Public Health England

Protecting and improving the nation's health

Annual Report and Accounts 2014/15

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

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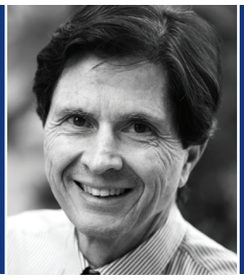


Professor
David L Heymann CBE
CHAIR

Chair's report

Our unique ability to provide specialist, scientific services alongside broader public health support came into its own this year. We proved ourselves on the front lines of an international health emergency—offering expert assistance to help bring the Ebola outbreak in West Africa under control and co-ordinating effective action to protect people in the UK. We joined forces with NHS England to change the way that public health is conceived and delivered—publishing the *NHS Five Year Forward View*, which calls for greater effort to promote wellness and prevent disease. Locally, we helped health communities identify and tackle their most pressing health issues.

Behind the scenes, we have been laying the foundations for long-term success. We are refining our structure, aligning resources around priorities, and equipping the public health system for future challenges. Internationally, we are building relationships with others in order to strengthen global health security. Fundamental to our future success, however, is to remain at the forefront of public health research so that we have evidence on which to base decisions and shape services.

Public health does not stand still. New diseases and environmental hazards continue to emerge while challenges such as dementia, obesity and diabetes affect increasing numbers. Meanwhile, new technologies offer new ways to improve and protect health. In the laboratory, we are realising the benefits of genomics, novel disease biomarkers and other innovations. In the community, mobile phones, online communication and wearable technology are transforming the way we care for people and encouraging them to keep well.

Research, development and innovation must continue to underpin all our work. Whether conducted alone, or in concert with partners, we must translate research into front line applications. This could include new diagnostic techniques, new protocols for controlling threats to health, better ways of treating and managing patients, and strategies that empower people to improve their own health.

We need to keep abreast of, and lead, research into microbiological, clinical, behavioural and social sciences. The knowledge we gain from activities such as surveillance, disease registration and intelligence networks must be second to none. That means investing in our research base, renewing our expertise, focusing on research areas that matter most, collaborating with academia, industry and other institutions, maintaining our scientific independence and looking for new ways to apply our science.

PHE has, on the one hand, to understand the health profile of the nation in intricate detail, collecting data at individual, local authority and national levels. This knowledge helps us to determine the nature of health inequalities and how they can be reduced; we can assess which public health programmes have the greatest impact and how health can be most improved.

On the other hand, we have to prepare for health challenges that arise suddenly, in the UK or overseas. Our staff should be proud of the way they responded quickly and effectively to an evolving threat like Ebola. We must continue to plan for, and anticipate, these kinds of challenges—sharing our expertise, sharing our insight, and helping where we can.

Duncan Selbie
CHIEF EXECUTIVE

Chief Executive's review

During the past year our duty to protect the public from infectious diseases and other environmental hazards has been in the public eye as never before. Our response to Ebola, summarised elsewhere in this report, is an ongoing priority. Our staff are on the front line in Sierra Leone, providing additional port of entry screening in the UK, and through our laboratories at PHE Porton and Colindale. I am profoundly grateful for the courage and professionalism our people have shown. This is but one example of our ongoing health protection work, which includes emergency preparedness, resilience and response, surveillance systems, diseases registration, screening and vaccination programmes.

We also continue to support local authorities, the NHS and others to help people live longer, healthier, happier lives and reduce health inequalities, recognising that the £200m reduction in this year's public health grant brings with it new challenges for our local authority partners, while at the same time the prospect of devolution creates new opportunities.

The government has explicitly prioritised prevention and we have a key role to play in putting this into practice. There are huge opportunities to prevent illness and improve the health and wellbeing of local communities. The *NHS Five Year Forward View* and *From Evidence into Action* call for a much greater focus on prevention. In the short term, we have identified a clear need to focus on identifying and helping those at risk of poor health, but who do not yet have clinical conditions. That is why we are focusing on reducing childhood obesity, on preventing type two diabetes, and reducing the number of people who smoke or drink to excess.

We also know that there is a pressing need to tackle some of the more long-term public health issues such as adult obesity, supporting those with multiple complex illnesses, caring for our ageing population and ensuring our children have the best start in life. Addressing these will not only improve the health of local communities, but will enable the NHS to deliver the efficiencies required to sustain and improve standards of care, support economic growth, and contribute to the establishment of safer streets and neighbourhoods.

So what does all this tell us we need to do to enable us to go further, faster?

We are strengthening our capability in economic modelling and return on investment.

We will exploit the opportunity afforded by the *NHS Five Year Forward View* to reduce growth in NHS activity and to save money but also, crucially, to close the gaps between the poorest and the most wealthy.

We will look to accelerate that by supporting devolution wherever the energy and commitment to it exists, and where it can be shown that by working in different ways they can close the gaps faster than can be done today.

We also need to strengthen our science, to create a great future for it, so that we can provide the right health protection and health improvement support, in the right way, whenever it is needed.

And finally, we can only meet our commitments, locally and nationally, with the support of others and we will be doing our best to ensure that our partnerships at every level are mutually beneficial and productive.

PHE at a glance

To deliver a broad range of products and services PHE employs approximately 5,600 staff:

2397
Protection from infectious diseases
National centres, regional network and capability to identify infectious disease, surveillance and management of outbreaks

517
Protection from environmental hazards
Including chemical, radiation and environmental hazards, emergency response

1075
Local/ regional
- includes health protection - 536
- screening and imms - 243
- health improvement and population healthcare - 277

322
Knowledge, intelligence and digital
Translating data, research and experience into practical guidance for local decision making; digital capacity and supporting the use of digital technologies

293
Disease registration
Including the world's largest cancer database

264
Screening programmes
Developing and quality assuring cancer and non-cancer screening programmes

30
Research translation and innovation
Conducting rigorous research-led evaluation of public health interventions both locally and nationally

199
Health and wellbeing
National expertise in public health evidence-based interventions

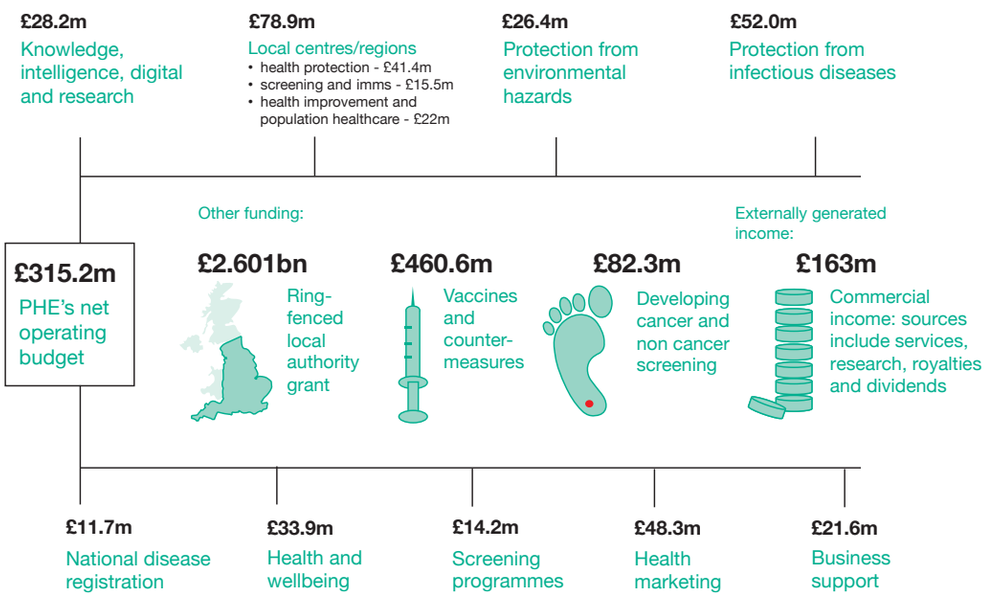
60
Health marketing
Delivering healthy behaviour change campaigns

20
Global health
Protecting the UK from emerging international threats, maintaining and developing relations with WHO and other international and national public health agencies

With business support from:

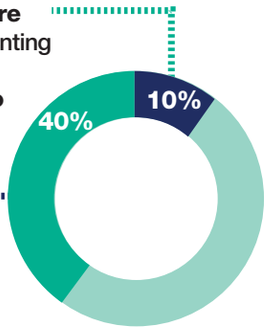
Financial and commercial	Infrastructure (ICT and estates)	Human resources	Communications	Corporate
167	136	47	66	64

PHE funding 2015/16



Some of the challenges we face

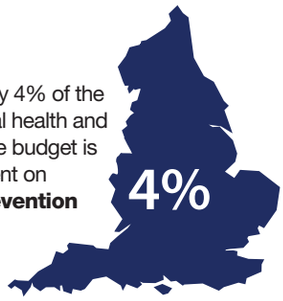
International studies suggest **healthcare contributes only about 10%** to preventing premature deaths, while **changes in behavioural patterns is estimated to contribute 40%**

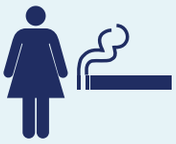


It is estimated that if the public were fully involved in managing their health and engaged in prevention activities

£30 billion
could be saved

Only 4% of the total health and care budget is spent on **prevention**





UK women, on average, smoke **3% more** than the EU average

In the UK in 2008, **61.1% of males** were estimated to be physically inactive and **71.6% of females**

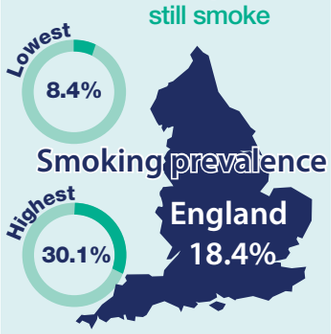
The average consumption of alcohol by adults in the UK is **10% higher** than the EU average

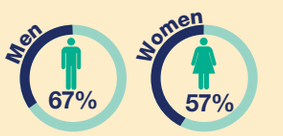
Our lifestyles increase the risk of ill health

Smoking

Englands biggest killer, causing nearly **80,000** premature deaths a year

Nearly **8 million** people in England still smoke



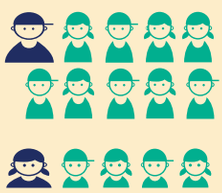


Percentage of men and women who are overweight or obese

Obesity

An estimated **70,000** premature deaths in the UK could be avoided each year if diets matched nutritional guidelines

1 in 10 five year olds are obese, rising to **1 in 5** by age eleven



Overall alcohol harm cost society £21 billion a year with the costs to the NHS at £3.5 billion

9 million
adults now drink at levels that increase the risk of harm

Alcohol

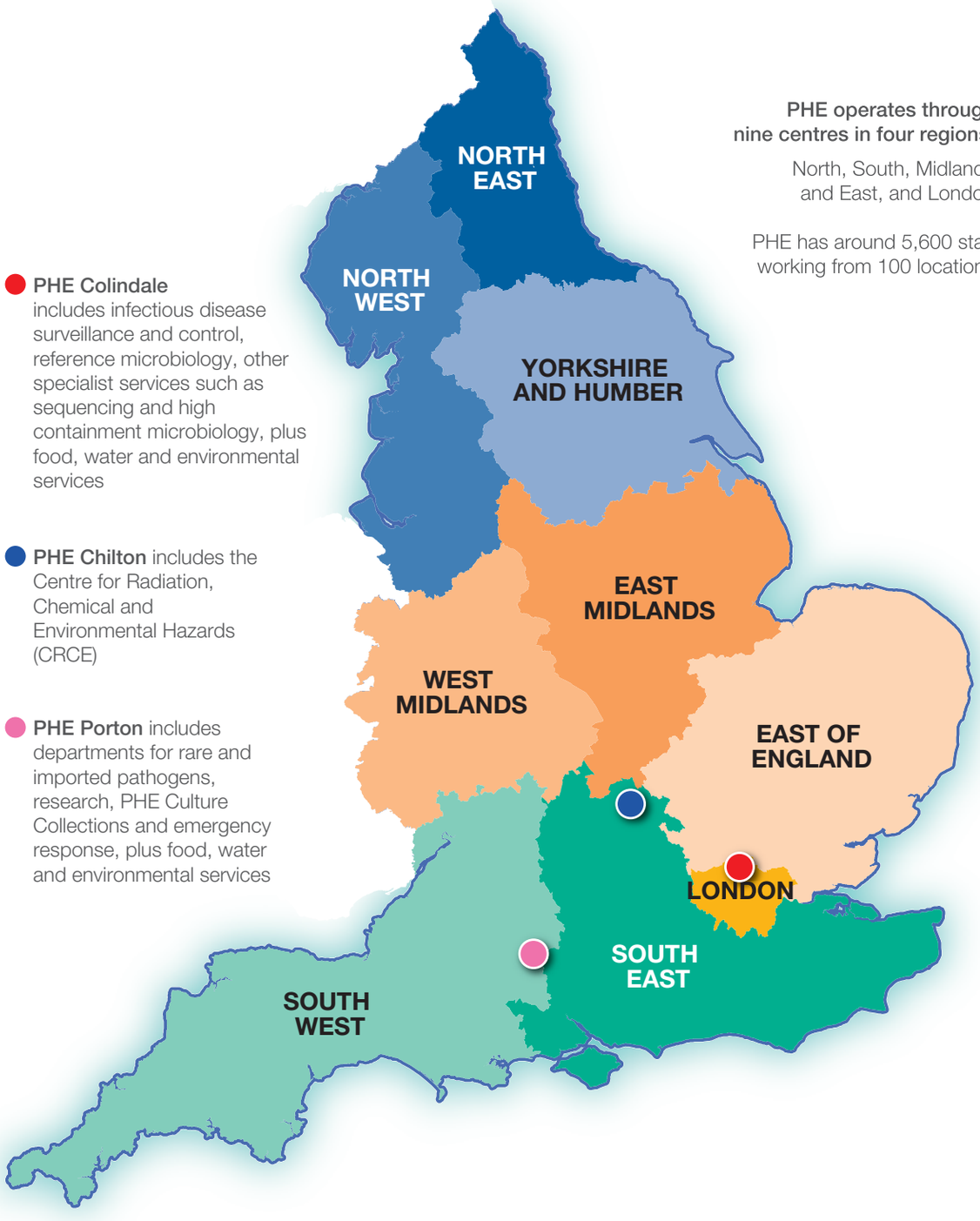
Alcohol is the leading risk factor for preventable death in 15 to 49 year olds

Our national and local presence

PHE operates through nine centres in four regions:

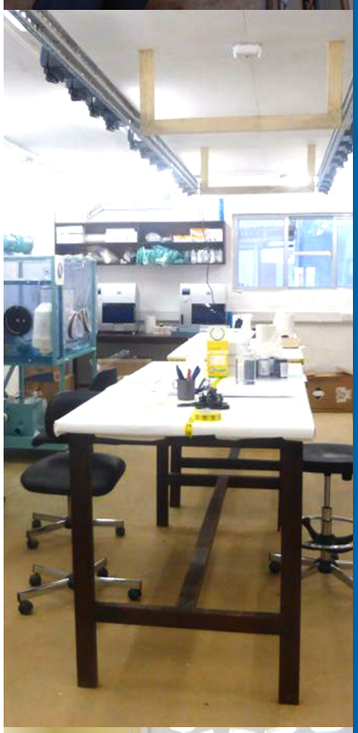
North, South, Midlands and East, and London

PHE has around 5,600 staff working from 100 locations



- **PHE Colindale** includes infectious disease surveillance and control, reference microbiology, other specialist services such as sequencing and high containment microbiology, plus food, water and environmental services
- **PHE Chilton** includes the Centre for Radiation, Chemical and Environmental Hazards (CRCE)
- **PHE Porton** includes departments for rare and imported pathogens, research, PHE Culture Collections and emergency response, plus food, water and environmental services

PHE has eight regional public health laboratories based in large NHS hospitals



Responding to the Ebola crisis

The world's largest recorded outbreak of Ebola virus disease (EVD) came to international attention in March 2014 when Guinea reported a rapid increase in cases. By April 2015, more than 25,000 cases and over 10,000 deaths had been reported in Guinea, Liberia and Sierra Leone.

PHE has been central to the UK's contribution to the international response to Ebola. Our expert scientific teams have been on the ground in West Africa undertaking vital diagnostic work to isolate Ebola cases, advising on public health management, and improving infection control in field hospitals. In the UK, many staff from across the organisation have contributed scientific and clinical expertise, logistical and managerial support, training to prepare volunteers and the military for deployment to Ebola-affected regions, research into vaccines and treatments, and screening at five major UK ports.

International response: We made an extensive contribution to the humanitarian effort to defeat Ebola, deploying 130 staff to Sierra Leone, Liberia and Guinea during the year. Staff have provided expert advice to the United Nations and the World Health Organisation, and supported the government of Sierra Leone.

Research scientists, experienced in dangerous pathogens, have volunteered to carry out diagnostic testing in the field, travelling to the affected countries in rotating groups. Some have worked in mobile laboratories (photo bottom), provided by the European Mobile Laboratory consortium, but most have been deployed to Sierra Leone where we have established three new laboratories (PHE Makeni Laboratory pictured top and middle left) to increase diagnostic capacity and isolate Ebola cases more rapidly.

Our laboratories at Kerry Town, Port Loko and Makeni have made a significant contribution to reducing Ebola transmission, testing more than 10,000 samples during the year. We have provided training and equipped the laboratories, which are now the largest in Sierra Leone. Volunteers from PHE, the NHS, universities and other UK partners have helped to run the laboratories, working in teams of around ten.

Protecting the UK: We rapidly strengthened our systems to ensure the UK was ready to detect, manage and treat any imported cases of Ebola. The national response has been co-ordinated through our National Incident Control Centre, supported by specialist cells, from where horizon scanning and epidemiological updates have been produced along with guidance for the public and health professionals.

Our microbiology staff have advised organisations across the UK and Europe on infection prevention and control. During the year, PHE scientists ran Ebola tests on people returning to the UK. They continue to investigate potential vaccines and treatments, as well as rapid diagnostic tests to detect EVD in the field.

Screening: In October, we rapidly established screening arrangements at the UK's main ports of entry to identify, advise and monitor passengers who may have been at risk of infection, provide reassurance and protect the public's health.

Within five days, the first screening teams were deployed to Heathrow and, within weeks, screening was underway at Gatwick, Birmingham and Manchester airports and London's Eurostar terminal. More than 5,700 passengers were screened in 2014/15. All workers returning from the affected areas were monitored for 21 days to ensure they remained well.

Local health systems: Our centres worked with NHS England, GPs, hospitals and ambulance services to plan and test local health systems in preparation for a possible Ebola patient.

In December 2014, a Scottish nurse working in Sierra Leone contracted Ebola, which was diagnosed on her return home. In a contact-tracing exercise, nearly 250 potential contacts were identified, in collaboration with Health Protection Scotland, and given advice and reassurance. We played a lead role in the cross-government response to this case, demonstrating that effective systems had been put in place to protect the public.

DEFEATING EBOLA TIMELINE

DECEMBER 2013: Death of a boy in Guinea marks the probable first case in the epidemic

MARCH 2014: Médecins Sans Frontières (MSF) and WHO report a worsening Ebola outbreak in Guinea, and Liberia confirms its first case. PHE deploys its first scientists to undertake diagnostics in European Mobile Laboratories and provide training in the UK

MAY: Sierra Leone confirms its first Ebola case

JUNE: MSF warns that the outbreak is escalating

AUGUST: WHO declares an international health emergency. The first UK national with Ebola is repatriated and recovers

SEPTEMBER: The UK government pledges funding for treatment centres

OCTOBER: PHE Kerry Town laboratory opens. The UK port screening programme is introduced

DECEMBER: PHE Port Loko Laboratory and PHE Makeni Laboratory open. The first case of Ebola is diagnosed in the UK

JANUARY 2015: WHO records a decline in new cases in Sierra Leone, Guinea and Liberia

MARCH: The second UK national with Ebola is repatriated and recovers

JUNE: Weekly case incidence is around 20

Operating review

October 2014 saw a pivotal moment in the history of public health when, for the first time, the need for the NHS to focus actively on prevention was formally acknowledged in the *NHS Five Year Forward View* (FYFV), a collaboration between PHE, NHS England, Monitor, the Trust Development Authority, Health Education England and the CQC. It makes clear that getting serious about prevention, tackling obesity, alcohol and tobacco and helping us all to live healthier lives is essential both for better health and a sustainable NHS.

We expanded on this message in our own priorities document, *From evidence into action: opportunities to protect and improve the nation's health*, which was published at the same time. Designed to be read in tandem, it sets out how we can make greater progress on obesity, smoking, alcohol, ensuring a better start in life, reducing dementia risk and robustly tackling TB and antimicrobial resistance.

Both documents put prevention at the very heart of our NHS and public health systems, which will enable us to better manage demand, improve efficiency and tackle funding pressures.

We all have something to contribute to this, as individuals, families, society as well as leaders in the health and care system. NHS England, PHE and, crucially, local government, will be working to ensure that real progress is made in key areas such as diabetes where a shift in emphasis from treatment to prevention will not only reduce the burden of disease on those who might otherwise have been affected by it, but also enable the redirection of resource to fund other vital services.

We are working with the NHS so that it can achieve the ambition of being 'an ambassador for health', showcasing for other employers what can be done to support the health and wellbeing of both staff and local communities.

The seven priorities in *From evidence into action* are by no means our only areas of interest, nor do they represent the full range of contributions that we make to protecting and improving the public's health, the Government's expectations of us being set out more fully in the annual remit letter from Ministers. They are, however, the areas that we have identified as most in need of improvement in the coming years and on which we will relentlessly focus our efforts.

Early progress on each of these is reported below under the core PHE function to which they primarily relate, together with highlights of our wider work in these areas in what was an energising and immensely productive year.

1. Protecting the public's health

We provide national and international leadership and scientific advice to reduce harm from infectious disease and environmental hazards. We ensure that there are effective surveillance arrangements in place nationally and locally to identify threats and for preparing, planning and responding to health protection concerns and emergencies. This is a global concern as diseases cross borders so our work is UK-oriented but international too, as demonstrated by the Ebola outbreak in West Africa.

Our global health strategy sets out five aims: improving global health security; responding to outbreaks and incidents of international concern as well as humanitarian disasters; building public health capacity globally; strengthening international aspects of non-communicable diseases; and strengthening UK partnerships for global health activity.

We play a key role in the UK's contribution to the global health security agenda, particularly around antimicrobial resistance (see below). As well as Ebola, we have played a significant part in responding to the MERS Co-V virus outbreak in the Middle East and have provided expert advice to the UN-led work on disaster risk reduction.

Looking ahead, we are developing plans to establish a PHE field office in Sierra Leone as part of the UK contribution to rebuilding public health capacity and capability there, including laboratory infrastructure development.

We are developing a number of mutually beneficial relationships with a wide range of countries across the world. For example, in partnership with the Department of International Development, we are working with the government of Pakistan to support them in meeting the International Health Regulations and building an integrated infectious disease surveillance system. We are also in the early stages of a collaborative relationship with China, focusing on non-communicable diseases and lifestyle factors including hypertension, diet, diabetes and climate change.

We received a wide range of visitors and secondments from international partners during the year including Thailand, Nigeria and Singapore, and have seconded our staff to countries such as Laos, Cambodia and South Africa. Our eight World Health Organization Collaborating Centres have also remained highly active throughout the year.

PHE priority: Tackling the growth in antimicrobial resistance

It is critical that we act to prevent the overuse and misuse of antibiotics, which is resulting in many bacteria becoming resistant to these vital medicines. Unless we take greater care, our current antibiotics could soon be ineffective. Each year in Europe alone, 25,000 people already die due to antibiotic resistant bacteria.

Antibiotic resistance is a global challenge but one which the UK can help to lead. In PHE we provide expertise both operationally and strategically to the NHS on the diagnosis, surveillance, prevention and control, and treatment of infection, notably due to antibiotic resistant bacteria. We also work in partnership with industry in developing new interventions and are therefore well placed to help meet the challenge posed by antibiotic resistance.

A strong surveillance system forms the backbone of our process for monitoring human infections, antimicrobial resistance and healthcare associated infections. In December 2014, we introduced the Second Generation Surveillance System, collating data from every laboratory in the country, leading to better identification of cases and improved data quality. All of the acute hospitals in England have agreed to share their prescribing data, enabling more timely and accurate reporting of antimicrobial consumption.

We launched the Antibiotic Guardian campaign in the autumn of 2014, a pledge campaign supported by NHS England and the Chief Medical Officer, committing health professionals and the public to taking action to avoid unnecessary antibiotic use.

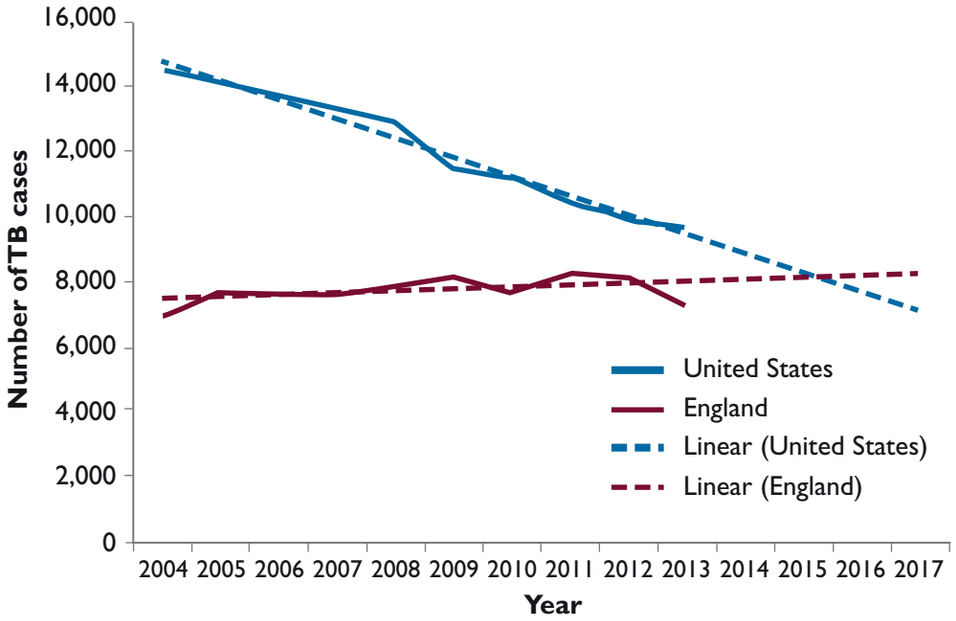
We published the first report of the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) in October 2014. Bringing together GP and hospital data for the first time, it showed that between 2010 and 2013 there was a 6% increase in the combined antibiotic prescribing of GPs and hospitals, and a 12% increase in antibiotic resistance in bloodstream infections caused by *E.coli*. The report will help local clinical commissioning groups (CCGs) to monitor the prescribing of hospitals and surgeries in their area and see how they compare against a benchmark, helping to identify where action needs to be taken.

We developed a data capture system for reporting healthcare-associated infections, which will go live in 2015. We will be able to respond to user demand and surveillance changes by configuring data collections and security settings, and updating reference data.

We are developing a new national framework for infection prevention and control (IPC) across the health and care system. The framework will provide direction on leadership and governance, roles and responsibilities, quality and standards, education and training, and the streamlining and standardising of guidance.

PHE priority: Achieving a year-on-year decline in TB incidence

England has one of the highest tuberculosis (TB) rates in Western Europe, and there are examples of outbreaks in other European countries originating in the UK. The incidence of TB in England is more than four times higher than in the US, and, if current trends continue, England could have more TB cases than the whole of the US within two years.



TB has major health and social impacts for those affected. In addition, it contributes to increasing health inequalities in already deprived populations. Each infectious case represents a risk of onward transmission and the failure to protect communities from TB transmission should be regarded as a failure of public health systems.

In partnership with NHS England, we launched in January 2015 the Collaborative Tuberculosis Strategy for England 2015 to 2020. The ten point action plan, backed by new investment of £11.5 million, aims to reduce and ultimately eliminate TB as a public health problem in England. The programme will target those most vulnerable to TB by improving access to screening, diagnostic and treatment services as well as establishing in places of high incidence the Find & Treat mobile health unit that has proved so effective in London.

Our work with local government, the NHS and other partners has focused on areas of high incidence, and our nine centres are leading on the establishment of TB control boards in their respective areas. The joint TB and hepatitis C virus summit, organised by PHE, DH and the Local Government Association (LGA), held in March 2015, brought together public health leaders and councillors whose communities

have the highest burden of these diseases to explore multi-partnership working across communities to successfully deliver the TB strategy.

Our pilot programme of whole genome sequencing (WGS) for tuberculosis will provide evidence for developing a TB-WGS service for the diagnosis, treatment and public health management of TB. Design and delivery is being undertaken in partnership with the NHS, academe and international public health partners and is underpinned by Genomics England's strategy for clinical genomics. In 2015/16, we will validate the utility and cost-effectiveness of WGS in improving early diagnosis, detecting drug resistance and decreasing transmission of TB, HIV and hepatitis C.

We have been supporting NHS England to introduce active case finding in underserved populations and the systematic implementation of new entrant latent tuberculosis testing and treatments. Co-ordinated national latent TB infection screening in areas of high TB incidence, targeted at new entrants, will help in detecting and treating asymptomatic TB infection and reduce the incidence of TB in England. Our study on the predictive value of latent TB tests has recruited and tested nearly 10,000 new entrants and contacts at high risk of TB.

In 2014, the European Union made a substantial (€25M) commitment to the development of a new improved vaccine for TB through two Horizon 2020 consortia projects. The importance of our scientific work in the field of TB vaccines is recognised by the central role that we have in both projects, providing pre-clinical data to demonstrate the potency of new vaccine candidates.

Wider progress

We progressed our plans for the establishment of the PHE National Infection Service (NIS), which went live in June 2015. This brings together the teams that work on infectious and communicable disease into a new directorate, providing a great opportunity to develop our scientific base and create an 'end-to-end' service that extends our impact in working with the NHS, government science agencies, academe, industry and local authorities to protect the public's health and reduce the burden of disease. Professor Derrick Crook, recently appointed as Director of the NIS, will lead the translation of genomic technologies to transform microbiology practice across England in a collaboration between us and universities hosting NIHR Health Protection Units. 13 Health Protection Research Units, in which PHE is a partner, went live in March 2015 and are operating successfully.

World class science is at the heart of our capability and is central to our evidence base. Our work at PHE Colindale on hepatitis E virus (HEV) is at the cutting edge, both in relation to the impact of this virus on the human population and in understanding its spread in animals in the UK and beyond. The virus, which is contracted from certain undercooked foods, causes serious progressive liver disease in people who are immuno-suppressed. In partnership with NHS Blood and Transplant (NHSBT), we undertook a study of the potential for transmission of HEV by blood transfusion. This was a world first and provided new and essential information on transmission rates which will be reviewed, together with other

findings, by a sub-group of the Advisory Committee on the Safety of Blood, Tissues and Organs.

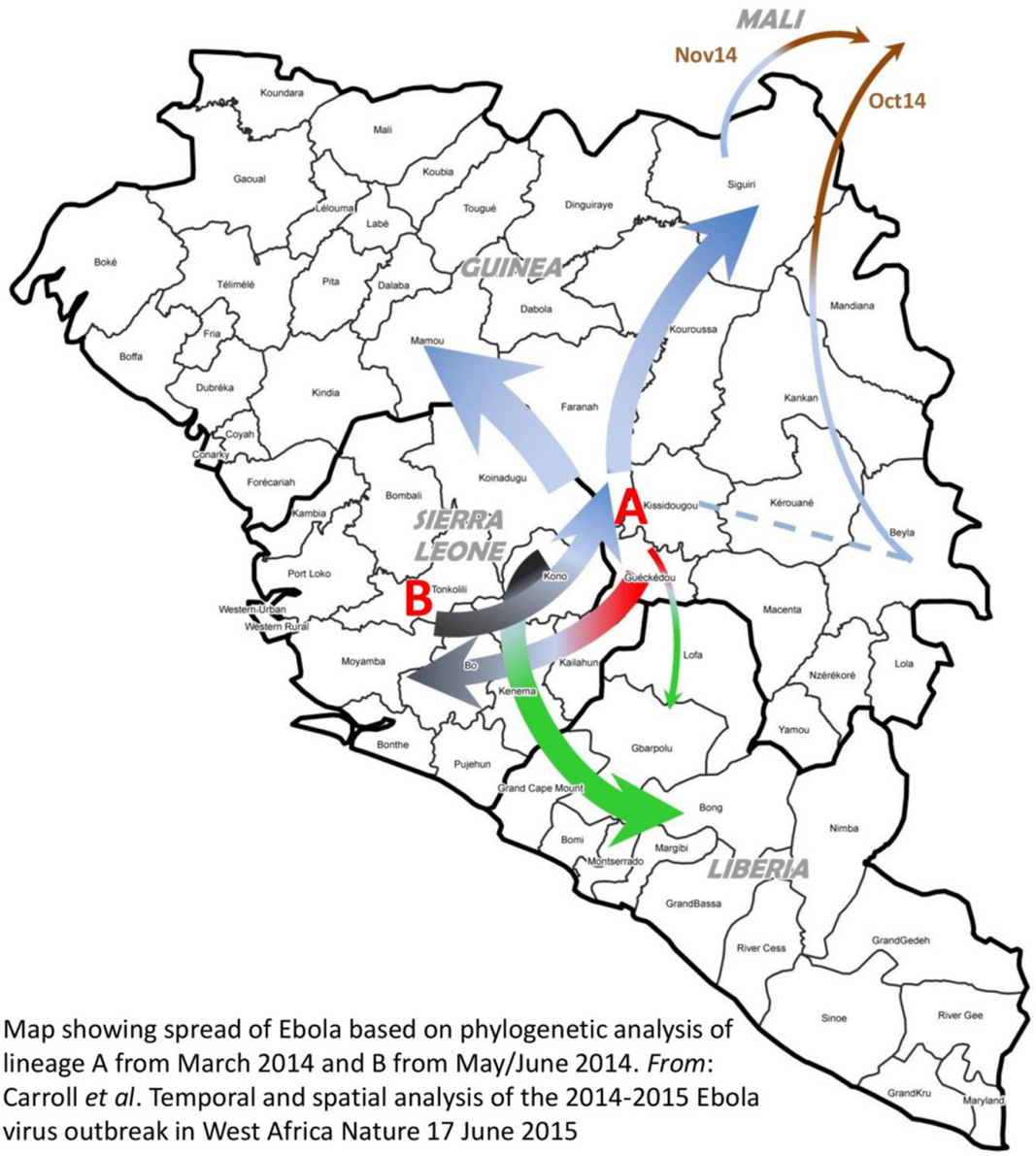
Our Rare and Imported Pathogens Laboratory (RIPL) provides the national acute diagnostic and clinical advice service for many unusual or imported infectious diseases, including Ebola and Lassa Fever, as well as indigenous infections such as Lyme disease. As highlighted elsewhere in this report, RIPL led the UK laboratory response to Sierra Leone, setting up and operating three labs with the help of volunteers from across PHE, the NHS and academe, and testing over 19,000 samples. With the aid agencies, RIPL staff have been working on research projects ranging from environmental decontamination to evaluating new diagnostic tests for Ebola. Through the national Imported Fever Service, a partnership between RIPL and the London and Liverpool Tropical Disease Units, 396 travellers were evaluated for possible Ebola, of whom 240 were tested at RIPL or satellite centres established in Edinburgh, London, Belfast and Newcastle. The UK leptospirosis service also transferred to RIPL, and all these activities have been supported by development and evaluation work through the diagnostic support group attached to the department.

Lyme disease has attracted a great deal of interest from patients and the public. RIPL has been actively involved in working with patient groups to understand their needs and improve support from PHE and the NHS where there is evidence for change. Through the Emerging Diseases Health Protection Research Unit at Liverpool, RIPL has two new PhD studentships on Lyme disease, as well as one on hantavirus. RIPL led a public health study on this virus in pet rat owners as several cases have occurred in this community. Other studies include Q-fever in certain cardiac patients, advice on the management of building sites potentially contaminated with anthrax and two large EU projects. *FastVac* brings together vaccine institutes across Europe working on emerging diseases to protect Europe and beyond. RIPL staff led the scientific component to review over 9 million papers to develop tools for improving vaccine design and testing using data extraction techniques developed with the Food and Environment Research Agency and Sheffield University. RIPL also provided the scientific strategy for *ERINHA*, a project to build a pan-European research infrastructure to reinforce the European co-ordination and capacities for the study and the surveillance of highly pathogenic micro-organisms.

Our scientific staff are making a major contribution to translational research on a number of important pathogens, including those that cause TB, Ebola and Crimean Congo Haemorrhagic Fever (CCHF) as well as to the global response to the threats raised by emerging diseases. CCHF, a serious and often deadly disease caused by a tick-borne virus, is endemic in many countries in Africa, the Middle East, Asia and Eastern Europe, including Turkey and Bulgaria. Outbreaks have been reported in tourist areas including Greece and India, and cases have been imported into the UK. We have developed a new vaccine that has been shown to be 100% protective when tested in a preclinical model of infection. A tick-feeding model has also been established at high containment, so it can be used with the most dangerous of

viruses. This new capability will enable us to monitor UK species of tick to see if any carry and could transmit dangerous viruses.

Our research strengths are recognised by our ability to publish in the most prestigious international scientific journals, including *Nature*, in which a paper co-authored by several of our scientists based at PHE Porton was most recently published. This showed how the Ebola outbreak in West Africa spread geographically and how the virus evolved, based on samples collected in early 2015



Map showing spread of Ebola based on phylogenetic analysis of lineage A from March 2014 and B from May/June 2014. *From*: Carroll *et al*. Temporal and spatial analysis of the 2014-2015 Ebola virus outbreak in West Africa Nature 17 June 2015

analysed by whole genome sequencing. This information will help to develop new treatments for the disease.

We worked with NHS England to successfully extend the childhood flu vaccination programme to all children aged 2 to 4 and pilot the delivery of flu vaccinations to primary school aged children and those in secondary school years 7 and 8. An additional 230,000 children aged 2 to 4 were vaccinated compared with the previous year.

We are leading the infectious disease element of the 100,000 Genomes Project for Genomics England. Our specialist microbiology network is implementing whole genome sequencing. In what is a revolution in microbiology, we have already sequenced the genomes of more than 28,000 bacteria and viruses. We are leading the implementation of whole genome sequencing of HIV, TB and hepatitis C. This new technology has already enabled us to improve our surveillance capability and outbreak investigations and we are determined to harness its full potential in supporting the NHS to deliver the best care for patients.

In the summer of 2014, we investigated an outbreak of Salmonella infection, with almost 250 cases reported across several English regions. This is the first time that whole genome sequencing was used as part of a national investigation of this kind, and confirmed that the cases shared a common source. This made the data available in 'real time', helping to contain an outbreak while it was still under way. Together with our European partners, the evidence indicated that the outbreak was associated with the consumption of eggs from a single source outside the UK.

There are 24 public analyst food laboratories in the UK, of which six in England are in public ownership. We worked with the Department of Health and local government colleagues to configure the laboratories around an integrated shared service that will provide government with a direct public health response capability and support ongoing surveillance to detect emerging health problems faster.

A PHE-authored paper, on the potential of climate change to increase tick and mosquito borne diseases in the UK has become one of the 50 most popular Lancet articles of all time for news and social media interest. The article highlights how climate change could accelerate the emergence of vector-borne diseases, such as dengue fever, chikungunya and West Nile virus, in the UK.

2. Securing improvements to the public's health

We support local authorities, the NHS and central government to secure the greatest gains in health and wellbeing and reductions in inequalities through evidence-based interventions. We act nationally where we are uniquely placed to do so, promoting actions to build healthy places, people and communities, making the case for prevention and early intervention.

PHE priority: Tackling obesity, particularly among children

We have worked with NHS England to begin implementing the commitments to preventing and tackling obesity set out in the FYFV. The NHS Prevention Board, chaired by PHE's Chief Executive, is one of five that will oversee delivery of the FYFV. Our initial focus is on the introduction of a nationwide diabetes prevention programme, a first in the world at this scale. It will be key in demonstrating that we can intervene early and prevent the development of conditions that blight individual lives and place a great burden on families and taxpayers. It will also support the NHS in becoming an exemplar employer concerned for improving the health of its staff.

In March 2015, we launched, with NHS England and Diabetes UK, the seven local demonstrator sites we will work with to co-design and test the programme. We will use a national procurement exercise to secure the capability and capacity to provide lifestyle programmes to cut the risk of developing diabetes. The programme will be based on well-established international evidence and will be scaled up to become a nationwide service. The potential benefits are significant; every year around 20,000 people with diabetes die early, and it is a major contributor to preventable ill health.

In October 2014, we published *Everybody active, every day*, our evidence-based approach to physical activity. Since the 1960s, our overall levels of activity have fallen by 24 per cent and unless we take action, this trend will continue. Lack of activity is implicated in one in six deaths and is responsible for up to 40 per cent of all long-term conditions so being active is genuinely a life saver and we need to work together to get everybody moving more.

We prepared our evidence package on the health benefits of reducing sugar consumption and tested this with stakeholders in March 2015. This included the Scientific Advisory Committee on Nutrition's draft report on carbohydrates and health. We will publish evidence on the health benefits of reducing sugar consumption in the summer of 2015.

Our Change4Life campaign has delivered real behavioural change, with over 2.7 million people having signed up. We work in partnership with over 200 national organisations, including Disney, Asda and Boots, as well as over 70,000 local supporters. This gives us opportunities to reach families in new and exciting ways and take action in communities across the country. Partner contributions provide significant additional value above and beyond our own investment. The Change4 Life Sugar Swaps campaign launched in January 2015 aims to get families, particularly those from lower socioeconomic groups, to make simple swaps to their everyday food and drinks in order to cut back on sugar. Over 410,000 people have registered with the campaign. Purchase data showed an 8.6% reduction in purchasing of carbonated sugary drinks during the Sugar Swaps campaign compared to the same period in the previous year, with a sustained average fall of 5% in purchasing over the next six months.

The Sugar Swaps checklist for parents, published in 2015

Change4Life's 10 Minute Shake Up partnership with Disney added an extra five minutes to participating children's mean daily activity levels; altogether generating an extra 104 million active minutes in total. Over 125 local authorities supported the campaign running over 2,500 summer events and activities.

As a result of seeing Start4Life advertising, more pregnant women reported that they had spoken to a midwife or GP about healthy lifestyle and nutrition (43%) and managing their weight (39%). Over half agreed that the advertising made them want to make changes and have a healthy pregnancy.

PHE priority: Reducing smoking and stopping children starting

We continued to advise government on the evidence for the introduction of standardised packaging of tobacco products, legislation on which was passed by Parliament in March 2015.

Our internationally renowned stop smoking programme supported 778,000 quit attempts through three highly successful campaigns. More than 250,000 people signed up for Stoptober in 2014, 62% of Stoptober participants in 2014 were still smoke-free at 28 days; our employers programme reached 1.4 million people via 256 national and regional employer partners. Our campaign also received support

from over 50 of the largest national and 200 regional and local employers, providing them with the new Stoptober 'Break the Habit' workplace toolkit, reaching over 1.5 million employees. In addition over 7,500 pharmacies across England supported the campaign with point-of-sale displays.

To coincide with the landmark vote in Parliament in February 2015 to end people smoking in cars when carrying children, we launched our Smokefree Homes and Cars campaign. It provides a range of free support and quitting advice, which shows that 80 per cent of secondhand smoke is invisible, raising public awareness of this forthcoming change in the law.

We brought together data and evidence that illustrate the case for local investment in tobacco control and support its effective commissioning. Tools include infographics, quantitative data and good practice prompts for planning comprehensive tobacco control interventions.

We ran seminars across England to support local partners in addressing smoking and mental health, smoking in pregnancy and making the case for comprehensive local tobacco control. Information gathered from these events is being used to inform the next phase of the national tobacco control work plan, which will support local partners in the development of their own action plans.

We published *Reducing Smoking in Prisons: Management of tobacco use and nicotine withdrawal* in March 2015. The guidance brings together research on smoking in prisons and outlines a joined-up care pathway for treatment.

We completed our review of the emerging evidence on e-cigarettes to provide evidence-based recommendations to support smoking cessation, tobacco control and inform the government's future thinking.

PHE priority: Reducing harmful drinking and alcohol-related hospital admissions

Liver disease is the third biggest killer of working age adults after ischaemic heart disease and self-harm, with 75 per cent of people with cirrhosis only being diagnosed once they are admitted to hospital. It is also a disease of stark inequalities, as shown in our Liver Disease profiles that we published in October 2014, with a fourfold difference in avoidable mortality across local authorities. These profiles help health and wellbeing boards to understand the disease and its risk factors in their areas and better design effective local population level interventions. We have developed work programmes on all the major risk factors and will be publishing our Liver Disease Framework in the summer of 2015, setting out our proposals for tackling this preventable disease that kills so many young people. It will combine data, expertise and public health action to tackle the three major risk factors: unhealthy alcohol consumption, viral hepatitis and obesity.

We supported Alcohol Concern's Dry January campaign. Over 2 million adults took part, with 50,000 people signing up for support, more than twice the number who registered the previous year. If the results of the 2014 pilot are replicated, we expect

approximately 70% of participants to sustain reduced levels of harmful drinking six months later. Approximately half of unitary local authorities ordered campaign materials from us and some ran complementary activity. We saw many examples of positive collaboration between local authorities across a region, for example the North East ran supplementary TV, radio and digital activity to generate sign-ups.

We published the annual Health Profiles for every local authority in England, including Alcohol Profiles. Alcohol-related hospital admissions among under 18s are continuing the downward trend of the last three years. However, there is still much work to be done. More than half of local authorities in England saw a slight increase in the number of adult alcohol-related hospital admissions, with the rates of admission 55 per cent higher in the most deprived areas. Alcohol continues to be the leading risk factor for deaths among men and women aged between 15 and 49 years in the UK, and the number of deaths has remained virtually unchanged over the past decade, yet much of this harm is preventable.

We have completed our research on the latest evidence and effective policy interventions and treatment to prevent and reduce harm from excess alcohol. The report will form the basis of clear advice to government on the action it could take to reduce the harm from drinking and this will be published in summer 2015.

PHE priority: Ensuring every child has the best start in life

Local government takes on the commissioning of public health services for children aged 0-5 in October 2015, bringing all the associated opportunities and benefits of bringing together all services for young children. In partnership with NHS England, we have been working closely with local authorities to ensure they are well prepared for this transfer, for example, through a guide to councils on capturing key 0–5 data and a rapid review of evidence to support councils in delivering the 0–5 Healthy Child Programme. We also published a rapid review of the programme, setting out the latest evidence on what works in universal and early intervention.

Health visitors play a vital role in supporting parents in ensuring their children are physically and emotionally healthy and we were pleased to take on responsibility for their professional leadership in April 2015.

We have worked with NHS England to increase the number of places available through the Family Nurse Partnerships (FNPs) to 16,000, up from 11,000 in 2013. The programme is being delivered in 135 local authorities, and is commissioned by NHS England until the transfer of commissioning responsibilities in October. Many of the most vulnerable young people will benefit, helping to break the cycle of deprivation for them and the next generation. FNPs form an important part of wider preventive public health services, working closely with health visiting, social care and other children's services.

In partnership with NHS England, the Department of Health and the Department for Communities and Local Government, we launched a 'health offer' for the Troubled Families programme, which will result in local doctors, nurses and community health workers taking a more integrated approach to working with councils' Troubled Families teams and other local authority services. It also means that Troubled Families teams can more easily get the information they need on health concerns and specialist health training. In addition, there is new guidance on sharing health information, which we hope will help identify a family's health problems at an earlier stage. Including health as an objective in the national programme will encourage and support families to access the services they need, such as GPs, pharmacies and dentists, rather than relying on A&E. The 51 'early starter' local authorities in the programme began to use the health offer late last year in advance of roll out across the country in April 2015, helping up to 400,000 families over the next five years.

PHE priority: Reducing the risk of dementia

PHE and the UK Health Forum published a joint consensus statement in June 2014 on the need for action to promote brain health and reduce the risk of dementia. Fifty nine organisations and experts, including practitioners and researchers, also signed the statement, known as the Blackfriars Consensus. This emphasised the importance of national and local action on the risk and protective factors that influence our rate of brain ageing. 'Think heart, think brain' needs to become the way we think about health and wellness. Managing risk factors including smoking, drinking, sedentary behaviour and poor diet, not only reduces the risk of dementia in later life but that of other conditions such as heart disease, stroke and many cancers.

Our campaign to support the Alzheimer's Society's Dementia Friends programme helped over 1 million people learn about the things they can do to help others with dementia. Over 30 commercial organisations were involved in the campaign, including Marks and Spencer, Asda, Santander, EasyJet, Homebase, Argos, BT and Bourne Leisure, who encouraged their employees to become Dementia Friends.

We launched our National Mental Health Dementia and Neurology Intelligence Network, providing commissioners, local decision makers and health professionals with authoritative intelligence, research and evidenced best practice using our Fingertips platform. It brings together, for the first time, data from 13 separate sources into a single online resource.

We are working with University College London Partners to develop a brain age tool or personalised risk assessment calculator that will show people how factors such as smoking, drinking, sedentary behaviour and poor diet might increase their risk of dementia and encourage them to pursue healthier lifestyles.

We scoped options for developing the evidence base on dementia risk reduction and improving the modelling of dementia incidence and prevalence. A project to model dementia prevalence and risk factors is now being progressed by the Department of Health and the University of Cambridge.

Wider progress

The NHS Health Check is an opportunity for individuals, aged 40-74, to take control over their own health, taking early action to reduce their risk of developing conditions such as heart disease, stroke, kidney disease and type 2 diabetes. This is an important step for many people towards improving their health and wellbeing and becoming more aware of what they can do to lead a healthier life. Economic modelling of the programme suggests that it presents a significant opportunity to save 650 lives, prevent 1600 heart attacks and strokes as well as detect over 4,000 new cases of diabetes each year and 20,000 cases of diabetes or kidney disease earlier.

A massive effort by local government saw the programme make excellent progress in their first year of being responsible for it, offering 15 million people in England an assessment of their cardiovascular and other risks, followed by a range of preventive interventions of proven effectiveness. In 2014/15, there was a 7.4% increase in the total number of people receiving an NHS Health Check – an additional 102,475 people compared to the previous year.

High blood pressure affects more than 1 in 4 adults and is the second most important risk factor for premature death and disability; diseases caused by high blood pressure cost the nation more than £2bn each year. In November 2014 we published *Tackling High Blood pressure: From evidence into action,* a joint action plan with partners to tackle high blood pressure setting out the steps to improve the prevention, early detection and management of high blood pressure. The plan and accompanying resource, including a resource hub, educational quiz and interactive data maps, have been viewed more than 25,000 times since the launch. Over ten years, the plan estimates that 45,000 life years and £850 million could be saved if the average population blood pressure was reduced.

In partnership with the Daily Telegraph, we ran the Health X competition in the summer of 2014, attracting 139 entries from early stage tech businesses. The aim was to encourage digital entrepreneurs to focus their innovative thinking on how to reach people of all ages and circumstances to encourage them to move more and eat better. This was our first toe in the water of bringing together what we know of the behavioural sciences and harnessing it to the digital revolution, making it personal for real people living real lives. The three winning entries were the ‘Fee fi fo fit’, an app targeted at children and families to boost fitness; ‘Foodswitch’, a smartphone app to provide consumers with nutritional information to help them make healthier choices when shopping; and ‘Youniverse’, a 28-day exercise and diet planner which generates daily meal plans, shopping lists and exercise ideas. The winners were provided with a springboard to launch their digital product, including access to the 10 million unique visitors each week to NHS Choices.

In October 2014, we published the results of our first national survey of the oral health of three year olds in England. Although the majority of these children had no decay at all, one in eight had an average of three decayed teeth, with the variation in the prevalence of tooth decay ranging from two per cent to 34 per cent across the country, high levels of decay being associated with high levels of deprivation. The cause of this painful condition is mainly down to consuming too many sugary foods and drinks too often and not brushing teeth regularly. We have recently published guidance for health practitioners and local authorities on 'what works' in combating this entirely preventable disease.

In March 2015, we launched our new Rise Above campaign which reaches out to 11-16 year olds on a range of topics that concern them including puberty, relationships, alcohol, smoking, drugs, peer pressure and mental health. The aim is to help them build emotional resilience by equipping them with the skills and knowledge they need to make informed decisions and also to help them deal with the pressures of growing up. The website encourages online conversations among their peer group and with professional support. In partnership with the Children & Young People's Mental Health Coalition, we also published our guidance *Promoting children and young people's emotional health and wellbeing: A whole school and college approach*. Many schools and colleges are already investing a lot of time and resources into improving pupils' emotional health and this briefing builds on this work and wider evidence.

In October 2014, we published a joint report with the Association of Directors of Public Health on drug and alcohol services commissioning across local authorities in England. The review showed that so far about one third of local authorities have undertaken a root and branch review and are seeking to make them more efficient, while a number are spending the same amount of money to achieve more ambitious outcomes. Understandably, local authorities are looking hard at what they are getting for their money and they and we wish to see drug and alcohol recovery rates improve year on year.

The local authority public health allocations for next year were confirmed in late 2014, along with details of the pilot health premium incentive scheme. Successful completion of drug treatment will be the sole national indicator determining which local authorities receive the additional money. This also reinforces a new grant condition seeking year-on-year improvement in recovery rates. The choice of drug recovery as the indicator was strongly supported in the consultation responses. To support local authorities to see, comparatively, how they are doing we launched a new digital tool, *Healthier Lives – Alcohol and Drugs*, to make performance even more transparent.

In March 2015 we announced the successful applicants for £10 million capital funding for services that are helping people in England with drug or alcohol problems to recover from their addiction. More than 50 projects, in partnership with local authorities, will receive grants and a substantial proportion of these have been awarded to those providing tailored education, training, skills and employment support to people in recovery. Evidence-based drug and alcohol treatment services play a vital part in turning around people's lives, improving family and community cohesion and reducing health inequalities.

We worked in collaboration with the University of Manchester to establish the Well North programme to develop, test and pilot a set of linked interventions to improve the health of the poorest, fastest, in some of the most deprived areas of the North of England. Overseen by the Well North Board, chaired by PHE's Chief Executive, it seeks to reach and engage with people and work with them to identify holistic solutions for themselves and their families. The aim is to improve their health, bring the health system and economic growth priorities into closer alignment and build a best practice framework which can be replicated and delivered across the North and potentially elsewhere in the country.

Our London Region worked closely with Lord Darzi, the Greater London Authority health team, NHS England, local authorities and a wide range of expert, lay and third sector organisations in developing the recommendations for the London Health Commission. Professor Yvonne Doyle, our Director for London, who is the statutory health adviser to the Mayor, chaired an expert group on health and inequalities which strongly influenced the final recommendations. The plan will help deliver the Mayor's ambition to make London the healthiest major global city within 10 years. It proposes a raft of measures, unprecedented in their scope, to combat the threats posed by tobacco, alcohol, obesity, lack of exercise and pollution. The Commission has set 10 specific ambitions for the next decade, almost all of which dovetail with our own priorities for improving the public's health including: giving all the capital's children a healthy, happy start to life; getting London fitter with better food, more exercise and healthier living; making work a healthy place to be; helping Londoners kick unhealthy habits such as smoking; and caring for the most mentally ill so they live longer, healthier lives.

Our guidance for local authorities assists them in using latest thinking to deliver a suicide prevention strategy. Our Suicide Prevention Profile tool enables local authorities and clinical commissioning groups to easily access and compare suicide-related data. We are piloting a real-time surveillance system in three areas in collaboration with the police, which will provide information to local authority and NHS staff to enable them to respond to local clusters of suicides and provide appropriate support to bereaved family and friends.

3. Improving population health through sustainable health and care services

We are the public health adviser to NHS England, supporting NHS commissioners and providers as they seek to improve population health and tackle inequalities, and to develop more personalised, proactive care that can help each of us maintain the best possible health and wellbeing. Our specialist staff provide the evidence and analysis to help the NHS and local authorities allocate their resources most effectively, with a greater shift towards prevention and early intervention.

Working closely with our partners in the NHS, we have:

- delivered the 60% target of centres providing bowel screening by the end of the year; out of 62 centres, 39 of them now offer this. This is expected to reach 100% by the end of next year. For every 300 people screened, the examination could prevent two people getting bowel cancer and save the life of one person who already has cancer
- delivered our target for piloting faecal immunochemical tests (FIT) with over 46,566 test kits distributed. The single use kit is a more sensitive and specific test, and promotes a better uptake of screening. There was a significant increase in uptake compared to the previous kit, in particular, it showed an increased uptake in men, who are traditionally less likely to undertake bowel cancer screening, and demonstrated increased uptake of screening across all deprivation quintiles
- delivered life-saving screening with the expansion of the NHS Newborn Blood Spot Screening Programme.This now includes four rare metabolic diseases: homocystinuria, maple syrup urine disease, glutaric aciduria type 1, and isovaleric acidaemia. Although incredibly rare, early detection leading to early treatment for those babies and families affected is life changing, preventing disability and, in some cases, death
- piloted and are evaluating the addition of pulse oximetry to newborn screening and link screening for cardiological defects from the antenatal to the newborn period. Fifteen NHS hospitals are participating and a nationally agreed screening clinical pathway has been developed
- delivered 73% uptake for winter flu vaccine in people aged 65+, the second highest in Europe, and 180,000 more people than the previous year, supporting NHS England and local government to reduce winter emergency admissions

are delivering the abdominal aortic aneurysm screening programme, preventing hundreds of premature deaths among men aged 65 and over. The first set of data shows that more than 260,000 men were screened in England during 2013 to 2014 with nearly 3,700 aneurysms detected. Of these, 491 men had potentially life-threatening aneurysms and had surgery while others are being monitored through the programme to ensure they receive treatment should their aneurysms grow

The *Be Clear on Cancer* campaign had another successful year, supporting individuals to identify and act on the signs and symptoms of cancer at an early stage. Early data from the lung campaign shows that 700 more people were diagnosed with lung cancer compared to the previous year. Following the national bowel campaign, there were around 250 additional colonoscopies each working data compared to the same period in the previous year. The campaign is a joint partnership with NHS England and DH and was recognised by the UK marketing industry when it won silver in the prestigious 2014 IPA effectiveness awards, the professional body for advertising, media and marketing communication agencies in the UK.

We are piloting and assessing the benefits of HPV primary screening in the English Cervical Screening Programme. Initial results show that detection of high-grade cancers (CIN2 and CIN3) is significantly higher with HPV primary screening.

In support of NHS England's work, we produced a series of reports on high spend areas of specialised commissioning, including chemotherapy, renal dialysis, neonatal intensive care, specialised cancers and complex cardiology. Our recommendations focused on controlling costs and improving outcomes by reducing unwarranted variation in access, use and delivery of services. This will help NHS England to shape its approach to commissioning specialised services and in developing whole care pathways.

We are supporting local authorities to make the best use of resource through the rollout of the return on investment tools developed by the National Institute for Health and Care Excellence (NICE). Over 50% of local authorities requested one-to-one user training from us or took part in a webinar. As part of our health economics work programme, a workshop for local authorities will be held in 2015/16 to support them in cost-effective interventions and return on investment.

Data published by our National Cancer Intelligence Network in August 2014 showed that cancer survival in England for breast, lung, prostate, colorectal and ovarian cancer continues to improve. This work drew on the huge advances in the quality and completeness of cancer staging data by the NHS and the timeliness of the information gathered through our National Cancer Registration Service, one of the most advanced anywhere in the world. The findings also emphasised the importance of early diagnosis. Being able to analyse data for the whole population so quickly gives the NHS front line the information they need in making treatment decisions and is important for supporting research.

In July last year we published the 2014 Health Profiles, bringing together many data sources into one place to provide a snapshot of health and wellbeing in every local authority in England. They include information on a range of indicators for local populations such as the proportion of children in poverty, adult smoking rates, levels of child and adult obesity, hospital stays and early mortality rates. We also updated the data in the accompanying Local Health tool, which can display information down to ward level. By making comparisons with peer areas and the national average, we provided local authorities and CCGs with 'conversation starters' on local challenges and priorities.

The What Works Centre for Wellbeing went live in October 2014, a significant development in the 'What Works Network', launched by the Government in 2013 to improve public services through evidence-based policy and practice. With its development team hosted by us, this independent centre, the first of its kind in the world, will identify examples of good practice – what works – in improving wellbeing, and together with the other funding bodies, we will be sharing our findings with local authorities, health and wellbeing boards, the voluntary and community sector and business partners. The centre will also help tackle health inequalities and support the commissioning of services that reduce demand on the health and care system.

We have reviewed our quality assurance functions for cancer and non-cancer screening programmes to deliver a more harmonised service. An independent team identified many areas of good practice and recommended that these should be shared and built into a new quality assurance (QA) service. This now brings cancer and non-cancer together into a single organisation and the standardised QA operating model will define generic processes and procedures to be used across all screening programmes.

In September 2014, in partnership with the LGA, the Association of Directors of Public Health (ADPH), NHS England, and the Department of Health, we launched a comprehensive guide to the commissioning of sexual health, reproductive health, and HIV services. The aim of *Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV* is to help commissioners ensure that service users experience integrated, responsive services that deliver the best outcomes.

4. Building the capacity and capability of the public health system

We support the development of the public health system as a whole by ensuring access to the best evidence and intelligence, the current and future excellence of the public health workforce, and through publishing outcomes to ensure transparency and promote improvements. We work closely with local authorities, the ADPH, the Faculty of Public Health (FPH), the Chartered Institute of Environmental Health, the voluntary and community sector, and the NHS as we build the capacity and capability of the public health system as a whole.

In August 2014, we published guidance on organising and managing multidisciplinary public health teams in local government, which we co-produced with the LGA, ADPH and FPH. As public health teams become further embedded in local government, their elected members and officials need to engage a range of public health professionals. The guidance helps local authorities identify the mix of skills best suited to their needs as well as providing advice on the issues they may need to consider as they build their capacity and capability.

In collaboration with the ADPH and LGA, we published *Providing early support to local authorities with performance challenges in public health and managing the risk of underperformance* in November 2014. This sets out the arrangements for supporting the sector-led improvement work of local authorities to help them ensure that they can best deliver their responsibilities for improving the public's health.

Since our establishment, we have been collaborating in the development of leadership and capability across the public health system in a number of ways. We have worked with the Department of Health, the Society of Local Authority Chief Executives (SOLACE), the cross public sector Leadership Centre, the NHS

and others to develop people at every stage in their career. 65 senior public health professionals have taken part in the aspirant Director of Public Health programme, of whom 24 have since secured Director of Public Health posts, and four have gained senior public health posts in other public health organisations. More than 500 staff have undertaken the Skills for Systems Leadership programme and many more will go through this in the coming year. Two pilots of a system-wide approach to talent management are under way. We are also road testing a skills passport to support the freedom of movement of staff irrespective of employer throughout their career. Through these initiatives we are building capability for the present and for the future, of critical importance to local government and to the wider public health family.

In February 2015, in partnership with the LGA, we published *Local Leadership, new approaches,* which looks at how new ways of working are helping improve the health of local communities. It focuses on the power of leadership and what this can achieve when local authorities and local health teams work together to improve the health of their communities by focusing on prevention and early intervention. We have brought together practical examples of what works. They reflect different local priorities but they all have at their heart a single theme: give people the support they want, in ways that suit them and that can help with the things that matter to them – their health, their jobs, homes, families and neighbourhoods.

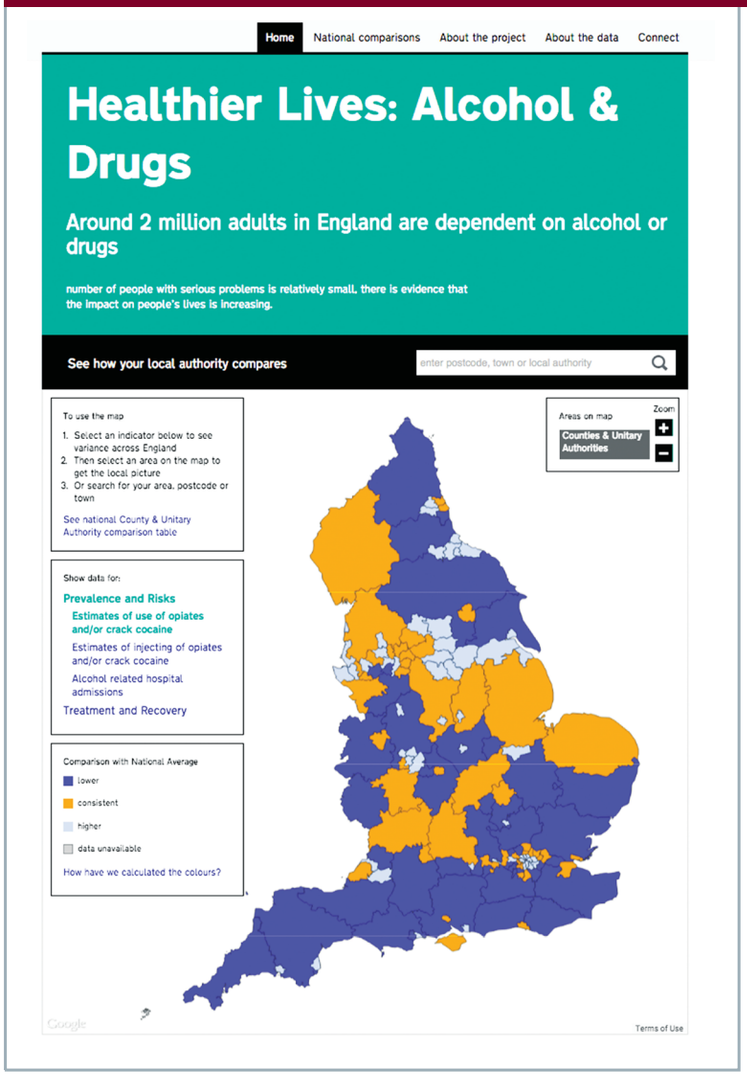
In collaboration with DH, and developed in partnership with practitioners and leaders, we published *A Framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals* in July 2014. Designed for use at both national and local level, it supports and shapes health promoting practice and encompasses both personalised care and population health across all ages, care settings and with individuals, families and communities. We know that this kind of health-promoting practice is essential to meet the health challenges in our society. We also know that we need to develop practice, leadership and systems to value health and wellbeing and therefore support prevention and health promotion as well as high-quality treatment. This work, together with the related programme for the UK and Republic of Ireland *Nurses and Midwives Caring for the Public's Health* and our advice to WHO/Europe has led to us being recognised as a leading country in public health nursing and midwifery in Europe.

We continued to develop and refine the Public Health Outcomes Framework with quarterly refreshes throughout the year. Feedback from a number of sources suggests that it is widely used and relied on by the health and care system in England.

The Longer Lives/Healthier Lives website has put more health data into the public domain and explained public health trends across England in a clearer, more transparent way. A digital tool, it enables local authorities and the local NHS to look in depth at the causes of premature mortality in their areas and across England.

The next phase of this work, *Healthier Lives: Diabetes*, was launched in October 2014. As before, there is an interactive 'heat map', but it also includes information on prevalence, complications and quality of care by local authority, CCG and GP practice. The new tool covers diabetes in depth but also high blood pressure and the Annual Health Check programme. The data shows a picture of considerable achievement compared with some ten years ago, when diabetes care was a very hit and miss affair, but there is still a huge opportunity remaining to prevent illness and reduce demand for NHS care across the country. The new tool will be a powerful support to the message from us and NHS England that the NHS needs to focus on prevention and early intervention in everything that it does if we are to see people living well for longer and to ensure that services can cope better with future demand.

Estimates of the prevalence of opiate use and/or crack cocaine use, 2011/12, as depicted on the Healthier Lives website



Our organisation

Securing our Future

Through our strategic review, we have carefully looked at how we best organise ourselves in delivering our remit, play a central role in making the case for prevention and deliver more and better for less. As a result, we are changing the way we work, focusing on three core themes:

- ensuring that our science continues to compete with the best in the world and this has underpinned the creation of a unified National Infection Service in June 2015. This builds naturally on the direction of travel set out in the options to create a PHE Science Hub of national and international importance in protecting and improving the public's health, the outline business case for which was submitted to DH on time in July 2014

  The scientific future for PHE is incredibly exciting and recently a number of our team presented to Sir Mark Walport, the Government Chief Scientist, about the opportunities of the 'big data' revolution. This is relevant to all our work, including obesity, surveillance, cancer and infectious disease. For example, in infectious disease, the links between the new technologies that enable our teams to sequence the genome of infectious organisms, with the 'big data' techniques of analysing and presenting large volumes of data to support decision-making, are at the very heart of the new NIS. Professor Derrick Crook has joined us from Oxford University as its Director and the detailed design work which will bring together our epidemiologists, microbiologists, bio-informaticians, laboratory scientists and others in creating a world-leading 'end to end' infection service has started

- bringing that same research rigour to bear on our health improvement work, combining our assets in knowledge and intelligence, health and wellbeing and strategy, to develop and deliver the products and services that the front line wants. We are reviewing the products and services we provide to the public health system, for example, health profiles, our spending and outcomes tool (SPOT), Longer Lives, our Atlases of Variation, evidence-based guidance and service frameworks among many others. We want to ensure these are relevant to local authority and NHS requirements and so we will be introducing a more structured approach to obtaining stakeholder feedback and on their priorities for future product development. We are also addressing the frequent request for more help in articulating the return on investment from public health interventions and, in addition to the LGA and NHS England, we will be involving a range of experts in this, including CIPFA, the third sector and university departments. We understand the imperative to realise cash savings in the local system and investing in prevention is one of the routes to achieving this

- aligning our local presence around how local government organises itself, moving from 14 local centres plus London, to eight plus London. One of our key objectives is to be focused on the priorities that are set by local health and wellbeing boards, bringing evidence and expertise to bear, publishing performance and strengthening transparency on outcomes, and to be of practical utility and relevance in all of our contributions. We want to be an organisation that strives to provide central support for local action and we know that this depends on building and investing in local relationships, and that whatever we do nationally ultimately expresses itself at local level. This speaks to the heart of how we see our role

Staff engagement

Our second year has been an energising and challenging one for our organisational and workforce development team, as we considered what our staff, customers and stakeholders' emerging needs and preferences were. They have focused in particular on how we support our staff and how we change our ways of working to deliver *Securing our Future*.

Our in-house team has worked closely with many different professions across the organisation throughout the course of the year. Their initial focus was on creating and sustaining high performing teams, making best use of their bespoke organisational development programmes. This included the design and delivery of a suite of online tools to enable teams to create their own development programmes. For those staff that preferred more hands-on support, the team recruited and trained 120 facilitators, using in-house expertise and skills. They also developed in-house psychometric capability and provided over 200 expert psychometric assessments and products to staff individually and in groups. More recently, the team has focused on creating and rolling out an agile methodology for *Securing Our Future* and providing programme management support to it. We resourced this internally, recruiting a dedicated group of project and business people to manage this key transformation programme.

At the beginning of the year, we appointed Marcus Safadi as our Registrar, adopting the John Lewis model of an independent voice to help our leaders support their staff and demonstrate the behaviours that we say matter. With direct access to the Chief Executive, this 'critical friend' role operates very much as the conscience of PHE, offering professional insight on how we are performing across the organisation, particularly around our behaviours, where the gaps are and how we might best address them. The Registrar leads our staff engagement team, who, over recent months, have involved grass roots staff opinion from across the organisation to influence and shape our new behaviours, ensuring that our staff have a real say in how we go about doing what we do. These will be core to how we deliver future recruitment, induction, appraisal, performance management, the annual staff survey and learning and development.

The staff engagement team is responsible for supporting and developing our network of over 100 engagement agents, who come from a wide range of levels and backgrounds across the organisation. They work closely alongside our network of 150 health and wellbeing champions to ensure there is seamless support for our staff. The team also delivers expert guidance and coaching on staff engagement, and influence and coach leaders to develop a culture of continuous improvement. As well as encouraging individual ownership and responsibility, leaders are also challenged to seek out staff opinion and ideas and act upon them. Our annual people survey, which is part of the annual Civil Service survey, gives us valuable insight into how our people are thinking and feeling and responding to change. Advice is given on how to interpret the results alongside practical advice on how to deliver improvements.

We developed and delivered a joint HR and OD initiative to strengthen our management capability, a bespoke one day programme across the country, offering all of our managers the tools and techniques to improve their own skills particularly around feedback, team development and inclusivity. Over 1,000 managers participated during the year.

We have improved internal communication through *Team Talk*, a monthly organisation-wide set of conversations at all levels on contemporary key topics. We have also developed our senior leadership forum where our most senior leaders get together regularly to discuss priorities, share best practice, challenge and support each other, and review progress. In response to feedback from staff, we refreshed our induction processes, ensuring that new staff of all grades and backgrounds are welcomed into our organisation by our most senior leaders and provided with all necessary information to enable them to succeed in their role.

More formally, the Staff Partnership Forum, which the Chief Executive chairs, is the focus for negotiation and consultation with recognised trade unions, enabling discussion on the staffing implications of strategic and operational decisions, the working environment and HR policies and procedures. It also negotiates agreements with recognised trade unions, with the exception of pay, including other terms and conditions of employment within the delegated authority set out in the Framework Agreement, and facilities arrangements for accredited employee representatives.

Health and safety

Our health and safety policy commits to protecting our staff and others from harm and to reduce the risk to their health, safety and wellbeing as far as possible. We undertake a wide range of activity in our scientific work 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, where we are regarded by the Health and Safety Executive as the sector leader. Our strategy and management systems for health and safety aim to ensure the highest standards are achieved with the overarching aim of continuous improvement. Our annual plan sets out a number of priorities and key performance indicators, delivery against which is overseen by the

Health and Safety Steering Group chaired by the Chief of Staff, the membership of which includes staff side colleagues.

We have in place general controls to protect staff from harm as part of good risk management, with suitable and sufficient assessment of its activities and putting in place control measures to prevent and reduce risks. Our health and safety policy is supported by a *My Safety: My Health* handbook for all staff and a laboratory precautions handbook for those working with biological agents. These cover a number of specific areas and risks, and are complemented by 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. We consult our staff about any changes to the health and safety system through a network of safety representatives and advocates.

Sickness absence

During 2014/15, the total number of whole time equivalent (WTE) days lost to sickness absence was 55,239 days, an average of 6.3 working days per employee WTE per year; and a sickness absence rate of 4.19% (2013/14: 55,025 days; average 6.6 working days per employee WTE per year; and 4.38% sickness absence rate).

Workforce equality and diversity

Over the last year we have demonstrated our commitment to creating a diverse and talented workforce by establishing a dedicated team led by the new Head of Diversity and Staff Inclusion. A comprehensive action plan has been created which is currently under way and the team is delivering the following initiatives:

- appointment of National Executive Diversity Champions
- establishment of business-led staff diversity networks to learn from the excellent work of the Lesbian, Gay, Bisexual and Transgender (LGBT) network
- accurate collection of diversity data leading to production of scorecards for each directorate with directors accountable for addressing any under-representation identified
- continuing roll-out of diversity confidence training for all staff
- embedding inclusive management within all management development programmes and behaviour and competency frameworks
- developing bespoke talent management programmes for protected groups, commencing with black and minority ethnic sponsorship programmes and LGBT role modelling
- developing the Disability Apprentice programme in partnership with Leonard Cheshire and the Movement to Work scheme

- implementation of a 'Reasonable Adjustment Passport' for staff with disabilities and/or long-term health conditions in summer 2015
- working in partnership with community based organisations such as JobWise to use our expertise to develop diverse youth into 'job ready' candidates
- collaborative learning and sharing of best practice across the public and private sector including the provision of training and presentations at large scale conferences and events including the Faculty of Public Health annual conference and Westminster forums

Our workforce is 34% male and 66% female. We have a fair and open recruitment process for all candidates regardless of their protected characteristics. Equality and diversity information is collected from candidates on application which is not shared with the recruiting manager. In addition, in order to support candidates with disabilities and/or long-term health conditions, we ask candidates if they require any reasonable adjustments. The recruitment team takes steps to meet their needs and where necessary with the support of the recruiting manager short-listing team. We also offer candidates the opportunity to apply under the DWP Guaranteed Interview Scheme.

National Executive members have been provided with inclusive management training to mitigate against bias during recruitment. Specifically, executive Diversity Champions, including disability, have an equality and diversity objective within their performance framework and are accountable for ensuring that a diverse and inclusive workforce is achieved in line with business objectives. All National Executive members have a diversity and staff inclusion objective. Since the beginning of 2015, when recruiting to National Executive positions, the interviews have included bespoke questions around creating a diverse and inclusive organisation.

Civil Service and PHE-led talent management programmes are open to all staff. On application for programmes, staff are asked if they require any reasonable adjustments and steps are taken to meet these needs, with the support of the Head of Diversity and Staff Inclusion if required. We are currently scoping a bespoke talent management programme to assist disabled staff to progress under positive action.

We will be using ESR self service to update data held on the protected characteristics of the workforce. From July 2015, reports will break down the workforce by grade and protected characteristic. On a quarterly basis, we will prepare reports to show this information against promotions, turnover and absence rate. This will include information on disabled staff. Currently the data held on disability is not as complete as we would like and we are therefore launching an initiative to collect accurate data on this in August 2015, enabling accurate monitoring in the future. This will also allow us to identify where there is under-representation of disabled people and in particular where promotion is not happening. Our senior managers will be accountable though their annual performance review for addressing any under-representation in their respective areas.

Reducing health inequalities and meeting the public sector equality duty

Action to reduce health inequalities is at the heart of our mission. The Health and Social Care Act 2012 established specific legal duties on health inequalities for us to meet. We also have a public sector equality duty to consider the needs of all individuals in our work in shaping policy and delivering services, and in relation to our own employees.

Throughout the year, we worked to embed a focus on reducing health inequalities and promoting equality and diversity across our programmes, and to support our partners across public services to reduce inequalities.

Our health equity board provides governance on health inequalities and equality and diversity activity both within PHE and in relation to leadership across the health and care system. The board met three times in the year and is leading a strategic, evidence-informed approach to these issues, giving focus across our work programmes, for example on:

- health and health equity in all policies, a whole of society approach for systematically considering health implications of decisions
- equity and equality issues in our priority areas that will have an impact on health inequalities, for example, giving every child the best start in life
- development of indicators to measure progress in reducing health inequalities across our functions, as well as national trends in health outcomes and wider determinants of health
- our operating model for reducing health inequalities

There is, of course, inequity in every community, even within the most wealthy, but the social gradient in health, the health of the poorest, is of particular concern in the North of England. We commissioned an independent inquiry to contribute to the evidence base on the socioeconomic determinants of health and provide fresh insight and understanding of health inequalities in this part of the England. The report of the inquiry, Due North, was published in September 2014.

During the year, we published a report describing how we worked to meet the public sector equality duty in 2014. This report contains information about our workforce and the integration of equality and diversity into our services.

We aim to ensure that the health and care system has access to the best knowledge to inform priorities, including intelligence to help target interventions at people in most need. As part of this work, we:

- published a series of evidence papers by the UCL Institute of Health Equity that outlined practical proposals to help local areas reduce health inequalities

- expanded the Public Health Outcomes Framework to include measures of inequality where data is available. A total of 73 of the 136 indicators have at least one further inequality dimension published. For example, smoking prevalence is now available by age, sex, occupational group, broad ethnic group, religion and sexual orientation
- collaborated with the UCL Institute of Health Equity to give local authorities a new set of Marmot indicators of social determinants of health, health outcomes and social inequality
- developed an inequalities calculation tool that provides formulae for the calculation of commonly used measures of inequality
- updated and expanded the segment tool to give local authorities information on the causes of death that drive inequalities in life expectancy, including the contribution of deaths from causes related to alcohol misuse
- improved recording of ethnicity data in our cancer surveillance, which now supports analysis of cancer incidence by broad ethnic group

We assessed the use of the Health Equity Assessment Tool introduced in 2013/14 to support programmes when considering and responding to equity and equality issues and have continued to promote its use across the organisation.

To raise awareness about the legal duty on health inequalities, we and NHS England organised a series of regional workshops for professionals working in CCGs and local authorities. We developed a *National Conversation on Health Inequalities* programme to stimulate dialogue about health inequalities, with elements including:

- a toolkit to engage the public in discussion about health inequalities, based on social research with members of different communities
- an event on community-centred approaches to health and wellbeing
- events for professionals in local bodies on health and health equity in all policies, including master classes for directors of public health
- a series of video stories and written case studies describing how health inequalities affect people's lives and what can be done locally to make positive change for individuals and communities

Public involvement

The FYFV called for a radical upgrade in the NHS's contribution to prevention and improving the public's health. Our social marketing programmes are already contributing to the prevention agenda by driving lifestyle change across a wide range of health-related behaviours. All campaigns are researched with the target audience to ensure messages are relevant, understood and likely to generate action. For example, for the *Be Clear on Cancer* campaign, we developed a sophisticated understanding of the barriers and triggers for patients to visit their GP when they notice symptoms.

In 2014, for the first time, more people accessed online content by following links in social media sites than by searching for it directly. This switch illustrates the scale of social platforms. In a single day it is possible to reach 24 million daily users of Facebook in the UK. This makes Facebook nearly five times bigger than the circulation of *The Sun* newspaper, and even for older, less affluent people, we are seeing usage increase: 40% of 40 to 60-year-olds in the C2D socio-economic group visit Facebook daily. Social channels also allow us to reach people directly when they are thinking about their health.

Increasingly rapid technological development is transforming our capacity to inspire and support health-related behaviour change to a broad audience. As a result, interactive digital technologies, supported by smartphones, tablets and apps are increasingly becoming the key channels by which we recruit and interact with our target audiences. Since 2014, we have started to move away from annual 'big' campaign bursts and have been supplementing them with lower levels of 'always on' activity and now have a constant presence in the market via digital channels. This meets people's needs better as they may be looking to make healthier changes at any time throughout the year.

We have continued to develop our People's Panel, which now has 1,300 people. We ran eight focus groups with the panel, helping us to improve the way we provide advice and information to the public. Three focus groups have been specifically run to review our response to Ebola. The Equality Forum ran two seminars — one explored the way local authorities can take better account of inequalities when planning public health services and the other looked at the role of carers as providers of public health insight. Each seminar included delegates from the People's Panel, the Equality Forum, the local NHS, local authorities and voluntary sector organisations.

Freedom of Information

We received 703 information access requests (2013/14: 530), the majority of which were handled under the Freedom of Information Act 2000, others being handled under the Environmental Information Regulations 2004 and Data Protection Act 1998.

Enquiries through www.gov.uk/phe

We received 4,642 online enquiries from the public and stakeholders (2013/14: in excess of 3,000).

Parliamentary questions

We responded to 714 parliamentary questions on a wide range of subjects (2013/14: 568). Topics that generated the most questions were infectious disease; public health marketing campaigns; diet; chemical, radiation and environmental hazards; drug misuse; and hepatitis.

Complaints

We are committed to providing a high-quality service to everyone we deal with. Where complaints arise, we want to resolve them promptly and constructively and have published a complaints procedure, which is available at www.gov.uk/phe. A total of 72 complaints were handled during the year (2013/14: 41).

Sustainable development

We have agreed a number of carbon related reduction targets for our estate. These include utility use, business travel, water consumption and total waste. The financial year 2013/14 is our baseline year for carbon reporting, relative to the government's Greening Government Commitment and HM Treasury's reporting strategy.

During the year, a number of monitoring and measuring processes were implemented to allow our staff to evaluate and develop reduction strategies to meet and, where possible, exceed our targets.

Greenhouse gas emissions

We set a target to reduce carbon emissions by 3% annually for the period to March 2020, compared to the baseline year of 2013/14. Preliminary analysis indicates that our total carbon emissions for 2014/15 were 25,896 tCO_2e, compared to 26,274 tCO_2e for 2013/14, representing a reduction of 1.4% overall. This figure includes the carbon emissions from business travel as well as water usage and waste water disposal from our reportable and non-reportable sites (those offices or laboratories that are being reported separately by the premises' landlord).

The main impact on the environment from our activities comes from electricity and gas consumption at our main sites at Chilton, Colindale and Porton. Carbon emissions from electricity usage have been affected by the change in the conversion factor published by the Department of Environment, Food & Rural Affairs. In the last year, this has been increased by 11% for emissions related to electricity. This suggests an increase in carbon emissions, whereas in reality, electricity consumption across the whole organisation has fallen by more than 2.5 million kWh; this represents a reduction of almost 8% in actual consumption, reflecting our work over the last year to minimise energy usage.

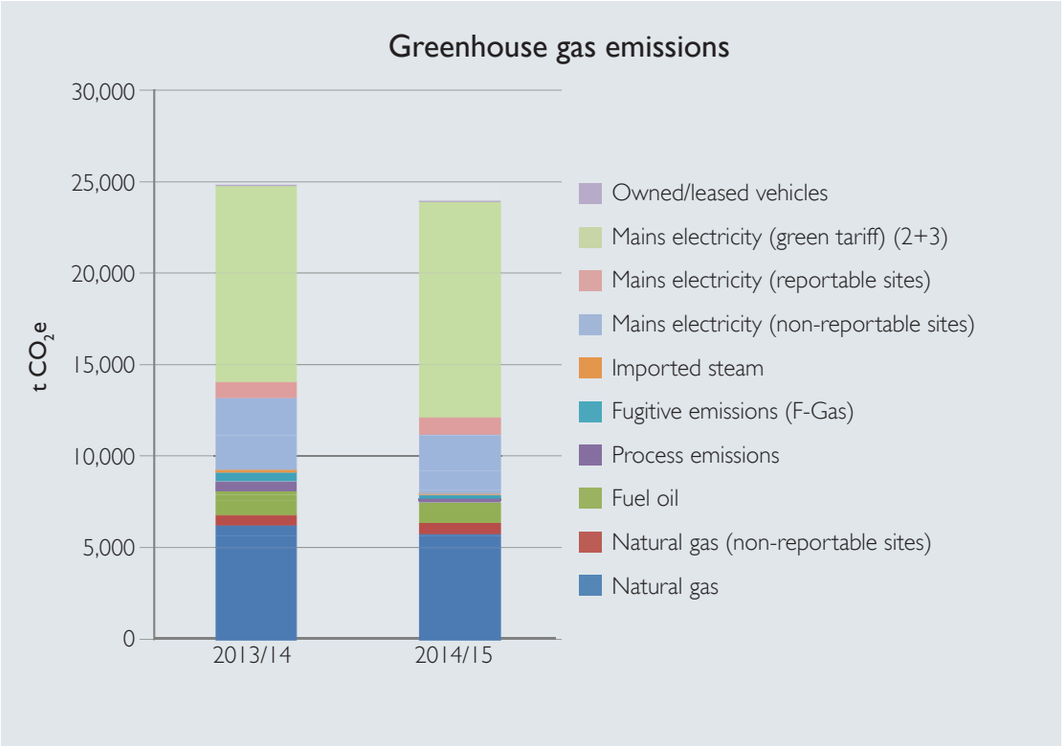
We continue to engage staff through a mandatory e-learning training programme on sustainable development, which has recently been updated to include sections on climate change and its health impacts, and on sustainability in relation to health and wellbeing. This provides staff with a good understanding of sustainable development and encourages them to act appropriately and take into account their impact on the environment.

We are fully committed to sustainable development in all our activities. Our sustainable development management plan, which includes a section on carbon reduction, sets out our aims for future work to help us operate in more sustainable ways. For example, we continue to embed sustainability into our contracts, which has helped to highlight risks arising from our procurement activities. We also continue to use the tools developed by the Government Procurement Service, ensuring we maintain a robust approach to sustainability throughout the supply chain. A number of capital projects to improve the efficiency of energy usage have begun at PHE-owned sites, with sub-metering of utility supplies being introduced to facilitate greater local control.

GREENHOUSE GAS EMISSIONS		2013/14	2014/15
SCOPE 1+ 2			
Non-financial indicators (tCO_2e)	Natural gas	6,229	5,757
	Natural gas (non-reportable sites)	577	603
	Fuel oil	1,290	1,131
	Process emissions*	342	362
	Fugitive emissions (F-Gas)	504	192
	Imported steam	161	140
	Mains electricity (non-reportable sites)	3,924	3,215
	Mains electricity (reportable sites)	847	966
	Mains electricity (green tariff) (2 + 3)	10,723	11,670
	Owned/leased vehicles	92	88
Related energy consumption (kWh)	Natural gas	34,087,464	31,122,541
	Natural gas (non-reportable sites)	3,133,382	3,301,240
	Fuel oil	4,747,646	5,758,424
	Process emissions*	1,858,695	1,967,390
	Imported steam	874,444	756,667
	Electricity (non-reportable sites)	7,790,559	5,768,624
	Electricity (reportable sites non green tariff)	2,075,589	2,010,903
	Electricity (green tariff)	22,174,537	21,712,905
Related consumption ($kgCO_2e$)	**Fugitive emissions (F-Gas)**	**504,038**	**192,424**
Related scope 1 travel (km)	**Owned/leased vehicles**	**433,108**	**442,976**
Financial indicators (£)	Natural gas	1,353,637	1,332,346
	Fuel oil	326,155	305,699
	Owned/lease vehicles (fuel/i-expenses)	18,551	18,271
	Fugitive emissions (F-Gas)**	32,682	2,669
	Imported steam	70,124	51,057
	Mains electricity (reportable)	2,576,149	2,642,677
Total emissions scope 1 + 2		**20,188**	**20,305**
Total gross emissions from non-reportable sites scope 1 + 2		**4,501**	**3,818**

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

We own six premises and have a direct relationship with the utility provider at a further four. We also have 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 of carbon emissions from these properties, they have been identified separately for reporting purposes. We have no properties within Sites of Special Scientific Interest (SSSI) or Area of Outstanding Natural Beauty (AONB) boundaries.



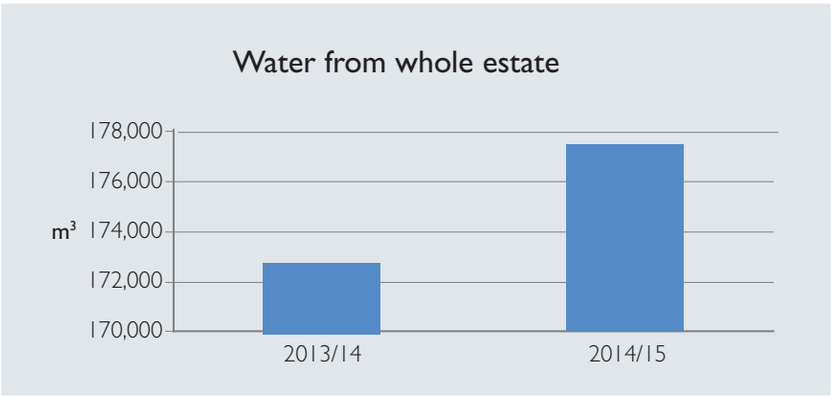
Water consumption

Our major impact on the environment, in terms of water consumption, continues to be from our sites at Chilton, Colindale and Porton, where there are a large number of laboratories and a manufacturing facility. We have set a target to reduce its water consumption by 2% annually to 2020.

WATER		2013/14	2014/15
SCOPE 3 (Water)			
Non-financial indicators (m^3)	Water from office estate (reportable)	684	572
	Water from office estate (non-reportable)*	6,971	8,431
	Water from whole estate (reportable)	172,757	177,528
	Water from whole estate (non-reportable)*	17,318	17,067
Financial indicators (£)	**Water supply costs****	**169,947**	**164,156**

* Estimated usage
** Water costs from owned sites (i.e. water that was directly supplied to those sites which are within the reporting boundary)

The reportable usage of water for our estate was 177,528 m^3, with a further estimated 17,067 m^3 being used by non-reportable sites. Overall, this represents a 2.3% rise in consumption from last year. PHE-owned sites continue to have a mixture of office and non-office facilities, making it difficult to differentiate their water usage into any meaningful datasets. A number of projects have been identified to reduce water consumption. We believe that the increase in water usage is due, at least in part, to an increase in manufacturing activity over the year.



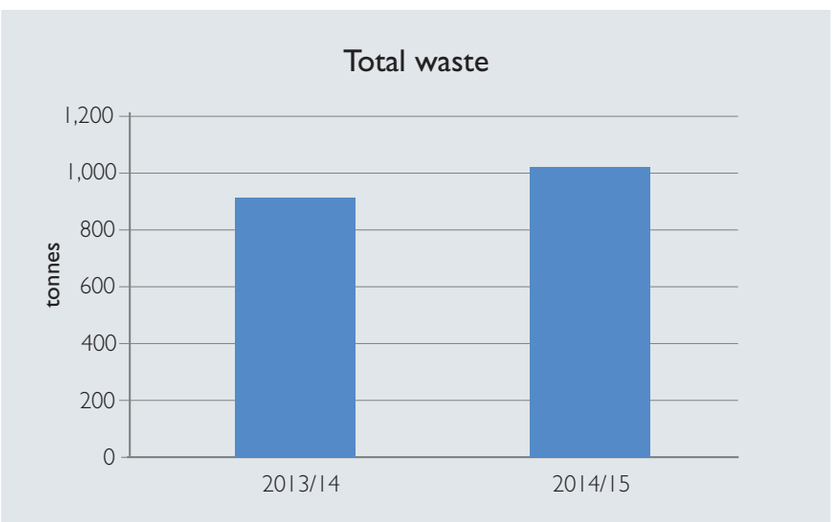
Water that was consumed at offices and laboratories embedded in tenanted, non-reportable accommodation was estimated using a recognised benchmarking algorithm.

The water supply to our major owned sites at Chilton, Colindale and Porton was monitored and measured, and therefore the pattern of daily usage was known. A number of sub-meters were fitted in the last year to help monitor usage in specific areas. Our facilities managers use this information to develop strategies for reducing water usage.

Waste

We have set a total waste reduction target of 2% annually to March 2020. Preliminary figures indicate an 11% increase in total waste over the last year. Our total waste figure for 2014/15 was 1,018 tonnes, compared to the figure for 2013/14 of 912 tonnes. Waste sent to landfill increased by only 2 tonnes over the year, with a 31% rise in the amount of waste being recycled.

A third-party provider has been engaged to recycle securely and reuse, wherever possible, all redundant ICT equipment. This method of disposal is effective and in line with government policy. A total of 35 tonnes of ICT waste was processed this way in the year, more than double the previous year. A significant proportion of the increase in ICT waste (20 tonnes) was due to the corporate roll-out of new ICT



WASTE	2013/14	2014/15
SCOPE 3 (Waste)		
Non-financial indicators (tonnes)		
Waste recycled externally (non-ICT equipment)	254	332
Waste reused externally (non-ICT equipment)	0	4
Waste recycled externally (ICT equipment)	8	17
Waste reused externally (ICT equipment)	8	16
Waste composted or sent to anaerobic digestion	17	34
Waste incinerated with energy recovery	252	220
Waste incinerated without energy recovery (clinical waste)	329	314
Total ICT waste	15	35
Total waste not to landfill	867	937
Total waste sent to landfill	45	47
Total waste	**912**	**1,018**
Total landfill waste deemed hazardous (incl. clinical waste)	29	36
Financial indicators (£)		
Waste recycled externally (non-ICT equipment)	55,939	54,304
Waste reused externally (non-ICT equipment)	0	250
Waste recycled externally (ICT equipment)	7,504	11,624
Waste reused externally (ICT equipment)	0*	16,827
Waste composted or sent to anaerobic digestion	2,175	2,836
Waste incinerated with energy recovery	50,957	50,012
Waste incinerated without energy recovery (clinical waste)	446,758	356,377
Total waste sent to landfill	9,761	22,494
Total costs	**617,691**	**534,858**
Total landfill waste deemed hazardous (incl. clinical waste)	44,598	20,134
* Data not available		

equipment, replacing old desktop computers with laptops and CRT monitors with flat screen monitors.

An additional 62 tonnes of non-ICT waste was sent for recycling from our site at Porton in the second quarter of the year. This resulted from a reduction in waste holding facilities on the site, and the disposal of various stockpiles of redundant electrical equipment.

Due to the nature of the work carried out at a number of our sites, a significant quantity of hazardous waste is produced and controls have been put in place to manage this. The majority of this waste was sent for incineration, in compliance with government guidelines. A number of initiatives have been introduced to reduce waste at all locations, covering both offices and laboratories. Contractors working at our sites are continually reminded about their obligation to reduce their waste wherever possible, in line with our waste policy and the associated management arrangements.

We continue to pursue a progressive programme to reduce our total waste, especially to landfill, and to increase the level of recycling wherever practicable.

Business travel

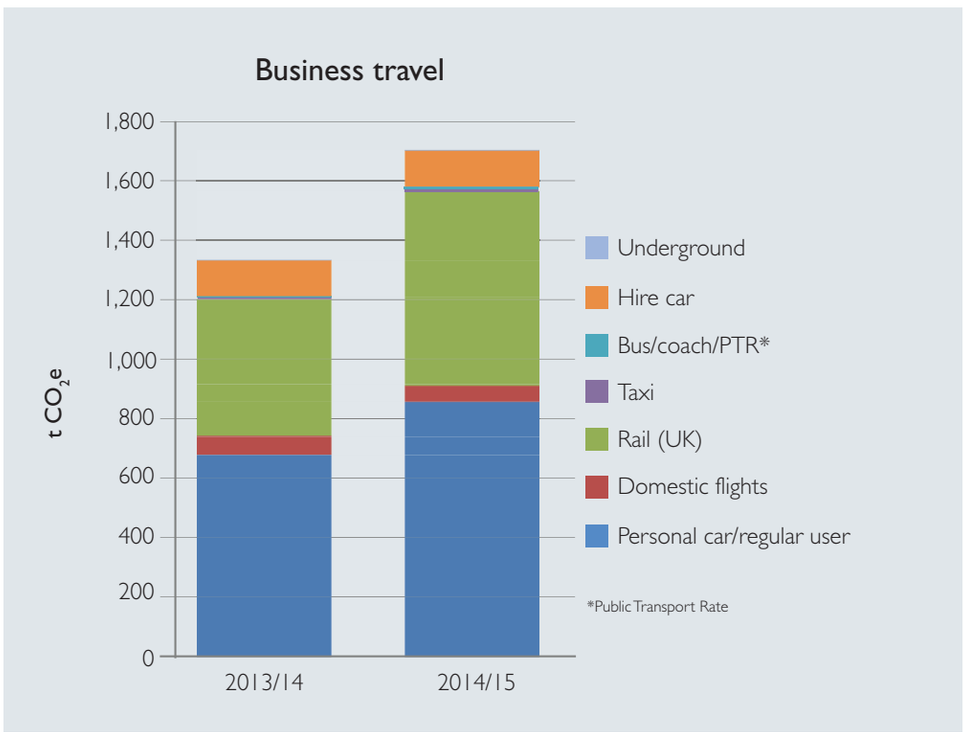
We set a target to reduce business travel by at least 2% annually, relative to our baseline year of 2013/14 to March 2020. Staff are encouraged to limit journeys wherever possible and when they must travel, to use the most sustainable modes of transport.

Business travel rose by 14% during 2014/15, caused in part by recruitment to vacant posts. A further factor was our response to the Ebola crisis in West Africa, with large numbers of staff engaged across the UK and others travelling overseas, in particular, to Sierra Leone.

Our drive to reduce travel to meetings was supported by the installation of Microsoft Lync on all laptops to encourage more video conferencing.

We recognise that less business travel will benefit health by reducing air pollution, support our plans to reduce carbon and save money. Further initiatives have therefore been introduced to monitor business travel locally. The importance of travelling in a sustainable manner is also highlighted in our sustainability e-learning package.

A breakdown of the impact of the various types of business travel is given below.



Other activities

A number of other measures were taken to improve reporting and knowledge of the social, environmental and financial impacts of our operations. A sustainable development programme board was established to oversee sustainability work and to help formulate and co-ordinate advice to local authorities when required.

BUSINESS TRAVEL		2013/14	2014/15
SCOPE 3			
Non-financial indicators (tCO_2e)	Personal car/regular user	681	854
	Domestic flights	120	56
	Rail (UK)	458	652
	Taxi	5	10
	Bus/coach/PTR	4	7
	Hire car	122	121
	Underground	1	1
	Total	1,392	1,702
Related scope 3 travel (km)	Personal car/regular user	3,580,880	4,510,395
	Domestic flights	366,392	361,677
	Rail (UK)	9,346,189	13,759,549
	Taxi*	36,830	55,507
	Bus/coach*/PTR	39,822	65,791
	Hire car*	641,065	640,602
	Underground*	7,962	16,063
	Total	14,019,140	19,409,584
Financial indicators (£)	Personal car/regular user	1,022,687	1,264,866
	Domestic flights	66,494	75,084
	Rail (UK)	2,970,871	3,705,995
	Taxi	79,901	123,353
	Bus/coach/PTR	19,739	17,552
	Hire car	87,639	88,216
	Underground	45,625	74,365
	Total	4,292,956	5,349,431
Other business travel (km)	Short-haul international average	1,918,087	1,962,413
	Long-haul international average	4,370,326	5,215,474
	Rail - Eurostar	113,679	95,444
Total	Total gross emissions scope 3 business travel	1,392	1,702
	Total financial cost scope 3 business travel	**4,292,956**	**5,349,431**
	Total other financial cost	**497,078**	**636,887**
* Figures calculated using own conversion table			

We continued to work with the Sustainable Development Unit, jointly funded by and accountable to us and NHS England, on the implementation of the public health and social care sustainable development strategy. Work also continued on delivering health advice about a changing climate through our commitment to the national adaptation programme.

We have an active programme to reduce paper usage. The 'Banner' closed loop recycling system was introduced at several PHE-owned sites, which has already led to savings. The move to multi-function devices for printing continues across the business and 'follow me' printing has been introduced on a number of sites. Paper usage is also being reduced through signs and messages about minimising printing.

Our work on sustainability was recognised by a number of external organisations during the year. We were highly commended in the Public Sector Sustainability Awards for our work on travel reduction and greening of its office and laboratory estate.

Duncan Selbie
Chief Executive
2 July 2015

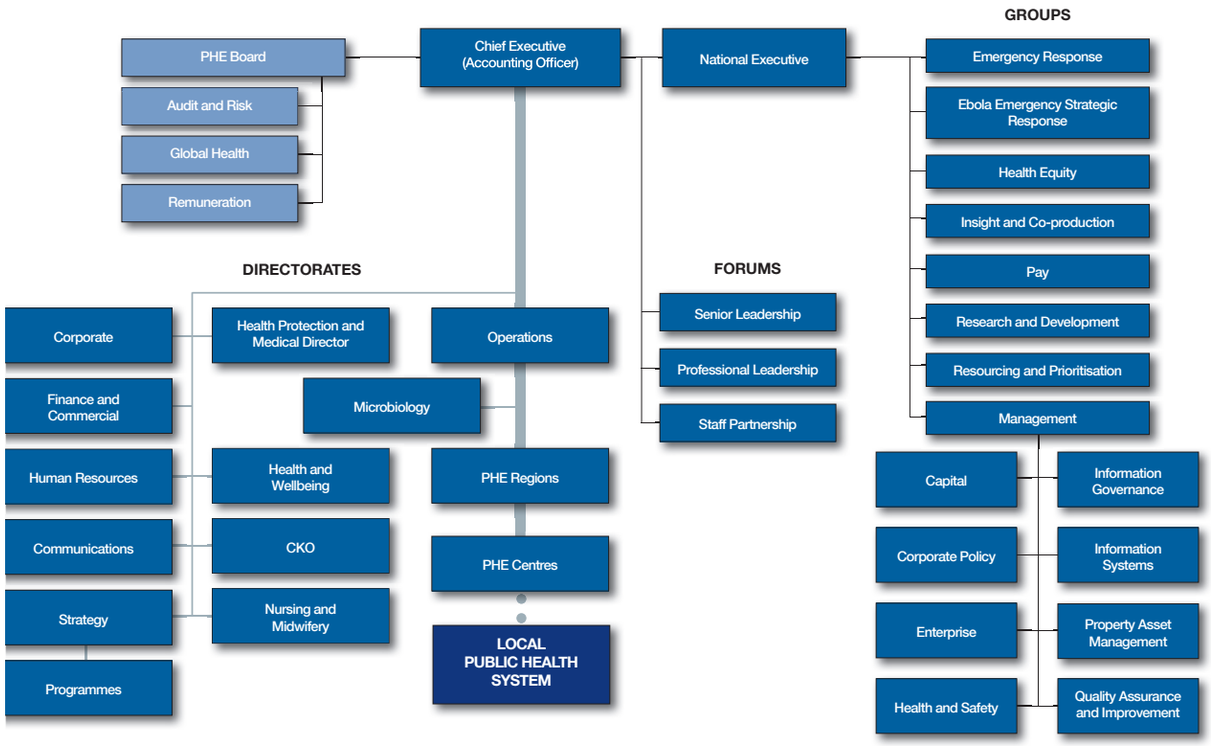
2 Directors' reports

Annual governance statement

Introduction

PHE is as an executive agency of the Department of Health (DH). Our role, duties and priorities are set out in the Framework Agreement with DH and an annual remit letter from ministers, both of which are publicly available at www.gov.uk/phe.

The governance arrangements in place in 2014/15 and up to the date of this statement are shown below:



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, Dr Felicity Harvey, Director General for Public and International Health

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 our corporate governance arrangements. Its terms of reference are available at www.gov.uk/phe.

The Board comprises a non-executive Chair, 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 our business plan
- our 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

Primarily through its Audit and Risk Committee, the Board provides independent and constructive support, challenge and scrutiny to me as Accounting Officer on the discharge of my responsibility 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 Board was strengthened at the beginning of the year by the appointment of two additional non-executive members, taking it to its full complement of seven non-executive members other than the Chair. The Board met six times during the year. Each meeting considered a key public health theme, to which external stakeholders made expert contributions and provided valuable insight into shaping our approach in each of the following areas: personalization of healthcare, air pollution, tuberculosis, antimicrobial resistance, mental health, rural health and the local public health grant. The recommendations arising from these discussions 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. Going forward, the Board has agreed that each of the non-executives will review a particular area of the watch list and seek assurance that the issues are being satisfactorily addressed. The Board also received regular reports on our financial performance from the Finance and Commercial Director and from the Chairs of the Audit and Risk Committee and Global Health Committees of the Board on issues considered by them.

As part of our commitment to openness and transparency, the Board meets in public and its papers are published in advance at www.gov.uk/phe. The Board invites members of the public who attend its meetings to ask any questions they might have on any aspect of our business and responds to them as appropriate.

At my request, the Board considered and advised on a complaint received in the autumn of 2014 about the national breast screening programme age extension trial. The Board was reassured to note that the trial had received renewed ethical approval from the Harrow National Research Ethics Service Committee, for which the NHS Health Research Authority is responsible. The Board agreed unanimously that the trial presents an important opportunity to explore the benefits and harms of breast screening for a wider range of women and is satisfied that it is being carried out within an appropriate governance and ethical framework. The Board fully supports the trial, including its management team and governance approach, and will review progress in the summer of 2015.

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 our main 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.

Our Senior Departmental Sponsor ensures that there is an annual objective setting and review process in place for the Chair, who in turn sets and assesses performance against objectives for individual Board members. The Board reviews its effectiveness on an ongoing basis as part of ensuring that it adds the most value to the organisation.

As part of their programme of work for 2014/15, the internal auditors undertook a review of the Board's effectiveness, providing 'moderate' assurance. While a small number of recommendations were raised, which we welcomed and will act on as part of the ongoing development of the Board, their assessment was that the overall governance arrangements are effective. A number of positive observations were made during the course of the review, including on the Board's commitment to continuous improvement and the progress made since our establishment in April 2013. The Board considered the findings in depth at its away day in April 2015, at which it agreed a small but measurable set of priorities against which it could measure its own effectiveness going forward, as well as reviewing its composition and forward programme of business.

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 and National Executive 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. We have undertaken an assessment of our compliance with the provisions of *Corporate Governance in Central Government Departments: Code of Good Practice 2011* issued by HM Treasury, concluding that we comply with those requirements that apply to us as an Executive Agency and in the context of the Framework Agreement of November 2013.

PHE Audit and Risk Committee

The Audit and Risk Committee is chaired by Sir Derek Myers, an independent non-executive member of the Board 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 and its Management Committee 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 our objectives. The Audit and Risk Committee has a crucial function in reviewing our 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 the Board. 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 Chair, I, the Chief of Staff, Finance and Commercial Director, Head of Internal Audit, the external auditor (National Audit Office) and a representative of our sponsor team in DH routinely attend their meetings. The Board Secretary also attends and acts as secretary to the committee. The committee met on four occasions in the 2014/15 financial year.

PHE Board and Audit and Risk Committee attendance in 2014/15

	Attendance at meetings in 2014/15	
	Board	Audit and Risk Committee
David Heymann*	6/6	-
Rosie Glazebrook	6/6	4/4
George Griffin	5/6	-
Sian Griffiths	5/6	-
Martin Hindle	6/6	4/4
Poppy Jaman	5/6	4/4
Paul Lincoln	6/6	-
Derek Myers*	5/6	4/4
Richard Parish	6/6	-
Duncan Selbie	5/6	3/4

*Indicates chair of Board or committee

The Chair of the Audit and Risk Committee reports key issues to the Board after each meeting. He also prepares and submits 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 2014/15 included:

- the ongoing development of the system of risk management and assurance
- considering our 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
- a governance report at each meeting collating information on compliance with statutory duties and best practice in a wide range of areas, for example, adverse incidents, public information access requests (FoI), parliamentary questions, complaints, clinical governance, health and safety and information governance, which provided insight into critical perspectives of our infrastructure

During 2014/15, the internal auditors undertook 27 reviews (24 assurance, 3 advisory) as part of the plan agreed with management and approved by the Audit and Risk Committee.

The Chief of Staff and Finance and Commercial Director are standing attendees at the Board and its Audit and Risk Committee. 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 the organisation's management arrangements. The National Executive, supported by the Management Committee which I chair that focuses on the discharge of my responsibilities as Accounting Officer, helps mobilise internal resources to deliver our duties and functions. Chaired by the Deputy Chief Executive, its membership comprises the national and regional directors and focuses on how we to the national and local public health systems and identifying and solving problems and challenges facing us in our work with partners. I have a standing right of attendance and exercised this as frequently as my schedule of visits to local authorities across the country allowed.

The National Executive has considered and agreed a wide range of public health strategies, for example, on research and development, TB and AMR. Together with its Resourcing and Prioritisation Committee, it has also overseen the development and implementation of our strategic review and the subsequent organisational change programme, *Securing our Future*. The attendance of members of the National Executive at meetings during 2014/15 was as follows:

	Attendance at National Executive meetings in 2014/15
Richard Gleave* (Deputy Chief Executive and Chief Operating Officer)	22/25
Viv Bennett (Director of Nursing and Midwifery)	18/25
Lis Birrane (Director of Communications)	20/25
Michael Brodie (Finance and Commercial Director)	21/25
Paul Cosford (Director for Health Protection and Medical Director)	21/25
Yvonne Doyle (Director – London)	21/25
Kevin Fenton (Director of Health and Wellbeing)	16/25
Jenny Harries (Director – South of England)	22/25
Paul Johnstone (Director – North of England)	19/25
Christine McCartney (Director of Microbiology)[1]	20/25
Jonathan Marron (Director of Strategy)	19/25
Stephen Morris[1] (Development Adviser)	2/8
Deborah McKenzie[2] (Director of Organisational Development)	14/18
John Newton (Chief Knowledge Officer)	19/25
Duncan Selbie (Chief Executive)	11/25
Rashmi Shukla (Director – Midlands and East of England)	22/25
Alex Sienkiewicz (Chief of Staff)	16/25
Tony Vickers-Byrne (Director of Human Resources)	22/25
1 Joined the National Executive in October 2013	
2 Joined the National Executive in July 2014	
*Indicates chair of committee	

The Management Committee provides dedicated support to me in the exercise of my role as Chief Executive and Accounting Officer. The focus of its work is on overseeing the delivery of our responsibilities under the Framework Agreement and our governance arrangements. The attendance at Management Committee meetings during 2014/15 was as follows:

	Attendance at Management Committee meetings in 2014/15
Duncan Selbie* (Chief Executive)	9/10
Richard Gleave (Deputy Chief Executive and Chief Operating Officer)	9/10
Michael Brodie (Finance and Commercial Director)	9/10
Paul Cosford (Director for Health Protection and Medical Director)	7/10
Jonathan Marron (Director of Strategy)	7/10
Deborah McKenzie[1] (Director of Organisational Development)	1/2
Alex Sienkiewicz (Chief of Staff)	9/10
1 Joined the Management Committee in February 2015	
*Indicates chair of committee	

The Management Committee has amongst other things received and considered regular reports on financial performance, information governance, health and safety and adverse incidents.

PHE Remuneration Committee

As Chief Executive, I am responsible for the structure and staffing of PHE. This includes decisions on the creation, regrading or reduction of Senior Civil Service (SCS) posts, on which I consult with the DH Permanent Secretary. As a matter of good governance, the Board has established a Remuneration Committee to assist me in the discharge of this duty, which met twice during the year, primarily to review and approve SCS and NHS Very Senior Manager (VSM) consolidated and non-consolidated pay awards. The Chief of Staff acts as Secretary to the Committee.

	Attendance at meetings in 2014/15
	Remuneration Committee
David Heymann*	2/2
Rosie Glazebrook	2/2
Martin Hindle	2/2
Richard Parish	2/2
Duncan Selbie	2/2
*Indicates chair of Board or committee	

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, in the case of SCS and VSM staff, making recommendations for decision to the Remuneration Committee of the Board
- 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 remuneration report
- any case which we are 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 Remuneration Committee of the Board and in the context of DH and government-wide recruitment controls (see above).

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:

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

Other processes in place include:

- a formal meeting between me, the Chair 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; we appeared before the Health Select Committee twice during the year to give evidence on our contribution to the national and international Ebola response and on the impact of physical activity and diet on obesity. I also gave evidence to the Public Accounts Committee (PAC) on the local authority public health grant further to the NAO's report on the subject
- regular contact between DH's sponsor team and PHE

Quality assurance

Further to the update in last year's statement, we currently undertake a limited range of quantitative modelling work. We are, however, increasing both the scope and scale of our modelling output and are therefore developing quality assurance processes in line with the recommendations of the Macpherson review. During 2014/15, we:

- established a strategic modelling group with identified internal expertise to further improve the quality improvement process
- actively engaged with the Analytic Management Oversight Committee established by DH as an umbrella modelling assurance group

We await further guidance on the application of the Aqua Book guidance on modelling and will act on this accordingly once it is available.

Internal control

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, which are set out in the Framework Agreement, remit letter, and our seven priorities published in *From evidence into action: opportunities to protect and improve the nation's health*. 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 our 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 2015 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 have been 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 Committee. He is also the senior responsible owner (SRO) for the PHE Science Hub Programme
- 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 our emergency response function, including as the Incident Director in charge of our contribution nationally and internationally to the Ebola outbreak in West Africa; with the Director of Nursing and Midwifery, managing the strategic development and implementation of quality and clinical governance, reporting this to the Board and National Executive through its Quality Assurance and Improvement Group; the assessment and reporting of clinical risk; and, supported by our Responsible Officer and his team, medical revalidation. The Director for Health Protection and Medical Director is also our Caldicott Guardian
- the Chief of Staff, who has delegated responsibility for managing the development and implementation of strategic and corporate risk management and health and safety, in particular, that appropriate health and safety policies and procedures relevant to our operation are in place together with governance and assurance systems to facilitate compliance with relevant legislation, including the establishment of a comprehensive suite of corporate policies to direct and guide staff on a range of matters
- the Chief Knowledge Officer, who as our 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

Our risk framework and procedures continued to be developed during the year and have improved from internal audit's weak assurance rating in 2013/14 to moderate assurance.

The National Executive, supported by its Management Committee, has been responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. National Executive members were responsible for risk management within their areas of responsibility, which included promoting risk awareness and supporting staff in managing risk.

Corporate risk leads in each directorate are responsible for informing and advising their director on risk management issues such as how best to implement risk management policies and procedures. The risk leads meet monthly as part of a newly established risk leads group to discuss management and escalation of risks and identify any cross-cutting themes for review by the Management Committee, who in turn review the strategic risk register on a regular basis.

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.

In the context of the Harris Review, published by DH in 2013, which highlighted technical irregularities in the delegation arrangements in some former Strategic Health Authorities, the Secretariat finalised a review of the statutory duties and powers exercised by us on behalf of the Secretary of State for Health. We are clear about the legislative requirements associated with each of these duties and powers, including any restrictions on delegation of those functions. The review will be updated in 2015/16 in light of the changes to the organisation's structure as part of the *Securing our Future* programme.

The system of internal control was based on an ongoing process designed to identify and prioritise the risks to the achievement of our 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 2015, and accorded with HM Treasury guidance.

Capacity to handle risk

Risk management training is provided both to staff involved in risk management on a day-to-day basis as well as to managers who have wider risk management responsibilities. We have recently reviewed and updated our risk management policy, and our procedures and guidance documentation, describing particularly the roles and responsibilities in relation to the identification, management and control of risk. All relevant risk management documentation and tools are available to staff through our intranet (PHENet), which now includes an agreed approach to risk appetite at the corporate level.

We aimed to minimise adverse outcomes such as harm, loss or damage to the organisation, 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 our intranet. To improve the quality of adverse incident investigations and action plans, a number of managers were trained in root cause analysis.

Our 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. Our generic emergency preparedness, resilience and response (EPRR) arrangements are set out in its National Incident Response Plan (NIRP). This describes the mechanisms by which we discharge the duties delegated by the Secretary of State for Health to staff that are responsible for emergency planning, resilience and response, such that they operate as if we ourselves 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 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 the EPPR Oversight Group, chaired by the Director for Health Protection and Medical Director, and are exercised on a regular basis. More significantly, they were implemented at scale in response to the Ebola outbreak in West Africa, which developed beyond an initial health protection incident acute response to a multi-faceted activity involving a number of workstreams. This is described in more detail in the key risks section below.

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. We 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, it leads a programme of work on reducing health inequalities, and provides leadership across the organisation to ensure that we act 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

Our health and safety function, part of the new Corporate Risk and Assurance division of the Corporate Affairs directorate, works with colleagues across the organisation to ensure compliance with relevant legislation. In particular, it has worked closely with the Microbiology Directorate, now part of the National Infection Service, 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 work with radioactive material in the course of their work.

Our 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 our health and safety strategy, improvement plans, arrangements and

performance to ensure that they were appropriate. The Health and Safety Executive proposes and agrees with us an annual intervention plan each year, which is reviewed at an annual meeting with them at the end of each year.

We have implemented a Business Continuity Management (BCM) policy, which is aligned to ISO 223012012: Societal Security – Business Continuity Management Systems – Requirements. A BCM programme is in place, which complements our emergency preparedness resilience and response approach. We continue to develop our BCM capability as an ongoing activity and follow the 'plan-do-check-act' model for continual improvement. Assurance is provided through a process of self-assessment, evidence-based assurance reviews and internal audits.

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

Capturing and responding to risk information

The strategic risk register continued to be developed over the course of the year with input from the National Executive and the Board, and was reviewed regularly by the Audit and Risk Committee. It was also considered as a standing item at the quarterly accountability meeting with DH.

Directorates and corporate programmes have identified, monitored and managed risks, which have fed into top-level risk management processes as appropriate. Operational risk registers were maintained at sub-directorate level for priority programmes and key projects.

We mapped our risk registers down to divisional level in a way that anticipated the future structure of the organisation. This helped us to ensure that as much risk management as possible from the divisional level upwards uses organisational tools, facilitating the collection, analysis and feeding back of cross-organisational risk themes. 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 organisation.

Assessment of the adequacy of controls is a key part of our systematic approach that attempts to limit risk to an acceptable residual level, rather than obviate risk altogether. The risk management team develops our 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.

We have in place 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 Management Committee of the National

Executive on a monthly basis. We also published reports on major events and these were used to share lessons learnt for both us and our partners.

We work with a variety of stakeholders through partnerships and other arrangements. Partnership risks were identified through a number of forums, in particular, through our Centres, 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. We have therefore engaged closely with local government, the NHS, government agencies and the voluntary and community sector to test our impact and effectiveness. As part of this, we commissioned Ipsos MORI to undertake a second annual stakeholder research exercise to assess how we are perceived externally and how well stakeholder relationships are developing. This report, which is available at www.gov.uk/phe, demonstrates that progress has been made and we are well regarded by our stakeholders.

The Quality Assurance and Improvement Board ensures that robust clinical and health protection governance systems operate in PHE through implementation of a clinical governance framework. 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. We are ensuring that an effective quality system is in place that is appropriately aligned with the National Quality Board's guidance on quality (safety, effectiveness and experience) and that this is applied at population and partnership level. The Director for Health Protection and Medical Director and the Chief Nurse have delegated authority to design and deliver our quality and clinical governance. They are leading the *Sound Foundations* programme, which will ensure a clear line of sight and accountabilities for service delivery through them to me as Chief Executive and Accounting Officer. This includes executive and clinical leadership, our responsibilities for medical revalidation and requirements for all registered health care professionals. It will streamline how we meet recommendations from relevant national inquiries and clinical and public health audits. *Sound Foundations* will ensure that there is clarity on the accountabilities for national and local leaders; an escalation system is clearly communicated; and that learning is effectively disseminated and acted upon. We operate within a system-wide context and this work will include ensuring quality system interfaces support effective system and partnership working.

Information governance

The flow of patient identifiable data (PID) between us 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 our Chief Knowledge Officer, our SIRO, to ensure that all such data is adequately safeguarded. Our 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 us to govern information risks and improve risk and assurance information. Our adverse incident and serious untoward incident management policy and procedures provided a framework for the management of incidents involving personal data.

We continuously update our IT systems in response to emerging cyber-security threats. In addition to this, during the 2014/15 year, our National Drug Treatment and Monitoring System (NDTMS) team and IT colleagues implemented tailored security enhancements and upgrades to ensure that the system continues to meet stringent and ever increasing standards of information governance and security. This was part of our rapid and proportionate response to what was an isolated and unauthorised but unsuccessful attempt detected in real time through our IT monitoring processes to extract data from the system, which was subsequently reviewed and confirmed as such by forensic computing professionals. As an additional safeguard, the decision was taken by the SIRO to suspend access to the system during the period of investigation. We have since been working closely with stakeholders in the drug and alcohol treatment sector to support them in ensuring that the data submissions required for the year for NDTMS are completed by the deadline of 31 July 2015.

There was one incident in the reporting period that fell under the criteria for reporting data loss to the Information Commissioner's Office (ICO). This concerned the inappropriate access and use by an administrator in our Occupational Health department of the personal mobile telephone number of a member of staff, contrary to the PHE and Civil Service Codes of Conduct, contractual requirements on confidentiality, and the terms of the specific confidentiality agreement in place for staff working in this department. Following due investigation under our disciplinary procedure, the member of staff was dismissed for gross misconduct and the incident reported to the ICO. The ICO concluded that there had been an offence under section 55 of the Data Protection Act 1998 against us but, in light of the management action taken, closed their file on the matter.

Principal risks facing PHE during 2014/15

Ebola

We declared a Level 4 incident in response to the Ebola outbreak on 10 October 2014, as detailed in our Emergency Planning, Resilience and Response Concept of Operations Plan (CONOPs). Our initial response followed the reporting structures and roles set out in the CONOPs. However, it rapidly became clear that this needed to be adapted to the complex requirements that differ from an England-based public health emergency, as well as taking into account a more 'steady state'. We therefore implemented a different model of working to provide the span of command and control required to cover cross-government engagement and deliver the operational oversight command and control for a complex international and national response.

The Director for Health Protection and Medical Director is responsible for the strategic leadership of our response and accountable for the overall Ebola Emergency Programme. The National Incident Director is responsible for the operational delivery of the overall response as are the workstream leads for the delivery of their programme of work. To enable this, we established an Ebola Emergency Strategic Response Group (EESRG) to provide broad leadership and direction for the Ebola Emergency Programme.

It has met weekly and reported to the National Executive monthly on any main developments. The Chair and co-chair of EESRG also report to other strategic groups in government, including the Devolved Administrations, and other key stakeholders such as the NHS and international NGOs. The EESRG is the strategic decision-making body. It is responsible for the identification of strategic risks (and allocating relevant actions), ensuring that wider lessons are learned, and for the forward look for the organisation and wider system on issues that may arise and the response needed. Its main tasks are to:

- provide overall strategic leadership and direction to the programme
- track progress against agreed work streams and deliverables
- ensure that there is sufficient resource to deliver agreed work streams
- ensure there are appropriate levels of governance and programme management
- identify, monitor and where possible mitigate against risks in the programme
- make recommendations and escalate issues to the National Executive
- report progress to the National Executive

The EESRG also provides professional leadership to all those involved in the Ebola response programme. It does this by ensuring consistency in communications to staff, and by promoting support to all staff who have been directly involved in any aspect of the response programme. Finally, the EESRG will have a role in the evaluation of the Ebola response following eventual de-escalation of the incident. It will consider the outputs of such an exercise and how our emergency response systems need to change to accommodate them.

Pandemic flu

Pandemic influenza is one of the top risks in the National Risk Register of Civil Emergencies. We continue 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. We concluded that this 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.

Behavioural change

One of our key challenges is to support individuals in taking more control of their health and make positive changes to their lifestyles, thereby securing improvements to the public's health. This requires interventions, environments and polices designed to go with the grain of human behaviour, making it easier for individuals to achieve good health outcomes. A range of incentives need to be in place, for example, consistent public messaging about the risks of unhealthy behaviours and our evidence-based advice to national and local government and the NHS on wider interventions that they can deliver.

Marketing is widely acknowledged to be an effective, evidence-based methodology for addressing public health issues and a key lever for catalysing the step-change in behaviour that is required. We have significant strengths and capability in this area; our marketing strategy for 2014-17, available at www.gov.uk/phe, describes how we will use health marketing to support local and national government objectives to tackle avoidable mortality and enable people to live longer and to enjoy longer healthy lives. It is an ambitious agenda for promoting healthy changes by: delivering creative and innovative nationwide programmes that help a wider range of people than ever before; focusing on the national ambitions that make the biggest difference to our health, fastest; wholeheartedly supporting and integrating with local government; organising around people's lives and popular culture; and using technology innovatively and investing in 'mobile-first' digital public health.

Our behavioural insights team is delivering a portfolio of innovative and affordable behavioural science interventions with partners. All of these are evidence based and evaluated for effectiveness. In 2014/15, we designed and implemented interventions in five key policy areas to contribute to reductions in childhood obesity, prevention of diabetes, reduced risk of antimicrobial resistance, reduced consumption of alcohol, and increased uptake of NHS Health Checks and cervical cancer screening. For childhood obesity, we are testing improvements in parental recognition of childhood obesity and uptake of weight management services through enhancements to the National Child Measurement Programme feedback letter. We are partnering with a local authority to test whether an education and exercise programme enhanced with digital technology and behavioural insights can reduce risk among pre-diabetic people. We have a national randomised controlled trial under way to test the effect of personalised feedback and social comparison to GPs to motivate reductions in antibiotic prescribing in general practice.

Our work on health equity and mental health helps us to tackle the root causes of ill-health and the conditions for effective behaviour change - through increasing people's sense of control, motivation, self-worth and social connectedness. Our recent publication on community-centred approaches to health and wellbeing describes a new evidence-based framework to inform local practice. There is increasing commitment across the system that community-centred approaches are needed at scale as part of efforts to reduce health inequalities and increase self-management. We will continue to disseminate evidence, support its implementation and provide leadership for this agenda with national partners, working with NHS England, the Local Government Association, the Social Care Institute of Excellence, Think Local Act Personal, and NICE.

In the most recent annual remit letter, the Government made clear its expectation that we should be an authoritative voice speaking for the public's health and ensuring that public health evidence is clearly heard as part of the policy debate, with the Government providing the national policy response. By way of example, we are currently completing the work on the following reviews commissioned from us by Government in the 2014/15 remit letter:

- the emerging evidence on e-cigarettes to ensure local action on smoking cessation and tobacco control is informed by best evidence and provide evidence-based recommendations to inform the Government's future thinking, complementing the work of NICE and the MHRA
- an evidence review and provision of advice on the public health impacts of alcohol and possible evidence-based solutions; and
- draft recommendations to inform the Government's future thinking on sugar in the diet

The five health improvement priorities set out in *From Evidence into Action* (tackling obesity, reducing smoking, reducing harmful drinking, ensuring every child has the best start in life and reducing dementia risk) provide appropriate focus for the organisation to drive forward the behavioural change agenda. We will also work closely with NHS England on delivering the FYFV, which rightly places significant emphasis on prevention and the role that the NHS has to play in supporting health improvement. For example, I chair the recently established NHS Prevention Board, which is focussing on early identification of those at risk of diabetes and referring them into evidence-based lifestyle management programmes.

Ring-fenced public health grant

The Health and Social Care Act 2012 made fundamental changes to the system for funding and delivering public health. Responsibility for commissioning local public health services returned to local authorities from the NHS. Local authorities now have a statutory duty to improve the health of their populations. In 2014/15, we gave local authorities £2.7 billion via a ring-fenced grant to carry out their new public health responsibilities.

The public health activities expected from the grant include encouraging healthier lifestyles and reducing the very large health inequalities across England, especially in life expectancy.

We 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 our Annual Accounts that the funding has been used on the purposes intended by Parliament. We gain assurance in a number of ways, including from the published grant conditions, reviewing the local authority published spend data, local author ity accountability and governance, a range of internal and external audit assurance, member-led scrutiny in local government, Department for Communities and Local Government governance arrangements and sector-led improvement and benchmarking. The assurance process has also been strengthened through a requirement for directors of public health to sign the annual assurance statement to us in addition to each local authority's Chief Executive or Section 151 officer.

Our support to the local government ring-fenced public health grant was reviewed by the National Audit Office in the autumn of 2014, following which I and the Finance and Commercial Director appeared before the Public Accounts Committee (PAC) on 19 January 2015. We very much welcomed the PAC's subsequent report of 3 March, which recognized the good start we had made but made several recommendations for us, with which we agree and are already starting to implement.

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 has stabilised to levels from before the transition of public health to local government to the NHS but, as the PAC has highlighted, there is more to be done to ensure that the profile and impact of public health work in local authorities is not undermined by high vacancy rates. We will be working with DH, the LGA and other stakeholders on this, including what changes might be possible by way of terms and conditions to encourage movement of public health staff between the NHS, local government and PHE.

Information governance

The Chief Knowledge Officer, our SIRO, and his Information Governance team have led a significant piece of work to improve the organisation's compliance with the Health and Social Care Information Centre (HSCIC) Information Governance toolkit. This has resulted in an improved score of 66%. This ensures our continued access to patient identifiable information, which is key to us carrying out our public health duties, for example, with respect to the Cancer Register for England. We welcomed the support from our colleagues in DH in clarifying with the HSCIC early in 2015 the legal basis on which we access such information, which is now enshrined in the Memorandum of Understanding agreed with HSCIC in April 2015, and which will be reviewed in October 2015. As a volume processor of patient identifiable data for a range of public health purposes, this is critical in us achieving the duties set out in the Framework Agreement and annual remit letter. Further work is required to ensure that we continue to maintain the rightly high, and ever increasing, standards expected of organisations with such data in their care, which will be led by the SIRO as Chair of our Information Governance Group.

PHE Science Hub

The Programme Board, chaired by the Deputy Chief Executive as its SRO, has continued to oversee development of the business case, identifying and monitoring key risks as they arise. Further to the commitment set out in our business plan for 2014/15, we submitted the outline business case (OBC) to DH on time in July 2014 in anticipation of a decision being made by government in the early autumn. A Gateway 2 review was carried out in September 2014, which concluded that the delivery confidence status of the programme was 'amber'. We have since been addressing the recommendations made by the review team that would have otherwise resulted in an 'amber-green' rating.

In February 2015, we were advised that a decision on the OBC, which had been approved by DH ministers, would not be taken until after the general election in May. This delay brings with it some additional risks that are being carefully managed, for example, a prolonged period of uncertainty among current and potential future staff could impact on our ability to recruit, retain and motivate appropriate scientific expertise. It will also delay the realisation of the benefits and financial efficiencies that we are confident the programme will deliver, not least considering the ageing estate at PHE Porton, which is nearing the end of its useful life and as such requires ever-increasing levels of ongoing maintenance. We are

working closely with our staff and DH colleagues to mitigate these risks as far as possible and with a view to a positive decision on the OBC being made as early on as possible in the life of the new government. As part of this, we have appointed Professor Derrick Crook to lead the creation of our new National Infection Service. This is an integrated, scientifically-led service covering all the public and population health aspects of infectious disease and the basis of the new model of service and staffing that will be used to ensure that the Science Hub is a centre of world-leading science.

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.

Through its Management 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 our strategic risk register

The Board received reports from the Chair 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 our 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. Audit actions from previous audits are now monitored by management on a routine basis and outstanding actions reported regularly to the Audit and Risk Committee.

Internal audit completed 27 planned reviews in the period of which three were advisory in nature, the remaining 24 being assurance based. Of these, 16 were rated moderate and eight were limited. No reviews were rated as unsatisfactory or substantial. The Head of Internal Audit has advised me that, when compared to performance last year where they completed 24 assurance reviews (of which one was rated substantial, 14 were moderate, and nine were limited – no reviews were rated as unsatisfactory), looks very comparable. One review was not substantially complete at the end of the year and this work has been carried forward into 2015/16. The Head of Internal Audit has advised me that, for the three areas on which they must report, they have concluded that:

- in the case of risk management, we have continued to develop risk management and have seconded in a suitably experienced risk manager to help them to develop their processes and approach. Internal Audit has continued to follow up the recommendations made as part of the audit plan from last year (limited rating) and conducted a follow up review in the first half of 14/15 which resulted in a moderate rating. They can therefore see improvement to this area, but would encourage further work to fully embed risk management
- in the case of governance, we have been going through a further period of structural reform and change, but good communication with staff on this process and the outcomes from the board effectiveness and governance review have been positive. There is, however, still work to be done to improve clinical governance processes and to fully embed quality programmes as evidenced by the limited rated reports in these areas; and
- in the case of control, we have adequate control mechanisms in place on financial systems and these are continually evolving however, there remains scope for improvement in the management of programmes and projects, IT capability, resilience and security and occupational health

The Head of Internal Audit has therefore advised me that they can give reasonable assurance to me as PHE's Accounting Officer that the organisation has had adequate and effective systems of control, governance and risk management in place for the reporting year 2014/15 but more remains to be done to fully embed these.

Taking forward our governance

We recently completed an internal review of our governance arrangements in the context of *Securing our Future,* the recent NAO and PAC reports, internal audit reports, the MORI and PHE Staff Surveys and the new government to ensure that they are fit-for-purpose and the key changes that will take effect in July 2015 are summarised below.

At its recent away day, the Board agreed to develop its own set of medium to long-term objectives, which will focus and guide their work and maximise their contribution to PHE. These were shared at a recent executive away day and will be finalised over the coming months. They will form the basis of the Board's forward work programme and frame the leadership team's engagement with them. The Board also agreed a new process to monitor and assure delivery of their 'watch-list', ensuring that the actions from their consideration of key public health themes are embedded into our strategies, products and services. A non-executive will be assigned to each of the themes and Directors will co-ordinate action accordingly through the Management Committee (see below).

The Management Committee will continue to be the prime mechanism for supporting me in my role as Accounting Officer and the focus of PHE's governance. Amongst its responsibilities will be the approval and monitoring of our budget, agreement of our priorities and the design and structure of the organisation. Key governance groups will report to the Management Committee.

As part of ensuring a greater focus on delivery of the priorities set out in the business plan, and building on the annual remit letter and *From Evidence Into Action*, we will establish a Delivery Board, reporting to the Management Committee. Chaired by the Deputy Chief Executive, it will be the forum where, on my behalf, he ensures that we deliver our in-year priorities and functions as set out in the annual remit letter and business plan, and that this is done effectively, efficiently and economically.

We will establish a Strategy Board as the forum at which we will debate and settle the key strategic issues we face and how we respond to them. This will be chaired by the Director of Strategy and report to the Management Committee. It will consider proposals that have been co-produced by representatives of national directorates and centre teams and make final recommendations to the Management Committee for approval and, where appropriate, to the Board, on our 'position' on these key factors.

The Resourcing and Prioritisation Committee will continue in its current form but report to the Management Committee. Its remit will continue to be focused on internal business management of our resources (people, finance, estate etc) and will continue to be chaired by the Deputy Chief Executive. A new sub-committee will be established, which will meet weekly, to deal with investment and approvals in a more agile way.

As part of addressing the findings of recent internal audit reports on our quality and clinical governance arrangements, and, more generally, developing them to the standards expected of national organisations in the health and care sector, the Director for Health Protection and Medical Director and the Chief Nurse are jointly leading our *Sound Foundations* programme, details of which are set out above. As part of this, and in providing clear top-level commitment to this agenda, we will establish a Quality and Clinical Governance Committee of the Board. This will be chaired by a non-executive and will act as the prime provider of assurance to the Board and me on this area and on ensuring that we promote a safety and quality-focused culture throughout the organisation. The minutes of this Committee will be shared with the Audit and Risk Committee (ARC) as a standing agenda item of the latter, the ARC retaining the prime role and responsibility of providing the Board with an independent and objective review of our systems and processes and compliance with laws and regulations applying to PHE.

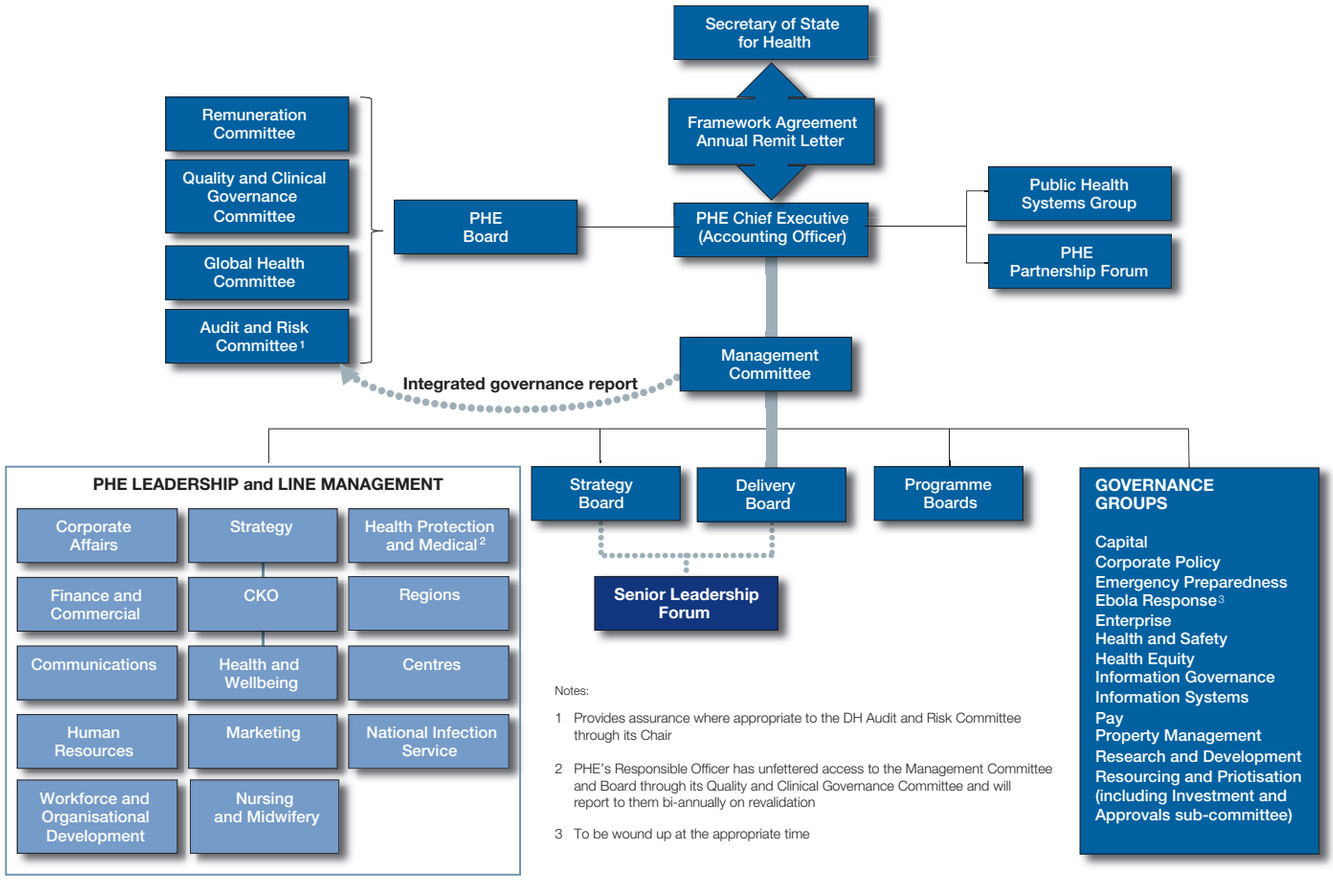
During the year, internal audit made a number of recommendations for bringing greater consistency and effectiveness to our programme and project management arrangements. In response, we have started a piece of development work to not only deliver their recommendations, but also to work with other delivery partners on cross-sector programme and project management peer-review support. As recognised by internal audit in their review, there are areas of excellent programme and project management work across the organisation, particularly on major initiatives such as the Science Hub and ICT. We will therefore be building on the good practice already developed, ensuring that these are developed and embedded across the organisation.

Through *Securing Our Future*, we are undertaking a major re-design of PHE that changes not only the structures within the organisation but also ways of working. The prime route for governance and accountability is through line management reporting to me through my direct reports. The recent programme of management seminars for all line managers reinforced the critical role that line management plays in all parts of the organisation delivering high quality, cost effective services.

Effective collaboration between teams across the organisation in different line management arrangements is a key contributor to our success. There will be a range of mechanisms in place to achieve this but the two main approaches are, firstly, the local management team. Each Centre Director will bring together all the teams working in a specific part of the country through a local management team to ensure that our local presence is aligned and working together to deliver responsive services to local partners.

Secondly, the PHE Improvement Hub – the collaboration between teams at a corporate level that undertakes the co-production and co-design for key pieces of work within PHE. In addition, we will explore the concept of an Innovation Lab as an informal setting for experimentation and testing of ideas.

The National Executive will be discontinued in light of these changes. The governance arrangements for the next phase of our development are set out below:



Conclusion

I am satisfied that, overall, there have been adequate and effective governance, risk and control systems during 2014/15. As set out in the section above on taking forward our governance, these systems have recently been reviewed and new arrangements for our third year of operation will be implemented next month. These will be monitored and overseen by the Board, Audit and Risk Committee and Management Committee and their effectiveness reported on in next year's statement.

Duncan Selbie
Chief Executive
2 July 2015

Remuneration report

This report details the policy on the appointment, appraisal and remuneration of members of our Board and the National Executive for the year ended 31 March 2015. It has been prepared in consultation with our Pay Committee, and is based upon the provisions contained within the *Government Financial Reporting Manual 2014/15*.

Accountability

As a sub-committee of the National Executive, the Pay Committee is accountable to the National Executive. In the case of Senior Civil Service (SCS) or Very Senior Manager (VSM) pay, the committee is accountable to the Remuneration Committee of the Board.

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:

- the application of the performance-related pay process
- the approval of any premature retirement application on the grounds of 'the interests of the efficiency of the service'
- approval of the annual Remuneration Report
- any case which we are required to submit to DH or HM Treasury, and specifically for individual cases for:
    - any redundancy package with a capitalised cost of more than £100,000
    - compensation in lieu of notice of £50,000 or more
    - ex gratia payments to a member of 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
- making recommendations to the National Executive on any aspect of pay policy
- making recommendations to the Remuneration Committee of the Board on SCS and VSM pay

The committee does not deal with matters concerning its own pay; rather issues concerning its members' pay are considered and decided by the Remuneration Committee of the Board.

Committee membership

The Pay Committee consists of four members of the National Executive. The members for 2014/15 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 the Chair through an annual appraisal process. The appraisal process for the Chair was conducted by our Senior Departmental Sponsor, the DH Director General of Public and International Health.

Remuneration of non-executive Board members

The table below lists all non-executive members who served on the Board during the year ended 31 March 2015. The date of their appointment is accompanied by the total remuneration due to each individual during their tenure in post in 2014/15.

Total remuneration due to each individual during their tenure in post in 2014/15	Date of appointment	Total salary, fees and allowances	Total salary, fees and allowances
		Year ended 31 March 2015	Year ended 31 March 2014
		£'000	£'000
Professor David Heymann (Chair)	1 April 2013	35 - 40	35 - 40
Rosie Glazebrook	26 March 2014	5 -10	0 - 5
Professor George Griffin	1 June 2013	5 -10	5 -10
Professor Sian Griffiths (Associate)	1 January 2014	5 -10	0 - 5
Poppy Jaman	26 March 2014	5 -10	0 - 5
Martin Hindle*	1 June 2013	10 - 15	5 - 10
Derek Myers**	1 June 2013	10 - 15	10 - 15
Professor Richard Parish	1 June 2013	5 -10	5 -10
Paul Lincoln*** (Associate)	1 June 2013	5 -10	5 -10

* The remuneration of Martin Hindle reflects his additional commitments as Chair of the PHE Science Hub Programme Board.
** The remuneration of Derek Myers reflects his additional commitments as Chair of the PHE Audit and Risk Committee, to which he was appointed specifically by the Secretary of State for Health.
*** 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.

Appointment and appraisal of National Executive members

We adhere 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 has 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.

Performance was assessed against agreed objectives and a set of core management skills and leadership qualities. The Chief Executive's appraisal was conducted by the DH Permanent Secretary, taking into account feedback from the Board.

The number of persons by gender serving on the National Executive was 10 males and seven females. The number of persons at senior management level in the wider organisation was 223 males and 230 females.

REMUNERATION OF NATIONAL EXECUTIVE MEMBERS 2014/15

	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 2015			
				Bands of			
				£5,000	£5,000	£2,500	£5,000
Duncan Selbie (Chief Executive)	1 April 2013		6 months	185 - 190	10 - 15	87.5 - 90.0	285 - 290
Viv Bennett[1]	1 April 2013			105 - 110		37.5 - 40.0	145 - 150
Lis Birrane	1 April 2013		3 months	100 - 105		27.5 - 30.0	130 - 135
Michael Brodie	24 June 2013		3 months	140 - 145		50.0 - 52.5	190 - 195
Professor Paul Cosford[2]	1 April 2013		3 months	155 - 160		(22.5 - 25.0)	135 - 140
Professor Yvonne Doyle[2]	1 April 2013		3 months	180 - 185		17.5 - 20.0	195 - 200
Professor Kevin Fenton	1 April 2013		3 months	175 - 180		65.0 - 67.5	240 - 245
Richard Gleave	1 April 2013		3 months	135 - 140		32.5 - 35.0	170 - 175
Dr Jenny Harries	1 April 2013		3 months	125 - 130		30.0 - 32.5	155 - 160
Professor Paul Johnstone[2]	1 April 2013		3 months	180 - 185		50.0 - 52.5	230 - 235
Jonathan Marron	1 April 2013		3 months	110 - 115	10 - 15	27.5 - 30.0	150 - 155
Dr Christine McCartney	1 October 2013	31 March 2015	3 months	115 - 120		-	115 - 120
Deborah McKenzie[3,6]	15 July 2014			75 - 80		40.0 - 42.5	120 - 125
Stephen Morris[4,5]	1 April 2013	15 July 2014	3 months	35 - 40		2.5 - 5.0	35 - 40
Professor John Newton[2]	1 April 2013			165 - 170		7.5 - 10.0	175 - 180
Dr Rashmi Shukla[2]	1 April 2013		3 months	165 - 170		25.0 - 27.5	190 - 195
Alex Sienkiewicz[4]	1 April 2013			115 - 120		45.0 - 47.5	160 - 165
Tony Vickers-Byrne	1 April 2013		3 months	100 - 105		22.5 - 25.0	125 - 130
Sally Warren	1 April 2013	31 May 2014	3 months	10 - 15		0.0 - 2.5	10 - 15

1. Seconded from the Department of Health on a part-time basis at no cost to PHE.
2. The remuneration of these members of the National Executive included a clinical excellence award.
3. Seconded from NHS Central Southern Commissioning Support Unit.
4. Seconded from Brighton and Sussex University Hospitals NHS Trust on a full-time basis.
5. Stephen Morris is no longer a member of the National Executive. However, he remains on secondment from Brighton and Sussex University Hospitals NHS Trust on a full-time basis.
6. Pro-rata due to only serving part of year on National Executive

REMUNERATION OF NATIONAL EXECUTIVE MEMBERS 2013/14

	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			
				Bands of			
				£5,000	£5,000	£2,500	£5,000
Duncan Selbie (Chief Executive)	1 April 2013		6 months	185 - 190		42.5 - 45.0	225 - 230
Viv Bennett[1]	1 April 2013			105 - 110		40.0 - 42.5	145 - 150
Lis Birrane	1 April 2013		3 months	100 - 105	10 - 15	22.5 - 25.0	130 - 135
Michael Brodie[2,5]	24 June 2013		3 months	105 - 110		7.5 - 10.0	115 - 120
Professor Paul Cosford[3,4]	1 April 2013		3 months	160 - 165		65.0 - 67.5	225 - 230
Professor Yvonne Doyle[3]	1 April 2013		3 months	165 - 170		42.5 - 45.0	210 - 215
Professor Kevin Fenton	1 April 2013		3 months	175 - 180		25.0 - 27.5	200 - 205
Richard Gleave	1 April 2013		3 months	130 - 135		25.0 - 27.5	155 - 160
Dr Jenny Harries	1 April 2013		3 months	125 - 130		82.5 - 85.0	205 - 210
Professor Paul Johnstone[3]	1 April 2013		3 months	180 - 185		50.0 - 52.5	230 - 235
Jonathan Marron	1 April 2013		3 months	110 - 115		25.0 - 27.5	135 - 140
Dr Christine McCartney[5,9]	1 October 2013	31 March 2014	3 months	55 - 60		-	55 - 60
Stephen Morris[7]	1 April 2013			120 - 125		30.0 - 32.5	150- 155
Professor John Newton[3]	1 April 2013		3 months	165 - 170		25.0 - 27.5	190 - 195
Dr Rashmi Shukla[3,6]	1 April 2013		3 months	165 - 170		47.5 - 50.0	215 - 220
Alex Sienkiewicz[7]	1 April 2013			115 – 120		47.5 - 50.0	160 - 165
Tony Vickers-Byrne[8]	1 April 2013		3 months	100 - 105	10 - 15	47.5 - 50.0	160 - 165
Sally Warren[8]	1 April 2013		3 months	80 - 85	10 - 15	32.5 - 35.0	130 - 135

1. Seconded from the Department of Health on a part-time basis at no cost to PHE.
2. 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.
3. The remuneration of these members of the National Executive included a clinical excellence award.
4. 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.
5. The full year equivalent salary in respect of Michael Brodie was £140,000 and in respect of Dr McCartney was £117,024.
6. Dr Shukla's remuneration includes a one-off payment of £2,545 for untaken annual leave for the leave year 2012/13 while Dr Shukla was employed at the Department of Health.
7. Seconded from Brighton and Sussex University Hospitals NHS Trust on a full-time basis.
8. The bonus payments relate to performance in predecessor organisations.
9. 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 2015. A summary of their employment contract is accompanied by the total remuneration due to each individual during their tenure in post in 2014/15.

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 2015.

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 Department of Health 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.

Performance-related bonuses were paid to two members of the National Executive in accordance with the performance-related pay provisions available to those employed on Senior Civil Service (SCS) or Very Senior Manager (VSM) terms and conditions. The National Executive remuneration package consists of a salary and pension contributions. In determining the package, the Department of Health 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 2014/15, some members of the National Executive, employed on SCS terms and conditions, received consolidated increases of £800, which were made in line with the national arrangements published by the Cabinet Office. Also, in recognition of his additional duties as Deputy Chief Executive, the Remuneration Committee agreed that Richard Gleave, the Chief Operating Officer, should receive a consolidated award of £6,000. There were no consolidated increases for staff employed on VSM or medical and dental terms and conditions.

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 £153,397 and £144,742, respectively. The NHS Central Southern Commissioning Support Unit was paid £148,120 for the services of Deborah McKenzie.

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 2015, no benefits in kind were made available to any non-executive Board member or any National Executive member.

Pension entitlements

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 2015 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 2015	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 1 April 2014	Cash Equivalent Transfer Value at 31 March 2015	Real increase in Cash Equivalent Transfer Value	Total pension entitlement at 31 March 2015
	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 £5,000
Chief Executive								
Duncan Selbie[1]	5.0 - 7.5	0.0 - 2.5	115 - 120	0 - 5	1,692	1,844	65	115 - 120
Executive directors								
Viv Bennett	0.0 - 2.5	0.0 - 2.5	5 - 10	0 - 5	51	89	26	5 - 10
Lis Birrane[1]	0.0 - 2.5	2.5 - 5.0	10 - 15	40 - 45	283	326	35	10 - 15
Michael Brodie	2.5 - 5.0	0.0 - 2.5	5 - 10	0 - 5	25	59	21	5 - 10
Professor Paul Cosford	(0.0 - 2.5)	(2.5 - 5.0)	50 - 55	150 - 155	918	946	3	50 - 55
Professor Yvonne Doyle[1]	0.0 - 2.5	0.0 - 2.5	45 - 50	135 - 140	918	1,011	68	45 - 50
Professor Kevin Fenton	2.5 - 5.0	0.0 - 2.5	5 - 10	0 - 5	55	103	29	5 - 10
Richard Gleave	0.0 - 2.5	0.0 - 2.5	5 - 10	0 - 5	41	79	22	5 - 10
Dr Jenny Harries	0.0 - 2.5	2.5 - 5.0	30 - 35	95 - 100	655	687	14	30 - 35
Professor Paul Johnstone[1]	2.5 - 5.0	0.0 - 2.5	5 - 10	0 - 5	31	68	36	5 - 10
Jonathan Marron	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	22	45	12	0 - 5
Dr Christine McCartney[2]	-	-	-	-	-	-	-	-
Deborah McKenzie	0.0 - 2.5	0.0 - 2.5	5 - 10	0 - 5	65	96	29	5 - 10
Stephen Morris	0.0 - 2.5	0.0 - 2.5	40 - 45	125 - 130	813	881	47	40 - 45
Professor John Newton	0.0 - 2.5	0.0 - 2.5	55 - 60	170 - 175	1,132	1,209	46	55 - 60
Alex Sienkiewicz	0.0 - 2.5	2.5 - 5.0	10 - 15	30 - 35	116	138	19	10 - 15
Dr Rashmi Shukla	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	40	74	33	0 - 5
Tony Vickers-Byrne[1]	0.0 - 2.5	2.5 - 5.0	35 - 40	115 - 120	752	817	44	35 - 40
Sally Warren	0.0 - 2.5	0.0 - 2.5	15 - 20	45 - 50	174	176	1	15 - 20

1. Continuity of membership from predecessor body.
2. 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 the financial year 2014/15 was £200,000 to £205,000 (2013/14: £185,000 to £190,000). This was 5.7 times the median remuneration of the workforce (2013/14: 5.1), which was £35,704 (2013/14: £36,163).

In 2014/15, remuneration across our workforce ranged from £15,350 to £216,000 (2013/14: £14,653 to £208,000). Three employees (the same as 2013/14) received remuneration in excess of the highest paid director.

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 2015
Highest earning director's total remuneration	£200,000 to £205,000
Median total remuneration*	£35,704
Ratio of median remuneration and remuneration of highest earning employee	5.7 : 1

*The calculation of the median salary is based on the total remuneration of staff employed at 31 March 2015 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 91.

Duncan Selbie
Accounting Officer
2 July 2015

Financial review

Accounts direction

The financial statements contained within our second Annual Report and Accounts relate to the financial year 1 April 2014 to 31 March 2015. 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

Our 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* (FReM) issued by HM Treasury, 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 of a number of functions transferred into PHE on a going concern basis from April 2013. During the 2014/15 year, our 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 Vaccines and Countermeasures Response (vaccines)
- 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. We also receive significant additional income from services provided to customers, grant-funded bodies and the devolved administrations.

Funding in 2014/15

For 2014/15, the funding provided by DH for our three operating segments was as follows:

- local authority grants: specific programme revenue within a limit of £2,794m (2013/14: £2,662m)
- vaccines: specific programme revenue within a limit of £387m, including depreciation and the cost of disposals (2013/14: £412m)
- operating activities: non-specific admin and programme revenue within a limit of £448m (2013/14: £405m)

Financial performance

In 2014/15, we achieved our financial targets by managing resources in line with the budgets set and voted through the parliamentary supply process. Our out-turn for the 2014/15 year was an underspend of £5.4m on a total operating budget of £3,629m (0.2%). This compares with the 2013/14 underspend of £7.0m on an operating budget of £3,503m.

Financial control is achieved across PHE through budgetary allocations, which are flexed during the year as required and depending on public health priorities. Financial performance is monitored through high level reports to DH, the PHE Board and Management Committee and by detailed reports to directorate senior management teams and individual budget holders.

In the 2014/15 year, cognisant of future financial pressures, we operated at staffing levels below its budgeted establishment in order to maximise the scope for future organisational redesign. As a result of this, we were able to absorb the costs of the Science Hub project, which had been budgeted by DH separately from our main allocation, and was able to accommodate the significant exit costs arising from its Strategic Review of its services.

Our financial out-turn was supported by operational income of £169.4m (2013/14: £170.0m) earned from trading activities and research funding.

Vaccines and Countermeasures Response ('vaccines') sales of £66.5m (2013/14: £61.9m) were made to other government agencies in the year, with most being to the devolved administrations. These sales are a transfer of stock and also statutory services related to preparedness for pandemics and are reported as non-trading income within the analysis of operational income. The sales are made largely at cost with an overhead contribution of £0.7m reported in the accounts.

We are operating in a challenging economic climate but consider that we are well-placed to continue to manage resources and deliverables in line with anticipated future funding settlements. Expenditure will be reviewed continually as part of the efficient management of the organisation, following a strategic review performed during 2014/15. The operating expenditure of PHE will 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 2014/15 totalled £3,623.2m (2013/14: £3,498.3m). The table below provides a summary of our financial performance for the year showing a high level breakdown of income and expenditure against budget for the year.

Net Expenditure (£m)	2014/15			2013/14		
	Budget	Actual	Variance	Budget	Actual	Variance
External income:						
Operating activities	169.4	169.4	-	170.7	169.9	(0.8)
Vaccines	66.5	66.5	-	61.7	61.7	-
Total external income	**235.9**	**235.9**	**-**	**232.4**	**231.6**	**(0.8)**
Expenditure:						
Pay	316.7	315.1	1.6	300.3	285.5	14.8
Non-pay	276.2	272.4	3.8	287.7	294.9	(7.2)
Local authority grants	2,794.9	2,794.9	-	2,661.8	2,662.9	(1.1)
Vaccines (excluding depreciation)	453.4	453.4	-	463.2	463.2	-
Depreciation	23.3	23.3	-	24.7	23.4	1.3
Total expenditure	**3,864.5**	**3,859.1**	**5.4**	**3,737.7**	**3,729.9**	**7.8**
Net expenditure	**3,628.6**	**3,623.2**	**5.4**	**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 £2.6m

Operational income

An important part of our work is the provision of products and services to national and local government, the NHS, industry, academe and research bodies throughout the UK and worldwide.

Any income generated from our products and services supports public health work, offsets the cost to taxpayers, and serves to maximise our impact on public health, whilst supporting the life sciences and UK economic growth.

In 2014/15, we generated total external income of £235.9m, including operational income of £169.4m from supplies and services to third parties, which is broken down below:

External Income (£m)	2014/15			2013/14		
	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m
NHS laboratory contracts	51.0	53.0	2.0	44.5	43.8	(0.7)
Research grants	24.5	23.8	(0.7)	34.5	30.8	(3.7)
Commercial services	29.2	28.9	(0.3)	30.0	26.3	(3.7)
Products and royalties	56.0	53.8	(2.2)	57.6	60.1	2.5
Other	8.7	9.9	1.2	4.1	8.9	4.8
Operating activities	**169.4**	**169.4**	**-**	**170.7**	**169.9**	**(0.8)**
Vaccines	66.5	66.5	-	61.7	61.7	-
Total External Income	**235.9**	**235.9**	**-**	**232.4**	**231.6**	**(0.8)**

Public health grants

We provide a public health grant (£2.79bn in 2014/15) to local authorities to support the 152 upper tier and unitary local authorities to fulfil their 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. We support them by providing evidence and knowledge on local health needs and by taking action nationally where it is best placed to do so.

Vaccines and Countermeasures Response (vaccines)

Within our statutory remit, we undertake for DH the overall vaccine procurement, distribution and inventory control for England. Vaccines that relate to 'emergency stocks' are capitalised rather than charged as revenue expenditure, however, the administration costs are accounted for within our budget and in-year funding is variable and dependent on the priorities set by the department/ministers. For 2014/15, the revenue and capital expenditures were impacted by disposals of assets (emergency stocks) which had reached expiry dates. Such disposals are planned events and are in line with policy for holding emergency stocks. The revenue and capital funding for the year is shown below:

Vaccines and Countermeasures Response (£m)	'Cash'	'Resource'	Total
Revenue items	334.4	52.9	387.3
Capital items	36.1	(54.0)	(17.9)
Total	**370.5**	**(1.1)**	**369.4**

Relationships with suppliers

We are committed to the Better Payment Practice Code. Our policy is to pay suppliers within 30 days of receipt of a valid invoice. To this end internal targets are set, as below:

- 75% to be paid within 10 days of receipt of a valid invoice, and
- 95% to be paid within 30 days of receipt of a valid invoice

Our systems currently record the invoice date rather than the date of receipt, so payment will have been faster than the recorded statistics.

In 2014/15, 82% of supplier bills were paid within 10 days and 94% within 30 days, as shown below. 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	**230,290**	**59,011**	**71,934**	**32,443**	**393,678**
	59%	15%	18%	8%	100%
Number of invoices	**68,165**	**14,382**	**11,810**	**6,043**	**100,400**
	68%	14%	12%	6%	100%

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

Exposure to liquidity and credit risk

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

We participate 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 our business-as-usual processes and complement operational management. During the 2014/15 year, we initiated a strategic review to challenge its operational structures and to seek more efficient ways of working and thereby in delivering best value for money. The outcomes of the review are now being implemented as revised organisational structures and closer working relationships.

Back office review

We are committed to continuously improve its 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. We are committed to delivering back office services to best practice benchmark standards and have developed a record of delivering efficiency gains in these areas.

Hosted services

In 2014/15, as part of value for money considerations, we provided a hosted service to the Medicines and Healthcare products Regulatory Agency in respect of transactional accounting. The income and expenditure entries, as processed through the hosted service, do not form part of our accounts. The income received by us for the provision of the hosted service was £305,000. This arrangement will continue through 2015/16.

From April 2015 we will also provide transactional accounting services for Porton Biopharma Ltd (see below).

Porton Biopharma Ltd

In 2014/15, in conjunction with DH, we agreed a business case to create a spin-out company to undertake its pharmaceutical development and production. Porton Biopharma Ltd (PBL) was formed on 1 April 2015, with 202 of our staff being transferred to the new company, which is based at our site at Porton. PBL is a company limited by shares, with 100% of the shares being owned by the Secretary of State for Health (SoS). In turn, the SoS has directed that the operational relationship with PBL should be through PHE.

The funding contribution from the pharmaceutical manufacturing activity previously earned under PHE will be replaced by an annual dividend from PBL. The dividend will be paid from profits generated by PBL.

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 2015/16 and beyond. Like all public services, we face significant financial challenges in the short term. In 2014/15, we undertook a strategic review of all our functions, which is summarised elsewhere in the annual report. Other operational functions will adopt closer, more efficient, working relationships whilst all the back office functions have been set efficiency savings targets.

Our operational GIA in 2015/16 has been reduced significantly. To prepare for this reduction we initiated voluntary exit and redundancy programmes, agreed with DH and Cabinet Office, which will reduce the workforce by around 200 net whole-time equivalents.

Going concern basis

We came into operation on 1 April 2013. Based on normal business planning and control procedures, and with the continuing financial support of government, the Chief Executive and Board have reasonable expectation that PHE has adequate resources to continue in operational existence for the foreseeable future. For this reason, we adopt 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 our external auditor under section 7 of the Government Resources and Accounts Act 2000. The auditor's remuneration was £190,000 for 2014/15. This is a notional fee. In addition, NAO provided audit services in respect of the provision of an EU grant at a cost to PHE of £3,840. 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 information that has not been available to the NAO's audit team.

Duncan Selbie
Accounting Officer
2 July 2015

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 in *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 2015 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 2015 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
8 July 2015

Statement of comprehensive net expenditure

FOR THE PERIOD ENDED 31 MARCH 2015

Administration costs	Note	2014/15 Staff Costs £000	2014/15 Other Costs £000	2014/15 Income £000	2013/14 Staff Costs £000	2013/14 Other Costs £000	2013/14 Income £000
Staff costs	3	128,435			119,661	-	-
Other administrative costs	4		77,327		-	78,938	-
Operating income	6			(56,026)	-	-	(57,996)
Non-operating income				-			(333)
Total		**128,435**	**77,327**	**(56,026)**	**119,661**	**78,938**	**(58,329)**
Programme costs							
Staff costs	3	186,671			165,793	-	-
Programme costs	5		3,466,648		-	3,365,446	-
Operating income	6			(179,825)	-	-	(173,228)
Total		**186,671**	**3,466,648**	**(179,825)**	**165,793**	**3,365,446**	**(173,228)**
Total costs		**315,106**	**3,543,975**	**(235,851)**	**285,454**	**3,444,384**	**(231,557)**
Net operating cost				**3,623,230**			**3,498,281**
Gain on transfer by absorption	1.30			-			(826,393)
Total net costs				**3,623,230**			**2,671,888**

On 1 April 2015, PHE's operations relating to pharmaceutical manufacturing activity transferred to Porton Biopharma Ltd. The financial implications of this are detailed in note 23.

Other comprehensive expenditure

FOR THE PERIOD ENDED 31 MARCH 2015

	Note	2014/15 £000	2013/14 £000
Total net costs for the year ended 31 March		3,623,230	2,671,888
Items that will not be reclassified to net costs:			
Net (gain) on revaluation of property, plant and equipment	7	(2,647)	(837)
Total comprehensive expenditure for the year ended 31 March		**3,620,583**	**2,671,051**

Statement of financial position

FOR THE PERIOD ENDED 31 MARCH 2015

	Note	2014/15	2013/14
		£000	£000
Non current assets:			
Property, plant and equipment	7	920,375	927,591
Intangible assets	8	13,326	6,411
Other non-current assets	12	144	92
Total non current assets		**933,845**	**934,094**
Current assets:			
Trade and other receivables	12	57,904	44,163
Inventories	11	143,334	131,719
Cash and cash equivalents	13	159,674	129,430
Total current assets		**360,912**	**305,312**
Total assets		**1,294,757**	**1,239,406**
Current liabilities			
Trade and other payables	14	(158,737)	(123,308)
Provisions	15	(17,126)	(6,722)
Total current liabilities		**(175,863)**	**(130,030)**
Non current assets plus net current assets		**1,118,894**	**1,109,376**
Non current liabilities			
Provisions	15	(2,373)	(2,597)
Total non current liabilities		**(2,373)**	**(2,597)**
Assets less liabilities		**1,116,521**	**1,106,779**
Taxpayer's equity			
General fund		1,078,951	1,073,167
Revaluation reserve		37,570	33,612
Total taxpayer's equity		**1,116,521**	**1,106,779**

The notes on pages 97 to 134 form part of these accounts
The financial statements on pages 93 to 96 were signed by:

Duncan Selbie
Accounting Officer
2 July 2015

Statement of cash flows

FOR THE PERIOD ENDED 31 MARCH 2015

Cash flows from operating activities	Note	2014/15	2013/14
		£000	£000
Net operating cost		(3,623,230)	(3,498,281)
Adjustments for non cash transactions			
Auditor remuneration	4	190	210
Loss on de-recognition of property, plant and equipment	4/5	53,883	76,846
Loss on disposal of asset held for sale	5	-	65
Reclassification of stockpiled goods	7	440	157
Amortisation and depreciation	4/5	22,948	23,375
Provision for impairments	4	566	29
Gain/(loss) on disposal of inventories	11	7	(48)
Revaluation of assets written off to the statement of comprehensive net expenditure	10	-	50
Impairments	10	73	1,008
Transfers relating to modified and absorption accounting		-	122,768
(Increase) in trade and other receivables		(14,307)	(44,163)
(Increase) in inventories		(11,615)	(131,719)
Increase in trade payables		35,429	123,308
Expenditure charged to provisions	15	(481)	(188)
Increase in provisions	15	10,661	9,507
Net cash outflow from operating activities		**(3,525,436)**	**(3,317,076)**
Cash flows from investing activities			
Purchase of property, plant and equipment	7	(69,260)	(126,684)
Purchase of intangible assets	8	(5,136)	(2,800)
Increase in non-current financial assets		(52)	(92)
Net cash outflow from investing activities		**(74,448)**	**(129,576)**
Cash flows from financing activities			
Net parliamentary funding		3,630,128	3,576,082
Net cash inflow from financing activities		**3,630,128**	**3,576,082**
Net increase in cash and cash equivalents in the period		**30,244**	**129,430**
Cash and cash equivalents at the beginning of the period	13	129,430	-
Cash and cash equivalents at the end of the period	13	**159,674**	**129,430**

Statement of changes in taxpayers' equity

FOR THE PERIOD ENDED 31 MARCH 2015

	Note	General fund £'000	Revaluation reserve £'000	Total £'000
Balance at 1 April 2014	1.30	1,073,167	33,612	1,106,779
Transfers under absorption accounting	1.30	-	-	-
Net parliamentary funding		3,630,128	-	3,630,128
Non-cash charges: auditor's remuneration		190	-	190
Net (gain) on revaluation of property, plant and equipment	7	-	2,647	2,647
Release of revaluation reserve in respect of de-recognised assets		521	(521)	-
Loss on disposal of inventory		-	7	7
Transfers between reserves	7/8	(1,825)	1,825	-
Total net operating costs for the year		(3,623,230)	-	(3,623,230)
Balance at 31 March 2015		**1,078,951**	**37,570**	**1,116,521**

Transfers between reserves includes an amount of £1,887,000 in respect of an incorrect transfer during 2013/14 offset by an amount of £62,000 in respect of assets which were de-recognised during 2013/14.

	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	7/8	-	(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) 2014/15 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 taxpayers' 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 two defined benefit schemes:

The Principal Civil Service Pension Scheme
The NHS 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 capitalised. Capitalisation occurs when the assets are capable of being 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 revalued 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 derecognised 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 revalued 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 International Accounting Standard (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 pound 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 Accounting for the costs of the Carbon Reduction Commitment Energy Efficiency Scheme

PHE participates in the Carbon Reduction Commitment Energy Efficiency Scheme. 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 2014/15.

1.31 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 2014/15. The application of the Standards as revised would not have a material impact on the accounts in 2014/15, were they applied in that year:

IFRS 13 – Fair Value Measurement

1.32 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 judgements 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 remit related to the improvement of public health and reduction of preventable deaths. These are:

1) The payment of ring-fenced public health (PH) grants to local authorities

2) The oversight of expenditure on vaccines and emergency countermeasures (vaccines)

3) 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.

	2014/15				2013/14			
	Operations	Public health grants	Vaccine programme	Total	Operations	Public health grants	Vaccine programme	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Gross expenditure	610,389	2,794,899	453,793	3,859,081	603,450	2,662,900	463,488	3,729,838
Income	(169,335)	-	(66,516)	(235,851)	(169,869)	-	(61,688)	(231,557)
Net operating cost	**441,054**	**2,794,899**	**387,277**	**3,623,230**	**433,581**	**2,662,900**	**401,800**	**3,498,281**

The major sources of operational income are as follows:

	2014/15	2013/14
	£000	£000
NHS laboratory contracts	53,009	43,800
Research grants	23,746	30,840
Commercial services	32,839	26,300
Products and royalties	55,248	62,761
Other	71,009	67,856
External operational income	**235,851**	**231,557**

Notes to the financial statements Continued

Operational activities
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, and metropolitan and London Boroughs) in England, intended to enable relevant local authorities to discharge their 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

	2014/15				2013/14			
	Operations	Public health grants	Vaccines programme	Total	Operations	Public health grants	Vaccines programme	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Total net expenditure per statement of operating cost by segment	441,054	2,794,899	387,277	3,623,230	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	**441,054**	**2,794,899**	**387,277**	**3,623,230**	**(392,812)**	**2,662,900**	**401,800**	**2,671,888**

Notes to the financial statements Continued

3 STAFF NUMBERS AND RELATED COSTS

Staff costs comprise:

	2014/15			2013/14		
	Permanently employed staff	Other staff	Total	Permanently employed staff	Other staff	Total
	£000	£000	£000	£000	£000	£000
Wages and salaries	234,233	19,025	253,258	215,554	23,572	239,126
Social security costs	19,377	-	19,377	18,550	-	18,550
Other pension costs	32,205	-	32,205	28,470	-	28,470
Subtotal	**285,815**	**19,025**	**304,840**	**262,574**	**23,572**	**286,146**
Redundancy and other department costs	13,328	-	13,328	2,050	-	2,050
Less recoveries in respect of outward secondments	(2,421)	-	(2,421)	(1,728)	-	(1,728)
Less recoveries in respect of staff engaged on capital projects	(641)	-	(641)	(738)	(276)	(1,014)
Total net costs	**296,081**	**19,025**	**315,106**	**262,158**	**23,296**	**285,454**

Other staff comprises personnel 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.

Average number of persons employed

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

	2014/15			2013/14		
	Permanently employed staff	Others	Total	Permanently employed staff	Others	Total
Directly employed	5,234	-	5,234	4,801	-	4,801
Other	-	317	317	-	390	390
Staff engaged on capital projects	7	-	7	-	5	5
Total	**5,241**	**317**	**5,558**	**4,801**	**395**	**5,196**

Notes to the financial statements Continued

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

Exit package cost band	2014/15 Number of redundancies	2014/15 Number of other departures agreed	2014/15 Total number of exit packages by cost band	2013/14 Number of redundancies	2013/14 Number of other departures agreed	2013/14 Total number of exit packages by cost band
< £10,000	15	-	15	22	-	22
£10,000 - £25,000	53	-	53	8	-	8
£25,000 - £50,000	89	-	89	19	-	19
£50,000 - £100,000	64	-	64	9	-	9
£100,000 - £150,000	13	-	13	2	-	2
£150,000 - £200,000	9	-	9	-	-	-
£200,000 +	5	-	5	-	-	-
Total number of exit packages	**248**	**-**	**248**	**60**	**-**	**60**
Total resource cost (£000)	13,328	-	13,328	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.

All exits where the cost is in excess of £100,000 are subject to a robust governance process including sign-off by the Cabinet Office. The significant increase in numbers of exits during 2014/15 is as a result of the planned strategic review of PHE's functions which contribute to the delivery of recruitment savings planned for 2015/16.

Notes to the financial statements Continued

3.2 Pensions

a) Pension scheme participation

PHE's employees are covered by two pension schemes: the Principal Civil Service Pension Scheme (PSCPS) and the National Health Service Pension Scheme (NHSPS).

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 2014/15, employers' contributions were payable to the PCSPS at one of six rates in the range 1.5% to 8.85% (2014: 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 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	3.00%	5.00%
£21,001 - £30,000	4.48%	6.48%
£30,001 - £47,000	5.27%	7.27%
£47,001 – £50,000	5.27%	7.27%
£50,001 - £60,000	6.06%	8.06%
£60,001 - £150,000	6.85%	8.85%
Over £150,000	6.85%	8.85%

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 nationally 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% (2014: 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:

	2014/15 Annual pensionable pay	2014/15 Employee contribution
Tier 1	up to £15,431.99	5.00%
Tier 2	£15,432 - £21,387.99	5.60%
Tier 3	£21,388 - £26,823.99	7.10%
Tier 4	£26,824 - £49,472.99	9.30%
Tier 5	£49,473 - £70,630.99	12.50%
Tier 6	£70,631 - £111,376.99	13.50%
Tier 7	£111,377 and over	14.50%

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 2014/15* requires the scheme to be accounted for as defined contribution in nature.

d) 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:

	2014/15 £'000	2013/14 £'000
The PCSPS	9,650	4,816
The NHSPS	22,555	22,936
The UKAEA CPS		718
Total contributions	**32,205**	**28,470**

e) Retirement due to ill health

During 2014/15, there was one (2014: four) early retirement from PHE on ill-health grounds; the total additional accrued pension liabilities on the year amounted to £150,980 (2014: £314,158).

Notes to the financial statements Continued

4 OTHER ADMINISTRATIVE COSTS

	Note	2014/15 £000	2013/14 £000
Accommodation		2,192	12,712
Auditor remuneration		4	4
Bank charges		60	59
Education, training and conferences		1,678	2,008
Foreign exchange (gains) / losses		(25)	129
Hospitality		44	23
Insurance		4	21
Laboratory consumables and services		13,539	9,699
Legal fees		185	54
Rentals under operating leases		11,127	617
Research & development		172	67
Supplies and services		25,650	34,288
Travel and subsistence		4,121	3,227
Voluntary sector grants		146	524
Non cash items:			
Auditor remuneration		190	210
Provision for impairments		566	29
Depreciation		15,475	13,328
Amortisation		1,902	1,641
Loss on de-recognition of property, plant and equipment and intangible assets		297	298
		-	
Total		**77,327**	**78,938**

During the year, PHE purchased no non-audit services from its auditor, the National Audit Office (NAO). NAO undertook an audit of an EU grant which is separate to the statutory remit. The amount of this was £3,840 (2014: £3,600).

During the year, PHE re-assessed the classification of its allocation of expenditure in respect of the adminstration and programme classification.

5 PROGRAMME COSTS

	Note	2014/15 £000	2013/14 £000
Accommodation		27,646	13,591
Education, training and conferences		3,228	2,390
European Union grant expenditure		1,323	230
Hospitality		43	46
Insurance		189	206
Inventories written down	10	10,084	12,656
Inventories consumed	10	327,748	323,009
Laboratory consumables and services		37,948	36,363
Legal fees		820	126
Loss on disposal of asset held for sale		-	65
Public health grants		2,794,899	2,662,919
Rentals under operating leases		1,296	14,392
Research & development		2,427	1,563
Supplies and services		169,205	185,993
Travel and subsistence		5,867	5,868
Voluntary sector grants		169	14,508
Capital grants		13,865	
Non cash items:			
Depreciation		3,392	6,352
Amortisation		2,179	2,054
Loss on de-recognition of property, plant and equipment and intangible assets		53,586	76,548
Provision provided for in year	15	10,661	5,509
Revaluation of fixtures and fittings	7	-	50
Impairment	10	73	1,008
Total		**3,466,648**	**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, and metropolitan and London Boroughs) in England, intended to enable relevant local authorities to discharge their 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.

Capital grants
Capital grants made under section 31 of the Local Government Act 2003, were granted in the year to fund projects relating to drugs and alcohol recovery centres in line with the PHE remit in health and wellbeing, as per the agreed framework.

Revenue grants made to the Voluntary Sector
Capital and revenue 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 derecognition 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.

6 INCOME

6a Operating income

	2014/15			2013/14		
	Administration £000	Programme £000	Total £000	Administration £000	Programme £000	Total £000
Laboratory and other services	19,962	74,744	94,706	54,435	16,977	71,412
Grants from the United Kingdom government	1,299	2,364	3,663	85	1,905	1,990
Grants from the European Union	301	3,241	3,542	90	3,535	3,625
Products and royalties	31,488	11,664	43,152	903	59,173	60,076
Research and related contracts and grants	714	15,827	16,541	962	24,263	25,225
Education and training	531	1,337	1,868	446	1,182	1,628
Vaccines income	-	66,516	66,516	-	61,688	61,688
Other operating income	1,731	4,132	5,863	1,075	4,505	5,580
Total	**56,026**	**179,825**	**235,851**	**57,996**	**173,228**	**231,224**

6b Non-operating income

	2014/15			2013/14		
	Administration £000	Programme £000	Total £000	Administration £000	Programme £000	Total £000
Proceeds from sale of investment	-	-	-	333	-	333
	-	**-**	**-**	**333**	**-**	**333**

During the year, PHE re-assessed the classification of its allocation of income in respect of the adminstration and programme classifications.

Notes to the financial statements Continued

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:

	2014/15 Income £000	2014/15 Full cost £000	2014/15 Surplus/ (Deficit) £000	Details of financial objective	Details of performance against the financial objective
Clinical Microbiology	60,079	62,086	(2,007)	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	45,795	40,416	5,379	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	9,092	9,215	(123)	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual Property Management	21,740	-	21,740	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Emergency preparedness and response	1,627	1,627	-	Charges for various radiation services	Met: broadly in line with internal targets
Commercial Radiation Services	8,448	10,487	(2,039)		
Total	**146,781**	**123,831**	**22,950**		

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.

	2013/14 Income £000	2013/14 Full cost £000	2013/14 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**		

7 PROPERTY, PLANT AND EQUIPMENT

	Land	Buildings (excluding dwellings	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 2014	28,050	117,826	2,577	69,044	31,370	710,285	43,597	1,002,749
Reclassification of assets	-	-	-	-	-	-	(5,961)	(5,961)
Transfer to inventory	-	-	-	-	-	(440)	-	(440)
Additions	-	-	-	59	-	36,099	33,102	69,260
Transfer of AUC	-	16,149	741	9,755	9,573	-	(36,218)	-
Revaluations	-	-	56	1,536	-	1,940	-	3,532
De-recognition	-	(43)	(200)	(1,356)	(855)	(53,543)	-	(55,997)
At 31 March 2015	**28,050**	**133,932**	**3,174**	**79,038**	**40,088**	**694,341**	**34,520**	**1,013,143**
Depreciation								
At 1 April 2014	-	6,380	1,607	39,694	27,477	-	-	75,158
Charge for year	-	7,140	223	6,887	4,617	-	-	18,867
Revaluations	-	-	35	850	-	-	-	885
De-recognition	-	(43)	(148)	(1,121)	(830)	-	-	(2,142)
At 31 March 2015	**-**	**13,477**	**1,717**	**46,310**	**31,264**	**-**	**-**	**92,768**
Carrying value								
At 31 March 2015	**28,050**	**120,455**	**1,457**	**32,728**	**8,824**	**694,341**	**34,520**	**920,375**
At 31 March 2014	28,050	111,446	970	29,350	3,893	710,285	43,597	927,591
Asset financing								
Owned	**28,050**	**120,455**	**1,457**	**32,728**	**8,824**	**694,341**	**34,520**	**920,375**

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.

Reclassification of assets
During the year an amount of £5,961,000 was transferred to intangible assets in respect of assets under construction (AUC) relating to intangible assets. In previous years, all AUC have been classified as property, plant and equipment.

Notes to the financial statements Continued

	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

8 INTANGIBLE ASSETS

Cost or valuation	Software £000	Website £000	Assets under construction (AUC) £000	Total £000
At 1 April 2014	20,265	2,359	-	22,624
Additions	-	-	5,136	5,136
Reclassification of assets	-	-	5,961	5,961
Transfer from AUC	5,546	415	(5,961)	-
Impairment	(73)	-	-	(73)
De-recognition	(2,346)	-	-	(2,346)
At 31 March 2015	**23,392**	**2,774**	**5,136**	**31,302**
Amortisation				
At 1 April 2014	14,076	2,137	-	16,213
Charge for year	3,774	307	-	4,081
De-recognition	(2,318)	-	-	(2,318)
At 31 March 2015	**15,532**	**2,444**	**-**	**17,976**
Carrying value				
At 31 March 2015	7,860	330	5,136	13,326
At 31 March 2014	6,189	222	-	6,411
Asset financing				
Owned	7,860	330	5,136	13,326

Reclassification of assets

During the year an amount of £5,961,000 was transferred to intangible assets in respect of assets under construction relating to intangible assets. In previous years, all AUC have been classified as property, plant and equipment.

Cost or valuation	Software £000	Website £000	Total £000
At 1 April 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
Reclassification of assets	-	-	-
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

Notes to the financial statements Continued

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.

During the year to 31 March 2014, PHE received Euro income equivalent to £7,309,000 (2014: £4,010,000) and US Dollar income equivalent to £4,834,000 (2014: £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 £311,000 (2014: £254,000) and a US Dollar bank balance valued at £253,000 (2014: £384,000). PHE operates Euro and US Dollar bank accounts to handle transactions denominated in those currencies. This helps to manage potential exchanger rate fluctuations.

10 IMPAIRMENT

	2014/15			2013/14		
	Charged to statement of comprehensive net expenditure	Charged to revaluation reserve	Total	Charged to statement of comprehensive net expenditure	Charged to revaluation reserve	Total
	£000	£000	£000	£000	£000	£000
Revaluation reserve	-	-	-	1,008	(1,008)	-
Intangible assets	73	-	73	-	-	-
Total	**73**	**-**	**73**	**1,008**	**(1,008)**	**-**

11 INVENTORIES

	Pandeminc Flu and Pre Pandemic Flu	Emergency Preparedness	Vaccines	Drugs	Consumables	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2014	-	-	123,443	3,127	5,149	131,719
Additions	-	-	339,802	1,687	7,511	349,000
Transfer from stockpiled goods	12	428	-	-	-	440
Consumed/Disposed of	(12)	(428)	(318,156)	(3,127)	(6,025)	(327,748)
Written Down	-	-	(10,084)	-	-	(10,084)
Revaluation	-	-	-	-	7	7
Balance at 31 March 2015	**-**	**-**	**135,005**	**1,687**	**6,642**	**143,334**

	Emergency Preparedness	Vaccines	Drugs	Consumables	Total
	£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**
Other	-	-	-	-	**-**
Balance at 31 March 2014	**-**	**123,443**	**3,127**	**5,149**	**131,719**

Notes to the financial statements Continued

12 TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2014/15 £000	2013/14 £000
Amounts falling due within one year		
Accrued income	15,355	13,479
Other receivables	18,121	13,576
Prepayments	3,886	5,625
Taxation	5,291	1,126
Trade receivables	15,251	10,357
	57,904	**44,163**
Amounts falling due after more than one year		
Advances to United Kingdom Atomic Energy Authority combined pensions scheme	123	71
Leasehold premium prepayment	21	21
	144	**92**

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

	2014/15 £000	2013/14 £000
Balances with other central government bodies	5,422	3,635
Balances with local authorities	-	991
Balances with NHS bodies	8,087	8,175
Balances with the Department of Health	5,967	5,938
Balances with public corporations and trading funds	-	211
Balances with bodies external to government	38,572	25,305
Total	**58,048**	**44,255**

In the 2014/15 year PHE agreed with the North Bristol Trust (NBT) to pay £5.1m for a laboratory for PHE's use within a new building being constructed by NBT. Following discussions with NBT and the Department of Health (DH), the method of payment was agreed in March 2015. PHE surrendered £5.1m of its 2014/15 capital grant-in-aid allocation back to the DH. The DH then awarded additional funding (public dividend capital) to the NHS, specifically to NBT. This payment method means that no accounting entries have been reflected in PHE's books and therefore PHE has not reflected the asset in its Statement of Financial Position (SOFP). PHE has agreed with NBT a 25-year right of occupation of the laboratory. If the asset were to be reflected in PHE's SOFP it would be regarded as a prepayment for lease rental rather than as a building asset. The prepayment would be charged to the Statement of Comprehensive Net Expenditure over the 25-year period, starting in 2015/16.

Investments

PHE inherited a 1% interest in Proacta from the Health Protection Agency (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. During the year, the operations of Proacta were ceased. PHE received no cash consideration in respect of its share-holding which has now lapsed.

PHE also inherited a 3.1% interest in Spectrum from the 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.

13 CASH AND CASH EQUIVALENTS

	2014/15 £000	2013/14 £000
Balance at 1 April	129,430	-
Net change in cash and cash equivalents	30,244	129,430
Balance at 31 March	**159,674**	**129,430**
The following balances at 31 March were held at:		
Government Banking Service	156,633	128,307
Commercial banks and cash in hand	3,041	1,123
Balance at 31 March	**159,674**	**129,430**

14 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

	2014/15 £000	2013/14 £000
Amounts falling due within one year		
Accruals	123,607	75,966
Deferred income	13,089	13,169
EU grant income held on behalf of third parties	353	780
Other payables	6,630	7,549
Other taxation and social security	-	937
Trade payables	15,058	24,907
	158,737	**123,308**

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

	2014/15 £000	2013/14 £000
Balances with other central government bodies	1,154	1,018
Balances with local authorities	-	1,992
Balances with NHS bodies	14,284	24,836
Balances with the Department of Health	4,230	6,795
Balancs with public corporations and trading funds	-	191
Balances with bodies external to government	139,069	88,476
Total	**158,737**	**123,308**

Notes to the financial statements Continued

15 PROVISIONS

	Future costs of early retirement	Leasehold dilapidations	High activity sealed radiation sources	Overseas tax	Redundancy	Contractual entitlement claims	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2014	1,171	1,573	419	109	-	6,047	9,319
Provided in the year	-	422	44	67	1,247	9,000	10,780
Provisions not required written back	-	(27)	(53)	-	-	(39)	(119)
Provisions utilised in the year	(99)	(30)	-	(39)	-	(313)	(481)
Balance at 31 March 2015	**1,072**	**1,938**	**410**	**137**	**1,247**	**14,695**	**19,499**
Analysis of timing of discounted cashflows							
Not later than one year	99	948	-	137	1,247	14,695	17,126
Late than one year and not later than five years	396	888	236	-	-	-	1,520
Later than five years	577	102	174	-	-	-	853
Balance at 31 March 2015	**1,072**	**1,938**	**410**	**137**	**1,247**	**14,695**	**19,499**

Future costs of early retirement

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 in respect of several claims by employees regarding the transfer of pension rights into the Civil Service pension scheme for a number of staff transferring from sender functions for which the Government Actuary's Department is currently finalising an estimate.

Redundancy

This is a provision for staff who are anticipated to leave the employment of PHE under the 'Securing our Future' voluntary exit scheme.

	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 2014	-	-	-	-	-	-	-
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)**
Borrowing costs (unwinding of discount)	-	-	-	-	-	-	**-**
Balance at 31 March 2015	**-**	**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**

16 CAPITAL COMMITMENTS

	2014/15 £000	2013/14 £000
Contracted capital commitments at 31 March not otherwise included in these accounts		
Property, plant and equipment	15,105	29,892
Intangible assets	1,364	246
	16,469	**30,138**

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

17 COMMITMENTS UNDER LEASES

Obligations under operating leases for the following periods comprise:

	2014/15				2013/14			
	Land £000	**Buildings £000**	**Other £000**	**Total £000**	Land £000	Buildings £000	Other £000	Total £000
Not later than one year	-	4,635	291	4,926	-	6,254	126	6,380
Later than one year and not later than five years	-	10,257	229	10,486	-	12,612	93	12,705
Later than five years	-	2,240		2,240	-	2,562	-	2,562
	-	**17,132**	**520**	**17,652**	**-**	**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 those with commercial suppliers for laboratory equipment leased 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:

	2014/15 £000	2013/14 £000
Not later than one year	369,498	342,164
Later than one year and not later than five years	322,191	211,670
Present value of obligations	**691,689**	**553,834**

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

Notes to the financial statements Continued

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 £40m. 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

	2014/15		2013/14	
	Number	£000	Number	£000
Monetary losses	4	7	8	15
Loss of accountable stores	1	5	-	-
Fruitless payment	1	22	-	-
Constructive loss	4	62,571	7	87,299
Claims waived or abandoned	4	30	2	10
Total	**14**	**62,635**	**15**	**87,324**

Details of cases over £300,000

Constructive losses

Vaccines and counter-measures

PHE wrote-off £62,498,000 in relation to countermeasures held for pandemic flu preparedness that have now passed their shelf life. These write offs are a planned consequence of the preparedness strategy that involves central stockpiling.

20(b) - Special payments

	2014/15		2013/14	
	Number	£000	Number	£000
Compensation	9	1	4	10
Ex gratia	3	9		
Total	**12**	**10**	**4**	**10**

There were no cases over £300,000.

Notes to the financial statements Continued

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.

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	141 (89)	517 (478)	20 (19)	18 (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	417 (723)	(5) (66)	1 (31)	51 (-)
UK Health Forum	Paul Lincoln	Associate non-executive PHE Board member/Chief Executive	- (-)	457 (451)	- (-)	- (-)
London Borough of Wandsworth	Paul Lincoln	Associate non-executive PHE Board member/Partner of Director of Public Health	1 (24,738)	25,431 (-)	- (-)	- (-)
London Borough of Kensington and Chelsea	Derek Myers	Non-executive PHE Board member and Audit and Risk Chair/Pension beneficiary	- (20,636)	21,214 (-)	- (-)	- (-)
Royal College of Physicians	Derek Myers	Non-executive PHE Board member and Audit and Risk Chair/Honorary member	- (-)	103 (-)	- (-)	- (-)

Comparative figures shown in brackets

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.

	2014/15 £000	2013/14 £000
Buildings	2,149	2,149
Plant and equipment	1,919	1,919
Total	**4,068**	**4,068**

23 EVENTS AFTER THE REPORTING PERIOD DATE

In accordance with the requirements of IAS 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.

With effect from 1 April 2015, the functions of PHE's development and production department located at Porton Down, transferred to a new organisation called Porton Biopharma Ltd. Porton Biopharma Ltd is 100% owned by the Secretary of State for Health. The effect on PHE's financial statements is as follows:

	PHE closing balance as at 31 March 2015	To be transferred to Porton Biopharma Ltd.	PHE opening balance as at 1 April 2015
	£000	£000	£000
Non current assets:			
Property, plant and equipment	920,375	(19,953)	900,422
Intangible assets	13,326	(1,736)	11,590
Other non-current assets	144	-	144
Total non current assets	**933,845**	**(21,689)**	**912,156**
Current assets:			
Trade and other receivables	57,904	(731)	57,173
Inventories	143,334	(3,657)	139,677
Cash and cash equivalents	159,674	(2,500)	157,174
Total current assets	**360,912**	**(6,888)**	**354,024**
Total assets	**1,294,757**	**(28,577)**	**1,266,180**
Current liabilities			
Trade and other payables	(158,737)	92	(158,645)
Provisions	(17,126)	-	(17,126)
Total current liabilities	**(175,863)**	**92**	**(175,771)**
Non current assets plus net current assets	**1,118,894**	**(28,485)**	**1,090,409**
Non current liabilities			
Provisions	(2,373)	-	(2,373)
Total non current liabilities	**(2,373)**	**-**	**(2,373)**
Assets less liabilities	**1,116,521**	**(28,485)**	**1,088,036**
Taxpayer's equity			
General fund	1,078,828	(28,305)	1,050,523
Revaluation reserve	37,693	(180)	37,513
Total taxpayer's equity	**1,116,521**	**(28,485)**	**1,088,036**

The funding contribution in 2014/15 from the pharmaceutical manufacturing activity transferred to Porton Biopharma Ltd. (PBL) was £14.9m (derived from income of £43.7m and expenditure of £28.8m). This contribution will be replaced by an annual dividend from PBL. The dividend will be paid from profits generated by PBL.

The Accounting Officer authorised these financial statements for issue on 8 July 2015.

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