Public Health England

Protecting and improving the nation's health

Annual Report and Accounts 2015/16

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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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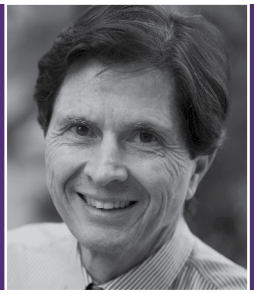


Chair's report

Professor
David L Heymann CBE

Now in its fourth year, PHE is in a position to look back and reflect on our progress to date, and see where we need to push harder, delve deeper or take further action.

Each month, the Board has invited a panel discussion on one of our strategic objectives or priority areas, involving both PHE directors and external experts from around the country. Following this, we have made a 'watch list' of areas that we want to improve, and this list is reviewed again every six months to see how our comments have been useful or effective. It has been a joy to hear of our many achievements, but a useful reminder of how much more there is to do.

We have also been working closely with the Chief Executive and his team to help make sure our guidance to the public remains independent and without bias. This forms part of PHE's commitment to improving the public's health through the provision of credible, evidence-based advice.

It is always rewarding to see this evidence translated into action. A great example of this is the launch of the National Diabetes Prevention Programme – the first of its kind in the world. The programme falls under the work of the new NHS Prevention Board, chaired by our Chief Executive, and can help us strengthen our position as a key partner for local authorities and the NHS in improving health and return on investment. It also demonstrates the importance of using local knowledge and experience to address national issues.

Our independent evidence reviews have also influenced and stimulated national policymaking to improve population health. For example, our world-leading evidence review of the best ways to reduce excessive sugar consumption in England has underpinned the government's recent decision to introduce a levy on sugary drinks – one of our recommended measures to support healthier eating. And our expert review of the evidence on electronic cigarettes has influenced debate worldwide; we welcome the recent Tobacco Products Directive that will ensure e-cigarettes are regulated and safe to use as the country's most popular tool to quit smoking.

As well as reviewing existing evidence, we are tasked with providing new information on diseases and environmental hazards that continue to threaten us at home and abroad. During the year we formed the National Infection Service, bringing together our epidemiologists, biological scientists, microbiologists and support staff to further develop how we work together to protect the public from infectious diseases.

Following a significant contribution to the global response to the Ebola outbreak in West Africa, PHE continues to support Sierra Leone's transition to a post-Ebola era by strengthening the country's public health system for the longer term, improving emergency preparedness and resilience and training local laboratory staff. And we remain vigilant against new threats – carefully monitoring the evolving Zika virus outbreak in South and Central America and the Caribbean and issuing regular updated advice for those at risk.

Our ability to remain ready to respond to emerging health threats is reliant on continued investment in public health science, and earlier this year the Chancellor of the Exchequer agreed our proposals to build a new state-of-the-art science research facility. Our new Science Hub at Harlow will include PHE's headquarters and bring together world-renowned scientists working to protect and improve the health of the nation.

Finally, at the heart of the new public health system is local government, focusing on people and place, with the ability to influence the determinants of good health as they – and not others – determine them. We will continue in our unrelenting support to them as best we can and especially through sharing expertise on return on investment and 'what works'.

Chief Executive's review

Duncan Selbie

As I look back over the three years since the establishment of Public Health England and the start of a locally-led public health system, I am struck by how much there is to be proud of, but also by how much remains to be done. I was delighted when the public health minister, Jane Ellison MP, recently gave evidence to the Health Select Committee on how well PHE was performing in the new system, but we are far from complacent. As set out in the Health of the Nation section later on in this report, England has made real progress in life expectancy but we still need to tackle the huge gap caused by health inequalities. Life expectancy for a man born in the most affluent area of the country is more than nine years longer than for someone born in the most deprived. And a falling death rate is only part of the story. We may be living longer but we are spending more years in poor health.

The goal is to create the conditions where people can live healthy lives for as long as possible. The fact is, there has never been a better opportunity to improve the public's health in this country because everything that is necessary is in place. The essential structures have been established, making the critical connection between people's health and the places where they live and work.

Local authorities are showing that they are best placed to improve the health of local people. They understand the determinants of good health in their communities and they appreciate the need to work with the NHS locally, maximising value out of every pound available to the system. The traditional divide between healthcare and other statutory and voluntary local services will increasingly dissolve and local organisations are already finding new ways to work together to provide services that are integrated around people and place.

As a country, we have recognised the need to get serious about prevention. The NHS is stepping up to the plate with the *NHS Five Year Forward View* which welds prevention and treatment together like never before and gives us the opportunity to shift the balance from one to the other. We now have planning guidance for the NHS, jointly issued, with prevention at its heart. Four out of five of the 44 sustainability and transformation plan areas emphasised that their number one priority is prevention. Working together with NHS England and NHS Improvement, we have provided them with a menu of interventions, setting out what they could do and what impact they could expect to see. And there is also significant national action including the government's legislation on standardised packaging for tobacco and on childhood obesity through the levy on sugary drinks announced in the 2016 Budget and Queen's Speech. National policy changes such as these will benefit a generation of children not yet born.

In many areas we are seeing evidence that public health delivers but we are always vigilant in addressing those indicators which are going in the wrong direction. We are particularly concerned about the rise in sexually transmitted infections and in the coming year we will be focusing on how we use digital platforms to reach 15 to 24 year olds to raise awareness of the risks of infection and to promote condom use.

Permeating all that we do is a commitment to speak to the evidence and our professional judgement. The past year had its moments of controversy but, whether it is the analysis we offered government on the most effective measures for reducing sugar consumption to inform the forthcoming childhood obesity strategy, or the advice we gave consumers on e-cigarettes, we have consistently demonstrated our freedom to do so.

We recently published our strategic plan for the next four years: *Better Outcomes by 2020*. This builds on our publication *From Evidence into Action*, the *NHS Five Year Forward View* and the Department of Health's *Shared Delivery Plan 2015 to 2020*. Our plan describes our place within the public health system, sets out our vision for success, identifies the opportunities that we can harness now to deliver change over the longer term, highlights some of our recent achievements and sets out our future objectives.

From the time of our establishment in 2013, I had two early ambitions for how PHE's wider progress should be measured, both of which have been met. First, that local government got off to a good start and the Public Accounts Committee agreed that they have and were commending of our part in that. And second, the Chancellor announced in the autumn an investment of over £400m in a new Science Hub, which will provide world-class public health laboratories at Harlow, Essex, relocating existing facilities from Porton and Colindale into one integrated campus.

Looking ahead, I have three overarching ambitions. The first is to win the argument in the next Spending Review on the need to acknowledge and invest in prevention. This is not a question of who does what – it is about how the country as a whole benefits, creating a movement between national and local government, the NHS, industry and civil society to make this happen. Secondly, to accelerate our work in supporting local government in their duty to improve the health of the people, particularly in light of the move to funding through business rates retention from 2018. And thirdly, the positive decision on Harlow was only ever the end of the beginning – we need to bring our people, both present and future, with us as we embark on a long-term major change programme, which will take years of careful and inclusive work.

Finally, I would like to stress that our first and foremost duty is to protect the nation's health. Infectious diseases know no borders and nor do we in fighting them: this means we must remain international in our outlook. The recent EU referendum result is a major event for the UK but does nothing to alter our professional relationships and collaborative work with colleagues from the EU and we will do everything necessary to show our support for them as we navigate the coming months and years.

Some of our achievements

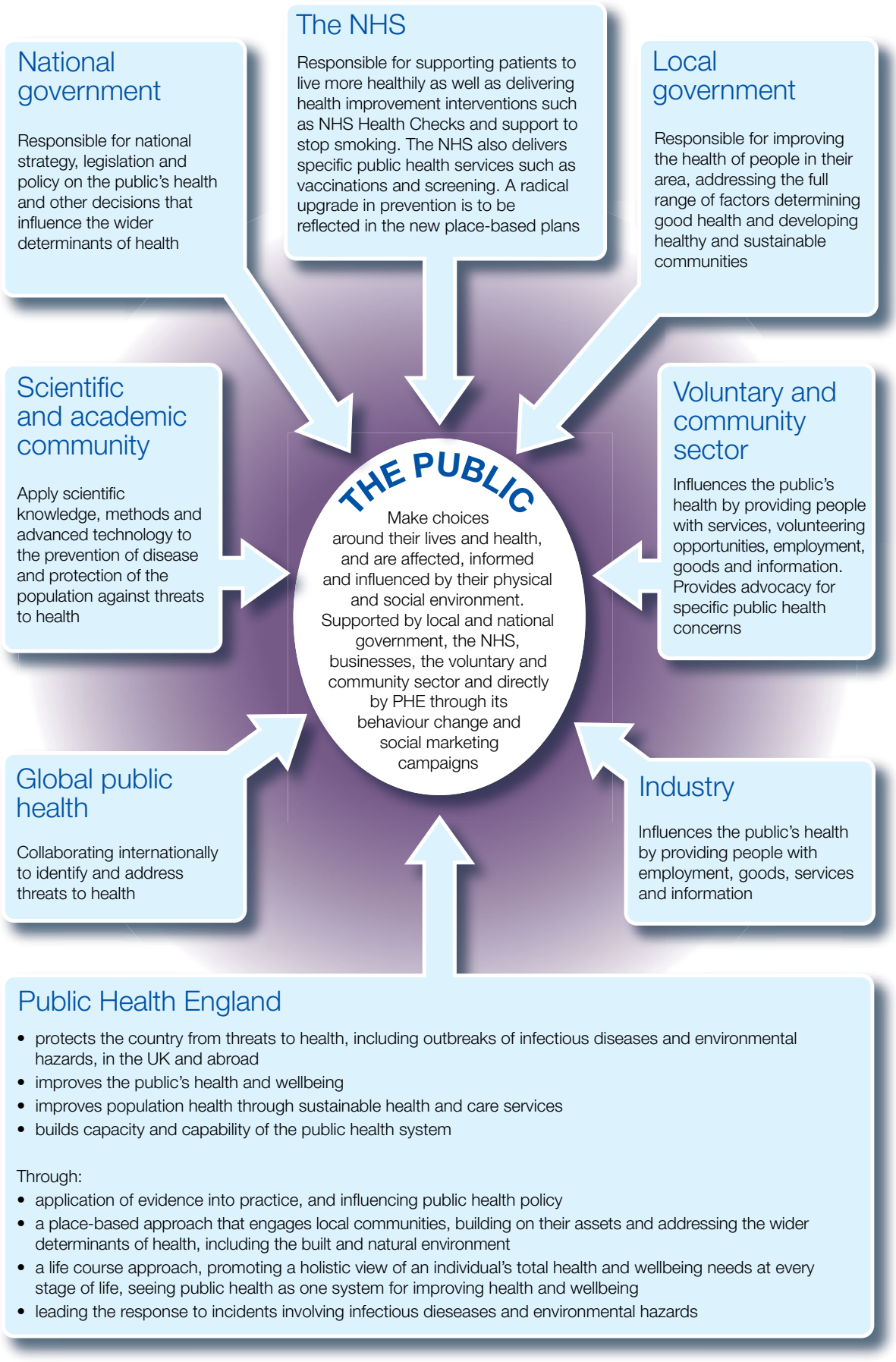
We continue to be at the forefront of public health locally, nationally and globally. As this brief summary of some of our achievements shows, through the skill and commitment of our staff and with the support of our partners, we have continued to reach millions of people directly to help them to make healthier choices; kept people safe by delivering effective emergency preparedness, resilience and response; established world leading new screening and vaccination programmes; and published robust evidence that has influenced the public health debate across the world.

This has been achieved by working across the health and care system and across government to promulgate the importance of prevention, while reconfiguring ourselves to ensure that we can meet the needs of our customers and deliver best value for the taxpayer. We have:

- made a significant contribution to the world's response to the West Africa **Ebola outbreak**, while keeping people safe in the UK; we successfully screened more than 14,000 passengers arriving from West Africa at the UK's main ports of entry
- published a world leading evidence review of how best to **reduce the nation's excessive sugar consumption**, which has underpinned the upcoming national childhood obesity strategy and the government's recent decision to introduce a levy on sugary drinks
- developed a **sugar smart app** which has been downloaded by over 2 million people to see how much sugar is in their everyday food and drink so that they can take action to reduce consumption
- launched **One You**, our innovative adult health behaviour change campaign, which generated over 1 million responses in the first two weeks
- held the most successful **Stoptober** yet, resulting in 16% of all smokers reporting an attempt to quit in October
- published an expert independent **evidence review on e-cigarettes** which has influenced the debate worldwide
- developed guidance and resources to support **smoke free mental health units**
- published analysis of the incredibly rich **Global Burden of Disease** data at a sub-national level. This is a world first and allows us and our partners to understand and action the data by English region
- for the first time, made available in one place a suite of healthy behaviour dementia risk indicators through the **Dementia Intelligence Network**
- developed our disease registration capability to make **cancer registration** data available quicker than ever before
- launched the new **data capture system** to enable the mandatory surveillance of healthcare-associated infections
- completed research funded by more than £20 million in external income, publishing almost **1,000 peer-reviewed papers** and contributing to the evidence base for improved public health
- established a new **knowledge management platform**, facilitating access to the evidence base for those working in public health through comprehensive, systematic searching of relevant literature
- established an innovation fund for new ways to tackle HIV as well as establishing the first national home sampling service, which issued 12,000 **HIV home test kits**
- supported the formulation, testing and batch release of the live attenuated **influenza vaccine** to the UK and world markets
- played a key role in the successful Phase III clinical trial to evaluate the efficacy and safety of the first **Ebola vaccine**
- conducted a Phase I trial of antibody therapy against ***Clostridium difficile*** infection and lead dosing of volunteers completed

- evaluated the impact of the national introduction of **pertussis vaccination** in pregnancy on the immune response of UK infants to their primary vaccination
- established world leading new vaccination programmes including introducing the first infant **meningitis B vaccination** programme anywhere in the world, with 94% coverage for the first dose, and implementing the **meningitis ACWY vaccination** programme for adolescents
- worked with NHS England to extend **childhood flu vaccination** to all children in school years 1 and 2 in addition to children aged 2 to 4
- commissioned the **UK National Poisons Information Service** that directly contributes to the treatment of poisoned patients presenting to NHS 111, GPs and hospitals
- provided a dedicated **radon website**, www.ukradon.org, that received over 350,000 separate visits in 2015 allowing people to understand more about the health risks, which areas are affected by radon and the measurement services that are available
- developed and implemented the **pulse oximetry pilot**, screening over 32,000 newborn babies for critical congenital heart disease, allowing those at risk to be referred early for assessment and, in some cases, life-saving surgery
- supported a **fall in tuberculosis cases**, with the most recent data showing a decline for the fourth year in a row
- contributed to the ***NHS Five Year Forward View*** independent reviews of mental health, cancer and maternal care
- established the NHS Prevention Board and, working alongside NHS England and Diabetes UK, launched the world's first **National Diabetes Prevention Programme**
- developed a surveillance strategy for **non-communicable disease**
- established a long term **'air pollution and health' work programme** to support local and national government, to raise awareness and to build and communicate the evidence base
- opened field offices in **Pakistan** and **Sierra Leone** to support long-term public health capacity building
- supported the successful transfer of commissioning of **public health services for 0 to 5-year-olds** from the NHS to local authorities
- collaborated to improve and deliver the Leadership for Change and Local Vision **systems leadership programmes** to identify and develop future directors of public health
- hosted and supported the **What Works Centre for Wellbeing** as it transitioned to an independent charity. The centre has now developed four initial evidence programmes
- aligned our **local centres** around local government regions, increasing the effectiveness of our local engagement
- published the PHE's **People Charter** after extensive engagement with our staff because we believe that our values and the way we behave will have a significant impact on the delivery of our objectives
- continued to **rationalise our estate**, reducing our like-for-like holding from 116 buildings to 74, making significant savings for the taxpayer and improving the quality of our estate
- achieved the **fourth highest score**, for any public body Ipsos MORI has studied in the last decade, for how positively our stakeholders speak about us in our **2016 stakeholder survey**
- published the **One Health report** on human and animal antibiotic use, sales and resistance
- formed the **National Infection Service**, bringing together our epidemiologists, biological scientists, microbiologists and support staff to further develop how we work together and continue to protect the public from infectious diseases
- compiled, for the first time, a comprehensive picture of the complexity, size and nature of the **public health workforce** in England together with People in UK Public Health, the Department of Health and the Centre for Workforce Intelligence
- delivered seminars to our **1,600 people managers** to develop their skills in driving great staff engagement, staff wellbeing and team leadership

The public health system and our place within it



Our role

We exist to protect and improve the public's health and wellbeing and reduce health inequalities. We do this through world-class science, advocacy, partnerships, knowledge and intelligence, and the delivery of specialist public health services.

We are the expert national public health agency that fulfils the Secretary of State for Health's statutory duty to protect health and address inequalities, and discharges his power to promote the health and wellbeing of the nation. The Minister for Public Health sets out the government's requirements of us in an annual remit letter and strategic priorities.

We have operational autonomy. Our freedoms and obligations are described in the Framework Agreement with the Department of Health, which makes clear that we are free to speak to the evidence and its professional judgement. We act globally and nationally, where we are uniquely placed to do so and support local priorities through our network of PHE centres.

We have a skilled and committed workforce who have already made a significant impact on the health and care system. We have worked to put prevention at the heart of the health and care system, enabling the NHS and public health system to better manage demand, improve efficiency and tackle funding pressures. We set out our priorities in *From evidence into action: opportunities to protect and improve the nation's health*, published alongside the *NHS Five Year Forward View*: addressing obesity, smoking and alcohol, ensuring a better start in life, reducing dementia risk and robustly tackling tuberculosis and antimicrobial resistance.

We also identified a number of game changers that offer unique opportunities for positive change and much faster progress on our public health priorities: place-based approaches led by local authorities; evidence on return on investment of public health interventions to support prioritisation and spending decisions; behaviour change, particularly the opportunity to exploit digital technology; the contribution of employers to improving the health and wellbeing of their staff; measures of 'wellness' to give a broader, person-centred view of health; and developing evidence-based NHS preventive programmes in partnership with NHS England and NHS Improvement.

Our resources - 2016/17

To deliver a broad range of products and services we employ 5,522 staff:

2,272
Protection from infectious diseases
National centres, regional network and capability to identify infectious disease, surveillance and management of outbreaks

486
Protection from environmental hazards and emergency preparedness
Including chemical, radiation and environmental hazards, emergency response

1,010
Local centres and regions
includes:
- health protection - 479
- screening and imms - 286
- health improvement and population healthcare - 245

316
Knowledge intelligence, digital and research
Enabling rigorous researched evaluation; translating data, research and experience into practical guidance for national and local decision making; and supporting the use of digital technologies

319
National disease registration
Including the world's largest cancer database

273
Screening programmes
Developing and quality assuring cancer and non-cancer screening programmes

10
Nursing
National and international public health nursing and midwifery, leadership and professional advice (including principal advisors to government). Giving children the 'Best Start in Life'

202
Health and wellbeing and strategy
National expertise in public health evidence-based interventions

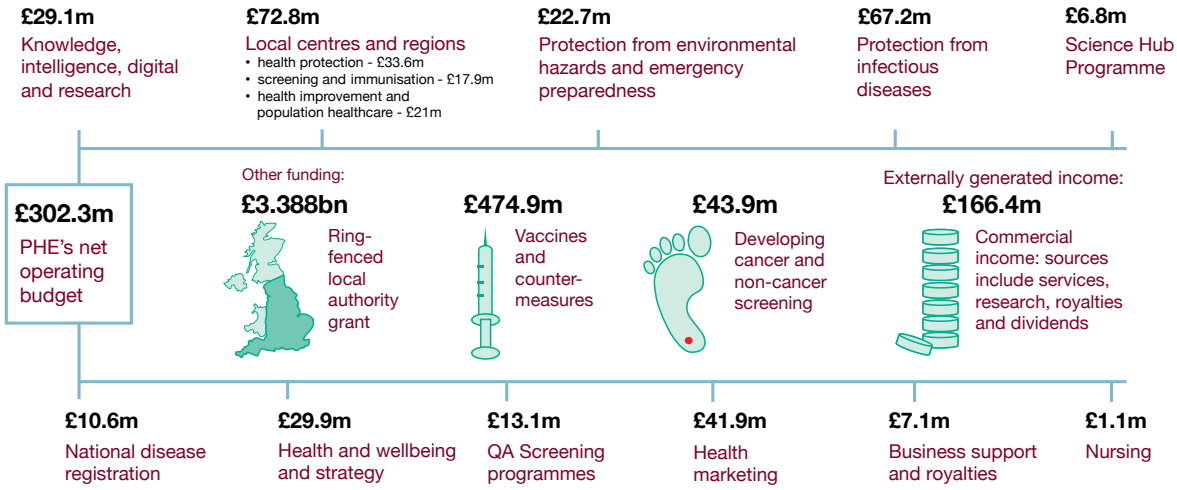
65
Health marketing
Delivering healthy behaviour change campaigns

37
Global health
Protecting the UK from emerging international threats, maintaining and developing relations with the WHO and other international and national public health agencies

With business support from:

162 Financial and commercial
121 Infrastructure (ICT and estates)
70 Communications
65 Corporate affairs
50 Human resources
35 Science Hub programme
29 Organisational development

Our revenue funding



Our national and local presence

PHE operates through nine centres in four regions:

North, South, Midlands and East, and London

PHE has 5,522 staff working from 74 locations

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

● **Harlow,** the location of the future PHE Science Hub, including our headquarters

● **PHE Chilton** includes the Centre for Radiation, Chemical and Environmental Hazards

● **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 Porton** includes departments for rare and imported pathogens, research, PHE Culture Collections and emergency preparedness, plus food, water and environmental services

Focus on:

E-cigarettes

Kevin Fenton, Director of Health and Wellbeing

"For me personally, but also for PHE as an organisation, it was a crucial moment. We saw that we can take some risks, based on the evidence and push the agenda forward."

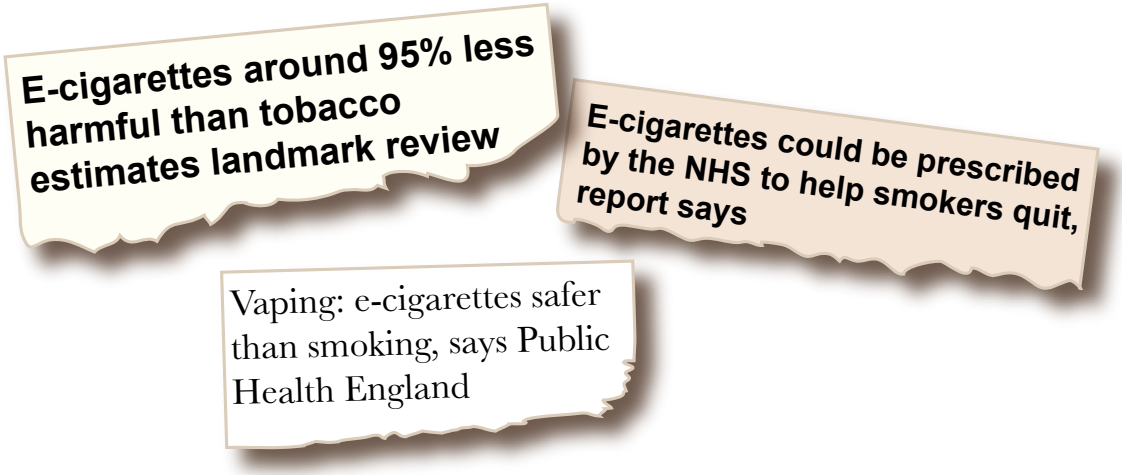
For Professor Kevin Fenton, Director of Health and Wellbeing, the publication of our evidence review on e-cigarettes marked a coming of age for PHE. "One of the roles of a national public health agency is to lead. Sometimes we need to be in those spaces where others aren't, even if it means opening ourselves up to controversy and criticism."

In 2015 we were the first national public health agency, anywhere in the world, to look systematically at the evidence on e-cigarettes as an approach to reducing harm for smokers and to make the pronouncement that e-cigarettes are significantly less harmful than smoking cigarettes.

This was the third peer-reviewed evidence review into e-cigarettes we had conducted and the findings were consistent and striking, indicating that e-cigarettes were in fact around 95% less harmful than normal cigarettes. As a consequence, we recommended that all smokers who are not ready to quit should be encouraged to reduce the harm to their health by switching to e-cigarettes. We also recommended that smoking cessation services should begin to welcome e-cigarettes as another tool to help smokers to quit.

It was a contentious decision. The report attracted headlines internationally. Some key public health figures disagreed vehemently with our conclusions, and editorials criticising the report came thick and fast. Our evidence was dismissed by some as 'flimsy' and some contributors to the report were accused of being 'industry-funded'.

The condemnation we faced was not confined to the UK. Perhaps this is not surprising since our report staked out a significantly different position from the received wisdom in North America. Canada's health agency has banned the import and sale of e-cigarettes and, in the US, the Food and Drug Administration has recently cracked down on e-cigarettes, ruling that their regulation should be in line with the existing rules for cigarettes.



Professor Fenton believes PHE's stance on e-cigarettes follows an honourable British tradition of focusing on realistic harm reduction rather than a purist fixation on the eradication of harm. He quotes *The New England Journal of Medicine*, which discussed the e-cigarette debate in the light of the different public health traditions in the UK and the US. In simple terms he says: "The Brits are historically much more open to reducing harm. For instance, our openness and leadership in promoting needle exchange and the use of condoms to reduce HIV transmission. We take the view that we also need to take care of those who are dealing with an addiction or unhealthy behaviours to reduce harm until they are ready to stop."

Despite the furore produced by the report, 12 prominent public health organisations, including Cancer Research UK and the British Lung Foundation, defended PHE's position. Their joint press release underscored a public health responsibility to encourage smokers to switch to e-cigarettes, often in conjunction with the help of local smoking-cessation programmes. Since then we have also had a consensus statement from all national public health agencies in England supporting our position, as well as reports from Royal College of Physicians of London stating that e-cigarettes are less harmful than smoking.

Professor Fenton believes that what's happened in the months following the publication of the report has been incredible. "We now have mental health institutions considering vaping policies, prisons are beginning to think through how they handle e-cigarettes and NHS trusts are changing their policies, looking at updating policies around vaping on hospital property. This is a health-promoting stance for smokers who are struggling to quit."

Before we published our guidance, there was no consensus on e-cigarettes and there was no clear advice to smokers. Yet in the UK we have already seen a market explosion in e-cigarettes with nearly 1.7 million people using them to try to stop smoking.

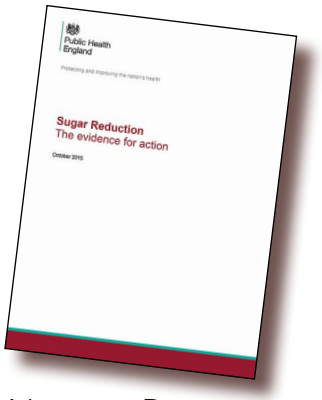
Professor Fenton is keen to stress that PHE is committed to ongoing research in this area, looking at the long-term impact and uptake of e-cigarettes, including toxicity, and, as new evidence evolves, we will continue to update our position. "But last August we looked at the available evidence and took the view that the public had the right to know that e-cigarettes carry a fraction of the health risk of smoking tobacco." In early July 2016, Ministers committed to commissioning PHE to update our evidence report annually until the end of the current Parliament and to include within our quit smoking campaigns consistent messaging about the safety of e-cigarettes.

Reflecting on how it felt to face the onslaught of criticism that followed publication of the report, Professor Fenton says: "When you put that crucible in the fire and you are standing in the blazing heat you think, My God will I get out of this alive? Then you take the crucible out and when it's cooled you realise you've changed." In Professor Fenton's view, both he himself and PHE as an organisation have emerged from the e-cigarettes debate braver and more self-confident, with an even stronger sense of purpose and conviction.

"Tough as it may have been, this is an example of PHE leading globally in a challenging area and being true to our values of looking at the evidence and making recommendations on that basis. Smoking is England's biggest killer. We can't have 80,000 people dying every year from smoking and not do the best to encourage all smokers to quit and help them to reduce harm to themselves and others."

Sugar

This year has marked a seminal moment in the nation's relationship with sugar and Professor Fenton is upbeat about the possibility of change. Nobody recognises the scale of the public health challenge presented by obesity better than he does. With two thirds of adults and a third of all 11-year-olds either obese or overweight, obesity is already responsible for an estimated 70,000 premature deaths a year in the UK. "But in public health", he says, "we play the long game" and the progress that has been made in the past year gives him reason for quiet optimism.



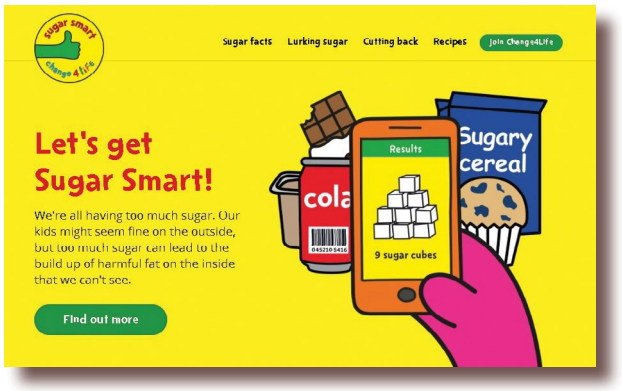
"The road to change is never linear and it is never to the timescale you'd expect. Duncan always says 'keep your eye on the prize'. Sometimes it's tough, but you have to keep moving forward."

The first milestone came last July when the government changed its dietary advice to the population about the maximum amount of sugar we consume each day. The Scientific Advisory Committee on Nutrition (SACN) published the first in-depth review in the UK in more than 20 years on the impact of carbohydrates, sugar and fibre on health outcomes. SACN recommended that the maximum recommended sugar intake should be halved, arguing that no more than 5% of our calorie intake should come from 'free sugars'. The previous recommendation was 10%. The new advice said that adults should consume no more than 30g (or seven teaspoons of added sugar a day) and that children should consume much less than that. The government accepted the committee's recommendations in full.

Then, in October, we published our analysis of research across the world, *Sugar Reduction: the evidence for action*, which considered the most effective actions that can be taken in the areas of marketing and advertising, reformulation and fiscal measures, among others, to reduce sugar consumption. It was clear that no one action on its own would be effective, so our advice to government suggested implementing a broad range of measures which, together, would be likely to work. Among those measures was a sugar levy on fizzy drinks.

Initially Number 10 ruled out a sugar tax but in the budget in March this year the Chancellor, George Osborne, announced he would impose a sugar levy on the soft drinks industry. The money raised from the levy will be used to boost funding for sport and exercise in schools. The health community and charities had campaigned vociferously for the levy but the most high-profile supporter was TV chef Jamie Oliver, who set up an e-petition that saw more than 150,000 people backing a tax.

Professor Fenton sees this as a “fabulous example of shared ownership”. PHE provided the evidence but, in his view, there are very few interventions where evidence alone changes public policy. “The beautiful thing about public health is that we love the big tent because when you have alignment between celebrity, industry, community, public health and politicians, that’s when you get change.”



“We all have seperate but complementary roles to play. Jamie Oliver brought passion to the table, a visibility and an ability to engage with consumers. We were able to engage with politicians, who ultimately are going to develop new policies, regulations and laws.”

The evidence from PHE’s sugar report was a major contributor to the government’s commitment to publishing a childhood obesity strategy. Already work has begun on a number of our recommended measures including reformulation and social marketing, while the Department of Culture, Media and Sport has started a consultation on the advertising of foods to children.

Meanwhile, we have developed a sugar smart app that has been downloaded by more than 2 million people to see how much sugar is in their everyday food and drink so they can take action to reduce consumption. PHE has also received global recognition in the digital community for the partnership with MySupermarket.com where online shoppers are automatically told how much sugar is in their weekly shop and how to reduce the sugar content in their basket.

Professor Fenton is hoping that the UK will be developing the most robust and far reaching childhood obesity strategy in the world.

“It cannot be right that one in three 11-year-olds is overweight or obese. Doing nothing will not reverse this. Three years ago we didn’t think we’d get plain packaging of cigarettes but we have. This year we didn’t think we’d get a sugar levy but it’s here and will be implemented in two years. It’s all about playing the long game and keeping your eye on the prize. Remember that sometimes the impossible is possible”.

Science – National Infection Service

Professor Derrick Crook doesn't sleep much these days. You get the impression he probably never has done, given a career that has taken in intensive care medicine in his native South Africa, tropical medicine in London, infectious diseases and bacterial molecular genetics in the US and clinical microbiology at Oxford. Today, as head of our National Infection Service, he's got a particular reason to burn the midnight oil. He's a man with a vision.

Derrick Crook, Director of the National Infection Service

"We are on the brink of a public health revolution and we are well placed to lead the way globally." Public health medicine, he asserts, was born here in England when Dr John Snow linked the Broad Street pump in Soho to more than 500 deaths from a cholera epidemic in 1854. "But the breakthrough that's coming next will be bigger still." Pausing to let this statement sink in, he justifies his claim with just one word. 'Data.'

In fact, Professor Crook points out, there are two digital revolutions going on simultaneously. The first is in genomics, where whole-genome sequencing is changing the way public health scientists and doctors investigate infectious disease. "It's already less and less about growing things and looking at them down a microscope and more and more about the maths behind the sequencing. The really geeky stuff. We did some truly fantastic work using genome sequencing to track down a pan-European salmonella outbreak to eggs in Bavaria. It's published and it's beautiful. We're getting enquiries from public health agencies around the world to share what we're doing."

The second part of the revolution is the impact that data, especially big data, will have on epidemiology. Using this technique, known as 'syndromic surveillance', our microbiologists were able to interrogate vast data sets to assess who was likely to suffer gastrointestinal infections following the severe flooding on the Somerset Levels in January 2014. "Combine the two," Professor Crook believes, "and you have a completely new base for much of the current practice in fighting communicable disease."

Professor Crook has been working for several years on translating the new molecular technologies and advances in informatics into the investigation of microbial transmission and the diagnosis of infectious disease. Genomic information, he explains, can be used to delve into the genealogy of germs. "Just as your family tree tells you who was born where, so we can use genomics to trace the lineage of germs. With TB, for example, you can track the transmission chain and identify which drugs a particular strain is resistant to and which drugs to use." PHE is already doing this. "We are leading the world in this," he claims, and, to prove the point, he shows an email he's received from the Canadians asking to use our system.

But he is far from complacent. This is a man who is impatient to use the new technologies to achieve much more. “Traditionally, it takes somewhere between 6 to 8 weeks to diagnose TB but at PHE we can currently do it in under 2 weeks. That may be world class, but it’s not good enough.” He won’t be satisfied until TB can be diagnosed on the same day. “Every day while people are waiting for a diagnosis they are out in the community potentially transmitting the disease to others. Some very resistant strains of TB have a 50% mortality rate. Think of the lives that can be saved if people are diagnosed immediately. The benefits are almost incalculable.”

For Professor Crook, our current use of data resembles the early days of mobile phone technology when people carried around a device that was as heavy as a brick and as limited as a landline. “What we’re working with at the moment is like a 1980s Motorola. We’ve got to look beyond that and have the vision to imagine the possibility of an iPhone 6. That’s incredibility difficult. It takes effort and courage but somehow we’ve got to reinvent the creativity and innovative flair that put the UK at the forefront of public health in the late 19th and early 20th centuries.”

The challenge, in part, is to transform the potential we know genomics holds from the closed experiments we have already undertaken and to turn that knowledge into a product that can work day in, day out, year after year. ‘Running a successful experiment is a closed thing. Making the technology work in an open-ended way is 1000 times more difficult. We all made assumptions about what we could do with genomics but we underestimated how hard it would be to turn it into a useful technology. ’

The international competition to transform this knowledge into practical tools to fight infectious disease is intense. ‘It’s like a greyhound race and the UK is ahead of the field but just by a nose.’ Holding that lead is not going to be easy and requires a new understanding of science. ‘The fact is, we need a nexus of skills. You have to take the science of the bugs, the science of disease, the science of epidemiology, the science of computers, the science of clinical evaluation and some deep maths to enable you to extract the information which will allow us to understand the bugs better and the diseases better.’

Professor Crook has a clear ambition: ‘We don’t just want to participate, we want to lead the digital revolution in public health’. He recognises the task ahead is a huge endeavour but clearly relishes the challenge. The scientific community at PHE, he suggests, are not so different from the intelligence services: ‘they can examine millions of mobile phone data and recover information that identifies a link between ten people within a country who may be involved in nefarious behaviour’. We may be tracking down germs rather than terrorists but Professor Crook is determined to see the day when staff at PHE are using similar techniques to protect the public. Of all the jobs he’s undertaken, in an eventful and illustrious career, this one, he admits, presents a challenge which is possibly the most taxing and the most formidable he’s ever faced.

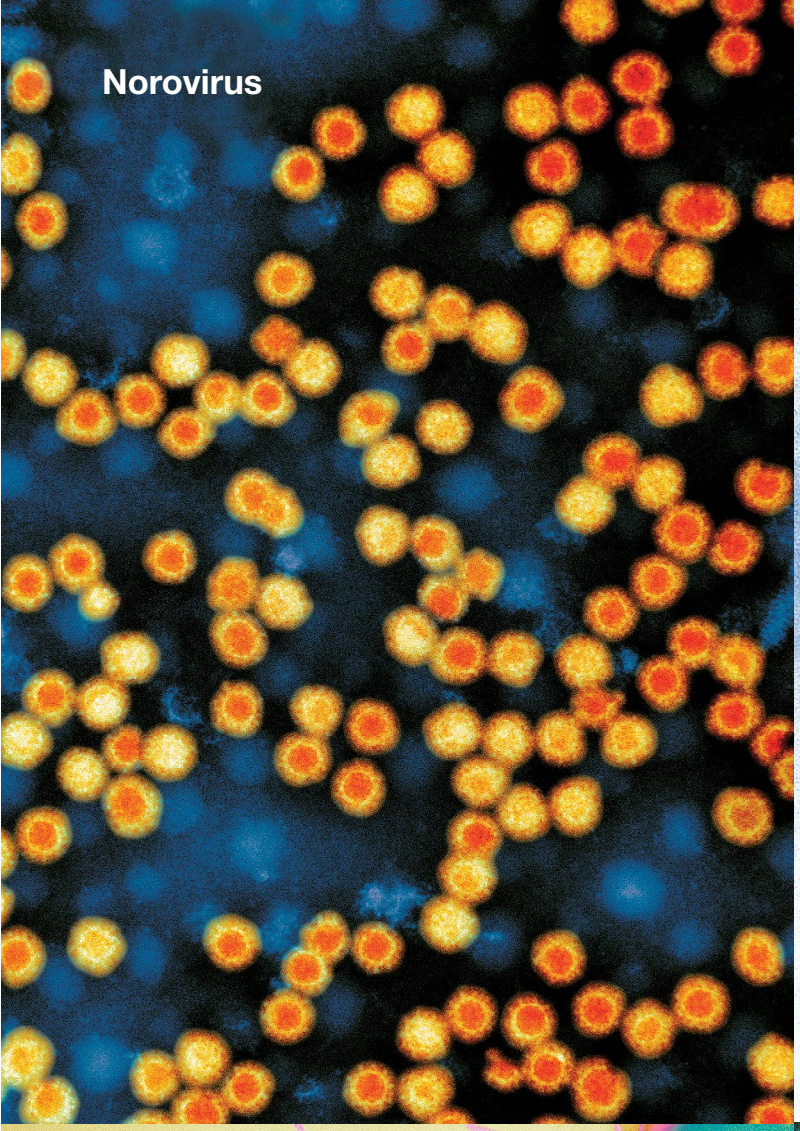
PHE Research

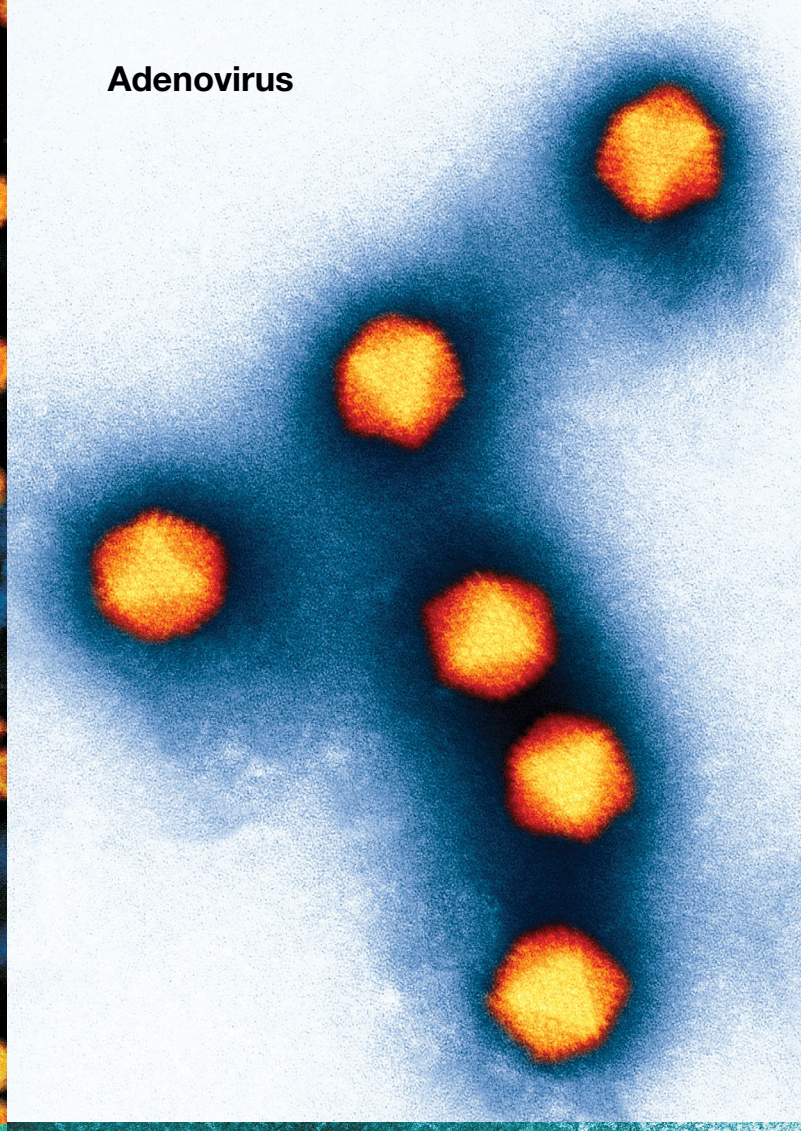
Each of our four core functions is underpinned by world-class scientific evidence drawn from laboratory and clinical sciences, behavioural and social sciences, data sciences and others.

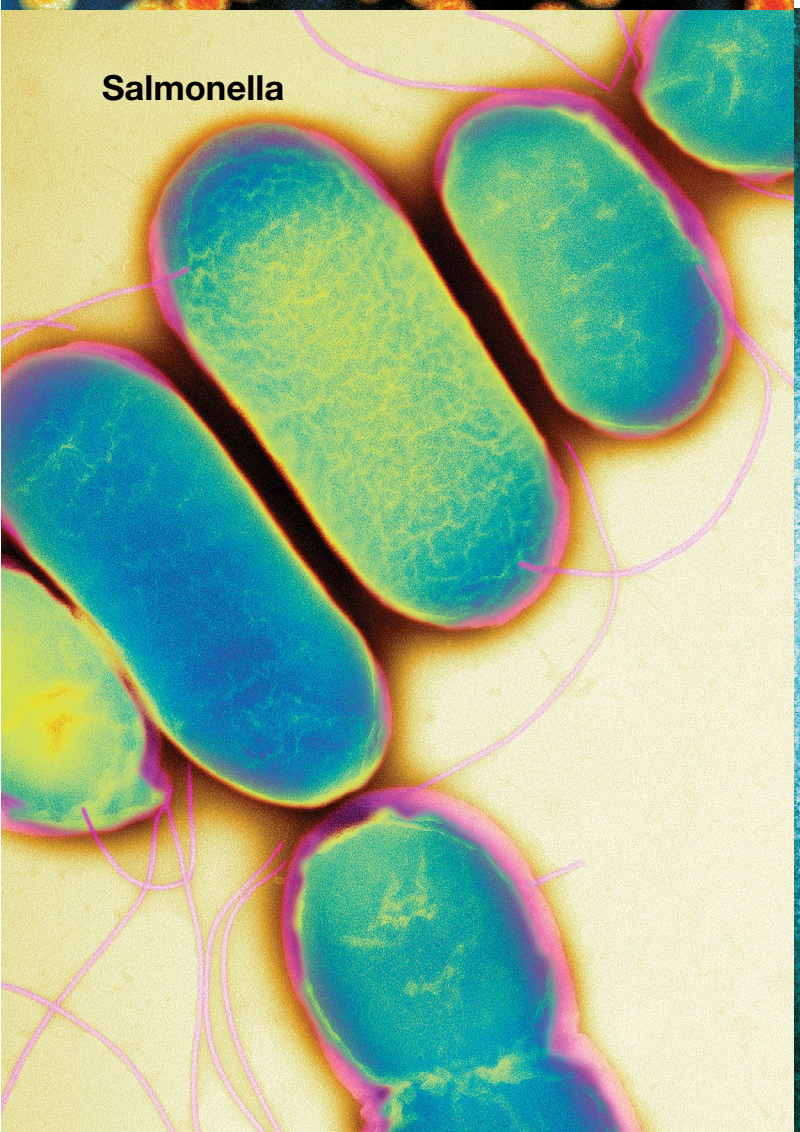
In January 2016, we published *PHE Research 2014 to 2015: annual review*, highlighting that 669 peer-reviewed articles featured in more than 200 different journal titles, reflecting the huge scope of our remit, and secured £22m of external funding. Most importantly, of course, this research made significant contributions to the evidence base for public health policy and practice.

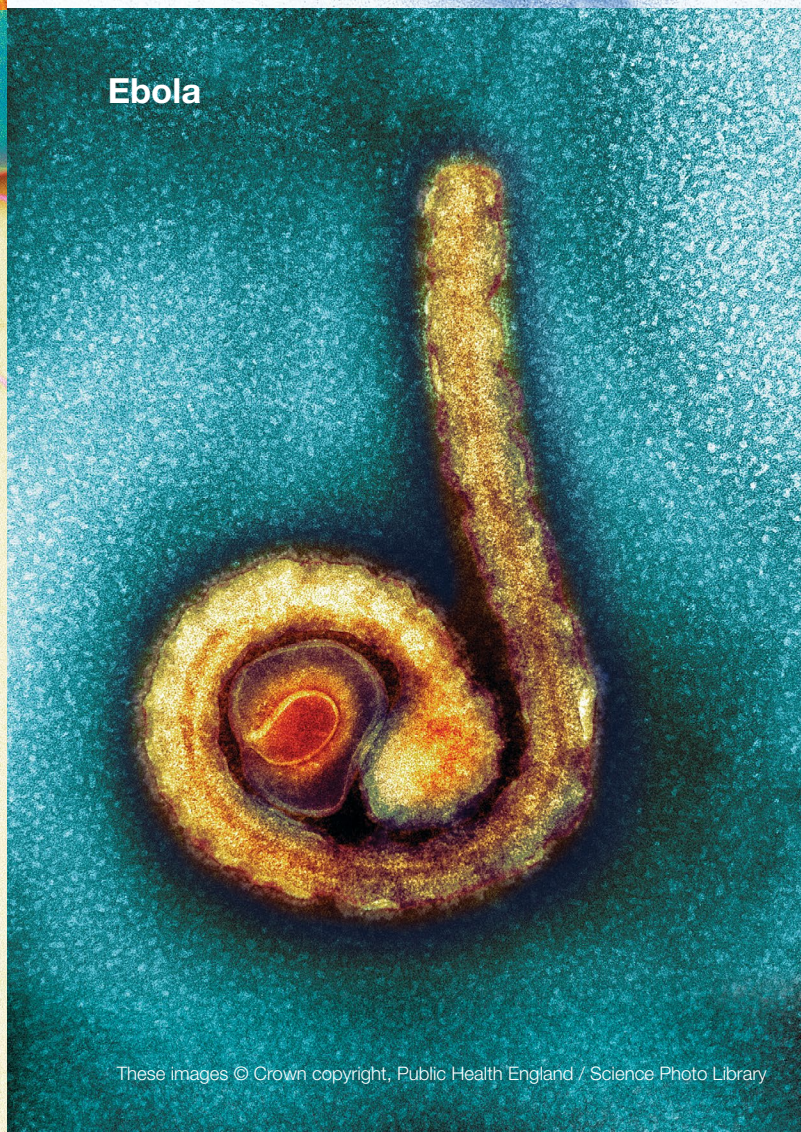
There are many examples of where our scientists have led the way. For example, they played a key role in an Ebola virus genetic fingerprinting study published this week in the journal *Nature*. Scientists deployed to West Africa as part of the European Mobile Laboratory (EMLab) and the WHO epidemiology team in Guinea used a cutting-edge miniature sequencing device to rapidly analyse diagnostic samples from patients suffering from Ebola virus disease. The data helped frontline epidemiologists to identify transmission chains. This was the first time the device had been used to provide real time sequencing information in a virus outbreak. The success of this study was achieved through effective collaboration between the EMLab, Birmingham University, WHO and the Oxford-based company that supplied the device.

Our scientists have prepared two case studies for this report to illustrate the depth and breadth of our research activity and how this translates into practice on the NHS frontline.









Investigating the source of infections associated with open-heart surgery

When we consider problems with waterborne opportunistic pathogens in hospitals we generally think of *Legionella pneumophila* or *Pseudomonas aeruginosa*, organisms that are well known to hospital water safety groups. However, following recent alerts in Switzerland and the Netherlands, experts from our National Infection Service were mobilised to assess a new threat to patients involving a slow growing non tuberculous mycobacterium known as *Mycobacterium chimaera*. The alerts had identified an unusual association between a specific brand of heater-cooler unit (HCU), used by perfusionists to control patients' body temperature during open-heart surgery, and *M. chimaera* infections arising months or years after surgery.

Having established that the implicated HCUs were being used in UK hospitals, an Incident Management Team was rapidly formed in 2015 including colleagues from MHRA, DH, representatives from the devolved administrations, NHS hospitals and a number of professional cardiac and perfusionist groups. As a recently identified species, tests were not available in the UK to distinguish *M. chimaera* from other members of the *M. avium* complex so development and evaluation of such tests was started immediately by the National Mycobacteriology Reference Laboratory. In the meantime, a number of parallel investigations were launched. A nationwide retrospective case finding exercise was initiated by staff at PHE Colindale by linking laboratory data to hospital admissions to identify patients with *M. avium* complex infections who had undergone cardiopulmonary bypass-operations in the four years before diagnosis in any hospital in England. Colleagues at PHE Porton investigated the presence of *M. chimaera* and the potential for release of microbial aerosols from HCUs in situ as well as under controlled laboratory conditions (see photo).

Within a matter of weeks, we had identified probable cases of *M. chimaera* infection from cardiac centres across the country. Archived clinical isolates were retested with the new diagnostic techniques developed and confirmed as being *M. chimaera*. Water and air samples taken from HCUs in theatre identified the presence of *M. chimaera* and other potential respiratory pathogens of concern, including *Legionella* raising concerns for the safety of theatre staff. As a result, the HSE also became involved. Laboratory investigations at PHE Porton on a decommissioned HCU identified for the first time the release of aerosols containing *M. chimaera* from specific breaches in water tanks. However, despite the identification of a mechanism for transmission in theatre and the widespread contamination of these machines, the long interval between the samples being taken and patients' infections developing meant that evidence of a causal link between the HCUs and patient infections remained tenuous.

To date, 18 probable cases of cardiopulmonary bypass-associated *M. chimaera* infection have been identified, all of whom had undergone valve replacement between 2007 and 2015 in 11 different cardiothoracic centres. Interestingly, and reflecting the slow growing natures of these micro-organisms, there was a median 19-month gap between surgery and onset of infection. Endocarditis, bacterial contamination of the heart, was found to be the most common infection. While the true risk of infection is unknown, as patients with endocarditis have not up to now been tested for mycobacterial infections, we estimate this as low, affecting less than 1 patient in 10,000 undergoing these procedures. However, the outcome for patients was very poor with half dying from their infection.

With mounting evidence that HCUs were the source of these infections, colleagues at the University of Oxford were brought into the investigation to assess the similarity of strains using whole genome sequencing (WGS) of clinical and environmental isolates along with an extensive control group. Results from this analysis are keenly awaited and are being compiled with those from other countries, including from the HCU manufacturing site, to assess whether a point-source contamination could be behind these infections. As the risk was assessed as low, and given the life-saving nature of open-heart surgery, the machines have been kept in use while longer-term solutions are identified.

Through partnerships working across expert disciplines and organisations, along with access to national health data repositories, we were able to mount a rapid and decisive response to this potential threat within a matter of weeks. On the basis of evidence generated by the investigation, briefing packs for the NHS and independent sector cardiac centres were issued advising the implementation of the following changes:

- active management of HCUs on an ongoing basis including regular microbiological sampling from water circuits and recording the specific unit used for a given patient to facilitate traceability
- heightened clinical awareness of the possibility of *M. chimaera* infection in patients with endocarditis or disseminated infection and a prior history of cardiothoracic surgery
- active case reporting for ongoing monitoring and reassessment of risk

Biosafety staff undertake sampling of a heater cooler unit under controlled and reproducible laboratory conditions to assess the aerobiological risk

Combating antimicrobial resistance

With increasing use of broad spectrum antimicrobials, multidrug resistance has significantly increased over the last decade and at the same time no new antibiotics have been developed. In acute care settings Carbapenemase-producing Enterobacteriaceae (CPE), such as Klebsiella spp., Escherichia coli, and Enterobacter spp., are emerging threats to public health. Outbreaks caused by Extended-spectrum beta-lactamase-producing Enterobacteriaceae (EBSLE) and carbapenemase-producing Enterobacteriaceae (CPE) have been reported, particularly in intensive care units (ICUs) throughout the UK.

CPE produce carbapenemases, which confer resistance to most beta-lactam antibiotics, and are frequently associated with genetic mechanisms of resistance to other classes of antimicrobials. In such circumstances, treatment options are limited and this contributes to the high mortality (70%) and increased need for intensive care associated with clinical infection.

Environmental reservoirs have been found during outbreaks and CPE have been recovered from moist environments associated with potable water, sinks, handwash basins and drain traps in a number of European countries.

Inappropriate discarding of waste material (for example patient secretions, body fluids, unwanted antibiotics) can directly introduce CPE to a hospital sink waste trap. However, the open nature of drains means that a wide range of microorganisms are continually present. Once in the drain, these organisms can form complex biofilms that can facilitate transfer of genetic material between different micro-organisms.

Through a collaboration with a number of NHS hospitals, the Biosafety, Air and Water Microbiology Group at PHE Porton has designed a laboratory model that encompasses both sinks and handwash basins that will enable investigations to be carried out on the survival of antimicrobial resistant strains in drains under controlled and reproducible conditions and the mechanisms that return these organisms back into the clinical environment.

The model will incorporate hospital pipework that has been identified as being positively contaminated with antibiotic resistant strains and as a consequence has been removed from hospital wards. The primary aims of the study will be to:

- characterisation of the microbiome in the drain sections
- assess the antibiotic resistant micro-organisms present
- assess the ability of short and long term decontamination strategies
- understand the mechanisms that allow the agents to return to the clinical environment
- provide guidance for NHS hospitals

PHE laboratory sink and drain model for the investigation of control measures for CPE in hospitals

Dr Ginny Moore working on the PHE laboratory sink and drain model

Health economics

Both the *NHS Five Year Forward View* and *From Evidence into Action* called for a much greater focus on prevention, and we have since strengthened our capability in economic modelling and return on investment (RoI). Led by Professor Brian Ferguson, our Chief Economist, the team focuses on:

- identifying and disseminating the evidence base on cost-effectiveness and supporting the use of evidence and RoI tools in key priority areas
- developing tools and resources to support local authorities and the NHS to make the case for prevention and early intervention
- commissioning high-quality projects to support the priorities of PHE and its key partners
- building health economics capacity by providing tailored training and awareness-raising activities both within PHE and with key stakeholders

Although small in size, the team has hit the ground running in delivering against these objectives, for example, through the Health Economics Commissioning Framework. This comprises seven research projects commissioned to improve understanding of the potential cost-effectiveness and RoI of preventive interventions, working across the health and social care system:

Commissioning cost-effective prevention services for mental health and wellbeing, a tool that estimates at local level the cost of providing interventions and their RoI, by sector, over different time periods. Alongside the tool there will be a report summarising the evidence on the cost-effectiveness of mental health promotion and disorder prevention initiatives, presenting local areas with up-to-date intelligence on interventions that work and provide a clear RoI

Commissioning cost-effective primary prevention services for dementia, a report summarising the evidence from studies of the impact on dementia of changes in behaviours (e.g. smoking) or in people's conditions or circumstances, for example, loneliness, obesity or depression. The report also looks at barriers and facilitators to primary prevention of dementia, and recommends next steps for rolling out implementation of interventions to reduce its prevalence

Future levels of ill-health and impact on health services, expenditure and outcomes, an interactive tool and accompanying reports exploring how changes in behavioural risk factors will affect health outcomes and the demand for health and social care services (and consequently expenditure) in the future

Understanding the health economics of palliative and end of life care, a tool and accompanying report to support commissioners and planners to deliver cost-effective end of life care. This project will also bring together what is known about the health, social and voluntary sector costs of palliative and end of life care across the care pathway, and identify the most cost-effective interventions that produce the greatest RoI

Efficient commissioning of colorectal cancer care, a user-friendly tool and accompanying reports that will enable clinical commissioning groups for the first time to estimate costs and benefits at a local level of improving outcomes in colorectal cancer, with a specific focus on helping commissioners to make the business case for appropriate investment to improve early detection

Health economics support to the National Diabetes Prevention Programme (DPP), another user-friendly tool to allow local commissioners to quantify the RoI of the NHS DPP, along with reports to help them explore the current system incentives in relation to diabetes prevention and provide them with analysis of DPP cost-effectiveness by population sub-group

Learning from approaches to RoI in other sectors, a project explores how RoI and other economic appraisal tools and methods are used in other government departments. The project focuses on the approaches taken to investment decisions and what lessons the health sector can learn

All of these tools and reports have been developed with the support of academic and other partners through our Health Economics Commissioning Framework and will be published in the early autumn.

As well as developing the evidence base to enable better decision-making, the health economics team has also been building economic capacity in local areas to ensure that new evidence and tools are used to inform decisions.

Six individuals from each PHE centre took part in a two-day training course on health economics. As well as learning about the fundamental principles of economics, the course included practical application of economics in decision-making. These 'virtual teams' are now beginning to take the lead on local prioritisation and economic exercises with the support of the health economics team. In addition to the two-day training, a two-hour 'Bitesize Health Economics' course has been delivered by the health economics team to over 200 staff across PHE centres. The team has also engaged directly with local authorities by inviting two individuals from each upper tier authority in England to take part in a one-day training course.

Through the training and awareness-raising activities, we have promoted wider use of our Spend and Outcomes Tool (SPOT) across centres and local authorities, providing a better understanding of spend against a selection of relevant outcomes, including those paid for from the public health grant. We have also promoted other relevant tools such as those produced by the Value for Money team in the Alcohol, Drugs and Tobacco division, for example, a tool to help commissioners understand and improve the cost-effectiveness of alcohol and drug treatment interventions. Part of the promotion and support activity is aimed at explaining the differences between such tools and the circumstances in which they should be used.

Looking ahead, 2016/17 promises to be another exciting year as products and tools from this year become available to local systems to help improve decision-making to make the case for investing in prevention and early intervention. New work will be commissioned through the framework, working closely with a range of colleagues across PHE and external partners. A clear narrative is being developed of how PHE works with NICE on health economics issues (including the development and promotion of RoI tools).

As well as ongoing support to major policy areas such as alcohol and obesity, a major focus of the health economics team's work will be on continuing to build a compelling case for investing in prevention.

Behavioural insight

We bring together behavioural theory with cutting edge marketing techniques to deliver behaviour change at scale. We make change accessible and appealing through engaging campaigns that prompt people to change

- **Norms**: we know that people are guided by how other people are acting. *Stoptober*, which asks people to give us smoking for one month, gets people to give up smoking at the same time
- **Chunking**: we know there can be mental barriers to making big changes and so breaking things up into smaller actions makes them more palatable. We do this in 10 Minute Shake Up through inspiring kids to do bursts of activity which help them to meet the daily recommended levels
- **Hyperbolic discounting**: we know that people choose smaller short term benefits over larger long term benefits, such as health. Our tobacco advertising focuses on the immediate impact of smoking through showing mutations forming as someone smokes a cigarette
- **Choice architecture**: we know that the way in which choices are presented can influence behaviour. We use this in our Change4Life Sugar Smart campaign by highlighting products that are low in sugar on online shopping websites so that people are prompted to switch at the time of purchase
- **Heuristics**: we know that people use rules of thumb to remember things and this drives their behaviour. We use this in our ACT FAST stroke campaign by abbreviating symptoms to make them more memorable

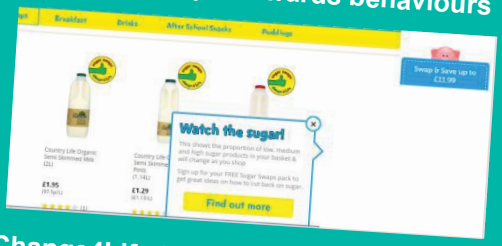
SELF-EFFICACY: change is more likely when people feel in control of the outcome

One You prompts people to reappraise their health and take control

CHUNKING: choices can be made more palatable through a smaller ask

10 Minute Shake Up inspires kids to do small chunks of exercise

CHOICE ARCHITECTURE: framing choices can nudge people towards behaviours



Change4Life badges healthy products online to prompt swapping

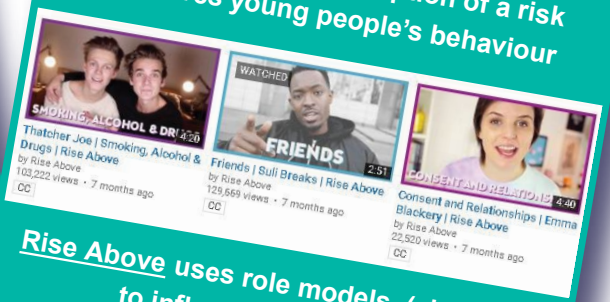
HYPERBOLIC DISCOUNTING: we choose short term rewards over long term ones

Our tobacco advertising shows immediate harm through mutations

HEURISTICS: mental shortcuts or rules of thumb drive behaviour

ACT FAST provides a shortcut for remembering stroke symptoms

RISK IMAGES: the perception of a risk taker drives young people's behaviour



Rise Above uses role models (vloggers) to influence risk images

The health of England in 2016

This part of the Annual Report looks at the health of England in 2016 by summarising some of the important messages emerging from the key cross-cutting outputs produced by our Chief Knowledge Officer and his team over the last year.

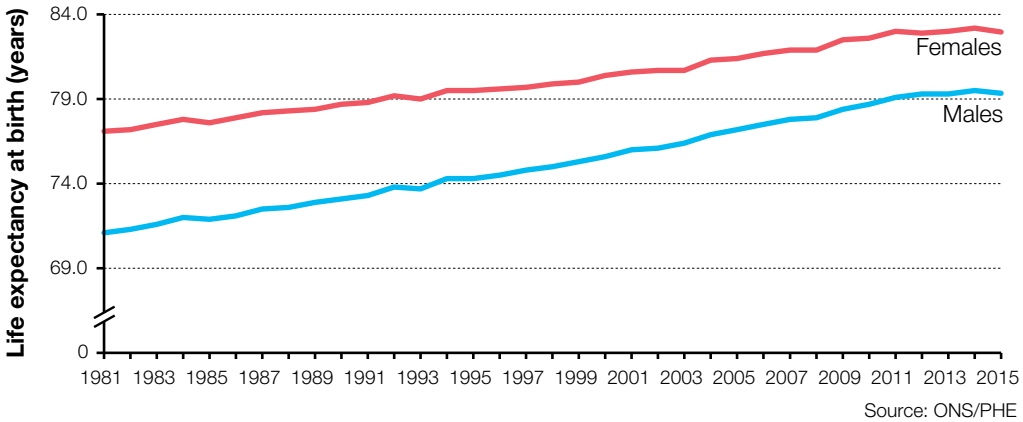
To set the scene it examines trends in life expectancy at birth and in causes of death. This comes from *Provisional analysis of death registrations: 2015*, a report by the Office for National Statistics to which PHE contributed. It then identifies the top causes of disability adjusted life years (DALYs) and the risk factors contributing to these using the latest findings from the Global Burden of Disease (GBD) study.

The main analysis focuses on indicators within the Public Health Outcomes Framework (PHOF). The PHOF *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

The progress of all indicators within each of the domains is presented in the 'at a glance' summary starting at page 52. This summary identifies those indicators that have improved, worsened or remained stable since the previous time point and since the baseline year for PHOF. The main analysis focuses on selected indicators from the 'at a glance', giving examples of areas of success, those that warrant further monitoring, as well as examples of inequalities that exist. Where possible these examples relate to diseases and risk factors identified in the GBD study, but also focus on the wider determinants of health.

Trends in life expectancy at birth

Life expectancy at birth, England, 1981 to 2015

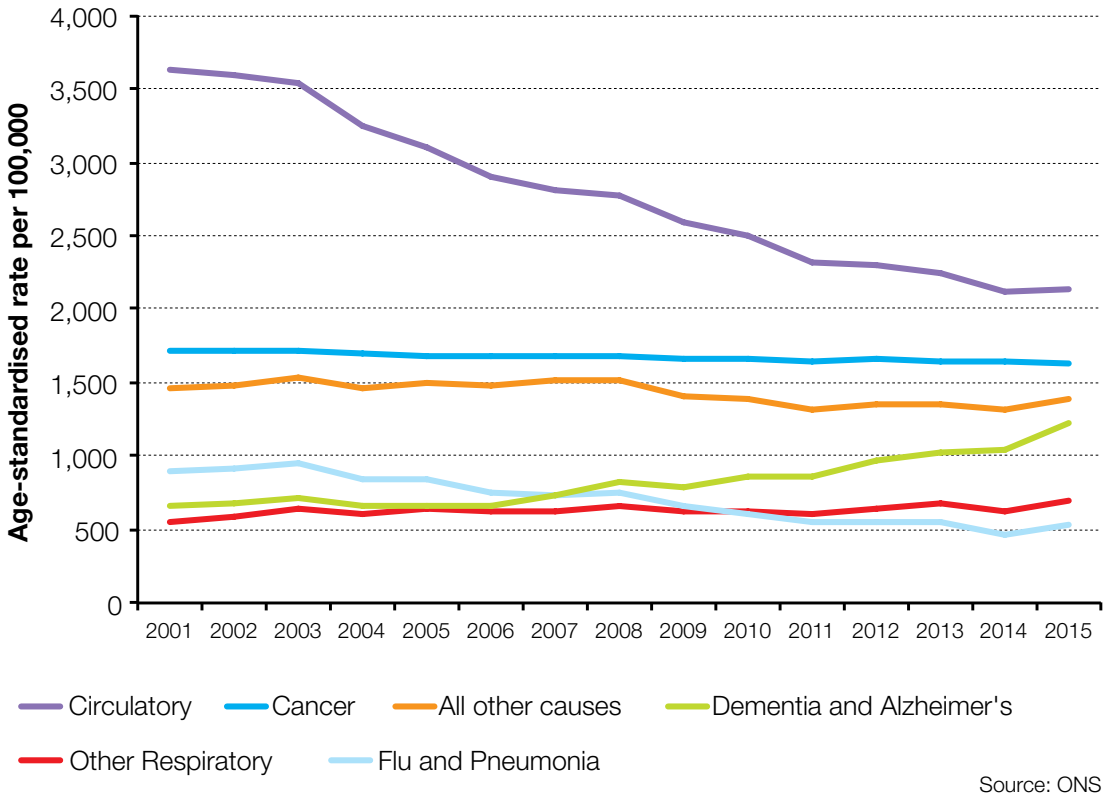


Source: ONS/PHE

- life expectancy at birth has been consistently increasing for a number of years, with the gap between males and females reducing
- in the year 2014, life expectancy at birth was 79.5 years for males and 83.2 years for females
- however, provisional analysis shows that life expectancy at birth in 2015 has fallen for both males (79.3 years) and females (83 years)
- life expectancy data for 2015 is currently provisional

Trends in causes of death

Mortality rates by cause, England and Wales, 2001 to 2015



Source: ONS

- between 2014 and 2015, there was a fall in the death rate from cancers. There was a rise in all other groups of causes shown, with the biggest percentage increases from dementia and Alzheimer's disease (18.6% increase) and flu and pneumonia (15.6% increase)
- compared with 2014, in 2015 there were 24,201 extra deaths in those aged 75+, 86% of the total excess. Of these extra deaths in those aged 75+, 41% had an underlying cause of dementia and Alzheimer's disease, while 31% had an underlying cause of respiratory disease
- death data for 2015 is currently provisional

Global burden of disease – top causes of DALYs

Rank of causes, all ages, England

2013 Rank	Cause of death or injury
1	Lower back and neck pain
2	Ischemic heart disease
3	Cerebrovascular disease
4	COPD
5	Lung Cancer
6	Alzheimer's disease
7	Sense organ diseases
8	Depressive disorders
9	Skin diseases
10	Falls

Increase in rank since 1990

Decrease in rank since 1990

Source: Institute for Health Metrics and Evaluation GBD 2013 © 2015 University of Washington

- analysis of the Global Burden of Disease indicates the top cause of disability adjusted life years (DALYs) in 2013 was lower back and neck pain
- one DALY can be equated to one year of "healthy" life lost to death and/or disease. The sum of these DALYs across the population can be thought of the total burden of disease
- the percentage of DALYS attributed to ischemic heart disease and cerebrovascular disease have seen a decrease since 1990
- Alzheimer's disease was ranked 11th in 1990 and is ranked 6th in 2013

Global burden of disease – top risk factors

Rank of risks, all ages, England

2013 Rank	Risk factor
1	Dietary risks
2	Tobacco smoke
3	High body mass index (BMI)
4	High systolic blood pressure
5	Alcohol and drug misuse

Source: Institute for Health Metrics and Evaluation GBD 2013 © 2015 University of Washington

- in 2013 10.8% of DALYs were attributed to dietary risk. This remains the highest ranked risk factor in 2013 as it was in 1990
- smoking is ranked second in 2013, moving up from a rank of third in 1990, despite a decrease of 32.3% in total DALYs between 1990 and 2013
- high systolic blood pressure has seen a decrease since 1990 of about 52.2% in total DALYs but still remains one of the top risk factors

Public Health Outcomes Framework – change in indicators since the previous time point

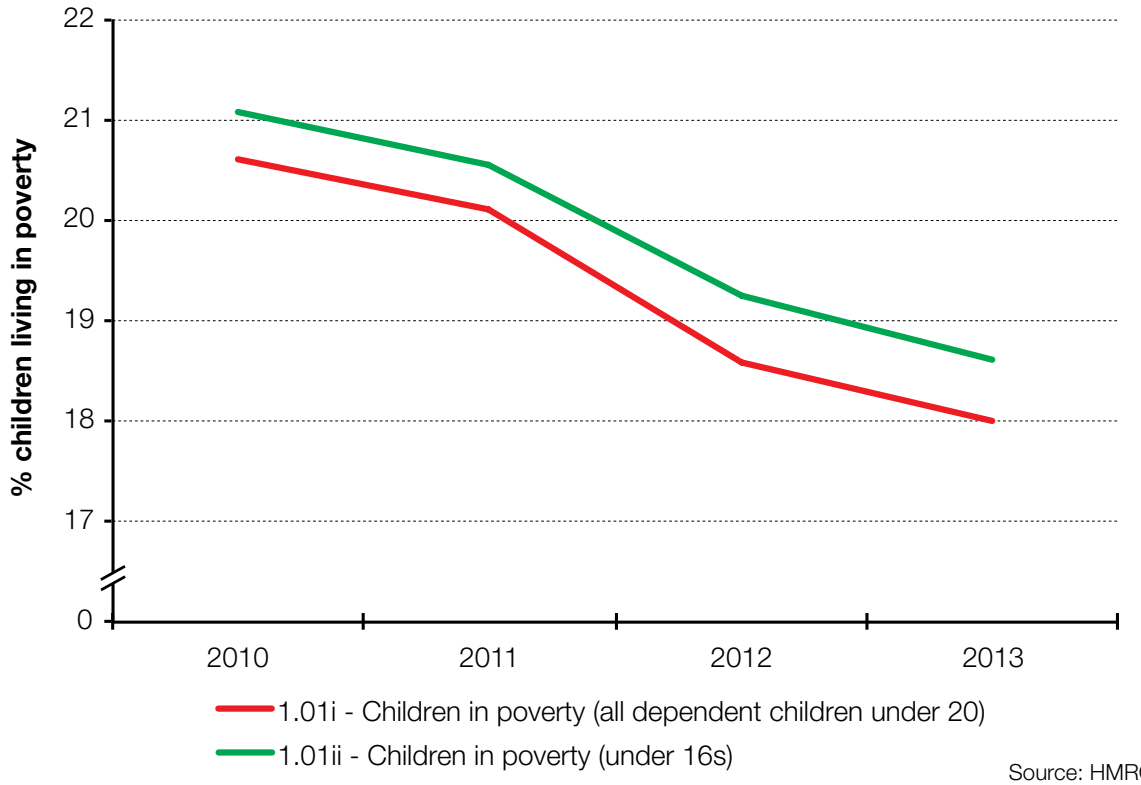
	Number improving	Number stable	Number worsening	Number parity unknown
Overarching indicators	4	10	0	6
Wider determinants of health	19	9	6	18
Health improvement	21	8	16	16
Health protection	7	3	10	5
Healthcare public health and premature mortality	32	32	0	2
TOTAL	83	62	32	47

The previous time point is dependent on the year of most recent data for each of the PHOF indicators, in other words, it varies.

- using data in the Public Health Outcomes Framework data tool in May 2016, where the parity of indicators is known, 82% show an improvement or are stable since the previous time point (145 out of 177). However, this varies by domain and around a third of indicators within the health protection domain show a worsening since the previous time point

Wider determinants of health – children in low income families

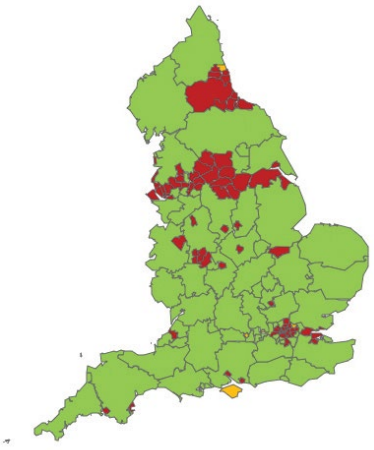
Children in poverty (all dependent children under 20 and under 16s), England, 2010 to 2013



Source: HMRC

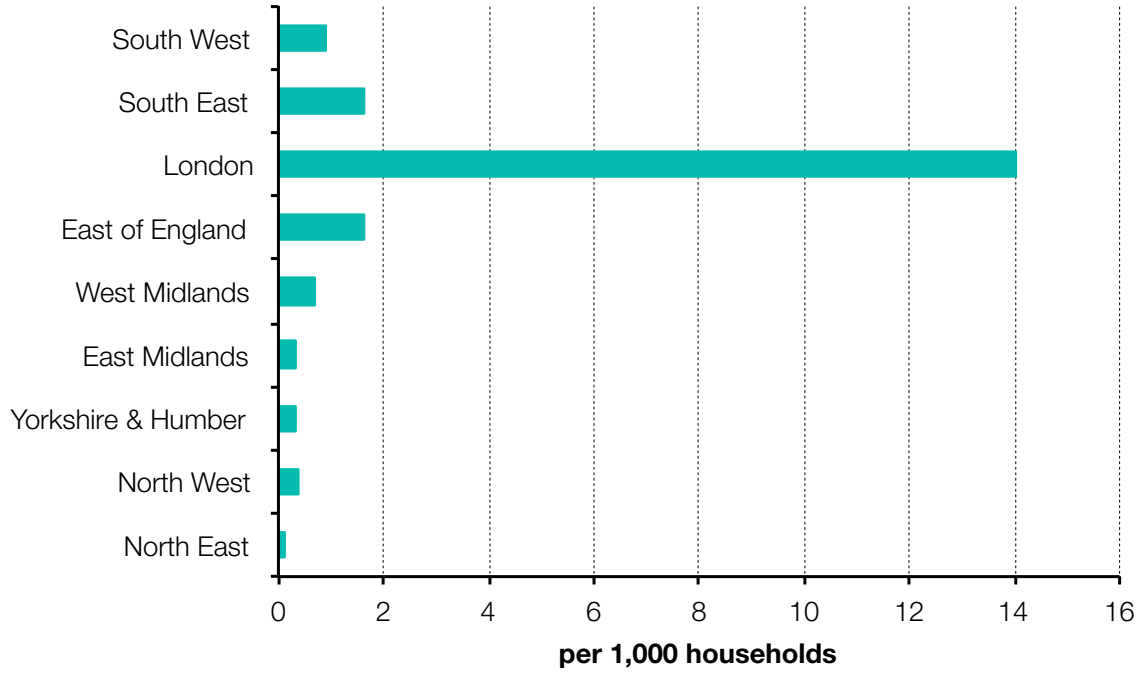
- between 2010 and 2013 (the latest year that data are available), there was a significant decrease in the percentage of children living in low income families
- this improvement was seen both in the group consisting of all children under the age of 16 (from 21.1% in 2010 to 18.6% in 2013) and the group consisting of all dependent children under the age of 20 (from 20.6% in 2010 to 18% in 2013)
- however, there exist inequalities within England. As the map indicates (based on all dependent children under the age of 20 in 2013), it is primarily those local authorities covering cities or urban areas where the percentage of children in low income families is significantly higher than the England average. The pattern for all children under 16 is virtually identical

Map of County and UAs in England for 1.01i - Children in poverty (all dependent children under 20) (Proportion - %, 2013)



Wider determinants of health – households in temporary accommodation

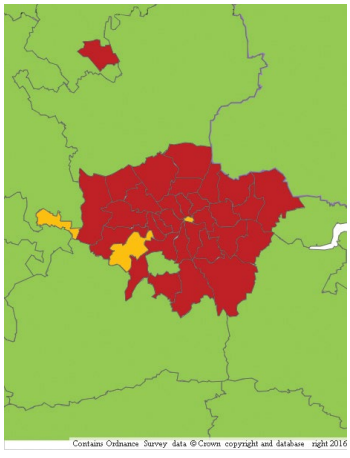
Households in temporary accommodation, by region, 2014/15



Source: DCLG

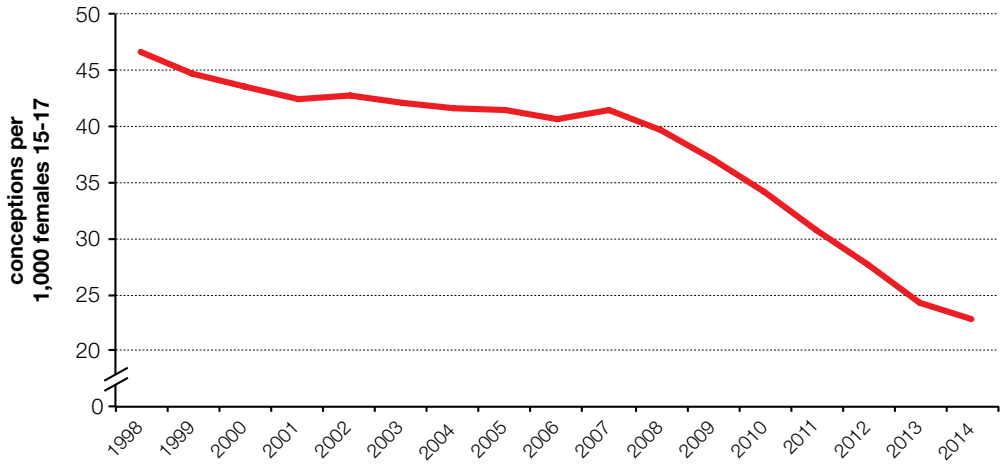
- the rate of households in temporary accommodation has increased significantly since 2010/11. The rate per 1,000 households in England was 2.2 per 1,000 in 2010/11, rising every year to a rate of 2.8 per 1,000 in England in 2014/15 (the latest year of data available)
- as the above chart and map indicate, this is an issue that affects London more than anywhere else in England. In 2014/15, the rate of households in temporary accommodation was 14 households per 1,000 in London, compared to 1.6 per 1,000 in the next highest regions (South East and East)
- 30 out of 33 local authorities in London have rates of households in temporary accommodation significantly above the England average. In contrast, there are only 3 other local authorities in England where the rates are significantly above the England average (Luton, Reading and Brighton and Hove)

Map of County and UAs in England for 1.15ii - Statutory homelessness - households in temporary accommodation (Crude rate - per 1000, 2014/15)



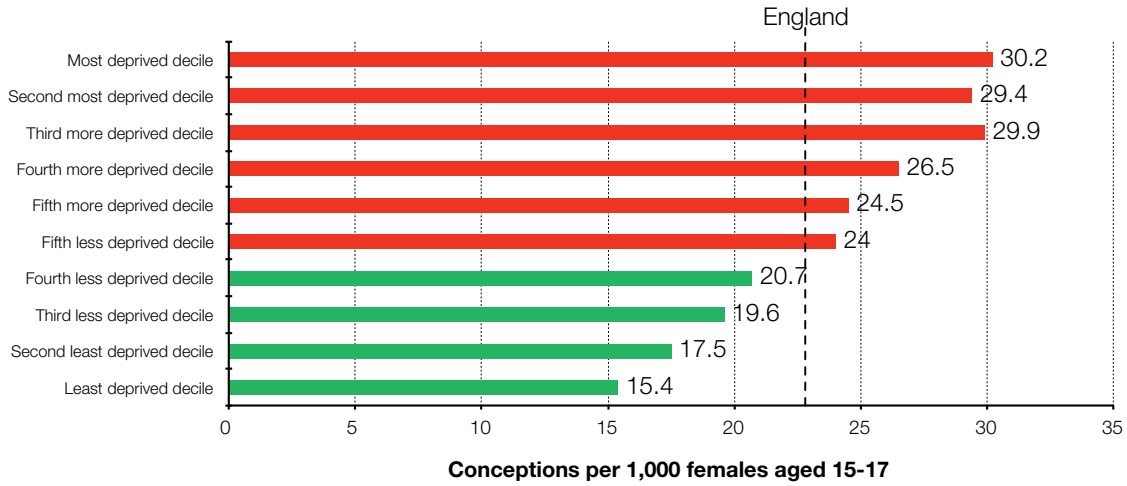
Health improvement – teenage pregnancy

Under 18 conceptions, England, 1998 to 2014



Source: ONS

Under 18 conceptions by deprivation decile, 2014

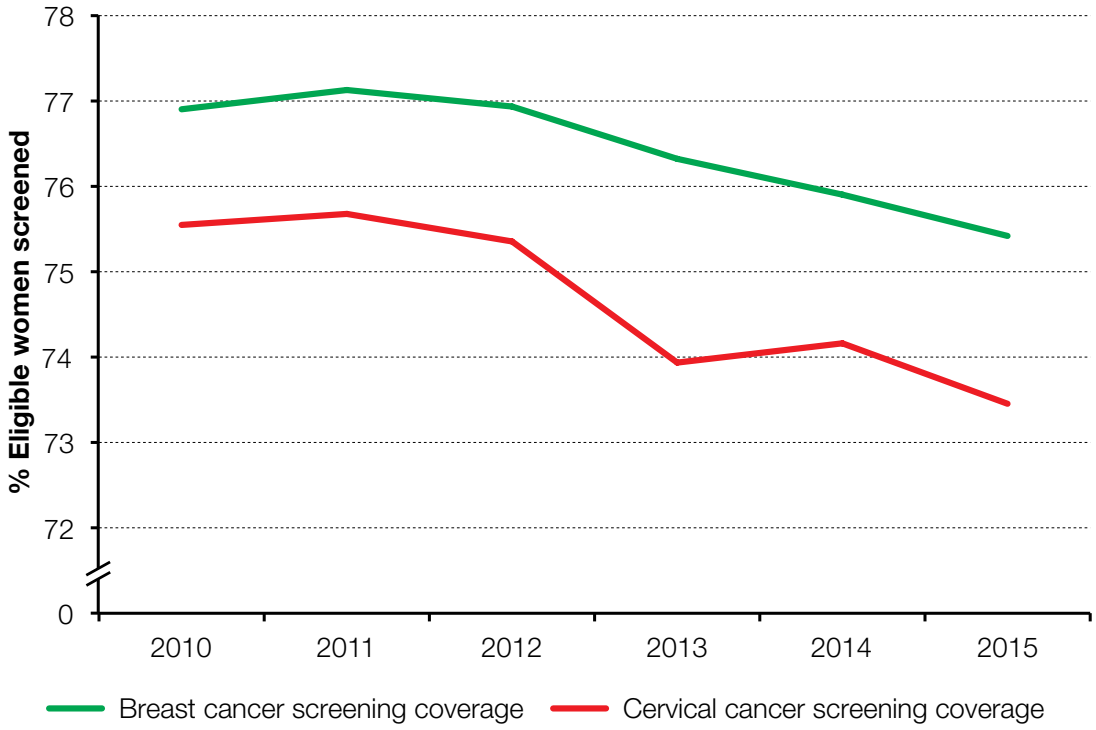


Source: ONS

- in 2014 the rate of under-18 conceptions decreased from 24.3 per 1,000 females aged 15-17 to 22.8 per 1,000 females aged 15-17. This is the seventh year in a row that there has been a statistically significant improvement in the rate of under-18 conceptions. Compared to 1998 (the first time-point contained within the PHOF data tool), the rate has more than halved
- this trend is also seen in the rate of conceptions in those aged under 16. In 2014, the rate was 4.4 per 1,000 females aged 13-15. In 2009, the first year of data in the PHOF data tool, the rate was 7.3 conceptions per 1,000 females aged 13-15
- there remain significant inequalities within this indicator however. As the chart above indicates, in 2014 the rate of teenage pregnancies was almost double in the most deprived of local authorities compared to the least deprived

Health improvement – breast and cervical cancer screening

Cancer screening coverage (breast and cervical), England, 2010 to 2015

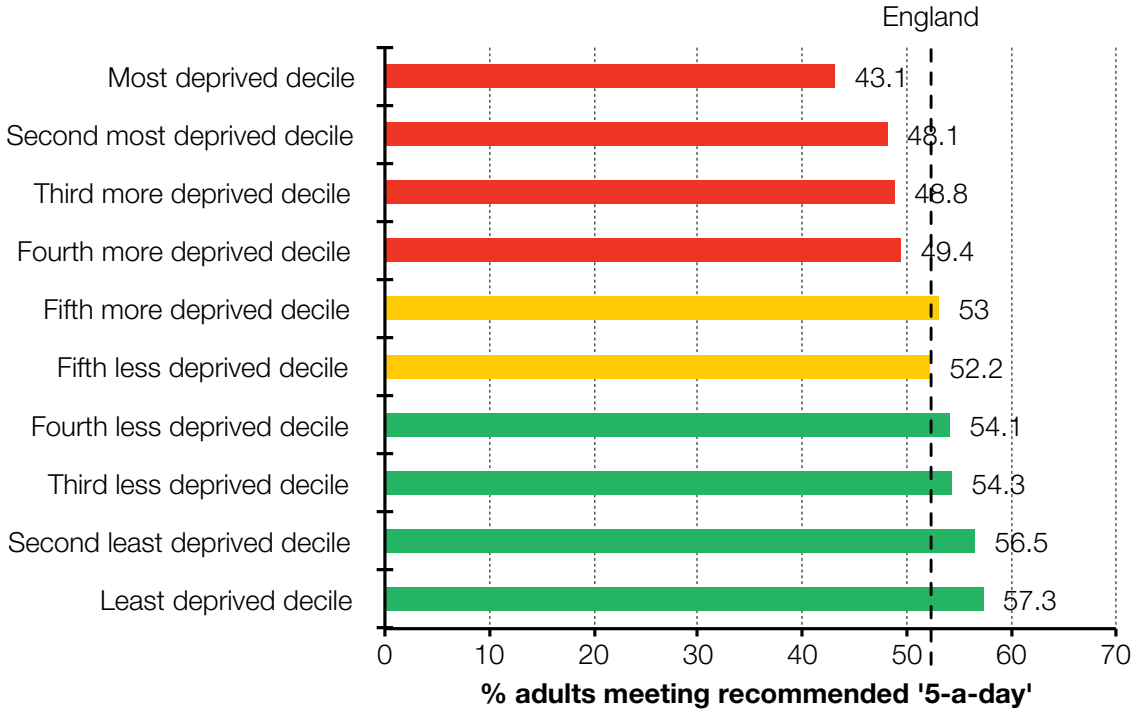


Source: Open Exeter

- between 2010 and 2015 there have been statistically significant decreases in the percentage of eligible women screened for both breast and cervical cancer in England
- in 2010, 76.9% of eligible women were screened for breast cancer while 75.5% of eligible women were screened for cervical cancer. However, in 2015 these figures had fallen to 75.4% for breast cancer and 73.5% for cervical cancer. Although a relatively small decrease, if the percentage of eligible women being screened had remained constant, this would have resulted in an extra 86,000 women being screened for breast cancer and 295,000 women being screened for cervical cancer in the period of eligibility up to 2015
- the pattern is consistent by region in England: between 2014 and 2015 eight out of nine regions saw a decrease in breast cancer screening while all nine regions saw a decrease in cervical cancer screening

Health improvement – inequalities in fruit and vegetable consumption

Percentage of the population meeting the recommended '5-a-day' by deprivation decile, England, 2015

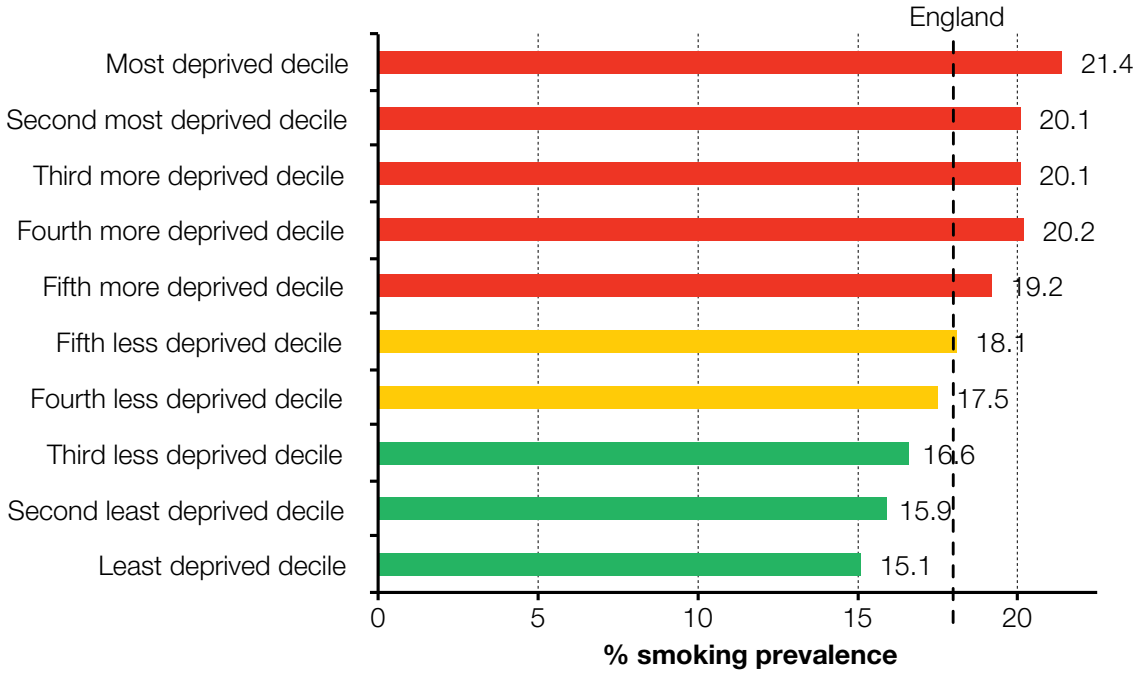


Source: Active People Survey

- between 2014 and 2015 there was a small but statistically significant decrease in the proportion of the population in England eating their recommended '5-a-day' portions of fruit and vegetables (from 53.5% to 52.3%)
- there remain significant inequalities in behaviours that are considered beneficial to one's health. In 2015, data from the Active People Survey showed that those in the most affluent local authorities were more likely to consume 5 portions of fruit and vegetables a day in line with dietary guidelines than those in the most deprived local authorities
- these figures suggest that if the prevalence of consumption of fruit and vegetables was the same in all of the deprivation deciles as it was in the least deprived decile, then potentially as many as 2.2 million more adults aged 16+ in England would be meeting the recommended intake of fruit and vegetables
- data from the Active People Survey is not intended to be, and should not be compared directly with other sources of diet data

Health improvement – inequalities in smoking

Prevalence of smoking in adults by deprivation decile, England, 2014

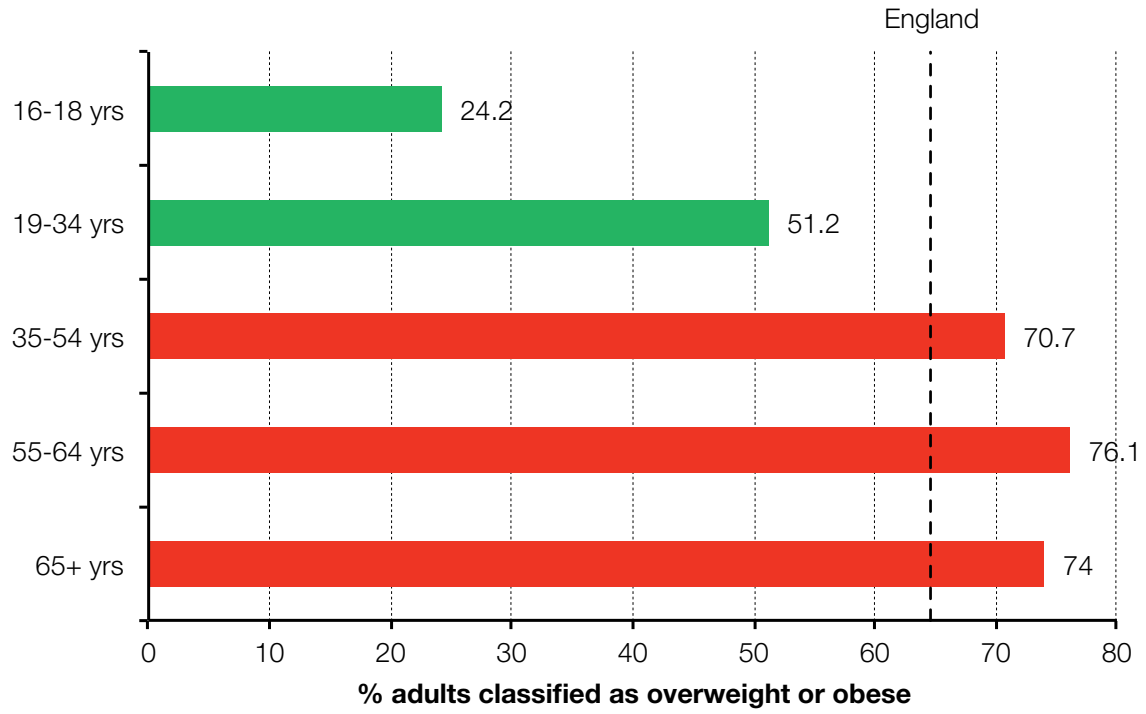


Source: Integrated Household Survey

- although the overall prevalence has continued to decrease in England in recent years, there still remains a clear gradient from those living in more deprived local authorities to those living in less deprived with over a 6 percentage point difference between the most deprived decile of local authorities and the least deprived decile
- these figures suggest that if the prevalence of smoking was the same in all of the deprivation deciles as it was in the least deprived decile, then potentially as many as 1.25 million fewer adults aged 18+ would be smoking

Health improvement – inequalities in excess weight in adults

Excess weight in adults by age group, England, 2012 to 2014

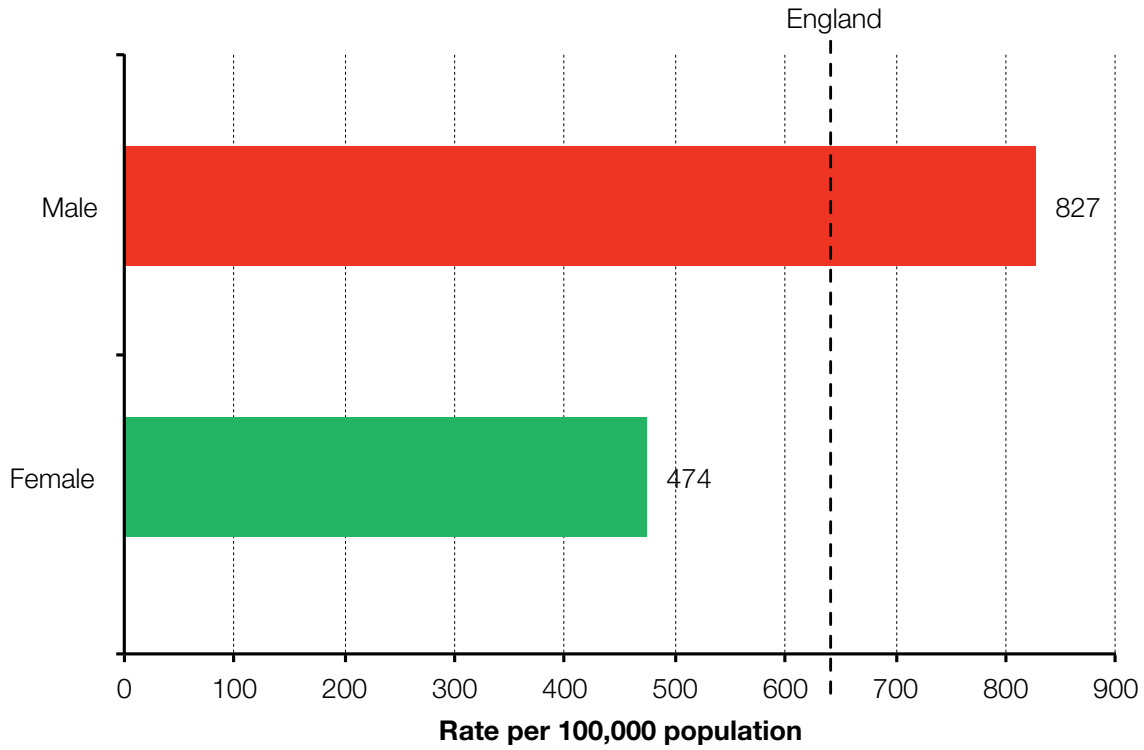


Source: Active People Survey

- in the period 2012-14, the percentage of adults in England classified as either overweight or obese was 64.6%. Trend data are not currently available for this indicator
- unlike smoking and healthy eating, there appears not to be a clear gradient between deprivation and excess weight in adults. The most deprived decile of local authorities in England had the lowest percentage of adults classified as either overweight or obese (62.3%)
- however, there does appear to be a relationship between age and levels of excess weight, with those in older age groups more likely to be overweight or obese than younger age groups
- there are also differences between ethnic groups, with those in the 'White' and 'Black' ethnic groups experiencing higher levels of excess weight than those in other ethnic groups

Health improvement – inequalities in alcohol related admissions to hospital

Hospital admissions for alcohol related conditions by gender, England, 2014/15

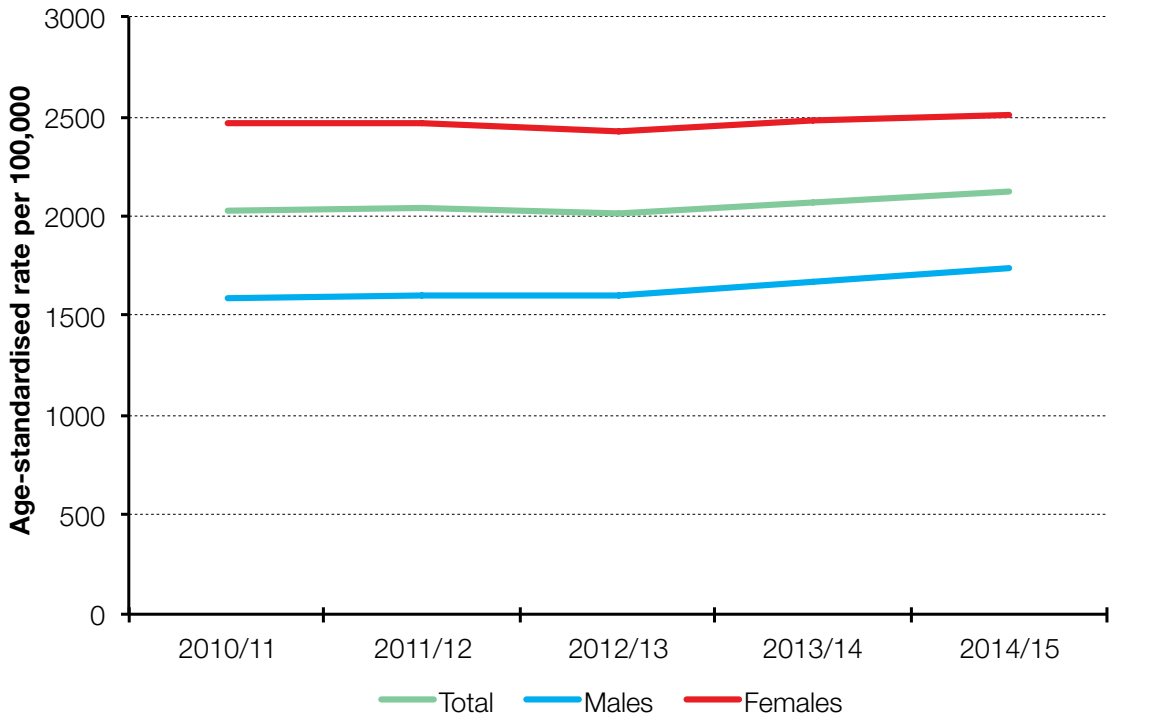


Source: Hospital Episode Statistics (HES)

- in 2014/15, the rate of admissions to hospital for alcohol related conditions was 641 per 100,000 population. Compared to 2008/09 (the first year of data in the PHOF data tool) this is a statistically significant increase from 615 admissions per 100,000 but a statistically significant decrease compared to 2011/12 when the rate of admissions was 653 per 100,000
- there exist significant inequalities within this indicator. Within local authorities in England in 2014/15, the rate of admissions ranged from 1,223 per 100,000 in Blackpool to 379 per 100,000 in Wokingham
- the rate of admissions among females (474 per 100,000) was also close to half that of the rate of admissions among males (827 per 100,000) in 2014/15

Health improvement – falls in people aged 65 and over

Falls in people aged 65+, England, 2010/11 to 2014/15

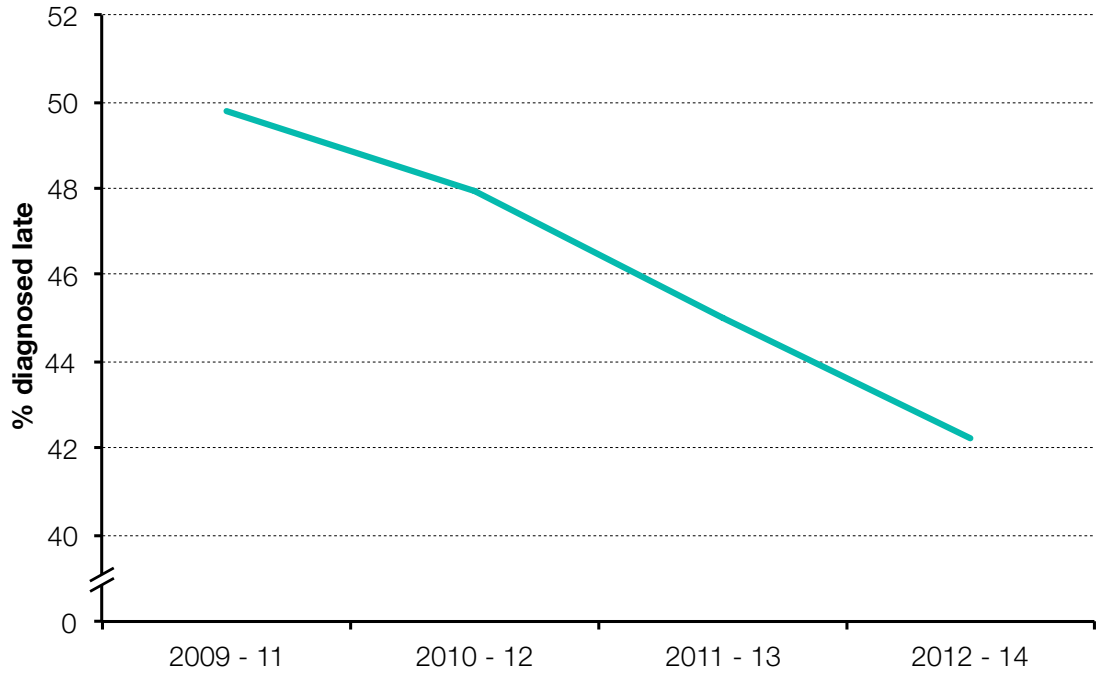


Source: Hospital Episode Statistics (HES)

- between 2010/11 and 2014/15, the rate of emergency hospital admissions due to injuries from falls in England increased from 2,030 per 100,000 to 2,125 per 100,000
- although rates are significantly higher among females than males (1,740 per 100,000 in 2014/15 compared to 2,509 per 100,000) both sexes show near identical patterns; fairly static between 2010/11 and 2012/13 followed by an increase from 2012/13 onwards
- this increase appears to be driven by an increase in hospital admissions for falls in those aged 80+. Between 2010/11 and 2014/15, the rate of emergency hospital admissions for injuries from falls actually fell in those aged 65-79 (from 1,021 per 100,000 to 1,012 per 100,000) but in the 80+ age group increased from 4,953 per 100,000 to 5,351 per 100,000 over the same period

Health protection – late diagnosis of HIV

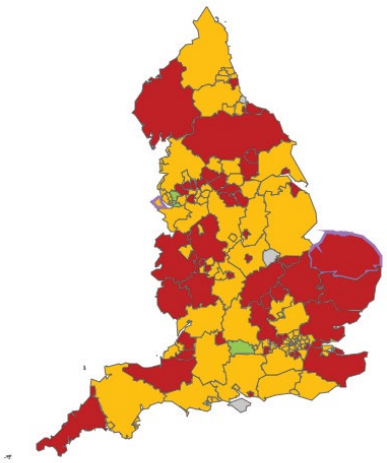
Late diagnosis of HIV, England, 2009/11 to 2012/14 Indicator



Source: PHE

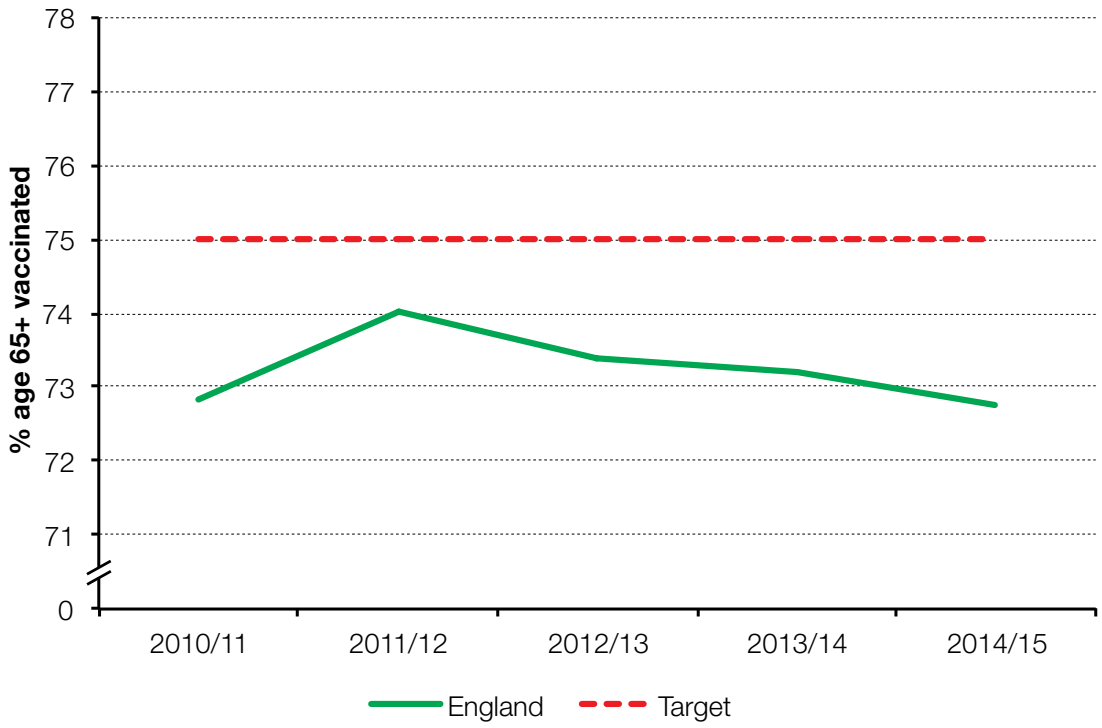
- between 2009-11 and 2012-14 (the latest period of data available), the percentage of new diagnoses of HIV classified as “late” improved from 49.8% to 42.2%
- local authorities should be aiming to have no more than 25% of new diagnoses of HIV as late. In the period 2012-14, only 4 local authorities in England achieved this goal (St Helens, Halton, West Berkshire and Islington), while many local authorities had the percentage of late diagnosis of HIV at over 50% (those local authorities coloured in red in the map)
- late diagnosis of HIV is the most important predictor of morbidity and mortality among those with HIV infection

Map of County and UAs in England for 3.04 - HIV late diagnosis (Proportion - %, 2012/14)



Health protection – population vaccination coverage: Flu (aged 65+)

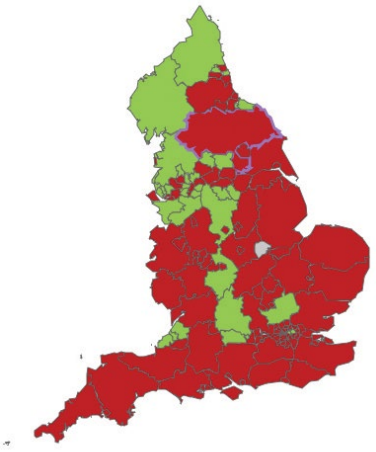
Population vaccination coverage: Flu (aged 65+), England, 2010/11 to 2014/15



Source: PHE

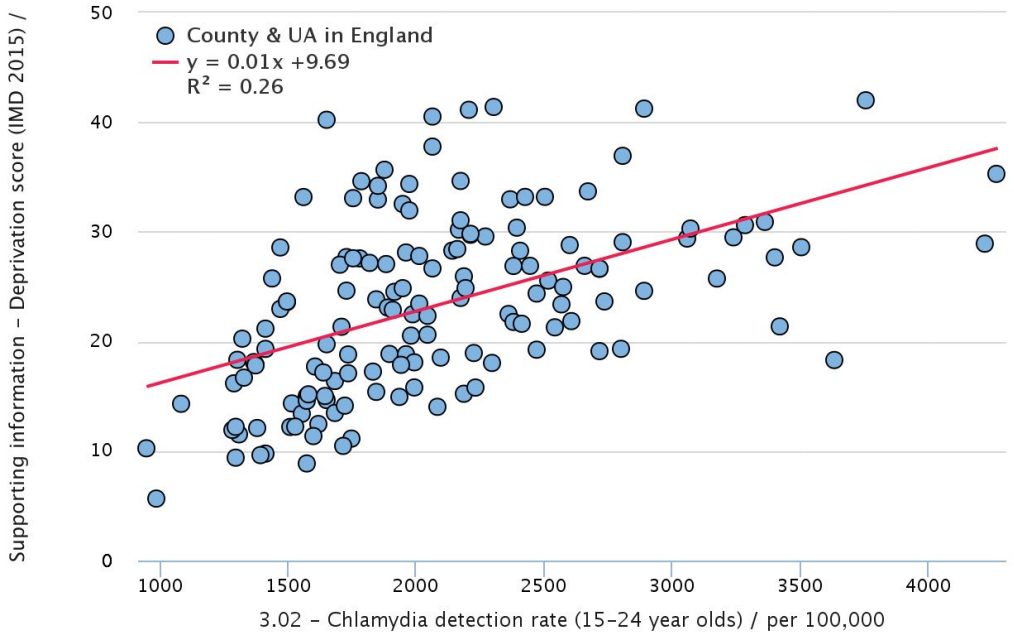
- since 2011/12, the percentage of adults aged 65+ who have been vaccinated against flu has decreased every year. Although there was an increase between 2010/11 and 2011/12 (from 72.8% to 74%), the percentage vaccinated in 2014/15 was at 72.7%
- local authorities should be aiming for at least 75% of residents aged 65 and over to be vaccinated against flu: in 2014/15 only 35 local authorities achieved this goal (about 23%)
- although the decline may seem relatively small, if the percentage vaccinated against flu in 2014/15 was the same as that in 2011/12, it would have meant that around 125,000 extra people aged 65+ would have been vaccinated. If the goal of 75% had been reached it would mean that an extra 220,000 people aged 65+ in England would have been vaccinated

Map of County and UAs in England for 3.03xiv - Population vaccination coverage - Flu (aged 65+) (Proportion - %, 2014/15)



Health protection – chlamydia detection rate (15 to 24-year-olds)

Chlamydia detection in young people aged 15-24 by local authority, 2014 Vs Index of multiple deprivation, 2015

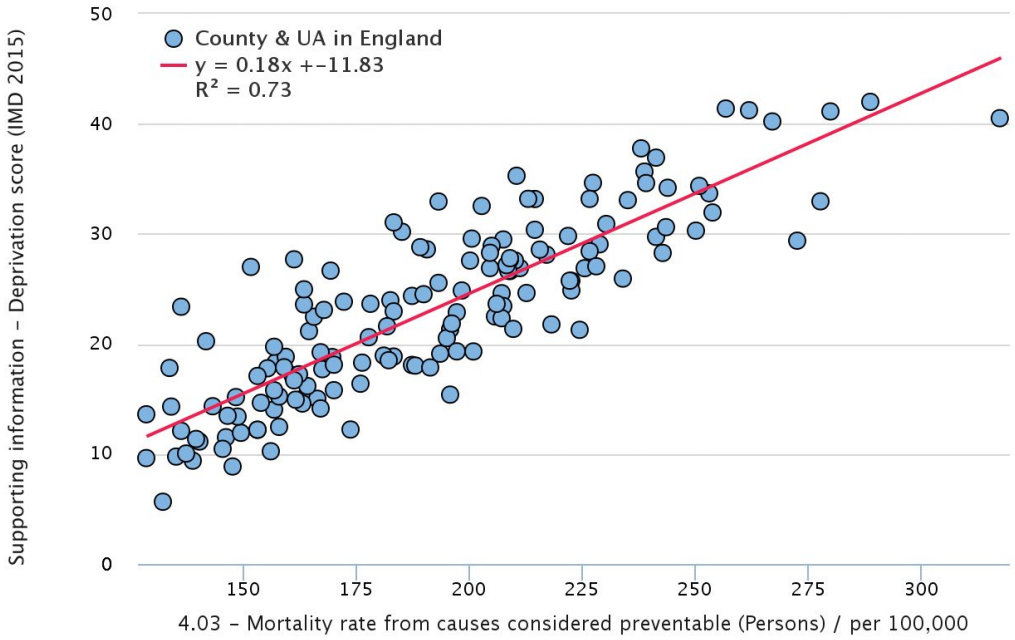


Source: PHE/DCLG

- between 2012 and 2014, the chlamydia detection rate in England decreased from 2,074 cases per 100,000 young people aged 15-24 to 2,012 cases
- the rates of chlamydia detection among both males and females decreased during this period. For males the rate fell from 1,440 per 100,000 to 1,335 per 100,000. For females, the rate fell from 2,689 per 100,000 to 2,664 per 100,000
- there is a goal associated with this indicator of a rate of detection of 2,300 cases per 100,000. In 2014, only 28% of local authorities achieved this. Four of the top 5 local authorities with the highest rates of detection were in London (Hackney, Lambeth, Wandsworth and Lewisham)
- the most deprived decile of local authorities had one of the highest rates of detection (2,320 per 100,000, second to the third most deprived decile with 2,620 per 100,000), while the most affluent decile of local authorities had the lowest rate of detection (1,374 per 100,000). The chart above shows that more deprived local authorities tend to have higher chlamydia detection rates

Healthcare and premature mortality – mortality from causes considered preventable

Mortality from causes considered preventable by local authority, 2012-14 Vs Index of multiple deprivation, 2015

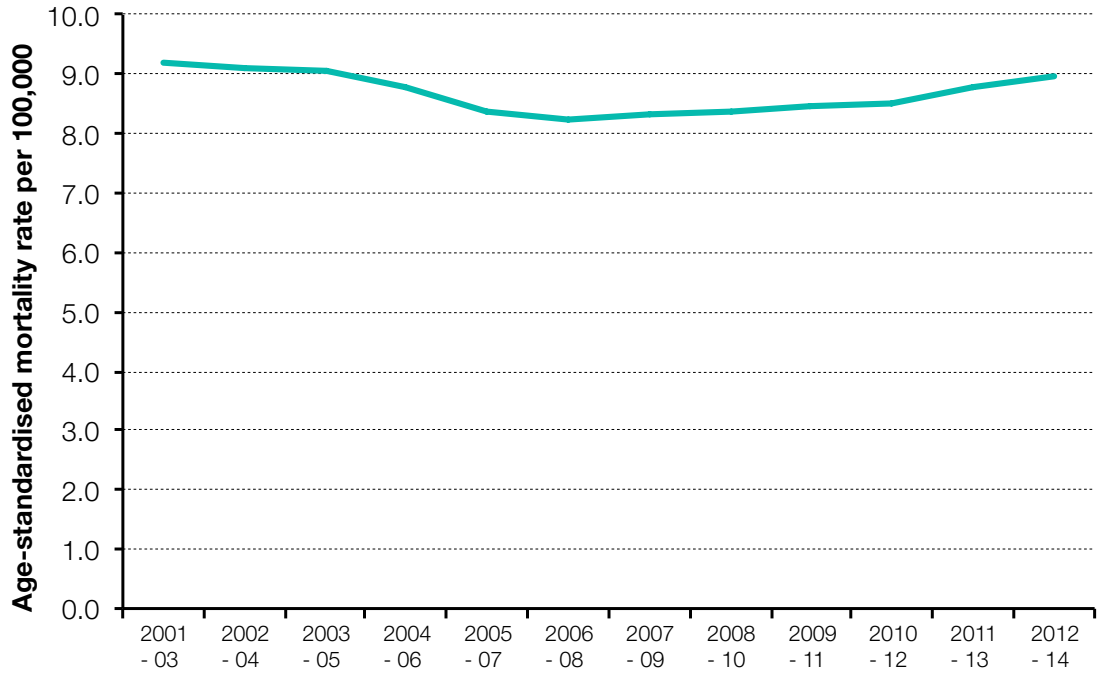


Source: PHE/DCLG

- in 2012-14 the directly age-standardised rate of mortality considered preventable was 182.7 per 100,000. This has decreased every year since 2001-03 (the first year of data within the PHOF) when the rate stood at 250 per 100,000, a reduction of over 25%
- there is however significant inequality between local authorities within England: the rate in the highest local authority (Manchester, 317.5 per 100,000) is nearly 2.5 times that of the local authority with the lowest rate (Rutland, 128.6 per 100,000)
- included in the definition of preventable mortality are ischemic heart disease, COPD and lung cancer, which are all in the top five causes of DALYS from the Global Burden of Disease study
- as the above chart shows, preventable mortality is also closely associated with deprivation: local authorities that on average have higher levels of deprivation experience higher levels of preventable mortality than more affluent local authorities

Healthcare and premature mortality – suicide rate

Suicide rate (persons), England, 2001/03 to 2012/14

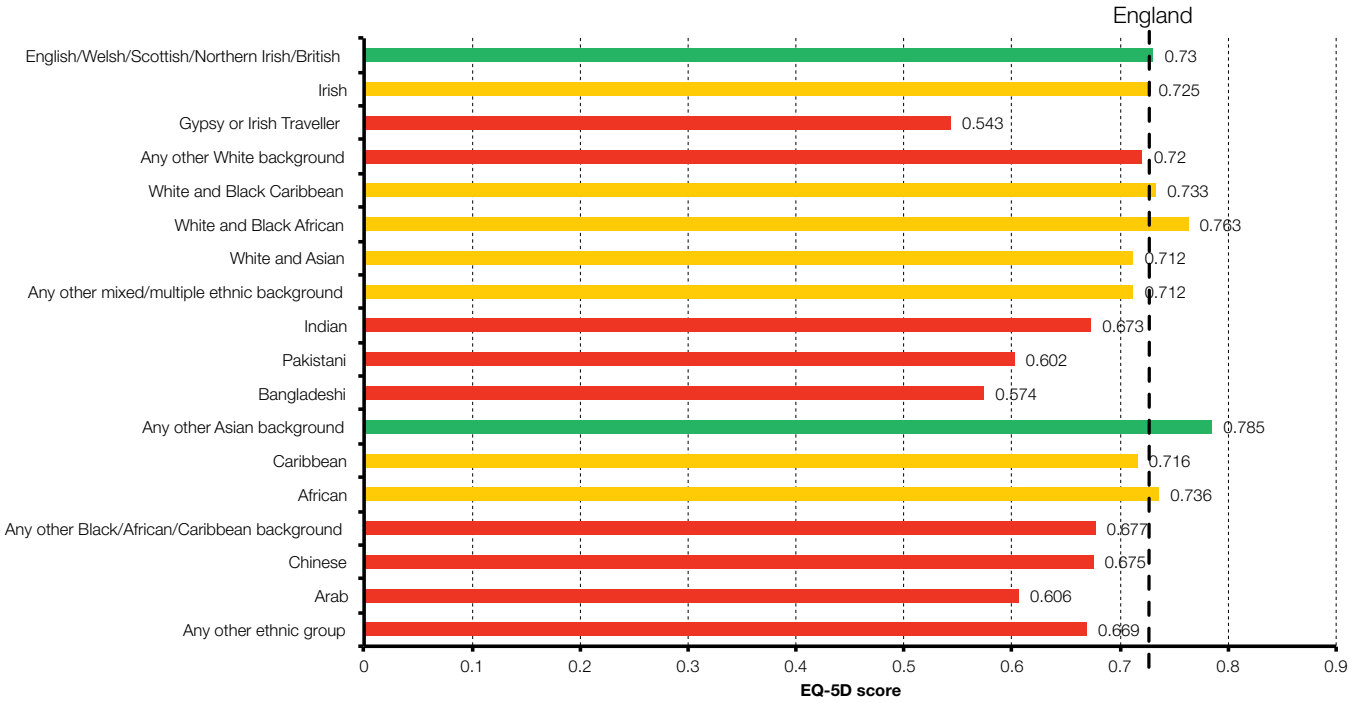


Source: PHE

- in 2012-14, the directly age standardised rate of suicides in persons in England was 8.9 per 100,000 population. In 2006-08, the rate was 8.2 per 100,000 and has risen slowly every year since
- the rate of suicides is significantly higher among males compared to females. In the period 2012-14, the suicide rate for males was 14.1 per 100,000 compared to 4 per 100,000 for females
- figures from the Suicide Prevention Profile published by the Mental Health Intelligence Network within PHE shows that the 5 year crude rate of suicides in the period 2010-2014 was highest in males aged 35-64 at a rate of 20.5 suicides per 100,000 population. The lowest rate in the same period was seen among females aged 15-34 (3.4 suicides per 100,000 population)

Healthcare and premature mortality – health related quality of life for older people

Health related quality of life for older people by ethnicity, England, 2013/14



Source: GP Patient Survey

- between 2011/12 and 2013/14, the average EQ-5D score improved very slightly in England from 0.726 to 0.727
- inequalities exist in the health related quality of life for older people. The chart above shows the average EQ-5D score in 2013/14 for different ethnicities
- the EQ-5D is a standardised instrument for respondents to questionnaires to describe their health status across 5 domains (mobility, self care, usual activities, pain/discomfort, anxiety/depression) while controlling for potential confounding variables (such as age, gender, long term conditions etc.). The higher the score the better
- for some ethnicities, the health related quality of life past the age of 65 is worse compared to others. Those who describe their ethnicity as Gypsy or Irish traveller, Indian, Bangladeshi, Pakistani, Chinese or Arab have a significantly worse average EQ-5D score than the average score

Summary

Although life expectancy has been increasing steadily in males and females for a number of years, provisional analysis indicates a decrease for both genders in 2015. This is driven by an increase in mortality among those aged 75 and over, primarily from dementia and Alzheimer's disease, and respiratory disease.

Analysis from the Global Burden of Disease study indicates that in 2013, the highest cause of disability adjusted life years (DALYs) in England was caused by lower back and neck pain, followed by ischaemic heart disease. The risk factors causing the most DALYs are dietary risks and tobacco smoke.

TThe Public Health Outcomes Framework (PHOF) data tool currently tracks more than 200 indicators. Using the data available in May 2016, over 80% of these were stable or had improved since the previous time point. The overall picture is of continuing improvements in health. Significant progress has been made in some areas (such as lowering rates of teenage pregnancy and mortality considered preventable), there exists areas that warrant further monitoring and inequalities remain, in many cases driven by deprivation.

Public Health Outcomes Framework

Indicators at a glance (May 2016)

The Public Health Outcomes Framework (PHOF) data tool (www.phoutcomes.info) presents data for the indicators in the framework for the most recent period available and accompanying trend data where possible. Inequalities data are provided where these are available. The progress of all indicators within each of the domains is presented in the following 'at a glance' summary. This summary identifies those indicators that have improved, worsened or remained stable since the previous time point and since the baseline year for PHOF.

A list of indicators updated, for the most recent and previous releases, can be found in the Public Health Outcomes Framework Collection within www.gov.uk.

Notes:

- Value cells are shaded red, amber or green where the England value can be benchmarked against a goal.
- In the change columns, prev refers to the change in value compared to the previous data point; base refers to the change in value compared to the baseline value.
- Changes are only shown if they are statistically significant. An upwards arrow (↑, ↑ or ↑) represents a significant increase in the indicator value, a downwards arrow (↓, ↓ or ↓) represents a significant decrease. A sidewards arrow (↔) is displayed if there has been no significant change.
- The arrows are coloured **green** and **red** for those indicators where a change can be described as improving or worsening respectively.
- Indicators where data has been updated or revised in the latest update have been shaded in the tables.
- Indicators where the value is marked with * have a data note attached to them. See www.phoutcomes.info for full details.
- Indicators where inequalities data is available in the webtool are marked with a ≠.

Summary for England

Domain: Overarching indicators					
Indicator	**Period**	**Value**	**Unit**	**Change from prev**	**Change from base**
0.1i - Healthy life expectancy at birth (Male) ≠	2012 - 14	**63.4**	Years	↔	↔
0.1i - Healthy life expectancy at birth (Female) ≠	2012 - 14	**64.0**	Years	↔	↔
0.1ii - Life Expectancy at birth (Male) ≠	2012 - 14	**79.5**	Years	↑	↑
0.1ii - Life Expectancy at birth (Female) ≠	2012 - 14	**83.2**	Years	↑	↑
0.1ii - Life Expectancy at 65 (Male) ≠	2012 - 14	**18.8**	Years	↑	↑
0.1ii - Life Expectancy at 65 (Female) ≠	2012 - 14	**21.2**	Years	↑	↑
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male) ≠	2012 - 14	**9.2**	Years	↔	↔
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female) ≠	2012 - 14	**7.0**	Years	↔	↔
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male) ≠	2012 - 14	**80.0**	Count	↔	↔
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female) ≠	2012 - 14	**67.0**	Count	↔	↔
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male) ≠	2012 - 14	**-**	Years		
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female) ≠	2012 - 14	**-**	Years		
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male) ≠	2012 - 14	**0.0**	Years	↔	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female) ≠	2012 - 14	**0.0**	Years	↔	
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male) ≠	2012 - 14	**19.0**	Years	↔	↔
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female) ≠	2012 - 14	**20.2**	Years	↔	↔
0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Male) ≠	2009 - 13	**-**	Years		
0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas (Female) ≠	2009 - 13	**-**	Years		
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Male) ≠	2012 - 14	**-**	Years		
0.2vii - Slope index of inequality in life expectancy at birth within English regions, based on regional deprivation deciles within each area (Female) ≠	2012 - 14	**-**	Years		

Domain: Wider determinants of health					
Indicator	**Period**	**Value**	**Unit**	**Change from prev**	**Change from base**
1.01i - Children in poverty (all dependent children under 20) ≠	2013	**18.0**	%	↓	↓
1.01ii - Children in poverty (under 16s) ≠	2013	**18.6**	%	↓	↓
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception (Persons) ≠	2014/15	**66.3**	%	↑	↑
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception (Male) ≠	2014/15	**58.6**	%	↑	↑
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception (Female) ≠	2014/15	**74.3**	%	↑	↑
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception (Persons) ≠	2014/15	**51.2**	%	↑	↑
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception (Male) ≠	2014/15	**42.6**	%	↑	↑
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception (Female) ≠	2014/15	**60.3**	%	↑	↑
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check (Persons) ≠	2014/15	**76.8**	%	↑	↑
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check (Male) ≠	2014/15	**73.0**	%	↑	
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check (Female) ≠	2014/15	**80.8**	%	↑	
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Persons) ≠	2014/15	**64.7**	%	↑	↑
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Male) ≠	2014/15	**59.5**	%	↑	
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (Female) ≠	2014/15	**70.1**	%	↑	
1.03 - Pupil absence ≠	2013/14	**4.5**	%	↓	↓
1.04 - First time entrants to the youth justice system ≠	2014	**409.1**	Crude rate per 100,000	↓	↓
1.05 - 16-18 year olds not in education employment or training ≠	2014	**4.7**	%	↓	↓
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons) ≠	2014/15	**73.3**	%	↓	
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male) ≠	2014/15	**73.2**	%	↓	
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female) ≠	2014/15	**73.1**	%	↓	
1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons) ≠	2014/15	**59.7**	%		
1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male) ≠	2014/15	**58.4**	%		
1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female) ≠	2014/15	**61.3**	%		
1.07 - People in prison who have a mental illness or a significant mental illness	2013/14	**5.6**	%	↑	↔
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2014/15	**8.6**	Percentage point		

1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (persons) ≠	2014/15	**66.9**	Percentage point		
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (male) ≠	2014/15	**71.8**	Percentage point		
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate (female) ≠	2014/15	**62.3**	Percentage point		
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (persons) ≠	2014/15	**66.1**	Percentage point		
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (male) ≠	2014/15	**72.6**	Percentage point		
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (female) ≠	2014/15	**59.3**	Percentage point		
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week ≠	2011 - 13	**2.4**	%	↔	↑
1.09ii - Sickness absence - The percent of working days lost due to sickness absence ≠	2011 - 13	**1.5**	%	↔	↔
1.10 - Killed and seriously injured (KSI) casualties on England's roads ≠	2012 - 14	**39.3**	Crude rate per 100,000	↔	↓
1.11 - Domestic Abuse	2014/15	**20.4**	Crude rate per 1,000	↑	↑
1.12i - Violent crime (including sexual violence) - hospital admissions for violence ≠	2012/13 - 14/15	**47.5**	DSR per 100,000	↓	↓
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population ≠	2014/15	**13.5**	Crude rate per 1,000	↑	↑
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population ≠	2014/15	**1.4**	Crude rate per 1,000	↑	↑
1.13i - Re-offending levels - percentage of offenders who re-offend ≠	2013	**26.4**	%	↑	↔
1.13ii - Re-offending levels - average number of re-offences per offender ≠	2013	**0.8**	Crude rate per offender	↑	↑
1.14i - The rate of complaints about noise ≠	2013/14	**7.4***	Crude rate per 1,000	↓	↓
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	**5.2**	%		
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	**8.0**	%		
1.15i - Statutory homelessness - homelessness acceptances ≠	2014/15	**2.4**	Crude rate per 1,000	↑	↑
1.15ii - Statutory homelessness - households in temporary accommodation ≠	2014/15	**2.8**	Crude rate per 1,000	↑	↑
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2014 - Feb 2015	**17.9**	%	↔	↑
1.17 - Fuel Poverty ≠	2013	**10.4**	%	↔	↓
1.18i - Social Isolation: Percentage of adult social care users who have as much social contact as they would like ≠	2014/15	**44.8**	%	↔	↑
1.18ii - Social Isolation: Percentage of adult carers who have as much social contact as they would like ≠	2014/15	**38.5**	%	↓	↓
1.19i - Older people's perception of community safety - safe in local area during the day ≠	2014/15	**97.6**	%	↔	↔
1.19ii - Older people's perception of community safety - safe in local area after dark ≠	2014/15	**67.6**	%	↔	↔
1.19iii - Older people's perception of community safety - safe in own home at night ≠	2014/15	**94.3**	%	↔	↔

Domain: Health improvement					
Indicator	**Period**	**Value**	**Unit**	**Change from prev**	**Change from base**
2.01 - Low birth weight of term babies ≠	2014	**2.9**	%	↔	↔
2.02i - Breastfeeding - Breastfeeding initiation ≠	2014/15	**74.3**	%	↑	↑
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth ≠	2014/15	**43.8**	%	↓	↓
2.03 - Smoking status at time of delivery ≠	2014/15	**11.4***	%	↓	↓
2.04 - Under 18 conceptions ≠	2014	**22.8**	Crude rate per 1,000	↓	↓
2.04 - Under 18 conceptions: conceptions in those aged under 16 ≠	2014	**4.4**	Crude rate per 1,000	↓	↓
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds ≠	2014/15	**21.9**	%	↓	↓
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds ≠	2014/15	**33.2**	%	↓	↔
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2014/15	**109.6**	Crude rate per 10,000	↓	↓
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2014/15	**137.5**	Crude rate per 10,000	↓	↓
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2014/15	**131.7**	Crude rate per 10,000	↓	↓
2.08 - Emotional wellbeing of looked after children	2014/15	**13.9**	Score		
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey) ≠	2014/15	**8.2**	%		
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey) ≠	2014/15	**5.5**	%		
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey) ≠	2014/15	**2.7**	%		
2.09iv - Smoking prevalence at age 15 years - regular smokers (SDD survey)	2014	**8.0**	%	↔	↓
2.09v - Smoking prevalence at age 15 years - occasional smokers (SDD survey)	2014	**5.0**	%	↓	↓
2.11i - Proportion of the population meeting the recommended '5-a-day' ≠	2015	**52.3**	%	↓	↓
2.11ii - Average number of portions of fruit consumed daily ≠	2015	**2.5**	Count	↓	↓
2.11iii - Average number of portions of vegetables consumed daily ≠	2015	**2.3**	Count	↔	↔
2.12 - Excess Weight in Adults ≠	2012 - 14	**64.6**	%		
2.13i - Percentage of physically active and inactive adults - active adults ≠	2014	**57.0**	%	↑	↑
2.13ii - Percentage of physically active and inactive adults - inactive adults ≠	2014	**27.7**	%	↓	↓
2.14 - Smoking Prevalence ≠	2014	**18.0**	%	↓	↓
2.14 - Smoking prevalence - routine and manual ≠	2014	**28.0**	%	↔	↓
2.15i - Successful completion of drug treatment - opiate users ≠	2014	**7.4**	%	↓	↑
2.15ii - Successful completion of drug treatment - non-opiate users ≠	2014	**39.2**	%	↑	↑
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	**46.9**	%		
2.17 - Recorded diabetes ≠	2014/15	**6.4**	%	↑	↑

2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons) ≠	2014/15	**640.8**	DSR per 100,000	↔	↓
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Male) ≠	2014/15	**826.9**	DSR per 100,000	↓	↓
2.18 - Admission episodes for alcohol-related conditions - narrow definition (Female) ≠	2014/15	**474.2**	DSR per 100,000	↔	↔
2.19 - Cancer diagnosed at early stage (Experimental Statistics) ≠	2014	**50.7**	%	↑	↑
2.20i - Cancer screening coverage - breast cancer ≠	2015	**75.4**	%	↓	↓
2.20ii - Cancer screening coverage - cervical cancer ≠	2015	**73.5**	%	↓	↓
2.20iii - Cancer screening coverage - bowel cancer ≠	2015	**57.1**	%		
2.21i - Antenatal infectious disease screening – HIV coverage	2014/15	**98.9***	%	↓	↓
2.21ii - Antenatal screening for Hepatitis B - coverage	2013	**97.9**	%		
2.21ii - Antenatal screening for syphilis – coverage	2013	**98.0**	%		
2.21iii - Antenatal Sickle Cell and Thalassaemia Screening - coverage	2014/15	**98.9***	%	↔	↔
2.21iv - Newborn bloodspot screening - coverage	2014/15	**95.8**	%	↑	↑
2.21v - Newborn Hearing screening - Coverage	2013/14	**98.5**	%		
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2012/13	**79.1**	%	↓	↔
2.21viii - Abdominal Aortic Aneurysm Screening	2014/15	**97.4**	%	↑	↑
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check ≠	2013/14 - 14/15	**37.9**	%		
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check ≠	2013/14 - 14/15	**48.9**	%		
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check ≠	2013/14 - 14/15	**18.6**	%		
2.23i - Self-reported wellbeing - people with a low satisfaction score ≠	2014/15	**4.8**	%	↓	↓
2.23ii - Self-reported wellbeing - people with a low worthwhile score ≠	2014/15	**3.8**	%	↓	↓
2.23iii - Self-reported wellbeing - people with a low happiness score ≠	2014/15	**9.0**	%	↓	↓
2.23iv - Self-reported wellbeing - people with a high anxiety score ≠	2014/15	**19.4**	%	↓	↓
2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score	2010 - 12	**37.7**	Score		
2.24i - Injuries due to falls in people aged 65 and over (Persons) ≠	2014/15	**2124.6**	DSR per 100,000	↑	↑
2.24i - Injuries due to falls in people aged 65 and over (Male) ≠	2014/15	**1739.8**	DSR per 100,000	↑	↑
2.24i - Injuries due to falls in people aged 65 and over (Female) ≠	2014/15	**2509.5**	DSR per 100,000	↑	↑
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (persons) ≠	2014/15	**1012.0**	DSR per 100,000	↑	↔
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (male) ≠	2014/15	**825.7**	DSR per 100,000	↑	
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (female) ≠	2014/15	**1198.2**	DSR per 100,000	↔	
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (persons) ≠	2014/15	**5351.3**	DSR per 100,000	↑	↑
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (male) ≠	2014/15	**4390.5**	DSR per 100,000	↑	
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (female) ≠	2014/15	**6312.0**	DSR per 100,000	↑	

Domain: Health protection					
Indicator	**Period**	**Value**	**Unit**	**Change from prev**	**Change from base**
3.01 - Fraction of mortality attributable to particulate air pollution ≠	2013	**5.3**	%		
3.02 - Chlamydia detection rate (15-24 year olds) (Persons) ≠	2014	**2012.0**	Crude rate per 100,000	↓	↓
3.02 - Chlamydia detection rate (15-24 year olds) (Male) ≠	2014	**1355.3**	Crude rate per 100,000	↓	↓
3.02 - Chlamydia detection rate (15-24 year olds) (Female) ≠	2014	**2664.2**	Crude rate per 100,000	↓	↔
3.03i - Population vaccination coverage - Hepatitis B (1 year old) ≠	2014/15	**-**	%		
3.03i - Population vaccination coverage - Hepatitis B (2 years old) ≠	2014/15	**-**	%		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) ≠	2014/15	**94.2**	%	↔	↔
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) ≠	2014/15	**95.7**	%	↓	↓
3.03iv - Population vaccination coverage - MenC	2012/13	**93.9***	%	↔	↑
3.03v - Population vaccination coverage - PCV ≠	2014/15	**93.9**	%	↓	↑
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) ≠	2014/15	**92.1**	%	↓	↑
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old) ≠	2014/15	**92.4**	%	↑	↑
3.03vii - Population vaccination coverage - PCV booster ≠	2014/15	**92.2***	%	↓	↑
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) ≠	2014/15	**92.3**	%	↓	↑
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) ≠	2014/15	**94.4**	%	↑	↑
3.03x - Population vaccination coverage - MMR for two doses (5 years old) ≠	2014/15	**88.6**	%	↑	↑
3.03xii - Population vaccination coverage - HPV	2013/14	**86.7**	%	↑	↑
3.03xiii - Population vaccination coverage - PPV ≠	2014/15	**69.8**	%	↑	↓
3.03xiv - Population vaccination coverage - Flu (aged 65+) ≠	2014/15	**72.7**	%	↓	↓
3.03xv - Population vaccination coverage - Flu (at risk individuals) ≠	2014/15	**50.3**	%	↓	↓
3.04 - HIV late diagnosis	2012 - 14	**42.2**	%	↓	↓
3.05i - Treatment completion for TB	2013	**84.8**	%	↔	↑
3.05ii - Incidence of TB ≠	2012 - 14	**13.5**	%	↓	↓
3.06 - NHS organisations with a board approved sustainable development management plan	2014/15	**56.5**	%		
3.07 - Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies ≠	2014/15	**95.2**	%		

Domain: Healthcare and premature mortality					
Indicator	**Period**	**Value**	**Unit**	**Change from prev**	**Change from base**
4.01 - Infant mortality ≠	2011 - 13	**4.0**	Crude rate per 1,000	↔	↓
4.02 - Tooth decay in children aged 5	2011/12	**0.9**	Mean dmft per child		
4.03 - Mortality rate from causes considered preventable (Persons) ≠	2012 - 14	**182.7**	DSR per 100,000	↓	↓
4.03 - Mortality rate from causes considered preventable (Male) ≠	2012 - 14	**230.1**	DSR per 100,000	↓	↓
4.03 - Mortality rate from causes considered preventable (Female) ≠	2012 - 14	**138.4**	DSR per 100,000	↓	↓
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons) ≠	2012 - 14	**75.7**	DSR per 100,000	↓	↓
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male) ≠	2012 - 14	**106.2**	DSR per 100,000	↓	↓
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female) ≠	2012 - 14	**46.9**	DSR per 100,000	↔	↓
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons) ≠	2012 - 14	**49.2**	DSR per 100,000	↓	↓
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male) ≠	2012 - 14	**74.1**	DSR per 100,000	↓	↓
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female) ≠	2012 - 14	**25.6**	DSR per 100,000	↓	↓
4.05i - Under 75 mortality rate from cancer (Persons) ≠	2012 - 14	**141.5**	DSR per 100,000	↓	↓
4.05i - Under 75 mortality rate from cancer (Male) ≠	2012 - 14	**157.7**	DSR per 100,000	↓	↓
4.05i - Under 75 mortality rate from cancer (Female) ≠	2012 - 14	**126.6**	DSR per 100,000	↓	↓
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons) ≠	2012 - 14	**83.0**	DSR per 100,000	↓	↓
4.05ii - Under 75 mortality rate from cancer considered preventable (Male) ≠	2012 - 14	**90.5**	DSR per 100,000	↓	↓
4.05ii - Under 75 mortality rate from cancer considered preventable (Female) ≠	2012 - 14	**76.1**	DSR per 100,000	↓	↓
4.06i - Under 75 mortality rate from liver disease (Persons) ≠	2012 - 14	**17.8**	DSR per 100,000	↔	↔
4.06i - Under 75 mortality rate from liver disease (Male) ≠	2012 - 14	**23.4**	DSR per 100,000	↔	↔
4.06i - Under 75 mortality rate from liver disease (Female) ≠	2012 - 14	**12.4**	DSR per 100,000	↔	↔
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons) ≠	2012 - 14	**15.7**	DSR per 100,000	↔	↔
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male) ≠	2012 - 14	**21.0**	DSR per 100,000	↔	↔
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female) ≠	2012 - 14	**10.6**	DSR per 100,000	↔	↔
4.07i - Under 75 mortality rate from respiratory disease (Persons) ≠	2012 - 14	**32.6**	DSR per 100,000	↔	↓
4.07i - Under 75 mortality rate from respiratory disease (Male) ≠	2012 - 14	**38.3**	DSR per 100,000	↔	↓
4.07i - Under 75 mortality rate from respiratory disease (Female) ≠	2012 - 14	**27.4**	DSR per 100,000	↔	↓
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons) ≠	2012 - 14	**17.8**	DSR per 100,000	↔	↑

4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male) ≠	2012 - 14	**20.1**	DSR per 100,000	↔	↔
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female) ≠	2012 - 14	**15.7**	DSR per 100,000	↔	↑
4.08 - Mortality from communicable diseases (Persons) ≠	2012 - 14	**63.2**	DSR per 100,000	↓	↓
4.08 - Mortality from communicable diseases (Male) ≠	2012 - 14	**74.0**	DSR per 100,000	↓	↓
4.08 - Mortality from communicable diseases (Female) ≠	2012 - 14	**56.4**	DSR per 100,000	↓	↓
4.09 - Excess under 75 mortality rate in adults with serious mental illness ≠	2013/14	**351.8**	Indirectly standardised ratio	↔	↑
4.10 - Suicide rate (Persons) ≠	2012 - 14	**8.9**	DSR per 100,000	↔	↑
4.10 - Suicide rate (Male) ≠	2012 - 14	**14.1**	DSR per 100,000	↔	↑
4.10 - Suicide rate (Female) ≠	2012 - 14	**4.0**	DSR per 100,000	↔	↔
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons) ≠	2011/12	**11.8**	Indirectly standardised proportion	↔	↔
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male) ≠	2011/12	**12.1**	Indirectly standardised proportion	↔	↔
4.11 - Emergency readmissions within 30 days of discharge from hospital (Female) ≠	2011/12	**11.5**	Indirectly standardised proportion	↔	↔
4.12i - Preventable sight loss - age related macular degeneration (AMD) ≠	2013/14	**118.8**	Crude rate per 100,000	↔	↓
4.12ii - Preventable sight loss - glaucoma ≠	2013/14	**12.9**	Crude rate per 100,000	↔	↑
4.12iii - Preventable sight loss - diabetic eye disease ≠	2013/14	**3.4**	Crude rate per 100,000	↔	↔
4.12iv - Preventable sight loss - sight loss certifications ≠	2013/14	**42.5**	Crude rate per 100,000	↔	↔
4.13 - Health related quality of life for older people ≠	2013/14	**0.7**	Score	↔	↔
4.14i - Hip fractures in people aged 65 and over (persons) ≠	2014/15	**571.3**	DSR per 100,000	↓	↔
4.14i - Hip fractures in people aged 65 and over (male) ≠	2014/15	**425.1**	DSR per 100,000	↔	
4.14i - Hip fractures in people aged 65 and over (female) ≠	2014/15	**717.6**	DSR per 100,000	↓	
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (persons) ≠	2014/15	**239.2**	DSR per 100,000	↔	↔
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (male) ≠	2014/15	**166.8**	DSR per 100,000	↔	
4.14ii - Hip fractures in people aged 65 and over - aged 65-79 (female) ≠	2014/15	**311.6**	DSR per 100,000	↔	
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (persons) ≠	2014/15	**1534.6**	DSR per 100,000	↓	↔
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (male) ≠	2014/15	**1174.1**	DSR per 100,000	↔	
4.14iii - Hip fractures in people aged 65 and over - aged 80+ (female) ≠	2014/15	**1895.2**	DSR per 100,000	↓	
4.15i - Excess Winter Deaths Index (Single year, all ages) (persons) ≠	Aug 2013 - Jul 2014	**11.6**	Ratio	↓	↓
4.15i - Excess Winter Deaths Index (Single year, all ages) (male) ≠	Aug 2013 - Jul 2014	**10.0**	Ratio	↓	↓

4.15i - Excess Winter Deaths Index (Single year, all ages) (female) ≠	Aug 2013 - Jul 2014	**13.2**	Ratio	↓	↓
4.15ii - Excess Winter Deaths Index (single year, age 85+) (persons) ≠	Aug 2013 - Jul 2014	**15.8**	Ratio	↓	↓
4.15ii - Excess Winter Deaths Index (single year, age 85+) (male) ≠	Aug 2013 - Jul 2014	**16.4**	Ratio	↓	↓
4.15ii - Excess Winter Deaths Index (single year, age 85+) (female) ≠	Aug 2013 - Jul 2014	**15.5**	Ratio	↓	↓
4.15iii - Excess Winter Deaths Index (3 years, all ages) (persons) ≠	Aug 2011 - Jul 2014	**15.6**	Ratio	↓	↓
4.15iii - Excess Winter Deaths Index (3 years, all ages) (male) ≠	Aug 2011 - Jul 2014	**13.7**	Ratio	↓	↔
4.15iii - Excess Winter Deaths Index (3 years, all ages) (female) ≠	Aug 2011 - Jul 2014	**17.5**	Ratio	↓	↔
4.15iv - Excess Winter Deaths Index (3 years, age 85+) (persons) ≠	Aug 2011 - Jul 2014	**22.3**	Ratio	↓	↔
4.15iv - Excess Winter Deaths Index (3 years, age 85+) (male) ≠	Aug 2011 - Jul 2014	**21.8**	Ratio	↔	↔
4.15iv - Excess Winter Deaths Index (3 years, age 85+) (female) ≠	Aug 2011 - Jul 2014	**22.5**	Ratio	↓	↔
4.16 - Estimated diagnosis rate for people with dementia	2013/14	**52.5**	%		

Corporate objective	Outcomes	Actions	Performance summary
Protecting the public's health We provide national and international leadership and scientific advice to reduce harm from infectious diseases and environmental hazards. We ensure there are effective surveillance arrangements nationally and locally to identify threats and prepare, plan and respond to health protection concerns and emergencies.	**Outcomes:** • tackle antimicrobial resistance • reduce TB • apply cutting-edge science to our work • contribute to improved global health security	Lead health sector delivery of 4 of the 7 national workstreams set out in the antimicrobial resistance implementation plan.	**Achieved**
		Produce new data and intelligence for the NHS on antibiotic prescribing that helps reduce their use.	**Achieved**
		Deliver the first year actions in the TB Strategy for England, including the establishment of local TB control boards in partnership with local government and NHS England.	**Achieved**
		Review and implement a methodology for reference and diagnostic work on TB, including the link into surveillance.	**Achieved**
		Improve access to HIV testing outside conventional sexual health services through working with local authorities to establish a national home sampling service, delivering up to 50,000 postal kits.	**Achieved**
		Deliver routine genome sequencing of specific infectious organisms, enabling developments in whole genome sequencing as part of the 100,000 Genome Project.	**Partially achieved** An ongoing programme of work, but the National Infection Service has already taken significant steps towards delivering TB and salmonella services.
		Review our Centre for Radiation, Chemical and Environmental Hazards (CRCE), strengthening the profile and understanding of its work, and ensuring that its functions are those required by the UK and internationally.	**Achieved**
		Pilot the Global Health Security Agenda (GHSA) assessment tool, making proposals for further development and identifying best practice to share with other participating nations in advance of the annual GHSA ministerial event in September.	**Achieved**
		Continue our support to the international response to Ebola in West Africa and establish a PHE Field Office in Sierra Leone as part of rebuilding its public health capacity.	**Achieved**
		Devise a programme to support national and local action to reduce the health burden in England attributable to air pollution.	**Partially achieved** 2016/17 remit letter sets out joint work with government colleagues.
		Undergo an assessment by the International Association of National Public Health Institutes (IANPHI) of our contribution to the UK and international public health systems, identifying opportunities for further development.	**Deferred** IANPHI is on hold due to implementation of a review of PHE's international function

Corporate objective	Outcomes	Actions	Performance summary
Improving the public's health and wellbeing 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. We promote actions to build healthy places, people and communities, making the case for prevention and early intervention.	**Outcomes:** • reducing smoking and harmful drinking • tackling childhood obesity • reducing dementia risk • ensuring every child has the best start in life • improving workplace health and wellbeing	Deliver over 550,000 quit attempts through our smokefree campaigns, including Stoptober.	**Achieved**
		Publish independent evidence-based reports and advice to government on addressing the health effects of sugar, alcohol and e-cigarettes.	**Largely achieved** Published evidence packages on e-cigarettes (August 2015) and sugar reduction (October 2015). Alcohol: report and advice to be published in autumn 2016.
		Recruit 135,000 new parents into the Start4Life Information Service for Parents and 750,000 new registrations with Change4Life.	**Achieved**
		Review the evidence on what can be expected of the drug treatment and recovery system and provide advice to government to inform future policy.	**Largely achieved** We currently anticipate that the review will be complete and with ministers by the summer.
		Publish a Liver Disease Framework on tackling this preventable disease.	**Largely achieved** The framework is largely complete and is expected to be published in summer 2016.
		Support the development and implementation of a new tobacco control plan, focussed on smoking in pregnancy and targeting wide regional variation.	**Achieved**
		Increase the uptake of the NHS Health Check, giving more people aged 40-74 the opportunity to take increased control over their own health.	**Partially achieved** 68 local authorities either increased the number of people having a check or were on track for 75% of eligible people taking up a check by 2017/18. We remain committed to supporting all local authorities to increase the number of their residents taking up the check.
		Raise awareness of actions people can take to reduce their risk of dementia through NHS Health Checks and provision of evidence-based tools, data and guidance.	**Partially achieved** This forms part of the PM 2020 Challenge on Dementia and we have an action plan in place for the deliverables.
		Successfully transition the Dementia Friends programme to the Alzheimer's Society.	**Achieved**

Corporate objective	Outcomes	Actions	Performance summary
		Roll out a type 2 diabetes prevention programme for 10,000 people at high risk of developing this avoidable disease.	**Partially achieved** 27 first wave sites selected. We expect 10,000 people to enrol in 2016/17.
		Support the development and implementation of a national childhood obesity strategy.	**Largely achieved** We published our evidence package on sugar reduction in the autumn and have since been working closely with DH colleagues on the development of the strategy. At Ministers' request, we have begun the technical work with industry necessary to implement the strategy once published.
		Support an increase in local physical activity by promoting tools, new initiatives and the latest evidence, particularly on sedentary behaviour and its impact.	**Achieved**
		Support the transfer of 0-5 children's public health commissioning from the NHS to local authorities in October.	**Achieved**
		Increase the number of local authorities running a Workplace Wellbeing Charter Scheme using national standards, as well as the number of NHS and other organisations working for accreditation under this scheme.	**Largely achieved** PHE has continued to work with local authorities to support the adoption of the national standards. The majority of existing schemes have now aligned to the national standard.
		Develop evidence-based tools for schools and educational settings to support pupils' mental wellbeing.	**Partially achieved** Toolkit to support schools to measure pupil mental wellbeing has been commissioned.
		Continue to improve recovery rates for drug and alcohol treatment and reduce health-related harms, HIV, hepatitis, TB transmission and drug-related deaths.	**Partially achieved** This is a key area of focus in 2016/17
		Progress towards reaching a chlamydia detection rate of 2,300 per 100,000 nationally by supporting local authorities to increase detection and treatment.	**Achieved**
		Promote and share locally the evidence-base to support sustainable services to deliver the healthy child programme and early intervention to enable families and communities to give all children the best start in life.	**Achieved**

Corporate objective	Outcomes	Actions	Performance summary
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.	**Outcomes:** • establish prevention programmes that reduce growth in NHS activity and improve outcomes in the following areas: atrial fibrillation; hypertension; falls in the frail elderly; smoking in pregnancy; diabetes; and alcohol harm • improve quality and coverage and reduce inequality in uptake of national screening programmes • extend and improve world-class immunisation programmes • support individual and societal behavioural change	Help the NHS to provide a healthy environment for patients, staff and visitors and establish itself as a leader in workplace health and wellbeing.	**Achieved**
		Play our full part in implementing the recommendations of the independent task forces on mental health, cancer and maternal health.	**Largely achieved** This has been completed for mental health and maternal health. Implementation of the cancer recommendations is ongoing, overseen by our new Cancer Programme Board.
		Lead implementation of a preventive service programme to help reduce demand and contribute to the NHS efficiency challenge.	**Achieved**
		Support the Vanguard programme to enable local pilots to maximise their contribution to improving population health.	**Partially achieved** A supporting integration narrative has been developed.
		Implement the quality assurance operating model for national screening.	**Partially achieved** Year one of a three-year plan is mostly complete. Staff in place and consistent operating models in final draft preparing for national training and roll out. Full programme visit schedule planned for 2016/17.
		Assess the faecal occult blood bowel cancer screening trial and publish recommendations on national roll out by March 2016.	**Achieved**
		Complete the second phase pilot of the addition of pulse oximetry to the new born screening programme by spring 2016.	**Achieved**
		Publish an evidence review on the HPV primary screening pilot in 2015.	**Achieved**
		Pilot changes to the screening interval in diabetic eye screening from 1-2 years.	**Partially achieved** The business case has been agreed, and the funding and operation of the system agreed between PHE and NHS England. The re-usability of the system is to be resolved before procurement starts.
		Maintain progress on the roll-out of the bowel scope screening programme so that lead commissioning can transfer into the main section 7A agreement for 2016/17 and continue to progress towards 100% of centres live by the end of 2016.	**Largely achieved** Progress towards complete roll out in December 2016 is ongoing. 48 of the 62 of centres now inviting people for screening.

Corporate objective	Outcomes	Actions	Performance summary
		Improve coverage for flu vaccine for those aged 65 and over and increase coverage for under 65s with liver diseases, neurological disease and immune suppressed, exceeding 50% for each group.	**Largely achieved** 71% uptake in the over 65s.
		Target 60% uptake overall, and at least 40% for each eligible cohort for childhood flu vaccination to children aged 2-4, and school Years 1 and 2; and undertake an end of season evaluation of the impact of health inequalities on coverage.	**Largely achieved** Childhood flu programme was rolled out nationally to all of 17,000 primary schools in England and achieved an uptake rate of 52.8%.
		Review the evidence and make recommendations on the scope of a public campaign to raise awareness of sepsis.	**Achieved**
		Run two national early diagnosis symptom campaigns: Be Clear on Cancer in summer 2015 and a second in early 2016, and pilot a generic symptom awareness campaign in early 2016.	**Achieved**
		Re-run the FAST campaign on recognising and acting on the early signs of stroke.	**Achieved**
Building the capacity and capability of the public health system We support the development of the public health system as a whole – ensuring access to the best evidence and intelligence, to ensure the current and future excellence of the public health workforce and by publishing outcomes to ensure transparency and promote improvement. We work closely with local authorities, the Association of Directors of Public Health, the Faculty of Public Health, the Royal Society of Public Health, Chartered Institute of Environmental Health, the voluntary and community sector, universities and the NHS as we build the capacity and capability of the public health.	**Outcome:** • ensure the public health system is able to tackle today's challenges and is prepared for those emerging in future	Review and make recommendations to government on the future capability, skills and experience of the public health workforce to operate across all public health functions; and to understand the barriers to effective working and freedom of movement in public health irrespective of employer.	**Achieved**
		Review and make recommendations to government on effective health interventions that can support people to return to work in order to inform wider programmes to tackle ill health and support people back into the workplace.	**Largely achieved** PHE continues to work with the Joint Unit on Health and Work on this agenda.
		Support the establishment of a What Works Centre for Wellbeing as an independent charity.	**Achieved**
		Review the evidence on health outcomes of improvements in services for people in detained settings to inform future government health interventions and prioritisation.	**Achieved**
		Support the development of a Mental Health Intelligence Network, creating a transparent and effective benchmarking tool for local authorities and CCGs.	**Achieved**

Corporate objective	Outcomes	Actions	Performance summary
		Establish a single comprehensive national rare disease registration service and non-communicable disease surveillance system.	**Achieved**
		Work with local government and other partners to develop public health professionals at every stage of their career, ensuring a pipeline of future directors of public health ready to meet the challenges of tomorrow.	**Achieved**
		Support local authorities in developing new place-based approaches to improving the public's health.	**Achieved**
		Support local authorities to have an effective suicide prevention plan.	**Achieved**
		Publish a report of the Global Burden of Disease 2013 model with an update for England compared with other countries, including analysis by region and deprivation.	**Achieved**
		On behalf of the NHS National Information Board, and in partnership with NICE, lead work to provide citizens with access to a set of health and care apps endorsed by the NHS.	**Largely achieved** Contracts have now been awarded to providers.
		Further digitise the Personalised Care and Population Health framework and assess the impact of extending nurses, midwives and allied health professionals' knowledge base and their health improvement and protection roles.	**Achieved**
		Implement a cross-government engagement strategy, identifying the priority organisations to influence this year, the actions to achieve maximum impact and measures to review success.	**Achieved**
		Work with the Chief Fire Officers Association and other local and national stakeholders to develop and integrate the public health role of fire and rescue services.	**Achieved**

Our organisation

The outcome of the Spending Review was announced in November 2015, which for us means further reductions in our central grant. Through *Securing our Future*, we had already been considering how best to deliver more for less and so our budget for the spending review period is manageable. As a result we are now much better prepared and able to deliver our remit as well as meet the challenging savings requirements for the coming years. By managing this ourselves we not only save a great deal of money which others may pay to management consultants, but also hold ourselves to account directly when it goes well and when it does not.

The new arrangements for strengthening our local presence went live in July 2015. We changed our geographical footprint to match the nine regions of local government so that we can further improve our focus on supporting place-based work, our response to local priorities, and stronger local delivery of our national functions. Each of the four PHE regions continue to be led by a director who, as well as supporting the eight centre directors, will also be the public health adviser to NHS England in their region. London remains a combined centre and region. We completed the appointment of centre directors with the arrival of Dr Aliko Ahmed as centre director of the East of England, who joined us from Staffordshire where he was director of public health.

We were delighted with the decisions announced in the Autumn of 2015 on our outline business case to establish a PHE Science Hub. In September, the Chancellor announced the government's support for the move of the majority of the functions currently based at PHE Porton to Harlow. In his Spending Review statement in November, he subsequently gave the go ahead for Colindale to join Porton in Harlow and also for this to become our headquarters, creating a single campus for UK public health science. This is a very significant investment in the critical infrastructure of the UK and will ensure we have public health science facilities capable of meeting the nation's needs for decades to come.

The next key steps for the programme are:

- the design required by the local authority as part of the planning submission and for construction procurement to commence
- securing planning permission, a condition for acquiring the former GSK site at Harlow
- site acquisition - leading to enabling and construction work
- procurement of Tier 1 construction suppliers through an OJEU process, leading to detailed design and Tier 2/3 construction procurement

All of these are required for the full business case submission and approval, which we anticipate will be in 2018. A programme of community engagement has now begun, starting with a briefing to members and officers of Harlow Council. Key stakeholders have also been identified for future engagement. A three-day public exhibition was held in Harlow in May 2016, attended by more than 300 local people with the majority of feedback being very positive. The event will be repeated later in the year when the developed plans for the site will be presented reflecting the feedback where possible. The first community newsletter was distributed to coincide with the exhibition. Others will be circulated during important milestones in the programme. A series of other engagement events are also planned including presentations, displays and talks. A web landing page was also launched to keep the community updated with developments.

As reported elsewhere in this report, the annual Ipsos/MORI stakeholder survey results continue to be strong. There are, however, clear opportunities for us to do more. One area for further attention is local government where their positive experience of PHE has dipped in the past year from the consistent high we have previously seen. We think this is in part due to our in-year move from 14 to eight local centres, in part to the system maturing and their needs of us changing, and in part to the in-year cuts and the sense that there might have been more we could have done to reduce or avert these.

This suggests we need to do at least two things better: to re-energise our regular personal contact with local government at a local level, which we know they value, and to accelerate our work on products and services that help on return on investment (ROI) and value for money, and both of these are in hand. We have continued in our commitment to help local government and the NHS know the relative value of different options and have worked to identify and summarise the available ROI tools in relation to the five health improvement priority areas set out in *Evidence into Action*. The aim is to understand how local government and local PHE centres currently use these ROI tools, what type of additional support might be needed from PHE, and gaps in what is currently available. The final report on this work is imminent and we will share its findings in the most useful way, including the development of a searchable database of ROI material. We are also developing new 'opportunity profiles' that set out in simple terms the impact that prevention could have at local level in each geographic area. This is in addition to our existing work on the Commissioning for Value packs and Spend and Outcome Tools for CCGs and local authorities. There is more to come from our cross-PHE health economics programme, led by Professor Brian Ferguson, as set out elsewhere in the annual report.

We commissioned and are acting on the findings of two external reviews during the year, the first of which was on global health – our international work being an inseparable part of our role as the national public health agency. It also generates income, which is increasingly important as we seek to reduce our costs and maintain services and standards at home. We play a wide range of roles on the global stage advising, researching and responding to public health concerns and events all over the world. We act for the UK as the focal point for the World Health Organization International Health regulations and contribute to UK work on global health security. We also have contracts with the Department for International Development to provide support on the ground to Pakistan and Sierra Leone as part of the UK Global Health Strategy and we support work on antimicrobial resistance in different parts of the world. The review points the way towards PHE seizing these opportunities by making sure we understand all of our various global health activities through a new central knowledge management system and clear and unambiguous leadership, and both are in hand.

In recognition of the global nature of public health, the Chancellor has set aside funding for a Public Health Rapid Response Force to allow the UK to deploy on the ground anywhere in the world within 48 hours. The international experience from Ebola in West Africa suggests that had such a capability been in on the ground at the outset of the outbreak, many lives would have been saved and much of the economic damage prevented. This is a joint endeavour between PHE and an academic partner. Money has also been allocated to support the poorest parts of the world to meet the International Health Regulations and to improve international tobacco control.

The second review considered the long-term vision for our Centre for Radiation, Chemical and Environmental Hazards (CRCE). It is clear from the feedback of the high level of appreciation there is for the services and authoritative advice CRCE provides. It is vital that these talents are, as the report recommends, drawn into a clear overarching PHE environmental public health strategy. CRCE will play a leading role in this and, again, we will optimise our approach to environmental public health by better co-ordinating all of our efforts across PHE. With the environment becoming an increasingly obvious public health concern, for example air quality and climate change, we have an opportunity to redefine our role in this sphere while tackling some of the biggest issues of our age.

The principal risks facing the organisation are set out in the Governance Statement on pages 97 to 124.

Staff engagement

Alongside the changes delivered through *Securing Our Future,* we have placed significant emphasis over the past year on how we have changed our way of working to deliver efficiencies with a real focus on getting the most from the resources we have available alongside a developing programme of how we ensure we look after people's health and wellbeing.

Through a joint HR and organisational development (OD) initiative to strengthen our management capability, we completed and delivered 18 bespoke one-day development programmes across the country, offering over 1,500 of our managers the tools and techniques to improve their own skills particularly around feedback, team development, health and wellbeing, and diversity and inclusion.

Staff across PHE have been closely involved in the development of our People Charter, which describes our values and highlights four key elements to think about when working with colleagues both internally and externally: communication, achieving together, respect for each other and excelling for our customers. A number of sessions for managers on how to embed the Charter have been delivered, and seminars open to all staff are currently being rolled out. The Charter sits alongside our *PHE Code of Conduct* and will be considered in this year's staff appraisal process. Our Code of Conduct, which incorporates both the Civil Service Code that applies to all our staff, and our professional responsibilities as the national public health agency, is critically important to our staff and stakeholders alike. Agreed with central government colleagues during the passage of the reforms to the health and care system, it safeguards our scientific and public health professionals' right to speak and publish freely to the evidence while at the same time recognising the requirements of the Civil Service Code. During the year, one member of staff raised concerns about compliance with the Civil Service Code. This has been investigated by the Civil Service Commissioners, who will be convening a panel of Commissioners to decide on the complaint in the summer of 2016, the outcome of which will be reported by them in the public domain.

To support our People Charter, we developed a one-pager on ground rules called 'Let's Talk', which forms the basis of all our interactions on a one-to-one level; working with teams and in meetings. These are produced in easily accessible form for meeting rooms across organisation. Our in-house organisational development team has continued to work with many different teams and professions across the organisation throughout the year. Over 200 separate team facilitations have taken place with many more being delivered locally. Our focus has continued to be on creating and sustaining high performing teams so that PHE is a great place to work, stay and make a difference. Through this we support the public health system promoting this as a great profession to join, be part of and influence.

Our online teams and leadership website www.teams-and-leadership.com, receiving around 10,000 hits a month, continues to offer support and resources available to individuals and teams. It includes a repository of our own development resources that are used by our 80 in-house trained facilitators. Alongside this we have delivered over 300 individual and team psychometric assessments.

In addition to the facilitators network we also have over 100 engagement agents who come from a range of levels and backgrounds across the organisation. They work collaboratively with our 150 health and wellbeing champions to ensure there is seamless support for our staff, ensuring clear communication and opportunities for staff to influence.

At the start of this year we developed a PHE coaching and mentoring scheme which allows any of our staff to access to over 50 trained coaches to be an in-house resource matched appropriately at a significantly reduced cost. This builds on our culture of continuous improvement and encourages individual ownership and responsibility across all levels.

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, and we have reflected on the key messages in the Governance Statement elsewhere in this report. More generally, advice has been given on how to interpret the results alongside practical advice on how to deliver improvements. We also ran a follow-up survey to ask staff: 'What one action would most improve things for you at work in the next 12 months?' The results from this were combined with the main results to develop our corporate action plan, which is driving our response to the survey across the organisation.

As part of our response to staff wanting an organisation that allows us to 'speak out', we have revised and improved our whistleblowing policy working collaboratively with our trade union partners and incorporating best practice from the charity Public Concern at Work. We have appointed a number of 'speak out advisers', who are trained PHE staff separate from HR and the line management, available to support any individual who requires it. We have also launched our own internal workplace mediation service, to help resolve conflict in the workplace and drive effective relationships at work.

Following the government's agreement to the outline business case to create a world-class public health facility at Harlow, we have started to develop our emerging engagement strategy that will look at how we create the vision and enthusiasm as we prepare to start to move many of our functions in 2019. Working in partnership with staff side colleagues, we are now developing a suite of bespoke policies for the Science Hub programme on organisational change, relocation, flexible working, recruitment and retention and so on. We are also in the early stages of developing relocation support, commissioned through Cartus as the government framework provider for this, who have extensive experience of other major public sector relocations. In addition, we have started workforce planning for the relocation process and developing resources for managers and their staff to support discussions on change and relocation. A monthly Science Hub bulletin was launched in April 2016, featuring regular updates around communications and engagement, design updates, the forward plan and construction.

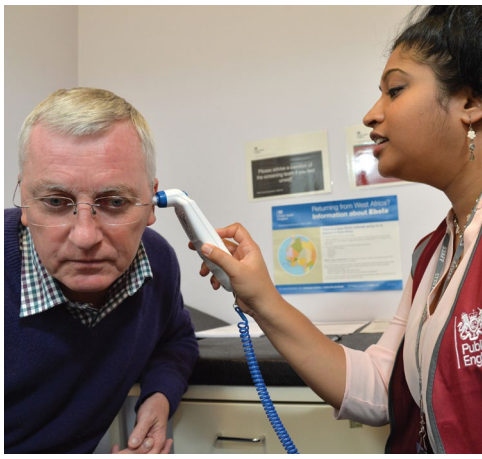
Our internal monthly communication *Team Talk* continues to inspire a wide set of conversations at all levels on contemporary key topics. We have also developed our senior leadership forum where our most senior leaders get together regularly to discuss priorities, share best practice, challenge and support 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 facilitates arrangements for accredited employee representatives.

Occupational health and staff wellbeing

In April 2015, we brought together our in-house occupational health and staff wellbeing teams into one overarching service under the leadership of Dr Sally Coomber, a consultant occupational physician. The aim is to protect and improve the health of our staff through a range of primary, secondary and tertiary services based on six clinical workstreams:

- hazardous substances, including: occupational immunisations (over 1,000 appointments during the year); health surveillance to rapidly identify and act on any work-related ill-health; and responding to any workplace exposure
- mental health, including: prevention by helping identify and manage work stressors; supporting a network of trained mental health first aiders; individual support through the employee assistance programme; and advice on work and interventions for staff who become unwell and the managers who support them

- musculoskeletal health, focusing on a more proactive approach, particularly for those working in laboratory settings. 232 staff received physiotherapy to help them return or stay well at work during the year
- travel health, working in partnership and collaboration with other partners in the NHS and beyond to ensure staff engaged in overseas work are well prepared, particularly when travelling to the tropics
- advice to managers, including 167 new starter assessments following pre-placement screening and 576 formal management referrals for existing staff
- staff wellbeing, including: encouraging our staff to be more physically active, more resilient and through a network of workplace wellbeing champions ensure staff are informed and engaged in what services are available; responding to the results of the 2015 staff wellbeing survey; providing flu vaccination; and launching our *One You* campaign



Workforce diversity and inclusion

During 2015/16, we strived to create a more diverse and talented workforce by:

- improving the quality of our workforce data for staff with protected characteristics through the use of the Electronic Staffing Record self-service facility
- expanding the role of the Head of Diversity and Staff Inclusion to incorporate recruitment and learning and development functions as head of diverse and talented workforce
- launching the workforce diversity dashboard to support senior managers in addressing any diversity issues within their directorates
- ensuring that mandatory and management training includes diversity confidence, unconscious bias and inclusive management modules
- developing the Diverse and Talented Workforce subgroup, which oversees delivery of actions related to workforce equality issues
- having dedicated executive champions who provide senior accountability for the delivery of their part of the workforce diversity plan
- developing three active staff diversity networks: Black and Minority Ethnic (BAME); Disability; and Lesbian, Gay, Bisexual and Transgender (LGBT). Our position in the Stonewall Workplace Index rose by 89 places. We currently rank at 128 out of all UK employers that take part in the annual national survey, and we aim to at least reach the top 100 next year

- launching the internal mentoring circle for BAME staff, which is led by senior lead mentors for each circle
- increasing the fairness and equality of recruitment through unconscious bias training in recruitment and selection workshops and bespoke guidance around job descriptions and panels
- ensuring all staff achieve their potential through targeted mentoring, coaching and innovative trainee management programmes
- partnering with external specialist agencies to widen our talent pool
- continuing to benchmark against external best practice
- working with Project Search to provide placements for young adults with learning disabilities
- working with MOSAIC to provide paid placements for adults who are living with a mental health condition
- reporting against the Workforce Race Equality Standard developed by NHS England
- creating 19 apprentices by 31 March 2016, with a target of 120 by March 2017
- providing over 50 opportunities for work placements for young people aged 18 to 24 who are not in employment, education or training through the Movement to Work scheme, resulting in 17 placements and four subsequent appointments

In May 2016, we held our first Diversity and Staff Inclusion Awards, celebrating the commitment and achievements of PHE staff to help make sure our organisation is an inclusive place to work, and highlighting the value of diversity in the workplace. Looking forward, our aims for 2016/17 are to:

- increase the declaration of protected characteristics through a number of declaration campaigns
- launch internal mentoring circles for identified targeted groups, including senior women and isolated LGBT staff
- develop an emerging leaders programme to uncover ‘whispering talent’, including staff who share certain protected characteristics
- development of carers and flexible working champion networks
- continue to reduce the rate of sickness absence and grievances among all groups of staff, including those with protected characteristics
- launch a reasonable adjustment passport to support staff with a disability within the workplace
- extend the PHE diversity and staff inclusion awards to include categories for other external partners
- continue to offer free consultancy and support for external organisations, making the clear link between effective diversity and staff inclusion and the health and wellbeing of staff

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 Director of Corporate Affairs, 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.

Management Committee 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, including the local site safety committees at our scientific campuses at Chilton, Colindale and Porton.

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 setting out specific legal duties on this 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 staff.

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, which meets biannually, provides governance on health inequalities and equality and diversity activity both within PHE and in relation to leadership across the health and care system.

In February 2016, we published *Equality in Public Health England: How we met the public sector equality duty in 2015*, available at www.gov.uk/phe. This was prepared by our Health Equity Unit with contributions from our Equality Working Group, which has representation from across the organisation. It covers key activities and publications that have supported fulfilment of our equality objectives and describes equality and diversity information about our staff. The report gives an account of our commitment to equality and diversity and identifies specific areas for further improvement, for example, in relation to the quality of data we hold on staff characteristics. There is good evidence of progress on equality issues across the organisation, for example, as evidenced through our new *PHE Framework for Action on Health Inequalities*. Designed for staff, it explains our role in promoting equality and diversity and reducing health inequalities and the governance arrangements. It sets out the general activities staff can take to make progress on equality and reducing health inequalities, such as using our Health Equity Assessment Tool. At the heart of the framework for action is a set of specific commitments that we will undertake in 2016/17.

Our seven equality objectives were developed in 2014 and so we will be consulting our staff, stakeholders and the public on an update to our equality objectives to ensure that they are relevant and appropriate. This work will be undertaken by the Health Equity Unit in 2016, with the aim of publishing new equality objectives in 2017.

Public involvement

Our social marketing programmes contribute 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. Reflecting the widespread availability of the internet, particularly through the prevalence of smart phones, 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. In March 2016 we launched *One You*, a new evidence-based campaign designed to reduce health inequalities. The Global Burden of Disease UK study, *The Lancet* in September 2015, revealed that in the past 25 years there has been little, if any, reduction in the gap between life expectancy for those living in the most deprived areas and those living in the least deprived areas. *One You* aims to support people in taking control of their own health, with three important new features. First, it openly recognises the influence of the social environment on health. Second, it helps people to think about stress, and how to reduce this. And third, it makes use of cloud and smart phone capability to allow us to move from advertising to personalised information and support.

We have continued to increase the membership of our People's Panel, maintaining its position as the largest health sector consumer panel of its kind in the UK, and have updated our public involvement strategy. In November 2015, we took part in the Children Commissioner's Takeover Day, joining hundreds of organisations who welcomed young people in to take part in their day-to-day business. Eight young people took over that month's Board meeting, sharing their views and posing some challenging questions. Their views and suggestions were captured in the Board's watchlist and they will be updating us on whether or not they think we have acted on these later this year.

Freedom of information

We received 686 information access requests (2014/15: 703), the majority of which were handled under the Freedom of Information Act 2000, others being under the Environmental Information Regulations 2004 and Data Protection Act 1998.

Enquiries received through www.gov.uk/phe

We received 4,581 online enquiries from the public and stakeholders (2014/15: 4,642).

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 82 complaints were handled during the year (2014/15: 72).

The Parliamentary Health Service Ombudsman (PHSO) investigated three complaints raised by MPs on behalf of their constituents. Two complaints were about testing services for Lyme disease and were not upheld. The PHSO has yet to conclude their assessment of a complaint concerning PHE's advice regarding radiofrequency electromagnetic fields.

Parliamentary questions

We responded to 696 parliamentary questions on a wide range of subjects (2014/15: 714). Topics that generated the most questions were diet and obesity, screening, immunisations, public health marketing campaigns, and infectious diseases.

PHE Honours in 2016

Chief Nurse Professor Viv Bennett received a CBE for her services to nursing

Head of Microbiology Technical Services Neil Bentley received an OBE for setting up mobile diagnostic laboratories in Sierra Leone during the Ebola outbreak

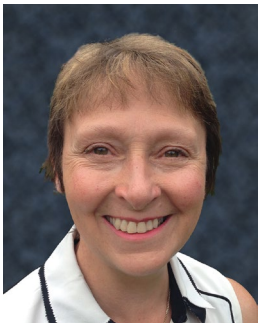
Director of the Rare and Imported Pathogens Laboratory Dr Tim Brooks received a CBE for leading the UK laboratory response to Ebola

Director for Health Protection and Medical Director Professor Paul Cosford was appointed a Companion of the Order of the Bath (CB)

Director for London, Professor Yvonne Doyle, was appointed a Companion of the Order of the Bath (CB)

Director for the South of England Dr Jenny Harries received an OBE for leading Ebola screening at the main UK ports of entry throughout the Ebola outbreak

Consultant in Dental Public Health Eric Rooney received an MBE for services to dentistry



Pauline Watts received an OBE for services to nursing

The Ebola Medal for Service in West Africa

In April 2015 the Queen approved a proposal for the issue of a special medal to recognise service by civilian and military personnel involved in the response to the Ebola crisis in West Africa. The following PHE staff received the medal:

Dr Emma Aarons
Dr Babak Afrough
Dr Christina J Atchison
Barry Atkinson
Simon R Bate
Neil Bentley
Marie Louise Blackman-Northwood
Daniel Paul Carter
Dr Samuel L Collins
Lauren Cowley
Sofiri I Daminabo
Dr Jacqueline Findlay
Dr Simon GP Funnell
Yper Hall
Mahmoud Haque
Laura Holding
Thomas Robert Scott Inns
Professor Paul Johnstone
Halima Koroma
Dr Angie Lackenby
Faye Lanni
Stephanie Yan Kei Leung
Dr Christopher H Logue
Dr Richard Loy
Hitiksha Maru
Tanya Mikaiel
Rory Wenman Miles
Sophie Newitt
Dr Autilia Newton
Didier Ngabo
Dr Jim OBrien
Thomas Pottage
Dr Kevin S. Richards
Charlotte Anne Louise Sarfas
Dr Andrew JH Simpson
Kimberley Steeds
David Stevenson
Dr Ruth E Thom
Howard Tolley
Suzan CM Trienekens
Dr Jane Turton
Dr Inês Vitoriano
David Wooldridge
Neill Keppie
Clare Wend-Hansen
Massimo Mentasti
Dr Nick Gent
Dr Julie Johnson
Hilary J Moulsdale
Dr Anjna Badhan
Kieran Allen
Dr Bengü Said
Professor Noel Gill
Dr David Bibby
Diana Blackshaw
Dr Laura Bonney
Shane Breckenridge
Phillip Brown
Samantha Buck
Joseph Buckler
Jason Busuttil
Professor Miles Carroll
Michelle Cole
Anthony Crook
Jade Derrick
Dr Meeta Desai
Monika Dlubala
Clare Etheridge
Edward Fuller
Dr Benedict Gannon
Laura Grice
Dr Suzanna Hawkey
Becky Haywood
Dr Charlotte Hendon-Dunn
Dr Kevin Herbert
Martin Hesford
Dr Graham Holliman
Samantha Kitchener
Colin Klobuch
Matthew Knight
Dr Arinder Kohli
Anna Kwiatek
Cristina Leggio
Marlon Martinez
Aleksandra Miłoszewska
Sarah Phillips
Danielle Pixton
Dr John Poh
Jacquelyn Potgieter
Jade Richards
María Saavedra-Campos
Dr Nandini Shetty
Angela Short
Dr Katherine Sinka
Yvonne Suehong
Jessica Townley
Eleanor Watts
Dr Sabrina Weiss
Katie L Williams
Dr Julia Yelloly
Andrew Bosworth
Katy-Anne Moseley
Kerstin Shand
Katherine Allanson
Samuel Bowditch
Amy Coward
Amanda Daniel
Dr Michaela Day
Steven Diggle
Ibrahim Dumbuya
Danielle Hall
Rachel Hart
Dr Charlotte Hind
Dr Lisa Ottowell
Lisa McLean
Dr Bruno Pichon
Michael Putland
David Roberts
Sweety Tulcidas
Annie Browne
Antonio Isidro Carrión Martín
Mark Ware
Christopher Hudson
Maria Teixeira
Wilfred Nyoni
Shea Creaven
Benjamin Brown
Dr Jane Greatorex
Christiana Adesanwo
James Barnes
Fran Ludwig
Natasha Ohemeng-Kumi
Elaine Cheung
Firat Kartal
Kate Nolan
Aziz Osman
Elizabeth Halkett
Danielle Anderson
Dr Shoshanna May
Elsa Barrero
Philippa Unsworth
Dr Antonio Peña-Fernández
Barry Gibney
Dr Jane Shallcross
Jodie Clewlow
Melanie Clifford
Maj (Retd) Nick Cairns
Dr Barry Evans
Ian Rufus
Dr Mark Salter
Amy Mikhail
Dr Hamish Mohammed
Dr Keith Neal
Nicola Cook
Dr Addisalem Gulilat Taye
Kate Martin
Ross Fothergill
Stephanie Walker
Delaram Akhavein
Dr Makie Taal
Dr Vivienne James
Kathryn Ann Ryan
Roble Barre

Financial review

Accounts direction

The financial statements contained within our third annual report and accounts relate to the financial year 1 April 2015 to 31 March 2016. They have been 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.

During the 2015/16 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 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

Our 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 awarding bodies and the devolved administrations.

Funding in 2015/16

For 2015/16, the funding provided by the DH for our three operating segments was as follows:

- local authority grants: specific programme revenue within a limit of £3,036m (2014/15: £2,794m)
- vaccines: specific programme revenue within a limit of £476m, including depreciation and the cost of disposals (2014/15: £387m)
- operating activities: non-specific administration and programme revenue within a limit of £429m (2014/15: £448m)

Financial performance

In 2015/16, 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 2015/16 year was an underspend of £1.6m on a total operating budget of £3,941m. This compares with the 2014/15 underspend of £5.4m on an operating budget of £3,629m.

Financial control is achieved across the organisation 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 2015/16 year, cognisant of future financial pressures, we operated at staffing levels below our budgeted establishment in order to maximise the scope for future organisational redesign. As a result, we were able to absorb the costs of the Science Hub project, which had been budgeted by DH separately from our main allocation.

Our financial out-turn was supported by operational income of £152.2m (2014/15: £169.4m) earned from trading activities and research funding. The 2015/16 income was lower than the previous year because PHE has since corporatised its biopharmaceutical manufacturing function through creating Porton Biopharma Ltd.

Vaccines and counter measures response ('vaccines') sales of £75.9m (2014/15: £66.5m) 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 and fully in line with operational guidelines.

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 is reviewed continually as part of the efficient management of the organisation.

Our operating expenditure 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 2015/16 totalled £3,939.7m (2014/15: £3,623.2m). The following table 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)	2015/16			2014/15		
	Budget	Actual	Variance	Budget	Actual	Variance
External income:						
Operating activities	169.4	152.2	(17.2)	169.4	169.4	-
Vaccines	75.9	75.9	-	66.5	66.5	-
Total external income	**245.3**	**228.1**	**(17.2)**	**235.9**	**235.9**	**-**
Expenditure:						
Pay	311.4	303.6	7.8	316.7	315.1	1.6
Non-pay	262.0	251.0	11.0	276.2	272.4	4.9
Local Authority Grants	3,036.2	3,036.2	-	2,794.9	2,794.9	-
Vaccines (excluding depreciation)	551.0	551.0	-	453.4	453.4	-
Depreciation	26.0	26.0	-	23.3	23.3	(1.1)
Total expenditure	**4,186.6**	**4,167.8**	**18.8**	**3,864.5**	**3,859.1**	**5.4**
Net expenditure	**3,941.3**	**3,939.7**	**1.6**	**3,628.6**	**3,623.2**	**5.4**

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

- net gain on revaluation of property, plant, equipment assets of £10.1m (2014/15: gain 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, universities 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 the wider public health system, while supporting the life sciences and UK economic growth.

In 2015/16, we generated total external income of £228.1m, including operational income of £152.2m from supplies and services to third parties, which is broken down in the following table:

External income (£m)	2015/16			2014/15		
	Budget	Actual	Variance	Budget	Actual	Variance
NHS laboratory contracts	61.1	59.5	(1.6)	51.0	53.0	2.0
Research grants	20.3	22.7	2.4	24.5	23.8	(0.7)
Commercial services	30.6	27.8	(2.8)	29.2	28.9	(0.3)
Products and royalties	43.4	25.6	(17.8)	56.0	53.8	(2.2)
Other	14.0	16.6	2.6	8.7	9.9	1.2
Operating activities	**169.4**	**152.2**	**(17.2)**	**169.4**	**169.4**	**-**
Vaccines	75.9	75.9	-	66.5	66.5	-
Total external income	**245.3**	**228.1**	**(17.2)**	**235.9**	**235.9**	**-**

The 2015/16 income was lower than originally budgeted primarily because third party royalties were lower than budget and because biopharmaceutical products are now sold by Porton Biopharma Ltd and the first dividend will be received in the 2016/17 year. This was recognised during the year and internal targets were adjusted accordingly.

Local government public health grant

We provide a public health grant (£3.0bn in 2015/16) to local authorities to support every upper tier and unitary local authority to fulfil its duty to improve the public's health. I am the Accounting Officer for the grant. Local authorities are required to discharge a number of mandated services, but are otherwise free to set their own priorities, working with local partners, through their health and wellbeing boards. As set out elsewhere in this annual report, we support local authorities by providing evidence and knowledge on local health needs and by taking action nationally where it is best placed to do so. I have reflected on the reductions to the grant in-year and across the Spending Review period, as well as on the future of the grant, in my Governance Statement elsewhere in this annual report.

Vaccines and countermeasures response (vaccines)

Within the remit set out in the Framework Agreement and annual remit letter from ministers, we undertake on behalf of 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 2015/16, 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 counter measures response (£m)	'Cash'	'Resource'	Total
Revenue items (including depreciation)	369.6	106.2	475.8
Capital items	48.5	(105.5)	(57.0)
Total	**418.1**	**0.7**	**418.8**

Relationships with suppliers

We are committed to the Better Payment Practice Code. Its 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
- 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 slightly faster than the recorded statistics.

In 2015/16, 80% of supplier bills were paid within 10 days and 90% 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
Value of invoices (£000s)	243,485	32,367	68,422	66,864	411,137
	59%	8%	17%	16%	100%
Number of invoices	**65,452**	**9,135**	**9,441**	**9,567**	**93,595**
	70%	10%	10%	10%	100%

Full monthly statistics on our prompt payment data can be found 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 15 to the financial statements and in the Remuneration and Staff Report.

Efficiency measures and delivering value for money

We participate fully in the government's governance controls and transparency rules. Expenditure and procurement controls are embedded throughout our business-as-usual processes and complement operational management. As reported elsewhere in this annual report, during the 2015/16 year we concluded the Securing Our Future programme, which challenged operational structures and sought more efficient ways of working, thereby delivering best value for money. The outcomes of the review are being implemented as revised organisational structures and closer working relationships.

Back office review

We are committed to continuously improve our 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 our back office services to best practice benchmark standards and have achieved efficiency gains in these areas.

Hosted services

In 2015/16 we continued to provide a hosted service to the Medicines and Healthcare products Regulatory Agency (MHRA) in respect of transactional accounting. The income and expenditure entries as processed through the hosted service do not form part of our accounts. This arrangement will continue through 2016/17 but is expected to cease by the end of the year, with MHRA taking the service into their new accounting system.

From April 2015, we provided a range of support services to Porton Biopharma Ltd (see below). These services formed part of an overall charge for 'overheads'. As with the MHRA arrangement, the income and expenditure transactions processed by us do not form part of our accounts.

Porton Biopharma Ltd

In 2014/15, in conjunction with DH, we agreed a business case to create a spin-out company to undertake our pharmaceutical development and production processes. 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 PHE's site at Porton, in Wiltshire. PBL is a company limited by shares, with 100% of the shares being owned by the Secretary of State for Health (SoS). In turn, 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. As 2015/16 was PBL's first year of trading no dividend was declared 'in year'. The dividend to be paid in respect of PBL's profits for 2015/16 will be taken as income by us in our 2016/17 accounts.

Future developments

The government spending review process continues the drive to reduce public spending, with plans for significant reductions in funding in 2016/17 and beyond. Like all public services, we face financial challenges in the short term. As reported above and elsewhere in this annual report, we concluded our major change programme, Securing Our Future, transitioning into business as usual from 1 April 2016 onwards. Other operational functions will adopt closer, more efficient, working relationships while all the back office functions have been set efficiency savings targets.

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 Board and Management Committee have reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future. For this reason, the Board and Management Committee 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 the external auditor of PHE under section 7 of the Government Resources and Accounts Act 2000. The auditor's remuneration for 2015/16 was £194,000. This is a notional fee. 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.

Sustainable development

Since our establishment in 2013 we have introduced a number of carbon related reduction targets for our estate, including for utility usage, business travel, water consumption and total waste. Our baseline year for carbon reporting is 2013/14, relative to the Greening Government Commitment initiative and HM Treasury reporting strategy.

We own six of the premises we operate from and have a direct relationship with the utility provider at a further six. We also have shared facilities embedded in government-owned properties (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 SSSI or AONB boundaries. Details of our sustainability activities in 2015/16 are set out below.

We have set a target to reduce our carbon emissions by 3% annually to March 2020, compared to our baseline year of 2013/14, which is in line with the government's Greening Government Commitment initiative. Preliminary analysis indicates that PHE's total carbon emissions for 2015/16, inclusive of business travel and water use are 24,963 tCO_2e, compared to 26,274 tCO_2e for 2013/14. This represents a reduction of 4.98% on the baseline year; and a 2.59% reduction on the 2014/15 figure. These data comprise the Scope 1, 2 and 3 carbon emissions from our reportable and non-reportable sites, namely those offices and or laboratories that are being reported separately by the premises landlord. As noted below, PBL's emissions are being reported by us for this financial year as a non-reportable site for transparency purposes.

In April 2015, our Porton site saw a major change, with its manufacturing infrastructure separated as a new government enterprise, Porton Biopharma Limited (PBL), a company wholly owned by the Secretary of State. We will cease to report data for PBL in future but, for completeness this year, its 2015/16 carbon emissions have been included as non-reportable data.

There has been a significant decrease in business travel from using our owned or leased vehicles over the last year. We continue to engage staff through our mandatory e-learning training programme on sustainable development. This training is undertaken on a three-year cycle and provides our staff with a good understanding of sustainable development. It also encourages them to act in a sustainable manner and to take into account their impact on the environment.

We have introduced an interactive dashboard that allows members of staff to access quarterly sustainability data for business travel, utility usage (electricity, gas and water), total waste produced and training. This dashboard has been very effective in keeping staff informed about carbon emissions, as well as the associated financial cost to the organisation.

We continue to strengthen our commitment to our green procurement initiatives, by introducing new ways of procuring goods and services. We have also brought together professionals from across the organisation to form a Procurement Action Group that is working to streamline the procurement process and improve efficiency and effectiveness. We also continue to implement our sustainable development management plan, to focus work on sustainability and help the organisation to operate in more sustainable way.

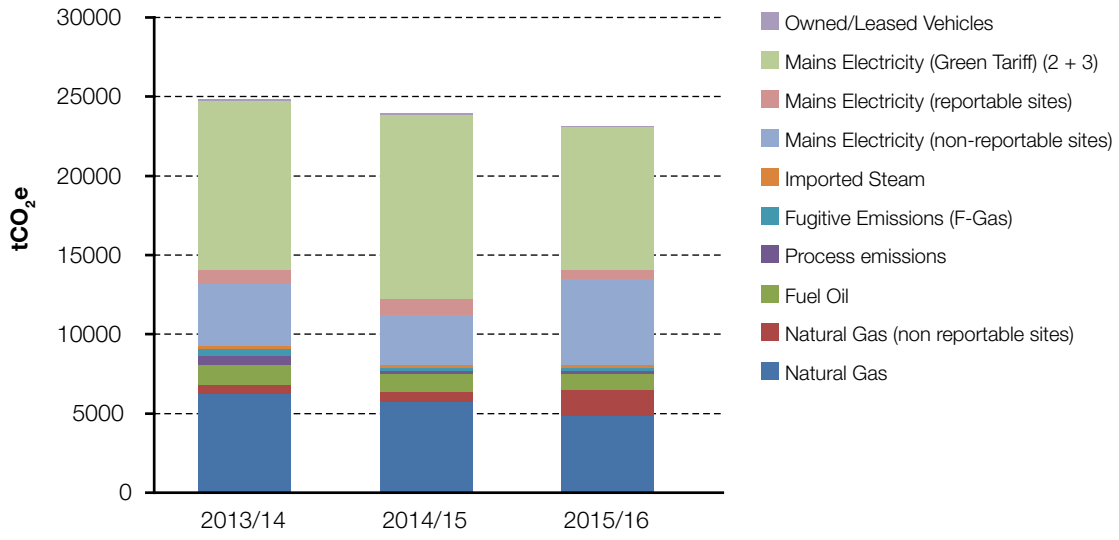
Greenhouse gas emissions

The major impact on the environment from our activities continues to come from electricity and gas consumption at the main sites at Colindale, Porton and Chilton.

Greenhouse gas emissions		2013/14	2014/15	2015/16
SCOPE 1 + 2				
Non-financial indicators (tCO2)	Natural gas	6,229	5,757	4,873
	Natural gas (non-reportable sites)*	577	603	1,618
	Fuel oil**	1,290	1,131	1,026
	Process emissions***	342	362	365
	Fugitive emissions (F-Gas)	504	192	184
	Imported steam	161	140	150
	Mains electricity (non-reportable sites)*	3,924	3,215	5,503
	Mains electricity (reportable sites)	847	966	544
	Mains electricity (green tariff) (2 + 3)	10,723	11,670	9,028
	Owned/leased vehicles	92	88	58
Related energy consumption (kWh)	Natural gas	34,087,464	31,122,541	26,418,276
	Natural gas (non-reportable sites)*	3,133,382	3,301,240	8,811,147
	Fuel oil**	4,747,646	5,758,424	1,328,909
	Process emissions***	1,858,695	1,967,390	1,983,696
	Imported steam	874,444	756,667	812,223
	Electricity (non-reportable sites)*	7,790,559	5,768,624	10,663,221
	Electricity (reportable sites non green tariff)	2,075,589	2,010,903	1,086,342
	Electricity (green tariff)	22,174,537	21,712,905	18,043,598
Related consumption (kg)	Fugitive emissions (F-Gas)	504,038	192,424	184,186
Related Scope 1 travel (km)	Owned/leased vehicles	433,108	442,976	301,851
Financial indicators (£)	Natural gas	1,353,637	1,332,346	1,043,937
	Fuel oil***	326,155	305,699	63,309
	Owned/lease vehicles (fuel/i-expenses)	18,551	18,271	19,923
	Fugitive emissions (F-Gas)****	32,682	2,669	58,407
	Imported steam	70,124	51,057	17,115
	Mains electricity (reportable)	2,576,149	2,642,677	1,986,886
Total Emissions Scope 1 + 2 (tCO_2)		20,188	20,305	16,225
Total gross emissions from non-reportable sites Scope 1 + 2 (tCO_2)		4,501	3,818	7,122

* Porton Biopharma Limited included for 2015/16, as breakdown of data is an estimate.
** Fuel oil only calculated for reportable sites
*** Process emissions from the Porton incinerator waste (kWh x 0.184 conversion factor)
**** F-Gas costs from PHE's major owned sites are absorbed as part of the service contract.

Greenhouse Gas Emissions



Water consumption

We have set a target to reduce our water consumption by 2% annually to 2020, in line with the government's Greening Government initiative. The reportable usage of water for the whole estate was 114,318 m^3, with a further estimated 95,636 m^3 being used by our non-reportable sites. For our reportable sites, this represents a 36% reduction in consumption from last year and a 34% reduction on our baseline year. This is due, in part, to PBL now being included as a non-reportable facility.

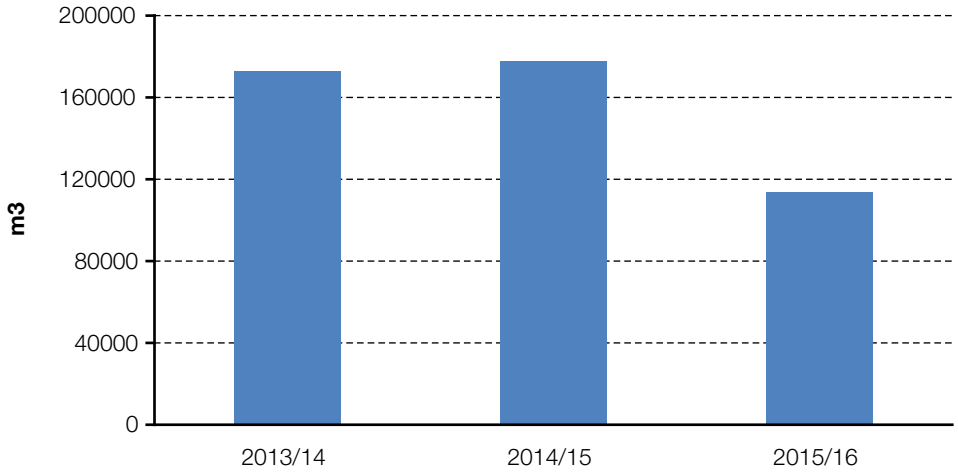
Water		2013/14	2014/15	2015/16
SCOPE 3 (Water)				
Non-financial indicators (m^3)	Water from office estate (reportable)*	684	572	538
	Water from whole estate (reportable) [excluding office estate]	172,757	177,528	113,780
	Total for reportable estate (m^3)	173,441	178,100	114,318
	Water from office estate (non-reportable)**	6,971	8,431	9,556
	Water from whole estate (non-reportable)** [excluding office estate]	17,318	17,067	86,080
	Total for non-reportable estate (m^3)	24,289	25,498	95,636
Financial indicators (£)	Water supply costs***	169,947	164,156	107,190
	Porton Biopharma water costs	-	-	61,261

* Estimated usage from our 6 reportable sites
** Estimated usage (Includes water usage from PBL's manufacturing facility at Porton)
*** Water costs from owned sites

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 overall water consumption.

The financial cost shown in the table above relates to the water that was directly supplied to those sites which are within the reporting boundary. PBL data is being included as a non-reportable facility this year for transparency, but this has significantly reduced our overall reporting burden.

Water from Whole Estate (Reportable)



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

The water supply to our campus sites was monitored and measured, and therefore the pattern of daily usage was known. A number of sub-meters were fitted in 2015/16 to help monitor usage in specific areas and this will facilitate a more refined understanding of usage in future years. Facilities managers will be able to use this information to develop strategies for reducing our water usage.

Waste

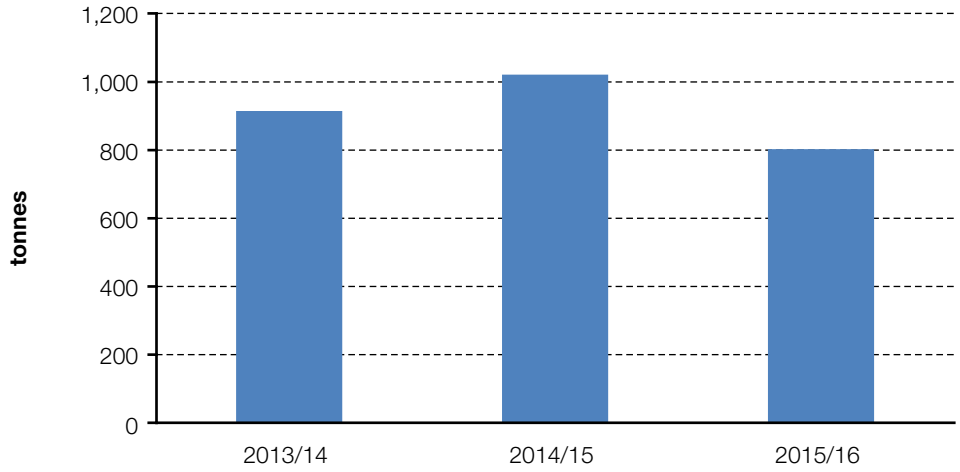
We have set a total waste reduction target of 2% annually to March 2020, in line with the government's Greening Government initiative. Preliminary analysis indicates our total waste figure for 2015/16 was 830 tonnes, a 21% decrease in total waste compared to 2014/15 and a 12% decrease on the baseline figure.

Waste	2013/14	2014/15	2015/16
SCOPE 3 (Waste)			
Non-financial indicators (tonnes)			
Waste recycled externally (non-ICT equipment)	254	331	243
Waste reused externally (non-ICT equipment)	0	4	6
Waste recycled externally (ICT equipment)	8	21	7
Waste reused externally (ICT equipment)	8	17	6
Waste composted or sent to anaerobic digestion	17	34	31
Waste incinerated with energy recovery	252	225	178
Waste incinerated without energy recovery (clinical waste)	329	324	293
Totals			
Total waste not sent to landfill	867	955	764
Total waste sent to landfill deemed non-hazardous	45	57	41
Total waste sent to landfill deemed hazardous (including clinical waste)	29	45	25
Total waste	941	1,057	830
Financial indicators (£)			
Waste recycled externally (non-ICT equipment)	55,939	54,304	60,201
Waste reused externally (non-ICT equipment)	0	250	350
Waste recycled externally (ICT equipment)	7,504	3,196	0
Waste reused externally (ICT equipment)	*0	0	0
Waste composted or sent to anaerobic digestion	2,175	2,836	8,493
Waste incinerated with energy recovery	50,957	49,873	64,733
Waste incinerated without energy recovery (clinical waste)	446,758	356,377	512,779
Totals			
Total non-hazardous waste sent to landfill	9,761	22,494	15,348
Total landfill waste deemed hazardous (including clinical waste)	44,598	25,214	40,847
Total waste (£)	617,692	514,493	702,751

* Data not available

We continue to pursue a robust programme to reduce our total waste, especially non-hazardous waste to landfill, and to increase the level of recycling and reuse wherever practicable.

Total waste



Due to time delays with waste contractor billing data, not all information is currently available and a more detailed analysis will be published in our annual sustainability report later in the year. It should also be noted that the waste data reported here do not include waste produced from our non-reportable sites.

The contractor CDL has been engaged to recycle and reuse, wherever possible, all redundant ICT equipment. ICT waste is collected and disposed of at no cost to PHE, mostly as part of our government contract with CDL. This approach continues to be an effective method of disposal for this waste stream, which is supported by government policy. A total of 13 tonnes of ICT waste has been processed in this manner in the last financial year.

There was a 16-tonne reduction of non-hazardous waste sent to landfill, compared to last year, and a 4-tonne reduction compared to the baseline year.

Due to the nature of the work carried out at a number of our sites, a significant quantity of hazardous waste is produced and the majority of such waste was sent for incineration in compliance with government guidelines. Various controls have been put in place to manage this and we have reduced the hazardous waste sent to landfill in 2015/16 by 20 tonnes compared to 2014/15, and by 4 tonnes compared to the baseline year.

A number of initiatives have been introduced to reduce waste at all PHE locations, covering both offices and laboratories. Contractors working at our sites are regularly reminded about their obligation to reduce their waste wherever possible, in line with our waste policy and associated management arrangements.

Business travel

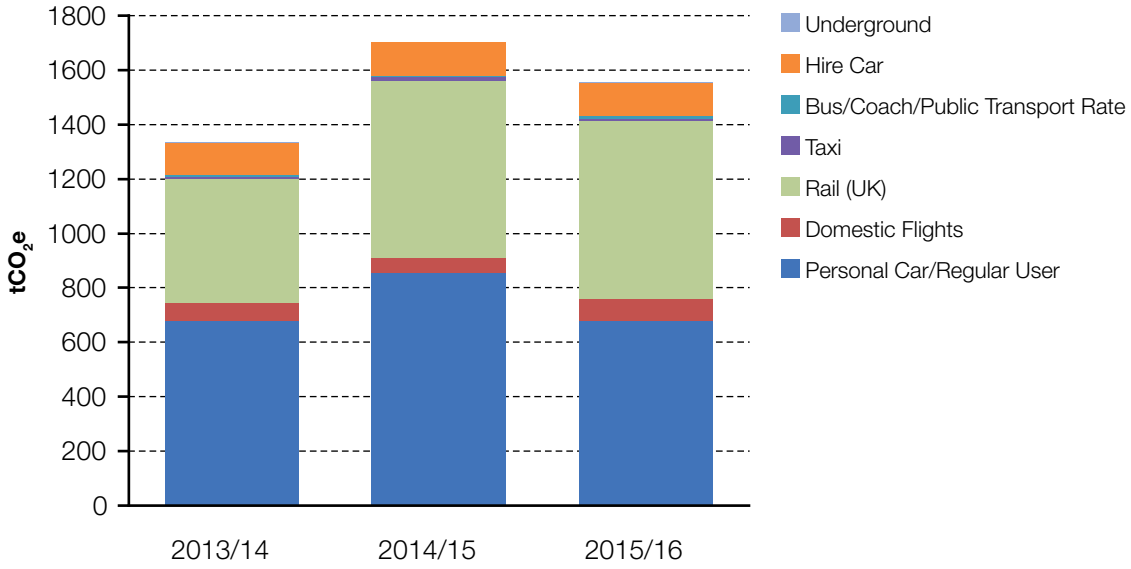
We have set a target to reduce business travel by at least 2% annually, relative to the baseline year of 2013/14, through to March 2020. Staff are encouraged to limit journeys wherever possible and when they must travel, to use the most sustainable modes of transport.

Preliminary analysis indicates that we produced some 1,554 tCO_2e due to business travel in 2015/16. This is an 8.6% reduction in our reportable carbon emissions from business travel, compared to the previous year. We recognise that there is still work to be done to reduce carbon emissions below those from its baseline year. However, the higher figures for the past year reflect factors such as our greater public health involvement in the regions and our continued involvement with Ebola in West Africa.

We have managed to reduce our carbon impact from the use of private vehicles by almost 21% compared to last year, by encouraging staff to use public transport (particularly the train) instead. This is in line with our transport strategy and we will continue to press for improvements in this area.

We have an ongoing campaign to reduce business travel to meetings. Microsoft Lync has been installed on all corporate laptops and staff are actively encouraged to use this and reduce the need to travel. It is recognised that a reduction in our business travel would not only improve local air quality, with the associated health co-benefits, but also support our plans to reduce carbon. This, in turn, leads to cost-savings. A number of further initiatives have therefore been introduced to monitor business travel locally and travelling in a sustainable manner has been highlighted in our sustainability e-learning package. A breakdown of the impact of the various types of business travel is given below.

Business Travel



Business travel		2013/14	2014/15	2015/16
SCOPE 3				
Non-financial indicators (tCO_2)	Personal car/regular user*	681	854	678
	Domestic flights	63	56	83
	Rail (UK)	458	652	653
	Taxi	5	10	8
	Bus/coach/PTR	4	7	7
	Hire car	122	121	125
	Underground	1	1	1
	Total	1,334	1,702	1,555
Related Scope 3 travel (km)	Personal car/regular user	3,580,880	4,510,395	3,637,801
	Domestic flights	366,392	361,677	524,039
	Rail (UK)	9,346,189	13,759,549	14,460,906
	Taxi**	36,830	55,507	50,468
	Bus/coach*/PTR	39,822	65,791	72,150
	Hire car**	641,065	640,602	668,295
	Underground**	7,962	16,063	15,672
	Total	14,019,139	19,409,584	19,429,331
Financial indicators (£)	Personal car/regular user	1,022,687	1,264,866	1,028,793
	Domestic flights	66,494	75,084	92,970
	Rail (UK)	2,970,871	3,705,995	3,882,894
	Taxi	79,901	123,353	112,143
	Bus/coach/PTR	19,739	17,552	33,986
	Hire car	87,639	88,216	102,068
	Underground	45,625	74,365	71,237
	Total	4,292,956	5,349,431	5,324,091
Other business travel (km)	Short-haul international average	1,918,087	1,962,413	1,991,556
	Long-haul international average	4,370,326	5,215,474	6,210,706
	Rail: Eurostar	113,679	95,444	98,988
Total	Total Gross Emissions Scope 3 Business Travel (tCO_2)	1,392	1,702	1,555
	Total Financial Cost Scope 3 Business Travel (£)	4,292,956	5,349,431	5,324,091
	Total Other Financial Cost, not covered in Scope 3 (£)	497,078	636,887	875,865

* The Regular user allowance ended in Q1 of 2014/15
** Figures calculated using our own conversion table

Other activities

We have been engaged in a number of other measures to improve reporting and our understanding of the social, environmental and financial impacts of our operations. A new Sustainable Development and Climate Change Programme Board has been established to oversee sustainability work across the organisation and to help formulate and co-ordinate the advice we give to local authorities.

We have continued to work actively with the NHS Sustainable Development Unit, which we jointly sponsor with NHS England, in the implementation of the NHS public health and social care sustainable development strategy. Work also continues on delivering health advice about the impact of a changing climate, through our commitment to the National Adaptation Programme.

We have installed a large photo voltaic (PV) array at our site in Porton, with a capacity of 650kW. Our Colindale site has also benefited from the installation of PV panels on large sections of its roof.

Our work in sustainability has been recognised by a number of external organisations this year; we have been highly commended for our work on the science of climate change and health, and as an advocate for a more sustainable and healthier lifestyle.

In February the joint NHS/PHE Sustainable Development Unit published its latest assessment of the progress we are making in the *Sustainable Development in Health and Care Report – Health Check 2016*. This report spells out what work has been done to reduce carbon emissions from the NHS and social care. These efforts are working, with a 13% reduction in carbon emissions from the health and care sector between 2007 and 2015. This is good progress especially when considering health and care activity has increased by 18% over the same period. However, more will need to be done to reach the Climate Change Act target of 80% by 2050. The report also identifies, as others have recently, that positive public health action will also have positive carbon impacts. For example, by helping people make changes in their life that prevent or delay ill health, we can collectively reduce the burden on NHS and local authority services, cut waste and find alternatives for harmful gases used in some medical devices and procedures. Initiatives such as these will improve public health, save money and reduce carbon emissions.

Duncan Selbie

Accounting Officer

6 July 2016

2 Accountability report

Directors' report

The Directors' report disclosures are contained in the Governance Statement on pages 97 to 124.

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.

I can confirm that, as far as I am aware, there is no relevant audit information of which the entity's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that PHE's auditors are aware of that information.

I can confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Governance statement

Structure of governance

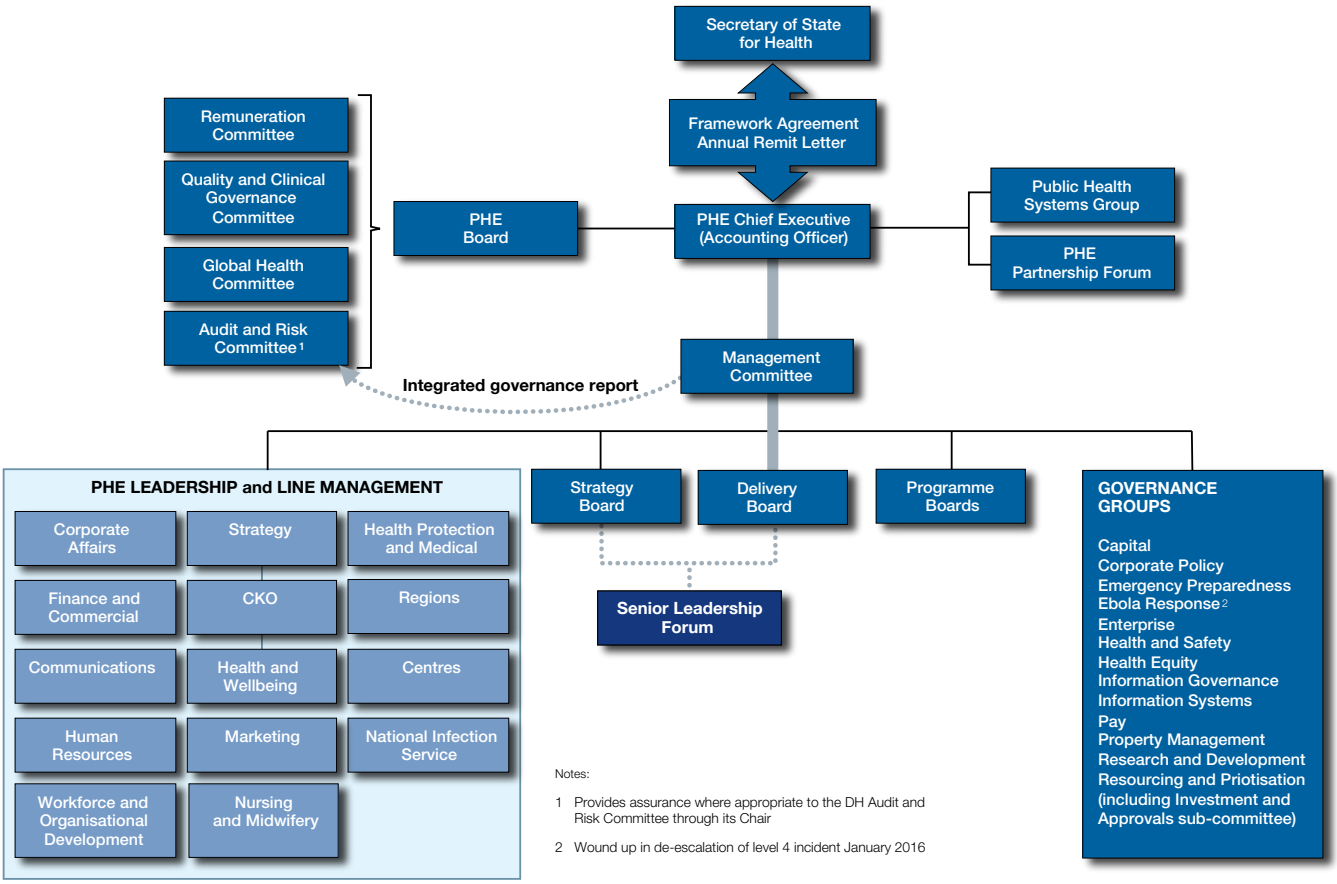
Our governance reflects the need to balance the requirements of being an executive agency of the Department of Health (DH) with the need to maintain independence, the highest professional and scientific standards in preparing and publishing our advice to the public and government, and commanding the confidence of the professional and scientific communities related to public health.

Our role, duties and priorities are set out in:

- our framework agreement with DH
- our annual remit letter from ministers
- *From Evidence Into Action: opportunities to protect and improve the nation's health*, which we published at the same time as the *NHS Five Year Forward View*, a collaboration between us, NHS England, Monitor and the NHS Trust Development Authority, now known as NHS Improvement, Health Education England and the Care Quality Commission
- our strategic plan for the next four years: *Better outcomes by 2020*
- *Who we are and what we do: Annual Plan 2015/16*

In addition, the *PHE Code of Conduct* incorporates both the Civil Service Code, which applies to all of our staff, and our professional responsibilities as the national public health agency. This safeguards our scientific and public health professionals' right to speak and publish freely to the evidence while at the same time recognising the requirements of the Civil Service Code.

All of these documents are publicly available at www.gov.uk/phe. The governance arrangements in place in 2015/16 and up to the date of this statement are shown on the next page:



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 our objectives, which includes formal quarterly accountability meetings chaired by the DH senior departmental sponsor

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, which include a clear division of responsibility between the Chair of the Board and my role as Chief Executive and Accounting Officer. In summary, the Chair is responsible for the leadership and effective working of the Board and I am responsible for the matters set out above and elsewhere in this statement.

The Board members 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 Management Committee attend by standing invitation.

Professor David Heymann CBE (Chair), Head and Senior Fellow, Centre on Global Health Security at Chatham House, Professor of Infectious Disease Epidemiology at the London School of Hygiene and Tropical Medicine.
Term of office: 1 April 2013 to 31 March 2017

Sir Derek Myers (Deputy Chair), government-appointed Lead Commissioner Rotherham Borough Council, Chair of the Board of Trustees of Shelter, former joint Chief Executive at the Royal Borough of Kensington and Chelsea and London Borough of Hammersmith and Fulham, former Chair of the Society of Local Authority Chief Executives (SOLACE).
Term of office: 1 June 2013 to 31 March 2017

Professor Sian Griffiths OBE (Associate), independent health consultant, Emeritus Professor at the Chinese University of Hong Kong and Visiting Professor at the Institute for Global Health Innovation, Imperial College London.
Sian was appointed for a further one-year term by the PHE Board on 25 May 2016

Poppy Jaman, Chief Executive of Mental Health First Aid England and a founding member of the City Mental Health Alliance.
Term of office: 26 March 2014 to 31 May 2017

Rosie Glazebrook, Chair of a Research Ethics Committee, and non-executive Board member of the Human Tissue Authority and recently appointed as such to the Food Standards Agency.
Term of office: 26 March 2014 to 31 May 2017

Professor George Griffin, recently retired as a consultant physician and Professor of Infectious Diseases and Medicine at St George's, University of London, and former Chair of the Advisory Committee on Dangerous Pathogens (2004-2015).
Term of office: 1 June 2013 to 31 March 2017

Martin Hindle, Chair of the East Midlands Academic Health Science Network, Chair of Porton Biopharma Limited and a Non-Executive Director at the Medicines and Healthcare products Regulatory Agency, former Chair, University Hospitals of Leicester Hospitals NHS Trust.
Term of office: 1 June 2013 to 31 May 2016. Martin was appointed as an independent member of the Audit and Risk Committee on 1 June 2016.

Professor Richard Parish CBE, formerly Chief Executive of the Royal Society for Public Health and Chair of the Pharmacy and Public Health Forum.
Term of office: 1 June 2013 to 31 May 2016. Richard was appointed as an associate non-executive on 1 June 2016.

Paul Lincoln OBE (Associate), Chief Executive of the UK Health Forum. Paul did not seek a further term as an Associate member of the Board and his appointment concluded on 31 May 2016.

I held the following roles prior to being appointed as PHE's Chief Executive in the summer of 2012: Chief Executive, Brighton and Sussex University Hospitals 2007-12; Director General of Programmes and Performance for the NHS and subsequently the first Director General of Commissioning, Department of Health 2004-07; Chief Executive roles at South East London Strategic Health Authority (2001-03) and South West London and St George's Mental Health NHS Trust (1997-2001)

The Board advises me on:

- the development of our strategic and business plans
- our financial and performance objectives and progress on meeting them
- ensuring that we maintain independence, and the highest professional and scientific standards in preparing and publishing our 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 our strategic direction

Primarily through its Audit and Risk Committee (ARC), the Board is responsible for ensuring that effective arrangements are in place to provide assurance on risk management, governance and internal controls. Through the ARC, 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 set 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.

Board business in 2015/16

The Board, which meets in public, met on eight occasions 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:

- air pollution
- global disaster risk reduction
- public involvement
- children, young people and families
- obesity
- research
- end of life care
- the future public health workforce

The Board also:

- discussed our approach to marketing and digital public health
- reviewed how we meet the public sector equality duty
- considered the findings of the annual Ipsos/MORI public opinion and stakeholder surveys
- discussed the findings from the pilot assessment of UK compliance with the US Centers for Disease Control and Prevention's Global Health Security Agenda
- endorsed implementation of recommendations arising from external reviews commissioned by the Management Committee into our work on global public health, and the future of the Centre for Chemical, Radiation and Environmental Hazards (CRCE)

- participated in the young people's takeover day in November 2015, where young people ran the Board meeting and discussed public health issues facing people of their age and shared their views on how the system could be improved
- received an update on the national breast screening programme age extension trial, a complaint about which it had previously considered in 2014/15. The Board continues to support the trial

The recommendations arising from these discussions were captured in a 'watch list', which was reviewed and acted on by the Management Committee as appropriate with progress reported to the Board on a regular basis. During the year, the Board agreed and introduced a new system to review the watchlist whereby a non-executive led a review process of watch-lists on previous topics, with a formal update at a Board meeting.

This has provided an additional layer of assurance to ensure that actions identified during thematic discussions are acted on appropriately. The Board also received regular reports on PHE's financial performance from the Finance and Commercial Director and from the Chairs of the following committees and the issues considered by them. The Board has also received reports from a new committee of the Board convened to oversee quality and clinical governance and chaired by a member of the Board.

Role of the Head of Governance and Board Secretary

The Head of Governance and the Board Secretary are 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 Management Committee
- 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, as well as briefings by the Management Committee and visits to our main sites, including our scientific campuses at Chilton, Colindale and Porton.

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, as well as to meet Rt Hon Robert Halfon MP, the Member for Harlow, following the Chancellor's decision in the autumn of 2015 on the PHE Science Hub (see below).

Objectives for the Chair are set and assessed by the DH senior departmental sponsor, Dr Felicity Harvey, Director General for Public and International Health. The Chair 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 value to the organisation.

Register of interests

We maintain a register of interests to ensure potential conflicts of interest can be identified and addressed in advance of board discussions, which is publicly available at www.gov.uk/phe. Where potential conflicts exist, they are recorded in the Board minutes, along with any appropriate action taken to address them.

Standards

The Board and the Management Committee are committed to the highest standards of corporate governance. We undertook a further voluntary review of our governance against the *Corporate governance in central government departments: Code of Good Practice*, published by HM Treasury in July 2011. This was considered by the Audit and Risk Committee at its meeting in February 2016, which was satisfied that we are compliant with the requirements of the code where they are relevant to us and our status as an executive agency, in most cases complying with the letter and the spirit of the code's provisions. Where the requirements of the framework agreement and the code differ, we will always seek to comply with the framework agreement. For example, the code requires boards of departments to be chaired by the lead minister and for membership to be balanced, with an equal number of ministers, senior officials and non-executive members (provision 3.3). In addition, as part of the tailored review currently underway, we have carried out a further self assessment, which will be published as part of the subsequent report and recommendations.

Audit and Risk Committee (ARC)

The ARC is chaired by Sir Derek Myers, an independent non-executive member with significant experience of financial leadership at board level. The primary role of the ARC is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. It is the responsibility of the Management Committee to agree and implement this.

The ARC 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 ARC has a crucial function in reviewing our external reporting disclosures in relation to finance and internal control, including the annual report and accounts, this statement and other required declarations.

The ARC's membership is drawn exclusively from independent non-executive members of the Board and externally co-opted members. During 2015/16, an external independent adviser, Michael Hearty, was appointed to the ARC to provide additional specialist expertise on accounting-related matters. It is supported by the work programmes of internal and external audit, which ensures independence from executive and operational management. At the invitation of the committee Chairman, I, the Director of Corporate Affairs, the Finance and Commercial Director, the Head of Internal Audit, the external auditor (National Audit Office) and a representative of our sponsor team in DH routinely attend ARC meetings. The Head of Governance also attends and acts as secretary. The ARC met on four occasions in the 2015/16 financial year and has met once so far in 2016/17 to consider the Annual Report and Accounts for 2015/16, including this statement. The Chair of the ARC reported key issues to the Board after each meeting. He also prepared and submitted an annual report on the committee's work to the Board, which was made publicly available as part of the papers for the April 2016 Board meeting. In addition, the minutes of the ARC are made publicly available as part of the papers for Board meetings (www.gov.uk/phe).

Areas for particular focus for the ARC in 2015/16 included:

- the ongoing development of the system of risk management and culture across PHE
- considering the 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 me as Accounting Officer, in particular, those relating to the public health grant to local government
- how we are meeting the commitments arising from our appearance before the Public Accounts Committee in January 2015
- financial issues, including counter fraud arrangements
- the development of quality and clinical governance across PHE
- a governance report at each meeting collating information on incidents, public information access requests, parliamentary questions, complaints, clinical governance, health and safety and information governance, which provided insight into critical perspectives of our infrastructure
- the Internal Audit programme, including management engagement with it and the extent to which we are addressing the actions and recommendations from internal audit reviews
- increasingly, challenging the executive to focus on value for money across all of our activities, which is being addressed through the development of a value for money strategy

During 2015/16, the internal auditors undertook 16 reviews as part of the plan agreed with management and approved by the Audit and Risk Committee.

PHE Board and ARC attendance in 2015/16

Board		ARC
David Heymann	8/8*	
Rosie Glazebrook	8/8	4/4
George Griffin	6/8	-
Sian Griffiths	8/8	-
Martin Hindle	8/8	4/4
Poppy Jaman	5/8	1/4
Paul Lincoln	8/8	
Derek Myers	7/8	4/4*
Richard Parish	6/8	
Duncan Selbie	7/8	2/4

*Indicates Chair of Board or ARC

Michael Hearty joined the ARC as an independent member in February 2016 and attended 1/1 meetings since his appointment

The Director of Corporate Affairs and the Finance and Commercial Director are standing attendees at the Board and its ARC. The Board also received regular updates from the following members of the Management Committee 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 Chief Nurse, all of whom attend meetings of the Board.

Remuneration Committee

As Chief Executive, I am responsible for the structure and staffing of the organisation. 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 established a Remuneration Committee in 2014/15 to assist me in the discharge of this duty, which met once during the year, primarily to review and approve SCS and NHS VSM consolidated and non-consolidated pay awards. The Director of Corporate Affairs acts as secretary to the committee and absents himself from discussion and decisions on his own pay.

Attendance at meetings in 2015/16	
Remuneration Committee	
David Heymann*	1/1
Rosie Glazebrook	1/1
Martin Hindle	1/1
Richard Parish	1/1
*Indicates chair of committee	

Quality and Clinical Governance Committee

The *Sound Foundations* approach to improving quality and clinical governance, led by the Chief Nurse and the Director of Health Protection and Medical Director, has taken the best of what was already in place and, through the PHE Quality Model, devised a quality framework that reaches all parts of the organisation, giving a clear line of sight to the Management Committee and the Board. We have established quality hubs in a wide variety of locations with appointed quality leads in all areas playing a key role in developing our quality plans. We have also been a pilot site for the Nursing and Midwifery Council's testing of nurse revalidation, with the Chief Nurse leading implementation of this for our nurses and midwives.

We very much welcomed the follow-up audit this year, which provided substantial assurance on implementation of the previous internal audit recommendations, with 24 of 28 recommended actions completed and progress made in the other areas, including developing a quality and clinical governance scorecard, embedding quality and developing a repository of best practice. Through strategic and local leadership, directors are signing off their quality plans with an emphasis on embedding improvement, innovation and learning into our culture and way of doing business.

Building on *Sound Foundations* is cultivating our commitment, compliance and innovation to deliver optimal public health outcomes. As part of this, and to provide a clear top-level commitment to this agenda, a Quality and Clinical Governance Committee of the Board was established in November 2015 and has met three times since its establishment. Chaired by Rosie Glazebrook, a non-executive member of the Board, it acts as the prime provider of assurance to the PHE Board and Chief Executive on safety and quality performance within the organisation, and ensures that we promote a safety and quality-focused culture throughout the organisation. The minutes of this committee are shared with the 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. An external independent adviser, Andrew Blakeman, was appointed to this committee to provide additional specialist expertise.

The Quality and Clinical Governance Committee is supported by a new Quality and Clinical Governance Steering Group, chaired by the Chief Nurse.

Attendance at meetings in 2015/16	
Quality and Clinical Governance Committee	
Rosie Glazebrook*	3/3
George Griffin	2/3
Andrew Blakeman**	3/3
Viv Bennett	3/3
Paul Cosford	1/3

*Indicates chair of committee
** Indicates independent adviser to the committee

Executive governance

As Chief Executive and Accounting Officer, I have the authority and responsibility to determine the most appropriate governance structure for PHE save for the Board, whose role and remit is set out at section 5 of the Framework Agreement and corresponding terms of reference, and its ARC.

We have implemented the proposed governance changes summarised in last year's statement, which I believe are now well embedded and functioning well. In the early part of 2015/16, the Management Committee assumed the role of the most senior executive decision-making committee. It is principally supported by its Delivery and Strategy Boards (see below). Policies have been updated to reflect the changes to the governance arrangements.

The wider senior leadership team, which includes the centre directors, meets quarterly in a time-out environment, and works closely with the Senior Leadership Forum (see below) to consider the longer-term opportunities and risks for PHE and the public health sector, and our evolution as the national body responsible for protecting and improving the nation's health.

Management Committee

The Management Committee is the prime mechanism for supporting me in my role as Accounting Officer and the focus of PHE's governance. Amongst its responsibilities are approval and monitoring of our revenue and capital budgets, agreement of priorities and the design and structure of the organisation, decisions on which are based on prior discussion with all members of my Leadership Team and the groups set out below as appropriate. Key governance groups, for example on Health Equity, Health and Safety and Emergency Planning, Preparedness and Response, report to the Management Committee, with the exception of the Quality and Clinical Governance Committee, which, as set out above, is a committee of the Board. Attendance at Management Committee meetings during 2015/16 was as follows:

Attendance at meetings in 2015/16	
Management Committee	
Duncan Selbie – Chair (Chief Executive)	9/10
Richard Gleave (Deputy Chief Executive and Chief Operating Officer)	9/10
Michael Brodie (Finance and Commercial Director)	10/10
Paul Cosford (Director for Health Protection and Medical Director)	8/10
Jonathan Marron (Director of Strategy)*	4/10
Deb McKenzie (Director of Organisational & Workforce Development)	10/10
Alex Sienkiewicz (Director of Corporate Affairs)	9/10
Kevin Fenton (Director of Health and Wellbeing)	5/10
John Newton (Chief Knowledge Officer)	7/10
Viv Bennett (Chief Nurse)	9/10
Rashmi Shukla (Director Midlands and East)	7/10
Paul Johnstone (Director North)	5/10
Yvonne Doyle (Director London)	7/10
Jenny Harries (Director South)	7/10
*Left PHE in January 2016	

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

Delivery Board

As part of ensuring a greater focus on delivery of the priorities set out in the business plan, building on the annual remit letter and *From Evidence Into Action*, we established a PHE Delivery Board, reporting to the Management Committee. Chaired by the Deputy Chief Executive and Chief Operating Officer, it is 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.

At its heart are relevant national and local directors, and it considers and approves the scorecard that forms a core part of the quarterly accountability meetings with DH.

Strategy Board

The Strategy Board is the forum at which we debate and settle the key strategic issues we face and how we respond to them. It is chaired by the Director of Strategy and reports to the Management Committee.

The Strategy Board provides strategic oversight of our vision and role, and sets our forward agenda. It carries out horizon scanning and is the forum for senior level discussions on key emerging public health issues; how we can best identify and meet customer needs; and, the handling of the launch or publication of significant products and services. It also considers proposals that have been co-produced by representatives of national directorates and centre teams and decides our position on these key factors.

It has also considered the development of the annual remit letter and the strategic plan.

Resourcing and Prioritisation Group

The group has continued to focus on internal business management of our resources – people, finances and estate – in particular, overseeing the implementation of our in-house strategic review of our functions and services through the *Securing our Future* programme. The group also established a sub-committee to deal with investment and approvals in a more agile way.

Management of the organisation

The prime route for governance and accountability in PHE is through line management, reporting to me through my direct reports. A series of management seminars has 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 are a range of mechanisms in place to achieve this but the three main approaches are:

- the local management team. Each centre director has brought together all the teams working in their 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
- 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. This has initially focused on non-communicable disease and health and wellbeing, as well as decisions on how to achieve PHE-wide collaboration in our functions
- the Senior Leadership Forum, bringing together over 100 senior staff from all parts of the organisation to come together quarterly to focus on the most important issues for the organisation from the range of different perspectives

Corporate programmes

We have established nine corporate programmes, each of which has a programme board and clear deliverables for the most important programmes necessary for us to achieve our duties and priorities:

- PHE Science Hub
- Securing our Future
- Antimicrobial resistance
- Tuberculosis
- Best start in life
- Smoking/tobacco control
- Delivering prevention at scale
- Diabetes and obesity
- Supporting place

A further programme was added in the year to take forward our work in response to the Independent Cancer Task Force chaired by Sir Harpal Kumar, Chief Executive of Cancer Research UK. These are all run to a common discipline, namely Managing Successful Programmes methodologies.

The portfolio of programmes report progress to the Delivery Board. Where they identify major issues of policy and strategy, they take specific issues for decision to the Strategy Board. We differentiate between those programmes that require corporate involvement, and the programmes and projects that are more focused and can therefore be delegated for directorate level consideration. We are reviewing these arrangements in the autumn of 2016.

Pay Committee

The Pay Committee is a sub-committee of the Management Committee 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 Management Committee 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

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 the PHE business plan and the specific priorities and associated deliverables set out in the annual remit letter from ministers
- performance against the PHE 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 us and any other key issues identified in delivery of the department's strategic objectives

Other processes in place include:

- a formal meeting between me 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; PHE appeared before the Health Select Committee to give evidence on our sugar evidence package and later on the post 2013 reforms to public health, the Public Accounts Committee on the management of adult diabetes, improving cancer services and outcomes and the impact of the Spending Review, and the Science and Technology Committee on science in emergencies – UK lessons from Ebola
- regular contact between DH's sponsor team and PHE
- the first Tailored Review of PHE, led by DH and part of a programme of reviews of all ALBs that supports their stewardship function, considering key issues around performance, efficiency and governance

We also play a full role in the Strategic Oversight Group, the key accountability mechanism for delivery of the national public health services that NHS England commissions through the Section 7A agreement. This mechanism has successfully introduced an unprecedented number of new and amended immunisation and screening programmes as well led to improvements in the delivery of prison public health programmes and sexual assault referral centres.

Quality assurance

Further to the update in last year's statement, the modelling sub-group (MSG) has continued to oversee implementation of the DH Analytical Modelling Oversight Committee (AMOC) recommendations across the organisation, which has included:

- work on governance for modelling in PHE, for example, distinguishing between operational level and strategic goals, the former resting with individual directorates and their teams and the latter being the MSG's responsibility. The MSG will further develop the PHE modelling strategy and provide a corporate view on the assurance framework while at the same time delegating delivery of individual actions to directorates as appropriate
- reviewing the main tools for implementation of the MacPherson review recommendations, namely HM Treasury's publication of March 2015 *The Aqua Book: guidance on producing quality analysis for government* and the AMOC triage template. Both tools need to be adapted to the specific roles and responsibilities within PHE, for example, the Aqua criteria and the definitions of risk and risk level in the AMOC documentation do not entirely apply to our work, in particular with respect to political and financial risk. We are matching project management recommendations to PHE practice and mapping the Aqua professional categories to PHE team members, and DH is closely involved in this exercise
- defining the overall PHE modelling strategy and linking it to the current informatics review that has been commissioned by the Chief Knowledge Officer

System of internal control and its purpose

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives. 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 the DH Principal Accounting Officer of 10 February 2013.

It 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 has been in place for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Risk and control framework

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

- the Deputy Chief Executive, who has delegated responsibility for managing operational risk, and assists me in the day-to-day running of the organisation, including through chairing the Delivery Board. He is also the senior responsible officer 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, and is chair of the Resourcing and Prioritisation Group

- the Director for Health Protection and Medical Director, who has delegated responsibility for managing PHE's emergency response function, including during the year as the Incident Director in charge of PHE's contribution nationally and internationally to the Ebola outbreak in West Africa; medical revalidation, supported by PHE's Responsible Officer and his team; and PHE's Caldicott Guardian function
- the Chief Nurse, who with the Director of Health Protection and Medical Director, has delegated responsibility for managing the strategic development and implementation of safety and quality governance, for reporting this to the recently established Committee of the Board, and for the assessment and reporting of clinical risk.
- the Director of Corporate Affairs, 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 the organisation's senior information risk owner (SIRO), has delegated responsibility for the organisation's information governance arrangements and advising me of any serious control weaknesses concerning information risk and governance. The Chief Knowledge Officer also has delegated responsibility for the governance of research activity we carry out

The Management Committee is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. Management Committee members are responsible for risk management within their areas of responsibility. This includes promoting risk awareness and supporting staff in managing risk.

During the year, the Corporate Risk and Assurance team developed a three-lines-of-defence assurance model to support the organisation in identifying, assessing and managing risk:

Line 1: Operational management is responsible for maintaining effective internal controls and for executing risk and control procedures on a day-to-day basis. They identify, assess, control and mitigate risks, guiding the development and implementation of internal policies and procedures and ensuring that activities are consistent with departmental/divisional objectives.

Managers design and implement detailed procedures that serve as controls and supervise execution of those procedures by their employees. They are also responsible for implementing corrective actions to address process and control deficiencies.

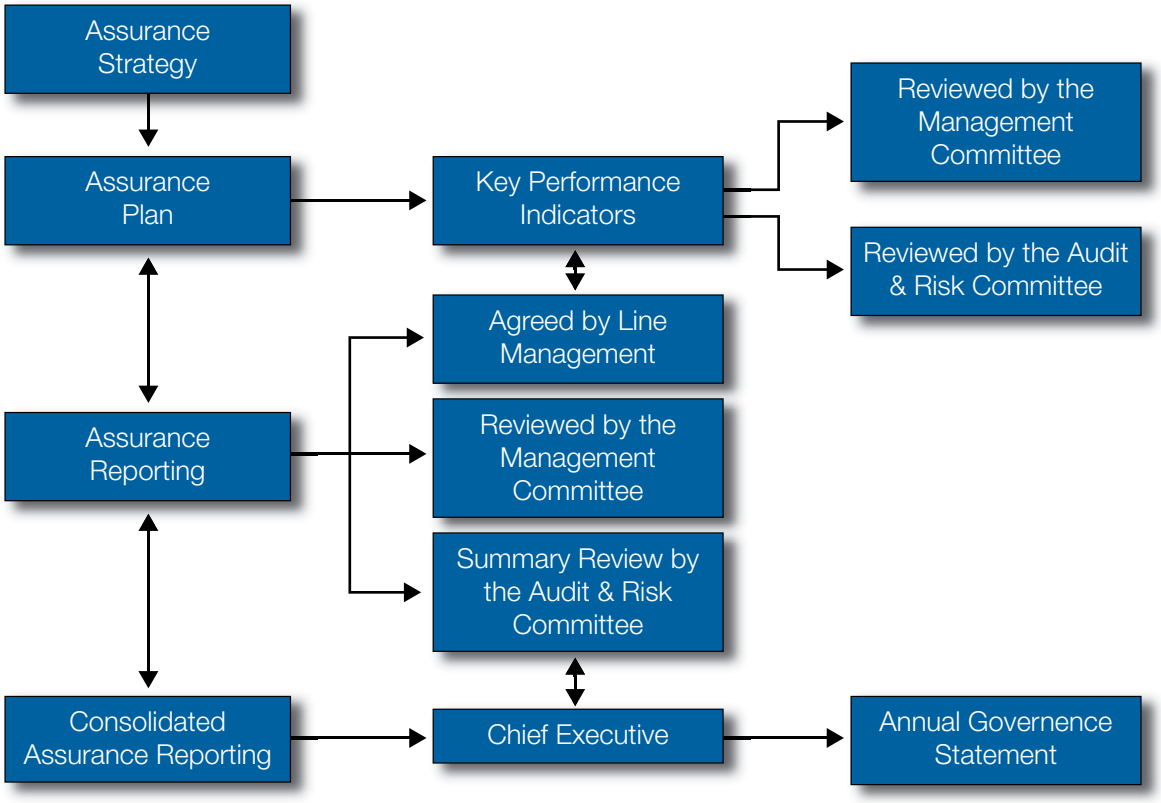
Line 2: Concentrates primarily on the work associated with the oversight or management activities of a particular function. It is separate from those responsible for delivery as above, but not independent of the management chain as a corporate whole. It typically includes compliance assessments or reviews carried out to determine that policy or quality arrangements are being met in line with our expectations.

Line 3: The third line of defence relates to the more objective and independent forms assurance and focuses, among other things, on the role of Health Group Internal Audit. They carry out a programme of work specifically designed to provide the Accounting Officer with a wholly independent and objective opinion on the framework of governance, risk management and control throughout the organisation, including the manner in which the first and second lines of defence achieve risk management and control objectives. It also focuses on the ARC, the Board and some of the wider government spending control groups established by DH and Cabinet Office.

This approach was confirmed by the Management Committee through their approval of the PHE Assurance Strategy and Framework. The committee also agreed that we will develop, agree and implement an assurance map, which will:

- map current controls, systems/processes and assurances identified against those strategic risks
- identify cross-agency assurance providers against those key areas of risk
- link those strategic systems/processes to those strategic objectives

We have developed an annual assurance plan for 2016/17 to deliver the Assurance Strategy and Framework, the process for which is summarised in the diagram below:



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 risk leads group to discuss management and escalation of risks and identify any cross-cutting themes for review by the Management Committee, who review the strategic risk register on a regular basis.

The ARC provided an independent perspective of the strategic processes for risk management, and provided constructive challenge to the Management Committee on its responsibility for risk, controls and associated assurance. The Board has also reviewed the strategic risk register during the year to provide an additional level of insight and challenge. During the year, the Corporate Risk and Assurance team developed a PHE assurance strategy, which was approved by the Management Committee in January 2016, with the 2016/17 plan approved in May 2016.

The system of internal control was based on an ongoing process designed to identify and prioritise the risks to the achievement of PHE's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system was in place up to the year ended 31 March 2016, 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 the PHE intranet, 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, its people or property, or those who received its services, through adequate supervision and training, appropriate delegation, continuous review of processes and the environment, and the sharing of lessons learnt and best practice.

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

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. We have worked hard throughout the transition process and beyond to ensure that we are able to provide effective public health emergency preparedness, resilience and response in the UK, including providing support to local and national resilience partners and to international crises as part of our role in disaster risk reduction.

Our generic emergency preparedness, resilience and response (EPRR) arrangements are set out in its National Incident Response Plan. This describes the mechanisms by which we discharge the duties delegated by the Secretary of State for Health to its staff that are responsible for emergency planning, resilience and response, such that they operate as if 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 of PHE as required. Incidents that are assessed as level 3-5 are considered to need national co-ordination and/or control and leadership, with the extent of national involvement determined on a case-by-case basis. If national co-ordination is required, a National Incident Co-ordination Centre (NICC) is opened. These arrangements are overseen by 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 in response to the Ebola outbreak in West Africa, which developed beyond an initial health protection incident acute response to a multifaceted activity involving a number of strands of work.

Our second duty is to secure improvements in 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 Management Committee twice a year, 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 Corporate Risk and Assurance Division of the Corporate Directorate, works with colleagues across the organisation to ensure compliance with relevant legislation. In particular, it works closely with the National Infection Service, which conducts activities considered by the Health and Safety Executive (HSE) to be 'high hazard'; some staff work with the most dangerous pathogens (which, in some cases, have no therapeutic response), while others with radioactive material. Our arrangements to mitigate health and safety risk include the work of the Health and Safety Steering Group, chaired by the Director of Corporate Affairs, which implemented and reviewed our health and safety strategy, improvement plans, arrangements and performance to ensure that they were appropriate. It also reviewed the small number of incidents notified to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 and the action plans to prevent any recurrence. The HSE proposes and agrees with us an annual intervention plan each year, which is reviewed at an annual meeting at the end of each year.

We have developed and implemented a business continuity plan in order to be able to respond to any disruption to business and to recover time-critical functions where necessary. We have completed a self-assessment against the key areas of ISO 22301 Societal Security – Business Continuity Management Systems and has rated its arrangements as adequate.

We have completed an assessment against the requirements of the revised Cabinet Office Security Policy Framework and overall compliance was acceptable. We work closely with the DH Security Team to ensure our staff have the appropriate national security clearance.

We have in place a financial governance framework, with policies and procedures to ensure compliance with the requirements of *Managing Public Money*, International Accounting Standards, EU Procurement Legislation, government spending controls and internal approval levels. We have identified that on a small number of occasions controls on good procurement practice have not always been met. Where this has occurred, remedial action has been taken to regularise arrangements where possible and prevent recurrences. More generally, we continue to develop our financial governance arrangements, key elements of which include enhanced transparency and reporting, refreshed Standing Financial Instructions and Scheme of Delegation, further roll-out of finance and procurement training and strengthened accountability arrangements.

We have undertaken a review of our international travel policy, with a particular focus on air travel, to ensure taxpayer value. The policy update we made in January 2016 means that we are operating the most stringent policy across government, whereby all travel is economy class except on grounds of a reasonable adjustment for a disability or, with director approval, where the journey is longer than eight hours and staff are expected to go straight into meetings on arrival at their destination, in which case premium economy is possible. Internal audit will review our overarching travel arrangements as part of their plan for 2016/17.

Capturing and responding to risk information

The strategic risk register continued to be developed over the course of the year with input from the Management Committee and the Board, and was reviewed regularly by the ARC and 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 have mapped our risk registers down to divisional level in a way that reflects as far as possible the structure of the future organisation. The exercise has also helped us to ensure that as much risk management as possible from the divisional level upwards utilises 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 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 have continued to work with our many and varied partners, particularly local government and the local NHS, to protect and improve the public's health. Partnership risks were identified through a number of forums, in particular, through PHE centres and regions and the corporate programmes. Our success or otherwise depends on being a valued and effective partner, especially given the scale of change in both the health and care sector.

In addition to the achievements in 2015/16 set out elsewhere in the annual report, we have:

- published our analysis of the incredibly rich Global Burden of Disease data at a sub national level. This is a world first and allows us and our partners to understand the data by English region and deprivation and plan action accordingly
- developed our disease registration activity to make cancer registration data available quicker than ever before
- supported a fall in the cases of TB, the fourth year in a row that rates have declined
- established world-leading new vaccination programmes including introducing the first infant meningitis B vaccination programme anywhere in the world, with 94% coverage for the first dose, and implementing the meningitis ACWY vaccination programme for adolescents
- worked with NHS England to extend childhood flu vaccination to all children in school years 1 and 2 in addition to children aged 2 to 4
- developed a surveillance strategy for non-communicable disease
- extended our relationship with NHS England, working closely with the organisation on how to turn our joint vision on prevention into practical and demonstrable action capable of relieving some of the significant financial and capacity issues likely to face the health and care system in the future. This has been translated into excellent work on a healthy NHS workforce, diabetes prevention, the National Prevention Board that I chair, and the joint sustainability and transformation plans.

The annual Ipsos/MORI survey of stakeholders and public opinion show we continue to enjoy largely positive and improving ratings:

- fourth highest rated organisation of all public sector bodies surveyed by Ipsos MORI over the last decade, the others being organisations established for longer than PHE
- we remain highly valued by stakeholders as the 'go to' organisation for public health expertise and advice
- working relationships are positive with 75% stating their relationship with us was good and 85% saying we worked with them to a great or some extent
- particular progress on public recognition: 41% had heard of PHE and 76% stated they would be fairly confident of our advice (both being an increase on 2014)

We also received clear messages on areas for development and these are aligned with our work on evidence and return on investment.

Statement of information risk

Our employees have privileged and appropriate access to data and information, including patient identifiable data, to support the discharge of our duties to protect and improve the nation's health. We have a duty to respect this privileged access and to ensure that the personal information entrusted to us is safeguarded properly.

Through the SIRO, we continue to focus on preserving the security of information held not only now but also to ensure that we can do so in the future. While assurance can never be absolute, we have a range of measures in place, including:

- physical security measures which align with the current threat level of 'heightened', particularly those parts of the organisation that are part of the critical national infrastructure
- information technology measures, including those to protect against cyber threats
- information security measures, including a network of information asset owners
- personnel security measures
- annual mandatory training and assessment of staff to ensure they are kept up to date on current and new security policies and procedures
- focus by senior management on security risks
- a work programme overseen by the Information Governance Group with regular updates to the Management Committee on PHE's compliance with the Health and Social Care Information Centre's Information Governance Toolkit
- regular engagement with DH and its ALBs through participation in information assurance forums

Personal data-related incidents

There was one incident during the year reportable to the Information Commissioner's Office. This concerned the inappropriate access by a member of staff to the electronic staff record system. While there was no data loss, the matter was reported to the police, who have investigated the actions of the individual, who is no longer an employee. The individual has admitted to offences under the Computer Misuse Act and the case has been referred to the Crown Prosecution Service.

Principal risks facing PHE during 2015/16

Information governance and data flows across the health and care system

We collect, collate and use data on individuals, their health and wellbeing, and their interactions with the NHS, as well as data on the wider social, economic and environmental determinants that affect health outcomes. This data is used to enhance healthcare experiences for individuals, expand knowledge about disease and appropriate treatments, strengthen understanding about the effectiveness and efficiency of our health care system and support improving public health outcomes.

It is however equally critical to ensure there are adequate safeguards to maintain the balance between the benefit of disclosing data and an individual's right to confidentiality. To address the challenges of providing access to data, we established the Office for Data Release (ODR) to provide a systematic approach to reviewing requests to release personal confidential data.

The ODR operates within the legal frameworks of the Common Law Duty of Confidentiality, the Data Protection Act 1998 and the Caldicott Principles. All applicants to the ODR must demonstrate why they need access to data held by PHE, how they will use it and how they will protect it from unauthorised use, disclosure or loss. The ODR publishes a register of all releases of personal data processed through it on a quarterly basis. This is publicly available at www.gov.uk/phe.

Much of the data processed is collected directly but we also rely on data supplied by national partners like the Office for National Statistics and, in particular, the Health and Social Care Information Centre (HSCIC). In order to ensure the timely supply of business-critical data sets, we agreed a memorandum of understanding with the HSCIC on data exchange. This has been working well in recent months and has supported the efficient and effective delivery of new services, for example, the monthly cancer outcomes metric for the Secretary of State for Health.

We are working with DH and the HSCIC to ensure that the safe and effective operation of nationally-important public health functions such as disease screening, registration and surveillance are not adversely affected by implementation of the type 2 opt-out system. We are also working closely with the National Data Guardian and DH to ensure that key public health functions are not adversely affected by the new consent model.

In order to ensure that we continue to be a safe and trusted processor of personal confidential data, work continues to ensure compliance with information governance best practice standards, including the NHS Information Governance Toolkit. We recently submitted a level 2 compliant assessment on this to the HSCIC. This has also included preparing for the new information security standards that the National Data Guardian will be recommending apply across the whole of the health and care system.

As part of their programme for 2015/16, internal audit undertook a review similar to that carried out by Sir Nick Partridge, non-executive member of the HSCIC, of that organisation's procedures on data release and the requirements of the Data Protection Act 1998. The internal audit review considered our governance and assurance arrangements supporting the management of information and release of data; compliance with the DPA and section 251 of the NHS Act 2006; and assessed the extent to which arrangements are efficient and effective. The review provided limited assurance, at the same time noting that an overall information governance framework was in place, and that the ODR had clear data sharing procedures, although not all parts of PHE were operating to the same consistent standard.

Internal audit made four high priority and four medium priority recommendations, all of which we have accepted and are acting on as a matter of priority, progress on which will be monitored monthly by the Management Committee and reported on in next year's statement.

At a public health system level, there has been some concern on the part of local authorities and their public health teams with respect to their ability to access the data that they require to properly discharge their statutory public health duties. We have also been working closely with the HSCIC on ensuring that it is able to access the Health Episode Statistics (HES) data extract, and around 50 local authorities have taken this up with funding from PHE; they are now able to access anonymised HES data to inform the development and implementation of their local public health strategies. More remains to be done, however, and this will require action by authorities other than just PHE. For this reason we have dedicated our September Board meeting to a 'deep dive' on how we can work together to improve access to data, balancing this with the need to comply with data protection requirements.

PHE Science Hub and Securing our Future

The government agreed the £420m capital investment and additional transitional revenue funding over the Spending Review period in the PHE Science Hub at Harlow in autumn 2015. Work on this now truly begins, with planning permission and Full Business Case approval the next major milestones, along with the start of an extensive local public engagement campaign, as well as work led by our Director of Organisational and Workforce Development on how we truly integrate our public health and scientific professionals with our corporate functions so that Harlow becomes our new integrated headquarters.

We have completed our major organisational change programme, *Securing our Future*, to implement last year's strategic review. This has reduced the number of PHE Centres from fifteen to nine so that we can provide more concentrated support to, in particular, local government. We have established the National Infection Service in preparation for the move to the new Science Hub in Harlow of the UK's major public health laboratories at Porton and Colindale. This also provides leadership in responding to the rapidly changing technological and scientific environment. We have brought together our work on knowledge, wellbeing and strategy to create a single responsive service making available the best evidence for policy makers, local government leaders, industry, the third sector and our partners in the NHS.

Throughout the process, there has been an unrelenting focus on delivering best value for the taxpayer; we have delivered over £100m of recurrent savings over the last two years, nearly half of which have been cash reductions and in 2016/17 we plan to deliver a further £28.5m. But for the actions required to deliver these savings, PHE would cost 40% more than it does now. At the same time, we have protected our core external income streams (over £160m), further reducing our call on the taxpayer.

Our annual staff survey results show a dedicated workforce who are strongly engaged with their own work areas but not yet as engaged as we would wish. Our goal had been to raise the staff engagement score but the results are nonetheless pleasing given the amount of change and uncertainty during the year, the survey having taken place in the midst of Securing our Future, and in the immediate aftermath of the decision on the PHE Science Hub, which affects over half the workforce. The appointment of the innovatory staff engagement lead post after a two-year pilot, based on the long enduring and successful registrar model developed by the John Lewis Partnership, will support our continuing efforts to improve the score and we engaged staff extensively on the bottom-up development of the new PHE People Charter, which is being adopted and supported across the organisation. The charter focuses particularly on treating people fairly and with compassion, recognising that we are going through a period of significant change and will be for some time to come as the Science Hub becomes a reality for our staff.

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 delivered ground-breaking national public health campaigns such as:

- Stoptober 2015, our most successful yet, resulting in 16% of all smokers reporting making a quit attempt in October
- our Sugar Smart app, which has already been downloaded 2 million times
- One *You*, the world's first at scale prevention campaign aimed at 40 to 60-year-olds, which generated over 1 million responses in the first fortnight

As set out in the framework agreement, and subsequently reflected in each of the annual remit letters from ministers, PHE is free to publish or speak on issues relating to the nation's health and wellbeing in order to set out the professional, scientific and objective judgement of the evidence base, with ministers remaining responsible and accountable for policy decisions. In response to government's request for advice, we made two important interventions at a national and international policy level through our evidence reviews of e-cigarettes and sugar. The evidence on sugar has informed the development of the government's forthcoming childhood obesity strategy, on which we have worked closely with policy officials in DH, and this played its part in the government's recent decision to introduce a levy on sugary drinks as announced by the Chancellor in the March 2016 Budget.

Ebola

The level 4 incident continued until January 2016 and was led by the Director for Health Protection and Medical Director as the national incident director. Throughout the incident, we played a leading global role as part of the UK's response to the epidemic both in West Africa and back in the UK through port of entry screening. We are now leading the development of a newly created rapid support team in partnership with the London School of Hygiene and Tropical Medicine and Oxford University, as well as establishing a field office in Sierra Leone as part of building public health capacity there.

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.

Local authority public health grant

Local authorities have a statutory duty to improve the health of their populations and are given a ringfenced grant by PHE to carry out their public health responsibilities for which I am the Accounting Officer. While delivery of the grant and potential future developments do not constitute a direct risk to PHE, as Accounting Officer I nonetheless believe it appropriate to reflect in my statement on the potential risks to the wider public health system.
In 2015/16 the total grant amounted originally to £2.8 billion, supplemented by a further £430 million when responsibility for services for children aged 0 to 5 transferred to local authorities from NHS England on 1 October. In June 2015, the Chancellor of the Exchequer announced a package of savings to be made across government in 2015/16 to reduce public debt, including £200m to be saved from the public health grant. Following a subsequent consultation, DH decided to reduce every local authority's allocation by a standard, flat rate percentage. In the subsequent Spending Review in November 2015, the Chancellor announced a further 9.6% cash reduction on the overall local government public health grant over the next five years.

While no one would ever argue that reducing the public health grant was a good thing, it does provide clarity on the next five years. I am confident that local government will manage this and prioritise with the least possible impact; there is a significant period of certainty and, working together, we will use this to put our plans into action and secure the maximum benefit for the public's health.

I know from my conversations with local government leaders and directors of public health around the country, and those led by our centre directors, that this settlement can be managed and I am confident that ways will be found of continuing the very real progress of the past three years. Local government remains the best home for public health. It is the only place with the levers and the legitimacy to tackle economic prosperity, creating the decent jobs and homes for local people that we know underpin good health and reduce health inequalities.

Looking beyond the ring-fence period, we will be working closely with colleagues in DH and the Department for Communities and Local Government on the accountability arrangements for the grant for the final two years of the Spending Review period, as well as working with them and HM Treasury on the proposal that public health funding will become entirely the responsibility of local authorities through business retention rates, an issue on which the government will consult. We are a visible and active player in emerging devolution models, ensuring that public health is at the heart of public sector reform in London and Greater Manchester and through me chairing the recently established Commission for Health and Social Care Integration in the North East.

In the meantime, we will continue with the assurance process set out in last year's statement 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.

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 Management Committee 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, ARC and Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board, ARC, 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 ARC has provided the Board with an independent and objective review of financial and corporate governance, and internal financial control within PHE. The Board and Management Committee 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 ARC.

The Management Committee 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 matter considered by the ARC are summarised in the relevant section above so are not repeated here save to say that the PHE Board received reports from the Chair of the ARC concerning risk, control and governance, and associated assurance together with an annual report on its work.

Internal audit provides an independent, objective assurance and consulting service designed to add value and improve PHE's operations. Its work is based on an agreed audit plan, which is carried out in accordance with government internal audit standards. This helps to ensure that the work undertaken by internal audit provided a reasonable indication of the controls in operation across the whole of PHE. Findings from work carried out during the year were presented to the ARC. There were no audits where an 'unsatisfactory' assurance ratings were provided and one audit where 'limited' assurance was given, as summarised in the principal risk outlined above on information governance and data sharing.

For the three areas on which they must report, the Head of Internal Audit has concluded the following:

- in the case of risk management, PHE has continued to develop risk management and they have seen an improvement in this area. However, there is still further work required to ensure that risk registers are regularly reviewed and risks clearly articulated

- in the case of governance, PHE has been going though a further period of structural reform and change as part of the *Securing Our Future* programme, which they found to be well managed. They have also seen improvements through the *Sound Foundations* programme. There is, however, still work to be done to improve knowledge sharing across the PHE centres
- in the case of control, PHE has adequate control mechanisms in place on financial systems and these are continually evolving. However, there remains scope for improvement in information management and the management of electronic staff records

Given that the picture of assurance in their opinion shows an improvement on performance last year, the Head of Internal Audit has therefore advised me that they can give reasonable assurance to me as Accounting Officer that the organisation has had adequate and effective systems of control, governance and risk management in place for the reporting year 2015/16.

Conclusion

Good governance is not just about process. Rather it should provide ambitious, effective yet prudent direction that helps to deliver success over time. The arrangements that we have put in place and developed since the time of our establishment three years ago have played their part in ensuring that 2015/16 was a year in which PHE has made the transition from a new organisation that brought together nearly 6,000 people from over 100 sender bodies into one that, through Securing Our Future, is maturing and well placed to face the challenges of today and tomorrow.

There will continue to be an unrelenting focus on ensuring value for money in all that we do. The Board, ARC and Management Committee will monitor and oversee the ongoing development of our processes so that we can face the challenges and make the best of the opportunities over the coming period, the most significant of which are:

- with national government and policy makers, to continue to win the argument for the priority of effective, evidence-based interventions in the short and long term to improve the public's health, so that increased longevity is matched by improved quality of health throughout life and particularly in later years
- with local government, to continue to support effective place-based interventions improving the quality and health of the lives of people, families and communities where and how they live their lives
- with the NHS and local government to take full advantage of the opportunities provided by devolution in ensuring generational improvement in the public's health remains a visible and achievable goal
- in our international role, to consolidate productive partnerships with the US and China Centers for Disease Control, the latter of whom we signed a memorandum of understanding on non-communicable diseases with during the year, and to further long-term development work with Pakistan, India and Sierra Leone

I am able to report that there were no significant weaknesses in PHE's system of internal controls in 2015/16 and up to the date of this statement that affected the achievement of PHE's key policies, aims and objectives.

Remuneration and staff report

This report details the policy on the appointment, appraisal and remuneration of members of our Board and the Management Committee for the year ended 31 March 2016. It has been prepared in consultation with our Pay Committee, and is based upon the provisions contained within the government *Financial Reporting Manual 2015/16.*

Accountability

The accountability arrangements for the Pay Committee and Remuneration Committee of the Board are set out in the Governance Statement elsewhere in this annual report.

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 this 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 cost of more than £95,000
  - 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 Management Committee on any aspect of pay policy
- making recommendations to the Remuneration Committee of the Board on Senior Civil Service (SCS) and Very Senior Manager (VSM) pay

The committee does not deal with matters concerning its own pay; rather issues concerning its members' pay and that of staff employed on SCS and VSM terms and conditions are considered and decided by the Remuneration Committee of the Board, whose role is set out in the Governance Statement.

Committee membership

The Pay Committee consists of four members, who in 2015/16 were:

- 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 (Director of Corporate Affairs)

All four members served on the Committee throughout the year. In addition, Lis Birrane, Director of Communications, was co-opted to the committee for discussions and decisions on moderation of annual performance ratings for Civil Service staff up to and including grade 6 and for staff on legacy Agenda for Change terms up to and including AfC band 9.

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 2016. The date of their appointment is accompanied by the total remuneration due to each individual during their tenure in post in 2015/16. Their terms of office are set out in the biographies in the Annual Governance Statement elsewhere in the annual report.

Audited table

Total remuneration due to each individual during their tenure in post in 2015/16	Date of appointment	Total salary, fees and allowances Year ended 31 March 2016 £'000	Total salary, fees and allowances Year ended 31 March 2015 £'000
Professor David Heymann (Chair)	1 April 2013	35 - 40	35 - 40
Rosie Glazebrook	26 March 2014	5 - 10	5 - 10
Professor George Griffin	1 June 2013	5 -10	5 -10
Professor Sian Griffiths (Associate)	1 January 2014	5 - 10	5 -10
Poppy Jaman	26 March 2014	5 - 10	5 -10
Martin Hindle*	1 June 2013	10 - 15	10 - 15
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. He is also non-Executive Chairman of Porton Biopharma Limited, a company wholly owned by the Secretary of State for Health

** 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. Paul Lincoln's term as an Associate non-executive came to an end on 31 May 2016.

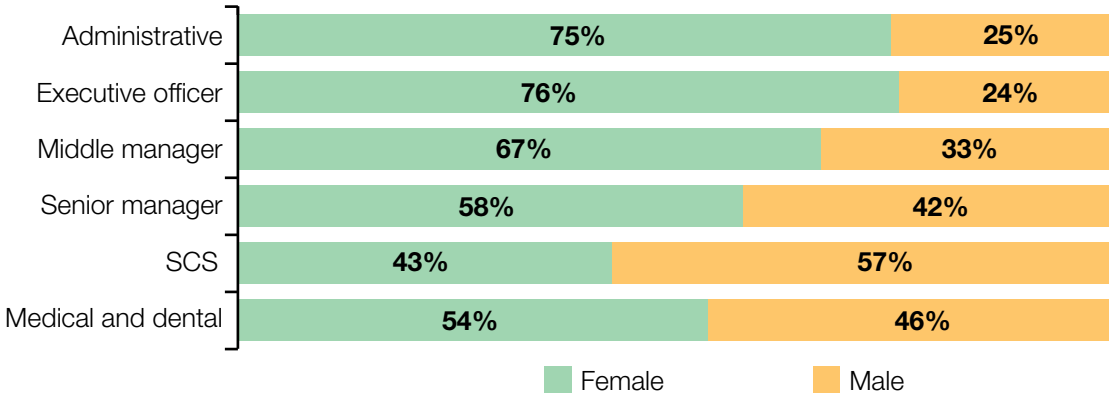
Appointment and appraisal of Management Committee members

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 Management Committee 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 Management Committee was 9 males (64%) and 5 females (36%). The overall gender profile of the PHE workforce is 66% female and 34% male. The graph below shows the profile by grade and gender.



Audited table

REMUNERATION OF MANAGEMENT COMMITTEE MEMBERS 2015/16

	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 2016			
				Bands of			
				£5,000	£5,000	£2,500	£5,000
Duncan Selbie	1 April 2013		6 months	185 - 190	10 - 15	85 - 87.5	280 - 285
Viv Bennett[1]	1 April 2013		3 months	70 - 75		27.5 - 30	100 - 105
Michael Brodie	24 June 2013		3 months	140 - 145	10 - 15	55 - 57.5	205 - 210
Paul Cosford[2]	1 April 2013		3 months	155 - 160		40 - 42.5	195 - 200
Yvonne Doyle[2]	1 April 2013		3 months	180 - 185		142.5 - 145	320 - 325
Kevin Fenton	1 April 2013		3 months	175 - 180		67.5 - 70	240 - 245
Richard Gleave	1 April 2013		3 months	140 - 145		37.5 - 40	175 - 180
Jenny Harries[5]	1 April 2013		3 months	140 - 145	0 - 5	70 - 72.5	210 - 215
Paul Johnstone[2]	1 April 2013		3 months	180 - 185		77.5 - 80	255 - 260
Jonathan Marron[4]	1 April 2013	31 January 2016	3 months	95 - 100	10 - 15	37.5 - 40	140 - 145
Deborah McKenzie[6]	1 April 2015		3 months	115 - 120		27.5 - 30	140 - 145
John Newton[2]	1 April 2013		3 months	165 - 170		32.5 - 35	200 - 205
Rashmi Shukla[2]	1 April 2013		3 months	165 - 170		60 - 62.5	225 - 230
Alex Sienkiewicz[3]	1 April 2013		3 months	115 - 120		35 - 37.5	150 - 155

1. 1.0 FTE until 31 May 2015, then changed to 0.6 FTE and was seconded from the Department of Heath until she transferred to the PHE payroll on 1 April 2015.
2. The remuneration of these members of the Management Committee included a clinical excellence Award
3. Seconded from Brighton and Sussex University Hospitals NHS Trust on a full-time basis from 1 April 2015 to 31 May 2015, when he was appointed to a permanent position following an open competition chaired by one of the Civil Service Commissioners
4. Left PHE on this date to take up a permanent appointment at the Department of Health
5. Jenny Harries was paid an additional amount of £10-15k for work in relation to the PHE Ebola response
6. Previously seconded from NHS Central Southern Commissioning Support Unit and transferred to a permanent post in PHE on 1 April 2015

Audited table

REMUNERATION OF NATIONAL EXECUTIVE COMMITTEE 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	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
Michael Brodie	24 June 2013		3 months	140 - 145		50.0 - 52.5	190 - 195
Paul Cosford[2]	1 April 2013		3 months	155 - 160		(22.5 - 25.0)	135 - 140
Yvonne Doyle[2]	1 April 2013		3 months	180 - 185		17.5 - 20.0	195 - 200
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
Jenny Harries	1 April 2013		3 months	125 - 130		30.0 - 32.5	155 - 160
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
Christine McCartney	1 October 2013	31 March 2014	3 months	55 - 60		-	55 - 60
Deborah McKenzie[3,5]	15 July 2014			75 - 80		40.0 - 42.5	120 - 125
John Newton[2]	1 April 2013			165 - 170		7.5 - 10.0	175 - 180
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
Lis Birrane	1 April 2013	31 March 2016	3 months	100 - 105		27.5 - 30.0	130 - 135
Stephen Morris[4,5]	1 April 2013	15 July 2014	3 months	35 - 40		2.5 - 5.0	35 - 40
Sally Warren[5]	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. Pro-rata due to only serving part of year on the then National Executive
6. Lis Birrane and Tony Vickers-Byrne did not become members of the Management Committee on its establishment at the beginning of 2015/16
7. Christine McCartney was not a member of a pension scheme

Remuneration of Management Committee members

The table on the previous page lists all persons who served on the Management Committee in the year ended 31 March 2016. A summary of their employment contract is accompanied by the total remuneration due to each individual during their tenure in post in 2015/16.

Compensation for loss of office

No payment of compensation for loss of office was made to any member of the Board or Management Committee during the year ended 31 March 2016.

Remuneration policy

Non-executive Board members

Non-executive Board members' remuneration is not performance related, and is determined by the Secretary of State for Health. The remuneration package is subject to review by the Secretary of State and no changes have been notified to us.

Members of the Management Committee

The policy for remunerating members of the Management Committee 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 three members of the Management Committee in accordance with the performance-related pay provisions available to those employed on SCS or VSM terms and conditions. The Management Committee 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 Management Committee members are reviewed annually by the Remuneration Committee, having regard to the relevant terms and conditions applicable. For the financial year 2015/16, some members of the Management Committee 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 should receive an additional consolidated award of £700. 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 Management Committee members

The amount paid to Brighton and Sussex University Hospitals NHS Trust for the services of Alex Sienkiewicz between 1 April and 31 May 2015 was £29,325. He was appointed permanently to PHE on 1 June 2015 following a recruitment exercise overseen by the Civil Service Commission.

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 Management Committee members were published quarterly in arrears on the PHE website.

Bonuses

In accordance with Cabinet Office guidance, the best performing SCS staff are eligible for a non-consolidated (ie non-recurrent and non-pensionable) payment. The sum available for non-consolidated awards is set centrally and for 2015/16 was 3.3% of the total SCS pay bill. The Remuneration Committee of the Board agreed that, based on performance in the 2014/15 reporting year, all SCS staff in the 'top' performing category should receive a non-consolidated payment of £11,000 (ie the same amount for SCS1, 2 and 3 staff). The bonus payments to SCS3 (the Chief Executive) and SCS2 staff (the Director of Strategy and the Finance and Commercial Director) are disclosed elsewhere in this Remuneration and Staff Report. Ten SCS1 staff received a bonus.

Benefits in kind

During the year ended 31 March 2016, no benefits in kind were made available to any non-executive Board member or any Management Committee member.

Pension entitlements

The Management Committee 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 Management Committee members who were in post at 31 March 2016 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.

Audited table

PENSION ENTITLEMENTS OF MANAGEMENT COMMITTEE 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 2016	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 1 April 2015	Cash Equivalent Transfer Value at 31 March 2016	Real increase in Cash Equivalent Transfer Value
	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
Chief Executive							
Duncan Selbie	5 - 7.5	0 - 2.5	120 - 125	0 - 5	1,844	2,078	70
Executive directors							
Viv Bennett	0.0 - 2.5	0.0 - 2.5	5 - 10	0 - 5	89	121	17
Michael Brodie	2.5 - 5	0.0 - 2.5	5 - 10	0 - 5	59	98	21
Paul Cosford	0.0 - 2.5	(0.0 - 2.5)	50 - 55	150 - 155	946	982	25
Yvonne Doyle	5.0 - 7.5	17.5 - 20.0	50 - 55	150 - 160	1,011	1,172	150
Kevin Fenton	2.5 - 5	0.0 - 2.5	10 - 15	0 - 5	103	157	28
Richard Gleave	0.0 - 2.5	0.0 - 2.5	5 - 10	0 - 5	79	125	29
Jenny Harries	2.5 - 5.0	7.5 - 10.0	35 - 40	105 - 110	687	770	75
Paul Johnstone[1]	2.5 - 5	0.0 - 2.5	90 - 95	0 - 5	1,524	1,719	70
Jonathan Marron	0.0 - 2.5	0.0 - 2.5	5 - 10	0 - 5	45	64	12
Deborah McKenzie[2]	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	0	33	25
John Newton	0.0 - 2.5	2.5 - 5.0	55 - 60	175 - 180	1,209	1,266	43
Rashmi Shukla[1]	2.5 - 5	0.0 - 2.5	65 - 70	0 - 5	1,045	1,184	53
Alex Sienkiewicz[3]	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	0	17	10

1. CETV values as at 1 April 2015 have been recalculated to accurately reflect the opening values.
2. Pension benefits earned since she joined the PCSPS on taking up a permanent post in PHE from secondment on 1 April 2015.
3. Pension benefits earned since he joined the PCSPS on taking up a permanent post in PHE from secondment on 1 June 2015.

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 (audited)

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. Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The banded remuneration of the highest paid director in the financial year 2015/16 was £195,000 to £200,000 (2014/15: £200,000 to £205,000). This was 5.3 times the median remuneration of the workforce (2014/15: 5.7), which was £37,260 (2014/15: £35,704).

In 2015/16, remuneration across our workforce ranged from £15,350 to £223,541 (2014/15: £15,350 to £216,000). Two employees (2 in 2014/15) received remuneration in excess of the highest paid director. Their salaries are disclosed in the Cabinet Office's list of senior officials 'high earner' salaries: www.gov.uk/government/publications/senior-officials-high-earners-salaries.

Staff report

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). The pension schemes available to PHE employees are defined benefit schemes, all of which prepare separate scheme statements, which are readily available to the public. Details of the major pension schemes are provided below.

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 2012. Details can be found in the resource accounts of the Cabinet Office: Civil Superannuation (www.civilservice-pensions.gov.uk).

For 2015/16, employers' contributions were payable to the PCSPS at an average of 21.1% (2015: 18.9%) 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	Alpha 2015 scheme	All other schemes
Up to £15,000	3.00%	4.60%
£15,001 - £21,000	4.60%	4.60%
£21,001 - £47,000	5.45%	5.45%
£47,001 - £150,000	7.35%	7.35%
Over £150,000	8.05%	8.05%

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

The NHS Pension Scheme (NHSPS)

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

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

Under NHSPS regulations, PHE and participating employees are required to pay contributions, as specified by the Secretary of State for Health. These contributions are used to defray the costs of providing the NHSPS benefits. Employer contributions are charged to operating costs as they become due. Employer contributions are 14.3% (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:

	2015/16 Annual pensionable pay	**2015/16 Employee contribution**
Tier 1	Up to £15,431.99	5.00%
Tier 2	£15,432 to £21,477.99	5.60%
Tier 3	£21,478 to £26,823.99	7.10%
Tier 4	£26,824 to £47,845.99	9.30%
Tier 5	£47,846 to £70,630.99	12.50%
Tier 6	£70,631 to £111,376.99	13.50%
Tier 6	£111,377 and over	14.50%

In the March 2016 budget, the Chancellor announced a change in the superannuation contributions adjusted for past experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform annual reports, the CETV figures quoted in this report for members of the NHS pension scheme are based on the previous discount rate and have not been recalculated. However, for those individuals in the principal civil service pension scheme myCSP have used the 2.8% rate to calculate CETVs.

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 2015/16 requires the scheme to be accounted for as defined contribution in nature.

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:

	2015/16 £'000	2014/15 £'000
The PCSPS	31,994	9,650
The NHSPS	7,671	22,555
Total contributions	**39,665**	**32,205**

As at 1April 2015, all PHE staff who were not in the clinical ring fence transferred to the PCSPS penision scheme from the NHSPS.

Retirements due to ill-health

During 2015/16, there were five (2015: one) early retirements from PHE on ill-health grounds; the total additional accrued pension liabilities on the year amounted to £228,233 (2015: £150,980).

Reporting of civil service and other compensation schemes – exit packages

Audited table

	2015/16			2014/15		
Exit package cost band	**Number of redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	13	-	13	15	-	15
£10,000-£25,000	23	-	23	53	-	53
£25,000-£50,000	24	-	24	89	-	89
£50,000-£100,000	32	-	32	64	-	64
£100,000-£150,000	4	-	4	13	-	13
£150,000-£200,000	2	-	2	9	-	9
£200,000+				5	-	5
Total number of exit packages	**98**	**-**	**98**	248	-	248
Total resource cost (£000)	4,158	-	4,158	13,328		13,328

Redundancy costs have been calculated in accordance with the NHS Pension Scheme. Exit costs have been accounted for in full in the year of departure. Where the agency has agreed early retirements the additional costs are met by the agency and not by the pension scheme.

Senior civil service staff by band

The table below shows a breakdown of staff employed on (SCS) terms and conditions as at 31 March 2016:

Unaudited table

Bands	Total
SCS1	42
SCS2	9
SCS3	1
Total	**52**

Average number of persons employed

The table below lists the average number of whole time equivalent persons employed during the year:

Audited table

	2015/16			2014/15		
	Permanently employed staff	**Others**	**Total**	**Permanently employed staff**	**Others**	**Total**
Directly employed	4,963	-	4,963	5,234	-	5,234
Other	-	391	391	-	317	317
Staff engaged on capital projects	10	2	12	7	-	7
Total	**4,973**	**393**	**5,366**	**5,241**	**317**	**5,558**

Staff composition

The table below shows the PHE staff composition by headcount as at 31 March 2016:

Unaudited table

	Male	Female	Total
Directors	9	7	16
Senior Civil Service	25	17	42
Other Staff	1,781	3,503	5,284
Total	**1,815**	**3,527**	**5,342**

	2015/16 £000			2014/15 £000		
	Permanently employed staff £000	Other staff £000	Total £000	Permanently employed staff £000	Other staff £000	Total £000
Wages and salaries	221,682	22,023	243,705	234,233	19,025	253,258
Social security costs	19,872	-	19,872	19,377	-	19,377
Other pension costs	39,665	-	39,665	32,205	-	32,205
Subtotal	**281,219**	**22,023**	**303,242**	**285,815**	**19,025**	**304,840**
Redundancy and other department costs	4,158	-	4,158	13,328	-	13,328
Less recoveries in respect of outward secondments	(2,836)	-	(2,836)	(2,421)	-	(2,421)
Less recoveries in respect of staff engaged on capital projects	(936)	-	(936)	(641)	-	(641)
Total net costs	**281,605**	**22,023**	**303,628**	**296,081**	**19,025**	**315,106**

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.

Sickness absence

During 2015/16, the total number of whole time equivalent (WTE) days lost to sickness absence was 53,166 days, an average of 6.4 working days per staff WTE per year; and a sickness absence rate of 4.11% (2014/15: 55,239 days; average 6.3 working days per staff WTE per year; and 4.19% sickness(absence rate). It should be noted that the percentage absence figure is higher than reported to the Cabinet Office (2.84%), which is based on absence in working days; the figure above is based on total absence in calendar days.

Staff policies

PHE is part of the Jobcentre Plus 'two ticks' scheme that guarantees an interview for all applicants who declare to have a disability and who meet the essential criteria of the job role. Additional information is also provided for all applicants on how to complete an application form. In order to provide a level playing field, PHE will make the necessary reasonable adjustment requested by the candidates.

PHE is committed to supporting all staff during their period of employment. By working closely with the individual, we can ensure that the appropriate reasonable adjustments are made and that the staff member has the right access to training.

The training and development of our staff is key to PHE. All staff are provided with the opportunity to further enhance their skills and abilities to enable them to fulfil the requirements of the role and help maximise their talent. Managers within PHE are expected to apply consistency and equity in line with the learning and professional development policy.

Consultancy spend

Based on the Cabinet Office definition:

"the provision to management of objective advice relating to strategy, structure, management or operations of an organisation. Such advice will be provided outside the 'business-as-usual' environment when in-house skills are not available and will be time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not the delivery of) the implementation of solutions".

Source: www.gov.uk/government/publications/cabinet-office-controls/cabinet-office-controls-guidance-version-40

Total PHE spend in 2015/16 was £92,400 including VAT, on three approved business cases.

Off-payroll engagements

The following table shows all off-payroll engagements as of 31 March 2016, with a value of more than £220 per day and that last for longer than six months:

Unaudited table

Nature off-payroll engagement	**Number**
Number that have existed for less than one year at time of reporting	**3**
Number that have existed for between one and two years at time of reporting	**-**
Number that have existed for between two and three years at time of reporting	**-**
Number that have existed for between three and four years at time of reporting	**-**
Number that have existed for four years or more years at time of reporting	**-**
Total	**3**

The following table shows all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, with a value of for more than £220 per day and that last longer than six months:

Unaudited table

Nature off-payroll engagement	**31 March 2016 (Number)**
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	21
Number of the above which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	21
Number for whom assurance has been requested	21
Of which…	
Number for whom assurance has been received	20
Number for whom assurance has not been received	1
Number that have been terminated as a result of assurance not being received	1

There were no off-payroll engagements of board members and/or senior officials, with significant financial responsibility, between 1 April 2015 and 31 March 2016.

Additional payments to staff during level 4 incident

During the level 4 Ebola response, we deployed a number of scientific and expert staff to West Africa, particularly to the mobile diagnostic laboratories we established in Sierra Leone. Staff at below SCS or equivalent grade were offered a deployment compensation package in line with that made available to colleagues from the Defence Science and Technology Laboratory (DSTL).

Auditable and non-auditable elements of this report

The tables in this remuneration and staff report specified as audited, 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 General's opinion is included within his certificate and report on page 142.

Duncan Selbie

Chief Executive

6 July 2016

Parliamentary accountability and audit report

Remote contingent liabilities

We have the following remote 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. We have 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 smallpox vaccines that we inherited from DH on our establishment in 2013. Its value is £40m and covers 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. We will only ever call upon this contingency if the vaccine were ever used and if people suffered side effects as a result. As agreed by the National Audit Office, it is reported every year as a continuing liability.

Fees and charges - audited

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

	2015/16 Income	2015/16 Full cost	2015/16 Surplus/ (deficit)	Details of financial objective	Details of performance against the financial objective
Clinical microbiology	55,147	60,384	(5,237)	Charges for pathology tests, mostly to the NHS and to local authorities	Met: broadly in line with internal targets
Supplies of cell cultures and related services	5,102	5,830	(728)	Supplies of cell cultures and related services	Met: broadly in line with internal targets
Vaccine evaluation and external quality assurance schemes	10,210	11,114	(904)	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual property management	20,391	-	20,391	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Emergency preparedness and response - externally funded	1,404	1,597	(193)	Charges for various emergency response advisory services	Met: broadly in line with internal targets
Commercial radiation services	9,259	9,891	(632)	Charges for various radiation services	Met: broadly in line with internal targets
Total	**101,513**	**88,816**	**12,697**		

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 IFRS8 purposes

	2014/15 Income	2014/15 Full cost	2014/15 Surplus/ (deficit)	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	0	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	0	Charges for various emergency response advisory services	Met: broadly in line with internal targets
Commercial radiation services	8,448	10,487	(2,039)	Charges for various radiation services	Met: broadly in line with internal targets
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. It is difficult to separate the costs of these activities without a burdensome process. This will be reviewed further in the coming year with the aim to identify such costs more clearly.

This note has not been provided for IFRS 8 purposes.

Losses and special payments

Losses statement - audited

	2015/16		2014/15	
	Number	£000	Number	£000
Monetary losses	3	1	4	7
Loss of accountable stores	1	4	1	5
Fruitless payment	3	4	1	22
Constructive loss	4	116,095	4	62,571
Claims waived or abandoned	3	40	4	30
Total	**14**	**116,144**	**14**	**62,635**

Details of cases over £300,000

Constructive losses

PHE wrote off £115,224,000 in relation to countermeasures held for emergency preparedness and vaccines that have now passed their shelf life. These write-offs are a planned consequence of our preparedness strategy that involves central stockpiling.

Following a government decision to change TB screening policy, screening at airports was discontinued and there was no requirement for the X-ray machines which had been purchased for use at Heathrow and Gatwick elsewhere in the health family. The remaining value of these machines and their related costs were written off as a constructive loss (£871,000).

Special payments - audited

	2015/16		2014/15	
	Number	£000	Number	£000
Compensation	3	72	9	1
Ex gratia	-	-	3	9
Total	**3**	**72**	**12**	**10**

Details of cases over £300,000

Nil

Duncan Selbie

Chief Executive

6 July 2016

The certificate and report of the Comptroller and Auditor General to the House of Commons

I certify that I have audited the financial statements of Public Health England for the year ended 31 March 2016 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 and staff report and the Parliamentary Accountability disclosures that is described in those reports 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 Performance and Accountability 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 2016 and of the net operating expenditure 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 parts of the Remuneration and staff report and the Parliamentary Accountability disclosures to be audited have been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000; and
- the information given in the Performance and Accountability Reports 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 parts of the Remuneration and staff report and the Parliamentary Accountability disclosures 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 CE Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
London
SW1W 9SP
11 July 2016

3 Accounts

Statement of comprehensive net expenditure

FOR THE PERIOD ENDED 31 MARCH 2016

	Note	2015/16 £000	2014/15 £000
Income from sale of goods and services	5	(188,358)	(206,242)
Other operating income	5	(39,354)	(29,609)
Finance income		(426)	-
Total income		**(228,138)**	**(235,851)**
Staff costs	3	303,628	315,106
Purchase of goods and services	4	696,871	645,407
Depreciation and impairment charges	4	26,002	23,587
Provision expense	4	(2,290)	10,661
Other operating expenditure	4	3,143,595	2,864,320
Total expenditure		**4,167,806**	**3,859,081**
Net operating expenditure		**3,939,668**	**3,623,230**
Other comprehensive expenditure			
Items that will not be reclassified to net operating costs:			
Net (gain) on revaluation of property, plant and equipment	6	(10,148)	(2,647)
Comprehensive net expenditure for the year ended 31 March		**3,929,520**	**3,620,583**

Statement of financial position

FOR THE PERIOD ENDED 31 MARCH 2016

	Note	2015/16	2014/15
		£000	£000
Non current assets:			
Property, plant and equipment	6	852,185	920,375
Intangible assets	7	17,906	13,326
Investment property	8	9,344	-
Financial assets	12	30,184	-
Other non-current assets	12	92	144
Total non current assets		**909,711**	**933,845**
Current assets:			
Trade and other receivables	12	103,278	57,904
Inventories	11	179,279	143,334
Cash and cash equivalents	13	82,576	159,674
Total current assets		**365,133**	**360,912**
Total assets		**1,274,844**	**1,294,757**
Current liabilities			
Trade and other payables	14	(161,548)	(158,737)
Provisions	15	(13,642)	(17,126)
Total current liabilities		**(175,190)**	**(175,863)**
Non current assets plus net current assets		**1,099,654**	**1,118,894**
Non current liabilities			
Provisions	15	(1,804)	(2,373)
Total non current liabilities		**(1,804)**	**(2,373)**
Assets less liabilities		**1,097,850**	**1,116,521**
Taxpayer's equity			
General fund		1,054,693	1,078,951
Revaluation reserve		43,157	37,570
Total taxpayer's equity		**1,097,850**	**1,116,521**

The notes on pages 148 to 173 form part of these accounts

The financial statements on pages 144 to 147 were signed by:

Duncan Selbie

Accounting Officer

Statement of cash flows

FOR THE PERIOD ENDED 31 MARCH 2016

Cash flows from operating activities	Note	2015/16	2014/15
		£000	£000
Net operating cost		(3,939,668)	(3,623,230)
Adjustments for non cash transactions			
Auditor remuneration	4	194	190
Loss on de-recognition of property, plant and equipment	4	104,196	53,883
Reclassification of stockpiled goods	6	1,733	440
Amortisation and depreciation	4	24,839	22,948
Provision for impairments	4	565	566
Gain/(loss) on disposal of inventories	11	(45)	7
Impairments	10	598	73
(Increase) in trade and other receivables		(46,670)	(14,307)
(Increase) in inventories		(39,602)	(11,615)
Increase in trade payables		2,903	35,429
Expenditure charged to provisions	15	(1,763)	(481)
Increase/(decrease) in provisions	15	(2,290)	10,661
Net cash outflow from operating activities		**(3,895,010)**	**(3,525,436)**
Cash flows from investing activities			
Purchase of property, plant and equipment	6	(78,133)	(69,260)
Purchase of intangible assets	7	(10,507)	(5,136)
Cash transferred to Porton Biopharma Ltd		(2,500)	-
Increase in non-current financial assets	12	52	(52)
Net cash outflow from investing activities		**(91,088)**	**(74,448)**
Cash flows from financing activities			
Net parliamentary funding		3,909,000	3,630,128
Net cash inflow from financing activities		**3,909,000**	**3,630,128**
Net increase in cash and cash equivalents in the period		**(77,098)**	**30,244**
Cash and cash equivalents at the beginning of the period	13	159,674	129,430
Cash and cash equivalents at the end of the period	13	82,576	159,674

Statement of changes in taxpayers' equity

FOR THE PERIOD ENDED 31 MARCH 2016

	Note	General fund £'000	Revaluation reserve £'000	Total £'000
Balance at 1 April 2015		1,078,951	37,570	1,116,521
Transfers to Porton Biopharma Ltd		1,880	(180)	1,700
Net parliamentary funding		3,909,000	-	3,909,000
Non-cash charges: auditor's remuneration		194	-	194
Net (gain) on revaluation of property, plant and equipment		-	10,148	10,148
Loss on disposal of inventory		-	(45)	(45)
Transfers between reserves	7/8	4,336	(4,336)	-
Total net operating costs for the year		(3,939,668)	-	(3,939,668)
Balance at 31 March 2016		**1,054,693**	**43,157**	**1,097,850**

	Note	General fund £'000	Revaluation reserve £'000	Total £'000
Balance at 1 April 2014		1,073,167	33,612	1,106,779
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 reserves 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**

Notes to the financial statements

1 STATEMENT OF ACCOUNTING POLICIES

1.1. Statement of accounting policies

Public Health England (PHE) is required, in accordance with Treasury directions made under the Government Resources and Accounts Act 2000, 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) 2015/16 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.

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

By virtue of the Health and Social Care Act 2012, 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 as its primary source of financing is grant-in-aid from the Department of Health.

1.5. 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 public health responsibilities.

1.6. 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.

1.7. 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 relevant expenditure or capitalised if it relates to a non-current asset.

1.8. 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.

1.9. 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 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. 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, by management, to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. A valuation was last undertaken on 31 March 2013.

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. Management consider that these are the most appropriate indices for this purpose. IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at fair value.

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

Subsequent expenditure

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

Assets under construction

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

Stockpiled goods

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.

Stockpiled goods are held at last price paid as a proxy for fair value. Where necessary, provision is made for obsolete, slow moving and defective inventories.

Stockpiled goods held by PHE are held at fair value. PHE undertakes an annual review of the difference between the last price paid for stockpiled goods and fair value. Where the difference is found to be material, the stockpiled goods are re-valued to fair value.

1.10 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 licences.

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.

1.11 Non-current assets – investment property

PHE owns facilities that were used for the manufacture of biopharmaceutical products until March 2015. From April 2015, PHE's biopharmaceutical products function was transferred to Porton Biopharma Ltd (PBL). These facilities are now classified as investment properties in line with IAS 40 and are leased to PBL.

Investment property assets are valued on the same basis as property, plant and equipment assets, ie they are initially measured at cost and subsequently at depreciated replacement cost being used as a proxy for fair value. Movements in fair value are recognised as a profit or loss in the statement of comprehensive net expenditure.

It is expected that the facilities will have a life considerably greater than the current 10-year lease term and PHE has no intention to derecognise the assets in the foreseeable future. Transfers to, or from, investment property shall be made when, and only when, there is a change in use, evidenced by commencement of owner-occupation, for a transfer from investment property to owner-occupied property. The investment property shall be derecognised on disposal or when the investment property is permanently withdrawn from use and no future economic benefits are expected from its disposal.

1.12 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.

1.13 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.

1.14 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 on a straight-line basis.

PHE does not enter into finance leases.

1.15 Inventories

Inventories are valued at the lower of cost (or net current replacement cost if materially different) and net realisable value.

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 held by PHE are held at last price paid as a proxy for the lower of cost and net realisable value. This is considered to be a reasonable approximation due to the high turnover of stocks.

1.16 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.

Cash and bank 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.

1.17 Provisions

Provisions are reviewed at least 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.

1.18 Contingent liabilities and contingent assets

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

1.19 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 2015/16. The application of the standards as revised would not have a material impact on the accounts in 2015/16, were they applied in that year:

IFRS 9 – Financial Instruments

IFRS 14 – Regulatory Deferral Accounts (not relevant for the Department of Health group)

IFRS 15 – Revenue from contracts with customers

IFRS 16 – Leases

1.20 Significant accounting policies and material judgements

Estimates and the underlying assumptions are reviewed on a regular basis by PHE's senior management. Provisions and accruals have been included taking into account all relevant facts as they are known. There are no other judgements or estimates made or used by management that have a significant impact on the financial statements.

2 STATEMENT OF OPERATING COST BY OPERATING SEGMENT

PHE's 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 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 to its Management Committee 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.

	2015/16				2014/15			
	Operations	Public health grants	Vaccine programme	Total	Operations	Public health grants	Vaccine programme	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Gross expenditure	579,854	3,036,236	551,716	4,167,806	610,389	2,794,899	453,793	3,859,081
Income	(152,222)	-	(75,916)	(228,138)	(169,335)	-	(66,516)	(235,851)
Net operating cost	**427,632**	**3,036,236**	**475,800**	**3,939,668**	**441,054**	**2,794,899**	**387,277**	**3,623,230**

The major sources of operational income are as follows:

	2015/16	2014/15
	£000	£000
NHS laboratory contracts	59,466	53,009
Research grants	22,668	23,746
Commercial services	27,822	32,839
Products and royalties	25,248	55,248
Other	92,934	71,009
External income	**228,138**	**235,851**

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

	2015/16				2014/15			
	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	427,632	3,036,236	475,800	3,939,668	441,054	2,794,899	387,277	3,623,230
Reconciling items	**-**	**-**	**-**	**-**	-	-	-	-
Total net expenditure per statement of comprehensive net expenditure	**427,632**	**3,036,236**	**475,800**	**3,939,668**	**441,054**	**2,794,899**	**387,277**	**3,623,230**

3 STAFF COSTS

	2015/16 £000			2014/15 £000		
	Permanently employed staff £000	**Other staff £000**	**Total £000**	**Permanently employed staff £000**	**Other staff £000**	**Total £000**
Wages and salaries	221,682	22,023	243,705	234,233	19,025	253,258
Social security costs	19,872	-	19,872	19,377	-	19,377
Other pension costs	39,665	-	39,665	32,205	-	32,205
Subtotal	**281,219**	**22,023**	**303,242**	**285,815**	**19,025**	**304,840**
Redundancy and other department costs	4,158	**-**	4,158	13,328	**-**	13,328
Less recoveries in respect of outward secondments	(2,836)	-	(2,836)	(2,421)	-	(2,421)
Less recoveries in respect of staff engaged on capital projects	(936)	-	(936)	(641)	-	(641)
Total net costs	**281,605**	**22,023**	**303,628**	**296,081**	**19,025**	**315,106**

Please also see page 136 of the Renumeration and the staff report

4 OTHER EXPENDITURE

	Note	2015/16 £000	2014/15 £000
Accommodation		31,642	29,838
Auditor remuneration		4	4
Bank charges		56	60
Education, training and conferences		4,156	4,906
European Union grant expenditure		1,744	1,323
Foreign exchange (gains) / losses		(196)	(25)
Hospitality		34	87
Insurance		84	193
Inventories written down		13,034	10,084
Inventories consumed		372,295	327,748
Laboratory consumables and services		40,425	51,487
Legal fees		1,202	1,005
Public Health grants		3,036,236	2,794,899
Rentals under operating leases		12,496	12,423
Research & Development		1,840	2,599
Supplies and services		209,715	194,855
Travel and subsistence		9,750	9,988
Voluntary sector grants		5	315
Capital grants		1,554	13,865
Non cash items:			
Auditor remuneration		194	190
Charge of provision for impairments		565	566
Depreciation	6/7	20,664	18,867
Amortisation	6/7	4,175	4,081
(Profit)/loss on de-recognition of property, plant and equipment and intangible assets	6/7	104,196	53,883
Provision provided for in year		(2,290)	10,661
Impairment	10	598	73
Total		**3,864,178**	**3,543,975**

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 (2015: £3,840).

Significant 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 de-recognition of property, plant and intangible assets and impairment.

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. Assets are impaired when the recoverable amount of an asset is less than its carrying amount.

Provisions

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

5 INCOME

	2015/16 Administration £000	2015/16 Programme £000	2015/16 Total £000	2014/15 Administration £000	2014/15 Programme £000	2014/15 Total £000
Sale of goods and services						
Laboratory and other services	7,273	78,291	85,564	19,962	74,744	94,706
Products and royalties	23,619	1,629	25,248	31,488	11,664	43,152
Education and training	470	1,254	1,724	531	1,337	1,868
Vaccines income	-	75,822	75,822	-	66,516	66,516
Other operating income						
Research and related contracts and grants	704	11,147	11,851	714	15,827	16,541
Grants from the UK government	3,474	2,705	6,179	1,299	2,364	3,663
Grants from the European Union	1	4,637	4,638	301	3,241	3,542
Rental from investment property	8,500	-	8,500	-	-	-
Other operating income	866	7,320	8,186	1,731	4,132	5,863
Finance income						
Interest receivable	19	407	426	-	-	-
Total	**44,926**	**183,212**	**228,138**	**56,026**	**179,825**	**235,851**

6 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 2015	28,050	133,932	3,174	79,038	40,088	694,341	34,520	1,013,143
Transfer to Porton Biopharma Ltd	-	-	-	(9,608)	(57)	-	(15,063)	(24,728)
Reclassification of assets (to investment property)	-	(11,018)	-	-	-	-	-	(11,018)
Transfer to inventory	-	-	-	-	-	(1,733)	-	(1,733)
Impairment	-	-	-	(2,579)	-	-	-	(2,579)
Additions	-	-	-	28	-	42,137	35,968	78,133
Transfer of AUC	-	10,872	763	7,768	4,428	-	(23,831)	-
Revaluations	-	-	22	449	-	9,967	-	10,438
De-recognition	-	(67)	(588)	(1,027)	(1,403)	(103,816)	-	(106,901)
At 31 March 2016	**28,050**	**133,719**	**3,371**	**74,069**	**43,056**	**640,896**	**31,594**	**954,755**
Depreciation								
At 1 April 2015	-	13,477	1,717	46,310	31,264	-	-	92,768
Transfer to Porton Biopharma Ltd	-	-	-	(4,718)	(57)	-	-	(4,775)
Impairment	-	-	-	(1,981)	-	-	-	(1,981)
Reclassification of assets (to investment property)	-	(1,116)	-	-	-	-	-	(1,116)
Charge for year	-	7,758	303	6,899	5,146	-	-	20,106
Revaluations	-	-	12	278	-	-	-	290
De-recognition	-	(21)	(433)	(914)	(1,354)	-	-	(2,722)
At 31 March 2016	**-**	**20,098**	**1,599**	**45,874**	**34,999**	**-**	**-**	**102,570**
Carrying value								
At 31 March 2016	28,050	113,621	1,772	28,195	8,057	640,896	31,594	852,185
At 31 March 2015	28,050	120,455	1,457	32,728	8,824	694,341	34,520	920,375
Asset financing								
Owned	28,050	113,621	1,772	28,195	8,057	640,896	31,594	852,185

During the year, an amount of £9,902,000 was transferred to investment property in respect of the buildings leased to Porton Biopharma Ltd.

	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.

Reclassification of assets

During 2014/15, an amount of £5,961,000 was transferred to intangible assets in respect of assets under constructions relating to intangible assets. In previous years, all assets under construction have been classified as property, plant and equipment.

Valuation of assets

Land and building was valued by the Valuation Office Agency on 31 March 2013. All other property, plant and equipment is valued using relevant indices from the Office for National Statistics.

Revaluation

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

7 INTANGIBLE ASSETS

	Software and software licences	Website	Assets under construction	Total
Cost or valuation	**£000**	**£000**	**£000**	**£000**
At 1 April 2015	23,392	2,774	5,136	31,302
Transfer to Porton Biopharma Ltd	(5,797)	-	-	(5,797)
Additions	-	-	10,507	10,507
Transfer from AUC	10,739	63	(10,802)	-
De-recognition	(436)	-	-	(436)
At 31 March 2016	**27,898**	**2,837**	**4,841**	**35,576**
Amortisation				
At 1 April 2015	15,532	2,444	-	17,976
Transfer to Porton Biopharma Ltd	(4,062)	-	-	(4,062)
Charge for year	4,021	154	-	4,175
De-recognition	(419)	-	-	(419)
At 31 March 2016	**15,072**	**2,598**	**-**	**17,670**
Carrying value				
At 31 March 2016	12,826	239	4,841	17,906
At 31 March 2015	7,860	330	5,136	13,326
Asset financing				
Owned	12,826	239	4,841	17,906

	Software and software licences	Website	Assets Under Construction	Total
Cost or valuation	**£000**	**£000**	**£000**	**£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

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

8 INVESTMENT PROPERTY

	Note	2015/16	2014/15
		£000	£000
Buildings leased to Porton Biopharma Ltd	1.11	9,344	-
Total		**9,344**	**-**

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 its investment in Porton Biopharma Ltd (see note 12) 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 2016, PHE received Euro income equivalent to £5,375,000 (2015: £7,309,000) and US Dollar income equivalent to £6,549,700 (2015: £4,834,000) upon which there was some currency risk.

The only other currency risk is that of a Euro currency bank balance valued at £251,000 (2015: £311,000) and a US Dollar bank balance valued at £278,000 (2015: £253,000).

10 IMPAIRMENT

	2015/16			2014/15		
	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
Property, plant and equipment	598	-	598	-	-	-
Intangible assets	-	-	-	73	-	73
Revaluation reserve	-	-	-	-	-	-
Total	**598**	**-**	**598**	**73**	**-**	**73**

The impairment relates to two assets held for use in tuberculosis screening at UK airports (which has been discountinued as a result of a change in government policy). The assets no longer have any operational use to PHE and have been impaired to nil value.

11 INVENTORIES

	Pandeminc Flu and Pre Pandemic Flu	Emergency Preparedness	Vaccines	Drugs	Consumables	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2015	-	-	135,005	1,687	6,642	143,334
Transfer to Porton Biopharma Ltd	-	-	-	(1,687)	(1,970)	(3,657)
Additions	-	-	418,017	-	5,226	423,243
Transferred to/(from) stockpiled goods	1,453	280	-	-	-	1,733
Consumed/disposed of	(1,453)	(280)	(364,831)	-	(5,731)	(372,295)
Written down	-	-	(13,034)	-	-	(13,034)
Revaluation	-	-	-	-	(45)	(45)
Balance at 31 March 2016	**-**	**-**	**175,157**	**-**	**4,122**	**179,279**

	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
Transferred to / (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**

12 TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2015/16	2014/15
	£000	£000
Amounts falling due within one year		
Accrued income	22,061	15,355
Other receivables	53,847	18,121
Prepayments	2,711	3,886
Taxation	2,615	5,291
Trade receivables	22,044	15,251
	103,278	**57,904**
Financial assets		
Investments	20,000	-
Loan	10,184	-
	30,184	**-**
Amounts falling due after more than one year		
Accrued income	71	123
Asset held for sale	21	21
Prepayments	**92**	**144**

Investments

On 1 April 2015, the Secretary of State for Health acquired a 100% shareholding in Porton Biopharma Limited. The investment has been agreed as £20 million of equity shares and a £10.2 million debt, repayable over five years at an interest rate of 4% with capital repayments deferred for two years.

PHE also inherited a 3.1% interest in Spectrum from the Health Protection Agency on 1 April 2013; 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 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

	2015/16	2014/15
	£000	£000
Balance at 1 April	159,674	129,430
Net change in cash and cash equivalents	(77,098)	30,244
Balance at 31 March	**82,576**	**159,674**
The following balances at 31 March were held at:		
Government Banking Service	81,903	156,633
Commercial banks and cash in hand	673	3,041
Balance at 31 March	**82,576**	**159,674**

14 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

	2015/16	2014/15
	£000	£000
Amounts falling due within one year		
Accruals	113,521	123,607
Deferred income	15,177	13,089
EU grant income held on behalf of third parties	259	353
Other payables	2,747	6,630
Trade payables	29,844	15,058
Total	**161,548**	**158,737**

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 2015	1,072	1,938	410	137	1,247	14,695	19,499
Provided in the year	-	226	37	-	-	-	263
Provisions not required written back	-	(36)	-	(91)	(415)	(2,011)	(2,553)
Provisions utilised in the year	(103)	(144)	-	-	(832)	(684)	(1,763)
Balance at 31 March 2016	**969**	**1,984**	**447**	**46**	**-**	**12,000**	**15,446**
Analysis of timing of discounted cashflows							
Not later than one year	104	1,492	-	46	-	12,000	13,642
Later than one year and not later than five years	416	405	253	-	-	-	1,074
Later than five years	449	87	194	-	-	-	730
Balance at 31 March 2016	**969**	**1,984**	**447**	**46**	**-**	**12,000**	**15,446**

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 GAD is currently finalising an estimate.

	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							
Provided in the year	1,171	1,573	419	109	-	6,047	9,319
Provisions not required written back	-	422	44	67	1,247	9,000	10,780
Provisions utilised in the year	-	(27)	(53)	-	-	(39)	(119)
Borrowing costs (unwinding of discount)	(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
Later 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**

16 CAPITAL COMMITMENTS

	2015/16 £000	2014/15 £000
Contracted capital commitments at 31 March not otherwise included in these accounts		
Property, plant and equipment	89,968	15,105
Intangible assets	862	1,364
	90,830	**16,469**

These commitments relate to contractual amounts payable on capital projects.

17 COMMITMENTS UNDER LEASES

	2015/16				2014/15			
	Land £000	**Buildings £000**	**Other £000**	**Total £000**	Land £000	Buildings £000	Other £000	Total £000
Not later than one year	-	3,687	94	3,781	-	4,635	291	4,926
Later than one year and not later than five years	-	11,992	110	12,102	-	10,257	229	10,486
Later than five years	-	1,621	-	1,621	-	2,240	-	2,240
	-	**17,300**	**204**	**17,504**	**-**	**17,132**	**520**	**17,652**

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:

	2015/16 £000	2014/15 £000
Not later than one year	381,142	369,498
Later than one year and not later than five years	206,174	322,191
Later than five years	-	-
Present value of obligations	**587,316**	**691,689**

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

19 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 2016, no Board members, members of senior management, or other parties related to them have undertaken any material transactions with PHE except for those shown in the table below and the following disclosure. At the beginning of 2016, the North East Combined Authority and the local NHS in the North East of England established a Commission for Health and Social Care Integration in the North East. Its purpose is to identify opportunities for further collaboration and integration in order to improve the health and wellbeing of residents and reduce health inequalities in that part of the country. Duncan Selbie has been appointed as Chair of the Commission, and receives no remuneration for this role. PHE does not have direct transactions with this Commission but carries out normal business with the local authorities and NHS organisations locally that formed the commission.

Related party	Name of the PHE Board Member or senior manager	PHE appointment	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
Academy of Medical Sciences	George Griffin	Non-executive PHE Board member	Academic Foreign Secretary	- (-)	3 (3)	- (-)	- (-)
Centre for London (Charity 1151435 England)	Derek Myers	Non-executive PHE Board member, Chair of Audit and Risk Committee	Trustee	- (-)	10 (30)	- (-)	- (-)
Human Tissue Authority	Rosie Glazebrook	Non-executive PHE Board member	Board member	- (-)	5 (7)	2 (-)	- (-)
London School of Hygiene and Tropical Medicine	David Heymann	PHE Board Chair	Lecturer	- (141)	570 (517)	51 (20)	60 (18)
	Paul Lincoln	Associate non-executive PHE Board member	Advisory panel member				
Medical Research Council	Paul Lincoln	Associate non-executive PHE Board member	Member of National Prevention Research Initiative Strategic Review Group	- (65)	170 (112)	- (-)	- (3)
Medicines and Healthcare products Regulatory Agency	Martin Hindle	Non-executive PHE Board member	Non-executive Board member	390 (417)	7 (5)	- (1)	- (51)
Mental Health First Aid England	Poppy Jaman	Non-executive PHE Board member	Chief Executive	- (-)	41 (-)	- (-)	- (-)
Porton Biopharma Ltd	Martin Hindle	Non-executive PHE Board member	Chair	56,244* (-)	- (-)	- (-)	56,240* (-)
	Michael Brodie	Finance and Commercial Director	Non-executive Director of the Board (shareholder representative on behalf of the Secretary of State for Health)				
	Richard Gleave	Chief Operating Officer	Non-executive Director of the Board (shareholder representative on behalf of the Secretary of State for Health)				
Royal College of Physicians	Paul Lincoln	Associate non-executive PHE Board member	Honorary member	- (-)	8 (103)	- (-)	- (-)
Royal Society for Public Health	Sian Griffiths	Non-executive PHE Board member	Trustee	1 (3)	86 (57)	1 (43)	- (-)
UK Health Forum	Paul Lincoln	Associate non-executive PHE Board member	Chief Executive	- (-)	1,663 (456)	48 (-)	- (-)
University of Chester	Paul Lincoln	Associate non-executive PHE Board member	Visiting Professor	1 (1)	5 (-)	- (-)	(-)
Durham University	Michael Brodie	Finance and Commercial Director	Audit Committee independent lay member	6 (8)	112 (70)	47 (-)	5 (-)
The Chartered Institute of Public Finance and Accountancy (CIPFA)	Michael Brodie	Finance and Commercial Director	Member of the Executive Committee of CIPFA North East	- (-)	1 (4)	- (-)	- (-)
Oxford University	Richard Gleave	Chief Operating Officer	Visiting tutor	- (23)	823 (1,509)	110 (-)	6 (24)

Comparative figures for 2014/15 are shown in brackets

* This figure includes the investment in Porton Biopharma Ltd (note 12)

20 THIRD PARTY ASSETS

In addition to the assets disclosed at note 8, PHE held buildings at the Porton Down site, 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.

	2015/16 £000	2014/15 £000
Buildings	2,149	2,149
	1,992	1,919
Total	**4,141**	**4,068**

21 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.

The Accounting Officer authorised these financial statements for issue on 11 July 2016.

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