Public Health England

Protecting and improving the nation's health

Annual Report and Accounts 2017/18

Credible, independent and ambitious

HC 1380

Public Health England

Annual Report and Accounts 2017/18

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HC 1380

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

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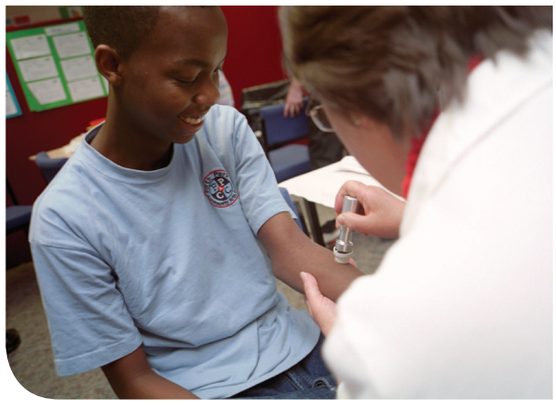


1 Performance report

Chair's report

Sir Derek Myers

PHE is an executive agency of the Department of Health and Social Care. Working with government and other departments of state, it has a critical role in developing and delivering first-class public health services, and so protecting and improving the health of the nation. Ministers have come to depend on the expertise and professionalism the organisation provides, particularly in the light of recent events such as those in Salisbury.

The organisation's Advisory Board has a particular role to play to ensure that PHE is diligent, efficient and effective. 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 innovative ways of working. PHE has a considerable number of delivery partners and other stakeholders – national and local – and part of the Advisory Board's role is to ensure PHE secures close ties with them. Over the last year we have built a close working relationship with public health colleagues from Wales, Scotland and Northern Ireland to discuss common issues and provide support to each other.

Over the last five years, our achievements have been many and substantial, and the organisation has been recognised internationally as being at the forefront of public health provision. This report highlights some of the excellent and sometimes ground-breaking work that we have delivered over the last 12 months, particularly on health protection, sugar reduction and the Health Profile for England.

Our People Survey, covered in detail later in the report, shows that the organisation's management and leadership are getting stronger, and that staff are feeling more valued.

But the organisation faces major challenges in future including:

- preparing the organisation for the UK leaving the European Union
- ensuring that it continues to play a lead role in influencing and supporting the provision of local public health services in light of the changes to local government funding
- ensuring robust planning is in place to ensure we meet our goal of providing a world-class science campus in Harlow

As Interim Chair, I commend the efforts that PHE has made over the last 12 months, and am sure that it is in good shape to face the above challenges head-on, and turn them into real opportunities for the organsiation as it moves forward.

Derek Myers

Sir Derek Myers
Interim Chair, PHE Advisory Board

Chief Executive's review

Duncan Selbie

Public Health England turned five years of age this year and we look forward from a position of strength and confidence to our next five years.

We have an opportunity to build together the most research-ready, data-enabled and impactful public health agency in the world and this is our ambition.

Today in England, the threats to health from environmental hazards and from infectious disease at home and from abroad remain as great as ever. And people living in the most deprived areas of the country spend nearly a third of their lives in poor health; twice as long as the most affluent. These health inequalities are present in our chances of dying early from heart disease, being obese, taking up smoking or surviving cancer, and at all stages of life.

This is as much an economic imperative as a matter of good health. Health and wealth are two sides of the same coin and having a decent income is the main determinant of your health outcome. Helping people to stay well for longer, to stay in the workplace for longer and to live in their own home for longer is the bedrock of a strong economy and a sustainable health and care system.

We are stepping up our work at the interface of new digital technologies, behavioural science, big data and genomics. We aim to foster greater innovation, increase our reach and relevance to those in the poorest health, and extend choice and personalisation wherever possible.

Three themes will characterise the coming period:

- first, local government has led the local public health system for five years and is doing a sterling job. We plan to refresh our covenant with them on how we can best support and challenge each other to be even more ambitious for the next five years
- second, we will work hand in glove with NHS England and NHS Improvement to make prevention and early intervention central to the forthcoming ten year plan for the NHS
- third, we will refresh our infectious disease and environmental science strategies and further our plans for our move between 2021 and 2024 to Harlow in Essex, a purpose designed science campus and future HQ for PHE as a whole

And finally, a message for our PHE colleagues who 24/7 protect and save lives and make a positive difference to the wealth and health of our country, we say thank you.

Duncan Selbie
Chief Executive

Our role and how we operate

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care (DHSC), and a distinct delivery organisation with operational autonomy.

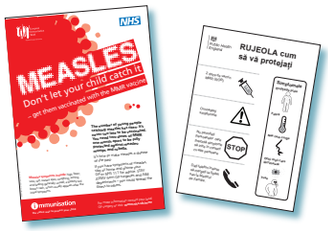
We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Some of our achievements in 2017/18

Keeping the public safe

We work 24/7 to protect people from infectious diseases, public health emergencies and environmental hazards:

We responded to 10,000 disease outbreaks and emergencies. Up and down the country our health protection experts worked alongside local authorities and emergency services to keep the public safe. Our expertise was exemplified in our response to the Manchester Arena bombing, the Grenfell Tower fire and the Salisbury poisoning.



We achieved official 'measles elimination status' by the World Health Organization, thanks to the hard work and perseverance of public health and NHS professionals and our world-leading vaccination programme.

World Health Organization

To help eliminate hepatitis B, we successfully introduced a new hexavalent vaccine into the childhood vaccination programme.

Helping people to be healthier

Locally and nationally PHE is having a positive impact on people's health. This year we:

Reached the milestone of over 6 million people benefiting from an NHS HealthCheck – the largest prevention programme in the world. People from our most disadvantaged communities are benefitting the most.

NHS HEALTH CHECK
Helping you prevent
diabetes
heart disease
kidney disease
stroke & dementia

Launched the most ambitious food reformulation programme in the world to reduce 20% of sugar from the food that children eat the most.

Supported NHS Sustainability and transformation partnerships with data, advice and economic analysis to help shape new care models.

Partnered with the NHS and Diabetes UK to scale the Diabetes Prevention Programme to cover 75% of England, one year ahead of schedule.

NHS England

DIABETES UK
CARE. CONNECT. CAMPAIGN.

Contributed to new HIV diagnoses among men having sex with men falling by 17% in England and by 25% in London.

Contributed to the lowest levels of smoking prevalence since records began.

Signed up 35 national organisations to our national Prevention Concordat for Better Mental Health.

Speaking to people

We use social marketing campaigns to help people make the healthy choice the easiest choice. This year we:

Launched our first 'Keep Antibiotics Working' Campaign.

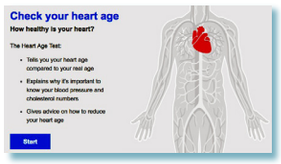
Keep Antibiotics Working

Delivered a new sexual health campaign to remind young people of the importance of wearing condoms.

STAY WELL THIS WINTER

Supported the NHS with our 'Stay Well This Winter' campaign that won the 2017 Civil Service Award for outstanding communications.

Reached 1.8m people with our Heart Age Tool.



Helped nudge over 2 million families to make healthier choices through our 'Sugar Smart' and 'Be Food Smart' apps.

Evidence into action

Our expertise in data analysis and research means we are a credible source of evidence for policymakers:

Our landmark Health Profile for England report brought together for the first time a full picture of the health of the people in England.

Subscriptions to our popular Health Matters evidence series have more than doubled.

Healthmatters

The Government's Drugs Strategy, Tobacco Control Plan, Clean Air Plan, Industrial Strategy and Improving Lives Plan are underpinned by PHE evidence.

Published our fifth Routes to Diagnosis, covering over 3 million cancer diagnoses, making it the most comprehensive data of its kind worldwide.

Science at PHE

We have 2,500 scientists – many of whom are international leaders in their fields. This year:

For the first time worldwide we used whole genome sequencing to diagnose tuberculosis.

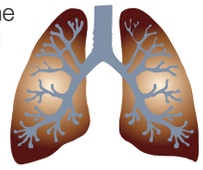
In partnership with the North Bristol NHS Trust, a new state-of-the-art pathology laboratory was opened at Southmead Hospital.

Our laboratories carried out more than 6 million microbiology tests.

More than 850 peer-reviewed scientific and clinical papers were published in prestigious academic journals.

Expanded our award winning National Cancer Registry to include data on over 200,000 non-melanoma skin cancers.

Contributed to the sustained annual decline in the number of new TB cases by a further 10%.



Our radiation experts carried out personal dosimetry tests helping to ensure the safety of more than 70,000 NHS clinicians and other workers handling X-ray equipment and other sources of radiation.

Developing PHE

Our ambition is to be the most effective public health agency in the world. This year:

Our plans to create a new world-leading science campus at Harlow took an important step forward with confirmation of planning permission. Building works begin next year.

We achieved our financial targets delivering efficiency savings of over £13 million in year including through the implementation of our new taxpayer value strategy.

We achieved Top 30 status in the Employer for Working Families awards and have successfully implemented mentoring schemes for BAME and LGBT staff.

The latest Ipsos MORI stakeholder survey gave PHE the third best score for positive advocacy for the work of any public body surveyed by MORI over the past decade.

We further improved our staff engagement score by 3% to 59%, our best so far.

Our regions and centres

Nine teams and four regions around England support delivery of public health services where people live and work:

Received an unqualified opinion from the National Audit Office on our financial statements, including our assurance processes to ensure the ring-fenced public health grant was used in accordance with the grant conditions by local authorities.

In the North West, we have been working with the Greater Manchester Health and Social Care Partnership, to support their ambition to reduce smoking prevalence levels at a pace and scale greater than any other major global city as set out in the city region tobacco strategy – 'Making Smoking History: A Tobacco Free Greater Manchester'.

WEST MIDLANDS VIOLENCE PREVENTION ALLIANCE

PHE West Midlands hosts a Violence Prevention Alliance – a collaboration focused on preventing and reducing violence. Projects include working with GPs to help recognise, support and refer victims of domestic violence; and promote classes in personal resilience to help young people cope with home and school.

Alongside the Mayor of London and London councils, we were co-signatories to a historic pledge to join the global Fast-Track Cities initiative, a major commitment to reduce rates of new HIV infections.

FAST-TRACK CITIES

Our North East team worked with the local NHS and other partners to develop the Weight off your Mind programme – a healthy weight plan for patients in contact with mental health services.

PHE South East organised the largest ever meningitis B vaccination exercise following the tragic death of a student at university.

In Kent, we led the response to the discovery of a potential invasive insect – the Tiger mosquito and minimised any risk to the local population.

PHE London signed a ground-breaking devolution deal alongside the Mayor of London, London Councils and the Secretary of State for Health and Social Care, giving London's leaders more control over health and care in the capital.

People and budgets

Net operating budget
£291.9m
5,500 staff

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

Budget: **£80.0m**
Staff: **2082**

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

Budget: **£15.0m**
Staff: **372**

Chief nurse, maternity and early years
National and international public health nursing and midwifery, advice and leadership. Giving children the 'Best Start in Life'

Budget: **£1.4m**
Staff: **17**

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

Budget: **£22.9m**
Staff: **516**

Health marketing
Delivering healthy behaviour change campaigns

Budget: **£41.7m**
Staff: **98**

Local centres and regions
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

Budget: **£69.2m**
Staff: **1042**

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

Budget: **£2.9m**
Staff: **30**

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

Budget: **£13.4m**
Staff: **282**

Business support, dispersed estate and digital*
Providing business support functions and PHE's digital expertise and capability. This includes the full property cost of our estate

Budget: **£57.7m**
Staff: **573**

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

Budget: **£19.2m**
Staff: **257**

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

Budget: **£31.2m**
Staff: **236**

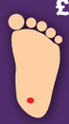
Royalties and balances
Budget: **-£62.6m**

*Communications, Corporate Affairs, Financial and Commercial, People Directorate, PHE Harlow, Infrastructure (ICT, Digital and Estates)

Other funding:

£3,011.1m
Ring-fenced local authority grant

£644.0m
Vaccines and counter-measures



£42.8m
Developing cancer and non-cancer screening

Externally generated income:

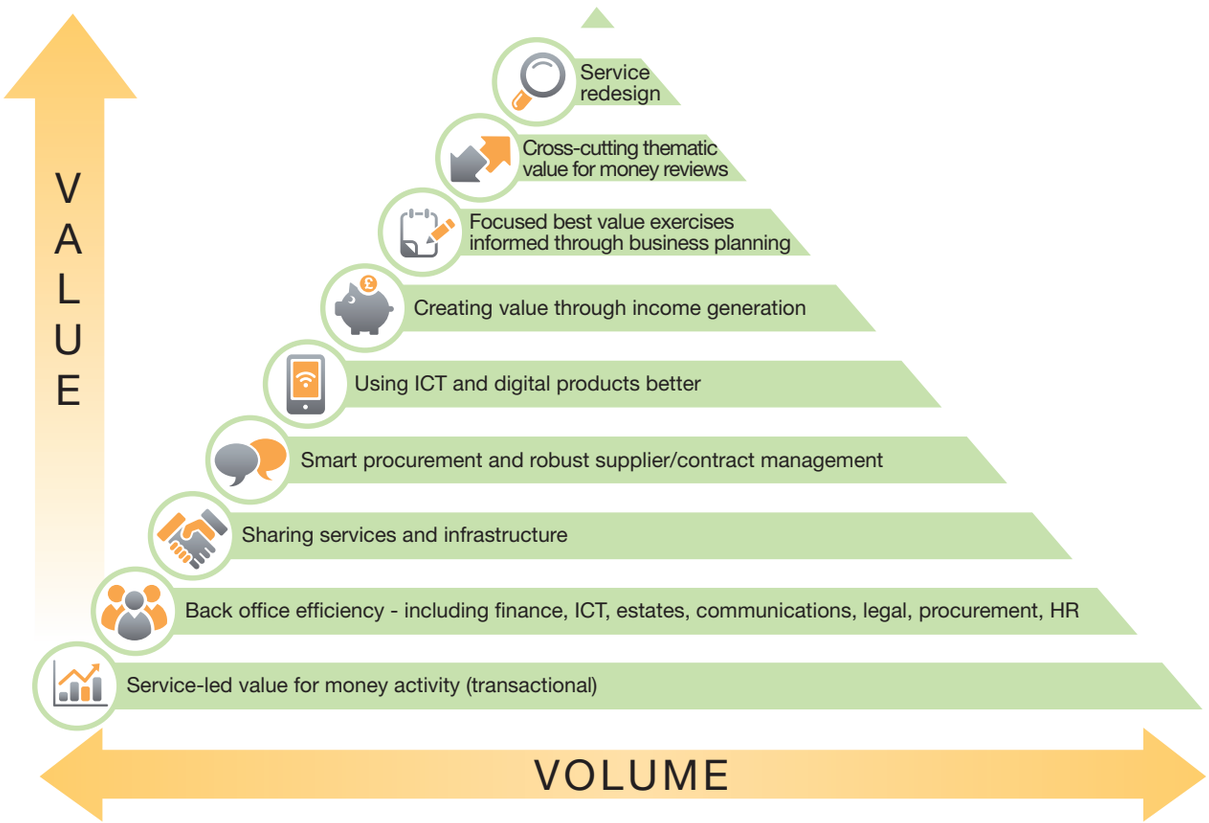
£183.9m
Commercial income: sources include services, research, royalties and dividends

These are budget figures, not the actual out-turn reported in the accounts (section 3).

Taxpayer value strategy and delivery

Through a relentless focus on value for money, encapsulated in our taxpayer value model below, we have delivered recurrent efficiency savings of £145m. This is a saving of more than 30% of our net operating costs and cumulatively represents around £0.5bn savings for the taxpayer since we were formed in 2013.

We have achieved this while continuing to keep the nation safe from infectious disease, environmental hazards and working to improve the public's health.



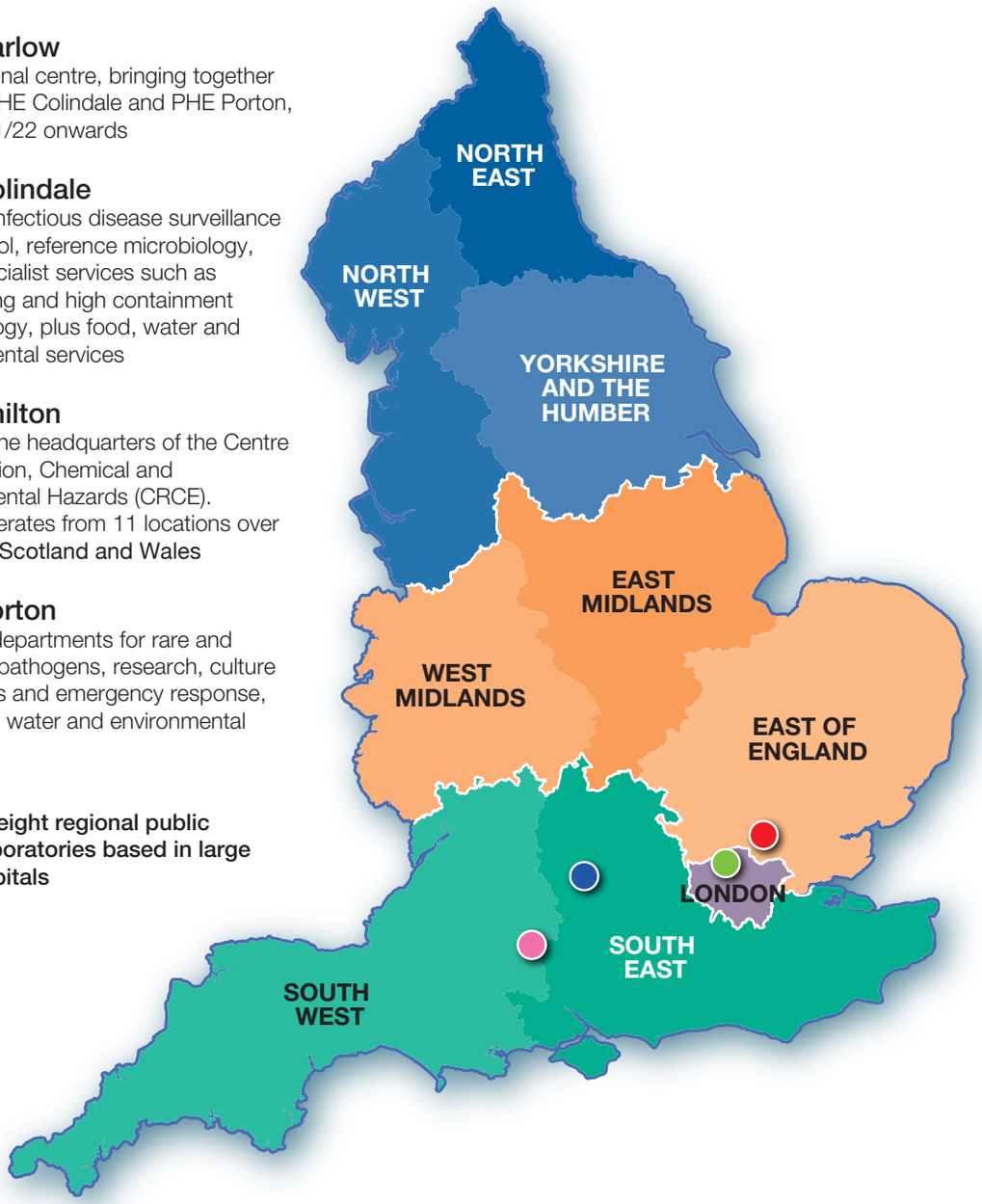
Our national and local presence

PHE has nine teams in four regions around England to support delivery of public health services where people live and work. We are a nationwide organisation offering a range of specialist public health services to support the work of local government, the NHS and the whole public health system in every part of the country.

Our staff work from 52 locations

- **PHE Harlow**
  PHE national centre, bringing together work of PHE Colindale and PHE Porton, from 2021/22 onwards
- **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). CRCE operates from 11 locations over England, Scotland and Wales
- **PHE Porton**
  includes departments for rare and imported pathogens, research, culture collections and emergency response, plus food, water and environmental services

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



PHE science campuses

PHE Chilton

PHE Harlow

PHE Colindale

PHE Porton

Focus on health protection

PHE works 24/7 to protect people from infectious diseases, public health emergencies and environmental hazards. We work with other agencies to make sure the right action is taken to protect the health of anyone who could be affected and prevent further harm to the health of the wider population.

This includes far-reaching specialist public health services such as managing outbreak and incident control teams, contact tracing people who could be affected, using epidemiology skills to monitor and analyse the causes, and giving advice and information to the public.

Over the past year, PHE scientists, local public health teams and health protection experts have responded to several high-profile atrocities including the Manchester Arena and Westminster Bridge terror attacks, the poisoning in Salisbury and the tragic fire at Grenfell Tower.

Our major incident response work includes supporting UK citizens abroad – such as in the British Virgin Islands, Turks & Caicos Islands and Anguilla in the aftermath of Hurricane Irma. We have also been part of the international response to serious disease outbreaks such as Lassa Fever in Nigeria and diphtheria in Bangladesh (Cox's Bazaar) by deploying the UK Rapid Support Team (a PHE/London School of Hygiene collaboration).

PHE responds to over 11,000 outbreaks each year including E.coli in the food chain, clusters of measles across the country, Legionnaire's disease, scarlet fever, shingles and of course flu, to name only a few.

This year, our 'Elimination of HIV' and 'HIV Testing' reports highlighted three firsts in the thirty year history of the UK HIV epidemic. In London, all the global UNAIDS 90:90:90 targets have been met with 90% of people living with HIV infection diagnosed, 97% of people diagnosed receiving treatment and 97% of those receiving treatment virally suppressed. HIV transmission among gay and bisexual men has fallen and death rates among people with HIV who are diagnosed promptly and on treatment are now comparable to the rest of the population. This is huge progress in eliminating HIV and AIDS related deaths in the UK.

For newborn babies the hexavalent 6-in-1 vaccine was made available as part of the routine vaccination schedule. The roll out of this vaccine, which replaced the 5-in-1 vaccine, means that now all babies will be protected against the serious hepatitis B infection, rather than just those in high risk groups.

We published the fourth report from our English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR), which now has data available by clinical commissioning group, acute hospital, general practice and local authority via our Fingertips health profiles. The report showed that between 2012 and 2016, antibiotic prescribing reduced by 5%, however significant regional variation in antibiotic use continues to occur.

These are just some of the many achievements that are testament to the hard work of our scientists and health protection teams up and down the country, and this will remain our foremost priority.

Focus on the Calorie Reduction Programme

On average, both children and adults consume too many calories. This increases our chances of becoming overweight and obese, which are leading causes of poor health and premature death, costing the NHS £6 billion a year.

Over a third of children in England are overweight or obese by the time they leave primary school, making them more likely to face stigma and suffer low self-esteem. Being obese in childhood also increases the chance of being obese as an adult, which increases the risk of type 2 diabetes, heart disease and some cancers. As it stands, around two-thirds of adults in England are also overweight or obese.

PHE plays a major role in addressing the obesity challenge. This includes delivering significant parts of the government's Childhood Obesity Plan, published in August 2016.

Among the commitments for PHE was to oversee a structured and transparently monitored sugar reduction programme, as well as wider reduction and reformulation (e.g. calories, salt and products aimed at babies and toddlers) programmes, to improve everyday food and drink.

In March 2018, in 'Calorie reduction: The scope and ambition for action', we presented the evidence on children's calorie consumption and initial details of the calorie reduction programme, which challenges all sectors of the food industry to achieve a 20% calorie reduction in popular foods contributing the most to children's calorie intakes, by 2024. We will set industry guidelines for calorie reduction by mid 2019 and publish the first progress report in 2021.

The health and economic benefits of reducing excess calorie consumption are significant. Achieving the 20% calorie reduction over 5 years would prevent 35,370 premature deaths, save the NHS around £4.5 billion healthcare costs, and save social care costs of around £4.48 billion over a 25-year period.

Around a quarter of adults' calories come from food eaten outside of the home. Alongside the calorie reduction programme, we launched a new One You campaign for adults. This encourages adults to follow a simple guide when eating on the go: 400-600-600 – the number of calories to aim for at breakfast, lunch and dinner – with a couple of snacks in between to take them to the recommended daily calorie intake (2,000 for women and 2,500 for men).

PHE partnered with businesses such as McDonald's, Greggs, Starbucks, Boots, Subway, Marks & Spencer and Tesco – where millions of people buy their food every day – to signpost customers to their healthier choices in store.

Focus on Health Profile for England

People living in the most deprived areas of the country spend nearly a third of their lives in poor health, twice as long as the most affluent. The rich data that we produce, collect and analyse is fundamental to tackling such health inequalities and improving health, but we need to understand the picture across the whole country.

To improve our capability to do this, in July 2017 we published our Health Profile for England using our data and knowledge to tell a story about the health of the people in England.

This was a landmark moment for PHE, as it was the first time that we brought together many different sources of data, and provided this digitally, focusing on the questions 'Are we living longer?' and 'Are the extra years spent in good or bad health?'

In seven chapters, which can be read alone or as a series, the profile summarises and interprets current trends in health outcomes in England, in particular life expectancy, healthy life expectancy, causes of death, disease and disability, and how England compares with European counterparts. Inequalities in health outcomes and the impact of the social determinants of health are also summarised.

The data confirms key aspects about our population's health and trends: people are living longer lives, some of which will be spent in poor health, and many people will have to contend with disease and disability before they collect their pension; being overweight or obese has a large influence on the risk of poor health; lower back and neck pain causes the most ill health and disability; and in poorer parts of the country people have lower life expectancy and fewer years of living in good health.

Good health is about much more than good health care, and the findings in the Health Profile for England are a strong reminder that for most people the opportunity to lead a healthy life will depend on things such as a good education, a good job, a healthy diet, a suitable roof over your head, and people to care for and about.

We encourage colleagues across national and local government, and the NHS, to use the Health Profile for England to think about the health impact of all of their policies, from education and planning, to social care and the environment.

Following the positive feedback on the profile last year, we will be launching an update at the PHE annual conference in September 2018. The profile will be restructured slightly to take on board feedback from last year and will also include an additional chapter on giving children the best start in life.

Behavioural insights and social marketing

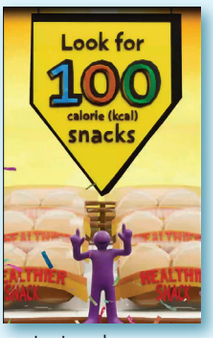
We have used social marketing techniques to engage, motivate and support people to make positive changes to their health behaviours.

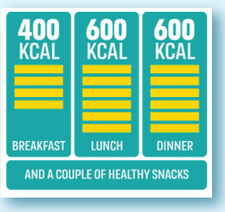
Supporting PHE's core priorities with national behaviour change campaigns

PHE's programme of insight-driven social marketing activity continued to engage people to make positive changes to their health.

In October 2017 we launched PHE's first national 'Keep Antibiotics Working' campaign with the aim of reducing patient pressure on GPs to prescribe antibiotics. Research shows that 78% of the target audience said they were unlikely to ask for antibiotics following the campaign. GPs responded positively with 93% saying that the campaign supports GPs to say no to patients requesting antibiotics when they are not needed.

Helping to reduce the nation's calorie consumption, as part of an integrated approach across government and industry, was the key focus of our campaigns in the last quarter of the year. The New Year Change4Life snacking campaign encouraged parents to choose healthier snacks by following a simple tip – 'Look for 100 calorie snacks, two a day max.' Appearing on TV, radio, digital media and supermarket posters the campaign encouraged parents to sign up to Change4Life to receive money-off vouchers for healthier snacks and to download the new Food Scanner app to help them make healthier choices.





The campaign generated over 900,000 visits to the Change4Life website in the campaign period, 215,000 downloads of the Food Scanner app and 175,000 requests for the voucher pack. The One You adult nutrition campaign followed in March and focused on the simple rule of thumb 'aim for 400-600-600' calories to help adults make healthier meal choices, particularly when eating on the go.

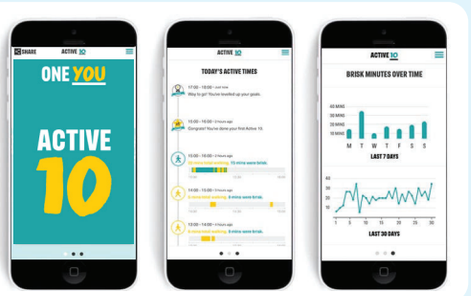
Innovation and smart tools

Using the very latest tools and techniques to inspire people to make a positive change is central to our marketing approach. PHE's audiences are increasingly tech literate and expect to have relevant information and support brought directly to them, wherever they are.

This year we developed our first Alexa 'skill', the Start4Life Breastfeeding Friend. Launched with support from Amazon, it uses voice technology to provide new mothers with tailored, NHS-endorsed guidance on breastfeeding, hands free and 24/7. It has received five star user ratings, enjoys almost double the average usage time compared to other skills and is now the default response to any breastfeeding query received by Alexa.

Our products support behaviour change at scale. The Change4Life Food Scanner builds on the previous successes of Sugar Smart and Be Food Smart, enabling parents to see the sugar, salt, fat and calories inside the food and drinks they give to their children. To date, there have been over 8 million items scanned using these apps.

We continue to help adults get the benefits of physical activity. In the last year there have been over 600,000 downloads of the Active 10 brisk walking app. Our Couch to 5k app remains incredibly popular with 5 star user reviews and over 500,000 downloads this year, bringing the overall total to over 1 million.



Our search engine optimisation work is helping us to improve performance in organic search and appear closer to the top of page rankings. This will play a particularly important role in next year's mental health campaign which will respond to digital signals to give people targeted advice and support.

Working with partners

Our partnerships programme has gone from strength to strength this year. The One You '400-600-600' nutrition campaign brought new partnerships with Boots, Greggs, McDonald's, Starbucks and Subway signposting customers to a wide range of healthier choices when eating on the go.

The Change4Life 10 Minute Shake Up campaign with Disney continued to grow with more than 1.7 million children getting active over the summer with our schools programme playing a critical role in driving awareness among parents.


For the first time, we put partners at the centre of our programme to relaunch the popular Heart Age Test, working with Argos, Omron and Lloyds Pharmacy alongside charity partners British Heart Foundation and Blood Pressure UK. This partner-centred campaign saw almost 250,000 people complete the Heart Age Test as well as taking action to find out their blood pressure.

The Change4Life snacking campaign, galvanised a broad range of retail and manufacturer partners such as Tesco, Co-op, Waitrose and Booker Group, supported through instore point of sale signposting and digital activation. We also launched a dental toolkit with top tips and key messages to parents with over 3,000 packs and 250,000 leaflets distributed.

Campaigns to support our core public health priorities

The Stay Well This Winter campaign targets at risk audiences to ensure they know what to do to keep well during the winter period, including take-up of the annual flu vaccination and getting advice from a pharmacist at the first signs of illness. This year's campaign achieved strong reported flu vaccination uptake and generated an estimated 1.6 million additional visitors to pharmacy. The campaign continued to promote trust in the NHS with 81% of people over the age of 75 agreeing with the statement 'The ads made me feel the NHS is looking after me'.

The new Tobacco Control Plan for England, published in July 2017, is strongly supported by PHE's award-winning national quit smoking campaigns such as Stoptober and New Year 'health harms' campaigns. 16% of smokers reported having made a quit attempt as a result of the Stoptober 2017 campaign.

Mental Health is a major new priority for the next three years. We have done considerable preparatory work in 2017/18 to build the foundations of a nationwide programme to help all adults actively look after their mental health. In addition to a high-profile advertising campaign we are developing a suite of evidence-based products to encourage and equip people to take action to improve their own mental health and that of others. The programme will be tested extensively in 2018/19.

Performance analysis

We measure our performance against the objectives set out in our Strategic Plan: Better outcomes by 2020 and the annual remit letter from Ministers.

On the following pages is a status report on each of the high-level objectives indicating whether they have been fully met or not. Where they have not been fully met, a brief commentary has been provided on the deliverables associated with each.

National government - Promoting health in all policies

	Actions	Status	Performance summary
1	deliver the programme of work to significantly reduce childhood obesity, by implementing the sugar reduction programme; developing work on salt, fat and total calorie reduction; supporting local delivery including by the wider public health workforce, and working with industry, schools, local government and the NHS	Largely completed 	National Child Measurement Programme (NCMP): delays with publishing evidence and a report by University College London (UCL) – **completed**. Sugar reduction programme – publish rationale, evidence and ambition: **completed**. Report on progress towards the 5% reduction in sugar levels: **completed**. Consultation on options for a revised nutrition profiling model: delays due to additional testing. Consultation responses now due to be published in October 2018. Publish the report from the Scientific Advisory Committee on Nutrition (SACN) on saturated fat. Publication date pushed back following feedback from SACN. Publication expected summer 2019.

	Actions	Status	Performance summary
2	implement the PHE-led commitments in the forthcoming tobacco control plan, focusing on reducing variation in England and including publication of an updated evidence report on e-cigarettes and novel tobacco products	Completed 	
3	support the follow-up to the work, health and disability green paper, in particular developing tools and information for employers and the public; and supporting the promotion of both health at work and the importance of work as a health outcome, across all business sectors, local employers, partners and among clinicians and the NHS	Completed 	
4	support cross-government commitments to tackle child sexual abuse and exploitation	Completed 	
5	implement PHE-led commitments in the Home Office's drugs strategy	Completed 	

	Actions	Status	Performance summary
6	support the Government's ambition to reduce antimicrobial resistance (AMR) by working with the NHS, in particular on reducing inappropriate prescribing (including through behaviour change); and reducing healthcare associated Gram-negative bloodstream infections; as well as implementing the PHE-led commitments	Completed 	
7	contribute to cross-government activity on addressing environmental factors that can pose a risk to public health, including but not limited to air pollution	Largely completed 	Contribute to the Department for the Environment, Food and Rural Affairs (DEFRA) evidence base on the impact of NO2: **completed**. UK Health Forum commission on the effects of air pollution on the NHS: **completed**. Publish Environmental Public Health Strategy: delays due to initial outputs being revised. Publication now expected by end of summer 2018. Undertake a review of the evidence for reducing the harm from air pollution. Due to complete in August 2018.
8	contribute to the development of the industrial strategy	Completed 	

Local government - Sharing our expertise and evidence on what works

	Actions	Status	Performance summary
9	support local delivery through promoting sustained improvement and reduced variation in public health outcomes by supporting local government to deliver effective and efficient public health interventions and services in line with the Public Health Grant conditions and regulations	Partially completed 	Publish 10 local government reports on public health interventions: reports on mental health, oral health and tobacco completed and being peer reviewed. All to be published by March 2019. Support to Greater Manchester Business Rate Retention pilot: **completed**. Proposal for PHE support on sector-led improvement: work being led by the Local Government Association (LGA) with PHE input. Awaiting proposals from LGA. Completion date now March 2019. Prevention delivery in partnership with London: delivery planned but not yet delivered. This work will continue into 2018.
10	support the development of a new assurance and financial framework for the public health system (greater devolution and a future move from grant funding to 100% Business Rates Retention) promoting transparency of public health outcomes and supporting local accountability and improvement	Completed 	PHE completed the actions planned and required in 2017/18. Work on this programme will continue for the next few years with expanded actions to be delivered.
11	deliver targeted and usable information via Health Matters to support the commissioning of effective evidence-based public health interventions at a local level	Completed 	

	Actions	Status	Performance summary
12	work with local government and the NHS to maximise the delivery and outcomes of the NHS Health Check programme	Completed 	
13	promote good mental health, prevent mental health problems and improve the lives of people living with and recovering from mental illness, including through the implementation of the key PHE commitments from the Five Year Forward View for Mental Health	Partially completed 	Launch Prevention Concordat for Better Mental Health: **completed**. Stock-take on local authority multi-disciplinary suicide plans: **completed**. Work with DHSC on quality assuring local suicide prevention plans: Process to commence in 2019/20. Evidence base to support mental health social marketing support: independent evaluation being pursued and discussions between DHSC and PHE continuing prior to campaign launch in autumn 2018.
14	implement actions to enhance commissioning of sexual and reproductive health services, focusing on helping delivery organisations reduce the variation in health outcomes in England, as well as supporting NHS England and local government in implementing the PrEP pilot	Partially completed 	Social marketing campaign pilot: **completed**. PHE research contribution to clinical trials: **completed**. Commissioning pilots early lessons report: delays in securing commitment to participate. Commitment to publish reports by Quarter 3 2018/19. Development of new return on investment (RoI) commissioning tool: due to be completed in spring/summer 2019.

	Actions	Status	Performance summary
15	support the identification of local health priorities through provision of robust intelligence and the assessment of what works to improve population health outcomes, while taking due regard for data confidentiality and security	Completed 	
16	work with local government and health visitors on Best start in life to drive improvements in child health outcomes at scale, assure local delivery of the five 0-5 universal checks (to all children, everywhere) and provide evidence on priority interventions in universal plus and universal partnership plus service; support the development of a strategy to address the needs of children living with alcohol dependent parents; and lead the prevention workstream within the national Maternity Transformation Programme working across the local NHS and local government	Completed 	
17	partner with Wiltshire Council and the Defence Scientific Technology Laboratories to develop the Porton Science Park	Completed 	
18	support local action to reduce health inequalities, working in partnership with the Department of Health, the Local Government Association, NHS England and relevant national bodies	Completed 	

	Actions	Status	Performance summary
19	continue our work with the Well North programme supporting local community based approaches to public health, in particular through helping its transition to a community interest company and assisting with the finalisation of its evaluation strategy	Completed 	

The NHS - getting serious about prevention and support for STPs

	Actions	Status	Performance summary
20	make the case for prevention with the Department of Health and NHS England, and work with the NHS and local government to support local implementation of the NHS Five Year Forward View prevention agenda – particularly on closing the health, financial and quality gaps – to help reduce avoidable increases in demand on NHS services. In particular: - support the implementation and delivery of sustainability and transformation plans helping NHS and local government commissioners to deliver savings, and to prioritise activities with greatest impact on the public's health in order to support improved value for money - support NHS England in delivering a two-year programme, which will promote the implementation of preventative interventions at scale by the NHS, in collaboration with local health and care partners - developing proposals to make better use of behavioural science to help people take more control of their health, with a specific focus on increasing uptake of prevention programmes to reduce demand on the NHS	Completed 	

	Actions	Status	Performance summary
21	introduce the hexavalent vaccine for the primary infant vaccinations (diphtheria, tetanus, pertussis, poliomyelitis, Haemophilus influenzae type B and hepatitis B) to the childhood vaccination programme	Completed 	
22	design and finalise an implementation strategy for the faecal immunochemical test (FIT) within the bowel cancer screening programme	Completed 	PHE completed the implementation strategy in 2017/18. The procurement exercise is being led by the NHS

Directly to the public - Making the healthy choice the easy choice

	Actions	Status	Performance summary
23	educate, inform and secure behavioural change through campaigns: - starting well: helping every child to have the best start in life though: Change4life, Start4life, RiseAbove and Frank campaigns - living well: tackling lifestyle behaviours in 40- 60 age group such as smoking though One You, Smoking cessation and sexual health campaigns - ageing well: supporting the public to identify signs and symptoms and encourage them to access healthcare through Be Clear on Cancer, Act FAST (stroke), AMR and sepsis campaigns	Completed 	
24	help people to take more control of their own health by understanding the evidence of behavioural science in improving health and informing new interventions	Largely completed 	Develop process for evaluation of new digital behavior change interventions: **completed**. Publish at least two behavioural change analyses: analyses on purchasing food and drink in hospitals, and diabetes and weight management complete (being peer reviewed prior to publication). Scoping other work.
25	engage over 1 million adults on their heart health by promoting access to the Heart Age Tool	Completed 	

Global health - Protecting people living in the UK

	Actions	Status	Performance summary
26	work closely with the DHSC as part of a strategic 'one government' approach on global health, to: - strengthen the co-ordination of global health activities on infectious disease, environmental hazards and health improvement to protect people living in the UK, support the development of public health systems and improve capacity and expertise in agreed countries - implement the global health security agenda	Completed 	
27	deliver research on chemical, radiation and hazardous assessment of substances, through international and EU collaborations	Partially completed 	Project to improve hazard assessment of substances: preliminary results received in March 2018. Project to be completed by July 2018. Paper on 'heat not burn' tobacco risks: work continuing prior to publication in 2018.

Developing the public health system - Building capacity and capability

	Actions	Status	Performance summary
28	work in partnership with the voluntary, community and social enterprise sector, DHSC and NHS England through the new Health and Wellbeing Alliance programme to drive transformation of health and care systems to promote equality and address health inequalities	Completed 	
29	continue to build capability in the public health workforce to enable leadership and delivery of the public health priorities now and in future, including taking the lead in implementing 'Fit for the Future'	Largely completed 	Commission leadership development programme: **completed**. Explore viability of a digital service to support the implementation of the Public Health Skills and Knowledge Framework (PHSKF): successfully progressing through digital development. Final report was sent to DHSC in June 2018. Deliver next phase of skills passport: procured and due to be delivered by summer 2018. Develop an apprenticeship standard: work continues on development. Standard to be submitted to the Institute for Apprenticeship with completion expected to be secured by September 2018. Pilot leadership development programme for scientists: **completed**. Work with the LGA to deliver employer standards for public health: **completed**. Publish ethics paper: **completed**. Produce and publish a series of digital publications: **completed**.

	Actions	Status	Performance summary
30	scale up the 'All Our Health' (AOH) programme to reach 200,000 health and care professionals to embed and extend prevention, health protection and promotion of wellbeing and resilience into everyday practice	Completed 	
31	act on the specific recommendations and actions of the most recent Caldicott Review and the Review of Informed Choice	Completed 	
32	contribute to the implementation of the Academy of Medical Sciences report 'Improving the Health of the Public by 2040'	Completed 	
33	protect the public's health by working with system partners to complete the audit of local health protection arrangements, including the development of a national system to collate and disseminate lessons learnt from incidents	Completed 	The audit was completed in 2017/18 and the feedback provided to Local Health Resilience Partnerships to help them take the actions that are their responsibility. On disseminating lessons learnt from incidents, PHE has set up a system and are planning to develop it further.

	Actions	Status	Performance summary
34	build on whole genome sequencing (WGS) with a view to extending testing to a further three high priority pathogens	Largely completed 	Bring staphylococcus aureus WGS into routine use (phase 1): **completed**. Develop and implement project plans for hepatitis C virus (HCV) and s.pneumonae WGS: s.pneumonae **completed**. HCV still being developed, with delays due to software testing and implementation. The revised date for supporting the plan is summer 2018. Develop and implement a strategy for HIV: now to be included as part of next generation sequencing (NGS) so this will not be progressed at this time. Agree costing model for WGS : **completed**.
35	submit the planning application for PHE Harlow	Completed 	
36	build health economics capacity and capability across the system	Partially completed 	Deliver 2017/18 health economics commissioning framework: cardiovascular disease return on investment tool and two others commissioned late in 2017/18 are still being developed. Completion later in 2018. Promotion of virtual teams model: **completed**. Draw up options for developing economic modelling in-house: **completed**.

	Actions	Status	Performance summary
37	continue to strengthen the economic case for prevention at national and local levels	Partially completed 	Delivery of the 2016/17 and 2017/18 health economics commissioning framework projects: most projects have been completed, however the health inequalities project remains outstanding. Completion later in 2018. Prioritisation Framework to support local authorities to invest in prevention: **completed**. Publish map of expenditure on prevention: health economics analysis completed. To be published later in 2018.
38	work with government and NHS England to develop a joint programme of work and produce plans for the public health system's response to high-consequence infectious disease incidents	Completed 	
39	support the dissemination and increased use of research outputs from the National Institute for Health Research (NIHR) Health Protection Research Units, including novel analytical tools, online resources and masterclasses to provide timely, reliable evidence about emerging health threats	Completed 	

Developing PHE - Strengthening skills, building resilience

	Actions	Status	Performance summary
40	strengthen organisational capability and operational effectiveness as well as long-term sustainability and resilience by acting as a learning organisation by continually learning from benchmarking information and reviews, including international reviews	Completed 	
41	strengthen the skills of our leadership to manage change well, inspiring and engaging our staff, by supporting every team, over the next two years, to use the teams and leadership digital platform to accelerate reflective practice securing continuous improvement in our staff engagement scores	Completed 	
42	National Infection Service: start implementation of the new organisational arrangements	Largely completed 	Recruitment of leadership posts: **completed**. Development programme for senior leaders: **completed**. Agree NIS strategic framework: relies on the full involvement of the new senior leadership team that has only recently been completed. Good progress now being made with a further objective agreed for the 2018/19 business plan.

	Actions	Status	Performance summary
43	strengthen our digital and information and communications technology capacity and capability	Partially completed 	Implement PHE's digital strategy: some small delays in technical preparations, but these are now underway and the project moves on a pace. Define and begin to implement PHE's ICT strategic objectives: E-mail migration, work on a Unified Communications Platform and a User Device Upgrade have had their challenges but are now progressing well.
44	take forward the Tailored Review recommendations	Completed 	
45	establish and implement a systematic approach to managing and delivering research and development that strengthens PHE's position in a competitive research landscape and supports the attraction, career development and retention of excellent public health scientists	Completed 	
46	achieve maximum use of the PHE estate by co-locating staff from Skipton House to Wellington House in London, West Dean to PHE Porton, and staff based in Sheffield into a single location	Completed 	
47	further embed our taxpayer value strategy to deliver more and better services for less, supported by our robust and enhanced financial governance framework	Completed 	

	Actions	Status	Performance summary
48	work alongside the Chartered Institute of Public Finance and Accountancy to launch a new model for demonstrating return on investment in upstream prevention	Partially completed 	Publish model/tool and develop new transparent financial reporting arrangements: the content for this has been agreed, and a launch date is expected by summer 2018.
49	embed our new Integrated Emergency Response Plan to further strengthen our effective response to public health incidents and outbreaks by a programme of cross-sector exercising and testing throughout the year	Completed 	

Our organisation

IANPHI peer review

A peer review of PHE by the International Association of National Public Health Institutes (IANPHI) concluded that "in less than five years PHE has, under strong and visionary leadership, transformed a geographically and functionally siloed group of 129 bodies into a strong, capable, co-ordinated, united and efficient public health agency that rivals any in the world".

IANPHI is a membership organisation of over 100 national public health institutes and agencies and were asked to assess progress in three key areas focusing on:

- leadership, strategy and delivery
- whether we are set up effectively and efficiently
- if we have the necessary impact and influence we need to fulfil our mission

The report highlighted our Ebola response, our immunisation, obesity and smoking cessation programmes and the value that local knowledge and intelligence services brings to those making decisions on the front line. Our commitment to working towards a healthier, fairer society struck a chord with the panel, though they highlighted concern that PHE does not have the lead role in determining the distribution of funding for public health work to local government.

Inviting an external body to give a frank assessment has provided us with both food for thought and reason to celebrate. As ever, there is more to do but so much to be proud of too.

Ipsos MORI survey

Our annual Ipsos MORI stakeholder research continues to be an important source of feedback on where we are performing well and areas we can improve. More information on the latest survey can be found in the Governance statement.

People directorate update

Since its creation in June 2017 the People Directorate has focused on how we deploy and develop our directorate resources to best combined effect in supporting PHE staff and managers. The improvement journey will carry on into 2018 with a focus on systems and processes for recruitment, HR query handling and advice, workforce planning and learning and development. We continue to strive to support the business in creating an environment that is a great place to work and where our staff can come to do their best work.

PHE continued with the annual strategy to encourage staff employed on 'legacy' terms and conditions to transfer voluntarily to PHE terms with over 240 further staff transferring from 1 April 2017.

Pay

PHE has also developed a number of targeted pay initiatives to address high staff turnover rates in the National Infection Service and Specialist Microbiology Division, and embarked on a strategic review of its pay arrangements. A new strategy will be developed during 2018/19.

Building a diverse and inclusive workforce that reflects the people we serve is one of our top priorities in PHE. This includes taking action to both narrow and close the gender pay gap, in an open and transparent way. The Department of Health and Social Care's 'Pay Gap' report published in December 2017 identified a gender pay gap of 16% in PHE and it is our absolute priority to take steps to rectify this. We have commissioned work to properly analyse the data, so we can understand the different reasons behind this and to guide appropriate action. The gap reflects the complex make-up of PHE, where women account for two-thirds of the workforce but there are also many more women than men working at lower paid grades. Additionally, there are a significant number of senior and specialist staff on pre PHE legacy terms and of course length of service will influence some salaries.

We recognise that career progression for some can also be affected by caring commitments that may result in a need to reduce working hours or leave paid work temporarily. This is why flexible working matters so much and we will review our family friendly policies to put the very best possible support in place for parents who are returning after paternity, maternity or adoption leave and others who have caring responsibilities.

PHE is morally and legally committed to equal pay for equal work and we will keep staff informed as we carry out this review.

People survey

Our annual people survey, also known as the staff engagement survey, gives us valuable insight into how people in PHE are thinking, feeling and responding to change. Just under 4,000 of our staff took part in 2017, delivering another improved response rate of 73%, ahead of the previous year's 70% and 1% ahead of Civil Service organisations of a similar size.

The results showed that we have made good progress across the board, with an improved engagement index of 59%, up from 56%. Interestingly, as we have just celebrated our fifth birthday, our greatest forward movement came in 'organisational objectives and purpose', reflecting increasing staff understanding of PHE's identity and their role in delivering PHE's success. Leading and managing change also improved on last year. We will strengthen our approach to supporting and training our staff and managers in areas where there is major change. We recognise that decency and kindness sit at the heart of every successful enterprise.

We have more targeted action this year in support of teams with lower levels of staff engagement. Similar to many other organisations, we are more overtly tackling inappropriate behaviour, including bullying and harassment. This is not about strategy or policy but about behaviour and how we are with each other, irrespective of profession or seniority. We aim to treat others as we would ourselves wish to be treated. We do remarkable work in PHE and both what we do and how we do it is important.

In recognition of our need to refresh our learning and development offer PHE published a learning and development strategy 'Building for the Future'. We have begun the process of developing PHE as a true 'learning organisation' by revising our staff appraisal process to focus on personal development and by ensuring clearer and easier access to learning and development opportunities for all our people. We also continue to make good progress with our improved dedicated digital platform 'Teams and Leadership', which we are encouraging every team across PHE to use, to help improve staff engagement.

Our 2017 staff survey had told us that PHE needed to do more to help them achieve a good work-life balance, so there was an increased focus on our approach to flexible working and this year PHE was recognised as one of the top 30 organisations across the UK for leading the way in building flexible, family friendly workplaces by Working Families. Employers large and small from many sectors compete annually to gain a place on the list and the award was presented at the start of their National Work-Life Week initiative that PHE took part in.

Review of occupational health and staff wellbeing services

An external review of PHE's Occupational Health and Staff Wellbeing service was carried out in 2017 by two eminent occupational health clinicians: Dr Steve Boorman CBE and Mandy Murphy.

The review identified a range of actions to make the service an upper quartile performer across all employers by 2019. A multidisciplinary programme board and clinical services subgroup have been making a series of recommendations to the Management Committee on a business plan and case for the future staff health and wellbeing service. Additional interim clinical staffing resources have been identified pending the final service plan.

A new enhanced occupational health service has also been put in place for the Public Health Rapid Support Team and PHE's Global Health Team.

Diverse and talented workforce

Diversity and inclusion

During 2017/18 we built upon our previous successful Diverse and Talented Workforce Programme. We placed a strong emphasis on developing and strengthening our range of diversity staff networks, each with an executive diversity champion, plus embedding our 'Pathways to Work' programme, offering employment opportunities for people from underserved communities.

Senior Civil Service (SCS)

As well as Civil Service targets to increase the number of new SCS staff with a black, Asian and minority ethnic heritage or with a disability, aspirational PHE diversity and inclusion targets in 2018/19 for our 425 senior managers will help management to focus on particular issues affecting their local teams, including:

- diverse shortlisting and recruitment panels
- the gender pay gap
- increasing staff diversity declarations
- addressing comparatively high levels of bullying and harassment and discrimination identified in the staff survey
- mentoring and work shadowing
- encouraging their teams to become involved in staff networks and other D and I initiatives to support their colleagues and communities

Staff networks

Further staff networks were developed during 2017/18, including:

- new younger and older people and Christian networks were set up, and our disability network was refreshed. These were all in addition to our existing staff networks: BAME; flexible working; gender balance; lesbian, gay, bisexual and transgender (LGBT); and Muslim
- a number of high-profile staff network events took place, with leading external inspirational speakers
- staff network leads meet monthly with PHE managers, diversity and inclusion experts, previous internal diversity and inclusion award winners, and staff side representatives to develop proposals for our diversity and inclusion work programme, including the development of our first transgender employment policy

Pathways to work

The following was achieved:

- the second cohort of our Project SEARCH students commenced their nine month programme at our Colindale campus in September 2017, providing work experience and educational support for young people with learning difficulties. This followed the graduation of ten Project SEARCH students in June 2017
- our Mosaic programme, offering work opportunities for adults with mental health conditions, continued in London
- we continued to offer work placements for young people aged 18 to 24 who are not in employment, education or training through the Movement to Work scheme
- we have developed plans to offer work opportunities and young people with autism in 2018/19

National recognition

During 2017/18, PHE received the following diversity and inclusion awards:

- top 30 employer for working families
- top 100 employers: business in the community race equality awards
- an increase of 67 places in stonewall workplace equality index to 115th
- two of our staff and two of our teams were recognised in the Civil Service LGBT Impact Index

In addition we received a Silver rating in the Mind Workplace Wellbeing Awards, and achieved a staff survey score of 79% for inclusion and fair treatment in the October 2017 Civil Service survey.

Our diversity and inclusion staff are also regularly asked to present at national conferences and workshops.

Data reporting

Our reporting included the following:

- providing PHE management with monthly reports on our staff diversity self-declaration rates. Future declaration campaigns are planned
- we participated voluntarily in the NHS England Workforce Race Equality Standard survey, comparing our BAME staff data with that of arms-length bodies of the DHSC and the average for NHS trusts, and a joint action group across the different organisations is planned
- we produced our first gender pay gap report with DHSC and MHRA, and an action plan to reduce the gap year on year is under development with the gender balance staff network, our executive diversity champion and People directorate

Staff development

The following were provided:

- sessions on unconscious bias and diversity confidence are part of all PHE corporate staff inductions
- a diversity and inclusion management development module is planned for 2018/19 to supplement e-learning
- a personal diversity and inclusion objective will appear in the performance objectives for over 400 senior staff across PHE in 2018/19

PHE Harlow: milestones and future actions

PHE has been granted planning permission to create a world-leading public health science campus and headquarters at Harlow in Essex. The plans were approved in December 2017 by Harlow District Council's development management committee and will see the creation of the second-largest base for applied public health science in the world.

This landmark decision is a major milestone that sets PHE on the road to an exciting future in what will be world-renowned facilities at the very forefront of global public health. It is also evidence of the government's commitment to public health and to PHE.

PHE will relocate facilities and staff from Porton in Wiltshire, Colindale in north London, as well as its central London headquarters to a single centre of excellence. It will be home to up to 2,750 people by 2024, with possible future expansion.

Building work is expected to start in 2019 with phased occupation starting in 2021.

Other significant milestones reached include:

- site purchased
- construction partners appointed
- network of university contacts expanded – now covering Cambridge, Essex, Hertfordshire and Anglia Ruskin
- the Infrastructure and Projects Authority's external review successfully completed

- communications and engagement plan development and approved with workstreams for PHE directors
- business change strategy developed and approved

Health and safety is our first and foremost priority at our scientific campuses and network of regional laboratories, and maintaining PHE Porton to modern day safety standards and investing in this until 2024 will be crucial.

National Infection Service's new structure

The National Infection Service (NIS) has been undergoing a redesign in order to ensure that, working with our colleagues across PHE, we are better placed to continue to provide excellent scientific advice to protect and improve the health of the public. From 10 April 2018, NIS has been operating it's new organisational structure. The new structure is based on a number of topic specific services and cross-cutting functions.

The new structure brings a number of benefits to help the NIS strengthen and develop our world-renowned expertise and leadership in protecting the public's health through communicable disease control locally, regionally, nationally and internationally. The new structure will achieve this through a better-integrated service and one that is fit for the future. This is the culmination of a vast amount of hard work and activity across 2017/18, and is an exciting time for the NIS. The redesign has been a collaborative effort with successful design work by and with our staff members supported by their colleagues across PHE.

Establishment of the Health Improvement Directorate

A new Health Improvement directorate has been created in PHE that brings together many functions previously carried out by the Health and Wellbeing and Chief Knowledge Officer's directorates.

This change took place following discussions around how best to organise the skills and expertise of staff across health and wellbeing, strategy and chief knowledge tri-directorate. These changes also built on our remit letter and business plan, and will help us respond to the changes underway in the NHS and local government. The changes came into effect on 1 June 2017.

The health Improvement directorate is now made up of the following teams:

- alcohol, drugs, tobacco and justice
- diet, obesity and physical activity
- health intelligence
- national disease registration
- programme and priorities
- behavioural science, research, translation and innovation
- screening programmes

Creating this directorate has meant closer alignment of PHE's surveillance, data, evidence and research capability with our policy advice expertise.

There were some areas where there were differing views about how their function and priorities should best be further developed, and a decision was taken to review some areas in more depth, including digital which is covered in more detail below.

Digital review

The PHE digital review, which was commissioned in May 2017 and published in November 2017, recommended that a relevant change expert should be recruited on an interim basis to drive and oversee this important work. A new Chief Digital and Technology Officer, to lead the strategic programme of digital, data and technology transformation, has been appointed and will ensure PHE delivers world class digital services.

The post holder is accountable to the Chief Executive and his role complements that of the Head of Digital and Head of ICT.

The digital review describes how a digitally enabled PHE could:

- better support the NHS prevention agenda
- provide digital products to support our partners in local government
- collaborate with the commercial sector to ensure we are at the leading edge of innovation in public health
- be a more effective organisation by introducing digital ways of working
- ensure that data, digital and ICT are being used in a joined-up fashion
- support the health and wellbeing of our staff through digital interventions

McNeil Review

One of the principle recommendations of the DHSC Tailored Review of PHE published in April 2017 was that health data should be collected, stored and managed to minimise costs, ensure data security and maximise benefits to patients and the public.

In response, PHE and NHS Digital invited Professor Keith McNeil, the Chief Clinical Information Officer for Health and Care, to carry out an independent review of the data collections PHE manages and recommend whether any of these might be better undertaken by NHS Digital. NHS Digital is the national data repository for the health and social care system in England. Its role is to improve health and care by enabling technology, data and information to work in the interests of patients, clinicians, commissioners, analysts and researchers.

Professor McNeil's review was published in November 2017 and sets out a process for PHE and NHS Digital to follow to decide which public health collections should move and when. Many of these collections are large and complex so the process of moving them is not straightforward. PHE, NHS Digital and the DHSC have also agreed that no collection should move if this is likely to affect the quality or timeliness of the data, or the way it is used by PHE and others to protect and improve public health.

Steady progress is being made to review PHE's data collections and agree which will benefit from moving to NHS Digital. A small number of collections have been identified to test the approach recommended by Professor McNeil. Although there is still a great more to do, PHE is committed to working closely with NHS Digital to ensure that the national public health data collections continue to be well managed in future.

Internal communications

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.

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.

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. 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 (HSSG) 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 Health and Safety Executive (HSE) as part of its 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 continue to have an annual meeting between staff side and the Management Committee on health and safety.

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.

PHE's Health Equity Unit launched Reducing Health Inequalities: System, Scale and Sustainability in August 2017. Published in response to demand from across the public health system, the guidance is an update of the Health Inequalities National Support Team (HINST) background document: Systematically Reducing Health Inequalities. This originated from the work done between 2006 and 2010 by HINST.

The revised publication was developed under the expert eye of Professor Chris Bentley, who led the original HINST. In turn, PHE was supported by a large stakeholder group of colleagues from across public health and local government. As a result the guidance provides broad scope for application, taking people through different levels of intervention on health inequalities. It explores risk, impact of interventions over time and across the life course, emphasising the importance of acting at scale to reach large sections of the population and have real effect. PHE centres and local knowledge and intelligence teams will be working together to deliver this guidance to develop locally focused webinars that will further support the local public health system.

Cardiovascular disease (CVD) is one of the conditions most strongly associated with health inequalities. The NHS Health Check is offered every five years to all eligible people aged 40 – 74 in England. PHE advocates, through guidance, a universal approach to NHS Health Checks that also allows local authorities to tailor the programme to the needs for their population. PHE supports approaches that prioritise invitations to those at greatest risk. Evaluations of the programme show that deprived communities are receiving either as many or more checks than communities that are not defined as deprived.

A second major driver of health inequalities is smoking. Reducing inequalities is central to The Tobacco Control Plan for England (2017), which prioritises support and action for: i) People in routine & manual occupations, ii) Smokers in the healthcare system, iii) Pregnant smokers, and iv) Smokers with mental health problems. The targeted media campaign for smoking cessation showed that 40% of people hearing about Stoptober made them think they should stop putting it off, and stop smoking now.

Throughout the year, we continued to embed a focus on promoting equality and diversity across our programmes. Our Health Equity Board, which meets biannually, provides governance on equality and diversity activity (as well as health inequalities work) both within PHE and in relation to leadership across the health and care system.

PHE's equality duty report for 2017 highlighted the major achievements of the organisation in promoting equality and diversity, such as the establishment of new staff diversity networks, as well as giving numerous examples of work within PHE that illustrate how we contribute to meeting our agreed equality objectives.

The new equality objectives for 2017 to 2020, focus on ensuring that equality considerations are built into processes, practices and ways of working and that they are implemented as fairly and transparently as possible and kept under continuous review. We intend to review progress against our objectives on a regular basis, revising them where necessary or updating actions required for effective implementation. Management fully support new objectives and are keen to see their delivery embedded within the delivery of our organisational priority areas. Progress on the new set of objectives will be reported annually through the PHE equality duty report.

Public access: Freedom of Information requests, public enquiries and complaints

We received 1,004 information access requests (2016/17: 743), most of which were handled under the Freedom of Information Act 2000, others being handled under the Environmental Information Regulations 2004 and Data Protection Act 1998.

We received 4,727 on-line enquiries from the public and stakeholders (2016/17: 4,184).

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 80 complaints were handled during the year (2016/17: 71).

Parliamentary questions

We responded to 723 parliamentary questions on a wide range of subjects (2016/17: 705). Topics that generated the most questions were diet, obesity and nutrition; chemicals, radiation and environmental hazards; and immunisation.

Financial review

Accounts direction

The financial statements contained within our fifth annual report and accounts relate to the financial year 1 April 2017 to 31 March 2018. 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 on pages 129 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 of PHE.

During the 2017/18 year, our financial performance was reported in three operating segments:

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

Our funding regime – budget analysis

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

Funding in 2017/18

For 2017/18, the funding provided by DHSC for our three operating segments was as follows:

- local authority grants: specific programme revenue within a limit of £3,091m (2016/17: £3,388m)*
- vaccines and countermeasures response (VCR): specific programme revenue within a limit of £431m, including the cost of disposals (2016/17: £484m)
- operating activities: non-specific administration and programme revenue within a limit of £382m (2016/17: £401m)

* In 2017/18 the local authority public health grant payments made by PHE did not include the amounts for the ten local authorities in Greater Manchester. These payments (of £213.4m) were made by the local authorities retaining the agreed sum from their business rates received. The total grant programme for 2017/18 was for £3,304m.

Financial performance against budget

In 2017/18, 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 2017/18 year was an underspend of £5.3m on a total operating budget of £3,909m. This compares with the 2016/17 underspend of £1.4m on an operating budget of £4,274m.

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

In the 2017/18 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 again able to absorb the costs of the Science Hub programme, which had, until 2016/17, been budgeted by DHSC separately from our main allocation.

Our financial out-turn was supported by operational income of £173.9m (2016/17: £163.5m) earned from trading activities, royalties and research funding.

VCR sales of £72.8m (2016/17: £72.7m) 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 DHSC. 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 against budgets

Net expenditure for 2017/18 totalled £3.903.6m (2016/17: £4,272.6m). 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)	2017/18			2016/17		
	Budget	Actual	Variance	Budget	Actual	Variance
External income:						
Operating activities	172.2	173.9	1.7	163.6	163.5	(0.1)
VCR	72.7	72.7	-	72.7	72.7	-
Total external income	**244.9**	**246.6**	**1.7**	**236.3**	**236.2**	**(0.1)**
Expenditure:						
Pay	305.8	298.6	7.2	312.5	301.9	10.6
Non-pay	253.5	257.1	(3.6)	253.1	262.2	(9.1)
Subtotal	**559.3**	**555.7**	**3.6**	**565.6**	**564.1**	**1.5**
Local Authority Grants	3,090.5	3,090.5	-	3,388.0	3,388.0	-
VCR	504.0	504.0	-	556.7	556.7	-
Total expenditure	**4,153.8**	**4,150.2**	**3.6**	**4,510.3**	**4,508.8**	**1.5**
Net expenditure	**3,908.9**	**3,903.6**	**5.3**	**4,274.0**	**4,272.6**	**1.4**

Prior year figures have been restated.
Certain numbers may not match exactly due to roundings.

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 and equipment and investment property and assets held for sale of £34.0m (2016/17: gain of £0.2m) and note 2 (segmental reporting).

Income against budget

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 2017/18, we generated total external income of £246.6m. This is broken down in the following table:

External income (£m)	2017/18			2016/17		
	Budget	Actual	Variance	Budget	Actual	Variance
NHS laboratory contracts	53.5	55.8	2.3	60.6	62.5	1.9
Research grants	22.7	20	-2.7	19.2	20.5	1.3
Commercial services	32.5	31	-1.5	32.9	29.2	(3.7)
Products and royalties/dividend	44.6	44.9	0.3	37.3	36.7	(0.6)
Other	18.9	22.2	3.3	13.6	14.6	1
Operating activities	**172.2**	**173.9**	**1.7**	**163.6**	**163.5**	**(0.1)**
VCR	72.7	72.7	-	72.7	72.7	-
Total external income	**244.9**	**246.6**	**1.7**	**236.3**	**236.2**	**(0.1)**

Prior year figures have been restated.
Certain numbers may not match exactly due to roundings

This note is presented using internal management report classifications, as opposed to the statutory reporting classifications used for note 5.

Local government public health grant

We provide a public health grant (£3,091m in 2017/18) to local authorities (except those in Greater Manchester which were funded directly from business rates retention) to support upper tier and unitary local authorities to fulfil their duties 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 to do so.

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 statistics recorded below.

In 2017/18, 88.5% and 81.5% of supplier bills (by value and volume respectively) were paid within 10 days and 95.5% and 91.2% within 30 days, as shown below. Interest payments of £3.8k were made to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998 (2016/17: £1.6k).

Payment period in days	0 to 5	6 to 10	11 to 30	Over 30	Total
Value of invoices (£000s)	772,536	31,683	44,839	27,518	876,576
Percentage	81.00%	7.50%	7.00%	4.50%	100.00%
Number of invoices	67,372	5,024	6,036	5,347	83,779
Percentage	75.00%	6.50%	8.70%	9.80%	100.00%

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

During 2017/18, we provided a range of support services to Porton Biopharma Ltd. These services formed part of an overall charge for 'overheads'. 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 and Social Care. 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 2017/18 (£10.5m) represented an agreed amount from the profits earned by PBL in 2016/17.

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 2018/19, 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 2017/18 was £194,000. This is a notional fee. The internal audit function has been provided by DHSC internal auditors (Health Group Internal Audit Service) 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 Public Health England's (PHE's) fifth year of reporting on sustainable development. We have introduced a number of carbon reduction targets for the owned estate to meet the government's greening government strategy. This report describes PHE's energy use, business travel, water consumption and total waste arising during the 2017/18 financial year. Our baseline year for carbon reporting, relative to the Greening Government Commitment (GGC) initiative and HMT reporting strategy, is 2013/14.

We have set a target to reduce our carbon emissions by 3% annually to March 2020, compared to our baseline year of 2013/14, which is in line with GGC requirements.

Preliminary analysis indicates that PHE's total reportable carbon emissions for 2017/18 are 16,495 tCO_2e, compared to 18,892 tCO_2e for 2016/17, and 20,693 tCO_2e for 2013/14 representing a reduction of 12.68% on the previous year, and a 20% reduction on our baseline year overall. At the time of writing, some data were not available, but a more comprehensive sustainability report will be produced in the autumn of 2018.

Over the current reporting period PHE's estate has been further consolidated in line with government targets, however, it should be noted that in June 2017 we purchased a site in Harlow which will become PHE's future science hub. The carbon data for this site will be reported separately from the main dataset this year, to better facilitate comparison with earlier years. There will be a period of construction in future years but once the site becomes operational its carbon data will be included in the overall carbon footprint for the organisation and a new baseline developed.

The carbon emissions data presented here comprise the Scope 1, 2 and 3 carbon emissions from our reportable and non-reportable sites, including emissions related to water usage and sewage. Non-reportable sites are those offices and or laboratories that are reported separately by the premises landlord. PHE generates some energy from renewable sources and these energy figures are subtracted from the reportable total as they are seen as a saving.

Over the year, there has been a decrease of 8.1% in business travel emissions compared to 2016/17. This was largely due to a reduction in the use of private vehicles for business over the last year and a reduction in domestic air travel.

We continue to engage staff through our mandatory e-learning training programme on sustainable development, which 1,270 members of staff completed last year. This bespoke training provides our staff with a good understanding of sustainable development in our organisation and encourages them to act in a sustainable manner by considering their impact on the environment.

We keep our staff informed of our carbon emissions through an interactive dashboard so they can access the quarterly sustainability data on business travel, utility (electricity, gas and water usage) total waste produced and training for their part of the business. This has been very effective in keeping our staff informed about our carbon emissions and the associated financial costs to the organisation.

We have initiated various capital projects on our owned estate to improve the efficiency of our energy usage, including the installation of over a hectare of photo voltaic panels at our Colindale, Chilton and Porton sites. An initial transformer fault caused difficulties on one site, but this has been rectified and the site is now benefitting from a significant carbon-free contribution to its energy usage.

Greenhouse gas emissions

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

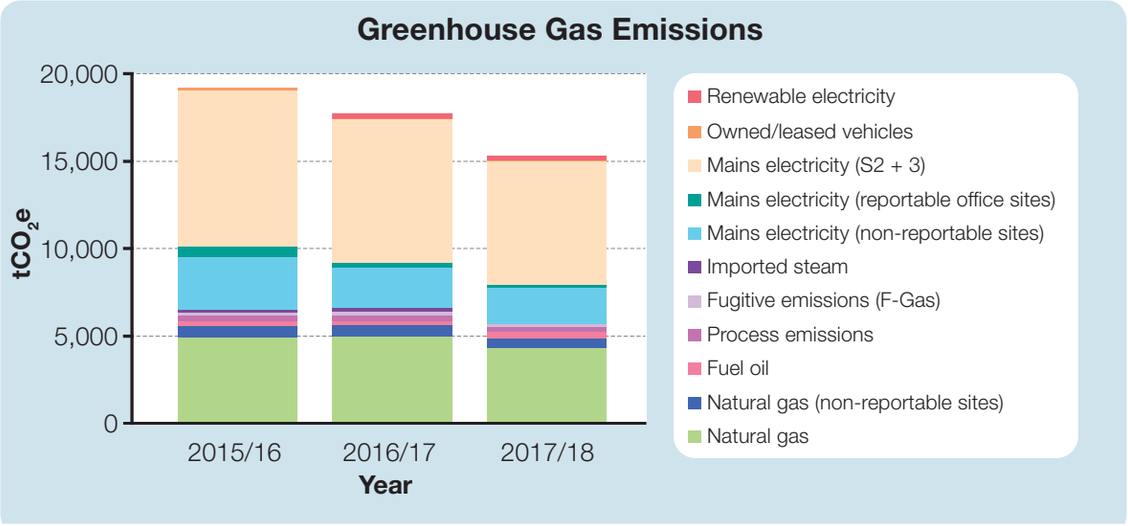
Greenhouse Gas Emissions		2015/16	2016/17	2017/18
SCOPE 1 + 2				
Non-Financial Indicators (tCO_2)				
	Natural Gas (Owned estate)	4,873	4,948	4,261
	Natural Gas (non-reportable sites)	658	623	597
	Fuel Oil	249	230	353
	Process emissions*	365	319	349
	Fugitive Emissions (F-Gas)	184	259	137
	Imported Steam***	150	135	-
	Mains Electricity (non-reportable sites)	3,096	2,426	2,125
	Mains Electricity (reportable sites other)	544	304	139
	Mains Electricity (Owned estate)	9,028	8,173	7,102
	Owned/Leased Vehicles	58	68	70
	Renewable Electricity**	-	307	231
Related Energy Consumption (kWh)				
	Natural Gas (Owned estate)	26,397,298	26,890,722	22,800,533
	Natural Gas (non-reportable sites)	3,565,456	3,384,729	3,239,745
	Fuel Oil	1,328,909	831,506	1,279,918
	Process emissions*	1,983,696	1,733,696	1,895,109
	Imported Steam***	812,223	736,233	-
	Electricity (non-reportable sites)	6,437,394	5,398,338	5,527,730
	Electricity (reportable sites other)	1,086,342	676,416	361,235
	Electricity (Owned estate)	18,043,598	18,190,192	18,473,225
	Renewable Electricity**	-	684,097	600,653
Related Consumption ($kgCO_2$)	Fugitive Emissions (F-Gas)	184,146	259,256	137,148
Related Scope 1 travel (km's)	Owned/Leased Vehicles	301,851	352,791	291,172
Financial Indicators (£)				
	Natural Gas	865,065	616,550	632,856
	Fuel Oil	63,309	48,380	69,797
	Owned/Lease Vehicles (Fuel/i-expenses)	21,076	17,130	21,802
	Fugitive Emissions (F-Gas)	58,407	58,320	36,775
	Imported Steam***	17,115	18,920	-
	Mains Electricity (reportable)	1,986,829	1,970,817	2,080,463
	Renewable Electricity	-	66,069	56,478
Total Gross Emissions Reportable Scope 1 + 2		**15,450**	**14,436**	**12,412**
Total Gross Emissions from Non-Reportable Sites Scope 1 + 2		**3,872**	**3,048**	**2,722**
Renewable Energy tCO_2 ****		**-**	**307**	**231**

* Process emissions from Porton's Waste Incinerator

** Renewable energy is derived from Porton, Chilton and Colindale PV farms

*** Imported steam is no longer used due to the closure of our laboratories in Bristol

**** Renewable energy is subtracted from total emissions, as it is a saving



PHE's Scope 1 and 2 emissions

Scope 1 and 2 emissions for PHE Harlow, are detailed below.

PHE Harlow greenhouse gas emissions	2017/18
Non-Financial Indicators (tCO_2)	
Natural Gas	102
Mains Electricity	1,308
Related Energy Consumption (kWh)	
Natural Gas	555,301
Mains Electricity	3,401,300
Financial Indicators (£)	
Natural Gas	117,952
Mains Electricity	368,081
Total Gross Emissions Reportable Scope 1 + 2	**1,410**

Water consumption

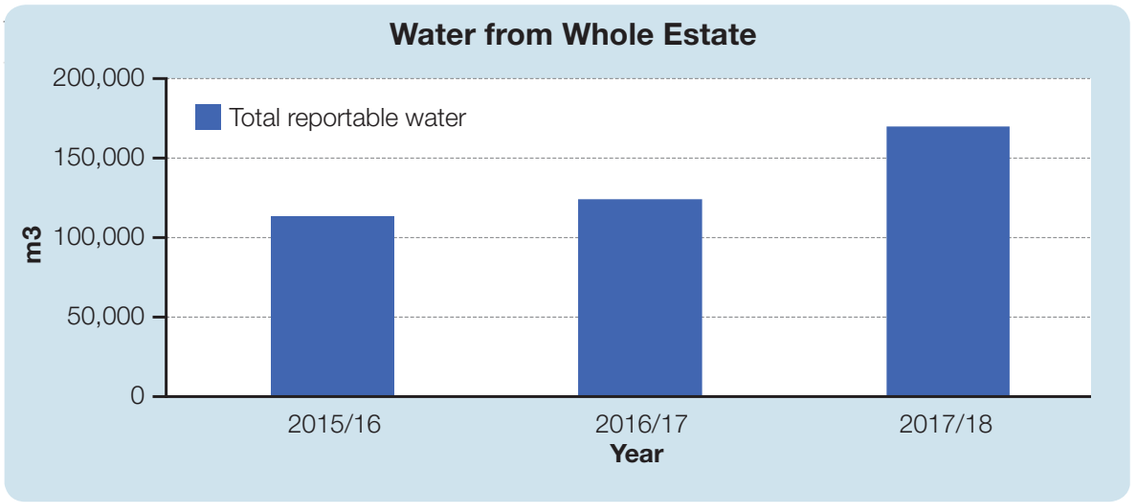
PHE has set a target to reduce its water consumption by 2% annually to 2020, in line with the greening government initiative. The reportable usage of water for the estate was 170,004 m^3, with a further estimated 21,253 m^3 being used by our non-reportable sites, though this is estimated in many places due to the lack of metering. Overall, this represents a significant rise in consumption of 37% from last year. This was due, in part, to a number of major leaks which were detected at two of our larger sites; these have now been repaired.

Water consumption at our owned larger sites at Colindale, Porton and Chilton, continues to be an ongoing challenge because their laboratories require large quantities of water.

SCOPE 3 (WATER)	2015/16	2016/17	2017/18
Non-Financial Indicators (m3)			
Water from Office Estate	538	262	216
Water from Whole Estate	113,780	123,942	169,788
Total reportable water	**114,319**	**124,204**	**170,004**
Water from Office Estate*	11,228	10,389	15,536
Water from Whole Estate*	21,910	7,089	5,987
Total non-reportable water	**33,138**	**17,478**	**21,523**
Financial Indicators (£)			
Water supply costs**	**107,244**	**132,738**	**199,079**

*Estimated usage
**Cost from our owned estate only

PHE's 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 try and reduce our water consumption.



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 campus sites 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 can use this information to develop strategies for reducing our water usage.

WATER (Harlow)		2017/18
Non-Financial Indicators (m3)	Water usage	5,483
Financial Indicators (£)	Water supply costs	2,800

Note: water data costs have been estimated.

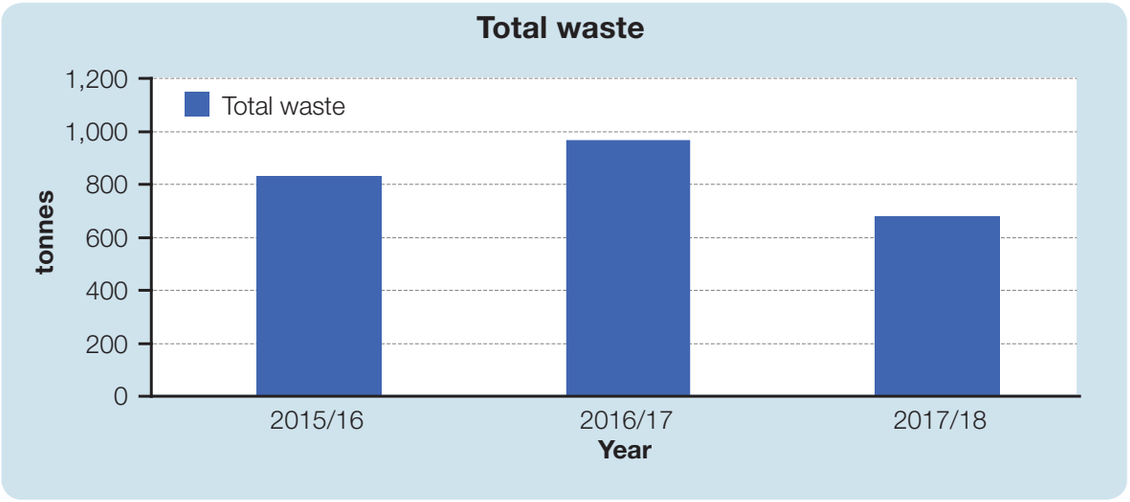
The main use of water at our new site in Harlow is for the flushing of the pipework to prevent legionella contamination. Construction on the site is due to start in the near future, when water supplies to existing buildings across the site will be isolated.

Waste

PHE has 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 19.7% decrease in total waste over the last year. PHE's total waste figure for 2017/18 was 682 tonnes, compared to the figure for our baseline year in 2013/14 of 895 tonnes.

Due to timing of waste contractor billing data, not all information is currently available and a more detailed analysis will be published in PHE's Annual Sustainability Report in the autumn of 2018.

SCOPE 3 (WASTE)	2015/16	2016/17	2017/18
Non-Financial Indicators (tonnes)			
Waste recycled externally (non-ICT equipment)	243	239	188
Waste reused externally (non-ICT equipment)	6	28	39
Waste recycled externally (ICT equipment)	7	12	3
Waste reused externally (ICT equipment)	6	5	7
Waste composted or sent to anaerobic digestion	31	43	27
Waste incinerated with energy recovery	178	226	188
Clinical waste incinerated without energy recovery	293	244	163
Total ICT waste	17	17	11
Total waste not to landfill	**764**	**797**	**615**
Total waste sent to landfill	41	43	30
Total hazardous landfill waste (incl. clinical waste)	31	10	36
TOTAL WASTE	**836**	**850**	**682**
Financial Indicators (£)			
Waste recycled externally (non-ICT equipment)	**60,104**	**57,671**	**49,209**
Waste reused externally (non-ICT equipment)	**350**	**-**	**-**
Waste recycled externally (ICT equipment)	**-**	**238**	**43**
Waste reused externally (ICT equipment)	**-**	**-**	**-**
Waste composted or sent to anaerobic digestion	**8,581**	**10,163**	**7,240**
Waste incinerated with energy recovery	**64,773**	**118,214**	**117,849**
Waste incinerated without energy recovery (Clinical waste)	**515,125**	**267,222**	**172,460**
TOTAL WASTE SENT TO LANDFILL	**15,162**	**13,747**	**10,124**
TOTAL LANDFILL WASTE DEEMED HAZARDOUS (INCL. CLINICAL WASTE)	**40,847**	**2,484**	**20,889**
TOTAL WASTE	**704,913**	**469,739**	**377,814**



WASTE (Harlow)		2017/18
Non-Financial Indicators (kgs)	Waste incinerated with energy recovery	**3,288**
Financial Indicators (£)	Waste costs	**406**

Note: waste data for the Harlow site have been estimated.

As shown above, waste at the Harlow site is disposed of via an incinerator with energy recovery. The site produced some 3.3 tonnes of general waste in the period in 2017/18 that we have owned it.

Waste sent to landfill from across our owned estate decreased by 13 tonnes over the year, helping us to move towards our goal of zero waste to landfill.

ICT waste is collected and disposed of as part of the government contract with Computer Disposals Limited (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 and this is supported by government policy. Approximately 10 tonnes of ICT waste have been processed in this manner in the last financial year.

We continue to pursue an aggressive 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 PHE sites are constantly reminded about their obligation to reduce their waste wherever possible, in line with PHE's waste policy and the associated management arrangements.

Business travel

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 business travel wherever possible and where our staff must travel, we encourage the use of the most sustainable modes of transport.

There has been an 8.1% decrease in overall business travel carbon emissions compared to the previous year. A number of factors have been identified which might account for this decrease, including our greater public health involvement in the regions and our continued involvement in supporting international health programmes.

We have managed to reduce our carbon impact from domestic flights by some 4.6% compared to last year. UK rail emissions were up by 2.2%, believed to be due to a reduction in business travel by personal car of 14.8% compared to last year.

Business travel over the last three years, is illustrated below. Emissions factors used to calculate carbon levels have changed since last year, so as it may appear that we have travelled more although our carbon emissions have in fact reduced.

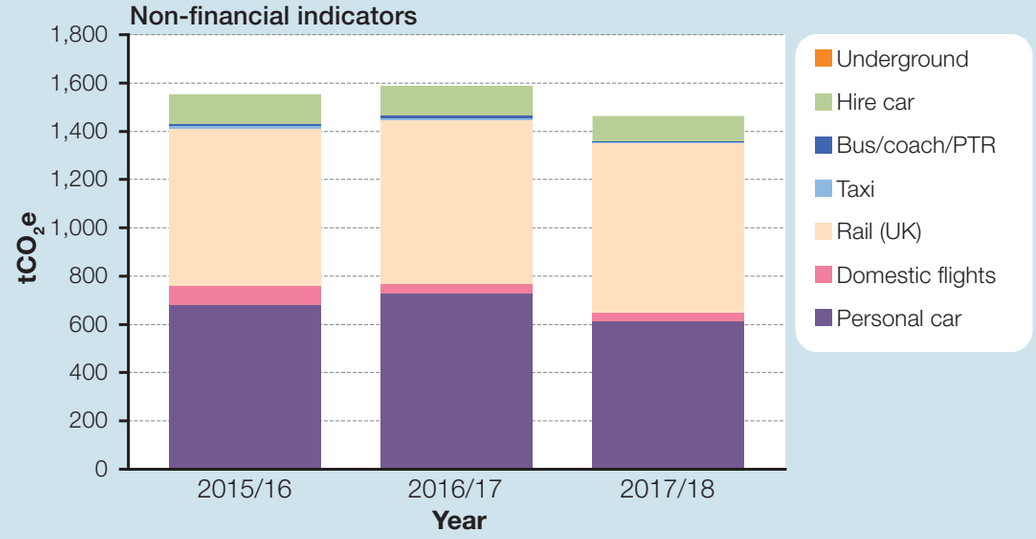
We have continued to reduce business travel to meetings and the roll-out of Microsoft Skype for Business across the whole organisation will further reduce the need to travel. This will not only improve local air quality (with the associated health co-benefits), but also support our plans to reduce carbon. 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.

Business Travel		2015/16	2016/17	2017/18
SCOPE 3				
Non-Financial Indicators (tCO_2)				
	Personal Car	678	727	619
	Domestic Flights	83	43	41
	Rail (UK)	653	677	692
	Taxi	8	7	6
	Bus/Coach/Public Transport Rate	7	8	5
	Hire Car	125	125	96
	Underground	0.88	0.88	1
	Total	**1,554**	**1,589**	**1,460**
Related Scope 3 travel (km)				
	Personal Car	3,637,801	3,890,555	3,921,112
	Domestic Flights	524,039	288,386	117,088
	Rail (UK)	14,460,906	13,867,076	14,785,302
	Taxi*	50,468	45,943	41,250
	Bus/Coach/Public Transport Rate	72,150	83,213	47,734
	Hire Car*	668,295	668,882	528,772
	Underground*	15,672	15,183	29,257
	Total	**19,429,331**	**18,859,238**	**19,470,514**
	Personal Car	1,028,793	1,101,425	925,888
	Domestic Flights	92,970	55,306	22,341
	Rail (UK)	3,882,894	3,692,035	4,089,704
	Taxi	112,143	102,096	91,666
	Bus/Coach/Public Transport Rate	33,986	32,608	25,260
	Hire Car	102,068	116,109	79,706
	Underground	71,237	69,012	62,110
	Total	**5,324,091**	**5,168,661**	**5,296,675**
	Short Haul International Average	1,991,556	1,693,778	600,551
	Long Haul International Average	6,210,706	4,588,151	1,660,820
	Rail - Eurostar	98,988	101,482	74,982
Other business related information				
	Domestic Flights undertaken	869	627	614
	Total Gross Emissions Scope 3	**1,554**	**1,589**	**1,460**
	Total Financial Cost Scope 3 Business Travel	**5,324,091**	**5,168,661**	**5,296,675**
	Total Other Financial Cost**	**875,565**	**485,165**	**256,151**

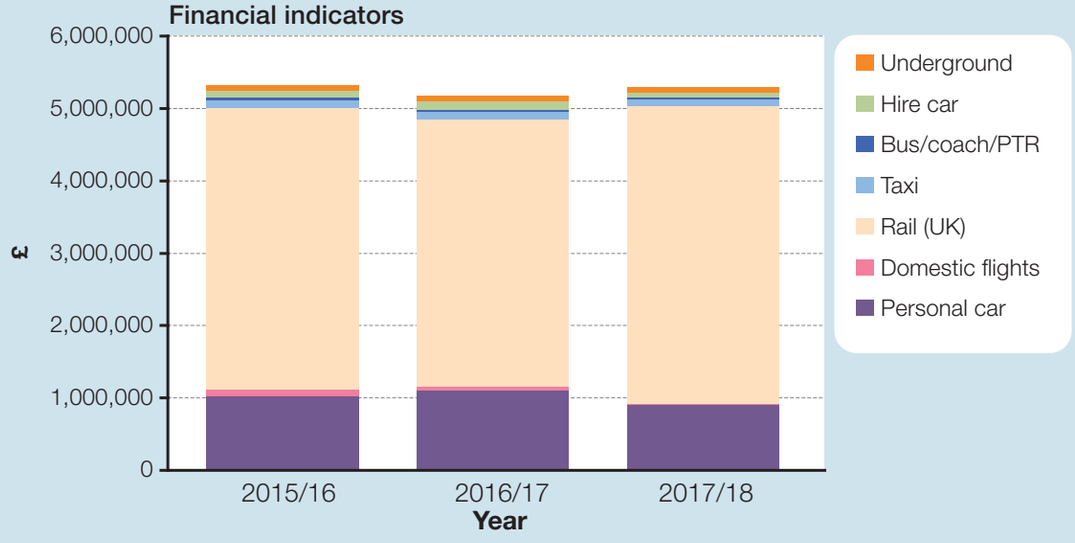
*Figures calculated using our own conversion table

Business Travel

Non-financial indicators



Financial indicators



Other activities

We continue to play an active role with the Sustainable Development Unit in the implementation of the NHS public health and social care sustainable development strategy. Work also continues on delivering health advice about a changing climate through our commitment to the National Adaptation Programme (NAP).

We have installed a further photo voltaic (PV) array this year at PHE's Chilton site. The benefit of this renewable energy source is helping to minimise our carbon footprint and reduce our energy bills.

Sustainable procurement

PHE continues to strengthen its commitment to its green procurement initiatives, by introducing new ways of procuring goods and services. We have also engaged stakeholders with regards our commitment to the Social Value Act and Modern Slavery Act via our Procurement Strategy Group.

Single-use plastics

We are working closely with colleagues from our procurement department and others to identify the level of single-use plastics that fall into scope for removal from our office estate waste streams, once identified we will be removing them wherever possible, this is in line with the government's ambition to remove all single-use plastics by 2020.

Climate change

PHE has contributed to the Climate Change Risk Assessment (CCRA) reports, as the health sector champion for the first CCRA in 2012. Through authorship, workshop attendance and the evidence review PHE also contributed to the second CCRA, published in 2016.

The formal report (CCRA 2017) was published by Defra in January 2017. PHE has also been working with colleagues from the Department of Health, NHS England and the Sustainable Development Unit on reporting on the progress of the current NAP The CCRA 2017 will inform the next NAP, which is due early 2018.

PHE Harlow

We have developed a robust strategy for sustainability, and the procurement of goods and services associated with the major construction project being undertaken at our new facility in Harlow.

We have written into our planning documentation that the specification and design of all construction projects shall take due account of the contribution the project can make towards the greening government commitment and that as a minimum all suppliers are to follow "Achieving Excellence in Construction Procurement Guide 11: Sustainability".

Procurement for this project will take account of the Government Buying Standard for Construction. As a minimum, this requires:

- any new procurement project (whether new build, refurbishment, purchased, leased or the procurement of a service, eg managed workspace) must fall into the upper quartile of energy performance for the building type, except where specific operational requirements prevent this
- all timber or timber products (including timber used solely during the construction process such as temporary fencing, hoardings or shuttering) are to be purchased in accordance with the government's timber procurement policy

Governance

Governance for sustainability is being overseen by our Sustainable Development and Climate Change Programme Board, details of which can be found in our Sustainable Development Management Plan (SDMP) published online. Responsibility for delivery of the SDMP, and realising the opportunities that it offers, lies with all of PHE's members of staff, from the most junior to the most senior.

Support and commitment to our SDMP aspirations, obligations and legal requirements by PHE's Management Committee also demonstrates true leadership to the organisation and others. Our ambition is to be an exemplar organisation for sustainability in the health sector.

Sustainable Development Goals

We have undertaken a corporate evaluation exercise utilising the SDU's Sustainable Development Assessment Tool (SDAT), in relation to the United Nations' Sustainable Development Goals (SDGs). This evaluation assessed the work PHE is undertaking to meet the SDGs 17 goals. Below are examples of some of the work being undertaken by our regional teams:

Goal 3	**Good health and wellbeing** • working with partners to implement health improvement programmes including promoting physical activity, health eating and weight management
Goal 5	**Promote gender equality in all policy areas**
Goal 6	**Clean water and sanitation** • provide advice to partner organisation on maintaining and improving the quality of water supplies, particularly private sources of water
Goal 8	**Decent work and Economic Growth/Goal 9 Industry, innovation and Infrastructure**
Goal 11	**Sustainable Cities and Communities** • working with local authorities and regional government to support inclusive growth agenda • providing comment and support on the development of regional planning and transport strategies • promoting the sustainable development agenda

Goal 10	**Reducing inequalities** • working with local authorities and the NHS to reduce health inequalities and ensure fair access to health care for all
Goal 12	**Responsible consumption and production** • raising awareness among PHE staff
Goal 13	**Climate action** • encouraging staff to use public transport and consider their carbon foot print
Goal 14 **Goal 15**	**Life below water** **Life on Land** • managing health protection incidents which involve water and land contamination to reduce environmental pollution and protect human and animal life • working with local authorities to provide advice and support in their actions to improve air quality

In line with the government strategy, PHE continues with the consolidation of its estate. This in turn, has led to a reduction in PHE's carbon footprint.

We continue to report our carbon emissions to the DHSC on a quarterly basis. Our interactive dashboard, which allows members of staff to access quarterly sustainability data for business travel, utility usage (electricity, gas and water), total waste produced and data on sustainability training, continues to be a success. This has been very effective in keeping staff informed about our carbon emissions and the associated financial cost to the organisation.

In order to facilitate a comparison of travel emissions across the various parts of the organisation, PHE uses the measure of tCO_2e per whole time equivalent (wte) staff. One of the key changes to our travel footprint compared with last year was a significant overall reduction in both domestic and international flights.

PHE has no properties within SSSI or AONB boundaries, although where we believe we may have an impact on the local biodiversity (for example, due to planned building works), biodiversity assessments are made to understand any impact on the local flora and fauna. We continue to compost waste at our larger establishments and have set up bee hives at our Colindale site. Bird boxes have also been put up at some of our sites, to attract birds to nest in our trees.

Duncan Selbie
Accounting Officer
3 July 2018

2 Accountability report

Directors' report

The directors' report disclosures are contained in the Governance Statement on pages 72 to 104 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 DHSC 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 and balanced.

Governance statement

Our governance structures have been developed and implemented in accordance with the requirements of the Framework Agreement with DHSC – renewed in February 2018 – 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 shall be free to publish and speak on those issues which relate to the nation's health and wellbeing in order to set out the professional, scientific and objective judgement of the evidence base."

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

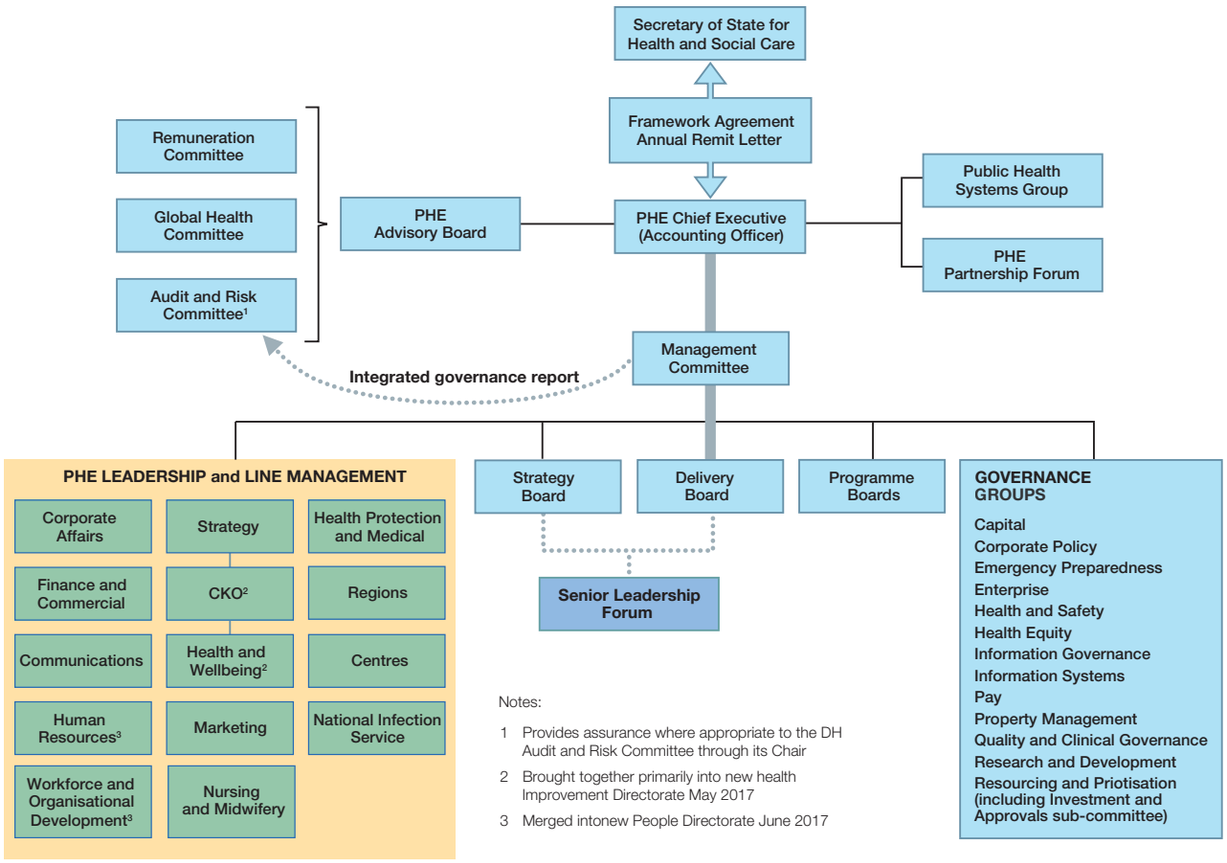
We undertake a range of evidence-based activities that span the full breadth of public health, working locally, nationally and globally, and are responsible for four critical functions:

- 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; 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 2017/18 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 DHSC 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 DHSC, accounting to Parliament and the public for PHE's financial performance and the delivery of its objectives
- accounting to the DHSC Permanent Secretary, who is the Principal Accounting Officer (PAO) for the whole of the DHSC's budget, providing a line of sight from DHSC to PHE
- 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 DHSC 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 DHSC Permanent Secretary undertakes my annual appraisal, taking account of feedback from the Chair.

The Chair is accountable to the Secretary of State for Health and Social Care through the DHSC 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 DHSC.

PHE Advisory Board

The Advisory Board comprises the Chair, up to five non-executive members appointed by the Secretary of State, three associate non-executive members, the Chief Executive, and four executive members. Its role is 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 DHSC 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 Interim Chair and I have agreed a statement on our respective responsibilities as part of the terms of reference, which are available at www.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:

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 term as an associate non- executive by the PHE Advisory Board until 31 March 2019.

Poppy Jaman, a founding member of the City Mental Health alliance, and Chief Executive of Mental Health First Aid England until 31 May 2018.

Term of office: 26 March 2014 to 31 May 2017, extended by the Secretary of State in January 2017 to 30 November 2017 and subsequently on 1 December 2017 for a further term of office until 31 March 2020.

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 CBE, 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 the Secretary of State in January 2017 to 30 November 2017 and subsequently on 1 December 2017 for a further term of office until 31 March 2020.

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 March 2019.

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 DHSC 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 DHSC Regional Director of Public Health in the South of England (2011-12), DHSC 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, DHSC 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. Since 2017, Michael has been a member of the Advisory Board and Chair of the Audit Committee of the National Infrastructure Commission. He is also a member of the Council of the Chartered Institute of Public Finance and Accountancy (CIPFA) and an independent Chair of the Audit Committee for the disability charity Scope.

In his capacity as interim Chair of the Audit and Risk Committee (ARC), Michael Hearty was appointed as a temporary associate non-executive adviser to the Advisory Board. As Sir Derek Myers is also a member of the ARC and reports to the Advisory Board on its business, Michael Hearty only attends Advisory Board meetings when required.

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 six occasions during the year. Each meeting considered either a key public health theme, to which external stakeholders made expert contributions or a core area of PHE's business and provided valuable insight into shaping our approach. The following topics were considered by the Advisory Board:

- sugar reduction and reformulation programme
- sexual health
- IANPHI peer to peer review report
- Ipsos MORI public opinion survey
- PHE's diversity and inclusion programme

The Advisory Board also established Board In Committee meetings. These internal sessions provide the Advisory Board with an overview to help them understand what progress means and looks like, with a focus on where the Board can add value in terms of applying influence in the wider health and social care system. The topics that had been considered in 2017/18 included:

- PHE's Cancer and Rare Diseases Registry
- health economics
- air quality
- global public health

The Advisory Board also received regular reports on PHE's financial performance from the Finance and Commercial Director, from a member of the Audit and Risk Committee and from the Global Health Committee.

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.

The Advisory Board will undertake 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, following the appointment of a new, permanent Chair.

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 member. Objectives for the Chair are set and assessed by the DHSC 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 31 March 2020. Recruitment of new non-executives will commence following the appointment of a permanent Chair.

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 Advisory Board minutes, along with any appropriate action taken to address them.

PHE Advisory Board attendance in 2017/18

Advisory Board	
Sir Derek Myers	6/6
Rosie Glazebrook*	1/1
George Griffin	4/6
Sian Griffiths	5/6
Poppy Jaman	6/6
Richard Parish	2/6
Duncan Selbie	4/6
Richard Gleave	6/6
Paul Cosford	3/6
Yvonne Doyle	6/6
Michael Brodie	4/6

* Rosie Glazebrook's term ended on 31 May 2017

Audit and Risk Committee (ARC)

As set out in last year's statement, in June 2017 the Advisory Board appointed Michael Hearty, a non-executive adviser to PHE, as the interim ARC Chair for the duration of Sir Derek Myers' tenure as interim Chair of the Advisory Board. Sir Derek chaired the June 2017 meeting of the ARC, with Michael chairing the meetings in September 2017, November 2017 and February 2018.

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 DHSC sponsorship team routinely attend ARC meetings. The Head of Governance also attends and acts as Secretary.

The ARC met on four occasions in the 2017/18 financial year. It approved this Governance statement at its June 2018 meeting. The interim Chair of the Advisory Board is also a member of the ARC and has, on behalf of the Chair of the ARC, reported key issues to the Advisory Board after each ARC meeting. The Chair of the ARC 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 2018 Advisory Board meeting. In addition, the minutes of the ARC meetings 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.

The Committee focuses regularly on a number of key governance and assurance areas including:

- strategic risk management, including scrutiny of PHE's strategic risk register; whether the organisation has robust policies and procedures in place for risk management; how well these are understood and followed by individual directorates; and, whether there is a strong risk management 'culture' in PHE (individual directorates are invited to each meeting to present how they manage risks and what their key risks are)
- monitoring and scrutiny of the Government Internal Audit Service's (GIAS's) internal audit programme, including how well PHE engages, agrees and supports the programme of audits; and, whether the actions and recommendations arising from audits are being met within agreed timescales. During 2017/18, the internal auditors undertook 19 reviews as part of the plan agreed with management and approved by the Audit and Risk Committee
- external audit through the reports received from the National Audit Office (NAO)
- scrutiny of a number of cross-organisational governance issues through an integrated governance report, including adverse incident reporting; health and safety incidents; information governance; clinical governance; and security and sustainability
- 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, losses and special payments
- increasingly, challenging the executive to focus on value for money across all our activities, which is being addressed through the implementation of a Taxpayer Value for Money Strategy
- 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

The Committee has taken a proactive role in scrutinising, challenging and supporting some of the organisation's most significant risks, tasks and challenges during 2017/18. Some of the more important pieces of work that came to the Committee in the year included:

- fraud assurance and the National Fraud Initiative – the Committee received an update on progress towards developing a comprehensive fraud risk register and counter fraud framework, and how the organisation links into PHE's broader Taxpayer Value Strategy and its emerging work on minimising Fraud, Error and Debt
- there was also a summary of PHE's participation in the National Fraud Initiative (NFI) for the 2016/17 year (the NFI is an integral counter-fraud tool to help prevent and detect fraud)
- in addition, PHE has now introduced mandatory training on fraud, bribery and theft for all staff, and introduced a fraud risk assessment framework and tool, with all directorates reporting their assessment each year
- cyber security – the Committee received an update in June 2017 on the development of a cyber security strategy for PHE, as well as a report on handling the ransomware attack that took place at that time. A further discussion on this subject took place in November 2017. PHE has made excellent progress in implementing its strategy and the Committee is assured that processes are robust. DHSC also praised PHE for the steps it has taken to protect itself. The Chair of the ARC is a member of DHSC's Data Security Assurance Board (DSAB), the core role of which is to offer constructive challenge and assurance to the data and cyber security programmes of DHSC, its agencies and its arm's-length bodies. As well as giving feedback at each ARC meeting, he has also initiated regular briefing meetings with PHE's cyber security lead before each DSAB meeting
- NAO PHE Procurement Review – NAO reviewed PHE's procurement processes in 2016 and provided PHE with recommendations to improve compliance. PHE reported on progress at the June 2017 and February 2018 meeting. Their latest report concluded that PHE had made good progress in meeting the recommendations made and had a good understanding of the challenges it faces in embedding good procurement practice across it's business. Quarterly Single Tender Action (STA) reports are provided to each meeting of the Committee
- PHE Harlow – an update on progress was provided at the Committee's November 2017 meeting. The Committee concluded that although good progress was being made across all parts of the programme, the scale of the programme and its funding dictated that careful scrutiny and management would be needed going forward. Further updates will come to the Committee during 2018
- General Data Protection Regulations (GDPR) and the McNeil Review of PHE's data collection and information management – both important issues were focused on at the November meeting and the ARC Chair has had individual meetings with officials to determine the risks and challenges
- EU exit – a report was received at the February 2018 meeting on the arrangements that PHE has in place to manage the impact of the UK's exit from the EU and the steps which are being taken to mitigate any risks
- whistleblowing – an oral report was provided to the February 2018 meeting on the revised Whistleblowing Policy which has a clear line of sight to the Committee
- health and safety compliance – there have been several discussions at Committee meetings on health and safety as part of the regular integrated governance report item. Further detailed discussions and scrutiny have taken place on specific health and safety incidents. The Committee has considered PHE's HSE Intervention Plan, and the Chair of the ARC will be attending the next PHE/Health and Safety Executive (HSE) Annual Meeting

PHE ARC attendance in 2017/18

ARC	
Sir Derek Myers *	3/4
Michael Hearty **	4/4
Martin Hindle *****	4/4
Duncan Selbie ***	3/4
Michael Brodie ****	4/4

* Chaired the June 2017 meeting of the ARC

** Chaired the September 2017, November 2017 and February 2018 meetings of the ARC

*** Attends ARC as Chief Executive and Accounting Officer

**** Attends ARC as Finance and Commercial Director

***** Martin Hindle is an independent member of the ARC and Science Hub Programme Board. He was appointed to this role on 1 June 2016. As such he attends meetings of the Advisory Board at the invitation of the Chair.

His term of office as a non-executive member to the Advisory Board was 1 June 2013 to 31 May 2016.

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 DHSC 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.

PHE Remuneration Committee attendance in 2017/18

Remuneration Committee	
Sir Derek Myers*	1/1
Martin Hindle	1/1
Richard Parish	1/1
Duncan Selbie	1/1

* Chair of 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.

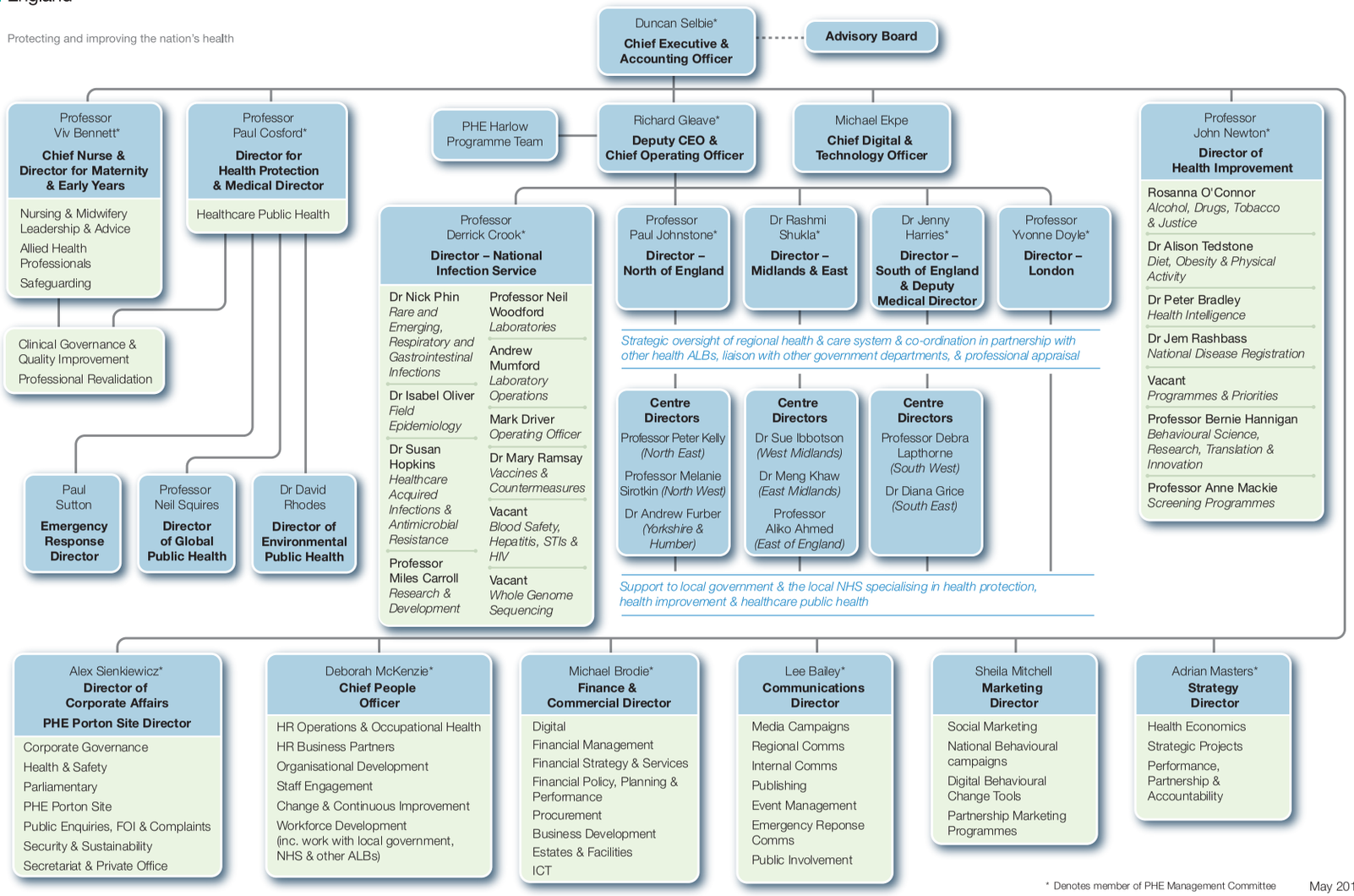
The responsibilities of the wider senior leadership team are set out in the diagram on the next page.

This meets quarterly and works closely with the Senior Leadership Forum 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

Leadership Organogram



* Denotes member of PHE Management Committee

May 2018

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 2017/18 was as follows:

Management Committee attendance in 2017/18

Management Committee	
Duncan Selbie – Chair (Chief Executive)	9/10
Richard Gleave (Deputy Chief Executive and Chief Operating Officer)	8/10
Michael Brodie (Finance and Commercial Director)	9/10
Paul Cosford (Director for Health Protection and Medical Director)	7/10
Adrian Masters (Director of Strategy)	9/10
Deb McKenzie (Chief People Officer)	7/10
Alex Sienkiewicz (Director of Corporate Affairs)	9/10
John Newton (Director of Health Improvement)	8/10
Derrick Crook (Director – National Infection Service)*	9/9
Viv Bennett (Chief Nurse and Director Maternity and Early Years)	8/10
Lee Bailey (Communications Director)	9/10
Rashmi Shukla (Director Midlands and East)	7/10
Paul Johnstone (Director North)	8/10
Yvonne Doyle (Director London)	8/10
Jenny Harries (Director South and Deputy Medical Director)	10/10

* Joined Management Committee 23 May

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 (DB) and the PHE scorecard

Chaired by the Deputy Chief Executive and Chief Operating Officer and reporting to the Management Committee, the DB 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 PHE's corporate scorecard that forms a core part of the quarterly accountability meetings with DHSC. 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 DB in detail and additional actions identified to improve performance where necessary. Outcomes from DB 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 DB 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 corporate scorecard, the DB has a systematic programme for "deep dives" on its 10 corporate programmes covering the organisations most important programmes of work (see section below on Programmes and project management), and a rotating review of delivery in the four regions and their constituent centres. Actions may be set by the DB when considering these presentations.

The Deputy Chief Executive, Director of Strategy and the Finance & Commercial Director also hold a series of directorate based meetings at two points in the year:

- "validation" meetings in February/March, focusing 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)
- "checkpoint" meetings in the autumn which focus on mid-year delivery progress, specifically on any red rated and other material items on the scorecard

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. 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

Programme and project management (PPM)

PHE has ten corporate programmes, each of which has a corporate programme board; clear aims, objectives and deliverables; and, membership and representation from across PHE to reflect the cross-cutting nature of these important pieces of work. A ‘One PHE’ approach is being promoted for all of PHE’s cross-cutting work.

The ten corporate programmes cover:

- PHE Harlow
- antimicrobial resistance (AMR)
- tuberculosis (TB)
- best start in life
- smoking/tobacco control
- Supporting the Five Year Forward View (5YFV) - delivering prevention at scale
- obesity
- supporting place
- cancer
- global public health

A new coprorate programme covering Sexual Health will commence in 2018/19.

These are all run to common disciplines and governance, with their management based on robust programme and project management methodologies.

This portfolio of programmes reports progress to the DB through regular deep-dive sessions. Where the DB identifies major issues of policy and strategy, it will recommend further discussion at the Strategy Board. We differentiate between these corporate programmes that require corporate involvement and scrutiny, and other programmes and projects that are more focused and can therefore be delegated for directorate level consideration and management.

During 2017/18, we have delivered the following actions to promote good programme and project management (PPM):

- established a central PHE Portfolio Management Office (PMO) to support portfolio management in directorates, divisions and teams, and to provide advice and support on all aspects of PPM development
- Introduced comprehensive and robust PPM policy and procedure documents and supporting tools and templates, and introduced an 'Introduction to Programme and Project Management' in-house training programme (with around 300 staff being trained in 2017/18)
- established a PHE PPM Community consisting of experts, champions and others with an interest across the organisation, and engaging with similar interests in DHSC and other health arm's-length bodies and agencies through a Knowledge Hub Project Delivery Profession site
- begun to use the PHE PPM Community to mobilise 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)
- brought together the PMO, the People Directorate and workforce development networks to consider how we develop our PPM capacity and capability, including how we make best use of the project management Government On-line Skills Tool (GOST)
- introduced 26 project management apprentices

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 Advisory 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 report later in this document)
- any case which we are required to submit to DHSC 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

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 DHSC and government-wide recruitment controls.

Performance

The DHSC Senior Departmental Sponsor chairs quarterly accountability and partnership meetings attended by me and other PHE and DHSC 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 DHSC reviews:

- our contribution against the DHSC'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 DHSC'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
- regular contact between DHSC's sponsor team and PHE.

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 DHSC Analytical Modelling Oversight Committee (AMOC) recommendations across the organisation.

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 Accounting Officer Appointment Letter to me from the DHSC 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 happening 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 2018 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 and Director for Maternity and Early Years, who jointly with the Director of Health Protection and Medical Director, has delegated responsibility for managing the strategic development and implementation of Sound Foundations PHE system for quality improvement and governance and 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 DHSC and Cabinet Office.

This approach was confirmed by the Management Committee through their approval of the PHE Assurance Strategy and Framework.

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 provides an independent perspective of the strategic processes for risk management, and provide constructive challenge to the Management Committee on its responsibility for risk, controls and associated assurance.

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 in place comprehensive risk management policies, procedures and guidance 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 aim 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 Emergency Response Plan. This describes the mechanisms by which we discharge the duties delegated by the Secretary of State for Health and Social Care 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.

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, 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 DHSC

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 incidents notified to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 and the action plans to prevent any recurrence. The HSE proposes and agrees with us an annual intervention plan each year, which is reviewed at an annual meeting at the end of each year.

We have developed and implemented a business continuity plan in order to be able to respond to any disruption to business and to recover time-critical functions where necessary. We have completed a self-assessment against the key areas of ISO 22301 Societal Security – Business Continuity Management Systems and has rated its arrangements as adequate. We declared an Enhanced Business Continuity Incident in January 2018 to manage the necessary action in response to two steam leaks at the PHE Porton site, more details on which are set out in the principal risks section below.

We work closely with the DHSC 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.

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 Strategic Risk Register (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 DHSC.

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.

Our annual Ipsos MORI stakeholder research continues to be an important source of feedback on where we are performing well and areas we can improve. We were encouraged by the findings, including that:

- PHE continues to be a well-respected organisation with a lot of goodwill held towards it. The research found that 57% of stakeholders would speak highly of PHE, a result that compares very favourably to other public sector organisations (3rd highest across organisations surveyed by Ipsos Mori over the last 10 years)
- stakeholders compliment a range of PHE services, in particular our health protection functions and contribution of intelligence and data to the sector, and talk positively about PHE's staff and senior leadership, acknowledging the high levels of expertise and passion held within the organisation
- a high proportion of stakeholders describe their working relationship as very good or fairly good (86%)
- the majority of stakeholders continue to feel that PHE understands the priorities of their organisation well or very well (62%)

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

- there are some constraints on PHE which stakeholders recognise as limiting PHE's potential impact, including capacity constraints and system constraints
- there are still calls for PHE to exert its influence at the highest strategic levels across government, though this year there is less critique of PHE not being seen 'at the top table'. Mixed views are held as to whether PHE has been impactful on Sustainability and Transformation Partnerships to date and some stakeholders continue to call for more visible involvement of PHE in this area
- there are calls from Local Authorities for more practical support from PHE in terms of "boots on the ground" resource provision, assistance in navigating and manipulating datasets and sharing best practice guidance

As part of our remit to build capacity and capability across the public health system, PHE worked with a range of partner organisations such as Health Education England on strengthening the workforce. We lead the national framework *Fit for the Future*, and have made some important developments this year including:

- commissioning an aspiring leadership programme (from Birmingham University) for those with ambitions to serve as directors of public health and continuing work with the Association of Directors of Public Health to support directors of public health
- developing 'Employer Standards for Public Health Teams', which was published by the Local Government Association
- developing proposal for a 'Public Health Practitioner' degree level apprenticeship which was accepted by the Institute of Apprenticeships
- working with the Faculty of Public Health and the UK Public Health Register on ways to make training more flexible, such as credentialing
- continuing to work on digitising the Public Health Skills and Knowledge Framework

Information governance

As the national expert agency for public health, PHE collects and uses large amounts of data and information. Some of this it collects itself, some comes from the NHS, and some is provided to it by organisations such as NHS Digital.

To do its job, PHE often needs to use personally identifiable data. An example is the work its laboratories do to identify infectious diseases and help provide individual care to patients. But for much of the work it does, PHE uses de-personalised and anonymous grouped data to help protect the patient confidentiality. For example, its national disease registers need to collect personally identifiable data in the first instance to link the right diagnosis and treatment information to the right patients' records.

But most of the ways PHE then takes this combined data to improve health, care and services through research and planning is based on the use of de-personalised or anonymous grouped data. And PHE never publishes any information that could be used to identify individuals.

Overall responsibility for the data and information used by PHE lies with the Chief Executive, who is provided with expert support by the Senior Information Risk Owner and the Data Protection Officer, both of whom are PHE directors. The Caldicott Guardian also serves as the 'conscience' of PHE and provides expert advice on the way personally identifiable data is used in the interests of patients.

All PHE staff are required to undertake training each year to ensure they understand how to protect the different types of data and information they use as part of their jobs. Staff who need to use personally identifiable and de-personalised data are also required to undertake extra data security training.

Strong security controls are in place to protect PHE's computer systems from external threats. PHE works closely with the National Cyber Security Centre, which is part of GCHQ, the government's intelligence and security organisation, and CareCERT, the computer emergency response team based in NHS Digital, to ensure it has access to the best advice on how to avoid computer security threats.

In terms of the sharing of data to help improve health, care and services through research and planning, this is carefully managed by specialist staff in its office for data release. This team is responsible for ensuring that personally identifiable data is only ever shared by PHE where the law allows. This team is also responsible for ensuring that only the minimum amount of data needed by other organisations and researchers is shared. All the personally identifiable and de-personalised data shared by PHE is listed in a register published on the gov.uk website. The wording used in this register has been changed recently to try and better describe the types of data shared with other organisations and researchers.

All of the process PHE has put in place to protect the data and information it uses and shares have helped it achieve Level 2 for the Information Governance Toolkit, the standard set by the DHSC and NHS Digital for organisations that use information from the NHS. For 2018/19, PHE will be completing the Data Security and Protection Toolkit, the replacement for the Information Governance Toolkit, which is based on the strengthened data security standards recommended by the National Data Guardian for health and social care.

Another change PHE is prepared for is the General Data Protection Regulation. The purpose of the GDPR is to update, strengthen and harmonise the ways in which personal data is protected. The main concepts and principles are the same as under Data Protection Act 1998 but the GDPR does include a number of new and strengthened requirements. PHE has appointed a Data Protection Officer – its Director of Corporate Affairs – to oversee its preparations. The steps it has taken were reviewed by the Government's Internal Audit Agency at the end of January 2018. The rating given to PHE was 'moderate' – the auditors noted the work PHE had done but, giving the timing of the audit, acknowledged that some of its planned actions had yet to be completed. For example, PHE is ensuring that all the contracts it has with suppliers of information services meet the requirements of the GDPR. This work is progressing well.

A further change that PHE has prepared to meet is the implementation of the new national data opt-out. This was recommended by the National Data Guardian and provides NHS patients with more say about how information about them is used to help plan services, improve the care provided, and undertake research into developing new treatments and preventing illness. The DHSC has agreed that the national data opt-out will not apply to data and information from the NHS that is used by PHE for the disease screening programmes it runs, its work to protect the nation from communicable diseases and other risks to public health, and its national disease registers. But PHE will be implementing these national data opt-outs to the personally identifiable data it shares with other organisations and researchers, where the government has decided they apply.

One incident involving personally identifiable data was reported by PHE to the Information Commissioner's Office in 2017/18. Doctors are required to report cases of infectious diseases such as tuberculosis to PHE. These reports contain the name, address, date of birth, ethnic group and NHS Number of patients as well as details about the infectious disease. In March 2018, seven notification reports were sent by a GP practice and a hospital in the East of England to an office that we had vacated in May 2016. The envelopes containing these reports were opened by the new occupants of the office. The ICO investigated the incident and decided that no further action would be taken. This was on the basis that we had taken care to inform GP practices and hospitals in the area of our change of address in advance of moving. We also reinstated the mail forwarding service that had been in place for a year-and-a-half after the move, and sent fresh reminders of our new address to all GP practices and hospitals in the area.

Principal risks facing PHE during 2017/18

Preparing for 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. The site has now been purchased and planning permission has been granted.

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 2017/18, we continued to progress 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 proposed this year.

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 was scrutinised further in autumn 2017 by the government’s Infrastructure and Project Authority.

PHE Porton

The main building at PHE Porton was built between 1948 and 1951, and its increased age has been one of the drivers for the planned move to Harlow. The highest containment laboratories will be the last to move, which is scheduled to be in 2025. In the meantime, we are wholeheartedly committed to maintaining this capability, ensuring that PHE Porton is at all times match fit and ready as a part of the UK’s critical infrastructure to protect the nation from the threat of infectious disease.

The age of the building has presented some challenges during the past year, particularly with respect to the steam pressure system, which services the scientific laboratories. In late December 2017, a small section of steam pipework failed, which was immediately isolated locally, with a smaller and separate leak from the floor underneath one of the laboratories a few weeks later which again was immediately isolated. Both instances were notified promptly to the Health and Safety Executive, with no issues with respect to microbiological containment.

The first instance also affected part of the electrical supply, and rapid remedial work has been taken to both the steam and electrical systems to the satisfaction of the HSE, which has been managed through an Enhanced Business Continuity Incident under PHE’s National Incident Emergency Response Plan, led by the Director of Corporate Affairs. Operational capability has been maintained 24/7 throughout at the same time as longer-term resilience measures have been put in place to ensure that planned and reactive maintenance can be undertaken but without affecting core services on the site, which includes Porton Biopharma Limited.

We recognise that further investment will be required over the coming years to maintain the site and, as part of this, the Director of Corporate Affairs has recently taken on an extended role as PHE Porton Site Director, with responsibility for providing a safe and secure facility from which our scientists carry out their work. The Porton Estates, Engineering and Facilities Team now reports to him and he will work in ongoing close partnership with National Infection Service colleagues.

The National Incident is expected to be stood down at the end of July, with a lessons learned exercise to be carried out under the NIERP to inform future PHE Business Continuity Incidents as well as the systemic improvements that can be applied across our scientific campuses and regional laboratory network.

Breast Cancer Screening Programme

On 2 May 2018, the Secretary of State informed the House of Commons of a serious failing in the national breast screening programme in England and a series of subsequent actions that would be taken by the health and care system, including PHE. The Secretary of State also announced an external review, the terms of reference for which were set out in his subsequent Written Ministerial Statement (WMS) of 4 June [https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-06-04/HCWS731/].

In that update, revised numbers were provided on the number of women who may have had their lives shortened as a result of missing their screening, which, at the time of the WMS, was estimated to be less than 75. PHE continues to work closely with the NHS, especially NHS England and NHS Digital, co-ordinating its internal activities through an Enhanced Incident under its National Incident Emergency Response Plan that was declared earlier this year, as well as through the Multi-Agency Oversight Group convened to oversee the wider response.

We are currently in the latter stages of our own internal review, led by Professor Paul Cosford, PHE's Director for Health Protection and Medical Director. We will co-operate fully and openly with the external review, which is due to report in November 2018, and will be providing the findings of Professor Cosford's review as part of this. A full disclosure will be made in next year's Governance Statement.

EU exit

Following the EU referendum in June 2016, PHE's strategy directorate undertook a rapid analysis of the potential impact of EU exit on PHE and on public health. Subsequently, PHE established a dedicated internal EU exit programme, overseen by its own steering group and reporting into PHE's Management Committee. It was agreed in February 2017 that PHE would lead on health protection and security, reflecting PHE's responsibility as a Category 1 responder under the Civil Contingencies Act 2004 to protect the UK population from any new emerging infection or developing radiation, chemical or environmental hazard. This work has been captured as part of a broader public health workstream within DHSC's EU exit programme. EU exit was subsequently included in PHE's 17/18 corporate scorecard with deliverables reported on through the Quarterly Accountability Review (QAR) meetings with DHSC and has been included in PHE's 18/19 Remit letter.

As part of the health protection and security workstream, PHE has been working with colleagues across government to develop the UK's preferred negotiating position on health

security, whilst simultaneously identifying and delivering contingency plans against a range of outcomes. These contingency plans ensure PHE is considering the impact of EU exit across a broad spectrum of functions, including:

- surveillance and early alerting (including for infectious diseases, chemicals and novel psychoactive drugs)
- emergency preparedness and response to all serious cross-border threats to health
- maintaining our training and capability, particularly in field epidemiology and public health microbiology
- ensuring the continuing supply of vaccines and countermeasures

PHE is also feeding its expertise into other EU exit work-streams where the lead sits elsewhere across government, including workstreams on tobacco, nutrition, food safety, research funding, and radiation. In addition, PHE also has several internal work-streams looking at the impact of EU exit on PHE as an organisation. This work has included PHE establishing its own peer-led EU exit staff network to support staff who may be affected by EU exit.

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.

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 DHSC 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 DHSC.

Local authority public health grant

Further to the update in last year's statement, we have continued to work closely with colleagues in DHSC and the Ministry of Housing, Communities & 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 business rate retention will come into effect in April 2020. We have engaged with Directors of Public Health as part of early preparatory work and will develop this further during 2018/19. We are also working with them and HM Treasury on how the future business rates retention funding model will work, including any redistribution. In the meantime, we continue with the existing assurance process that demonstrates how, as Accounting Officer, I can be assured of the regularity of spend by local authorities so that I can assert as part of our annual accounts that the funding has been used on the purposes intended by Parliament.

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.

As part of the Government Internal Audit Agency, the Head of Internal Audit's team is fully independent and remains free from interference in determining the scope of internal audits, in performing its work throughout the year, and in communicating results to management and the PHE ARC. The Head of Internal Audit has direct access to the Accounting Officer, and meets regularly with his senior team. The Head of Internal Audit has reported generally very strong engagement during the year with senior leaders and staff across PHE, and both the ARC and senior managers have worked hard to ensure that their work is taken seriously throughout the organisation. The Head of Internal Audit's view is that this speaks to a strengthening overall control environment and that this has served PHE well as it has responded during the year to several significant incidents, a number of which have been played out under intense media and public scrutiny.

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

- in the case of risk management, as he and his team completed our risk-based audits during the year, they have seen clear evidence that Public Health England 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. For example, PHE has responded positively in managing a number of high-risk and high-profile incidents during the year, including risks to national security, and is working to ensure that lessons learned from these incidents are applied to future operations. PHE also introduced a fraud risk assessment framework which has been successfully implemented throughout the organisation. He notes that PHE does not yet have a single, coherent assurance framework in place that the Accounting Officer can rely on at the year-end, and we would strongly recommend that such an assurance mapping exercise is completed in 2018/19

  Risk management arrangements could be further enhanced by:

  - within its business plans, PHE identifying the specific risks associated with the impact on delivering key priorities arising from a response to public health emergencies
  - formally approving a GDPR implementation risk appetite in the PHE risk register

- in the case of governance, PHE has a well-established governance structure which is operating consistently across the organisation. The Business Planning procedures have continued to improve, with good integration between strategic priorities, business planning and the performance scorecards. Leadership days, workshops and an evaluation review identifying improvements to the business planning process, have further strengthened the overall governance processes

  He notes that PHE's whistleblowing-related policies and procedures meet the NAO best practice criteria, providing clear guidance on roles and responsibilities, reporting lines and confidentiality arrangements

  Internal Audit's first review indicated that preparations for GDPR compliance were credible and proceeding as planned. PHE was confident that GDPR requirements would be met on time. However, as preparations were still at a comparatively early stage at the time of their review, a further audit is planned in quarter 1 of 2018/19

  There are established governance processes in place to oversee mandatory training and staff appraisals, and PHE is responding positively to the Tailored Review for Global Health, with structures having been set up to implement the recommendations

  Based on their recommendations during the year, further opportunities identified to enhance the effectiveness of the governance arrangements include:

  - greater communication between management and staff on the operation of whistleblowing procedures, and providing increased opportunities for training and enhancing the provision of 'speak out advisors'
  - maintaining the pace and progress of GDPR readiness, for example by both updating and improving the granularity of the Information Asset Register and introducing GDPR impact assessments

  - implementing PHE's approach to ensuring the use of consent, with all data processed on the grounds of consent to be identified
  - introducing a systematic mechanism for monitoring staff compliance with mandatory training in place of locally held records
  - introduction of governance arrangements for monitoring the 18 Global Health recommendations made in the Tailored Review

- in relation to control, he and his team's reviews during the year have indicated that PHE has a relatively strong system of internal control in place across the organisation, including in relation to its financial systems, and that overall control mechanisms are continually evolving. In a cross-cutting review, they found that Bank mandate fraud controls are adequately designed and are effective

Looking forward to 2018/19, PHE should consider the following:

a. Following multiple high-profile and high-intensity incidents during the year, we recommend that PHE considers both its capacity and resilience to deal simultaneously with emerging risks in the future, and to consider the impact on the delivery of business as usual activities
b. The effectiveness of all screening programmes/algorithms, especially where PHE has to rely on other organisations to maintain legacy systems
c. Following the "Wannacry" ransomware attack earlier in the year, a need to act consistently with the recommendations of the report prepared by the Chief Information Officer for the health and care sector, as far as these are relevant to PHE and the need to generally strengthen the response to other cyber threats
d. The need to maintain strong governance in respect of Brexit implementation, especially in terms of relations with the Department and other ALBs in the health family, as well as the wider public health and care system
e. A need to maintain the pace and progress of implementing new GDPR rules
f. In line with all other organisations in the health family, a need to maintain general financial controls, particularly in relation to staff expenses, the use of payment cards, and in cases where payments are made to third parties

The Head of Internal Audit reports that he has seen evidence of good and excellent practice across the three key areas of risk, governance and internal control during the year, and a further improvement in the overall control environment compared to the previous year. Their plan for 2018/19 is based on those areas where PHE has the greatest concerns, and where the internal audit team can add the greatest value and insight.

In conclusion, therefore, and taking each of these three areas into account, the Head of Internal Audit's overall opinion is that he can give **Moderate Assurance** to Public Health England's Accounting Officer, that PHE has had adequate and effective systems of risk management, governance and control in place during the 2017/18 reporting year.

Conclusion

We are committed to be a learning organisation and building this into our culture. The governance arrangements that we have put in place and developed since our establishment over five 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, implementing the recommendations peer review by a team comprising international counterparts from around the world that reported last autumn, the action plan for which was considered and endorsed by the PHE Advisory Board

I am able to report that there were no significant weaknesses in PHE's system of internal controls in 2017/18 and up to the date of this statement that affected the achievement of our key policies, aims and objectives.

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 2018. It has been approved by the Remuneration Committee of the PHE Advisory Board and is based upon the provisions contained within the Financial Reporting Manual 2017/18.

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'
- preparation of this report
- any case which we are required to submit to DHSC 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 2017/18 were:

- Tony Vickers-Byrne (Director of Human Resources, Chair) - up to 4 June 2017
- Deborah McKenzie (Chief People Officer, Chair) – from 5 June 2017
- Michael Brodie (Finance and Commercial Director)
- Richard Gleave (Deputy Chief Executive and Chief Operating Officer)
- Alex Sienkiewicz (Director of Corporate Affairs)

Appointment and appraisal of non-executive Advisory Board members

Non-executive Advisory Board members are appointed by the Secretary of State for Health and Social Care 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, DHSC agreed that this would be increased to three for the duration of the Interim Chair arrangement, and in January 2018, that associate members could be appointed for a further fourteen month term. 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 DHSC Director General for Global and Public Health.

Remuneration of non-executive Advisory Board members

The table below lists all non-executive members who served on the Advisory Board during the year ended 31 March 2018. The date of their appointment is accompanied by the total remuneration due to each individual during their tenure in post in 2017/18. 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:

- Michael Hearty became a temporary associate non-executive adviser to the Advisory Board during tenure as interim Chair of the ARC in June 2017. As Sir Derek Myers is also a member of the ARC and reports to the Advisory Board on its business, Michael Hearty only attends Advisory Board meetings when required
- the Secretary of State for Health and Social Care has extended the terms of office of Professor George Griffin and Poppy Jaman as non-executive members until 31 March 2020
- Rosie Glazebrook's term ended on 31 May 2017
- Martin Hindle is an independent member of the ARC and Science Hub Programme Board. He was appointed to this role on 1 June 2016. As such he attends meetings of the Advisory Board at the invitation of the Chair. His term of office as a non-executive member was 1 June 2013 to 31 May 2016
- Paul Lincoln was an associate non-executive member of the Board. His term concluded on 31 May 2016
- David Heymann's term as Chair of the Advisory Board was from 1 April 2013 to 31 March 2017

Advisory Board members' remuneration

Audited table

Total remuneration due to each individual during their tenure in post in 2017/18	Date of appointment	Total salary, fees and allowances	Total salary, fees and allowances
		Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Sir Derek Myers*	1 June 2013	35 - 40	10 - 15
Rosie Glazebrook ***	26 March 2014	0 - 5	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
Professor Richard Parish	1 June 2013	5 - 10	5 - 10
Michael Hearty**	1 July 2017	10 - 15	-

* The remuneration of Sir Derek Myers reflects his additional commitments as Interim Chair of the Advisory Board

** Michael Hearty has been incuded here for completeness to reflect his additional commitments as interim Chair of the ARC, and his appointment as a temporary associate non-executive adviser to the Advisory Board.

*** R Glazebrook left 31 May 2017

The remuneration of the executive members of the Advisory Board is set out in the audited table on page 109.

Appointment and appraisal of Management Committee members

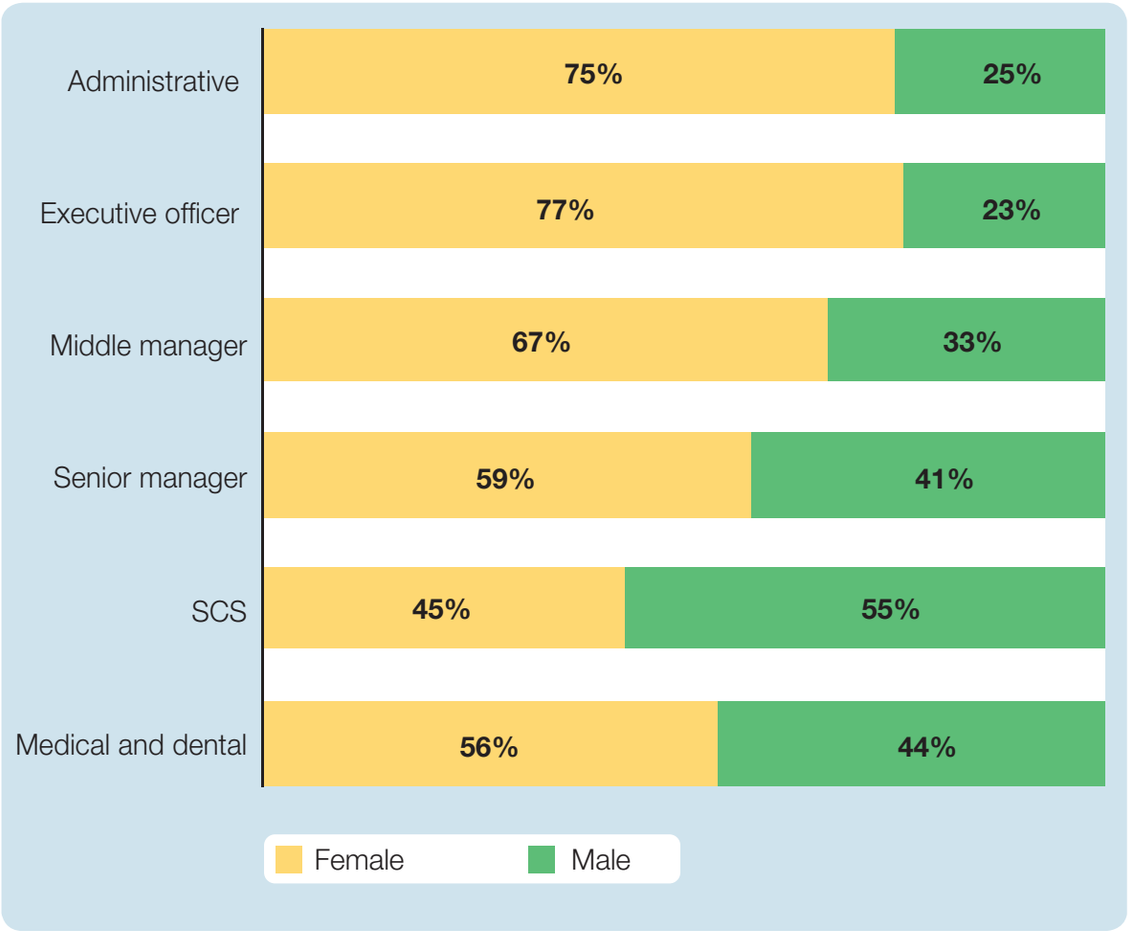
We follow the provisions of the Constitutional Reform and Governance Act 2010, which requires that Civil Service appointments are made on merit on the basis of fair and open competition. The recruitment principles published by the Civil Service Commission specify the circumstances when appointments may 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 DHSC and HM Treasury guidelines.

Performance was assessed against agreed objectives and a set of core management skills and leadership qualities. The Chief Executive's appraisal was conducted by the DHSC 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 following table shows the profile by grade and gender:

Unaudited table



Remuneration of Management Committee members 2017/18

Audited table

	Date commenced, reappointed or extended	Expiry date of current contract	Notice period	Total salary, fees and allowances Year ended 31 March 2018 Bands of £5,000	Bonus payments Bands of £5,000	Pension benefits to the nearest £1,000	Total remuneration Bands of £5,000
Duncan Selbie[9] (Chief Executive)	1 April 2013		6 months	185 - 190		0	185 - 190
Lee Bailey	26 Sept 2016		3 months	115 - 120		45,000	160 - 165
Viv Bennett	1 April 2013		3 months	85 - 90		35,000	120 - 125
Michael Brodie[7]	24 June 2013		3 months	140 - 145	10 - 15	56,000	205 - 210
Paul Cosford[1,6,7]	1 April 2013		3 months	185 - 190		122,000	305 - 310
Derrick Crook[4]	1 January 2015	31 Dec 2019	3 months	155 - 160		22,000	175 - 180
Yvonne Doyle[1,7,9]	1 April 2013		3 months	180 - 185		0	180 - 185
Richard Gleave[7]	1 April 2013		3 months	140 -145	10 - 15	32,000	180 - 185
Jenny Harries[8,9]	1 April 2013		3 months	130 - 135		0	130 - 135
Paul Johnstone[1]	1 April 2013		3 months	195 - 200		5,000	200 - 205
Adrian Masters[2]	1 July 2016	30 June 2020	3 months	160 - 165		55,000	215 - 220
Deborah McKenzie	1 April 2015		3 months	120 - 125		35,000	155 - 160
John Newton[1,3]	1 April 2013		3 months	165 - 170		18,000	185 - 190
Rashmi Shukla[1,5]	1 April 2013		3 months	180 - 185		16,000	195 - 200
Alex Sienkiewicz	1 April 2013		3 months	115 - 120	10 - 15	46,000	170 - 175

1. The remuneration of these members of the Management Committee included a Clinical Excellence Award.
2. Seconded from NHS Improvement from 1 July 2016, the legal body being Monitor.
3. Appointed as Director of Health Improvement from 1 April 2017.
4. Seconded from Oxford University Hospitals NHS Trust from 1 January 2015. Derek joined the Management Committee on 23 May 2017. FTE Salary, fees & Allowances = £155-£160.
5. Includes backdated pay award from 1 March 2016.
6. Includes backdated Clinical Excellence Award to 1 April 2016.
7. Indicates Advisory Board member since 1 February 2017.
8. Retired 29th March 2017 - Reappointed 1 April 2017 (reduced hours April and May) with Civil Service Commissioner approval.
9. Opted out of pension therefore no pension benefit in 2017/18.

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 Year ended 31 March 2018 Bands of £5,000	Bonus payments Bands of £5,000	Pension benefits to the nearest £1,000	Total remuneration Bands of £5,000
Duncan Selbie (Chief Executive)[11]	1 April 2013		6 months	185 - 190	10 - 15	24,000	220 - 225
Lee Bailey[6,8]	26 Sept 2016		3 months	55 - 60		23,000	80 - 85
Viv Bennett[1]	1 April 2013		3 months	75 - 80		31,000	105 - 110
Michael Brodie*	24 June 2013		3 months	140 - 145	10 - 15	56,000	205 - 210
Paul Cosford[2,9*,11]	1 April 2013		3 months	155 - 160		19,000	175 - 180
Yvonne Doyle[2,7*]	1 April 2013		3 months	180 - 185		0	180 - 185
Kevin Fenton[10]	1 April 2013		3 months	175 - 180		68,000	245 - 250
Richard Gleave*	1 April 2013		3 months	140 - 145	10 - 15	36,000	185 - 190
Jenny Harries[2,9,11]	1 April 2013		3 months	155-160		239,000	395 - 400
Paul Johnstone[2,8]	1 April 2013		3 months	175 - 180		26,000	205 - 210
Adrian Masters[4,6]	1 July 2016	30 June 2020	3 months	120 - 125		26,000	145 - 150
Deborah McKenzie[5]	1 April 2015		3 months	115 - 120		30,000	145 - 150
John Newton[2,9,11]	1 April 2013		3 months	165-170		32,000	200 - 205
Rashmi Shukla[2,11]	1 April 2013		3 months	165 - 170		31,000	195 - 200
Alex Sienkiewicz[3,11]	1 April 2013		3 months	115 - 120		45,000	160 - 165

1. 0.6FTE was seconded form the Department of Health until she transferred to the PHE Payroll on 1 April 2015.
2. The remuneration of these members of the Management Committee included a Clinical Excellence Award.
3. Previously seconded from Brighton and Sussex University Hospitals NHS Trust and transferred to a permanent post in PHE on 1 June 2015.
4. Seconded From NHS Improvement (Monitor) from 1 July 2016.
5. Previously seconded from NHS Central Southern Commissioning Support Unit and transferred to a permanent post in PHE on 1 April 2015, and seconded to the Cabinet Office on a part-time basis 0.6 FTE from 1 December 2016.
6. FTE salaries for starters and leavers during the financial year; Lee Bailey £115-120k, Adrian Masters £160-165k.
7. Opted out of pension 1 March 2016.
8. Pension benefit figures re-calculated by MyCSP for 2016/17.
9. Pension benefit re-stated to exclude employee contributions.
10. Kevin Fenton seconded to Southwark Council in April 2017 and therefore not shown as part of the PHE Management Committee in 2017/18 table.
11. Incorrect numbers shown in ARA 2016/17

* Indicates Advisory Board member since 1 February 2017

Remuneration of management committee members 2017/18

The table on page 109 lists all persons who served on the Management Committee in the year ended 31 March 2018. A summary of their employment contract is accompanied by the total remuneration due to each individual during their tenure in post in 2017/18.

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 2018.

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 and Social Care. 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 DHSC 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, DHSC 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 2017/18, five members of the Management Committee employed on SCS terms and conditions received a consolidated gross increase of between £550 and £1,000,

and in one case £7,500, which was to reflect a significant increase in responsibilities in a wider role. These payments were made in line with the national arrangements published by the Cabinet Office. There was a 1% consolidated increase for staff employed on medical and dental terms and conditions. No award was made to the one member of the Management Committee employed on ESM terms.

Payments to a third party for services of Management Committee members

The amount paid to NHS Improvement (Monitor) for the services of Adrian Masters was £270,422.68 and to Oxford University Hospitals NHS Trust for the services of Derrick Crook was £152,835.58.

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 2017/18 was 3.3% of the total SCS pay bill. The Remuneration Committee of the Advisory Board agreed that, based on performance in the 2016/17 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 SCS2 staff (the Finance and Commercial Director, the Deputy Chief Executive and Chief Operating Officer and the Director of Corporate Affairs) are disclosed elsewhere in this Remuneration and Staff Report. Ten SCS1 staff received a bonus, which was the same amount as for SCS2 staff disclosed above.

Benefits in kind

During the year ended 31 March 2018, no benefits in kind were made available to any non-executive Advisory Board member or any Management Committee member.

Pension entitlements

The Management Committee are members of the Civil Service or NHS pension schemes. Details of both pension schemes, including benefits payable, are included below. The pension entitlements of Management Committee members who were in post at 31 March 2018 are shown in the table on the following page.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially-assessed, capitalised value of the pension scheme benefits accrued by a scheme member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefit in another scheme or arrangement that the individual has transferred to the Civil Service or NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Pension entitlements of management committee members

Audited table

	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 2018	Lump sum at age 60 related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Cash Equivalent Transfer Value at 31 March 2018	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[1]	0.0-2.5	0.0-2.5	0.0-5.0	0.0-5.0	2,181	0	0
Lee Bailey[4]	2.5-5.0	0.0-2.5	5.0-10.0	0.0-5.0	63	91	18
Viv Bennett	0.0-2.5	0.0-2.5	10.0-15.0	0.0-5.0	152	189	25
Michael Brodie	2.5-5.0	0.0-2.5	15.0-20.0	0.0-5.0	134	174	24
Paul Cosford	5.0-7.5	17.5-20.0	60.0-65.0	185.0-190.0	1,088	1,260	136
Derek Crook[5,7]	0.0-2.5	5.0-7.5	65.0-70.0	200.0-205.0	0	0	0
Yvonne Doyle[2]	0.0-2.5	0.0-2.5	0.0-5.0	0.0-5.0	0	0	0
Richard Gleave	0.0-2.5	0.0-2.5	10.0-15.0	0.0-5.0	168	215	26
Jenny Harries[3]	0.0-2.5	0.0-2.5	0.0-5.0	0.0-5.0	1,064	0	0
Paul Johnstone[4]	0.0-2.5	0.0-2.5	95.0-100.0	0.0-5.0	1,786	1,907	4
Adrian Masters[6]	2.5-5.0	0.0-2.5	40.0-45.0	0.0-5.0	646	735	29
Deborah McKenzie	0.0-2.5	0.0-2.5	5.0-10.0	0.0-5.0	69	113	31
John Newton	0.0-2.5	5.0-7.5	60.0-65.0	190.0-195.0	1,380	1,473	57
Rashmi Shukla	0.0-2.5	0.0-2.5	70.0-75.0	0.0-5.0	1,263	1,364	14
Alex Sienkiewicz	2.5-5.0	0.0-2.5	5.0-10.0	0.0-5.0	42	67	15

1. Opted out of pension 1 January 2017
2. Opted out of pension 1 March 2016
3. Opted out of pension 29 March 2017
4. Pension figures recalculated by MyCSP for 2016/17
5. Pension figures reflect scheme membership with Oxford University Hospital Trust
6. Pension figures reflect scheme membership with NHS Improvement (Monitor)
7. Over NRA therefore no CETV

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 2017/18 was £195,000 to £200,000 (2016/17: £195,000 to £200,000). This was 5.3 times the median remuneration of the workforce (2016/17: 5.4), which was £37,810 (2016/17: £36,426).

In 2017/18, remuneration across our workforce ranged from £17,110 to £219,188 (2016/17: £16,523 to £223,965). One employee (two in 2016/17) 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 2017/18, employers' contributions were payable to the PCSPS at an average of 21.1% (2016/17: 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	4.60%	4.60%
£15,001 - £21,422	4.60%	4.60%
£21,423 - £51,005	5.45%	5.45%
£51,006 - £150,000	7.35%	7.35%
£150,000 and above	8.05%	8.05%

Further details about the Civil Service pension arrangements can be found at: www.civilservicepensionscheme.org.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 and Social Care. 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% (2016: 14.3%) of pensionable pay in all cases. The Department of Health announced in March 2017 that they will introduce a levy on employers to pay for the administration of the NHS Pension Scheme. This levy is 0.08 per cent of pensionable pay and will be collected at the same time and in the same way as normal employer contributions. In practical terms, this means employers will pay 14.38 per cent of pensionable pay.

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

	2017/18 Annual pensionable pay	2017/18 Employee contribution
Tier 1	Up to £15,431.99	5.00%
Tier 2	£15,432 - £21,477.99	5.60%
Tier 3	£21,478 - £26,823.99	7.10%
Tier 4	£26,824 - £47,845.99	9.30%
Tier 5	£47,846 - £70,630.99	12.50%
Tier 6	£70,631 - £111,376.99	13.50%
Tier 7	£111,377 and over	14.50%

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

The Government Financial Reporting Manual 2017/18 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

	2017/18	2016/17
	£'000	£'000
The PCSPS	33,231	32,660
The NHSPS	6,841	6,897
Total contributions	40,072	39,557

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 (audited)

During 2017/18, there was one (2017: four) early retirement from PHE on ill-health grounds; the total additional accrued pension liabilities on the year amounted to £184,526 (2017: £194,405).

Reporting of civil service and other compensation schemes – exit packages

Audited table

2017/18				2016/17		
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	22	1	23	18	-	18
£10,000-£25,000	11	-	11	36	-	36
£25,000-£50,000	5	-	5	35	-	35
£50,000-£100,000	5	-	5	54	-	54
£100,000-£150,000	2	-	2	5	-	5
£150,000-£200,000	1	-	1	3	-	3
£200,000	-	-	-	2	-	2
Total number of exit packages	46	1	47	153	-	153
Total resource cost (£000)	-	-	1,182	-	-	6,869

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 2018:

31 March 2018 data

Unaudited table

Bands	Totals
SCS1	50
SCS2	10
SCS3	1
Total	61

Average number of persons employed

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

Audited table

	2017/18			2016/17		
	Permanently employed staff	Others	Total	Permanently	Others	Total
Directly employed	4,926	-	4,926	5,003	-	5,003
Other	-	316	316	-	342	342
Staff engaged on capital projects	40	1	41	32	2	34
Total	4,966	317	5,283	5,035	344	5,379

Staff composition

The table below shows our staff composition by headcount as at 31 March 2018:

Unaudited table

	Male	Female	Total
Directors	11	6	17
Senior Civil Service	29	21	50
Other Staff	1,731	3,669	5,400
Total	1,771	3,696	5,467

Analysis of staff costs

Audited table

	2017/18 £000			2016/17 £000		
	Permanently employed staff	Other staff	Total £000	Permanently employed staff	Other £000	Total £000
Wages and salaries	220,162	17,702	237,864	218,200	19,262	237,462
Social security costs	24,221	-	24,221	23,932	-	23,932
Apprentioceship levy	1,126	-	1,126	-	-	-
Other pension costs	40,072	-	40,072	39,557	-	39,557
Subtotal	**285,581**	**17,702**	**303,283**	**281,689**	**19,262**	**300,951**
Redundancy & other dept. costs	1,182	-	1,182	6,869	-	6,869
Less recoveries in respect of outward secondments	(3,612)	-	(3,612)	(3,631)	-	(3,631)
Less recoveries in respect of capital projects	(2,259)	-	(2,529)	(2,302)	-	(2,302)
Total net costs	280,892	17,702	298,594	282,625	19,262	301,887

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 (Unaudited)

During 2017/18, the total number of whole time equivalent (WTE) days lost to sickness absence was 51,852 days, an average of 6.3 working days per staff WTE per year; and a sickness absence rate of 4.18% (2016/17: 51,662 days; average 6.4 working days per staff WTE per year; and 4.2% sickness absence rate. It should be noted that the percentage absence figure is higher than reported to the Cabinet Office (2.80%), which is based on absence in working days; the figure above is based on total absence in calendar days.

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:

The provision to management of objective advice relating to strategy, structure, management or operations of an organisation. Such advice will be provided outside the 'business-as-usual' environment when in-house skills are not available and will be time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not the delivery of) the implementation of solutions.[1]

Total PHE spend in 2017/18 was £41,107 (2016/17: £51,465) on one approved business case.

Off-payroll engagements

The following table shows all off-payroll engagements as of 31 March 2018, with a value of more than £220 per day and that last for longer than six months:

Unaudited table

	2017/18	2016/17
Number that have existed for less than one year at time of reporting	-	3
Number that have existed for between one and two years at time of reporting	-	-
Number that have existed for between two and three years at time of reporting	-	-
Number that have existed for between three and four years at time of reporting	-	-
Number that have existed for between four and five years at time of reporting	-	-
Total	-	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 2017 and 31 March 2018, with a value of for more than £220 per day and that last longer than six months.

Unaudited table

Off-payroll engagement	2017/18	2016/17
Number of new engagements, or those that reached six months in duration, between 1 April and 31 March	-	12
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
Number for whom assurance has been requested	-	12
Of which…		
Number for whom assurance has been received	-	10
Number for whom assurance has not been received	-	2
Number that have been terminated as a result of assurance not being received	-	1

There were no off-payroll engagements of Advisory Board members and/or senior staff, with significant financial responsibility, between 1 April 2017 and 31 March 2018 (2016/17: None).

Trade Union (Facility Time publication Requirements) Regulations 2017

The table below contains information on facility time taken by PHE trade union representatives

Unaudited table

Number of accredited representatives	25
WTE	23.22
Percentage of time spent on facility time – 0%	1 employee
Percentage of time spent on facility time – 1-50%	24 employees *
Percentage of time spent on facility time – 51-99%	0
Percentage of time spent on facility time – 100%	0
Total cost of facility time	£88,595
Total pay bill	£286,000,000
Percentage of total pay bill spent on facility time	0.03%
Paid trade union activities	0%

*This figure includes five employees who did not provide information and it has been estimated that they would fall into this category.

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 126-128.

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.

Smallpox vaccines

This is a continuing contingent liability in respect of the smallpox vaccines that we inherited from DHSC on our establishment in 2013. Its value at the time of PHE's creation was estimated at £40m and no further work has been done to reassess the estimate, given the remoteness of the liability. 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:

	2017/18				
	Income	**Full Cost**	**Surplus / (Deficit)**	**Details of financial objective**	**Details of performance against the financial objective**
	£000	£000	£000	£000	£000
Clinical microbiology	58,154	70,649	(12,495)	Charges for pathology tests, mostly to the NHS.	Met: broadly in line with internal targets
Supplies of cell cultures and related services	4,980	5,575	(595)	Supplies of cell cultures and related services	Met: broadly in line with internal targets
Vaccine evaluation and external quality assurance schemes	8,144	7,573	571	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual property management	40,932	-	40,932	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Commercial radiation services	10,989	9,853	1,136	Charges for various radiation services	Met: broadly in line with internal targets
Total	123,199	93,650	29,549	-	-
Income that is not subject to fees and charges disclosure	123,425	-	-	-	-
Total income (note 5)	246,624	-	-	-	-

	Restated 2016/17				
	Income	**Full Cost**	**Surplus / (Deficit)**	**Details of financial objective**	**Details of performance against the financial objective**
	£000	£000	£000	£000	£000
Clinical microbiology	55,917	68,927	(13,010)	Charges for pathology tests, mostly to the NHS.	Met: broadly in line with internal targets
Supplies of cell cultures and related services	5,134	5,323	(189)	Supplies of cell cultures and related services	Met: broadly in line with internal targets
Vaccine evaluation and external quality assurance schemes	7,260	8,612	(1,352)	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual property management	33,535	-	33,535	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Commercial radiation services	10,907	9,779	1,128	Charges for various radiation services	Met: broadly in line with internal targets
Total	112,753	92,641	20,112	-	-
Income that is not subject to fees and charges disclosure	123,475	-	-	-	-
Total income (note 5)	236,228	-	-	-	-

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.

Comparatives figures have been restated to reflect PHE's new methodology for this note.

Losses and special payments

Losses statement – audited

	2017/18		2016/17	
	Number	£000	Number	£000
Monetary losses	1	1	1	-
Loss of accountable stores	4	6	1	12
Fruitless payment	8	14	5	101
Constructive loss	35	39,722	14	37,652
Claims waived or abandoned	7	91	3	20
Total	55	39,834	24	37,785

Details of cases over £300,000

Constructive losses

PHE wrote off £39,446,000 (2017: £37,462,000) 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

	2017/18		2016/17	
	Number	£000	Number	£000
Compensation	3	58	6	5
Ex gratia	2	11	3	37
Total	5	69	9	42

Details of cases over £300,000

Nil.

Duncan Selbie
Accounting Officer
3 July 2018

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

Opinion on financial statements

I certify that I have audited the financial statements of Public Health England for the year ended 31 March 2018 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, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.
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 2018 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder

Opinion on regularity

In my opinion, in all material respects the income and expenditure 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.

Basis of opinion

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent of Public Health England in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Government Resources and Accounts Act 2000.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK), I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Public Health England's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management
- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on Public Health England's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

I am required to obtain evidence sufficient to give reasonable assurance that 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.

Other Information

The Accounting Officer is responsible for the other information. The other information comprises information included in the Performance Report and Accountability Report, other than the parts of the Accountability Report described in that report as having been

audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with HM Treasury directions made under the Government Resources and Accounts Act 2000
- in the light of the knowledge and understanding of the entity and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report and Accountability Report; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and have been prepared in accordance with the applicable legal requirements

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

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse
Comptroller and Auditor General
6 July 2018

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

3 Accounts

Statement of comprehensive net expenditure

For the period ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Income from sale of goods and services	5	(192,998)	(186,464)
Other operating income	5	(42,769)	(43,510)
Total operating income		**(235,767)**	**(229,974)**
Staff costs	3	298,594	301,887
Purchase of goods and services	4	682,468	701,869
Other operating expenditure	4	3,131,461	3,469,391
Depreciation and impairment charges	4	35,429	32,787
Provision expense	4	2,329	2,940
Total operating expenditure		**4,150,281**	**4,508,874**
Net operating expenditure		**3,914,514**	**4,278,900**
Finance income	5	(10,857)	(6,254)
Net expenditure for the year		**3,903,657**	**4,272,646**
Other comprehensive net expenditure			
Items which will not be reclassified to net operating costs:			
Net (gain) on revaluation of property, plant and equipment and investment property and assets held for sale	6/8/9	(34,015)	(151)
Comprehensive net expenditure for the year		**3,869,642**	**4,272,495**

The notes on pages 133 to 160 form part of these accounts.

Statement of financial position

For the period ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Non current assets:			
Property, plant and equipment	6	894,797	843,258
Intangible assets	7	16,135	16,451
Investment property	8	16,041	9,353
Financial assets	13	65,765	56,568
Other non-current assets	13	72	72
Total non current assets		**992,810**	**925,702**
Current assets:			
Assets Held for Sale	9	1,300	-
Trade and other receivables	13	62,768	67,802
Inventories	12	161,348	144,843
Cash and cash equivalents	14	103,858	92,970
Total current assets		**329,274**	**305,615**
Total assets		**1,322,084**	**1,231,317**
Current liabilities			
Trade payables and other current liabilities	15	(137,029)	(135,103)
Provisions	16	(17,845)	(15,843)
Total current liabilities		**(154,874)**	**(150,946)**
Non current assets plus net current assets		**1,167,210**	**1,080,371**
Non current liabilities			
Provisions	16	(1,979)	(1,826)
Total non current liabilities		**(1,979)**	**(1,826)**
Assets less liabilities		**1,165,231**	**1,078,545**
Taxpayer's equity			
General fund		1,094,218	1,040,207
Revaluation reserve		71,013	38,338
Total taxpayer's equity		**1,165,231**	**1,078,545**

The notes on pages 133 to 160 form part of these accounts. The financial statements on pages 129 to 160 were signed by:

Duncan Selbie
Accounting Officer
3 July 2018

Statement of cash flows

For the period ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Net operating expenditure		(3,914,514)	(4,278,900)
Adjustments for non cash transactions			
Auditor remuneration	4	194	194
Loss on de-recognition of property, plant and equipment and intangible assets	4/7	38,481	69,722
Stockpiled goods transferred to inventory and reclassified	6	951	55,886
Amortisation and depreciation	4/6/7	31,537	32,539
Provision for impairments	4	798	248
Revaluation of inventories	12	(9)	-
Impairments	4/11	3,094	-
(Increase) / decrease in trade and other receivables		4,236	35,228
(Increase) / decrease in inventories		(16,505)	34,436
Increase / (decrease) in trade payables		1,926	(26,445)
Provisions utilised in the year	16	(174)	(717)
(Increase) / decrease in provisions	16	2,329	2,940
Net cash outflow from operating activities		**(3,847,656)**	**(4,074,869)**
Cash flows from investing activities			
Purchase of property, plant and equipment	6	(94,646)	(144,374)
Purchase of intangible assets	7	(4,613)	(3,249)
Total finance income	5	10,857	6,254
(Increase) in investment in Porton Biopharma Ltd		(9,197)	(26,384)
Decrease in other non-current assets	13	-	20
Net cash outflow from investing activities		**(97,599)**	**(167,733)**
Cash flows from financing activities			
Net parliamentary funding		3,956,143	4,252,996
Net cash inflow from financing activities		**3,956,143**	**4,252,996**
Net increase in cash and cash equivalents in the period		10,888	10,394
Cash and cash equivalents at the beginning of the period	14	92,970	82,576
Cash and cash equivalents at the end of the period	14	103,858	92,970

The notes on pages 133 to 160 form part of these accounts.

Statement of changes in taxpayers' equity

For the period ended 31 March 2018

	Note	General fund	Revaluation reserve	Total
		£000	£000	£000
Balance at 1 April 2017		1,040,207	38,338	1,078,545
Net parliamentary funding		3,956,143	-	3,956,143
Non-cash charges: auditor remuneration		194	-	194
Net gain on revaluation of property, plant and equipment, investment property and assets held for sale	6/8/9	-	34,015	34,015
Revaluation of inventory	12	-	(9)	(9)
Transfers between reserves		1,331	(1,331)	-
Net expenditure for the year		(3,903,657)	-	(3,903,657)
Balance at 31 March 2018		**1,094,218**	**71,013**	**1,165,231**

	Note	General fund	Revaluation reserve	Total
		£000	£000	£000
Balance at 1 April 2016		1,054,693	43,157	1,097,850
Net parliamentary funding		4,252,996	-	4,252,996
Non-cash charges: auditor remuneration		194	-	194
Net gain on revaluation of property, plant and equipment, investment property and assets held for sale		-	151	151
Release of revaluation reserves in respect of de-recognised assets		-	-	-
Revaluation of inventory		-	-	-
Transfers between reserves		4,970	(4,970)	-
Net expenditure for the year		(4,272,646)	-	(4,272,646)
Balance at 31 March 2017		**1,040,207**	**38,338**	**1,078,545**

The notes on pages 133 to 160 form part of these accounts.

Notes to the financial statements

1. Statement of accounting policies

1.1 Statement of accounting policies

Public Health England (PHE) is required, in accordance with Treasury directions made under the Government Resources and Accounts Act 2000, to prepare financial statements that present a true and fair view of its results for the year.

The financial statements have been prepared in accordance with the Government Financial Reporting Manual (FReM) 2017/18 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 vaccine and countermeasures response 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, investment property and assets held for sale and stockpiled goods.

1.4 Going concern

By virtue of the Health and Social Care Act 2012, PHE exists as an executive agency established within the Department of Health and Social Care (DHSC) 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 DHSC.

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

Income comprises fees and charges for goods and services (as detailed in note 5) 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.

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 DHSC 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. All assets held for their service potential are carried at current value in existing use. 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 2018.

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. 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 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 (see note 1.9).

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.

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 2017/18.

IFRS 9 Financial Instruments

IIFRS 9 becomes effective for accounting periods commencing on or after 1 January 2018. IFRS 9 introduces changes to the classification and measurement of financial instruments. Within the scope of IFRS 9, PHE holds investments and loans of £65,765,000, as well as trade receivables and other financial assets of £54,222,000, trade payables and other financial liabilities of £127,522,000 and cash of £103,858,000. PHE does not have complex financial instruments, and has identified no significant classification issues. PHE intends to make the irrevocable election to measure the investment and loan at fair value through other comprehensive income. This means changes in fair value will not pass through income and expenditure. Whilst entailing the same valuation basis as under IAS 39, the election under IFRS 9 restricts even further the scenarios in which changes to fair value impact on income and expenditure.

The impact of implementing IFRS 9 is not expected to be material for PHE.

IFRS 15 Revenue for Contracts with Customers

IFRS 15 is due to be implemented from 1 April 2018 and we have performed a preliminary assessment of the impact. The material elements of revenue are shown in note 5, with these elements being earned “over time” or at a “point in time”. Our expectation is that there will be no change in the timing of the recognition of this income. The impact of implementation has been assessed to be immaterial but any changes will be recognised through reserves as the option to restate under IAS8 has been withdrawn.

IFRS 16 Leases

IFRS 16 becomes effective for accounting periods commencing on or after 1 January 2019. The new standard supersedes IAS 17. A single model for lessees will be required, changing the accounting for operating leases. Related lease assets and liabilities will, therefore, be presented in the Statement of Financial Position and the presentation and timing of income and expense recognition in the Statement of Comprehensive Net Expenditure will change. PHE currently has operating lease commitments of £14,975,000 which IFRS 16 requires to be recognised on the Statement of Financial Position as right of use assets with corresponding lease liabilities. Any potential adaption for the public sector of IFRS 16 is still under review by HM Treasury. As a result, beyond the information above, it is not yet practicable for PHE to provide a reasonable estimate of the effect of IFRS 16.

The following standards have no impact on PHE:

- IFRS 17 Insurance Contracts
- IFRIC 22 Foreign Currency Transactions and Advance Consideration
- IFRIC 23 Uncertainty over Income Tax Treatments

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 fair value of stockpiled goods and inventory as referred to in note 1.9 and 1.15 respectively.

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 vaccine and countermeasures response (VCR).
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.

	2017/18				2016/17			
	Operational activities	**Public health grants**	**Vaccine and Counter-measure Response**	**Total**	**Operational activities**	**Public health grants**	**Vaccine and Counter-measure Response**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Gross expenditure	555,714	3,090,533	504,034	**4,150,281**	564,193	3,387,958	556,723	**4,508,874**
Income	(173,865)	-	(72,759)	**(246,624)**	(163,536)	-	(72,692)	**(236,228)**
Net operating cost	**381,849**	**3,090,533**	**431,275**	**3,903,657**	**400,657**	**3,387,958**	**484,031**	**4,272,646**

Description of segments

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 and Countermeasure Response

The VCR programme represents the costs of maintaining stockpiled goods held for use in national emergencies. VCR income includes vaccine income included in note 5.

3 Staff costs

	2017/18			2016/17		
	Permanently employed staff £000	**Other staff £000**	**Total £000**	**Permanently employed staff £000**	**Other staff £000**	**Total £000**
Wages and salaries	220,162	17,702	237,864	218,200	19,262	237,462
Social security costs	24,221	-	24,221	23,932	-	23,932
Apprenticeship Levy	1,126	-	1,126	-	-	-
Other pension costs	40,072	-	40,072	39,557	-	39,557
Subtotal	**285,581**	**17,702**	**303,283**	**281,689**	**19,262**	**300,951**
Redundancy and other department costs	1,182	-	1,182	6,869	-	6,869
Less recoveries in respect of outward secondments	(3,612)	-	(3,612)	(3,631)	-	(3,631)
Less recoveries in respect of staff engaged on capital projects	(2,259)	-	(2,259)	(2,302)	-	(2,302)
Total net costs	**280,892**	**17,702**	**298,594**	**282,625**	**19,262**	**301,887**

Further information on staff costs can be found in the Remuneration and Staff Report (pages 105 to 121)

4 Other expenditure

Purchase of goods and services	2017/18 £000	2016/17 £000
Accommodation	31,700	26,656
Auditor remuneration	4	4
Education, training and conferences	3,428	2,731
Hospitality	83	47
Insurance	267	59
Inventories written down	1,434	2,217
Inventories consumed	398,545	451,674
Laboratory consumables and services	40,707	40,161
Legal fees	1,235	1,377
Rentals under operating leases	10,746	11,838
Research & Development	592	653
Supplies and services	184,417	155,215
Travel and subsistence	9,116	9,043
Non-cash items:		
Auditor remuneration	194	194
Total purchase of goods and services	**682,468**	**701,869**
Other operating expenditure		
Bank charges	49	43
European Union grant expenditure	1,576	886
Foreign exchange (gains) / losses	(41)	(132)
Public Health grants	3,090,533	3,387,958
Voluntary sector grants	(3)	34
Capital grants	866	10,880
(Profit) / loss on de-recognition of property, plant and equipment and intangible assets	38,481	69,722
Total other operating expenditure	**3,131,461**	**3,469,391**
Depreciation and impairment charges		
Non-cash items:		
Charge of provision for impairments	798	248
Depreciation	26,611	27,904
Amortisation	4,926	4,635
Impairment	3,094	-
Total depreciation and impairment charges	**35,429**	**32,787**
Provision expense		
Provision provided for / (released) in year	2,329	2,940
Total provision expenses	**2,329**	**2,940**
Total	**3,851,687**	**4,206,987**

During the year, PHE did not purchase any 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 (2017: £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 16.

5 Income

	2017/18			2016/17		
	Admin £000	Programme £000	Total £000	Admin £000	Programme £000	Total £000
Sale of goods and services						
Laboratory and other services	1,213	82,746	83,959	378	80,946	81,324
Products and royalties	133	34,412	34,545	18	30,860	30,878
Education and training	341	1,652	1,993	290	1,592	1,882
Vaccines income	-	72,501	72,501	-	72,380	72,380
Total sale of goods and services	**1,687**	**191,311**	**192,998**	**686**	**185,778**	**186,464**
Other income						
Research and related contracts and grants	373	10,720	11,093	338	10,078	10,416
Grants from the United Kingdom government	552	4,955	5,507	190	5,751	5,941
Grants from the European Union	149	3,221	3,370	66	4,326	4,392
Rental from investment property	-	8,858	8,858	-	8,500	8,500
Other operating income	1,799	12,142	13,941	2,597	11,664	14,261
Total other operating income	**2,873**	**39,896**	**42,769**	**3,191**	**40,319**	**43,510**
Finance income						
Interest receivable	-	407	407	2	407	409
Income from dividends	-	10,450	10,450	-	5,845	5,845
Total finance income	**-**	**10,857**	**10,857**	**2**	**6,252**	**6,254**
Income Total	**4,560**	**242,064**	**246,624**	**3,879**	**232,349**	**236,228**

The dividend received was from Porton Biopharma Ltd.
Vaccines income is included in VCR income in note 2

6 Property, plant and equipment

	Land	Buildings	Fixtures and fittings	Plant, equipment and transport equipment	Information technology	Stockpiled Goods	Assets under construction (AUC)	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost								
At 1 April 2017	28,050	148,083	3,817	79,233	44,319	627,735	39,282	970,519
Reclassification of assets	(400)	(4,343)	-	469	-	(805)	-	(5,079)
Transfer to inventory	-	-	-	-	-	(146)	-	(146)
Impairment	(500)	(352)	-	-	-	-	(1,616)	(2,468)
Additions	16,736	-	-	113	-	24,717	53,080	94,646
Transfer of AUC	-	8,230	17	7,882	669	-	(16,798)	-
Elimination of accumulated depreciation	-	(46,517)	-	-	-	-	-	(46,517)
Revaluations	4,739	43,221	40	798	-	(20,147)	1,715	30,366
De-recognition	-	-	(791)	(4,041)	(1,051)	(38,011)	-	(43,894)
At 31 March 2018	**48,625**	**148,322**	**3,083**	**84,454**	**43,937**	**593,343**	**75,663**	**997,427**
Depreciation								
At 1 April 2017	-	35,241	1,841	51,821	38,358	-	-	127,261
Reclassification of assets	-	(51)	-	182	-	-	-	131
Charge for year	-	16,245	317	7,291	2,758	-	-	26,611
Revaluations	-	-	19	541	-	-	-	560
Elimination of accumulated depreciation	-	(46,517)	-	-	-	-	-	(46,517)
De-recognition	-	-	(791)	(3,578)	(1,047)	-	-	(5,416)
At 31 March 2018	-	4,918	1,386	56,257	40,069	-	-	102,630
Carrying value								
At 31 March 2018	**48,625**	**143,404**	**1,697**	**28,197**	**3,868**	**593,343**	**75,663**	**894,797**
At 31 March 2017	28,050	112,842	1,976	27,412	5,961	627,735	39,282	843,258
Asset financing								
Owned	**48,625**	**143,404**	**1,697**	**28,197**	**3,868**	**593,343**	**75,663**	**894,797**

Reclassification of assets

As part of the professional valuation, several assets totalling £3,384,000 were identified as being held as buildings but which did, in fact, constitute investment assets leased to Porton Biopharma Ltd (see note 8). These assets were reclassified with effect from 1 April 2017. In addition, buildings valued at £1,300,000 at PHE's Bristol site were reclassified as an asset held for sale under IFRS 5. Furthermore, an adjustment has been made to the classification of cost and depreciation on certain classes of plant and equipment to correct historical inaccuracies in the split. Depreciation charges against revenue have been correct in all intervening years.

Valuation of assets

A professional valuation of land and building was carried out on 31 March 2018 by the Valuation Office Agency (an independent body) in accordance with the professional standards of the Royal Institution of Chartered Surveyors. This valuation last took place on 31 March 2013. This resulted in a valuation surplus on assets classified as land and buildings of £47,960,000, of investment property (note 8) of £3,930,000 and of assets held for sale (note 9) of £279,000.

	Land	Buildings	Fixtures and fittings	Plant, equipment and transport equipment	Information technology	Stockpiled Goods	Assets under construction (AUC)	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost								
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	1,772	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 it was, in fact, investment property in respect of the buildings leased to Porton Biopharma Ltd.

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.

7 Intangible assets

	Software and software licences £000	Website £000	Assets Under Construction £000	Total £000
Cost or valuation				
At 1 April 2017	29,459	3,729	5,373	38,561
Transfer from AUC	1,331	-	(1,331)	-
Additions	-	-	4,613	4,613
De-recognition	(520)	-	-	(520)
At 31 March 2018	**30,270**	**3,729**	**8,655**	**42,654**
Amortisation				
At 1 April 2017	19,095	3,015	-	22,110
Charge for year	4,686	240	-	4,926
De-recognition	(517)	-	-	(517)
At 31 March 2018	**23,264**	**3,255**	**-**	**26,519**
Carrying value				
At 31 March 2018	7,006	474	8,655	16,135
At 31 March 2017	10,364	714	5,373	16,451
Asset financing				
Owned	7,006	474	8,655	16,135

	Software and software licences £000	Website £000	Assets Under Construction £000	Total £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)	-
Impairment	-	-	-	-
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

8 Investment property

	Notes	2017/18	2016/17
		£000	£000
Buildings leased to Porton Biopharma Ltd			
Opening Balance		9,353	9,344
Reclassification of assets		3,384	9
Impairment	11	(626)	-
Revaluation		3,930	-
Closing Balance		**16,041**	**9,353**

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.

The reclassification of Investment Property is referred to in note 6. A professional valuation was carried out as at 31 March 2018 as detailed in note 6.

9 Asset Held For Sale

	2017/18	2016/17
	£000	£000
Myrtle Road, Bristol		
Opening Balance	-	-
Reclassification of assets from property, plant and equipment	1,021	-
Revaluation	279	-
Closing Balance	**1,300**	**-**

The reclassification of Asset Held for Sale is referred to in note 6. A professional valuation was carried out as at 31 March 2018 as detailed in note 6.

10 Financial instruments

Due to the largely non-trading nature of its activities, and the way in which it is financed, PHE is not exposed to the degree of financial risk faced by most other business entities. PHE has no authority to borrow or to invest without the prior approval of the Department of Health and Social Care 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 13) 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 2018, PHE received Euro income equivalent to £4,723,000 (2016/17: £6,642,000) and US Dollar income equivalent to £3,754,000 (2016/17: £3,893,000) upon which there was some currency risk.

The only other currency risk is that of a Euro currency bank balance valued at £503,000 (2016/17: £473,000) and a US Dollar bank balance valued at £225,000 (2016/17: £510,000).

11 Impairment

	2017/18			2016/17		
	Charged to statement of comprehensive net expenditure £000	**Charged to revaluation reserve £000**	**Total**	**Charged to statement of comprehensive net expenditure £000**	**Charged to revaluation reserve £000**	**Total**
Property, plant and equipment	2,468	-	2,468	-	-	-
Investment Property	626	-	626	-	-	-
Total	**3,094**	**-**	**3,094**	-	-	-

12 Inventories

	Pandemic Flu and Pre Pandemic Flu £000	Emergency Preparedness £000	Vaccines £000	Consumables £000	Total £000
Balance at 1 April 2017	-	-	140,709	4,134	**144,843**
Additions	-	-	411,380	4,967	**416,347**
Transferred from stockpiled goods	4	142	-	-	**146**
Consumed/Disposed of	(4)	(142)	(393,754)	(4,645)	**(398,545)**
Written Down	-	-	(1,434)	-	**(1,434)**
Revaluation	-	-	-	(9)	**(9)**
Balance at 31 March 2018	**-**	**-**	**156,901**	**4,447**	**161,348**

	Pandemic Flu and Pre Pandemic Flu £000	Emergency Preparedness £000	Vaccines £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**

13 Trade receivables, financial and other assets

	2017/18	2016/17
	£000	£000
Trade and other receivables (amounts falling due within one year)		
Accrued income	19,255	21,050
Other receivables	23,299	28,050
Prepayments	5,427	3,008
Taxation	3,119	1,596
Trade receivables	11,668	14,098
	62,768	**67,802**
Financial assets		
Investments	58,976	46,384
Loan	6,789	10,184
	65,765	**56,568**
Other non current assets (amounts falling due after more than one year)		
Advances to UKAEA combined pensions scheme	52	52
Leasehold premium prepayment	20	20
	72	**72**

Investments

On 1 April 2015, the Secretary of State for Health and Social Care acquired a 100% shareholding in Porton Biopharma Limited. The initial investment was agreed as £20 million of equity shares and a £10.2 million debt, repayable over 5 years at an interest rate of 4% with capital repayments deferred for 2 years. During 2017/18, a further £12,592,000 (2016/17: £26,384,000) has been invested by PHE and repayment of the loan has commenced as agreed.

PHE also inherited a 3.1% interest in Spectrum from the Health Protection Agency; 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.

14 Cash and cash equivalents

	2017/18	2016/17
	£000	£000
Balance at 1 April	92,970	82,576
Net change in cash and cash equivalents	10,888	10,394
Balance at 31 March	**103,858**	**92,970**
The following balances at 31 March were held at:		
Government Banking Service	103,858	91,854
Commercial banks and cash in hand	-	1,116
Balance at 31 March	**103,858**	**92,970**

15 Trade payables and other current liabilities

	2017/18	2016/17
	£000	£000
Amounts falling due within one year		
Accruals	107,425	95,179
Deferred income	9,507	14,757
EU grant income held on behalf of third parties	-	242
Other payables	3,249	4,264
Trade payables	16,848	20,661
	137,029	**135,103**

16 Provisions

	Taxation	Future costs of early retirement	Property	High activity sealed radiation sources	Redundancy	Contractual entitlement claims	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2017	-	875	2,309	485	-	14,000	**17,669**
Provided in the year	772	-	663	10	625	639	**2,709**
Provisions not required written back	-	-	(380)	-	-	-	**(380)**
Provisions utilised in the year	-	(78)	(57)	-	-	(39)	**(174)**
Balance at 31 March 2018	**772**	**797**	**2,535**	**495**	**625**	**14,600**	**19,824**
Analysis of timing of discounted cashflows							
Current							
Not later than one year	772	78	1,560	210	625	14,600	**17,845**
Total	**772**	**78**	**1,560**	**210**	**625**	**14,600**	**17,845**
Non-current							
Later than one year and not later than five years	-	312	792	232	-	-	**1,336**
Later than five years	-	407	183	53	-	-	**643**
Total	**-**	**719**	**975**	**285**	**-**	**-**	**1,979**
Balance at 31 March 2018	**772**	**797**	**2,535**	**495**	**625**	**14,600**	**19,824**

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.

Property (previously leasehold dilapidations)

This provision is for the estimated costs of rectifying small issues following a relocation within PHE and the 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.

Redundancy

This is a provision for staff who have been identified as being at risk of redundancy during 2017/18 (and are anticipated to leave the employment of PHE during 2018/19) but for whom formal notice has not yet been served.

Taxation

During a recent audit, HMRC identified areas in which PHE may not have charged VAT correctly on services provided. PHE is currently awaiting the outcome of this audit and this provision represents the estimated underpaid VAT.

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.

Contractual entitlements

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

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. The increase in year is an increase to the estimate of the cost of these claims.

	Future costs of early retirement	Property	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
Total	**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
Total	**782**	**559**	**485**	**-**	**-**	**-**	**1,826**
Balance at 31 March 2017	**875**	**2,309**	**485**	**-**	**-**	**14,000**	**17,669**

17 Capital commitments

	2017/18 £000	2016/17 £000
Contracted capital commitments at 31 March not otherwise included in these accounts		
Property, plant and equipment	44,094	25,337
Intangible assets	949	783
Total	45,043	26,120

These commitments relate to contractual amounts payable on capital projects.

18 Commitments under leases

Obligations under operating leases for the following periods comprise:	2017/18 £000				2016/17 £000			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Not later than one year	-	4,101	474	4,575	-	4,204	204	4,408
Later than one year and not later than five years	-	8,716	806	9,522	-	11,045	193	11,238
Later than five years	-	878	-	878	-	1,272	-	1,272
	-	**13,695**	**1,280**	**14,975**	**-**	**16,521**	**397**	**16,918**

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

Other leases include leases 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.

19 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.

	2017/18	2016/17
	£000	£000
Not later than one year	326,230	412,748
Later than one year and not later than five years	254,823	160,557
Later than five years	-	-
Total value of obligations	**581,053**	**573,305**

The majority of these commitments relate to the purchase, storage and distribution of stockpiled goods. Contracts are typically arranged for more than 1 year.

20 Related party transactions

PHE is an executive agency of the Department of Health and Social Care, which is regarded as a related party. During the year, PHE has had various material transactions with DHSC itself and with other entities for which DHSC is regarded as the parent entity. These include NHS bodies including 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 include the Home Office, the 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 2018, 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.

Current year figures are shown in bold, prior year figures are shown in italics

Further information on compensation paid to management can be found in the Staff and remuneration report.

Related party	1. Name of the PHE Board Member or senior manager 2. PHE Appointment 3. 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
Food Standards Agency	1. Rosie Glazebrook 2. Non-executive PHE Board Member 3. Non-executive Board Member	1,587 (2016/17: 1,669)	- (2016/17: -)	- (2016/17: -)	900 (2016/17: 716)
Porton Biopharma Ltd*	1. Michael Brodie 2. Finance and Commercial Director 3. Non Executive Director	23,830 (2016/17: 31,534)	- (2016/17: -)	- (2016/17:76)	6,850 (2016/17: 9,045)
	1. Martin Hindle 2. Independent member of the Audit and Risk Committee and PHE Science Hub Programme Board 3. Chairman				
	1. Richard Gleave 2. Chief Operating Officer 3. Non Executive Director				

*This excludes investment in and loan to Porton Biopharma Ltd referred to in note 13.

21 Third party assets

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

	2017/18	2016/17
	£000	£000
Buildings	2,149	2,149
Plant and equipment	1,992	1,992
Total	**4,141**	**4,141**

22 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. These financial statements were authorised for issue by the Accounting Officer on the date they were certified by the C&AG.

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