial statements is as follows:

	2013/14 Income £000	Full cost £000	Surplus/ (Deficit) £000	Details of financial objective	Details of performance against the financial objective
Clinical Microbiology	50,906	54,500	(3,594)	Charges for pathology tests, mostly to the NHS and to local authorities	Met: broadly in line with internal targets
Supplies of products, product development and related services	54,485	45,095	9,390	Supplies of products, including Erwinase, anthrax vaccine and cell cultures and related services	Met: broadly in line with internal targets
Vaccine Evaluation and External Quality Assurance Schemes	9,810	8,982	828	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual Property Management	23,200	146	23,054	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Commercial Radiation Services	8,188	10,590	(2,402)	Charges for various radiation services	Met: broadly in line with internal targets
Total	**146,589**	**119,313**	**27,276**		

Some of the staff involved in PHE's income generating work are also required to work on core research and public health activities during the year.

This note has not been provided for IFRS 8 purposes.

Notes to the financial statements Continued

7 PROPERTY, PLANT AND EQUIPMENT

	Land	Buildings	Fixtures and fittings	Plant, equipment and vehicles	Information technology	Stockpiled Goods	Assets under construction (AUC)	Total
Cost	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2013	-	-	-	-	-	-	-	-
Transfers under modified absorption accounting (note 1.30)	28,050	106,385	2,630	64,789	15,005	-	27,950	244,809
In-year transfer (absorption gain) (note 1.30)	-	-	-	679	13,663	697,099	-	711,441
Reclassification of assets	-	-	-	-	-	(157)	-	(157)
Additions	-	-	-	5	-	117,368	42,126	159,499
Transfer of AUC	-	11,652	190	8,748	3,089	-	(23,679)	-
Transfer of AUC to intangible assets	-	-	-	-	-	-	(2,800)	(2,800)
Revaluations	-	-	(139)	(3,804)	-	2,528	-	(1,415)
De-recognition	-	(211)	(104)	(1,373)	(387)	(106,553)	-	(108,628)
At 31 March 2014	**28,050**	**117,826**	**2,577**	**69,044**	**31,370**	**710,285**	**43,597**	**1,002,749**
Depreciation								
At 1 April 2013	-	-	-	-	-	-	-	-
Transfers under modified absorption accounting (note 1.30)	-	-	1,531	35,581	11,201	-	-	48,313
In-year transfer (absorption gain) (note 1.30)	-	-	-	430	10,706	-	-	11,136
Charge for year	-	6,591	260	6,865	5,964	-	-	19,680
Revaluations	-	-	(81)	(2,121)	-	-	-	(2,202)
De-recognition	-	(211)	(103)	(1,061)	(394)	-	-	(1,769)
At 31 March 2014	**-**	**6,380**	**1,607**	**39,694**	**27,477**	**-**	**-**	**75,158**
Carrying value								
At 31 March 2014	**28,050**	**111,446**	**970**	**29,350**	**3,893**	**710,285**	**43,597**	**927,591**
At 31 March 2013	-	-	-	-	-	-	-	-
Asset financing								
Owned	28,050	111,446	970	29,350	3,893	710,285	43,597	927,591

Donated assets
PHE had no donated assets during the year.

Valuation of assets
Land and buildings were valued by the Valuation Office Agency on 31 March 2013.

All other property, plant and equipment is valued using relevant indices obtained from the Office for National Statistics.

Revaluation
Within the revaluation of fixtures and fittings is £50,000 which has been charged directly against the statement of comprehensive net expenditure.

8 INTANGIBLE ASSETS

Cost or valuation	Software £000	Website £000	Total £000
At 1 Apr il 2013	-	-	-
Transfers under modified absorption accounting (note 1.30)	16,193	-	16,193
In-year transfer (absorption gain) (note 1.30)	1,671	2,309	3,980
Reclassification of assets	-	-	-
Transfer from AUC	2,750	50	2,800
Impairment	-	-	-
De-recognition	(349)	-	(349)
At 31 March 2014	**20,265**	**2,359**	**22,624**
Amortisation			
At 1 April 2013	-	-	-
Transfers under modified absorption accounting (note 1.30)	9,956	1	9,957
In-year transfer (absorption gain) (note 1.30)	1,058	1,850	2,908
Charge for year	3,409	286	3,695
De-recognition	(347)	-	(347)
At 31 March 2014	**14,076**	**2,137**	**16,213**
Carrying value			
At 31 March 2014	6,189	222	6,411
At 31 March 2013	-	-	-
Asset financing			
Owned	6,189	222	6,411

9 FINANCIAL INSTRUMENTS

Due to the largely non-trading nature of its activities, and the way in which it is financed, PHE is not exposed to the degree of financial risk faced by most other business entities. PHE has no authority to borrow or to invest without the prior approval of the Department of Health and HM Treasury. Financial instruments held by PHE comprise mainly assets and liabilities generated by day-to-day operational activities and are not held to change the risks facing PHE in undertaking its activities.

PHE operates foreign currency bank accounts to handle transactions denominated in Euro (€) and US Dollar ($).This helps to manage potential exposure to exchange rate fluctuations. The fair value of cash is the same as the book value as at the statement of financial position date.

Notes to the financial statements Continued

During the year to 31 March 2014, PHE received Euro income equivalent to £4,010,000 and US Dollar income equivalent to £7,707,000 upon which there was some currency risk.

The only other currency risk is that of a Euro currency bank balance valued at £254,000 and a US Dollar bank balance valued at £384,000.

10 IMPAIRMENT

	Charged to statement of comprehensive net expenditure	Charged to revaluation reserve	Total
	£000	£000	£000
Property, plant and equipment	-	-	-
Intangible assets	-	-	-
Revaluation reserve	1,008	(1,008)	-
Total	**1,008**	**(1,008)**	**-**

12 TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

2013/14

11 INVENTORIES

	Emergency Preparedness	Vaccines	Drugs	Consumables	Other	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2013	-	-	8,550	4,547	-	**13,097**
Transfers under absorption accounting (note 1.30)	-	125,905	-	-	-	**125,905**
Additions	-	316,349	3,043	6,268	-	**325,660**
Transfer (to)/ from stockpiled goods	157	-	-	-	-	**157**
Consumed/Disposed of	-	(308,925)	(8,466)	(5,618)	-	**(323,009)**
Written Down	(157)	(12,499)	-	-	-	**(12,656)**
Revaluation	-	2,613	-	(48)	-	**2,565**
Balance at 31 March 2014	**-**	**123,443**	**3,127**	**5,149**	**-**	**131,719**

	£000
Amounts falling due within one year	
Accrued income	13,479
Other debtors	13,576
Prepayments	5,625
Taxation	1,126
Trade receivables	10,357
	44,163
Amounts falling due after more than one year	
Advances to UKAEA combined pensions scheme	71
Leasehold premium prepayment	21
	92

Balances within the totals for trade receivables and other assets are as follows:

	2013/14
	£000
Balances with other central government bodies	3,635
Balances with local authorities	991
Balances with NHS bodies	8,175
Balances with the Department of Health	5,938
Balances with public corporations and trading funds	211
Balances with bodies external to government	25,305
Total	**44,255**

Investments

PHE inherited a 5.1% interest in Syntaxin from the Health Protection Agency (HPA) which had acquired the interest in 2005/06. HPA acquired the holding for a cash consideration of £2,565 and was made up of 100 Series B preferred shares of £1 each and 2,465,000 ordinary shares of 0.1p each (2012: 2,465,000). During the year, PHE sold this investment; the proceeds are shown in note 6.

PHE inherited a 1% interest in Proacta from HPA; this is made up of 25,052 shares of the US$ 0.001 common stock of Proacta, for which there was no cash consideration.

PHE also inherited a 3.1% interest in Spectrum from HPA; this is made up of 3,125 ordinary shares of £0.01 in Spectrum, which were acquired for no cash consideration. The company does not trade and has no assets other than £100 share capital.

PHE has no significant influence over the operating and financial policies of Proacta or Spectrum. There is no easily ascertainable market value for each investment, so they are disclosed on a historic cost basis as permitted under International Accounting Standard 39.

Notes to the financial statements Continued

13 CASH AND CASH EQUIVALENTS

	2013/14 £000
Balance at 1 April 2013	-
Net change in cash and cash equivalents	129,430
Balance at 31 March 2014	**129,430**
The following balances at 31 March 2014 were held at:	
Government Banking Service	128,307
Commercial banks and cash in hand	1,123
Balance at 31 March 2014	**129,430**

14 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

	2013/14 £000
Amounts falling due within one year	
Accruals	75,966
Deferred income	13,169
EU grant income held on behalf of third parties	780
Other payables	7,549
Other taxation and social security	937
Trade payables	24,907
	123,308

Balances within the totals for trade payables and other current liabilities are as follows:

	2013/14 £000
Balances with other central government bodies	1,018
Balances with local authorities	1,992
Balances with NHS bodies	24,836
Balances with public corporations and trading funds	191
Balances with the Department of Health	6,795
Balances with bodies external to government	88,476
Total	**123,308**

15 PROVISIONS

Legal claims

PHE inherited several legal claims for which a provision had been made from the Health Protection Agency. The liability for these has now passed to the Secretary of State and is no longer required by PHE.

Future costs of early retirement

	Legal claims	Future costs of early retirement	Leasehold dilapidations	High activity sealed radiation sources	Overseas tax	Contractual entitlement claims	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2013	-	-	-	-	-	-	-
Transferred under modified absorption accounting (note 1.30)	1,529	1,260	567	426	166	50	**3,998**
Provided in the year	-	-	1,495	-	72	6,017	**7,584**
Provisions not required written back	(1,529)	-	(489)	(7)	(30)	(20)	**(2,075)**
Provisions utilised in the year	-	(89)	-	-	(99)	-	**(188)**
Balance at 31 March 2014	**-**	**1,171**	**1,573**	**419**	**109**	**6,047**	**9,319**
Analysis of timing of discounted cashflows							
Not later than one year	-	89	58	419	109	6,047	**6,722**
Late than one year and not later than five years	-	356	1,515	-	-	-	**1,871**
Later than five years	-	726	-	-	-	-	**726**
Balance at 31 March 2014	**-**	**1,171**	**1,573**	**419**	**109**	**6,047**	**9,319**

This provision relates to an early retirement scheme inherited from the Health Protection Agency for past members of the UKAEA Combined Pension Scheme.

Leasehold dilapidations

This provision is for the estimated costs of making good dilapidations on various properties leased by PHE, when these properties are returned to the lessors on the termination of the leases. The sum represents the expected costs of making good dilapidations.

High activity sealed radiation sources

This provision is for the estimated costs of PHE's liabilities for the disposal of radioactive sources falling within the scope of the High Activity Sealed Radioactive Sources and Orphan Sources Regulations 2005. The sum represents the expected costs of disposal.

Overseas tax

This provision is in respect of foreign income tax due in respect of employees seconded abroad, which may not be recovered in the UK under relevant double taxation treaties.

Contractual entitlements

This is a provision of in respect of several claims by employees regarding contractual entitlements and the transfer of pension rights into the Principal Civil Service Pension Scheme for which the Government Actuary's Department is currently finalising an estimate.

Notes to the financial statements Continued

16 CAPITAL COMMITMENTS

	2013/14 £000
Contracted capital commitments at 31 March 2014 not otherwise included in these accounts	
Property, plant and equipment	29,892
Intangible assets	246
	30,138

These commitments relate to the contractual amounts payable on capital projects.

17 COMMITMENTS UNDER LEASES

	2013/14			
Obligations under operating leases for the following periods comprise:	**Land £000**	**Buildings £000**	**Other £000**	**Total £000**
Not later than one year	-	6,254	126	6,380
Later than one year and not later than five years	-	12,612	93	12,705
Later than five years	-	2,562	-	2,562
	-	**21,428**	**219**	**21,647**

Building leases comprise accommodation leases within NHS bodies for PHE laboratories and office accommodation leased from the Department of Health, other government bodies and NHS trusts.

Other leases include leases with commercial suppliers for laboratory equipment for use in PHE laboratories, photocopiers for use in PHE offices and vehicles leased for use by PHE staff.

18 FINANCIAL COMMITMENTS

PHE has entered into non-cancellable contracts (which are not leases or PFI contracts). The payments to which PHE is committed are as follows:

	2013/14 £000
Not later than one year	342,164
Later than one year and not later than five years	211,670
Later than five years	-
Less interest	-
Present value of obligations	**553,834**

The majority of these commitments relate to the purchase, storage and distribution of stockpiled goods.

19 CONTINGENT LIABILITIES

PHE had the following contingent liabilities:

Iodine tablets
In the event of a nuclear emergency it would be necessary to distribute stable iodine tablets to the general public to prevent the uptake of radioactive iodine. PHE has undertaken to indemnify those, other than qualified medical personnel, distributing the tablets against any action resulting from adverse reactions. Expert medical opinion is that adverse reactions to stable iodine are most unlikely. The contingent liability is unquantifiable.

Smallpox vaccines
This is a continuing contingent liability in respect of the new smallpox vaccines that PHE has purchased. Its value is £40 million. It is to cover possible side effects that might occur in the population if the smallpox vaccine was ever used and It is required because the vaccine is not licensed for use, and even if it were, the vaccine carries a well-known adverse effects profile.

PHE will only ever call upon this contingency if the vaccine is ever used and if people suffer side effects as a result. As agreed by the Public Accounts Committee, it is reported every year as a continuing liability.

20 LOSSES AND SPECIAL PAYMENTS

20(a) - Losses statement

	2013/14	
	Number	£000
Cash losses	8	15
Claims waived or abandoned	2	10
Constructive loss	7	87,299
Total	**17**	**87,324**

Notes to the financial statements Continued

Details of cases over £300,000

Emergency preparedness stockpile
PHE authorised write-offs relating to date-expired stock items in line with existing accounting standards. PHE holds countermeasures inventory for use in the event of an accidental or malicious release of chemical, biological, radiological or nuclear agents. If no such incidents occur the inventory inevitably reaches the end of its useable life and needs to be disposed of and replaced in order to maintain a measure of protection for the UK's population. The value of inventory written off in the period April 2013 to March 2014 due to expiration of their shelf life was £7,716,518.

Pandemic flu countermeasures stockpile
PHE wrote off £18,007,973 in relation to countermeasures held for pandemic flu preparedness that have now passed their shelf life. These write-offs are a planned consequence of our preparedness strategy that involves central stockpiling.

Tamiflu (antiviral) exchange programme
PHE exchanged a volume of capsules sufficient to maintain approximately 50% population coverage with Roche. This involves returning stock with one month's residual shelf life in exchange for new product with a shelf life of approximately seven years. The exchange fees are approximately 60% of the new product purchase price. The exchange fees for 2013/14 are £49,066,790.

Expired vaccines
PHE disposed of expired vaccines with a total value of £12,499,000 in respect of the children's flu programme (with a short shelf life of 12 weeks), an unlicensed rabies immunoglobin held as an insurance policy following shortages during 2013, HPV vaccines and strategic flu reserves.

20(b) - Special payments

	2013/14	
	Number	£000
Compensation	4	10
Total	**4**	**10**

There were no cases over £300,000.

21 RELATED PARTY TRANSACTIONS

PHE is sponsored by the Department of Health, which is regarded as a related party. During the year, PHE has had various material transactions with the Department of Health itself and with other entities for which the Department of Health is regarded as the parent entity. These include NHS bodies including the NHS Litigation Authority, the NHS Business Services Authority, NHS England, Clinical Commissioning Groups, Commissioning Support Units, NHS Trusts and NHS Foundation Trusts.

In addition, PHE has had transactions with other government departments and central government bodies. These included the Home Office, the Ministry of Defence, the Food Standards Agency, the Department for Environment, Food and Rural Affairs and the Medical Research Council.

Compensation for key management personnel has been disclosed in the Remuneration Report.

During the year ended 31 March 2014, no Board members, members of senior management, or other parties related to them have undertaken any material transactions with PHE except for the following:

Related party	Name of PHE Board member or senior manager	PHE/related party appointment	Value of goods and services provided to related party £000	Value of goods and services purchased from related party £000	Amounts owed to related party £000	Amounts due from related party £000
London School of Hygiene & Tropical Medicine	David Heymann	PHE Board Chair/Lecturer	89	478	19	27
	Paul Lincoln	Associate non-executive PHE Board member/Member of Health Premium review group and also member of advisory panel for Public Health NIHR centre Spiral programme				
Medicines and Healthcare products Regulatory Agency (MHRA)	Martin Hindle	Non-executive PHE Board member/ Non-executive Board member	723	66	31	-
UK Health Forum	Paul Lincoln	Associate non-executive PHE Board member/Chief Executive	-	451	-	-
University Hospitals of Leicester NHS Trust	Martin Hindle	Non-executive PHE Board member/ Chair to September 2013	135	222	31	23
London Borough of Wandsworth	Paul Lincoln	Associate non-executive PHE Board member/Partner of director of public health	24,738	-	-	-
London Borough of Kensington and Chelsea	Derek Myers	Associate non-executive PHE Board member/Chief Executive	20,636	-	-	-
London Borough of Hammersmith and Fulham	Derek Myers	Associate non-executive PHE Board member/Chief Executive	20,287	-	-	-
Brighton and Sussex University Hospitals NHS Trust	Alex Sienkiewicz	National Executive Board member/director	141	1,064	98	7
GSK	John Newton	National Executive Board member/ provider of epidemiological advice to Arnold Porter LLP, who represented GSK in a case in the High Court in 2014	-	2,730	-	-

Notes to the financial statements Continued

22 THIRD PARTY ASSETS

In addition to the assets disclosed at note 8, PHE held property, plant and equipment which were funded and remain in the ownership of third parties. These are not PHE assets and are not included in the accounts. These assets are set out in the table below.

	2013/14 £000
Buildings	2,149
Plant and equipment	1,919
Total	**4,068**

23 EVENTS AFTER THE REPORTING PERIOD DATE

In accordance with the requirements of International Accounting Standard 10, events after the reporting period are considered up to the date on which the accounts are authorised for issue. This is interpreted as the date of the Certificate and Report of the Comptroller and Auditor General.

The Accounting Officer authorised these financial statements for issue on 25 June 2014.

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