Public Health England

Protecting and improving the nation's health

Annual Report and Accounts 2016/17

Credible, independent and ambitious

Public Health England

Annual Report and Accounts 2016/17

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

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1 Performance report

Chair's report

Sir Derek Myers

PHE's primary accountability is to the Secretary of State for Health, reflecting the importance Ministers attach to both the advice that they can depend upon from PHE and the centrality of our mission to protect and improve the health of the nation.

The Advisory Board has its own particular contribution to make, which we see as assuring that PHE is at all times credible, independent and ambitious. We do this by providing advice, support and constructive challenge to the Chief Executive and his team and playing our part in ensuring that PHE is rigorous about clinical evidence, original research and the promotion of what works. We want PHE to be efficient and effective. We want government – both local and national, the NHS and the wider world to see PHE as dependable and professional. We also want to work in ever closer partnership with colleagues from Wales, Scotland and Northern Ireland, and internationally as the UK focal point for the International Health Regulations, which aim to help prevent and respond to acute public health risks that have the potential to cross borders and threaten people worldwide.

As a former Chief Executive in local government, I was very encouraged by the strong results in the most recent independent stakeholder review of PHE. Duncan Selbie and his senior leadership team have shown PHE to be a listening and learning organisation, taking on board and acting on feedback as it matures in its role and work. Internally, staff engagement has improved with an increased score in the annual staff survey, no mean achievement during what was a further period of major change. This provides a strong platform on which to build as PHE accelerates its plans to make Harlow its future home.

The review of the year past set out in this annual report has also been characterised by a relentless focus on improving taxpayer value, representing a 30% saving on the opening position in 2013. As an Advisory Board member since that time, and now as Interim Chair, I commend and recognise the considerable efforts of all PHE staff and our partners in the pursuit of our mission. None of this we can do by ourselves and we are by far stronger when we work together.

Derek Myers

Sir Derek Myers
Interim Chair, PHE Advisory Board

Chief Executive's review

Duncan Selbie

We are now into our fifth year and have a much greater understanding of how we can have the strongest influence and where we can make the greatest impact as the nation's public health agency.

The results of our most recent annual stakeholder survey show that they feel we are maturing as an organisation and making an impact through the evidence we provide, the influence we have with government and the support we provide to the NHS and local authorities. We have re-energised our regular personal contact with local government at a local level, which we know they value, and accelerated our work on products and services that help on return on investment (ROI) and value for money. 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 *From Evidence into Action*. It is encouraging to see that 57% of stakeholders say they would speak positively of PHE – the third highest score of all the public sector bodies surveyed by Ipsos/MORI over the past decade.

Over the past year, we have provided the most comprehensive and up-to-date review of the evidence on alcohol harm and the effectiveness of alcohol control policies. We have pioneered new ways of using whole genome sequencing to diagnose tuberculosis and other infections more quickly and more accurately – a world first. And we are leading what we believe will be the most extensive, formal and structured programme of food reformulation anywhere in the world, removing 20% of the sugar from the food categories that contribute the most to children's diets by 2020.

Speed is key in dealing with public health emergencies and, in November 2016, the government launched a specialist team of health experts who will be ready to deploy to tackle a health crisis anywhere in the world within 48 hours. The UK Public Health Rapid Support Team, run jointly by PHE and the London School of Hygiene and Tropical Medicine, comprises clinicians, scientists and academics who will be on call to respond to urgent requests, such as disease outbreaks, where they happen. The Ebola crisis highlighted the need for the international community to develop the capability to help low income countries respond to, and control, disease outbreaks before they develop into a global public health emergency. Halting diseases at source is the most effective way of keeping people in the UK safe at home and the government has made £20 million available to fund the team over five years.

Moving into 2017/18, we will build on our achievements, and the lessons we have learned to further consolidate our position as the leading experts on public health.

By continuing to invest in science, research and innovation we will further consolidate our position as a trusted, objective and authoritative source of evidence and knowledge. We will identify and tackle potential threats to the public's health with real world solutions.

Public health interventions offer opportunities to secure savings for public services and society as a whole. We will work with the public, employers, industry and retailers to make the healthy choice, the easy choice, and we will support local government and the local NHS to maximise the value from the local pound as they move to full funding through business rate retention and implement NHS sustainability and transformation plans.

We will continue to drive local and national action – across government – to tackle the wider determinants of health that help narrow the health gap between the poorest and the most affluent. We will use our expertise in behavioural science to make sure our interventions and messages reach those with the greatest need.

Across everything we do, we will be taking on board advice from our stakeholders on where we can do more and better: broadening our support for local authorities to help them get the most out of limited resources; reaching out to other parts of the system that impact on health; and securing our place at the top table on key issues such as integration, devolution and sustainability and transformation plans.

Finally, I would like to say farewell and thank you to Professor David Heymann, whose term as Chair concluded in March after eight years – firstly of the Health Protection Agency and then PHE's Advisory Board. Widely respected nationally and internationally, David has provided an expert guiding hand and sounding board throughout our first four years, ensuring that we enter the next phase of our development from a position of strength and confidence. I would also like to thank Sir Derek Myers for taking on the role of Interim Chair, who, as one of our non-executives since 2013, combines a deep knowledge and understanding of our work with that gained from his time as a Chief Executive in local government and more recently as the government-appointed Lead Commissioner in Rotherham.

Duncan Selbie
Chief Executive

Our role and how we operate

PHE exists to protect and improve the nation'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's statutory duty to protect health and address inequalities, and executes his power to promote the health and wellbeing of the nation. The Minister for Public Health sets out the government's requirements of us, including our strategic priorities in an **annual remit letter**.

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

The Tailored Review carried out by the DH during 2016 confirmed the importance of our role and functions in the health and care system, and concluded that we have made good progress with integrating the staff, cultures, working practices and physical assets of the 100 plus organisations from which we were created.

Our business plan for 2017/18 should be read in conjunction with our **Strategic Plan: Better Outcomes by 2020,** which builds on '*Evidence into action: opportunities to protect and improve the nation's health*' and the **NHS Five Year Forward View**. It sets out the steps we will take in the second year of our four-year plan, and reflects our contribution to national policies, system-wide priorities and support for local partners, as well as how we will deliver the local objectives and shared goals of the public health system.

Some of our achievements in 2016/17

National government

- embarked on an ambitious programme to reduce the level of sugar in food and drink by 20% by 2020
- published a comprehensive review of evidence on alcohol harm in England, providing national and local policy makers with the latest evidence to identify policies that will best prevent and reduce alcohol-related harms
- provided expert advice and support in managing the threat of Zika in the UK and its overseas territories
- published atlases of variation for suicide prevention, dementia and NHS diagnostic services
- published a comprehensive review on the performance of the drug misuse treatment system in England

Local government

- supported devolution agreements across England and particularly with Greater Manchester, London, East of England and the North East
- formed new partnerships with the Police and Fire and Rescue services in their work with the most vulnerable people
- published our first return on investment reports
- co-produced the commissioning guidance for the London Homeless Health Programme
- through the West Midlands Strategic Migration Partnership, improved health screening arrangements and access to services for asylum seekers
- contributed to Thrive West Midlands, the West Midlands' Combined Authority's Mental Health and Wellbeing Concordat
- co-produced a briefing for directors of public health on air quality, working with Defra

The NHS

- published a menu of preventative interventions to address avoidable ill-health and reduce demand on hospitals and general practice
- achieved a 30% reduction in four years in tuberculosis cases in England, and launched the TB Whole Genome Sequencing Service
- contributed to the antimicrobial resistance strategy resulting in fewer antibiotics being prescribed by GPs and hospital clinicians
- launched a campaign to encourage all hospitals and mental health services to go tobacco-free
- secured agreement for the inclusion of "preventing ill-health by risky behaviours" into the Commission for Quality and Innovation (CQUIN) payments framework for hospitals

Directly to the public

- launched the Change4Life Be Food Smart Campaign to help families make healthier food choices. Our Be Food Smart app shows how much sugar, saturated fat and salt is in everyday food and drink and has already been downloaded more than half a million times
- our Healthier You: NHS Diabetes Prevention Programme, run together with NHS England and Diabetes UK, helped over 10,000 people reduce their risk of developing type 2 diabetes
- launched public awareness campaigns on sepsis and meningitis affecting young children
- 12% of all adults took action to improve their health after seeing the new One *You* adult health behaviour change campaign
- Stoptober 2016 resulted in 16% of all smokers making a quit attempt, with 4 in 10 of those staying quit for 28 days, earning the PHE marketing team the Gold Award from the Institute of Practitioners in Advertising Effectiveness

Global health

- launched the UK Public Health Rapid Support Team capable of being deployed on the ground within 48 hours anywhere in the world, making use of the best evidence from research, to respond to public health threats affecting the UK
- our Field Epidemiology Training Programme achieves outstanding status from TEPHINET, the global accrediting body
- supported the development of public health infrastructure internationally, including a new integrated disease surveillance system in Pakistan and the transformation of Ebola laboratories in Sierra Leone to have broader infectious diseases capabilities
- provided science and technical support for implementing the United Nations Sendai Framework for Disaster Risk Reduction
- Nursing and Midwifery team designated by the World Health Organization as its first Nursing and Midwifery Public Health Collaborating Centre

Developing the public health system

- published 'Fit for the Future', a review of the public health workforce future capabilities and skills, supported by the whole public health family
- delivered a cross-system emergency response exercise Cygnus to assess preparedness and response to an influenza pandemic in the UK
- launched the world's first systemic anti-cancer treatment (SACT) database for chemotherapy
- delivered high-quality training for local government staff in health economics and in making use of our return on investment tools
- commissioned and supported the successful aspirant Director of Public Health Programme, preparing 30 more leaders to take on senior roles in public services

Developing PHE

- our staff's work was recognised on several occasions. We received the Civil Service Award for best use of data and evidence for our National Cancer Registration and Analysis Service, and our estates team won the Association of Chief Estates Surveyors Award for Excellence in Property Management for innovative co-locations and collaborations with local authority partners delivering substantial financial savings and better working environments
- our 2016 public opinions survey showed that 83% of the public have confidence in our advice, and we have improved our staff engagement index by 4% to 56%
- our new National Infections Service public health microbiology framework will deliver greater agility, improved value for money and greater use of small and medium-sized organisations
- black and ethnic minority external applicants are now twice as likely to be appointed to posts than when we were created in 2013
- published 'Digital-first public health', our strategy for PHE becoming a digital organisation
- completed research funded by more than £20.5 million in external income, contributed to training over 100 PhD students and published more than 770 peer reviewed research papers

People and budgets

Protection from infectious diseases
2,201
National centres, regional network and capability to identify infectious disease, surveillance and management of outbreaks

Protection from environmental hazards and emergency preparedness
438
Including chemical, radiation and environmental hazards and emergency response

Local centres and regions
1,033
The front door of PHE responsible for assuring that the service and expertise provided are truly focused on local needs. They partner with the local public health system and tailor services to the needs of local government, clinical commissioning groups and the local NHS

Health Improvement
879
National expertise in public health evidence-based interventions

Producing and interpreting information on health, inequalities and priorities for action; supporting research and use of the best evidence

Collecting high quality population-level data on cancer, congenital anomalies and rare disease to support patients, healthcare and public health

Screening programmes
278
Developing and quality assuring cancer and non-cancer screening programmes

Nursing and midwifery
12
National and international public health nursing and midwifery, advice and leadership. Giving children the 'Best Start in Life'

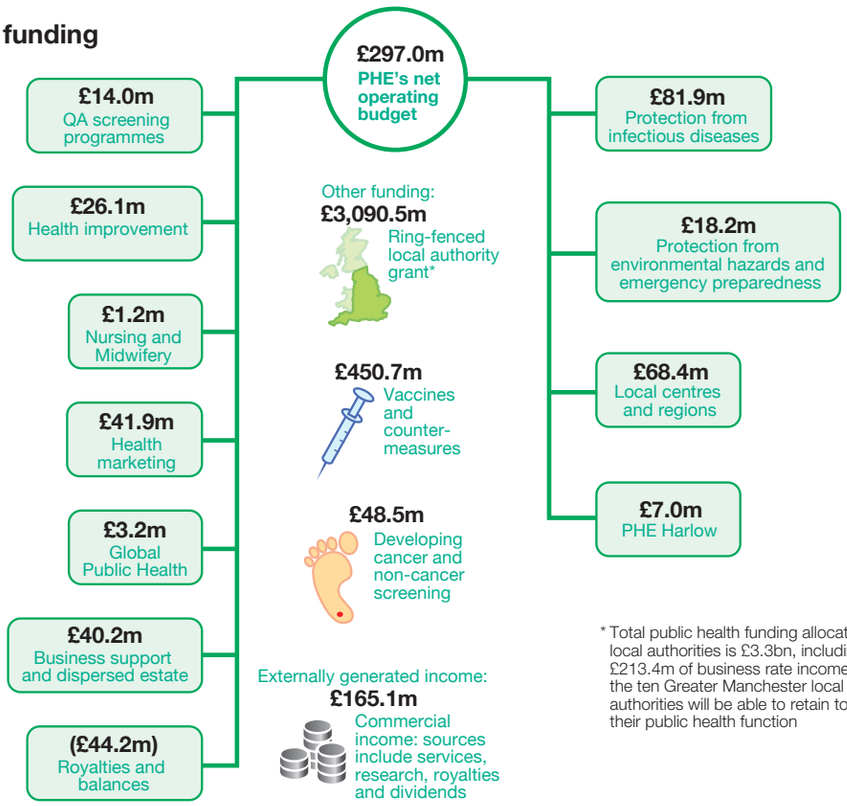
Health marketing
94
Delivering healthy behaviour change campaigns

Global public health
66
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:

165 Financial and commercial
122 Infrastructure (ICT and estates)
73 Communications
42 Corporate affairs
80 People
10 PHE Harlow

Our revenue funding



* Total public health funding allocated to local authorities is £3.3bn, including £213.4m of business rate income that the ten Greater Manchester local authorities will be able to retain to fund their public health function

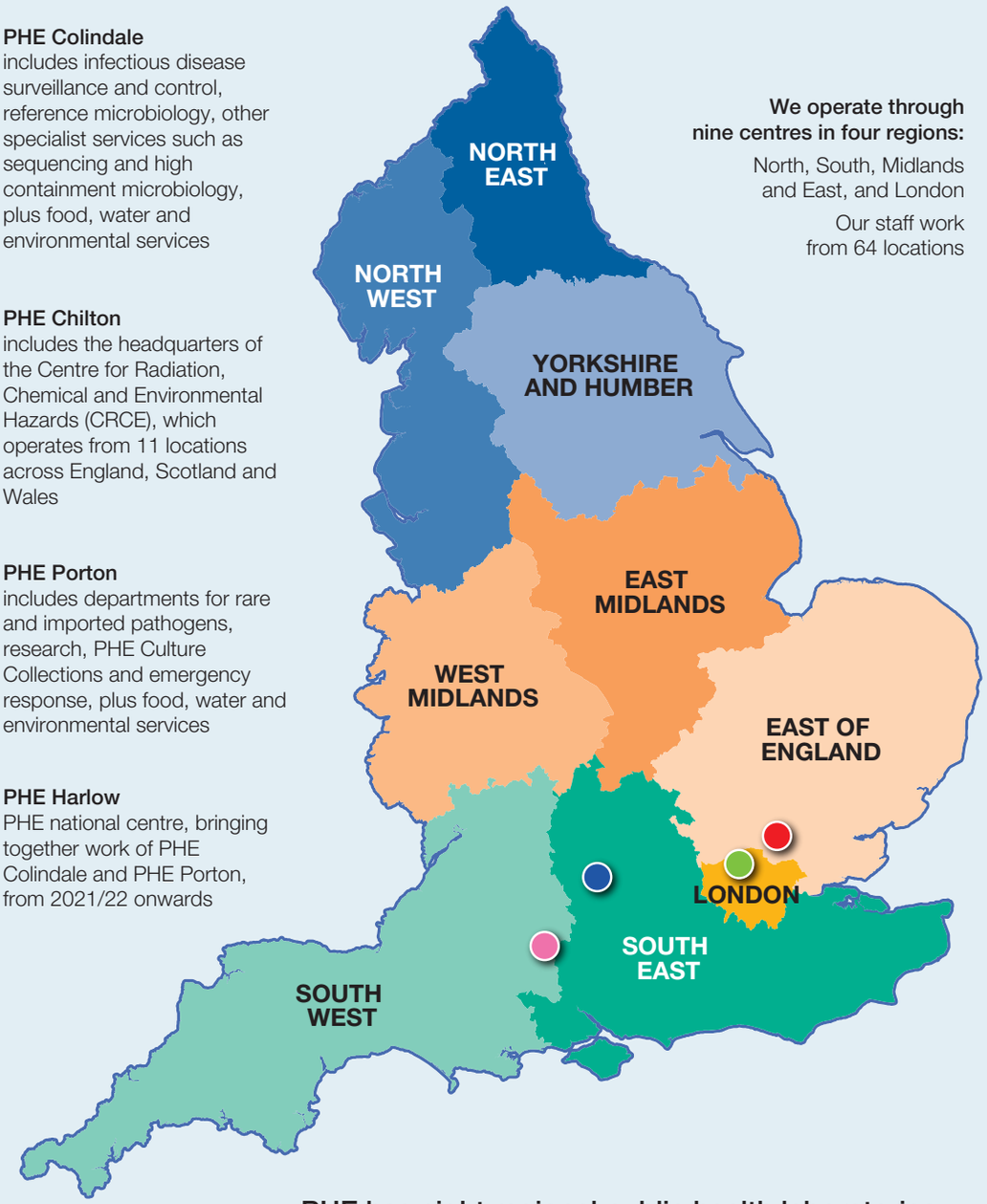
Our national and local presence

PHE Colindale
includes infectious disease surveillance and control, reference microbiology, other specialist services such as sequencing and high containment microbiology, plus food, water and environmental services

PHE Chilton
includes the headquarters of the Centre for Radiation, Chemical and Environmental Hazards (CRCE), which operates from 11 locations across England, Scotland and Wales

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

PHE Harlow
PHE national centre, bringing together work of PHE Colindale and PHE Porton, from 2021/22 onwards



We operate through nine centres in four regions:

North, South, Midlands and East, and London

Our staff work from 64 locations

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

Focus on: whole genome sequencing

At the end of 2016, we began using whole genome sequencing to identify different strains of tuberculosis (TB) at our Birmingham laboratory, the first time that this has been used to diagnose and manage a disease at this scale anywhere in the world.

In the same way that we can use the genetic fingerprint of a child to determine paternity, we can use sequencing to better understand whether TB infections in different patients are related and the degree to which this is the case.

This new technique, developed in partnership with the University of Oxford, allows faster and more accurate diagnoses. Where previously it could take up to a month to confirm a diagnosis of TB, confirm treatment and undertake contact tracing to detect spread, we can now do this in just over a week, with the potential to reduce transmission and slow the spread of the disease.

We can also use it to identify strains of TB that are drug resistant, which need to be treated differently to a non-resistant infection. In less than 24 hours, we can find out if a specific infection is likely to be resistant to a particular drug and recommend a different course of treatment. This supports our wider strategy to tackle antimicrobial resistance as it can help us to avoid drugs that will not work and could contribute to increased levels.

In future, the application of sequencing in other conditions will allow us to test and treat patients at the bed side, rather than needing to wait days and sometimes weeks for results. The implementation of this technology will also contribute to achieving the government's ambition of sequencing 100,000 genomes, a project that will ultimately allow us to better understand major diseases and how to treat them.

We have pioneered the development and early use of whole genome sequencing to investigate and control multiple infectious diseases. We have been using it for salmonella since 2014 and its use has had an unprecedented impact on our ability to detect and investigate outbreaks effectively. It allows us to have a much greater degree of confidence in determining where the bacteria came from and whether it is linked to similar outbreaks nearby, helping us to take action to protect more people from becoming unwell.

For example, over the past year, we have identified that *Salmonella Enteritidis* outbreaks in the UK and other European countries were genetically related and part of a large EU-wide outbreak. This type of sequencing enabled us to confirm the link between human disease cases and salmonella-contaminated eggs sourced from another EU country. Using it alongside traditional epidemiological and food-chain investigations, we identified the source farms in the other country so that public health protection measures could be taken to stop the supply of contaminated eggs. Sequencing will continue to help us reduce infection and contribute to better health for people in England.

We now have a significantly improved understanding of the genetic structure of salmonella and other gastrointestinal bacteria including shigella, listeria and pathogenic strains of *Escherichia coli*. We are starting to improve our knowledge of how we can use whole genome sequencing with other organisms such as campylobacter – the most common cause of food poisoning in the UK – to achieve the same benefits that we have seen with salmonella.

Focus on: alcohol

In December 2016, we published the most up-to-date and comprehensive review of the latest scientific evidence on alcohol harms in England and the effectiveness of alcohol control policies.

Commissioned by the government, the evidence review, also published in *The Lancet*, shows that as a nation we are drinking more alcohol than we did in the past: more than 10 million people drink at levels that increase their risk of health harm, and alcohol is now the leading risk factor for ill-health, early mortality and disability in 15 to 49-year-olds in England. For all ages combined, it is the fifth leading risk factor.

For the first time, the review showed that alcohol is a leading cause of years of working life lost, showing that alcohol harm is impacting people at a younger age. The cost of alcohol-related harm is estimated at between 1.3% and 2.7% of annual GDP, which equates to between £25 and £50 billion each year when applied to the UK. Alcohol also disproportionately impacts the poorest people in our society, with half of more than 1 million hospital admissions relating to alcohol occurring in the lowest three socioeconomic deciles.

Our review identified three key influences on alcohol consumption – price, availability and acceptability – and outlined the evidence supporting an extensive number of policies that seek to mitigate the health, social and economic harms caused by alcohol. It encourages an overall policy approach that is coherent and consistent in order to create an environment that supports individuals who wish to adopt healthier lifestyles by reducing their alcohol consumption and for those who drink at hazardous and dependent levels.

The review went through an exhaustive peer review process with 20 different peer reviewers, and we are using it in our conversations with government departments including the DH, HM Treasury and the Home Office to support them in understanding the latest evidence on what works to combat alcohol harm.

At local level, the review will also support commissioners and local public health teams to deliver the right interventions for their communities. In the past year, we have worked closely with NHS England and NHS Improvement on the latest Commissioning for Quality and Innovation (CQUIN) indicators, which include an incentive to identify and influence patients who are increasing risk or higher risk drinkers.

Our menu of preventative interventions, published in November 2016, also included two preventative interventions on alcohol – identification and brief advice in primary care and alcohol care teams in secondary care – that are estimated to improve health and save money in the health and care system within a five-year horizon.

Focus on: health economics

Our health economics team is increasingly playing a key role in explaining why investing in prevention is so important and exploring how we can incentivise local authorities, NHS commissioners and healthcare providers to invest more in prevention and early intervention and potentially disinvest in interventions with a poorer evidence base.

Diabetes is a good example of the potential cost of failing to take prevention seriously. The NHS is spending about £10 billion a year on diabetes. Almost three million people in England already live with diabetes and another seven million people are at risk. By preventing at-risk people from becoming diabetic, the NHS could potentially save millions of pounds in avoidable treatment costs.

In the autumn of 2016, we published the NHS Diabetes Prevention Programme return on investment tool in partnership with the University of Sheffield, which can be used by local authorities and clinical commissioning groups (CCGs) to understand the costs, savings and health benefits likely to be produced by implementing the programme in their area. The aim is for the programme to achieve nationwide coverage by 2020 and the tool has also been used to update the programme's impact analysis report.

This is one of many examples of how public health professionals can help to analyse data and pull out the most useful evidence to support funding decisions for different services. Last year, we were able to support NHS England to drive improved outcomes and potentially reduce costs in colorectal cancer by developing a return on investment tool for use by CCGs and now cancer alliances and sustainability and transformation plans. Colorectal cancer accounts for one out of nine cancer cases in England and an estimated 14,000 deaths in 2014. The five-year survival rates in England are worse than in peer countries, and this gap has not closed significantly over time unlike those for breast and ovarian cancers.

Our knowledge and intelligence and health economics teams used data held by PHE and NHS England to build up a comprehensive picture of the patient pathway, which can be used to identify variations in service provision and ensure value for money. This user-friendly tool enables organisations at a local level to estimate the costs and benefits of improving outcomes in bowel cancer, and provides information that helps commissioners to make the business case for appropriate investment to improve early detection. The teams have also provided training on health economics to our staff and local authorities to improve the understanding and use of health economics in decision making and policy development.

Importantly, we do not actually know what the health and social care system as a whole currently spends on prevention. We are therefore working with the Chartered Institute of Public Finance and Accountancy (CIPFA) to map spending on prevention across the country, with more information to come during 2017/18 on this and the value that is derived from that preventative spend.

Many of the tools that we have developed or commissioned will help local systems to make the business case for investment in prevention, drawing upon the best available cost-effectiveness evidence. Working closely with the NHS and other partners, we are taking every opportunity to develop a genuinely long-term approach to the economics of prevention, with huge potential benefits for the health of the population, the health and social care system and the wider economy.

Working locally

We have one of the strongest local footprints of any national public health agency across the world, and are committed to supporting local government, the NHS and the wider system to improve the health of the people they serve.

Working with Local Government

We provide expert support and scientific advice to all tiers of local government across England, first and foremost with Directors of Public Health, Chief Executives and elected leaders in the 152 upper tier authorities. We know from the annual Ipsos/MORI stakeholder survey that they particularly value our local teams specialising in health protection, field epidemiology and local public health microbiology and environmental public health.

Over the past year, we have worked particularly closely with local authorities across the country on prospective and actual devolution deals in terms of both combined authorities and, more recently, the metro mayors elected in May. For example:

- we supported Greater Manchester by completing an analysis on the health needs of people who are out-of-work to help a common approach to developing targeted services across the boroughs
- with the West Midlands Combined Authority, we provided data and intelligence to drive the ambitions of their mental health commission, and developed metrics for the health and wellbeing ambitions in their strategic economic plan
- in the East of England, our centre has supported the Cambridgeshire and Peterborough Combined Authority to develop an approach that embeds 'health in all policies' across the Major's five priority areas of work. We also supported the development of prioritisation framework to drive the ambitions of their Inclusive Growth strategy including metrics for assessing health and wellbeing improvements

We also work in partnership with local government on a wide range of local public health priorities, for example:

- our combined region and centre in London provides advice to the Mayor of London and have shaped the forthcoming mayoral Health Inequalities Strategy, which includes a health offer in all the strategies of the Greater London Authority. We have also shaped Thrive London, our system offer on mental health for Londoners, led by the Mayor and focussing on resilient communities, reducing stigma and early access for those with mental distress
- our South West centre supported local authorities to develop applied suicide intervention skills training. They convened a rapid suicide response team to help support Bristol City Council and Bristol University in managing a suspected suicide cluster among students
- as part of our work on improving health inequalities, our North West centre took part in a sector-led improvement review that focused on deaths of children aged less than one, which shared evidence on actions and how to reduce the number of deaths. The scope included maternal smoking, co-sleeping, safeguarding around abuse and neglect, drug and alcohol misuse and obesity. All but one of the North West authorities took part in the review, and recommendations have been agreed through local networks. We have shared good practice and worked with local authority partners to test the potential for local campaigns on key factors such as safe sleeping and foetal alcohol syndrome

Working with the NHS

Local authority public health teams provide core support to NHS Clinical Commissioning Groups and acute and mental health providers. We provide additional specialist services such as health protection, specialised commissioning advice, screening, immunisation and public health in criminal justice settings, and knowledge and intelligence expertise to NHS England.

A central focus our work with the NHS over the past year has been our contribution to Sustainability and Transformation Partnerships (STPs) across the country. This has focused on addressing the health and wellbeing gap and helping STP leaders develop strong partnerships with the local public health system. We produced a menu of preventable interventions and are working to help STPs use the new incentives through Commissioning for Quality and Innovation payments (CQUINS) for prevention and for anti-microbial resistance.

Other examples of our work with the NHS include the clinical network commissioning guidance in the South East; the independent review into specialist vascular services in Yorkshire and the Humber; and our partnership working with Health Education England on building public health capacity in the wider system, including training healthcare professionals to take preventive actions such as Making Every Contact Count.

Joining it up – supporting the local public health system

As well as local government and the NHS, we work with key local partners such as the police, fire brigade and job centres, local education and research organisations, especially universities, and the voluntary and community sector.

Responsibility for commissioning local sexual health services is shared between local government and the NHS, and we led a survey on this that will be published later this summer. The action plan that we have already developed will pilot more integrated approaches to commissioning and delivery to maintain progress in areas where it has been made and, as importantly, address the rises in other infections.

An ongoing priority is to support continuous improvement and the spreading of innovation and good practice across the country. For example, working with the East Midlands Association of Directors of Public Health, our local PHE centre developed a self-assessment tool for stopping smoking services in relation to smoking in pregnancy, which is now been adopted in other parts of the country.

Behavioural insight

We have used social marketing techniques to engage, motivate and support people to make positive changes to their health behaviours.

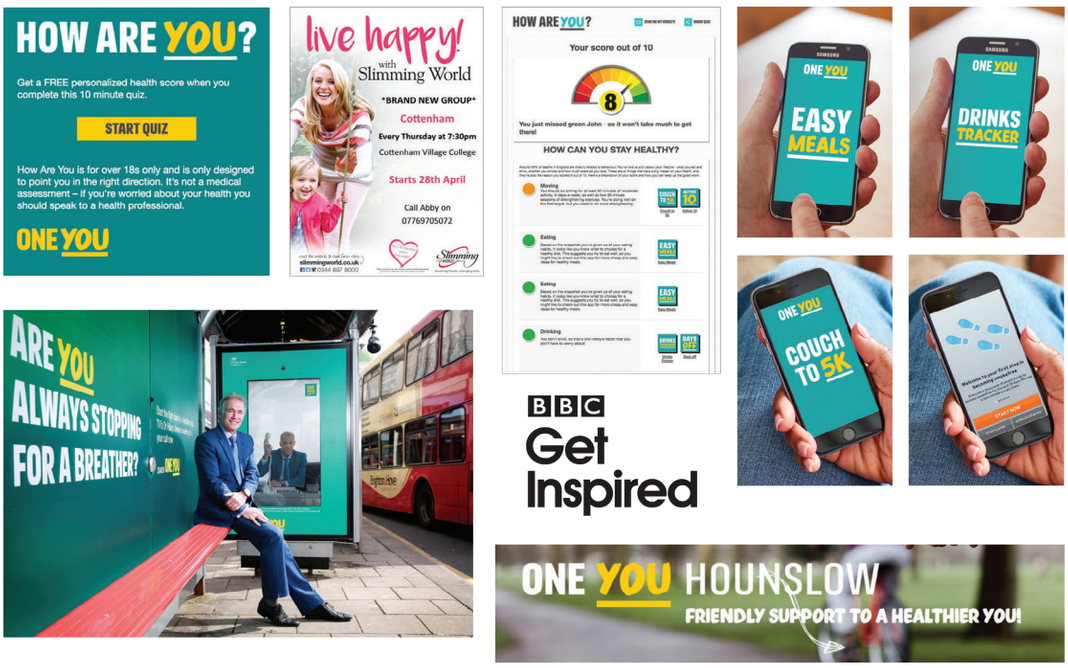
Launch of One *You*: the first major new public health brand in 7 years

Launched in March 2016, One *You* helps adults across the nation to take control of their health and understand that it is not too late to make a difference.

2.1 million people took the online **How Are you? quiz**, with 75% reporting taking action as a result. Over 700,000 people have downloaded one of the One *You* support tools such as smoking cessation apps, meal suggestions and alcohol trackers, with 83% of app users reporting taking action and 600,000 people signing up for One *You* updates.

Partners have been actively supporting One *You* since launch. Local authorities have used One *You* to rebrand their frontline services, simplifying access for local people. One *You* pop-up shops have provided blood pressure checks and health advice.

Asda supported this work by delivering free blood pressure checks in store, Slimming World created a bespoke offer to join its programme, BBC Get Inspired co-created the new Couch to 5K app, and Amazon developed a new health hub for the campaign.



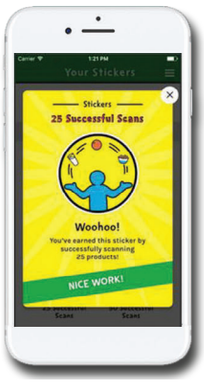
Developing a range of digital tools and products to help people improve their health

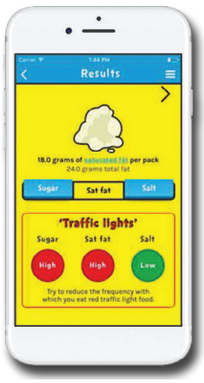
Digital tools and products such as online quizzes, apps and chatbots have the potential to engage large numbers of people and help to make changes in health-related behaviours more achievable.

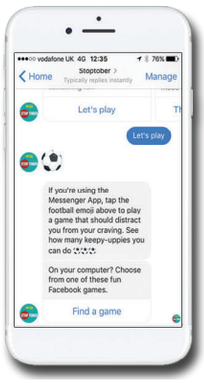
In 2016/17, we created the new **Be Food Smart** app, building on last year's award winning **Sugar Smart** app. The new app incorporates salt and saturated fat, helping parents make even more healthy choices for their children. We built on our partnership with the **MySupermarket** website to highlight the volume of sugar, saturated fat and salt in shoppers baskets at point of purchase, and suggest healthier alternatives.

We also worked with academic leaders to develop new apps, partnering with leaders in motion technology and behavioural scientists to develop **Active 10**, an app designed to encourage inactive adults to undertake greater levels of physical activity.

We created two new **chatbots** on Facebook messenger – one to support people stopping smoking with **Stoptober** and a new Start4Life **Breastfeeding** bot.





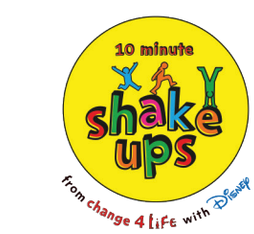


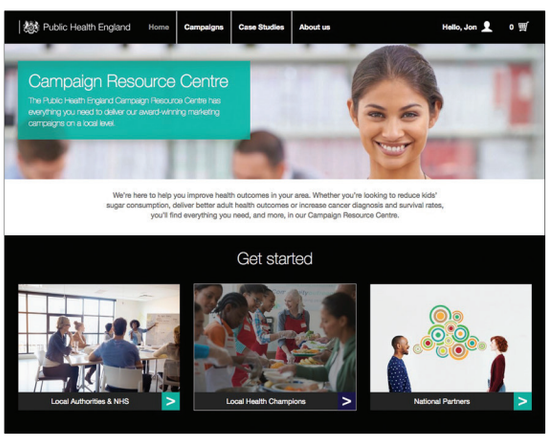
Working with partner organisations

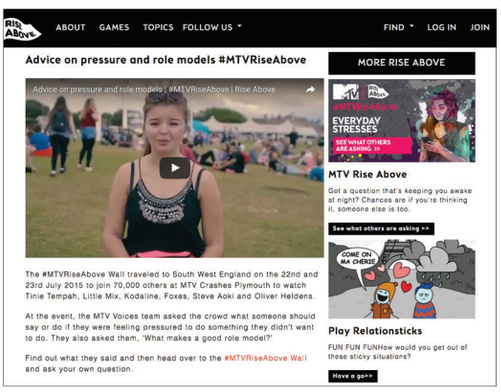
Our partnerships are impactful. We successfully inspired children to do a total of 192 million more minutes of activity as part of our **10 Minute Shake Up collaboration with Disney**. Most of the major supermarkets have supported one or more of our campaigns and high street pharmacies now deliver activity throughout the year.

We are extending our campaigns beyond the health and care system into local communities. Firefighters are delivering branded **Stay Well This Winter** thermometers to vulnerable residents. Our online **Campaign Resource Centre** is now the first port of call for a fast-growing community of public sector organisations.

Schools sit at the core of our delivery. The **Change4Life** campaign offers teaching resources reaching 16,500 primary schools. The new '**Our Healthy Year**' tools offer a year-round programme supporting the National Child Measurement Programme. All state secondary schools now receive lesson plans that enable teachers to talk to 11 to 16-year-olds about topics such as smoking and bullying. We have been working with the Personal, social, health and economic education (PSHE) Association to develop accredited lesson plans that enable teachers to talk confidently to 11-16 year olds about topics such as smoking and bullying. Using content co-created with young people for the Rise Above website, the lesson plans will be circulated to all state secondary schools this September.







Creating campaigns to support current and emerging priorities

Stay Well this Winter: The campaign encouraged people at risk of hospital admission to get the flu vaccine and seek advice from a pharmacist at the first sign of a winter illness. It also promoted uptake of the vaccine amongst eligible groups such as people with long term conditions, pregnant women and children. The campaign drove an estimated 1.85 million additional pharmacy visits and supported an increase in the vaccination uptake in key groups.

Sepsis: In response to concerns on the number of deaths from sepsis, PHE and the UK Sepsis Trust launched a campaign in December 2016. Targeted at parents of children under 5, it aimed to improve awareness of the symptoms of sepsis and when to seek urgent help, supporting measures taken by the NHS to improve early recognition and timely treatment. So far, 1.8 million leaflets and posters have been distributed and the accompanyingsocial media films have been viewed 3.2 million times.

Antimicrobial resistance (AMR): Tackling the growing problem of AMR is one of our seven key priorities. We ran a pilot campaign in the North West in February 2017, which aimed to reduce patient pressure on GPs to prescribe antibiotics. Research suggests that the campaign has had an impact; people in the pilot region reported that they were less likely to ask their GP for antibiotics and GPs reported a decrease in their patients asking for them.

Diabetes Prevention Programme: 1 million 'Healthier You' branded posters were ordered by the NHS, local authorities and commercial partners.

Performance analysis

We measure our performance against the objectives set out in our *Strategic Plan: Better outcomes by 2020*. For 2016/17, we set out a number of actions we would take to achieve our aims of protecting and improving the public's health, reflecting actions in the DH's *Shared Delivery Plan*, the *NHS Five Year Forward View*, *From Evidence into Action* and the priorities highlighted in the annual remit letter from Ministers. There is a clear link between the work of PHE and the way in which we focus on delivery of our objectives.

National government

Actions	Performance summary
Enable England to become the first country in the world to significantly reduce childhood obesity, contributing to the delivery of the government's Childhood Obesity Strategy and the development of the sugary drinks levy	We **achieved** our actions for 2016/17, including through contributing to the Childhood Obesity Strategy published by the government in August 2016 and the soft drinks industry levy, recently enacted by Parliament as part of the Finance Act 2017
Support the government to develop new strategies on tobacco control, illegal drugs, biosecurity, life chances and reducing the disability employment gap	**Achieved.** We contributed to the government's consultation on the Work, health and disability green paper: improving lives and provided expert advice and insight on tobacco control and drugs
Maximise the health impact of the European Tobacco Products Directive and the establishment of the Competent Authority function within PHE	**Largely achieved.** As the new Competent Authority, we have established a helpdesk and published support products to maximise health benefits
Provide estimates of the number of children likely to be affected by the drug or alcohol use of their parents, and provide advice to national and local government on where action could have the greatest impact on improving life chances	**Achieved.** Publication of this information was linked to the Department for Work and Pensions (DWP) policy paper "Improving Lives - Helping Workless families" in April 2017
Support the rollout of the workplace charter and work with the Joint Unit on Health and Work to develop the national strategy to close the disability employment gap in England	**Partially achieved.** In response to external factors, we are pursuing a broader approach that recognises a range of evidence-based schemes across local areas

Actions	Performance summary
Support work across government on sustainable travel to promote increased levels of physical activity through walking and cycling and contribute to the implementation of the government's sports strategy	**Largely achieved.** We delivered a gap analysis of the national recommendations in *Everybody Active Every Day* for the Department for Culture, Media and Sport (DCMS) in support of the Sport Strategy
Support the piloting of new approaches to dementia awareness and tackling risk factors via the national NHS Health Check programme	**Achieved.** We have worked with Alzheimer's Society and Alzheimer's Research UK to develop four pilot areas in Bury, Manchester, Birmingham and the south of England. Training across all four pilot sites is complete and data has been collected
Respond to the CQC/Dame Fiona Caldicott review of data security	**Achieved.** We have continued to ensure the lawful and secure processing of confidential patient data by the cancer screening programmes, cancer and congenital anomaly registers, and the drug and alcohol treatment monitoring service through continued section 251 approval for the Health Research Authority Confidential Advisory Group. Robust and transparent data exchange agreements are in place with national partners We have further strengthened our information governance and will continue to do so to meet new security controls
Publish an independent evidence-based report on alcohol	**Achieved.** The evidence review commissioned by DH was published in December 2016

Local government

Actions	Performance summary
Support local government in delivering improved public health outcomes and better value for money from the public health grant	**Largely achieved.** Local government has given very positive feedback in the annual Ipsos/MORI stakeholder survey We have continued our comprehensive assurance system on use of the grant, with assurance statements received from all local authorities. Our forthcoming *Health of the Nation* report will summarise public health outcomes for 2016/17
Support the political leadership role of local authorities in local places and their role to deliver place-based leadership through health and wellbeing boards	**Achieved.** Our staff have worked to support local government elected leaders, CEOs and Directors of Public Health, and in partnership with the Local Government Association (LGA), at national level
Maximise the potential of devolution deals to integrate services and improve health outcomes, as demonstrated by Greater Manchester and London, and reduce health inequalities by sharing best practice from a range of localities	**Largely achieved.** We have supported devolution proposals across the country, particularly in Greater Manchester, the North East, the West Midlands and London
Align PHE's products and services to local government's needs, develop tools for supporting local health and wellbeing initiatives when making difficult investment decisions	**Largely achieved.** The most recent Ipsos/MORI stakeholder survey found that 70% of local authority stakeholders agree that they get what they need when they contact us. Gathering and disseminating evidence is seen as a crucial role that we play in the system and frequently cited as our key strength

Actions	Performance summary
Develop an economic tool to support local and national investment decisions on evidence-based interventions to reduce inequalities and improve health	**Largely achieved.** Our colorectal cancer ROI tool is already being used across Cancer Alliances and included in sustainability and transformation plans (STPs) to inform decisions, and will be used by Health Education England (HEE) to support the case for investment in endoscopy capacity. Our diabetes prevention programme ROI tool has been used by NHS England to make the case for national rollout and on-going investment decisions relating to the programmes
Support commissioning of public health services for children aged 0-5, in particular, review mandated universal health visitor reviews by autumn 2016, and assess the benefits of the expanded and transformed health visitor service	**Achieved.** The then Minister for Public Health and Innovation confirmed in March 2017 the legislation would continue with immediate effect from the start of April. In 2017/18, we will share findings of the Health Visiting Programme benefits realisation review with local authorities to inform the evidence base and economic/social returns on investment for commissioning 0-5 services
Support local government to collaborate effectively with NHS bodies and with the wider system to secure the best outcomes for each locality	**Largely achieved.** National programmes such as NHS Health Checks have led to targeted action in those areas that need the most support. For example, we supported Local Authorities and the NHS to deliver 1.3 million NHS Health Checks. It is estimated that around 130,000 people at high risk of cardiovascular disease have been identified and received individualised support to lower or manage their risk; 32,700 patients with high blood pressure, 6,500 patients with type 2 diabetes and over 2,000 patients with chronic kidney disease have been diagnosed earlier and treated by the NHS
Improve sexual health outcomes by working with the Association for Directors of Public Health using the findings from the recent sexual health survey, outcomes data and other relevant information, to support the commissioning of services locally	**Largely achieved.** In November 2016, we awarded £600,000 from our new HIV Prevention Innovation Fund to support 13 innovative voluntary-led projects across England. We will shortly be publishing results of a whole system commissioning survey, including recommendations and actions

Actions	Performance summary
Provide expert advice on the health aspects of town planning, housing and homelessness, raising awareness and developing the skills of the public health workforce for local joint action	**Achieved.** We have delivered a series of skills development and building capability workshops on housing and health through our network of local centres
Work with local government, police and crime commissioners, NHS England and clinical commissioning groups to raise awareness about how they can improve the health of offenders as well as help reduce reoffending behaviour	**Achieved.** We have delivered primarily in three areas: • our system leadership role to colleagues in local government, the NHS, the criminal justice system and third sector has influenced work to reduce smoking and harmful drinking and improve recovery outcomes from drug and alcohol treatment in custodial settings • our report on Integrated Drug Treatment Systems in prisons has been provided and analysed • we are developing a ROI tool for effective interventions to reduce health inequalities This work will continue in 2017/18
Publish an evaluation of the impact of fire and rescue service interventions on winter related illness	**Achieved.** Our report concluded that these services could have a significant impact on winter-related ill-health. Fire and rescue services recognise their wider potential to focus on issues important to health such as prevention of falls and social isolation
Work with the Chartered Institute of Public Finance and Accountancy, HM Treasury and a range of key stakeholders to develop a structured model/code for demonstrating return on investment in prevention that is recognised as the accepted way to describe the public pound multiplier effect of upstream action across all public bodies in a 'place'	**Achieved.** The draft code was well received by CIPFA's Health and Integration Panel and is now being finalized prior to roll-out in late summer 2017

The NHS

Actions	Performance summary
Provide the NHS and local government with the public health evidence, intelligence, knowledge and analysis to support and review the development of local sustainability and transformation plans by the end of June 2016 and support local implementation including proposals to release efficiency savings to the NHS and local government by 2020	**Achieved.** We worked in partnership with NHS England and provided STPs with a menu of interventions on investments that can lead to realisable financial savings
Enable at least 10,000 people to benefit from the Diabetes Prevention Programme, working in partnership with NHS England and Diabetes UK	**Achieved.** Over 13,000 people have had an initial assessment The number of referrals during the year in demonstrator sites was 3,170, with over 2,000 subsequently beginning an intervention programme
Expand and improve the world-class screening and immunisation programmes, in particular, complete the roll-out of the bowel scope screening programme, extend the screening intervals in the diabetic eye programme and expand flu vaccination to all children aged 2, 3 and 4 and school years 1, 2 and 3	**Largely achieved.** The childhood flu vaccination programme was rolled out to all children in school year 3 in 2016/17 and continued to be offered to those aged 2, 3 and 4 and school years 1, and 2. Provisional data shows higher flu vaccine uptake in all age cohorts in the childhood programme compared to previous years 97% of screening centres are now rolling out bowel scope screening We are working in partnership with NHS England to develop a strategy for diabetic eye screening
Lead implementation of the domestic health elements of the UK Antimicrobial Resistance Strategy in England, by specifically supporting the implementation of the Commissioning for quality and innovation (CQUIN) and Equality and outcomes framework (QoF) payments and development of local system action plan	**Achieved.** Our Fingertips resource now includes 81 indicators on AMR to support the design and delivery of local NHS plans and interventions in six key domains

Actions	Performance summary
Take forward the recommendations of the Mental Health Taskforce, in particular, the development of a national Mental Health Prevention Concordat programme by summer 2017 and support delivery of the national suicide prevention strategy, including supporting all local areas to have multi-agency suicide prevention plans in place by 2017	**Largely achieved.** We published suicide prevention planning guidance and will shortly launch our practical guide for local areas alongside the Mental Health ROI publication and Mental Health joint strategic needs assessment (JSNA) Guide. These will support delivery of the Concordat
Contribute to the all arms-length body cancer implementation plan and then deliver those actions for PHE, including continuing to deliver the Be Clear on Cancer campaigns	**Achieved.** We exceeded the standard required for national staging statistics and have partnered with the Office of National Statistics to lead on the production of National cancer Statistics and the data in the Public Health Outcomes Framework. Our data collection and analyses now supports the National Institute for Health and Care Excellence (NICE) and the new Cancer Drugs Fund. Our cancer registration service was rolled out across Wales while the National Cancer Registration Service won the Analysis and Use of Evidence Award in the national 2016 Civil Service Awards
Lead the public health and prevention workstream of the Maternity Transformation Programme, including maximising the public health contribution to the national maternity ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030	**Largely achieved.** Priorities for 2017/18, the second year of a three year programme, are: • smokefree pregnancy: lead a place based improvement approach in localities with highest rates of smoking produce impact measures • breastfeeding: re-energise approach with strategic partners and publish consensus statement on action for improvement • publish a visual prevention pathway for health and early years professionals, mapping the ‘prevention journey’ from preconception to the early weeks • perinatal mental health: provide local authorities with perinatal mental health tools, including a specific focus on parenting, and the prevention of postpartum suicide

Actions	Performance summary
Work collaboratively with local government and NHS bodies to secure a reduction in variation and the best outcomes for each locality	**Largely achieved**. Our centres work closely with local areas to deliver better outcomes and reduce variation by focusing on poor performance. The most recent Ipsos/MORI stakeholder survey shows that this is highly valued by local authorities
Work with healthcare professionals to extend their roles in prevention and population health through All Our Health and Making Every Contact Count	**Largely achieved**, including through publication of 22 different subject areas on the All Our Health website
Support the programme of work across the NHS to address staff health and wellbeing	**Achieved.** With NHS England, we have helped the NHS shape the CQUIN framework through its five year forward view commitment to a healthier NHS workforce This work will continue into 2017/18
Support people to make healthy choices, through the refreshed Change4Life programme and maximise the impact on the public's health of the age 40-60 healthy behaviours campaign (One You) to inspire and support positive behaviour change	**Achieved.** With over 1.3 million downloads, the Change4Life apps have helped people to eat more healthily, encouraging them to cut back on sugar, saturated fat and salt As part of One *You*, to date we have driven over 2.1 million completions of the How Are You? health quiz. Follow up evaluations have shown that 12% of all adults reported taking action after the campaign
Create a suite of digital content, apps and tools that support families and individuals to make changes (as we have with the Sugar Smart app) and ensure that we engage effectively with people through social channels as well as local and national media and other settings	**Largely achieved.** There have been a number of successful new product launches and refreshed tools. We are continuing to optimise existing apps and web tools and are working to ensure that all digital products are provided in the most appropriate format and where families and individuals need them

Directly to the public

Actions	Performance summary
Continue the Act Fast campaign that highlights stroke signs	**Achieved.** Evaluation showing an impact on emergency calls to 999 and lives saved. The latest campaign emphasised the need for urgent action if any signs of a stroke are seen The campaign is extremely cost effective, and modelling shows a 78% uplift in 999 calls for confirmed stroke and 5,365 fewer people have become disabled
Continue the Be Clear on Cancer campaign that gets more people to recognise symptoms that might indicate cancer, and to see their GP earlier	**Achieved.** Awareness of the 2016 respiratory symptoms campaign reached 82% amongst the target audience. The campaign aslo drove significant increases in knowledge that the key symptoms could be a sign of something serious
Deliver the Information Service for Parents and the Start4Life campaign, addressing maternal and early years health	**Partially achieved.** There were 30,677 new subscribers to the Information Service for Parents during the year compared to the 50,000 target. The service now has over 430,000 subscribers in total and in 2017/18 we will review how we can best offer a relevant, cost-efficient service
Continue the Rise Above and FRANK digital programmes to address prevention of uptake of exploratory behaviours in teens	**Achieved.** FRANK received over five million unique visitors during the year. 40% of those who had never taken drugs before say visiting the FRANK website has made them less likely to take drugs in the future Rise Above has reached over a million 11-16 year olds during the year

Actions	Performance summary
Recommission a new national HIV home testing sampling service to over 50,000 individuals to support NHS England and local government in improving prevention through targeted information and resources to enable people to make safer and sustainable sexual health choices	**Achieved.** By December 2016, the national HIV self-sampling service had exceeded the target, delivering 55,726 kits of which 29,333 (53%) were returned
Raise awareness of the risk factors of dementia and the best steps to mitigate them	**Largely achieved.** We supported wider action on dementia risk reduction, including through ongoing development of the Brain Age Calculator
Test a public awareness approach to antimicrobial resistance	**Achieved.** We developed a new campaign on antimicrobial resistance which ran in the north west of England between February and April 2017

Global public health

Actions	Performance summary
Work as part of the One HMG strategy on global health to strengthen global health activities on infectious disease, environmental hazards, health improvement and to support the development of health systems by: • establishing the UK public health Rapid Support Team with an academic partner • supporting the international response to outbreaks and emergencies • supporting capacity building and expertise in developing countries such as Sierra Leone and Pakistan	**Achieved.** The UK Public Health Rapid Support Team was established in November 2016 As part of the UK-funded Resilient Zero programme, we have supported the government of Sierra Leone in laboratory and emergency preparedness and response capacity We have worked with the government of Pakistan to strengthen their integrated disease surveillance and response system at federal and local level, and are now working towards the pilot of a national public health system
Support the implementation of the International Health Regulations (IHR), strengthening public health systems globally and supporting international tobacco control, using Official Development Assistance funds	**Largely achieved.** We continue to work with DH on a long-term project to support IHR implementation by strengthening public health systems globally. This includes completed scoping missions to six countries and meetings with the World Health Organisation (WHO)
Contribute to the development and implementation of the UK's global health strategy and the Global Health Security Agenda	**Largely achieved.** We have continued to work with and through DH and other cross-government collaborations. We host the health protection-related WHO Collaborating Centres, including for Global Health Security and Mass Gatherings, and continue to support the work of the Global Outbreak Alert and Response Network Through supporting the Global Health Security Agenda (GHSA) and UK approach to global health security, we contribute to international efforts to protect the health of people everywhere, including the UK, and to build resilient public health systems

Actions	Performance summary
Support the international component of the delivery of the UK cross-government strategy on antimicrobial resistance	**Largely achieved.** We continue to contribute to international efforts to combat AMR through the contribution of the WHO Collaborating Centre for Antimicrobial Resistance and Healthcare Associated Infections Reference Unit, and its contribution to the scientific evidence base

Developing the public health system

Actions	Performance summary
Continue to develop the resilience of PHE's scientific response to threats to the public's health through ongoing scientific advances (including PHE's role in the next steps of the 100,000 Genome programme), and contributing to preparedness by revising PHE's incident response plan and running national simulations such as Exercise Cygnus	**Achieved.** We have maintained national coverage of cancer, congenital anomalies and rare disease cases across the whole population of England to a standard and quality that supports accurate data linkage and immediate and long-term disease surveillance Exercise Cygnus was successfully delivered in October 2016. The subsequent report and lessons identified are being incorporated into our Concept of Operations (CONOPS) and National Incident Emergency Response Plan (NIERP)
Develop a joint programme of work and production of plans for the public health system's response to high consequence infectious disease incidents (HCID), working with national government and NHS England – expect to be completed in 2017/18 with interim outputs throughout 2016/17	**Largely achieved.** The joint programme of work has been developed for delivery in 2017/18. Several interim products have been produced, including a pilot monthly 'Global high consequence infectious disease events' and a draft organizational algorithm for identifying, responding and managing HCIDs
Develop new accountability arrangements with local authorities, in response to the proposed shift of business rates retention, to replace the arrangements surrounding the ring- fenced Public Health Grant	**Partially achieved.** The move of the ring-fenced public health grant to 100% business rate retention will come into effect in April 2019. We have engaged with Directors of Public Health as part of early preparatory work and will develop this further during 2017/18
Contribute to the development and implementation of a new public health workforce strategy, building on the thematic review carried out in 2015/16, to develop and sustain a workforce that is fit for the future	**Largely achieved.** We led a prioritisation exercise on the recommendations set out in the May 2016 publication *Fit for the Future* to inform a refreshed strategic approach to public health workforce development. A new Skills and Knowledge Framework has been published, and the Public Health Careers website run by Health Education England has been refreshed

Actions	Performance summary
Deliver the Leadership for Change and Local Vision programmes to support the development of systems leadership	**Achieved.** PHE and the Association of Directors of Children's Staff College ran a further cohort of Future Directors aimed at preparing aspiring Directors of Public Health for senior leadership roles. The Local Vision learning network supported systems leadership development through a further cycle of learning events

Developing PHE

Actions	Performance summary
Further strengthen the UK public health infrastructure by progressing the science hub programme to create a national centre of expertise for public health science, focusing on key milestones in 2017/18 of town planning	**Achieved.** We are on track to make the planning application to the local authority in Harlow in summer 2017
Complete the development of the National Infection Service to enable an improved service to those treating patients and managing infectious disease outbreaks	**Largely achieved.** During the year, we extended the consultation period on what is a significant organisational change programme affecting half the organisation in order to ensure our staff were able to fully engage in the design phase and take account of their views on the way forward. Appointments to the new senior team will start to be made in summer 2017 with implementation of the new service due to be completed in 2019
Develop a PHE Environmental Health approach, strengthening the operation of the Centre for Radiation, Chemicals and Environmental Hazard	**Largely achieved.** We have developed an Environmental Public Health Strategy, which will be finalized following the appointment in May 2017 of a new Director to lead the service
Further strengthen our emergency preparedness, resilience and response functions	**Achieved.** In 2016/17, our systems and policies were revised and tested through Exercises Cygnus and Typhon, with lessons identified reports for continuous improvement in our EPRR functions
Further develop the capability of PHE centres to work with and support local devolution agreements	**Largely achieved.** Our work on supporting place is one of our priority corporate programmes and the corresponding board is ensuring consistent messaging and support to regions, centres and directorates to support local devolution

Actions	Performance summary
Review the vaccines ordering and distribution system	**Partially achieved.** The first stage of the review was completed, following which the Tailored Review concluded that the next stage will be delivered by DH
Develop our non-communicable disease surveillance function and modelling capability	**Largely achieved.** The approach for the development of non-communicable disease (NCD) surveillance was agreed in December 2016
Implement Sound Foundations – PHE's quality and clinical governance programme	**Achieved.** The follow-up review by our internal audit service provided full assurance that the recommendations to which the programme responded have been delivered
Implement 'Doing, supporting and using public health research: the PHE strategy for research, translation and innovation'	**Achieved.** The strategy has been published and is being implemented
Develop a cross-cutting approach to information management to maximise the opportunities from our ICT, digital and informatics	**Largely achieved.** Digital, ICT and data science strategies are now in place. Partnership working and engagement will continue to develop in 2017/18
Continue to focus on creating value through further income generation, enhanced use of our technology, continuing our property rationalisation process, smart procurement and supplier relationship management and enhanced financial management and reporting	**Achieved.** We have developed a Taxpayer Value Strategy, including a summary of savings achieved to date. Going forward, an annual value for money report will be produced, highlighting delivery against the Strategy
Develop and engage our staff across PHE to ensure that we have high performing teams with the right skills to meet changing demands	**Largely achieved**. Our annual staff survey score increased by four percentage points at a time of major organisational change. We have delivered over 200 staff engagement and Organisational Development events alongside local events. Web-based teams and leadership self-diagnostic tools were improved and re-launched in late 2016 to aid teams self-assess and monitor continued improvement

Actions	Performance summary
Support a wellbeing culture across PHE, including flexible working arrangements, and implement diversity and staff wellbeing initiatives, such as the diversity dashboards	**Largely achieved.** Diversity dashboards are now in place across the organisation, with positive action plans being developed to address any inequalities. New Muslim and gender balance networks have been launched, and eight executive diversity champions are in place. Project SEARCH, Movement to Work and Mosaic work experience/placement programmes are in operation. An audit in 2016 showed that external BAME applicants are now twice as likely to be appointed to PHE posts compared to 2013
Embed an apprenticeship programme across all parts of PHE, offering at least 130 apprenticeships	**Partially achieved.** The revised target of 120 is due to be delivered by March 2018. We have appointed 32 apprentices so far
Embed and bring to life the PHE people charter, which defines our values and behaviours. Our charter will ensure that how we behave in PHE is just as important as what we do	**Largely achieved.** Our PHE People Charter has been widely promoted and disseminated and is also covered in the 'One PHE' corporate induction programme, and Management Seminars, which are run on a regular basis

Our organisation

Arm's length bodies across government are reviewed at least once every Parliament, examining their performance, effectiveness, efficiency and governance. We went through the Tailored Review process in 2016, which included a call for evidence from a variety of stakeholders. The Cabinet Office and DH concluded that our core functions remain unchanged and the full reportwas published in April 2017 and is available on gov.uk. As a learning organisation, we have worked in partnership with DH and other stakeholders in implementing the small number of recommendations.

Our annual people survey gives us valuable insight into how our people are thinking, feeling and responding to change. Over 3,700 of our staff took part in 2016, a response rate of 70% and an improvement on the previous year's 63%. The results showed that we have made significant progress in leading and managing change, with a 20% improvement in our score year-on-year. Our engagement scores are in line with organisations similar to us. Despite this, 6 in 10 of our people believe we don't manage change well and many have provided feedback on what we can do differently, much of which is high impact and low cost. Examples include: eradicating inequalities in the provision of learning and development; listening more to staff views on how to make change happen; providing better guidance and practical support in how to manage change well; being clear on why changes are necessary as well as describing what we are seeking to change. Over the next year, we plan to go further and faster in getting better at this, particularly at team level. We have a dedicated digital platform - Teams and Leadership - designed to help individuals improve their own leadership styles and help teams to become as effective as they can be. Over the next two years, we will use this to accelerate reflective practice in each and every team, aiming to secure continuous improvement in our staff engagement scores.

We commissioned two externally-led reviews during the year of services that are key to helping our people through the next phase of our development. Firstly, to help shape how our HR team best supports the many and various parts of PHE in a complex and ever changing environment. Secondly, to help us ensure that our Staff Health and Wellbeing service delivers consistent, high quality occupational health services to all our staff. The HR review reported in May 2017, and we accepted their principal recommendation that we should bring together our HR and Organisational and Workforce Development teams under the leadership of a new Chief People Officer. This reflects how the best performing organisations look after and develop their people and we are delighted that Deborah McKenzie has taken on this role. The second review will report later in the summer and we look forward to receiving Dr Steve Boorman's recommendations on how we can develop a best in class Staff Health and Wellbeing offer for our staff.

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, problem solve, 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 at all grades and backgrounds are welcomed by our most senior leaders and provided with all necessary information to enable them to succeed in their role.

More formally, the PHE Partnership Forum, chaired by the Chief Executive, continues to be the focus for negotiation and consultation with our 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 our recognised trade unions on all our terms and conditions of employment (with the exception of pay) within the delegated authority set out in the framework agreement, and facilitates arrangements for accredited employee representatives.

Diverse and talented workforce

During 2016/17, we strived to create a more diverse and talented workforce by:

- improving the quality of our workforce data for staff with protected characteristics through use of the Electronic Staffing Record self-service facility
- delivering an enhanced 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 and supporting five active staff diversity networks: black and minority ethnic; Muslim; disability; lesbian, gay, bisexual and transgender; and gender balance
- 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 a number of apprenticeship roles across the organisation
- providing 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

Going forward, Tony Vickers-Byrne will build on this in a new role reporting to the Chief Executive as Chief Adviser - Diversity and Inclusion and Staff Health and Wellbeing.

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 continue to be 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 health and safety 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.

These have all been delivered, and, in partnership with Staff Side members, HSSG has increasingly focused on ensuring appropriate and timely follow-up of recommendations made by the HSE as part of their planned inspection programme and that incidents with high or major impact are reviewed and acted on swiftly, with lessons learned, identified and disseminated across the organisation in a timely way. We have also established an annual meeting between Staff Side and the Management Committee on Health and Safety, which first met in March this year.

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 of 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 2017, we published Equality in Public Health England: How we met the public sector equality duty in 2016, 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 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 2017/18.

Public access: FoI, public enquiries, complaints and whistleblowing

We received 743 information access requests (2015/16: 686), most which were handled under the Freedom of Information Act 2000, others being under the Environmental Information Regulations 2004 and Data Protection Act 1998.

We received 4,184 online enquiries from the public and stakeholders (2015/16: 4,581).

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 71 complaints were handled during the year (2015/16: 82).

The Parliamentary Health Service Ombudsman (PHSO) investigated a complaint concerning PHE's advice regarding radiofrequency electromagnetic fields which was not upheld.

During the year, we handled a particular complaint concerning port of entry screening for Ebola during the international public health emergency in 2014. As part of seeking to resolve the complaint through our internal procedures, the Chief Executive met the complainant in March 2017.

In February 2017, the Civil Service Commissioners determined a complaint made by a member of staff concerning compliance with the Civil Service Code, which forms part of the PHE Code of Conduct. The Commissioners upheld one element of the complaint, for which PHE has apologised to the member of staff. This concerned the timeliness of establishing the internal investigation into their concerns about compliance with regulations governing a particular type of scientific research were not being followed. The Commissioners concluded that there had been no other breach of the Civil Service Code and noted that the HSE as regulator concurred with the findings of the internal investigation, namely that the allegations were not substantiated. The Commissioners findings and recommendations are publically available at http://civilservicecommission.independent.gov.uk/2016-17-civil/

In the summer of 2016, we revised and strengthened our whistleblowing policy and procedures in collaboration with our staff side colleagues and Public Concern at Work, a national charity and leading authority in the field. We have provided regular updates through DH as required by Cabinet Office and have invited our internal auditors to review the effectiveness of our arrangements as part of the 2017/18 audit plan.

On 5 July 2017, we signed the concordat on openness in animal research in the UK as part of being clear with the public and our stakeholders about when, how and why we use animals in our scientific research to protect the nation's health from infectious disease, our first and foremost duty.

Parliamentary questions

We responded to 705 parliamentary questions on a wide range of subjects (2014/15: 696). Topics that generated the most questions were diet and obesity, screening, immunisations, public health marketing campaigns, and infectious diseases.

Financial review

Accounts direction

The financial statements contained within our fourth annual report and accounts relate to the financial year 1 April 2016 to 31 March 2017. 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

The accounts set out at page 119 onwards consist of primary statements that provide summary information and accompanying notes. They 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 financial affairs.

During the 2016/17 year, our financial performance was reported in three operating segments:

- 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 2016/17

For 2016/17, the funding provided by DH for our three operating segments was as follows:

- local authority grants: specific programme revenue within a limit of £3,388m (2015/16: £3,036m)
- vaccines: specific programme revenue within a limit of £484m, including depreciation and the cost of disposals (2015/16: £476m)
- operating activities: non-specific administration and programme revenue within a limit of £402m (2015/16: £429m)

Financial performance

In 2016/17, 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 2016/17 year was an underspend of £1.4m on a total operating budget of £4,274m. This compares with the 2015/16 underspend of £1.6m on an operating budget of £3,941m.

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 Advisory Board and Management Committee, and by detailed reports to directorate senior management teams and individual budget holders.

In the 2016/17 year, in recognition of current and future financial pressures, we continued to operate 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 programme, which had previously been budgeted by DH separately from our main allocation.

Our financial out-turn was supported by operational income of £163.8m (2015/16: £152.2m) earned from trading activities, royalties and research funding.

Vaccines and countermeasures response ('vaccines') sales of £72.4m (2015/16: £75.9m) were made to other government agencies in the year, with most being to the devolved administrations. These sales are a transfer of stock and also statutory services related to preparedness for pandemics, and are regarded as non-trading income within our management reporting. 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 supports 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 2016/17 totaled £4,272.6m (2015/16: £3,939.7m). 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)	2016/17			2015/16		
	Budget	Actual	Variance	Budget	Actual	Variance
External income:						
Operating activities	163.9	163.8	(0.1)	169.4	152.2	(17.2)
Vaccines	72.4	72.4	-	75.9	75.9	-
Total external income	**236.3**	**236.2**	**(0.1)**	**245.3**	**228.1**	**(17.2)**
Expenditure:						
Pay	312.5	301.9	10.6	311.4	303.6	7.8
Non-pay	221.8	230.9	(9.1)	262.0	251.0	11.0
Local Authority Grants	3,388.0	3,388.0	-	3,036.2	3,036.2	-
Vaccines (excluding depreciation)	555.2	555.2	-	551.0	551.0	-
Depreciation	32.8	32.8	-	26.0	26.0	-
Total expenditure	**4,510.3**	**4,508.8**	**1.5**	**4,186.6**	**4,167.8**	**18.8**
Net expenditure	**4,274.0**	**4,272.6**	**1.4**	**3,941.3**	**3,939.7**	**1.6**

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 £0.1m (2015/16: gain of £10.1m).

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 the taxpayer, and serves to maximise our impact on the wider public health system, while supporting the life sciences and UK economic growth.

In 2016/17, we generated total external income of £236.2m, including operational income of £163.8m from supplies and services to third parties, which is broken down in the following table:

External income (£m)	2016/17			2015/16		
	Budget	Actual	Variance	Budget	Actual	Variance
NHS laboratory contracts	60.6	62.5	1.9	61.1	59.5	(1.6)
Research grants	19.2	20.5	1.3	20.3	22.7	2.4
Commercial services	32.9	29.2	(3.7)	30.6	27.8	(2.8)
Products and royalties/dividend	37.3	36.7	(0.6)	43.4	25.6	(17.8)
Other	13.9	14.9	1.0	14.0	16.6	2.6
Operating activities	**163.9**	**163.8**	**(0.1)**	**169.4**	**152.2**	**(17.2)**
Vaccines	72.4	72.4	-	75.9	75.9	-
Total external income	**236.3**	**236.2**	**(0.1)**	**245.3**	**228.1**	**(17.2)**

Local government public health grant

We provide a public health grant (£3.4bn in 2016/17) 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 new arrangements for the funding of the grant from 2017/18 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 2016/17, 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'	'Non-cash'	Total
Revenue items (including depreciation)	391.8	92.2	484.0
Capital items (stockpiled goods)	112.0	(125.2)	(13.2)
Total	**503.8**	**(33.0)**	**470.8**

Relationships with suppliers

We are committed to the Better Payment Practice Code, the policy being to pay suppliers within 30 days of receipt of a valid invoice. We have established the following internal targets:

- 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 2016/17, 82% of supplier bills (by volume) were paid within 10 days and 90% within 30 days, as shown below. Interest payments of £1.6k were made to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998 (2015/16: nil).

Payment period in days	0 to 5	6 to 10	11 to 30	Over 30	Total
Value of invoices (£000s)	716,271	66,540	61,889	39,857	884,557
Percentage	81.0%	7.5%	7.0%	4.5%	100.0%
Number of invoices	70,024	6,072	8,079	9,159	93,334
Percentage	75.0%	6.5%	8.7%	9.8%	100.0%

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 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.

Hosted services

In 2016/17 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 came to an end on 1 April 2017, when the MHRA took the service in-house.

During 2016/17, 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

Porton Biopharma Ltd (PBL) was formed on 1 April 2015, as a spin-out company undertaking our former pharmaceutical development and production processes. PBL is a company limited by shares, with 100% of the shares being owned by the Secretary of State for Health (SoS). In turn, the Ministers have directed that the operational relationship with PBL should be through PHE. The company is based at Porton Down, within the facility owned by PHE.

The funding contribution from the pharmaceutical manufacturing activity previously earned under PHE is now replaced by an annual dividend from PBL. The dividend is paid from profits generated by PBL. The dividend received by PHE in 2016/17 (£5.8m) was the first to be paid and represented the profits earned by PBL in 2015/16.

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, which include our funding being included in the Departmental Estimate for 2017/18, the Advisory Board and Management Committee have reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future. For this reason, we adopt the going concern basis for preparing the financial statements.

Audit services and costs

The Comptroller and Auditor General is head of the National Audit Office (NAO) and is appointed as the external auditor of PHE under section 7 of the Government Resources and Accounts Act 2000. The auditor's remuneration for 2016/17 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 and environmental management

This is our fourth year of reporting on sustainable development. We have introduced a number of carbon-related reduction targets for the owned estate to meet the governments greening government strategy. This report details our utility use, business travel, water consumption and total waste from the 2016/17 financial year. 2013/14 is our baseline year for carbon reporting relative to the Greening Government Commitments initiative and HMT reporting strategy.

We have set a target to reduce our carbon emissions by 3% annually to March 2020, compared to our baseline year of 2013/14; this is in line with the government's Greening Government Commitment initiative.

Preliminary analysis indicates that our total carbon emissions, for 2016/17 are 18,772 tCO_2e, (2015/16: 24,963 tCO_2e) representing a reduction of 25% on the previous year, and a 28% reduction on our baseline year overall. This year, we are not including PBL within our reporting boundary and this has accounted for approximately 7.3% of the year's reductions.

Over the current reporting period, our estate has been consolidated in line with government targets. We have also continued on our carbon reduction programme by fitting renewable energy at our largest sites as well as other carbon reduction projects.

The carbon emissions figure comprises the Scope 1, 2 and 3 carbon emissions from our reportable and non-reportable sites, including emissions from water usage and sewage. Non-reportable sites are those offices and or laboratories that are being reported separately by the premises' landlord.

There has been a slight increase in business travel compared to last year of some 2%. This was primarily from using our owned or leased vehicles over the last year, although we did have a 49% reduction in domestic flight usage.

We continue to engage staff through our mandatory e-learning training programme on sustainable development, which has seen 1,340 staff undergoing this bespoke training this past year. This provides our staff with a good understanding of sustainable development and encourages them to act in a sustainable manner and take into account their impact on the environment.

As part of keeping our staff aware of our carbon emissions, we utilise an interactive dashboard which gives access to their directorate's quarterly sustainability data on business travel, utility (electricity, gas and water usage) total waste produced and training. This dashboard has been very effective in keeping our staff informed about our carbon emissions per WTE, as well as financial costs to the organisation.

We continue to strengthen our commitment to its green procurement initiatives by introducing new ways of procuring goods and services.

A number of capital projects to improve the efficiency of our future energy usage have begun at our owned sites, including the fitting over a hectare of Photo Voltaic panels at our Colindale and Porton sites.

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

Greenhouse gas emissions

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

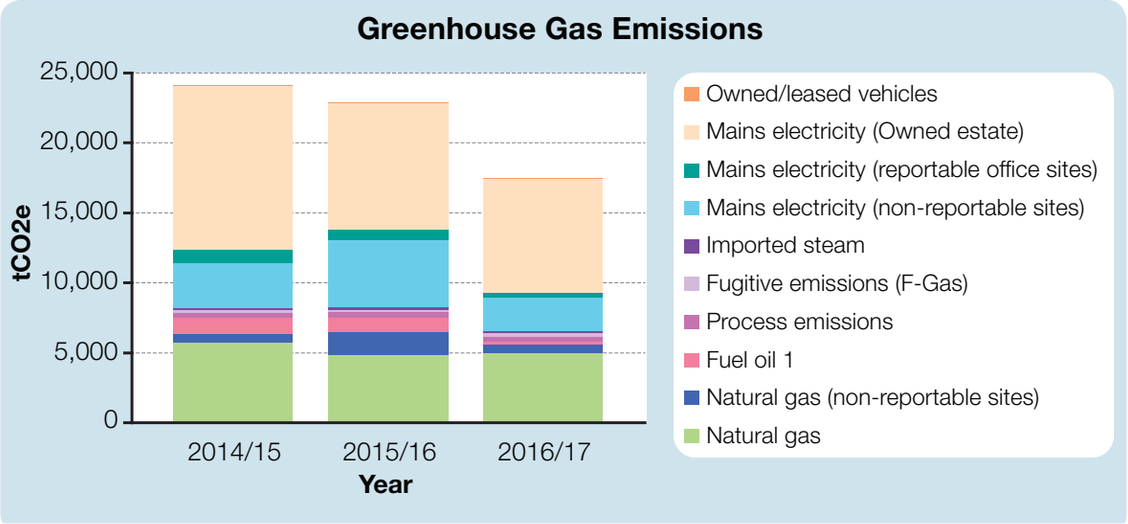
Greenhouse Gas Emissions		2014/15	2015/16	2016/17
SCOPE 1 + 2				
Non-Financial Indicators (tCO_2)				
	Natural Gas (Owned estate)	5,757	4,869	4,948
	Natural Gas (non-reportable sites)	603	1,615	623
	Fuel Oil[1]	1,131	1,025	230
	Process emissions*	362	365	319
	Fugitive Emissions (F-Gas)	192	184	259
	Imported Steam	140	150	135
	Mains Electricity (non-reportable sites)	3,215	4,848	2,426
	Mains Electricity (reportable sites other)	966	749	304
	Mains Electricity (Owned estate)	11,670	9,028	8,173
	Owned/Leased Vehicles	88	58	68
	Renewable Electricity[2]	0	0	307
Related Energy Consumption (kWh)				
	Natural Gas (Owned estate)	31,122,541	26,397,298	26,890,722
	Natural Gas (non-reportable sites)	3,301,240	8,793,116	3,384,729
	Fuel Oil[1]	5,758,424	1,315,271	831,506
	Imported Steam	756,667	812,223	736,233
	Electricity (non-reportable sites)	5,768,624	9,354,619	5,398,338
	Electricity (reportable sites other)	2,010,903	1,496,620	676,416
	Electricity (Owned estate)	21,712,905	18,043,598	18,190,192
	Renewable Electricity[2]	0	0	684,097
Related Consumption (kg's)	Fugitive Emissions (F-Gas)	192,424	184,146	98,330
Related Scope 1 travel (km's)	Owned/Leased Vehicles	442,976	301,851	352,791
Financial Indicators (£)				
	Natural Gas	1,332,346	1,043,957	616,550
	Fuel Oil[1]	305,699	63,309	48,380
	Owned/Lease Vehicles (Fuel/i-expenses)	18,271	21,076	17,130
	Fugitive Emissions (F-Gas)	2,669	58,407	58,320
	Imported Steam	51,057	17,115	18,920
	Mains Electricity (reportable)	2,642,677	1,986,829	1,970,817
	Renewable Electricity[2]	0	0	66,069
Total Gross Emissions Reportable Scope 1 + 2		**20,305**	**16,428**	**14,436**
Total Gross Emissions from Non-Reportable Sites Scope 1 + 2		**3,818**	**6,464**	**3,048**
Renewable Energy		**0**	**0**	**307**

* Process emissions from Porton's Waste Incinerator

1 Fuel oil only calculated for reportable sites

2 Renewable energy from Porton and Colindale PV farms started 2016

Scope 1 and 2 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 estate was 124,204 m^3, with a further estimated 17,478 m^3 being used by our non-reportable sites, though this is estimated in many places due to the lack of metering. Overall, this represents an 8% rise in consumption from last year. The rise in water usage was due, in part, to a number of leaks which were detected at one of our larger sites, which have now been fixed.

Water consumption from our owned larger sites at Colindale, Porton and Chilton continues to be an ongoing challenge this is because each site, in part, has a large number of laboratories which are water intensive users.

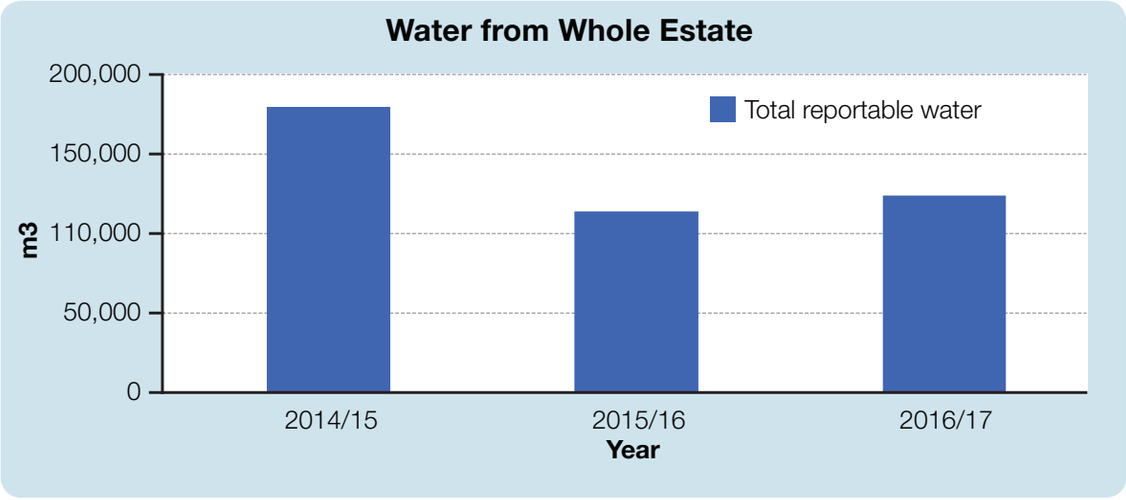
SCOPE 3 (WATER)		2014/15	2015/16	2016/17
Non-Financial Indicators (m3)				
	Water from Office Estate	572	538	262
	Water from Whole Estate	177,528	113,780	123,942
	Total reportable water	**178,100**	**114,319**	**124,204**
	Water from Office Estate *	8,431	9,556	10,389
	Water from Whole Estate *	18,173	86,080	7,089
	Total non-reportable water	**26,604**	**95,636**	**17,478**
Financial Indicators (£)	**Water supply costs****	**164,156**	**107,244**	**132,738**

* Estimated usage

** Water costs from owned sites

Our 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. However, a number of projects have been identified to reduce our 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.



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

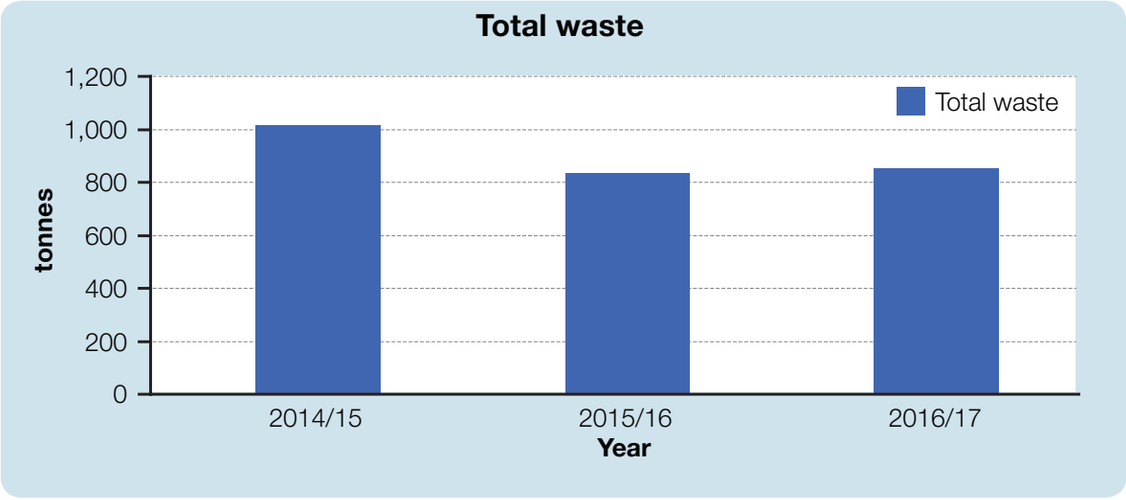
The water supply to our scientific campuses was monitored and measured, and therefore the pattern of daily usage was known. A number of sub-meters have been fitted in the last year to help monitor usage in specific areas. Facilities managers are able to use this information to develop strategies for 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 indicated a 2.3% increase in total waste over the last year. Our total waste figure for 2016/17 was 850 tonnes, compared to the figure for our baseline year in 2013/14 of 912 tonnes.

Due to timing of waste contractor billing data, not all information is currently available and a more detailed analysis will be published in our annual sustainability report in the autumn.

SCOPE 3 (WASTE)	2014/15	2015/16	2016/17
Non-Financial Indicators (tonnes)			
Waste recycled externally (non-ICT equipment)	332	243	239
Waste reused externally (non-ICT equipment)	4	6	28
Waste recycled externally (ICT equipment)	17	7	12
Waste reused externally (ICT equipment)	16	6	5
Waste composted or sent to anaerobic digestion	34	31	43
Waste incinerated with energy recovery	220	178	226
Waste incinerated without energy recovery (Clinical waste)	314	293	244
Total ICT waste	35	17	17
Total waste not to landfill	**937**	**764**	**797**
Total waste sent to landfill	47	41	43
Total landfill waste deemed hazardous (incl. Clinical waste)	36	25	10
Total waste	**1,018**	**831**	**850**
Financial Indicators (£)			
Waste recycled externally (non-ICT equipment)	**54,304**	**60,104**	**57,671**
Waste reused externally (non-ICT equipment)	**250**	**350**	**0**
Waste recycled externally (ICT equipment)	**3,196**	**0**	**238**
Waste reused externally (ICT equipment)	**0**	**0**	**0**
Waste composted or sent to anaerobic digestion	**2,836**	**8,581**	**10,163**
Waste incinerated with energy recovery	**49,873**	**64,773**	**118,214**
Waste incinerated without energy recovery (Clinical waste)	**356,377**	**515,125**	**267,222**
Total waste sent to landfill	**22,494**	**15,162**	**13,747**
Total landfill waste deemed hazardous (incl. Clinical waste)	**25,213**	**40,847**	**2,484**
Total waste	**514,542**	**704,913**	**469,739**



Waste sent to landfill increased by two tonnes over the year, with an 8.4% rise in the amount of waste being recycled. ICT waste is securely collected and disposed of as part of the government contract with CDL, who have been engaged to recycle and reuse, wherever possible, all redundant ICT equipment. This approach continues to be an effective method of disposal for this waste stream, which is supported by government policy. Approximately 17 tonnes of ICT waste have been processed in this manner in the last financial year.

We continue to pursue a pro-active programme to increase the level of recycling wherever practicable.

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

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

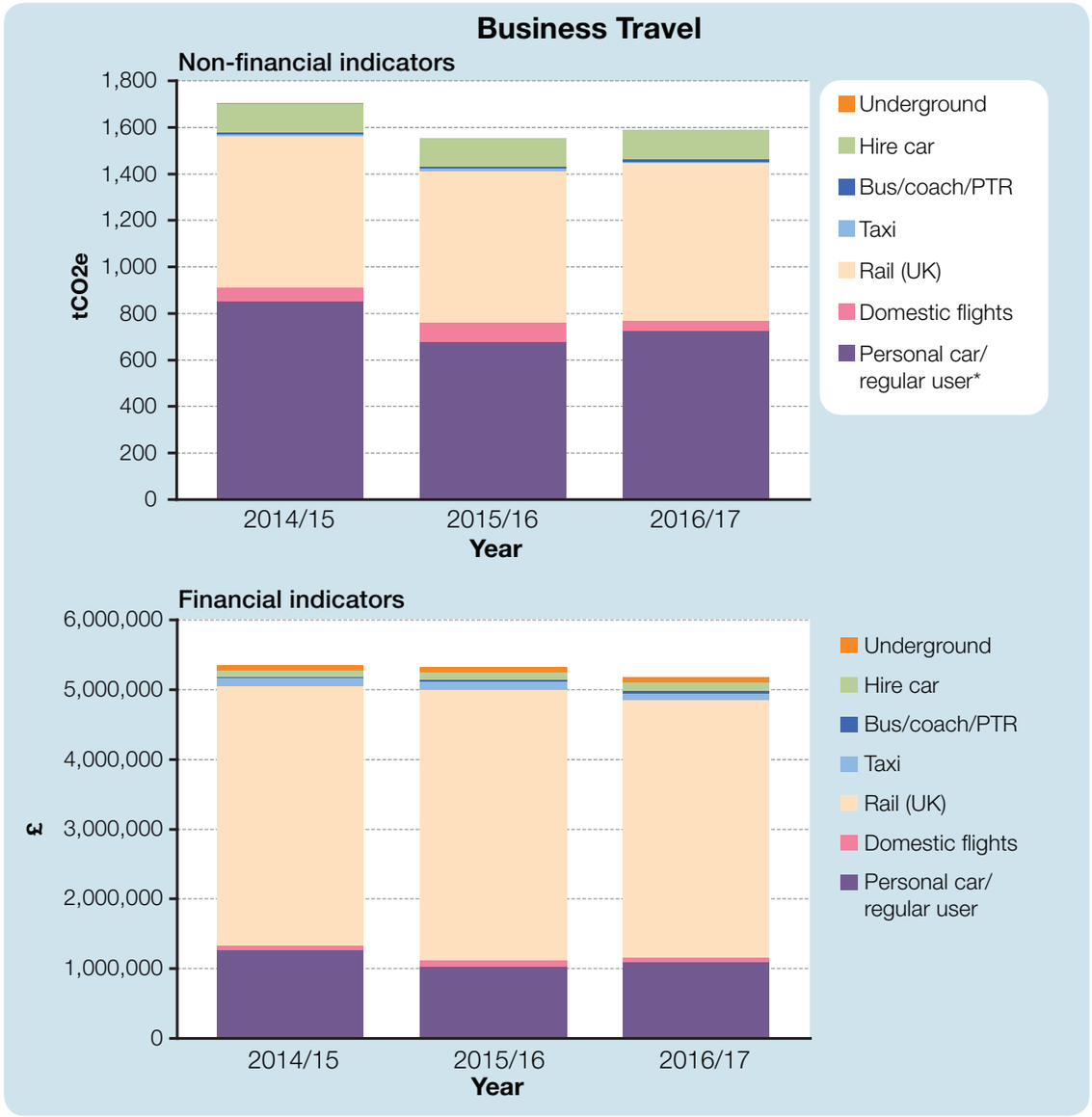
Business travel

Business Travel		2014/15	2015/16	2016/17
SCOPE 3				
Non-Financial Indicators (tCO2)				
	Personal Car	854	678	727
	Domestic Flights	56	83	43
	Rail (UK)	652	653	677
	Taxi	10	8	7
	Bus/Coach/Public Transport Rate	7	7	8
	Hire Car	121	125	125
	Underground	1.01	0.88	0.88
	Total	**1,702**	**1,554**	**1,589**
Related Scope 3 travel (km)				
	Personal Car	4,510,395	3,637,801	3,890,555
	Domestic Flights	361,677	524,039	288,386
	Rail (UK)	13,759,549	14,460,906	13,867,076
	Taxi*	55,507	50,468	45,943
	Bus/Coach/Public Transport Rate	65,791	72,150	83,213
	Hire Car*	640,602	668,295	668,882
	Underground*	16,063	15,672	15,183
	Total	**19,409,584**	**19,429,331**	**18,859,238**
Financial Indicators (£)				
	Personal Car	1,264,866	1,028,793	1,101,425
	Domestic Flights	75,084	92,970	55,306
	Rail (UK)	3,705,995	3,882,894	3,692,035
	Taxi	123,353	112,143	102,096
	Bus/Coach/Public Transport Rate	17,552	33,986	32,608
	Hire Car	88,216	102,068	116,109
	Underground	74,365	71,237	69,012
	Total	**5,349,431**	**5,324,091**	**5,168,661**
Other business travel (Kms)				
	Short Haul International Average	1,962,413	1,991,556	1,693,778
	Long Haul International Average	5,215,474	6,210,706	4,588,151
	Rail - Eurostar	95,444	98,988	101,482
Other business related information				
	Domestic Flights undertaken	788	869	627
	Total Gross Emissions Scope 3	**1,702**	**1,554**	**1,589**
	Total Financial Cost Scope 3 Business Travel	**5,349,431**	**5,324,091**	**5,168,661**
	Total Other Financial Cost**	**636,887**	**875,565**	**485,165**

*Figures calculated using own conversion table

We have set a target to reduce our business travel by at least 2% annually to 2020, relative to our baseline year of 2013/14. We limit journeys wherever possible and where staff must travel, we encourage the use of the most sustainable modes of transport. There has been a 2.4% increase in overall business travel carbon emissions compared to the previous year. A number of factors have been identified which might account for our business travel emissions being higher for this year, including our public health involvement locally, nationally and internationally.

We have reduced our carbon impact from domestic flights by 49% compared to last year. UK rail emissions were up by 4% and travel by personal car on business was 7% higher than last year.



We have continued to reduce business travel to meetings and the use of Microsoft Skype for business on all corporate laptops is actively encouraged to 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. A number of further initiatives have been introduced to monitor business travel locally and travelling in a sustainable manner is highlighted in our sustainability e-learning package.

Other activities

We have been engaged in a number of other measures to improve our reporting and understanding of the social, environmental and financial impacts of our operations. We have continued to play an active role with the Sustainable Development Unit in the implementation of the NHS public health and social care sustainable development strategy, and work continues on delivering health advice about a changing climate through our commitment to the national adaptation programme.

The photo voltaic (PV) arrays installed at our Porton and Colindale sites are now fully operational and the benefits of these renewable sources of energy and now having an impact on both minimising our carbon footprint and our energy bills.

We have reviewed our Sustainable Development Management Plan (SDMP) and this now includes proposals relating to the future move to Harlow.

We have also reviewed and updated all of our environmental policies to take account of the changes that have occurred in government and PHE since we were established in 2013.

Duncan Selbie
Chief Executive

10 July 2017

2 Accountability report

Directors' report

The Directors' report disclosures are contained in the Governance Statement on pages 61 to 95 inclusive.

Statement of Accounting Officer's responsibilities

Under the Accounts Direction given by HM Treasury in accordance with section 7(2) of the Government Resources and Accounts Act 2000, PHE is required to 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, as the Accounting Officer I am 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 DH has appointed me 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 PHE'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

Our governance structures have been developed and implemented in accordance with the requirements of the Framework Agreement with DH and the annual remit letter from Ministers, which taken together set out our duties and functions. They also reflect the government's expectation that, as an executive agency with operational autonomy, we are an authoritative voice on public health. The government acknowledges that this can include constructive mutual challenge between us as set out in the Framework Agreement:

"PHE is therefore 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. Ministers will remain responsible and accountable for policy decisions"

In addition, the PHE Code of Conduct incorporates both the Civil Service Code, which applies to all 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.

PHE's functions

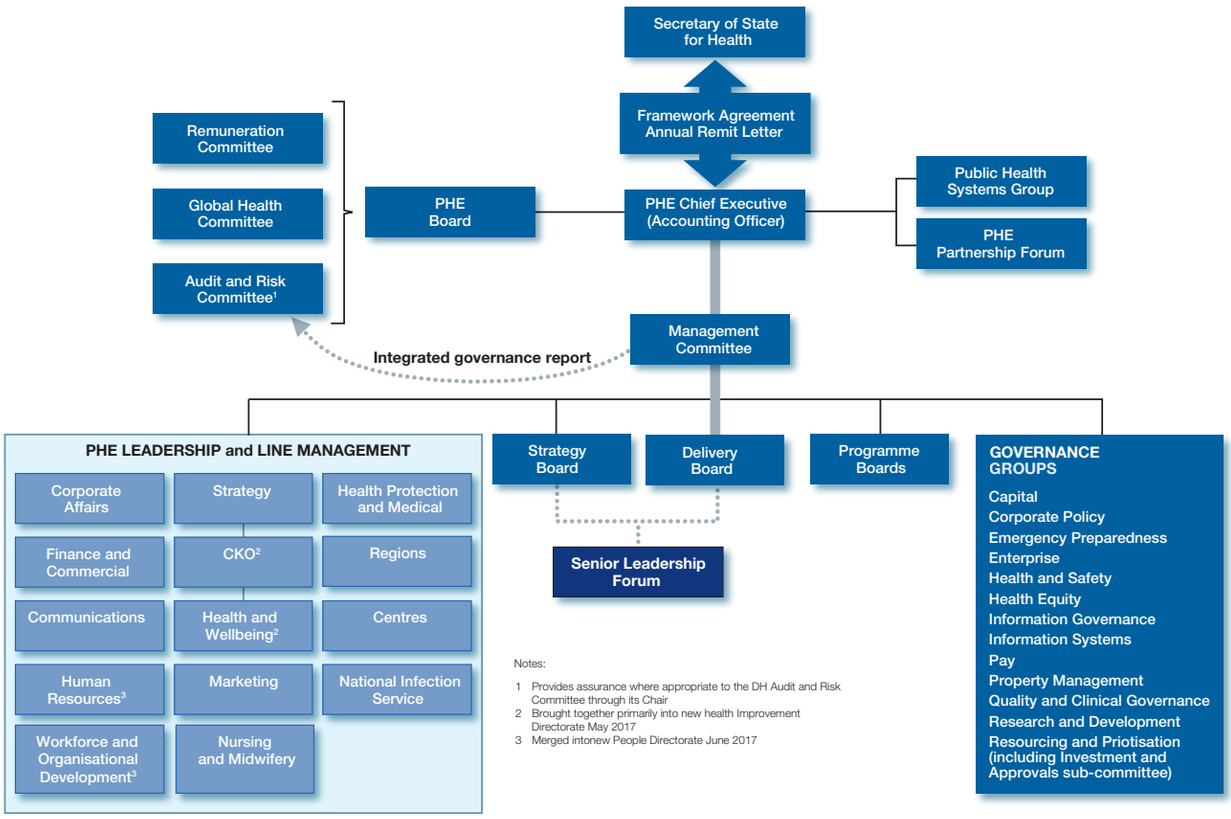
We undertake a range of evidence-based activities that span the full breadth of public health, working locally, nationally and globally, and are responsible for four critical functions:

- our first function is to fulfil the Secretary of State's duty to **protect the public's health** from infectious diseases and other public health hazards, working with the NHS, local government and other partners in England, and also working with the devolved administrations and globally where appropriate. This means providing the national infrastructure for health protection including: an integrated surveillance system; providing specialist services, such as diagnostic and reference microbiology; developing, translating and exploiting public health science, including developing the application of genomic technologies; investigation and management of outbreaks of infectious diseases and environmental hazards; ensuring effective emergency preparedness, resilience and response for health
- our next function is to **secure improvements to the public's health, including supporting the system to reduce health inequalities** and to deliver *From Evidence into Action* and the *Five Year Forward View* commitments for a radical upgrade in prevention. It should do this through its own actions and by supporting government, local government, the NHS and the public to secure the greatest gains in physical and mental health, and help achieve a financially sustainable health and care system. PHE will: promote healthy lifestyles; provide evidence-based, professional, scientific and delivery expertise and advice; develop data, information resources and tools (particularly on return on investment and value for money); and support the system to meet legal duties to improve the public's health and reduce health inequalities

- we have a key role in **improving population health through sustainable health and care services** through, for example: promoting the evidence on public health interventions and analysing future demand to help shape future services; working with NHS England on effective preventative strategies and early diagnosis; providing national co-ordination and quality assurance of immunisation and screening programmes, the introduction of new programmes and the extension of existing programmes; running national data collections for a range of conditions, including cancer and rare diseases; contributing to the 100,000 genomes project; and supporting local government and the NHS with access to high quality data and providing data analyses to improve services and outcomes
- we also ensure the public health system maintains the **capability and capacity** to tackle today's public health challenges and is prepared for the emerging challenges of the future, both nationally and internationally. This will mean: undertaking research and development and working with partners from the public, academic and private sectors to improve the research landscape for public health; supporting and developing a skilled workforce for public health; supporting local government to improve the performance of its functions; providing the professional advice, expertise and public health evidence to support the development of public policies to have the best impact on improving health and reducing health inequalities; and collecting, quality assuring and publishing timely, user friendly high quality information on important public health topics and public health outcomes

The Framework Agreement, annual remit letter and PHE Code of Conduct are all publicly available at www.gov.uk/phe.

The governance arrangements in place in 2016/17 and up to the date of this statement are shown below:



Accountability summary

As Chief Executive and Accounting Officer, I am responsible for the executive leadership of PHE, overall strategy and performance and am accountable to the DH Permanent Secretary. Specifically, I am responsible for:

- 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

The Advisory Board has a non-executive Chair, who ensures that I am supported and constructively challenged as Chief Executive and assures good corporate governance.

The DH Permanent Secretary undertakes my annual appraisal, taking account of feedback from the Chair.

The Chair is accountable to the Secretary of State for Health through the DH Director General for Global and Public Health as PHE's Senior Departmental Sponsor, who ensures that there is an annual objective setting and review process in place for them. The Chair has their own section in the annual report in which they may set out their independent view on the working of PHE, the progress of the public health system and the role of key stakeholders, including DH.

PHE Advisory Board

In January 2017, we agreed with DH that, in taking forward the governance-related recommendation of the Tailored Review, the Advisory Board should comprise the Chair, five non-executive members appointed by the Secretary of State, the Chief Executive, and four executive members. We also refreshed the Advisory Board's terms of reference, its role being to provide advice, support and constructive challenge to me and my team on:

- how we can best deliver PHE's duties and priorities, as well as on our vision and strategy, ensuring that this supports the wider strategic aims of DH and the Government
- how we can ensure operational independence and maintain the highest professional and scientific standards in the preparation and publication of our advice

- the effectiveness of our governance arrangements and the strategic risks facing the organisation, primary responsibility for this resting with the Audit and Risk Committee. Together they support 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
- the effective running of the organisation and key performance issues
- any emerging issues and policies, both within the public health system and from other Government departments, which could impact on the strategic direction of PHE
- any issue(s) on which I request their contribution

The Chair and subsequently the Interim Chair and I have agreed a statement on our respective responsibilities as part of the terms of reference, which are available at gov.uk/phe. In summary, I am responsible for all executive matters and the Chair is responsible for leading the Advisory Board. The Chair also works in partnership with me as a visible and credible ambassador for PHE as we build our reputation as the expert national public health agency.

The following people served on the Advisory Board during the year:

Professor David Heymann CBE (Chair until April 2017), 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 (Interim Chair), government-appointed Lead Commissioner Rotherham Borough Council 2015-17, former joint Chief Executive at the Royal Borough of Kensington and Chelsea and London Borough of Hammersmith and Fulham (to November 2013), former Chair of the Society of Local Authority Chief Executives (SOLACE).
Term of office: 1 June 2013 to 31 May 2017, appointed by Secretary of State in January 2017 for a further term until 31 May 2021. Sir Derek was appointed in April 2017 as Interim Chair until such time that a permanent appointment is made.

I held the following roles prior to being appointed as PHE's founding 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 2003-07; 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)

Professor Sian Griffiths OBE (Interim Deputy Chair), 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 as an associate non-executive by the PHE Board on 25 May 2016, since extended until 31 March 2018. With DH agreement she was appointed by the Board as Interim Deputy Chair in April 2017.

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, extended by the Secretary of State in January 2017 to 30 November 2017

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

Professor George Griffin, retired 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, extended by Ministers in January 2017 to 30 November 2017

Martin Hindle, Chair of the East Midlands Academic Health Science Network, Chair of Porton Biopharma Limited, Deputy Chair of the Medicines and Healthcare products Regulatory Agency, and 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, recently extended to 31 May 2018, and continues to be the non-executive member of the PHE Science Hub Programme Board. As such, he attends meetings of the Advisory Board at the invitation of the Chair.

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, since extended until 31 January 2018.

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

The following members of the Management Committee joined the Advisory Board in February 2017:

Richard Gleave, Deputy Chief Executive and Chief Operating Officer. Before joining PHE in April 2013, Richard was the Director of Programmes at NHS South of England. He was a Director at DH from 2001 to 2010 having previously been Chief Executive of the Royal United Hospital Bath NHS Trust.

Professor Yvonne Doyle CB, Director – London. Before joining PHE in April 2013, Yvonne was SHA and DH Regional Director of Public Health in the South of England (2011-12), DH Regional and SHA Director of Public Health for the Southeast of England (2006-2011) and held the additional role of Medical Director there from 2006-9. Yvonne was previously an SHA DPH in Southeast London (2003-6) and Southwest London (2002-3), and Director of Public Health at Merton, Sutton and Wandsworth Health Authority from 1999-2002.

Professor Paul Cosford CB, Director for Health Protection and Medical Director. Before joining PHE in April 2013, Paul was Director of Health Protection Services at the Health Protection Agency and was its Acting Chief Executive from September 2012 to March 2013. He was previously Regional Director of Public Health and Medical Director, leading the East of England's public health system in the NHS, DH and the then Government Regional Office.

Michael Brodie, Finance and Commercial Director. Before joining PHE in June 2013, Michael was Finance Director for the NHS Business Services Authority and previously held senior finance positions in local government and the police service. Michael acts as a shareholder (government) representative on the Board of Porton Biopharma Ltd.

Other members of the Management Committee attend and contribute to Advisory Board meetings as a matter of routine.

The Advisory Board, which meets in public, met on seven 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:

- alcohol
- tobacco
- accident prevention
- TB
- health inequalities
- mental health
- public involvement in our work
- the role of our four regions and their work
- data sharing across the public health system, particularly local authorities
- children, young people and families
- our marketing campaigns
- rural health

The Advisory Board also:

- discussed how we are approaching the development of the National Infection Service and our work on health economics
- reviewed how we meet the public sector equality duty
- considered the findings of the annual Ipsos/MORI public opinion and stakeholder surveys
- received a presentation from the Academy of Medical Sciences on their report Improving the Health of the Public by 2040
- visited Harlow, our future home
- visited the Kingfisher social enterprise in Gloucester

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 Advisory Board on a regular basis.

The Advisory Board also received regular reports on PHE’s financial performance from the Finance and Commercial Director and from the Chairs of the Audit and Risk Committee, Global Health Committee and Quality and Governance Committee on the issues considered by them.

Role of the Board Secretary

The Board Secretary is responsible for:

- advising the Advisory Board on all corporate governance matters
- ensuring that Advisory Board procedures are followed
- ensuring good information flow between the Advisory Board, its committees and the Management Committee
- facilitating induction programmes for non-executives

Standards and Board effectiveness

The Advisory Board and the Management Committee are committed to the highest standards of corporate governance, with the Board regularly reviewing its effectiveness as part of ensuring that it adds value to the organisation.

In July 2016, the Advisory Board and Management Committee undertook a further assessment of compliance against *Corporate governance in central government departments: Code of Good Practice,* published by the Treasury and Cabinet Office in July 2011. The Tailored Review (TR) team subsequently undertook their own independent assessment, concluding that the Advisory Board was effective in its role and agreeing that PHE complied with the requirements of the Code (set out in full in an Annex to their final report). As set out above, we have taken the opportunity of non-executive terms coming to a natural conclusion to refresh membership, as well as a small number of my senior team joining me as executive members.

Ministers appointed Sir Derek Myers as Interim Chair in April 2017 until such time that a permanent appointment is made, having been appointed for a further four year term as a non-executive. Objectives for the Chair are set and assessed by the DH senior departmental sponsor, Clara Swinson, Director General for Global and Public Health and International Health. The Chair sets and assesses performance against objectives for non-executive Advisory Board members.

The terms of Professor George Griffin and Poppy Jaman have been extended by Ministers until November 2017. Recruitment of new non-executives will commence following the appointment of a permanent Chair.

The TR further recommended that there should be a non-executive member who has responsibility for providing advice, support and challenge in relation to how PHE engages with our colleagues in Wales, Scotland and Northern Ireland. The Advisory Board has appointed one of its associate non-executive members, Professor Richard Parish, to undertake this role as past Chief Executive of the Royal Society of Public Health and his other roles outside of PHE. Richard will chair the Four Nations Public Health Committee of the Advisory Board.

On joining the Advisory Board, new 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.

Register of interests

We maintain a register of interests to ensure potential conflicts of interest can be identified and addressed in advance of Advisory 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.

Audit and Risk Committee (ARC)

The ARC has continued to be chaired Sir Derek Myers, an independent non-executive member with significant experience of financial leadership at board level. He chaired the June 2017 meeting given that first and foremost the business at that meeting related to the 2016/17 financial year. Corporate governance best practice recommends a clear separation of duties between the two roles of Advisory Board and ARC Chair. In June 2017, DH colleagues confirmed that, for the duration of the interim arrangements, the Board could appoint a third associate non-executive member and that this person could Chair the ARC. At its June 2017 meeting, the Advisory Board appointed Michael Hearty as the interim ARC Chair for the duration of Sir Derek Myers' tenure as interim Chair of the Advisory Board.

The primary role of the ARC, which reports to the Advisory Board, 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 Advisory Board and independent members appointed by the ARC for their particular skills and expertise. 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 Chair, 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 the DH sponsorship team routinely attend ARC meetings. The Head of Governance also attends and acts as Secretary.

The ARC met on four occasions in the 2016/17 financial year and has met once so far in 2017/18 to consider and approve the Annual Report and Accounts for 2016/17, including this statement. The Chair of the ARC reported key issues to the Advisory Board after each meeting. He also prepared and submitted an annual report on the committee's work to the Advisory Board, which was made publicly available as part of the papers for the June 2017 Advisory Board meeting. In addition, the minutes of the ARC are made publicly available as part of the papers for Advisory Board meetings (www.gov.uk/phe). There were no matters during the year and up until the date of this statement where the ARC considered it necessary to give formal advice to me as Chief Executive as Accounting Officer.

Areas for particular focus for the ARC in 2016/17 included:

- the ongoing development of the system of risk management and culture across PHE
- considering the accountability arrangements established to support me as Accounting Officer, in particular, those relating to the public health grant to local government
- financial issues, including counter-fraud arrangements
- an integrated 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 corporate infrastructure
- deep-dive risk presentations from Regions and Centres, the Chief Knowledge Officer, Chief Nurse and Human Resources, allowing the committee to scrutinise risk management arrangements at Directorate level, and offer advice and support on a continuous improvement basis
- 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 our activities, which is being addressed through the implementation of a value for money strategy
- a review of compliance with PHE's procurement governance. This has led to improved governance and the development of an action plan and regular reporting of single tender actions to the ARC, who are actively monitoring this enhanced and transparent process and reporting.
- the further strengthening of PHE's internal financial policies and procedures, in particular, the adoption of a refreshed set of Standing Financial Instructions and Delegations
- 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

During 2016/17, the internal auditors undertook 18 reviews as part of the plan agreed with management and approved by the Audit and Risk Committee.

PHE Advisory Board and ARC attendance in 2016/17

Advisory Board		ARC
David Heymann	7/7*	
Rosie Glazebrook	6/7	4/4
George Griffin	5/7	-
Sian Griffiths	7/7	-
Martin Hindle	2/2	3/4
Poppy Jaman	6/7	
Paul Lincoln	2/2	
Derek Myers	7/7	4/4*
Richard Parish	7/7	
Duncan Selbie	6/7	4/4**
Michael Hearty***	-	4/4

* Indicates Chair of Advisory Board or ARC

** Attends ARC as Chief Executive and Accounting Officer

*** Indicates independent member of the ARC, and, from 1 July 2017, Interim Chair of ARC

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 Remuneration Committee of the Advisory Board assists me in the discharge of this duty, primarily to review and approve SCS and NHS ESM 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 2016/17	
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 Quality and Clinical Governance Committee of the Advisory Board played a key role in driving forward our *Sound Foundations* programme, the key elements of which were summarised in last year's statement. Significant progress has been made, as recognised by the internal auditors in their recent follow-up review on clinical governance.

QCGC provides assurance to me 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 Advisory Board and me with an independent and objective review of our systems and processes and compliance with laws and regulations applying to PHE.

As part of the refresh of our corporate governance arrangements following the Tailored Review, it was agreed that the Committee would report to the Management Committee and be chaired jointly by the Chief Nurse and the Director for Health Protection and Medical Director. There continues to be non-executive involvement through membership of the Committee.

Attendance at meetings in 2016/17	
Quality and Clinical Governance Committee	
Rosie Glazebrook*	3/3
Andrew Blakeman**	3/3
Viv Bennett	3/3
Paul Cosford	2/3

* 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 Advisory Board, whose role and remit is set out at section 5 of the Framework Agreement and the refreshed terms of reference of January 2017, and its ARC.

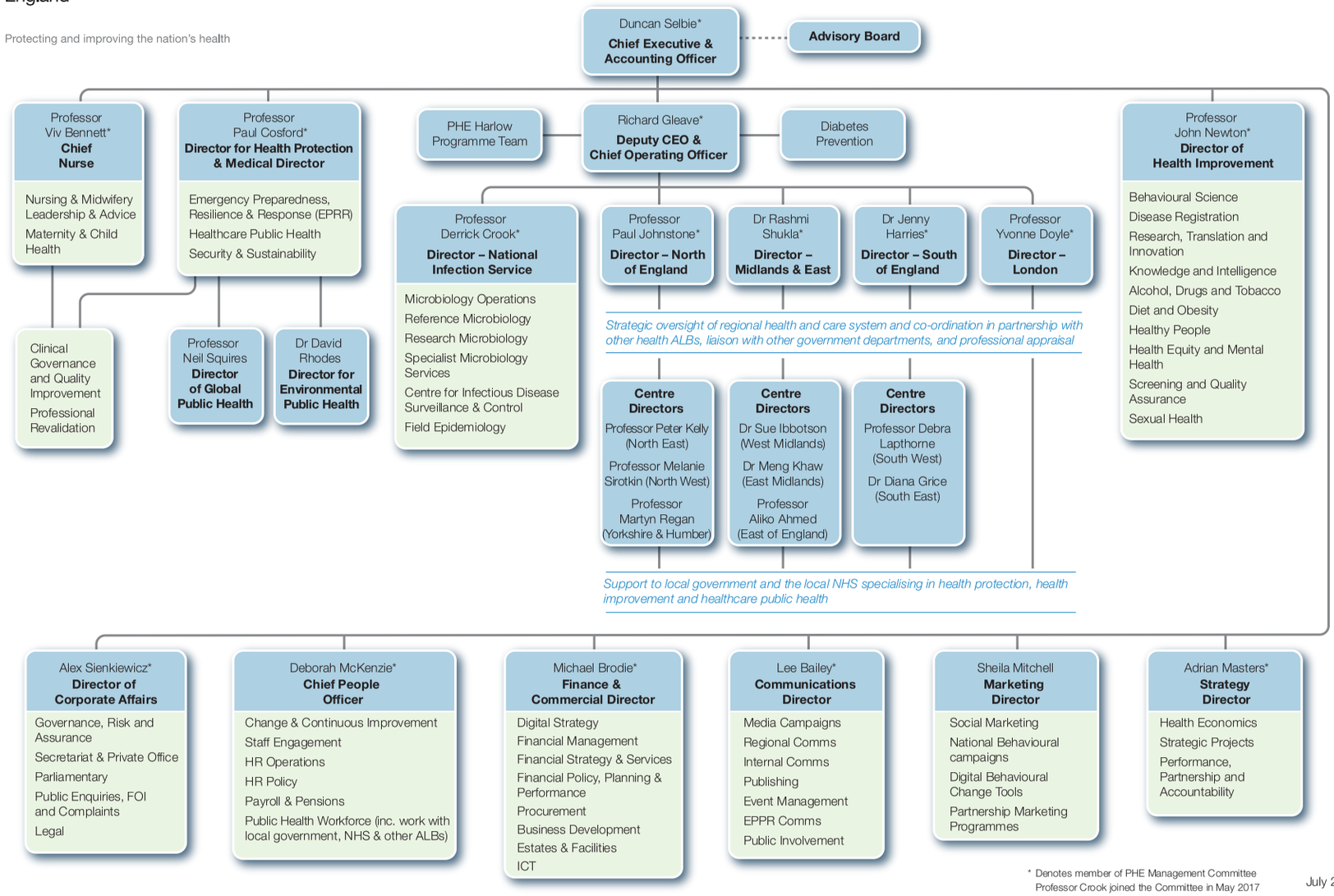
I am supported by a Management Committee, which meets monthly, and provides executive management and governance of the operations and delivery of PHE. The Management Committee holds the Directorates to account for the achievement of agreed objectives and the management of PHE's financial resources and people. It supports me by overseeing the agreed programme of work set out in our business plan and the annual remit letter, and is supported by the work of three key reporting groups, the Delivery Board, Strategy Board and the Resourcing and Prioritisation Group.

The responsibilities of the wider senior leadership team are set out in the diagram below. This meets quarterly 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.

Public Health England

Protecting and improving the nation's health

Our Leadership



* Denotes member of PHE Management Committee
Professor Crook joined the Committee in May 2017

July 2017

Management Committee

The Management Committee is the key 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 the senior 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. Attendance at Management Committee meetings during 2016/17 was as follows:

Attendance at meetings in 2016/17	
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)	6/10
Adrian Masters (Director of Strategy)*	7/8
Deb McKenzie (Director of Organisational & Workforce Development)	8/10
Alex Sienkiewicz (Director of Corporate Affairs)	10/10
Kevin Fenton (Director of Health and Wellbeing)	6/10
John Newton (Chief Knowledge Officer)	9/10
Viv Bennett (Chief Nurse)	8/10
Lee Bailey (Communications Director)**	4/5
Rashmi Shukla (Director Midlands and East)	8/10
Paul Johnstone (Director North)	7/10
Yvonne Doyle (Director London)	7/10
Jenny Harries (Director South)	8/10

* Joined PHE in July 2016

** Joined PHE in September 2016

Derrick Crook, Director of the National Infection Service, joined the Management Committee in May 2017.

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

Delivery Board and the PHE scorecard

Chaired by the Deputy Chief Executive and Chief Operating Officer and reporting to the Management Committee, the Delivery Board is the forum that, on my behalf, ensures 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. This is prepared by the Strategy Directorate based on submissions from across the organisation. Directorates provide numerical data and commentary on trends, as well as updates on agreed milestones and deliverables on key commitments set out in the annual business plan and remit letter. The Strategy Directorate undertakes an initial 'check and challenge' process of Directorate responses to propose a RAG rating, which is then reviewed by the Delivery Board in detail and additional actions identified to improve performance where necessary. Outcomes from Deliver Board discussions include:

- a revised RAG rating
- identification of immediate action, either within PHE by Directorates and for local government and the NHS, and/or for Centres and Regions to do some specific work
- commissioning of further work for the Delivery Board to review, often in the form a "deep dive" within PHE or a system-wide piece of work
- commissioning of planned that work addresses specific issues or concerns; in addition to the scorecard, the DB has a systematic programme for "deep dives" on the ten corporate programmes and a rotating review of delivery in the 4 regions (including centres) and so actions may be picked up in specific aspects of these pieces of work. In addition, there are a series of "deep dives" jointly with NHS England on section 7A services
- testing of alignment with Advisory Board "watchlist" actions

The Deputy Chief Executive, Director of Strategy and Finance & Commercial Director also hold a series of directorate based meetings at two points in the year: the "checkpoint" meetings in February/March focus on the business plan for the following year (including any material items on the scorecard that will need to roll-over into the following year) while the "validation" meetings are in the autumn and focus on a mid-year delivery progress, specifically on any red rated and other material items on the scorecard.

During the year, a number of improvements were identified and acted on to improve the scorecard, including:

- developing metrics that cover areas of continuous improvement/business as usual work, for example, a small number of high-level metrics on the corporate services and on delivery of core public health services by PHE, such as incident response and laboratory activity and turnaround times
- more explicit consideration of the links between the scorecard and the strategic risk register (SRR) so that the scorecard results will more explicitly inform the ratings in the SRR. This is consistent with the explicit link between the business planning process for 2017-18 and the SRR, where actions to address and reduce risk will be clearer in the business plan

Strategy Board

The Strategy Board is the forum at which we debate and settle key strategic issues 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.

It has also considered the development of the annual remit letter and the annual business 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 full implementation of our in-house strategic review of our functions and services through the *Securing our Future* programme, which has now been wound up and transferred to business as usual. The group also has a sub-committee to deal with investment and approvals in an 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. Line management plays a key role in all parts of the organisation delivering high-quality, cost-effective services. Effective collaboration between teams across the organisation is also a key contributor to our success. There are a range of mechanisms in place to achieve this but the two 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 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

Programmes and project management (PPM)

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

- PHE Harlow
- antimicrobial resistance
- tuberculosis
- best start in life
- smoking/tobacco control
- delivering prevention at scale
- diabetes and obesity
- supporting place
- cancer
- global public health

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.

A 2015 internal audit review recommended a number of actions to bring consistency and robustness to PHE's PPM processes. Since then, a number of positive developments have taken place:

- a PHE PPM Development Group has been established, chaired by PHE's Head of Profession, and is accountable to the Delivery Board
- a corporate programme portfolio has been established with each providing monthly reports on a number of governance areas. Reports are provided to each Delivery Board meeting
- regular corporate programme deep-dive sessions are taking place at Delivery Board meetings
- ongoing awareness and support is being provided to the corporate programmes
- a PHE PPM Community with over 200 people has been established as part of a health sector-wide programme for sharing information and development through a Knowledge Hub
- we have been working with the DH and other agencies/ALBs to ensure a consistency of approach across the health family
- new PPM policy and procedures have been introduced
- a PPM in-house training programme has been developed and is being rolled out
- PPM in-house awareness training for senior managers

- trial of a PPM capability assessment tool for those wishing to specialise in this area, which will be available for staff to use in the summer of 2017
- embedding a process across the whole organisation for agreeing new programmes and projects, and agreeing how scrutiny will take place

During 2017/18, we will build on this progress by delivering the following actions:

- establishment of a PHE Portfolio Management Office (PMO)
- designing PPM portfolio management across PHE
- designating PPM leads and PPM 'champions' for each directorate and region (representing their centres)
- with PPM leads and champions, mobilising directorate PPM resource to where it is needed (e.g. those with PPM skills working part-time in other parts of the directorate where a programme or project is being taken forward, as a developmental opportunity)
- filling PPM capacity and expertise gaps

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 ESM 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 and staff report (see pages 96 to 112)
- 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 Advisory Board and in the context of DH and government-wide recruitment controls.

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 DH's strategic objectives, together with 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 DH'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 Advisory Board
- Select Committee hearings; PHE appeared before the Health Select Committee to give evidence to their inquiry in the summer of 2016 into public health post 2013 reforms, and also to their inquiries on suicide prevention (November 2016) and delivery of the government's childhood obesity strategy (February 2017)
- 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. Implementation of the recommendations is being overseen by a joint meeting of DH and PHE senior staff, Chaired by the DH Senior Departmental Sponsor, and with progress being reported jointly by us to the DH Permanent Secretary

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 organization.

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 to me from the DH Principal Accounting Officer of 21 February 2013.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. It 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 2017 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 and Chief Operating Officer, who has delegated responsibility for managing operational risk, and assists me in the day-to-day running of the organisation, including through chairing the Delivery Board. He is also the senior responsible officer for the PHE Harlow 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; medical revalidation, supported by his Responsible Officer team; and the Caldicott Guardian function
- the Chief Nurse, who jointly 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 Management Committee, 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 Director for Health Improvement, 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. He 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.

We have continued to develop and implement 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 Advisory 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. They 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

Throughout 2016/17 further work has been undertaken to translate the 'assurance environment' into measurable and manageable assurance standards. This included:

- delivering a comprehensive cross-organisation assurance training package
- defining bespoke expectations sets specific to specialist organisational functions (for example, the Regional Laboratory Network, Quality and Clinical Governance, Emergency Preparedness, Resilience and Response)
- producing a standard cross-organisation reporting mechanism, the findings of which are agreed in partnership with responsible management teams
- producing a standard cross-agency improvement plan. This provides a platform for each assurance provider to make the necessary improvements necessary so as to mitigate the identified weakness in their risk management and internal control environment
- preparing an assurance map setting out those assurance providers managing strategic risk and significant mitigating controls
- developing and maintaining clear communication links with the internal auditors

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 chaired by the Deputy Director - Corporate Risk and Assurance, 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. 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 2017, 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 identification, management and control of risk. All relevant risk management documentation and tools are available to staff through the PHE intranet, which includes an agreed approach to risk appetite at 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 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. During the year, the PHE Concept of Operations (CONOPS) and National Incident Emergency Response Plan (NIERP) underwent a major review and update to take into account our experience of higher level incidents so far in PHE, particularly on Ebola, and to reflect the new arrangements in place with the establishment of the National Infection Service. They were tested in the autumn of 2016 as part of Exercise Cygnus. A national pandemic influenza planning exercise, deferred previously due to the Ebola response, NIERP includes contingency planning for multiple emergencies occurring concurrently and this was tested in exercise Typhon in February 2017, the lessons learnt from which are being implemented with oversight from the EPPR Oversight Group.

The Ebola crisis highlighted the need for the international community to develop a system to help countries respond to and control disease outbreaks that pose a threat to public health before they can develop into a global emergency. Working in partnership with the London School of Hygiene and Tropical Medicine, we have established and jointly run the UK Public Health Rapid Support Team. The team comprises clinicians, scientists and academics, can be deployed to tackle outbreaks of disease anywhere in the world within 48 hours. They will be on call to respond to urgent requests from countries around the world and fly in to help tackle disease outbreaks at source. The government has made £20 million available from the UK development assistance budget to fund the team over 5 years with the University of Oxford and King's College London as academic partners. When not responding to a disease outbreak, the team will research how best to deal with different types of outbreak. They will also train a group of public health reservists to make sure we are able to scale up our response to any disease outbreak or health emergency.

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 Affairs directorate, works with colleagues across the organisation to ensure compliance with relevant legislation. In particular, it works in close partnership 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 reviews the small number of three incident 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 work closely with the DH Security Team and staff from other government agencies to ensure our staff have the appropriate national security clearance and have reviewed and refreshed our approach to this during the year.

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. This included an internal review of the programme management and governance of our digital programme, the recommendations of which are being taken forward. We will continue to report progress on this to the ARC.

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.

Capturing and responding to risk information

The SRR continued to be developed on a rolling basis over the course of the year with input from the Management Committee and the Advisory Board, and was reviewed regularly by the ARC and considered as a standing item at the quarterly accountability meeting with DH. We also carried out a comprehensive review and refresh of the SSR this year by interviewing individual Management Committee members on their current risks and emerging risks, and, from November 2016 onwards, having a deep dive at each Management Committee meeting on at least one risk on the SRR to: determine whether each risk remains a strategic risk or could be de-escalated for management at Directorate level; the current risk rating and mitigating controls; and what further mitigating action if any is required. We have also increasingly focused on the timeliness of delivery of mitigating actions, something on which we are challenged routinely by the ARC, as well as defining our risk appetite for each of the strategic risks.

Directorates and corporate programmes have identified, monitored and managed risks, which have fed into top-level risk management processes as appropriate. We have initiated a key risk indicators (KRIs) project for the Directorates' risks as part of continuous improvement of our risk management framework. Through the KRIs work stream, Directorates have begun to identify and evaluate suitable KRIs which can be used to monitor the direction of travel for our risks which in turn will help us to link to our corporate key performance indicators (KPIs). 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. This has 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. In particular, the quarterly analyses of the tactical risk registers provides us with a tactical level risk summary profile (heat map) which is reviewed by our corporate risk leads group on a quarterly basis. 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.

Working with stakeholders

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 our 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.

The annual Ipsos/MORI survey of stakeholders and public opinion continues to be an important source of feedback on how we are performing and areas for improvement. We were strongly encouraged by the findings of these reports, including that:

- we are the third highest rated organisation of all public sector bodies surveyed by Ipsos MORI over the last decade, the others being organisations established for longer than us
- working relationships are positive with 93% of local authorities stating their relationship with us was good, up from 84% the previous year, and 85% saying we worked with them to a great or some extent
- particular progress on public recognition: 50% had heard of us and 83% stated they would be fairly confident of our advice (both being an increase on 2015)
- there have been a number of positive shifts in the quantitative metrics, particularly for local authority stakeholders, and qualitatively stakeholders talk of relationships having matured and entering into a positive and constructive steady state
- our stakeholders are strong advocates of the organisation, with advocacy scores having risen and comparing very favourably to other public sector organisations of longer standing
- we and our staff are well liked; stakeholders are invested in our success recognising us as a critical cornerstone in the system. Stakeholders depend on us to keep prevention on the national agenda and provide a strong, credible evidence base. Local Authorities in particular rely on, and strongly value, our health protection function

- as reported in last year's statement, there had been some declines in positivity among local authorities following in-year cuts to public health funding, the outcome for them of the Comprehensive Spending Review and our re-structure. We have shown ourselves to be a listening organization, taking on board criticism and improving how we work, for example, carrying out better engagement around evidence reviews. Points of contact have been re-established, frequency of contact matches levels from before our restructure and relationships appear to be back on a positive trajectory

Alongside this, there were some clear messages for us to reflect and respond to over the coming year:

- whilst we are seen to be increasingly effective in our work despite the challenging climate, our stakeholders believe restricted funding and capacity threatens our ability to reach our full potential, and many local authorities share this concern for their own impact on the public's health
- whilst their message was a strongly positive one, stakeholders identified areas in which we could improve: they felt that we are not always present in the conversations they believe we should be. They are looking for us to have a greater presence at the top table to further push the prevention agenda; linked to this, local authorities expressed a desire to work more closely with us and for us to be more pro-active, action-oriented organisation
- local authorities remain interested in specific advice to assist them in decision-making at local level and this year talked of a need for us to broaden the support we offer them. They believe that we could do more to support the public health workforce of the future and better support local authorities in embedding prevention in the evolving landscape of healthcare delivery

Information Governance

Our employees have privileged and appropriate access to data and information, including patient identifiable data, to support the discharge of our duty to protect and improve the nation's health. We have a responsibility 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 that align with the current threat level, 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 NHS Digital's Information Governance Toolkit
- regular engagement with DH and its ALBs through participation in information assurance forums

In May 2017, there was a world-wide cyber-attack that affected a number of private and public sector organisations, particularly NHS acute hospitals. In order to protect the integrity of our systems and the data held on them, we took a range of prompt, real-time action, including the suspension of our data connection with the NHS. There was a short-term corresponding impact on the full operation of data systems that rely on data through this route, but this was limited to a one week period. One of our regional microbiology laboratories, all of which are hosted by NHS acute trusts, was affected by the host's decision to shut down all IT systems as a precautionary measure following a major power outage. Non-urgent work was suspended over the weekend following the incident, with critical tests redirected to another of our regional laboratories. Another regional laboratory invoked its business continuity plan. We are reviewing our response to the incident to identify any further opportunities to ensure that our systems and processes continue to be able to respond to this kind of threat, including under NIERP where appropriate.

There were two incidents during the year reportable to the Information Commissioner's Office (ICO). The first concerned an allegation made by a now former member of staff that patient identifiable data had been left unattended in the one of the clinical suites at the secure Occupational Health facility. On independent investigation, the allegation was found to be unsubstantiated.

The second concerned the theft of an unencrypted external hard drive during a violent robbery of the home of a public health trainee who held an honorary contact. This was reported to the Police and has been investigated within PHE as a Serious Untoward Incident. First and foremost, this was a criminal act, although the report recommended a small number of actions that we are delivering to mitigate against the potential for such an event. The potential for loss of data has been assessed as minimal based on police advice, and we have contacted the people to whom this data related to in order to assure them of this.

In last year's statement, we reported an incident concerning 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 investigated the actions of the former employee. The individual admitted to offences under the Computer Misuse Act and received a Police caution.

I have reflected further on information governance and data flows across the health and care sector in the principal risks section below.

Principal risks facing PHE during 2016/17

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, our Office for Data Release (ODR) provides 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 us, 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, which 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 NHS Digital. In order to ensure the timely supply of business-critical data sets, we continue to have in place a Memorandum with them on data exchange. This supports the efficient and effective delivery of new services, for example, the monthly cancer outcomes metric for the Secretary of State.

We are working with DH and NHS Digital 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 Information Governance Toolkit. We recently submitted a level 2 compliant assessment on this to NHS Digital. 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.

Following the limited assurance review last year from internal audit on our arrangements for managing information and releasing data, we have taken further steps to ensure that the data we share with other organisations for purposes other than the direct care of patients such as research are tightly managed by the ODR. This ensures that strong and clear safeguards are in place to protect patient confidentiality where we do share data, and that all our sharing of data complies with the law. We are also taking steps to further improve the way we manage the data and information we collect, for example by ensuring that all our staff are well-trained in their responsibilities to protect patient confidentiality.

At a public health system level, there has understandably been 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. The challenges of data access for local authorities were identified as a key issue in the Health Select Committee's report of its inquiry in the summer of 2016 on public health post-2013. They included: logistical and organisational barriers to accessing anonymised data; the lack of a common local authority requirement for data access and information services; and variation in local health intelligence capability and capacity. We have been working with partners across the system to address these issues, including through agreeing and implementing a joint Memorandum of Understanding for data sharing, which the ICO provided supportive advice and guidance on during its development. At the deep dive session at the November 2016 Board meeting, the Chief Executive of NHS Digital affirmed his organisation's commitment to ensuring that local government remained a priority for them.

Data is the lifeblood of public health practice and research and so we will continue to champion the need for clearly available data with linked data sets on public health. We have an important role to play in supporting new ways of working, particularly on supporting local authorities in developing workforce plans, and ensuring that there are clear data flows throughout the system and ease of access.

PHE Harlow

Our scientific campuses at Colindale and Porton are respectively over 30 and 60 years old and, in approving the Outline Business Case in the autumn of 2015, the government recognised the need for public health science to be delivered from modern facilities. Bringing together health protection and health improvement experts in one place will also hugely strengthen our capacity in the key factors that support implementation of key public health interventions. We expect the first phase of PHE Harlow to be complete in 2021 and fully operational from 2024.

During 2016/17, we accelerated our work on the design and creation of PHE Harlow, a major element in our "One PHE" approach. We have ensured that our organisational development and business change strategies are based on planning for the relocation, recognising that this is a significant change for over half of our people. We are committed to encouraging as many of our current staff as possible to relocate as well as undertaking local, national and international recruitment for when PHE Harlow opens. The framework within which staff relocations will be managed will be consulted on with staff and finalised this year.

Engagement with external stakeholders is also key to the success of the project. We held the first public consultation event in May 2016 to share our initial proposals and gather valuable feedback from the local community to help shape them. We held our second public consultation in October 2016 to update local people on how our plans had developed. We will continue to consult the public and the main stakeholders as we create detailed designs and proposals for the site.

We are on track to submit an outline planning application to the local authority in summer 2017. They will then run their own public consultation, giving local people another opportunity to share their views. Their planning committee will then decide the application.

During the year, the ARC has played an active part in scrutinising and constructively challenging aspects of the programme, including the potential for risk of slippage in the timetable. The programme and management of key risks will be scrutinised further in autumn 2017 by the government's Infrastructure and Project Authority.

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 policies tailored and responsive to 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.

As set out elsewhere in this report, marketing is 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 deliver ground-breaking national public health campaigns such as Be Food Smart and 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. Over the past year, almost 400,000 people benefited from completing the online Heart Age Tool, allowing them to understand their individual risk and what action can be taken to reduce their risk. This means that over 1.2 million people have benefited from this tool since its introduction in 2015.

Pandemic flu

Pandemic influenza continues to be one of the top risks in the National Risk Register of Civil Emergencies. We continue to maintain an appropriate 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

Further to the update in last year's statement, we have continued to work closely with colleagues in DH and the Department for Communities and Local Government on the accountability arrangements for the grant in the final years of the Spending Review period. The move of the ring-fenced public health grant to 100% business rate retention will come into effect in April 2019. We have engaged with Directors of Public Health as part of early preparatory work and will develop this further during 2017/18. We are also working with them and HM Treasury on how the future business rates retention funding model will work, including any equalization.

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

The Advisory 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 Advisory Board with an independent and objective review of financial and corporate governance, and internal financial control within PHE.

The Advisory 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 matters considered by the ARC are summarised in the relevant section above so are not repeated here, save to say that the Advisory 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 our effectiveness. 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 two audits where 'limited' assurance was given, the first of which is summarised in the principal risk outlined above on information governance and data sharing. The other relates to a review we invited internal audit to undertake into contract management, where we have not made as rapid progress as we would have liked, but which reflects the priority we have attached during the year to further strengthen financial controls, as set out elsewhere in this statement.

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

- in the case of **risk management**, **PHE has continued to improve the processes it has in place to identify and manage risk, and to ensure that those processes are embedded throughout the organisation.** However, there is still further work required to ensure consistency in applying the risk management procedures across the different parts of PHE and in the escalation of tactical and operational level risks
- in the case of **governance**, **PHE has a well-established governance structure which is operating consistently across the organisation.** During the year, PHE has been going through a further period of structural reform and change as part of its formation of the National Infection Service, which is still in progress. They found this programme to be well managed
- in the case of **control**, **PHE has adequate control mechanisms in place in respect of its financial systems and these are continually evolving.** There are also adequately designed and effective Cyber Security controls. However, they found in relation to both information management, and the management of contracts, that there are a number of opportunities for improvement, namely:
  - improved consistency in the management of records
  - the maintenance of a comprehensive central record
  - clarification of roles and responsibilities
  - management assurance that relevant training has been completed

During the year, the Head of Internal Audit has seen evidence of good and excellent practice across the three key areas of risk, governance and control, but have also identified a number of areas for improvement, especially in terms of enhancing consistency across different parts of the organisation. In conclusion, and taking each of these three areas into account, **the Head of Internal Audit's overall opinion is that they can give moderate assurance to me as Accounting Officer that PHE has had adequate and effective systems of control, governance and risk management in place during the 2016-17 reporting year.** I consider this to be a fair assessement and welcome their findings on the three areas on which they are obliged to report, as set out above.

Refocusing PHE

We recently refocused our senior leadership responsibilities and consolidated these through a new Health Improvement directorate encompassing many of the functions provided through the Health and Wellbeing directorate (previously led by Professor Fenton) and the Chief Knowledge Officer's directorate (led by Professor Newton).

The new Health Improvement directorate will be led by Professor Newton and will support closer alignment of our surveillance, data, evidence and research capability with our policy advice expertise. We are also strengthening our focus on behavioural science and health economics, on digital opportunities and on health care public health in pursuit of our ambition to be the most local of national organisations and relevant to policy and decision makers across the health and care system.

As set out elsewhere in this report, we recently brought together our HR and Organisational and Workforce Development Directorate under the leadership of a Chief People Officer to ensure we provide the best possible development and support to our staff.

Conclusion

We are committed to be a learning organisation and building this into our culture, and going through the Tailored Review process has been a valuable part of this. The governance arrangements that we have put in place and developed since our establishment over four years ago have played their part in ensuring that we move into the next phase of our development from a position of strength and confidence.

We will continue to focus on ensuring value for money in all that we do. The Advisory 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:

- 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
- developing our international role. We have recently benchmarked ourselves against the IANPHI framework for national public health agencies, and a peer review by a team comprising international counterparts from around the world is taking place this summer

I am able to report that there were no significant weaknesses in PHE's system of internal controls in 2016/17 and up to the date of this statement that affected the achievement of our key policies, aims and objectives.

Duncan Selbie
Chief Executive and Accounting Officer

10 July 2017

Remuneration and staff report

This report details the policy on the appointment, appraisal and remuneration of members of the Advisory Board and the Management Committee for the year ended 31 March 2017. It has been approved by the PHE Pay Committee, and is based upon the provisions contained within the *Financial Reporting Manual 2016/17.*

Accountability

The accountability arrangements for the Pay Committee and Remuneration Committee of the Advisory Board are set out in the Governance Statement elsewhere in the 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
  - 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 Advisory Board on Senior Civil Service (SCS) and NHS Executive and Senior Manager (ESM) 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 ESM terms and conditions are considered by the Chief Executive in consultation with the Remuneration Committee of the Advisory Board, whose role is set out in the Governance Statement.

Committee membership

The Pay Committee consists of four members, who in 2016/17 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)

In addition, in his capacity as PHE's Medical Director, Professor Paul Cosford participated in discussions concerning the review of additional PAs and management allowances for senior staff employed in the clinical ring-fence.

All four members served on the Committee throughout the year.

Appointment and appraisal of non-executive Advisory Board members

Non-executive Advisory Board members are appointed by the Secretary of State for Health for a defined term. In addition, the Advisory Board's terms of reference provide that it may appoint up to two associate non-executive members. In June 2017, DH agreed that this would be increased to three for the duration of the Interim Chair arrangement. The performance of non-executive Advisory Board members was assessed by the former chair through an annual appraisal process. The appraisal process for the Chair was conducted by our senior departmental sponsor, the DH Director General for Global and Public Health.

Remuneration of non-executive Board members

The table below lists all non-executive members who served on the Advisory Board during the year ended 31 March 2017. The date of their appointment is accompanied by the total remuneration due to each individual during their tenure in post in 2016/17. Their terms of office are set out in the biographies in the Governance Statement elsewhere in the annual report.

The following changes to Advisory Board membership have taken place since the time of the last annual report:

- the terms of office of Martin Hindle and Professor Richard Parish, who were appointed by the Secretary of State for Health in 2013, concluded on 31 May 2016. With agreement of DH, the Advisory Board appointed Professor Parish as an associate non-executive member with effect from 1 June 2016 and Martin Hindle as an independent member of PHE's Audit and Risk Committee. In January 2017, Professor Parish and Professor Griffiths terms as associate non-executive members were extended to 31 January 2018, and in May 2017 Martin Hindle's term as an independent member of ARC was extended to 31 May 2018
- Paul Lincoln's term of office as an associate non-executive member of the Advisory Board concluded on 31 May 2016
- Professor Heymann's term of office as Chair concluded on 31 March 2017
- Rosie Glazebrook's term of office as a non-executive member concluded on 31 May 2017
- the Secretary of State for Health has appointed Sir Derek Myers for a further term as a non-executive member and as Chair of the Audit and Risk Committee, concluding on 31 May 2021. He was appointed as Interim Chair of the Advisory Board on 1 April 2017 until a permanent appointment is made
- the Secretary of State for Health has extended the terms of office of Professor George Griffin and Poppy Jaman as non-executive members until 30 November 2017
- Richard Gleave, Professor Paul Cosford, Professor Yvonne Doyle and Michael Brodie joined as executive members on 1 February 2017
- in April 2017, the Advisory Board appointed Professor Griffiths as Interim Deputy Chair until a permanent Chair is appointed

Audited table

Total remuneration due to each individual during their tenure in post in 2016/17	Date of appointment	Total salary, fees and allowances	Total salary, fees and allowances
		Year ended 31 March 2017	Year ended 31 March 2016
		£'000	£'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
Sir 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	0 - 5	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. FTE is £7,833. Actual pay for his role as a non-executive to 31.5.16 was £1,314, independent member of the ARC from 1.6.16 £6,569 and as non-executive member of the Science Hub Programme Board £3,336

** The remuneration of Sir 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

*** Richard Parish's term as a non-executive appointed by Ministers concluded on 31 May 2016. He was subsequently appointed by the Advisory Board as an associate non-executive member, extended by the Advisory Board in January 2017 to 31 January 2018

**** 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. His term expired on 31 May 2016

As set out in the Governance statement, four additional executives joined the Chief Executive as members of the Advisory Board in February 2017. Their remuneration is set out in the audited table on page 103.

Appointment and appraisal of Management Committee members

We follow 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.

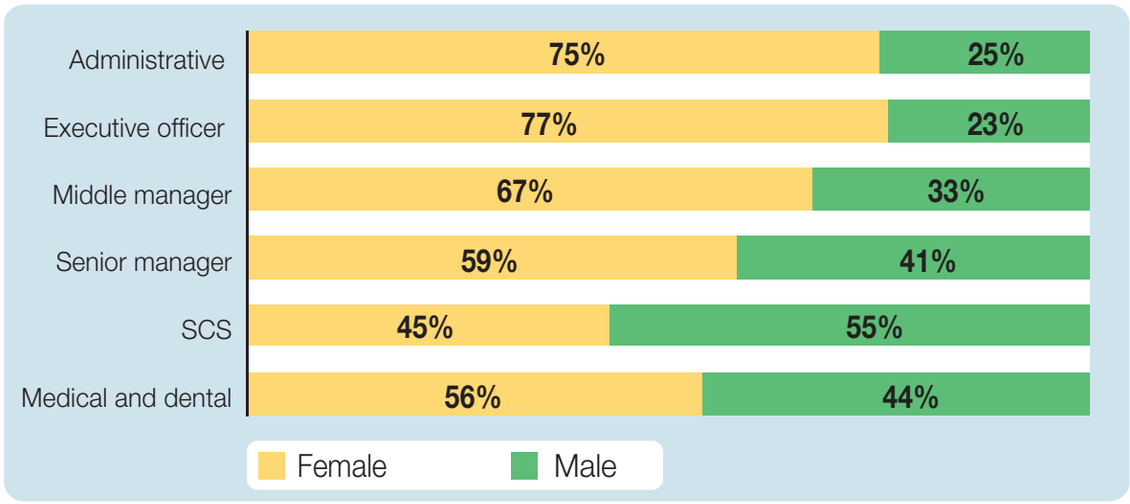
Early termination by PHE, other than for misconduct, would result in the individual receiving compensation in accordance with Civil Service or NHS terms and conditions. Compensation for loss of office would be agreed by the Pay Committee, with reference to DH and HM Treasury guidelines.

In addition it should be noted that, following a competitive selection process chaired by a Civil Service Commissioner, Adrian Masters, Director of Strategy, was seconded from NHS Improvement with effect from 1 July 2016.

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 Chair of the Advisory Board.

The number of individuals by gender serving on the Management Committee was 10 males (67%) and 5 females (33%). The overall gender profile of the PHE workforce is 67% female and 33% male. The table below shows the profile by grade and gender:

Unaudited table



Remuneration of Management Committee members 2016/17 - Audited table

	Date commenced, reappointed or extended	Expiry date of current contract	Notice period	Total salary, fees and allowances (bands of £5,000) £000	Bonus payments (bands of £5,000) £000	Pension benefits (to nearest £1,000) £000	Total remuneration (bands of £5,000) £000
				Year ended 31 March 2017			
Duncan Selbie	1 April 2013		6 months	180 - 185	10 – 15	24	220 - 225
Lee Bailey[1]	26 Sept 2016		3 months	55 - 60		27	85 - 90
Viv Bennett[2]	1 April 2013		3 months	75 - 80		31	105 - 110
Michael Brodie*	24 June 2013		3 months	140 - 145	10 – 15	56	205 - 210
Paul Cosford[3]*	1 April 2013		3 months	180 - 185		40	200 - 205
Yvonne Doyle[3]*	1 April 2013		3 months	180 - 185		0[7]	180 - 185
Kevin Fenton	1 April 2013		3 months	175 - 180		68	245 - 250
Richard Gleave*	1 April 2013		3 months	140 - 145	10 – 15	36	185 - 190
Jenny Harries[3]	1 April 2013		3 months	175 - 180		262	415 - 420
Paul Johnstone[3]	1 April 2013		3 months	175 - 180		37	215 - 220
Adrian Masters[1,4]	1 July 2016	30 June 2020	3 months	120 - 125		26	145 - 150
Deborah McKenzie[5]	1 April 2015		3 months	115 - 120		30	145 - 150
John Newton[3]	1 April 2013		3 months	190 - 195		54	220 - 225
Rashmi Shukla[3]	1 April 2013		3 months	165 - 170		31	210 - 215
Alex Sienkiewicz[6]	1 April 2013		3 months	115 - 120		45	145 - 150

1 FTE for starters during 2016/17 as follows: Lee Bailey £115 - 120k; Adrian Masters £160 - 165k

2 0.6 FTE and was seconded from the Department of Heath until she transferred to the PHE payroll on 1 April 2015.

3 The remuneration of these members of the Management Committee included a Clinical Excellence Award

4 Seconded from NHS Improvement from 1 July 2016, the legal body being Monitor

5 Previously seconded from NHS Central Southern Commissioning Support Unit and appointed through open competition to a permanent post in PHE on 1 April 2015 and seconded to the Cabinet Office on part time basis 0.6 FTE from 1 December 2016

6 Previously seconded from Brighton and Sussex University Hospitals NHS Trust and appointed through open competition to a permanent post in PHE on 1 June 2015.

7 Opted out of pension scheme 1 March 2016

* Indicates Advisory Board member since 1 February 2017

Remuneration of management committee members 2015/16 - Audited table

	Date commenced, reappointed or extended	Expiry date of current contract	Notice period	Total salary, fees and allowances (bands of £5,000) £000	Bonus payments (bands of £5,000) £000	Pension benefits (to nearest £1,000) £000	Total remuneration (bands of £5,000) £000
				Year ended 31 March 2016			
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 Jan 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 PHE 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 appointed through open competition to a permanent post in PHE on 1 April 2015

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 2017. A summary of their employment contract is accompanied by the total remuneration due to each individual during their tenure in post in 2016/17.

Compensation for loss of office

No payment of compensation for loss of office was made to any member of the Advisory Board or Management Committee during the year ended 31 March 2017.

Remuneration policy

Non-executive Advisory Board members

Non-executive 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 DH in agreement with the Cabinet Office as part of the process for making permanent appointments. Their terms and conditions are either Senior Civil Service or NHS (if their posts are designated within the clinical ring fence). For those within the clinical ring fence, the terms and conditions applicable are either NHS Medical and Dental or ESM in Arm's Length Bodies. 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 ESM terms and conditions. The Management Committee remuneration package consists of a salary and pension contributions. In determining the package, DH and Cabinet Office had regard to pay and employment policies elsewhere within the Civil Service and NHS as well as the need to recruit, retain and motivate suitably able and qualified people to exercise their different responsibilities.

The salaries of Management Committee members employed on SCS or NHS ESM are reviewed annually by the Chief Executive with support of the Remuneration Committee of the Advisory Board, having regard to the relevant terms and conditions applicable. For the financial year 2016/17, some members of the Management Committee employed on SCS terms and conditions received consolidated gross increases of £764, which were made in line with the national arrangements published by the Cabinet Office. There was a 1% consolidated increase for staff employed on ESM and medical and dental terms and conditions.

Payments to a third party for services of Management Committee members

The amount paid to NHS Improvement for the services of Adrian Masters 1 July 2016 and 31 March 2017 was £166,001.

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 an individual's duties. Expenses paid to Advisory Board members and Management Committee members are published quarterly in arrears on gov.uk/phe.

Bonuses

In accordance with Cabinet Office guidance, the best performing SCS staff are eligible for a non-consolidated (i.e. non-recurrent and non-pensionable) payment. The sum available for non-consolidated awards is set centrally and for 2016/17 was 3.3% of the total SCS pay bill. The Remuneration Committee of the Advisory Board agreed that, based on performance in the 2015/16 reporting year, all SCS staff in the 'top' performing category should receive a non-consolidated payment of £11,000 (i.e. the same amount for SCS1, 2 and 3 staff). The bonus payments to SCS3 (the Chief Executive) and SCS2 staff (the Finance and Commercial Director and the Deputy Chief Executive and Chief Operating Officer) are disclosed elsewhere in this Remuneration and Staff Report. Nine SCS1 staff received a bonus.

Benefits in kind

During the year ended 31 March 2017, no benefits in kind were made available to any non-executive Advisory 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 2017 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 2017	Lump sum at age 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Cash Equivalent Transfer Value at 31 March 2017	Real increase in Cash Equivalent Transfer Value
	Bands of £2,500 £000	Bands of £2,500 £000	Bands of £5,000 £000	Bands of £5,000 £000	To nearest £1,000 £000	To nearest £1,000 £000	To nearest £1,000 £000
Duncan Selbie	0 - 2.5	0 - 2.5	125.0 - 130.0	0 - 5.0	2,078	2,181	19
Lee Bailey	0 - 2.5	0 - 2.5	5.0 - 10.0	0 - 5.0	68	81	11
Viv Bennett	0 - 2.5	0 - 2.5	5.0 - 10.0	0 - 5.0	121	152	22
Michael Brodie	2.5 - 5.0	0 - 2.5	10.0 - 15.0	0 - 5.0	98	134	23
Paul Cosford	0 - 2.5	10.0 - 12.5	55.0 - 60.0	165.0 - 170.0	982	1,058	75
Yvonne Doyle[1]	0 - 2.5	0 - 2.5	0 - 5.0	0 - 5.0	1,172	0	0
Kevin Fenton	2.5 - 5.0	0 - 2.5	15.0 - 20.0	0 - 5.0	157	207	31
Richard Gleave	0 - 2.5	0 - 2.5	5.0 - 10.0	0 - 5.0	125	168	29
Jenny Harries	10 - 12.5	32.5 - 35.0	45.0 - 50.0	140.0 - 145.0	770	1,064	293
Paul Johnstone	0 - 2.5	0 - 2.5	95.0 - 100.0	0 - 5.0	1,719	1,829	34
Adrian Masters	0 - 2.5	0 - 2.5	35.0 - 40.0	0 - 5.0	591	646	18
Deborah McKenzie[3]	0 - 2.5	0 - 2.5	0 - 5.0	0 - 5.0	33	69	26
John Newton	0 - 2.5	5.0 - 7.5	60.0 - 65.0	180.0 - 185.0	1,266	1,380	114
Rashmi Shukla[2]	0 - 2.5	0 - 2.5	65.0 - 70.0	0 - 5.0	1,180	1,263	28
Alex Sienkiewicz[4]	2.5 - 5.0	0 - 2.5	0 - 5.0	0 - 5.0	19	42	15

1 Opted out of pension scheme 1 March 2016 and has option under 1995 scheme of drawing pension in September 2017

2 CETV values as at 1 April 2016 have been recalculated to accurately reflect the opening values

3 Pension benefits earned since she joined the PCSPS on being appointed to PHE following fair and open competition on 1 April 2015

4 Pension benefits earned since he joined the PCSPS on being appointed to PHE following fair and open competition on 1 June 2015. The past year CETV numbers have been restated

The real increase in CETV

This is the element of the increase in accrued pension funded by the Exchequer. It excludes increases due to inflation and contributions paid by the employee. It is calculated using common market variation 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.

On this basis, the banded remuneration of the highest paid director in the financial year 2016/17 was £195,000 to £200,000 (2015/16: £195,000 to £200,000). This was 5.4 times the median remuneration of the workforce (2015/16: 5.3), which was £36,426 (2015/16: £37,260).

In 2016/17, remuneration across our workforce ranged from £16,523 to £223,965 (2015/16: £15,350 to £223,541). Two employees (two in 2015/16) 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.

Pension scheme participation

Our staff 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 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 we are 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 2016/17, employers' contributions were payable to the PCSPS at an average of 21.1% (2016: same) of pensionable pay, based on salary bands. The scheme's actuary reviews employer contributions every four years following a full scheme valuation. The contribution rates reflect benefits as they are accrued, not when the costs are actually incurred, and reflect past experience of the scheme. The contribution rates are as follows:

Full time pay range	Classic members	All other schemes
Up to £15,000	3.80%	4.60%
£15,001 - £21,210	4.60%	4.60%
£21,211 - £48,471	5.45%	5.45%
£47,472 - £150,000	7.35%	7.35%
£150,001and above	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. We are 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% (2015: 14.3%) 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:

	2016/17 Annual pensionable pay	**2016/17 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%

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 2016/17 requires the scheme to be accounted for as defined contribution in nature.

Employer contributions

We have accounted for our employer contributions to these schemes as if they were defined contribution schemes. PHE's contributions were as follows:

Audited table

	2016/17	2015/16
	£'000	£'000
The PCSPS	32,660	31,994
The NHSPS	6,897	7,671
Total contributions	39,557	39,665

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

Retirements due to ill-health

During 2016/17, there were four (2016: five) early retirements from PHE on ill-health grounds; the total additional accrued pension liabilities on the year amounted to £194,405 (2016: £228,233).

Reporting of civil service and other compensation schemes – exit packages

Audited table

2016/17				2015/16		
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	18	-	18	13	-	13
£10,000-£25,000	36	-	36	23	-	23
£25,000-£50,000	35	-	35	24	-	24
£50,000-£100,000	54	-	54	32	-	32
£100,000-£150,000	5	-	5	4	-	4
£150,000-£200,000	3	-	3	2	-	2
£200,000	2	-	2			
Total number of exit packages	153	-	153	98	-	98
Total resource cost (£000)	6,869	-	6,869	4,158		4,158

Redundancy costs have been calculated in accordance with the NHS Pension Scheme and Civil Service Compensation Scheme (a statutory scheme made under the Superannuation Act 1972) as appropriate. 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.

All exits where the cost is in excess of £95,000 are subject to a robust governance process, including sign off by the Cabinet Office.

Senior civil service staff by band

The table below shows a breakdown of staff employed on (SCS) terms and conditions as at 31 March 2017:

Unaudited table
31 March 2017 data

Bands	Total
SCS1	44
SCS2	9
SCS3	1
Total	**54**

Average number of persons employed

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

Audited table

	2016/17			2015/16		
	Permanently employed staff	Others	Total	Permanently employed staff	Others	Total
Directly employed	5,003		5,003	4,963	-	4,963
Other	-	342	342	-	391	391
Staff engaged on capital projects	32	2	34	10	2	12
Total	5,035	344	5,379	4,973	393	5,366

Staff composition

The table below shows our staff composition by headcount as at 31 March 2017:

Unaudited table
31 March 2017 data

	Male	Female	Total
Directors	10	6	16
Senior Civil Service	25	19	44
Other Staff	1,727	3,495	5,222
Total	**1,762**	**3,520**	**5,282**

Audited table

	2016/17			2015/16		
	£000			£000		
	Permanently employed staff £000	Other staff £000	Total £000	Permanently employed staff £000	Other staff £000	Total £000
Wages and salaries	218,200	19,262	237,462	221,682	22,023	243,705
Social security costs	23,932	-	23,932	19,872	-	19,872
Other pension costs	39,557	-	39,557	39,665	-	39,665
Subtotal	**281,689**	**19,262**	**300,951**	**281,219**	**22,023**	**303,242**
Redundancy and other department costs	6,869	-	6,869	4,158	-	4,158
Less recoveries in respect of outward secondments	(3,631)	-	(3,631)	(2,836)	-	(2,836)
Less recoveries in respect of staff engaged on capital projects	(2,302)	-	(2,302)	(936)	-	(936)
Total net costs	**282,625**	**19,262**	**301,887**	**281,605**	**22,023**	**303,628**

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

Sickness absence

During 2016/17, the total number of whole time equivalent (WTE) days lost to sickness absence was 51,662 days, an average of 6.4 working days per staff WTE per year; and a sickness absence rate of 4.22% (2015/16: 53,166 days; average 6.4 working days per staff WTE per year; and 4.11% 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. The system for recording sickness absence changed during the year to a manager self-service system. Arrangements have been put in place to monitor regularly the compliance with the new system to ensure accurate sickness absence reporting.

Staff policies

We are part of the Job Centre 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, we make the necessary reasonable adjustment requested by the candidates.

We are 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 are expected to apply consistency and equity in line with the learning and professional development policy.

We develop all our employment-related polices in partnership with recognised trade unions through the Partnership Forum, chaired by the Chief Executive.

Consultancy spend

Based on the following Cabinet Office definition:

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[1]

Total PHE spend in 2016/17 was £51,465 including VAT (2015/16: £92,400) on three approved business cases.

Off-payroll engagements

The following table shows all off-payroll engagements as of 31 March 2017, with a value of more than £220 per day and that last for longer than six months:

Unaudited table

Off-payroll engagement	2016/17 Number	2015/16 Number
Number that have existed for less than one year at time of reporting	3	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	3

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

The following table shows all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, with a value of for more than £220 per day and that last longer than six months:

Unaudited table

Off-payroll engagement	31 March 2017 (Number)	31 March 2016 (Number)
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	12	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	12	21
Number for whom assurance has been requested	12	21
Of which…		
Number for whom assurance has been received	10	20
Number for whom assurance has not been received	2	1
Number that have been terminated as a result of assurance not being received	1	1

There were no off-payroll engagements of Advisory Board members and/or senior staff, with significant financial responsibility, between 1 April 2016 and 31 March 2017 (2015/16: None).

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 pages 117-118.

Duncan Selbie
Chief Executive

10 July 2017

Parliamentary accountability and audit report

Remote contingent liabilities - audited

PHE has 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.

Small pox 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. It is to cover possible side effects that might occur in the population if the smallpox vaccine was ever used and it is required because the vaccine is not licensed for use, and even if it were, the vaccine carries a well-known adverse effects profile.

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

Unlicensed BCG vaccine

We have a contract for the supply of UK licensed BCG vaccine. However, there have been significant problems with manufacture leading to delays with deliveries and a shortage of stock in the UK. Following assessment of the available alternatives, clinical acceptability and feasibility of delivery, BCG vaccine manufactured by another supplier has been secured and has been issued to the NHS since June 2016. The unlicensed vaccine has had WHO prequalification since 1991 and is used in over 100 countries globally. In February 2016, the Joint Committee for Vaccination and Immunisation advised that they agreed with the supply of an unlicensed vaccine for the UK programme, during the period where the standard vaccine would be unavailable. Checks have confirmed there are no reported adverse events from the use of the unlicensed vaccine. PHE would indemnify anyone administering the vaccine in accordance with the issued guidance, against any action resulting from adverse reactions. Expert opinion is that adverse reactions to the unlicensed BCG vaccine are most unlikely. The contingent liability is unquantifiable.

Fees and charges - auditable tables

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

	2016/17			Details of financial objective	Details of performance against the financial objective
	Income £000	Full cost £000	Surplus/ (Deficit) £000		
Clinical Microbiology	60,298	67,859	(7,561)	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	5,354	5,560	(206)	Supplies of cell cultures and related services	Met: broadly in line with internal targets
Vaccine Evaluation and External Quality Assurance Schemes	9,864	9,704	160	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual Property Management	33,933	-	33,933	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Emergency Preparedness and Response	5,029	4,650	379	Charges for various emergency response advisory services	Met: broadly in line with internal targets
Commercial Radiation Services	7,225	10,025	(2,800)	Charges for various radiation services	Met: broadly in line with internal targets
Total	**121,703**	**97,798**	**23,905**		

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

	2015/16			Details of financial objective	Details of performance against the financial objective
	Income £000	Full cost £000	Surplus/ (Deficit) £000		
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	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 our staff involved in 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.

Losses and special payments

Losses statement - audited

	2016/17		2015/16	
	Number	£000	Number	£000
Monetary losses	1	-	3	1
Loss of accountable stores	1	12	1	4
Fruitless payment	5	101	3	4
Constructive loss	14	37,652	4	116,095
Claims waived or abandoned	3	20	3	40
Total	**24**	**37,785**	**14**	**116,144**

Details of cases over £300,000

Constructive losses

PHE wrote off £37,462,000 (2016: £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.

Special payments - audited

	2016/17		2015/16	
	Number	£000	Number	£000
Compensation	6	5	3	72
Ex gratia	3	37	-	-
Total	**9**	**42**	**3**	**72**

Details of cases over £300,000

Nil.

Duncan Selbie
Chief Executive

10 July 2017

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 2017 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 these reports and disclosures 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 2017 and of the net expenditure for the year then ended
- 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
- 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 visited by my staff
- 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
- 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
13 July 2017

3 Accounts

Statement of comprehensive net expenditure

For the period ended 31 March 2017

	Note	2016/17 £000	Restated 2015/16 £000
Income from sale of goods and services	5	(186,464)	(188,358)
Other operating income	5	(43,510)	(39,354)
Total operating income		(229,974)	(227,712)
Staff costs	3	301,887	303,628
Purchase of goods and services	4	701,869	696,871
Other operating expenditure	4	3,469,391	3,143,595
Depreciation and impairment charges	4	32,787	26,002
Provision expense / (release)	4	2,940	(2,290)
Total expenditure		**4,508,874**	**4,167,806**
Net operating expenditure		**4,278,900**	**3,940,094**
Finance income	5	(6,254)	(426)
Net expenditure for the year		4,272,646	(3,939,668)
Other comprehensive expenditure			
Items that will not be reclassified to net operating costs:			
Net (gain) on revaluation of property, plant and equipment	6	(151)	(10,148)
Comprehensive net expenditure for the year ended 31 March		**4,272,495**	**3,929,520**

The restatement of the 2015/16 figures relates to a presentational change in the reporting of finance income, which had originally appeared within the total operating income figure.

Statement of financial position

For the period ended 31 March 2017

	Note	2016/17	2015/16
		£000	£000
Non current assets:			
Property, plant and equipment	6	843,258	852,185
Intangible assets	7	16,451	17,906
Investment property	8	9,353	9,344
Financial assets	12	56,568	30,184
Other non-current assets	12	72	92
Total non current assets		**925,702**	**909,711**
Current assets:			
Trade and other receivables	12	67,802	103,278
Inventories	11	144,843	179,279
Cash and cash equivalents	13	92,970	82,576
Total current assets		**305,615**	**365,133**
Total assets		**1,231,317**	**1,274,844**
Current liabilities			
Trade and other payables	14	(135,103)	(161,548)
Provisions	15	(15,843)	(13,642)
Total current liabilities		**(150,946)**	**(175,190)**
Non current assets plus net current assets		**1,080,371**	**1,099,654**
Non current liabilities			
Provisions	15	(1,826)	(1,804)
Total non current liabilities		**(1,826)**	**(1,804)**
Assets less liabilities		**1,078,545**	**1,097,850**
Taxpayer's equity			
General fund		1,040,207	1,054,693
Revaluation reserve		38,338	43,157
Total taxpayer's equity		**1,078,545**	**1,097,850**

The notes on pages 123 to 151 form part of these accounts. The financial statements on pages 121 to 122 were signed by:

Duncan Selbie
Accounting Officer

10 July 2017

Statement of cash flows

For the period ended 31 March 2017

Cash flows from operating activities

	Note	2016/17 £000	Restated 2015/16 £000
Net operating expenditure		(4,278,900)	(3,940,094)
Adjustments for non cash transactions			
Auditor remuneration	4	194	194
Loss on de-recognition of property, plant and equipment	4	69,722	104,196
Reclassification of stockpiled goods	6	55,886	1,733
Amortisation and depreciation	4	32,539	24,839
Provision for impairments	4	248	565
Gain/(loss) on disposal of inventories	11	-	(45)
Impairments	10	-	598
(Increase) / decrease in trade and other receivables		35,228	(46,670)
(Increase) / decrease in inventories		34,436	(39,602)
Increase / (decrease) in trade payables		(26,445)	2,903
Expenditure charged to provisions	15	(717)	(1,763)
Increase / (decrease) in provisions	15	2,940	(2,290)
Net cash outflow from operating activities		**(4,074,869)**	**(3,895,436)**
Cash flows from investing activities			
Purchase of property, plant and equipment	6	(144,374)	(78,133)
Purchase of intangible assets	7	(3,249)	(10,507)
Interest and dividend income	5	6,254	426
(Increase) in investment in Porton Biopharma Ltd		(26,384)	(2,500)
(Increase) / decrease in non-current financial assets	12	20	52
Net cash outflow from investing activities		**(167,733)**	**(90,662)**
Cash flows from financing activities			
Net parliamentary funding		4,252,996	3,909,000
Net cash inflow from financing activities		**4,252,996**	**3,909,000**
Net increase in cash and cash equivalents in the period		**10,394**	**(77,098)**
Cash and cash equivalents at the beginning of the period	13	82,576	159,674
Cash and cash equivalents at the end of the period	13	92,970	82,576

The restatement of the 2015/16 figures relates to a presentational change in the reporting of finance (interest) income, which had originally appeared within the opening figure for net operating expenditure. This amount is now shown separately, within the “cash flows from investing activities” section.

Statement of changes in taxpayers' equity

For the period ended 31 March 2017

	General Fund £000	Revaluation Reserve £000	Total £000
Balance at 1 April 2016	1,054,693	43,157	1,097,850
Net parliamentary funding	4,252,996	-	4,252,996
Reversal of non-cash charges: auditor's remuneration	194	-	194
Net (gain) / loss on revaluation of property, plant and equipment	-	151	151
Transfers between reserves	4,970	(4,970)	-
Total net expenditure for the year	(4,272,646)	-	(4,272,646)
Balance at 31 March 2017	**1,040,207**	**38,338**	**1,078,545**

	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) / loss on revaluation of property, plant and equipment	-	10,148	10,148
Loss on disposal of inventory	-	(45)	(45)
Transfers between reserves	4,336	(4,336)	-
Total net expenditure for the year	(3,939,668)	-	(3,939,668)
Balance at 31 March 2016	**1,054,693**	**43,157**	**1,097,850**

Note 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) 2016/17 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 (DH) 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 DH.

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 from DH 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 with an interim desktop valuation performed in year 3. 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 in existing use basis. A valuation was last undertaken on 31 March 2013.

Other property, plant and equipment are valued at depreciated replacement cost in existing use, which is used as a proxy for fair value. The depreciated replacement cost in existing use is calculated by applying, annually, the producer price indices published by the Office for National Statistics (ONS). 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 in this way.

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 only to the extent that there is a balance on the reserve for the asset. Any excess over that reserve balance is charged 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 expenditure.

Assets under construction

Assets in the course of construction are carried at cost, less any impairment loss. Cost includes professional fees. They are reclassified when they are capable of being brought into use, and their cost is depreciated and revalued in the same way as other assets within their new classification.

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 historic cost as a proxy for fair value unless a further stock of exactly the same assets and replacement date is subsequently purchased and in that case they are revalued at the latest price. PHE undertakes an annual impairment review of stockpiled goods, charging any impairment (including the value of stockpiled goods that have passed their shelf life) to expenditure. This impairment is also disclosed in the losses and special payments section of the parliamentary accountability and audit report.

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 in existing use 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 by PHE 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 still owned by PHE and 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, i.e. they are initially measured at cost and subsequently at depreciated replacement cost in existing use 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 ten 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.

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 in the parliamentary and accountability report, 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 2016/17. The application of the Standards as revised would not have a material impact on the accounts in 2016/17, were they applied in that year:

IFRS 9 Financial Instruments
IFRS 14 Regulatory Deferral Accounts
IFRS 15 Revenue from Contracts with Customers
IFRS 16 Leases
IFRIC 22 Foreign Currency Transactions and Advance Consideration

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, other than the approximation of inventory as referred to in note 1.15.

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.

	2016/17				2015/16			
	Operational Activities £000	**Public Health Grants** £000	**Vaccine programme** £000	**Total** £000	**Operational Activities** £000	**Public Health Grants** £000	**Vaccine programme** £000	**Total** £000
Gross expenditure	564,193	3,387,958	556,723	4,508,874	579,854	3,036,236	551,716	4,167,806
Income	(163,536)	-	(72,692)	(236,228)	(152,222)	-	(75,916)	(228,138)
Net operating cost	**400,657**	**3,387,958**	**484,031**	**4,272,646**	**427,632**	**3,036,236**	**475,800**	**3,939,668**

The major sources of operational income are as follows:	**2016/17**	**2015/16**
	£000	**£000**
NHS laboratory contracts	52,691	59,466
Research grants	20,749	22,668
Commercial services	30,515	27,822
Products and royalties	30,878	25,248
Other	101,395	92,934
External income	**236,228**	**228,138**

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

	2016/17				2015/16			
	Operational Activities	**Public Health Grants**	**Vaccine programme**	**Total**	**Operational Activities**	**Public Health Grants**	**Vaccine programme**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Total net expenditure per statement of operating cost by segment	400,657	3,387,958	484,031	4,272,646	427,632	3,036,236	475,800	3,939,668
Reconciling items	-	-	-	-	-	-	-	-
Total net expenditure per statement of comprehensive net expenditure	**400,657**	**3,387,958**	**484,031**	**4,272,646**	**427,632**	**3,036,236**	**475,800**	**3,939,668**

3 Staff costs

	2016/17 £000			2015/16 £000		
	Permanently employed staff £000	Other staff £000	Total £000	Permanently employed staff £000	Other staff £000	Total £000
Wages and salaries	218,200	19,262	237,462	221,682	22,023	243,705
Social security costs	23,932	-	23,932	19,872	-	19,872
Other pension costs	39,557	-	39,557	39,665	-	39,665
Subtotal	**281,689**	**19,262**	**300,951**	**281,219**	**22,023**	**303,242**
Redundancy and other department costs	6,869	-	6,869	4,158	-	4,158
Less recoveries in respect of outward secondments	(3,631)	-	(3,631)	(2,836)	-	(2,836)
Less recoveries in respect of staff engaged on capital projects	(2,302)	-	(2,302)	(936)	-	(936)
Total net costs	**282,625**	**19,262**	**301,887**	**281,605**	**22,023**	**303,628**

Please also see page 110 of the Remuneration and staff report.

4 Other expenditure

	2016/17 £000	2015/16 £000
Purchase of goods and services		
Accommodation	26,656	31,642
Auditor remuneration	4	4
Education, training and conferences	2,731	4,156
Hospitality	47	34
Insurance	59	84
Inventories written down	2,217	13,034
Inventories consumed	451,674	372,295
Laboratory consumables and services	40,161	40,425
Legal fees	1,377	1,202
Rentals under operating leases	11,838	12,496
Research & Development	653	1,840
Supplies and services	155,215	209,715
Travel and subsistence	9,043	9,750
Non cash items:		
Auditor remuneration	194	194
Total purchase of goods and services	**701,869**	**696,871**
Other operating expenditure		
Bank charges	43	56
European Union grant expenditure	886	1,744
Foreign exchange (gains) / losses	(132)	(196)
Public Health grants	3,387,958	3,036,236
Voluntary sector grants	34	5
Capital grants	10,880	1,554
(Profit) / loss on de-recognition of property, plant and equipment and intangible assets	69,722	104,196
Total other operating expenditure	**3,469,391**	**3,143,595**
Depreciation and impairment charges		
Non cash items:		
Charge of provision for impairments	248	565
Depreciation	27,904	20,664
Amortisation	4,635	4,175
Impairment	-	598
Total depreciation and impairment charges	**32,787**	**26,002**
Provision expense		
Provision provided for / (released) in year	2,940	(2,290)
Total provision expenses	**2,940**	**(2,290)**
Total	**4,206,987**	**3,864,178**

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 (2016: £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

	2016/17			2015/16		
	Administration £000	Programme £000	Total £000	Administration £000	Programme £000	Total £000
Sale of goods and services						
Laboratory and other services	378	80,946	81,324	7,273	78,291	85,564
Products and royalties	18	30,860	30,878	23,619	1,629	25,248
Education and training	290	1,592	1,882	470	1,254	1,724
Vaccines income	-	72,380	72,380	-	75,822	75,822
Total sale of goods and services	**686**	**185,778**	**186,464**	**31,362**	**156,996**	**188,358**
Other operating income						
Research and related contracts and grants	338	10,078	10,416	704	11,147	11,851
Grants from the United Kingdom government	190	5,751	5,941	3,474	2,705	6,179
Grants from the European Union	66	4,326	4,392	1	4,637	4,638
Rental from investment property	-	8,500	8,500	8,500	-	8,500
Other operating income	2,597	11,664	14,261	866	7,320	8,186
Total other operating income	**3,191**	**40,319**	**43,510**	**13,545**	**25,809**	**39,354**
Finance income						
Interest receivable	2	407	409	19	407	426
Income from dividends	-	5,845	5,845	-	-	-
Total finance income	**2**	**6,252**	**6,254**	**19**	**407**	**426**
Income Total	**3,879**	**232,349**	**236,228**	**44,926**	**183,212**	**228,138**

The dividend received in 2016/17 was from Porton Biopharma Limited. No dividend was received in 2015/16 as it was their first year of trading.

6 Property, plant and equipment

Cost	Land £000	Buildings £000	Fixtures and fitting £000	Plant, equipment and vehicles £000	Information Technology £000	Stockpiled Goods £000	Assets under construction £000	Total £000
At 1 April 2016	28,050	133,719	3,371	74,069	43,056	640,896	31,594	954,755
Reclassification of assets		(16)	6	(6)				(16)
Transfer to inventory	-	-	-	-	-	(55,886)	-	(55,886)
Additions	-	-	-	93	-	111,992	32,289	144,374
Transfer of AUC	-	14,380	602	6,439	3,180	-	(24,601)	-
Revaluations	-	-	13	319	-	-	-	332
De-recognition	-	-	(175)	(1,681)	(1,917)	(69,267)	-	(73,040)
At 31 March 2017	**28,050**	**148,083**	**3,817**	**79,233**	**44,319**	**627,735**	**39,282**	**970,519**
Depreciation								
At 1 April 2016	-	20,098	1,599	45,874	34,999	-	-	102,570
Reclassification of assets	-	(7)	3	(3)	-	-	-	(7)
Charge for year	-	15,150	337	7,166	5,251	-	-	27,904
Revaluations	-	-	6	175	-	-	-	181
De-recognition	-	-	(104)	(1,391)	(1,892)	-	-	(3,387)
At 31 March 2017	-	35,241	1,841	51,821	38,358	-	-	127,261
Carrying value At 31 March 2017	28,050	112,842	1,976	27,412	5,961	627,735	39,282	843,258
At 31 March 2016	28,050	113,621	1,722	28,195	8,057	640,896	31,594	852,185
Asset financing								
Owned	28,050	112,842	1,976	27,412	5,961	627,735	39,282	843,258

Reclassification of assets

During the year, it was identified that one asset had been incorrectly classified as land and buildings during 2016/17, when they were, in fact, investment property in respect of the buildings leased to Porton Biopharma Ltd.

Donated assets

PHE had no donated assets during the year.

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.

Cost	Land £000	Buildings (excluding Fixtures £000	Fixtures and fitting £000	Plant, equipment and vehicles £000	Information Technology £000	Stockpiled Goods £000	Assets under construction £000	Total £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	-	(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)
Charge for year	-	7,758	303	6,899	5,146	-	-	20,106
Impairment	-	-	-	(1,981)	-	-	-	(1,981)
Reclassification of assets	-	(1,116)	-	-	-	-	-	(1,116)
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	1,722	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	1,722	28,195	8,057	640,896	31,594	852,185

Reclassification of assets

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

Donated assets

PHE had no donated assets during the year.

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 licenses	Website	Assets under construction	Total
	£000	£000	£000	£000
Cost or valuation				
At 1 April 2016	27,898	2,837	4,841	35,576
Additions	-	-	3,249	3,249
Transfer from AUC	1,825	892	(2,717)	-
De-recognition	(264)	-	-	(264)
At 31 March 2017	**29,459**	**3,729**	**5,373**	**38,561**
Amortisation				
At 1 April 2016	15,072	2,598	-	17,670
Charge for year	4,218	417	-	4,635
De-recognition	(195)	-	-	(195)
At 31 March 2017	**19,095**	**3,015**	**-**	**22,110**
Carrying value				
At 31 March 2017	10,364	714	5,373	16,451
At 31 March 2016	12,826	239	4,841	17,906
Asset financing				
Owned	10,364	714	5,373	16,451

	Software and software licenses	Website	Assets under construction	Total
	£000	£000	£000	£000
Cost or valuation				
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

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

	2016/17 £000	2015/16 £000
Buildings leased to Porton Biopharma Ltd		
Opening balance	9,344	-
Reclassification of assets	9	9,344
Closing balance	**9,353**	**9,344**

PHE owns facilities that were used by PHE 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 still owned by PHE and are now classified as investment properties in line with IAS 40 and are leased to PBL. Further information can be found in note 1.11.

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 DH 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 2017, PHE received Euro income equivalent to £6,642,000 (2016: £5,375,000) and US Dollar income equivalent to £3,893,000 (2016: £6,549,700) upon which there was some currency risk.

The only other currency risk is that of a Euro currency bank balance valued at £473,000 (2016: £251,000) and a US Dollar bank balance valued at £510,000 (2016: £278,000).

10 Impairment

	2016/17			2015/16		
	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	-	-	-	-	-	-
Revaluation reserve	-	-	-	-	-	-
Total	**-**	**-**	**-**	**598**	**-**	**598**

There were no impairments during 2016/17.

The impairment in 2015/16 related to two assets held for use in tuberculosis screening at UK airports (which has been discontinued 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

	Pandemic Flu and pre pandemic flu £000	Emergency preparedness £000	Vaccines £000	Drugs £000	Consumables £000	Total £000
Balance at 1 April 2016	-	-	175,157	-	4,122	179,279
Additions	-	-	359,239	-	4,330	363,569
Transferred from stockpiled goods	55,528	358	-	-	-	55,886
Consumed / disposed of	(55,528)	(358)	(391,470)	-	(4,318)	(451,674)
Written down	-	-	(2,217)	-	-	(2,217)
Balance at 31 March 2017	**-**	**-**	**140,709**	**-**	**4,134**	**144,843**

	Pandemic Flu and pre pandemic flu £000	Emergency preparedness £000	Vaccines £000	Drugs £000	Consumables £000	Total £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 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**

12 Trade receivables, financial and other assets

	2016/17	2015/16
	£000	£000
Amounts falling due within one year		
Accrued income	21,050	22,061
Other receivables	28,050	53,847
Prepayments	3,008	2,711
Taxation	1,596	2,615
Trade receivables	14,098	22,044
	67,802	**103,278**
Financial assets		
Investments	46,384	20,000
Loan	10,184	10,184
	56,568	**30,184**
Amounts falling due after more than one year		
Advances to UKAEA combined pensions scheme	52	71
Asset held for sale	20	21
	72	**92**

Investments

On 1 April 2015, the Secretary of State for Health acquired a 100% shareholding in Porton Biopharma Limited. The initial 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 A further investment of £26,384,000 has been made during 2016/17.

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

	2016/17 £000	2015/16 £000
Balance at 1 April	82,576	159,674
Net change in cash and cash equivalents	10,394	(77,098)
Balance at 31 March	**92,970**	**82,576**
The following balances at 31 March were held at:		
Government Banking Service	91,854	81,903
Commercial banks and cash in hand	1,116	673
Balance at 31 March	**92,970**	**82,576**

14 Trade payables and other current liabilities

	2016/17 £000	2015/16 £000
Amounts falling due within one year		
Accruals	95,179	113,521
Deferred income	14,757	15,177
EU grant income held on behalf of third parties	242	259
Other payables	4,264	2,747
Trade payables	20,661	29,844
Total	**135,103**	**161,548**

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 2016	969	1,984	447	46	-	12,000	15,446
Provided in the year	-	431	38	-	-	2,517	2,986
Provisions not required written back	-	-	-	(46)	-	-	(46)
Provisions utilised in the year	(94)	(106)	-	-	-	(517)	(717)
Balance at 31 March 2017	**875**	**2,309**	**485**	**-**	**-**	**14,000**	**17,669**
Analysis of timing of discounted cashflows							
Not later than one year	93	1,750	-	-	-	14,000	15,843
Later than one year and not later than five years	375	456	253	-	-	-	1,084
Later than five years	407	103	232	-	-	-	742
Balance at 31 March 2017	**875**	**2,309**	**485**	**-**	**-**	**14,000**	**17,669**

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 was in respect of foreign income tax due in respect of employees seconded abroad, which is no longer required.

Contractual entitlements

This is a provision in respect of several claims by staff 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.

There are three elements:

- £12m relates to the actuarial shortfall in the UKAEA scheme that relates to retired staff from one of PHE's predecessor bodies. The liability was inherited by PHE on its creation in 2013
- £1.5m relates to PHE staff transferring from a University pension scheme into the CS pension scheme, at the point of PHE's creation in 2013
- £0.5m relates to an actuarial shortfall in respect of staff transferred out to a commercial pension scheme through an outsourcing arrangement, inherited by PHE from one its predecessor bodies

	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**

16 Capital commitments

	2016/17	2015/16
	£000	£000
Contracted capital commitments at 31 March not otherwise included in these accounts		
Property, plant and equipment	25,337	89,968
Intangible assets	783	862
	26,120	**90,830**

These commitments relate to contractual amounts payable on capital projects.

17 Commitments under leases

	2016/17				2015/16			
	Land	Buildings	Other	Total	Land	Buildings	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Not later than one year	-	4,204	204	4,408	-	3,687	94	3,781
Later than one year and not later than five years	-	11,045	193	11,238	-	11,992	110	12,102
Later than five years	-	1,272	-	1,272	-	1,621	-	1,621
	-	**16,521**	**397**	**16,918**	**-**	**17,300**	**204**	**17,504**

Building leases comprise accommodation leases within NHS bodies for PHE laboratories and office accommodation leased from DH, 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:

	2016/17 £000	2015/16 £000
Not later than one year	412,748	381,142
Later than one year and not later than five years	160,557	206,174
Later than five years	-	-
Present value of obligations	**573,305**	**587,316**

The majority of these commitments relate to the purchase, storage and distribution of stockpiled goods. Contracts are typically arranged for more than one year.

19 Related party transactions

PHE is an executive agency of DH, which is regarded as a related party. During the year, PHE has had various material transactions with DH itself and with other entities for which DH is regarded as the parent entity. These include NHS bodies including the NHS Litigation Authority (now called NHS Resolution), 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; Ministry of Defence; Food Standards Agency; Department for Environment, Food and Rural Affairs; Medical Research Council; and all upper tier local authorities in England in respect of the ring-fenced public health grant.

During the year ended 31 March 2017, no Advisory Board member, member of senior management, or other party related to them has undertaken any material transactions with PHE except for those shown in the table below and the following disclosure.

Related party	Name of the PHE Advisory 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
Porton Biopharma Limited (PBL)	Martin Hindle	Non-executive Advisory Board member & subsequently independent Member of PHE Audit and Risk Committee	Chair, PBL Board	31,534 *(56,244*)*	- *(-)*	76 *(-)*	9,045 *(56,240*)*
	Michael Brodie	Finance and Commercial Director	Non-executive, PBL Board				
	Richard Gleave	Deputy Chief Executive & Chief Operating Officer	Non-executive, PBL Board				
UK Health Forum Registered Charity 803286	Paul Lincoln	Associate non-executive Advisory Board member (until 31.5.16)	Chief Executive	- *(-)*	174 *(1,663)*	220 *(48)*	- *(-)*

Comparative figures for 2015/16 are shown in brackets underneath the 2016/17 figures.
* 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 Porton Down, 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.

	2016/17	2015/16
	£000	£000
Buildings	2,149	2,149
Plant and equipment	1,992	1,992
Total	**4,141**	**4,141**

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.

We have summarised our plans to make Harlow our future home in the annual report section of this document.

PHE completed the process of purchasing the site in Harlow from GlaxoSmithKline in early June 2017 at a cost of £25m (excluding VAT). Once the redevelopment of the site has been completed, then the value in use of the site will be in the region of £400m.

The Accounting Officer authorised these financial statements for issue on 12 July 2017.

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